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MANAGED CARE AND MEDICAID

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This session will address the increased cases of managed care in Medicaid states. This will include some indication of how utilization patterns differ for those populations versus commercial populations.

MR. THOMAS D. SNOOK: I think we will discuss a very interesting and certainly a very hot topic among the states these days, and we have a good panel assembled to talk about it. Many states have implemented managed care programs for Medicaid and may be looking to expand those programs, and many others are looking to start up Medicaid managed care programs, so that's what we will talk about. We will talk about Medicaid managed care programs kind of generally, about Medicaid utilization rates and how they differ, especially compared with commercial utilization rates, about what the issues are related to pricing the Medicaid contract, and a little bit about the intrinsic characteristics of the Medicaid population, why they behave the way they do and how that differs from the commercial Medicare population you're more accustomed to dealing with.

I will speak as well as moderate. I'm from Milliman & Robertson in Houston. I will give kind of a broad overview of Medicaid managed care and talk also about the due processes. Tim Ross will talk in more detail from the actuarial aspects of developing Medicaid capitation and premium rates. Tim is a consulting health actuary and senior manager at the Minneapolis office of Deloitte & Touche. Clients served include state government associations. Tim's practice focuses on rate setting, capitation, and the development and evaluation of risk-sharing arrangements. He has been involved in the rate settings for the Medicaid and Minnesota care populations which is why he is here. Prior to joining Deloitte & Touche, he was a group underwriter and managed care underwriter for Prudential.

Rose Leben is a nurse consultant in the Milwaukee office of Milliman & Robertson. Rose has worked in the health care field for 25 years both in clinical care and in medical management. She specializes in assisting clients in evaluating present UM programs, identifying opportunities through medical chart review, training, and education, and implementing jointly identified recommendations for efficiency improvement. Before going to M&R, Rose worked in utilization review, chart planning, case management, recertification of both inpatient and outpatient services, and maintenance organization for a provider of client resources for a regional Medicaid HMO. That's why she's here. Her experience includes developing a program to reduce inpatient hospital days, proactive education of utilization management, and identifying efficiency opportunity for your chart. Rose is a registered nurse licensed in Wisconsin.

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She's not an actuary and has a different perspective on the Medicaid population. Rose is also an active member of the Case Management Society of America.

I will talk about Medicaid risk contracts. Why managed care for Medicaid? Well, it is simple. The Medicaid budget is exploding in most, if not all, states. We're all taxpayers, we don't like states having a budget crisis, but we ask the states to reduce the cost. The total Medicaid eligibles grew nationally from 28.3 million in 1991 to 33.6 million in 1994, which is 15–20%. Borrowing some terms from a speaker I heard once, I will categorize Medicaid managed care models into three types. Type one is a fee-for-service-based gatekeeper, a primary care physician (PCP) who receives the case management fee for managing care. There is little incentive for the PCP to really manage care effectively, and these models, although popular at one time, seem to be dying a slow death. Type two is an at-risk primary care gatekeeper in a partially capitated plan. The financial incentive for utilization are cost targets because there is a capitated PCP and fee for service. Type three is the HMO free care health plan model in which the Medicaid recipient enrolls in an HMO under a fully capitated plan. The state essentially buys insurance, a managed care plan for the Medicaid enrollees, and that member is treated like any other member of the HMO, at least in theory. This appears to be the emerging, preferred model. We're seeing it more and more as the states expand their Medicaid programs and get the Medicaid waivers. This really seems to be the way the states are likely to go.

Medicaid eligible enrollment in some sort of managed care plan almost tripled from 1991 to 1994. Over half are in the fully capitated HMO or in health insuring organizations (HIOs). Sixteen percent are in partially capitated plans, and the remainder are in the primary care case management type-one plan.

So what have the states done? Well, I can't talk about all 50 states, we'll be here all day, but I'll talk about a few states. Arizona was the last state to implement a Medicaid program and when it did so in 1982, it went the fully capitated managed care approach. It was probably a trendsetter in that area. You may have read or heard stories of Tenncare or worked on Tenncare plans. Tennessee went to full managed care, rolling in the uninsured population in 1994. Florida has choices between an HMO and a PCP type-one model. California is implementing a two-plan or a multiple-plan model in its largest county.

I've talked about the risk group. I will skim this quickly because Rose will go into it in more detail. There are two major risk groups in Medicaid: Aid to Families with Dependent Children (AFDC) and Social Security Income (SSI), which includes the blind, the disabled, and the aged. The AFDC recipients are on Medicaid because they're poor and they have dependent children. AFDC constitutes 71% of the Medicaid population cost. The SSI recipients are eligible for Medicaid because they're old or sick or both; they have the largest proportion of the cost. Services are covered under capitated Medicaid contracts. Generally speaking, remember that Medicaid has two components: the acute care medical care component and the long-term-care, nursing home, and so on, component. The states are focusing on acute care. That's the easiest theory I saw applied to managed care concepts. Long-term care is generally excluded, although long-term care constitutes about two-thirds of the Medicaid cost. Arizona and Minnesota are the only states that I'm aware of that have included long-term care in managed care for Medicaid.

