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**FINAL REPORT**

**MOVING TO MEDICAID MANAGED CARE:  
LESSONS FROM STATE EXPERIENCES  
UNDER THE SECTION 1115 WAIVER AUTHORITY**

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## EXECUTIVE SUMMARY

This final report from the Evaluation of Medicaid Health Reform Demonstrations, sponsored by the Centers for Medicare and Medicaid Services (CMS), synthesizes the findings from a major body of research on the experiences of four states that applied for federal Section 1115 waiver authority to move their Medicaid programs towards managed care and other related studies. The four states included as project sites were Kentucky, Minnesota, New York, and Vermont. A fifth project site was Los Angeles County, for which the State of California was granted an 1115 Medicaid waiver under special circumstances. The work was conducted by The Urban Institute, and its subcontractors-- Research Triangle Institute (RTI) and Mathematica Policy Research (MPR).

### Medicaid Managed Care Goals for the Project Sites

Section 1115 of the Social Security Act allows the Secretary of the U.S. Department of Health and Human Services (DHHS) to waive specified requirements of Medicaid law to carry out demonstration projects that are “likely to help in promoting the objectives” of the program. The Medicaid waiver plans of the four states whose experiences are included in this report illustrate the types of changes envisioned by states as they think about moving their Medicaid programs towards managed care:

- *Kentucky.* Kentucky’s Health Care Partnership Program was designed to create eight partnerships (one per geographic region in the state) of public and private providers to deliver Medicaid acute care services through managed care arrangements to Temporary Assistance for Needy Families (TANF) and poverty-related eligible women and children, Supplemental Security Income (SSI) beneficiaries and medically needy enrollees.
- *Minnesota.* The Prepaid Medical Assistance Program Plus (PMAP+) built on an existing 1115 waiver program by extending mandatory managed care from 8 counties largely located in the Twin Cities metropolitan area to all 87 counties in the state. The PMAP+ waiver also included an eligibility expansion where the state was able to collect Medicaid federal financial participation for TANF and poverty-related beneficiaries in families with incomes at or below 275 percent of the federal poverty line. Under PMAP+, TANF and poverty-related populations were mandatorily enrolled in capitated managed care plans; the disabled were generally excluded.
- *New York.* The New York State Partnership Plan was designed to move most TANF, poverty-related and SSI beneficiaries in the state into managed care plans. New York also planned to develop special needs plans or SNPs for persons with serious mental illness and for persons with HIV/AIDS. New York’s initial waiver also called for expanding coverage to the state’s general assistance population. The expansion was later broadened to include enrollees in Family Health Plus, a state sponsored health insurance program for low-income families.

- *Vermont.* The Vermont Health Access Plan (VHAP) was designed to move most TANF, poverty-related and SSI beneficiaries into managed care, expand Medicaid eligibility to low-income adult residents of the state, and implement a prescription drug benefit for low-income elderly and disabled residents.

In addition to these four state waivers, the Medicaid managed care evaluation project included a waiver granted specifically for Los Angeles County. The Los Angeles County (LAC) 1115 waiver provided a federal financial relief package in addition to waiver authority. In return for the federal funds, LAC agreed to fundamentally restructure its delivery of care to the indigent by increasing access to county-funded ambulatory care services and reducing the number of inpatient beds in county hospitals.

### **Beneficiary Experiences Under Medicaid Before Managed Care**

A key component of the project reviewed the experiences of Medicaid beneficiaries before the introduction of managed care (i.e., under fee-for-service Medicaid) to help inform states about potential beneficiary access and care quality problems that might be ameliorated by managed care, and provide a benchmark against which any changes produced by Medicaid managed care could be measured.

TANF and Poverty-Related Beneficiaries. Our information on the Medicaid experiences of TANF and poverty-related beneficiaries under fee-for-service comes from a representative telephone survey of Minnesota beneficiaries living in rural counties served by fee-for-service Medicaid in 1998. TANF beneficiaries in rural Minnesota were not badly off under fee-for-service Medicaid. Conspicuous is the fact that almost all of them reported having a usual source of care other than the emergency room and a doctor visit over the past year. In several areas, however, considerable proportions of the Medicaid population gave answers that suggest where Medicaid beneficiaries might be better served through a move to managed care. Unmet need appears to be the area where the greatest improvements for the TANF and poverty-related populations might be achieved by managed care. More than half of adult beneficiaries and one-quarter of children reported some type of unmet need in the last 12 months. Further, about one-quarter of the adults and one-quarter of the children visited an emergency room in the last 12 months.

Disabled Non-Elderly Beneficiaries. Given their typically low health and functional status, persons with disabilities are heavy users of health care and thus are costly to serve. Managed care strategies could potentially realize major savings by increasing the cost-effectiveness of care for this group. However, the extent and range of their needs must be carefully calibrated if managed care is to succeed. Project data on disabled beneficiary experiences under fee-for-service Medicaid for urban and suburban SSI beneficiaries come from beneficiary surveys in two sites in New York State and for rural SSI beneficiaries from surveys in two regions in Kentucky.

For both urban and rural SSI beneficiaries, findings indicate that the vast majority had a usual source of care and had seen a physician in the past 12 months. Nearly half of both adults and children had at least one ER visit in the past year, however. Respondents also reported

considerably longer travel and wait times in the office before being seen than did the TANF and poverty-related beneficiaries. Finally, despite being frequent users of health care services and having a usual source of care, 40 percent of urban and 25 percent of rural adult SSI beneficiaries reported an unmet need in the past year. On all these measures, managed care could bring potential improvements.

Lessons Learned. For TANF and related populations, our findings indicate that Medicaid fee-for-service is generally doing an adequate job of linking beneficiaries to the health care system at least in rural Minnesota. The major areas where an effective managed care system might achieve cost-effective improvements appear to be; reducing ER use for non-immediate needs, particularly for adults, reducing travel times to care and wait times in office before being seen, and reducing unmet need for doctor and dental care.

The situation is more complex for disabled beneficiaries. This is a highly vulnerable and costly population about which relatively little is known, particularly in a managed care context. Project data collected but not shown here indicate a wide diversity in the types of health conditions among this population of both adults and children, from physical afflictions such as muscular dystrophy, cerebral palsy, and AIDS to mental health conditions including mental retardation, schizophrenia, and paranoia. States need to have solid information on the needs of this population if they are to develop sound managed care systems, particularly in the area of capitation rates.

Our data show that managed care has the potential to benefit this population, if based on a clear understanding of the issues to be confronted—with urban beneficiaries in New York currently having less satisfactory experiences under fee-for-service Medicaid than Kentucky rural beneficiaries. This difference may be due, at least in part, to Kentucky beneficiaries who are in poorer health. Thus, the fact that they receive more care may be because they need more care. It remains true, however, that Kentuckians report less unmet need and more satisfaction with their care than do their New York counterparts.

The main areas states should focus on in their efforts to improve care for Medicaid beneficiaries with disabilities--adults and children, urban and rural--appear to be improving ease of access (travel time and office wait times), reducing unnecessary ER use, and reducing unmet need, particularly for adults in the areas of medical/physician and dental care.

### **Program Implementation and Operational Experiences under Medicaid Managed Care**

The experiences of project states can potentially help other states as they think about how best to maximize their chances of successful managed care implementation. We begin with Minnesota, which was ultimately successful in bringing capitation to the state's Medicaid program. We then discuss the experiences of New York, Kentucky, and Vermont, none of which was able to sustain mandatory capitation on a statewide basis during the project period.

Minnesota's PMAP+. Project site visits were made to Minnesota in September 1996, May 1998, and October 2000. The new waiver program was to begin program phase-in by geographic area in early 1996, and extend coverage to the whole state by 1997. By the end of

1996, however, PMAP+ had added only 8 more counties to the original 8 under managed care as the state faced significant resistance from a range of powerful stakeholders.

Counties, the most prominent critics, had two major concerns. The first was that managed care would result in a cost shift to them, reducing needed care to some and forcing counties to provide services that Medicaid was no longer covering entirely at county expense. The second was resentment at the imposition of a single program model on all counties when local authorities felt they knew what worked best for their communities. Providers echoed these concerns, and some consumer groups also feared the effects of “rationing” care.

Stakeholders went to the state legislature during the 1995-1996 session, which introduced two changes to ameliorate their concerns. The first was introduction of a county role in plan selection and in the capitation implementation timetable. The second was the granting of authority to design county-based purchasing (CBP) models as an alternative to PMAP+. CBP—which was facilitated by provisions of the 1997 Balanced Budget Act—granted counties the option of running their own Medicaid demonstration projects with advance payment from the state, as long as they accepted full risk and met state and federal requirements.

As of 2003, the state had successfully implemented PMAP+ in 70 of its 87 counties, with the remaining counties having implemented CBP (or being in the process of doing so).

