S. HRG. 104-794

MEDICAID "1115" WAIVERS

HEARING

BEFORE THE

SUBCOMMITTEE ON MEDICAID AND HEALTH CARE FOR LOW-INCOME FAMILIES

OF THE

COMMITTEE ON FINANCE — UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

FIRST SESSION

MARCH 23, 1995

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

23-091 CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-054230-8

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MEDICAID "1115" WAIVERS

THURSDAY, MARCH 23, 1995

U.S. SENATE,
SUBCOMMITTEE ON MEDICAID AND HEALTH CARE
FOR LOW-INCOME FAMILIES,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:05 p.m., in room SD–215, Dirksen Senate Office Building, Hon. John H. Chafee (chairman of the subcommittee) presiding.

Also present: Senators Rockefeller, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND, CHAIRMAN OF THE SUBCOMMITTEE

Senator CHAFEE. All right, ladies and gentlemen, the hearing this afternoon is on Medicaid 1115 waivers.

Over the past 2 years, we have seen a dramatic increase in the number of States seeking Statewide demonstration waivers under the Medicaid program.

The Department of Health and Human Services has approved 8 of these waivers to date. I understand the Department currently has before it 10 additional applications, and that even more will be coming this year.

Medicaid waivers give States additional flexibility in administering an exceedingly complicated program. As both Senator Rockefeller and I are former Governors, we are naturally sympathetic to the Governors' need for additional flexibility.

I believe, however, we should proceed cautiously. I am hopeful that this and future hearings will prove useful to the Members of this Committee—meaning not only this subcommittee, but the full Finance Committee—as we begin to explore proposals to give States even greater flexibility in administering the Medicaid program.

Now there have been lots of success stories under these waivers. And States such as Arizona, which has had a decade of experience operating its program under an 1115 waiver, have enjoyed high quality of care, consumer satisfaction, and a relatively slow rate of growth in program costs, when compared to other States. We are also beginning to get positive reports from Oregon.

Conversely, we have heard reports of problems in States such as Tennessee under the 1115 waiver, and Florida under a 1915 waiver.

There have been reports of inadequate funding, inadequate access to services, and reports of insolvency of the health plans. I understand that many of these problems were related to initial implementation of the programs. The administration is working closely with these States, as I understand it, to correct these problems.

So I hope we will be able to discuss these problems, not with any sense of castigating the States, but just trying to learn from the mistakes, and avoid making them in the future.

We have a distinguished panel of witnesses who will provide insight into the successes and failures and, hopefully, present suggestions on how we ought to move to improve the process. So I look forward to their testimony.

I am glad to have the very distinguished Junior Senator from West Virginia here, a former Governor, and one who is very familiar with and long interested in these issues.

Governor Rockefeller.

Senator ROCKEFELLER. I am speechless.

Senator CHAFEE. He is caught speechless by such an introduction.

All right. On this first panel is Sally K. Richardson, Director of the Medicaid Bureau at HCFA and William Scanlon, Associate Director of the Health Financing Issues, General Accounting Office.

So, Ms. Richardson, we are delighted that you are here. Please proceed.

STATEMENT OF SALLY K. RICHARDSON, DIRECTOR, MEDICAID BUREAU, ACCOMPANIED BY KATHY BUTO, ASSOCIATE ADMINISTRATOR FOR POLICY, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Ms. RICHARDSON. Thank you, Mr. Chairman, members of the subcommittee.

We appreciate the opportunity to be here today, and talk to you about health care reform demonstrations under Medicaid waivers.

For about a decade, Medicaid laws included program waivers, which allow States to enroll Medicaid beneficiaries in managed care systems, and to cover home and community-based care as an alternative to institutionalization.

These so-called 1915 waivers permit States to make meaningful changes to their Medicaid programs, but they do not provide the States the opportunity to pursue more innovative approaches.

So the demonstration waiver authority under section 1115 of the Social Security Act has become very prominent with States because it gives them the flexibility to test new strategies for organizing, financing and delivering health care services to low-income populations. Through these programs, States can test the effectiveness and efficiency of their new ideas.

As you pointed out, Arizona operated the only Statewide Medicaid demonstration prior to 1993. Since 1993, HCFA has approved Statewide health care reform demonstrations in 7 more States: Oregon, Hawaii, Tennessee, Rhode Island, Kentucky, Florida and Ohio. And we have also approved South Carolina's program framework, and are working with the State to build system infrastructure, and be able to award the waivers.

Tennessee, Oregon, Rhode Island and Hawaii implemented their programs during 1994. And, as a direct result of these demonstrations, an additional 550,000 low-income Americans now have health care coverage. This figure should reach 655,000 when these programs are fully phased in. And once Kentucky, Florida and Ohio obtain authorizing legislation, and begin enrollment, approximately 1.6 million more individuals could be covered.

There are, as you say, more States to follow. We do have 10 additional demonstration proposals, and we do anticipate additional ones that we have not yet received.

Senator CHAFEE. Just one question here. As I understand it, the reason you are giving additional coverage is because the savings that the States make, under the rules you have, have to go to expand coverage. Am I correct in that?

Ms. RICHARDSON. That is right. In States where we have additional coverage, they have proposed that they use their savings from the waivers to extend coverage to low-income populations.

Senator CHAFEE. But they have to do it, as I understand the ground rules. Is that correct? If State A gets a waiver, and makes savings through managed care, do they not have to use those savings to expand coverage?

Ms. RICHARDSON. That is not a requirement of the waivers, no.

Senator CHAFEE. Well, if they wanted to, could they pocket it?

Ms. RICHARDSON. No.

Senator CHAFEE. I do not want to beat this to death, but I thought the ground rules were that savings had to be plowed back into the program, but apparently they are not. And I suppose it could be increased benefits, rather than increased coverage.

Ms. RICHARDSON. It could be increased benefits. We only match the actual dollars that the State expends. So, basically, it is done on a matching basis. If the money is not expended, we do not match it.

They could use it for additional benefits, but it is not a requirement that they expand coverage. Many of them under consideration right now are using these programs to allow them to maintain coverage, and not have to reduce services.

They are also using these demonstrations to look at more innovative ways to manage their care, and more innovative ways to basically reshape their delivery systems. They hope that, with these managed care systems, they can improve current delivery systems and thus enhance primary and preventive care for the Medicaid population.

They have largely focused on managing acute care services for low-income women and children and, in some cases, the aged and disabled.

They also want to pursue other kinds of concepts. Some of them have proposed innovative approaches to quality assurance and beneficiary access and protections. And we are committed to encouraging more ideas and flexibility within the Medicaid program, as we work through this program in partnership with the States.

We have sought to fulfill this commitment beginning with our work with the National Governors Association, and the efforts we are putting in to streamline the process and work day-to-day with

the States from concept development all the way through their implementation.

We want the States to refine and strengthen various kinds of program elements that are of high priority to the Medicaid program. These elements include things like protection for current beneficiaries, quality improvement systems, access guarantees, innovative program design and program feasibility through infrastructure and systems.

And we ensure that States solicit and consider public input when designing their demonstration programs.

In addition, we ensure budget neutrality. The Federal Government and the State agree in advance to the amount of Federal financial participation available to the State during this demonstration period. As a matter of fact, we have found that agreeing on this particular projection is often the most difficult and time-consuming part of the approval process.

Finally, we work with the States to make sure that the day-to-day implementation and long-term outcomes of each of these programs can be adequately monitored and evaluated.

We are already learning things about the program, and have seen strengthening of the State delivery systems because of these waivers. They have expanded health care coverage for low-income Americans and they are developing new strategies for measuring and monitoring quality of care.

Each State that has come in has used a different strategy to realize their goals. For example, in Rhode Island, they are enrolling 31,000 AFDC recipients, and pregnant women and young children, with incomes to 250 percent of the Federal poverty level in their RIteCare program. They are also demonstrating that their emphasis on primary and preventive services will improve access and enhance the enrollees' health status.

Rhode Island also bolstered its commitment to primary care by contracting in this demonstration with the health plan established by the Federally-qualified health centers in the State.

Rhode Island has proposed a second demonstration, the CHOICES program, which will consolidate State and Federal funding sources for adults with developmental disabilities, into a single managed care delivery system. I thought you might like to know, Senator, that we notified the State today that we will be awarding them a planning grant to assist the State in their program development efforts for the CHOICE waiver.

An approved, but not yet implemented, demonstration is the Florida Health Security System, which is testing the ability of a voluntary employer-based program to provide access to health insurance for uninsured individuals and families.

This will bring in under this demonstration approximately 1.1 million Floridians with incomes below 250 percent of the poverty level, who would not otherwise be eligible.

Other indications of recent accomplishments include a client satisfaction survey in Tennessee's TennCare program, where 8 out of 10 participants are pleased with the care they are getting. And Oregon's success in implementing a very complicated combination of program expansion, a move to capitated managed care, and use of

a priority list of services that were defined in the Medicaid benefit package.

We have learned a lot from this partnership with the States. We have learned how important early dialogue, technical assistance, monitoring and a well-thought-out plan of implementation can be to the ultimate success of the demonstration.

And we have also learned that HCFA has to adapt its entire processes to respond to these innovations in this rapidly changing world of State health care reforms.

We really welcome State efforts to test innovations and improve the Medicaid program. And we are committed to using section 1115 waivers to strengthen Medicaid.

We will work with States to develop demonstrations that mirror goals of protecting current beneficiaries and future enrollees, of establishing innovative approaches and testing workable new program designs.

We believe that these efforts will help us point the way to new directions for the Medicaid programs.

Thank you, Mr. Chairman. I will be pleased to answer your questions. Should they get me in over my head, Kathy Buto, who is responsible for the Office of Research and Demonstrations (ORD) in HCFA, is here to back me up.

Senator CHAFEE. Thank you very much.

What we will do is hear from each of the panelists. And then we will ask our questions.

So, Dr. Scanlon, please go ahead.

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

STATEMENT OF WILLIAM SCANLON, Ph.D., ASSOCIATE DIRECTOR, HEALTH FINANCING ISSUES, GENERAL ACCOUNTING OFFICE, WASHINGTON, DC; ACCOMPANIED BY CHERYL A. WILLIAMS, SENIOR EVALUATOR, GENERAL ACCOUNTING OFFICE, SEATTLE REGION, PORTLAND, OR

Dr. SCANLON. Thank you, Mr. Chairman and members of the subcommittee.

We are very pleased to be here today, as the subcommittee begins its review of section 1115 Statewide Medicaid waivers.

I would like to introduce to you my colleague, Cheryl Williams, who is also from the health financing area at GAO.

As you and Ms. Richardson have indicated, considerable interest in these waivers exists, as more than half the States have sought, or are considering seeking, such a waiver.

However, except for Arizona, only 4 of these States have actually implemented their waivers, and each of these has less than 15 months of operational experience.

The disparity between interest in obtaining and ability to operate under a waiver highlights an important aspect of the 1115 phenomenon. That is, implementing these enormously complex, and often controversial, demonstrations involves overcoming potential barriers at both the Federal and State levels.

As more States seek Federal approval of an 1115 waiver, the time it takes to approve a waiver appears to have lengthened. The slowdown seems to be attributable to both the controversy sur-

rounding some of the implemented demonstrations and the increasing number of requested waivers, which presumably has tested HCFA's review capacity.

It is also clear that HCFA approval of a waiver is only an intermediate step to a State's program implementation because consensus on the waiver design begins at the State level.

Both Florida and Kentucky have had Federal approval, but have not received the go-ahead from their legislatures.

A common feature of the Statewide section 1115 waivers being sought is the use of mandatory enrollment of large segments of the State's Medicaid populations into capitated managed care arrangements.

In moving into managed care, States face significant challenges in shifting their program focus away from a traditional fee-for-service system.

Our work over the years on the Medicaid program and States' experience with managed care indicates that the emphasis that States place on program planning and implementation, and program oversight, may significantly affect how successful they are in using managed care to contain costs and increase access to quality health care.

Planning and implementing a program more slowly allows time to build the consensus and infrastructure to avoid many start-up problems. Having appropriate safeguard and oversight mechanisms helps to assure that beneficiaries are receiving sufficient care of acceptable quality.

Financial incentives to underserve are inherent in managed care, and may lead to problems. Large private-sector employers have recognized the importance of oversight, and are demanding strong quality assurance systems in health plans throughout the country. For the vulnerable Medicaid populations, no less should be expected.

Effective State oversight of managed care requires good data collection efforts and information systems to assess beneficiaries' experiences in accessing services. It also requires continued monitoring of health plan solvency and allocation of revenues to ensure that financial pressures do not compromise care, and that program dollars are used primarily for health services, and not for excessive management and administrative expenses.

The experiences of two States, Oregon and Tennessee, help illustrate how investments in planning and implementation, and oversight, appear to influence the degree to which States realize their program objectives.

Thus far, Oregon's managed care program appears successful. The State had operated a partially capitated program since 1985, and began its current 1115 waiver more than 5 years ago. State planners held numerous community meetings to try to build a consensus about the new program with key stakeholders.

The State also applied many lessons from the implementation of their first program to smooth the implementation of its more recent, much larger program.

Oregon has also implemented an array of safeguards designed to insure access and quality. It required plans to limit the financial pressure felt by any one provider to guard against underservice.

In addition, the State adopted an extensive quality assurance program, including annual independent reviews of medical records, client satisfaction surveys, and disenrollment surveys.

In contrast to Oregon, the TennCare program has encountered a number of difficulties, resulting in part from its rapid implementation. Prior to the start-up of its managed care program last year, Tennessee had almost no experience with managed care in its Medicaid program. Nevertheless, the State moved quickly, and began operating its Statewide managed care program less than 9 months after announcing the plan.

This quick transition created a number of problems. First, providers have generally been critical of the State for not being included in the planning and development of the program. Beneficiary advocates, in contrast, were a part of the planning process, and have generally been supportive of the program.

The quick implementation also affected the participating health plans. Their information systems had not been fully developed beforehand, and significant delays occurred before many bills were paid.

Delays also occurred in health plans' provision of data on service use to the State, data that are important to be able to assess the quality of care provided. Only recently have such data been available, and begun to be analyzed.

Tennessee did adopt an extensive quality assurance program, similar to Oregon's, including client satisfaction surveys, a hot line, and grievance procedures. It remains critical, however, that the quality assurance program is operated in an effective manner over time.

In conclusion, I would like to note that the widespread State interest in 1115 waivers foreshadows a potential major shift in the Medicaid program.

The mandatory enrollment of the bulk of the Medicaid population in managed care may become much more the norm, rather than the exception.

Our work suggests that adequate planning and implementation, and adequate oversight mechanisms, will help insure that this transformation results in access to quality care for the large populations involved.

Mr. Chairman, this concludes our prepared statement. We would be happy to answer any questions you or Members of the subcommittee may have.

[The prepared statement of Dr. Scanlon appears in the appendix.]

Senator CHAFEE. Well, thank you very much, Dr. Scanlon.

We have been joined by a distinguished former Governor. And, if you have any statement, Senator Graham, now is a good time,

Senator GRAHAM. Thank you, Mr. Chairman. I appreciate your calling this first of what I gather will be a series of hearings on Medicaid.

I do not have an opening statement, other than to say that I am very interested in the issues that are being raised here this afternoon.

My State is one of those which has been in the process for over a decade of attempting to secure a waiver in order to move forward

with a managed care system, and to extend coverage to the working poor.

I will be particularly interested in the assessment of how those States which have been successful in implementing such a system have performed.

Senator CHAFEE. Thank you, Senator.

Now I am giving each of you a little chart that outlines the program as I see it. If I am mistaken, feel free to let me know.

In your base program, you deal with eligibility, benefits, payments to providers, and fee for service. Then you go for a 1915(b) waiver, which is all the same, except that the States may use managed care. Am I on target, Ms. Richardson?

Ms. RICHARDSON. Mostly on target. I would say that, under a 1915(b) waiver, we deal with the payments to plans, but not necessarily to providers, unless it is a managed care program that is what we call a primary care case management waiver.

Senator CHAFEE. Well, all right. Let us go on to the 1115, and there you give the States much greater flexibility. They can expand eligibility, as has been pointed out here, some of the States have done—I guess Oregon.

There is flexibility in benefits; there is flexibility in payments; and the States may use managed care.

Can you explain the difference between the obtaining of a 1915(b) waiver and an 1115? What is the difference?

Ms. RICHARDSON. Yes, sir. The 1915(b) waiver has been in operation since the early 1980's. And the requirements for 1915 are written into law. The application process has been underway, and has been pretty well understood, for a long time.

