HB 393

HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: April 3, 1996 **FURTHER REFERRALS:**

Date of Committee Action: 4/12/96

The FINANCE Committee considered: **HB 393**

HOUSE BILL NO. 393 **MANAGED CARE PROGRAM FOR MEDICAID**

"An Act relating to managed care for recipients of medical assistance; and providing for an effective date."

recommends it be replaced with the following committee substitute CSHB393(FIN) [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee

[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [X] zero fiscal note(s) DHSS; 3/27/96

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
Foster	X			
Hanley	X			
Mulder	X			
Martin	X			
Parnell	X			
Kohring	X			
Grussendorf	X			
Brown			X	
Kelly			X	
Therriault			X	

CO-CHAIR'S SIGNATURE: Mark Hanley Hanley Richard Foster Foster

STATE OF ALASKA
1996 LEGISLATIVE SESSION

Bill Version: CSHB 393(HESS)
(H) Publish Date: 3/27/96

Revision Date:
Title: "An Act relating to managed care for recipients of medical assistance; ..."
Sponsor: Rep. Rokeberg
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Services
COMPONENT SERIAL NO. 2077
See also (SN#):

Expenditures/Revenues: (Thousands of Dollars)

OPERATING EXPENDITURES	FY97	FY98	FY99	FY00	FY01	FY02
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES (	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1037 GF/Mental Health	0.0	0.0	0.0	0.0	0.0	0.0
Other (please specify)	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY98) cost: $0.0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

HB 393 charges the Department of Health and Social Services with development of managed-care or capitated health care systems for recipients of medical assistance. A project is already underway within the division to accomplish the purposes of HB 393 with completion scheduled for June of 1996. For this reason there is no cost shown on the fiscal note for the development of the managed care system.

The Division of Medical Assistance began a project in late 1995 that is expected to identify the appropriate approaches for managed care for medical assistance programs and the steps necessary for implementation. This project is to be completed by June of 1996. Division staff are being assisted by a contractor in review of program cost and utilization data to identfy those medicaid services that may be successfully administered under a managed care approach. Identification of recipient participation requirements is included in the contract. The contractor is familiar with managed care arrangements used by medical assistance programs of other states and will help division staff to identify those which appear practical for Alaska based upon historical cost and utilization data and the availability of health-related resources in Alaska.

Prepared by: D. Williams
Division: Division of Medical Assistance
Phone: 465-3355
Date: 01/17/96

Approved by Com: Karen Perdue, Commissioner
Agency: Department of Health & Social Services
Date: 1-23-96

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ALASKA STATE LEGISLATURE
House of Representatives

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Representative Norman Rokeberg

Sponsor Statement CSHB 393(HES)
"An act relating to managed care for recipients of medical assistance; and providing for an effective date"

The debate in Congress over Medicaid is focused on two proposals: replacing Medicaid with block grants ("MediGrants") to the states or instituting a *per capita* cap on the federal contribution to Medicaid spending. The former plan would remove the individual entitlement, which guarantees services to eligible persons; the latter would retain the individual entitlement. Both plans would offer states unprecedented flexibility in administering their programs but there will be significant reductions in federal funds.

As the costs of medical care rises, managed care is a way of ensuring a high level of care while keeping costs down. Medicaid costs have risen by more than 50 percent over the last four years, and will cost the state $336 million dollars this year.

Persons eligible for Medicaid include the Aid to Families with Dependent Children group -- AFDC adults, poor pregnant women, and generally healthy, but poor children; and the SSI-related group -- the elderly and persons who are aged, blind and disabled. The AFDC-related group represents about 71 percent of all Medicaid recipients nationwide, but accounts for only about 30 percent of all spending.

Medigrants will distribute funds to states without regard to the particular needs and circumstances in a state and literally ignores changes in enrollment. HB 393 will prepare the state for changes in Medicaid funding at the federal level. The bill ensures adequate public debate over the issue. HB 393 asks the Department of Health and Social Services to develop legislation creating a managed care program for Medicaid.

Managed care replaces current "fee for service" program with one that requires recipients to use designated doctors and other medical providers to be eligible for benefits. Recipients can use only pre-approved doctors. At recent count, 43 states have some form of managed care in their programs.

HB 393 makes sure that the program developed by the department is one that takes into account the views of the public, the medical community and the legislature. A managed care program developed by the department should be crafted with input from everyone affected by the program. ***The legislature should have a voice in this matter.***

Furthermore, the department has already begun working on a Medicaid Managed Care Project. As recent as October 1995, an RFP was awarded to a health management company to assist the Division of Medical Assistance in a draft five-year managed care plan. HB 393 will require legislative approval of a plan, and allow the department to have the benefit of public debate surrounding this issue.

HB 393 is a timely bill. I urge your support for this legislation.

Adopted

AMENDMENT # 1

OFFERED IN THE HOUSE FINANCE COMMITTEE

TO: CS HB 393 (FIN) version K

Page 2, line 17, after "submit":

Insert "through the governor"

Page 2, line 17, after "would":

Delete "authorize"

Insert "provide for"

9-LS1451\K
Lauterbach
4/10/96

Adopted 4/12/96 Fr

CS FOR HOUSE BILL NO. 393( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINETEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG

A BILL

FOR AN ACT ENTITLED

"An Act relating to managed care for recipients of medical assistance; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* **Section 1.** FINDINGS AND PURPOSE. The Legislature finds that

(1) the Medicaid program has provided adequate health care for low income individuals in the state since its enactment in Alaska in 1972;

(2) Medicaid program costs have increased an average of 13.9 percent a year over the past five years, and the number of eligible individuals has grown from 57,251 in 1991 to 86,445 in fiscal year 1995 due to the addition of services and eligible groups by the Congress and the Alaska State Legislature;

(3) Medicaid program management has evolved from a fee-for-service payment structure to a point where, by 1995, 94 percent of the states include some type of managed care model in at least one geographic area of their state;

(4) primary care case management offers an effective system of care, similar

to the existing fee-for-service environment, which can generate program savings and preserve quality of care, and which has been successful in both urban and rural areas; and

(5) Alaska has many unique features due to the geography, weather, and wide dispersion of population centers that challenge the ability to have successful managed care systems in the state; however, the projected downturn in state revenue requires the state to seek creative solutions in providing health care coverage for low-income persons at a reduced cost in the future.

* **Sec. 2.** MANAGED CARE PROGRAM. (a) The Department of Health and Social Services shall begin development of a managed care system for recipients of medical assistance under AS 47.07 by designing and planning to implement two innovative managed care pilot projects. The projects must be in one or more predominantly urban areas of the state that take into account the unique features of the project areas and include a rural element, if feasible. The department shall involve affected consumers and providers of health care services in the probable project areas in the development of the managed care system that will be used in the projects.

(b) Upon developing a system required under (a) of this section, the Department of Health and Social Services shall submit draft legislation that would authorize implementation of the proposed system in two or more pilot project areas to the legislature on the first day of the First Regular Session of the Twentieth Alaska State Legislature.

(c) The draft legislation under this section may require that a recipient of medical assistance under AS 47.07 must participate in a managed care system in order to remain eligible for medical assistance under AS 47.07. This participation requirement may be based on geographical, financial, social, medical, and other factors that the Department of Health and Social Services determines are relevant to the development and efficient management of the managed care system.

(d) The draft legislation under this section may authorize the Department of Health and Social Services to apply for waivers of federal law or for other federal approval if federal approval is required in order to implement the pilot projects for the managed care system developed under this section.

* **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).

TANANA CHIEFS CONFERENCE, INC.
122 First Avenue, Suite 600
Fairbanks, Alaska 99701-4897
Phone 907/452-8251 • Fax 907/459-3850

Feb. 16, 1996

Rep. Con Bunde &
Rep. Cynthia Toohey
Co-chairs, HESS
House of Representatives
Mail Stop 3101
State Capitol
Juneau, AK 99801-1182

RE: HB 393

Dear Reps. Conde and Toohey,

I am writing on behalf of the Tanana Chiefs Conference, Inc. in general support of House Bill 393. We are aware that similar health delivery models have been implemented successfully in other states. Conceptually, we have no problem with recipients of medical assistance being served through a managed care model.

The bill does raise some questions about how Indian Health Service (IHS) beneficiaries will be treated under this bill. We note that Section 1(b) states *A system developed under (a) of this section MAY require that a recipient... participate.* Will IHS beneficiaries be exempt from participation under this clause, assuming they will continue to receive care at IHS funded facilities?

We would appreciate receiving any additional information to help us understand the full intent of HB 393, particularly as it applies to IHS beneficiaries. And, as always, the opportunity to comment is appreciated. Thank you.

Sincerely,

TANANA CHIEFS CONFERENCE, INC.

Eileen Kozevnikoff

Eileen Kozevnikoff
Director, Health Services

SUPPORT

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

March 21, 1996

Representative Con Bunde, Co-Chair
Representative Cynthia Toohey, Co-Chair
Health, Education & Social Services Comm.
Alaska House of Representatives
Juneau AK 99811-1182

Re: Support, HB 393
Medicaid Managed Care

Dear Co-Chair & Members House HESS:

Community hospitals and nursing homes support HB 393, directing the DHSS to develop a managed care or capitated health care system for Medicaid recipients.

Up until now, we have tended to dismiss "managed" care as not feasible in Alaska because of our small population and large (geographic) size, but the "no growth" Medicaid budget and/or potential reductions in Medicaid funding now mandates that we look at all options for the purchase and payment of health care.

Secondly, we understand HB 393 sponsor, Representative Rokeberg, is considering a substitute bill that would encourage the Department to work with provider groups in the development of a managed care option for the state, and that this plan would allow "pilot projects" to determine the feasibility of managed care before it is implemented statewide. These amendments strengthen HB 393.

Sincerely,

Harlan R. Knudson
President/CEO

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

[redacted]LASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662 • FAX (907) 561-2063

MAR 29 1996

March 26, 1996

Representative Norman Rokeberg
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Re: HB 393 Managed care for Medicaid beneficiaries

Dear Representative Rokeberg:

The Alaska State Medical Association has no position on your bill, HB 393.

We are aware that DHSS has contracted to develop plans for managed care for Medicaid beneficiaries.

Two of our committees will be considering HB 393:

Legislative Committee	March 30
Medicaid Physician Resource Committee	April 17

I shall let you know if an opinion of the Association emerges from these meetings. I realize that it is late in the session already and apologize for our slowness in addressing this important issue.

Sincerely,

Rodman Wilson, MD
Acting Executive Director

ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE

Division of Legislative Finance

P.O.Box 113200
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FAX (907) 463-4885

MEMORANDUM

DATE: January 8, 1996

TO: Representative Norman Rokeberg
Attn: Mia Costello

FROM: Jetta Whittaker
Fiscal Analyst

SUBJECT: Medicaid Funding

You asked for a five or ten year summary of Medicaid funding broken out by major funding source. The attached spreadsheet offers a funding history starting with Actuals from FY92.

In order to get you some information as soon as possible, I started with data that was fairly readily available. To present a history for the years before FY92 Actuals will take a bit more effort, in that General Funds summaries were not routinely done and the numbers will have to be calculated. If you would like me to pursue this further, please don't hesitate to call.

Department of Health and Social Services
Medicaid Funding - Total Funds, General Funds, and Other Funds*

	FY92	FY93		FY94		FY95		FY96
	Actual	Auth	Actual	Auth	Actual	Auth	Actual	Enacted
Medicaid Facilities	99,548.1	126,863.4	105,609.0	112,951.3	131,803.1	125,387.3	131,465.5	145,270.4
General Funds	49,970.2	63,221.1	52,751.5	56,827.2	66,176.3	62,925.4	65,130.8	72,765.9
Other Funds	49,577.9	63,642.3	52,857.5	56,124.1	65,626.8	62,461.9	66,334.7	72,504.5
Medicaid Non-Facilities	86,446.6	90,893.2	100,766.7	116,460.5	114,343.9	133,892.6	121,220.5	135,333.4
General Funds	42,957.4	44,839.1	50,695.2	58,291.5	57,004.8	66,226.0	61,058.4	66,473.6
Other Funds	43,489.2	46,054.1	50,071.5	58,169.0	57,339.1	67,666.6	60,162.1	68,859.8
Indian Health Services	12,672.6	16,529.8	16,673.2	16,698.0	20,150.9	19,822.0	21,149.0	24,432.7
General Funds	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Funds	12,672.6	16,529.8	16,673.2	16,698.0	20,150.9	19,822.0	21,149.0	24,432.7
Medicaid State Programs	3,954.6	5,174.7	4,601.6	11,784.9	17,444.5	19,385.2	19,353.8	19,945.2
General Funds	0.0	186.6	0.0	1,663.3	3,649.5	2,081.7	2,187.8	3,523.2
Other Funds	3,954.6	4,988.1	4,601.6	10,121.6	13,795.0	17,303.5	17,166.0	16,422.0
Waivers Services				11,485.6	724.7	8,881.5	4,006.2	11,248.8
General Funds				5,741.9	362.4	2,364.8	886.6	2,256.3
Other Funds				5,741.7	362.3	6,516.7	3,119.6	8,992.5
TOTAL	202,621.9	239,461.1	227,650.5	269,378.3	284,467.1	307,368.6	297,195.0	336,230.5
General Funds	92,927.6	108,246.8	103,446.7	122,523.9	127,193.0	133,597.9	129,263.6	145,019.0
Other Funds	109,694.3	131,214.3	124,203.8	146,854.4	157,274.1	173,770.7	167,931.4	191,211.5

* "General Funds" includes General Fund, General Fund Match, General Fund/Program Receipts, General Fund Mental Health,and General Fund Program Receipts/Designated. "Other Funds" includes mainly Federal Funds, but may also include some InterAgency Receipts.

ALASKA STATE LEGISLATURE
House of Representatives

Mar 12 1996

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Representative Norman Rokeberg

Memorandum

To: Representative Cynthia Toohey
Chair, House Health, Education and Social Services Committee

From: Representative Norman Rokeberg

Date: March 12, 1996

Re: Managed Care for the Alaska Medicaid Program

I thought you'd be interested in the attached pages taken directly from the Department of Health and Social Services FY 97 budget overview.

As this paper indicates, the department is aggressively pursuing managed care and has already awarded a contract for a review of managed care options for the Alaska Medicaid Program.

Without passage of HB 393, the public, health care providers, health care consumers and the legislature are left without a voice in the matter. The bill requires the department to introduce their managed care program in the form of legislation next year.

I believe the department will benefit from having this managed care discussion in the public forum. Again, I urge your support for HB 393.

BACKGROUND

EXAMINING MANAGED CARE ALTERNATIVES

Background

In FY 94, the Legislature provided a clear message that the Division should manage medical assistance programs to slow down the rate of growth in the program. (See Legislative intent statement, Ch. 3, FSSL.'. 94, page 21, lines 36-38). Some actions were taken during FY 94 to assure appropriate use of services, resulting in cost avoidance/savings of about $25 million. Many cost savings actions were enhanced or initiated in the past two fiscal years to achieve both the Legislative intent and the department's goals. The Division's Annual Reports provide brief descriptions of these activities, including contracting for case reviews and services, and initiating special projects for development of case management services and managed care programs. Some of these actions are designed to show an immediate reduction in costs, while others were begun with the knowledge that cost savings will not occur until later. Some cost-saving measures which, at first, appeared to promise savings were later found to be impractical because the action would result in utilization shifts to services which cost more, would be contrary to federal law, or cost more to administer than the service cost savings gained.

Managed Care

Building on the successes of the past two years, the division awarded a contract in the fall of 1995 for a review of managed care options for the Alaska Medicaid Program. This contract will update health care delivery information formerly contained in the now defunct State Health Plan, analyze expenditure information, review other states experiences in implementing managed care arrangements, and make recommendations for managed care delivery system options likely to work in the state. Because Alaska's health care system has not developed a managed care infrastructure, the division will not be able to simply purchase services from existing managed care networks. Movement into the managed care arena will necessitate the education of health care providers and fostering the development of health care delivery networks in addition to receiving required federal waiver approvals. The contract is timely, in that its recommendations should assist the division in dealing with Congressional restructuring, and budget reductions, currently being debated in Washington.

The division is giving special consideration to implementation in FY 97 of a managed care model called Primary Care Case Management (PCCM). The PCCM project would begin in selected areas of the state. PCCM is a case management system in which a patient enrolls with primary care provider for basic medical care. The primary care provider also manages the care of the patient, authorizing certain services such as laboratory, x-ray, and emergency room care. PCCM is the managed care model usually adopted in rural areas of the country where Health Maintenance Organizations (HMOs) don't exist.

This PCCM approach using physicians and mid-level practitioners, such as advanced nurse practitioners and physician assistants as case mangers, allows states to provide appropriate access for recipients to primary care, and to reduce unnecessary Medicaid expenditures. Under PCCM, Medicaid recipients typically are required to select a physician or mid-level practitioner who will be their case manager -- providing primary care services and authorizing in advance all other medical services (except for instances of bona fide emergency). In this way the primary care case manager functions as a "gatekeeper" for recipients who may over-utilize services and/or prescriptions. As a result of the responsibility vested in the case manager, the physician or mid-level practitioner provides more individual oversight of the recipient and, thereby, assures that the total use of services is appropriate. This effort increases the quality of care for those recipients and, at the same time, reduces expenditures for duplicative or overlapping and unnecessary services.

A waiver from the federal Health Care Financing Administration is required before the state may initiate a PCCM program. To obtain a waiver for this purpose the state must complete an application for review by the federal Health Care Financing Administration. The waiver application must clearly delineate and document the characteristics of the population to be served, the geographic area to be covered, the cost-efficiency of the proposed activity. An assurance must be made that the recipient's access to care is not limited. Waivers granted for this purpose have been relatively flexible, allowing states to design a program for physician enrollment as a primary care case manager that meets the particular need identified by the state.

be achieved. Insufficient provider participation is one common explanation of why existing programs have not expanded on a broader and/or statewide basis.

Thirdly, small-scale implementation also allows the conversion of systems to accommodate managed care and testing of the system on a more manageable number of providers and recipients before incorporating the program as a statewide initiative.

The AFDC and AFDC-related populations are clearly the most common groups of Medicaid recipients currently enrolled in any type of managed care program. Even states that now enroll SSI clients began their mandatory programs with AFDC populations.

CARE MANAGERS (PCCM PROGRAM)

In most states, medical care managers (or case managers) sign a provider agreement before they can participate in the program. In many instances, this agreement is an addendum to an existing agreement for the provision of services to Medicaid recipients. In at least one state, North Dakota, a separate agreement is not necessary as long as the physician has signed the standard provider agreement.

While the preference for care manager is a primary care physician, several states allow other practitioners and/or group providers to be care managers. In most instances, the allowance of other providers to manage care is a result of an insufficient number of physicians to meet the needs of the Medicaid population eligible for enrollment in the PCCM program. Roughly one-half of the states with PCCM programs permit nurse practitioners to be care managers. Several states allow federally qualified health centers, community/rural health centers, Indian health centers, and hospitals to be care managers. Of the states that do have nurse practitioner care managers, state licensing requirements stipulate that a close relationship must be in place between the nurse practitioner and a physician.

The PCCM model is often used within a broader capitated model as well, but it is then the managed care organization's responsibility to recruit providers and monitor performance.

Program specifications vary across states regarding the number of recipients a single care manager can manage and still provide sufficient access and quality of care. In general, the upper limit for the number of enrollees a single provider can manage ranges from 1,000 to 2,000.

As part of a managed care provider agreement, the provider must have a mechanism in place to provide 24-hour coverage. This ensures that there is an alternative to hospital emergency room care. The intention is to reduce inappropriate emergency room visits, thereby reducing overall program costs. Despite this 24-hour coverage requirement, controlling inappropriate emergency room use continues to be a constant battle across the country.

EDUCATION

The importance of managed care education for both providers and recipients cannot be understated. The amount of education that is offered never seems to be enough.

Based on the experience of other states, providers should be brought into the process as early as possible. If feasible, they should be included in the conceptual stages, well before implementation. This ensures that the provider community is aware of the plans and feels some ownership of the program. Adequate provider education in the early stages also tends to increase the ability to recruit needed providers. As an example, the State of Virginia received endorsement from the Virginia Medical Society for its PCCM program early in the implementation process and

experienced no problems in recruiting physicians for participation in the program. Nebraska, on the other hand, quickly implemented a PCCM plan without much recipient, provider, or advocate input, and is receiving a backlash from those groups excluded from the formation process.

The education of Medicaid recipients on available managed care programs and how to seek services once enrolled is a continuous process. States have tried a variety of methods of communication with hopes of improving the effectiveness of education. Methods include face-to-face meetings, brochures, and videos. The need for prior authorization for certain services and inappropriate use of emergency rooms are two areas with which states have the most compliance difficulty.

MOTIVATION BEHIND IMPLEMENTATION

In general, the motivation for a state to implementing a Medicaid managed care program is to increase access to care, to contain costs, or both. Regardless of which type of managed care program is implemented, access to care should increase, as long as the State assures adequate recruitment of providers and good contract oversight. The type of program implemented, however, greatly affects the ability to realize any cost savings. In general, because of the very nature of and risk associated with HMOs, i.e., controlled and directed utilization and focus on preventative care, implementation of HMOs provides the greatest opportunity to reap predictable program costs. The implementation of a PCCM program, on the other hand, may result in additional costs, at least in the beginning, due to an increase in the continuity of care and accessibility to providers. Decreased use of the emergency room for inappropriate/non-emergent care and decreased inpatient admissions are areas where savings can be realized. Note that Alaska may not see decreased emergency room use because of the unavailability of other providers.

COST

Cost reduction or containment is the major goal of most states when managed care plans are designed and implemented. HCFA requires through the waiver process that states show a cost savings therefore the evaluation of the managed care plan(s) includes a section that compares the cost of the Medicaid program under a fee-for-service reimbursement structure with the cost of delivering services under the managed care plan(s). All states have experienced cost savings when implementing managed care plans including the PCCM plan. Cost savings continue to accrue as long as the plans are in operation for most states. A few states have incurred additional costs when implementing a PCCM but that was usually due to providing better access for recipients at the same time fee screens paid to providers were increased.

Managed care plans save the most money in areas where recipients have an oversupply of providers. This oversupply may lead them to seek medical services more often than is appropriate. For example, the Physician Sponsor Plan in Michigan was initially implemented in Wayne County, Michigan. The City of Detroit is located in Wayne County. Wayne County's supply of doctors, hospitals, and other medical providers is plentiful. Recipients there often "doctor shopped", that is sought care from many different doctors which often resulted in increased costs without a corresponding increase in health status. Recipients were also observed using the emergency room of local hospitals for non urgent conditions. This practice added substantial expenditures to Medicaid costs. When the Physician Sponsor Plan, Michigan's PCCM plan, was introduced savings were experienced immediately because utilization patterns were changed. Studies have shown this did not result in a decrease of health status for enrollees.

Florida also experienced a immediate savings (20%) over the same fee-for-service population in the first ten months operation of MediPass, their PCCM plan. This savings was used for justification of the statewide expansion of the plan.

Other state's experience has mirrored Michigan and Florida, so managed care plans have become a popular way to decrease cost while improving access and offering quality care. As more of the state's population becomes enrolled in managed care, the base of fee-for-service recipients decreases which creates difficulty when attempting to figure cost savings. States usually project costs based on experience and inflation factors when the fee-for-service populations decreases. All states report cost savings but the amount or percentage of cost savings varies depending on the benefit structure, the number of enrollees, and the cooperation of the provider community.

PREVENTION SERVICES

The focus on prevention services by managed care organizations and models assumes recipients will be given preventive care, which will in turn result in lower overall costs because persons will receive necessary care before situations become acute. Since Alaska Medicaid does not currently offer many preventive services for adults, this may be reflected in the overall cost savings (or lack of savings) of any managed care plan that is implemented.

The success of a PCCM program, both in operational and financial terms, is highly dependent on recruiting a sufficient number of primary care providers to participate in the program. Within the HMO structure, the HMO is responsible for ensuring an adequate provider base. In the fee-for-service system, the individual must navigate the system and find providers willing to accept Medicaid. By transitioning to a PCCM program, the State assumes the responsibility of determining an adequate provider base and assuring recipient access.

QUALITY

While cost may be the first reason states look to managed care programs, another concern, that of quality, can also be addressed through the use of managed care plans. If patients are assigned a particular provider or set of providers, those providers can be held responsible in part for the health of their enrollees. Outcome measures are now being developed to help providers and patients become informed about best treatment methods. Measuring the quality of care also becomes easier if access by the patient is limited to a particular set of providers. Chart reviews are more complete if patients have a primary care provider who must either render or authorize medical care.

Michigan and Kentucky are among the states that give "report cards" to their PCCM providers that compare the PCCM's practice patterns with other like PCCM providers. The report cards serve a dual purpose, one of encouraging providers to bring their practice patterns nearer to the norm thus offering a positive incentive to providers and second, one of monitoring and eventually removing providers who continue to practice outside of accepted norms for a prolonged period of time.

As states gain greater experience with managed care programs and organizations they are becoming more sophisticated in looking for and measuring quality of care for Medicaid recipients.

ACCESS

States also look to managed care to help them guarantee access to quality medical care. In a fee-for-service system it is often assumed that recipients are able to access medical care when they need it. In a managed care system, recipients are assigned to providers. Underserved areas are quickly identified under this system and states can become proactive in encouraging more provider participation in the Medicaid program, especially in the areas known to have too few providers.

BARRIERS TO IMPLEMENTATION OF A MANAGED CARE PROGRAM

Although each state implemented its managed care program under its own set of circumstances and time constraints, common barriers are prevalent throughout the country.

LESSONS LEARNED

Each state interviewed emphasized that they had often made mistakes. Following is a summary of suggestions other states believe should be given careful consideration, when designing and implementing a managed care plan, so the mistakes they made will not be repeated.

- Communication with providers, recipients, agency staff, and the community is paramount to the success of the program. Communication must be begun early and sustained throughout the life of the endeavor.

- System design must be done carefully with adequate timeframes allowed for testing.

- Begin implementation in a small area and gradually increase the number of providers and recipients by bringing on other regions on a gradual basis.

- Form an advisory committee made up of providers to help in the design and implementation of the plan.

- Ask your provider community to be a part of the program at the very beginning of your design phase.

- Assign adequate staff to sustain your effort.

- Education of providers and recipients must be a primary focus of the program.

- Coordination with other state agencies helps ensure success.

- Carefully select your initial implementation area.

- Design a solid referral authorization system.

- Using contractors for the enrollment and education function is often a good idea.

- Be sure you have a commitment from the governor, legislature, and department to support the program.

Each of these components will be more fully developed in later sections of the report.

