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MEDICAID

Factors to Consider in Managed Care Programs

Statement of Janet L. Shikles, Director
Health Financing and Policy Issues
Human Resources Division

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SUMMARY

Medicaid is being severely strained by the continuing rise in the size of its population and cost. At the same time this tremendous growth is occurring, however, there is general unhappiness with the traditional fee-for-service Medicaid program. Federal and state policy makers are turning to managed care as a possible way of getting better access and quality for the money they spend.

"Managed care", or "coordinated care" as it is sometimes referred to, is widely used in private sector health care. Generally it refers to a health care delivery system with a single point of entry. A primary care physician participating in the health plan provides basic care and decides when a referral to a specialist or admission to a hospital is necessary.

Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency. In our work on Chicago health maintenance organizations we reported on incentives to underserve when the financial risk of providing care was passed down to a single physician or small group of physicians. We also found inadequacies in quality assurance programs, utilization data, and follow-up to correct quality of care problems.

Results from our current review in Oregon, however, indicate that concerns about these problems can be lessened through oversight and appropriate safeguards. In developing its program, Oregon put a number of safeguards in place to prevent providers from inappropriately reducing service delivery and quality. In its proposed demonstration, however, Oregon has raised other concerns about provider capacity and financial oversight such as disclosure of ownership and control information.

Managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives in such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for recipients. States need to monitor contractors and subcontractors to ensure that financial arrangements are not in place that could induce providers to inappropriately reduce services. Further, states should require plans to routinely disclose ownership and control information.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to testify on the role of managed care in state Medicaid programs. GAO has been looking at these programs for years and currently has a number of reviews underway. More recently, we reviewed the managed care program in Oregon. Our report on this program was issued a week ago.[1] Based on this body of work we have gained insights that may be helpful to the Congress as it considers removing barriers to states' use of managed care in the Medicaid program. As you requested, today we will focus our comments on the financial oversight needed in the Medicaid managed care programs.

BACKGROUND

Medicaid, the largest government program financing health care for the nation's poor, is being severely strained by the continuing rise in its size and cost.[2] Faced with continued growth in the number of Medicaid eligibles and program costs, federal and state policy makers are turning to managed care as a way of getting better access and quality for the money they spend.

"Managed care", or "coordinated care" as it is sometimes referred to, is widely used in private sector health care. Generally it refers to a health care delivery system with a single point of entry. A primary care physician participating in the health plan provides basic care and decides when a referral to a specialist or admission to a hospital is necessary. Usually the health plan receives a set monthly fee (called a capitation payment) to provide care and is then put at financial risk. That means that if the cost of services provided to an enrollee is greater than the fee received by the health plan, the health plan loses money.

Managed care plans in Medicaid cover a wide variety of health delivery arrangements. These range from health maintenance organizations (HMOs) that are capitated for providing all health

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[1]Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992). We are also conducting a review of Medicaid managed care programs throughout the country, at the request of the chairman of the House Subcommittee on Oversight and Investigations.

[2]From 1989 to 1991, total recipients increased almost 18 percent, to 27.7 million. This number is expected to reach 30.1 million in 1992. For 1992, expenditures are estimated at $127.2 billion, a 38 percent increase over the 1991 total of $92.2 billion. Some predictions see Medicaid matching--if not exceeding--the size of the Medicare program by the middle of this decade.

services an enrollee needs, to groups of physicians in independent practice who are paid a small case management fee in addition to fee-for-service payment for managing other services delivered (primary care case management).

In the 1980s, the federal government increased states' options for use of managed care delivery programs as a way to contain costs in the Medicaid program. Although there have been managed care programs in Medicare and Medicaid since the 1970s, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981 -- P.L. 97-35) gave states greater flexibility in contracting with HMOs or other managed care health plans. OBRA 1981 also allowed the Secretary of Health and Human Services, through HCFA, to grant states waivers of federal Medicaid rules--specifically, the requirement that clients have a free choice of providers to permit the states to develop, among other things, managed care systems.[3]

The Administration, facing the same pressures from program growth as the states, is advocating managed care as a potential solution to problems of cost, quality, and access for Medicaid clients. The President's Comprehensive Health Reform Program presented in February 1992 proposed a radical transformation of the Medicaid program from a fee-for-service system to a managed care system.

SAFEGUARDS AND OVERSIGHT ARE CRUCIAL IN MANAGED CARE PROGRAMS

To make managed care work, adequate safeguards and oversight are crucial. Our previous reviews of Medicaid managed care programs have identified problems with access to care, quality of services, and oversight of provider financial reporting, disclosure, and solvency.[4] For example, our 1990 report on

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[3]By 1991, 32 states and the District of Columbia had one or more managed care plans for Medicaid recipients. Medicaid managed care enrollment increased from 187,340 in 1981 to 2,837,500 in 1991, and growth is expected to continue. Approximately 11 percent of all Medicaid recipients currently are enrolled in managed care programs. Of this total 36 percent are in HMOs and 45 percent are in primary care case management fee-for-service programs.

