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Stories About Managed Medicaid Plans

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Summary: In this session, the panel presents the risks and rewards of managed Medicaid plans from both the perspective of the managed care organization and the state. True-to-life success stories as well as some problem experiences are discussed.

Mr. William J. Thompson: I'm going to give a very brief overview on a couple of Medicaid issues, and I'll leave the rest of it to the experts.

Bryan Miller will be following me. He is assistant vice president of actuarial rating for Blue Cross and Blue Shield of Kansas City in Kansas City, Missouri. He's responsible for rating and underwriting support for over $500 million in insured health premiums. Much of the technical work is presently being focused on analyzing Medicare and Medicaid HMO programs that Blue Cross has established in Missouri and Kansas. Our other panelist is Rex Durington who's an associate actuary at Milliman & Robertson (M&R) in St. Louis. Rex is an ASA and has been with M&R for the last few years. He has been working with several states in rate setting for managed Medicaid plans and the medical behavioral health and transportation program. He has developed some great calculation methodologies analyzing fee-for-service and encounter data and for calculating capitation rates. He also does some work through the Kansas City Regional Office of the Health Care Financing Administration (HCFA).

I'd like to talk a little bit about the Aid to Families with Dependent Children (AFDC) population for Medicaid, which is the common place that people start. What are we looking for? How do we contrast it with the typical commercial type of

population? On the education side, we're typically dealing with people with a high school education at most. Many of the people are childbearing age because it is a very young population. There could be several language issues, depending on what part of the country you're in. Understanding something other than English becomes very important because there are issues that these people have to face. Housing is often unstable and there are a lot of transients. There are transportation needs, such as getting to doctors appointments. Sometimes they don't have phones at home. How do you follow up with them? Nutrition and diet concerns are not necessarily good. There is an unstable employment base and absence of economic stability. Many people are between jobs so there is limited income. There is also a lack of maternal health planning or prenatal care. These factors create a challenge in and of themselves.

What are some of the medical needs? There is often a lack of primary care and therefore no allegiance to any physician. A fairly common characteristic is people tend to be noncompliant; they do not really follow directions. There is a higher use of the emergency room. They might not trust the health care providers, and there is a lack of comfort with the whole delivery system.

What are some issues for success? There is much more to a Medicaid program than there is to a regular managed care program. I've heard it said in some situations that the success in a managed Medicaid program is about one-third managed care and two-thirds social policy. A great deal of direct intervention and one-on-one contact with members is needed. You need community outreach, social agencies, and other such institutions in the program, including viable transportation. You need patient advocates and the coordination of the social and community services with the medical services.

There are some added aspects of provider education. If you're going to have a successful plan, providers need to be part of it to understand what it is they're doing with the Medicaid population. The physician or the clinic needs to be working as a gatekeeper to really control access to the delivery system. You must understand cultural diversity and language barriers. Bilingual providers are very important in the success of a managed Medicaid plan. You need to ensure that people understand the directions. Provider education with respect to emergency room and urgent care is also important. Providers need to educate people and redirect care to the most appropriate treatment setting. You can't have success if there is a great deal of overuse of the emergency room. You also need to direct care to in-plan providers—people in your network—as opposed to going out-of-network and creating problems on that side.

Another issue is the education of the members. What is managed care? What is this plan that they have? How do you access the services of the plan? When do you go to the emergency room? The urgent care center? Your primary care physician (PCP)? They must know all these essential ingredients if you're going to have success.

The importance of preventative care must be stressed. Encourage members to get flu shots and immunizations for the kids. These treatments fall under the role of the PCP. There are also more viable instructional methods. Give instructions in person. You really have to deal one-on-one with people. Telephone patients, if you can reach them by phone. Printed material is another useful way to provide information, but you might need to have it printed in multiple languages in order to really distribute the information to everybody.

Transportation is another issue. When should one use an ambulance? It shouldn't just be a convenient way of getting to the doctor's office. There must be close monitoring of the nonurgent transportation that patients are using. What sorts of services are there? How do you advise them? How do you provide the right services so that those costs aren't getting out of control?

There must be a liaison with the provider offices. They should be working with the member and the provider to help schedule the appointments, which includes helping the members get the appointments, rescheduling appointments when they aren't kept, verifying eligibility, and ensuring that people are eligible for the services that they're getting. They must assist the members in getting those appointments and send reminder notices to people.

Here is one story that typifies what happens with members in a plan. A young woman was pregnant and she was contacted. She was told that she really needed to go for prenatal visits, so the appointment was set up, but she didn't show up for the first visit. They called her to reschedule the appointment and she didn't show up for the second visit or even the third visit. When they contacted her again, they asked her what was going on and whether there was a problem? She said, "The problem is I don't have any shoes to wear, and I feel embarrassed going to the doctor's office." In a managed Medicaid plan, part of the success is you really need to know what's going on. If you don't talk to that member one-on-one, how are you going to deliver the care?

To sum up: What are the keys to success? You really need a Medicaid-oriented delivery system. You can't just take a regular system, put it in place, and assume it's going to work for the Medicaid population. The member outreach and education is so important. You must also inappropriate emergency room use. Get people to the

right place at the right time. There must be access to primary care. These are some of the key ingredients in any managed Medicaid arena.

