Mandatory HMO care for Milwaukee's poor
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Prologue: Five years ago, as a consequence of intense fiscal pressures on states and the federal government’s new willingness to grant them broader flexibility in casting health policy, many states began to re-shape their Medicaid programs. The Omnibus Budget Reconciliation Act of 1981 was the first most sweeping in a continuing series of federal legislative acts that attempted to redefine the federal-state Medicaid program. This law modified the long-standing program requirement that individual Medicaid recipients have the freedom to obtain services from any qualified provider of care. In the ensuing years, more than half of the states have sought from the Health Care Financing Administration waivers from the freedom-of-choice requirement. Wisconsin is one such state. In this paper, authors Diane Rowland and Barbara Lyons look at the design and implementation of Wisconsin’s effort to enroll Medicaid beneficiaries in prepaid health plans that offer patients a limited choice of provider. Wisconsin’s initiative is one of the largest in the nation. Beginning in January 1985, more than 110,000 recipients of Aid to Families with Dependent Children (AFDC) were required to enroll in health maintenance organizations (HMOs) as their source of medical care. Given the liberal political traditions of Wisconsin, a state that has had a generous Medicaid program from the start, its experience with the mandatory enrollment of AFDC recipients in HMOs is being watched closely in Washington, Rowland is completing work on a doctorate in health policy and management at The Johns Hopkins School of Hygiene and Public Health. She also is associate director of the Commonwealth Fund’s Commission on Elderly People Living Alone and a consultant on long-term care issues to the House Energy and Commerce Subcommittee on Health and the Environment. Lyons holds a master’s degree in health finance and management from the same school and has worked on a variety of health care financing projects.
Prepaid and managed care is a new direction for the delivery of services to the poor covered by Medicaid. Paying for health services for the poor under a fee-for-service system without controls on utilization of services or choice of providers is now viewed by many states as a very costly approach to financing care. Increased flexibility provided by the 1981 Omnibus Budget Reconciliation Act (OBRA) allows states to limit freedom of choice of providers and permits case management for the care of Medicaid beneficiaries. As a result, several states have initiated Medicaid program changes to provide care from a more limited range of providers with stronger controls over access to services.

Wisconsin is one state that has embarked on a major Medicaid reform using prepayment. Compared to other states, Wisconsin traditionally has had a very generous Medicaid program with liberal eligibility standards, comprehensive benefits, and relatively unrestricted provider payment rates. However, faced with a deficit in the state budget and rapidly escalating Medicaid costs, the Wisconsin legislature in 1983 enacted a major reform. Under the “Medicaid HMO Preferred Enrollment Initiative,” Medicaid beneficiaries receiving cash assistance from the Aid to Families with Dependent Children (AFDC) program and living in either Milwaukee or Dane County were required to choose a health maintenance organization (HMO) as their source of care. The fee-for-service option was effectively eliminated. In Dane County, site of the state capital, 10,000 Medicaid beneficiaries were enrolled in HMOs. In Milwaukee County, 106,600 Medicaid beneficiaries were enrolled in eight prepaid health plans over a six-month period. Over 90 percent of AFDC beneficiaries are now enrolled in HMOs in the two counties, and in October 1986, Eau Claire County beneficiaries were added.

The Medicaid reform strategy was part of a broader state strategy to curb health care spending by encouraging the growth of HMOs. A 1983 state statute (SB83) permitted closed-panel HMOs to operate under state law without federal qualification and changed the health benefit structure for state employees to provide a strong economic incentive for HMO enrollment. As a result, 66 percent of all state employees were enrolled in HMOs in 1984, compared to 15 percent the previous year. These initiatives helped give HMOs status as quality providers and paved the way for the Medicaid program reform.

This article looks at the design and implementation of the Wisconsin Medicaid HMO enrollment initiative and its impact on health care to the poor in Milwaukee. A case study was undertaken to assess how the participants view the experiment and what lessons could be learned from the Milwaukee experience.
The Preferred Enrollment Initiative In Milwaukee

The Medicaid Preferred Enrollment Initiative was implemented for over 100,000 AFDC beneficiaries in Milwaukee in October 1984, based on positive results from two pilot projects carried out in the Marshfield area and in Dane County. The state’s implementation tasks involved selecting HMOs for beneficiary enrollment, matching beneficiaries to plans, determining appropriate payment levels, and monitoring the results.

