

A State Medicaid Director On Medicaid Managed Care

Most Medicaid managed care programs have focused on the “easy” groups of low-income adults and children. Now for the hard part: enrolling high-cost elderly and disabled persons.

BY DONNA CHECKETT

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THE FINDINGS OF Marsha Gold and colleagues regarding the implementation of Medicaid managed care and its successes and failures serve more to confirm much of the “policy by anecdote” that is now abreast in the field than to identify startling new conclusions. It is hardly surprising that states that are able to set adequate capitation rates after a careful planning process, in communities with reasonable managed care penetration, will have a smoother implementation than states without such luxuries. Equally bland is the finding that states with adequate administrative resources—expert staff, information systems, and education and enrollment funding—will be able to best monitor and improve Medicaid managed care programs over time. Finally, and most significantly, it is obvious that states with governors and legislatures that understand the three legs of the managed care stool—access, quality, and cost savings—will be able to best attract the highest-quality health plans that are interested in the Medicaid managed care business as long-term partners.

A popular saying among Medicaid directors is: “If you have seen one Medicaid program, you have seen one Medicaid program. This saying will remain true as long as states tailor Medicaid managed care programs to meet the future fiscal and policy priorities of governors and legislatures.

The 1995 data from the Health Care Fi-

ancing Administration (HCFA) indicate that eleven million of the nation’s thirty-five million Medicaid beneficiaries are enrolled in managed care. Those of us at the front lines comfortably predict that the 1996 numbers will be considerably higher. The vast majority of the implementation efforts have focused on low-income adults and children—segments of the population that are transferred most easily to managed care because their health needs do not differ greatly from those of a more commercial population. In states that are recruiting health plans to participate in Medicaid, low-income adults and children appear to pose the lowest risk.

These gains are trivialized, however, by the fact that low-income adults and children—70 percent of Medicaid recipients—consume only 30 percent of Medicaid dollars. Yet this is the group that is subject to mandatory enrollment in managed care. Only now are a few states making major headway into managed care for the high-cost Medicaid beneficiaries: the elderly and persons with disabilities.

It is clear that enrolling high-cost beneficiaries in managed care will produce the greatest savings. Measures ranging from reducing inpatient costs to managing care in home and community settings will comprise the next stage of managed Medicaid.

UNIQUE PLANNING NEEDS

First, states will need a reasonable timetable

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for planning and implementation of Medicaid managed care for the elderly and persons with disabilities. Eighteen to twenty-four months is not unreasonable, especially in light of the medical complexities associated with disability and old age.

■ **SYSTEMS OF CARE.** The current practice of controlling costs by requiring prior authorization of every service that is not delivered by a primary care physician will not work for enrollees who rely on specialists. In general, commercial health plans lack the expertise, networks, and systems that are necessary to deal with large numbers of elderly and disabled persons. New systems of care—many of which most likely are not in existence yet—must be created to manage the demand for specialty care, the frequent use of multiple pharmaceuticals, and the increased need for case management. A marriage between chronic, long-term health problems and non-acute care systems based in neighborhoods and communities will provide a solid foundation for reducing prolonged and unnecessary institutionalization.

■ **RATE SETTING.** States also should be testing innovative rate-setting methodologies for these high-cost beneficiaries. Principles that are basic to capitation, such as risk sharing, are challenged when the population needs continuous rather than intermittent access to care. Regardless, states need expertise for rate setting and risk setting. The challenge of determining actuarially sound Medicaid rates is exacerbated by the dynamics of a chronically ill population.

■ **QUALITY IMPROVEMENT.** After several years of development, the Medicaid Health Plan Employer Data and Information Set (HEDIS) has been released. States already have completed some training in Medicaid HEDIS, but all are indicating that full-scale implementation is not likely in the near future. Ironically, the development of quality indicators that specifically focus on the unique aspects of disability and old age is still in its infancy. Yet these are the very persons with the most to gain, and lose, under managed care. Striking a balance between appropriate

utilization review and unnecessary paperwork is always a challenge in managed care—a challenge that will be even greater with a high-use, high-cost population.

■ **CONSUMER PROTECTION.** The role of consumer and advocacy groups must be accounted for in the earliest planning phases. For the most part, states have implemented managed care for the low-income Medicaid population with fairly limited consumer and advocacy input. Attempting to implement this measure for the senior and disabled populations would show political naiveté. Many of these persons come from middle-income families that are educated and empowered. They bring with them advocacy groups that are well funded, well organized, and politically savvy. Capable of crawling through any bureaucratic undergrowth, they will demand inclusion in the implementation process and most likely will receive it.

CONCLUDING COMMENTS

The impact of these issues converges in the actual managed care contract and the ability of a state to monitor compliance. Increasingly, states are relying on these contracts to address a myriad of problems, including improving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) participation rates and protecting essential community providers. Considering the lack of resources that is characteristic of many state Medicaid agencies, there is great risk that Medicaid managed care contracts will require performance that cannot be audited or enforced.

While the findings of Gold and colleagues are not surprising, they nevertheless have great value. Quick-fix decisions about cost savings, time lines, staffing, and enrollment shape the long-term success of a managed care program more than states sometimes want to acknowledge. Let us use the findings of this research to develop managed Medicaid programs that truly achieve their goals.