Basically, we have an agreement with the States—and it may be part of our regulations—that we will process these waivers in 90 days. They have much more limited flexibilities. While they can target populations, and they can target geographic areas, they cannot change eligibility, or the level of benefits.

As you said in your chart, they may use managed care as a principle, but they must maintain choice, either among plans or, in a primary care case management system, among gatekeepers.

And we have a great deal more experience in this area than we do in the newer 1115 demonstrations.

Senator CHAFEE. But a State that wants a 1915(b) waiver can get one pretty quickly, can it?

Ms. RICHARDSON. Yes, sir.

Senator CHAFEE. It would seem to me that they might go that way. I notice the problems that have arisen, say in Tennessee, with inexperience in dealing with managed care.

Why do they not take a two-step process, just out of curiosity, go 1915(b) and then go into the managed care, which I think, as Dr. Scanlon mentioned, is what they are all trying to get anyway?

Ms. RICHARDSON. There are some limitations with the 1915(b) waiver that States have found frustrating. One of those limitations is that a managed care plan under a 1915(b) waiver must contain no more than 75 percent Medicaid enrollees, and at least 25 percent of the enrollees in the waiver must be non-Medicaid beneficiaries.

Senator CHAFEE. In a plan?

Ms. RICHARDSON. In a plan.

Senator CHAFEE. Now that is not on the 1115? You do not have that?

Ms. RICHARDSON. No.

In addition to that, all of the regular eligibility rules apply in a 1915(b), so there is no opportunity to lock beneficiaries into a managed care plan for any substantial length of time. And that is a difficulty that managed care plans perceive. They cannot deviate at all from the traditional Medicaid package. Some of them basically would like to do deviations. So it is a much more limiting circumstance.

On the other hand, we have States like California that have proposed a major 1915(b) waiver. They have had experience with 1915(b) waivers, and they like that system for their beneficiaries. And that waiver has been proposed, and is currently under review.

Senator CHAFEE. When you talk about flexibility in benefits, what does that mean?

Ms. RICHARDSON. Flexibility in the way the delivery system is constructed and delivers benefits is primarily what we mean.

The only time we have given an 1115 waiver that does not require the State to provide the same benefits under the waiver as they would have provided without the waiver, is the Oregon waiver.

Over a long period of time, and a great deal of public input, the State made some community decisions about the kinds of benefits, or the priority of benefits, that they believed should be available, not only under their Medicaid program, but under all insurance programs in the State.

Senator CHAFEE. I was wondering about that. But if you give out a 1115 waiver to Florida or Rhode Island, that does not include the flexibility in benefits? That is, in all cases except in Oregon?

Ms. RICHARDSON. We have not allowed that.

Senator CHAFEE. In other words, you have the benefit package that goes with Medicaid, and they have to provide that?

Ms. RICHARDSON. That is right.

Senator CHAFEE. Now all these waivers, as I understand it, have to budget-neutral. In other words, it is not going to cost the Federal Government any more and it has to expand on Medicaid. How do you calculate the derivative growth in Medicaid for those States that have the 1115 waiver?

For instance, what do you do about the DSH payments, the disproportionate share payments?

Ms. RICHARDSON. Well, basically, DSH is calculated on an aggregate basis, and it is projected at the national trend for DSH.

Senator CHAFEE. Do you have a figure? Do you have a national trend for the disproportionate share payments?

Ms. RICHARDSON. I do not have it with me today.

Senator CHAFEE. I am not asking for it, but is there such a thing?

Ms. RICHARDSON. Yes, there is such a figure.

Senator CHAFEE. Oh, I see. So in a State that has a very high disproportionate share payment, you would calculate the rate growth of their regular Medicaid, and then a separate figure for the disproportionate share?

Ms. RICHARDSON. Yes, DSH is calculated separately.

The rate of growth in the program itself can be calculated two different ways, either on a per-capita basis or on an aggregate basis. There are actually only two States where we have calculated it on an aggregate basis—Tennessee and Florida.

But it is a question of determining the base. And we try to get that base as close to the start of the program as possible, so we have truly accurate figures for expenditures. And then we agree on what trend factors best represent what the growth in that program would be. And, of course, those trend factors vary by what populations are being included, so it gets fairly complex. But we have set up a special working group on this so that we can start working with the State on this budget neutrality issue almost from the very beginning.

Senator CHAFEE. All right.

Senator Moseley-Braun, we are glad you are here. Do you have a statement you would like to fit in quickly?

Senator MOSELEY-BRAUN. I do have a statement for the record, Mr. Chairman. But I would just as soon continue with questions.

Senator CHAFEE. That is fine. All right. We will take that for the record.

[The prepared statement of Senator Moseley-Braun appears in the appendix.]

Senator CHAFEE. Senator Rockefeller.

Senator ROCKEFELLER. Thank you, Mr. Chairman. I am very happy that Sally Richardson is the first witness because she and I worked together for all 8 years that I was Governor, and all 4 years that I was President of West Virginia Wesleyan College. She has had some of the most truly horrible jobs you can imagine. [Laughter.]

Senator GRAHAM. And people with whom to work.

Senator ROCKEFELLER. And people with whom to work.

And so she comes to Washington and runs Medicaid, just to top it off. This is a woman who believes in self-punishment. [Laughter.]

Sally, obviously I am very happy to see you.

Ms. RICHARDSON. Thank you, Senator.

Senator ROCKEFELLER. One of the worries of all of this is that you are dealing with poor kids and people at the bottom of the ladder. So it is important to think 1115's, or whatever waivers, through.

And I have a little side comment here to my colleague, Senator Graham. He said they have been trying to get a waiver since he was Governor, which was some 48 years ago. [Laughter.]

So I assume that you are thinking very carefully about it.

But there is a reason for that, right?

Ms. RICHARDSON. Yes, sir.

Senator ROCKEFELLER. I would be interested in it because, as far as I know, this administration has never denied an 1115, never denied a waiver. And, in fact, I think it has given more waivers than the last two administrations.

Nevertheless, they have to be thought through carefully. I would just like to have you explain why.

Ms. RICHARDSON. Well, as you say, this is a very complex program. And it is a very vulnerable population. And making sure that the program works for them is uppermost in our minds.

I think, as a matter of fact, we are probably doing a fairly expedited job of managing these waivers. It has caused us to work in teams, which is something we are all learning, and doing pretty well.

And we put in things like concept discussions with the States from the very beginning, so that from the time they come in with a concept paper, and sit down and discuss this, we are giving technical assistance.

But we care about the fact that these waivers protect the beneficiaries in the Medicaid program, that they have the infrastructure that allows them to assure quality, both at the plan level and at the State level, and that we can have assurance of that quality.

We make sure that the State has the capacity in systems and infrastructure to implement one of these waivers so that it works for the people it is supposed to serve.

We like the thought of having a good plan for implementation, like how people will be enrolled in the waiver itself. We like to see all of that laid out, and it takes discussions with the States. It takes negotiating with the States. And, in some instances, it even takes help with implementation, which our regional offices do.

But that is the kind of effort that is put into the approval of these waivers.

Senator ROCKEFELLER. All right. So you have to set them up very carefully and well.

Now I am going to ask something here which is going to sound political. I think it will offend Senator Chafee a lot less than perhaps some of his colleagues.

Medicaid has been growing at about a 9.9 percent rate. Of course, there are reasons for that.

Ms. RICHARDSON. There are.

Senator ROCKEFELLER. It is health care costs, or population because of economic conditions, and all kinds of things.

There has been a lot of talk about massive cutbacks in Medicare and Medicaid. A number of people have talked about capping Medicaid. The numbers tend to range from 4.6 to 6 percent.

If the growth is at, let us say, 10 percent last year, and if there were to be a cap, is there any possibility that we could carry on with waivers, or that waivers that have been granted would be able to operate?

Ms. RICHARDSON. Basically, the waivers would be very disadvantaged with a spending cap. For one thing, we have a term and condition in each waiver that says that they must abide by all applicable law.

Senator ROCKEFELLER. Continuity of care, and all kinds of things. Yes.

Ms. RICHARDSON. And that relates to the payment for the waivers as well, the Federal match for the waivers as well.

The difficulty is that a cap on States, and a limit on the Federal spending for States, basically leaves them to have to deal with increases in enrollment, changes in the nature of technology——

Senator ROCKEFELLER. The States, that is?

Ms. RICHARDSON. The States, that is.

Senator ROCKEFELLER. The giant cost shift in the name of an unfunded mandate. Right?

Ms. RICHARDSON. Well, it would certainly require the States to begin to limit either beneficiaries in the program, services in the program, or the payments to providers. And that would become something that would be outside the waiver terms and conditions. So they would have to be stopped.

Senator ROCKEFELLER. My time is up. I thank the Chairman.

Senator CHAFEE. Thank you.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to use this first round to discuss some specific issues relative to waivers and then, in subsequent rounds, get into some more generic questions on the program.

How many current waivers are there before HCFA? Do you have an estimate of how many people are potentially affected by those waivers, Ms. Richardson?

Ms. RICHARDSON. There are 10 waivers that are currently before HCFA. Basically it covers about 23 percent of our acute care services.

Senator GRAHAM. Are there any of the waivers in the area of long-term care?

Ms. RICHARDSON. The State of Arizona, I believe, has a waiver for long-term care, which has been operating about 3 years, that is, up and operating. I believe that is the only one. I can find out for sure for you.

Senator GRAHAM. One of the concerns about the waiver process has been its high degree of process orientation.

After better than a decade of attempting to get a waiver, Florida has gotten a response to the waiver which contains some 60 conditions that have to be met in order to implement the waiver, many of which are very procedurally stringent.

Has HCFA ever looked at using a performance-based approach to waivers? That is, setting out what is desired to be accomplished with the waiver between the Federal Government and the State government, and then allowing the State some latitude in how to accomplish those performance objectives?

Ms. RICHARDSON. As a matter of fact, one of the things that started before the 1115 demonstrations began to come in in such numbers was the whole development of an outcome-oriented management of quality within managed care for the Medicaid program.

We began that under our 1915(b) waiver process. Basically, it sets standards for what managed care plans should be like, and what contracts should be required of managed care plans. One of the standards, for instance, is that a managed care plan must have an internal quality improvement program underway.

Senator GRAHAM. But do they have any standards in terms of what is the ultimate goal, in terms of affecting the health and welfare of the people who are served by the program?

Ms. RICHARDSON. Well, in addition to that, we are now working with private industry, and with some foundations and associations to develop and take the private sector Hedis model of clinical out-

comes and quality, and change it. It is a private sector model, so it needs to be changed to be relevant to the Medicaid population.

We are in the process of doing that. Once we have gotten that done, and are sure that it works, we are going to be moving that into managed care, into our monitoring of quality in managed care. That is why we are putting a lot of effort into it.

So we are getting more outcome-oriented, but I think you also need to understand that we are changing a whole system, from a fee-for-service system into a managed care system, in a State like Florida, where everyone is going to be in managed care.

And there are a lot of processes that have to be changed to be able to understand, to monitor, to have oversight, to have financial accountability, to do all of those things in managed care that States did not have before.

So one of the parts of our terms and conditions is just to make sure that those things are done in the implementation process before people are actually coming to the managed care plans and the system is on line.

Senator GRAHAM. Would it be helpful if the Medicaid law were to be both more specific relative to the grant of waivers, but also more facilitating in terms of the grant of waivers?

For instance, Senator Moynihan last year had a proposal that would have targeted on those waivers that related to managed care, and given them somewhat of a more expedited procedure, in terms of their approval process.

Are there some legislative changes which, based on your experience, would be appropriate, which would better serve the interests of the States in being diverse and innovative?

Ms. RICHARDSON. I think, Senator Graham, there are several types of modifications that we have under consideration. We certainly would be glad to share them with you when they are developed.

The waivers do give us a great deal of flexibility in the Medicaid program. One of the things that we believe strongly in is that they allow us demonstrations of better ways to do Medicaid.

I am sure there are some things that can be improved in the process, and we would be happy to work with you.

Senator GRAHAM. Thank you.

Senator CHAFEE. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. Welcome, Ms. Richardson.

Ms. RICHARDSON. Thank you.

Senator MOSELEY-BRAUN. I have a question. There has been a lot of debate around the Congress in recent times about unfunded mandates.

As you know, that subject has a broad understanding, and a lot of people define unfunded mandates in various ways.

But it seems to me that, when you reach the bottom of the food chain, if you will, when the payments stop and Government passes on costs to the private sector, in a sense that is kind of an unfunded mandate as well.

There has been experience in some of the States in which the States themselves are slow to pay vendors, do not pay the vendors, and the vendors wind up carrying paper for a long time—debts

that the State owes under Medicaid. And, for all intents and purposes, that is a type of a pass-along, an unfunded mandate, if you will, from a State government to the private sector.

Particularly in Medicaid, one of your reports—and I cannot see the dates because I do not have my glasses—looks like, with regard to vendor payments, fully 69 percent of vendor payments out of the Medicaid program overall, are to vendors that provide services to the aged, blind and disabled.

So, for all intents and purposes then, what we have with the phenomenon of slow pay and no pay by State governments to vendors of Medicaid services, is that essentially these people are providing services to the aged, blind and disabled, and then being penalized for providing those services by not being paid in a timely manner by the State government that contracted for them in the first place.

My question to you is, what provisions, what processes, what systems, if you will, does HCFA have in place, if any, to really get on the States to stop this practice of slow pay and no pay to vendors, passing along costs to vendors for services that they provided correctly to the aged, blind and disabled under the Medicaid program?

Ms. RICHARDSON. We have timely payment requirements in the Medicaid program. When a State exceeds those timely payment requirements, we have a compliance process which comes into play to try to work with the State and get them to correct the situation, to give us a plan of correction.

Obviously, if we proceed on down the road, and we cannot reach an understanding with the State, we take a compliance penalty, which is generally an administrative penalty on administrative funds, from the State.

Most States want to avoid this administrative penalty so, basically, States try to come into compliance when we put them on report.

Senator MOSELEY-BRAUN. Previously, my own State of Illinois had received a waiver of sorts to allow for the development of a managed care kind of plan in the State.

GAO subsequently did a report in August of 1990 regarding the activities under that program. And what it found was that the program was deficient in a lot of different areas, including incentives to undertreat the population, lack of solvency requirements, no requirements to integrate populations, lack of attention of quality of care, the slow pay issue that I just mentioned.

I imagine this happens in States other than Illinois. My question is, what steps, if any, were taken following the GAO report, to follow up to make certain that findings such as these are addressed? How does HCFA follow up to make certain that States that receive waivers are actually required to make certain that the objectives of the program continue to be met and, once it has been documented that they have not been met, that appropriate corrections are made?

Ms. RICHARDSON. Basically, we have regional offices around the country. When we find that a State is not living up to the terms of its State plan, either because of late payments or lack of provision of services, we do get into the compliance process. We do get into the process of working with them.

This is a process that is actually, for due process reasons, written out and documented in regulation. We work with them as much as we can because we do not want to cut funds off to a State. That would only diminish their ability to serve our beneficiaries. But we will do that when we have to. We work with the State to try to get plans of correction, try and get things corrected and moving forward.

I cannot tell you what we did, but I can find out for you about the 1990 GAO report. I was not with the Medicaid program then, but I can get that information for you.

But our regional Medicaid office folks would have worked with the State on site, and made the corrections that were needed to be made so that they could be in compliance.

Senator MOSELEY-BRAUN. Mr. Chairman, may I ask just one last question?

Senator CHAFEE. Sure.

Senator MOSELEY-BRAUN. Thank you.

My State currently has a waiver pending. And my question is that, given our current existing compliance problems taken into account by HCFA, with regard to the granting of additional waivers for other changes in the program administration within the State, does current history and the record that you have now count as you address the issue of waivers?

Ms. RICHARDSON. We are aware of the compliance problems in Illinois. And that is a matter of real concern as we are considering the waiver, and it is being taken into consideration.

Senator MOSELEY-BRAUN. Thank you very much. Thank you, Mr. Chairman. Thank you, Ms. Richardson.

Senator CHAFEE. Thank you. We will have another round here quickly of this panel.

Senator Hatch has a statement that he is submitting for the record, and we will accept that.

[The prepared statement of Senator Hatch appears in the appendix.]

Senator CHAFEE. Senator Breaux wanted me to thank you, Ms. Richardson, and your HCFA staff for spending a considerable amount of time and energy with him, and with the State Medicaid officials from Louisiana, in trying to work out some very difficult issues. So he wanted to make sure that those thanks were extended to you and your staff.