Selecting the prepaid plans. Prior to the Preferred Enrollment Initiative, Milwaukee County had no HMOs with contracts to serve the Medicaid population. To implement the new initiative, the state Medicaid program had to stimulate the development of enough HMO capacity to serve over 100,000 Medicaid beneficiaries. The Wisconsin Department of Health and Social Services, the entity responsible for implementation of the initiative at the state level, issued a solicitation to HMOs in July 1983 and signed contracts in the fall with eight HMOs. The contract between the state and the participating plans specified both the capitation payment per enrollee and the maximum number of Medicaid beneficiaries who could be accommodated per plan. Capitation rates were generally consistent among HMOs and averaged about $65 per enrollee per month.

The plans awarded contracts included four operational HMOs and four plans that were created solely to enroll the AFDC Medicaid population. As shown in Exhibit 1, the size of enrollees varies significantly among the participating plans, and approximately 70 percent of

<table>
<thead>
<tr>
<th>HMO</th>
<th>First year of operation</th>
<th>Medicaid beneficiaries enrolled</th>
<th>Medicaid beneficiaries as a percent of plan enrolled</th>
<th>Distribution of Medicaid enrollees of plan</th>
<th>Sponsorship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1983</td>
<td>116,903</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CompCarea</td>
<td>1971</td>
<td>10,045</td>
<td>8.6%</td>
<td></td>
<td>Blue Cross-Blue Shield</td>
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<tr>
<td>Family Health Plans</td>
<td>1979</td>
<td>1,509</td>
<td>1.3%</td>
<td></td>
<td>Nonprofit cooperative</td>
</tr>
<tr>
<td>WHO-HealthPlus</td>
<td>1984</td>
<td>17,620</td>
<td>15.1%</td>
<td></td>
<td>St. Anthony’s Hospital</td>
</tr>
<tr>
<td>HealthReach</td>
<td>1984</td>
<td>12,569</td>
<td>10.7%</td>
<td></td>
<td>Community health centers</td>
</tr>
<tr>
<td>MaxiCare</td>
<td>1982</td>
<td>12,923</td>
<td>11.0%</td>
<td></td>
<td>National Proprietary HMO Company</td>
</tr>
<tr>
<td>PrimeCare</td>
<td>1983</td>
<td>15,063</td>
<td>12.9%</td>
<td></td>
<td>Local physicians</td>
</tr>
<tr>
<td>Samaritan Health Plan*</td>
<td>1981</td>
<td>13,643</td>
<td>11.7%</td>
<td></td>
<td>Good Samaritan Medical Center</td>
</tr>
<tr>
<td>St. Francis*</td>
<td>1985</td>
<td>3,861</td>
<td>3.3%</td>
<td></td>
<td>St. FrancisChurch</td>
</tr>
<tr>
<td>TotalCare</td>
<td>1984</td>
<td>29,670</td>
<td>25.4%</td>
<td></td>
<td>Milwaukee Children’s Hospital</td>
</tr>
</tbody>
</table>

Source: Wisconsin Department of Health and Social Services and Insurance Commissioner’s Office.

*Federally qualified.

St. Francis was added during second contact year.
the Medicaid AFDC population were enrolled in HMOs that were new or less than two years old. In order to enroll large numbers of Medicaid beneficiaries quickly without enrolling a corresponding proportion of private patients, the four new plans obtained a temporary waiver of the federal Medicaid requirement that at least 25 percent of an HMO’s total enrollees must be privately insured patients.

Only one plan is a staff-model HMO with physicians employed on a full-time salaried basis to care exclusively for HMO enrollees. One of the HMOs is a group model, and the others are individual practice associations (IPAs). The four IPA-model HMOs are all provider-sponsored and were formed specifically to enroll Medicaid beneficiaries. In the IPA model, physicians see a mix of prepaid and fee-for-service patients in private offices located throughout the area instead of at a central site. The HMO receives the capitation payment, but the physicians continue to be paid fee-for-service although this fee is usually discounted for prepaid patients.