Fully capitated HMO Medicaid risk contracts vary quite a bit from state to state. One category is voluntary risk vs. mandatory. Some states allow Medicaid recipients to choose their own HMO or stay outside the HMO in a traditional fee-for-service environment. Other states require all Medicaid recipients to join an HMO and if they don't select an HMO, one will be assigned to them. States also vary in their code of eligibility classes—AFDC versus SSI. The services include capitated contracts, although it's a global cap of a premium rate. Some states are carving out. We'll see sometimes mental health carved out not by the health plan sort of capitation and subcap arrangements, but the state is managing in a different way. Statewide this is a specific part of it. Again, I gave California as the example in which Medicaid managed care is being implemented, not statewide, but in certain largely urban-versus-rural areas. Finally, and from an actuary's standpoint what's most important is the fixed-price-versus-the-bid process. Some states will determine the premium rate for the health plan and say, "Here's what we'll charge or here's what we'll pay, take it or leave it." Other states will use a competitive bid process where membership as a substitute is assigned, and a portion is based on how competitive your bid rate is within certain constraints, letting free market economy generate for the state.

I'm going to talk a little bit now about developing the Medicaid bid. Basically, it has two components: the technical proposal and the business proposal. The technical proposal talks a lot about coverage areas and the PCP to the state, and you can actually provide care for this population. The business proposal is the capitation rate. Generally, capitation rates will vary by various rate categories, and the rate categories vary greatly from state to state. For example, Arizona has one category for AFDC and Oklahoma has eight categories for AFDC, differentiating between age and sex and by age group. Also, there are geographic areas where a separate bid process goes on in different areas. Typically included in the business proposal would be a pro forma financial or a financial projection consistent with the rates that you're bidding. I've seen a couple states require actuarial certification that the rates that you're bidding are actuarially sound, whatever that means.

So how do you go? You want to get into Medicaid; now you develop a bid price. You want to ask some questions first. How much will it cost as a health plan to serve the Medicaid population? How do you do this? You first want to look at your experience data sources and other data sources that are available, evaluate the impact of managed care, and consider other factors. I'll talk about each of these three in a little bit more detail. As in any business situation, the numbers and the actuarial analysis do not drive everything. They're important considerations, important pieces of information, but you also must know how aggressive management wants to be in the bid process. Why do they want to be in this line of business, and how badly do they want the line of business?

Essentially, you can use three data sources to develop an actuarial cost model for a Medicaid population. I'm thinking in terms of a state that has been largely traditional fee for service and is moving to a managed care environment, or maybe, it is a voluntary managed care plan and is moving to a mandatory environment. Obviously, if you're just renewing the managed care contract, you have your own experience to judge. But assuming that you don't have Medicare lives in force, it's predated. One is an historical experience under the fee-for-service environment, which is a useful and

probably the best place to start, but consider that these must be significantly modified to reflect the impact of managed care.

In a typical unmanaged experience, inpatient about 1,000 days per 1,000 members per year, emergency room (ER) visits are at about 900. These vary from state to state, from plan to plan; these are ballpark numbers. Surprisingly, high PCP business, without many referral visits and prescription drugs, is slightly above the commercial low.

You can also use data from other states. You're bidding the absolute experience of state B according to the managed care experience available in state B. Well, that's a good tool but you must consider the source and the caveat. Eligibility rules for Medicaid vary greatly from state to state. AFDC eligibility, for example, varies from 16% of the federal poverty level to as high as 77% of the federal poverty level. With that variation in the poverty level, there is variation in health generally speaking. Also, provider participation and, more importantly, payment levels vary a great deal. Medicaid preschedules can vary quite a bit from state to state. That all said a lot of data available from managed care states. California and Arizona are two examples that I'm aware of.

The third way to go about pricing a Medicaid risk contract would be to start with a commercial group and modify it from there. It's useful for AFDC; it's not very useful for the other groups. Of course, you first need to reflect age and sex. It makes a difference if the population is largely female or largely young or if there are many kids as well. Once you do that demographic adjustment, there are still significant differences in morbidity levels in the population. The neonatal rates are higher, the maternity and delivery rates will obviously be higher because there are many women of childbearing age. The ER use is quite a bit higher. This approach is a useful exercise but it requires scenario testing.

When going from indemnity fee-for-service Medicaid to managed care, what is the impact of managed care? If you're in a competitive bid situation, you're bidding as low as you possibly can stand. You're obviously going to need to change the pattern of care quickly to provide the premium rates or the cap rate that you bid. The traditional goal, reducing inpatient days and ER visits two-to-one, would be the easiest things to do. You cut them quickly. You cut inpatient days 30–50% quickly and you cut the ER visits 50–70% quickly. Rose will tell you how.