New York’s Partnership Plan. Project site visits were made in 1998 and 1999. As of April 1999, New York had made substantial progress in implementing the Partnership Plan, with all major urban areas in the upstate area having started mandatory managed care for their TANF/safety net population. However, implementation in New York City and implementation for other beneficiary groups upstate had moved more slowly than planned. No mandatory enrollment of the SSI populations had taken place, and the state had made only limited progress in moving forward with the SNPs.

What were the major barriers slowing progress toward capitation in the early phases of New York’s waiver? Four were cited by site visit respondents. The first, similar to the situation in Minnesota, was resistance by local government. Second, the strong state economy at the time, along with declining Medicaid enrollment, reduced the fiscal imperative for managed care. Third, New York City hospitals gave the program only lukewarm support because they viewed the capitation rates as too low for viability. Finally, a strained relationship between the state and the Health Care Financing Administration (now CMS) in the beginning phases of waiver implementation was also viewed as impediment. Despite these challenges, as of January 2003, the Partnership Plan had been implemented in 21 of the state’s 57 counties and all parts of New York City. But only TANF and poverty-related populations had mandatory enrollment.

The Kentucky Health Care Partnership Program. Project site visits took place in May 1999 and October 2000. When the waiver was approved, most of the state’s urban beneficiaries were already in a primary care case management program (PCCM), which paid physicians a monthly case management fee but reimbursed all services on a fee-for-service basis. The intent was to build on this system by introducing capitated managed care statewide and extend

managed care to the SSI population, by dividing the state into 8 regions—each with its own services delivery network (Partnership).

At the time of the first site visit, Partnerships had been implemented in the two most urban regions of the state—surrounding the cities of Louisville (Region 3) and Lexington (Region 5). Their partnerships had begun enrolling TANF and poverty-related eligibles in late 1997 and the SSI population in spring 1998. By October 2000, however, none of the other regions had formed partnerships and Region 5 had decided to dissolve its partnership.

General reasons for failure included the fact that creating a monopoly plan in each region reduced the state’s leverage in subsequent rate negotiations. In addition, many of the regions were so sparsely populated that they had difficulty generating the necessary capital to initiate a partnership agreement with the state. A comparative analysis of Region 3 and Region 5—both regions with adequate catchment areas—suggests further that Region 3’s success was due to (a) designing a payment plan that was less onerous to providers in its risk-bearing provisions than Region 5’s turned out to be, (b) making extensive public relations and administrative services efforts to accommodate provider concerns, and (c) having a long history of providers working together on indigent care.

The Vermont Health Access Plan (VHAP). Project site visits took place in October 1997 and November 1999. The state began the waiver process in August 1995 with a solicitation for Medicaid capitated managed care plan proposals. Because of delayed response, however, in early 1996 Vermont began providing limited benefits on a fee-for-service basis to uninsured Vermonters below the poverty line (the “expansion” population). The state was able to execute contracts with two plans later that year, which began enrolling both traditional and expansion populations around the end of the year. Mandatory enrollment in capitated managed care began in March 1997 and was completed in all areas of the state except one by May.

Though fully implemented, Vermont’s capitated system of Medicaid managed care proved unsustainable in Vermont, however, and within a couple years the state transitioned to a Primary Care Case Management managed care program for its enrollees. Several factors contributed to the demise of Vermont’s effort to establish a capitated managed care program, including having trouble maintaining health plan participation and having a health system with few inefficiencies even before capitation.

Lessons Learned. All four project states—Minnesota, Kentucky, New York, and Vermont—have substantial rural areas. The common problems faced by all four in their efforts to introduce Medicaid capitation applied in large part to their efforts in the rural parts of their states. Beyond the challenges of implementing managed care in rural areas, the states faced other obstacles as well. These can be encapsulated in the following considerations for states contemplating Medicaid managed care, particularly capitation:

- Ensure that the area has a sufficient number of covered lives
- Be prepared to allow some flexibility for provider networks
- Be realistic in assessing potential cost-savings
- Set feasible capitation rates
- Allow for local differences and local input.

## **Effects of Medicaid Managed Care on Beneficiaries**

Project analyses examined effects on beneficiary access to, and satisfaction with care for three groups: the rural TANF and poverty-related populations, rural low-income populations more generally, and SSI beneficiaries (beneficiaries with disabilities).

Rural TANF and TANF- Related Beneficiaries. The effects of Medicaid capitated managed care on rural TANF and poverty-related beneficiaries were analyzed by comparing their experiences with the experiences of similar beneficiaries in counties under Medicaid fee for service. The analysis is based on data from beneficiary surveys fielded in 1998 and 2000.

Our findings show that the introduction of PMAP+ had virtually no significant impact on beneficiaries' access to and quality of care. The one notable exception is that parents in Medicaid families were significantly less likely to find it easy to obtain prescription drugs for their children in managed care than in fee for service counties. There was no increase in unmet need for drugs among children, however, implying that children under managed care were able to get the drugs they needed, even if obtaining them was more difficult.

State Medicaid staff maintained that program costs were lower under managed care than they would have expected under fee for service. Even though the state has no hard data to support this finding, it is consistent with national findings from other studies. Thus, the major achievement of Medicaid managed care in rural Minnesota may have been to maintain the same level of care as under fee for service but at lower cost.

Rural Health Care Experiences under Medicaid. The findings in this section are based primarily on the 1997, 1999, and 2002 waves of the National Survey of America's Families, covering adults ages 19 to 64. For the population as a whole, it is well known that rural residents fare worse than their urban counterparts in securing access to care. For Medicaid beneficiaries, however, project analyses find rural-urban differences to be much smaller than they are for either low-income privately insured individuals or those who are uninsured. When population and health care market characteristics are held constant, rural-urban differences among Medicaid beneficiaries totally disappear. The analysis shows, further, that Medicaid managed care holds additional promise for rural beneficiaries. Rural beneficiaries in counties with Medicaid managed care were more likely to have a usual source of care and to have had a doctor visit in the past year and less likely to have an emergency room visit than rural beneficiaries under fee-for-service Medicaid.

Urban and Rural Disabled Beneficiaries. In the search for Medicaid cost saving, disabled beneficiaries are particularly prominent, given that they account for about 15 percent of the beneficiary population but more than 40 percent of program expenditures nationally. Our findings on Medicaid managed care impacts for SSI beneficiaries are based on five years of the National Health Interview Survey.

Urban SSI beneficiaries, regardless of type of Medicaid managed care, were significantly less likely than those under fee for service to report any contact with health care providers in the past year, and also less likely to report having had an office visit in the past year. Further,

beneficiaries in urban counties with mandatory Medicaid HMO coverage were significantly less likely to have had a specialist visit in the past 12 months than urban beneficiaries under weaker forms of managed care or under fee for service. Although the reduction in specialist visits may reflect great efficiency, it is more likely to reflect increased access problems—suggesting that decision-makers and consumers are right to be cautious in extending managed care to this population in urban areas.

SSI beneficiaries in rural areas, in contrast, fared considerably better under managed care than their fee-for-service counterparts. They were more likely to have a usual source of care other than an ER. They were also more likely to have had contact with physician extenders such as nurse practitioners and a dental visit within the past year.

Lessons Learned. The Minnesota experience reported here applies to Medicaid managed care for TANF and TANF-related adults and children living in rural areas. Findings suggest that for this population, managed care may not have much effect on improving access to care or care delivery patterns compared with Medicaid fee-for-service. Medicaid officials in that state maintained, however, that their managed care system did increase the cost-effectiveness of the care delivered to its rural beneficiaries. In addition, our national look at rural health care experiences under Medicaid revealed a somewhat different picture on the potential for managed care in rural areas. With a national perspective we find that Medicaid managed care improved access to ambulatory care providers and reduced emergency room use.

Our national examination of access to care and satisfaction in urban compared with rural areas yields the encouraging finding that Medicaid managed care does have some potential for improving health care delivery, particularly for primary care services, for rural Medicaid beneficiaries with disabilities (i.e., the SSI population). This finding does not carry over to urban areas, however, suggesting that states should be cautious about extending managed care coverage to disabled Medicaid beneficiaries in urban areas. Access to care for this population is typically problematic under fee-for-service. And characteristics of the urban SSI population and/or the health care system in low-income metropolitan areas may make it harder for managed care to make improvements than in more sparsely populated rural areas. More research is needed to better understand the implications of Medicaid managed care and the factors behind the differences found in the research reported here.

### **Commercial Plan Choices in a Changing Medicaid Market**

If states are to keep commercial plans in the Medicaid managed care market, it is important for them to understand the factors that influence such plans' decisions to continue in or exit that market. Project findings are based on analysis of two years of InterStudy data on county Medicaid enrollment levels. Comparing data for 2000 with data from 2001 allows us to identify plans that were participating in one year but not in the next.

