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MANAGED CARE: Oregon Program Appears Successful but Expansions Should Be Implemented Cautiously

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Before the
Subcommittee on Health and
the Environment
Committee on Energy and Commerce
House of Representatives

SUMMARY

GAO was asked to review the Oregon proposal to expand its current prepaid managed care activities as part of a demonstration that would restructure its entire Medicaid program. In response to this request, we examined the Oregon proposal in the context of findings from our reviews of other state Medicaid managed care programs. In those reviews we identified problems related to access to care, quality of services, and the financial oversight of participating providers. Our review of Oregon's proposal focused on the existing managed care program that will serve as the foundation for the proposed demonstration project.

Oregon's Medicaid managed care program began in 1985 with the approval of the Health Care Financing Administration. The program has grown gradually to an enrollment of about 65,000, primarily women and children. The state has contracts with 16 health service providers, with enrollments ranging from 800 to more than 16,000 Medicaid managed care clients. All but one of these providers are capitated (i.e. receive a fixed monthly fee for enrollees) for physician and outpatient services only. Inpatient services for these Medicaid clients are provided on a fee-for-service basis.

The Oregon Medicaid demonstration project is designed to expand Medicaid eligibility to all persons with incomes up to 100 percent of the federal poverty level while redefining the scope of health care services the state will reimburse. Services will be provided through a managed care system that is moving toward full service prepaid health plans capitated to provide inpatient as well as ambulatory care. Full implementation of the demonstration will begin in July 1992.

Our review to date indicates that Oregon has avoided most of the problems we have documented in other states. For example, the state has instituted safeguards to prevent financial incentives that would lead to inappropriate reduction in service delivery and quality. In addition, the state has complied with federal requirements on quality assurance measures that include an independent review of patient medical records.

We have concerns, however, about whether Oregon can implement, by July 1992, the statewide system needed to serve the threefold increase in Medicaid managed care enrollments. In addition, we believe that financial oversight and monitoring activities should be strengthened. Because of these concerns, we believe that HCFA should require Oregon to demonstrate that there is adequate provider capacity and sufficient oversight in place before it is allowed to implement the demonstration project.

Mr. Chairman and Members of the Subcommittee:

You asked us to review the Oregon demonstration proposal to expand its prepaid managed care activities as part of a larger proposal to restructure its entire Medicaid program. Oregon intends to institute a more cost-effective Medicaid program while substantially expanding eligibility by (1) establishing a priority list of covered services and (2) instituting a statewide managed care program. Eligibility would be extended over a period of time to all individuals in the state with incomes up to 100 percent of the federal poverty level.

In response to your request, we examined the Oregon proposal in the context of findings from our reviews of other state Medicaid managed care programs. In those reviews we identified problems related to access to care, quality of services, and the financial oversight of participating providers. Our review of Oregon's proposal focused on the existing managed care program that will serve as the foundation for the demonstration project.

Our review to date indicates that Oregon has avoided most of the problems we have documented in other states. The state appears

to have developed a managed care program that successfully affords access to quality health services for a majority of eligible women and children. This program, operating in the more populous areas of the state, has had few problems.

Expanding the managed care program statewide, however, raises some concerns. This proposal calls for a threefold increase in managed care enrollment and moving to a fully capitated system for most of the enrollees: that is, a system in which a fixed monthly fee is paid for each enrollee to cover all inpatient and ambulatory care. It is not clear that Oregon will be able to develop the provider network to assure access for the program's eligibles according to its timetable. In addition, Oregon's current program does not have financial disclosure rules for providers to help assure the appropriate expenditure of dollars for health care. The state has no plans to put such requirements into the demonstration. Also, financial reporting requirements need to be strengthened to give the state an effective tool for monitoring provider solvency.

BACKGROUND

Managed care is an important means of health care delivery in the United States today. In 1989, over 34 million Americans (about 15 percent of the population) were enrolled in health maintenance organizations (HMOs), the standard model of managed care. In the

1980s, the federal government funded and promoted managed care delivery in the Medicare and Medicaid programs. In 1989, 5 percent of the Medicaid population was enrolled in HMOs. By August 1990, 28 states and the District of Columbia had one or more prepaid health plans for Medicaid recipients.

Managed care is designed to promote access to and quality of care, while controlling costs. Health care providers, usually a type of HMO, are paid a fixed monthly fee for each enrollee. In exchange, the provider agrees to make available a specified set of services and guarantees that they will be available to enrollees. Because providers are financially responsible for these services, they should be motivated to deliver more preventive care, thus keeping enrollees healthy, and reducing costly hospitalizations and inappropriate use of hospital emergency rooms. However, because they are financially responsible for the services, without appropriate safeguards, providers may also be motivated to deliver fewer services than needed, thus compromising the quality of patient care.

