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MEDICAID

Oregon's Managed Care Program and Implications for Expansions

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Human Resources Division

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The Honorable Henry Waxman
Chairman, Subcommittee on Health
and the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

In response to your request, this report reviews the Oregon Medicaid managed care program and the state's proposal to expand the program as part of a larger demonstration. The report reviews issues of access, quality of care, and financial oversight.

Included in the report are recommendations to the Secretary of Health and Human Services. They are intended to ensure that the Oregon demonstration project, if it is approved, will have adequate provider capacity and increased financial oversight.

Copies of the report are being sent to the Secretary of Health and Human Services, the Governor of Oregon, and other interested parties.

If you have any questions concerning this report, please contact me on (202) 512-7119. Other major contributors are listed in the appendix.

Sincerely yours,

Janet L. Shikles

Janet L. Shikles
Director, Health Financing
and Policy Issues

Executive Summary

Purpose

Medicaid, the largest government health care program for the poor, has faced rising enrollments and soaring costs that have strained federal and state budgets. These trends show no sign of letup: between fiscal years 1991 and 1992, enrollments are expected to rise by almost 9 percent and costs by more than 38 percent. To deal with rising costs, many states have shifted some of their Medicaid clients to "managed care" programs, like health maintenance organizations (HMOs), which offer the potential for controlling costs while providing access to care. The state of Oregon proposes, under a special demonstration project, to triple the enrollment of its Medicaid managed care program within 1 year. Oregon's proposal requires the approval of the Secretary of Health and Human Services.

The Chairman, Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked GAO to review Oregon's current Medicaid managed care program and its expansion proposal in light of problems identified with such programs in other states. GAO's review focused on questions of access to health care, quality of health care, and financial oversight of managed care plans. GAO did not assess whether the Secretary of Health and Human Services should approve or disapprove Oregon's demonstration proposal.

Background

Medicaid is funded jointly by states and the federal government, which on average pays about 57 percent of the costs. In 1992, about 30.1 million people are expected to receive health care under the program. Medicaid typically pays for care on a fee-for-service basis, but in 1991, 32 states and the District of Columbia used managed care approaches as well. Under managed care, a health plan such as an HMO receives a fixed monthly fee to provide health services to enrolled clients. Many view managed care, which figures prominently in the President's 1992 Comprehensive Health Reform proposals, as a promising approach to containing medical costs, because it encourages health plans to control service use and deliver services in cost-effective settings. But safeguards are needed to ensure that plans do not try to save money by limiting patient services inappropriately or by providing substandard services. Reviews of Medicaid managed care programs in some states have found the potential for these problems, along with financial weaknesses in some health care plans.

In Oregon's current Medicaid managed care program, begun in 1985, about 73,000 people in 11 counties were enrolled in managed care plans as of April 1992. The proposed demonstration is part of changes aimed at extending Medicaid coverage to more people without health insurance and

implementing managed care delivery throughout the state. Money saved through managed care is expected to help offset the costs of covering more people under the demonstration.

Oregon's demonstration proposal, submitted to the Health Care Financing Administration (HCFA) in August 1991, calls for implementing a managed care delivery system statewide that would serve more than 220,000 Medicaid clients during the first year. This would require contracting with many new HMOs, physician care organizations, and individual physicians. Other changes would include redefining covered services and implementing a new cost-based reimbursement system. Even with the savings anticipated from managed care, Oregon expects that expanding eligibility for Medicaid will increase federal and state costs by about $205 million above current Medicaid program costs over the 5-year demonstration.

Results in Brief

Oregon's Medicaid managed care program has avoided many of the problems identified in other states. The program is well accepted by providers and Medicaid clients, who are generally satisfied with access to and quality of care. The program has in place many of the safeguards needed to prevent inappropriate restrictions in access to health care, and its quality assurance monitoring meets federal requirements.

The current program, while generally sound, could be improved. Oregon Medicaid administrators need to ensure that efforts underway to improve child health screening services receive high priority and that Oregon revises its client satisfaction surveys. Oregon also needs to intensify its oversight of health plan solvency and require better financial information from plans. Requiring contractors to disclose information about health plan ownership and control would help the state detect and prevent Medicaid fraud.

Regarding the proposed demonstration, GAO is concerned that Oregon may not be able to recruit enough managed care providers within the first year to ensure access to health services for the quickly expanded managed care enrollment. Adequate capacity is needed if the project is to save enough money through managed care to extend Medicaid coverage to people who have no health insurance.

Principal Findings

Oregon's Program Reported Successful in Providing Access to Services

Oregon's current managed care program provides adequate access to health services, according to HCFA reviews and a state advisory committee. This is true despite indications of strained capacity that the state is working to address by recruiting more health plans. Medicaid client advocacy groups have reported no major access problems, and program clients have had few complaints about access.

A managed care system raises the risk that if fixed payments do not cover the cost of providing the services required, health plans may seek to cut costs by inappropriately denying or reducing access to services. Oregon's program has safeguards to limit this risk. For example, the program offers stop-loss protection, a form of state-supported insurance that sets a dollar limit on a plan's financial liability for services to individual enrollees.

Quality Assurance Processes in Place and Efforts Underway to Improve Health Screening for Children

Oregon's current program meets federal quality assurance requirements by (1) ensuring that participating health plans maintain internal quality assurance activities, (2) assessing client satisfaction through opinion surveys and grievance procedures, and (3) using an independent contractor to conduct annual medical record reviews. In 1991, Oregon officials visited most participating health plans and found their quality assurance activities to be substantially in compliance. Oregon's opinion surveys and grievance procedures likewise disclosed few problems, though GAO found that the surveys have limited usefulness because of problems with questionnaire design and low response rates. Oregon's independent medical record review process, validated by GAO physician consultants, identified few quality problems in the program but concluded that health screening services for children should be improved. The approach Oregon has taken in response has been slow to produce specific improvement plans.

Effectiveness of Financial Oversight Could Be Improved

Although there have been no contractor failures in Oregon's managed care program, the effectiveness of its financial oversight systems could be improved. First, in testing the state's methods of assessing health plan solvency, GAO found that monitoring could be improved by providing guidance on financial reporting, defining the state's solvency indicators and evaluation criteria, and extending reporting requirements to

subcontractors. Second, Oregon is the only state for which federal requirements that contracting health plans disclose ownership and control information in effect have been waived. Such information could help program managers ensure that Medicaid dollars are not diverted from the delivery of health services. Oregon Medicaid officials reported that plans would be required to meet federal disclosure requirements beginning in October 1992.

Demonstration Project's Statewide Expansion Raises Concerns About Capacity

Oregon's proposed demonstration project would continue existing access safeguards, quality assurance activities, and financial oversight measures. GAO's chief concern about the demonstration is whether Oregon can develop adequate health plan and physician capacity, statewide, within 1 year, to serve three times its current managed care enrollment. This concern is based on the size of the proposed expansion, physician shortages in some parts of the state, and the fact that during 1991, some managed care clients experienced difficulty enrolling with their preferred health plan or a primary care physician. Although Oregon reports that more than 20 health providers have expressed interest in participating in the demonstration, this interest is in the form of nonbinding letters of intent that do not commit the providers to sign contracts. If the demonstration is approved, the state plans to require binding letters and additional information enabling it to determine whether adequate capacity would be available to serve the expected enrollment.

Recommendations

If the Secretary of Health and Human Services approves the proposal, GAO recommends that the Secretary direct the Administrator of HCFA to require that Oregon (1) demonstrate by binding letters of intent or other means that adequate health plan and physician capacity can be put in place to serve the expected enrollment before it allows Oregon to implement the demonstration project and (2) meet fully the usual Medicaid disclosure requirements in both its current program and the proposed demonstration project.

GAO also recommends that the Secretary, through HCFA, direct Oregon to continue to improve quality assurance activities in the current program. Specifically, Oregon should intensify its efforts to improve child health screening services and revise its client satisfaction surveys. Further, Oregon should improve its health plan solvency monitoring by defining financial indicators, evaluation criteria, and guidance for reporting. Under

the expanded demonstration, Oregon should include risk basis subcontractors in this monitoring.

Agency Comments

GAO discussed its findings with HCFA and Oregon Medicaid program officials and incorporated their comments as appropriate. HCFA officials did not comment on GAO's recommendations. Oregon disagreed with the recommendations regarding provider capacity, quality assurance activities, and monitoring subcontractors for solvency. They reported, however, that they plan to improve financial reporting and require disclosure of ownership information from contracting providers.

Contents

Abbreviations

GAO	General Accounting Office
AFDC	Aid to Families With Dependent Children
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
IPA	individual practice association
OMAP	Office of Medical Assistance Programs
OMPRO	Oregon Medical Professional Review Organization
PCO	physician care organization

Introduction

Medicaid, the largest government program financing health care for the nation's poor, is strained by an enrollment expected to reach 30.1 million people in fiscal year 1992 and by health care expenditures expected to rise from $92.1 billion to $127.2 billion—more than 38 percent—between fiscal years 1991 and 1992. These strains affect both the federal government, which on average pays 57 percent of the costs, and the states, which administer the program and pay the remaining costs. Medicaid is the second largest and generally the fastest growing component of state budgets, constituting 13.6 percent of total state expenditures in fiscal year 1991.

States are looking to various "managed care" options,[1] such as those provided by health maintenance organizations (HMOs), as one approach to controlling Medicaid costs while protecting access to services and quality of care. The Health Care Financing Administration (HCFA), which administers the Medicaid and Medicare programs at the federal level, is on record in support of managed care approaches. Moreover, the President's Comprehensive Health Reform Program, proposed on February 6, 1992, would allow states new flexibility in the use of managed care.

In response to 1983 state legislation aimed at controlling Medicaid costs, and with HCFA approval, Oregon developed a managed care program that, as of April 1992, served about 32 percent of Oregon's approximately 229,000 Medicaid clients. In 1989, the Oregon Legislature adopted a comprehensive strategy to reform public and private health services delivery in the state. This strategy called for, among other things, substantial expansion and changes in the state's Medicaid managed care program. In August 1991, Oregon submitted a research and demonstration project application to HCFA seeking permission to implement its new Medicaid proposal.

Medicaid managed care programs in some states have experienced problems ensuring access to care, providing quality health services, and ensuring the financial solvency of participating health providers. The expansion of managed care called for under Oregon's Medicaid demonstration proposal has raised concerns among national advocacy groups, such as the Children's Defense Fund, and in the Congress, which

[1]"Managed care" is sometimes referred to as "coordinated care." For consistency, we use "managed care" throughout this report. Managed care includes health systems that integrate the financing and delivery of services to covered individuals by arrangements with selected providers, formal quality assurance and utilization review, and financial incentives for covered individuals to use providers selected by the plan. Managed care systems range from providers who receive prepaid set payments to coordinate and deliver all inpatient and outpatient services to providers who receive a case management fee to coordinate services and fee-for-service payment for the services.

asked the Office of Technology Assessment to report on issues surrounding the offered services.[2] The Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked us to look at how Oregon's current program has addressed these concerns and how they would be addressed under the demonstration project. As part of this work, we testified in September 1991 on issues related to expanding Oregon's Medicaid managed care delivery program.[3]

Rising Medicaid Costs Create Problems for Federal and State Governments

Established in 1965 as title XIX of the Social Security Act,[4] Medicaid is a federally aided, state-administered medical assistance program expected to serve about 30.1 million low-income people in fiscal year 1992. Federal support averages 57 percent of payments for services but ranges from 50 percent to nearly 80 percent, the exact percentage depending on the state's per capita income.

Medicaid programs vary considerably from state to state. At the federal level, the program is administered by HCFA, which is part of the Department of Health and Human Services (HHS). Within broad HHS guidelines, each state designs and administers its own Medicaid program and sets eligibility standards and coverage policies. Participating states must provide eligible clients with certain basic benefits, such as inpatient and outpatient hospital and physician services and health examinations for children. States may also choose to provide additional services, such as dental care and prescription drugs.

Generally, people receiving cash assistance under the Aid to Families With Dependent Children (AFDC) and Supplemental Security Income programs are eligible for Medicaid. To qualify for these programs, certain criteria for income and assets must be met. For example, on average across the states, to qualify for AFDC a family's 1989 income could not exceed 48 percent of the federal poverty level (for a family of three, the federal poverty level in 1989 was $10,060). Qualifying for AFDC is the primary means through which most infants, children, and pregnant women become eligible for Medicaid.[5]

[2]U.S. Congress, Office of Technology Assessment, Evaluation of the Oregon Medicaid Proposal, April 10, 1992.

[3]Managed Care: Oregon Program Appears Successful but Expansions Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 16, 1991).

[4]42 U.S.C. 1396-1396s.

[5]Since 1984, the Congress has expanded Medicaid eligibility for low-income women and children who may not meet AFDC requirements. The Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), for example, requires Medicaid to cover pregnant women and their children up to age 6 if their income is less than 133 percent of the federal poverty level. In Oregon, this group is called the Poverty Level Medical group.