Plan characteristics are strong predictors of plan decisions, other things equal. Plan with a large share of the local Medicaid managed care market, for example, and plans serving large proportions of Medicaid enrollees in the state are less likely to quit the Medicaid market. Plans affiliated with Blue Cross/Blue Shield, provider-sponsored plans, and for-profit plans are also

less likely to leave the Medicaid market. Medicaid policies also have a major influence on plan decisions. Higher capitation rates reduce the likelihood that a plan will exit Medicaid. Mandatory enrollment in managed care increases the likelihood of exiting Medicaid. Finally, a strong managed care presence in the private market seems to help plans continue participating in Medicaid managed care.

Lessons Learned. Our analysis of factors influencing health plan decisions about whether or not to participate in the Medicaid program suggests that many of these factors are within the control of state policymakers and program administrators. The first lesson is that states need to establish sound capitation rates that reflect the true costs of serving the Medicaid population enrolled in managed care, as well as to ensure that service carve-outs and similar policies are not interfering with the ability of plans to manage care in a cost-effective way. The other major lesson is that states should work to ensure that plans can enroll an adequate number of Medicaid enrollees to operate effectively.

### **Reconfiguring the Safety Net: The Experience of Los Angeles County**

Los Angeles County has the largest county population in the nation. One-third of its non-elderly population lacks health insurance, and another fifth is covered by California's Medicaid program (Medi-Cal). By 1995, years of shrinking revenue streams, health service demand increases, and the cost of maintaining the county's deteriorating health system infrastructure had culminated in a funding crisis for the county. In response, it applied for and was granted a five-year financial relief package in federal Medicaid funding, in return for which it agreed to fundamentally restructure its delivery of health care to the indigent. The project's analysis of LA county's experiences under its waiver are based on two case-study site visits, one in 1997, the second in 2001.

The primary goal of the waiver was the restructuring ambulatory care via two major components: a public-private partnership (PPP) program, which extended county-funded indigent care provision to the private sector, and better integration of the system of care. The PPPs were universally considered one of the big successes of the waiver program, resulting in 81 private partners delivering primary care at over 100 sites. The major contribution of the integration effort was creation of a system of referral centers, whereas previously all access to specialty care for the indigent had come through the ER.

In addition, plans were made to increase the efficiency of hospital-based care was to be increased by reducing inpatient beds and admissions (by downsizing the county's major medical center and privatizing two hospitals) and by hospital "reengineering." While the medical center was effectively downsized, the effort to privatize two hospitals failed due to a lack of potential buyers and community opposition. With respect to the reengineering efforts, considerable savings were achieved from purchasing improvements, although, auditors were not confident that even these savings could be sustained in the future.

Lessons Learned. The major lesson to be learned from the waiver experience of Los Angeles County is that substantial financial relief and a serious restructuring effort may not be enough to restore financial viability to a public safety-net health care system on the brink of

collapse. Waiver efforts did succeed in expanding geographic access to non-hospital indigent care; cutting the number of inpatient beds, inpatient days, and average length of stay; and implementing a hospital reengineering system that produced some savings through better purchasing of supplies, equipment, and prescription drugs. Observers also agreed that the culture of indigent care provision had improved, bringing more attention to patient care quality and communication among providers throughout the system.

But the large number of uninsured in the county has not been reduced and the obligation to meet their health care needs remains. A new waiver is providing \$900 million in federal funding over the 2001-2005 period, which is scheduled to phase out over that period. The state is providing an additional \$300 million in combined state and federal matching funds through cost-based reimbursements to all county clinics and private clinics with county contracts for Medi-Cal ambulatory care. Further, the county has committed \$400 million. Whether or not actions under the new waiver will stimulate enough additional financing and operational reforms in the LACDHS system to make it financially stable remains an open question. But if past is prologue, it is hard to be optimistic.

### **Pharmacy Assistance Programs and Determinants of Enrollment and Impacts of Enrollment on Use and Costs of Drugs and Medical Services**

Vermont offers three pharmacy benefit programs to low-income elderly and disabled residents—*VHAP Pharmacy*, *VScript* and *VScript Expanded*. Only expenditures under VHAP Pharmacy and VScript are eligible for the federal match under Vermont's VHAP Section 1115 waiver program. Script Expanded is supported entirely by state appropriations.

Using a combination of medical and pharmacy claims and a survey of enrolled and eligible or near-eligible beneficiaries for Vermont's pharmacy assistance programs, project analyses focused on three questions: to identify the primary determinants of enrollment; to assess the impact of enrollment on the use and cost of drugs, and unmet needs; and to analyze the impact of enrollment on the use and cost of non-drug medical services.

Our findings show the pharmacy assistance programs enrolled a substantial minority (16 percent) of Vermont's Medicare beneficiaries. Further, the programs are enrolling the most vulnerable individuals. For example, compared to people who are eligible for, but not enrolled, enrollees are more likely to be older, have less education, have lower income, live alone, and be sicker. We also found that people with drug coverage have 85 percent lower odds of enrolling compared to people without coverage. Similar to other public health program, lack of awareness is a barrier to enrolling people, although 43 percent of eligible nonenrollees were familiar with the program.

Analyses also suggest that the pharmacy assistance programs appear to have lowered the rate at which beneficiaries spend down to full Medicaid benefits. The proportion of dually eligible beneficiaries fell from nearly one-quarter in 1994 to less than 20 percent in 2000. The proportion of newly enrolled dual eligibles was reduced by half, from 2.9 percent to 1.4 percent. Once in a pharmacy assistance programs, enrollees were twice as likely to have more than 20 prescriptions filled per year than nonenrollees. Further, 65 percent of enrollees had more than 20 prescriptions filled within the year. Enrollees were 82 percent less likely than nonenrollees to have out of pocket costs of 200+ /month. This effect varied across the three programs in a way

that is consistent with the enrollee cost sharing and benefit rules. Finally, enrollees were 48 percent less likely than nonenrollees to have skipped drugs or taken fewer than prescribed, and 62 percent less likely to not fill a prescription because of cost.

We found that enrollment in a pharmacy assistance program was associated with a 17 percent reduction in annual expenditures for inpatient services and a 19 percent increase in annual expenditures for professional services. Enrollment in VScript and VScript Expanded was associated with a 35 percent increase in annual expenditures for professional services. Enrollees in VScript Expanded also exhibited a 25 percent increase in outpatient facility costs.

Lessons Learned. Our analysis of Vermont's pharmacy assistance programs has important implications, especially for the recently enacted new drug benefit under Medicare. First, state pharmacy assistance programs and, ultimately, Part D, play an extremely important role in providing outpatient prescription drug coverage to one of the most vulnerable and least insured groups of Medicare beneficiaries. Subsidies provided under Part D to the non-dually eligible low-income population will be crucial for building on the achievements made by states and ensuring continued access to outpatient prescription drugs among the near-poor.

Participants in publicly subsidized drug programs also tend to be those with the greatest needs. However, late enrollment penalties imposed under Part D should help limit the deleterious impact of adverse selection on future plan costs. Finally, while the new Medicare drug benefit may help reduce the number of unnecessary hospitalizations and lower inpatient expenditures, Part D may conversely lead to higher outpatient and Part B expenditures. The potential for savings is likely to be greatest among beneficiaries with chronic conditions where outpatient prescription medication is particularly effective for avoiding illness and preventing unnecessary medical service use. It may, thus, be useful to consider condition- and drug-specific factors when Part D and Medicare Advantage plans develop their drug formularies and cost sharing rules.

## **Suggestions for Future Research**

The Evaluation of Medicaid Health Reform Demonstrations addressed a number of issues related to state 1115 waiver initiatives, providing new information on a range of issues. As with any research project, the findings from those research efforts raise new questions. Areas that would benefit from additional work include:

- Exploring the impacts of Medicaid managed care for TANF and poverty-related populations in states beyond Minnesota. In particular, what is the impact of MMC for populations in rural areas in states without a strong health care system and a generous Medicaid program (for which Minnesota is known)?
- Examining if there is a qualitative difference in beneficiaries' satisfaction or a quantitative difference in access to acute and preventative care for enrollees in regular PMAP and those enrolled in CBP.