Bryan F. Miller: When I first saw the title of this session on managed Medicaid plans, I tried to think of a famous title that would be appropriate for our experience in 1997, and the title that first came to mind was "Treasure Island," but it has been anything but that. I almost settled on "Great Expectations," and I decided to leave it as a question—comedy or a tragedy? I would say, at this point, from our plan's perspective, it hurts too much to laugh, but it's probably too early to cry.

To give you some idea of where we started this year with the new managed Medicaid program in Missouri, I need to take you back to what preceded the new program. For a 14-year period we were part of a Medicaid demonstration project in Jackson County, Missouri, which is the essential core of the city of Kansas City, although it covers parts of three counties. This covered the AFDC market only, so it was rather limited in scope compared to what happened this year for us.

That demonstration project featured a choice on the part of the Medicaid beneficiary. They could essentially remain in the fee-for-service market by electing a primary care physician to operate as a gatekeeper for their care. In that situation the state assumed full risk. They also had the option to join one of three or four managed care plans during that period which received a capitation from the state based on about 90% of its Medicaid fee schedule. In that case, the HMO assumes most, but not all, of the risk. There was a stop-loss provision that plans were liable for only $20,000 per person per year. So there were limitations on what the HMOs faced in terms of risk. Our enrollment grew in this plan over the years and reached a maximum in early 1996 of about 12,000. In January 1997, we started out with about 19,000 members. So there was a pretty significant jump with the start of a new program.

Bill talked mainly about the AFDC population, but there are four categories of Medicaid beneficiaries. Of course, you're familiar with AFDC, which is category 1. There's also category 2, pregnant women, which is probably classified best as a temporary enrollment situation. Women are eligible for the period of their pregnancy, and once the child is delivered, they are no longer eligible for that program. In the Missouri program, you get a monthly capitation during the pregnancy. There's also what's called a "kick payment" or a "lump-sum payment" at the time of delivery to better time the care that you're providing with the payment from the state. Category 3, general relief, was not included in Missouri's program for 1997, and I'm not aware of any states that are including general relief recipients in their managed care program. We did include Category 4, foster children.

Let me tell you about the program that Missouri instituted in our area of the state in 1997. Central Missouri and the eastern part of the state went into this managed care program a year ago. Essentially, all Medicaid eligibles in Categories 1, 2 and 4—AFDC, pregnant women, and foster children—must receive care through an HMO. The option to stay in a fee-for-service environment is gone. There are two ways to get in: they either elect a specific HMO or they are assigned one based on the competitiveness of the bid and other categories that I'll explain later. There were additional benefits and services that were brought into the Medicaid benefit package as a part of this new program. Finally, the contracts were awarded to HMOs based on a competitive bidding process, not a capitation rate set by the state based on its fee-for-service experience.

Let's briefly go over the benefits that the state brought into its program for this year that we had not previously covered in the AFDC demonstration. There are prescription drugs and dental benefits. Bill referenced the issue of transportation, and that's a significant point. It's usually a benefit that plans do not provide to their commercial membership. There is mental health, substance abuse and newborn care, although it is somewhat limited. The State also required that you purchase stop-loss insurance. So there is some control of that risk.

The bidding process is important. Those of you who are in states that are considering or are about to get into this process may find a lot of parallels between the way that your state does it and the way Missouri set this up. The previous program, as I mentioned, set a capitation rate roughly equivalent to 90% of the fee-for-service cost in the market. The consultant with whom we worked on this bid estimated that the acceptable rate range that the state set for the 1997 bids was somewhere between 80% and 90%. It achieved the state's goal of continuing to reduce its cost for the program.

There were some minor changes to the age and gender category. If, for example you have been capitating your providers ages one to four, and the new categories are one to six, you've got to go back and reallocate costs and look at experience to better set your rates and actually make a bid. The stop-loss limit of $20,000 per person was removed. So, except for the newborns, we've got unlimited liabilities, which obviously creates a significant increased risk to the plan. As I mentioned previously, those eligibles who don't select an HMO at their enrollment opportunity are assigned one based on the competitiveness of the rates bid.

There were four criteria used in determining the competitiveness of your rate. The costs accounted for 40% of the bid or 40% of the evaluation. Your experience in the Medicaid market counted for 15%. Your expertise as a managed care

organization accounted for 10%, and the proposed method of performance counted for 35%. Cost was an important element, but by no means the only one.

Let me tell you a little bit about our Medicaid bid strategy. We had learned from the previous plans and from our consultant's experience in this market, that we wanted to make sure, as each plan did, that the rates you bid for each of the demographic categories was within the range that the state had set up. If you refused to meet those requirements, that was grounds for being excluded from the program. Our goal was to be close to the middle of the bids. If you're more competitive on a price basis, you're giving up revenue that you might not needed to have given up. If you are rating too high in the range, and they only take four of seven, for example, then you are likely to be excluded for that reason as well.