The size and cost of the Medicaid program are continuing to rise. From fiscal year 1989 to 1992, total clients increased almost 28 percent, from 23.5 to 30.1 million. The administration's budget estimates that clients will number 31.5 million by fiscal year 1993. Federal and state expenditures are rising even more rapidly than enrollments. For 1992, expenditures are estimated at $127.2 billion, a 38-percent increase over the 1991 total of $92.1 billion. Estimated Medicaid expenditures for 1993 total $148 billion.

State governments have come to view Medicaid as a substantial financial burden. In fiscal year 1991, the states' share of Medicaid constituted 13.6 percent of all state expenditures, second only to elementary and secondary education (22.4 percent).[6] State Medicaid expenditures increased an average 10 percent per fiscal year between 1984 and 1989, while state revenues increased at a rate below 8 percent. Increased Medicaid spending puts pressure on funding for other services, particularly in states with balance budget requirements. This burden shows no signs of letup: the number of Medicaid clients and the costs of their care are likely to increase in future years, due to a combination of economic, social, and demographic trends coupled with already mandated program expansions.

To keep Medicaid spending within budget limits, many states have used available administrative options, such as restricting eligibility, services, or provider reimbursement. Nationwide, only about half the poor are eligible for Medicaid, and a number of states limit the amount, duration, and scope of covered services.

Managed Care: an Approach to Controlling Costs While Protecting Access

Managed care offers an approach to controlling Medicaid expenditures while protecting access and quality of care.[7] Under managed care arrangements, enrollees are somewhat restricted in their choice of providers, and they must choose a primary care physician who participates in the managed care plan in which they are enrolled. Usually,

[6]Total state expenditures include both state and federal funds. In Oregon, Medicaid accounted for 9.6 percent of total fiscal year 1991 state expenditures.

[7]State Medicaid programs typically pay providers on a fee-for-service basis: that is, they pay a specific amount for each service delivered to Medicaid clients. Under prepaid managed care, by contrast, Medicaid pays a designated health plan a fixed monthly fee in advance to care for each client. This capitation payment is calculated to cover average costs per enrollee per month. By careful management, the health plan should be able to provide all services its group of enrollees needs without exceeding its total capitation payments. If expenditures exceed capitation payments, the plan must cover the loss; but if expenditures are less, the plan keeps the difference. The health plan is therefore said to be "at risk" for costs exceeding its capitation payments.

enrollees are required to contact their chosen primary care or "gatekeeper" physician to obtain referrals for specialists or inpatient care.

Medicaid managed care plans cover a wide variety of health delivery arrangements. These range from HMOs that are paid a set monthly fee in advance (called a prepaid capitation payment) for providing all inpatient and outpatient medical services an enrollee needs, to groups or individual physicians who are paid a small case management fee to manage all Medicaid services and receive fee-for-service payment for the services delivered.

In the 1980s, the federal government approved Medicaid managed care delivery programs as a way to contain costs.[8] HCFA also recognized that managed care could help ensure access and quality of care for Medicaid clients. The Secretary of HHS, through HCFA, granted states waivers of federal Medicaid rules—specifically, the requirement that clients have a free choice of providers—to permit them to develop managed care systems.[9]

By June 1991, 32 states and the District of Columbia had one or more prepaid managed care plans for Medicaid clients. Medicaid managed care enrollment increased from 187,340 in 1981 to 2,837,500 in 1991, and this growth is expected to continue. Approximately 11 percent of all Medicaid clients currently are enrolled in managed care programs: of these, 36 percent are in HMOs and 45 percent are in primary care case management fee-for-service programs.[10] For comparison, in 1989 over 34 million Americans (about 15 percent of those insured) were enrolled in prepaid managed care in HMOs.

The administration supports expanded use of managed care in Medicaid. The proposed President's Comprehensive Health Reform Program would restructure the Medicaid program to rely primarily on managed (coordinated) care delivery systems. In addition to fiscal incentives for states to pursue managed care, states would have flexibility to reform their Medicaid programs in other ways.

[8]There were managed care programs in Medicare and Medicaid before the 1980s, but the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) gave states greater flexibility in contracting with HMOs or other prepaid health plans. In 1982, HCFA funded Medicaid managed care demonstrations in six states.

[9]For this reason, many of the current Medicaid managed care programs are called "freedom of choice" waiver programs. They also may be called "section 1915(b)" waiver programs, referring to the section of the Social Security Act in which they are described.

[10]The remaining 19 percent are enrolled in other undefined types of managed care programs.

Some Medicaid Managed Care Programs Have Had Problems

Amid these expressions of support to expand Medicaid managed care, concerns have been raised about some potentially negative effects of such programs. Reviews of Medicaid managed care programs in some states, conducted between 1984 and 1989, identified potential problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. After examining Medicaid managed care programs in Arizona, Philadelphia, and Chicago,[11] 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. We recommended a series of safeguards—usually policies and procedures—to help ensure that appropriate services are provided and to help states avoid such potential problems as the following.

- Managed care contractors may transfer financial risk for the costs of patient care to subcontractors, through capitation agreements. HCFA's quality monitoring regulations do not apply to subcontractors. If a small group of subcontracting physicians receives capitation payments intended to cover all services, including costly inpatient services, the financial risk to them may be excessive, because there may be few enrollees over whom to spread the risk and few providers to absorb any losses. In such cases, when clinical decisions are closely related to financial gain, there may be adverse effects on quality of care.
- Managed care contractors may become insolvent if they are inexperienced in the financial risks associated with prepaid managed care. If contractors become insolvent, they may leave medical bills unpaid and enrollees may have trouble obtaining services.
- Managed care contractors may create operating arrangements that allow excessive profits or divert money from the provision of health care. For example, a nonprofit, tax-exempt health plan might own or control a for-profit provider with which it contracts for services—which could allow unnecessary administrative costs and excessive profits. Underserving of the Medicaid population may occur if program payments are used to pay unnecessary administrative costs or excessive profits among related businesses rather than to provide medical services.

[11] 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).

Oregon Proposes to Expand Its Medicaid Managed Care Program

Oregon initiated Medicaid managed care in the context of serious state budget shortfalls in the early 1980s. Since HCFA approval late in 1984 and client enrollment beginning in 1985, the program has expanded—in April 1992 it covered 11 counties and served about 32 percent of all Oregon Medicaid clients. With the exception of one HMO that is fully capitated for inpatient and outpatient services (and a second HMO that joined the program in May 1992), contractors in Oregon's current program are physician care organizations, or PCOs, which receive capitation payments for physician (primary and specialty) and certain outpatient services only.[12]

Oregon has received national attention for its proposal to build upon this program as a foundation for a major Medicaid expansion demonstration, described in an application submitted to HCFA in August 1991.[13] In July 1991, when we interviewed all of the participating providers, and in October 1991, at the beginning of the current contract year, the Oregon managed care program was operating in 10 counties, with 1 HMO and 15 PCOs. By April 1992, the program had expanded to 11 counties with 1 HMO and 20 PCOs. In May 1992, Oregon Medicaid officials reported that the program had expanded to 15 counties with 2 HMOs and 21 PCOs. Under this proposal, the state would greatly increase the number of Medicaid clients in managed care, and the managed care delivery network would be expanded statewide. The state would contract with fully capitated plans like HMOs in 9 of the 11 counties now in managed care, with new PCOs in additional counties, and with individual physicians as primary care case managers in rural areas. The cost savings anticipated from managed care would be used to help offset the costs of extending Medicaid to all residents with incomes under 100 percent of the federal poverty level, including persons currently ineligible for Medicaid.

As of May 1992, Oregon's Medicaid demonstration proposal was still under review by HCFA and the Secretary, who must approve the waivers necessary for Oregon to implement its proposal. Although HCFA supports

[12]PCOs are also responsible for managing hospital emergency room use and inpatient services, which are paid by the state on a fee-for-service basis.

[13]The Medicaid demonstration project, which must be approved by the Secretary before it can be implemented, is part of a comprehensive plan for state health reform. The Oregon Health Plan (passed in 1989 with related bills passed in 1991) comprises three major programs. Senate Bill 27 authorized the Medicaid demonstration project, which will expand eligibility to all persons with incomes below 100 percent of the federal poverty level, deliver services through a prepaid managed care system, and develop a prioritized package of covered health services. The other two programs do not require federal approval. The first will encourage businesses to offer basic health insurance to employees and dependents. If voluntary participation targets are not met, businesses will be required to offer basic health insurance in 1995. The second program will establish a high-risk insurance pool for Oregonians who do not qualify for Medicaid and cannot get health insurance because of preexisting medical conditions.

increased use of managed care delivery, Oregon's proposal projects $204.6 million in additional federal and state expenditures adjusted for inflation during the 5 years of the demonstration. This runs contrary to HCFA's policy that such Medicaid programs should not cost the federal government more than the program already in place.

Objectives, Scope, and Methodology

Because of his concerns about problems documented in other Medicaid managed care programs, and the major expansion proposed for Oregon's existing program, the Chairman of the Subcommittee on Health and the Environment, House Committee on Energy and Commerce, asked us to review Oregon's current and proposed Medicaid managed care programs. We focused our review of Oregon's experience under its current Medicaid managed care program on the following objectives:

- Describe how the current program operates.
- Determine if the program has safeguards that ensure access to care and prevent inappropriate reductions in services.
- Determine if the program has safeguards that help ensure that acceptable quality services are delivered.
- Determine if the program provides adequate oversight of the financial reporting, disclosure, and solvency of participating providers.

We examined the implications of Oregon's experience to date in these areas for its plans to implement the proposed Medicaid demonstration project. We did not compare Oregon's managed care program to its fee-for-service Medicaid program or to private practice in the state. We also did not assess whether the Secretary of HHS should approve or disapprove Oregon's demonstration proposal.

We performed our work in the Oregon Medicaid program offices in Salem and in the offices of participating Medicaid providers, client advocacy groups, and other interested organizations throughout the state. We also worked with HCFA officials in the federal Region X office in Seattle. We interviewed federal and state officials and reviewed documentation to determine how Oregon's current Medicaid managed care program addresses concerns about access, quality of care, and financial oversight. In addition, we obtained their views on Oregon's demonstration project to supplement our review of the demonstration waiver application that was submitted to HCFA in August 1991.

We visited all 16 health plans that contracted with the Oregon Medicaid managed care program in July 1991, meeting with administrative, financial, and medical staff. We obtained and reviewed provider data, such as numbers of participating physicians and Medicaid enrollees, and obtained provider views on the demonstration proposal, current program operations, program effects on access to care and service delivery, provider capacity, quality assurance activities, patient relations, and operational and financial management issues. In addition, in the critical area of quality assurance activities, we contracted with a group of physicians for an independent review of Oregon's medical record audit process.

We reported the preliminary results of this work on September 16, 1991, in testimony before the Subcommittee. In addition, we reviewed our findings with HCFA and Oregon Medicaid program officials and incorporated their comments as appropriate. We performed our work between November 1990 and December 1991 in accordance with generally accepted government auditing standards.

Oregon's Current Managed Care Program: Safeguards Protect Access, Although Capacity Has Been Strained

Oregon's current Medicaid managed care program has grown since 1985 to about 73,000 clients as of April 1992. The program serves clients eligible through the Aid to Families With Dependent Children program in 11 of the state's most populous counties. Oregon uses a variety of managed care providers, including HMOs and contractors known as physician care organizations, or PCOs.

Medicaid clients indicate they are generally satisfied with access to health care under the Oregon program. Some clients had difficulties adjusting to the restrictions inherent in managed care, such as restrictions on emergency room use, but complaints have been relatively few. Oregon's managed care program has incorporated safeguards to help ensure that access to needed services is not reduced inappropriately. These safeguards include monitoring health plan performance through site visits, limiting the financial risk the plans assume, and limiting incentives that might encourage plans to reduce services.

In terms of the program's ability to provide access to health services for all enrollees, however, there are signs that the program's capacity at times has been strained. During 1991, problems related to health plan capacity and the availability of primary care physicians were reported in 8 of the 10 counties where the program then operated. Oregon has worked with health plans to address these problems and in 1992 was expanding available capacity.

Current Managed Care Program Has Grown Gradually

Enrollment in the Medicaid managed care program has grown gradually from about 20,000 in the 4 counties where it started in 1985, to about 73,000 in 11 counties as of April 1992. The program serves about 32 percent of the state's approximately 229,000 Medicaid clients.