PROVIDER SUPPORT

As with any type of change, the provider community in most states has viewed the introduction of Medicaid managed care, at least initially, with apprehension and skepticism. However, states that have acknowledged early in the development stages that this may be a problem, and those who have taken actions to address it, have had more success in gaining provider support. For example, Colorado, Kansas, Kentucky, and Michigan had open lines of communication with their provider community and therefore engendered much support from them when their plans were implemented. South Dakota has instituted a four-month implementation process for both providers and recipients which is followed when managed care moves into a new county. This process has been successful in increasing awareness of the program and educating both providers and recipients in an organized and timely manner.

The problems encountered with providers include not involving them early in the implementation process, not educating them regarding the program and their participation, and failing to anticipate their fear of change and of the introduction of managed care. One result of each of these barriers has been difficulty in recruiting enough providers to sustain the program and to allow it to meet its primary objective: linking each eligible Medicaid recipient with a primary care physician. Although involving providers in the development stage may slow the planning and implementation process, states agree the feelings of provider ownership that can be generated by this process reaps many later rewards in terms of provider participation.

Alaska in particular may have a difficult time convincing providers that the introduction of managed care will not adversely affect them. Some providers may have moved to Alaska to escape managed care, while others have never been a part of a managed care system, but have heard from colleagues in the lower 48 states of the negative impact of managed care on a private physician's practice.

HMOs often have the most difficulty recruiting providers in geographic areas which have not previously experienced capitation or risk. The FFS system has worked well for providers and there is distrust of any arrangement where the goal is cost containment. Also, HMOs introduce another administrative layer and, often, standards of participation.

ENROLLMENT

The management of the program, specifically as it relates to tracking enrollment and eligibility, has posed major problems for some states. Nonetheless, states which implemented their managed care program on a pilot basis have faced fewer problems from an enrollment perspective. While it is exciting to implement a new program statewide and take advantage of the enthusiasm of those involved, the ability to learn from mistakes on a pilot basis can be beneficial.

Because of the Alaska's demographics and the relatively small number of concentrated Medicaid recipients, the benefits of implementing the program in only a few areas is applicable to Alaska. One issue to be resolved is the amount of direct marketing to recipients to allow managed care entities. While this decreases the amount of education the State must provide, it increases the potential for inappropriate information dissemination.

INFRASTRUCTURE/AGENCY ORGANIZATION

The structure of the Medicaid agency and other agencies involved in managed care activities must be modified to meet the different needs and demands of a managed care program. The States we talked with often did not anticipate the amount of additional staff time the formation and implementation of a managed care program would require. Many states commented that allocating

full-time staff to the development and implementation of a managed care plan would have ensured a more successful program. After implementation, often full time staff must be devoted to the administration of the managed care plan. In addition, many other positions in the department will be forced to devote a portion of their time to the operation of the managed care plan in areas such as:

- claims processing,
- contracting, and
- utilization review.

States that did not allocate appropriate staffing to their programs negatively affected overall agency morale and seriously jeopardized the success of the program. States often advise a slow start as opposed to an enrollment of hundreds of thousands of people simultaneously. This allows staffing to grow at appropriate levels and ensures that early problems can be resolved efficiently. Staff time necessary to make system changes and additions was often cited as problem areas for states. Most staff did not allocate enough resources nor allow enough time for systems changes to occur. Consequently, they experienced many problems such as:

- improper enrollments,
- inadequate notification of changes to providers and recipients, and
- prior authorization controls that did not work.

States also emphasized that the agency's commitment to the implementation and expansion of a managed care plan is crucial to its success. Agency commitment usually means widespread support for the program not only within the agency but in the State generally. Support from the governor's office, legislature, and other agencies give the department workers confidence that a well-planned program will be successfully implemented. Proper support helps ensure the necessary resources will be available to the agency. States that did not concentrate their efforts on the development and implementation of their new managed care delivery system often experienced political, advocate, provider, and recipient problems which inhibited enrollment in the plan.

Common organizational structures are described in more detail in the section titled "Administrative Management Practices."

RECIPIENT EDUCATION

From an operational standpoint, providing sufficient education to recipients enrolled in the program is an ongoing struggle and is often in need of improvement. During initial enrollment, recipients must be educated on all aspects of the program from a user's perspective. A fair amount of re-educating and hand-holding is necessary to make it as clear as possible what the recipient is expected to do and how the program works. Once the program is in place and recipients are enrolled, continued education is necessary, not only as a reinforcement on the operational aspects most frequently misused in the program, but also as a mechanism to provide new information and to communicate changes/modifications in the program.

Since every state continues to struggle with recipient education beyond the implementation phase, no state provided any real insight into how to improve education. Based on the experience of other states, however, it is clear that the need for and importance of recipient education is as important on an on-going basis as it is during initial enrollment. Some states are even increasing their emphasis on education. As an example, in North Carolina, where a PCCM program has been operational for five years, the State has reorganized its managed care division to include a team of "field workers" who do nothing but visit providers and recipients throughout the state for educational purposes.

ADMINISTRATIVE FUNCTIONS

From an administrative standpoint, there are some common functions which must be present in any managed care program. These functions, including ways various states address them, are described below.

PRIOR AUTHORIZATION

An enrollee in a PCCM program must obtain prior authorization from his/her care manager before obtaining services which require authorization. Most PCCM programs state that failure to obtain the necessary authorization for a non-emergency service results in the Medicaid recipient's responsibility to pay for the service. North Carolina, under its Carolina Access program, and South Dakota have developed forms which the recipient is obligated to sign prior to receiving the requested service acknowledging that the requested service has not been authorized and thereby agreeing to be financially responsible for this service.

The same is true of capitated arrangements; i.e., non-authorized, out-of-plan services are the financial responsibility of the recipient. It is important that the provider community is aware of the need for authorizations and what to do if a recipient presents for treatment and does not have the appropriate authorization.

"LOCK-IN"

Some states have implemented a "lock-in" policy for their PCCM enrollees. Locking an enrollee into the PCCM plan generally means requiring the enrollee to remain with the PCCM program for a specific period of time, generally six months or more. States often demand that the enrollee remain with the same PCCM provider during the lock-in period. Exceptions to this policy may be granted in the following circumstances: the provider leaves the program, the recipient moves, the patient and provider may have a disagreement.

The term "lock-in" should be distinguished from administrative programs that states have instituted, including Alaska, to closely monitor the utilization patterns of recipients who inappropriately use excessive amounts of services. "Lock-in" as used in this section refers to the ability of States to require enrollment in a managed care plan for a specific period of time, usually six months or one year.

The State has the option of requiring a six-month "lock-in" for recipients who join a federally qualified HMO. In addition, the 1915 (b) waiver authority includes the ability to have a "lock-in" to a program type, e.g., PCCM or HMO, as long as recipients can change providers within the program.

LEGAL

Before states can implement a managed care program, they must have the legal authority to do so. This usually requires support from the legislature and governor and often requires legislation which allows the department to implement the plan. The appropriation bill at the very least must fund the administration of the managed care plan. Often current rules and regulations must be researched to insure there are no conflicts. If conflicts are uncovered, rules and regulations must be modified prior to the implementation of the plan. Regulatory agencies of the State should be consulted and should review the plan as they may be involved in regulatory oversight of providers. It is much better to research laws and regulations during the design phase of the plan rather than be caught short during implementation.

WAIVER

States wishing to mandate enrollment in managed care plans must request waivers from the Health Care Financing Administration (HCFA) to allow them to implement their plan(s). Medicaid programs are administrated according to Title XIX of the Social Security Act. Most managed care plan waivers must be granted by HCFA before a State implements a program. Failure to seek and be granted a waiver jeopardizes Medicaid funding. HCFA utilizes two waiver authorities to grant exceptions to Title XIX regulations. Following is a brief description of the differences between the 1915(b) waiver and the 1115 waiver.

Both of these instruments allow the federal government to waive certain portions of Title XIX of the Social Security Act. In order for states to obtain federal financial participation for their Medicaid programs, the states must comply with the law as contained in Title XIX and the published regulations that further define the legislative intent. As an aside, the Social Security Act contains many other Titles which govern other programs such as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Children with Special Health Care Services, Medicare, etc. Title XIX, Medicaid, is our focus.

There are mandatory and optional portions of Title XIX. Each state submits a State Plan which must be approved by the federal government and is audited to assure compliance. The State Plan spells out how mandatory provisions are met, which of the optional provisions the state intends to implement, and how it will do so. There are several key regulations that dictate how services will be provided to Medicaid eligibles.

- Statewideness means that services must be provided to all residents of a state. Although provider availability cannot be guaranteed, the State must make every effort to assure that covered services are available throughout the state.

- Freedom of Choice assures that Medicaid eligibles may choose the provider from whom the recipient will receive services. States require that providers sign participation agreements and can preclude provider participation under certain conditions; however, to the extent that a provider type participates, recipients must be allowed to select their provider from those participating.

- Comparability of Services means that, except as prescribed by the law, services offered to one Medicaid recipient must be offered to all. The law does make some distinctions, particularly by age. For example, States may offer EPSDT services to children but not comparable services for adults. States may not make distinctions unless allowed under the Act. What this means, for example, is that the states cannot offer a particular service to adolescents and not offer it to all eligible children. They cannot provide nursing home services by diagnosis – they must be available to all eligibles who meet admission criteria.

Section 1915(b) waivers (a.k.a. Freedom of Choice waivers) allow states to waive regulations contained within Section 1902 of Title XIX. The three listed above are among the most commonly requested to be waived. A PCCM program does not usually begin statewide – instead counties or regions are added as networks are established and the State has capacity to handle enrollments. Freedom of Choice waivers are needed to mandate enrollment. Comparability of Service waivers are needed because the states usually mandate enrollment for only some Medicaid eligibles, e.g., AFDC. The intent of Congress in establishing the 1915(b) waiver authority was to give states flexibility in designing delivery of service systems. Note: voluntary enrollment in HMOs does not need a 1915(b) waiver; mandatory enrollment does.

The 1915(b) waivers must demonstrate three things: cost effectiveness, access to care, and quality of care at least equivalent to that of the Medicaid program without the waiver. Waivers are usually granted for two years and are renewable. The waiver process is fairly onerous and can be

expensive since states must evaluate cost effectiveness, access and quality through outside sources for at least the first two waiver periods.

This waiver authority has existed since the passage of OBRA-81 (although not implemented until 1982). Almost every state has at least one 1915(b) waiver or is in the process of obtaining a waiver. All of the PCCM programs have been implemented using 1915(b) as the vehicle.

Section 1115 waivers have been around for much longer than 1915(b) waivers, but until recently were quite unwieldy and unattractive because of the work they require and the time limiting factor. Section 1115 was set up to allow states to test reimbursement and eligibility innovations which might ultimately be incorporated into the Medicaid program through legislative action. The waivers are granted to allow a "Research and Demonstration" project to occur. In the past, the projects were limited to one three to five year period and then were terminated. An extensive research methodology was an essential part of the overall project. Grant money was available to the states. The 1115 application was not approved unless the design put forth was deemed to explore items of interest to the federal government. Waivers could be granted for all of Section XIX, unless clearly prohibited. The application process can be time consuming and does not have the activity schedule guaranteed as is done for the 1915(b).

Recently, the Clinton administration opened up the 1115 process. The intensive, short-term research & demonstration 1115 is still available. In addition, states can request a "waiver-only" 1115. The waivers may be requested for five year periods and, although they are not strictly renewable, the government says that it will provide assistance in changing statute to allow the program to continue if it is deemed a success. Programs may replicate other programs -- a clear departure from the research and demonstration philosophy. Also, the federal employees are *supposed* to assist states in the process and expedite the applications.

This 1115 vehicle allows the flexibility of waiving not only section 1902 but also 1903. It is in section 1903 that reimbursement and eligibility regulations reside. States are using the waiver-only 1115 to expand eligibility to currently uninsured poor who either exceed current income requirements or do not meet other categorical eligibility requirements. There is experimentation with copayments, reimbursement methods and, of course, managed care models. Many states are moving to expanded eligibility to achieve health care reform for uninsured or underserved state citizens since it now appears very unlikely that national health care reform will occur.

One of the key features of the 1115 is that it must be federal budget neutral. This is the most limiting factor for states. Fortunately, the budget neutrality can be spread over the life of the project. This means that expenses may be higher going in but savings achieved in later years can off-set the early expenditures. It is managed care that is expected to produce the savings set against an unfettered fee-for-service trend line.

INTERAGENCY AGREEMENTS

The successful operation and management of a managed care program is dependent on a smooth relationship and adequate communication between agencies and departments. It has been found that coordination with community agencies can foster linkages which can result in the state's increased ability to more effectively serve and educate the Medicaid population.

QUALITY ASSURANCE ACTIVITIES

Regardless of the type(s) of managed care program(s) used within a state, the State must monitor the quality of care provided to Medicaid recipients. According to federal requirements (42 CFR 434.34), state Medicaid agencies must ensure that the contracted plan has ". . . an internal quality assurance system that provides for: review by appropriate health professionals; systematic data collection of performance and patient results; interpretation of data to the practitioner; and

mechanisms for making needed changes." In addition to these general requirements, most states have developed state-specific guidelines, reporting requirements, and other activities (e.g., client satisfaction surveys). A few states, either monthly or quarterly, give their PCCM providers a report card which compares their patients utilization patterns with others in like practices. This reflects not only the doctor's clinical practice but the patient's use of services. Kentucky is using their report card to exclude providers who practice outside of the mean for a specific period of time. Michigan currently uses their report card as an incentive to providers to give quality care at a cost effective price. They may later add penalties for providers who continue to practice outside of the established norms.

In addition to current quality assurance activities, many states are currently reviewing Medicaid Health Plan Employer Data and Information Set (HEDIS) measures for possible use in gathering utilization information on capitated plan performance.

DATA/INFORMATION SYSTEM NEEDS

When transitioning to managed care, several states have found their existing Medicaid information systems (MIS) inadequate. Because of the time and financial resources involved in purchasing a new system, many states have attempted, with various degrees of success, to enhance existing systems to meet the demands of a managed care environment. Often the policy development occurs first and the related data system is in a catch-up mode with a looming implementation date.

While data system needs vary somewhat based on the type of managed care program being implemented, there are general items needed in a system to support a managed care environment. These items include the ability to: support and track beneficiary enrollment choices, link enrollment choices to claims payment systems, edit claims in support of gatekeeping functions, produce utilization reports, and collect/analyze data for quality assurance monitoring. This list expands to include rate calculation, cost sharing, and bonus settlements in capitated arrangements.

PCCM PROGRAM COVERED SERVICES

The types of services typically covered under a PCCM program are fairly consistent across states. In general, the typical state contract defines the scope of services to be provided by a care manager as all Medicaid-covered medically necessary services within the care manager's normal scope of practice, except those specifically excluded in the contract. The following list includes the most common services (subject to state-specific Medicaid coverage policies and limitations) which are either provided under a PCCM program or referred by the primary care physician (care manager).

- physician
- hospital inpatient
- hospital outpatient
- lab and x-ray
- EPSDT
- pharmacy

Services which commonly fall outside of the PCCM can be grouped into three categories: services outside the care manager's scope of practice, carve-out services already being managed through a separate mechanism (e.g., vision, mental health services), and priority services not needing authorization (e.g., emergency care, family planning, and sometimes prenatal care and EPSDT screening).

Recipients and providers need a list of covered services which do not require prior authorization and a list of covered services which do require prior authorization. It is also important to include a statement regarding when services are covered, i.e., medically necessary services, and any variations in coverage based on age or sex or disability.

Additionally, since inappropriate emergency room use is the most frequently violated part of any PCCM program, it is important to have clear statements for both providers and recipients on when emergency room use is appropriate and the consequences of inappropriate use.

Normally, capitated arrangements are more inclusive than PCCM programs. The capitation may be for an established, discrete set of services such as vision exams and eyeglasses. It may be more expansive and include all ambulatory care under capitation, but exclude hospital facility charges in a partially capitated model. It may be very inclusive and include all or most services in a full HMO model.

DISEASE MANAGEMENT/SPECIAL POPULATION PROGRAMS

Often after a state has initiated a managed care plan, they study ways in which special populations can be served within a managed care environment. Several states are experimenting with managed care programs specifically designed for disease management and or designed to target special populations who have greater needs for medical services. Several states, Michigan among them, have developed special managed care programs for high need children. They have recognized that these children often require specialized services at a higher rate than average thus the cost of providing care increases for this population. Michigan has created special capitation rates for these children so providers are treated fairly and access for this population is guaranteed. Michigan is also concentrating its efforts on the quality and type of care these children receive by requiring special programs and services be available to this population. The State will conduct strict oversight of this new initiative so the rights of the children are protected and well served.

Maryland has created a special disease management plan tailored after their PCCM program. The rationale behind developing the program is the desire to give appropriate care to patients with diabetic conditions thus preventing unneeded hospitalizations. Previously Medicaid spent a large share of money on inpatient care for diabetics. Studies now that prove the program is saving money.

Maryland pays a $20 case management fee to providers who enroll in this plan plus they pay all services rendered on a fee-for-service basis. In return the provider gives the diabetic patient primary care as well as providing specialized care for their diabetic condition which may entail visits to become knowledgeable about the patient's condition and setting up a treatment regiment, making referrals to specialist when appropriate, and following the patient's progress closely. The program caters to diabetics because it covers four additional special diabetes services: diabetes education, nutritional counseling, home glucometers, and special diabetic foot care. Maryland chose the amount of the $20 case management fee rather randomly, but decided a higher fee is warranted because diabetics often have multiple health problems.

Maryland has had no problem signing up providers across the state who are willing to participate in this plan. It is a voluntary program and, often, when patients decide to enroll, they already have a physician that they "bring along" with them as their PCP. They haven't had any problem expanding the program over the entire state.

Participation is relatively constant: 2,500 recipients, and 550 physicians.

To outreach to potential recipients, Medicaid's computer generates a list of those patients who have had an inpatient visit due to diabetes. They then send an outreach brochure to these individuals which encourages them to become part of the program.

References:

Medicaid Managed Care: A Guide for States. 2nd Edition, National Academy for State Health Policy, 1995.

National Summary of State Medicaid Managed Care Programs, U.S. Department of Health and Human Services, Health Care Financing Administration, Office of Managed Care, June 30, 1994.

HIGHLIGHTS OF SELECTED MANAGED CARE PROGRAMS IN TWENTY STATES

In addition to general information received through previous experience with other states, additional information was sought for those states where it was felt that their Medicaid managed care experience could be transferable to Alaska. While particular attention was paid to states with PCCM programs, information is also provided on states with fully and partially capitated plans. The level of sophistication of the managed care program and the amount of administration experience for each state varied therefore not all states could supply answers to all of the questions asked. The information provided is a summary of each program.

COLORADO

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STATUS OF PROGRAM

Colorado originally implemented its Primary Care Physician Program (PCPP) 12 years ago to confront high costs as well as improve access to and coordination of care. With each waiver renewal, program staff have demonstrated cost savings but have not gathered data on access to or coordination of care. Savings of $80 million was seen in inpatient hospitalization, with a net savings of $10.3 million during a two year time period. The Health Sciences Center of the University of Colorado conducted the evaluation of the PCPP for three of the HCFA waiver submissions at an estimated cost of $8,000 per evaluation. Colorado is beginning to consider contracting with an enrollment broker, but has not determined the cost.

Colorado's PCPP staff are looking at changing the focus of the program so that it serves as a safety net only. In other words, it would be used only in areas where no HMOs exist or for individuals with special needs which an HMO cannot serve. Staff are currently working on the legislation to restructure the program, and, if this passes, the program will change its focus in July of 1997.

BARRIERS

Because Colorado's program was implemented 12 years ago, current program staff did not have direct knowledge of the barriers encountered while implementing the program. They do know there was resistance to the program. The Department made an effort to work with the State Medical Society in order to give physicians an opportunity to have input in the formation of the PCPP. A physicians advisory committee was also formed in order to give direction to the PCPP. As Colorado moves in the direction of HMOs rather than PCPs, physicians have vocalized preference for the PCPP.

CHANGES

Colorado's PCPP has not seen many changes over the years. The major change will most likely occur in 1997, as discussed above.

STAFFING

There are four full-time PCPP staff: three hotline staff and one hotline supervisor. There is also a .25 FTE policy person. Current staff could not remark on past staffing requirements.

SYSTEMS

Systems changes were made in claims processing. The system now has an edit check to approve the PCP number on the claim. PCP reports are generated to identify which physicians are accepting clients. The reports are sent to each county. A report is also generated for each PCP. The estimated cost of system changes for the program is $100,000 in today's dollars.

ADMINISTRATIVE FUNCTIONS

Colorado imposes a year-long "lock-in" for recipients to remain with their physician. However, recipients may change providers if they show "good cause" (e.g., they join an HMO).

CARE MANAGERS

Only physicians, federally qualified health centers (FQHCs), and rural health centers (RHCs) can serve as care managers in Colorado's program. These providers are reimbursed on a fee-for-service basis plus a $4.50 per member per month (pmpm) case management fee. Care managers assume no financial risk.

There is technically no mandatory enrollment, but the program staff have the ability to make an assignment to a PCP. Colorado is considering mandatory enrollment for the HMO program. While there is not a maximum enrollment for each care manager, staff review physicians with large caseloads.

A PCP can be removed as a result of an issued sanction.

COVERED SERVICES

In Colorado's PCPP program, primary care physicians (PCPs) are responsible for providing primary care services, coordinating the provision of other necessary medical/health care, and monitoring their patients' use of Medicaid services. A referral is required for all other PCPP-covered services, such as inpatient hospital care and other specialty care. The following services, which are exempted from the PCPP, do not require a referral: pharmacy, community mental health, laboratory/radiology services, emergency care, transportation, family planning, podiatry, dental/vision under EPSDT, anesthesia, child abuse victim-related services, and pregnancy-related services.

Access to care and level of administrative difficulty were considered when deciding which services to include in an authorization process. For example, obstetrics was not included in the authorization process because of concern that the authorization process might impede a woman from seeking and obtaining prenatal care. Laboratory and radiology work were not included because it was determined that the authorization process would be too administratively cumbersome.

AUTHORIZATION PROCESS

The PCP number is the authorization number and must be documented on the bill in order for the PCP to receive reimbursement. The program does not require referral forms. There is an edit check in the system to verify the PCP authorization number in order to assure the integrity of the authorization system.

LESSONS LEARNED

The Colorado contact stressed the importance of open lines of communication between the State and physicians in the state (such as medical societies and other specialty groups). For example, Colorado staff suggested that Alaska seek feedback on the initial program design from the State Medical Society.

CONNECTICUT

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STATUS OF PROGRAM

Connecticut decided to implement a totally capitated managed care program. The program tried a small pilot PCCM program several years ago and found it accomplished the desired increase in access, but was too successful and led to significant cost increases. The state decided to control costs and guarantee access by soliciting HMO contracts through a bid process. It took two years to complete the program design, educate the provider community, win legislative approval, and issue RFPs. In addition to the contracted plans, the State is contracting out both the enrollment brokering function and the quality assurance function.

BARRIERS

When it began the design of the program, Connecticut had no active managed care program. While there were many HMOs providing services to commercial enrollees, none were serving Medicaid recipients. Working with the provider community and the HMO community was a lengthy and necessary task prior to implementation. The recipient and advocacy community were concerned about a change in the service delivery system, and wanted assurance that all aspects of the program had enough consumer protection built in to assure that adequate care would be accessible to enrollees. These concerns were very effectively transmitted to the legislature which resulted in a substantial delay in finalizing the program design and moving forward with implementation. Establishing a priority for changing and identifying all of the necessary systems changes also caused delays and modifications in the desired design.

CHANGES

In the 80's Connecticut attempted to implement a PCCM plan. While it did improve access, the program added cost to the Medicaid program and subsequently was disbanded. The design of the plan was faulty from the beginning if the goal of the program was cost savings. Connecticut chose an area to implement that traditionally had a lack of access and then to persuade providers to participate, they increased fee screens. The program was a success in improving access but substantially increased costs.

Connecticut did not abandon the idea of managed care however, but designed the next managed care program more carefully with the goal of cost savings firmly sighted. In 1995, Connecticut began the implementation of a capitated managed care plan which seems to be successful, although it is too early to have any outside evaluation of the program.

STAFFING

During the design phase of Connecticut's managed care plan, one manager, one analyst, and one secretary were assigned to the project full time. In addition Lewin received a contract to help with the design and implementation of the managed care. This was a two year contract and involved several subcontractors with a total involvement of approximately 12 persons. The State also subcontracted certain tasks for one year to one individual who was located in the State office building with the other managed care staff.

During implementation, the state added four more full time analysts and is considering adding more staff.

Connecticut also contracted with an enrollment broker who employs some staff on a daily basis depending on volume of enrollment and number of telephone calls received. Staff will continue to be added until the State has fully implemented managed care which is scheduled to be complete in two years.

SYSTEMS

At the time Connecticut was designing their managed care plan, they also rebid their MMIS which allowed them maximum flexibility. The new MMIS incorporated the needs of a program switching from primarily a fee-for-service system to a capitated system. In addition to their MMIS system, extensive changes were necessary in their eligibility system. Some of those changes involved linking the enrollee to a plan, linking family members to the same plan, assigning recipients who do not chose a plan, and sending enrollment notices on a timely basis. These and other changes were problematic because this system is operated by the department who often had conflicting priorities. Systems were not completely operational at initial implementation which continues to cause problems.

ADMINISTRATIVE FUNCTIONS

The implementation of its managed care program will be statewide, but will be phased-in over several months. An RFP was issued and 14 responses received. All HMOs meeting the program criteria may participate at least initially. In addition, a partially capitated model was available for federally qualified health center participants.

A separate RFP was issued to select a "default" Plan for those recipients who failed to voluntarily select a Plan. Two default plans (called Designated Providers) were selected, each covering half of the state.

The State contracted for assistance in all phases of program design, development and implementation. In addition, the State has contracted with an enrollment broker for all education and enrollment activities. The State will contract for a quality assurance contractor. The State will provide internal contract compliance with the capitated providers, the enrollment broker, and quality assurance contractors.

CARE MANAGERS

Connecticut contracts only with fully or partially capitated providers who supply the primary care managers to each enrollee. Providers who may serve as primary care providers are determined by each plan but providers must practice within the parameters of Connecticut's laws and regulations.

COVERED SERVICES

All Medicaid-covered services are included in the HMO capitation. There is some discussion about carving out mental health services and doing a separate mental health managed care program.

AUTHORIZATION PROCESS

Each capitated plan employs its own authorization process for referrals to specialty providers, hospitalizations, etc.

LESSONS LEARNED

Connecticut advises any state planning to implement a managed care plan to conduct public hearings so everyone feels enfranchised. The fears and misgivings of providers, advocates, and recipients must be aired and substantially resolved before implementation if the program is to be successful. This process took much longer than the State allowed in the timeframe and slowed the implementation of managed care.