You want to maintain at least some of your revenue, but you also want to get a significant proportion of the auto-assigns. These are people who did not select an HMO. You might, as we did, go through the process of determining what is the relative risk of those who select your plan versus those who are assigned to it. Our feeling was that people who chose our plan at the first opportunity probably chose it because there was a physician or a hospital or a specialist that they particularly wanted to use. That usually is bad news in terms of risk. We wanted to get a good share of the auto-assigns which we believe were a better risk overall than those who chose the HMO. Those reasons kind of forced us to the middle of the bid range, which I hope worked out in our favor. The state set these ranges for each cell, but they didn't tell us what the ranges were. At the first pass, as you go through and develop what you think the true costs are, the state came back and said, this rate is 10% above the top of the range. This rate is 5% below. They allowed us a couple of opportunities to get our rates back into where they believed they should be, and that was accomplished.

I want to tell you a little bit about our programs and our experience in the Medicaid market this year and some important differences between the way Kansas and Missouri have set up their programs. Kansas went to a Medicaid HMO program in December 1995, and we're essentially involved in a seven-county area with about 3,500 enrollees. Our year-to-date loss ratio is running about 88%. In Missouri, there are four different areas of the state that were set up at different times—the central section, the eastern part of St. Louis, northwest Missouri, which is primarily a rural area in the northwest corner of the state, and western Missouri, which includes Kansas City. We have the majority of our enrollment in that Kansas City contract. In the Missouri portion, the AFDC comprised 93% of all enrollees. It has, by far, the largest share of the enrollment.

Because of the way the two states set up their programs, their contracts are significantly different, and I want to distinguish those two. As I said, Missouri used Categories 1, 2 and 4—AFDC, pregnant women, and foster children—whereas Kansas only included 1 and 2. Missouri had a competitive bid process, whereas Kansas operated similarly to the way our AFDC contract worked in Missouri. The state set a capitation rate based on its Medicaid fee schedule. They offered it to you, and you had the option of taking it or leaving it. Kansas also has an option where the enrollees can opt out into a primary care case management system, like the previous Missouri program. So all the people are not covered by HMOs, whereas, in Missouri, the new program was a mandatory HMO enrollment.

Let's get to some of the numbers that we looked at this year to see what has gone wrong. One of the things we looked at was what has happened to our enrollment by demographic category. Two figures really stand out. One that is probably less important is that we had a slight decrease in the proportion of enrollees at age zero and a significant increase in the proportion of females aged 21–44, which can be tied to the inclusion of a pregnant women category, or Category 2, of AFDC. These two categories are the most expensive in terms of the cost and the capitation rates that were paid. They do carry quite a bit of weight. Most of the other categories didn't change very much, especially the middle categories like the age 7–13 males and females and age 14–20 males and females. There are very few older males and people over 45 involved in this. It's a very different mix than you might be used to in your commercially insured population.

Table 1 shows our experience thus far (this is incurred through June 1997 and paid through August 1997). I wanted to look at the various loss ratios for each of our segments to see if there were any significant patterns there. As you can see, there's a pattern. The numbers are all very high, but they take on a greater context when you look at how much each segment comprises in comparison to total revenue. You notice that children under the age of 14 make up 60% of our enrollment. That's a significant share and it is much higher than you're going to see in an insured population. When you add on the 21–44 females, you're talking about 80% of your enrollment. The experience on those four cells hasn't been very good, and it contributes a lot to the problems that we faced this year

Then we can look more specifically at various components of care (Table 2). On the inpatient side, I'm looking at calendar-year data 1992–96 and then year-to-date data through September 1997. Keep in mind that 1992–96 is primarily the Missouri AFDC population. It's difficult to compare the 1997 data with that, but it does give you an idea of our overall experience. There was a pretty good decline in the days-per-thousand over that time period, and I think that gave us a false sense of confidence that we were doing the right things with this population as it was

growing. The cost-per-day was relatively constant. You can see what's happened to it this year, and I'll get into some of the reasons why your inpatient contracting is so critical and actually difficult.

TABLE 1
1997 EXPERIENCE BY DEMOGRAPHIC SECTOR
OVERALL LOSS RATIO AND DISTRIBUTION OF TOTAL REVENUE

Beneficiary Category	Segment	Western MO Loss Ratio	Percentage of Total Revenue
Aid to Families with Dependent Children (I)	0 M/F	121%	23%
	1-6 M/F	102	21
	7-13 M/F	73	16
	14-20 F	128	9
	14-20 M	63	4
	21-44 F	140	19
	21-44 M	159	1
	45+ M/F	100	1
Poverty-Level Pregnant Women (II)	Under 20 F	92%	1%
	20+ F	140	2
Foster Children (IV)	0-6 M/F	105%	2%
	7-20 M/F	84	1
Total		**111%**	**100%**

TABLE 2
MEDICAID HMO INPATIENT UTILIZATION

YEAR	1992	1993	1994	1995	1996	1997
Days per 1,000	459	380	320	298	309	363
Cost per day	$427	$740	$670	$604	$635	$894
Total PMPM Cost	$16.33	$23.43	$17.87	$15.00	$16.35	$27.04

We've had a significant increase in the per-member-per-month costs on the in-patient side. Why is that? Would that alone cause you great problems? The answer is yes. In comparison to an individual HMO block and a group HMO block, the portion of expenses that the inpatient hospital portion makes up is much, much greater. This is attributable, in large part, to the pregnant women who may be in your plan for a month or two and then have a delivery. The inpatient hospital portion is a much greater share than you may be used to seeing in your regular population. At the same time, the outpatient hospital is a significantly smaller share,

and the others, the noncapitated physician, prescription drugs, and capitation, at least in our experience, have not been that much different than we might be used to seeing. This points out that handling your inpatient costs is critical to success.

