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MEDICAID

State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight

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Mr. Chairman and Members of the Committee:

I am pleased to be here today to testify on state flexibility to pursue innovative restructurings of their Medicaid programs. This hearing comes at a time when the Congress is searching for ways to slow down Medicaid spending growth. In response, many governors are asking the Congress for authority to initiate cost-conscious innovations without the burden of seeking federal waivers.

The urgency underlying cost containment in the $142 billion Medicaid program is readily apparent. Between 1985 and 1993, Medicaid costs tripled and the number of beneficiaries increased by over 50 percent. Medicaid growth outpaces that of most major items in the federal budget, including Medicare, and without modification, spending is likely to double in the next 5 to 7 years. It is also the fastest growing component of most state budgets at a time when governors and legislatures are under financial constraints and many are looking for ways to provide care to their uninsured populations.

My comments today will focus on (1) existing authority to waive Medicaid managed care restrictions, (2) the purpose behind such restrictions and the need for oversight in their absence, and (3) our concerns about the impact of recently approved waivers on federal Medicaid expenditures. This testimony is based on the reports we have issued over the years on states' experience with Medicaid managed care and on our recent work on statewide demonstration waivers under section 1115 of the Social Security Act. Appendix I contains a list of related GAO reports.

In brief, requiring states to obtain waivers to broaden use of managed care may hamper their efforts to aggressively pursue cost-containment strategies. At the same time, because current program restrictions on managed care were designed to reinforce quality assurance, their absence requires the substitution of appropriate and adequate mechanisms to protect both Medicaid beneficiaries and federal dollars. Finally, the reinvestment of managed care savings to expand Medicaid coverage to several million additional individuals suggests the need for up-front consultation with the Congress because of (1) the heavier financial burden such 1115 waivers may place on the federal government and (2) the issue of whether the U.S. Treasury should benefit from those savings.

OVERVIEW OF MEDICAID

Financed jointly by the federal government and the states, Medicaid is the nation's health care lifeline for 33 million low-income Americans--primarily women and children, but also the aged, blind, and disabled. By far, the majority of Medicaid funds are spent on behalf of this latter group. Although they represent only slightly more than a quarter of all beneficiaries, the aged, blind, and disabled incurred about 66 percent of Medicaid's expenditures in 1993. The per person cost of these beneficiaries was four times

more than the cost for women and other adults and seven times more than the cost for children. Moreover, long-term care spending for the aged, blind, and disabled--primarily nursing home care dollars--totaled just over one-third of overall Medicaid spending, only about 10 percent less than total expenditures on physician, hospital, and other acute care services.

In reality, Medicaid is not 1 but rather 56 separate programs that differ dramatically across states.[1] While federal statute mandates who at a minimum must be included as eligible for coverage and the broad categories of services that must be provided, each participating state designs and administers its own program within federal guidelines by (1) setting some income and asset eligibility requirements; (2) selecting optional groups and services to cover; (3) determining the scope of mandatory and optional services, for example, by limiting the number of covered hospital days per year; and (4) establishing the methods and amounts of provider payments. As a result of this flexibility, Medicaid eligibility and access to services vary considerably across states.

Currently, states must seek a federal waiver to diverge from the norm outlined in the Medicaid statute[2]--a statute whose fundamental reliance on fee-for-service and institutional providers has been changed little since the program's inception. Waivers are typically granted for between 2 to 5 years and states must reapply to continue their program innovations. Obtaining approval may take many months. Two waiver authorities have been widely used by states. Under section 1915(b) of the Social Security Act, more than 40 states require some portion of their Medicaid population to enroll in a managed care arrangement. Increasingly, states are seeking even greater flexibility in implementing statewide Medicaid managed care programs and are asking for authority to use potential savings to expand coverage to individuals not normally eligible for Medicaid. The degree of flexibility being sought is only available through demonstration waiver authority established by section 1115 of the act.