To participate in the Medicaid initiative, the HMO must provide all services covered by the Wisconsin Medicaid program, except dental and chiropractic services. To reduce the use of hospital emergency rooms as a source of primary care, participating HMOs are required to provide around-the-clock emergency care services directly or under contract with another provider. If a beneficiary has an emergency requiring immediate treatment outside the HMO, care may be obtained from any provider and the HMO is liable for payment. Participating HMOs are also required to provide all medically necessary treatment for mental or nervous disorders and alcohol or drug abuse problems and are financially liable for court-ordered mental health and substance abuse services for their enrolled population. The first round of provider contracts ended December 31, 1985; the second round runs eighteen months from January 1, 1986 to June 31, 1987.

Matching beneficiaries and plans. The HMO Preferred Enrollment Initiative is limited to those Medicaid beneficiaries who are receiving cash assistance under AFDC, a group composed largely of mothers and children, generally the most healthy group in the Medicaid population. The elderly and disabled are not included because their poorer health status makes the cost for their medical care harder to predict and because Medicare already covers most of their acute care.

Within the Medicaid AFDC population, families may be excluded from HMO coverage if a family member suffers from a severe medical condition, such as chronic mental illness and psychosis, drug abuse requiring methadone treatment, major functional impairment, severe developmental disability, or need for residential treatment care for three or more months during the past year. Individuals with other serious medical problems, such as sickle-cell anemia or leukemia, are not exempt
from HMO participation. Exempted individuals and their families continue to receive care on a fee-for-service basis and have to pay copayments on some services.

Beginning in January 1985, AFDC Medicaid beneficiaries were required to select an HMO from among the eight participating plans. Beneficiaries living more than twenty miles or thirty minutes from an HMO were exempted from the selection process. If beneficiaries did not voluntarily choose an HMO within four months, the state assigned them to the HMO nearest to their residence with the lowest capitation rate, as long as the HMO had not exceeded its maximum number of enrollees.

Enrollment forms were mailed to all AFDC recipients and were also available from doctors and hospitals. All HMO marketing information had to be approved by the state, and door-to-door canvassing to solicit enrollees was prohibited. To facilitate initial enrollment, thirteen orientation sessions were held for Medicaid beneficiaries.

Despite enrollment through the mail, 74 percent of eligible Medicaid beneficiaries voluntarily selected an HMO. Nearly 40,000 beneficiaries enrolled during the voluntary period and another 41,000 enrolled shortly thereafter when they realized they would be assigned to an HMO if they did not choose the one they preferred. The aggressive advertising campaigns that were carried out by the HMOs combined with physicians’ efforts to enroll their Medicaid patients in their affiliate HMO plans undoubtedly contributed to the high level of voluntary selection. By July 1, 1985, enrollment was virtually full, with 106,600 beneficiaries in Milwaukee voluntarily enrolled in or assigned to an HMO plan.

Beneficiaries are permitted to disenroll and switch HMOs after thirty days if they are dissatisfied. However, this option is limited because five of the nine Milwaukee plans are currently closed to new enrollees, having met their enrollment capacity.

**Paying the HMOs.** The Wisconsin Department of Health and Social Services pays each participating HMO a single rate per enrollee that is negotiated and specified in the contract. The capitation rate must be below a maximum rate determined by the state and is set to produce savings from expected fee-for-service spending.

The maximum acceptable capitation rate in Milwaukee during the first contract year was $68.70 per enrollee per month. The state set the maximum by using the 1983 fee-for-service spending of the AFDC population as a base. The base rate was then increased by 3 percent per year to account for inflation and adjusted to account for the HMOs’ additional claims processing costs and the state’s loss of revenue from the elimination of Medicaid copayments. Savings over fee-for-service are achieved by reducing the adjusted capitation rate by 7 percent for HMOs in Milwaukee. The Medicaid capitation payment is about 8 percent below commercial insurers' rates for individuals enrolled in HMOs. The
lower individual Medicaid rate tends to be offset because the Medicaid capitation is the same for children and adults, whereas commercial insurers use the family rate offered by HMOs. As a result, the overall state Medicaid payment is competitive with payment from commercial insurers.

With most Medicaid AFDC beneficiaries in Milwaukee now enrolled in HMOs, the fee-for-service experience is becoming less useful as the comparison point for the HMO capitation rate. In the future, the state plans to set the capitation rate based on a percentage reduction off the average cost per beneficiary enrolled in an HMO.