Mr. Thompson: I'm a little surprised to find the outpatient hospital number as low as it is relative to your individual and group population. I would have expected you to continue to have some emergency room problems and things that would tend to give you some fairly high costs there. Can you comment on that?

Mr. Miller: I think I agree with you in theory. I don't know how much of this can be attributed to the fact that a lot of these people were in the fee-for-service world. This may be their first experience with HMOs, and there may be conditions that are beyond the outpatient stage at this point. I don't know that we've had a significant problem with emergency room use. We did a lot of education of providers before this program came up. Obviously, those who had been in the program before with the AFDC population were aware that that's something that we try to discourage, but we have not seen the problems with emergency room use that I think other plans have.

Let me talk for a minute about problems you might encounter with inpatient contracting, which certainly was the case with us. Our existing reimbursement schedules, the per diem rates that we were paying to the hospitals in the previous demonstration program, were not going to work. It was clear from the outset that major changes were needed. The primary thing from the hospital perspective is that they were used to getting compensation for a disproportionate share of uncompensated care. When you go into a fully managed care program, those payments go away, and so the hospitals are going to be much less agreeable to settling for the rates they used to accept from you without this other income coming in. In our case, our network hospitals were minority partners in the HMO, giving them a lot more leverage in terms of decision making and rate setting. As a result, most of our hospital contracts are above Medicaid rates, and if you're getting the capitation that's based on Medicaid fee schedules, you must make it up somewhere else. Up to this point, we have not done so.

We also have to meet relatively stringent access requirements in the HMO programs which, with the advent of this new program, brought our hospital network from 10 to 38 facilities. It has greatly complicated our contracting efforts. The Children's Mercy Hospital in Kansas City was a tertiary care facility under the previous program, and we used it when we had to, but we didn't in another case because they provided care at a much higher cost. We could not exclude them from this network. They're right in the center of town, so they're getting a very high volume of business at a very high cost to us. You have to deal with federally licensed and

state-licensed clinics that must be included because they have traditionally served the Medicaid population. The bottom line on the inpatient side is that things get a lot more complicated in the Medicaid market than you might be currently staffed or currently set up to handle.

It's a different story for us on the outpatient side (Table 3). We were successful at reducing the case or the utilization rates, but we lost some control of the cost-per-case. In any event, we have been successful at reducing the per-member-per-month costs on the outpatient side. We are attempting to move from a discount off a bill to more of a case-cost type reimbursement. I hope that we can accomplish that in the next few years, but up to this point, the out–patient hospital side has not been a real source of problems for us.

TABLE 3
MEDICAID HMO OUT–PATIENT UTILIZATION

YEAR	1992	1993	1994	1995	1996	1997
Cases per 1,000	744	449	391	362	245	171
Cost per Case	$240	$470	$595	$578	$710	$787
Total PMPM Cost	$14.88	$17.59	$19.39	$17.44	$14.50	$11.21

On the physician side, our plan has attempted to bring more and more specialties into our capitation structure (Table 4). You can see the jump in 1997 as we brought a number of specialties in under capitation. You would think that might result in a reduction of your noncapitated cases–per–thousand. That has not been the case. In fact, we've lost on both ends there. You see a significant increase in our per-member cost on the physician side as well. There isn't a whole lot of good news, from our standpoint, thus far in 1997.

The conclusions that I would make based on the experience we've had thus far this year are that it is absolutely vital to understand the nature of Medicaid beneficiaries and the risks you are assuming. They vary quite a bit from what you might typically be used to handling in commercial business. It is likely that your provider panels and your reimbursement methods are not going to work in the Medicaid environment. This applies to the facilities that you are used to using. In addition, the rates and the schedules are, in many cases, inappropriate for this market. You might have to develop a whole new methodology for reimbursement of your institutional providers.

TABLE 4
MEDICAID HMO PHYSICIAN UTILIZATION

YEAR	1992	1993	1994	1995	1996	1997
Capitation	$13.83	$13.61	$14.75	$14.34	$12.34	$17.92
Cases per 1,000	1,562	1,582	1,465	1,700	1,904	1,904
Cost per Case	$61.27	$59.17	$60.93	$54.14	$62.72	$58.22
Total PMPM Cost	$21.81	$21.40	$22.19	$22.00	$22.29	$30.14

When I talked to our vice president of Medicaid, who assumed this business in the middle of increasing losses, he concluded that what we were doing over the last several years was managing cost and not managing care. We were successful at getting our per day costs down, and it appeared that we were getting our utilization rates down, but what we were doing is managing the costs. We were not really getting in there and managing people's care. We think that has come back to haunt us this year. We found that, in our market, there are a number of interested bidders in here. Not only do you have your traditional commercial competitors, but also a lot of the state-based clinics and public hospitals that are forming their own HMOs to get into this market. They are much more experienced at handling this market than we are. We're starting from a disadvantage, and it created difficulties for us this year, but we're hopeful that in the future we will learn from our lessons and move forward.