FLORIDA

CONTACTS

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STATUS OF PROGRAM

MediPass, Florida's PCCM program, began as a pilot program in four counties. Ten months after project implementation, an independent evaluation conducted by the University of Florida found that the program realized a 20% savings. This figure was used to legislate expansion of MediPass to the entire state. An independent evaluation in all participating counties was recently conducted, and a savings of 13.5% (compared to the fee-for-service program) was found. It is important to note this evaluation used the most conservative methodology available. Staff did not know the dollar amount of the savings. Savings were primarily realized in inpatient and out-patient hospital use.

MediPass, Florida's PCCM program, is currently operational in 31 counties with an approximate enrollment of 237,000 recipients. In March, 1996, the program will be expanded, with a goal of becoming operational in all 67 counties in Florida.

BARRIERS

Initially, the program met some resistance from the medical community. The State initially implemented the program in the Tampa area because physicians there voiced an interest in it and there is a significant Medicaid population in the area.

An insufficient number of providers in rural areas is a constant obstacle the State faces in its fee-for service program and in the expansion of the PCCM program. In counties where the Department of Public Health operates a primary care clinic, the MediPass program becomes operational very quickly because the public health clinic participates in MediPass. However, in some rural areas that do not have a public health clinic, Florida has had difficulty in securing an adequate number of physicians to operate the program. Sometimes the physicians have been initially reluctant to participate, but primarily the difficulty stems from insufficient physicians in some counties to meet the needs of the Medicaid recipients.

CHANGES

Florida has submitted a waiver request to HCFA to expand the provider base to include mid-level providers. Approval of the waiver is still pending. Expansion of the plan to the entire state is planned for 1996. Currently, MediPass is the default provider for Medicaid recipients, but Florida hopes to allow HMOs in some areas to fill this role.

In July, 1995, MediPass providers were required to do EPSDT outreach in addition to providing EPSDT services to enrollees. The State supplies MediPass providers with a monthly list of patients, their complete addresses, and the date of their last EPSDT or adult screening. Providers must contact enrollees to arrange for an appointment for the needed service.

STAFFING

There are 77 full-time staff members statewide who operate the MediPass program. There has not been a change in the composition of the staff, but the number of staff has grown. Florida uses no outside contractors to operate any portion of the MediPass program.

SYSTEMS

Many system changes were made. For example authorization edits were added and new reports were needed. Staff did not know the cost of the system enhancements.

ADMINISTRATIVE FUNCTIONS

There is a "lock-in" requirement in some counties. A recipient is given 60 days to make a selection of a MediPass provider. If a MediPass provider is not chosen, Florida assigns one to the recipient. The recipient is then "locked-in" to MediPass for a twelve-month period. After this period, the recipient may change MediPass providers, but may not disenroll from the program.

For most primary care services, a claim must be prior authorized before payment is made. Florida does not require the use of a particular referral form, but does require that the ID number of the MediPass provider appear on the claim form for payment. Florida sends each MediPass provider a monthly utilization report. This helps the provider control utilization and helps identify fraudulent claims, or claims with the ID number of a provider who has not approved the services.

CARE MANAGERS

Florida allows the following providers to be care managers: general practitioners, family practitioners, pediatricians, OB/GYNs, internists, rural health clinics, public health departments, and some specialists. The state determined care managers by examining who was responsible for providing primary care. The program does have mandatory enrollment. A full time provider has a capacity of 1,500, with an extension of 300 (with adjunct providers such as nurse practitioners and physician assistants).

Care managers receive a $3 pmpm case management fee, and are under no financial risk for utilization and/or services provided. Case management fees are paid on a monthly basis and are documented on the remittance advice.

Providers are removed if they do not have 24 hour access. Warning are given before removal is complete.

COVERED SERVICES

The following services do not require the authorization of the MediPass provider: dental, vision, maternity, mental health, and family planning. Services requiring authorization include: physician services, pharmacy, in and out-patient hospital, home health, x-ray and lab, ambulatory surgical center, rural health, podiatry, nurse practitioner services, physician assistant services, EPSDT, and chiropractic care. Managed care packages were reviewed to determine which services to exclude from the authorization process. Staff said maternity should be on the list of services requiring authorization.

AUTHORIZATION PROCESS

MediPass uses provider ID number for the authorization process. Assuring the integrity of the system is difficult, especially when using ID numbers. Fraudulent use is possible in any system, but staff are "amazed" because very little abuse is seen.

LESSONS LEARNED

A commitment to education is necessary if the program is to be successful. Staff in each area office are committed to client education. Area offices send notices to every eligible recipient, providing information about the program and area hotline numbers for recipient questions. Provider education is also completed by area staff, and includes: provider training seminars (classes are typically full), state and area quarterly newsletters, individual office visits and updated specialty referral lists. When the state is preparing to implement MediPass into a county, staff visit hospitals and other entities to explain the program.

The success of MediPass is largely due to extensive planning and preparation. For example, the department provided handbooks to potential recipients, operation books to areas, and worked closely with other agencies such as Child and Family Services, coordination with physician groups, hospitals, advocacy groups, etc. is vitally important. The program must be prepared for systems glitches.

Florida Staff does not recommend using managed care for the SSI population because there is no substantial data proving savings. (This finding is disputed by other states, Michigan in particular which found substantial savings in the SSI population.)

The Florida Medical Association was very supportive of the MediPass program. There was little political opposition because the program was mandated by legislation.

GEORGIA

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STATUS OF PROGRAM

Georgia Better Health Care (GBHC), the state's PCCM program, is operational in a few counties. There are plans for expansion, but due to the uncertainty of its long term future, nothing has been finalized. Georgia is currently developing an HMO program and believes HMOs will probably enroll most of the urban areas, leaving GBHC for the rural areas only.

The primary motivation for GBHC was financial, and cost savings have been realized.

BARRIERS

The initial barrier in implementation was resistance from the provider community to reimbursement other than fee-for-service. As a result, the locations for implementing GBHC were carefully aligned with those areas where provider interest was evident.

CHANGES

No major changes have been initiated. A pilot project was initiated to allow selected providers to do their own pre-certification and prior authorization. The pilot project was not extended because utilization within the pilot group was higher than in the control areas.

Georgia also plans to have a contractor enroll recipients in both the PCCM and HMO plans and be an information source for both. Those tasks are currently separate.

STAFFING

Georgia assigned six staff members on a permanent basis to their PCCM. Most were on board for the design phase but one was added during implementation. They believe they all should have been assigned during the design phase for continuity and sheer workload levels.

GBHC current enrollment is 175,000.

Georgia also contracted with a North Carolina group to develop materials and recruit providers. Another contractor operates their information and enrollment number. Initially the division answered the telephone and the overflow calls were given to a contractor who employed six people for that purpose. Georgia will substantially change that contract probably through an RFP purpose to include outreach and enrollment for the HMO and PCCM program. They expect the contractor will require fifty or more staff to fulfill the responsibilities of the program.

SYSTEMS

Staff did not know the cost of system improvement. The system changes were begun in April of 1993. GBHC enrollment began in October 1993, but the system changes were not complete until April 1, 1994. It took much longer to implement the systems changes than it was originally designed to take. The auto enrollment function proved to be the most problematic. EDS is their fiscal agent and the Department of Health and Human Services operates their eligibility computer.

ADMINISTRATIVE FUNCTIONS

Recipients are "locked-in" to their provider for a one-month period. Prior authorization is done via telephone and the physician's number must appear on the claim if it is to be processed (GBHC operates under a "paperless" system, that is, a paper referral is not necessary).

CARE MANAGERS

In addition to physicians, nurse practitioners, primary care clinics, rural health centers and community health centers can be care managers. Care managers receive a $3 pmpm case management fee which is paid on a separate remittance advice each month. Care managers assume no financial risk.

COVERED SERVICES

GBHC must provide primary care medical services covered by Medicaid, referral authorization for needed specialty services, other covered medical services, and arrange for 24-hour coverage. Services that require authorization are primary care services, most specialty services and inpatient hospitalization. Obestretical care, family planning, and mental health services are among those that do not require authorization.

AUTHORIZATION PROCESS

Georgia operates a paperless referral system. Referrals may be either prior or post authorized but claims are not paid unless the GBHC's provider identification number is placed on the proper line of the claim.

LESSONS LEARNED

Georgia found that primary care providers are enthusiastic about the GBHC but specialty providers are not because the specialty providers find it to be a restriction on their practice.

Georgia advised that any current efficient administrative practices not be abandoned by the state when a PCCM program is introduced.

IDAHO

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STATUS OF PROGRAM

Idaho's PCCM program, Healthy Connections, was implemented in October, 1993. It was targeted for urban areas, with the demand now exceeding the State's staffing resources devoted to the program. The program was instituted due to legislative pressure for cost savings. A 14% savings has been realized; the report containing this information has been submitted to HCFA, but it cannot be released to other parties until HCFA has granted approval.

BARRIERS

The primary barrier that Idaho incurred is the inability to expand the program as rapidly as the provider and recipient community would like. Lack of adequate staffing has forced the State to slow expansion efforts.

CHANGES

Since Healthy Connections is still a relatively new program, emphasis has been on expansion rather than changing the program. However, Idaho is now looking at quality and access to care issues.

STAFFING

Idaho employs eight person in their state office to administer the Healthy Connections program and an additional nine field representatives, one for each region, who assist with enrollment and education.

SYSTEMS

Healthy Connections staff made some system changes when the program was implemented in 1993. There are still bugs but they hope to design a new system in 1997 which will be tailored to managed care. Staff did not know the costs of system changes.

ADMINISTRATIVE FUNCTIONS

Healthy Connections demands 24-hour telephone access for recipients, but the program does allow physicians to work together to handle after-hour calls.

CARE MANAGERS

Care managers receive a $3 pmpm case management fee, and are under no financial risk for utilization and/or services provided. Case management fees are paid on the second Monday of each month and are documented on the remittance advice. The program may introduce risk to the Healthy Connections contracts in 1997. Mid-level providers may provide care to enrollees in a clinic setting, but only physicians may enroll as Healthy Connections providers.

COVERED SERVICES

All primary care must be authorized by a Healthy Connections provider before the State will pay a submitted claim.

AUTHORIZATION PROCESS

Recipients may receive the following services without the authorization of their Healthy Connections provider: vision, dental, family planning, podiatric, chiropractic, and immunizations. authorization process

Idaho also demands that the Healthy Connections provider ID number be on every claim for services which requires prior authorization. Individual providers use their Medicaid ID number. Providers who practice together can receive a group ID number that can be used by any member of the group to authorize payment for services rendered to any enrollee of the group.

LESSONS LEARNED

Being able to respond quickly to program demands as well as program staffing needs is an important consideration when designing and implementing a managed care plan.

IOWA

CONTACTS

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STATUS OF PROGRAM

Iowa has both a PCCM (MediPASS) and an HMO option for Medicaid eligibles. The managed care program was implemented in 1990 and the State has successfully renewed waivers based on the program performance. In 1993, the State elected to expand from the initial seven pilot counties. With the ultimate goal being statewide enrollment, the State's approach has been to incrementally add counties, beginning with the counties with high concentrations of Medicaid eligibles. The program enrolls AFDC and AFDC-related categories of assistance.

In addition to the primary care managed care program, Iowa also has a statewide behavioral health care contract and a statewide managed substance abuse contract.

BARRIERS

There are 100 counties in Iowa; each county has its own political base and, in implementing a managed care program, each must be approached as a unique entity. One significant problem was resistance to managed care from physicians in certain locations. Implementation of the MediPASS program in some areas had to be postponed for months (and in one county, begun and terminated) because of the physicians' collective refusal to participate. There are a few counties with a large Medicaid population, but most counties only have double to triple digit counts of AFDC eligibles. Although several HMOs were established in Iowa, many of them were reluctant to sign a contract with Medicaid. There were two primary reasons for this: lack of experience with the Medicaid population and low population in many areas. The areas with a high concentration of eligibles were fairly well-covered by the MediPASS program. HMOs could visualize a great deal of work for very little potential enrollment gain. This resistance was eventually overcome, but it took a great deal of hands-on work to break through the barriers.

CHANGES

The biggest change was contracting with an enrollment broker and moving the recipient enrollment activities from a local county office activity to the broker. This proved to be a very effective way of bringing consistency to the enrollment process, in reaching out to the recipients and conducting large scale enrollment activities.

STAFFING

At the time of implementation, Iowa employed three full time staff persons who were charged with overseeing both the PCCM and HMO managed care plans. They also contracted with Unisys who had the responsibility of staffing the recipient and provider hot line, provider recruitment and liaison, and enrollment of recipients into the plan. Following is the number of staff and their responsibilities:

- 1 Supervisor
- 2 Nurses (one part time) took care of provider complaints and provided liaison to the provider committee
- 4 staff for provider recruitment
- 3 staff for hot line and data entry

SYSTEMS

Systems problems plagued the program. The State contracts for its MMIS functions but carries recipient information on its own system. A successful managed care program requires an interactive integration of the information on the two systems. Such integration has proved to be difficult despite the best efforts of those involved Iowa also wanted to implement an assignment process which linked a recipient who failed to voluntarily choose one of the offered options to a physician that the recipient had seen in the past. Iowa considered, but decided not to use, a "default" system, turning to historical usage patterns instead. This assignment process took an extremely long time to produce results. In the meantime, recipients had to be manually assigned to a provider.

ADMINISTRATIVE FUNCTIONS

The MediPASS program is very similar to other PCCM waiver programs. Initially, county Income Maintenance Workers were responsible for recipient education and enrollment. When the major expansion effort was begun in 1993, the State elected to contract with an enrollment broker. Now, most of the education and enrollment efforts are handled through mail and toll-free phone activity. County offices receive training and participating physicians provide enrollment brochures in their offices. The contract let for the enrollment function (including design, production and dissemination of all recipient materials) also includes marketing to providers, both physicians and HMOs. Outcome goals (actual enrollments over each 12-month period) were established and tied to the contract reimbursement.

Recipients select their enrollment option or, if they fail to select within the allotted time, are assigned to a provider. Enrollment is for at least one full month but recipients may request a change at any time. The MediPASS doctor's ID number is used as the referral approval number.

CARE MANAGERS

Care managers may be general practice, family practice, general internal medicine, obstetrics/gynecology or pediatric physicians. The patient managers receive a $2 pmpm case management fee and are also reimbursed fee-for-service for any services provided.

COVERED SERVICES

Services requiring a MediPASS physician's authorization include: physician specialists, non-emergent visits to the ER, inpatient hospital care, clinic services, laboratory and radiology services, services of other medical practitioners, podiatric services, psychiatric services, and home health services. Medicaid may refuse payment for unauthorized care.

Certain services do not require the MediPASS physician approval or authorization; these include: emergency, family planning, chiropractic, and ophthalmology services.

Contracted HMOs are responsible for the provision of all covered Medicaid services except for the following: medical transportation, long term care facility costs, state mental health institutions, specialized psychiatric medical institutions for children, services provided by area educational agencies, candidate-enhanced services, dental, hospice, prescription drugs, chiropractic, and medical supplies. HMOs may contract for one or more of the following as an add-on to their contract: prescription drugs, chiropractic services and medical supplies. Stop loss is available to the HMOs.

Mental health services are now provided through a behavioral health care contract. Recipients enrolled in HMOs obtain their mental health services through the HMO. The HMO must provide coverage at least equivalent to the behavioral health care contract requirements. The HMO has the option of providing the services directly or of purchasing services from the State's behavioral health care contractor at the State capitation rate.

AUTHORIZATION PROCESS

All referrals and authorizations must be documented in the patient's record. The Department does periodic audits to verify that covered services not provided by the patient manager were documented as authorized in the patient record. Costs for services which the patient manager affirms as not authorized are recovered from the provider who failed to obtain authorization.

In addition to the periodic audits, MediPASS physician managers are sent quarterly utilization reports. They are to report any non-emergency, covered procedures which they did not authorize. The Department uses this information for further investigation.

LESSONS LEARNED

The use of an enrollment broker (or dedicated staff) assures that information will be provided according to schedule and in a consistent manner.

Early involvement of physicians is essential to the success of the project. Iowa had to postpone implementation in one of the more largely populated areas because the physicians banded together and refused to participate. We were able to eventually work with the physicians but it took a concerted effort.

The authorization process is very tricky. The Iowa process does not require a paper authorization but many of the specialists will not see the patient without a written authorization because they do not trust the referring doctor to enter the authorization into the patient record. If the record does not verify the authorization, it becomes the specialist's word against the patient manager's.

Be prepared to spend time on developing an enrollment system that works and that is linked to both eligibility and to claims processing.

KANSAS

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STATUS OF PROGRAM

Kansas' PCCM Program is called HealthConnect (was called Primary Care Network, or PCN, until 18 months ago). They have seen savings from their PCCM every year since 1984, with the most savings realized in the inpatient setting (and some in outpatient and possibly pharmacy). Last year, they had a "cost avoidance" of $22 million.

BARRIERS

Kansas found that each county that was introduced to HealthConnect was a new challenge. Each seemed to have a particular issue that had to be addressed. For example, one county resisted enrollment because providers there indicated they had not been consulted during program design. In reality the State had invited providers from that community to comment on the design but they had failed to attend any meetings. They were gradually able to overcome the objections by doing many of one on one and group meetings with providers. In the next county, staff prepared the providers first by having one on one meetings with key providers then introducing the concept to the group which worked better but other issues continued to be raised that had to be resolved. They believe there is no one method that will guarantee success.

CHANGES

The only change that Kansas made was to change mandatory enrollment from yearly to biyearly which is in line with HCFA requirements of an HMO.

STAFFING

The number of staff has changed over time. In 1982 (program inception), there was one administrator for PCN exclusively. Over the years, this administrator has become responsible for more and more programs; the current administrator has jurisdiction over eight programs. As of two years ago, however, Medicaid also developed a "managed care team," comprised of seven people, who work on HealthConnect as well as Kansas' capitated programs. The team is comprised of a quality manager, contract manager, fiscal manager, program manager for education and enrollment of consumers, the manager for the two capitated programs, an information systems manager, and a team director.

Kansas' uses their fiscal agent, EDS, as their enrollment broker (contract: $3.5 million annually, expires July '96, at which time BC/BS of Kansas will take over). They also use the Kansas Foundation for Medical Care to conduct an external quality review program (contract: $.5 million annually; have used up 2 years of a 5 year contract). They recommend using a contractor for both of these purposes. In particular, they feel it's very important to use the fiscal agent as the enrollment broker; otherwise, the two can't share information. (Missouri has apparently had a "nightmarish" situation because they use a different company as their enrollment broker and fiscal agent.)

SYSTEMS

Their computer system was modified so it could handle:

- case management fee payments
- referrals for services
- automated letter generation
- case management reports
- automated grievance procedures
- collection of encounter data
- sending of provider rosters
- collecting data from HMOs, and
- default assignment to recipients who don't choose a provider.

They aren't certain how much the changes cost, but they do know that the contract for the fiscal agent, which is $3.5 million annually, encompasses the cost of the systems changes.

ADMINISTRATIVE FUNCTIONS

Staff dedicated to client education are (1) fiscal agent representatives who work as Medicaid liaisons in 12 offices across the state and (2) five state employees who are regional coordinators and oversee the fiscal agent reps. For provider education, the state has four HealthConnect physician recruiters who give three types of seminars, make individual contacts with physicians, and send out recruitment information.

Care managers are removed from PCCM participation, but this is rare. Following are some of the possible reasons for removal: provision of inappropriate care over a period of time; the provider hasn't fulfilled his contract (e.g., a care manager refers a patient without seeing him at all), or the provider is convicted of Medicaid fraud.

CARE MANAGERS

Providers that can be care managers are: pediatricians, OB/GYNs, internists, general practitioners, family practice, Federally Qualified Health Centers, Rural Health Centers, associated registered nurse practitioners, and local health departments with primary care clinics. Enrollment for providers is voluntary, and for clients is mandatory. Providers and Medicaid negotiate the provider's capacity. It can range anywhere between 10 to 1800.

COVERED SERVICES

The following services require a referral from the care manager:

- Attendant Care for Independent Living
- Alcohol and Drug Addiction Treatment Facilities
- Ambulance (Non-emergent)
- Equipment and Supplies
- Impatient Hospital
- Local Education Agency Services
- Physicians
- KAN Be Healthy
- Podiatric Services
- Prosthetic and Orthotic Items*
- Audiology Services
- Dietitians
- Hospice
- Home Health
- Local Health Department
- Physical Therapist
- Psychiatry Services*

*Except for services listed below

Services **not** requiring a referral

- Adult Care Homes
- Behavior Management Services
- Community Mental Health Services
- Emergency Services (All types)
- Family Planning/Sterilizations
- Immunizations
- Laboratory and Radiology
- Pharmacy
- Pregnancy Related Diagnoses
- Prenatal Health Promotion and Risk Reduction Services
- State Institution Services
- Vision Services
- Anesthesia
- Chiropractic Services
- Dental
- HCBS Services
- Indian Health Services
- Non-Ambulance Medical Transportation
- Sexually Transmitted Disease Services
- Surgery Assistants

AUTHORIZATION PROCESS

The PCCM authorization process works as follows, the referral area of the claim form must contain the care manager's ID number. If the claim form does not contain the proper number the claim is rejected. The integrity of the system is maintained through the utilization review process. On selected cases, they look at the claim files of both the care manager and the "referred-to" provider to ascertain they both have a copy of the referral

LESSONS LEARNED

Kansas had three suggestions for other states interested in forming a PCCM program. One was to talk to the provider community (e.g., medical societies, various medical associations) before the State makes any plans for managed care. Even though this will take longer, the State cannot make this change without the providers on its side. The second suggestion is to make sure you monitor the private contractors closely (e.g., require weekly status reports). And third: PLAN AHEAD.

Kansas also had political support for implementation which was also key to its success. The legislature is very much in favor of implementing Medicaid managed care and, although it would prefer full capitation systems, it was in support of HealthConnect because of the state's rural nature.

OTHER

Kansas has a Peer Education and Resource Council, which is a group of 11 providers that advise the state on things such as the utilization report and quality assurance measures. It works well because it is peers advising peers.

KENTUCKY

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STATUS OF PROGRAM

KenPac, Kentucky's PCCM program, was implemented in 1986. Planning began in 1985 by State officials who initially contacted two other states, Michigan and Kansas, who had operating PCCM programs. These states were able to give invaluable advise and counsel on program design and implementation. After making contacts with Michigan and Kansas, State officials began meeting with providers, recipients, and advocates. Although suggestions from the other states helped Kentucky staff formulate KenPac, so did the comments of their citizenry.

BARRIERS

Because providers, advocates, and recipients were involved in the design of the program there was very little resistance to the implementation of KenPac.

CHANGES

Program changes have been few. Reports which measure an individual provider's utilization as compared to a statewide standard were developed as was a report which lists recipients assigned to that provider and their individual utilization.

STAFFING

It is difficult to measure staffing levels because most of the enrollment and education of the recipient is done at the county level. There are 120 counties in Kentucky, and each of them has an office that processes and maintains assistance cases including Medicaid. Medicaid recipients are asked to enroll in KenPac at the time they apply. Each family is given an information/education packet and asked to make a choice of a provider. The worker answers questions about the plan.

There are a total of eight staff members at the state level. One staff person is primarily assigned to answering the information line, with one backup. In reality, all of the staff members answer the telephone sometimes because of their particular expertise and other times to catch the overflow

calls. Three nurse consultants concentrate on medical issues, other staff members resolve claim disputes, and all take part in policy analysis and suggestions for improvement

SYSTEMS

Kentucky uses a fiscal agent who made all of the modifications necessary to implement and continue operation of the program. The present director did not know the cost of the changes and ongoing maintenance for systems.

ADMINISTRATIVE FUNCTIONS

Recipients choose a KenPac provider when they are determined eligible for Medicaid. The local county offices provide the recipient with information and answer questions about the plan and supply lists of participating doctors. The State also has an information line, which is operational during business hours. Recipients may call for answers to questions unable to be answered at the local level.

None of the staff is assigned to educational efforts although the state office does issue informational pamphlets that try to encourage healthy lifestyles and proper use of medical resources. The director would like to devote more time and staff to education but cannot at this time.

The information and education received by the recipient in the county office is uneven and sometimes incorrect based on the individual worker's expertise and interest in program.

CARE MANAGERS

Kentucky allows primary care physicians to become KenPac providers. Since specialists most often do not render primary care, they may not become KenPac providers. KenPac providers may enroll as many as 1500 recipients, but are only paid the case management fee for their first 1000 enrollees. They are paid fee-for-services for all care rendered to all enrollees.

While Kentucky has not allowed nurse practitioners to become KenPac providers, they do allow the practice of a particular physician to increase by 300 enrollees when a nurse practitioner is rendering care at the same site. For example, a solo KenPac physician may only enroll up to 1500 patients, but if a nurse practitioner also see patients at the same site, the KenPac physician may increase enrollment to 1800.

COVERED SERVICES

Most Medicaid services require the authorization of the KenPac provider before Medicaid will pay the claim. The following services do not require authorization:

- Dental Services
- Pregnancy Related Services
- Vision Care
- Family Planing
- Mental Health

Dental services, vision care and mental health services are not often provided by primary care providers, nor are providers typically responsible for overseeing this care; therefore these services

do not require authorization. Federal rules demand that family planning services be readily available so authorization is not required. Additionally, Kentucky decided that not many obstetricians were interested in participating in the program and since, most primary care doctors do not supervise pregnancy services, those services do not require authorization.

AUTHORIZATION PROCESS

Kentucky's authorization system requires the KenPac provider's number to be in the proper field of the claim form before services are paid. The provider number is made of the five digit license number of the provider plus a two digit prefix which describes the physician's practice and a one digit suffix check number which is randomly assigned. None of the numbers change on a regular basis.

Recipient identification numbers consist of the person's social security number plus a ten digit check number. The claim must also have the proper recipient identification number for payment.

Kentucky does issue to doctors who request it a list of all the services paid for a particular recipient for a specified period of time. Doctors can notify the State when services not authorized by them were paid.

The system is not foolproof, but seems to work well without many services paid that have not been authorized.

UTILIZATION REVIEW

KenPac compares all participating physicians' patients as an aggregate with a statewide mean and issues a monthly report to each provider. The following areas are measured:

- Emergency room
- Referrals to specialists
- Inpatient hospitalizations
- Laboratory
- Pharmacy
- Office Visits

If the physician exceeds the mean by two standard deviation points for two or more months, the provider is placed on probation for six months. If during the time of probation the provider continues to exceed the mean by two standard deviation points then the provider is placed on probation for another six months. If he or she continues to exceed the standard during the 2nd period of probation, the provider is removed from the program for one year.

Physicians who exceed the statewide mean may request a report which lists the recipients and the services that made the provider exceed the mean. If services were paid that were not authorized by the physician, the physician can notify the State so appropriate action can be taken.