- Expanding the analysis of the impacts of MMC on disabled populations. How do the effects of MMC on disabled beneficiaries vary in different states (with different MMC programs) and for different populations of disabled persons? What is driving differences in the effects of MMC for this population in urban and rural areas?
- Baseline studies of access and use for beneficiaries with disabilities under fee-for-service Medicaid. Much of the policy concern has focused on how Medicaid managed care may affect these beneficiaries, but little is known about how these beneficiaries are faring under the current fee-for-service delivery system.
- Expanding the analysis of commercial plan participation in Medicaid managed care to consider quality of care and plan entry. How does the quality of care provided by commercial plans compare to that of Medicaid-dominated plans? How can states attract additional commercial plans into county MMC markets?
- Expanding the analysis of the impacts of new safety net funding to look at the effects on beneficiaries as well as providers in Los Angeles County. Expanding the analysis of the health care safety net to other urban markets that have received substantial safety net funding as part of 1115 waivers (e.g., New York City).
- Exploring the impact of Part D implementation on the design of state pharmacy assistance programs, who enrolls, and the costs of these programs. Do states eliminate their pharmacy assistance programs and, if so, why? Do states that continue offering such programs change the benefit to wrap-around Part D or do they continue to offer independent programs? Does enrollment in state programs decline following implementation of Part D? How do total and per enrollee program costs change following the implementation of Part D?
- Understanding the impact of Part D on low-income individuals previously eligible for state coverage. What is rate of enrollment in Part D among low-income populations previously eligible for state coverage? Do out-of-pocket costs change following implementation of Part D for people previously eligible for coverage through a state program? Do patterns of utilization change? Do individuals change drugs (either within a therapeutic class or between brand-name and generic) after they enroll in Part D? Are there changes in access to prescription drugs and unmet need for low-income individuals who enroll in Part D plans?
- Investigating the impact of Medicare Part D on Medicaid spend-down, on prescription drug needs and out-of-pocket spending, and on use and cost of prescription medications and non-drug medical costs.

Finally, the findings from the Evaluation of Medicaid Health Reform Demonstrations highlights the challenges states and communities face in transforming their health care systems, whether that transformation involves switching from fee-for-service to Medicaid managed care or, as in the case of Los Angeles County, trying to reconfiguring a complex urban health care safety net system. In-depth case studies of program change are needed whenever states make system

changes, both to document what has been changed and to understand the process of change. Information on the challenges and successes that are faced by states as they implement change is critical to policymakers and program administrators in other states as they contemplate reforms to their Medicaid program or health care safety net.

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# CHAPTER I

## INTRODUCTION

This final report from the Evaluation of Medicaid Health Reform Demonstrations, sponsored by the Centers for Medicare and Medicaid Services (CMS), synthesizes the findings from a major body of research on the experiences of four states that applied for federal Section 1115 waiver authority to move their Medicaid programs towards managed care, and other related studies. The work was conducted by The Urban Institute, and its subcontractors, Research Triangle Institute (RTI) and Mathematica Policy Research. The data for the study came from a wide range of sources including case studies of particular sites, state-specific beneficiary surveys, Medicare and Medicaid claims data and analyses using national probability sample survey data. This report summarizes findings project reports on a wide range of topical issues (see Appendix A for full listing of project reports, publications and presentations.) At the beginning of each chapter we identify which specific reports were used in drafting the chapter. Readers are referred to individual reports for more details on project findings highlighted in this summary volume. Project reports used for this chapter are listed in the attached footnote.<sup>1</sup>

The case study and beneficiary survey data were collected for a sample of states that planned, with varying degrees of success, to implement Medicaid managed care and related reforms under the Social Security Act's Section 1115 waiver authority. The four states included as project sites were Kentucky, Minnesota, New York, and Vermont. A fifth project site was Los Angeles County, for which the State of California was granted its own 1115 Medicaid waiver

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<sup>1</sup> This chapter draws on the following project reports: Long et al. (1996) "Designing an Evaluation of the Medicaid Health Reform Demonstrations;" Coughlin, Marsteller, Rajan and Zuckerman (1997) "Expanding Medicaid Managed Care in Minnesota, 1<sup>st</sup> Site Visit Report;" and Bartosch, Urato, French and Kulas (2003) "Medicaid Managed Care in Vermont," as well as the site reports on which Chapter III's discussion is based. See Chapter III footnote 3 and Appendix A.

under special circumstances. Because the study sites were at very different stages of Medicaid managed care implementation during the project period, the types of data collected also varied by site.<sup>2</sup>

### **Medicaid Managed Care Goals for the Project Sites**

Section 1115 of the Social Security Act allows the Secretary of the U.S. Department of Health and Human Services (DHHS) to waive specified requirements of Medicaid law to carry out demonstration projects that are “likely to help in promoting the objectives” of the program. Programs performed under an 1115 waiver must be approved by DHHS and must be budget neutral to the federal government—i.e., have an overall cost to DHHS that is no greater than what the federal cost of the program’s operation would have been in the absence of the waiver.

Many key dimensions of a state’s Medicaid program can be changed under an 1115 waiver. These include eligibility, benefits, financing, and freedom of choice. States can, for example, promote mandatory enrollment in fully capitated managed care plans and expand coverage to populations or services not otherwise permitted under Medicaid.

Although 1115 Medicaid waivers have been available for many years, few states had applied for such waivers until the early 1990s when DHHS, in an effort to make 1115 waivers more accessible to states, substantially changed the waiver approval process. A central theme of 1115 waivers developed during the early 1990s was to control program spending by mandating enrollment of current Medicaid beneficiaries into managed care. Another was to use cost savings realized from the shift to managed care and extend Medicaid eligibility to previously uninsured individuals. As of June 2003, about 25 percent of the nation’s Medicaid beneficiaries

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<sup>2</sup> See Appendix B for detail on the project’s evolution and change.

was covered by 1115 waiver authority.<sup>3</sup> Section 1115 program experience, therefore, has far-reaching implications for the future of the Medicaid program.

The Medicaid waiver plans of the states whose experiences are included in this report illustrate the types of changes envisioned by states as they think about moving their Medicaid programs towards managed care:

*Kentucky.* The state's main objective in its Health Care Partnership Program, a waiver project approved in October 1995, was to create eight partnerships (one per geographic region in the state) of public and private providers to deliver Medicaid acute care services through managed care arrangements. Most current non-institutionalized Medicaid beneficiaries were to be covered by the demonstration, including Temporary Assistance for Needy Families (TANF) and poverty-related eligible women and children, Supplemental Security Income (SSI) beneficiaries and medically needy enrollees. Exempted groups included institutionalized individuals, those in other long-term care programs, and other eligibility categories. Most acute and primary care services were part of the waiver benefit, including inpatient and outpatient hospital, physician services, clinic, pharmacy, dental and home health. The one major exception to this was behavioral health services, which were slated to be capitated to separate behavioral health organizations. Like most managed care programs, long-term care services were largely excluded from the benefit package provided through capitated plans, but continued to be reimbursed by the state on a fee-for-service (FFS) basis. An important distinction of Kentucky's waiver program was that the state planned to contract with one Partnership entity in each geographic area; thus there would be no beneficiary choice of health plan as in most other states' managed care programs.

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<sup>3</sup> This is an Urban Institute estimate based on Medicaid managed care enrollment posted CMS's website and Medicaid enrollment reports (HCFA-2082) maintained by the Institute.

*Minnesota.* Through their Prepaid Medical Assistance Program Plus (PMAP+) demonstration, approved in April 1995, Minnesota planned to build on an existing 1115 waiver program by extending mandatory managed care from 8 counties (largely located in the Twin Cities metropolitan area) to all 87 counties in the state. The PMAP+ waiver also included an eligibility expansion, where the state was able to collect Medicaid federal financial participation for children and pregnant women in families with incomes at or below 275 percent of the federal poverty line.<sup>4</sup> Under PMAP+, TANF and poverty-related populations were mandatorily enrolled in capitated managed care plans; the disabled were generally excluded.<sup>5</sup> A broad range of services is provided under PMAP+, including most acute and primary care services, including dental, drugs and mental health services.

*New York.* The New York State Partnership Plan was designed to use waiver authority, approved in July 1997, to move most TANF and poverty-related and SSI Medicaid-eligible individuals in the state into partially or fully capitated managed care plans. Services covered by capitated health plans include both primary and acute care services. Most long-term care services such as institutional and personal care are excluded from the capitated plans and are reimbursed on a FFS basis. Although initially included in the capitated benefit package, prescription drugs were eventually carved out and were paid on a FFS basis. For the TANF populations mental health and substance abuse (MH/SA) services are included in the capitated benefit package but plans are subject to a stop loss provision for these services. By contrast, MH/SA services are completely carved out for the SSI population. New York had also planned to develop special needs plans (or SNPs) for persons with serious mental illness and for persons with HIV/AIDS.

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<sup>4</sup> More recently, Minnesota included parents and caretaker adults in their waiver expansion population. As of 2004, the state covers an additional 130,000 individuals through their PMAP.

<sup>5</sup> Though not the focus of this evaluation, the PMAP waiver also includes individuals 65 and over, including those dually enrolled in Medicaid and Medicare.