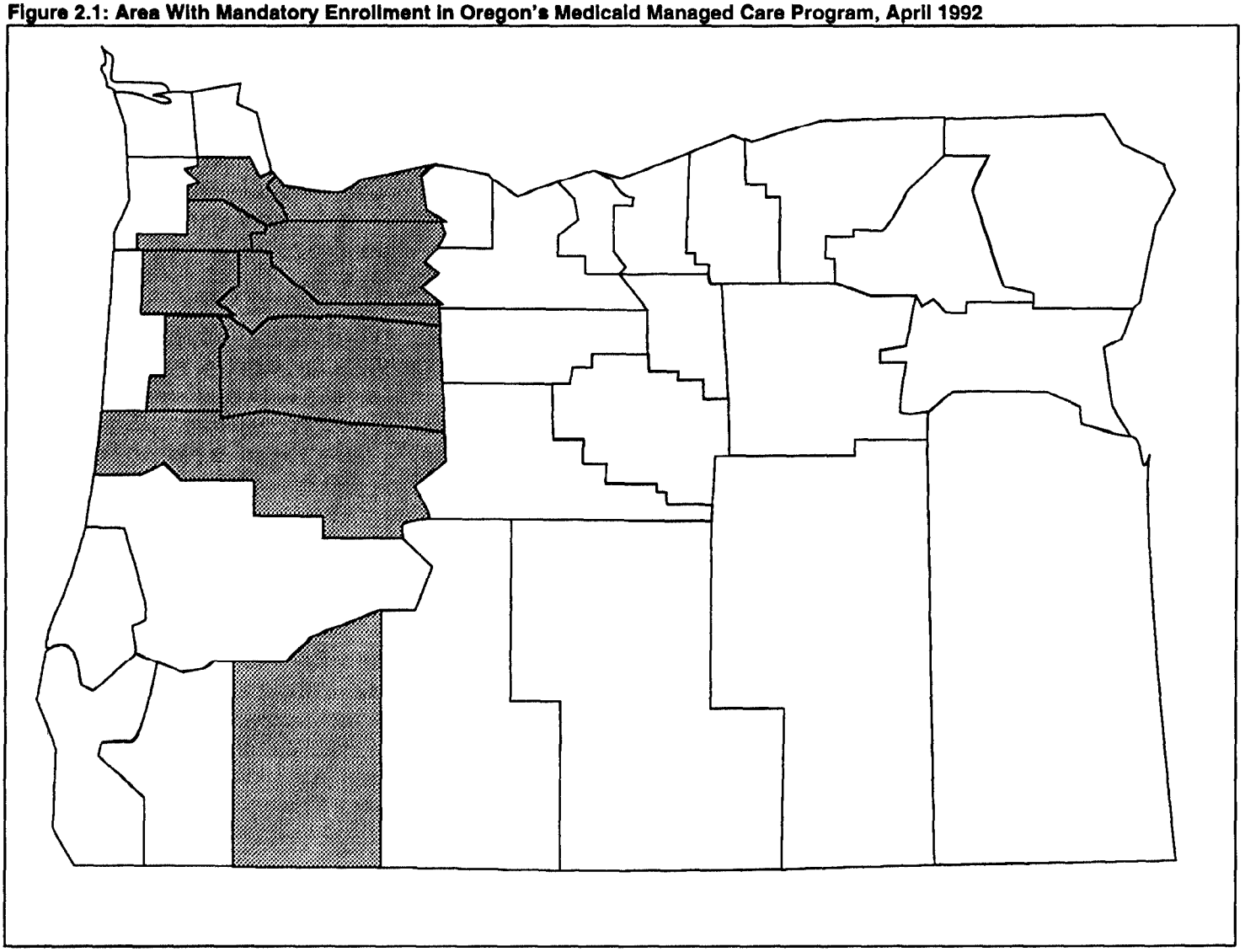
Administered by the Office of Medical Assistance Programs (OMAP) within the state's Department of Human Resources, the managed care program serves families and single pregnant women who are eligible as AFDC recipients.[1] These enrollees are covered for the same inpatient and outpatient health services as fee-for-service clients.

Enrollment in a managed care health plan (an HMO or a PCO) is mandatory for AFDC recipients who live in 10 of the 11 counties. Enrollment in the

[1]The 73,000 managed care enrollees (Apr. 1992) represent about 56 percent of the state's approximately 131,000 AFDC recipients. Categories of Medicaid recipients not included in the current managed care program are the Old Age, Disabled, and Blind; Medically Needy; Poverty Level Medical; and children in foster care.

remaining county is voluntary. Nine of these counties are located in the Portland metropolitan area and the Willamette Valley, which are the most densely populated parts of the state, and the other 2 counties are in southern Oregon (see fig. 2.1).

Figure 2.1: Area With Mandatory Enrollment in Oregon's Medicaid Managed Care Program, April 1992



Local branch offices of the state's Adult and Family Services Division (another part of the Department of Human Resources) are responsible for determining eligibility for AFDC and for processing enrollments into the managed care program. The branch offices inform eligible clients about how the managed care system works and how to select a managed care health plan. The branch offices in the 10 counties where enrollment is mandatory assign clients to a plan if they fail or refuse to select one.

Oregon's participating managed care health plans are not allowed to market to Medicaid clients or enroll them directly. The plans provide new enrollees with handbooks explaining how to select primary care practitioners, seek routine and emergency services, and resolve problems. Enrollees may switch plans every 6 months, if they desire, or change plans at any time if OMAP agrees that they have a serious complaint with a plan. In certain limited circumstances, the plans also may request the state to disenroll individual clients.

Current Program Uses a Variety of Health Plans

The current program delivers health services through two types of health plans—fully capitated and partially capitated. A fully capitated plan, such as an HMO, provides comprehensive outpatient and inpatient services under the monthly capitation fee paid by OMAP. Oregon's partially capitated plans—PCOs—provide physician services, outpatient laboratory and X-ray, and child health screening services[2] under a capitation payment and also manage the use of inpatient, emergency room, and outpatient hospital services, as well as prescription drug services for their enrollees, though these latter services are reimbursed on a fee-for-service basis.

As of April 1992, OMAP contracted with one fully capitated plan—a Portland-based HMO with a total enrollment of about 375,000, of which about 13,500 are Oregon Medicaid clients. OMAP also contracted with 20 partially capitated PCOs that collectively served about 59,800 Medicaid clients. Individual PCO capitated enrollments in mandatory counties ranged from about 1,000 to more than 16,400 clients. The types of medical organizations that contract as PCOs include independent practice

[2]Under Medicaid, these services are referred to as well-child screening services, or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. The Oregon Medicaid program refers to them as EPSDT or "Medicheck" services. They include regular examinations and evaluations of the general physical and mental health, growth, development, and nutrition of children.

associations,[3] multispecialty clinics, public health and hospital-based clinics, and primary care clinics. All are health plans or physician groups that treat a mix of patients, including privately insured, Medicare, and Medicaid patients.

Capitation rates for participating plans are developed each year by an outside actuary, based on the state's fee-for-service Medicaid reimbursement rates. Capitation rates for individual PCOs vary somewhat due to optional services and geographic cost differences, but the monthly payment in fiscal year 1992 was about $34 per enrollee.[4] PCOs may receive additional compensation in the form of savings payments if utilization rates for case managed services (i.e., hospital inpatient, emergency and outpatient care, and prescription drugs) are below target levels. The fully capitated HMO does not earn savings payments because its capitation payment—about $100 per enrollee per month in October 1991—covers all services.

OMAP recruits managed care providers by working with interested parties individually and by holding regional informational workshops. OMAP may contract with any organization that meets its standards for participation, as contained in the contract. These standards include, among other things, contractor agreement to (1) deliver or arrange for agreed-upon health care services, (2) provide access for enrollees 24 hours per day, 7 days per week, (3) maintain a system to document and track referrals, (4) maintain a medical record-keeping system for quality reviews, (5) maintain an internal quality assurance program with client grievance procedures, and (6) provide ongoing patient education.[5] OMAP has developed detailed measurements based on these standards for participation to evaluate contractor performance in site visits conducted every 2 years.

Oregon's managed care health plans sign a 1-year contract with no obligation to renew. They agree to enroll a stated maximum number of Medicaid clients, which they determine. Plans also agree to participate in state and federal monitoring activities and to provide OMAP with periodic financial and utilization reports.

[3]The individual practice association, or IPA, is characterized by an HMO contracting with individual physicians to provide services to HMO members in the physicians' private offices. Thus, development of an IPA model HMO requires minimal capital investment. These physicians generally are paid on a discounted fee-for-service basis.

[4]Capitation rates also are adjusted for the number of maternity cases cared for by each PCO, an adjustment that more closely reflects the risk each plan faces for maternity care.

[5]These standards derive from 42 C.F.R 434 and 431.55.

Current Program Appears Successful in Providing Access to Health Services

To assess the managed care program's success in providing access to health services, we examined the views of both those who oversee the program at the federal and state levels and those who receive services under it. Both groups indicated general satisfaction with the program and the access to services it provided.

Views of Federal and State Oversight Groups

HCFA's periodic assessments of the Oregon program have concluded that access to care is generally satisfactory. HCFA reviews managed care programs to ensure that they are both cost-effective and successful in maintaining access to health services. These reviews are part of the process of obtaining a waiver from Medicaid's requirement that clients have free choice of health care providers. Waivers, which are granted by the Secretary of HHS, are good for up to 2 years. HCFA's monitoring has disclosed some problems in Oregon—discussed later in this chapter—but since the initial waiver was granted in 1984, HCFA has approved all three applications for renewals.

Evaluations by an independent actuarial firm conducted in conjunction with HCFA's reviews found Oregon's Medicaid managed care program to be cost-effective.[6] The evaluations concluded that from March 1985 through September 1990, the program had saved about $13.8 million, or about $7.46 per enrollee per month, when compared with the estimated costs of health care under Medicaid fee-for-service delivery. About $5.2 million of the total savings (37.5 percent) has accrued to the state; the other $8.6 million, to the federal government.

In its own evaluations, the state has concluded that the program has generally worked well and has been well-received by enrolled clients. These evaluations have been conducted by the Oregon Health Care Cost Containment Advisory Committee,[7] which was created in 1983 to evaluate and monitor implementation of the managed care program, consult with

[6]Outside evaluations of program cost-effectiveness, necessitated by HCFA requirements for waiver renewal, have been performed by Coopers and Lybrand. The most recent evaluation (dated Oct. 17, 1991) covers the period October 1988 through September 1990. These reported savings are net of savings payments the state makes to providers for reducing utilization, and of the costs of administering the managed care program. As cost-effectiveness was not a focus of our review, we did not independently validate Coopers and Lybrand's findings. Oregon's managed care program was also reported to be cost-effective in W.P Welch, "Giving Physicians Incentives to Contain Costs Under Medicaid," Health Care Financing Review, Vol. 12, No. 2 (Winter 1990).

[7]Members of the advisory committee are appointed by the governor to represent the following groups: the Oregon Medical Professional Review Organization, the state Health Division and the Adult and Family Services Division, citizens with professional experience in health economics and capitated health care, Medicaid consumers, HMOs and contracting PCOs, nurses in managed care practice, and mental health practitioners.

state staff about it, and report periodically to the legislature. In its May 1991 evaluation report to the legislature, the Committee concluded that the managed care program has performed consistent with legislative intent and has saved money, with no tendency to provide lower quality care than received by the general population.

Views of Managed Care Clients

Several Medicaid client advocacy groups[8] gave us their views on client access to health services under the managed care program. None of the groups said they were aware of major problems with access. The Oregon Primary Care Association, for example, indicated that the Medicaid managed care program in general has improved access and is well-managed and responsive.

Medicaid enrollees have filed few formal grievances, which managed care plans must report to OMAP. Grievances most often have involved patient requests to change primary care physicians, obtain services denied by their PCOs, or have the PCO pay for medical services obtained outside the plan.[9]

The Cost Containment Advisory Committee, the Oregon Human Rights Coalition, and OMAP sponsored special client hearings around the state in 1991. Although relatively few Medicaid managed care enrollees attended the hearings, some reported problems gaining access to services. A frequently mentioned access problem had to do with emergency room services. Clients complained about difficulties in getting their PCOs to authorize emergency room use, especially on weekends or after hours.[10]

Based on these client hearings and other input from its client subcommittee, the Cost Containment Advisory Committee concluded in its May 1991 evaluation report that clients are generally satisfied with the managed care program. The committee attributed some client dissatisfaction to the access restrictions inherent in a managed care

[8]The Oregon Primary Care Association, the statewide Oregon Legal Services office, three county Legal Aid offices, and members of citizens' groups Oregon Health Action Campaign and Oregon Health Decisions.

[9]In 1989, 12 formal grievances involving 7 health plans were reported to OMAP. Seven of the grievances were resolved to the clients' satisfaction, and clients did not pursue the remaining 5. In 1990, 18 formal grievances involving 6 plans were reported to OMAP. Twelve were resolved to the clients' satisfaction, and clients did not pursue the remaining 6.