Oregon's Medicaid managed care program began in 1985, enrolling women and children eligible for Aid to Families with Dependent Children (AFDC) under a freedom-of-choice waiver (section 1915(b) of the Social Security Act) approved by the federal Health Care Financing Administration (HCFA). The program has grown gradually to an enrollment of about 65,000 primarily women and children (55

percent of the total state AFDC enrollment) in 10 counties, including the most densely populated parts of the state--the Willamette Valley from Portland south to Eugene, plus Medford. The state has contracts with 16 health service providers, with enrollments ranging from 800 to more than 16,000 Medicaid managed care clients.

All but one of the current providers receive a capitated payment for physician and ambulatory services. These "partially capitated" plans are called physician care organizations. In addition to providing ambulatory care, physician care organizations are responsible for managing the individual's inpatient care, which is reimbursed on a fee-for-service basis. They may receive compensation in the form of savings bonuses if their aggregate inpatient utilization is below target levels. The only "fully capitated" provider in the current program is an HMO with an enrollment of about 375,000, of which about 9,400 are Oregon Medicaid clients. This HMO is responsible for providing both ambulatory and inpatient care.

The Oregon Medicaid demonstration project is designed to expand Medicaid eligibility to all persons with incomes up to 100 percent of the federal poverty level, while redefining the scope of health care services the state will reimburse. Services will be provided through a managed care system that is moving toward fully capitated health plans. On August 15, 1991, Oregon

submitted a proposal to HCFA to obtain the waivers of federal Medicaid law that will be necessary to implement the demonstration project.

OREGON PROGRAM AVOIDS PROBLEMS

Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. Focusing on Medicaid managed care programs in Arizona, Philadelphia, and Chicago,[1] we identified a potential for what could be called "perverse incentives" in prepaid managed care: that is, while the incentives inherent in fee-for-service health care may encourage providers to deliver too many services, prepaid managed care may encourage providers to deliver fewer services, or poorer quality services, than enrollees need. Adequate safeguards need to be in place to ensure that appropriate, quality services are provided.

Oregon has avoided many of these problems in its current program and plans to take steps to avoid them in the demonstration project.

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[1] Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985); Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987); Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program (GAO/HRD-88-37, Dec. 22, 1987); and Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

Safeguards to Prevent Inappropriate Utilization Are in Place

Under Oregon's current program, safeguards comply with HCFA requirements and appear adequate to prevent inappropriate reductions in service delivery and quality that we have documented in other programs. These safeguards employ many of the features we recommended for programs in other states. Adequate safeguards will be especially important under the demonstration, because the number and types of providers, and the amount of financial risk experienced by some of them, will increase with full capitation. Oregon plans to continue its current safeguards in the demonstration.

For most of Oregon's current providers, Medicaid managed care represents a small share of business relative to private pay patients. This affords a broad protection against inappropriate reductions in services because, according to providers, Medicaid managed care patients receive the same services in the same facilities as other patients.

Our work in other states has shown that incentives to reduce service delivery and quality in Medicaid managed care may be reduced by limiting the amount of financial risk that providers assume under capitation. We found that the amount of risk is lower when: (1) providers are responsible for primary care not inpatient services; (2) physicians and patients are pooled in

larger rather than smaller groups; and (3) financial rewards in the system for controlling utilization are limited.

Specific safeguards in the current program address concerns that when physician compensation and incentive arrangements place too much financial pressure on individual physicians, treatment decisions may be adversely affected. Specifically, Oregon's current program addresses the types of concerns we identified in other programs. For example:

-- the state limits the financial risk most providers assume to the costs of physician, laboratory, X-ray, and well-child services, excluding inpatient services;
-- the state provides optional state-sponsored insurance (stop-loss) to limit the financial risk physician care organizations face;
-- the state pays a capped bonus to participating providers for savings from inpatient utilization below target levels, reflecting treatment decisions made by all physicians, as a group, for all Medicaid patients enrolled in that provider; and
-- the providers have incentive arrangements with their individual physicians based on treatment decisions made by all physicians about all patients.

Oregon plans to continue these safeguards for contracting

providers participating in the demonstration, with the addition that providers be required to purchase stop-loss or other insurance. Also, the state will monitor the incentive and risk-sharing arrangements adopted by the plans.

Further, Oregon requires providers in its current program to routinely report data on the number and types of services used by managed care patients. Analysis of such patient utilization data is one way of measuring appropriate service delivery. We were not able to analyze utilization data in the current program, however, because Oregon did not fully implement this requirement until October 1990. The demonstration also requires providers to report data on each patient service visit, in addition to quarterly summary utilization data. State enforcement of these requirements is essential when the data are used to monitor access to care.