The state went forward with HIV/AIDS SNPs (and as of summer 2004 has five such plans operating) but abandoned its efforts to establish SNPs for persons with mental illness. Finally, New York's waiver program included an eligibility expansion so that the state received federal Medicaid matching dollars for its state General Assistance (Safety Net) enrollees.<sup>6</sup>

*Vermont.* The Vermont Health Access Plan (VHAP) was designed to use waiver authority, approved in July 1995, to move much of the traditional Medicaid population (including SSI beneficiaries) into managed care, expand Medicaid eligibility for low-income adult residents of the state, and implement a prescription drug benefit for low-income elderly and disabled residents.<sup>7</sup> Distinct from the other states, VHAP health plans initially sought to provide the full array of Medicaid-covered services through prepaid plans—primary, acute, and long-term care services, including prescription drugs, hospice services, and mental health and substance abuse services. The state continued to pay for a few services on a FFS basis, including dental care, family planning, and eventually pharmaceuticals.

*Los Angeles County.* In addition to these four state waivers, as noted, the Medicaid managed care evaluation project included a waiver granted specifically to Los Angeles County. The Los Angeles County (LAC) 1115 waiver, approved in April 1996, was different from the other waivers covered in this report, not only because it was granted to a substate area, but more fundamentally because it provided a federal financial relief package in addition to waiver authority. Although not a managed care waiver in any direct sense, the fundamental intent of the waiver was similar—to produce cost-savings to the Medicaid program through increased efficiency in the care delivery process. In return for the federal funds, LAC agreed to

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<sup>6</sup> New York's expansion population was later expanded to include enrollees in Family Health Plus, a state-sponsored program that provided health insurance to low-income families. As of summer 2004, the expansion population under the waiver totals 440,000 individuals.

<sup>7</sup> Details of the prescription drug benefit are provided in Chapter VI.

fundamentally restructure its Department of Health Services and delivery of care to the indigent through increasing access to county-funded ambulatory care services, and reducing inpatient beds in county hospitals.

## **Project Findings in Brief**

Project analyses cast new light on several major issue areas important to policymakers and program administrators interested in moving their Medicaid programs toward managed care:

- *Operational Considerations.* Project sites encountered five common operational issues in their efforts to implement a financially viable managed care program: (a) ensuring an area has enough covered lives to make managed care financially viable, (b) setting feasible capitation rates, (c) being realistic in assessing whether potential cost-savings in the catchment area are actually likely, (d) allowing enough network flexibility to make beneficiary coverage in the area feasible with available resources, and (e) allowing for local differences and local input to avoid loss of key providers.
- *Impacts of Managed Care on Beneficiaries.* Our findings indicate that moving to managed care for TANF and TANF-related beneficiaries in rural areas is unlikely to have much impact on improving care, although it may achieve some cost savings for Medicaid without compromising existing care levels. For beneficiaries with disabilities (the SSI population), however—particularly in rural areas—the potential for improvement in health care delivery exists, especially in access to primary care services.
- *Health Plan Participation Decisions.* Our findings indicate three factors that can increase the chances that health plans will participate in Medicaid managed care: (a) establishing capitation rates that reflect the full costs of serving the enrolled population, (b) ensuring that plans can enroll enough beneficiaries to operate effectively, and (c) implementing policies that support managed care in the private market.

Project analyses also inform policymakers and program administrators interested in changing other parts of Medicaid and the health care safety net.

- *Potential for Reconfiguring the Health Care Safety Net.* Our project findings highlight the challenges that arise in attempts to reconfigure a fragile safety net in an area with a large number of uninsured and an institution-based health care delivery system. Substantial financial relief and a serious restructuring effort have not been enough to restore the financial viability of a health care system on the brink of collapse.

- *Pharmacy Assistance Program.* Our project findings highlight the importance of pharmacy assistance programs for a highly vulnerable population of Medicare beneficiaries. The findings also have important implications for the newly enacted Medicare Part D, including the potential impact on insurance crowd out and service use and costs.

## **Rest of the Report**

Chapter II provides context for the study findings by reviewing Medicaid beneficiary experiences in the study sites before waiver implementation (i.e., under FFS). Chapter III describes the implementation and operational experiences of states as they moved to implement Medicaid managed care. Chapter IV presents study findings on the effects of managed care on beneficiaries and on health plan participation decisions to participate in the Medicaid program. Of the study sites, only in Minnesota was a systematic evaluation of its managed care experience conducted. The project, therefore, augmented those findings with two analyses using national databases that provide detailed information on Medicaid beneficiary experiences under FFS and under managed care, also presented in Chapter IV. Chapters V and VI focus, respectively, on two unique programs introduced under section 1115 waiver authority. Chapter V describes Los Angeles County's efforts to restructure its health care safety net under 1115 waiver authority and the results of that restructuring. Chapter VI looks at the prescription drug benefit introduced by Vermont as part of its 1115 waiver program. We conclude with Chapter VII, which summarizes the lessons learned from the project and provides suggestions for future research.

**CHAPTER II**

**BENEFICIARY EXPERIENCES  
UNDER MEDICAID BEFORE MANAGED CARE**

States look toward managed care, not only as a way to control Medicaid program costs, but also as a potentially promising way to improve beneficiary access to care and quality of care. States hope that managed care will provide Medicaid beneficiaries with a medical home, where preventive care is promoted and primary care is readily available. Having such care is hoped to improve beneficiaries' continuity of care and reduce their use of costly services such as emergency rooms and inpatient hospital care. Managed care is not without risks, however, because it could reduce access to care—because it limits choice of provider and/or because it embodies incentives for providers to reduce health care use (including limiting medically necessary services).

This chapter summarizes the experiences of Medicaid beneficiaries before the introduction of managed care (i.e., under fee-for-service Medicaid) to (a) help inform states about potential beneficiary access and care quality problems that might be ameliorated by managed care, and (b) provide a benchmark against which any changes produced by Medicaid managed care can be measured. Information for this chapter comes from several reports written under the project; for more details on findings readers are referred to these reports.<sup>8</sup>

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<sup>8</sup> This chapter is based on a number of project reports and publications. The project reports are: Coughlin and Long (1999) "Impacts of Medicaid Managed Care on Adults: Evidence from Minnesota's PMAP Program;" Long and Coughlin (2000) "Effects of Medicaid Managed Care on Children: Evidence from Minnesota's PMAP Program;" Coughlin, Long and Kendall (2001) "Health Care Access, Use, and Satisfaction Among Disabled Working Age Adults in New York under FFS Medicaid;" Coughlin and Long (2003) "Health Care Experiences of Disabled Children Receiving Medicaid;" Mitchell, Hoover and Bir (2003) "Poor and Disabled in Rural Kentucky: Access to Care for SSI Adults and Children;" and Mitchell, Hoover and Bir (2003) "Poor and Disabled in Rural Kentucky: Access to Care for SSI Adults and Children." The project publications are: Coughlin and Long (2000) "Effects of Medicaid Managed Care on Adults" *Medical Care*; Long and Coughlin (2001) "Impacts of Medicaid Managed Care on Children" *Health Services Research*; Coughlin, Long, and Kendall (2002) "Health Care Access, Use and Satisfaction Among Disabled Medicaid Beneficiaries." *Health Care Financing Review*; Long, Coughlin and

The discussion is divided into the Medicaid experiences of the TANF and poverty populations (hereafter referred to as the TANF population) and of the SSI (non-elderly disabled) population. The TANF results are for rural residents. The SSI findings focus on urban and rural dwellers separately. For both groups, adults and children are considered separately.

### **Beneficiaries on Medicaid via Temporary Assistance for Needy Families (TANF) and Poverty-Related Expansions**

Our information on the experiences of TANF beneficiaries under fee-for-service Medicaid comes from a representative telephone survey of Minnesota beneficiaries living in rural counties served by fee-for-service Medicaid in 1998.<sup>9</sup> We focus on measures generally agreed to depict important dimensions of quality of care: continuity of care, use of care, access to care, unmet need, and beneficiary ratings of service quality. Table II.1 summarizes the experiences of TANF beneficiary adults (ages 19 to 64) and children (ages 0 to 18) under fee-for-service Medicaid in the Minnesota survey. The tables for each chapter are included at the end of the relevant chapter.

As can be seen, on most of the measures shown—as well as on a multitude of similar measures gathered in the survey—TANF beneficiaries in rural Minnesota were not badly off under fee-for-service Medicaid. Conspicuous is the fact that almost all of them reported having a usual source of care other than the emergency room (94.8 percent for adults, 98.3 percent for children). In several areas, however, considerable proportions of the Medicaid TANF population

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Kendall (2002) “Unmet Need Among Rural Medicaid Beneficiaries,” *Journal of Rural Health*; Long, Coughlin, and Kendall (2002) “Access to Care Among Disabled Adults on Medicaid” *Health Care Financing Review*; Long and Coughlin (2004, forthcoming) “Access to Care for Disabled Children.” *Health Care Financing Review*; and Long, Coughlin and King (2004, forthcoming) “Capitated Medicaid Managed Care In A Rural Area: The Impact of Minnesota’s PMAP Program” *Journal of Rural Health*.