**Monitoring the cost and the care.** Savings are guaranteed by the state's requirement that HMO rates be less than 93 percent of the expected fee-for-service costs. From 1985 to 1987, the state expects to save approximately $12-15 million statewide on Medicaid medical service and claims processing costs, with the bulk of these savings from the Milwaukee component of the HMO initiative. Offsetting administrative costs are estimated at approximately $1.1 million for start-up and $350,000 to $400,000 annually thereafter.

The University of Wisconsin-Madison's Center for Health Policy and Program Evaluation (CHPPE) was asked to evaluate the HMO Preferred Enrollment Initiative and to develop and implement a quality assurance monitoring program. HMOs are required to submit encounter data so the state can monitor utilization to detect underuse problems. However, encounter data are not yet available in useable form, and a recent CHPPE study found that most of the HMOs had quality assurance systems that were either poorly developed or not yet operational.

### The Views Of Participants In Milwaukee

**State perspective.** Wisconsin initiated the HMO Preferred Enrollment Initiative as a strategy for controlling a rapidly escalating Medicaid budget while maintaining access. State administrators feel these goals have been reasonably achieved, but recognize that implementation could have been improved with a longer lead time for the enrollment conversion and better beneficiary education. They attribute their success to careful planning, ongoing communication with involved parties, and a forceful administrator guiding early implementation.

The state had been developing an HMO initiative for the Medicaid population for over two years, but the initial planning lacked adequate resources, leadership, and an implementation deadline. After the legislation setting up the project passed in 1983, a project director was hired and staff resources were finally focused on making the initiative operational.

Despite their advance preparation, state administrators felt six months was too short a period to transfer over 100,000 beneficiaries from fee-for-
service care to HMOs. Many beneficiaries were confused by the process and the HMOs did not have adequate systems to monitor this rapid growth or accommodate the expanded population. State officials recognize that far more attention needs to be given to beneficiary education regarding how to select an HMO and how to obtain care in a managed situation. Medicaid beneficiaries who have traditionally relied on emergency room care need assistance in changing their utilization patterns. Face-to-face counseling at the time of HMO selection and ongoing education activities by the HMOs could reduce confusion for beneficiaries. In October 1987, the state plans to fund face-to-face counseling for enrollees to assist with initial HMO selection.

From the state's perspective, the most problematic areas were the initial enrollment process and the provision of emergency care and mental health benefits where the HMOs had to supercede existing providers or develop new linkages. At the initiative of the county, the state developed guidelines clarifying what was to be covered under the HMO capitation rate and issued Memorandums of Understanding, which the HMOs and other providers were required to sign. Also, contrary to initial expectations, enrollment of the AFDC Medicaid population into HMOs has not decreased the administrative workload at the state. Statewide, HMO enrollees account for only 27 percent of the total Medicaid population. Thus the state has to maintain the old fee-for-service claim system as well as the HMO system. Any administrative savings from the HMO initiative have been offset by additional costs for data systems for monitoring HMO quality and utilization.

**County perspective.** State and county relations in the HMO initiative have been rocky due to the interface of traditional responsibilities between the two levels of government. The state administers and finances the Medicaid program, but the county runs the eligibility determination process for AFDC and Medicaid, coordinates and delivers mental health services, and operates the county public hospital, which cares for the indigent. The HMO enrollment process and the scope of services to be provided by the HMOs have been points of conflict.

The state originally planned to have Milwaukee County handle HMO enrollment as part of the welfare and Medicaid eligibility determinations. Welfare caseworkers would have advised clients about HMO selection when they applied for cash assistance. However, county officials felt the welfare caseworkers had neither the time nor the training to be health benefits counselors and insisted new staff would have to be hired to provide face-to-face counseling for Medicaid beneficiaries. The state was unwilling to meet the county's price and instead contracted with an outside firm to handle enrollment by mail. Both the county and the state are now working to make space available to the firm for face-to-face counseling in the welfare enrollment offices.
Beyond enrollment issues, conflict has also arisen over the provision of services that by statute are the responsibility of the county, most notably care of the mentally ill, care of the mentally retarded, and services to substance abusers. In 1974, the legislature set up local public mental health boards, known as 51.42 boards, in each county to manage and coordinate these services. The state’s HMO initiative threatened to unravel this relationship by shifting gatekeeping responsibilities and Medicaid financing from the county to the HMOs. The county is now competing with HMOs to provide treatment for mental health and alcohol and drug abuse because these services are included in the HMO capitation rate. However, the most seriously impaired beneficiaries may be exempted from HMO participation and could then receive county mental health services on a fee-for-service basis.