Once you have built your cost model, you can build a bid. What are the other factors you need to consider? One is administrative cost. On a percentage-of-premium basis, the AFDC recipients are similar to the commercial population but differ in the sense that costs are incurred in different places. Rose will talk about some of the administrative issues of the AFDC population. Interestingly, states will occasionally limit this area. With a few states you cannot build into your bid more than 7.5% of premium as your administrative charge. This is both absurd and silly but in a certain sense, nobody can operate at 7.5% of the population when it only runs at typically 12% of premium. It's silly because they don't lose your profit charges so you just make it up somewhere else. You don't even need an actuary to figure that out.

Consider the cost of reinsurance. Most carriers that are providing managed care business will write Medicaid. Third-party recoveries, not surprisingly, is low. Rule of thumb—workers' compensation and subrogation and that type of thing run about, at most, one-half of 1% for the total claim cost. Finally, it forces the profit contingency load, which again is related to how aggressive you want to be in your bid. What do you want to bid?

Finally, when developing a bid rate, management will have to make some decisions. The numbers alone, as I mentioned, do not drive across by themselves. Business considerations play an important role. How aggressive do you want to be? How badly do you want the business? Why are you bidding? What purpose do you want it to serve? The aggressiveness can come in two main areas. One is in health care management. How well do you think you can manage care and reduce utilization, and how quickly can you get there? Second, how aggressive do you want to be on the administrative level? Do you want to build in all your variable expenses, or do you expect a lot of business to also cover some overhead, corporate earnings?

MR. TIMOTHY M. ROSS: I will present some of the rate-setting issues for the Medicaid and Medicare program. In this environment, a number of actuarial roles can be played, one of which is the actuary being involved in setting the HMO rate on behalf of the state. Another perspective, which I think Tom covered, is that of developing rates, developing a bid for an HMO in a competitive rate-setting environment. A very similar activity would be working for a provider in developing a capitated risk-sharing approach with an HMO in conjunction with either before or after the fact in a competitive bidding situation or otherwise. Finally, there is involvement in estimating the impact of covering the uninsured, a slightly different population from the AFDC population that we've talked about here. Certainly we've seen a lot of activity in that area as there has been a desire on a state-by-state basis to cover some of the uninsured and some of the Section 1115 waivers that are involved here.

Also as an aside here, the keynote address was about professionalism, and there are a few germane points to keep in mind here. When you're involved, for example, in rate setting for the state, there is the issue of who the users of a report are, and who is impacted by your work. We've done some of this work and we've seen some work from the other side. Of course, direct clients in these situations will be the state, but indirect users and people who are indirectly affected will be, of course, the legislature, the taxpayers, the HMOs (in terms of their ability to be profitable or otherwise)—there's a trickle-down effect on the providers—and the covered individuals. So the nature in which rates are set has an impact on many people in the state.

The impact of responsibility being proportioned to power and knowledge was discussed in earlier sessions. Certainly this is a very public activity. I think in that context, this is Medicaid being a U.S. program, if you look at the AAA guidelines on communications, it's important to consider these direct and indirect users of your report. Be relatively open and direct when communicating the results and controlling the work product. You see some similar issues with the estimating impact of covering the uninsured. There are some important budgetary issues of looking before you leap, before you start to cover large numbers of people not previously covered.

Regarding some of the general rate-setting issues that are considered, the federal regulations defined an upper-payment limit as being an amount that the state should not exceed when paying the HMOs. The objective is that the state should not pay the HMOs more than an actuarial equivalent amount for a population with similar characteristics under its fee-for-service Medicaid program. So this is a recurring theme that you see in rate setting, and it's generally where you're setting rates for a state or the state's setting rates and its objectives. Implementing a managed care program is, of course, to generate one of two things. One is to generate savings for the state, and the other is perhaps to deliver care in a more medically effective manner by having a more comprehensive delivery model. But this upper-payment limit very often is a foundation for assessing whether savings have occurred. Generally, that upper-payment limit does not take into account the impact of HMO administrative costs even though they are very real and very reasonable. The state may consider the incremental administrative costs that it may save by going to a prepaid program, but generally we find that those allowances are very small, on the order of 2–3%. That's very often a sticking point with the HMOs.

Another issue is that we find the state fee-for-service data vary in quality of available data. Generally, quite a few program nuances and details are very difficult to keep up with. I recommend that if you're involved in this sort of project that you find somebody at the state whom you can work with very closely in understanding its data set. Having good quality data from the state is very important.

Another issue is trend. Trend is always an issue in rate setting when you're going from last year to next year. But Medicaid trend is perhaps a little different than what you're normally used to. While there may be a utilization component to trend, the cost-per-service component of trend very often is defined according to the legislation and the laws of the state. We often see that the hospital reimbursement trends follow hospital cost reporting in a fairly reasonable fashion, but very often the physician components of the program in a fee-for-service environment will have only infrequent fee schedule updates rather than an annual fee schedule update. So when you calculate the trend, you need to be careful that you understand how that works. In addition, very often when you're working with fee-for-service data from last year and you're projecting in the next year, you have to consider the impact of programmatic changes.