<sup>9</sup> The reason for the rural nature of the sample was to be comparable (for a pre-post analysis) with a sample drawn from Minnesota counties that had been transferred to Medicaid managed care two years previously, which were rural counties.

gave answers that suggest potential areas in which Medicaid beneficiaries might be better served through a move to managed care.

*Continuity of Care.* As noted above, the overwhelming majority of TANF beneficiaries in fee-for-service Medicaid reported having a usual source of care outside the emergency room (ER). Furthermore, about three-fourths of both adults and children see the same health care professional for most or all of their visits to their usual source of care. This is encouraging because having a usual source of care and seeing the same provider over time are regarded as a good indicator of continuity of care. However, one-quarter of the adults and one-quarter of the children had visited an emergency room in the last 12 months. By instead emphasizing preventive and primary care, this suggests that an effective managed care system could potentially increase cost-effectiveness without reducing quality, by reducing the number of beneficiary ER visits for non-emergency conditions.<sup>10</sup>

*Use of Care.* Use of care statistics such as those shown can provide at least suggestive evidence of the extent of preventive care. Large majorities of both adults and children in the TANF population, for example, had a doctor visit in the past year. By itself this statistic suggests that the population may have a relatively high rate of regular (i.e., preventive) health care use. Most beneficiaries (adults and children) saw a dentist at least once in the last two years.

*Access to Care.* Relatively few had to wait in the office for one hour or more before they were seen. But one in five (of both adults and children) had to travel 30 minutes or more for their health care visit. An effective managed care system might be able to improve on this performance through better assignment of beneficiaries to primary care providers near their

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<sup>10</sup> The data do not allow us to know what proportion of these visits were for conditions that could have been treated adequately (and at lower cost) in a non-emergency setting, but it is unlikely that such a high proportion of visits was medically necessary.

homes. However, given the rural nature of the survey sample, the travel times, though long, may be in keeping with those of the general rural population.

*Unmet Need.* Unmet need appears to be the area where the greatest improvements for the TANF population might be achieved by managed care. More than half of adult beneficiaries reported some type of unmet need in the last 12 months. The same was true of nearly one-quarter of the children. Given the possibility that childhood illness or injury can have lifetime consequences, focusing managed care efforts on this unmet need promises to be especially beneficial. The need seems to be mainly in the areas of doctor and dental care, with little unmet need reported for hospital or specialist care.

*Perceived Service Quality.* As noted, TANF beneficiary perceptions of the health care received from their usual provider were typically overwhelmingly positive—an encouraging finding for the Medicaid program. With respect to wait time in the office, however, more than one in four judged their experiences (for adults and children) as less than good. And nearly half of the adults and one-third of the children found it not very easy to get evening or weekend care. An effective managed care system could potentially increase quality of care for Medicaid beneficiaries by focusing on office wait times and on greater access to non-emergency care in the evenings and on weekends.

### **Disabled Non-Elderly Beneficiaries on Supplemental Security Income**

The disabled population is particularly important for Medicaid because it is a vulnerable group with very complex medical and health conditions. In addition to physical disability, these beneficiaries include persons with developmental disabilities and serious mental illness.

Nationally, within the non-aged adults with disabilities group, about 40 percent have physical or sensory disabilities, 36 percent have mental illness, and the remainder has mental

retardation/developmental disabilities (U.S. House of Representatives 2004). Within the children with disabilities population, about 37 percent are physically disabled, 33 percent have developmental disabilities, about 30 percent are physically disabled, and the remaining 30 percent have a mental illness (Social Security Administration 2001).

Given their typically low health and functional status, persons with disabilities are heavy users of health care and thus are costly to serve. While they constitute less than 20 percent of the national Medicaid caseload, for example, they account for upwards of 40 percent of program spending (Kaiser Commission on Medicaid and the Uninsured 2001). Managed care strategies could potentially realize major savings by increasing the cost-effectiveness of care for this group. However, the extent and range of their needs must be carefully calibrated if managed care, particularly capitated managed care, is to succeed.

The data on urban SSI beneficiaries' experiences under fee-for-service come from beneficiary telephone surveys in two sites in New York (New York City and Westchester County) and two geographic areas in Kentucky (Regions 4 and 8 in the state's waiver).<sup>11</sup> The survey instruments were identical and the surveys were both fielded in 1999/2000. The New York survey provides data for urban and suburban beneficiaries; the Kentucky survey provides data for rural beneficiaries. Both were restricted to non-aged adults (ages 19 to 64) and children (ages 0 to 18) who were SSI beneficiaries living in the community. The surveys excluded beneficiaries who were also enrolled in Medicare ("dual eligibles").

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<sup>11</sup> For a discussion on the special methods used to conduct the survey of SSI beneficiaries see Appendix C, which provides an executive summary of a report completed as part of the project.

## Urban Beneficiaries with Disabilities

The findings for the New York sample are summarized in Table II.2. Since the results for New York City and Westchester County are very similar, for simplicity we focus our discussion on the New York City findings.

*Continuity of Care.* Over 90 percent of both adults and children are reported to have a usual source of care, and over 80 percent see the same provider all or most of the time. Both findings suggest a high degree of continuity of care for disabled beneficiaries under the Medicaid fee-for-service system.

*Use of Care.* Hardly surprising, given their precarious health status, disabled beneficiaries are heavy users of health care services. More than 80 percent of adults and more than 90 percent of children had a physical health care visit during the past year. Fewer had a mental health visit, in large part because only a minority of SSI beneficiaries had a mental health problem.

One measure of health care use that may be cause for particular concern is the substantial use of emergency rooms by this population. More than half of the adults and almost half of the children had at least one ER visit in the 12 months preceding the survey. These high levels of use might be reduced under a managed care system, if access to primary care for non-emergency health care needs can be improved.

*Access to Care.* Even though most beneficiaries with disabilities reported having a usual source of care, they reported long wait times in the office and travel times. Waits of 30 minutes or more in the office were the norm for 70 percent of adults and 56 percent of children with disabilities. In addition, four out of ten disabled adult beneficiaries (and three out of ten of the children) had to travel 30 minutes or more to their place of care. Though not shown here, project analyses revealed that respondents with long travel times also reported more difficulty finding a

doctor who accepts Medicaid, strongly suggesting that these wait times are not voluntary, and that an effective managed care system could substantially improve access for Medicaid beneficiaries with disabilities.

*Unmet Need.* As with the TANF population, unmet need is an area where an effective managed care system might achieve substantial improvements in service delivery for beneficiaries with disabilities. Despite being frequent users of health care services and having a usual source of care, almost 40 percent of adults and over 30 percent of children were reported to have had an unmet need in the past year--with medical and dental care the most common unmet needs reported. Limited availability of providers was reported to be a key factor across all types of unmet need.

*Perceived Service Quality.* Unlike the TANF beneficiaries, substantial minorities of urban SSI beneficiaries were not satisfied with the care they received, with finding a doctor appearing to be the most important single source of dissatisfaction.

*Differences Among SSI Beneficiaries.* Project analyses also revealed evidence of gaps in care for subgroups of disabled persons under the Medicaid program, particularly for adults and children with mental disability. Among children, those with mental disabilities (mental illness or MR/DD) are less likely than those with physical disabilities to have had an outpatient visit for physical health, a preventive care visit, or a dental visit in the past year, all else equal (Table II.3). Further, nearly 35 percent of children with mental illness do not have a usual source of care for mental health (data not shown). Similarly, among adults, we found that 25 percent of adults with mental illness did not have a usual source of care for mental health and only 75 percent had an outpatient visit for mental health in the past year (Table II.4). After controlling for health care needs, we found that adults with mental illness are less likely than the physically

disabled to have a usual source of care for physical health and are more likely to report unmet need for care (not shown in the table).

The multivariate analysis on the data for adult beneficiaries with disabilities revealed two additional noteworthy differences within this group. Not surprisingly, those in worse health (and presumably in greatest need) had the greatest difficulty getting care. More surprisingly, older beneficiaries with disabilities were better off than younger ones on most measures, suggesting that over time beneficiaries are able to develop a network of providers who offer them greater continuity of care.

Although we did find evidence of some differences in access to care for subgroups of disabled adults and children, the general finding from the multivariate analysis was that many of the barriers to care faced by disabled Medicaid beneficiaries are broad. For the most part, we found relatively little association between the characteristics of children or adults and the measures of access to care and unmet need.

### Rural Beneficiaries with Disabilities

The data on rural Medicaid SSI beneficiaries under fee-for-service come from a telephone survey of beneficiaries in two areas of Kentucky--Region 4 (16 counties in north central Kentucky) and Region 8 (21 counties in east central Kentucky) of the state's waiver program. The surveys were fielded in 1999. These regions are very rural and together include 43 percent of the non-dual SSI population of Kentucky. Their experiences under Medicaid managed care are summarized in Table II.5.