[10]For example, the mother of a child running a fever might be told by the PCO that it was not an emergency and to bring the child in the next day. If the worried mother took the child to the emergency room anyway, the PCO might refuse to pay, leaving the client or the emergency room with the bill.

system and pointed to the need to better educate new enrollees in how to use the system. The Oregon Primary Care Association agreed, indicating that since fee-for-service Medicaid clients tend to use the emergency room for basic health services, education is needed to change this behavior.

Current Oregon Program Has Safeguards Against Inappropriate Reductions in Access to Care

Oregon's current program incorporates safeguards that help protect Medicaid managed care clients against inappropriate reductions in access to care. Safeguards are important because a fixed monthly capitation payment, rather than payment for each service actually provided, is intended to encourage health plans to manage patient services carefully with attention to costs. Without safeguards, plans could be encouraged to limit access inappropriately to cut costs.

One safeguard in Oregon's program involves federal and state monitoring of participating health plans to ensure they are able to deliver contracted services. Other measures taken by the state and the health plans mainly involve limitations in (1) the financial risks associated with providing care under a capitated system and (2) the incentives that might encourage contractors to limit services inappropriately. These types of safeguards, often absent in the Medicaid managed care plans we have reviewed in other states, appear to be sufficiently present in Oregon's current program.

State and HCFA Monitoring

HCFA requires Oregon to ensure, through periodic audits and other means, that prepaid health plans are able to deliver contracted services. Oregon meets this requirement by on-site monitoring visits to the plans roughly every 2 years. OMAP has incorporated federal access requirements into its contract conditions for participation and has developed specific measures of plan performance related to these conditions for monitoring purposes. Performance measures for access include such items as recommended ratios of health professionals to enrollees, procedures for providing any service not directly obtainable from the plan, and travel time limits for the majority of enrollees to get to a physician. OMAP staff follow their monitoring site visits with letters to the plans commenting on compliance with contract conditions and performance measures. When appropriate, letters note the need and due date for corrective action plans addressing identified deficiencies.

In the winter of 1991, OMAP staff monitored 13 of the 16 contracting plans with on-site visits.[11] Ten of the 13 plans were found to be substantially in compliance. The other three plans were judged deficient in measures related to access, such as lacking health personnel to evaluate walk-in patients or phone calls, and procedures to schedule patient visits or follow ups. In two cases, state staff reported that the deficiencies were corrected by November 1991. In the remaining case, the plan was found severely deficient in such areas as policies and procedures for adequate physician backup, 24-hour phone access, and appointment scheduling. OMAP staff met with representatives of the plan to agree upon corrective actions; although progress was made, deficiencies remained at the end of 1991. A Medicaid official said the plan's contract would not be renewed in September 1992 unless all deficiencies were corrected.

HCFA periodically monitors Oregon's overall compliance with federal requirements for its Medicaid managed care waiver program. HCFA reviewed the Oregon program in 1991 during visits to the state offices and four contracting health plans (HCFA's visits to three of the four plans were concurrent with OMAP's on-site reviews, described above). HCFA concluded that three of the plans complied with access requirements, but cited one plan for deficiencies—the same plan cited by OMAP. HCFA recommended that OMAP take additional steps to ensure corrections, and OMAP took the actions described above.

As another means of monitoring access to care, Oregon is beginning to routinely collect utilization reports from the contracting health plans. Analyzing patient utilization data is one way to monitor for appropriate service delivery patterns by specific plans or physicians and to compare service usage between managed care and fee-for-service Medicaid clients. At present, such data for comparative purposes do not exist. Utilization data also would permit state and HCFA staff to determine whether plans are providing mandated services. In October 1990, Oregon implemented a quarterly data report on the numbers and types of services used by managed care enrollees, and since January 1991, all participating plans have supplied the reports. State staff are developing plans for analysis of the first year of data.

Program Features to Limit Risk

Managed care involves an element of financial risk for contracting health plans, in that capitation payments may not be sufficient to cover the cost

[11]Under Oregon's current program, plans must be visited after 1 year of operations and at least every 2 years thereafter. The other three plans will be visited in 1992.

of services that enrollees need. The more costly the services covered by the capitation payments, the greater the financial risk undertaken by the plan. Oregon's current program incorporates the following features that limit this risk and the accompanying pressure on plans to reduce services inappropriately.

- Limited exposure to risk for partially capitated plans. Oregon's 20 PCOs have a financial risk that does not include inpatient services, which generally are the most expensive services. For PCOs, risk is limited to the costs of outpatient physician, laboratory, X-ray, and well-child services. Inpatient care and some outpatient services, such as emergency room care, prescription drugs, and physical therapy, are paid by Medicaid on a fee-for-service basis. (This limitation in risk does not extend, however, to the participating HMO, which covers both inpatient and outpatient care on a capitated basis.)
- Adjustments for maternity care. OMAP staff prospectively adjust capitation rates for individual PCOs and HMOs to recognize differences in numbers of maternity cases, a high-cost service, on the basis of cases per 1,000 enrollees per year. This type of adjustment, based on actual plan experience, is intended to more accurately reflect the degree of financial risk each plan faces for maternity care.
- State-sponsored insurance. OMAP offers the health plans "stop-loss" protection, a form of reinsurance that sets a dollar limit on the financial liability for services provided to individual enrollees. Plans may purchase this protection, which is optional, through a reduction in the capitation rates they receive. If a plan that purchases stop-loss protection incurs expenditures for an enrollee that exceed the stop-loss ceiling selected by the plan ($3,000 or $5,000 per enrollee per enrollment year), the state will pay for additional services for that enrollee on a fee-for-service rather than a capitated basis. This insurance is available to both partially and fully capitated plans. In April 1992, all PCOs had purchased state stop-loss insurance, and the fully capitated HMO self-insured.

Health plan representatives we interviewed said they were happy with program features that helped limit their financial risk. Also, within state guidelines, the plans were satisfied because they were able to determine the geographic area they would cover and the number of Medicaid clients they would enroll.

State Limits Financial Incentives to Underserve

Oregon uses financial incentives to encourage the partially capitated PCOs to manage the patient services they provide on a fee-for-service basis.[12] Specifically, if a plan's enrollees use fewer noncapitated services (such as inpatient) than the geographically adjusted statewide average for an equivalent fee-for-service Medicaid population, OMAP shares the savings with the plan on a 50-50 basis, after deducting program administrative costs. In fiscal year 1990, these savings payments to the plans totaled $1.8 million. Most health plans reported passing along some or all of the savings to their physicians. Some reported using the savings to offset operating losses attributable to the Medicaid managed care portion of their business or to contribute to general business operations.

Like capitation payments, however, these savings payments carry the potential for encouraging inappropriate reductions in medical services. To minimize this potential, OMAP places a ceiling on the amount of savings any plan can receive per enrollee. In fiscal year 1990, the ceiling was $4.25 per member per month. To further lessen the chance that savings payments could adversely affect clinical decisions, the state issues payments 6 months after the end of the contracting year. Thus, any specific treatment decision is separated in time by at least 6 months from receipt of any savings resulting from the decision.

Plans Limit Risk and Incentives for Individual Physicians

In general, prepaid managed care plans offer their physicians incentives, through compensation and/or bonus arrangements, to encourage them to meet enrollee health needs in a cost-conscious manner. Some types of arrangements between health plans and physicians carry the potential for influencing physicians to limit access to services inappropriately. The arrangements reported to us by Oregon contractors are not among the riskier approaches.

Physicians in managed care plans may be compensated by salary, fee schedules, or capitation payments for all or selected health services. Capitation payments put physicians at greater financial risk than payment by salary or fee schedule. If capitation arrangements make an individual physician or a small group of physicians responsible for high-cost services, and if there are relatively few enrollees over whom to spread the risk, capitation payments may not be adequate to cover the costs of even one or two extremely expensive cases. Physicians in such circumstances (in the

[12]As of April 1992, the fully capitated HMO did not participate in this incentive program, because its capitation payment rate was calculated to cover all inpatient and outpatient Medicaid services.

absence of stop-loss protection or other safeguards) may hesitate to use costly treatments.

In Oregon, 9 of the 16 managed care plans we visited in July 1991 reported compensating their physicians through salary or fee schedules, mechanisms that do not place physicians at risk for patient care costs. Five plans use capitation payments for primary care services to compensate their physicians. The remaining 2 plans are partnerships that pay salaries to physicians, although full partners are at risk for overall business operations. Physicians in the 15 PCOs were covered by the plan's stop-loss protection, and the HMO provided its own stop-loss coverage.

Physician incentive arrangements may include periodic bonuses based on overall plan profitability or a share in savings achieved by meeting utilization targets (as in the state's savings payments to plans). When an individual or small group of physicians is responsible for a small number of enrollees, individual patient treatment decisions could potentially affect the amount of incentive payments physicians could receive. Conversely, when physician incentive payments are based on the combined performance of many physicians for a large number of patients, the potential for negative effects on treatment decisions and access to care is reduced.

The compensation and incentive arrangements used between plans and their physicians in Oregon are not among the riskier approaches we identified in reviews of other managed care plans. In the current program, health plans we visited reported arrangements that pool their physicians and patients into larger rather than smaller groups and that limit risk for physicians to the costs of outpatient care, at most, up to stop-loss insurance limits.

Current Managed Care Program Capacity Has Been Strained

There have been indications of strains in the capacity of Oregon's current managed care program, which created access problems for clients in some areas. The Cost Containment Advisory Committee, as well as some clients and client advocacy groups and the participating health plans we interviewed, expressed concerns about managed care program capacity.

In its May 1991 evaluation report to the legislature, the committee recognized areas where capacity was limited in the Oregon Medicaid managed care program. While recruiting more providers into the program would ease capacity problems, the committee cited low reimbursement

rates as one barrier to provider participation. It also noted that limited capacity in specific medical areas, particularly obstetrics and general practice services in rural areas, was a condition of the Oregon health care system in general that Medicaid policies could not be expected to solve.

Managed care clients at the advisory committee's client hearings in 1991 spoke of access problems due to limited health plan capacity, such as difficulties enrolling in their preferred plan, finding a physician within the plan, or changing physicians. Clients said they had the greatest difficulty finding obstetrical services.

Representatives of many of the 16 managed care plans in Oregon's program in July 1991 told us that provider capacity was tight, especially in the Portland and Salem areas. Plans said the main factor limiting their ability to enroll more Medicaid clients was the need for more participating physicians. Some plans also cited the need for more facility space and better reimbursement rates.

During 1991, problems relating to health plan capacity affected 8 of the 10 counties then in Oregon's managed care program. In the three-county Portland area, one contractor began to reduce its Medicaid managed care enrollment in 1990, citing inadequate reimbursement as the reason. To maintain enough capacity to require mandatory client enrollment, OMAP had to persuade the other Portland area plans to enroll more clients than they had planned. This put pressure on physicians and facilities in some plans and contributed to client complaints about reduced access and physician choice. OMAP staff report, however, that the problem had the beneficial effect of increasing overall capacity in the Portland area.

Managed care enrollees in the five-county area around Salem had difficulty obtaining access to primary care physicians in the spring and summer of 1991. Clients who spoke at the special client hearing in Salem reported this problem. OMAP staff attribute the problem to the limited numbers of primary care physicians in some counties and the unwillingness of some physicians to participate in the Medicaid program.

As of December 1991, OMAP continued to work with the leading contractor in the Salem area to alleviate these problems. Plan efforts included paying increased fees for participating PCO physicians, requiring minimum Medicaid enrollments for each primary care physician, encouraging

greater use of licensed nurse practitioners[13] in physician practices, and establishing a freestanding nurse practitioner clinic. The nurse practitioner clinic, operating under physician supervision, will accept both Medicaid and privately insured enrollees. Such clinics represent a realistic alternative for area health plans faced with physician shortages, according to state staff.

To increase provider capacity for future program expansions, OMAP focused its recruiting efforts in 1991 primarily on areas of the state new to Medicaid managed care—southern, central, and eastern Oregon. In May 1992, OMAP officials reported that new PCOs opened during April and May in southern and central Oregon counties and a second HMO began to provide health care to clients in the Portland area.

[13]The Oregon program, as approved by HCFA, considers certified physician assistants and nurse practitioners as acceptable primary care practitioners when they are certified and licensed in Oregon and adequately supervised by physicians according to standards established by the Oregon Board of Medical Examiners.

Quality Assurance Processes in Place and Efforts Underway to Improve Health Screening for Children

The Oregon Medicaid managed care program meets federal requirements for safeguarding the quality of care. It assesses quality through reviews of the quality assurance efforts of individual health plans and through annual reviews of patients' medical records. It also attempts to determine client views and problems through a grievance process, satisfaction surveys, and special hearings.

To a great extent, these quality assurance processes have been used effectively. We found no reports of severe or widespread problems with the quality of health services managed care clients receive. The statewide advisory committee concluded that quality of care for Medicaid clients differs little from that for the general population, and client advocacy groups we interviewed were generally satisfied with the quality of services provided under Oregon's program.