Tom mentioned the take-it-or-leave-it approach to rate setting, or what I refer to as the state-imposed rates. The rate-setting approach here is simply starting with the fee-for-service costs and applying some trend. You will generally find yourself looking at an HMO savings factor of something in the order of 10%, a very common figure for savings; again it's subject to what the state wants to see in terms of budgetary savings.

Now the rate setting and the reference to the upper-payment limit again makes reference to the fee-for-service cost environment. One of the problems that occurs is that as you move to, perhaps abruptly, everyone being in a managed care environment, your fee-for-service exposure base disappears over a couple years. So the question is, what is my fee-for-service equivalent basis? What's my basis for determining whether I have savings? How do I determine whether I am complying with the upper-payment limit? A number of solutions have been proposed for this.

One approach is an area factor method. For example, if a metropolitan area of the state has gone predominantly or exclusively prepaid and the rural areas of the state are still fee for service, one might be able to work with recent and current rural fee-for-service data and infer what the fee-for-service costs would have been in the metropolitan area by using historical area factor relationships. Another approach is simply to adopt a projection method, which is simply to say, we will start with rates, and we will trend them forward in conjunction with our knowledge of legislative trends and likely utilization trends. There are some problems there, of course. One is that you want to make sure you have some reliable and credible base rates to start with. We've seen that recently in Minnesota; that has been an issue.

Another approach is experience rating. The idea here is setting the rates based on the experience of the plan. There are some problems there. One is you can get utilization data, you can get cost data, but you probably want to adjudicate your utilization data against some sort of a common fee schedule of reimbursement rather than what's actually being paid to the providers. What's actually being paid to the providers may be a result of an arbitrary negotiation between the HMO and the providers. Another problem with experience rating is and it's a material problem, will experience rating provide appropriate incentives for plans to operate in an efficient manner? This leads to the final approach, which is a competitive bidding approach, which obviously encourages providers, like HMOs, to operate efficiently, to reimburse efficiently, and so on.

Tom talked about the competitive bidding model. From the state's perspective, very often you'll see a determination of an upper-payment limit. A range of rates considered to be acceptable in the bidding process is generally determined. The lower and upper end of that rate range is determined as a presumed range of savings that can be achieved through managed care. Generally that range is kept confidential from the bidding carriers. In developing the competitive bidding model in contrast to the state-imposed method, administrative costs are generally explicitly recognized. Very often after the initial bidding, there will be a round of negotiations in which the rates are negotiated generally in a downward direction to the effect of saving additional money for the state. You get into issues of reasonability there.

In a moment I'll talk about what it takes for an HMO to be competitive. I think Tom talked about that as well. At times if you're working for an HMO or a provider, the rate may appear to be using unreasonably low upper rates in the upper-rate range that will be considered to be the highest that will be considered reasonable as an acceptable bid. Just as an aside, there are a couple approaches to the competitive bidding approach. One is lowest bidder and another is to take multiple bidders that satisfy some range of reasonable results. I'm talking in the context of allowing more than one bidder at not necessarily only the lowest rate. If you're working for an HMO or provider that is serious about wanting to stay in this business in the Medicaid market and it thinks it has put out aggressive and competitive rates, and yet the state is saying it is too high, then you get into an issue of asking, what's going on here, why don't we agree? Is the state perhaps using unreasonably low and aggressive utilization assumptions? For example, if you're in the Midwest, if you're in a relatively newer managed care market or a less mature managed care market, are assumptions being made that are perhaps more consistent with something that you might see in a California environment, very aggressive managed care results? Certainly the learning curve of managed

care has improved over the years, but that's an issue. Another issue is whether or not reimbursement assumptions have been assumed as implicitly having discounts from existing fee-for-service reimbursement. Generally, the state, I believe, would say that it is not taking that approach but when you end up with very low rates, you find yourself wondering what the source is of these low rates. In those cases, it's probably worthwhile in terms of, again, communication issues and negotiation, to ask for some sort of an explicit development of that. I think Tom referred to that as an actuarial cost model.

From the HMO perspective on Medicaid capitation, the requirement is to run a plan on a profitable basis. Let's suppose that either by virtue of the state imposing the rates or by virtue of negotiations that we ended up with rates that are at the fee-for-service level minus 10%. Suppose in addition that the administration costs are 10% of premium. Then assume predominant sources of savings coming from hospital utilization, inpatient, ER, and so on. There's a need to drive down utilization very significantly to save approximately 20% of the total fee-for-service costs. It may be possible to drive down the days in a very severe fashion, but you must keep in mind that when you drive down utilization in the days department the intensity, the cost per day of the remaining days, tends to escalate. So a 30% or 40% reduction in days or a 50% reduction in days will not necessarily translate to a 50% reduction in your hospital cost per month per member (PMPM) because of that intensity component of the program in addition to the cost shifting from inpatient to outpatient.