Finally, our previous work identified problems when substantial financial risk for patient care is passed along through the use of subcontractors. The current Oregon program does not rely heavily on subcontractors, but the state anticipates greater use of subcontracts under the demonstration. If that is the case, the state will need to require financial reporting from subcontractors and monitor financial arrangements between the primary and secondary contractors.

No Serious Quality Problems Identified

In addition to the safeguards discussed above, a quality assurance program is another protection against inappropriate reductions in services under Medicaid managed care. HCFA has determined in its reviews that the current program complies with quality assurance requirements.

The state program complies with HCFA quality of care requirements in several ways. First, it conducts an annual medical record review. Second, it ensures that providers maintain internal quality assurance programs. And third, it assesses client satisfaction through client surveys and a grievance process. Oregon proposes to continue these checks on quality of care in the demonstration program.

As the only independent medical review of the care provided to Medicaid managed care clients, we believe an important quality assurance activity in the current program is the annual review of patient medical records performed by the Oregon Medical Professional Review Organization (OMPRO). The review assesses whether appropriate care has been provided, particularly well-child care and obstetrical care. Three years of OMPRO reviews have identified a small number of documentation problems and few quality problems. Medicaid staff work with providers identified as having problems to implement corrections.

Oregon incorporates HCFA requirements and other state quality assurance standards in its physician care organization contracts. During on-site visits conducted every 2 years, the state reviews provider documentation to ensure that effective internal quality assurance programs are in place. For example, each provider must keep minutes of internal quality committee meetings, document formal client grievance procedures, and submit quarterly grievance reports to the state. These reports detail the number and types of grievances as well as their disposition.

Several other mechanisms help the state evaluate the quality of care delivered to clients. For example, the state has developed and administered periodic disenrollment and client satisfaction surveys. However, in assessing the current program, we determined that the usefulness of the client satisfaction survey was limited by survey design problems. Oregon is working to improve client survey design, and will continue using these and other mechanisms in the demonstration project to evaluate client satisfaction and generate information on program outcomes.

Based on client hearings and interviews with advocacy groups and providers, we found agreement that most client complaints are due to the restrictions inherent in managed care. For example, they must first contact their primary care physician when seeking care and cannot use the emergency room for primary care services.

Also, the providers and the statewide managed care advisory committee agreed that the process to inform clients about the use of managed care is not effective. The demonstration plan includes steps to improve the situation. We believe that in order to protect clients' interests within a managed care system, they must be well informed on how the system operates, the choices they have to make, and the alternatives they have when problems or barriers are encountered.

SOME CONCERNS REMAIN

Despite the current program's success in providing access to quality health services, we have some concerns about the demonstration project's provider capacity and financial oversight.

Program Expansion Raises Concerns About an Adequate Number of Participating Providers

The project's cost estimates are based on the statewide application of managed care with a majority of the population enrolled in fully capitated programs. As Oregon extends Medicaid eligibility to all residents with incomes up to 100 percent of the federal poverty level, the size of the Medicaid-eligible population will increase threefold. To accommodate the expanded population, the demonstration calls for a substantial increase in

fully capitated, HMO-style service delivery, plus recruiting new managed care providers in all parts of the state, including some areas where health resources are limited. Currently 25 percent of the state's insured population is enrolled in HMOs. Yet only one HMO is participating in the Medicaid program now. We have concerns about Oregon's ability to develop an adequate and nearly fully capitated managed care delivery system that is ready to begin in July 1992.

By the end of the first year of the demonstration, Oregon's Medicaid managed care enrollment is expected to be 197,500. Oregon projects that they will be distributed as follows among the demonstration's proposed delivery options: 52 percent (103,200 enrollees) will be served by HMOs and other fully capitated health providers; 17 percent (33,400), by partially capitated physician care organizations; 24 percent (47,000), by primary care case managers; and 7 percent (13,900) will continue in fee-for-service Medicaid.

To implement this plan, Oregon expects to contract: (1) with HMOs and fully capitated providers in nine counties that currently have managed care; (2) with new physician care organizations in nine additional counties; and (3) with primary care case managers in the remaining 18 counties of the state. For reasons discussed below, we have concerns about the state's ability to put these resources in place by July 1992.

-- The demonstration assumes that the 103,200 Medicaid eligibles in the nine counties of the Willamette Valley will be served by HMOs and other fully capitated providers. This is a change from the current program, in which only one provider serving about 9,400 Medicaid clients contracts as an HMO and assumes financial risk for the full range of inpatient and ambulatory services. The other 15 providers contract as physician care organizations, which are capitated to provide physician, laboratory, X-ray, and well-child services to about 56,000 Medicaid clients.