Mr. Thompson: Can you tell me something about the length of the eligibility period for people covered by Medicaid, especially the AFDC population? How long is any lock-in to either their eligibility or to a particular health plan? The frame of reference I'm using is Connecticut, which moved to a managed Medicaid plan for AFDC a couple of years ago, and eligibility for Medicaid keeps changing. People are on and off the rolls, and then on again. People could sign up and then change plans every month if they wanted to as long as they were still eligible. There are a lot of problems with people getting a doctor's appointment, verifying eligibility, and getting the service. They might no longer be eligible under that plan at that time. There were several unhappy physicians along the way

Mr. Miller: We're in exactly the same position. We talked about instituting a lock-in, but it has not happened yet in Kansas. I've had more experience in Kansas than in Missouri. It has caused problems with eligibility questions and becomes a real nightmare when those things are not dealt with. There has been movement in that area, but nothing has been settled.

Mr. Thompson: I assume that requires some legislation.

Mr. Miller: Yes, it does.

Mr. Thompson: You haven't seen any interest in the legislature yet?

Mr. Miller: Not yet.

Mr. Rex Mitchell Durington: I just wanted to ask if anybody else is in a similar position of working with states developing capitation rates from the states' side. I'm the only one? You have to believe everything I say then. As the last speaker at the last session on the last day, I thought I'd make my presentation a little lighter and do some headline type stories that I've encountered in my work with the states.

We have a case that I think is pretty rare: an HMO giving money back to the state. There was a lawsuit involved in which the capitation contractor, the fiscal agent, and the state were all pointing fingers at who did something wrong. What happened was the capitation calculation was based on an understated eligibility. The problem was that the capitation payment for AFDC medical was basically similar to what Bryan was showing you. Two years ago, the capitation rate was $170 per-member-per month, which is fairly substantial for a midwestern state. The next year they figured out the problem to some extent and they dropped the rate to $130 per-member-per-month. Then we took over the project, started looking at the numbers, and we saw that it really should be something on the order of $110. We kept looking at the data but we couldn't find it. Finally the state said it believed its numbers because it did not want to come down that fast. That's one of the horror stories that I've run into, and it basically points out the risk to the state. Of course, they ran into bad publicity and it made the papers. It shows you the risks of poor program design or pricing or implementation. It was poor pricing in this case. The state's credibility suffers, which makes it more difficult in the future to negotiate with managed care organizations because nobody believes the numbers anymore.

Why would the HMO give the money back? They were afraid that the news would get out, and advocate or watchdog groups would find out. In the state of Missouri *The Post Dispatch* came out with an article on profitability levels of HMOs across the state. Some are losing money and some are making money, and that's something that is watched closely. They gave some of the money back, but I think they used some of it to subsidize their commercial business. It was an unusual case of reverse cost shifting.

In some states now there's more of a watchdog approach on requiring shadow claims in the request for proposal (RFP). I've seen one state starting to do withholds,

where you don't get all the money upfront. It goes into an account, and if things work out right, you get the rest of it.

While no fault has been found in this case, at least that I know of, it points out that the consultant's report of the capitation is really the key evidence. You get data from the fiscal agent, and all of it is summarized into the actuarial report. There is a lot of risk there for the actuary, because he represents what is seen by the public.

There is another point to consider. The previous consultant on this case did not employ actuaries. They used an actuarial consulting firm for peer review, which is very risky because the actuary really needs to be involved from the get-go on these projects. I had the pleasant task of explaining to the managed care organization that their rates were going to drop 30–40%. The moral of the story is: Use comparative data whenever possible for a reasonableness check. Actuaries serve a useful and essential role in capitation development, and you should know your data. The state should be forced to explain any problems or anomalies that you find in the data.

There is another data-related issue: As an actuary working for a state, you get your historical data and you have to filter it down and develop capitation rates. Much of the work is very heavily data oriented. The problem lies in that this is not the way the fiscal agents typically operate. They can't give you the data information that you need. It's an ad hoc request that doesn't come through clean very often. What you should do is plan on two or three more data requests; try to define it in as much detail as you can because things always go wrong. One thing I've discovered is you should not throw any data away. Don't filter out any data, because the state will often change the program midstream. It's always nice to keep it aside somewhere where you can get at it easily. I would also recommend, if you're doing work for the state, that you have the actuarial report show up as an addendum to the RFP, because when things change that quickly, you really don't have time to get it into the RFP.

There's a case where we actually used the encounter data submitted by HMOs. Arizona is a state where that happens a lot, but I haven't seen it very often. Here is a case where we actually did use the data. Typically, the historical data are not in a form that the state can use easily. The capitation is based on fee-for-service, utilization, and cost data, and in lieu of anything else, that's how the payment rate gets developed and how the pricing proceeds. You would typically do some adjustments for management of health care, such as cost shifts and the desired level of savings to the state. The HMO in this story provided encounter data that showed a vastly higher utilization per thousand on pregnant females. This is similar to what Bryan's data showed. You get more pregnant females in an HMO than you encounter in a fee-for-service plan. It is a word-of-mouth referral. Pregnant women

tell other women, "If you are going to have a baby–join this HMO because you get treated better." It was true. The utilization was higher by a factor of four in the HMO than in the fee-for-service plan.