Each month you can take several responses or tactics for strategies to take in response to what the HMO perceives to be low capitation rates from the state. One approach, which you would perhaps argue is the right approach, is to take very aggressive utilization management steps. Beyond that, and I think Rose will address that, another approach is to try and actually squeeze providers for discounts below the Medicaid reimbursement levels. That is an approach to take with some providers. There is room for negotiating with some providers to accept lower-than-Medicaid reimbursement levels. Of course, the other approach, which isn't perhaps an approach at all, is to forego overhead recovery and/or subsidize even the marginal administrative cost and take a real loss on the program. On the brighter side in which the HMO has managed to achieve either favorable capitation rates or very effective utilization management so it is essentially in a plus situation, it can take a number of approaches, one of which is to allow provider reimbursement above the Medicaid reimbursement levels. I think this would be viewed as a desirable policy outcome of Medicaid prepaid in the sense that generally Medicaid reimbursement levels to providers are aggressive and minimal. So the ability for an HMO to give some sort of bonus to the providers in terms of a more generous reimbursement level would be viewed favorably by the providers certainly. Another possibility is to provide some additional benefits or health care outreach activities, discussion of preventative care approaches and so on. Finally, of course, is just to take this profit and proved overhead recovery profit, and so on, to avoid subsidizing the Medicaid program with your commercial population.

In the fee-for-service environment certainly and in the Medicaid environment in general, a few providers take care of the Medicaid population in particular. The teaching hospitals and the children's hospitals can be very important to these programs. Historically, the states and the federal government have recognized this and have provided additional payments to these hospitals through the form of GME payments as

well as disproportionate share payments. Going back to the earlier discussion about the fee-for-service data, you must understand how the GME and disproportionate share of payments are built into that fee-for-service data. Are they in those data records? Are they built in as supplemental payments on the side?

When the state is adopting a state-imposed rate approach, it can take a couple tactics to support these institutions, one of which is to continue making supplemental payments on the side for these hospitals. Another approach that we've seen is to build in plan-specific rate adjustments for those plans that are utilizing these hospitals that need these rate adjustments. One problem with that is while we give the HMO more money for teaching and for disproportionate share, does that rate increment find its way to the actual hospital that has this additional expense load? But also, in the competitive bidding model, the bias is entirely in favor of the lower bidding rates. If I'm an HMO and I'm putting together a network and I want to have a desirable competitive bid and I want to have a product that is profitable or that at least breaks even, I do not have an incentive to work with these hospitals. Or if I do work with them, I have no incentive to give them a better deal than what I'm giving the hospital down the street that may not have some of these teaching loads. So I think the conclusion in this is that the state has some mixed and conflicting objectives in its program. On the one hand, it is saying to these teaching and children's hospitals, yes, we want to support you and traditionally we've done this through the supplemental payments. On the other hand, in the competitive bidding model it is essentially negating that effect by biasing its approach in favor of the lowest rates.

MS. ROSE LEBEN: I'm going to give you some information that will help your clients or the managed care organizations that you deal with see that Medicaid is a different line of business and that they can't treat it the same as they do commercial. A quick overview: the AFDC and the SSI population is what is considered. The AFDC population is usually where most HMOs and managed care organizations start. Most states put that into a risk arrangement before they put in the SSI, the easiest to manage. They think it's the most like commercial because women and children are usually relatively healthy and they just overutilize. So getting that utilization down is where they mostly start.

With regard to waivers, I think you probably all are familiar with what we desire and what they tend to accomplish. The primary care case management (PCCM) program is part of any waiver that's approached. It's either done as the only program in which the physicians get a rate and they are to manage the care, or it's part of a managed care organization in which the managed care organization helps the physicians manage the care for the population. I have a little bit on who benefits from Medicaid. About 75% of the population is women and children, but that only accounts for about 23% of the revenue for that population, but that still is where they think they can make the best inroads.

These are the mandated covered services:
- Inpatient hospital
- Outpatient hospital
- Physician
- Rural health clinics
- Federal qualified health centers

- Prenatal care
- Home health care
- Family planning
- Nurse midwife
- Early and periodic screening diagnosis and treatment (EPSDT) for children
- Lab and X-ray
- Nursing facility for adults over 21

As you can see, they're thorough. They mimic what is included in a standard HMO product.

Optional services that are included are:
- Outpatient prescription drugs
- Clinic
- Prosthetic devices and hearing aids
- Intermediate care facilities for the mentally retarded
- Optometric services
- Eyeglasses
- Dental services
- Transportation

I think transportation is probably the most important part of any Medicaid program that will go into managed care. If you can't get them to where they need to go, then they're not going to go and you won't make a difference.