Ms. RICHARDSON. Thank you very much. I will let the staff know.

Senator CHAFEE. All right.

Now, Dr. Scanlon, in your testimony you cited the importance of oversight, as being an important ingredient in the implementation of a Medicaid plan.

And you mentioned quality, access to care, and financial solvency. And you put considerable stress on solvency.

Could you elaborate on that? Is financial solvency an indicator of quality, for example? And why is it so important?

Dr. SCANLON. Our concern about solvency stems from the fact that plans under financial pressure, or providers under financial pressure, may feel the need to try to restrict their obligations and, in the process, reduce access to services and thereby affect quality.

It is not just a question of solvency at the level of the plan, but it is the question of what happens to the providers within a plan, since the risk is not always borne by the plan itself. It is sometimes either completely or partially transferred to the providers.

A provider may have has a small number of patients that are being served through a plan, and may be bearing a great deal of risk for those patients. If he or she has a few cases that turn out to be expensive, that provider in one sense is not going to be solvent with respect to this plan, and may not want to serve the beneficiaries in that plan as well they might otherwise.

Our concern is that too much financial pressure can result in reduced access to services.

Senator CHAFEE. All right. Now I am shifting gears. There are clearly certain Medicaid populations—the homeless, migrant workers, foster children, for example, as well as those with special health needs. How are the States going about implementing managed care programs dealing with these special needs populations? What do you do about foster children? How are they put in under the Medicaid managed care plan?

Dr. SCANLON. Ms. Williams, would you describe what happened in Oregon?

Senator CHAFEE. Yes. Ms. Williams, you work with Dr. Scanlon at the General Accounting Office?

Ms. WILLIAMS. Yes. More specifically, I am located in the Portland, Oregon location, which is part of the Seattle Region.

Senator CHAFEE. And you are an expert on Oregon's experience?

Ms. WILLIAMS. Well, I am also a State resident, and have been involved with the plan for a number of years, with the State's Medicaid program.

Oregon recently obtained approval for the second phase of its demonstration program, which does include the foster care kids. Up until February 1 of this year, they were not included.

Senator CHAFEE. Now what happened to those children in the interim?

Ms. WILLIAMS. They were in fee-for-service Medicaid.

Senator CHAFEE. They were in Medicaid fee-for-service. I get it.

Ms. WILLIAMS. And, in addition to the foster care kids, Oregon also brought the aged, blind and disabled into the acute care part of their managed care demonstration.

Senator CHAFEE. Do you mean long-term care?

Ms. WILLIAMS. No, not long-term care. It is only for acute care services.

Senator CHAFEE. I see.

Ms. WILLIAMS. And the State has a number of subcommittees that it has been working with over the years that are composed of providers, as well as advocacy groups, case workers and, in some cases, clients themselves, to address the special needs of each of those populations.

Also, as a result of this, they have required that each plan contract with the State. They have what they call an exceptional needs case coordinator. And beneficiaries are allowed to contact that ombudsman for each plan directly, to help coordinate all of their various health care needs.

For the foster care children, I believe the caseworkers are involved, as well as the foster parents, in making sure that their various health care needs are met.

Senator CHAFEE. All right.

Excuse me. If I could add, I think the general principle has been that most States have not included these populations within their managed care programs, and have decided to keep them in their fee-for-service system because of concerns about the fact that managed care organizations have not typically dealt with these populations, even in the private sector.

But, as we move more and more towards managed care, there may be more experience to draw from. And managed care, in terms of the continuity of care that a good managed care organization may provide, may hold some promise for some of these people.

Ms. Richardson, let me ask you a question I touched on before. As you know, the big thrust around this place is to go for managed care in all our programs, whether it is Medicare or Medicaid.

Your testimony seems to indicate that, when you talk about the great extension of populations that have been served as a result of these arrangements, the population is increasing under these waivers because the States are saving money, and putting the money into that. Am I correct?

Ms. RICHARDSON. That is correct.

Senator CHAFEE. So, therefore, does it follow from your experience that moving from fee-for-service, the setup that has been used in the past in Medicaid, to essentially managed care, results in a significant savings?

I know there are other things that come with it as well, as we pointed out in that chart. There is some flexibility in benefits, but not much. Only Oregon, as I understand it, has got any flexibility in benefits and payments.

But they have been able to do more with a single amount of money. In other words, managed care has been a dollar saver. Is that true?

Ms. RICHARDSON. That is true, although I may have misled you in an answer that I gave earlier. Kathy had pointed out to me that, for the extension populations—that is, the non-Medicaid beneficiaries to which care is being extended—very often the benefit package does change. Not only does it change but, in many of the waivers, there are copayments from the beneficiaries on some sliding scale, so that they are contributing.

Senator CHAFEE. Is that for the working poor, where they are extending the benefits? I think Rhode Island is going to 240 percent of poverty.

Ms. RICHARDSON. That is right.

Senator CHAFEE. But, nonetheless, it is money that has come from what otherwise would have been spent under a fee-for-service plan. Am I correct?

Ms. RICHARDSON. Yes, you are correct sir.

Senator CHAFEE. Now, Dr. Scanlon, when you have looked at this thing, is managed care less expensive than fee-for-service?

Dr. SCANLON. Well, I think the most current evidence was released by CBO recently, which suggests that HMO's can save about 19 percent relative to the fee-for-service provision of care. But inde-

pendent practice arrangements, where you have a network of physicians working independently, have only about a 1 percent savings, relative to the fee-for-service system.

So it depends in part upon whether or not you put in strong incentives to save by capitating the plans. And the plans, in turn, exercise control over the physicians and hospitals that are members of their plan.

Senator CHAFEE. Yes, but that is the whole point of why the States are doing it, is it not?

Dr. SCANLON. The States have managed, in a number of instances, to generate savings because they have gotten plans to accept their lower capitation rates, lower than what they would have paid under fee-for-service. Tennessee is a prime example, in that they have offered a capitation rate that is considerably lower than what was the average under the fee-for-service system.

Senator CHAFEE. And the plans are prepared to take them, obviously, or they would not otherwise take them.

Dr. SCANLON. The plans have taken them. And the issue for the long term is how well the plans do financially, and whether they will be willing to take them on a continuing basis.

Since we have very limited experience—as I indicated, only 4 States, other than Arizona, with a less than 15-month experience—we will have to wait and see how well we can control costs through managed care.

Senator CHAFEE. Well, the folk who are coming here for the next panel are going to be the folks from Arizona, so we will ask them.

So you come up with a 19 percent figure?

Dr. SCANLON. That is CBO's number for HMO's.

Senator CHAFEE. Well, you are from CBO, are you not?

Dr. SCANLON. No. I am from GAO.

Senator CHAFEE. GAO. Oh well, we certainly do not want to get stuck with CBO 4 years, do we?

Dr. SCANLON. No. We are happy to use the CBO number.

Senator CHAFEE. All right. Well it sounds good to me.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

I would like to just follow up on your last question, and then go to a different area of inquiry.

The point that I think Dr. Scanlon just underscored is that, because waivers have been so difficult to secure, the States have been crippled in their traditional role of being laboratories of experimentation.

To be parochial, if Florida's request for a waiver, which was made in the early to mid-1980's, had been granted at the time submitted, we would have had 10 years of experience in the fourth largest State in the country with a managed care program. And the nation would have been the beneficiary of that learning experience.

But, because of the rather pernicious way in which these waivers have been granted, we have been restricted in our learning curve.

To what degree, Ms. Richardson, do you think the intangible benefit of increasing our knowledge of how alternative health care arrangements actually operate should be a factor in the granting of waivers?

Ms. RICHARDSON. Well, I think there is no doubt about the fact that we believe that the waivers should be demonstrating something that we can learn from in terms of improving the Medicaid program.

And each of the States that have come in have put together a different strategy. That is one of the things that I think is a real benefit of the 1115 waiver program.

And we have learned a great deal, and have progressed, just on the 8 waivers we have granted since 1993. We have learned a great deal more about ways in which Medicaid can be improved for beneficiaries.

Senator GRAHAM. I would like to turn to another issue, which is the proposal that Medicaid become a block grant program, rather than the individual entitlement that we have today.

The proposal, as I understand it, is that the current formula for distributing funds among the States be maintained, with some percentage increase, as Senator Rockefeller suggested, in the 4½ to 6 percent range.

Several times in the last few years, GAO has issued reports on the Medicaid formula. They did it in 1983, 1991 and, most recently, in August of 1993. And I quote from that 1993 study, which states that, "These objectives, which include reducing differences among States in medical care coverage for the poor, have not been met, as evidenced by the fact that the type and amount of benefits continue to vary substantially among the States. States continue to face varying burdens in financing the costs of providing for those in need."

From your experience, Dr. Scanlon, has there been any improvement in that situation since August of 1993?

Dr. SCANLON. In more recent data, there has been some reduction in the variation in Medicaid spending across the States. However, there is still considerable variation that does exist, in part because with the current matching formula. The generosity or size of each State's Medicaid program is largely a function of what a State chooses in terms of the program that it wants to have, and that it can afford to have.

Senator GRAHAM. Given that background, what would be your thoughts as to the appropriateness of a national policy which went to a block grant approach to the States, which used as the beginning of that block grant allocation the current formula for Medicaid distribution of funds?

Dr. SCANLON. Well, block grants certainly change the incentives that States are going to face in terms of how they manage their programs. Given that they have, to varying degrees used managed care, the amount of flexibility they are going to have to live with under a block grant such as you described is going to vary.

It is an issue that we are currently looking at, and expect to be reporting on later. We would certainly be happy to share the results of our work with you. But we wanted to update the work we have done in the past to make it more current for the present consideration.

Senator GRAHAM. The second step in that proposal for block grants is then to have an annual growth factor.

According to a recent study by the Urban Institute, it estimates that the number of Medicaid beneficiaries will increase from the current 36.3 million to 43.4 million in the year 2000.

Ms. Richardson or Dr. Scanlon, are those numbers consistent with your assessment of the growth in the program?

Ms. RICHARDSON. The Urban Institute generally does its projections in a fairly conservative way. So I would say that they probably are.

Senator CHAFEE. Could you repeat those growth figures please?

Senator GRAHAM. According to the Urban Institute, the current Medicaid program enrolls 36.3 million beneficiaries. In the year 2000, the number will be 43.3 million.

Ms. RICHARDSON. Remember the demographics would cover the frail elderly. We are also bringing in the groups of children, which I think are at age 12 right now, and we are moving on upward.

So those are two of the reasons why our population is growing, and I am sure are part of the basis for that projection.

Senator GRAHAM. Are the numbers of increase fairly evenly distributed across the country, or are there significant variations from State to State as to the growth in the Medicaid population?

Ms. RICHARDSON. There are significant variations, particularly in the growth of, for instance, the elderly population. Some States have far less elderly than other States.

Senator GRAHAM. One other observation that has been made is that there seems to be some correlation between the increasing number of persons who are not being covered through their point of employment and the increase in the Medicaid beneficiaries, particularly women and children, where a spouse who in the past had health insurance, and no longer does. And the dependents of that individual has become Medicaid beneficiaries.

Are you seeing a relationship between changes in the pattern of employment-provided health care to the employed person or his dependents and the number of persons on Medicaid?

Ms. RICHARDSON. Partially because an increase in the poverty rates, there has obviously been an expansion in those eligible for Medicaid. And there is a study, published within the last couple of months, which has demonstrated that there is in fact a reduction in employer-based insurance, and an increase in the Medicaid population coverage without much change in the component that is called the uninsured.

So the conclusion can be drawn that there is some connection between the two.

Senator GRAHAM. One last question, Mr. Chairman.

Senator CHAFEE. Sure.

Senator GRAHAM. Is the indication that that trend of shifting responsibility from private insurance at the point of employment to a public Medicaid system stabilized or reversed, or is it continuing to grow.

Ms. RICHARDSON. The study was, I believe, of the year 1994. I am not sure whether it was 1994 or 1995, but it was certainly in very recent history.

Senator GRAHAM. And was the trendline continuing to increase in terms of the number of people who were shifting from a private health program at the point of employment to Medicaid?

Ms. RICHARDSON. I do not know, Senator, whether there was a trendline in it. Certainly the increases in poverty would indicate that that is true.

Senator GRAHAM. Thank you, Mr. Chairman.

Senator CHAFEE. Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. Just one question. This may come under the category that Senator Rockefeller described to you as someone who likes to deal with impossible situation. And, particularly following on Senator Graham's questions about the increase in the caseload, as you are well aware, there are proposals all over the place to cut the growth in spending for Medicaid over the next 5 to 7 years.

And the estimates for the cuts have ranged from some $75 billion for one of the proposals, to $150 billion for another. While we do not exactly know the exact magnitude of the cuts we will see, we know it is likely that they will be large ones.

Two studies, one by Families USA, and the other by the Kaiser Foundation, have demonstrated or spoken to the State-by-State impact of cuts of that magnitude.

The Families USA report estimated a $75 billion cut over 5 years, in which my State of Illinois would lose about $2 billion under that scenario.

The Kaiser Foundation estimated the impact of a 5 percent cut. Under that scenario, my State would lose about $3 billion over the next 5 years.

Given the fact that the State has an 1115 waiver pending right now, and considering also that the State currently has a $1.4 billion deficit in this area, what would be the impact of such cuts on the waiver and on the capacity and ability of the States to implement an alternative kind of plan to do the kind of experimentation that the waiver process is supposed to allow?

Ms. RICHARDSON. Well, it would obviously depend upon what the terms and conditions of the waiver were. As I stated earlier, there is a term and condition that the waiver must relate to applicable law. And the financial liability and feasibility of the waiver at a budget-neutral level, which would be at variance with whatever cap was set, would certainly make the waiver not feasible under this kind of cap.

The other thing that I think is important to remember is that slightly less than one-third of the Medicaid population are people who are frail elderly, blind or disabled. They use 70 percent of the services, many of which are in long-term care, and which the waivers do not address at all, with the exception of the fact that Arizona is now beginning to address services in that area.

But that is a much more difficult area for managed care because we have so little experience with it in this country. So no matter how you do the waivers, you are going to have this large component of Medicaid that is really not going to be impacted at all by the savings that might be obtained under the waivers. And it is in that area where you may really experience enormous reductions of service, if you have a block grant with a cap.

Senator MOSELEY-BRAUN. With regard to the block——

Senator CHAFEE. In other words, they do not apply the 19 percent, or whatever the percentage is, across the board?

Ms. RICHARDSON. Absolutely.

Senator CHAFEE. They would only apply the 19 percent to the 33 percent or the 30 percent?

Ms. RICHARDSON. That is right.

It is the majority of the population.

Senator CHAFEE. It is 7 percent of the population, but 30 percent of the cost?

Ms. RICHARDSON. That is right.

Senator CHAFEE. I am sorry to interrupt.

Senator MOSELEY-BRAUN. No. It is all right, actually. I would like to visit with Ms. Richardson, because there are particular questions about Illinois. So we will visit about those later.

I see my next meeting has arrived, so I am going to have to leave now.

Senator CHAFEE. All right. Thank you very much for coming.

Senator MOSELEY-BRAUN. I would like to submit the remainder of my questions to the witnesses.

Senator CHAFEE. All right. That is fine.

[The questions and answers appear in the appendix.]

Senator CHAFEE. Ms. Williams, you have come a long distance, and you are entitled to a question.

And my question is, you are from Oregon, and you are with GAO, are you not?

Ms. WILLIAMS. Yes, sir.

Senator CHAFEE. Regarding the Oregon situation, which Ms. Richardson mentioned in her testimony, everything seems lovely in Oregon, is that true?

I am not suggesting that what she said was not true, but how are you finding it as an on-the-scene observer?

Ms. WILLIAMS. We did a review of Oregon's 1915(b) program about 3 or 4 years ago. And it worked very well.

Senator CHAFEE. Well, they started with a 1915(b), did they not?

Ms. WILLIAMS. Yes. They had a partially——

Senator CHAFEE. But now they are in the 1115?

Ms. WILLIAMS. Right. They built in large measure on the successes of that previous program to form their 1115 waiver. They had authority to have a Statewide, partially capitated program for their women and children on AFDC, so they had a number of providers who were very familiar with managed care.

They had plans that were familiar with quality assurance. They had financial solvency, although we had some questions about some details in their financial solvency, particularly around disclosure of ownership.

But they transferred many of those processes and protections over into their 1115 program. So it was a familiar set of operations for the providers, the community and the beneficiaries.

So it appears that they have very good experience with their 1115 program to date.