To clarify the division of responsibility between the HMOs and county, a Memorandum of Understanding was issued splitting authority to control the provision of services between the HMO and the 51.42 board. The latitude given the HMO depends on the vulnerability of the patient and the importance of the service.

The HMO perspective. Rapid enrollment of large numbers of beneficiaries during initial enrollment created major administrative problems for the HMOs. The new HMOs became large operations virtually overnight. Several HMOs did not have adequate systems for monitoring this rapid growth and exceeded their contractual maximum number of enrollees. They were required to reduce their enrollment cap through attrition and could not enroll new patients even if the prospective enrollee was under the care of one of the plan’s physicians. This led to confusion for Medicaid beneficiaries seeking to continue care with the same doctor.

One of the major problem areas for HMOs is the payment of emergency care and ambulance services. Both services were included in the HMO benefit package and capitation rate because the state wanted HMOs to control overutilization in nonemergency situations. Thus, when a beneficiary uses either an ambulance or an emergency room, the ambulance company or the hospital must negotiate payment with the HMO. As gatekeepers, some HMOs have refused to pay these bills.

The state finally intervened in December 1985 after a highly publicized case in which an infant who did not receive emergency care died. As a result, the state issued criteria setting requirements for HMO payment of emergency care. HMO administrators, however, feel they have had to use emergency services more often than they think is appropriate or efficient to avoid bad publicity and to give the Medicaid population time to learn how to gain access to the health care system through an HMO.

Mental health benefits are another controversial part of the HMO
benefit package. These services traditionally fall to the county, whose mental health network is oriented toward both long-term inpatient and ambulatory care. HMOs have a primarily acute and ambulatory orientation and try to limit inpatient care. The HMOs wanted mental health services carved out of the capitation rate and left to the county to provide on a fee-for-service basis. However, the state wanted HMOs to control utilization and insisted that routine mental health services remain in the HMO benefit package. Most of the HMOs have not experienced difficulty providing services at the rate negotiated with the state, and some are reported to have generated a profit. However, two have experienced some financial difficulty, and the state may have to intervene to protect the enrolled beneficiaries. The HMOs are concerned that the state will try to lower the capitation rate in the future, making it no longer economically feasible to serve this population. Such reductions would also put the primarily Medicaid HMOs in serious financial jeopardy since Medicaid provides the bulk of their revenues.

Despite state requirements for quality assurance systems at the HMOs, most HMOs have poorly developed or not yet operational systems. The older HMOs are more experienced with quality evaluation and have large non-Medicaid populations that they also must satisfy. The newer HMOs appear to be heavily involved with daily administration and monitoring overutilization and have put less emphasis on quality assurance systems.

Physicians. When the state moved to transfer care of Medicaid beneficiaries to HMOs, physicians were quick to realize that, to continue to serve this population, they either had to join an HMO or form an IPA to affiliate with an HMO. For example, the 320 physicians at Mount Sinai Hospital formed the Mount Sinai IPA about one year prior to the state’s Medicaid initiative. The IPA was organized to contract with CompCare for private HMO patients and to provide an administrative mechanism to enable the Mount Sinai doctors to continue serving the Medicaid population under the new initiative. Obstetricians were especially interested in maintaining their Medicaid patient base since 60 percent of the births at Mount Sinai are financed by Medicaid.

While all IPA members are on the staff at Mount Sinai, physicians in the Mount Sinai IPA also belong to other IPAs. In fact, most physicians have four or five IPA contracts to ensure that they can continue to see new patients through a different HMO when an affiliated HMO plan reaches its enrollment cap and can no longer accept new patients.

The physicians in IPA-model HMOs continue to be paid on a fee-for-service basis. In general, physicians in the Mount Sinai IPA receive about the same payment whether the patient is on Medicaid or privately insured because the private rate is highly discounted as a result of adverse selection by high-risk patients to CompCare. Currently, doctors are no
worse off than before the HMO initiative, but they feel there is not much slack left in the system and are concerned about future cutbacks.