Access to care is important. In many areas, the communities do not have providers in the service area so getting providers into the service area be it physicians, hospitals, clinics, urgent care facilities, whatever it takes, is important. There are some creative ways to do this. Federal money is out there; it just needs to be found. Many sophisticated managed care organizations have found that money in block grants and in setting up providers on a rotating basis in a storefront in a community. Mobile vans is another area that has been very lucrative and has also been able to satisfy requirements. Some states have requirements that the provider has to be within five miles of the enrolled and other states have a lesser requirement. That's one thing to look at.

Another part of access to care is extended hours. If physicians are not going to have evening or weekend hours, you're going to see much utilization in the ER. If you look at your data, you'll find that ER utilization is primarily in the evenings and on weekends. That's when the AFDC population seeks care. If you don't have physicians or clinics, urgent care centers will provide services at those times.

As I alluded to, transportation is a big issue. Often the states say they want the HMO to provide the transportation. There's also federal money that will pay for that. We gave cab vouchers at a plan that I worked for before I came to being a consultant. We did it as a pass-through to the state. We managed it, the state paid for it. It's federal money, most states have it, but they just don't tell you about it. You need to find it. But if you can't get them by a cab with a voucher, by bus with a token, or by van service to their appointments, they're going to go by ambulance. They're going to go to the ER because they know an ambulance will take them, so you must bring that ambulance utilization down.

Education is a big part, but it will be labor-intensive. You must educate your providers as well. In most states where Medicaid resembles what I call a fee-for-service mentality, providers had no incentive to say, go to the ER. Or when they put sutures in a hand they had no incentive to come back and see me in a week and we'll take the stitches out. So the physicians as well as the ER and urgent care centers have to be told and educated about redirecting care back to the PCP and away from overutilization in that ER. If an ER is not part of a network, and many managed care organizations do not contract with every hospital in a service area, those hospitals that are outside a service area also have to be educated. If they see patients that are truly nonurgent, they will not get paid for those services. So if you can educate them, as well as the ones that you've contracted with, you're going to make inroads into that increased utilization in the ER.

The enrollees have to be educated. They're used to thinking, they can go where they want, when they want, and you're going to pay for it. We're still going to pay for it, but they can't go where they want when they want. So you're going to have to talk to them about the importance of preventive care. If you're a person who is worried about where your next meal's going to come from or whether you will still have a roof over your head by the end of the month, and you have an appointment for your baby to be seen in a well-baby clinic, what takes priority is finding out where your shelter's going to be and if you have food on the table. So help them through some of those issues, to see the importance of preventive care and seeing a PCP. They must hook up with a PCP rather than to the ER. Many people treat the ER as they would their PCP.

We had one lady who went to the ER because her hemorrhoids hurt. That's not something that needs to be seen in the ER unless they're hemorrhaging. People have to be instructed and that's labor-intensive. It's one on one. If you send out information booklets, they won't be read. They will be thrown in the garbage. So you have to do it verbally one on one. Member services is going to be a big part of that. They're the ones who will do a lot of the education. Their role is going to change. Most HMOs' member services departments deal more on the commercial side, outlining benefits and how to access care, and emphasizing the patient is responsible for doing it. You can't do that with a Medicaid population. You have to become their mom. Your mother tells you when to go to the doctor, makes your appointment for you, takes you there, listens to what the doctor has to say, helps you interpret it, and brings you home. That's what you have to do with a Medicaid population. So it will be labor-intensive on the member services side.

Member services representatives must know community resources because they're going to get calls and hear, I got kicked out of my apartment last night, I have no place to go, will you pay for me to stay in a hotel? You're not going to pay for people to stay in a hotel, but you will be able to provide a list of resources of where they can go to get some housing or temporary shelters and clothing.

Managed care organizations that deal with Medicaid become more of a social model; they have to know about all those community resources. Many times they have community liaisons, somebody out there in the community who deals with the population, deals with community resource providers, the Red Cross and the Department of Housing and Urban Development (HUD). That's something that you may want to

think about if you are working on the side of a managed care organization. Funding is part of that.

The other thing is provider offices. You have to be able to deal with the provider offices as far as eligibility. When a patient shows up in a physician's office and doesn't have his/her card and the physician doesn't know whether he is still eligible for Medicaid, the physician needs to call to find out. Usually the managed care organization will provide that information. The provider has gotten stung too many times for not getting paid. But he or she will turn the patient away and say, I can't see you, you'll have to go someplace else. If it is for an acute problem, the person will go to the ER.

Some managed care organizations call provider relations—patients can instantly check to see if they're still eligible with an HMO so that the provider knows he or she will get paid and not be out the money if a patient is seen who is not in a managed care organization. A big one for that is newborns. Many pediatricians will not see newborns until the mothers have put the baby on the card. In many states, they have 100 days to do that and another month to get the card. So a baby could be three to four months old before going to his or her first preventative visit. That's not good. Many things can happen in those first four months. They're going to be in the ER and admitted to the hospital if you don't have a way of providing the providers with verifications that the baby is part of an HMO.