Medical record reviews by the Oregon Medical Professional Review Organization and our consulting physicians identified relatively few quality problems in the managed care program, but concluded that health screening and preventive services for children should be improved. In response, Oregon has taken an approach intended to build an understanding among participating health plans about the problem and possible solutions. This approach has been slow to produce specific improvement plans. The survey OMAP has used to monitor client satisfaction also could be improved. In its current form and with its low response rate, the survey's results have had limited usefulness.

Oregon's Program Meets Quality Assurance Requirements

Oregon's Medicaid managed care program meets federal requirements by implementing quality assurance processes in three basic categories: (1) ensuring that participating health plans maintain internal quality assurance activities, (2) assessing client satisfaction through client opinion surveys and grievance procedures, and (3) conducting annual medical record reviews using an independent contractor.

These and other activities are part of an overall plan OMAP developed for coordinating and improving managed care quality assurance and program monitoring. Since 1990, a special Medical Quality Task Force composed of OMAP staff and outside experts has guided efforts to implement this plan. Recent additions to the plan include a survey of clients who disenroll from health plans and quarterly client service utilization reports from the plans.

Monitoring Health Plans for Quality Assurance Activities

OMAP reviews health plans' quality assurance activities as part of its program of site visits. Among other things, these visits examine compliance with HCFA's quality assurance requirements, which have been incorporated into health plan contracts. The requirements include such steps as an internal quality assurance program based on written policies and procedures, a medical record-keeping system that conforms with professional medical practice, and written procedures for accepting and responding to all client complaints and grievances.

Although not all of the health plans met all detailed performance measures associated with each contract requirement, Oregon concluded that 10 of the 13 plans reviewed in 1991 were substantially in compliance with quality standards. In these plans, the performance measures not met usually involved problems with documentation, such as a need to update policy and procedure manuals or to provide quality assurance committee membership lists and minutes.

Two health plans, however, had more serious deficiencies in meeting requirements for updated procedures manuals and quality assurance plans and follow-up on client complaints and grievances. OMAP required these plans to submit corrective action plans and reported that the deficiencies were corrected by November 1991. A third plan was judged to be "severely deficient" in these same areas. OMAP held a follow-up meeting with officials of that plan to agree on corrective actions, but although progress was made, deficiencies remained at the end of 1991. A Medicaid official said the plan's contract would not be renewed in September 1992 unless all deficiencies were corrected.

Assessing Client Satisfaction and Grievances

Oregon requires its managed care providers to report written grievances from clients on a quarterly basis. OMAP's compilations of these reports show a relatively low incidence of grievances. In 1990, the last full year for which data were available when we conducted our review, 18 formal grievances were filed involving six health plans. In addition to monitoring formal client grievances, OMAP has taken other steps to assess client satisfaction:

- OMAP has conducted client satisfaction surveys periodically since April 1986. Although the usefulness of these surveys is limited by low response rates and other factors, nearly three-quarters of the clients who did respond were satisfied with the quality of care.

- In September 1990, OMAP initiated a survey of Medicaid clients who had disenrolled from managed care plans. The purpose of the quarterly survey, which was revised in 1991, is to identify reasons for disenrollment and other client problems. OMAP staff have not formally analyzed survey responses, but have referred individual client problems reported through the survey to the health plans for action.
- In 1991 OMAP, the Cost Containment Advisory Committee, and the Oregon Human Rights Coalition sponsored a series of client hearings throughout the state. As discussed in chapter 2, clients attending these hearings complained more frequently about problems relating to access than quality of services. However, some speakers also reported not being treated well by individual PCO staff or physicians because they were Medicaid patients. OMAP staff met with the clients who had serious complaints about their care to follow up on the problems with the PCOs involved. OMAP and the advisory committee have considered convening focus groups, client councils, and regional workshops of health plans and clients to pursue issues raised by the client hearings, but they do not plan to hold further hearings.

Conducting Annual Medical Record Reviews

HCFA requires an annual medical audit of Medicaid managed care programs. Oregon's medical record review has been performed by the Oregon Medical Professional Review Organization (OMPRO), a federally qualified professional review organization that also holds the federal contract for Medicare quality reviews in Oregon. OMPRO has conducted four reviews of Oregon's Medicaid managed care program since 1987. In the early reviews, inadequate documentation and incomplete medical records were problems. OMPRO reports that documentation has improved, however, and the reviews have identified relatively few problems with the quality of services delivered.

We used consulting physicians to validate OMPRO's 1989-90 audit of outpatient medical records in Oregon's Medicaid managed care program.[1] Our review looked at study design, quality screening criteria, the medical record review process, and audit results. Our consulting physicians used OMPRO's criteria and process to review a sample of the records OMPRO reviewed in 1990. Our review showed that the medical record study design

[1]Our group of consulting physicians was associated with the Department of Health Care Science, George Washington University, Washington, D.C. That department is oriented to patient care, education, and research in primary care and is active in managed care programs. Coordinated by the chairman of the department, the six physicians who participated in the medical record review included specialists in internal medicine, pediatrics, and family practice.

was appropriate, the screening criteria were adequate and reasonable, and the record review process itself was sound.

Study Design

The 1989-90 OMPRO review focused on outpatient care for (1) obstetrical patients, (2) adult and child illness encounters, and (3) screening and preventive services for children (referred to as well-child screening services).[2] The objectives of the review were to determine that all necessary care was provided; care was timely, accessible, and provided in an appropriate setting; and the quality of medical care conformed to professionally recognized standards. The study design involved a judgmental sample that was representative of the population from which it was drawn, but not statistically valid for projecting findings to the larger Medicaid managed care population. Oregon Medicaid and OMPRO staff confirmed that the sample was selected for a study designed to monitor care and identify problems, not to analyze problems statistically.[3]

Quality Screening Criteria

The medical quality criteria used to screen Medicaid patient records for appropriate illness, obstetrical, and well-child care were developed by OMPRO physicians for ambulatory care screening purposes, based on guidelines published by national professional societies.[4] The screening criteria were adopted by OMPRO's board of trustees and approved by OMAP. Our consulting physicians concluded that OMPRO's three criteria sets were adequate and reasonable for screening records of ambulatory care, although applying the criteria necessarily required some subjective medical judgment.

Medical Records Review Process

OMPRO reviews the samples of medical records for each participating health plan in two steps. First, trained nurse reviewers apply the screening criteria to identify cases with possible quality problems and refer those records for physician review. Second, OMPRO physicians review the

[2]These services generally are referred to as well-child screening services, or Early and Periodic Screening, Diagnosis, and Treatment services. They comprise a group of services that all Medicaid programs are required to provide to eligible children (under the age of 21). These screenings are regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutrition of eligible children. At a minimum, well-child screenings must include a comprehensive health and developmental history, a physical exam, vision and hearing testing, laboratory tests, and dental services by referral.

[3]Sample size for each plan was based on a confidence level ranging from 80 to 95 percent, 50-percent expected rate of occurrence, and plus or minus 10 percent error rate, according to OMAP officials. Samples were drawn from records of enrollees who used services at least once during the study period.

[4]The societies included the American College of Obstetrics and Gynecology, the American Pediatric Association, and the American Academy of Family Practice Physicians. The well-child screening criteria also incorporate HCFA rules for Early and Periodic Screening, Diagnosis, and Treatment as they apply to Medicaid programs.

referred records, obtain additional information from the plan or medical specialists if necessary, and decide whether to confirm quality or documentation problems in each case. Our consulting physicians applied OMPRO's screening criteria and clinical judgment to about 10 percent of the cases OMPRO reviewed.[5] Our consultants found the criteria relatively simple to follow and apply, although as noted above, reviewer judgment was sometimes required to determine if criteria were met. They concluded that OMPRO's review process was reasonable and sound.

Clients Generally Satisfied With Quality of Care

For the most part, the quality assurance measures discussed above did not disclose serious problems with the quality of care in Oregon's program. Likewise, client advocacy groups we interviewed reported no major concerns about quality in the Medicaid managed care program. These sources said Medicaid managed care clients are generally satisfied with quality of care. Client complaints to the advocacy groups usually related to managed care restrictions on choice of physician or referrals, not quality problems.

The statewide Cost Containment Advisory Committee includes subcommittees representing both clients and providers. In its May 1991 evaluation of the Medicaid managed care program, it concluded that there was no reason to believe the quality of care for Medicaid clients differed from that provided to the rest of the state's population.

Health Screening for Children Could Be Improved

Although OMPRO reviews and state quality monitoring activities found few problems with the program, one area stands out as needing improvement—well-child health screening services. Both OMPRO and our consulting physicians identified problems in this area. OMAP officials agreed that OMPRO's 1989-90 review indicated well-child care remained an area needing significant improvement. OMAP convened a work group of health plan quality assurance coordinators in June 1991 to consider strategies for improving well-child services, but progress in developing and implementing those strategies has been slow. This may be due in part to the fact that problems in well-child screening services may have multiple causes, including failure to provide all screening services, failure to record screening services that were provided, and failure of parents to bring children in for screening.

[5]The purpose of our review was to validate the process and overall results of OMPRO's medical record audit, without comparing individual health plans. We selected a proportional random sample of about 10 percent of the records OMPRO reviewed for each plan.

OMPRO's 1989-90 medical record review found relatively few documentation and quality problems: 52 confirmed documentation problems and 6 confirmed quality problems in the 1,357 cases reviewed.[6] The review concluded that documentation of care for adult and child illness visits appeared to be good. In the area of well-child screening, however, OMPRO found that most plans did not provide well-child care according to recommended standards for most age groups. Records of pediatric visits often did not indicate that appropriate screening and immunization services had been provided. OMPRO recommended that all health plans review their internal documentation of well-child care to determine if inadequate screening results were due to poor record keeping or lack of care.

Our consulting physicians who retraced OMPRO's efforts concluded that well-child screening was inadequate, measured against Oregon's adopted criteria, and that most other problems identified were ones of documentation rather than direct concerns about the quality of care provided. Our consultants agreed with OMPRO that it cannot be determined from medical record reviews alone whether well-child screening failures resulted from the failure of health plans to inform parents or from the failure of parents to comply with screening needs. Nonetheless, in their judgment, the absence of well-child screening is a serious quality problem. About half of the well-child screening records they reviewed did not meet the criteria for appropriate periodic screening. In many cases, for example, no screening visits were recorded, or the physical exam or medical history was not complete.

Both OMPRO and our consultants identified well-child screening services as a weakness in Oregon's current Medicaid managed care program. Having identified and acknowledged the problem, Oregon has chosen to respond by a process of building understanding among the health plans about problems and possible solutions. This process, however, has been slow.

OMAP received OMPRO's draft report of results from the 1989-90 review in December 1990 and told us they accepted the report as final in March 1991. In June 1991, OMAP convened the health plan quality assurance coordinators to discuss and develop comprehensive plans for improving well-child screening services. Additional meetings of the coordinators were held in November 1991 and January, March, and April 1992. For the next scheduled meeting in July 1992, all health plans are required to

[6]One health plan accounted for all six quality problems and about half the documentation problems. OMAP contacted that plan directly and worked with it to develop and monitor implementation of a corrective action plan.

develop lists of the well-child care improvement strategies they intend to implement in the coming year. Thus, although the state's approach may have encouraged a consensus among plans, more than a year after OMPRO's 1989-90 report identified the need to improve well-child services, the group had not finalized or implemented specific corrective actions.

Although its 1990-91 review found that the documentation of well-child care had improved overall when compared to the 1989-90 review, OMPRO concluded that further improvement is still required. OMPRO reported that documentation of children's immunization status, for example, remained substandard. OMAP stated in May 1992 that it has taken the issue of well-child services seriously and will continue to give it high priority as a quality assurance objective.

OMAP's Client Surveys Have Limited Usefulness

OMAP's client surveys, which it conducts periodically to monitor clients' satisfaction with the care they receive from the program and its participating health plans, have limited usefulness. The last client survey, conducted in July 1990, had a response rate of 24 percent.

There are other problems with the information from these surveys. OMAP does not conduct a similar survey of fee-for-service Medicaid clients, so levels of satisfaction cannot be compared between the two groups. The survey questionnaire and methods do not provide valid information for comparisons among plans, or among client groups by area or over time. Survey questions often were vague and not time specific, and because there was no follow-up to obtain adequate responses, the results cannot be interpreted to reflect all clients' views. We discussed our evaluation of the survey with OMAP staff, who indicated in May 1992 they are considering using a new questionnaire, such as one developed and used nationally by the Group Health Association of America.

Results from OMAP's survey of Medicaid clients who disenrolled from managed care providers also have limited use. Begun in September 1990, the disenrollment survey has been modified more than once and currently is used primarily as a monitoring tool. As of December 1991, survey methods were being adjusted and results had not been analyzed.