*Continuity of care.* Along this dimension of care, fee-for-service Medicaid seems to do a good job for disabled beneficiaries. Virtually all have a usual source of care and almost nine out of ten see the same provider all or most of the time.

*Use of care.* As with urban disabled beneficiaries, rural SSI beneficiaries use a great deal of health care. Particularly dramatic is their considerable use of ER care. Almost half of the adults and children had an emergency room visit last year, even though nine out of ten of the children also had a preventive care visit and the vast majority had a usual source of care. The data do not show how many of these ER visits were of a non-emergency nature. But the very high incidence of ER use, combined with the fact that almost a quarter of adult beneficiaries had an unmet need for care last year, suggests that at least some of it could be prevented with an effective managed care system.

*Access to care.* One out of four adults and children had to travel more than 30 minutes to get care. And five out of ten adults (four out of ten children) had to wait in the office more than an hour before being seen. An effective managed care system should be able to improve these access statistics. While travel time is more of a challenge in rural areas, waiting time in an office is an area where managed care plans could make a difference.

*Unmet need.* With respect to unmet need, disabled adult beneficiaries fare substantially less well than the children on two major measures. More than one in ten of disabled adults had an unmet need for medical or surgery care in the last year (even though almost all of them had a usual source of care) and almost a quarter had an unmet need for prescription drugs.

*Service ratings.* Most beneficiaries rated most their care as good, very good, or excellent, with more than four out of five adults and children rating each category of health care service that way.

## **Cross-State Differences for Beneficiaries with Disabilities**

Combining surveys conducted by two other CMS-sponsored Section 1115 evaluations with surveys collected in this evaluation, a comparison of SSI beneficiaries in areas in four states—Kentucky (Regions 5 and 8), New York (New York City and Westchester County), Oregon (entire state), and Tennessee (urban and rural areas),<sup>12</sup> showed that disabled adults (Table II.6) and children (Table II.7) generally have access to a usual source of care and do receive care. However, there were significant differences in access to care for these populations across the states. For example, only about 80 percent of disabled children and adults in Tennessee had a physician visit in the past year, as compared to about 90 percent in the other states. Unmet need for doctor care ranged from 14 percent of disabled adults in New York to 22 percent in Kentucky and Tennessee. There was greater consistency in satisfaction with care across states, with around 20 percent of disabled adult beneficiaries and around 14 percent of disabled children rating the quality of medical care they received as fair or poor.

## **Conclusions and Lessons Learned**

For adult TANF beneficiaries and their children, our findings indicate that Medicaid fee-for-service is generally doing an adequate job of linking beneficiaries to the health care system, at least in rural Minnesota. The major areas where an effective managed care system might achieve cost-effective improvements appear to be reducing ER use for non-immediate needs, particularly for adults, following up to ensure preventive care appointments are made and kept,

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<sup>12</sup> The surveys in Oregon and Tennessee were conducted under other CMS funded projects. Research Triangle Institute conducted the survey in Oregon and Mathematica Policy Research conducted the survey in Tennessee.

reducing travel times to care and wait times in office before being seen, and reducing unmet need for doctor and dental care.

The situation is more complex for disabled beneficiaries. This is a highly vulnerable and costly population about which relatively little is known, particularly in a managed care context. Project data collected but not shown here indicate a wide diversity in the types of health conditions among this population, both adults and children, from physical afflictions such as muscular dystrophy, cerebral palsy, and HIV/AIDS to mental health conditions including mental retardation, schizophrenia, and paranoia. States need to have solid information on the needs of this population if they are to develop sound managed care systems, particularly in the area of capitation rates.

Our data show that managed care can have potential benefits for this population, if based on a clear understanding of the issues to be confronted—with urban beneficiaries in New York currently having less satisfactory experiences under fee-for-service Medicaid than Kentucky rural beneficiaries. This difference may be due, at least in part, to Kentucky beneficiaries who are in poorer health. Thus, the fact that they receive more care may be because they need more care. It remains true, however, that Kentuckians report less unmet need and more satisfaction with their care than do their New York counterparts.

The main areas states should focus on in efforts to improve care for Medicaid beneficiaries with disabilities--adults and children, urban and rural--appear to be improving ease of access (travel time and office wait times), reducing unnecessary ER use, and reducing unmet need, particularly for adults in the areas of medical/physician and dental care.

**TABLE II.1: EXPERIENCES UNDER FEE-FOR-SERVICE MEDICAID—RURAL TANF AND POVERTY-RELATED BENEFICIARIES**

Dimension of Care/Specific Measures	Percent with “Yes” Response	
	Adults	Children
<b>Continuity of Care</b>		
Usual source of care (other than ER)	94.8	98.3
Same health care provider for most/all visits	78.2	76.3
<b>Use of Care</b>		
ER visit in last 12 months	25.0	25.5
Doctor visit in past year	85.8	90.7
Dentist visit in past 2 years	76.0	87.2
<b>Access to Care</b>		
Travel time 30 minutes or more	21.2	20.7
Wait time in office one hour or more	12.5	11.8
<b>Unmet Need</b>		
Any	56.6	23.6
Hospital care	6.9	1.3
Doctor care	32.5	9.0
Specialist care	9.0	4.3
Dental care	41.2	14.8
<b>Perceived Service Quality</b>		
Rates care as fair or poor		
Health care from usual source	7.5	12.2
Wait time for appointment	17.3	17.5
Wait time in office	27.8	28.6
Ease of getting evening/weekend care	43.0	37.3

Source: 1998 Minnesota TANF Beneficiary Survey

<b>TABLE II.2: EXPERIENCES UNDER FEE-FOR-SERVICE MEDICAID—URBAN SSI BENEFICIARIES</b>		
<b>Dimension of Care/Specific Measures</b>	<b>Percent with “Yes” Response</b>	
	<b>Adults</b>	<b>Children</b>
<b>Continuity of Care</b>		
Usual source of care (other than ER)	93.3	95.5
Same health care provider for most/all visits	82.4	82.1
<b>Use of Care</b>		
ER visit in last 12 months	52.7	45.3
Physical health visit	81.1	91.7
Preventive visit	---	87.3
Mental health visit	32.0	35.6
Dental visit	69.6	84.8
<b>Access to Care</b>		
Travel time 30 minutes or more	41.3	33.9
Wait time in office one hour or more	70.1	56.4
<b>Unmet Need</b>		
Any	47.5	31.2
Medical	14.5	10.4
Mental	7.5	8.6
Dental	17.0	12.9
Physical, speech, occupational therapy	6.0	10.3
Prescription drugs	11.4	6.2
<b>Perceived Service Quality</b>		
Rates care as fair or poor		
Overall quality of medical care	17.8	16.0
Ease of finding doctor who accepts Medicaid	28.8	21.1
Ease of getting medical specialist care	14.5	10.4
Ease of getting mental health care	7.5	8.6

Source: 1999/2000 New York City Working-Age Adult and Child SSI Beneficiary Surveys

**Table II.3: Experiences Under Fee-for-Service Medicaid--Child Urban SSI Beneficiaries, by Disabling Condition**

Dimension of Care/Specific Measure	Percent with "Yes" Response	
	Mental Disability	Physical Disability
<b>Continuity of Care</b>		
Has Usual Source of Care (other than ER) for Physical Health	96.0	94.4
Sees Same Provider at All or Most Visits	80.0	87.1
<b>Use of Care in Last 12 months</b>		
Hospital Stay	14.3 **	28.5
Multiple Hospital Stays	4.2 **	15.6
Emergency Room Visit	42.1 **	53.0
Visit for Fall or Accident	10.5	10.3
Visit for Mental or Emotional Health <sup>1</sup>	5.9	2.9
Multiple Visits to Emergency Room	26.0 **	42.1
Outpatient Visit for Physical Health Care	89.0 **	98.5
Outpatient Visit for Preventative Care	83.8 **	95.5
Mental Health Care Visit	40.9 **	22.4
Dental Care Visit	82.6 *	90.7
<b>Access to Care</b>		
Travel Time to Provider of 30 Minutes or More	28.5 **	46.1
Wait in Office is 30 Minutes or More	61.6 **	44.5
<b>Unmet Need</b>		
Medical Care or Surgery (including Doctor Care)	10.8	9.6
Mental Health Care	10.7 **	2.9
Dental Care <sup>1</sup>	12.2	14.8
Physical, Occupational or Speech Therapy	11.2	8.1
Prescription Drugs	7.0	3.5
Special Medical Equipment	7.8	9.3
One or More of the Above	31.7	30.0
<b>Perceived Service Quality</b>		
Problems Communicating with Providers Due to Language Differences	14.5	13.3
Parent Rates Ease of Access as Fair or Poor for:		
Finding a Doctor Who Accepts Medicaid	21.6	20.1
Getting Specialist Medical Care <sup>2</sup>	26.2 *	18.1
Getting Emergency Medical Care <sup>2</sup>	22.9	17.0
Getting Mental Health Care <sup>2</sup>	21.7	26.0
One or More of the Above	38.1	36.8

Source: 1999/2000 New York City Child SSI Beneficiary Survey.