[4]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).

Chicago area HMOs participating in managed care under contract to the Illinois Medicaid agency, illustrates the abuses that can occur if safeguards and oversight are not adequate.

In Chicago, the HMOs were paid a capitated rate by the state for providing care, thus assuming the financial risk of providing the care. In some instances, however, the HMOs subcontracted with medical groups or individual practice associations, who would then contract for services with primary care physicians. At each stage the financial risk of providing care was passed along in the form of a capitation payment. This resulted in a large amount of risk being placed on an individual or small group of physicians, increasing the likelihood that clinical decisions would be inappropriately influenced by the cost of implementing those decisions.[5]

We also found inadequacies in the Chicago HMOs quality assurance programs, utilization data, and follow-up to correct quality of care problems. Although the disenrollment mentioned above could indicate widespread dissatisfaction with the services being provided, the state did not conduct, or have the individual HMOs conduct, patient satisfaction surveys. Despite warnings from both the contracted peer review organization and state quality assurance staff about a lack of services provided to enrollees, the state did not move quickly to determine whether there was a documentation problem or needed services had actually not been provided.

While we found serious problems with the transfer of financial risk in the Medicaid managed care program in Chicago, our current review of Oregon indicates that problems can be lessened through oversight and appropriate safeguards. Oregon's Medicaid managed care program does not place excessive financial risk on small groups or individual physicians.

The Oregon program, which began in 1985 with HCFA approval, has grown gradually to an enrollment of about 73,000, primarily women and children. The state has contracts with 22 health service providers, with enrollments ranging from 1,000 to more than 16,000 Medicaid managed care clients. All but two of these providers are capitated for physician and outpatient services only. Inpatient services for these Medicaid clients are provided on a fee-for-service basis.

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[5]One possible indication that Medicaid recipients enrolled in the Chicago HMOs were having trouble getting needed services was their high turnover rate. Over 58,000 Medicaid recipients voluntarily left their HMOs during fiscal years 1986 through 1988 to return to fee-for-service.

In developing its program, Oregon put a number of safeguards in place to help prevent inappropriate reductions in service delivery and quality.[6] For example,

-- the state limits the financial risk most providers assume to the cost of physician, laboratory, X-ray, and well-child services;

-- the state provides optional state-sponsored insurance (stop-loss) to limit the financial risk physician care organizations face;

-- the state pays a capped bonus to participating providers for savings from inpatient utilization below target levels, reflecting treatment decisions made by all physicians, as a group, for all Medicaid patients enrolled in that provider; and

-- the providers reported using incentive arrangements that pool their physicians and patients into larger rather than smaller groups. This is not among the riskier approaches identified in other reports.

To ensure adequate quality, Oregon requires providers to maintain internal quality assurance programs and annually conducts an independent review of medical records through a contract with a physician review organization. Further, Oregon assesses quality through a grievance procedure as well as client satisfaction and disenrollment surveys.

Although the Oregon program has avoided to date the problems of placing excessive risk on individual or small groups of physicians, as discussed in our recently released report, Oregon's proposal to expand significantly its managed care program raises other concerns. The state intends to triple the number of people that will be enrolled, and go statewide. We have concerns about the number of providers that will participate and whether financial disclosure occurs. To address these concerns, we have recommended that HCFA require Oregon to meet

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[5]The state currently has pending with the Secretary of Health and Human Services a proposal to substantially expand its Medicaid program. The demonstration project is designed to expand Medicaid eligibility to all persons with incomes up to 100 percent of the federal poverty level while redefining the scope of health care services the state will reimburse. Services will be provided through a managed care system that is moving toward full service prepaid health plans capitated to provide inpatient as well as ambulatory care. Full implementation is scheduled to begin six months after approval of the proposal.

the disclosure of ownership requirements under Medicaid, from which the state is currently exempt, and to improve its financial solvency monitoring. In addition, under the demonstration the state would be changing the financial arrangement with providers, and would depend on fully capitated health plans to a far greater degree. With such a change, the financial safeguards and oversight become even more important.

CONCLUSIONS

In conclusion, managed care programs can offer an opportunity to improve access to quality health care. Because of the financial incentives in such programs and the vulnerability of the Medicaid population, we believe a set of safeguards must be instituted to assure adequate protection for clients. In addition to requirements to ensure quality, we believe that HCFA should require states to have in place adequate financial safeguards and oversight as we have recommended for Oregon. Further, to reduce financial risks, we have additional recommendations for the states.

-- The states need to monitor the financial arrangements between the contracting plans and individual providers for incentives that could induce providers to inappropriately reduce services.

-- The states also need to monitor subcontractors that assume financial risk in the same manner as contractors because the same problems can arise.

-- States should require plans to routinely disclose ownership and control information.

-- Finally, states should use utilization data to determine if the appropriate amount of services are being provided.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions.

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