1115 WAIVERS PROVIDE THE MOST MANAGED CARE FLEXIBILITY

The Medicaid statute--drafted in the mid-1960s--reflects a bias toward the state-of-the-art health care delivery system of that era. However, that system has evolved considerably. Unrestricted choice of providers reimbursed on a fee-for-service basis has been superseded in importance by a continuum of managed

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[1]All 50 states plus the District of Columbia, Puerto Rico, and the four U.S. territories have Medicaid programs.

[2]Title XIX of the Social Security Act.

care delivery systems.[3] In 1993, about 60 percent of individuals with health benefits sponsored by large employers were enrolled in some type of managed care plan--up dramatically from a decade ago. In contrast during that same year and prior to the implementation of recent statewide 1115 Medicaid waivers, only 14 percent of Medicaid recipients--primarily women and children--were enrolled in managed care. To mandate enrollment of Medicaid recipients in a managed care plan, a state must either obtain a 1915(b) program waiver or an 1115 demonstration waiver. Section 1115 waivers provide a state the most flexibility in implementing a managed care program.

While states need no special authority to encourage voluntary enrollment in a managed care plan, the beneficiary must have a choice of fee-for-service and be allowed to disenroll at will. Two other options require a federal waiver under section 1915(b):

-- mandatory enrollment in multiple HMO systems with disenrollment allowed on a monthly basis (or every 6 months if an HMO meets certain federal requirements), and

-- mandatory enrollment in a physician gatekeeper system where the physician is either paid partially on a per patient basis or reimbursed under fee-for-service.

Section 1915(b) authority has been widely used since its enactment

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[3]Though no commonly accepted definition exists for the term "managed care," a number of features are typically associated with it: (1) provider networks with explicit criteria for selection, (2) alternative payment methods and rates that often shift some financial risk to providers, and (3) utilization controls over hospital and specialist physician services. Despite the confusing nomenclature used to distinguish a variety of managed care plans--HMO, PPO, PCCM--most include one or more of these common cost control features. Health maintenance organizations (HMO), the most tightly controlled type of managed care plans, require patients to use affiliated physicians who may be salaried, paid on a per capita basis (often referred to as "capitated"), or be reimbursed for each service. Typically, a patient's care, especially referrals to specialists and hospitalization, is coordinated by a primary care physician--often called a "gatekeeper." Preferred provider organizations provide enrollees with a financial incentive--lower cost sharing ("copays")--to receive care from a network of providers that are normally reimbursed at a discounted rate. Finally, many state Medicaid programs have conducted substate experiments using a primary care case management approach in which physician gatekeepers must provide authorization to see a specialist or obtain hospital care. Gatekeeper physicians may be partially capitated or paid for each service delivered.

in 1981. As of March 1995, 42 states operated 1915(b) waiver programs. These programs were primarily substate and involved physician gatekeepers rather than HMOs. To receive a waiver, a state must show that managed care will cost no more than its fee-for-service program, will not diminish access to adequate quality care, and will not adversely affect access to emergency care or family planning services. Authority to operate a 1915(b) waiver program may be renewed every 2 years.

Despite the availability of 1915(b) waivers, state officials believe that a number of provisions in the Medicaid statute inhibit implementation of broader managed care programs, particularly those involving HMO-style capitated plans. These provisions--the so-called 75/25-percent rule and the beneficiary enrollment lock-in provision--can only be waived under section 1115. Appendix I delineates the additional flexibility available under an 1115 waiver compared with 1915(b) waivers.

In keeping with the designation "demonstration," 1115 waivers have typically been granted for research purposes. Applications must include a formal research methodology and provide for an independent evaluation. Section 1115 waivers may be granted at the discretion of the Secretary of Health and Human Services for any demonstration project likely to assist in promoting the objectives of Medicaid. They are generally granted for between 3 and 5 years.