The HMO initiative also means more administrative paperwork for physicians, since they act as gatekeepers for services. In addition, physicians are concerned that, in the future, utilization controls on ambulatory care could become overly burdensome. Yet physicians admit that, for savings to continue over time, physicians need to learn to improve management of patients in a prepaid setting.

Hospitals. The hospitals in Milwaukee have had to respond to cost-containment pressures from all payers, not just Medicaid. There has been a dramatic drop in hospital patient days resulting in staff cutbacks and some bed reductions. With declining occupancy a major concern, hospitals were anxious to participate in the state's Medicaid initiative to assure a continued flow of Medicaid patients. Some hospitals sponsored their own HMOs, and others have aligned with a Medicaid-contract HMO.

Mount Sinai, a 250-bed teaching hospital affiliated with the University of Wisconsin and the Medical College of Wisconsin, is an example of a traditional inner-city provider of indigent care. It is a high-volume Medicaid provider and a subcontractor with CompCare and TotalCare. Fifty percent of adult and 60-70 percent of pediatric primary care patients are Medicaid beneficiaries. Twenty percent of the hospital revenue is generated from Medicaid patients. The hospital considered forming a hospital-based HMO, but decided affiliation with an ongoing HMO was a wiser course because of the hospital’s teaching mission and because HMO development required substantial up-front money for promotion and advertisement.

The Medicaid HMO initiative has affected Mount Sinai as a teaching and specialty referral center. It has altered the patient mix by bringing in more young women and children, which could result in a diminished training experience for residents if the hospital is unable to maintain a broad mix of patients. It has also changed Medicaid funding for the training of interns and residents. Graduate medical education payments were folded into the fee-for-service base used to calculate capitation rates for all HMOs and no adjustment was made to increase payments to HMOs that refer patients to teaching hospitals. Teaching hospitals fear other payers will also clamp down on payment rates.

One of the most difficult problems faced by Mount Sinai Hospital as a result of the HMO initiative is how to handle AFDC beneficiaries who seek care from the hospital’s emergency room. In a cooperative approach, the hospital convinced the HMOs to pay $18 as a triage fee for nonurgent care delivered to HMO enrollees in the emergency room. In addition, to reduce emergency room walk-ins, the hospital set up a telephone hotline that Medicaid enrollees could use to have their condition assessed by a nurse or emergency room doctor.
The most notable effect of the HMO initiative on Mount Sinai Hospital has been a dramatic drop in Medicaid utilization of inpatient services. The number of Medicaid patient days per 1,000 Medicaid beneficiaries has been cut in half, from 1,200-1,400 days per 1,000 before the initiative to 590 days per 1,000 currently. The biggest change has occurred for maternity patients, whose average stay has dropped from five days to two days.

Beneficiary advocates. Advocacy groups for the low-income population were actively involved in the transition of Medicaid beneficiaries from fee-for-service care to HMOs. In Milwaukee, community advocates tried to minimize the disruption of established physician-patient relationships, improve beneficiary understanding and education about the initiative, and monitor access to and quality of care in the HMOs. They tried to assure that receipt of services, including special services such as family planning, was not diminished.

The HMO's capitation rate is intended to cover comprehensive care even when out-of-plan specialty care is needed. Advocates are concerned that the HMO referral networks are slow to make referrals to the traditional provider or try to shift care because the HMO has an affiliation with a different provider. Traditional patterns of specialty care would thus be severed and could result in some beneficiaries with special health problems receiving disrupted or inadequate care.

Advocates also fear that the incentives in the HMO payment scheme will discourage physicians from providing specialized services and that HMO physicians will not be aware that many services, such as adolescent pregnancy counseling, may be available outside the HMO at no additional cost. Also, they worry that some HMO physicians may lack adequate experience to identify and treat children with developmental problems or persons with serious alcohol and drug abuse problems.

The initial enrollment period was a difficult time for Medicaid beneficiaries and the HMOs. Despite state efforts to make the process clear, many beneficiaries were confused and did not complete the enrollment forms properly. Beneficiaries with regular physicians often failed to select their physician's HMO or selected the proper HMO without specifying their physician as the desired provider.

Enrollment by mail and lack of postenrollment counseling result in frequent misunderstandings between beneficiaries and their HMOs. Advocates find that beneficiaries often do not understand the distinction between emergency and urgent care or understand how or where to obtain care and whether prior authorization from the HMO is required. Many are confused because physicians typically belong to several plans affiliated with different hospitals.