We recalculated capitation rates for this zone where this HMO is operating to reflect the higher utilization. The moral of this story is that if you have good encounter data, and can prove your point, the state is willing to negotiate and adjust things. The key is getting good data and proving your point. I think it's wise to have more of a partnership attitude with states rather than an antagonistic approach to why the rates changed so dramatically.

Mr. Thompson: I have a question about the data. How do you verify that it's accurate or complete? In some cases, on a renewal basis, you're taking data back from the plans to set what their rates might be in the future. If you're a start-up state that's just getting into it, you're dealing with whatever stuff the state has put together. What have you encountered as far as some of the data quality and completeness issues, and how do you go about making sure that it is reasonable and complete?

Mr. Durington: We will typically compare it to similar state data that we already have. M&R has a lot of state data that it can use for comparison. There are reasonableness checks. We check to see if there are records of men having babies—things like that actually do show up. I mean we have some podiatrists and optometrists performing mental health services. You also try to see if the rates are reasonable and internally consistent compared to other data that you have The end result is such data are usually all you have to work with. Unless somebody can prove that things are not what they appear to be, then that is what the capitation is based on. I guess you can look at commercial figures for the comparison, to some extent, but not really on Medicaid. Generally you can get a ballpark figure, but I guess the short answer is that you look at comparable data from other states. It's the most useful source.

Mr. John J. Lynch: In a renewal situation hasn't the data problem sort of gone away? Wouldn't the state know from their expenditures what's left in their checking account, and what's not left in the state's checking account? I'm thinking of a typical situation where there might be only a handful of contracting HMOs. Those HMOs know whether that capitation rate was $170 when it should have been $110. They got rich when they should have gotten poor. I would think that the state would know that information. It may not have been obvious in advance that $170 was too high, but after the fact it should have been. Should we commit the same sins again?

Mr. Durington: The real fear for a state is that once it capitates, it loses its fee-for-service base. It doesn't have much data to rely on anymore. The HMO might provide encounter data, but the state is not going to know the cost if it's just encounter data. They know what they paid out. They can look at the profitability level of the HMO. How is it doing? How do you identify what's Medicaid specific in that? You've got commercial and group, or whatever else is going on, that they can shift. Anybody can play with the books a little bit to make things look the way they want. A big concern from the state's side is how to monitor this? How do we keep this under control? How do we know we didn't overpay? The trend is more towards you ask for shadow claims or tell us what you're paying your providers. They need to see actual costs because utilization doesn't tell a lot. I've heard of only one occasion in which the encounter data were of sufficient volume and clarity to use to make an adjustment.

The follow-up is that the state pays twice. The HMO got fairly belligerent about the rates dropping from $170 to $110, which is understandable. When we started looking more closely at the encounter data, we found that maternity utilization was vastly different with the HMO, so we started looking at the fee-for-service for the same region. We saw that there was a big shift in chiropractic services, and that was a carve-out. The HMO could take it on an optional basis, but what actually happened is it didn't take the chiropractic services on a capitation basis. The state was paying it fee-for-service, and the utilization on chiropractic services was very high. I was actually involved in a phone conversation when everybody was arguing about the rates. We agreed that we would make the maternity adjustment because it made sense. The HMO was asking for more. We asked, "What about the chiropractic? We noticed that's really bad in your region." There was silence on the phone for about five seconds. These are just some of the things that the state will start to look for. They're getting wise, or they are really trying to be a partner with the HMOs so that everybody can play the game right. There are still some things that go on and if you look at the data closely, sometimes you'll find these problems. Much of this has been related to data—that is the key to the whole thing.

When you work for the state, you get into politics, even in a case where the program is well-designed. The RFP reads well, and everybody understands. You have a lot of providers lining up that want the contract. So what goes wrong? One factor is special interest groups. In a mental health setting, there are community mental health centers (CMHCs). They have safety net providers. These are people who have always provided these services. They are afraid they're going to get cut out of the pie, and so they get some political action going and block the whole program. You might find that you're probably going to be forced to accept some of these safety net providers as part of the deal. There are many provider questions too. Will I be cut out? How much will I get paid? Will I be paid less? Advocates

are always questioning whether there are going to be access issues that are changing, whether you're cutting out the traditional pathways that people use to access services. I see this more in mental health and substance abuse than I do in medical.

Another thing that stirs up the political issue is that state programs are trying to cut out much of the duplication of effort. There are various departments within the state that are all doing the same thing. They are providing transportation for this or that, and they're trying to combine this under one capitation to avoid much of the duplication of effort. However, that raises a bunch of political issues within a state. You hear, "I don't pay for this on a fee-for-service basis." What I've run into is Medicaid fee-for-service which pays for their transportation. They know how much they pay but there are other departments that really don't have records to base these things on, but they want to get in. You have to determine how much of your budget you will devote to join in this program. That becomes a real problem on the political side.