Senator CHAFEE. But I thought the big thing about Oregon was that they went to tremendous changes in the benefits.

Ms. WILLIAMS. They did.

Senator CHAFEE. And they made a study and certain services that had been given out freely before were not given out because

they were very expensive compared to the same amount of money being spent, say, in immunizing children.

Ms. WILLIAMS. The State had several goals when they authorized the legislation back in 1989 to move into the 1115 program.

One was that, under the existing Medicaid law, whenever a State ran into budgetary problems, it tended to cut out services or people. And Oregon wanted to change the reimbursement system and benefit structure so that you could cut off benefits, but you still would keep everybody covered.

So they worked with providers throughout the State to put together a set of benefits that would focus on primary and preventive care, and would eliminate payment for services for conditions that get better on their own, such as the common cold, or where aggressive treatment might not ultimately benefit the recipient, such as end-stage terminal disease.

Comfort care is provided in those situations, but not aggressive treatment.

Senator CHAFEE. Who makes the decision that this is in fact an end-stage terminal disease?

Ms. WILLIAMS. The physician treating the patient. And I think they have to get concurrence from another physician as well.

Senator CHAFEE. Suppose the family says "No"? This is not terminal at all. If you people would only get busy tending him, he would get better.

Ms. WILLIAMS. I am not familiar with how the State would resolve situations where the family was not in agreement with the recommended treatment.

Senator CHAFEE. All right. I want to thank this panel very much.

Yes, Ms. Richardson?

Ms. RICHARDSON. Senator, could I clear up something for the record?

Senator CHAFEE. Sure.

Ms. RICHARDSON. It has to do with the CBO estimate that 19 percent can be saved in the Medicaid program, or can be saved from the——

Senator CHAFEE. The acute care portion of Medicaid.

Ms. RICHARDSON. Yes. Basically, I think they said 19 percent for group staff model HMO's, which is not the majority of HMO's.

In addition to that, most of the managed care organizations in this country are not HMO's at all. So there are not that kind of savings to be realized by a move into managed care.

Our estimates are that, depending upon how mature the managed care network is for a State that moves into managed care, they can save somewhere between 5 percent, or maybe up to 15 percent. But overall, in the aggregate for the Medicaid program, you could not realize anything close to savings of 19 percent.

Senator CHAFEE. You mean if you included the long-term care?

Ms. RICHARDSON. And if you included long-term care, what you are doing is probably making a savings in the rate of growth, but we have not had any savings that our actuaries would really document as yet to include in managed care over the long haul.

Senator GRAHAM. No further questions.

Senator CHAFEE. All right. I want to thank the panel very much. I appreciate it.

If the next panel will come forward and take their seats, we would appreciate that.

We welcome Dr. Chen, Director of the Arizona Health Care Cost Containment System, from Phoenix, and Manuel Martins, Assistant Commissioner, Bureau of TennCare, from Nashville.

We appreciate both of you coming.

Dr. Chen, will you please start?

STATEMENT OF MABEL CHEN, M.D., DIRECTOR, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, PHOENIX AZ

Dr. CHEN. Good afternoon and thank you, Mr. Chairman, and members of the subcommittee.

My name is Mabel Chen. I am the Director of the Arizona AHCCCS program.

Today my testimony will address the status of our 1115 waiver, the cost effectiveness of our program, the impact of managed care on our members and providers, and some personal insight on the 1115 waiver process.

AHCCCS is Arizona's Medicaid program. It is a comprehensive managed care system, providing health care to about 457,000 people. We have a managed care program for both acute care and long-term care populations.

Prior to 1982, Arizona had no Medicaid program. Health care for indigents was funded by counties. In 1981, the legislature and Governor realized that counties could not continue to shoulder the burden, and looked for other alternatives.

State leaders wanted to create a managed care delivery system to provide quality care, and avoid the pitfalls of a fee-for-service system.

In 1981, the legislature created AHCCCS as the first Statewide managed care system in the nation. In 1982, Arizona applied to HCFA for a section 1115 waiver, in order to operate the AHCCCS program. HCFA approved the waiver in July of 1982. AHCCCS has been operating under the 1115 waiver authority, with reviews from HCFA, since then.

The State waiver authorization expires on October 1, 1997. The first few years of AHCCCS were both difficult and challenging.

Senator CHAFEE. Is AHCCCS the Arizona health care cost containment system?

Dr. CHEN. Yes, Mr. Chairman.

Senator CHAFEE. Thank you for the acronym. It saves considerable time.

Dr. CHEN. We had no administrative structure in the beginning. The service delivery system was not developed, since it was difficult to attract enough financially viable health plans and an adequate provider network.

By contrast, last year's bidding cycle brought 95 proposals from 21 different organizations in 15 counties. Today the State has the advantage of a more mature managed care infrastructure.

Senator CHAFEE. Dr. Chen, we have a vote now. I am very interested in your testimony, and I do not want to miss it.

So I think that both Senator Graham and I will go to vote. And if you would just remain in your position, we will come right back.

Dr. CHEN. Sure.

Senator CHAFEE. And I hope you can come back, Senator Graham.

Senator GRAHAM. I can.

Senator CHAFEE. All right. So we are just in recess.

[Whereupon, the subcommittee recessed at 3:28 p.m., to reconvene at 3:50 p.m.]

Senator CHAFEE. Dr. Chen, if you would proceed? And I hope we are going to be uninterrupted for a while.

Let us see. You were on page 2, I believe, of the testimony as we have it.

Dr. CHEN. All right.

The first few years of AHCCCS were both difficult and challenging because the State had no administrative structure. The service delivery system was not developed, since it was difficult to attract enough financially viable health plans and an adequate provider network.

But, by contrast, the last year bidding cycle brought about 95 proposals from 21 different organizations in 15 counties.

Today the State has the advantage of a more mature managed care infrastructure, as well as the opportunity to learn from Arizona and other States' experience.

However, the States must build the necessary administrative system to convert from traditional fee-for-service systems to managed care systems. This takes time, resources and a commitment to overcome the start-up problems that any new program is likely to face.

Some of the lessons we have learned in Arizona include: A managed care system must be a true public and private partnership. Health plans and beneficiaries must be involved in the design of the program. AHCCCS and the health plans successfully work together to develop the provider networks. Today, 70 to 80 percent of all physicians and other primary care providers participate in the Medicaid program.

A successful program must develop a commitment to consumer satisfaction. Our program has been evaluated by the Flinn Foundation in 1989, who reported a 95 percent member satisfaction with their health plan and our program. A more recent survey indicated 90 percent of women receiving prenatal care were satisfied with their care.

One of the cornerstones of the AHCCCS program which promotes member satisfaction is the member's ability to select a health plan and primary care provider. Today every eligible member has a choice of two health plans in each county.

We have found that over 55 percent of our members do exercise their right to select a health plan. We have open enrollment once a year but have found that, on average, fewer than 5 percent of our members change health plans.

Quality of care is also critical. AHCCCS has developed and implemented a quality management program, which relies on outcome measurements. Many of our health plans have developed programs which exceed our requirements.

The AHCCCS program has been cost effective for both the State and the Federal Government. According to a 1993 Laguna Research Associates report for HCFA, for the first 9 years of the

AHCCCS program, AHCCCS was able to constrain costs 44 percent below the projected cost of a traditional Medicaid program.

From 1983 to 1991, the average annual increase in AHCCCS per-member costs was 6.8 percent, compared to 9.9 percent for traditional Medicaid programs.

Further, the cost savings are not just one-time savings. For example, during last year's bidding cycle, due to increased competition, the State was able to reduce capitation rates by 8 percent, compared to the 1993 capitation rates.

The main reasons AHCCCS has been able to contain costs, when compared with fee-for-service systems, are the role of health plans and primary care providers encouraging preventive health care, the nature of the competitive bidding process and the cost containment feature of capitation payments.

We use an actuary to develop capitation rate ranges. Health plans bidding within acceptable ranges must agree to provide all services to our members within the contracted geographic area. The State provides reinsurance to health plans as financial protection against significant medical costs experienced by any one individual.

Last week, the State submitted an amendment to our existing waiver which, if granted, will enable us to further streamline our eligibility determination process and offer health care services to low-income and working poor individuals with incomes up to 100 percent of the Federal poverty level.

AHCCCS would not be the successful program it is today, without the strong support and assistance provided by HCFA. HCFA has done much to simplify and streamline the waiver process. However, the 1115 waiver process, both to initiate or to renew, requires a substantial investment of State and Federal resources and time.

If you believe that AHCCCS is one of the models for delivering high-quality, affordable health care to low-income populations, then States must be given the flexibility to implement these changes, either through changes to the existing Federal statute, or through the continuation of a streamlined waiver process.

There are many barriers in Federal law which make it impossible for States to operate a managed care program without a waiver.

Let me provide a few examples of managed care barriers we face under the current Federal law:

Health plans participating in Medicaid must be either Medicare certified or State-licensed HMO's. The requirement was probably initiated to protect members from financially unstable providers. However, this requirement restricts the type of organization which can provide services to Medicaid recipients.

The 75/25 rule states that Medicare and Medicaid recipients can represent no more than 75 percent of the membership in an HMO. This is an out-of-date proxy for quality care. Today commercial and governmental managed care programs have much more well-defined measures for quality of care.

AHCCCS cannot guarantee 6 months of enrollment to its members without a waiver, nor could we ask our members to select a health plan once a year, as most of us do for our own health care benefits. If members were allowed to change health plans at any

time, we would not be able to stabilize our program, insure continuity of care, and reduce the cost and risk for the health plans.

Under existing freedom of choice provisions in the Federal law, we could not require our members to be enrolled in a managed care health plan. We would have to run a parallel fee-for-service system, and let members choose between the two.

A few other barriers exist which hinder creative programs in the areas of eligibility, provider reimbursement policies and services. Under current law, States cannot simplify Medicaid eligibility rules by adopting a single income standard. We must provide 3 months of retroactive coverage to those found eligible. How can we manage care retroactively?

States cannot pay the best price available in the market because of court interpretations of the Boren amendment.

States cannot adopt commercial benefit packages for Medicaid members because of mandatory benefit requirements and restrictions on copayments.

I appreciate your interest in the managed care program and 1115 waiver, and encourage you to do what you can for States who operate under 1115 waivers.

After 12 years of running a successful program, AHCCCS is still not permanent, and there is no means to achieve permanent status under current law. At a minimum, I believe that a Federal law should be changed to provide some latitude for a State to operate permanent managed care programs without a continual waiver renewal process.

Mr. Chairman, and members of the subcommittee, I would be pleased to answer any questions you have.

Senator CHAFEE. Thank you very much, Dr. Chen. That was very helpful. You had a lot of specifics, and you gave us recommendations. That is what we are seeking.

[The prepared statement of Dr. Chen appears in the appendix.]

Mr. Martins, we welcome you.

STATEMENT OF MANUEL MARTINS, ASSISTANT COMMISSIONER, BUREAU OF TENNCARE, TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION, NASHVILLE, TN

Mr. MARTINS. Thank you, Mr. Chairman and members of the subcommittee. It is good to be here today to talk to you about TennCare and the waiver process.

On New Year's Day, 1994, Tennessee essentially withdrew from the Medicaid program and implemented a new health care reform program called TennCare.

TennCare was not simply an effort to move from a fee-for-service to a managed care system, but was an effort to do much more. It was an effort to revamp the sick-care system that we have in Tennessee and in this country to a more preventive well-care system, not only to cover the 800,000 Tennesseans who were on Medicaid, but to offer health care insurance to all of the uninsured and working poor, which we believe to be in the neighborhood of 400,000.

We moved in that direction for several reasons. Without a radical change in the health care program in Tennessee, the uncontrollable growth in the cost of Medicaid, as it has in many States, threat-

ened the financial stability of State government. Not only that, but the quality of the health care system in Tennessee would suffer.

Simply maintaining the previous level of Medicaid services would have required annual tax increases that equate to about ½ cent on the sales tax each year in Tennessee. Or it would have required reductions in eligibility levels or reductions in services that would have been provided to recipients.

All of these were deemed unacceptable. While we would have had to increase taxes, reduce benefits and reduce services, we would also have maintained a problem of having a system that encouraged dependency on welfare, and also failed the working poor. We would still have in Tennessee somewhere in the neighborhood of 400,000 to 500,000 people uninsured.

In order to implement the TennCare program, Tennessee applied for, and was granted by the Health Care Financing Administration, a 5-year demonstration waiver under section 1115 of the Social Security Act. We replaced the existing Medicaid program with a program of managed health care, and we covered the Medicaid population and those individuals in Tennessee who lacked access to an affordable health care insurance program through an employer-based system, or who were uninsurable as a result of preexisting conditions.

We developed a program and a comprehensive benefit package, and delivered all of the services through health maintenance organizations and preferred provider organizations, using an incentive to push those organizations to a primary care provider to manage all care.

All plans are required to have a gatekeeper approach by 1996. Many plans already have a gatekeeper approach.

TennCare services, again, are provided through HMO's and PPO's, with a benefit package which is similar to that offered to State employees, and keeps intact the Medicaid benefits package that was offered, especially for children, the Early and Periodic Screening and Diagnosis and Treatment programs.

We have at this time excluded from the managed care component of TennCare, long-term care services and Medicare cross-over payments, although it is part of our waiver cap. And those payments are provided as they had been previously under the Medicaid system.

TennCare envisions a three-phase approach. The first phase of the program has focused on the prevention of medical services and episodic mental health care. We are currently finalizing arrangements to bring under the managed care systems services to the severely and persistently mentally ill.

Future plans are to privatize services to children in the custody of the State, such as foster care, as well as services to developmentally disabled populations, which today are continued under a fee-for-service program.

MCO's would receive additional capitation payments when they serve these groups. We believe that inclusion of these vulnerable populations in TennCare will result in consolidation of many State services into a privatized system of care.

After having been in place for a full year, since January of 1994, we believe TennCare has experienced dramatic results. Despite in-

formation that is not accurate, there are 12 competing managed care organizations in Tennessee today. All of them are solvent. Primary care access is improving. Non-emergency use of emergency rooms are down. And the unnecessary use of hospitalization is down.

As of February 1, 1995, there were 1,221,225 enrollees in TennCare, and 438,000 of those did not have access to health care insurance a year before. We believe that approximately 92 percent of all Tennesseans now have health insurance.

There are more than 7,000 physicians currently participating in TennCare. More than 2,500 primary care providers are contracting with managed care organizations in serving TennCare enrollees.

The financial savings resulted in the implementation of TennCare are equally dramatic from our perspective. The increase in expenditures from Medicaid to TennCare, from State fiscal year 1993 to 1994 was less than 1 percent. This program had previously been growing by a rate of 15 to 20 percent a year.

It is projected that in the State fiscal year that ends this year, June 30, 1995, compared to where we would have been under the Medicaid program, we will be spending approximately $1 billion less in State and Federal funds. This occurs while we are expanding service to approximately 440,000 uninsured enrollees, who previously lacked health insurance.

While our program continues to experience the problems of any program in its infancy—and there are numerous problems—there has been success beyond expectation. In fact, Mr. Chairman, members of the subcommittee, a major concern of our program has been to assure that the quality of care to individuals not be compromised.

Recent surveys conducted by the University of Tennessee Center for Business and Economic Research indicate that the quality of care that is being provided is at least as good as that previously provided by the Medicaid program that it has replaced.

Certainly the standards that have been established for this program, in conjunction with the Health Care Financing Administration, are being met.

Mr. Chairman, and members of the subcommittee, as Congress continues its discussion on proposals that would change the basis of the Medicaid program, it is very important that States like Tennessee, who have pioneered health care reform, not be penalized financially or otherwise as a result of their efforts.

By that I mean Tennessee and many other States have already attempted to control costs in the program, and have done that. When percent increases are applied to an already constricted program, there are penalties that these States would realize.

I will be glad to answer any questions, and I appreciate the opportunity to be here and talk to you about TennCare.

Senator CHAFEE. Thank you very much, Mr. Martins. I think your final point is certainly a valid one that we have got to bear in mind. You have made your cuts. If we should go into a block granted program and give the States that have not made the cuts the amount they had in the previous year, and give you what we gave you in the previous year, obviously that disadvantages you.

Dr. Chen, in your testimony you mentioned that you are serving 20,000 people in the long-term category under managed care. How do you do that? Who takes the long-term care patients into a managed care program?

Dr. CHEN. Mr. Chairman, we have a managed care program for long-term care populations. The income criteria is 300 percent of SSI income standards. And we do have a preadmission screening test to make sure that only those people who really meet the requirements will be eligible for long-term care.