We talked about provider assistance, preventive care, and follow-up care. They're going to be making appointments for the patient, sending him or her a card as a reminder about the appointment next Tuesday. "Don't forget, the cab will be there at 2:00. Look for the cab to be out in front." They will follow up with the provider to make sure the patient went to the appointment so that he or she is kept on a cycle to remember to go to these appointments. Many Medicaid enrollees do not have watches. Many do not have clocks in their homes. They do not have calendars. One day is just like the next day. Many of the providers that I've talked to say that these enrollees come at 2:00 when they had an appointment at 10:00, and they want to be seen. They think that because they showed up on the same day, that's good enough. So you have to do a great deal of reminding. You can't send them something in the mail that's in a white envelope; they're going to throw it in the garbage. Color coding and trifolds work very well with this population; many pictures, little words. They have the maximum of a sixth-grade reading level. Missouri says they must be at a fourth-grade reading level to be accepted in the Medicaid population. That's all different from commercial insurance.

Although most managed care organizations have utilization management services for commercial, with a Medicaid population, it's more of a social problem. You'll find many avoidable hospital days, an excess in utilization because of social issues. Kids are left in the hospital because the parents can't be found. Now child protective services must get involved. A patient needs to go home with home care. He or she has no phone in the home, and the home care agency is demanding that there be a phone in the home. That's especially true with babies going home from a neonatal intensive care unit; most neonatologists won't discharge. I've seen a baby sit in the hospital for six weeks because no phone was hooked up at home. The family had a $1,000 phone bill and nobody would pay it. The phone company won't give the

family phone service. Those are all issues that are going to be handled by the utilization management department. As I said, many social issues drive much of utilization. This is true of outpatient services as well. The Medicaid patient population might show up in a specialist's office, say an orthopedic surgeon's office, to have a cast removed. The patient never saw this doctor before; he or she just happened to be walking down the street and notice a sign for an orthopedic doctor. He had a cast put on in the ER, it's six weeks later, and he was told he was supposed to have the cast off in six weeks. He walks into the office and wants somebody to take this cast off. So dealing with some of those issues, and making sure they're with the right providers who are part of your network, making sure that they have referrals, if that's part of the managed care organization's philosophy is all part of utilization management. It's going to be very labor-intensive for this population.

An important issue is 24-hour triage services. As I said before, the population gets sick evenings, weekends, and holidays. Somebody might be on an on-call basis, preferably a clinician who can answer questions, redirect them to the proper place, make sure that they're going to get seen so that they are not overutilizing the ER. After they're seen in the ER, the next day or the next week they should follow up with a PCP. That's all part of that. It's going to make a big impact on lowering those utilizations in the ER and also lowering the hospital days. If patients get to the ER, they're more likely to be admitted than if they get to a PCP's office. Most managed care organizations have quality improvement. Monitoring of state reporting is a new function for a managed care organization. These are state and federal requirements. Most states do not have to record this; they need management information systems (MIS) to give them these data and that will cost money.

The state will tell you whether you can market to this population. If it's a mandatory enrollment, then it's a soft sell or what I call indirect marketing. If it's a voluntary program in which you can go out and actually get them, you can do some direct marketing. Direct marketing may or may not be allowed to be done door to door. I've seen marketing agencies that have welfare offices; they park in the parking lot. They'll have a little van set up in the corner of the parking lot and as they come out after they've applied for their welfare benefits, they go right up to them and start talking to them about getting into a managed care organization and getting into welfare or into the AFDC program so that they can get these extra benefits. That's one thing you can do. Some indirect methods are sponsoring hunger walks or block parties that they have in their areas. Go down and give out little handouts, pay for some refreshments. Hunger walks are good. Health fairs are good: provide some basic screening, do some blood pressure checks, hand out some literature, give out little coloring books that have themes that deal with wellness. You can do all those things but they all cost money.

It can provide access to care, shift from acute care to primary and preventive care, implement member management techniques, and develop utilization control, a managed care organization will be able to stay within whatever the rate has been set and still make a profit. We had 16,000 Medicaid enrollees in the organization that I work for. In one year we made a $3 million profit, and that's a good profit.

MR. RONALD E. BACHMAN: All the services that are needed here cost money; you mentioned it several times. Many of the people have advocated governmental control and have pointed to the existing commercial market, for example, as being wasteful in

expenses and profits that are out there. In some sense, we're improving the cost of care 20–50%, and one-third to one-half of that is going into administrative expenses and profits. Somebody in the press will sooner or later pick up and understand that more. How do you counter that public perception that privatization is simply taking money away from the care that's going to the providers and that it is going into administrative costs and profits for HMOs?

MR. SNOOK: The headline of an article in the paper in Phoenix last year read, "Access HMOs made $40 million in 1993." (Access is the name of the Arizona Medicaid program.) The press has picked up on certain areas.