From the Floor: I just want to make a quick comment on transportation. What we found in some states is that the costs didn't even make it into the premium rates. I believe it was Oregon that actually organized volunteer pools. The little bit that was paid out in terms of taxi vouchers made it into the rate, but the bulk of the nonemergent transportation didn't even get funded.

Mr. Durington: I have seen that, too. I'm working with one state on a transportation issue, and I found that it is spending about $20 million a year on emergency transportation. I checked on other states to see how much they were paying. I might see $1 million. Transportation costs probably are not making it into the capitation rate much of the time.

Mr. Miller: The traditional Medicaid providers, like CMHCs, and the physical health providers, offer a huge opportunity for the health plan if you approach them as potential partners rather than as vendors. They need somebody to help them with their business processes and learn how to be a business partner. They're not going to be protected forever, and if they're going to exist, they are going to need help. There is also what I'll call a marketing opportunity associated with that. These are places where the patients are used to going, and it is beneficial if you can get these providers in your plan. Whether or not there's marketing allowed with that Medicaid program, it creates an appeal to the extent that enrollees can self-select which HMO they go into. It's almost imperative to have those folks on your panel. Many states are actually rewarding attempts to bring those people into your plan through different kinds of scoring points on the RFP.

Mr. Durington: Here's an interesting story. I don't have a lot of factual content on this; I just hear anecdotes. Foster kids cover the cost spectrum. They can be very cheap or they can be extremely expensive. These costs fall under the behavioral health area. There were wards of the state that were being shipped to California, and that seemed to be cost-effective. It was an economic decision; the state was just trying to dump expensive cases. There are a lot of developmental disabilities and things like that. Foster kids often get shuffled around, and require a unique management situation. I guess the moral of this story, what little there is of it, is that states are becoming more aware of potential abuses within their own state-run programs and also what they can contract out.

There's also a tendency to carve in some of these troublesome populations. The states have not proven themselves to be successful at managing care to a large extent. They will try to carve these people in. The trick, from the other side of the table, is to watch for costly hidden populations and services that may get folded in, and may be lost in a demographic ravine.

The state really wants a quality partner, and a quality partner would include a financially solvent, viable partner. That type of partner is not going to try to put the squeeze on as much as may be thought. Most people that I've talked to are genuinely interested in the population, and they want to see things done effectively. To some extent they're handcuffed by what they can do within the political process, and they would like to have a good partner who could take a higher percentage of the upper payment limit (UPL) rate and expand services. I see a real trend in moving away from the 90% of the UPL capitations to something on the order of 99% or 100%, provided things can be added to the program that the states are looking to have.

Generally the states are content with the predictable budget process and some modest cost savings that they can show to HCFA, which would demonstrate that things are cost effective. With the erosion of fee-for-service data, the partnership is going to become more and more important to the state. It is going to rely more and more on encounter data, and what they will be looking at is actual costs to the HMO and the level of profitability that the HMO shows in negotiating contracts.

I don't think there are very many Medicaid nonemergency transportation programs going on in the country. I found that two or three states have done some things on this, but this is a fairly aggressive attempt at getting capitation to work for nonemergency transportation. It is a challenge because there is very little comparable data. We talked briefly about data issues, and what to do with a start-up capitation when you don't have very good data. In our case, we got lucky that all of the transportations were kept on vouchers. There was fee-for-service type data

that was cleaner than most of the medical data I've seen. It was very understandable and usable. Preliminary results indicate that over 40% of the nonemergency medical transportation needs are being met by taxicabs. These patients take a cab. What's unusual in a particular state is that one side of the state prefers taxicabs. The other side of the state prefers minibuses or ambulatory transportation units.

What do we do when we have very little comparable data? This parallels the medical capitation. You start off with a small region of the state that has less providers. This is unique because there won't be a bidding war for who provides transportation. You have only one transportation provider. The buses, taxis, and ambulance services are there already. You're not going to get somebody to come in from the outside for the capitation and take it over. What they're looking for is a broker who will manage transportation needs.

From an actuarial point of view, as you do more medical and behavioral health capitation, you start thinking about the transportation issue from a medical perspective. Instead of an average length of stay, you have miles per trip. The intensity is measured by carrier type and miles or you can do cost-per-mile calculations which run anywhere from 40¢ a mile under the fee-for-service to $2.25 per mile for nonambulatory transportation with the wheelchair lift type carrier. The interesting thing is that about 97% of the carriers were using private automobiles. The average trip for just about all carriers is 15 miles or so per trip. Private automobiles get reimbursed 30¢ a mile. The average trip is 30 or 35 miles. Unless you have a more intense service with private automobiles, you're guessing that people are just jacking up their mileage.

In closing, I've dealt with problems and unusual things that I've seen in Medicaid managed care from a state perspective. The rewards that are out there from a state perspective are that they see the opportunity to become more efficient in the delivery of service. They sidestep political games, and they can eliminate some duplication of effort that goes on in state government. In the case of transportation, you basically have four divisions doing the same sort of thing, and this voucher system is very manually intensive. Somebody has to key the vouchers in and look at them and approve them. If they go to a dispatch service, it's much more efficient, and this frees up the employees to do more important things rather than just serving as bookkeepers. The state intends to channel a lot of the statements from the accounting function back into the administrative costs of the broker, and try to develop more efficient programs.