LESSONS LEARNED

KenPac's director indicated that KenPac was not a perfect system but it was a good system. It has accomplished a significant cost savings and, overall, providers and recipients are happy with it. He cautioned any new state beginning the program to watch the authorization process because that is the area of the program that is subject to the most fraud and abuse. He also indicated that the

number of providers that participate in the plan is a key to its success. If you have too few providers, the State may have to overlook some behavior in physicians that otherwise might be sanctioned. If participation levels are high, programs such as those described above that measure utilization and sanction unreasonable patterns may be possible. It might be noted that Kentucky's program has been operating since 1986 and staff have just begun to implement the overutilization program.

MASSACHUSETTS

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STATUS OF THE PROGRAM

The University of Massachusetts completed an independent cost and quality evaluation as part of the federal waiver application. The evaluation concluded an estimated net savings of $19.9 million was realized in 1992, with most of the savings in emergency room utilization. Massachusetts has not completed any other cost analysis.

STAFFING

There are 15 full-time staff members devoted to the PCCM program. Support staff designated for claims processing, provider enrollment and pre-administration work comprise 35% of Medicaid's administration time. An effort is made to hire people with prior managed care experience, but little change has been seen in staff composition.

Foundation Health, under contract since 1992, performs three functions: authorizing transportation, providing customer service (including a hotline) and completing the enrollment function. Staff recommend using a contractor because Foundation Health provides the type of special attention needed in order to reach the Medicaid population. Staff do not know the amount of this contract. The state also has a contract with Value Health for "network manager services." These services include PCC site outcome improvement, a hotline and a profile report to PCC sites. Staff do not know the amount of this contract.

SYSTEMS

There were many claims processing changes. For instance, claims do not get paid unless the referral number passes through specific edit checks. The new systems changes also track enhancement pay on certain primary care services. Staff do not know the cost of systems changes.

ADMINISTRATIVE FUNCTIONS

Internal staff are dedicated to client education. Foundation Health Contract also provides some member services and education. Foundation Health is conducting an analysis of the need and potential improvements for member education. Quarterly newsletters are also provided by the state to the PCC site.

The program did have political support for implementation. Initiation of the PCCM program was mandated in the annual House One Budget released by State administrative officials. Staff

established a partnership with the Massachusetts Medical Society in order to involve physicians in the implementation stage of the program.

CARE MANAGERS

Care managers are: pediatricians, OB/GYNs, internists, group practitioners, family practitioners, independent nurse practitioners, CHCs, and hospital out-patient departments. Staff determined care managers by using federal standards. The program has mandatory enrollment, but not all Medicaid recipients are eligible (those under the age of 65, those who have no insurance, etc. are eligible). Maximum enrollment is 1,500, and was determined through researching the benchmarks used by HMOs.

COVERED SERVICES

Services that do not require referrals from the care manager (Regulations: 106 CMR 450, 11/16/92)

- Abortion services
- Any services authorized and delivered under the Department's home and community based services waivers for the elderly and mentally retarded
- Dental Care
- Drugs (legend and non legend) and diabetic supplies
- Emergency care
- Family planning services and supplies
- HIV pre- and post-test counseling services
- HIV testing
- Hospice services
- Intermediate care facilities for the mentally retarded
- Mental health services
- Nursing facilities
- Sexually transmitted disease diagnosis and treatment when provided by entities that have contracts with the Massachusetts Department of Public Health
- Substances abuse services
- Transportation to reimbursable medical care
- Vision care services in the following categories: visual analysis, frames, signal vision prescriptions, bifocal prescriptions and repairs

AUTHORIZATION PROCESS

Determining which services to include in the authorization process was guided by federal guidelines and typical managed care benefits packages. The authorization process is verbal or written communication and requires the providers Medicaid number. Staff hopes to go to an electronic authorization process in the near future. The authorization system has a 95% integrity ranking that was determined through a quantitative analysis of claims and PCCs. If staff become aware of any problems or potential problems, they follow-up with the PCC and the providers.

The program does have a grievance system. The grievance is usually settled through the audit unit. However, if there is a "serious" grievance filed, then it is referred to the medical director. PCCs are removed or restricted when quality of care issues arise.

LESSONS LEARNED

Political support is very important. Managed care sometimes "gets a bad rap," and therefore, states need to obtain the support of advocates and providers. The state needs to assure people that it will be active in monitoring and managing the program, and not simply leave the program after its implementation.

MAINE

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STATUS OF PROGRAM

Maine implemented a PCCM program in two counties in July, 1994. However, because of systems problems related to enrollment, the program was suspended from March, 1995, until August, 1995. During this suspension, no new enrollees were accepted. Currently, there are 650 recipients enrolled in the program. The State is considering replacing the PCCM program, with HMO risk contracts in early 1996. The PCCM program will be instituted in three rural counties where an HMO option is not feasible. It is anticipated that the PCCM program as it currently exists will be modified before being implemented in the three rural counties, but no formal recommendations for modification have been made at this time.

BARRIERS

Information system problems were the biggest barrier to implementation. The problem was the result of the State's attempt to rely on its existing system with enhancements, rather than developing/purchasing a new system with the necessary managed care components.

Another barrier, and possible reason for the very low level of enrollment in the PCCM program, was the State's change in enthusiasm for the program. At first, the level of enthusiasm was very high. Shortly after implementation, however, the State changed its focus and energy to prepare for HMOs. As a result, the PCCM program suffered.

CHANGES

As mentioned previously, the major change is a shift from a PCCM-focused program to an HMO program. Changes may be made to the PCCM program when it is introduced in the three new counties, but no decisions have been made to date.

STAFFING

Maine staff dedicated to the PCCM plan, Prime Care, are a director of operations, a utilization review nurse, two managed care specialists, and one clerical support person. The State of Maine also contracts with a company that employs fourteen to fifteen people who perform outreach,

emphasizing prevention services especially EPSDT and encourages enrollment in a managed care plan.

SYSTEMS

Staff could not comment on the cost of systems changes but emphasized that they did not spend enough time designing the necessary systems changes that were needed instead they relied on minor changes to the current system which proved to be disastrous.

ADMINISTRATIVE FUNCTIONS

Because of the small number of enrollees and the plans to make changes, administrative functions were not discussed.

CARE MANAGERS

All care managers are physicians, and each receives $3 pmpm for case management services. Care managers are not at financial risk for services provided.

COVERED SERVICES

Most primary care services require the authorization of the Prime Care provider. Mental Health Services and family planning are some of the services that do not require the authorization of the primary care doctor.

AUTHORIZATION PROCESS

Claim forms must have the Prime Care's provider identification number in order for payment to occur for all services requiring authorization rendered to enrollees of Prime Care.

LESSONS LEARNED

Maine stressed the importance of proper system design and testing before large scale enrollment is attempted. They also believe the focus of the Medicaid agency on the program and its priority is important to the success of the program.

MICHIGAN

CONTACT

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STATUS OF PROGRAM

Michigan has a statewide PCCM program called the Physician Sponsor Plan (PSP) which was implemented July, 1982. Most Medicaid recipients must enroll in either PSP or, where available, a capitated plan. Currently, 816,707 recipients are enrolled in managed care, and 488,997 of these are with PSP. There are 60,177 recipients in the target programs who remain in fee-for-service, but will be enrolled in managed care in the near future. The State has achieved a 93% enrollment

toward its goal of enrolling all non-institutionalized, non-Medicare-eligible AFDC and SSI recipients into some form of managed care.

One of the primary reasons for implementation was cost containment, and another was increased access to care through a primary care provider. The program has been successful in achieving both goals.

Michigan Medicaid has had HMO contracts since 1972. There are currently 12 HMOs contracting with the Medicaid program. The HMOs serve 16 of Michigan's 83 counties and have a current enrollment of 286,369. The individual HMO Medicaid enrollment ranges from a high of 139,403 (the HMO covers 10 counties) to a low of 226 enrollees in a relatively new HMO providing service in one county.

The Medicaid program also contracts with partially capitated entities called Clinic Plans. These plans are capitated for all of the HMO-covered services, except inpatient hospital facility charges which are paid fee-for-service by Medicaid if prior authorized by the Clinic Plan. Michigan has five Clinic Plans currently operational and is in the process of certifying several others. Fifteen counties include Clinic Plans as part of the enrollment options. Total Clinic Plan enrollment as of December 1, 1995 is 41,341, and ranges among plans from 14,422 to 1,347. The Clinic Plan program was introduced in 1983 under a 1915(b) waiver.

BARRIERS

The biggest barrier to PCCM implementation was convincing client advocate groups that recipients' health would not suffer as a result of managed care enrollment. A secondary problem was convincing providers to participate, particularly outside of the large, urban areas.

A third problem, common to all models, was the task of educating and enrolling close to one million recipients and building a strong infrastructure to do so.

The Clinic Plan implementation was protested by both physicians and HMOs who saw a competitive disadvantage in allowing another model in the marketplace.

Door-to-door marketing is allowed by Clinic Plans and HMOs. This has led to some marketing abuses.

CHANGES

The biggest change to date has been moving from a pilot project (albeit in Detroit, with a huge Medicaid population) to statewide enrollment. The issues in a large, urban area differ significantly from the issues in a more rural area. Another change was the development of an automated "default" enrollment for assignment when recipients failed to select an enrollment option. A change now under consideration is to move from a fee-for-service system with a case management fee to a capitated primary care system with fee-for-service for other medically necessary services. The capitation would go directly to the primary care provider. In essence, the State would become an HMO using capitated PCPs.

The Medicaid agency wants to move into a totally capitated system to the extent possible. In those areas where there is an HMO option, the assignment default will be to the HMO. The Clinic Plans are being advised to seek an HMO license as the state plans to discontinue the Clinic Plan option at some time in the future. There is currently no inpatient risk for the Clinic Plans but a bonus if savings are realized. The 1996 contract will introduce some risk to the Clinic Plans if aggregate hospital expenditures exceed 100% of the anticipated target.

During 1996, the Medicaid agency expects to reach 100% enrollment of the current AFDC and SSI populations plus AFDC and SSI related categories. They also expect to begin enrolling all Medicaid eligibles currently excluded from participation. This includes Medicare/Medicaid dual eligibles, nursing home residents, Title V/Title XIX dual eligibles, migrants, and spend down eligibles. Voluntary enrollment has already begun with the two dual eligible groups and migrants.

STAFFING

At the time Michigan began statewide implementation of managed care the following staff were assigned to the PCCM program:

- 1 manager
- 1 full-time secretary
- 7 analysts for the following areas
    - Contract Compliance
    - Assignment Process
    - Exemptions/Utilization Review
    - 2 for Recruiting Physicians
    - Quality Assurance/policy/waiver renewal
    - Education/training
- 5 hot line staff
- 3 data coding staff
- 3 data entry staff

SYSTEMS

Michigan initially made many systems changes to link the Physician Sponsor to enrollee, enrollee to eligibility, and PSP enrollee claim to authorization number of PSP provider. Over the years many small and some large systems changes were made to improve the enrollment process, track claims, and produce report cards for PSP providers. Michigan operates its own MMIS and eligibility system so the cost of system improvements was not available.

ADMINISTRATIVE FUNCTIONS

Recipients may change their PCP on request. Changes are always effective the first of the month, so a change will take two to six weeks for processing. Prior authorization is required for non-emergency physician visits, inpatient and outpatient hospital visits, and home health agency visits. The provider of care is to call the PCP and obtain the PCP's billing ID number. This is placed on the invoice. Without the ID authorization number, the invoice will be rejected.

Federally qualified HMOs have a six month lock-in. Recipients may request disenrollment (which is actually a change since managed care enrollment in one of the models is mandatory) any time during the first month of enrollment and during the months of May and November thereafter.

Non-federally qualified HMOs and Clinic Plans have the same sort of administrative lock-in as the PSP; that is, the recipients may request a change at any time but it will take two to six weeks to

process and the change will always be effective on the first day of the month. One major difference between the programs is that PSP enrollees may request a change from one PSP doctor to another or to an HMO or Clinic Plan by completing an enrollment form or calling the hot line. HMO and Clinic Plan enrollees must complete a Plan disenrollment form and then complete an enrollment form for the physician/Plan that they wish to join.

The Medicaid agency performs most administrative functions internally. Because of the huge volume of calls to the toll-free hot line, the agency recently contracted with a private agency for overflow calls.

CARE MANAGERS

Physicians and nurse practitioners may be PSP providers. Physician Assistants are not enrolled Medicaid providers and therefore cannot be PCPs.

The $3 pmpm (to a maximum of $3,000) is paid once each month following the month of service through a gross adjustment. It is reported on the remittance advice. Each PSP provider may enroll a maximum of 2,000 recipients.

Currently, providers assume no financial risk. By the end of 1996, Michigan plans to introduce capitation and risk into the PCP contract. The extent of the services covered and the risk to be assumed have not yet been determined.

COVERED SERVICES

Non-emergency physician visits, inpatient and outpatient hospital, and home health agency services require an authorization. All other services may be obtained outside of the PSP authorization process. All services which require administrative prior authorization under FFS continue to require prior authorization even if the service now requires authorization of the PCP in addition.

HMOs and Clinic Plans are capitated for almost all of the Medicaid covered services. There are some exceptions. They include: dental, community mental health services (although the Plans have a significant mental health service requirement), home and community-based services, state mental institutions, certain educational-related services.

EDUCATION

In terms of recipient enrollment/education, there is currently very little patient education beyond the training provided to local case workers and the recipient's access to a 1-800 hot line. Enrollment booklets and a choice letter are sent to recipients to explain how to enroll. Michigan used Medicaid recipients to educate and enroll other Medicaid recipients into a managed care plan. This was very successful and Michigan received a HCFA award for this effort. Several county health departments also acted as an educational and enrollment source for recipients. Education and enrollment forms in Michigan are also available at each county office plus at many provider offices.

HMOs and Clinic Plans are required to provide new enrollee education and orientation materials within three months of the enrollment effective date.

Michigan just sent out the first physician report cards to PSP participating providers under a revised SURS system. The system still has bugs. Prior to this recent mailing, it had been years since a report on utilization was sent to physicians.

AUTHORIZATION PROCESS

Michigan requires that the Physician Sponsor Plan provider's identification number be placed in the appropriate place on the claim form for all services that require authorization. If the identification number is not correct the claim is rejected.

LESSONS LEARNED

Michigan stressed that ongoing communication with recipients and providers is important not only during start up and expansion but afterwards. Program improvements should always be considered but not implemented until adequate responses are received. Constant communication and effort by the Medicaid agency will usually bring the stated results, although the timeframe may be longer than the agency desires.

MONTANA

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STATUS OF PROGRAM

Montana implemented a PCCM, PASSPORT TO HEALTH, in January of 1993, via a 1915(b) waiver. AFDC, AFDC-related and SSI recipients are mandated to enroll. Among those excluded from participation are recipients who have Medicare, are in an institution, are medically needy, or who cannot find a primary care provider who will accept them. Implementation has been gradual.

Montana is currently implementing an HMO option as well. There is little HMO coverage in Montana. Three HMOs are licensed, but only one has a service area of a notable size.

BARRIERS

Geography and population play a major role in Montana's ability to provide a managed care environment. There is little concentration of recipient population. The greatest population in any one county is less than 10,000, and only three counties have a recipient population over 5,000. Many of Montana's counties are classified as frontier. Montana also has a high Native American population, some of whom are eligible for Medicaid. Because of its rural nature, availability of physicians is a major barrier to establishing a PCCM program. It also hinders HMO development. There are counties with no physicians and no clinics. There are counties with some physicians but not all of the types of physicians needed for an HMO license.

CHANGES

Montana initially used a local consultant to provide telephone support and enrollment information to clients. Provider marketing was done by Department staff. At the end of the contract period, Montana greatly expanded the scope of work and issued an RFP. The new contractor maintains a recipient and a provider 800 telephone number, provides recipients with enrollment information

and processes all of the enrollment forms, markets to physicians and to HMOs, facilitates a provider advisory group, and performs QA activities for the program.

HMO contracts were not part of the initial managed care effort. Montana has no Medicaid HMO contracts. There are three licensed Plans. Montana's goal is to contract with all three.

STAFFING

The program was initiated with two FTEs. That remains the State complement. The enrollment broker has four full time staff on-site in Helena consisting of a manager/marketer, a nurse for quality assurance and provider relations, two generalists who man the phone lines and process all enrollments.

SYSTEMS

The Montana system is similar to other states. The enrollment information is put on the Medicaid card. Edits on the system prevent payment of unauthorized covered services. The enrollment broker had to demonstrate the ability to link electronically with Montana's eligibility system (TEAMS).

ADMINISTRATIVE FUNCTIONS

The State initially implemented PASSPORT TO HEALTH on a pilot basis in the more populated counties. Montana uses a contractor for its MMIS and also contracted for a recipient hot line. In 1994, the State began a broad expansion of PASSPORT TO HEALTH and contracted for most of the administrative functions inherent within a managed care program. All enrollment and provider marketing activity was assumed by the contractor. In addition, the contractor began the process of developing an HMO option.

Medicaid recipients who reside in counties with PASSPORT TO HEALTH are required to select or be assigned a primary care provider. Enrollments and changes occur primarily by mail or phone. Either recipients or PCPs may request a change of enrollment which will take effect as soon as administratively feasible.

CARE MANAGERS

The following providers may contract as PCPs: family practitioners, internists, OB/GYNs, pediatricians, osteopaths, any other physician who agrees to provide primary care; federally qualified health centers, rural health centers, Indian Health Service centers on a reservation, other clinics who meet PASSPORT TO HEALTH criteria; and certified nurse practitioners and nurse midwives, and physician assistants working under a supervising physician (the supervising physician must sign a contract and is the recipient of the case management fees). Care managers receive a $3 pmpm case management fee, and do not assume risk for services provided.

Physicians are limited to an enrollment of 1,500 recipients, plus 1,200 for each physician assistant, certified nurse practitioner or certified nurse midwife on the physician's staff. An independent physician assistant, certified nurse practitioner, or certified nurse midwife may enroll a maximum of 1,200 Medicaid recipients.

COVERED SERVICES

The following services are managed by PASSPORT providers: inpatient hospital, outpatient surgeries, physician visits, mid-level practitioner, private group practices, federally qualified health centers, rural health clinics, Indian Health Service centers, chiropractic and well-child screens.

Services not covered under PASSPORT include: family planning, obstetrical care, vision, outpatient mental health, radiology, anesthesiology, pathology, immunizations, blood lead testing, and STD detection and treatment.

AUTHORIZATION PROCESS

Authorization of referred services is through the use of the PASSPORT provider's ID number. This must appear on the referred provider's invoice in order for the provider to be paid. While referrals may be verbal, Montana encourages written referrals.

OTHER

Quarterly reports are generated to PCPs comparing their experience with other PCPs in the areas of emergency room visits, physician specialty referrals, inpatient hospitalizations, office visits billed by the PCP, and total Medicaid expenditures for services billed or authorized by the PCP.

Quality assurance is monitored through the recipient hotline, periodic recipient surveys, and a grievance system. In addition, the PCP's 24-hour availability will be monitored through random calls to the PCP's 24-hour number.

LESSONS LEARNED

Montana chose not to re-invent the wheel. They considered states who had programs which they considered to be operating well and copied their design. The Montana program borrowed heavily from the Michigan program. Michigan's physician recruitment video was used by Montana in their early physician recruitment effort. Much of the program design is identical to Michigan's.

NEW JERSEY

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STATUS OF PROGRAM

The State of New Jersey has a mandatory managed care program which is midway through a two-year statewide phase-in. The State relies on the Garden State Health Plan (GSHP), a state-operated public HMO, plus contracts with private HMOs for the provision of care to Medicaid recipients.

The GSHP is available to Medicaid-eligible individuals on a voluntary basis as an alternative to the traditional fee-for-service Medicaid program. Administered through the Division of Medical Assistance and Health Services in the New Jersey Department of Human Services. GSHP is rooted in the philosophy that New Jersey's medically indigent population will receive more

appropriate, coordinated and cost-efficient health care services through a medical case management system than through fragmented, episodic care.

MAJOR FEATURES OF GSHP

Administratively, the GSHP is organized as an HMO with administrative, financial, marketing, medical, management information systems, and plan relations staff. A listing of the major features of the GSHP are listed below.

- A Physician Care Manager is responsible for the provision of primary care delivery, referral, and ancillary services for non-institutional Medicaid recipients, 24-hours a day/seven days a week.
- Reimbursement is paid on a capitated basis.
- Alternatives to inappropriate use of the emergency room or hospital outpatient department are in place.
- A grievance system and quality improvement monitoring are in place.
- A toll-free telephone number, operated by the GSHP, is available to members and providers with any problems or questions.
- Enrollees are "locked-in" to the plan for six month periods.
- Physicians participating in the plan are credentialed.

CARE MANAGERS

Individuals either choose or are assigned to physician care managers at enrollment. Primary care case managers are paid capitation for most primary care services. The primary responsibilities of the physician case managers are as follows:

- Coordination of member's health care needs and services, 24-hours a day/seven days a week;
- Provision of primary care for Plan members;
- Management of all referral services, including ancillary services, follow-up care, and higher level care; and
- Review and approval of all medical services and expenditures on behalf of the patient.

COVERED SERVICES

The following services are covered under the GSHP and must be either provided or authorized by the Primary Care Manager.

- All physician services
- Inpatient hospital services
- Outpatient services
- Clinic services at free-standing clinics
- Podiatrist services
- Vision care services
- Optical appliances
- Laboratory
- Radiology
- Prescribed drugs

- Emergency medical services
- Chiropractor services
- Home health services
- Prescriptions and Lab related to Mental Health and Substance Abuse
- Hearing aids
- Durable medical equipment
- Medical supplies
- EPSDT
- Preventive health care and health education services
- Rehabilitation services

The following list outlines GSHP-covered services which do not require PCM authorization.

- Second surgical opinion
- Certified nurse midwife services
- Physician fee for routine, in-hospital newborn care
- Pediatrician attendance for at-risk vaginal deliveries or cesarean sections
- Practitioner fee for normal prenatal, delivery and postpartum services
- Family planning

The following services are not included as benefits in the GSHP and may be accessed outside of the Plan through the traditional fee-for-service Medicaid system.

- Nursing facility care
- Medical day care
- All transportation
- Prosthetics and orthotics
- Dental services
- Mental Health and Substance Abuse (except related prescriptions and lab work)
- Services unique to special waiver programs
- Services unique to demonstration projects
- Any other Medicaid-covered services

BARRIERS

While the GSHP was under development, the State experienced difficulty in making the physicians feel comfortable with the idea of participating in a State-owned HMO for Medicaid recipients. It was also difficult to educate the recipients on the use of a new delivery system according to a new and foreign set of rules. Eventually, both of these barriers were overcome. The following table shows the increase in membership between 1991 and December, 1995.

Year	Number of Enrollees	Number of Participating Doctors
1991	4,800	132
1995	33,000	600

From an administrative point of view, the challenges of beginning and sustaining a State-owned and operated HMO were immense. Initially, the GSHP employed State workers with no prior HMO experience. Staff had to be retrained and often had to change their philosophical point of view. In 1995, the GSHP was able to hire a few people with prior managed care experience to operate their marketing department.

Continued and guaranteed funding by the State has been a problem for the GSHP from the beginning, even though the Plan has saved the State a great deal of money. Hiring freezes and civil service rules were often contradictory to the efficient operation of the HMO. For example, there were no position descriptions or job titles that fit many functions of the HMO. As a result, personnel found it cumbersome to operate an HMO within the confines of State Civil Service, not only because most of the GSHP employees did not fit into existing Civil Service classifications, but also because hiring and firing practices were not conducive to the efficient operation of the business.

The GSHP is regulated by other state agencies such as the Department of Insurance who holds them to the same standards as commercial HMOs. However, the GSHP is often not allowed, by the State, the flexibility to organize and operate as effectively as necessary. The GSHP currently employees 62 people to administer the health care of 33,000 enrollees. There is a need for several more employees, but the program is unable to hire additional staff due to the constraints of the current State budget.

The current governor has indicated a desire to sell the HMO to a commercial vender. Employees of the HMO are puzzled by this decision because they have struggled to gain provider and recipient credibility. Systems are now operating smoothly and the HMO is financially profitable. GSHP staff estimate the profit from the sale could be saved by the State in one year if it remained a State-owned entity.

NEBRASKA

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STATUS OF THE PROGRAM

The six-month-old PCCM program is too new to determine if any savings have been realized. They are expecting to see savings.

BARRIERS

The timing of project implementation did not allow opposition to form. There was a huge push by the State for the program to be organized and implemented as quickly as possible.

CHANGES

The program is too new to have experienced any substantial changes.

STAFFING

No specific staff are devoted to the program. Two people oversee all vendor contracts for the PCCM, but they also have duties outside the program. An implementation group at the beginning of the project as well, as identification of specific staff responsibility to certain pieces of the project, could have alleviated workload problems.

Maximus is contracted as the PCCM enrollment broker, and MedStat for management of data systems. Two HMOs have a contract (following a competitive bid); each HMO covers one half of the state. BC/BS was the successful bidder and is developing a statewide PCCM network. BC/BS will assume all of the administrative functions associated with operating a PCCM program. Staff did not have knowledge of the amount of the contracts, but did say the contracts are for a two-year time period. It is too early in the project for staff to be able to recommend this approach, although staff said the contractors were faster with the implementation of their pieces than the State could have been.

SYSTEMS

Systems changes are not complete, and have already exceeded cost by three times what was estimated (staff could not provide the dollar amount). Nebraska may have to use a contractor for claims processing because both cost and time estimates for systems changes, specifically claims processing, were unrealistic. More coding education is also needed.

ADMINISTRATIVE FUNCTIONS

Clients must enroll with physicians as their care managers. There is mandatory enrollment. Nebraska is in the process of adding the following groups not yet included: disability, Medicare/Medicaid recipients and people with adequate insurance. Maximum enrollment for a provider is 1,200. The PCCM network contractor is responsible for monitoring wait times, quality of care, and other such indicators to ensure that providers are capable of handling large numbers of enrollees.

Client and provider education are handled by the enrollment broker. There were community and provider education forums in the early stages of the project.

CARE MANGERS

Nebraska allows only family practice, obstetrician/gynecologist, internists, and pediatricians to become primary care providers in their PCCM plan. They emphasized that the plan only covers the urban areas of the state now and their is no shortage of physicians in these areas.

COVERED SERVICES

Specialty visits, laboratory and x-ray associated with specialty visits, physical therapy, occupational therapy, etc. require the authorization of the PCP provider. Family planning and dental services do not require the authorization of the primary care provider. Mental health services are provided through a vendor and are administered separate from the PCCM program.