We have 8 different HMO's serving the long-term care population. We pay capitation payments, and the HMO is responsible to provide all medical services in an acute care program. In addition, they will provide nursing home service and home and community services.

Senator CHAFEE. The thing I am having a little trouble understanding here is the evolution of these managed care outfits. Let us say the HMO's, are caring for both long-term and acute care Medicaid patients. Are these HMO's that have been set up especially for the Medicaid population or, in some instances, are they existing HMO's in which the State of Arizona purchase care?

Set aside the long-term care. Let us deal with the acute care. You go and buy the services and enroll them?

Dr. CHEN. Mr. Chairman, in the beginning, in 1988, we started the long-term care program. Before 1898, counties had the long-term care program. Long-term care and services were provided by the county long-term care program.

In 1988, we received approval from HCFA to implement long-term care under title 19. When we put out a bid, two major county long-term care programs came in to bid on the long-term care contract. So some HMO's continued to provide services to those people within the county. So they already have experience with the long-term care population.

We only had one private company bid in the first year to form a long-term care HMO, to hire some people from the county who had experience in serving elderly and physically disabled populations. That is how we started our program.

We have 5 HMO's in the long-term program today formed by the county, while the two private HMO's coming into long-term care serve the rest of the counties.

Senator CHAFEE. Now these private HMO's, they are not set up just for this population, are they? In other words, somebody else could join them if they wanted to? Could they or could they not?

Dr. CHEN. Mr. Chairman, the two private HMO's coming with us in long-term care also bid on an acute care program. So they kind of have two organizations within the HMO. One is especially to take care of the acute care population, and the other one takes care of the long-term care population.

Senator CHAFEE. As I understand it, in Arizona you have Medicare population under risk contracts. So you have got a substantial number of them into HMO's—the ones who want to go, I presume.

And I presume that they are joining regular HMO's that the private-pay patient belongs to. Is that right?

Dr. CHEN. Mr. Chairman, we have about 30,000 eligible members who are dually eligible for Medicare and Medicaid. We treat them

just like any other Medicaid population. When they become eligible for AHCCCS, they can choose a health plan within the county. They can also change health plans once a year during open enrollment.

But, for those people who are dually eligible for Medicare and Medicaid, Medicare will provide most of the medical services. Our HMO only provides services Medicare does not cover, and the deductible and coinsurance payment from Medicare benefits.

Senator CHAFEE. Now, as I understand it, your average annual increase in the per-capita cost was a little less than 7 percent, 6.8 percent. And, in recent years, you have reduced your capitation rates by 8 percent, in other words 8 percent of the 6.8 percent, I gather.

Dr. CHEN. Mr. Chairman, the 8 percent is the 1994 acute care bidding cycle. Due to the competition, the final average capitation rate for 1994 and 1995, compared with Federal fiscal year 1993 and 1994, is an 8 percent reduction. This is this year compared with last year.

Senator CHAFEE. Well, that is extraordinary.

Talking about the Medicaid population, would that include just the 30 percent that we previously talked about, the so-called acute care? That would include everybody?

Dr. CHEN. Mr. Chairman, Arizona started a managed care program in 1982. So our managed care program is offered to the AFDC eligible population, as well as SSI, SOBRA, everybody.

Everybody in the acute care program is enrolled in a managed care system. The 8 percent capitation rate reduction is mainly for the acute care program. Overall, the acute care program has an 8 percent reduction in capitation payments.

The population we are putting in managed care also includes foster children. They will also be enrolled in the managed care program.

Senator CHAFEE. I see.

All right. Thank you very much.

Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman.

Dr. Chen, we recently held a hearing in this Committee, in which we received some information on Medicare HMO's. Some of the problems that were identified at that hearing included selective enrollment, that is, enrolling only the healthiest of the Medicare-eligible population, a dumping of patients if they became ill through various devices that encourage them to leave the HMO and go back to a fee-for-service program, and complaints about low quality of service.

How have you dealt with those kinds of issues within your population?

Dr. CHEN. Mr. Chairman and Senator Graham, as I explained to you, our enrollment policy for the Medicaid population, or for those people who are qualified for both Medicare and Medicaid, are the same.

Senator GRAHAM. Excuse me. I was not talking about that specific population. I was just citing those as examples of some of the problems that have arisen in attempting to apply managed care to a Medicare population.

I was curious as to how you have dealt with those kinds of issues within your Medicaid population, both those who are dual-eligible, as well as those who are solely reliant on Medicaid.

Dr. CHEN. All right. Our enrollment policy is to provide a member freedom of choice. They can choose a health plan within 2 weeks. Then, if they do not choose, we assign a person to help them.

Based on a formula we developed, based on the proposed capitation rate, the health plan is not allowed to refuse to accept a patient.

As far as quality of care is concerned, AHCCCS has developed a quality management program. We do not follow the Utilization Review and Quality Assurance program under Medicaid. What we do is focus mostly on outcome measurement. So we work with the 14 HMO's we have. We invite their medical director and their physician representative to come to work with us to develop the quality indicator.

For example, the immunization rate for children, or the number of prenatal care visits for pregnant women. These are some of the indicators we have developed. And we are going to use the data we have in the computer system to evaluate the immunization rate by health plans, by county. And we will make the information available to the health plans for their continued quality improvement.

Senator GRAHAM. Mr. Martins, I am very interested in the fact that you have extended your coverage to the working poor.

Could you give us some characteristics, such as what percentage of poverty you are covering, and is there a copayment requirement for the working poor? And, if so, is it on a sliding scale?

Mr. MARTINS. Yes, Senator, I would be glad to.

First of all, we actually have no limit on the income one could make in coming into the TennCare program. However, our actual experience indicates that over 80 percent of the TennCare population is below 200 percent of the poverty level. We have very few people coming in that are above 300 percent of the poverty level.

We do have, and feel strongly about, appropriate incentives in the system. We believe that the willingness of an individual to pay their premium ought to be an incentive in the system. Therefore, we have established a sliding scale premium basis.

Obviously, if you are a Medicaid recipient, you have no premium. If you are below 100 percent of the poverty level, you have no premium. If you are above 100 percent of the poverty level, the premium is graduated, up to payment of full cost of the program at 400 percent of the poverty level.

The beginning premium is somewhere in the neighborhood of $2.74 per month, and is based on a sliding scale, essentially using title 20 income guidelines as the basis for the sliding scale premium. It goes as high as $136. per month.

Senator GRAHAM. I recognize that your program is relatively new. One of the concerns that has been expressed about a program such as TennCare, is that it might encourage some employers who are currently providing health insurance to drop their insurance, with the expectation that their low-income employees would move over to the State-assisted plan.

Have you seen such a phenomenon in Tennessee?

Mr. MARTINS. Not at this point, Senator. We have put measures in the program to try to avoid employer dumping. One is that we only have an open enrollment once a year for the uninsured population, and then an open enrollment is announced at a particular time. It is not a preset date.

Second, we have set a cap in the program of 1,300,000 people. And, as we reach a percentage of that cap, for instance 85 percent of that cap, we begin to enroll only the Medicaid population and the uninsurables in order to have room in the program to always include those populations.

As you know, because of ERISA requirements, we could not mandate insurance coverage in Tennessee. We evaluate each year, through a survey performed by the University of Tennessee Center for Business and Economic Research, the number of employers that are offering health insurance, and the number of people they offer that insurance to.

We will evaluate that each year. If we find that there is a major decline in that area, the program requires that we not have an open enrollment for that period of time. Therefore, there is a disincentive in the program to deal with employer dumping.

Senator GRAHAM. Mr. Chairman, I want to again——

Senator CHAFEE. Why not go ahead? If you have another question, go to it.

Senator GRAHAM. If I could. And then, I do apologize, but I must leave.

I wanted to say that the first panel, and Dr. Chen and Mr. Martins, have been excellent educators of this subcommittee on this important subject.

Dr. Chen, I would like——

Senator CHAFEE. If we were giving you marks under the skating marking system, what would you say, 6's?

Senator GRAHAM. I would say, on a scale of 0–10, they are in the eleventh or twelfth. [Laughter.]

Senator CHAFEE. Well, in skating, as you know, the maximum is 6.

Senator GRAHAM. In Florida, we are more familiar with diving and other competition. [Laughter.]

Senator CHAFEE. When you were working with that 10, I am not sure what you were working with.

Senator GRAHAM. Dr. Chen, back to your program relative to the elderly within Medicaid, what proportion of your 20,000 persons are in nursing homes, and what proportion are receiving home care services?

Dr. CHEN. Mr. Chairman and Senator Graham, in the 20,000 long-term care population, we have 8,000 developmentally disabled. Out of the 8,000 developmentally disabled, 95 percent of them are not in institutions. They are being placed in homes in the community, and receive home and community services.

The rest of the 12,000 are elderly and physically disabled. For these 12,000 people, 65 percent are in nursing homes, 35 percent are being served in the home and community services programs.

Senator GRAHAM. If you did not have such an aggressive home and community services program, do you think your number in nursing homes would be larger than the 65 percent of the 12,000?

Dr. CHEN. Yes, Senator. Before we implemented a long-term care program in 1988, I would say about 80 to 90 percent of the elderly, physically disabled people were in nursing homes.

What we have done is build in an incentive for the HMO. Every year when we negotiate a contract with the HMO, we set up a projected percentage of people who may be placed in the home and community services program.

For example, we may set the percentage at 35 percent. Our capitation rate is calculated based on 35 percent of the members this year being in the home and community services program.

If you do better than 35 percent—let us say you place 40 percent of the members in home and community services program—since we all know that people who stay at home cost less, you are going to make money. But the State is going to share the profit with you.

We allow the health plans to keep a certain percentage of the savings when they place more people in a home and community services program.

However, we do have a quality assurance program. When they keep people in their homes, we still do quality assurance review on them.

Senator GRAHAM. Thank you very much, doctor.

Dr. CHEN. Thank you, Mr. Chairman.

Senator CHAFEE. Well, Dr. Chen, you are a walking encyclopedia of facts, and certainly know your program.

Whoever deals with you had got to get up early in the morning, I think.

Let me ask Mr. Martins a couple of questions. I know that, like any new program, TennCare has had its start-up problems, and we understand that.

Dr. Chen gave some steps that she thought should be followed in setting up a program. Of course they have had 13 or 14 years of experience now, and you are just in your first year.

But what advice would you give to other States seeking to implement a similar program, problems they should be careful to avoid?

Mr. MARTINS. Mr. Chairman, I think——

Senator CHAFEE. And, I must say, Tennessee took off a big bite right off, I thought.

Mr. MARTINS. Well, I understand that. I appreciate that.

Mr. Chairman, I think it is important to first distinguish between the pains of health care reform and the pains of implementation and planning of a program, because I think they are two different issues.

I have been in the health care business in Tennessee for some 26 years, and am a State employee that has been a career employee. It is my considered judgment that, when you reform the system, in the magnitude of the reform that Tennessee has done, you are going to experience problems, and you must expect that you are going to experience those problems.

And some of those problems are very predictable. Those who have benefitted from the present system will vehemently oppose any type of reform. And I think you have to deal with that.

Short of that, I think it is important to do a better job in essentially planning the implementation than we did. We did it in a very short time frame. Now there are reasons for having done it in a

short time frame. One, obviously, was the financial situation that the State of Tennessee was in.

The fact of the matter is, Mr. Chairman, that the alternative to health care reform were far more scary than the actual reform.

We were in a situation where we would have had to reduce benefits drastically, reduce the number of people on the program drastically, and continue to the cost-shifting approach that exists in the health care system.

Senator CHAFEE. You mean cut your payments to providers?

Mr. MARTINS. By cost-shifting, I mean cutting payments to providers. Yes, sir.

We believed that we could rapidly move into a managed care system, that we could begin to cover the uninsured, therefore minimizing cost-shifting in the system. And I thought we had to do it in a time frame that was more rapid than would have been ideal. So more planning would have slowed us down.

Also, Mr. Chairman, I think it is important to recognize that, when you reform the health care system, and particularly dealing with a population like the Medicaid population, there is going to be a great deal of confusion in the system.

I do not think absence of confusion is an option, but certainly more education can be done on the front end to minimize confusion in the system.

And a third thing I would do, Mr. Chairman, would be to make more of an attempt to bring the provider groups along with us in the process, which we obviously failed to do a good job of in Tennessee.

Senator CHAFEE. I suppose, when you are dealing with the Medicaid population, you are dealing with a population that is, one, probably sicker than normal and, two, is probably terribly transient. Is it not?

Mr. MARTINS. Yes.

Senator CHAFEE. It is hard to keep them pinned down. They are going hither and yon.

Mr. MARTINS. That is correct.

Senator CHAFEE. I think, Dr. Chen, there has been some discussion of eliminating Medicaid coverage for legal aliens—now, mind you, I am saying legal aliens.

You are a border State. Do you have any views on that?

Dr. CHEN. Mr. Chairman, in Arizona, not only do we cover legal aliens, but we also cover undocumented aliens. But we only provide emergency services to them. We have about 5,000 undocumented aliens in the emergency services program. Of course, we have a lot of legal aliens, but I do not have the number available today.

Senator CHAFEE. That is the first number you have missed, Dr. Chen. [Laughter.]

I have never understood why legal aliens should be denied coverage, but you do cover legal aliens?

Dr. CHEN. Yes.

Senator CHAFEE. Could you tell me the difference, Mr. Martins, between enrolling the Medicaid population in preferred provider organizations, and enrolling them in HMO's, and different shades of that?

It would seem to me that, if you are really going to do it, you might get everybody into an HMO if possible. That is where your greatest savings are going to be, is it not?

Mr. MARTINS. Yes, Mr. Chairman.

Senator CHAFEE. A staff model HMO—if you have got them, if they are available.

Mr. MARTINS. Mr. Chairman, I would say this. Obviously, there is a major difference between the way a preferred provider organization and a health maintenance organization operate.

A preferred provider organization is a heavily discount volume-oriented type of provider of care. And an HMO tends to be a gatekeeper manager type of care. And, if you have your preference in developing a health care system, you would obviously want to use the managed care providers for several reasons.

One, it stresses preventive health, and that is what you are trying to do. And, second, it manages the care of the individual. It actually does a reasonable job of assuring that health care services are provided, and managing those service.

One of TennCare's basic requirements in either a PPO or HMO is that they move toward a gatekeeper approach within 3 years of the contract.

Senator CHAFEE. Now you say they move toward it—the people or the plan?

Mr. MARTINS. The PPO.

Senator CHAFEE. The PPO.

Mr. MARTINS. If you are a contractor of TennCare, by virtue of signing the contract, you have made an agreement that you must have a gatekeeper program in place within the third year of your contract.

The major PPO in Tennessee, Blue Cross-Blue Shield, has signed a 5-year contract with the TennCare program. They are already beginning to move toward gatekeeper approaches.

The question that you asked concerning a staff model, versus other health maintenance organizations, I too believe that there are probably greater savings in a staff model HMO. However, I believe there are also savings in HMO's that are not staff models. I believe the data I have seen shows anywhere from 12 to 15 percent.I think the data that Ms. Richardson referred to was 19 percent in a staff model. They clearly have a higher savings, but that does not mean that non-staff models do not have savings.

Mr. MARTINS. We have one staff model in Tennessee, Prudential, that operates in Shelby County in West Tennessee. And I think they have clearly shown the ability to provide services at less cost than some of the HMO's that are not staff model HMO's. But I would say that there is room for both.

Senator CHAFEE. Do any of you have a prediction as to what we, the Federal Government, might expect if we should block grant the Medicaid programs to the States, what we could expect for an annual percentage of growth? I know that is putting you on the spot, but I am just wondering if any of you would venture.

Your annual increase 1 year was 1 percent, was it not, Dr. Chen?

Dr. CHEN. Yes, Mr. Chairman.

Senator CHAFEE. What would you say would be something you could live with for a percentage increase?

Dr. CHEN. Mr. Chairman, actually we have a couple of concerns about a block grant option.

It is good to give the States flexibility to design the program they want. However, when we calculate a block grant, or the block grant distribution, what we would like the Congress to consider is future population growth. For example, Arizona is one of the States where the economy recovered much faster than the States around us.

So, in the last 12 months, we had a lot of people move to Arizona. But Arizona has not experienced any big increase in the Medicaid population. So this is one concern—the future population growth, which may not be included in the base year.

Number two, in a program like AHCCCS in Arizona, we have implemented managed care for the last 12 years. Our program is very efficient and effective now. But we do not want it to be penalized just because we run an efficient program. You would take 1 year, 1993, 1994, or 1992 as a base year, and give us either 4 or 5 percent increase. We feel that we are not being treated fairly.