Effectiveness of Financial Oversight Could Be Improved

In the past, Oregon performed limited financial oversight of individual health plans in its Medicaid managed care program. The state revised its financial monitoring and reporting requirements in anticipation of program expansions. The revised requirements will be applied to contractors during fiscal year 1992. After evaluating this new approach, we see two ways in which Oregon could improve its effectiveness. First, more detailed financial information from Oregon's managed care contractors would better allow the state to detect solvency problems. Second, Oregon could require contracting plans to disclose ownership, control, and other information. The state currently is not required to collect such information because the Congress granted the Secretary of HHS specific authority to waive the requirement for Oregon. OMAP officials told us that plans would be required to meet federal disclosure requirements beginning in October 1992.

Past Financial Monitoring Efforts Were Limited

In the past, Oregon's monitoring of health plan solvency in the managed care program was limited. Managed care plans were required to submit annual financial reports (principally financial statements prepared by independent accountants), which were reviewed annually by OMAP staff. OMAP's review looked for obvious signs of financial instability but did not follow a specific set of solvency indicators or evaluation criteria.[1] No set of performance measures was used to further define how plans were expected to comply with the contract standard to maintain financial solvency.

State officials cited three main reasons for the limited monitoring: (1) in the current program, contractor risk is limited to the costs of primary care, (2) most plans are experienced in either delivering managed care or serving Medicaid clients, and (3) other state agencies monitor or regulate some of the larger health plans. They pointed out that no contractor failures have occurred in the Oregon program since it began in 1985.

Assessing the financial solvency of managed care plans is an important tool program managers can use to help ensure that plans do not go out of business, leaving enrollees without access to health services. Monitoring financial solvency is particularly important when plans are inexperienced in providing prepaid managed care, with its inherent financial risk. A consistent monitoring approach allows a state to compare results over a

[1]Solvency indicators include, among others, measures of underwriting income (loss), net income (loss), general and administrative expenses as a percentage of income, total liquid assets as a percentage of total liabilities, and total net worth. Evaluation criteria consist of ranges or values for each indicator against which plans may be rated as strong, acceptable, or weak.

period of several years and to detect patterns that could identify possible weaknesses.

Our reviews of prepaid health programs in other states noted the financial difficulties plans may face in delivering health services under managed care systems, and hence the need for monitoring plan solvency.[2] The reviews, performed between 1986 and 1988, found that some managed care contractors in Arizona, Pennsylvania, and Florida experienced financial problems, including business failure.

In prepaid managed care programs, contracting plans assume financial risk for the difference between the amount received in capitation payments and the costs of patient health services covered by those payments. Capitation payments are based on a projected level of service use, over time, by specific types of enrollees. If enrollees in a given plan use fewer or less costly services than were assumed in the projection, the contractor experiences a cash flow "profit." If, on the other hand, enrollees use more or higher cost services, the plan experiences a cash flow "loss." These income and expense fluctuations often occur monthly. Inability to deal with such fluctuations can lead to business failure and resulting disruptions in patient services.

Revised Monitoring Methods for Current Program Could Be Improved

In anticipation of proposed expansions involving health plans new to managed care and Medicaid, OMAP staff revised and strengthened financial monitoring activities and reporting requirements. OMAP formed a work group in 1991 to develop indicators and criteria for assessing plan solvency. The state contracted with an independent financial consultant, who made recommendations regarding solvency indicators and evaluation criteria that could be applied. The state also revised its reporting requirements. Although the revisions are positive steps, in their present form the requirements for the current program display several weaknesses.

Solvency Indicators and Evaluation Criteria

We had great difficulty in trying to apply OMAP's solvency indicators. We applied the indicators to financial data submitted by current Oregon contractors. Considerable subjective judgment was needed to do this, because the plans do not present their financial information in a uniform

[2]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 Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

manner. The lack of uniform reporting prevented meaningful comparisons among plans on specific measures, and could make comparisons across time of the same plan unreliable. When contracting health plans did not separate revenues and expenses by type of business, we could not compare indicator results from the managed care portion of a plan's business with total business performance. Such comparisons could reveal how well the managed care portion of a plan's business performed and the relative significance of managed care to overall operations.

One example of the problems we encountered involved the medical loss ratio, which compares medical expenses to medical revenues. Oregon's financial consultant recommended it as useful for comparing plan performance. Industry experts consider the medical loss ratio a good indicator of financial and operational soundness, because it shows whether medical revenues cover medical expenses and contribute to administrative costs. In reviewing data reported by Oregon's contractors, we found no indication that plans share an agreed upon definition of medical revenue or medical expense. The uncertainty about what each plan included as expenses and revenues raised questions about the usefulness of the ratio in this case.

Even so, our test of the solvency indicators in OMAP's revised monitoring method showed some indications of financial weakness among the contractors. Three of the participating PCOs, covering 22 percent of enrollees, rated weak on two or more of the solvency indicators, according to criteria recommended by Oregon's consultant. These apparent weaknesses may have nonfinancial causes. For example, indicators relying on cash or other liquid assets may be weak for a year or two when plans build reserves or acquire facilities for expansion. Therefore, while we found indications of weakness in some plans, further investigation by the state would help determine whether the weak ratings result from sound business decisions or indicate potential financial difficulties.

Financial Reporting Requirements

Using recommendations by its outside financial consultant, Oregon in November 1991 adopted strengthened financial reporting requirements for the current program. Beginning with fiscal year 1992, all new and continuing contractors must submit externally reviewed or audited annual financial reports plus quarterly financial reports prepared for the state. Additionally, plans must submit descriptions of the accounting processes they use for financial reporting, projecting future cash requirements, managing incurred but not reported expenses, and determining physician

incentive payments. Contractors also must purchase stop-loss insurance from the state or demonstrate that private insurance or alternative risk management measures are adequate, and maintain restricted reserve funds[3] in amounts approved by the state.

These new financial reporting requirements should improve the information OMAP has available to monitor health plan solvency, a responsibility delegated to the states by HCFA. Quarterly reports in particular allow the state a more active role in determining the kind of information reported and provide more timely notice of developing problems.

The revised reporting requirements will be implemented as performance measures, not as contract standards. Therefore, the state may need to develop methods to obtain plan reporting compliance. Some plans already have indicated dissatisfaction with the level of monitoring and administrative requirements in the current program, which is lower than the level of the revised requirements. Although most plans told us that solvency monitoring is important, they did not feel it was necessary to submit more than annual statements.

The state recently requested detailed financial information substantially similar to the revised measures it has adopted, but received almost no response from the health plans. According to OMAP staff, plans are reluctant to supply the requested information for two principal reasons: (1) it increases the administrative burden, and (2) some plans consider such detailed information proprietary.

Exemption From Disclosing Plan Ownership Information Is Not Appropriate

Federal regulations require state Medicaid managed care programs to obtain disclosure of ownership and control information from participating health contractors. In 1985, Oregon sought certain statutory waivers to offer physician and outpatient services through PCOs rather than HMOs. The Congress granted the Secretary of HHS specific authority to waive the requirements for Oregon. In granting the waivers needed for the PCO service package, the requirement to disclose ownership, control, and other information was also lifted. Thus, the Oregon program is exempt from disclosure requirements.

[3]Restricted reserve funds are assets restricted by agreement as to use for specific purposes. Such funds may be deposited in escrow or held by the organization but not made available to fund current operations.

Our work in other states suggests that Medicaid program managers need to be aware of affiliations among contracting health plans. A review of managed care plans in Arizona revealed interconnected business relationships that could enable health plans to divert federal monies from their intended purpose—the provision of health care.[4] Specifically, some of the prepaid health plans were nonprofit corporations that contracted for needed services with for-profit corporations that were created by, or involved ownership interest on the part of, directors or officers of the nonprofit businesses.

Federal Regulations Require Ownership Disclosure for Managed Care Plans

Federal disclosure requirements were enacted to prevent and detect fraud and abuse in federal health care programs. Disclosure of ownership information gives Medicaid program managers a monitoring and audit tool to follow the flow of health care dollars among related business organizations, helping to ensure that moneys are not diverted from the provision of health care through unnecessary administrative charges or excessive profits. HCFA requires state Medicaid agencies to require contracting health plans to identify any individuals convicted of Medicaid- or Medicare-related criminal offenses, individuals with a 5-percent or more ownership or control interest in the plan, subcontractors in which the plan has a 5-percent or more interest and if requested, details of significant business transactions with subcontractors and wholly owned suppliers.[5]

Ownership Disclosure Requirements Do Not Apply to the Current Program

The federal requirements described above do not apply to Oregon's current Medicaid managed care program because in 1985 the state was granted a waiver[6] from certain provisions of the Social Security Act. This allowed the Oregon program to offer, through PCOs, a service package that otherwise would have required the plans to meet state and federal HMO requirements.[7] Oregon is the only state Medicaid program to obtain an exemption from these requirements. Among the provisions from which the current Oregon program is exempt is the requirement to collect

[4]Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985). See also Relationships Between Nonprofit Prepaid Health Plans With California Medicaid Contracts and For Profit Entities Affiliated With Them (HRD-77-4, Nov. 1976).

[5]The federal requirements are detailed in 42 C.F.R. 455.104-106.

[6]Section 9622 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, granted the Secretary explicit authority to grant such a waiver to Oregon.

[7]These requirements include, among others, limiting Medicaid and Medicare enrollment to less than 75 percent of total plan enrollment, allowing enrollees to disenroll without cause, and requiring plans to submit ownership and control information.

ownership, control, and the other information discussed above from contracting health plans. As a result, HCFA does not require and the state does not collect such information.

Ownership and control information reveals the existence of affiliated organizations and the potential for related party business transactions, which by themselves are neither uncommon nor improper. Awareness of such arrangements, however, can alert Medicaid program managers to the potential flow of health care dollars among related plans and physicians. The more money that flows between related organizations, the less that remains available for health care, since each business serving clients must charge for both its cost of care and its cost of doing business. State monitoring of such business relationships can help prevent the diversion of Medicaid dollars from the delivery of client health services.

Our review of available financial data and discussions in July 1991 with Oregon's contracting plans revealed that 8 of the 16 are affiliated with other health care organizations. However, we were unable to determine from available data the extent to which assets and risks are shared between affiliated organizations. Furthermore, the data did not reveal the names of plan owners or directors.

OMAP staff told us that collecting plan ownership and control information is important. The state's financial consultant recommended monitoring contractor ownership and control information, in part because the health care market in Oregon is changing rapidly. In May 1992 OMAP officials said plans would be required to meet federal disclosure requirements beginning in October 1992.

Statewide Expansion Under Demonstration Project Raises Concerns About Capacity

Facing the dual problems of growing numbers of medically uninsured residents and soaring health care costs, the Oregon Legislature in 1989 and 1991 passed comprehensive reforms designed to guarantee access to some level of health services for most state residents. As part of these reforms, the legislature proposed a demonstration project that would make Medicaid managed care a statewide program, tripling its size within 1 year. Expanding the managed care program is an essential part of Oregon's demonstration proposal, because the money to pay for covering more people is expected to come in part from the cost savings potentially available through managed care. To expand the managed care program and to make other related changes it is proposing, Oregon needs approval from the Secretary of HHS.

Oregon's proposal is controversial because of its mechanism for linking the types of services covered under the program to the level of funding available, and because it will cost the federal government an estimated $110 million in additional matching funds over the 5 years of the demonstration project. A report by the Office of Technology Assessment addresses issues surrounding what services would be covered under the demonstration.[1] Our chief concern about the Oregon proposal is whether the state can develop adequate provider capacity within a 1-year time frame. If Oregon triples the size of its managed care enrollee population within 1 year, as the demonstration proposes to do, the state will need to identify new providers and contract with many new managed care plans. It is not clear that Oregon can accomplish this in the time allowed, in part because of the magnitude of the proposed expansion and physician shortages in some areas of the state. However, as of April 1992, OMAP had received more than 20 nonbinding letters of intent to participate in the demonstration from state health providers.

The proposed demonstration project builds on experience gained in the current program, incorporating and expanding safeguards for ensuring access to care, maintaining the quality of care, and monitoring financial solvency. Given the size of the proposed program, enhancing oversight measures to resolve the problems discussed in earlier chapters of this report appears to be an important objective.

[1]U.S. Congress, Office of Technology Assessment, Evaluation of the Oregon Medicaid Proposal, April 10, 1992.