MS. LEBEN: You're saving money from decreasing the utilization of unnecessary hospital ER utilization. You're not denying care. In fact, this population, if all is done right, will be healthier than those under the fee for service. The profits that are going to be made are shared with the providers. We pay the providers in our organization more than what they would have gotten on fee for service. That's one thing that I think is paramount. You can't pay them less than what they're going to get paid on fee for service, whether you capitate them or whether you pay them out as a fee for any service they provide. You're redirecting the care and making the care that they get appropriate care in an appropriate setting. You're also giving them preventive screening and increasing the number of immunizations. So you're going to get a healthier population, I don't think anybody can argue with that.

MR. ROSS: Yes, I guess a follow-up to that is that the argument you're making is not unique to Medicaid. It's a common one that has been applied to managed care. The last time I checked, and frankly it's been quite a few years, administrative-services only (ASO) fees were down to 3–5%, but I don't think anybody wants to go back to 3–5% ASO fees and a completely unmanaged, let-the-providers-charge-what-they-want environment. The extra 5% or 7% you pay for HMO administration in the commercial environment has clearly been accepted as being reasonable. So I don't think it's a unique argument. I think that the commercial market has demonstrated that HMOs provide some value.

MR. SNOOK: I think it's a valid point.

MR. WESLEY S. CARVER: This is a question for any or all the panel members. I was wondering if you've had any experience in which the state sets the capitation rate and has set up the program, and then in the second or third year ratchets it down. If so, what has the response of your carrier clients been to that?

MR. SNOOK: I have not encountered that specific situation.

MR. ROSS: No, I haven't seen that. If the initial rates are relatively generous, it might be consistent with anticipating a pattern of improving utilization assumptions over time; perhaps there's a learning curve. I would hope that the state would have made that clear at the outset that it had this three- or four-year plan under which managed care would be assumed to be improving. Again this goes back to the communication issue when you work with the state.

FROM THE FLOOR: We're in our second year in one area with a Medicaid HMO plan, and we are facing that situation. I don't know yet what our response is.

MR. M. SCOTT LOCKWOOD: My question involves adverse selection in voluntary counties. What have the states done to assist the managed care entities in fighting that, by having people pop in and out of the managed care environment?

MS. LEBEN: Some states have given a lock-in period. They'll guarantee a managed care organization a six-month, what they call lock-in, or they will pay for the six months no matter what happens. They also put some safeguards on the side of the organizations, such as the welfare office, so that they will go out and look for these people, make sure that they get their paperwork in. What usually causes them to drop out is the fact they don't get their paperwork on time; then they drop out. They get put back in on a fee-for-service basis and then back into an HMO, so states have given six months. I've seen one that has given a year's lock-in.

MR. ROSS: Another comment on the antiselection issue: the flip side of that issue is that as managed care is implemented and a significant proportion of the population is covered by managed care, what we've seen, at least in Minnesota, is that there are some residual fee-for-service eligibility months, if you will. The effective claims per member per month are very high for that residual exposure after adjusting for demographics, which is generally due to the waiting period. For a while people are waiting to sign up, or conversely when people present themselves initially for Medicaid eligibility, there seems to be a disproportionate risk as being paid on a fee-for-service basis. For example, someone gets admitted to a hospital. The person is eligible for Medicaid, but he or she has not previously been enrolled. At that point, you'll see a fee-for-service claim at an obviously adverse select rate.

FROM THE FLOOR: I saw that there's a great deal of decrease in outpatient utilization. So it would seem that the primary ox being gored is the hospitals; that's where the savings are coming from. Is there any reaction you know of, or are hospitals giving flak, or is there cost shifting going on? Some hospitals in certain neighborhoods must be severely adversely impacted by this.

MR. ROSS: Well, I think that the hospital's ox has been in the process of being gored by managed care over a number of years as it was with the prospective payment system (PPS) program for Medicare back in 1983–84. There is essentially an oversupply of hospital beds in light of changing utilization patterns. It has been a rough environment for hospitals; they've had excess capacity.

MS. LEBEN: I agree. It's not unique to Medicaid. The biggest dollars are on the hospital and the inpatient side and the ER. So that's usually what managed care goes after first. It's that way for Medicare, Medicaid, and commercial insurance, so it's not something unique to Medicaid.

FROM THE FLOOR: My question is if you make the decision to enter the Medicaid market, are there any special implications for the commercial network, the provider network, that you have there?

MS. LEBEN: Usually there are separate contracts, and many times there are separate fee schedules. If it's going to be paid on a fee-for-service basis or if it's a capitation, there's usually a different rate so you have to have a separate contract for your providers. Many times the commercial providers don't want to deal with Medicaid so you have to go after the providers. If you're going to get into a managed care environment, seek out the providers that are now providing the care in a fee-for-service environment. Many will be hospital clinics, teaching centers, Indian health boards, those federally funded organizations that provide care to this population. That's where they're going to go for care whether they're in a managed care environment or not because that's where they're used to going for care. So if you can contract with them, pay them slightly more than what they're going to get now, you're going to have some happy providers.