Prior to 1993, use of 1115 waivers to establish mandatory Medicaid managed care programs was very limited.[4] However, to deal with pressures to contain costs while confronting the problem of the uninsured, a number of states have turned to section 1115 demonstration waivers. In an ambitious experiment, the Clinton administration has approved 10 statewide 1115 demonstrations to determine if the Medicaid program can actually save money while simultaneously expanding coverage to several million new beneficiaries. Nine more states have pending waivers, including New York, and other applications are anticipated. Approval of 1115 demonstration waivers has been facilitated by the administration's 1993 commitment to streamline the review process and to be more flexible in assessing whether waivers increase federal costs.

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[4]Two waivers were granted in 1982 to Arizona and Minnesota. Heretofore, Arizona had not participated in Medicaid. While Arizona established a statewide mandatory program under its waiver, the Minnesota program only operated in the Minneapolis metropolitan area and one rural county.

OVERSIGHT NEEDED FOR TRANSITION TO MANAGED CARE

Medicaid's restrictions on states' use of managed care reflect historical concerns over quality. In the 1970s, reports on quality of care problems in Medicaid HMOs--the predominant form of managed care at the time--prompted the Congress to enact certain provisions intended to ensure that health plans provide public clients the same standard of care available to private clients. The stipulation that more than 25 percent of a health plan's total enrollment consist of private-paying patients was intended as a proxy for quality since such patients presumably have a choice of health plans and can vote with their feet. A second provision allowing Medicaid beneficiaries to terminate enrollment in a health plan at almost any time aims to provide them a similar capacity to express dissatisfaction over the provision of care.

Beneficiary protections are essential because of the financial incentive to underserve inherent in managed care plans that are paid, and are themselves paying providers, on a per capita rather than on a per service basis. Large private sector employers have recognized the importance of adequate oversight and are demanding strong quality assurance systems.

The Health Care Financing Administration (HCFA) also seems cognizant of the need for adequate oversight. In agreeing to waive some of the traditional requirements aimed at ensuring managed care quality, it has required states under the terms and conditions of section 1115 waivers to operate alternative quality assurance systems and to collect medical encounter data that allow service use and access to be monitored. States can indicate their commitment by the resources and effort they devote to implementing and operating their oversight functions.

Our reviews of Oregon's experience with both a 1915(b) substate waiver and its recently initiated statewide 1115 demonstration suggest a significant commitment to maintaining adequate oversight. Oregon implemented its 1115 Medicaid demonstration only after a considerable planning and design effort. Its implementation planning began more than 5 years ago and included numerous community meetings and consultation with providers--some of whom were already participating in its substate managed care program dating from the mid-1980s. According to officials, lessons learned from this earlier effort have helped the state to implement its more ambitious statewide managed care program more effectively. As part of its program to enroll the aged, blind, and disabled, the state worked with advocacy groups and consumers to develop additional safeguards for these more vulnerable populations.

Oregon has implemented an array of safeguards designed to ensure access and quality. It requires plans to limit the

financial pressure on any one provider in an effort to guard against underservice. The state also adopted an extensive quality assurance program that requires plans to maintain internal safeguards and to contract annually for an independent examination of medical records by a physician review organization. Oregon uses client satisfaction and disenrollment surveys and a grievance procedure to further monitor quality. Finally, for the disabled and other persons with serious illnesses, it requires health plans to provide "exceptional needs care coordinators" and makes special ombudsmen available to handle grievances.

SOME STATES' 1115 WAIVERS COULD INCREASE FEDERAL SPENDING

In approving recent statewide 1115 Medicaid waivers, the administration has entered into 5-year budget commitments that allow each state to reinvest managed care savings and to redirect other funds in order to expand coverage to currently uninsured individuals. Compared with expenditure trends for the pre-demonstration programs, waiver states declare that the net result will be lower costs--even though managed care savings are being reinvested. The administration has given the federal stamp of "budget neutral" to all approved 1115 demonstrations, asserting that they will cost no more than continuation of the smaller pre-waiver programs. We disagree.