AUTHORIZATION PROCESS

Authorization is required for any services outside of the primary care office except for dental, prescriptions, and other non-primary care services. Staff were unable to locate the list of exceptions, but said the exceptions were determined by looking at protocol used by managed care companies and by using input from a managed care advisory group. The authorization process uses referrals issued by the provider. Referrals must identify the type of specialist, number of visits, and the reason for the visits. There is no assurance of the integrity of the system, but Nebraska is developing a system to analyze referral rates to evaluate whether they appear appropriate.

LESSONS LEARNED

Nebraska staff hopes other states can learn from their mistakes. States must take an honest look at their capabilities. Nebraska did not realize the amount of time needed for systems changes and failed to recognize what their capabilities were in terms of claims processing. Many folks in Nebraska saw the program as the "magic bullet," causing expectations for the project to be extremely high in its early stages. An overall plan and mission probably could have avoided this. Bringing people into the early planning stages and decision-making processes is absolutely essential. While there was very little time for opposition to form during the first stages of program implementation, it now faces opposition from hospitals, advocacy groups (such as the disability group) and certain providers. Staff also suggests examining the readiness of areas identified for initial project implementation. Nebraska started the program in three counties without determining if the counties were ready, this in turn, caused later problems. Neither providers or recipients accepted the program as readily as they might have if the proper planning had been executed.

NEW MEXICO

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STATUS OF PROGRAM

New Mexico's Primary Care Network (PCN) is currently a statewide PCCM program. With a 1996 scheduled implementation of a capitated managed care program, it is anticipated that the prevalence of PCN will decrease until eventually it is available only in those regions of the state where capitated managed care is not available, or where only one capitated health plan is available.

PCN was the State's first step in addressing a 1991 legislative mandate to implement cost containment measures. The State also implemented PCN to address the severe client access problems due to provider unwillingness to participate in the Medicaid program. The program has been very successful in both reducing costs and increasing access. Client access improved over 50%, with marked decreases in inappropriate use of the emergency room.

The PCN program is considered successful. A University of New Mexico study identified $32.3 million in gross savings in the period studied (1992-94), representing 5% of program benefit dollars. Emergency Room and hospital-based services declined; use of physician office services increased. The most substantial savings were achieved in the areas of physician services and laboratory and X-ray services.

BARRIERS

Initially, there was low provider participation, as providers feared the impact of adding additional Medicaid patients to their existing caseloads. Because the State did not actively market or recruit providers in rural areas, several areas of the state were exempted from PCN due to insufficient provider participation.

In early 1995, the new State administration aggressively marketed the PCN program on a statewide basis. As a result, there was enough provider participation in July to enable the State to expand the program statewide.

There was no proactive political support for implementation. There was political opposition from many sources. Objections were overcome by the success of the pilot, which demonstrated the worthiness of the concept. Savings were used to expand the program.

CHANGES

Initially, the program had many exempt populations and services which promoted extreme laxity and non-compliance, thereby reducing its effectiveness. There was also no control over referrals. In response, the program was redesigned to include more recipients, services, and controls.

Currently, a new referral process is being designed to gain greater control over referrals from primary care providers to specialists. The program has also removed the requirement to "lock-in" clients to pharmacies (per HCFA).

STAFFING

The MMIS fiscal agent performs some services associated with the PCN program, i.e., processing of mail-in enrollment applications. Blue Cross/Blue Shield of New Mexico has a contract to provide utilization review. The University of New Mexico was contracted to evaluate the PCN program. A contractor is helping the state with HMO implementation planning including actuarial analysis. When the State begins contracting with HMOs, it plans to contract with an enrollment broker. New Mexico believes it is important to contract for specialized services.

The PCN program was supported originally by two full time persons. Staff have been increased to six. Two of the six staff work for the fiscal agent.

SYSTEMS

The current MMIS is a fee-for-service processing legacy system. Numerous changes (approximately 300) have been required to support PCN contracting. The state is currently designing a replacement MMIS which will contain full PCN and HMO functionality.

ADMINISTRATIVE FUNCTIONS

Once a primary care physician is selected, recipients are "locked-in" to their provider for six months. The current referral process from the primary care provider to a specialist does not require any state authorization or intervention. Because of the potential for fraud, the State is currently looking at alternatives to control this process.

The fiscal agent supports managed care member services. The Medical Assistance Division performs provider recruitment. No staff are dedicated to client education.

CARE MANAGERS

Care managers may be physicians (family practice, pediatrician, OB/Gyn, internist, general practitioner), nurse practitioners, and physician assistants (under the supervision of a physician with hospital admitting privileges).

Care managers can be: primary care physician specialists, physician assistants, nurse practitioners, family practice physicians, OB/GYN doctors, and some specialists; and IHS providers. Enrollment is mandatory. Maximum enrollment per care manager is 1500 members, and 500 for physician assistants. No attempt is made to determine a practitioner's capacity.

New Mexico attempts to screen physicians before approving managed care contracts. PCPs have been removed under serious conditions, e.g., indictment.

Care managers receive a $2 pmpm case management fee paid on a separate remittance advice on a monthly basis. Care managers assume no financial risk.

COVERED SERVICES

The following services are provided by the care manager, or will be provided through other Medicaid providers with a referral from the care manager: professional services, including urgent care, prescription drugs, hospital inpatient services, hospital outpatient services, home health services, laboratory and radiological services,; ambulatory surgery, and rural health center services.

The following services are excluded from PCN and may be provided as under present regulations by any qualified Medicaid provider without a referral: psychiatric services, obstetrical services, eyeglasses and related services, dental services, services which are covered by Medicaid only for Medicare-eligible persons, and family planning services.

OTHER

Currently there are no written educational materials available for recipients or providers. Provider education is done through face-to-face meetings. An educational video for recipients has been planned for development in 1996.

AUTHORIZATION PROCESS

New Mexico is improving their referral authorization system by requiring that all services that must be approved by the PCP be given a unique authorization number that must appear on the claim before it is paid. The system has completed the design phase and is scheduled for implementation soon. The computer system will look for the unique identifier on the claim, if it is not there it will search the system for an assignment of a number for that service. If either is there, the claim will be paid. If neither is there the claim will be rejected. New Mexico is expecting to that the new process will save them substantial costs and will be accepted by the provider community.

LESSONS LEARNED

Tips are: (1) construct a solid model for the program; (2) think through all the components; (3) have a good implementation plan; (4) support the project with adequate personnel and financial resources; and (5) make sure the technical and operational infrastructures are in place.

NORTH CAROLINA

CONTACT

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STATUS OF PROGRAM

North Carolina has had a PCCM program, Carolina ACCESS, for five years. The program is currently operational in 38 of the 100 counties in the state, and covers approximately 50% of the eligible Medicaid population. The State has plans for further expansion in early 1996. The PCCM program was implemented primarily for financial reasons.

BARRIERS

Although Carolina ACCESS was implemented quite smoothly, three barriers were mentioned. These barriers were: provider fear of the program, struggles with mobilizing the infrastructure, and implementing the program on too large a scale. It is now felt that provider uneasiness with the program was probably due to the State's inadequate communication and education regarding the program. This has been overcome, although many providers are still apprehensive of losing control under any type of managed care environment. The mobilization of the infrastructure and support for the program among other State agencies at the local level is in place now, but was not coordinated well before program implementation. As a result, enrolling recipients and explaining the program was a disjointed effort. The manageability of a new program on any scale is difficult: in hindsight, North Carolina staff believe the program would have had a smoother start had they initially implemented on a smaller scale.

CHANGES

The only major change that has been made is in the way State employees serve the counties. Employees have been divided into two teams to better focus on problems. One team is responsible for addressing internal agency issues, while a second team works in the "field" on educational issues for both program enrollees and providers.

STAFFING

Eleven full time staff are dedicated to the administration of the PCCM program, this includes clerical persons. Five additional staff work on the HMO program. North Carolina does not use any contract staff for the administration of their PCCM program.

SYSTEMS

The capabilities of the data system must be known and in place before the program begins. The system needs to be able to track providers and monitor recipients (in other words, it needs to know

where care is being received and where services are being provided). Maintaining a system based on services provided, but not tracking where or how care is provided, is insufficient in a managed care environment.

ADMINISTRATIVE FUNCTIONS

There currently is no "lock-in" clause for enrollees in Carolina ACCESS. Prior authorization is required for some services. With the exception of inappropriate use of the emergency room, where there continue to be many claim denials, prior authorization works quite well.

CARE MANAGERS

In addition to physicians, physician assistants and nurse practitioners can be care managers, or personal care providers (PCPs), under Carolina ACCESS. The State felt comfortable in allowing these mid-level practitioners to be care managers because of the strong co-licensing system that is in place in North Carolina.

Care managers receive a case management fee of $3 pmpm for the first 250 enrollees and $2.50 pmpm for each enrollee in excess of 250. Care managers assume no financial risk for the covered services provided or authorized to Carolina ACCESS enrollees. While there are no formal plans to change the level of risk, there have been some informal discussions about how risk might be incorporated into the program.

COVERED SERVICES

A whole continuum of services are provided under the PCCM program. This continuum includes mental health, vision, pharmacy and home health.

The following services can be received without authorization: ambulance, anesthesiology, at-risk case management, dental, eye care, family planning, hearing aids, hospice, independent and hospital lab, mental health, pharmacy, and radiology/pathology.

AUTHORIZATION

The physician's provider identification number acts as the referral authorization number and must be placed in the proper field on the claim form before payment is made.

LESSONS LEARNED

In addition to the information provided above, the following general advice was offered. Once again staff stressed that the Medicaid agency coordinate the operations of the managed care program with other State departments, especially public health and social services, to ensure coordination of services and communication of problems.

The importance of continuous education cannot be stressed enough. The major problem North Carolina continues to have is getting recipients to stay with their PCPs and not go to the emergency room. This is a serious problem in North Carolina and is requiring a great deal of educational effort.

NORTH DAKOTA

CONTACT

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STATUS OF PROGRAM

North Dakota implemented a statewide PCCM program in January, 1994. The primary motivation for the program was financial in nature. Cost savings have been realized and the State is ready to submit a waiver renewal. AFDC and AFDC-related recipients are enrolled in the program.

BARRIERS

The primary obstacles experienced by the State during implementation all center around providers. In particular, the State indicated that the medical association was not brought into the process early enough. Subsequently, getting providers to buy into the process along with training them was more time-constrained than anticipated. Also, because of the shortage of physicians, especially specialists, problems were encountered with having enough physicians with whom to link Medicaid recipients. In hindsight, and as a recommendation to other states, it was suggested that an advisory group of physicians be formed and used during the development stage of the program.

CHANGES

No changes have been made to the program.

STAFFING

No full time staff have been added for the administration of their PCCM program, rather current staff has been given additional duties to perform. They use no contractors for the administration of their program.

SYSTEMS

Systems changes to accommodate the PCCM plan have cost approximately $60,000.

ADMINISTRATIVE FUNCTIONS

Only those Medicaid recipients who are severe overutilizers of services are subject to a "lock-in." In those instances, the recipient is assigned to a physician who is responsible for case management for a minimum of six months.

CARE MANAGERS

Because of the Native American population in North Dakota, Indian Health Service Centers can be care managers in addition to physicians. Care managers receive a $2 pmpm case management fee. Care managers assume no financial risk for services provided.

COVERED SERVICES

With the exception of vision and dental, most medically necessary services are provided under the PCCM or through prior authorization. The state is currently looking at carving out mental health.

AUTHORIZATION PROCESS

Is similar to other states, which requires the provider identification number to appear on all claims that require the authorization of the PCP.

LESSONS LEARNED

North Dakota strongly suggests that an advisory committee be set up to help with the design and the administrative decisions necessary to implement a PCCM plan. They would not limit the committee to only primary care providers but would include hospitals, nurse practitioners, other state agencies, and other interested providers.

SOUTH DAKOTA

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STATUS OF PROGRAM

South Dakota implemented its PCCM program in 1993 with the intention of decreasing growth in program costs through minimizing emergency room use and duplicated services. Medicaid staff are currently waiting for the federal government to approve its application for a 1915 (b) waiver renewal. Such approval would extend the program another two years.

BARRIERS

Because of its rural nature and large Native American population, South Dakota had a difficult time finding another state PCCM program to use as a model for its program. Medicaid staff ended up modeling their program on the PCCM in New Mexico.

ADMINISTRATIVE FUNCTIONS

South Dakota imposes a "lock-in" on Medicaid recipients for one year. However, they can choose a new provider at their annual renewal date for any reason, and can change at any other time if they have "good cause" to do so (for example, if they move to a new county). The primary care provider must prior authorize all services that are covered under the program.

CARE MANAGERS

Physicians, federally qualified health centers, Indian Health Service Centers, and rural health centers can serve as care managers in South Dakota's program. These providers receive fee-for-service reimbursement plus a case management fee of $3 pmpm.

COVERED SERVICES

The following services are provided under South Dakota's PCCM program:

Inpatient/outpatient hospital care, general medical and surgery care, mental health/community mental health center services, specialty care, medical equipment/prosthetics, prescription drugs, home health care, residential/chemical dependency treatment, and EPSDT screenings.

Recipients may obtain the following services outside of the PCCM:

Emergency services, family planning, dental care, optometry (basic vision), podiatry, ambulance/transportation, anesthesia, radiology/pathology, laboratory and x-rays, chiropractic care, and immunizations from home health providers.

VIRGINIA

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STATUS OF PROGRAM

Virginia started its PCCM program, Medallion, in January, 1992. As Medicaid HMO programs grow in the state, it is expected that the PCCM program will shrink and become primarily a rural program in areas where HMOs are not readily available.

The primary motivation for implementing a PCCM program was two-fold: to reduce costs and to improve the coordination and quality of care. A recent study indicated that the PCCM program generated a 5% savings over Medicaid fee-for-service expenditures. The same study showed that the coordination and quality of care objectives have been met.

BARRIERS

No barriers were mentioned. Unlike many other states, Virginia did not have a problem with provider willingness to participate. The Virginia Medical Society endorsed the program and recruitment went very well.

CHANGES

Two major changes have occurred since implementation of the program. Initially, participating providers received a $2 pmpm case management fee and a $2 pmpm incentive fee to control costs outside of the office visit to the care manager. The state had great difficulty calculating the incentive fee and got behind in payments. The incentive fee has been discontinued and the management fee has been increased to $3 pmpm.

The second change occurred in July, 1995, when the program was expanded to include 50,000 aged, blind and disabled non-Medicare/non-long term care recipients. This expansion has gone very smoothly.

STAFFING

Virginia employees 3.5 persons to administer the Medallion program. Staff:

- recruits physicians
- determines policy
- resolves billing disputes
- communicates with providers

In addition to staff assigned to the Medallion program, tasks necessary to the program have been integrated into many other jobs in the agency. Their help line staff numbers about twelve temporary workers who answer questions about the program and enroll recipients into the program. Virginia does not contract with any company for additional administrative duties.

SYSTEMS

Systems changes were necessary to insure only those services authorized by the Medallion provider were paid. The cost of system changes was approximately $250,000.

ADMINISTRATIVE FUNCTIONS

Enrollment in the PCCM program is mandatory, but a recipient can change providers on a monthly basis. Prior authorization can be made by the care manager through verbal or written referral.

CARE MANAGERS

Only physicians can be care managers. The State considered allowing physician assistants and nurse practitioners to participate, but decided against it. Nurse practitioners can see recipients enrolled in the program if a referral is made.

Care managers receive a $3 pmpm case management fee and assume no financial risk. Case management fees are paid separately the third week of each month.

COVERED SERVICES

Enrolled recipients receive all services within the PCCM with the exception of: mental health services, family planning, obstetrics, pharmacy, health department immunizations, vision and dental services.

AUTHORIZATION PROCESS

The HCFA 1500 form, lines 17 and 17A must have the authorization number of the Medallion provider for those services that require the authorization of the Medallion and rendered by another provider. Likewise the UB92 must have the proper name and identification number to be processed.

LESSONS LEARNED

Communication is the key to success. The support of your medical society is important also. Virginia put together an advisory committee which was originally made of physicians but later

included rural health centers and nurse practitioners. The advisory committee was an important communication link with the provider community but was not the only way Virginia spoke with concerned providers. The Medallion program was implemented in 1992 and now has over 2400 enrolled providers. It is estimated they well over three fourths of these providers received a one on one call by state staff before they enrolled in the program.

WISCONSIN

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STATUS OF PROGRAM

Wisconsin began its Primary Provider Program, a PCCM program, in December, 1994. The program is presently operational in one county with 8,934 enrollees and 193 providers. The motivation for implementing the program was cost savings. Since the program is so new, a comprehensive evaluation of the possible savings has not been completed. Preliminary studies are inconclusive.

Wisconsin allows recipients in a five-county area (Milwaukee, Dane, Kenosha, Eau Claire, and Waukesha) to choose an HMO as their managed care provider. The HMO option has been available to recipients since 1984. Since HMOs are unlikely to cover the entire state, due to rural nature, the Primary Provider Program was initiated to introduce managed care to those areas.

BARRIERS

Originally, Wisconsin planned to implement the Primary Provider Program in a seven-county area, the Fox Valley region of the state. However, providers in that region failed to participate because there was no apparent incentive. Wisconsin stated their biggest mistake was attempting to implement the program in too broad an area without first piloting the program in a small area of the state. Unfortunately, because of the lack of provider participation, inadequate systems testing, and too little recipient education, the State was forced to suspend enrollment and subsequently reintroduced the program in only one county.

CHANGES

As mentioned above, Wisconsin was forced to redesign the program, both in regard to the State's approach to providers and recipients, as well as in the State's internal policies and procedures concerning the enrollment and authorization system.

STAFFING

Two full time staff, one policy analyst and one contract monitor, are assigned to the Primary Provider Program. The enrollment contractors handles recipient enrollment and the fiscal agent operated both the recipient and provider help line which answers questions about the PCCM plan.

SYSTEMS

Systems problems adversely affected the recipient enrollment process. The Medicaid agency attempted to assign recipients to the last provider that had billed the Medicaid program for services. This resulted in many recipients being assigned to inappropriate providers, such as emergency room doctors, specialists, and doctors far from their residences. Consequently, Wisconsin was forced to redesign the enrollment system. Wisconsin also found that recipients were not given enough time to make a provider choice before an automatic assignment was made. Recipients are now given six to eight weeks to make a choice, in comparison to the previous 30-day time period. Education efforts are also being improved. The program is now operating smoothly and expansion plans for the upcoming year are underway.

ADMINISTRATIVE FUNCTIONS

Wisconsin's authorization system is prompted by a condition code on the claim. If the condition code indicates a life threatening emergency, authorization is not required.

Beginning in July, 1996, recipients in selected counties will be required to make a choice of a managed care provider. They may choose to participate in either an HMO or Primary Provider Program.

CARE MANAGERS

Wisconsin allows physicians, physician assistants, nurse practitioners, and nurse midwives to be primary care providers in their program. Providers are paid a $3 pmpm case management fee for all Primary Provider Program enrollees. Care managers do not assume any financial risk.

COVERED SERVICES

Mental health and substance abuse services may be accessed outside of the system and a recipient may obtain a health check-up anywhere. Most other physician and hospital services must receive prior authorization to be paid.

AUTHORIZATION PROCESS

Recipients assigned to a primary care provider must receive a referral from the PCP before accessing specialty services. The only exception to this is if a recipient is experiencing a medical emergency at which time he or she may access specialty care and the referral may be given retrospectively. When a specialist submits a claim he or she must include the certification number of the PCP on the claim form before the claim is paid.

LESSONS LEARNED

Wisconsin states they allowed individual doctors to become providers as well as clinics. Each had their own referral authorization number. In most cases this worked well but in cases where the doctor signed up as an individual and as a clinic, confusion resulted because the referral authorization number sometimes did not match that shown on the recipient file which caused claims to reject. They advised allowing providers to sign up either as individuals or clinics but not both.

Designing and testing the enrollment process for both recipients and providers in a small area is the best approach. Wisconsin began their program by mandating SSI enrollment in the Milwaukee

area, a large urban area. When the system was unable to process the number of enrollments, Wisconsin was forced to make the program voluntary and redesign their system.

Wisconsin also issues a different card to their PCCM enrollees. Providers unfamiliar with this card have refused to render services, which do not require authorization. A better educational effort may have adverted confusion.

ADMINISTRATIVE MANAGEMENT PRACTICES

Administrative management practices can occur within a managed care structure, alongside a managed care program or independent of a managed care program. Many states implement a variety of administrative management practices prior to the implementation of a managed care program. These practices often result in cost containment and administrative efficiencies. As a state moves toward implementation of a managed care approach, a review of the practices and consideration of their continued value must occur.

Often a PCCM program is built on top of the existing administrative management practices. For example, if a state employs a prior authorization (PA) process for non-emergent hospital admissions, that PA continues with the added requirement that the primary care provider (PCP) must also authorize the admission. Continued stay reviews remain a part of the program (PCPs normally do not become involved in continued stay reviews). HMOs, on the other hand, usually assume the State's role in monitoring the need for services and in determining how to most appropriately provide services.

The reason for the difference between PCCMs and HMOs is one of financial responsibility. The providers who serve as primary care providers in a PCCM are usually not at risk for program expenditures. While the program usually results in reduced costs, primarily through decreased ER usage and inpatient hospital admissions (which may be directly linked to decreased ER use), the PCP is paid FFS and has no financial liability if program costs do not decline. Therefore, it makes sense for the Medicaid program to continue successful administrative management practices. The HMO is at full risk for covered services. It is in the HMO's best interest to have a solid management program in place. Since the state agency is absolved of financial responsibility, the administrative responsibility shifts to one of assuring contract compliance and client access to appropriate care.

Introduction of managed care in the Medicaid agency always requires the realignment of the agency and forces employees to confront new issues. The transition from a fee-for-service environment to a managed fee-for-service and/or capitated arrangement(s) are always problematic. Strong leadership and a sense of mission helps the Medicaid Division accept the challenges of organizational and job restructuring.

AGENCY MISSION/CULTURE

As a state transitions from a claims payment agency to an agency that selects and offers managed care services, the culture of the Medicaid agency must change accordingly. Under managed care, Medicaid needs to excel as purchaser as well as payor. In a Primary Care Case Management Program, Medicaid needs to excel as contractor of services and as a payor. Much of the change will occur automatically as staff functions and responsibilities are modified to fit the managed care role.

However, as some states have experienced, this is not enough; the overall culture must change as well. The previous focus of the agency, which tended to encompass provider payment polices, becomes one of contractual oversight, especially with HMOs. In PCCM programs, all of the provider payment policies continue, while policies related to access and contract compliance are also necessary. In addition, a state's focus under managed care is enhanced to include a beneficiary focus where education, enrollment, access, quality and satisfaction play a bigger role in the success of the program. The state now has more control over influencing provider behavior and ensuring access to care. This means that the mission statement, if one exists, may have to be modified. Without this change in philosophy, states have had difficulty maintaining the support and enthusiasm of all the necessary parties. The failure to change the culture of the Medicaid

agency in Maine was provided as one reason the Maine's PCCM program has struggled and has only 650 enrollees two years after implementation. A representative from Maine's managed care division indicated that enthusiasm for the PCCM program was very high until just after implementation when staff switched their focus to HMOs and how they could work in Maine's Medicaid environment. Once this switch occurred, there was little direct support for the PCCM program, which was still in its infancy and in need of additional support.

ORGANIZATIONAL STRUCTURE

In addition to a change in the overall philosophy of Medicaid in a managed care environment, the structure of the agency from an operational standpoint must adapt to the agency's new role as well. To accomplish this, all of the states researched have separated managed care operations from other operations within the agency. This division is especially important if the traditional fee-for-service type programs continue, as it enables staff to narrow their focus on a particular type of health care delivery. Although the separation is beneficial from a work load perspective, it requires that procedures be developed to ensure appropriate communication among different units such as eligibility policy, payment policy, third-party liability, and information systems continues to occur. Some states have established a liaison between each area and the managed care unit to facilitate this communication.

In addition to the activities directly involved in the implementation and administrative responsibilities associated with a managed care program, the State must also consider the role of other state agencies, especially quality assurance activities and licensing issues. For example, in Michigan, the Department of Public Health (DPH) is responsible for licensure, so the Medicaid agency relies on DPH's information for some oversight of the managed care program rather than duplicating the work.

STAFFING

As a state prepares to implement a new program, the personnel components of successfully implementing and maintaining the new program are often not addressed until the policy issues related to program development are finalized. Ideally, these two aspects of the program should be developed simultaneously to ensure that what is being developed is administratively possible to execute.

Without discussions early on about the administrative feasibility of implementing new policies, a managed care program may be doomed to fail, or at least subject to what could be preventable hurdles before it gets started. In Maine, for example, the state decided to rely on their existing data system with last minute enhancements. When the system was unable to handle the needs of the PCCM program, enrollment into the program was suspended for six months. Had earlier attention been paid to ensure adequate systems were in place to handle the demands of the new program, this problem may have been avoided.

In conjunction with the change in the role of the Medicaid agency, the roles and responsibilities of staff must change accordingly. One key issue in this change is whether to hire new employees to carry out the new functions or to retrain existing employees. A number of factors will influence this decision. These include: the size of the managed care program (dollars and caseload), the receptivity of existing staff to the change, the ability to devote existing staff to managed care, whether the existing fee-for-service program continues, the hiring policies of the state, current budget constraints, and the political feasibility of adding staff to the agency.

Staffing demands and responsibilities are likely to change again as the managed care program evolves. One frequent change is the demand for additional staff as enrollment in the program

increases. While this may seem obvious, enrollment demands in at least one state, Idaho, have exceeded the State's personnel resources, thereby forcing the state to limit enrollment until adequate staff can be hired and trained. Michigan solved unmet demands on its client hotline by quickly doing a contract add-on to an existing contract (not primarily involved in managed care) to provide a back-up for overflow calls.

In North Carolina, where the PCCM program has been in operation for five years, the managed care unit was recently reorganized into teams. The primary reason for the reorganization was to allow the State to become more focused on attacking problems in a program that is past the implementation phase. The employees are divided into two teams, one which addresses internal agency issues and the other is in the "field" and has responsibility for training and maintaining the operations of the program. The second team focuses primarily on continuing education of recipients regarding the program components, in particular the appropriate use of the emergency room.

COMMON ADMINISTRATIVE MANAGEMENT PRACTICES

In conjunction with the change in the state's focus in a managed care environment, its administrative role changes as well. Regardless of which type of managed care program is implemented in the state there are several administrative practices which the state must oversee.