Beneficiaries who are not satisfied with the care they receive frequently do not know where or how to complain. All plans are required to
have a grievance procedure, but beneficiaries are often reluctant to complain directly to the HMO because they fear a complaint could jeopardize their Medicaid card. Although beneficiaries have the right to switch HMO plans every thirty days, advocates say most are poorly informed of their rights, and even if they change providers, their choice is still limited to an HMO.

**Overall Lessons And Policy Implications**

While it is too early to analyze the impact of the HMO initiative on cost, access to care, quality, or health status of Medicaid beneficiaries, the insights of state and local managers, providers, health plans, and beneficiaries offer valuable lessons. The Wisconsin initiative clearly shows that the conversion of Medicaid beneficiaries from a fee-for-service system to a capitated prepayment approach requires real commitment and careful planning by the state, the active participation and support of the provider community, and sufficient lead time and cooperation at all levels. All participants agreed that six months to enroll 106,600 beneficiaries in eight HMOs was too short.

Enrollment of the Medicaid population in HMOs works best for young and routine care Medicaid beneficiaries—AFDC children and their parents. Wisconsin did not attempt to enroll the aged or disabled beneficiaries into HMOs and provided for exemptions from HMO participation for AFDC beneficiaries with severe mental or functional limitations. It is doubtful that this initiative could be extended to the full Medicaid population without developing a more sophisticated capitation method that reflects the variations in health status among the aged and disabled and the health expenses of special population groups. Fee-for-service is a necessary option for the seriously impaired to assure that their complex and unpredictable medical needs are met.

The Wisconsin initiative also shows that implementing broad-scale reform is easier if the capitation rates are generous and competitive with private rates. The generous capitation levels, however, are not expected to last. The state continues to be pressed by the legislature to contain costs in the Medicaid program. In the future, the state plans to set capitation rates for participating plans based on a reduction off the HMO average cost per enrollee instead of using fee-for-service as the comparison point. As the state ratchets the rates down, the plans and participating physicians are likely to become less willing to treat the Medicaid population, and quality and access may be compromised.

Another major issue facing the HMO plans in the future is whether they can attract privately insured patients. Federal law requires that HMOs participating in Medicaid have at least one privately insured enrollee for every three Medicare or Medicaid enrollees after the third
year of operation. If the plans are unable to achieve this mix, the HMO initiative will have to be redirected to only those plans with an adequate private insurance base. Since most beneficiaries are now in predominantly Medicaid HMOs, it is doubtful that adequate HMO capacity can be maintained if these plans fold.

The Wisconsin experience provides many insights into HMO care for Medicaid patients, but it is not a test of whether Medicaid beneficiaries would willingly select HMO care. A grassroots survey of Medicaid beneficiaries showed that 82 percent of beneficiaries would not select HMO care over fee-for-service if given a choice.\textsuperscript{14} Wisconsin AFDC beneficiaries had no choice—they either picked an HMO or were assigned. And of those who wished to change plans, fewer than one-third were able to do so.\textsuperscript{15}

It is too early to know what the project has meant for access to care and health status of Medicaid beneficiaries as well as for quality of care and fiscal viability of providers. Medicaid hospitalization rates have plummeted, but the impact on health of the Medicaid population has not been assessed. It is especially troubling that after two years of operation, the state still lacks useable encounter data to monitor utilization and detect inadequate care. The potential for underservice to beneficiaries cannot be underestimated in a system where the fee-for-service option has been essentially eliminated for most AFDC beneficiaries.

Many questions remain unanswered. Has the system really saved money without sacrificing access or quality? Have the health plans provided a valuable service or just taken dollars away from services in their middleman role? Have beneficiaries really adjusted to the new system? What happens when the state starts to squeeze down on payment rates for the plans? The impact of the Wisconsin Preferred Enrollment Initiative on cost, quality, and access to care requires careful evaluation before its success or failure can be pronounced.

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NOTES


10. Sarah Dean, President, Mount Sinai Medical Center, Milwaukee, Wisconsin, personal communication, May 1986.

11. Thomas Jackson, Medical Director, Adult Primary Care, Mount Sinai Medical Center, Milwaukee, Wisconsin, personal communication, May 1986.