Expanded Managed Care Program Plays a Major Role in Oregon's Health Care Reforms

In the Oregon Basic Health Act of 1989, with 1991 modifications, Oregon adopted a comprehensive health care reform plan for the state. The reform plan has three major components that are interrelated and essential to overall success: an expanded Medicaid program, a state risk pool for people who are uninsurable due to preexisting medical conditions, and mandated employer-sponsored private insurance. Under the Medicaid component of these reforms, Oregon would expand eligibility to all residents with incomes below the federal poverty level and offset the costs of the expansion by (1) requiring more clients to enroll in managed care systems and (2) limiting services by ranking them in order of importance. The major managed care changes passed by the legislature and proposed to HCFA in the demonstration application can be summarized as follows:

- Increased size. The demonstration project would be much larger than the current managed care program in terms of numbers of enrollees, providers, and area served. In May 1992, OMAP officials projected total enrollment by the end of the demonstration's first year at 220,300—more than three times the enrollment in the current program. Under the proposal, managed care would be extended throughout the state rather than concentrated in the most populated areas.
- Expanded eligibility. Part of the growth in enrollment would come from extending Medicaid to persons not now covered in Oregon or in any other state, including single individuals and childless couples. In the demonstration, all individuals, as well as families, with incomes below the federal poverty level would be covered.
- Increased number of providers and fully capitated plans. The state proposes to add new providers and to expand enrollment at providers already in the program. In addition, it calls for at least some of the current partially capitated plans to be converted to fully capitated plans and for new fully capitated plans to be recruited. Over half the total enrollment would be served by fully capitated plans.
- Prioritized health services. The Oregon Legislature developed a process in which (1) a special Health Services Commission, with public input, reviews and ranks health services in order of importance to patients and effectiveness in improving health, (2) an actuary estimates the costs of providing each service to the eligible population, and (3) the legislature determines how much of the prioritized list to fund. Services below the line drawn by the legislature would not be covered for Medicaid clients. For example, the list of services approved for the demonstration project funds medical treatment for pneumonia and acne, but does not fund breast reconstruction after a mastectomy or liver transplants for alcoholic

cirrhosis. The commission biennially reviews, and may revise, the ranked list of services that it presents to the legislature for a funding decision.

- Cost-based reimbursement. The demonstration also would implement a new provider reimbursement system, which is expected to result in higher overall payments than under the current managed care or fee-for-service Medicaid programs. By state law, these capitation rates must be based on a formula that represents service delivery costs. The new cost-based formula, developed by an outside actuary, offers fully capitated providers approximately $130 per AFDC client per month for the approved package of services, compared with approximately $100 per client per month (fiscal year 1992) for the fully capitated HMO in the current managed care program.

Oregon's demonstration proposal will cost more than the estimated costs of its existing Medicaid program. The application to HCFA projects that, even if all anticipated savings are realized, state Medicaid spending over the 5-year demonstration period would increase by about 1.6 percent ($95 million) and federal spending by about 1.8 percent ($110 million).

Because the proposed Medicaid program changes are sweeping, Oregon submitted a demonstration project application to HCFA in August 1991.[2] The application anticipated approval by the Secretary in January 1992, with demonstration implementation beginning in July 1992. As of mid-May, however, the application had not been approved, and Oregon was moving back the demonstration start-up date accordingly. Oregon continues to plan on start-up within 6 months of HCFA approval.

Providers Generally Support Demonstration; Client Groups Express Concern About Coverage

The demonstration project was generally supported by most of the 16 managed care providers in the program in July 1991, Oregon health professional associations (including the Oregon Medical Association and the Oregon Association of Hospitals), and Oregon business organizations. These groups have expressed support for expanded Medicaid coverage, managed care delivery, the prioritized service package, and the new provider reimbursement system. Health plans participating in the current program also believe cost-based reimbursement may encourage new providers to participate in Medicaid. These plans also expressed some

[2]Section 1115 of the Social Security Act allows the Secretary to waive for demonstration projects sections 1902 and cost-related parts of 1903, at least to the extent of paying for costs that would otherwise not be covered by the state Medicaid plan. Under this authority, states may implement, for a limited and usually nonrenewable period, programs approved at the discretion of the Secretary of HHS. Such demonstration projects generally include a formal research component and provide for an independent evaluation. The Congress has periodically mandated extensions of specific projects that were scheduled to expire.

concerns, which focused on the project's costs and the adequacy of state funding. Although most felt the initial service package would be adequate, they did not want to see it change every year or shrink with declining state revenues. Some providers said the state should guarantee a minimum service package. There were concerns about responsibility for providing services below the priority line, especially if the package is reduced and more services are cut from coverage.

Advocacy and consumer groups expressed more concerns about the demonstration than providers did. Most of their concerns related to the prioritized service package rather than to managed care delivery, access, or quality of services. Although the groups expressed a wide range of concerns, the chief concern was the demonstration's system of linking the service package to variable state funding levels. The groups also viewed the demonstration as lacking strong cost control mechanisms, which could mean that if actual expenditures exceed projected budgets, there would be pressure to cut back the service package. Moreover, the groups feared the effects of state budget cuts required under a property tax relief initiative passed by voters in 1990. They agreed that the expansion of Medicaid coverage under the demonstration would be beneficial, and some said public input to the service priority-setting process was good. Some supported managed care as a delivery mechanism.

Capacity Problems Raise Concerns About Program Expansion

Medicaid clients in Oregon's demonstration project will not have adequate access to health services unless enough managed care contractors, including primary care case managers, participate in the project. The size of the proposed demonstration raises concerns about Oregon's ability to recruit enough managed care contractors, statewide, to provide access for all enrollees. Our concern in this regard is based on strained capacity experienced in 8 of the 10 counties under the current program in 1991, when some clients were unable to enroll in the health plan of their choice or select a primary care physician. The short time frame envisioned for provider recruiting may be unrealistic, and existing physician shortages in some parts of the state could make recruiting more difficult.

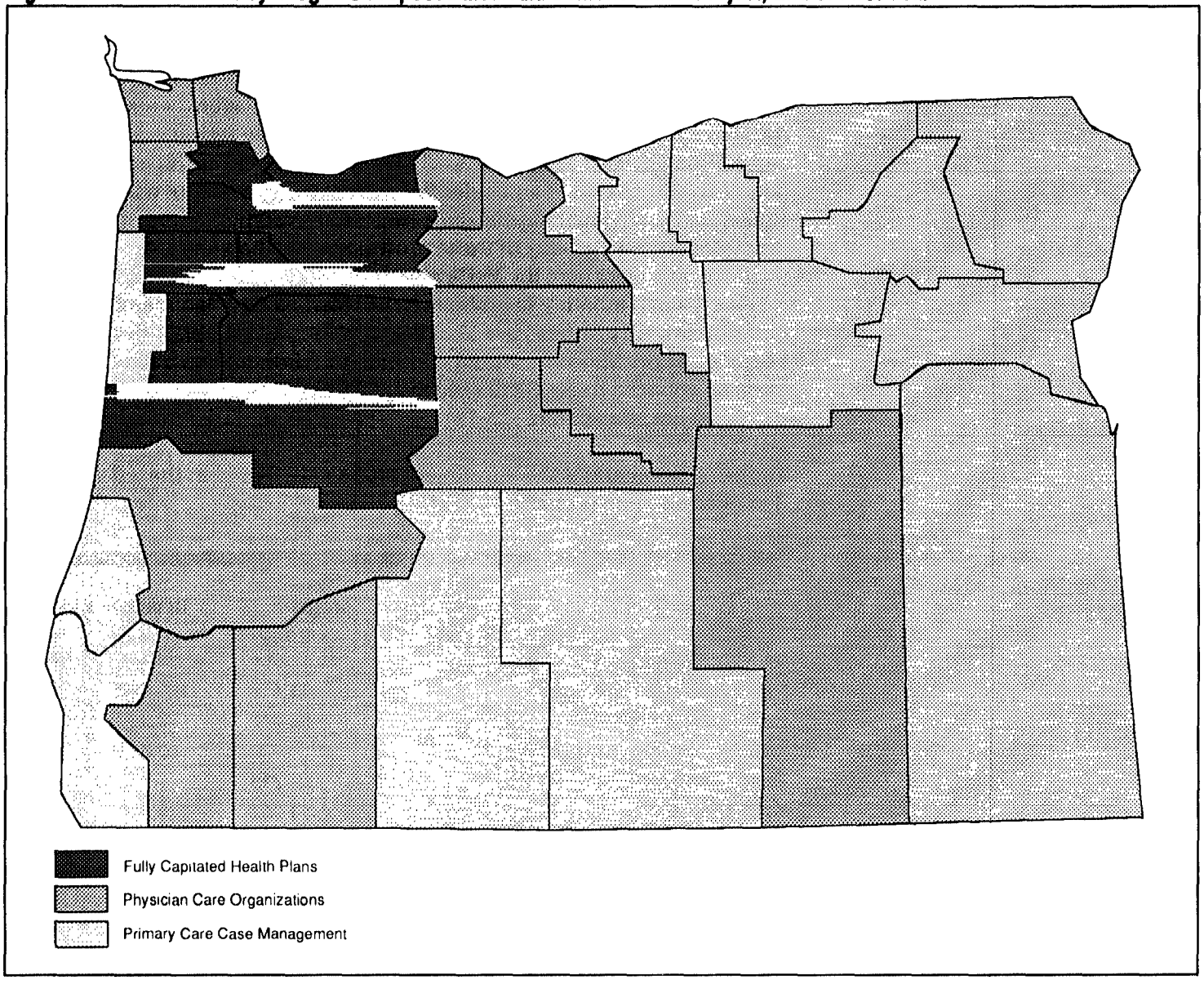
More Contractors Needed to Serve Expanded Demonstration Enrollment

The state anticipates a threefold increase in the number of people receiving managed health care by the end of the demonstration project's first year. The demonstration would require recruiting many new contractors, as well as converting most existing contractors to a new type

of contractual arrangement. Oregon expects to use three types of managed care contractors:

- Fully capitated plans. The demonstration assumes that persons eligible for Medicaid in the nine counties of the Portland metropolitan area and Willamette Valley will be served by HMOs and other fully capitated plans (see fig. 5.1). This is a change from the current program, which had one fully capitated HMO until a second was added in May 1992. To participate under the demonstration project in these nine counties, plans now operating as partially capitated PCOs will need to restructure or become affiliated with fully capitated plans. The number of persons covered by fully capitated plans is projected to grow from about 13,500 to more than 120,000.

Figure 5.1: Area Covered by Oregon's Proposed Medicaid Demonstration Project, End of First Year



- Partially capitated contractors. The demonstration project also assumes that partially capitated PCOs would serve clients in 12 additional counties. In April 1992, PCOs operated in 2 of these 12 counties. Within about 6 months of project approval, PCOs would need to be established and ready

to serve about 27,000 Medicaid clients, many of whom are not in the current managed care program. PCO enrollment would increase to about 39,000 clients at the end of the first demonstration year.

- Primary care case managers. Oregon's remaining 15 primarily rural counties would be served by primary care case managers, a managed care delivery system not currently used in the state. Case managers would serve about 22,000 enrollees initially and about 60,000 at the end of the demonstration's first year. Under this program, agreements would be signed with individual physicians, physician assistants, nurse practitioners, and groups of these professionals who would serve as medical case managers for Medicaid clients. As case managers, they would receive a small monthly fee (about $3 per Medicaid patient per month) for coordinating all primary care, making all referrals, and monitoring hospitalization. The state would continue to reimburse on a fee-for-service basis all services these clients receive, including primary care, specialty care, and hospitalization.

Table 5.1 summarizes the enrollment shifts anticipated in the demonstration project after 1 year.

Table 5.1: Comparison of Enrollments in Current and Proposed Managed Care Programs

	Current program	Demonstration	
Delivery system	**April 1992 enrollees**	**First year enrollees**	**Percent**
Full capitation (HMO-style)	13,472	120,629	55
Partial capitation (PCOs)	59,077	39,341	18
Primary care case management	0	60,330	27
Fee-for-service	713	0	0
Total enrollees	**73,262**	**220,300**	**100**

Health Resources Limited in Some Oregon Counties

Most of Oregon's counties contain federally designated underserved areas,[3] and OMAP staff acknowledge primary care physician shortages in parts of the state. The demonstration application itself, for example, reports an expected 20-percent decline in primary care physicians in rural Oregon during the 1990s.

[3]HHS's Bureau of Health Care Delivery and Assistance uses population data and health resource availability information to determine whether geographic areas and/or specific populations are underserved. Areas and populations designated as underserved are then eligible to apply for HHS Public Health Service grants.

A recent report from the Oregon Health Sciences University and the state Office of Rural Health indicates that Oregon has a maldistribution of physicians. In 1990, nearly 60 percent of the state's practicing physicians were located in the Portland metropolitan area, where only 41 percent of the population lives. The north-south corridor from Portland through the Willamette Valley comprising 15 miles on either side of Interstate Route 5 represents 9 percent of the state's area and contains 87 percent of its approximately 6,250 practicing physicians. Furthermore, over 75 percent of Oregon's towns and cities have fewer than 5,000 residents, and nearly two-thirds of these towns have no physicians. Limitations in the availability of health providers, which confront all residents in the affected areas, could make it difficult for OMAP to recruit enough case managers to expand the managed care program into Oregon's rural counties.