PROGRAM OVERSIGHT

The implementation of any type of managed care plan requires general oversight of the program. This is more than contract compliance. Its focus is on the general performance of the plan such as:

1. Quality standards set by the State
2. Adequate access to health care in the areas where managed care is operational
3. Client satisfaction
4. Educational efforts for providers and recipients

Marketing practices must be analyzed for their effect not only on individuals but their effect on the entire system. Other questions that must be posed are:

- Is the program credible; is it accomplishing its task of cost savings and access? The public must be assured that tax dollars are being spent to develop a program that will genuinely change client patterns of seeking health care when those patterns are inappropriate and costly. Providers must also be monitored for non-compliance with the program's objectives. They must be educated if misunderstandings are prevalent.
- Are recipient rights being protected?
- Does the system assure that recipients will be treated fairly and delivered medically necessary care? Programs must have formal complaint and grievance processes to which Plans and providers adhere. Report cards for both providers and recipients may be developed to encourage compliance with program rules and give feedback to all participants.

A formal yearly or bi-yearly evaluation may be required by HCFA and may also be desired by the State so adjustments to the program can be made.

CONTRACTUAL COMPLIANCE

Measures must be taken to ensure provider/managed care compliance with contractual agreements. This is frequently accomplished through the performance of audits and the review of required reports submitted by the provider or managed care organization.

Contract compliance often requires on-site reviews for program compliance. Some states such as Massachusetts require participating HMOs to provide space for a permanent state worker whose function is to oversee the plan's operation, policies and procedures, plus act as a liaison to the Medicaid Division. While an on-site presence may not be necessary, frequent visits with the purpose of both compliance and education may be warranted. Providers should be expected to provide space for state personnel who visit the office. Periodic chart reviews and examination of other office documents will be necessary from time to time. Reasonable telephone availability for problem solving, education, and enrollment is recommended for recipients and providers.

Some states operate their own information telephone lines and others contract that function to an enrollment broker. Contracts are often written for a period of two to three years. The enrollment broker or health benefits manger offers written and verbal educational material, conducts off-site workshops and seminars, and is responsible for enrolling recipients into the plan. In some cases the enrollment broker may work with the State to educate providers and answer provider related questions, or the State may be solely responsible for those functions, or the State may contract that piece to another company.

DATA MANAGEMENT

The type of data that is collected and maintained in a managed care environment differs from the data needs under a fee-for-service program. In many cases, the SURS system must be modified in order to accommodate the data needs of a managed care program.

The data must be configured to fulfill a new function. Although claims processing will continue to be a needed ability of the system, other requirements of the new delivery system may require a redesign of the system.

The data system must be able to support the following functions:

- prior authorization systems must link the recipient, provider and the claim,
- case management fees must be paid monthly,
- lists of enrolled recipients must be mailed to providers,
- recipients must be notified of enrollment,
- on-line eligibility and enrollment inquiry must be available to providers, and
- cost savings must be calculated

If capitation is a part of the managed care delivery system, the data system must provide the needed elements so rates can be calculated fairly.

PROGRAM EVALUATION

While it is important to regularly evaluate the effectiveness of any program, states which have received waivers for managed care programs are required by HCFA to submit an evaluation of their managed care programs.

The Health Care Financing Administration requires states that have obtained waivers of 1915 (b) of the Social Security Act to evaluate their programs by an outside contractor during the first two waiver periods. Programs are evaluated for cost savings, access to care, and the quality of care patients receive. Client and provider satisfaction of the managed care plan is often included in the evaluation.

IDENTIFYING OVER-UTILIZATION OF SERVICES

A Recipient Monitoring Program (aka "Lock-in") and prior authorization are both administratively simple and very effective means of controlling utilization and costs. Often only a few recipients account for high utilization within a Medicaid program. Both "lock-in" and prior authorization can focus directly on these recipients so administrative costs are minimized while the impact is maximized.

An aggressive Surveillance, Utilization and Review System (SURS) analysis unit, an efficient SURS subsystem, a decisive medical consultant team, and cooperative field workers are required for "lock-in" and prior authorization to be effective. The SURS analysis unit using, modifying and updating the SURS subsystem identifies high utilizers on a timely basis. Then it targets over-utilizers and abusers for "lock-in" or prior authorization, based on experience and general medical practice knowledge. With the help of the local field workers, the SURS analysis unit places over-utilizers and abusers in either "lock-in" or prior authorization. The medical consultant team reviews cases where the analysts are unsure or if the recipients or their providers object. If the medical consultant team agrees, the SURS unit convinces the recipients to accept the placements, or the cases are taken to administrative hearings where judges may mandate the placements.

Administrative costs for identifying and placing high utilizers in "lock-in" or prior authorization are kept to a minimum. Since only a few recipients are high utilizers of services, the SURS unit only targets a few of these for placement, and only a very few of these objects to placement.

Further, administrative costs beyond identification and placement are very low. Recipients' Medicaid cards must display an appropriate message alerting providers of the recipients' status. The claims payment system must have appropriate edits to prohibit payment for unauthorized claims or claims billed by inappropriate providers. Field workers time in completing prior authorization forms must be accounted for.

The reason "lock-in" and prior authorization are so effective is they work hand-in-hand to curb over-utilization without reducing access for those who truly need a large number of procedures or expensive procedures. The SURS unit "locks-in" over-utilizers to primary providers located near the recipients. These providers then provide or authorize all services that will be paid by Medicaid for these recipients. In cases where the SURS unit cannot find willing providers, in cases where the recipients are changing their providers, or in cases where for some other reason the recipients cannot be assigned to primary providers, the SURS unit places the recipients in prior authorization. This placement requires the recipients to go to local field workers' offices before any services are rendered. This places the local workers in the uncomfortable position of appearing to determine medical necessity of requested services. However, simply requiring the recipients to obtain prior authorization usually deters unwarranted requests and the worker rarely denies requests. As soon as possible recipients, placed in prior authorization are placed in "lock-in".

In summary, "lock-in" and prior authorization, especially when used together, are effective and administratively low-cost methods of controlling over-utilization and high costs. An aggressive SURS analysis team, along with an efficient SURS subsystem, zeroes in on high utilizers of services and holds administrative costs to a minimum. Substantial cuts in utilization and costs can be realized for a minimal investment.

State of Alaska
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Medical Assistance

MEDICAID PROGRAM CASE MANAGEMENT
RFP 95-0175

DELIVERABLE #3
REPORT OF OTHER STATES MANAGED CARE PROGRAMS

FEBRUARY 20, 1996

SUBMITTED BY:
FOX SYSTEMS INC.
HEALTH MANAGEMENT ASSOCIATES

SUBMITTED TO:
STATE OF ALASKA
DIVISION OF MEDICAL ASSISTANCE

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Exhibit A

Medicaid Managed Care Status
State by State Commentary

Medicaid Managed Care Status
State by State Commentary

Name of State	Comments	Contact Person(s)
Alabama	• No Medicaid managed care plans currently contracted • Plan to offer HMO option beginning in Mobile area in 1995 and then expand to other areas • 1115 Waiver submitted to HCFA, 7/95 • Licensing is slow • Capitation appears as if it would be low • 1915 waiver for a coordinated system of pregnancy related services	Evelyn Terry, Outreach and Marketing Director 205-242-5014 Debra Moore, Managed Care Division 205-242-5012
Alaska	• Plans for managed care currently underway • Currently have a contract for optical hardware	
Arizona	• Fully implemented prepaid capitated managed care plan statewide • Enrollment is mandatory for all eligible recipients except Native Americans • Three-year HMO contract bid let 10/1/94 (some areas have one HMO and others may have more than one HMO-It depends on the population and size of the area) • New RFP will probably be out in 2/97 • 1115 waiver pending to cover individuals up to 100% of poverty	John Black. Executive Consultant, Office of Managed Care 602-254-5522 ext. 7024

Name of State	Comments	Contact Person(s)
Arkansas	• Has a 1915(b) waiver • Operate a statewide PCCM • No HMO contracts • Nine county project for HMO option in the discussion stages • No commercial HMO covers the state now; BC/BS attempting to do so	Roy Jeffus 501-682-8329
California	• California aggressively seeking PHP contracts, just awarded dual choice (one county initiative, one private health plan) contracts in several counties • Very competitive • Statewide managed care program (combination of PCCM partially capitated and fully capitated programs) in place • Offers coordinated care programs for the elderly, ON LOK is an example • 1915 (b) waiver approved	Joseph Kelly/Kenneth J. Wagstaff, State of California-Health and Welfare Agency 916-654-8076 Jennifer Sugar Medi-Cal Managed Care Division 916-654-8070
Colorado	• Currently has a statewide PCCM plan; plan to phase out and use as "safety net" only in areas where no HMOs exist • Contracts with six HMOs, but HMOs do not cover the entire state • As HMOs become available in other service areas, will contract with them • 1915 (b) waiver approved	Kim Gordon 303-866-2220
Connecticut	• Received 14 responses to an RFP for fully and partially capitated plans to serve the Medicaid population beginning 7-1-95 • Phasing in statewide enrollment • May re-bid in two years • No PCCM program; no Medicaid contracted HMOs prior to the recent RFP • 1915 (b) waiver approved	James Gaito 203-424-5137

Name of State	Comments	Contact Person(s)
Delaware	• Received HCFA approval 5/95 for "The Diamond State Health Plan" (DSHP), which mandates enrollment in capitated managed care delivery systems • 1115 Waiver approved • Plan is effective 1/1/96	Kay Holmes, DSHP Coordinator 302-577-4900
District of Columbia	• Implemented DC Medicaid Managed Care program (combination of fee-for-service and capitated options) in 4/94 • Mandatory for AFDC and AFDC-related recipients • Medicaid Program is in financial difficulty • 1915 (b) waiver approved	Sue Brown, Commission of Health Care Finance 202-727-0735
Florida	• Florida has offered a managed care plan to Medicaid enrollees for 13 years • Plan to expand in March, 1996 • Has an HMO option, but it does not operate in all parts of the state; hopes to expand the areas where HMOs will serve Medicaid recipients • A QA study found all the capitated plans to be deficient so there is a temporary enrollment freeze for those plans • HMO Licensing both with the State and the Medicaid Agency is bogged down • Present enrollment is 1/3 MediPass (PCCM program) 1/3 HMO, and 1/3 regular fee-for-service • 1915 (b) waiver approved	Paige McGivern 904-487-3090

Name of State	Comments	Contact Person(s)
Georgia	• May begin to offer a Medicaid HMO option in the Atlanta area; currently reviewing HMO applications • Implemented their PCCM program, Georgia Better Health Care, in 10/1/93; operational in a few counties only • 1915 (b) waiver approved • Plans are underway to expand GBHC statewide	Patrick Williams 404-657-7793
Hawaii	• Hawaii Health Quest, which began 8-1-94, provides medical, dental, and mental health benefits through a capitated managed care delivery system to persons receiving AFDC, GA, and the State Health Insurance Program • Five private insurers have been given two-year contracts to provide benefits • One year lock-in • Will issue another RFP in late 1995 for the next two-year period • Open to accepting bids from mainland companies Current companies all Hawaii-based	Barbara Bianco, Public Information Officer 808-586-5454
Idaho	• PCCM model introduced in October, 1993 • No HMO option now • MMIS system will be reconfigured to meet managed care requirements. Work to be completed by 12/31/96. • After MMIS improved, will consider expanding the managed care option • Of the 44 counties, 7 are considered urban, 12 rural and 25 frontier (6 persons or less a square mile) • 1915 (b) waiver approved	Jan Cheever, Supervisor, of Healthy Connections 208-334-5804 or Robin Schmidt, Healthy Connections Representative 208-334-5804

Name of State	Comments	Contact Person(s)
Illinois	• 1115 waiver request pending with HCFA for MediPlan Plus, which will contract with HMOs statewide to care for the MediPlan Plus eligibles; a PCCM program is also operational • Has contracted with HMOs in portions of the state for 20 years • Hope to release an RFP soon for HMOs to bid • Medicaid eligibles concentrated in Chicago, Peoria, and East St. Louis	Dawn Claborn 217-524-7478 Ed Hartman Bureau of Managed Care 217-524-7478
Indiana	• Has a PCCM program and is introducing risk-based capitated managed care option • During the summer of 1994, implemented a mandatory managed care program called Hoosier-Healthwise • Phasing in managed care regionally over three-year period, depending on access and participation • Use an enrollment broker to enroll recipients • 1915 (b) waiver approved	Wendy Bokota 317-233-0237
Iowa	• Currently offers a mandatory PCCM or HMO option to Medicaid recipients • The HMO option is not available statewide • Iowa wants to contract with HMOs to serve areas currently not offering an HMO option • 1915 (b) waiver approved	Mary Roberts, Dept. of Human Services 515-281-8747

Name of State	Comments	Contact Person(s)
Kansas	• Has a statewide PCCM program • 1115 waiver pending: project (Community Care) would implement a managed cooperation demonstration project in four predominantly rural counties and would assess the success of a non-competitive managed care model in rural areas • In December, 1995, plans to offer an HMO option in Kansas City area and then will expand to different areas of the state • In December, 1996, proposes to sole-source contract with a prepaid health plan for the Wichita area (The plan is made up of hospitals and providers in Wichita)	Brenda Jackson 913-296-3981
Kentucky	• 1115 Waiver approved by HCFA but state legislature has not allowed implementation • Medicaid agency wants to implement a mandatory HMO program for Medicaid eligibles • Currently has a PCCM program statewide • 1915 (b) waiver approved	Larry McCarthy 502-564-8196
Louisiana	• State has amended 1115 waiver request (original waiver was disapproved by HCFA in 6/95); still under HCFA consideration • All Medicaid enrollees would be required to join competing HMOs under contract with the state • Currently has a PCCM program	Carolyn Maggio, Director 504-342-2964 Bonnie Butler, Analyst Health Development 504-342-5068

Name of State	Comments	Contact Person(s)
Maine	• HMO RFP was released in April 1995 • Intends to implement a mandatory managed care option • Established PCCM program; will be phased out except in three rural counties • 1915 (b) waiver approved	Deborah Curtis, Director, Division of Managed Care or Lauren Rice 207-287-3835
Maryland	• PCCM program (MAC Program) implemented 12/91 • HMO option available since 1975 • Enrollment in HMOs is voluntary • Capitation paid at 95.5% of fee-for-service, including a consideration for administration • 1915 (b) waiver approved	Dawn L. Grosshandler, Chief 410-225-5444
Massachusetts	• HCFA 1115 waiver, MassHealth, approved 4/95; awaiting approval from state legislature • Statewide HMO and PCCM option • Enrollment mandatory • Health benefit managers enroll recipients (currently have a bias toward the PCCM program)	Michael Bailit, Asst. Commissioner 617-348-5510
Michigan	• Has implemented a statewide mandatory managed care plan • Has a statewide PCCM plan, the Physician Sponsor Plan • The HMO option and the partially capitated plan, the Clinic Plan, are primarily available in central and southern MI, although expanding to other areas • Over 90% of non-institutionalized AFDC and SSI clients enrolled in managed care • 1915(b) waiver approved	Mark Verleger 517-335-5501

Name of State	Comments	Contact Person(s)
Minnesota	• 1115 waiver, Prepaid Medical Assistance Project Plus (PMAP), approved 4/95 • Will expand eligibility and place persons in integrated service networks • Especially interested in expansion in rural areas • HMO option currently available in some regions	Kathleen Schuler, Acting Director, Managed Care Division 612-297-4668
Mississippi	• Has a PCCM option; considering HMO option, but nothing has been developed • Currently has a 1915(b) waiver • HMO licensing regulations currently being changed by the legislature	Judith Michael 601-359-6133
Missouri	• Has submitted both a 1915 (b) and an 1115 waiver request; approval is still pending • Has operated mandatory choice health plan options program in Kansas City since 1984 • Seeking legislative support for managed care expansion • Plan a three to five year process to fully implement managed care on a regional basis • HMOs will bid based on a capitation range published in the RFP	Gary Bailey 314-751-6922 Linda Vaughn, Management Analysis Specialist; Managed Care Division 314-751-7820
Montana	• Expanding the PCCM option and introducing an HMO option • Many counties are rural and frontier • Encouraging HMO development/expansion in areas not covered currently • 1915 (b) waiver approved	Sharon Donavan 406-444-4148

Name of State	Comments	Contact Person(s)
Nebraska	• Let two competitively bid contacts (each covering one half of the state) with two HMOs who will cover the state in Spring, 1995 • Will not re-bid for two years • Implementing a statewide PCCM program using a contracted network manager	Bob Seiffert, Medical Services Division 402-471-9718
Nevada	• PCCM program since 1983 • Medicaid has contracted to provide care and service under a pre-paid health plan since May, 1988 • Current contractors are University of Nevada School of Medicine, NevadaCare, Inc., and Community Health Centers of Southern Nevada (an FQHC)	Joanne Grundmen, Program Specialist 702-687-4768
New Hampshire	• Currently contracts with HMOs • Voluntary program at this time • State is looking at pilot initiatives to help in the redesign of its healthcare system • 1115 waiver pending	Diane M. Kemp, Program Specialist 603-271-4365
New Jersey	• 1915 (b) waiver pending at HCFA • Plans to implement an HMO-only mandatory enrollment program • Currently contracts with HMOs but not in every area of the state • Have 400,000 additional recipients to enroll in a plan • Use health benefit managers to enroll recipients	Daniel Walsky, Director of Medicaid Managed Care 609-588-2705

Name of State	Comments	Contact Person(s)
New Mexico	• Primary Care Network (PCN), a PCCM program, is currently operational statewide • Plans to offer an HMO option in the urban areas in 1996 • Currently redesigning MMIS to support full managed care functionality • 1915 (b) waiver approved	Paul Benson, Chief Office of Managed Care 505-827-3122
New York	• Currently has capitated, partially capitated and PCCM programs • Plans to implement a mandatory HMO program throughout the state within the next two years • New York City plans to enroll all Medicaid eligibles living in NYC within one year, HCFA disallowed the plan • The governor appointed a director of managed care in the Dept. of Public Health who will coordinate all efforts outside of NYC • NYC will administer its own program • 1915 (b) waiver approved	Jim Wray Director, Office of Managed Care 518-473-5600
North Carolina	• Carolina Access, a PCCM program is in 38 of 100 counties (covers 50% of eligible population); currently re-grouping; plans to expand in early 1996 • Has an HMO contract with Kaiser Permanente • May introduce an HMO option in the Charlotte area • 1915 (b) waiver pending	Nancy O'Dowd or Joe Robbins, Division of Medical Assistance 919-715-5417

Name of State	Comments	Contact Person(s)
North Dakota	• PCCM program for AFDC eligibles; preparing waiver renewal for statewide program • May implement an HMO option in the eastern part of the state • Has done preliminary rate setting only • Only two small regional HMOs in the state now • 1915 (b) waiver approved	Darlene LeNoue, Administrator, Medical Services Division 701-328-4577
Ohio	• Plans to implement OhioCare; the 1115 waiver (approving OhioCare and expanding eligibility) was approved 1/95. However, State has decided to delay expansion pending Congress' discussion on budgetary matters • Current recipients will be moved into managed care plans; mental health and drug addiction benefits will be coordinated • Will rely heavily on HMO contracts • Currently contracts with HMOs to provide services for the Medicaid population • RFP will be issued • 1915 (b) waiver pending	Cynthia Burnell 614-466-4693
Oklahoma	• Wants to begin "Sooner Care"; HCFA approval of 1115 waiver is pending • Project would be a five-year statewide managed care program using both fully and partially capitated delivery systems. Emphasis will be to address access problems in rural areas • Issued an RFP to HMOs that was due back 3/24/95; will reopen HMO bidding annually	Leigh Brown, J.D. M.P.H., Deputy Administrator for Health Policy 405-530-3439

Name of State	Comments	Contact Person(s)
Oregon	• Began the Oregon Health Plan 1115 demonstration on 3/19/93 • Uses managed care models including fully capitated, partially capitated, and PCCM programs • Currently contracts with many HMOs • 90,000 eligibles enrolled in HMOs as of 6/1/94 • Considering proposal for $5 co-payment for doctor visits for those newly eligible • 1915 (b) waiver approved	Hersh Crawford, Director 503-945-5767 D'Anne Gilmore, Health Plan Unit 503-945-9827
Pennsylvania	• State has a PCCM program (HealthPASS) • Has some HMO contracts and is interested in contracting with additional HMOs in other areas of the state • Planning statewide expansion over next three year; expansions will begin 7/96 in Philadelphia area • Uses a competitively bid approach in parts of Philadelphia for an HIO to manage PCCM program; huge profits were reaped in first contract period • 1902 (b) waiver approved	Frank Lentz, Director, Bureau of Special Medical Assistance Programs Michael Jacobs 717-772-6198

Rhode Island	• 1115 waiver approved in Fall, 1993 for Rite Care which will:
	  • expand eligibility under Medicaid
	  • implement a fully capitated managed care delivery system
	• Recipients enroll in one of 5 existing HMOs
		Ron Ek
		401-464-3113

Name of State	Comments	Contact Person(s)
South Carolina	• Originally wanted to implement a statewide capitated managed care plan but have scaled that back and may not offer an HMO option at all, or if it does, will be voluntary • Currently has a PCCM program • 1902 (b) approved	Debbie Francis, Chief 803-253-6119
South Dakota	• 7/1/93 began a PCCM program • Currently awaiting approval of waiver renewal • No HMO contracts • 1902 (b) wavier approved	Donna Keeler, Dept. of Social Services 605-773-3495
Tennessee	• TennCare, 1115 waiver approved Fall 1993, replaced the Medicaid program and extended eligibility to 1 million additional recipients • Services are offered through five PPOs and seven HMOs • Market-based pricing	Manuel Martins, Ass't. Commissioner 615-741-0213
Texas	• Legislature currently debating the future of Medicaid • Many want to offer or mandate HMO coverage in most parts of the state • Has both an HMO and a PCCM option in different areas of the state • 1915 (b) waiver approved	Stacey Hull, Program Specialist 512-794-6852
Utah	• Choice of Health Care Delivery (CHCD), a 1915(b) waiver program, is mandatory in urban areas only; recipients choose between HMO and primary care physician • HMO option available in urban areas only • 1115 Waiver pending to expand eligibility to 100% of poverty	Ed Furia or Barbara Christensen, Div. of Health Care Financing, Bureau of Managed Health Care 801-538-6505 or 538-6456

Name of State	Comments	Contact Person(s)
Vermont	• 1115 waiver approved, The Vermont Health Access Plan, proposes to implement mandatory HMO enrollment. It will also expand coverage to 150% of poverty; HCFA approved the waiver 7/95 • State legislature has approved plan to expand coverage, effective 1/96; funding will be gained through cigarette tax revenues	Paul Willis 802-828-2900
Virginia	• There are three managed care programs: Medallion I, a PCCM, started in 1992; Options, the state's voluntary HMO; and Medallion II, the state's mandatory HMO. Medallion II is scheduled to go into effect 1/96 • Will begin to offer HMO option in the Norfolk area 1/96 and will implement in other urban areas every six months (Northern VA. Richmond, Roanoke) • PCCM program was expanded to cover elderly, blind and disabled recipients in July, 1995 • 1902 (b) waiver approved •	Thomas McGraw 804-371-6400
Washington	• Has a PCCM program • Mandatory enrollment in managed care is required for AFDC and AFDC-related • 1902 (b) waiver approved •	Joan Bentz, Acting Director, Office of Managed Care 206-586-2583
West Virginia	• Has a statewide PCCM program • In the planning stages and wants to offer an HMO option, probably one year away • 1902 (b) waiver approved	Sharon Carte 304-926-1717

Name of State	Comments	Contact Person(s)
Wisconsin	• Has both HMO and PCCM programs • HMOs are present in only 5 of the 72 counties; HMO enrollment is mandatory in these counties for AFDC recipients • PCCM program is available in 7 counties • Will release an RFP for statewide expansion in December 1995 • Plan to implement managed care in stages • 1902 (b) waiver approved	Ruth Belshaw, Managed Care Unit Supervisor 608-266-1935 Mary Durkin 608-267-7927
Wyoming	• No managed care programs in operation • Hoping to offer both a PCCM and HMO option	Kenneth C. Kamis, Administrator, Division of Health Care Financing 307-777-7531

Exhibit B
Glossary of Abbreviations
Used in the Text

Glossary of Abbreviations Used in the Text

Abbreviation	Meaning
1115 Waiver	A research and demonstration waiver granted by the Health Care Financing Administration
1915 (b) Waiver	A waiver granted by the Health Care Financing Administration aka Freedom of Choice Waiver
AFDC	Aid to Families with Dependent Children
BC/BS	Blue Cross Blue Shield
Carolina Access	North Carolina's primary care case management program
Case Managed Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as enhanced fee-for-service or managed fee-for-service.
Community Health Aide	A person living in a remote Alaskan village who has been appointed to oversee health care activities and provide services within a specified framework.
DMA	Division of Medical Assistance
DSHP	Diamond State Health Plan, Delaware's 1115 waiver program

Enhanced Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as case managed fee-for-service or managed fee-for-service.
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FFS or ffs	Fee-for-Service
FQHC	Federally Qualified Health Center
GA	General Assistance -- state-only funded medical program
GBHC	Georgia Better Health Care; Georgia's PCCM program
HCFA	Health Care Financing Administration
Healthy Connections	Idaho's primary care case management plan
HEDIS	National Committee for Quality Assurance, Health Plan Employer Data and Information Set
HIO	Health Insuring Organization
HMO	Health Maintenance Organization
IHS	Indian Health Services
KenPac	Kentucky's primary care case management plan
Lock-In	Refers to a period of time during which a health plan enrollee may not disenroll from a health plan except for good

	cause. May also refer to a recipient monitoring program developed to monitor access to care for high utilizing recipients.
Managed Fee-for-Service	A health plan which requires prior authorization of most services not rendered by the primary care provider. The primary care provider is usually paid on a fee-for-service basis. Also known as enhanced fee-for-service or case managed fee-for-service.
MCO	Managed Care Organization
MediPass	Florida and Iowa's primary care case management plan
MediPlan Plus	Illinois' 1115 waiver program
Mid-Level Providers	Nurse Practitioners, Nurse Midwives and Physician Assistants are often referred to as mid-level providers
MMIS	Medicaid Management Information System
Partial Capitation	Programs are structured to reimburse managed care organizations for a specific set of contracted services at a per member per month capitation rate. Members must seek care covered by the MCO within the MCO's panel of providers. Services outside of the partially capitated contract may be reimbursed through a contract or fee-for-service basis.
Passport to Health	Montana's primary care case management
PCCM	Primary Care Case Management

PCCP	Colorado's Primary Care Physician Program (a PCCM program)
PCN	Primary Care Network, New Mexico's primary care case management
PCP	Primary Care Physician
pmpm	Per Member Per Month
PPP	Primary Provider Program, Wisconsin's primary care case management program
PSP	Physician Sponsor Plan, Michigan's primary care case management program
QA	Quality Assurance
RFP	Request for Proposals
RHC	Rural Health Center
Rite Care	Rhode Island's 1115 waiver program
RMP	Recipient Monitoring Program, also known as "lock-in"
SSI	Supplemental Security Income
SURS	Surveillance, Utilization and Review System
Waiver	A mechanism by which HCFA authorizes a state Medicaid agency to "waive" Title XIX regulations. There are two waiver authorities that HCFA can do -- 1115 and 1915(b).