The third thing is a lot of States are moving in the direction to extend Medicaid eligibility to cover working poor. So why does a State start an initiative to extend a program, when Congress is considering to provide a block grant to the State Medicaid program? We would like to ask you to consider the extension in the base year. Otherwise, it will be very difficult to calculate what percentage of increase would be sufficient to support a State Medicaid program.

So, in conclusion, every State Medicaid program is different. And the States are all doing different things to change, to reform their Medicaid programs.

So, when you consider to provide block grants to the States, we hope these specific situations would be considered when you develop the formula.

Senator CHAFEE. I see.

And, Mr. Martins?

Mr. MARTINS. Mr. Chairman, I would suggest to you, as Dr. Chen did, that States will vary in their ability to deal with Medicaid systems and health care systems.

Our average growth over 5 years in the waiver, but not each year, is 7.1 percent, with the objective at the end of the 5 years to get it down to 5 percent growth. And we are covering the uninsured population.

I think it is important though, in looking at a block grant—and many States may consider this heresy, but I consider it responsibility—that several conditions ought to be looked at.

First of all, I think it is important that funds be used that are block granted to provide services to the beneficiaries that they are intended to provide services to. And that is to the Medicaid and, to the extent possible, to the uninsured population.

Second, I also think it is important for States to continue at some maintenance-of-effort level in the support that States are providing, in terms of dealing with the Medicaid and uninsured populations.

And, third, I believe that there needs to be some quality assurance oversight into the system, perhaps less than currently exists, but some.

I also believe that you need to really look at where States are in their implementation of programs before a block grant just arbitrarily sets a limit of 4½ to 6 percent. I think it is extremely important to see where States are, and what States are doing because today, unlike 3 years ago, States are at different level of providing health care to their populations. And States are even beyond the "traditional" Medicaid population. And that requires a different look, in terms of how percentages are calculated and looked at.

Senator CHAFEE. Well, I am asking these questions just because there has been talk of a block grant. I do not want anybody here to have the impression that I am necessarily for it. But I am curious to find out some thoughts from those of you in the front lines.

Thank you very much. I appreciate both of you coming, Dr. Chen and Mr. Martins. That was very good testimony.

Dr. CHEN. Thank you.

[Whereupon, on 4:30 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF MABEL CHEN, M.D.

Good afternoon Mr. Chairman and Members of the Senate Committee on Finance Subcommittee on Medicaid and Health Care for Low-Income Families. It is a pleasure to be here and discuss Arizona's Medicaid program and the 1115 waiver process as it impacts Arizona.

I will address the status of our existing 1115 waiver, the cost effectiveness of our program and the impact of managed care on the members enrolled with our system and our providers. Lastly, I will provide you with some personal insights on the 1115 waiver process and some ideas you may wish to consider. However, before I address these issues, I believe it would be helpful to give you a brief overview of our program and the 1115 waiver we have operated under since 1982.

The Arizona Health Care Cost Containment System, referred to as AHCCCS, is Arizona's Medicaid program and the state's health care program for persons who do not qualify for Medicaid. It is a statewide, managed care system which provides health care services to 457,000 persons: 404,000 are eligible for the Medicaid acute medical care program, 20,000 persons are enrolled in the Medicaid long term care program and 33,000 additional persons receive state-funded managed care through our Health Plans.

As a historical perspective, until October 1, 1982, Arizona was the only state in the nation without a Medicaid program. Prior to that time, health care for the indigent was provided and fully funded by the Arizona counties. In 1981, the State Legislature and the Governor recognized that the counties could not continue to pay the full cost for health care and began to explore various options which would relieve the counties and, for the first time, bring federal Medicaid dollars to the state.

Central to these discussions was a determination by state leaders to create a managed care delivery system which could deliver quality services, control costs, discourage the use of emergency rooms for primary care and avoid fraud and abuse practices which were reported in fee-for-service programs. In 1981, the legislature passed legislation to create AHCCCS as the first statewide, Medicaid managed care system in the nation based on prepaid, capitated arrangements with Health Plans.

In 1982, Arizona sought approval from the Health Care Financing Administration (HCFA) to operate AHCCCS based on the managed care principles approved by the legislature. In July 1982, HCFA approved the waiver, initially granting the state authority to operate an acute medical care demonstration program for three years. The waiver has been continually renewed by HCFA since the beginning; the most recent extension authorizes AHCCCS to operate until October 1, 1997.

The Subcommittee should know that the first few years of the AHCCCS program were both difficult and challenging. Since the state did not have a Medicaid administrative system in place, we had to create a new infrastructure from the ground up without sufficient time to develop the administrative structure before the scheduled implementation date. The service delivery system was not developed since it was difficult to attract enough financially viable Health Plans and develop an adequate provider network to serve the initial membership in the program. In contrast to the early years of the program, AHCCCS received an unprecedented 95 proposals from 21 different organizations to serve its membership in the 1995 bid cycle.

Today, states initiating managed care programs have the advantage of a much more mature managed care infrastructure as well as the opportunity to learn from Arizona. Clearly, states must build the necessary administrative systems to convert from traditional fee-for-service programs to managed care systems. This takes time,

resources and the commitment to overcome the start-up problems that any new program of this magnitude is likely to face.

AHCCCS has overcome the early problems of the program and, after 12 years of operation, has provided guidance to other states about our problems in beginning a managed care system. Perhaps one of the most fundamental lessons for managed care systems is that the Health Plans and providers are partners in any managed care effort. From the beginning, the AHCCCS program was envisioned as a private and public partnership which would use private and county-operated managed care Health Plans to mainstream Medicaid recipients into private physician offices. AHCCCS and the Health Plans were instrumental in building the provider networks necessary to realize this vision which is reflected by the fact that approximately 70 to 80 percent of all physicians and other primary care providers in this state actively participate in AHCCCS. These individuals are crucial to the program's success since they serve as gatekeepers for the system, improving access to care while managing all aspects of a member's medical care, without sacrificing quality of care.

In addition to the partnership with the Health Plans and primary care providers, AHCCCS recognizes that it must fulfill the same commitment to our members. I believe that we have lived up to that commitment. Outside evaluations of the program performed in 1989 by the Flinn Foundation indicated that " . . . the overwhelming majority of AHCCCS enrollees (95 percent) say they are completely satisfied with the program." A more recent member satisfaction survey indicated that 90 percent of women receiving prenatal care were "satisfied" to "very satisfied" with their care. AHCCCS is committed to the ongoing assessment of member satisfaction and will provide the results of satisfaction surveys to members to use when selecting Health Plans.

One of the cornerstones of the AHCCCS program which promotes member satisfaction is the member's ability to select a Health Plan and primary care provider. Medicaid members have a choice of ten Health Plans in Maricopa County (Phoenix); five Health Plans in Pima County (Tucson) and at least two Health Plans in the remaining counties. AHCCCS has found that over 56 percent of all Medicaid members exercise their right to select a Health Plan. Once a member chooses a Health Plan, the member stays with the Health Plan until the next open enrollment period, which is scheduled in August of each year. Historically, the number of members electing to change Health Plans has been low, averaging five percent of all enrolled members.

In order to ensure that members receive quality services which are not only adequate but accessible, AHCCCS has implemented a quality management program which relies on outcome measurements. The Health Plans have joined in this initiative and many have adopted programs which exceed the requirements contained in their contracts.

The AHCCCS program has been cost effective for the state and federal government. In 1993, Laguna Research Associates published their *Second Outcome Report* for HCFA and concluded: " . . . for the first nine years of the program, AHCCCS was able to constrain cost increases 44.1 percentage points below the projected cost of a traditional Medicaid program in Arizona. For the period from FY 83 to FY 91, the average annual increase in AHCCCS per capita cost was 6.8%, compared to 9.9% for a traditional Medicaid program." Contrary to assertions by opponents of managed care, our savings were not just one-time savings. This has benefited the state financially and validates the cost containment features of managed care. The most recent savings for the state and federal government occurred in the 1994 through 1997 contract cycle. Through the increased competition in this bid cycle, AHCCCS was able to reduce capitation rates paid to the Health Plans by eight percent when compared with the 1993 rates.

The main reasons AHCCCS has been able to contain costs when compared with fee-for-service systems is the role of Health Plans and primary care providers in encouraging preventive care, the nature of the competitive bidding process and the cost containment features of capitation arrangements. The 15 AHCCCS Health Plans are paid an up-front, or prospective, monthly capitation amount for each member enrolled with the Health Plan. AHCCCS uses an independent actuarial firm to develop the rate ranges, not the actual rates, which are the basis for the capitation rates. When a Health Plan submits a bid to participate in the AHCCCS program, the Health Plan agrees to provide a specified set of services for an established capitation rate for any individual within the contracted geographic area. Under this arrangement, Health Plans are at-risk for the services provided to a member since they must absorb the loss if the medical costs for a member exceed the monthly capitation payment made to the Health Plan. However, reinsurance is

provided to the Health Plans as financial protection against significant medical costs experienced by any one individual.

As I stated earlier, AHCCCS has been approved to operate its program under the current 1115 waiver until 1997. Just last week, the State submitted an amendment to the waiver, contingent on approval by the Arizona legislature, which will allow us to significantly streamline our eligibility determination process and offer health care services to low income and working poor individuals who have income levels up to 100% of the federal poverty level. We are hopeful that HCFA will approve the amendment and allow AHCCCS to move in new directions.

AHCCCS would not be the successful managed care program it is today without the strong support and assistance we receive from HCFA. In the early years of the program, the 1115 waiver process was much more cumbersome as both HCFA and the states attempted to break new ground and implement managed care programs. Recently, HCFA has concentrated on streamlining the waiver process and providing technical assistance to states who want to submit 1115 waivers. Nonetheless, the Section 1115 waiver process, both to initiate and renew, requires a substantial investment of state and federal resources and time.

If you believe as we do that the AHCCCS program is a sensible model for delivering high quality, affordable health care to low income populations, then states must be given the flexibility to implement these changes either through changes to existing federal statute which governs the Medicaid program or through the continuation of a streamlined waiver process. There are many barriers in federal law which make it impossible for states to operate a managed care program without a waiver. In fact, without our waiver, AHCCCS would be forced to convert to a fee-for-service approach or significantly modify our program.

Let me provide a few examples of the managed care barriers we face under current federal law as opposed to the way we operate under an 1115 waiver:

- Health Plans participating in the Medicaid program must either be Medicare certified HMOs or state licensed HMOs. The requirement was probably intended to protect members from financially unstable providers who provided low quality care. However, the requirement actually restricts the types of organizations who can provide services to Medicaid members. In lieu of certification or licensure, the AHCCCS program conducts ongoing operational and financial oversight and monitoring of its Health Plans which exceeds most state licensure processes.
- Medicare and Medicaid members can represent no more that 75 percent of total Health Plan enrollment. Since many of our Health Plans were formed to serve the AHCCCS population, they do not meet this requirement under the terms of our 1115 waiver. Although the 75/25 rule was designed to serve as a proxy for quality care, commercial and governmental managed care programs today have much more well-defined measures of quality of care than what is embodied in the 75/25 rule.
- AHCCCS could not guarantee six months enrollment to its members without a waiver nor could AHCCCS ask its members to select a Health Plan once a year as most of us do for our own health care coverage. Instead, AHCCCS would have to allow members to change Health Plans at any time without cause which prevents us from stabilizing the health of the members and protecting our Health Plans from unmanageable risk.
- Under existing freedom of choice restrictions, AHCCCS could not operate a comprehensive managed care program. We would be forced to operate a parallel fee-for-service system—an approach which would totally compromise the managed care benefits of our system.

These are some of the key barriers to managed care. However, Arizona and other states face other barriers which hinder creative programs in the areas of eligibility, provider reimbursement policies and services. Under current law:

- States cannot simplify current Medicaid eligibility rules by adopting a single income standard and must provide three months of retroactive coverage to those found eligible. It is impossible to "manage" care retroactively under these conditions.
- States can not pay the best price available in the market because of various courts' interpretations of the Boren Amendment and its impact on the payment rate for institutional services.
- States cannot adopt a commercial benefit package for Medicaid members because of mandatory benefit requirements and restrictions on copayments, even for the non-emergency use of the emergency room.

Any change in federal law should consider the diversity of the states and the need for flexibility in these areas.

I appreciate your interest in managed care programs and 1115 waivers and encourage you to do what you can for states who have managed care programs which are dependent on waivers for their very existence. After 12 years of operating on an 1115 waiver, AHCCCS is aware that this state does not have a "permanent" program. Although I am confident that HCFA will not terminate our program or withdraw their support, I am perplexed that a state can operate a program which works, saving money and providing quality care, yet has no means to achieve permanent status. At a minimum, I believe that under federal law there must be some latitude for states to operate permanent managed care programs which are not subject to the continual waiver renewal process.

Mr. Chairman, members of the Subcommittee, if you have any questions, I would be pleased to answer them.

AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Committed to excellence in health care

Fife Symington
Governor

Mabel Chen, M.D.
Director

April 27, 1995

Editorial Section
Committee on Finance
Room SD-219 Dirksen Building
Washington DC 20510

Re: ADDITIONAL QUESTIONS FROM MARCH 23 HEARING

Dear Ladies & Gentlemen:

This letter is in response to additional questions for the members of Panel II posed by Senator Moseley-Braun. I am responding to the Senator's question about managed care in rural areas.

The AHCCCS program is a statewide managed care system serving the health care needs of persons located in two urban centers; the balance of the population is located in less populated, rural counties. Therefore, building a network of health plans and practitioners in the rural locales of the state was critical to the success of the program. Currently, AHCCCS has two Health Plans in each rural county and can offer a choice of Health Plans to members located in our rural counties.

Recently, AHCCCS developed a strategy to attract more offerers in rural counties. In the last bid cycle, we limited the number of Health Plans who would receive a contract in each of the rural counties to a maximum of two Plans. This ensured prospective bidders that they could bid and secure sufficient enrollment to make the investment in the rural areas worthwhile. Secondly, by limiting the number of Health Plans in a given county, practitioners were assured that paperwork would be kept to a minimum which is an incentive to participate in AHCCCS. Our Health Plans also contract with the nine Federally Qualified Health Centers in the State which further expands the available network in rural and underserved areas.

I believe that managed care has been extremely successful in this State, particularly in the rural areas. Access to care has improved in the rural areas, directly benefiting the members enrolled with the system. It is critical that managed care programs recognize the pivotal role that Health Plans and practitioners play in the overall delivery of care. Medicaid agencies must encourage the active participation of these entities to improve the delivery of health care to the members, streamline the bureaucracy inherent in any major public program and to maximize practitioner participation, particularly in rural areas.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Mabel Chen

Mabel Chen, M.D.
Director

PREPARED STATEMENT OF ORRIN G. HATCH

Mr. Chairman: Thank you for allowing me to the opportunity to comment on the Medicaid program and waivers under section 1115 of the Social Security Act.

The state of Utah is in the process of submitting an 1115 waiver application. So as you might imagine, I have a very personal interest in making sure that States have the option of being innovative in providing needed health care services, in a high quality and cost effective manner.

As the Committee is aware from his testimony last year, the Governor of Utah, Mike Leavitt established a health policy committee which outlined a strategy for a state initiated health reform effort. Our "Health Print" was developed to utilize Medicaid expansion as a tool to cover individuals who have limited access or no access to health insurance.

Due to our time constraints, I will not go into full detail of the Utah health plan. However I will say that the goal is to bring all individuals up to 100% of the federal poverty level into the Medicaid program regardless of whether those individuals fit the federal categories that have been traditionally necessary to qualify for Medicaid.

Since Utah is still in the process of submitting the 1115 waiver, I will just mention a few highlights of the program:

- Approximately 56,000 new recipients, mainly the working poor, will become eligible for Medicaid.
- Eligibility for the program will be simplified and recipient reporting requirements will be streamlined.
- A voluntary, employer-based health insurance program will be developed to provide low-income employees with Medicaid subsidies, on a sliding fee basis. This will be a joint effort with both the employer and the employee, along with the state and federal governments, all participating in funding the program.
- And finally, there will be on-going evaluation and testing of this program with outcome studies to assure patient satisfaction and high quality, cost effective care.

I am very excited about the potential of this program in Utah. While certainly, the issue of cost is a primary driver of this initiative. However, another "driver" of this system, which I consider even more essential, is providing access to necessary health care services that many citizens have been shut out from in the past.