Status of Efforts to Recruit More Plans

OMAP staff said efforts are under way to recruit more managed care contractors for the demonstration. Specifically, OMAP held information and technical assistance conferences for interested parties during December 1991 in five locations around the state. As of April 1992, more than 20 health care providers had expressed interest in participating in the demonstration through nonbinding letters of intent. These letters do not commit the providers to sign contracts if HCFA approves the demonstration. At present, insufficient information exists from these potential contractors to determine if they would provide sufficient capacity in the appropriate parts of the state to serve the expected demonstration enrollment. In May 1992 OMAP officials said binding letters of intent would be obtained from providers within 2 weeks of demonstration approval, along with other materials to help OMAP determine the adequacy of capacity.

Demonstration Project Would Continue and Expand Current Access Safeguards

Oregon's demonstration project calls for continuing and in some ways strengthening access safeguards in the current Medicaid program (see ch. 2). Proposed safeguards include state and federal monitoring of contractors, limiting the financial risk for some providers by using partial capitation and primary care case management for about half the enrollees, and limiting the incentives that might encourage inappropriate service restrictions by capping program savings payments to partially capitated plans (then, as now, fully capitated plans will not be eligible for savings payments).

Additionally, the demonstration application states that Oregon will

- require contractors to purchase the state's currently optional stop-loss insurance or to demonstrate that other protective measures, such as privately obtained stop-loss insurance, are adequate;
- monitor risk-sharing and incentive arrangements adopted by contracting health plans to compensate their physicians; and
- require contractors to report data for each patient encounter, such as types of services provided, with diagnostic and treatment codes, in addition to the quarterly utilization data summary reports.

Demonstration Would Expand Quality Assurance Activities

Oregon's current Medicaid managed care program incorporates features to monitor and identify quality problems. The quality of health services is generally good, but medical record audits revealed that well-child screening services could be improved (see ch. 3). Oregon proposes to continue and strengthen its quality assurance activities in the demonstration project.

The demonstration application requests a waiver of the federal Early and Periodic Screening, Diagnosis, and Treatment mandate,[4] which requires state Medicaid programs to pay for treatment of conditions identified during periodic child health screenings. Oregon is seeking to waive this requirement because the Medicaid demonstration's service package, subject to biennial legislative change, may exclude services a physician might prescribe as the result of a well-child screening.

Specific quality monitoring activities proposed for the demonstration are as follows:

- Participating health plans would submit seven types of reports pertaining to health care quality, including reports on quality assurance committee meetings, identified problems and corrective actions, enrollee complaints and grievances, patient management, and medical outcomes.
- On-site reviews of the health plans conducted by OMAP staff would continue to focus on compliance with contractual standards, including a review of client complaint and grievance procedures.
- An external peer review organization such as OMPRO would perform medical record reviews as part of the quality-of-care assessment.
- Clients would be surveyed periodically to assess their satisfaction with the program and their understanding of how to obtain services in a managed care system.

[4]Section 1905(a)(4)(B), and referenced in 1902(a)(43)(A) of the Social Security Act.

- OMAP would monitor client orientation methods used when clients apply for assistance and data from disenrollment surveys and provider appeals.

Financial Oversight Expanded; Disclosure May Be Required

The solvency monitoring processes for the demonstration project build on those in the current program (see ch. 4) by listing specific solvency indicators and requesting more detailed financial information from contracting health plans. The effectiveness of this monitoring could be improved by providing contractors with specific reporting guidance to assure that submitted data measure comparable aspects of plan performance. Additionally, Oregon is requesting that its special exemption, which among other things exempts contracting plans from ownership and control disclosure requirements,[5] be continued under the demonstration project to allow it to contract with PCOs and fully capitated health plans that are not federally qualified HMOs. However, OMAP officials said in May 1992 that demonstration contractors will be required to meet federal disclosure requirements when contracts are signed.

Solvency monitoring and disclosure of ownership and control arrangements are of special concern in the demonstration, with its increased reliance on fully capitated plans. Expansion will add new contractors and subcontractors, some of which have limited experience with prepaid managed care and its financial risks. Subcontractors do not receive the federal and state financial oversight that primary contractors receive. As a result, less is known about their ability to manage the financial risks of a capitated payment system. Providers that are unable to manage the fluctuations in health service costs relative to capitation payments may be pressured to inappropriately reduce services or be forced out of business, causing disruptions in patient care. The demonstration proposal does not specify to what extent, if any, the state plans to include subcontractors, particularly those assuming risk for a comprehensive range of services including inpatient care, in its solvency monitoring processes.

For health plans contracting under the demonstration project, Oregon proposes to add several requirements to the revised and strengthened financial reporting requirements adopted for the current program. Additional requirements include separating revenues by public and private sources, reporting health care costs by categories of service, and listing specific solvency indicators. The effectiveness of these additional requirements could be improved through reporting guidance to assure that

[5]Section 9522 of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272.

solvency indicators measure comparable aspects of plan performance. OMAP officials plan to provide contractors with such reporting guidance before the demonstration is implemented.

Federal regulations require health plans to disclose information about ownership and control arrangements, criminal conviction of key personnel, and, if requested, significant business transactions with related parties. These requirements were enacted to help program managers detect and prevent fraud and abuse in federal health care programs. The Oregon program, as discussed in chapter 4, now is exempt from these requirements. The state proposes to continue the statutory exemptions that allow it to contract with PCOs and fully capitated plans that are not federally qualified HMOs, but OMAP officials said in May 1992 that plans will be required to meet federal disclosure requirements. This is important, since future expansions will include new plans in a variety of contracting arrangements.

Conclusions, Recommendations, and Agency Comments

Oregon has developed a managed care delivery program that is well accepted by providers and Medicaid clients and that has avoided many potential problems identified in programs in other states. The program has several of the safeguards we have recommended to prevent inappropriate restrictions to health care, and its quality assurance mechanisms are in place.

Oregon's current program, while generally sound, could be improved in several areas. Although quality assurance mechanisms indicate that well-child screening services should be improved, the state's response has been slow to produce specific improvement plans. The usefulness of OMAP's client opinion surveys also could be improved.

Oregon's current systems for assessing and monitoring health plan solvency merit attention. OMAP has taken steps to improve its reviews of health plan solvency, but the effectiveness of these changes could be further improved. OMAP could do this by defining the solvency indicators and evaluation criteria it will apply and by providing guidance to the plans on what items to include in various revenue and expense categories.

The substantial expansion proposed under Oregon's demonstration project, if approved by the Secretary of HHS, makes the quality assurance and solvency monitoring improvements noted above more important. Program expansion involving a variety of contracting arrangements and a greater reliance on fully capitated plans increases the need for state Medicaid staff to know and understand their contractor network, both to monitor contractor solvency and to detect and prevent Medicaid fraud. Given contractor dissatisfaction with the current level of reporting, it is not clear how the state will overcome the health plans' reluctance to supply more detailed financial information in the future.

Oregon does not plan either in the current Medicaid managed care program or in the proposed demonstration to monitor health plan subcontractors for solvency. We believe subcontractors that assume financial risk in the Medicaid managed care system for a service package that includes inpatient care should be subject to state solvency monitoring requirements.

Indications of strained capacity in Oregon's current managed care program, a need for rapid and substantial expansion, and health resource shortages in parts of the state raise concerns about Oregon's ability to meet its demonstration project capacity goals. The demonstration depends

on managed care delivery (and the prioritized service package) to achieve the savings necessary to help offset the costs of the expanded Medicaid enrollment. The ability to earn program savings from managed care, however, depends upon the availability of adequate managed care capacity. If too few managed care providers participate in the demonstration, or if prepaid providers cannot remain in business, many enrollees would have to be treated under fee-for-service Medicaid, thereby increasing costs. Failure to achieve the projected cost savings could strain the demonstration financially and create pressure to reduce the service package or increase state and federal Medicaid expenditures.

Recommendations

We are not taking a position on whether the Secretary of HHS should approve or disapprove Oregon's Medicaid demonstration proposal. We do, however, recommend improvements in Oregon's current Medicaid managed care program, and, if the Secretary approves the demonstration proposal, that certain requirements be met.

Provider Capacity

If the Secretary of HHS decides to approve Oregon's Medicaid demonstration project, we recommend that the Secretary direct the Administrator of HCFA to require Oregon to demonstrate, by binding letters of intent or other means, that adequate health plan and physician capacity can be put in place to serve the expected client population before it allows Oregon to implement the project. Provider capacity relative to managed care enrollment should be monitored carefully throughout project implementation.

Quality of Care

We recommend that the Secretary, through HCFA, direct Oregon to continue to improve quality assurance activities in the current program. Specifically, Oregon should intensify its efforts to improve the delivery and documentation of well-child screening services, which were identified as a weakness by OMPRO and GAO consulting physicians. Oregon also could increase the usefulness of its client satisfaction survey by revising the questionnaire and survey methods.

Monitoring Financial Solvency

We recommend that the Secretary, through HCFA, direct Oregon to improve its monitoring of contractor financial solvency in the current program, by such steps as (1) developing reporting guidance for the contractors to ensure that the state's adopted solvency indicators measure comparable

aspects of financial performance and (2) adopting evaluation criteria in the form of ranges or limits for use in assessing solvency indicators.

Further, we recommend that the Secretary, through HCFA, direct OMAP to require risk basis subcontractors of fully capitated health plans to meet standards for financial solvency. Specifically, entities subcontracting with fully capitated plans to provide a comprehensive range of services, including inpatient care, should be subject to the same solvency monitoring requirements as those for fully capitated plans.

Financial Disclosure Requirements

We recommend that the Secretary, through HCFA, require Oregon to meet Medicaid disclosure requirements in both its current Medicaid managed care program and the proposed demonstration project, if approved.

Agency Comments

We did not obtain written comments from HCFA or the state of Oregon's Office of Medical Assistance Programs on this report. We did, however, give officials of those agencies a draft of the report, and we met with them in May 1992 to discuss their comments. We have incorporated their views as appropriate. HCFA had no comments on our recommendations. Oregon's specific comments on our recommendations are summarized below.

Provider Capacity

Oregon disagrees with our recommendation that the state be required to demonstrate to HCFA that adequate provider capacity is available before it is allowed to implement the demonstration. Oregon believes evidence points to adequate delivery system capacity. Nevertheless, Oregon says it will require interested health plans to submit within 2 weeks after the waiver is approved binding offers that will specify capacity for enrollment under the demonstration. Given this information, Oregon will be able to determine whether adequate provider capacity is available to serve Medicaid clients in the appropriate locations. Oregon feels strongly that implementation should not be delayed unless capacity shortfalls are severe enough to outweigh the demonstration's benefits overall.

We believe that adequate managed care provider capacity is essential if the Oregon demonstration is to achieve the cost savings it needs for overall success and to avoid pressures to reduce client services. Evidence of interest among Oregon providers is encouraging. Nonetheless, we believe that HCFA should review provider capacity with Oregon before allowing

service delivery to begin and monitor the adequacy of capacity as the demonstration progresses.

Quality of Care

Oregon does not believe our recommendations for improving quality assurance activities are justified, because the current program has shown recent improvements in well-child services and quality assurance efforts. Oregon believes a deliberate, consensus-building approach to improving well-child services will be more effective than policing the behavior of individual plans. OMAP does not agree that its client surveys need improvement in order to be useful as monitoring tools.

While recognizing that efforts are underway in Oregon to improve well-child services, we believe these efforts should be intensified to produce earlier, more specific improvement, strategies, and results. Revisions to Oregon's client opinion surveys could improve results not only for monitoring purposes, but also for evaluating the program in general.

Monitoring Financial Solvency

Oregon says that it will provide financial reporting guidance to its contractors, possibly by June 1992, to ensure that submitted data are uniform. For the current program, solvency indicators and evaluation criteria suggested by the financial consultant will be incorporated into reporting guidance.

OMAP believes that monitoring subcontractors for compliance with access and quality standards provides more timely notice of financial distress than periodic reports on financial status. OMAP believes requiring subcontractors to meet standards for financial solvency is unnecessary and might jeopardize participation in the program, thereby jeopardizing program capacity.

We support Oregon's plans to improve financial reporting by its contractors and the methods of monitoring health plan solvency. We believe, however, that our recommendation is justified to the extent that subcontractors assume risk for a wide range of services (especially inpatient services), as is anticipated under Oregon's demonstration proposal.

Financial Disclosure Requirements

OMAP officials told us they will require contractors in the current program beginning in October 1992, and in the demonstration project beginning with the first contracts, to disclose ownership, control, and other information. They noted that Oregon's exemption from the usual disclosure requirements was inadvertent and unintentional.

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Susan D. Kladiva, Assistant Director, (202) 512-7114 Richard Jensen, Assignment Manager
Seattle Regional Office	Frank Pasquier, Assistant Director Ellen M. Smith, Evaluator-in-Charge Cheryl Williams, Evaluator Patricia Padilla, Evaluator Stanley G. Stenersen, Evaluator Dwayne Curry, Evaluator

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