State of Alaska
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Medical Assistance

MEDICAID PROGRAM CASE MANAGEMENT
RFP 95-0175

DELIVERABLE #3
REPORT OF OTHER STATES MANAGED CARE PROGRAMS

FEBRUARY 20, 1996

SUBMITTED BY:
FOX SYSTEMS INC.
HEALTH MANAGEMENT ASSOCIATES

SUBMITTED TO:
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DIVISION OF MEDICAL ASSISTANCE

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Report of Other States' Managed Care Programs

Table of Contents

INTRODUCTION

The State of Alaska is exploring the idea of managed care for its Medicaid and General Relief Medical programs. Managing the medical care of enrolled members is not a new concept; it has been available for decades. However, only in the past 15 years has it become prevalent as a vehicle for service delivery to Medicaid recipients. The foundation of a managed care program includes features which, if everything works well, create an atmosphere conducive to good medical care which benefits all of the participating parties; i.e., the Medicaid recipient, the providers of care, the Medicaid agency, and society in general.

This report lays the groundwork for Medicaid managed care future decision making in Alaska. It begins with a definition of terms common to managed care. Graphic displays of managed care features and models are provided. The report discusses several forms of managed care but focuses on managed or enhanced fee-for-service, also known as Primary Care Case Management (PCCM), partially capitated systems and fully capitated, and at risk systems. The PCCM program in particular is explored in regard to the following key features: providers, enrollee populations, the authorization process, systems requirements, and geographic implementation.

The report begins by providing some pros and cons of the possible systems ranging from unfettered fee-for-service to full capitation HMO. It proceeds with a discussion of managed care features and models as designed and implemented by other states. This is followed by a summary of managed care programs in selected states. The states were selected for review because of unique design features and/or because they have frontier counties which somewhat approximate Alaska's population demographics. A synopsis of all states' managed care programs is contained in Exhibit A. The final segment of the report focuses on administrative management practices both within and without a managed care structure with an emphasis on the PCCM model. A glossary of terms is found in Exhibit B of the report.

DEFINITION OF TERMS

To prepare the reader for a discussion of current State Medicaid managed care delivery systems, this section explains the terms used in the text. The major features of three delivery systems are described: primary care case management, partial capitation, and full capitation. Several states have incorporated each of the delivery systems within their Medicaid programs and some have implemented only one system. Most states gradually improve their delivery systems by adjusting policies and procedures as necessary to ensure that quality, cost-effective care is provided to recipients of Medicaid.

The following discussion will focus on the "ideal" managed care models. The reader should be mindful that many variations of these delivery systems exist.

Primary Care Case Management is emphasized in the description of terms because it has potential for relatively rapid implementation within Alaska's current health care system.

Primary Care Case Management (PCCM) plans are sometimes referred to as enhanced or managed fee-for-service. Features of these plans are as follows:

1. A primary care provider (PCP) either provides or authorizes a specified group of health care benefits.

2. Recipients enroll with the PCP of their choice for at least one month.

3. PCPs are usually paid a case management fee which may range from $2 to $6 per enrollee per month.

4. PCPs may be reimbursed on a fee-for-service basis or may be partially capitated. Most programs reimburse on a fee-for-service basis.

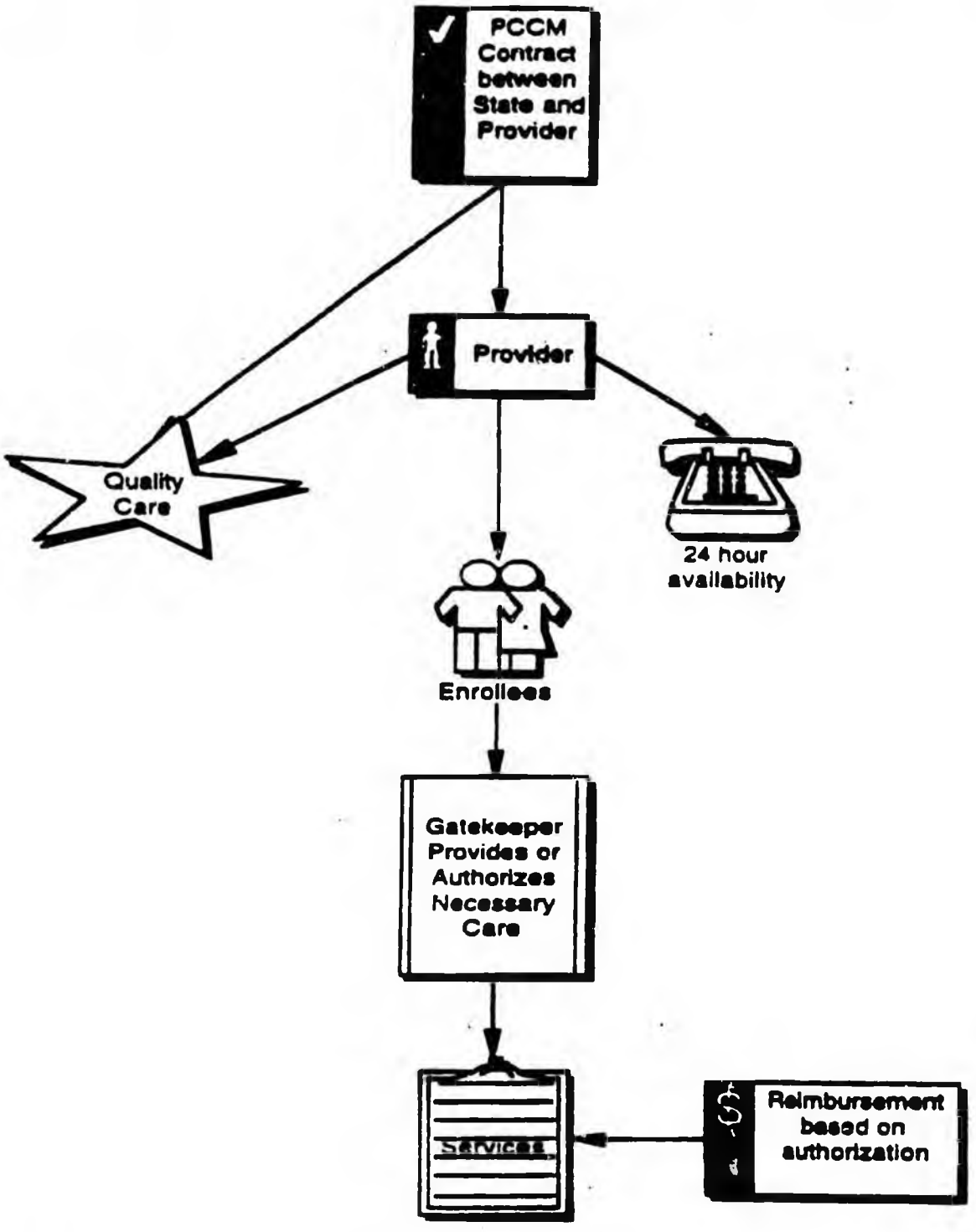
5. PCP's may be medical doctors, nurse practitioners, physician assistants, or other mid-level practitioners. A group of health care providers such as Rural Health Clinics, Federally Qualified Health Care Centers and Indian Health Centers may be designated as the PCP.

6. Different populations have been targeted for initial membership in the PCCM plan. The non-institutionalized AFDC and AFDC-related population are most often chosen for initial program implementation. SSI and SSI related eligibles are often added after the State gains experience.

7. PCCMs have usually been implemented in an urban area of the state first with expansion to the rural areas occurring as the plan becomes more familiar to providers.

8. States must design/modify information systems to accommodate needed functions of the PCCM plan such as a method for enrollment in the plan, claims tracking ability and editing linked to the PCP. Examples of necessary systems modifications includes: edits to prevent payment to providers who do not have authorization and system recognition of claims possessing the proper authorization codes.

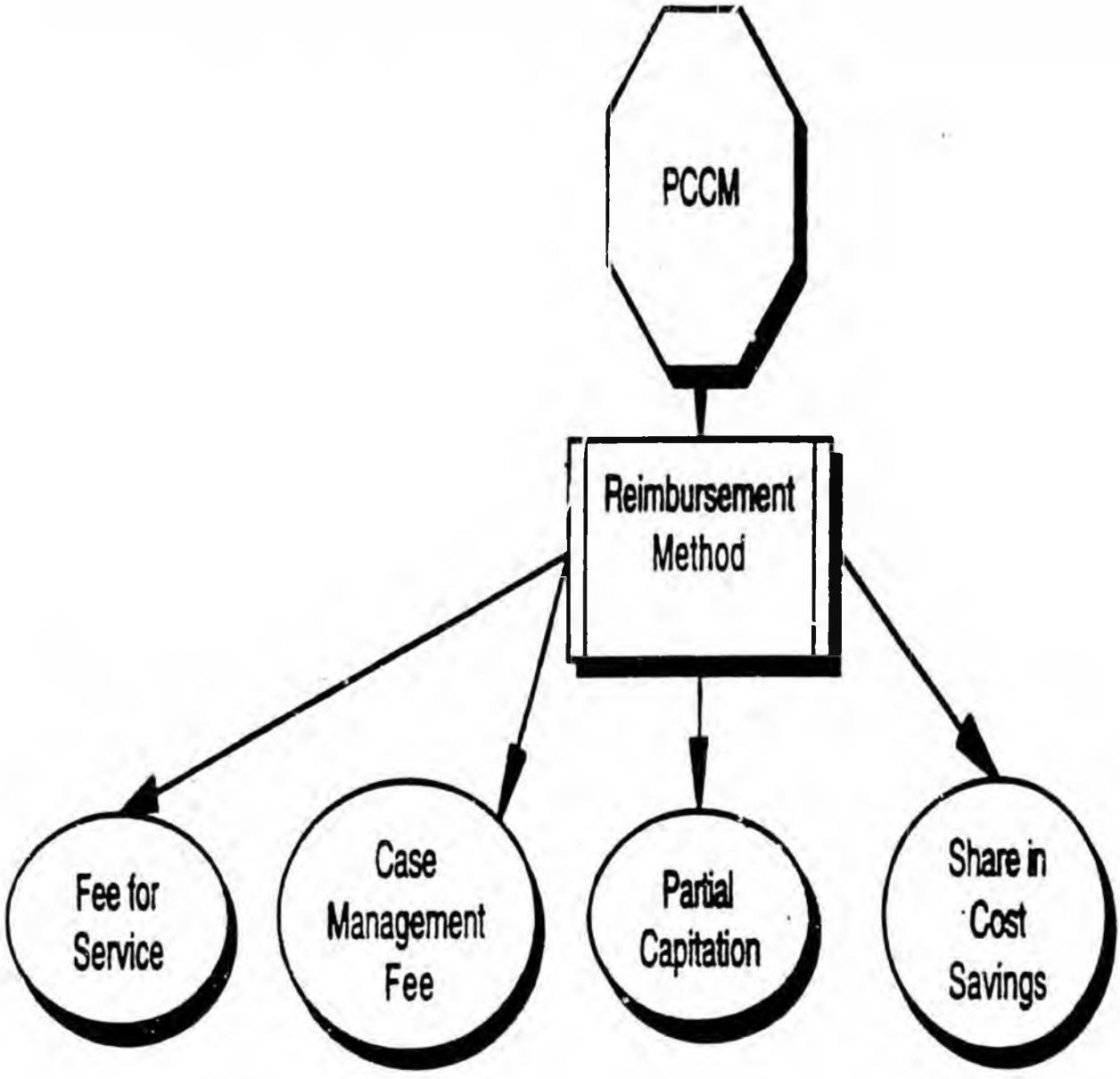
A diagram which depicts the operation of a **Primary Care Case Management** System is shown below.



PCCM Model

REIMBURSEMENT

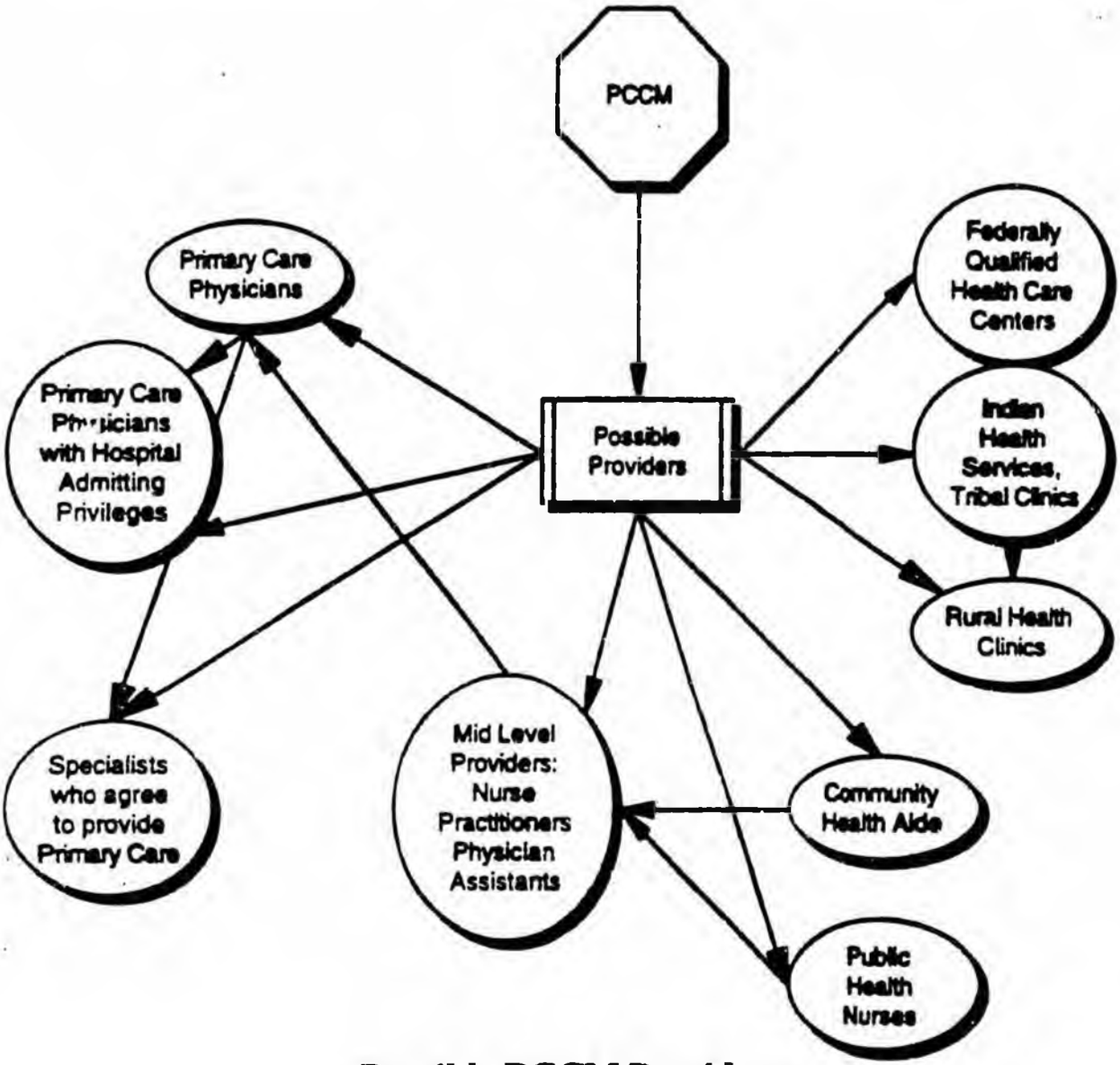
States may reimburse providers under a PCCM plan in a variety of ways. The following diagram indicates methodologies states have chosen to compensate the providers in their PCCM plans. One or more of the reimbursement methods may be combined.



Possible Reimbursement Methodology under a PCCM

PROVIDER PANEL

States must also decide who should be included in the panel of PCCM providers. Primary Care Physicians who practice either in a group setting or individually are always part of the program. Specialists who either have a primary care practice or agree to provide primary care to enrollees may be allowed to participate. Sometimes hospital admitting privileges are a program requirement. Additionally states have included other health care professionals to the panel such as nurse practitioners or physician assistants. Some states allow Federally Qualified Health Care Centers, Rural Health Centers, and Indian Health Service Clinics and Tribal Clinics to participate as single providers.

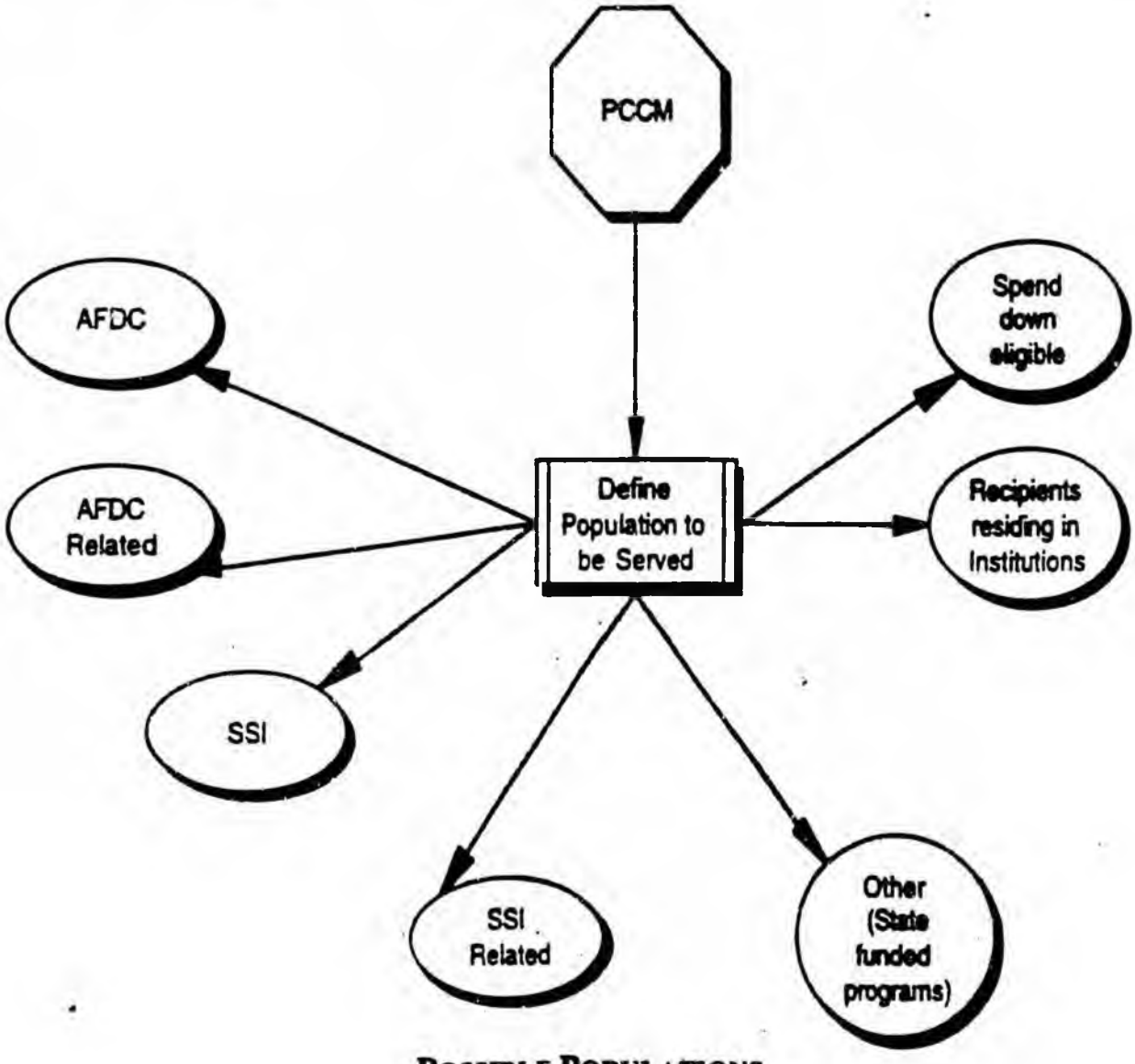


Possible PCCM Providers

PCCM ENROLLEE:

When designing a PCCM program, states must determine the target population. States have found that providers generally prefer to begin with the AFDC population. The benefit of this is that practitioners can begin to become educated about medical care management practices on a population that is generally healthy. As expertise in the provider and recipient community is gained, states generally begin adding the SSI population to the patient mix. This insures that doctors will not be overwhelmed with a caseload of very sick and/or disabled patients in the beginning of the program. One caution is patient load size. Enrolling AFDC recipients first may leave inadequate slots for SSI patients using the physicians.

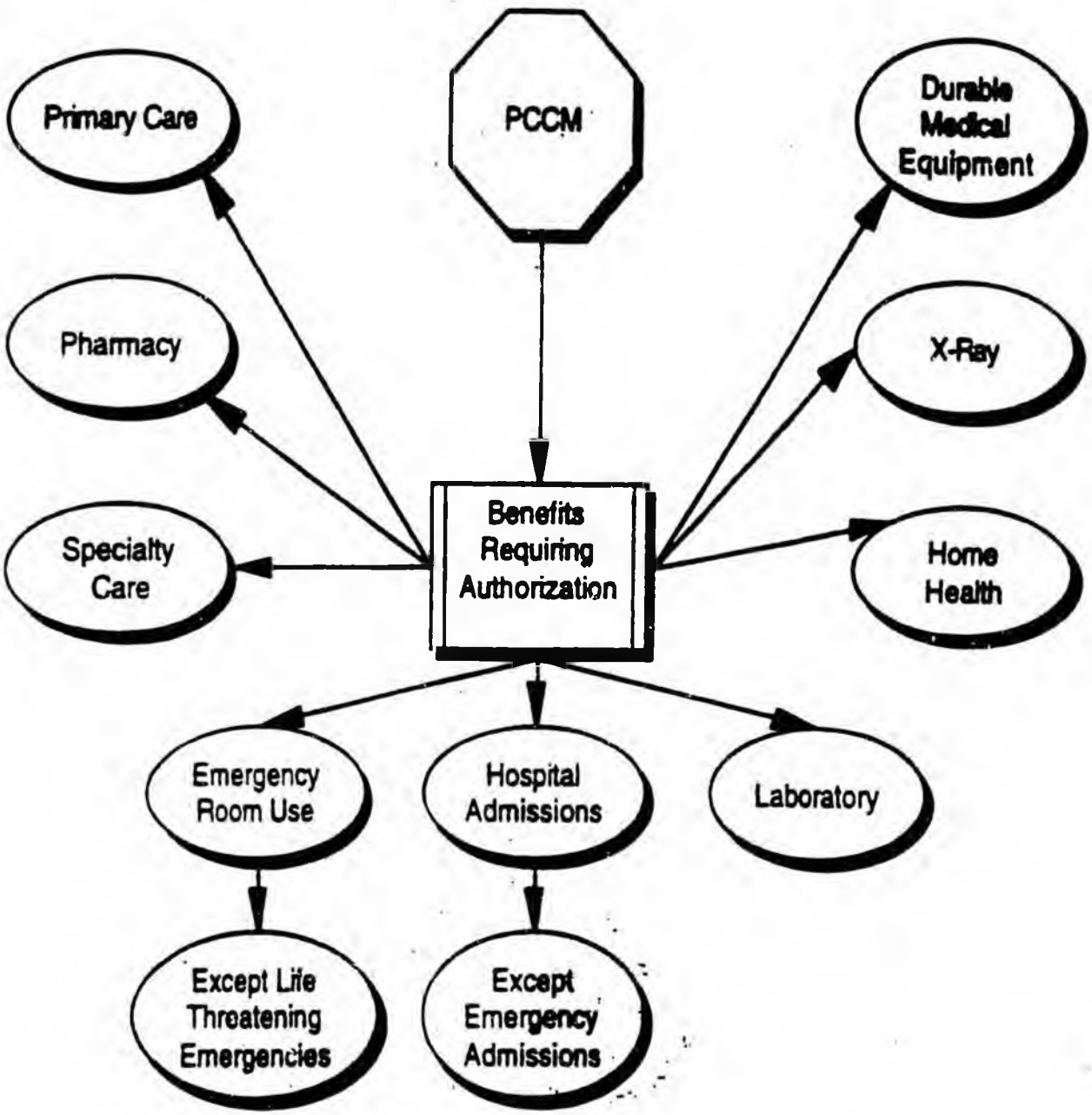
Usually recipients who gain Medicaid eligibility by "spending down" for medical care until they reach a level that Medicaid will pay additional medical care expenses, are excluded from enrollment in a PCCM because of the erratic on-again, off-again nature of their eligibility. Also patients who are institutionalized are usually excluded from enrollment.



POSSIBLE POPULATIONS

PCCM AUTHORIZATION:

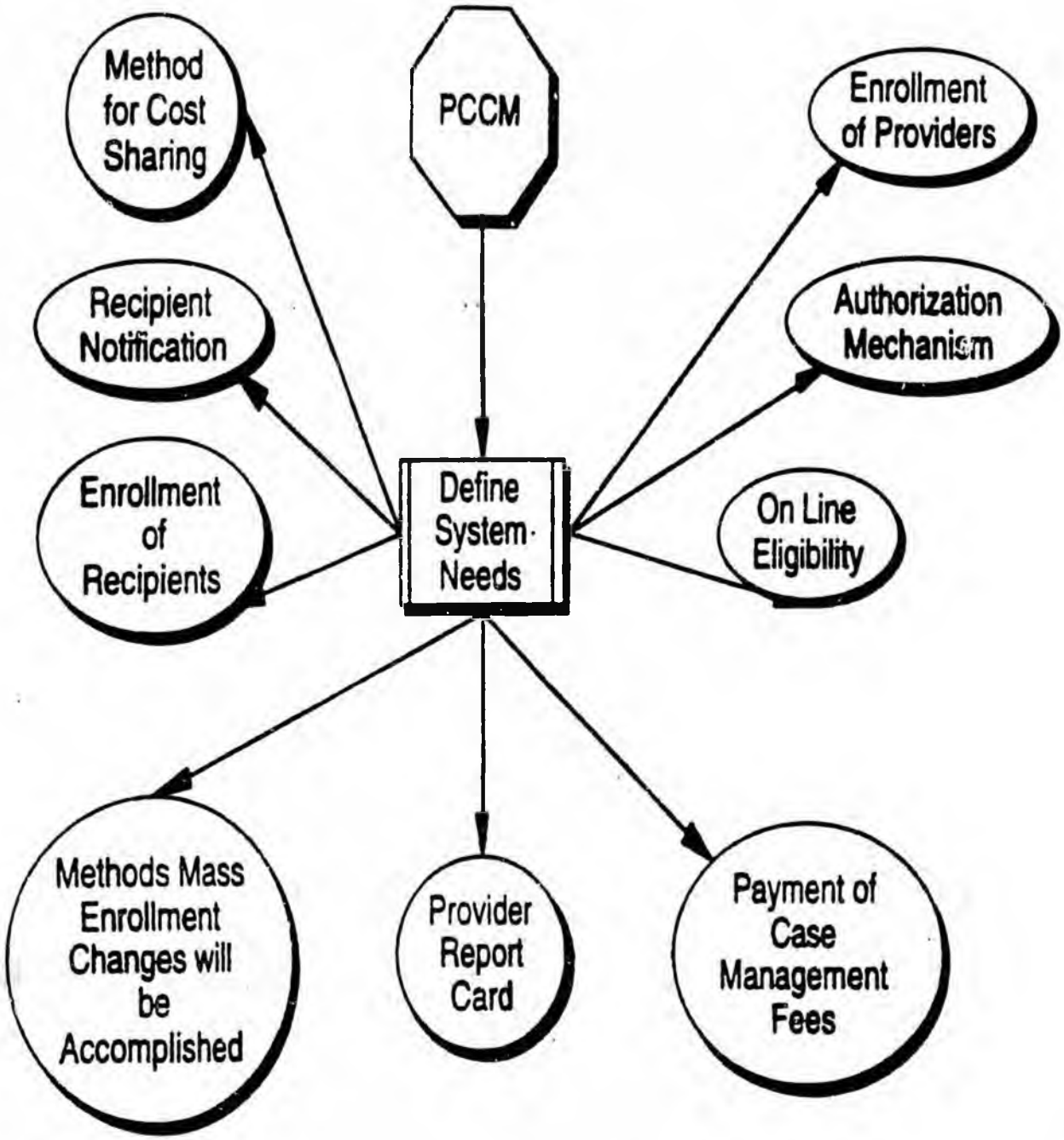
A cornerstone of the PCCM program is the authorization system implemented to curb overuse and misuse of services. States must carefully determine which Medicaid benefits require authorization. A sample of the benefits that may require authorization is listed below.