Mr. Craig M. Arnold: You discussed how a patient might not have a telephone. Sometimes, it's worse than that. The person may not even have an address. If you have a management book to send out, you might have a person who cannot read or doesn't have an address where you can send it.

The second comment I have is on administration. Don't underestimate the amount it will cost you to deal with the state. We had one case where every time someone changed an address or did some other kind of administrative function on the state's computer, the carrier automatically reverted to the state rather than the HMO. People were being pulled out. We were no longer getting capitation for somebody because their address changed. We were not getting paid capitation when the person wasn't getting care, we only got paid when they start getting care again.

Mr. George B. Davis: We have the same problem getting addresses. What we've decided to do is just send out a small packet of information to verify addresses, and then we would send them more stuff because we'd send out big packets of stuff at a few bucks a shot and then get them back. That was one way that we're trying to control things. Another problem that we've had with Medicaid is we've had a lot of people that weren't picking a primary care physician. We were finding the closest primary care physician and just assigning them. Then we started looking at our contracts with medical groups to decide where the closest doctor would be that was more efficient or had lower fees. That was another way we dealt with our costs.

Mr. Miller: Assigning people to a doctor doesn't mean they're going to go there. We've heard stories of people just showing up at someone else's office expecting care to be provided. Compliance is a big problem in this market and something you have to be prepared for.

Mr. Davis: How do you address those issues?

Mr. Miller: To be honest, I'm not sure. I think the education process is critical to not only those who are in your network but those who might be confronted with one of our patients. I think the key is to educate everyone in the system so they understand what to do in situations like that.

Mr. Durington: From the state perspective, if you want a certain type of compliance, you build it into the RFP, saying we want 90% compliance, and we'll leave it to you to solve that problem.

Mr. Stephen Michael Arnhold: There is quite a disparity in your experience between the two different areas in Missouri. I have a two-part question. One is, have you looked into why there are different practice patterns? I assume that,

administratively, you're doing a lot of the same things in those two areas. Second, it seems like the western Missouri experience is really quite new in terms of duration. I mean it's in its first year, and I'm wondering if you're seeing maybe some sort of adverse utilization just from these people seeing PCPs for the first time. Some of the people might not have been linked. Or perhaps you're seeing something that might be reflected in your incurred but not reported (IBNR) expenses or in your reserve methodology, where it might be breaking down at the duration or it might not be as bad as it looks.

Mr. Miller: Let me answer the second question first. I think a lot of it has to do with the fact that lot of these folks are in managed care for the first time, and a lot of them don't understand the system. We've probably experienced a higher level of office calls than we would have expected from these people. They don't understand what this program's all about. But when the state says you will be in an HMO, there's no option there.

As far as the disparity between Missouri and Kansas, that's something we haven't spent a lot of time looking at. As I mentioned, there are a number of differences in the way the programs were set up. We think the capitation rates that Kansas is offering us are probably a little more fair than those in Missouri. I think that has a lot to do with the difference in loss ratios. I was at a meeting in Topeka recently to discuss Kansas, and there are other HMOs that are unhappy with that capitation rate. As we've discussed, you would expect that the HMO experience would be used in the development of future capitation rates, but Kansas is still using a 1995 fee schedule data for 1998. They have not yet developed the ability to translate the encounter data that we give them into capitation rates. We're still working on the old system, and until those things get fixed, there will be problems with income.

From the Floor: Rex did a good job of explaining how tough a department the state was, and you did a good job of explaining how very different this business is from the commercial business. I will pose this question to you, Bryan. Why get involved?

Mr. Miller: Don't think that hasn't been asked internally a lot this year. We've been losing more than half a million dollars most months this year, and the issue of marketing was raised earlier. It has caused some real contention in our office. Our belief, in the actuarial department anyway, is that you don't want people to choose you. You want the auto-assigns. It is not a good idea to have billboards and television ads promoting this program if you're going to get high-risk people to select you. Internally, there are a number of areas of contention to our plan about the way we've handled the bid process, the way we're handling care, the way we've

set up our networks. We shouldn't have been caught by surprise by this thing. We knew it was coming. But the impact and how quickly it hit us I think did surprise us, and we've got to deal with those issues. I know that our company is committed to staying in this market long term despite, the losses we've incurred so far this year. These things simply have to be addressed. There's no alternative.

Mr. Thompson: I heard that when Connecticut first moved into a managed Medicaid plan for AFDC a couple years ago, the first year out they had 11 contractors. Now the bids are up for renewal, and I believe there are only five rebidding at this point. It appears that many of the HMOs have gotten cold feet. Does anybody have any success stories or good news or even horror stories on managed Medicaid?

Mr. Durington: I was just going to say that I think the motivation, to some extent, from the HMO side is that you get leverage with the state. Once you've been in a program for a little bit of time, you get to the point where you can wield some significant power against the state. They don't want you to leave. When they've finally got this thing up and rolling, they want you to stay. They will make certain concessions. I also think there are times when you need to get to the Medicaid population in order to get to another group that you like even better. Perhaps state employees' coverage or something along those lines may be a factor in some programs.