Oregon's current physician care organization contractors include large and small independent practice associations, multi-specialty clinics, public health and hospital-based clinics, and primary care group practices. To participate under the demonstration in the nine-county fully capitated area where they now operate, these physician care organizations will need to restructure to become fully capitated providers. These organizations along with

other new fully capitated providers will need to accommodate nearly twice the current enrollment (65,000 to 103,200).

-- The demonstration also assumes that new partially capitated physician care organizations will be established in nine additional counties and that they will be ready to begin operations in July 1992. The other 18 counties will be served by a primary care case manager program, which is not part of the current managed care system.

The primary care case manager program, which will reimburse on a fee-for-service basis, will contract with individual physicians, physician assistants, and nurse practitioners, and with groups of these providers, who will serve as case managers for Medicaid clients. As such, they will be responsible for providing all primary care, making all referrals, and monitoring hospitalization for their Medicaid clients. We do not know, however, whether this new program can be quickly implemented. Most of Oregon's counties contain federally designated underserved areas, and Oregon

Medicaid staff acknowledge primary care physician shortages in parts of the state. In at least one state, creating a network of primary care case managers took several years.

Oregon Medicaid staff told us efforts are underway to address these concerns about managed care capacity. The fully capitated providers will include providers who are new to the program, in addition to some of the current physician care organizations reorganized for full capitation. Four physician care organizations told us they have begun negotiations to become part of an HMO, and one new HMO already has agreed to begin serving Medicaid patients in spring 1992. However, when we interviewed the other physician care organizations currently participating in the program (which was before the waiver request was submitted), they did not know that only fully capitated plans would be operating in their area and assumed that their status would not be changing.

Second, new physician care organizations are scheduled to open this fall in four additional counties, and state staff are working now with interested health providers in the nine counties that are targeted for such organizations.

Third, Oregon Medicaid staff are convening an advisory group of

physicians and others to develop contract terms for the primary care case manager program.

The development of the significantly expanded and varied managed care arrangements that are needed by July 1992 to implement the demonstration statewide presents a major challenge. Oregon Medicaid staff will need to respond to new and increasing administrative requirements related to increased managed care enrollment and an expanded contractor network.

Improvement Needed in Financial Oversight Information

Financial oversight is important in Medicaid managed care programs because providers assume financial risk for contracted services. Federal law requires states with Medicaid managed care programs to:

-- determine provider solvency, as a means of protecting access to care by detecting financial weaknesses before a plan becomes insolvent; and
-- collect disclosure information such as provider ownership and criminal convictions of key personnel, to assist in detecting fraud and abuse of Medicaid dollars.

Oregon providers submit financial reports to help the state monitor solvency, but Oregon has obtained an exemption to exclude

providers from disclosure requirements.[2] We are concerned that Oregon is requesting a continuance of the disclosure exemption for the Medicaid demonstration project.

Medicaid staff perform an annual review of financial reports to determine the solvency of contracting providers. Our preliminary review of these financial data suggests that Oregon should refine its financial reporting requirements. For instance, because Oregon providers do not present their financial information in a uniform manner, we were unable to determine how well the managed care portion of a providers's business performed. Also, the state cannot determine from existing data the degree to which assets and risks are shared by contractors who are part of larger organizations.

Oregon is revising and strengthening its financial reporting requirements, and proposes to continue these requirements under the demonstration. This is particularly important because the Oregon Medicaid demonstration provider network will be substantially larger and more complex than under the current program.

The Oregon Medicaid program now is exempt from disclosure requirements. Continuing the disclosure exemption in the

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[2] Section 9255 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272.

demonstration is a concern. We believe it is important to know the ownership and control arrangements used by providers. Since the demonstration will add new providers assuming greater financial risk, continuing to exempt providers from disclosure could create a weakness in financial oversight. Therefore, we believe there should be a disclosure requirement for all demonstration providers.

CONCLUSIONS

While financial oversight activities and reporting requirements should be strengthened, our work to date indicates that Oregon has designed, implemented, and operated a Medicaid managed care program that provides access to quality care for most of its AFDC population. We do not know, however, whether Oregon can implement the statewide managed care system as rapidly as proposed, and whether financial oversight and monitoring activities will be adequate.

In our opinion, the apparent success of the Oregon program to date may be credited in large part to the deliberate pace with which it was implemented with proper state oversight. Moving to a statewide system in only 1 year seems very difficult. It is not clear that Oregon can establish the provider network to support the large enrollment that quickly. The state assumes that HMOs not now participating in the Medicaid program will

become interested and that the physician care organizations now participating will convert to full capitation or consolidate with other plans.

In conclusion, we believe that HCFA should require Oregon to demonstrate that there is adequate provider capacity and sufficient oversight in place before it is allowed to implement the demonstration project.

Mr. Chairman, that concludes my prepared statement. I will be happy to answer any questions you may have.