I fully support the expansion of the 1115 waiver program and believe that the state of Utah will prove to have an exemplary program.

PREPARED STATEMENT OF MANUEL MARTINS

On New Year's Day, 1994, Tennessee made history by withdrawing from the Medicaid program and implementing an innovative new health care reform plan called TennCare. TennCare required no new taxes and extended health coverage not only

to the nearly 800,000 Tennesseans in the Medicaid population, but also to approximately 440,000 uninsured persons using a system of managed care.

Without radical change, the uncontrollable growth in the cost of Medicaid threatened the financial stability of state government and the quality of Tennessee's health care delivery system. Simply maintaining the previous level of Medicaid services would have required annual tax increases and/or annual reductions in services that were unacceptable, while the working poor and other uninsured Tennesseans would have remained without coverage. It was determined that fundamental reform of the Medicaid program was the only acceptable alternative.

In order to implement TennCare, the State of Tennessee was granted approval by the Health Care Financing Administration for a five year demonstration project under Section 1115 of the Social Security Act. TennCare replaced the existing Medicaid program with a program of managed health care. Enrollees now choose between Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs), and (in most health plans) choose a "gatekeeper" primary care provider to personally manage their health care. All of the plans are required to have a "gatekeeper approach" by 1996.

TennCare services are provided by HMOs and PPOs and the benefit package is similar to that offered to state employees. Excluded from the managed care component of TennCare are long-term care services and Medicare cross-over payments which are continuing as they were under the former Medicaid system.

The first phase of TennCare has focused on the provision of all medical services and episodic mental health care. At the present time we are finalizing arrangements to bring under the managed care organizations (MCOs) services for the severely and persistently mentally ill. Future plans are to privatize services to children in the custody of the State, as well as services to the developmentally disabled population. MCOs will receive additional capitation payments for serving these groups. Inclusion of these vulnerable populations in TennCare will result in a consolidation of many State services in a privatized system.

After having been in place for a full year, TennCare has experienced dramatic results. There are twelve competing managed care organizations, primary care access is improving, non-emergency use of emergency rooms is down, and hospital days are down. As of February 1, 1995, there were 1,221,225 enrollees in TennCare (783,052 Medicaid enrollees and 438,173 uninsured enrollees) resulting in approximately 92% of all Tennesseans having health insurance. There are more than 7,000 physicians currently participating in TennCare. More than 2,500 primary care providers are contracting with MCOs and serving the TennCare enrollees.

The financial savings resulting from TennCare's implementation are equally dramatic. The increase in expenditures for Medicaid/TennCare from State Fiscal Year 1993 to State Fiscal Year 1994 was less than 1%. This resulted from the six months of TennCare implementation in the 1994 fiscal year. It is projected in the State Fiscal Year ending June 30, 1995, that approximately $1,000,000,000 in state and federal funds will be saved because of TennCare's implementation. That savings will occur with approximately 440,000 uninsured enrollees who previously lacked insurance now being covered.

While the program continues to experience some problems as any program in its infancy does, the success of the program has been beyond expectations.

PREPARED STATEMENT OF HON. CAROL MOSELEY-BRAUN

Thank you Mr. Chairman for convening today's hearing on medicaid waivers. My own State is in the midst of the medicaid waiver process and I am very interested in the experiences of those States that have implemented waivers. Several States, Arizona and Oregon, appear to have successful waivers in place. The news from Tennessee and Florida, however, appears to be mixed.

I am pleased that HCFA officials are testifying today. I am very interested in learning about the HCFA waiver approval process. In order to reduce soaring medicaid costs states have sought waivers to institute program-wide changes in service delivery such as managed care. I support State efforts to provide a continuum of care for medicaid beneficiaries and efforts to control costs. In Illinois, however, there are several problems with the existing medicaid program. It is very important that Illinois' pending waiver not exacerbate the existing problems nor deny access to services for medicaid beneficiaries.

Again, Mr. Chairman I believe this is a timely and important hearing. I look forward to hearing the testimony.

PREPARED STATEMENT OF SALLY K. RICHARDSON

Mr. Chairman and Members of the Committee:

I am pleased to be here this afternoon to discuss the Health Care Financing Administration's role in State health care reform demonstrations. As you know, more and more States are reforming their health care systems through Medicaid demonstration programs.

BACKGROUND

States typically request waivers of Medicaid provisions to make specific types of changes to their Medicaid program. The most common program waivers are freedom of choice waivers and home and community-based services waivers, which are authorized by section 1915 of the Social Security Act. This authority enables States to more efficiently organize their Medicaid programs and to target specific populations for specific services. Under section 1915 program waivers, States may establish primary care case management programs or require Medicaid beneficiaries to enroll in managed care plans. States may also provide home and community-based services to their Medicaid populations who would otherwise be institutionalized. These program waivers permit States to make meaningful changes to their Medicaid programs, but do not provide States the opportunity to pursue more innovative approaches.

In contrast, demonstration waiver authority gives States the flexibility and discretion to test new strategies for organizing, financing and delivering health services to low-income populations. Section 1115 of the Social Security Act gives the Secretary broad latitude to permit demonstrations that further the goals of the Medicaid program. Through these programs, States may test the effectiveness and efficiency of their new ideas. Historically, States have sought demonstration authority to test relatively narrow changes, such as changes to the Medicaid benefit package, payment methodologies or eligibility requirements for a defined group of beneficiaries or services. More recently, States have begun to develop broad, Statewide reform programs under this demonstration authority.

Prior to 1993, Arizona operated the only Statewide Medicaid demonstration program. However, since 1993, HCFA has approved Statewide health reform demonstrations in seven more States—Oregon, Hawaii, Tennessee, Rhode Island, Kentucky, Florida and Ohio. We have also approved South Carolina's program framework and are working with the State to build system infrastructure and award waivers. Tennessee, Oregon, Rhode Island and Hawaii implemented their programs during 1994. As a direct result of these demonstrations, an additional 550,000 low-income Americans now have health coverage. Once Kentucky, Florida and Ohio obtain authorizing legislation and begin enrollment, approximately 1.5 million more individuals could be covered.

More States may soon follow. HCFA is currently reviewing ten additional demonstration applications from Massachusetts, Delaware, Minnesota, Missouri, New Hampshire, Illinois, Louisiana, Oklahoma, Vermont and New York. We also anticipate receiving new applications from several other States.

Because of these demonstration activities, a significant portion of Medicaid funds will be spent in States with approved or pending demonstration programs. Total acute care spending in States with approved Statewide demonstrations accounts for over 11 percent of all Medicaid expenditures. Total acute care expenditures in States with pending applications represent an additional 17.4 percent of total Medicaid spending. As a caveat, these estimates include acute care services for populations that are not included in the demonstration program—which in States that have not included the aged and disabled in their waiver requests may be a substantial portion of their acute care spending.

States also continue to develop smaller-scale demonstration programs under 1115 demonstration authority. HCFA has approved twenty-three smaller, more targeted demonstrations since January 1993. Some of these demonstrations provide preventive services to low-income children, extend coverage of family planning services beyond the sixty-day postpartum limit, and establish alternative delivery systems in sub-state geographic areas.

Finally, State efforts to reform their welfare systems often interact with the Medicaid program. The Department also approves welfare reform demonstrations, using the section 1115 authority for both AFDC and Medicaid. While the Administration for Children and Families is the lead agency for welfare reform demonstrations, HCFA has concurred with the approval of fourteen welfare demonstrations that affect the Medicaid program.

STATES' INTEREST IN DEMONSTRATION PROGRAMS

States are proposing demonstrations under section 1115 waiver authority in order to test new approaches to improving the Medicaid program within limited resources.

First, many States intend to simplify Medicaid eligibility rules and simultaneously expand coverage to low-income residents who are excluded from the Medicaid program under current rules. Some States also want to promote coverage expansions by establishing a partnership with the private sector to encourage employer and individual participation in health reform programs for low-wage workers. This emphasis on streamlining eligibility and expanding coverage is at the heart of many demonstration programs.

Second, most States want to experiment with managed care and other innovative delivery systems. Many have sought to improve the efficiency and effectiveness of their Medicaid programs by enrolling current and new Medicaid beneficiaries in prepaid, capitated managed care arrangements. States believe that managed care systems will improve their current system infrastructure and enhance access to primary and preventive care for these vulnerable populations, while prepayment arrangements will lend greater predictability to Medicaid spending. States also want to encourage health plans and providers to develop new types of delivery systems that are designed to serve the special needs of low-income populations.

To date, States have developed demonstration programs that largely focus on managing acute care services for low-income women and children and, in a few cases, the aged and disabled. Because States are just beginning to enroll disabled and elderly populations in managed care, there is little experience with managed care's effects on cost and quality for these groups.

States also want to pursue other innovations. For example, States must currently contract with health plans that maintain a minimum commercial enrollment of 25 percent; this enrollment composition requirement serves as a rough proxy for quality of care. Section 1115 demonstration waivers afford States the opportunity to experiment with other approaches to quality assurance.

HCFA'S PRIORITIES FOR DEMONSTRATION PROGRAMS

President Clinton is committed to encouraging innovation and flexibility within the Medicaid program in partnership with the States. HCFA has fulfilled this commitment through our work with the National Governors' Association on parameters for Medicaid demonstrations, our efforts to streamline the application process, and our efforts to foster innovation by working with States as they move from concept development through implementation.

We focus much of our effort on reviewing States' demonstration applications and working with States to refine and strengthen various program elements that are of high priority to HCFA.

- *Protecting Beneficiaries*—First, we pay close attention to the program's impact on current Medicaid beneficiaries. HCFA seeks to ensure that the current Medicaid population retains effective coverage under a demonstration program.
- *Quality and Access*—We also concentrate on protecting all enrollees within demonstration programs in terms of access to quality health care. We carefully evaluate each proposal to determine whether the State has developed a performance-based quality improvement program and can guarantee access to critical health services. We work particularly closely with States to develop agreements on monitoring, quality assurance activities, and access standards.
- *Innovation*—Third, we look for innovative demonstration programs. States have sought to cover a variety of low-income populations through a spectrum of financing and delivery mechanisms while strengthening their existing Medicaid programs. We welcome these State-specific solutions to the near-universal problems of fragmented delivery systems, poor access and inadequate public and private insurance participation.
- *Feasibility*We also assess the program's overall feasibility. We ask whether the State has the health system infrastructure and capacity it needs to make the program a success, and we examine how program elements fit together to assess whether they comprise a workable whole. In a case where we were not comfortable moving forward with a proposal after we posed these questions—and worked with the State to answer them completely—we followed a more incremental approach that relies on pre-implementation milestones and enables the State to continue developing its program in partnership with the Federal government.

We also ensure that each proposal meets certain approval criteria. First, we ensure that States solicit and consider public input when designing their demonstration programs. Because HCFA believes that program beneficiaries should play a

central role in a demonstration program's development, we recently published public notice guidelines in the Federal Register.

Second, proposals must be budget neutral. A program is budget neutral if we anticipate that Federal matching payments will not exceed Federal payments without the demonstration. The Federal government and the State agree in advance to the amount of Federal financial participation available to the State during the demonstration period. We have found that agreeing on this projection is often the most difficult and time-consuming part of the application process.

Finally, HCFA focuses on evaluation issues and monitoring plans. We are always aware that these demonstration programs, if they are to be of real value to policy makers, must be rigorously evaluated. To support our evaluation efforts, we work with States as they design data collection efforts that complement both Federal and State research needs and ensure comparability across States. We also see program monitoring as a component that converges closely with evaluation, so we work with States to ensure that the day-to-day implementation and long-term outcomes of each demonstration program can be adequately monitored.

RECENT ACCOMPLISHMENTS

States have used demonstrations to make significant improvements to their Medicaid programs. Through earlier demonstrations, States have tested new approaches to serving the Medicaid population, such as home and community-based services, that are now commonplace. States also first tested Medicaid managed care innovations through 1115 demonstrations in Arizona, Minnesota and Wisconsin. Today's demonstration programs continue this tradition. They have strengthened State delivery systems, expanded health coverage for low income Americans, and developed new strategies for measuring and monitoring quality of care. Each State has used a different strategy to realize these goals.

For example, Rhode Island expanded Medicaid coverage for pregnant women and children through the RIteCare program. RIteCare enrolls over 31,000 AFDC recipients, pregnant women and children under age 6 with incomes below 250 percent of poverty into five fully-capitated managed care plans. The State seeks to demonstrate that RIteCare's emphasis on primary and preventive services—health plans must provide enhanced outreach and preventive services, such as nutrition counseling, home visits and parenting skills education, to RIteCare enrollees—will improve access to primary care and enhance enrollees' health status. Rhode Island also bolstered its commitment to primary care by including a health plan established by Federally-qualified health centers among its range of capitated providers. Rhode Island is also developing a new demonstration program for adults with developmental disabilities. The CHOICES program will consolidate State and Federal funding sources for this population into a single managed care delivery system organized under the managed competition model. HCFA is working with the State to more fully develop this proposal, and anticipates awarding Rhode Island a planning grant to assist this effort in the near future.

An approved-but-not-implemented demonstration, the Florida Health Security program, is expected to provide an opportunity to evaluate the ability of a voluntary, employer-based premium program to provide access to health insurance for low-income uninsured individuals and families. Florida Health Security would use a managed competition model to provide health insurance to approximately 1.1 million Floridians with incomes below 250 percent of poverty who are not Medicaid-eligible. Community Health Purchasing Alliances would broker the competitive interaction between health plans, while program participants would choose among alliance health plans using a combination of income-related Florida Health Security premium discounts and individual and employer-financed premium payments.

The Hawaii QUEST program has created a "seamless" delivery system by integrating Hawaii's Medicaid program with two State-funded programs for low-income residents. Under QUEST, participants with incomes below 300 percent of poverty no longer need to move from program to program as their income fluctuates.

Other indications of recent accomplishments include client satisfaction with Tennessee's TennCare program—eight out of ten TennCare participants are pleased with their care under the demonstration—and Oregon's success in implementing the complicated combination of a program expansion, move to capitated managed care, and use of a priority list to define covered services. While Oregon has worked to build managed care capacity throughout the State, it has also responded to local conditions by maintaining its primary care case management system in eight rural counties.

FUTURE DIRECTIONS

We have already learned many lessons from our intensive partnership with the States on Statewide health reform demonstrations. We have learned how important early dialogue, technical assistance, and well-thought-out implementation can be to the ultimate success of a demonstration program. Monitoring also plays a critical role in early-problem solving, averting crises and protecting beneficiaries. And we have learned that HCFA must adapt its internal processes to respond to the innovations facing us in the rapidly evolving world of State demonstration programs.

But some of our program discoveries are even more significant than these administrative lessons. These demonstrations will provide information on positive changes that may be applicable in other States or to the Medicaid program as a whole. States are developing new uses for encounter data and quality measures for monitoring quality of care and supporting quality improvement efforts. We expect that these demonstrations will bolster our efforts to develop new quality protections for Medicaid enrollees. We are also learning a great deal about managed care networks, including effective health plan designs and the numbers and types of providers needed to serve low-income populations. We have renewed appreciation for the importance of program planning, and we know that implementation timing and infrastructure development significantly affect a program's initial success. Finally, we believe we will discern a great deal about access—that is, how States can overcome financial and non-financial barriers to health care services that currently face low-income populations.

HCFA believes that we must use these lessons to approach the Medicaid program with leadership, vision and flexibility. In cooperation with the States, we must identify unmet needs and foster the innovation to address them. We believe that we can provide access to superior health care through Medicaid as long as we work as partners with the States and Congress to improve the Medicaid program.

CONCLUSION

HCFA welcomes State efforts to test innovations in State health reform. We are committed to using section 1115 demonstration authority to strengthen the current program. We will continue to work with States to develop demonstration programs that meet our important goals of protecting current beneficiaries and future enrollees, establishing innovative approaches and testing workable new program designs. We believe that these demonstration programs will illuminate positive new directions for the Medicaid program.

RESPONSES OF MS. RICHARDSON TO QUESTIONS FROM SENATOR MOSELEY-BRAUN

Question: How is HCFA ensuring against discrimination to beneficiaries under section 1115 waiver demonstrations?

Answer: In the review and approval process for section 1115 waivers, the Health Care Financing Administration works to ensure against discrimination of beneficiaries. During the review process, HCFA pays close attention to the structure of the proposed demonstration for attributes that could result in discrimination. One standard special term and condition of the award of waivers states that the process of contracting with managed care organizations will be open to all entities that meet participation standards, including minority-owned entities or providers. Also, as part of the review process a State must meet a series of Public Notice Requirements. These requirements include a public comment period, where advocates can give input concerning the proposed demonstration. During the demonstration, HCFA works with States to monitor the demonstration for problems of quality and access. Finally, HCFA will be conducting an independent evaluation of each demonstration. An extensive analysis will be conducted to determine whether beneficiaries are adversely affected under the demonstration.