Benefits Requiring Authorization

PCCM SYSTEMS REQUIREMENTS

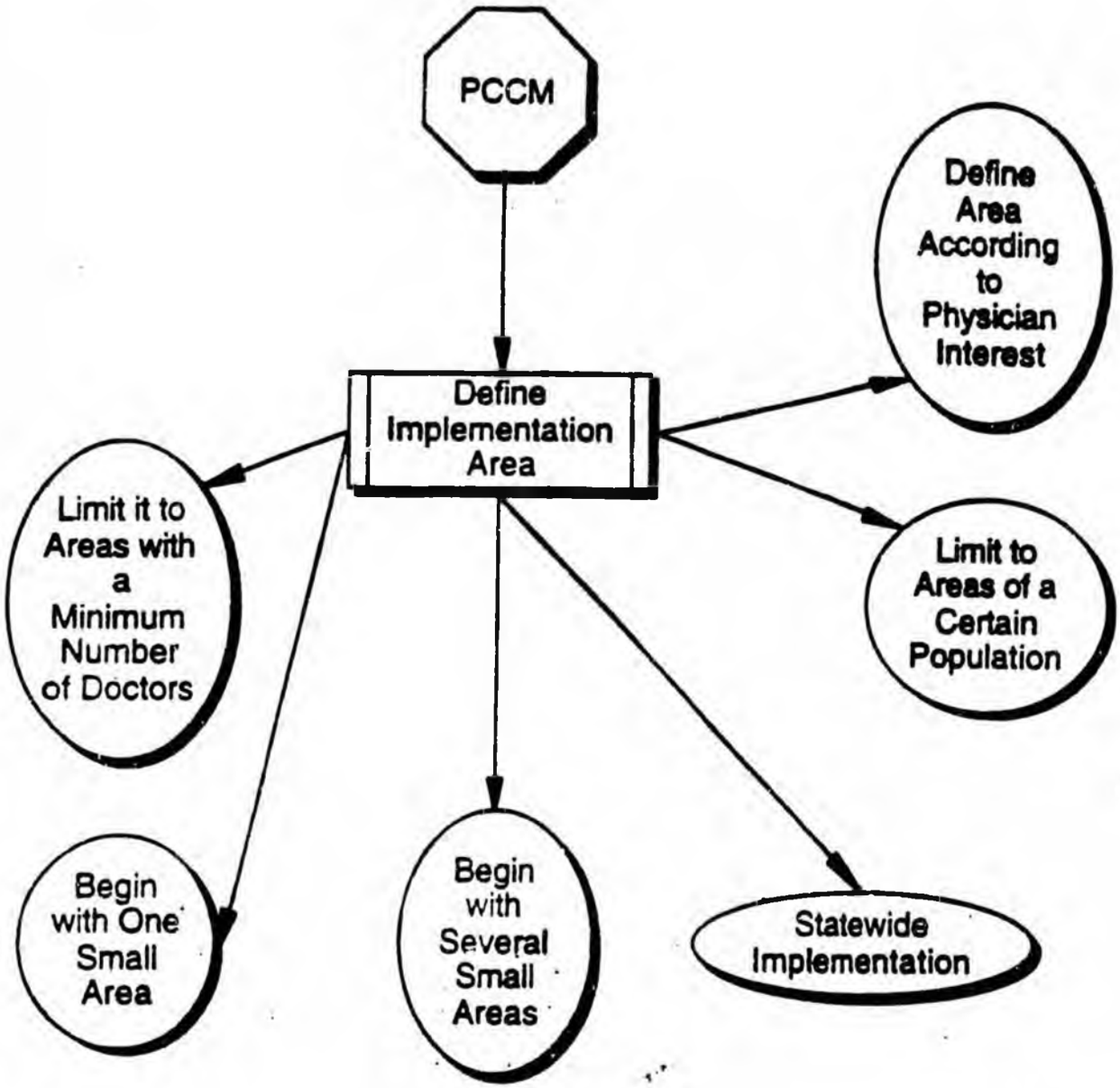
Changes in a delivery system require system adjustments and refinements so the tasks of the new program are functional. Examples of information system changes are shown below (this will vary depending on the features incorporated in the program design).



Define Systems Needs

PCCM IMPLEMENTATION AREA

As the PCCM program is conceived, States must determine the area of the state best suited for the initial implementation of the program. Considerations that may be discussed are depicted in the following diagram.

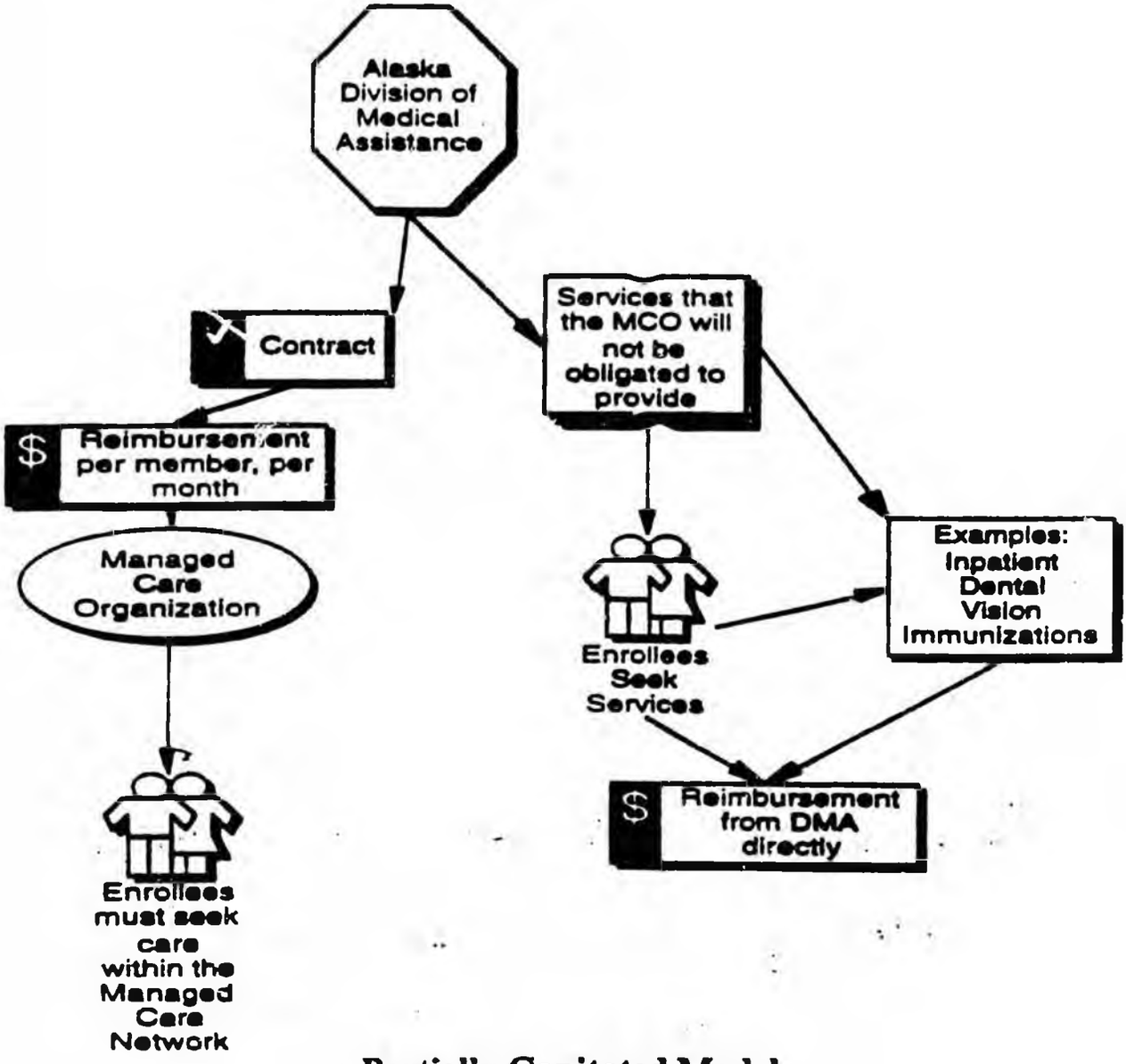


Implementation Areas

PARTIALLY CAPITATED REIMBURSEMENT SYSTEMS

Another reimbursement methodology that is used by states implementing managed care is a partially capitated system. Programs are structured to reimburse managed care organizations for a specific set of contracted services at a per member per month (pmpm) capitation rate. Members must seek care covered by the MCO within the MCO's panel of providers. Services outside of the partially capitated contract may be reimbursed through a contract arrangement or a fee-for-service basis. For example, a state may capitate all ambulatory services but continue to pay for inpatient hospital costs on a fee-for-service basis and pay for vision care under a separate contract.

The following diagram depicts a partially capitated system.



Partially Capitated Model

FULLY CAPITATED SYSTEMS

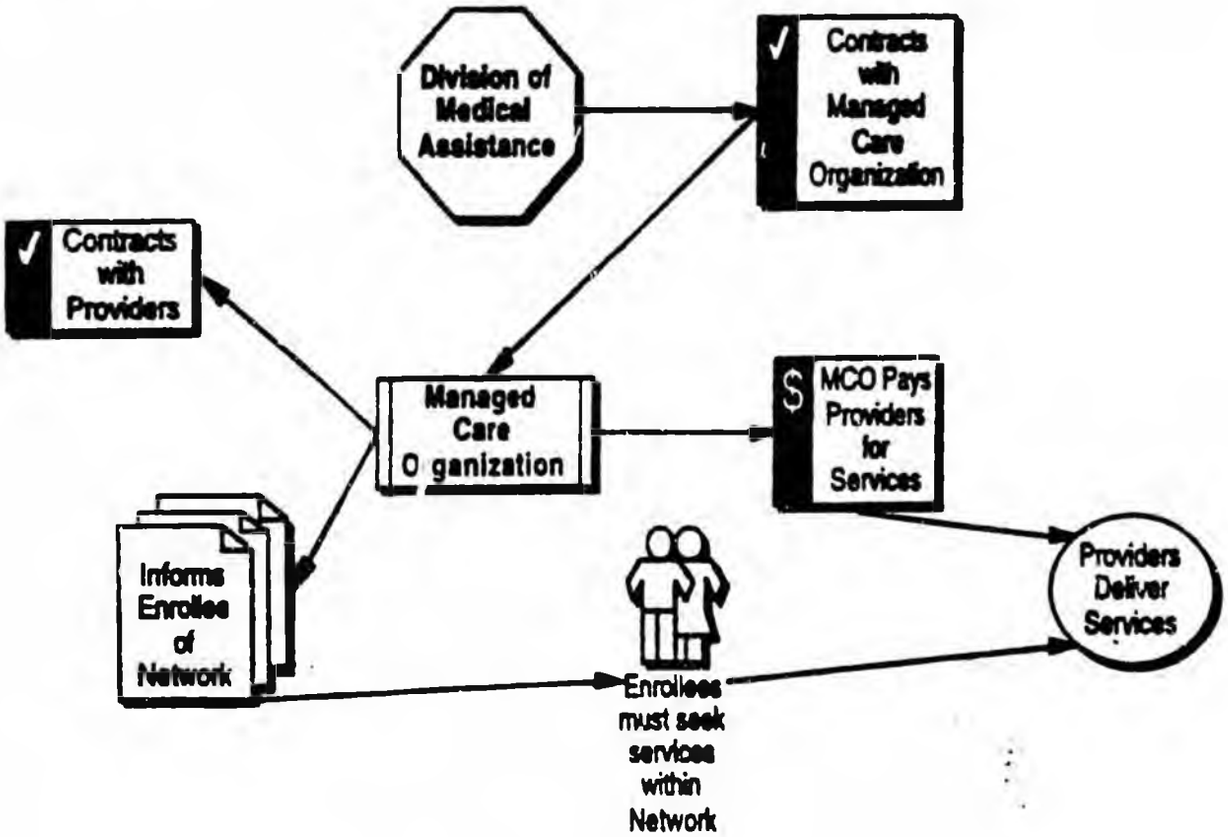
Under a fully capitated system, states contract with managed care organizations for the full continuum of care. The MCO is generally paid a capitation rate on a per member per month basis. Capitation rates may vary based on the enrollee's Medicaid category of assistance, age, sex, and geographic location in the state.

The MCO arranges all care that is medically necessary for their enrollees within its panel of providers. Enrollees are required to seek services within the MCO using the established internal referral process. Their freedom to seek treatment from any provider is restricted.

The MCO:

- administers the plan,
- contracts with providers,
- authorizes services,
- pays claims or contracted amounts to providers, and
- oversees the quality of care and utilization patterns

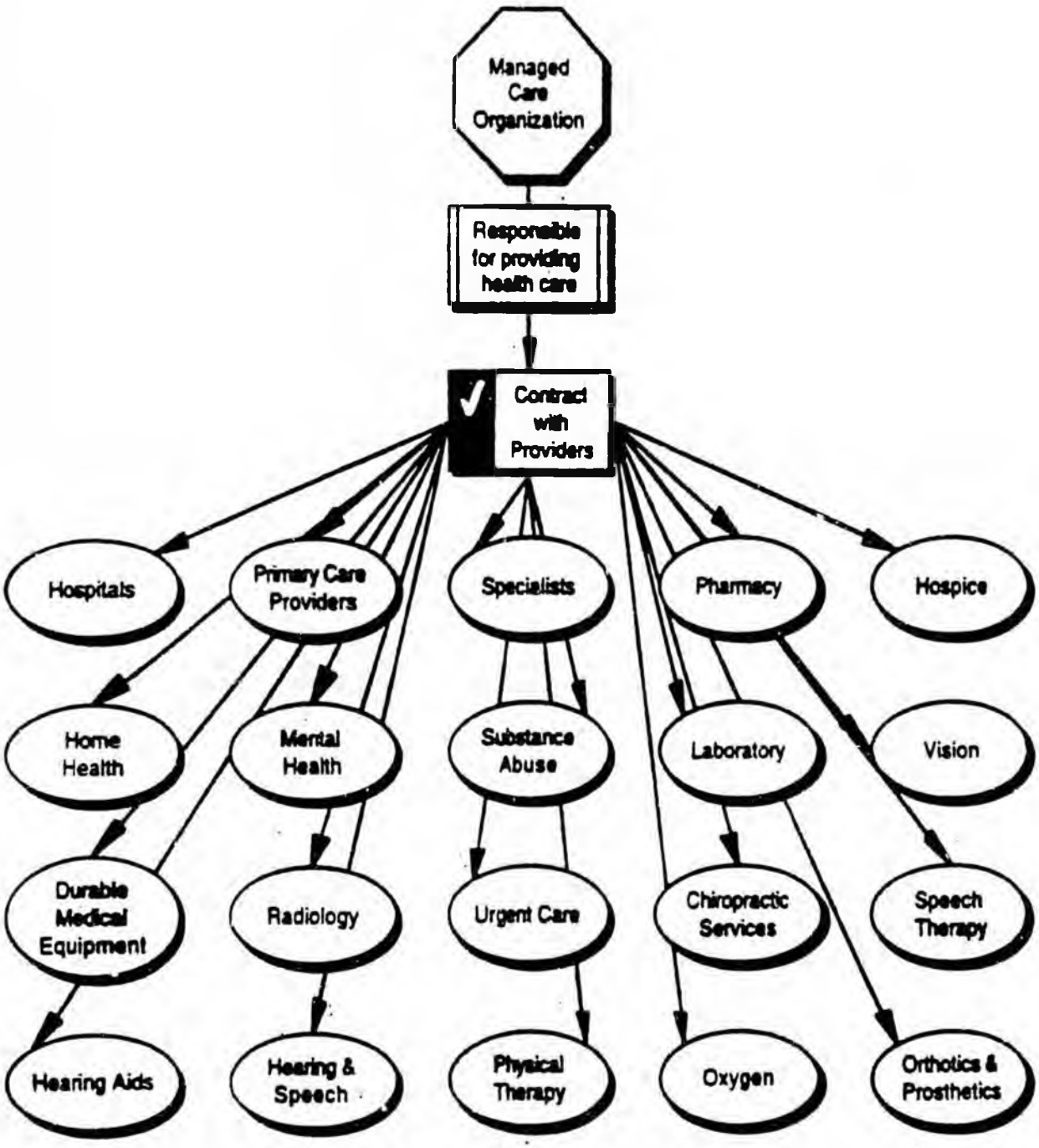
Most states require MCOs to be licensed. The Medicaid contract is obtained apart from the licensing process. The licensing agency and the Medicaid office oversee the operation of the MCO to ensure compliance with state laws and Medicaid policies and procedures.



Fully Capitated System

NETWORK OF PROVIDERS

Both partially capitated and fully capitated systems contract with a network of providers who furnish medical care to enrollees of the plan. The panel of providers may be very extensive for fully capitated systems that provide the full continuum of care.



An Example of a Network of Providers

PROS AND CONS OF DIFFERENT DELIVERY SYSTEMS

The following tables discuss both the favorable and unfavorable aspects of each delivery system discussed above. Fee-for-service is included since it is the current system that Alaska is using. Simply put, fee-for-service is a delivery system that pays providers for services rendered using a predetermined fee schedule. Patients are free to access benefits as they see fit. The state may have administrative procedures that limit access to some services; e.g., a Medicaid enrollee may only receive vision care that includes the dispensing of glasses once every two years because of limits the program has instituted.

Fee-for-Service

FFS	Pros	Cons
Definition: The traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.	• Freedom of choice for recipients • No risk for providers • Cost and utilization can be tracked through the payment system • Can set fee screen based on state's budget and need for access	• May encourage over-use of services (by providers, by recipients) • Recipients on their own to find and secure services • Payments are usually low, thus discouraging many providers from participating; however Alaska pays providers very well • No coordination of care • No continuity of care • No incentive to terminate treatment • Difficult to budget (open ended) • Extensive auditing required • Quality of care is difficult to measure and monitor

Managed Fee-for-Service

Managed Fee-for-Service	Pros	Cons
Also called Enhanced Fee-for-Service or Primary Care Case Management (PCCM), although PCCM can be also be capitated **Definition:** A managed care plan which reimburses providers on a fee-for-service basis but also pays a case management fee to providers who must deliver or authorize care for eligible enrollees.	• Monetary incentive for physician participation thus potentially increasing access to primary care • Some incentive for providers to manage care • Little, if any, risk to providers • Provision of a "medical home" decreases use of ER for routine and less urgent care • Tracking of encounters through the payment system allows creation of a "report card" for the Primary Care Provider (PCP) which allows comparison between provider's practices and may allow the state to disenroll providers who do not practice within the norm	• Providers may be unskilled in care management techniques • Providers may not be motivated to care manage; may not change any of their historical practice modes • Providers may not have the time or resources to devote to managing Medicaid recipients • Enrollees, especially assigned enrollees, may have had no previous contact with the assigned provider. There is no incentive for the provider to outreach to the client nor for the client to seek out the assigned provider • Primary care providers may be well equipped to provide care for AFDC-type patients but ill equipped to provide the specialized care needed by SSI eligibles • There is little disincentive to curtail excessive utilization of services • Less freedom of choice for the recipient • Type of care may differ widely by region • Ability to change each month may result in lack of continuity of care • Difficult to budget (open ended)

Partial Capitation

Partial Capitation	Pros	Cons
Definition: Programs reimburse managed care organizations for a specific set of contracted services at a per member per month capitation rate.	• Budget predictability is possible for the capitated services (although total eligible recipient numbers remain unknown) • Incentive to manage the capitated services • Some incentive to manage the non-capitated services if there is a bonus arrangement • Access to services is guaranteed through the contractual agreement • Quality assurance requirements are defined by contract and can be monitored • Licensing of the entity may be required • Utilization analysis may be possible to the extent that encounter reporting is required • Both coordination of care and continuity of care should be assured for the enrollee	• The provider is at risk for the capitated services • Incentive for underservice • May be cost shifting to the non-capitated services, even in a bonus arrangement • Less direct control of the providers rendering services (although credentialing is usually more thorough in a capitated system) • Utilization reporting with client level detail may not be available • Oversight by the State Agency requires more diligence and a shift from the FFS perspective

Full Capitation

Full Capitation	Pros	Cons
Definition: The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract for a negotiated per capita rate usually paid monthly.	• Budget predictability (although the number of eligibles will affect this) • The provider is contracted for services and population. The contract requirements can be measured and monitored with recourse if contract terms are not met • Offers lower cost solutions to prescribed treatments which may include services which are not currently covered • Cost shifting is curtailed if all benefits are included in the benefit package • Much of the provider and service provision oversight shifts to the managed care organization • Licensing is likely required • Federal contract rules provide additional regulatory oversight	• Incentive to underserve • Access through traditional providers (FFS) may dry up as more services are provided through MCOs. This can create problems if an MCO goes out of business or terminates the contract • Many traditional providers (FFS) do not like MCOs and refuse to contract with them; this may result in a continuity of care issue to the extent that recipients are required to change provider • High cost services may be hard to get even when medically appropriate • State oversight must be defined and in place • Utilization reporting may require new systems • Rate setting becomes more difficult as the FFS base disappears

COMPONENTS OF A MANAGED CARE SYSTEM

INTRODUCTION

The widespread introduction of managed care programs for Medicaid recipients over the past several years has resulted in a wealth of available information about the do's and don'ts of Medicaid managed care. Despite each state's uniqueness in terms of size, demography, location, and number of Medicaid recipients, many of the lessons learned and the experiences of other states are transferable from one state to another.

Every state has either implemented some form of managed care or is developing a program. Many states are nearing complete enrollment of their Medicaid population into one or more managed care programs. In Michigan, for example, 93 percent of the AFDC and non-institutionalized SSI Medicaid recipients are enrolled in some form of managed care.

The following synopsis provides a description of the components of Medicaid managed care programs throughout the country. Specific emphasis is being placed on the program components and specific state experience that have applicability to Alaska. The following states were contacted for additional information: Colorado, Connecticut, Florida, Georgia, Idaho, Iowa, Kentucky, Maine, Michigan, Montana, Nebraska, New Jersey, New Mexico, North Carolina, North Dakota, South Dakota, Virginia, and Wisconsin. Specific information received via telephone in response to a series of questions is included in the next section. Information on every state can be found in Exhibit A.

Primary Care Case Management (PCCM) programs and Health Maintenance Organizations (HMOs) are the two most common forms of managed care used across the nation for the Medicaid population. HMOs and other types of risk-based programs are used almost exclusively in urban areas or in areas where there is a large concentration of Medicaid recipients. Because of this and because of the risk associated with HMOs, states have, for the most part, initiated their mandatory managed care programs with a PCCM. Once managed care is established, one or more HMOs may be offered as a voluntary enrollment option, and then the Medicaid agency may migrate toward mandatory HMO enrollment or other risk-based arrangements as appropriate and feasible given the level of Medicaid recipients in the state, the availability of HMOs, and other considerations. Many states had experience with HMO contracting and voluntary enrollment prior to the early 1980s when 1915(b) waivers and larger scale implementation of mandatory and innovative approaches began.

Because of the vastness of Alaska and the relatively small number of Medicaid recipients in any one area, particular attention is paid to PCCM programs.

PROGRAM COMPONENTS

ENROLLMENT

Enrollment in a managed care program can be voluntary or mandatory. In terms of ease of implementation, it is simpler to introduce the program on a voluntary basis in a small area. This enables the State to "test" the program on a fairly small scale and make adjustments as necessary. When questioned about enrollment, several states emphasized the importance of starting on a small scale.

In addition to the manageability of a small-scale start-up, implementation on a limited basis also allows the State to focus its efforts on a geographic area where adequate provider participation can

HOUSE COMMITTEE REPORT

4/3/96

(7)

Date Referred to Committee: March 27, 1996 **FURTHER REFERRALS:** Finance

Date of Committee Action: _____ waived

The STATE AFFAIRS Committee considered: **HB 393**

HOUSE BILL NO. 393 **MANAGED CARE PROGRAM FOR MEDICAID**

"An Act relating to managed care for recipients of medical assistance; and providing for an effective date."

recommends it be replaced [ ] the same title
with the following committee substitute _____ [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM

CHAIR'S SIGNATURE _____ _____

(7) 10

3/27/96

State Affairs
Finance

HOUSE COMMITTEE REPORT

Date Referred to Committee: January 8, 1996 **FURTHER REFERRALS:**

Date of Committee Action: 3/26/96

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: **HB 393**

HOUSE BILL NO. 393 **MANAGED CARE PROGRAM FOR MEDICAID**

"An Act relating to managed care for recipients of medical assistance; and providing for an effective date."

recommends it be replaced with the following committee substitute CS HB 393 (HES) [X] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[X] zero fiscal note(s) H+SS [ ] zero fiscal note(s) _____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
G. Davis	✓			
Pekelberg	✓			
Bundy			✓	
Toohey		✓		
Robinson			✓	
Brice				✓
	(2)	(1)	(2)	(1)

10 - CHAIR'S SIGNATURE _____

Toohey