Three of four approved 1115 waivers we examined in detail provide access to additional federal Medicaid funds to help finance state coverage expansion goals. Only Tennessee's demonstration costs no more than the continuation of its smaller, pre-waiver program and, in fact, should result in savings. The spending limits for approved waivers in Oregon, Hawaii, and Florida are not budget neutral and could increase federal Medicaid expenditures. Overall, net federal spending in these four states could potentially exceed what Medicaid program expenditures would have been by several hundred million dollars over the duration of the waiver programs. Though the net additional federal funding is small in relation to demonstration spending allowed under federal expenditure caps, federal Medicaid costs could grow significantly if the administration shows a similar flexibility in reviewing additional waivers.

We believe that the granting of additional 1115 waivers merits further congressional scrutiny. Even if the proposed demonstrations did not require new federal dollars, the administration's approval of coverage expansions means that anticipated Medicaid savings will not be available to reduce federal spending. At issue is whether the U.S. Treasury should benefit from these savings and whether eligibility should be made available for new groups only after congressional debate and legislative action. Furthermore, Congress may face two equally unattractive alternatives if 1115 demonstrations exceed federal

spending caps: (1) increasing federal funding or (2) relying on states to reduce benefits or deny coverage to hundreds of thousands of people newly enrolled under the waivers. Consequently, we believe that demonstration waivers granted for a limited period may be a shortsighted approach to reducing states' uninsured populations.

CONCLUSIONS

Over 33 million low-income women, children, aged, blind, and disabled Americans depend upon health care made possible by the Medicaid program. However, the program's double-digit spending growth rate imperils efforts to bring the federal budget deficit under control. Consistent with the Committee's interest in constraining federal spending, states believe they need the flexibility to manage their own programs. Requiring states to obtain waiver approval in order to aggressively pursue managed care strategies may hamper their cost-containment efforts. Yet, because current program restrictions on managed care were designed to reinforce quality assurance, in their absence, continuous oversight of managed care systems is required to protect both Medicaid beneficiaries from inappropriate denial of care and federal dollars from payment abuses. Finally, the potential for increased federal spending under future statewide demonstrations suggests the need for greater consultation with the Congress.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the other Committee Members may have.

For more information on this testimony, please call William J. Scanlon, Associate Director, at (202) 512-4561. Other major contributors included Walter Ochinko and Richard Jensen.

APPENDIX I

COMPARISON OF MANAGED CARE FLEXIBILITY AVAILABLE UNDER 1915(B) VERSUS 1115 WAIVERS

1915(b) program waivers	1115 demonstration waivers
HMOs must still the meet federal requirement for more than 25 percent private enrollment	HMOs may enroll Medicaid patients exclusively
Full range of mandatory services must be offered	Benefits package may be modified
Enrollment lock-in limited to 1 month[a]	Enrollment lock-in may be extended to 12 months
No restrictions on access to family planning providers	Access to family planning providers may be restricted

[a]The lock-in is 6 months for an HMO meeting certain federal qualifications.

RELATED GAO PRODUCTS

Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, April 28, 1995).

Medicaid: Spending Pressures Drive States Toward Program Reinvention (GAO/HEHS-95-122, April 4, 1995).

Medicaid: Restructuring Approaches Leave Many Questions (GAO/HEHS-95-103, April 4, 1995).

Medicaid: Experience With State Waivers to Promote Cost Control and Access to Care (GAO/T-HEHS-95-115, March 23, 1995).

Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs (GAO/HEHS-94-167, Aug. 11, 1994).

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (GAO/HRD-93-67, May 7, 1993).

Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46. March 17, 1993).

Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, April 10, 1992).

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

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, August 27, 1990).

Medicaid: Lessons Learned from Arizona's Prepaid Program (GAO-HRD-87-14, March 6, 1987).

Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

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