Question: Does HCFA require the collection of utilization data by race?

Answer: HCFA does not generally require the specific collection of utilization data by race. Encounter level data, whether it be on a fee-for-service or capitated basis is collected and could potentially be cross-referenced with eligibility files to create utilization counts by race. Under the evaluation, HCFA will require its evaluation contractor to do analysis by eligibility groups and race.

PREPARED STATEMENT OF WILLIAM J. SCANLON

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to testify on the status of pending and approved statewide Medicaid waivers author-

ized by section 1115 of the Social Security Act (42 U.S.C. 1315) and on the effect these waivers have on access to and quality of care for Medicaid patients and providers. Our testimony is based on (1) numerous reports we have issued over the years on the Medicaid program and (2) states' experiences with Medicaid managed care programs.

The Congress has begun reexamining the $131 billion Medicaid program—one of the fastest growing components of both federal and state budgets. In 1993, Medicaid cost almost $100 billion more and served about 10 million more low-income recipients than it did a decade ago. To deal with this cost and enrollment explosion, many states are seeking greater flexibility in implementing statewide Medicaid managed care programs. Currently, the degree of flexibility being sought is available only through the waiver authority established by section 1115.

In brief, we found that while a large number of states have expressed interest in implementing waivers, only four states have waivers in place. Two additional states have received federal approval, but their plans still must be ratified by state legislatures.

As states move into managed care, they face significant challenges with this major shift in program focus away from the traditional fee-for-service system. More specifically, the emphasis that states place on program implementation and oversight may significantly affect the degree to which states' managed care programs are successful in containing costs while increasing access to quality health care.

BACKGROUND

Through section 1115 of the Social Security Act, the executive branch has been given broad authority to waive most requirements of the federal Medicaid statute to facilitate projects likely to further the objectives of the 30-year-old Medicaid program. The Health Care Financing Administration (HCFA) is the federal agency responsible for managing Medicaid. In 1993, in the midst of a national debate over eliminating barriers to health insurance, a handful of states sought section 1115 waivers from HCFA to simultaneously achieve two interrelated goals: (1) expand coverage to the uninsured and (2) contain the cost of publicly funded programs by shifting from fee-for-service to managed care delivery systems. The stated intent was to permit more individuals to be covered at little or no additional cost through more efficient delivery of medical services. The only prior use of section 1115 authority comparable to recent statewide waiver applications was the 1982 initiation of a managed care program in Arizona, a state that previously had not participated in Medicaid.

During 1994, the growing number of applications and the interest shown by many states has shifted section 1115 waivers from the fringes to the center of the debate over how the Medicaid program should evolve. The Clinton administration has favored linking managed care flexibility to expansion of Medicaid to previously ineligible groups. However, at least one recent section 1115 waiver applicant asked for greater flexibility to pursue managed care without expanding eligibility. This raises the question of whether states should be free or even mandated to adopt managed care as the standard for Medicaid.

The statewide section 1115 waivers, approved and pending, have certain common features. Most seek to expand Medicaid coverage to broader populations than those covered under the standard program. All of the states are seeking to use mandatory enrollment in capitated managed health care plans to better control program spending. While some states are limiting managed care to the Aid to Families with Dependent Children program (AFDC) and AFDC-related populations of women and children, others are expanding managed care to the aged and disabled, creating new challenges for these states and the participating health plans because these persons are not normally served by either public or private managed health care plans.

BARRIERS AT THE FEDERAL AND STATE LEVELS EXIST TO STATE USE OF SECTION 1115 WAIVERS

Since 1993, nearly half of the states have sought a statewide section 1115 waiver. However, only four states—Tennessee, Oregon, Hawaii, and Rhode Island—are actually implementing waivers today. (App. I shows the status of all approved and pending waivers; app. II summarizes the statewide demonstrations planned for each state with an approved waiver.)

The disparity between interest in obtaining and ability to operate under a waiver highlights an important aspect of the section 1115 phenomenon—implementing these enormously complex and often controversial demonstrations involves addressing issues beyond the formal federal review process. We found several of these is-

sues at the federal and state levels that may create barriers to state use of section 1115 waivers.

Federal Issues

As more states seek federal approval of a section 1115 waiver, the time period between waiver submission and approval has lengthened. Five waivers were submitted between November 1992 and mid-1993, and each was approved before the end of 1993. Hawaii's waiver was approved in 3 months, the shortest period of time, and Kentucky's was approved in 7 months, the longest. In 1994, however, only one of nine waivers pending since the end of 1993 was approved for implementation: Florida's approval took about 7 months of negotiations with HCFA.

This slowdown appears to be primarily caused by two factors: controversy about some of the implemented demonstrations and the increasing number of waivers requested.

Concerns have been raised about the rapid approval and implementation of Tennessee's waiver and that state's acknowledged failure to consult with all affected stakeholders, especially physicians. In June 1994, the National Association of Community Health Centers went to court to stop the implementation of statewide section 1115 waivers, arguing in part that approval was arbitrary and capricious because it failed to consider the views of all interested parties.

HCFA responded to these concerns by publishing principles and procedures governing section 1115 waivers, including guidelines designed to ensure that communities affected by a demonstration project would have adequate opportunity to comment. Another indication of HCFA's intention to respond to these concerns was its November 1994 conditional approval of South Carolina's section 1115 waiver. HCFA sanctioned the "framework" of South Carolina's waiver with the understanding that HCFA would approve implementation only after the state reached a number of milestones related to the adequacy of service delivery and capitation rates. The methodology used to develop and the adequacy of capitation rates have been a major and continuing criticism of the Tennessee waiver.[1]

In addition, the number of waivers now pending—ten as of mid-March 1995—has undoubtedly tested HCFA's review capacity. Furthermore, this backlog is likely increase: according to HCFA, as many as five additional states are considering potential waivers or are already drafting waiver concept papers. HCFA is establishing an office of state health reform that, together with HCFA regional offices, should more effectively support the development and implementation of statewide section 1115 waivers.

State Issues

HCFA approval of a waiver, however, is often only an intermediate step to a state's program implementation because consensus on the waiver design begins at the state level. For example, Florida asked for federal permission to implement its section 1115 program before obtaining waiver approval from the state legislature. Though approved at the federal level in September 1994, the waiver is only now being debated by the Florida legislature, and the outcome is uncertain. In Kentucky, state legislators doubted that managed care savings would be sufficient to expand coverage to additional groups, and they ultimately refused to authorize implementation of an approved waiver. Kentucky officials told us that they felt caught in a "catch 22" because the legislature demanded demonstrated savings before approving planned coverage expansions, and HCFA refused to allow the state to proceed with managed care initiatives unless Kentucky gave a specific date for expanding coverage to new groups. Ohio must also get state legislators' approval before implementing its recently approved waiver.

A relatively new hurdle to waiver implementation is the close link between demonstration waiver designs and comprehensive state health reform initiatives—initiatives that are increasingly being reexamined in the aftermath of the 1994 health care reform debate, the November 1994 elections, and state budgetary uncertainties. For example, Washington is delaying drafting and submitting its section 1115 waiver.

TWO FACTORS AFFECT SUCCESS OF TRANSITION TO MANAGED CARE

Two factors significantly affect the degree to which a state's Medicaid managed care program succeeds in meeting its goals of controlling costs while improving access to quality care:

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[1] We will address these and related financing issues in our forthcoming report on the Tennessee waiver program.

- implementation: how much time the state allows for planning and execution, and
- oversight: how much effort the state devotes to quality assurance, information gathering, and financial review.

Operating a wide-scale managed care program differs significantly from the traditional fee-for-service programs. Implementing a program more slowly allows time to acquire staff expertise; develop a community base of support; create an organizational structure and administrative operation; and properly educate staff, providers, and beneficiaries. A state with widespread managed care in the private sector should have an easier time with planning and implementation because the members of the community, particularly providers, are already familiar with managed care.

The second factor that contributes to the success of a state's managed care program is the degree to which appropriate oversight mechanisms are in place and utilized. Quality assurance systems are particularly important to ensure that beneficiaries are receiving sufficient care of acceptable quality. Financial incentives to underserve are inherent in managed care and may lead to problems. Large private sector employers have recognized the importance of oversight in this area and are demanding strong quality assurance systems in health plans throughout the country. For the vulnerable Medicaid population, no less should be expected.

State oversight of a managed care program cannot be effective, particularly in the area of quality assurance, without good data collection efforts and information systems to report on beneficiaries' experiences. Information systems are generally new because the information needs of a state with a managed care program are different from those for a fee-for-service program. We have found that states are more likely to have a successful program and fewer problems in transition if they take the time to develop and test their information systems.

Another important oversight function is the financial review of health plans' solvency and allocation of revenues. The financial condition of a plan can have a strong impact on the access to and quality of care. Moreover, the plan must ensure that program dollars are used primarily for health services and that management and administration expenses are limited.

The experiences of two states, Oregon and Tennessee, show how investment in implementation and oversight appear to influence the degree to which states realize their program objectives.

Oregon's Program Has Avoided Problems

Thus far, Oregon's managed care program appears successful. The state began planning its current section 1115 waiver program more than 5 years ago. State planners held community meetings and consulted providers, some of whom were already participating in the state's partially capitated managed care program, which began in 1985. The state learned lessons from the first program that have helped in implementing the much larger managed care program.

Oregon also implemented an array of safeguards designed to ensure access and quality. It requires plans to limit the financial pressure felt by any one provider in an effort to guard against underservice. The state also adopted an extensive quality assurance program, which requires plans to maintain internal quality assurance programs, and annually contracts with a physician review organization for an independent review of medical records. Finally, Oregon uses client satisfaction and disenrollment surveys, and a grievance procedure to further monitor quality.

Oregon is, however, facing some challenges. The state had operated a managed care program in the more populous parts of the state. But as the state expected, creating prepaid capitated systems in the more rural areas has been difficult. In some areas where neither the state nor the private sector had been operating managed care systems, the state has relied on a mixture of fee-for-service and managed care plans to establish a program. Also, the state is just beginning to enroll the elderly and disabled in managed care.

Tennessee Had Start-Up Problems

In contrast to Oregon, the more recent TennCare program has encountered a number of difficulties resulting, in part, from its rapid implementation. Before beginning its managed care program last year, Tennessee had almost no experience with managed care in its Medicaid program. In fact, the state's private sector had only a limited amount of managed care compared to the rest of the country. Despite this lack of familiarity, the state moved rapidly and began operating its statewide managed care program fewer than 9 months after announcing the plan.

This quick transition created a number of problems. First, providers have generally been critical of the state for not being included in the planning and develop-

ment of the program. Beneficiary advocates, however, were a part of the planning process and have generally been supportive of the program.

Even state officials admitted there was confusion among beneficiaries. For example, beneficiaries were required to select a health plan before the plans had completely identified which physicians would be participating, resulting in some beneficiaries not knowing if their physician would be available in particular plans. Further, beneficiaries received little education about how managed care works. The state, however, has since partnered with the advocacy groups to help educate beneficiaries and resolve their problems.

The quick implementation also affected the participating health plans. Their information systems had not been fully developed and tested by the time the program began, and this significantly delayed the payment of many bills. Problems with the implementation of information systems also delayed health plans' provision of data on service use so that the state could assess the quality of care provided. Only recently have such data been available and begun to be analyzed.

The state has adopted an extensive quality assurance program similar to Oregon's, including beneficiary satisfaction surveys, a hotline, and a grievance procedure. It remains critical, however, that the quality assurance program is operated in an effective manner over time.

CONCLUSIONS

Widespread state interest in section 1115 waivers foreshadows a major shift in the Medicaid program. In particular, the mandatory enrollment of the bulk of the Medicaid population in managed care may become much more the norm than the exception. However, while interest in restructuring Medicaid is great, experience to date has been very limited because only a handful of states have implemented their section 1115 waiver programs. Our prior work, though, consistently suggests that successful Medicaid managed care programs depend on allowing adequate time for planning and implementation and putting appropriate oversight mechanisms in place. As states continue to pursue statewide managed care programs, particular attention needs to be given to these factors to ensure access to quality care for the large populations involved.

Appendix I—

STATEWIDE SECTION 1115 MEDICAID WAIVERS SUBMITTED SINCE 1991

Approved

	Date submitted	Date approved	Start date
Oregon	November 1992 [1]	March 19, 1993	February 1994
Hawaii	April 19, 1993	July 16, 1993	August 1994
Kentucky	May 1993	Dec. 9, 1993	Suspended—not approved by state legislature
Tennessee	June 16, 1993	Nov. 18, 1993	January 1994
Rhode Island	July 20, 1993	Nov. 1, 1993	August 1994
Florida	Feb. 9, 1994	Sept. 15, 1994	Awaiting state legislative approval
Ohio	March 2, 1994	Jan. 17, 1995	Awaiting state legislative approval
Provisionally approved			
South Carolina	March 1, 1994	Nov. 18, 1994	

Pending

	Date submitted	Status
Massachusetts	April 12, 1994	Negotiations on-going
New Hampshire	June 1994	HCFA awaiting state response to questions
Missouri	June 30, 1994	HCFA awaiting state response to questions
Minnesota	July 27, 1994	Negotiations on-going over finance issues

Pending—Continued

	Date submitted	Status
Delaware	July 27, 1994	Negotiations on-going over finance issues
Illinois	Sept. 14, 1994	HCFA reviewing finance issues
Louisiana	January 3, 1995	HCFA reviewing proposal
Oklahoma	January 6, 1995	HCFA reviewing proposal
Vermont	Feb. 22, 1995	HCFA reviewing proposal
New York	March 20, 1995	HCFA reviewing proposal

[1] Oregon's initial waiver proposal, submitted in August 1991, was denied in August 1992. After revising certain sections, the state resubmitted its proposal in November 1992.

Appendix II—

MAJOR FEATURES OF APPROVED SECTION 1115 DEMONSTRATION WAIVERS

Oregon	Demonstration expands Medicaid eligibility to all persons with incomes up to the federal poverty level (FPL) while limiting health care services provided by ranking them in order of importance. Shifts delivery of services into fully and partially capitated plans and primary care case management programs. Aged, blind, and disabled persons were initially excluded. However, in September 1994, HCFA approved an amendment allowing inclusion of noninstitutionalized aged, blind, and disabled persons in the waiver demonstration.
Hawaii	Demonstration expands Medicaid eligibility to all persons with incomes up to 300 percent of the FPL. Shifts delivery of Medicaid services into a managed care system. Aged, blind, and disabled persons are excluded from the demonstration and managed care requirement. Requires cost sharing from most residents with incomes above the FPL.
Kentucky	Demonstration expands Medicaid eligibility to all persons with incomes up to the FPL. Medicaid services are delivered through the existing statewide primary care case management program with a gradual move into capitated managed care delivery. Aged, blind, and disabled persons are included in the demonstration and its managed care requirement.
Tennessee	Demonstration expands Medicaid eligibility to all persons without regard to income level. Cost-sharing requirements increase with income level. Medicaid services are delivered through capitated managed care plans. Aged, blind, and disabled persons are included in the demonstration and its managed care requirement.
Rhode Island	Demonstration expands coverage to pregnant women and children up to age 6 with family incomes at or below 250 percent of the FPL. Medicaid services to AFDC recipients and new beneficiaries will be delivered through prepaid health care plans.
Florida	Demonstration expands Medicaid eligibility to uninsured residents with incomes at or below 250 percent of the FPL. State will subsidize health insurance for those newly eligible through its existing system of 11 health purchasing cooperatives. Benefits package for the expansion population is more restrictive than that provided to traditional Medicaid beneficiaries. Both AFDC and aged, blind, and disabled Medicaid recipients are required to enroll in managed care.
Ohio	Demonstration expands Medicaid eligibility to all residents with incomes below the FPL. Medicaid benefits, including mental health and drug and alcohol addiction services, are delivered through prepaid managed care providers. Aged, blind, and disabled persons are excluded from the demonstration and its managed care requirement.

Appendix III—

RELATED GAO PRODUCTS

Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993).

Medicaid: HealthPASS—An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (GAO/HRD-93-67, May 7, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, Apr. 10, 1992).

Managed Care: Oregon Program Appears Successful But Expansion Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 16, 1991).

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (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).

Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

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