\*(\*\*) Indicates value for children with a mental disability is significantly different from that for children with a physical disability at the .05 (.01) level.

<sup>1</sup> Limited to children aged two or older.

<sup>2</sup> Limited to children who needed that particular type of care.

**Table II.4: Experiences Under Fee-for-Service Medicaid--Adult Urban SSI Beneficiaries, by Disabling Condition**

Dimension of Care/Specific Measure	Percent with "Yes" Response		
	Mental Illness	MR/DD	Physical Disability
<b>Continuity of Care</b>			
Has Usual Source of Care (other than ER) for Physical Health	88.8 **	91.9 **	96.9
Has Usual Source of Care (other than ER) for Mental Health	74.8 **	43.9 **	22.8
<b>Use of Care in Last 12 Months</b>			
Hospital Stay	25.8	15.3 **	32.8
Hospital Stay for Psychiatric Treatment	8.3 **	4.7 **	0.4
Multiple Hospital Stays	13.3	7.4 *	13.8
ER Visit	46.4	39.0 **	52.7
ER Visit for Mental/Emotional Problems	12.6 **	7.6 *	2.9
Multiple ER Visits	27.8	22.2	27.2
Outpatient Visit in Last 12 Months	95.3	92.0 *	96.8
Outpatient Visit for Physical Health Care	88.5 **	88.8 **	95.5
Outpatient Visit for Mental Health Care	74.8 **	42.9 **	25.9
Dental Visit	70.8	76.3 *	66.0
Flu Shot	35.9	32.7 *	41.9
Pap Smear (women)	71.3	59.9 **	75.6
<b>Unmet Need</b>			
Any Unmet Need	47.1 **	26.5	33.6
Medical care or surgery	18.2 *	7.6	10.8
Mental health care	11.2 **	5.8	3.9
Prescription drugs	17.4 **	5.7	8.9
Dental care	20.3 *	11.3	12.2
Physical, occupational, or speech therapy	4.6	6.4	3.9
Special medical equipment	8.9	4.2	7.1
<b>Perceived Service Quality</b>			
Rates One or More Aspects of Care as Fair or Poor:	65.0	62.8 *	72.9
Ease of finding a doctor who accepts Medicaid	29.5	26.3	29.0
Ease of getting:	23.1	25.0	26.0
Specialist medical care <sup>1</sup>	36.5	29.4	32.0
Emergency medical care <sup>1</sup>	17.9	17.2	19.7
Mental health care <sup>1</sup>	44.0	40.0	43.4

Source: 1999/2000 New York City Working-Age Adult SSI Beneficiary Survey

Note: Only respondents who had had a health care encounter over the past year were asked to rate the ease of finding a doctor or getting care.

(\*) (\*\*) Significantly different from individuals with a physical disability at the .05 (.01) level.

<sup>1</sup> Those indicating they did not need a particular type of care were excluded from this calculation.

<b>TABLE II.5: EXPERIENCES UNDER FEE-FOR-SERVICE MEDICAID—RURAL SSI BENEFICIARIES</b>		
<b>Dimension of Care/Specific Measures</b>	<b>Percent with “Yes” Response</b>	
	<b>Adults</b>	<b>Children</b>
<b>Continuity of Care</b>		
Usual source of care (other than ER)	96.6	99.2
Same health care provider for most/all visits	89.5	87.0
<b>Use of Care in Last 12 Months</b>		
ER visit	48.7	45.5
Physical health visit	91.9	93.0
Preventive visit	---	91.9
Mental health visit	36.4	35.8
Dental visit	53.7	64.5
<b>Access to Care</b>		
Travel time 30 minutes or more	24.7	26.1
Wait time in office one hour or more	52.6	42.4
<b>Unmet Need</b>		
Any	N/A	N/A
Medical care or surgery	12.0	7.8
Mental	6.7	6.7
Dental	10.9	8.5
Physical, speech, occupational therapy	3.8	8.9
Prescription drugs	22.5	11.8
<b>Perceived Service Quality</b>		
Rates as fair or poor:		
Overall quality of medical care	16.6	12.3
Ease of finding doctor who accepts Medicaid	18.9	16.4
Ease of getting medical specialist care	19.5	18.8
Ease of getting mental health care	19.7	19.8

Source: 1999 Kentucky SSI Beneficiary Survey

**Table II.6: Experiences Under Fee-for-Service Medicaid in Four States--Adult SSI Beneficiaries**

Dimension of Care/ Specific Measures	Percent with "Yes" Response				
	Kentucky	New York City	Oregon	Tennessee	Westchester County
<b>Continuity of Care</b>					
Have a usual source of care	96.5	95.9	96.3	94.2 **	93.0 ***
<b>Use of Care</b>					
Percent with service during past 12 months:					
Physician visit	91.0	91.1	--	79.9 ***	87.5 ***
ER visit	48.4	48.4	--	43.1 **	45.5
Inpatient stay	26.8	27.2	22.1 **	22.1 *	23.6 *
Dental visit	54.6	69.8 ***	53.4	53.1	68.4 ***
Blood pressure check	93.5	94.3	--	93.2	90.6 ***
Pap test (women only)	61.1	85.0 ***	--	75.8 ***	75.2 ***
Percent with service during past 3 months:					
Physician visit	82.1	81.4	74.1 ***	60.8 ***	73.2 ***
Mental health visit	17.7	32.2 ***	29.4 ***	26.1 ***	33.2 ***
<b>Unmet Need</b>					
Unmet need for:					
Doctor care	22.4	13.7 ***	--	21.8	15.7 ***
Dental care	10.9	15.5 ***	15.1 ***	42.0 ***	21.3 ***
Mental health / substance abuse	7.0	7.3	--	12.0 ***	6.7
Prescription medicine	22.1	11.8 ***	20.5	17.1 ***	10.2 ***
<b>Access to Care</b>					
Rates as fair or poor:					
Quality of medical care	16.7	17.9	--	17.9	21.5 ***
Ease of getting care from specialists	20.8	25.0 *	23.9	19.0	39.4 ***
Ease of getting care in emergencies	25.2	33.2 ***	--	29.1 *	29.2 **

\* (\*\*) (\*\*\*) Significantly different from Kentucky at the .10 (.05 (.01) level.

" -- " indicates that question was not asked on survey.

SOURCES: 1999 Kentucky SSI Beneficiary Survey; 1999/2000 New York City and Westchester County Working-Age Adult SSI Beneficiary Survey; 1998 Survey of Oregon Health Plan Recipients (Phase 2); 1998/99 Survey of SSI Enrollees in TennCare.

<b>Dimensions of Care/Specific Measures</b>	<b>Percent with "Yes" Response</b>			
	<b>Kentucky</b>	<b>New York City</b>	<b>Oregon</b>	<b>Tennessee</b>
<b>Continuity of Care</b>				
Has a usual source of care	99.2	98.2	98.5	96.2**
<b>Use of Care</b>				
Use of care in last 12 months:				
Physician visit	93.0	91.8	--	81.5***
ER visit	45.2	45.7	--	31.5***
Inpatient stay	19.0	18.6	19.6	13.2**
Dental visit	82.0	84.6	65.9***	67.6***
Use of care in last 3 months:				
Physician visit	33.4	26.8**	32.7	62.9***
Mental health visit	21.7	19.9	19.0	18.4
<b>Unmet Need</b>				
Unmet need for:				
Doctor care	6.7	6.4	--	9.7
Dental care	8.2	13.9**	14.4***	24.4***
Mental health /substance abuse	6.9	8.9	--	4.9
Prescription medicine	11.4	5.8***	11.0	11.5
<b>Access to Care</b>				
Rates as fair or poor:				
Quality of medical care	12.5	16.2	--	14.8
Ease of getting care from specialists	19.2	24.4*	50.5**	21.9
Ease of getting care in emergencies	19.7	20.8	--	30.8***

\* (\*\*) (\*\*\*) Significantly different from Kentucky at the .10 (.05) (.01) level.

" -- " indicates that question was not asked on survey.

SOURCES: 1999 Kentucky SSI Beneficiary Survey; 1999/2000 New York City Child SSI Beneficiary Survey; 1998 Survey of Oregon Health Plan Recipients (Phase 2); 1998/99 Survey of SSI Enrollees in TennCare.

**CHAPTER III**

**PROGRAM IMPLEMENTATION AND  
OPERATIONAL EXPERIENCES  
UNDER MEDICAID MANAGED CARE**

Converting a Medicaid program from one operating system or payment system to another is inevitably complex. States should always expect to run into unanticipated issues, however carefully they may have planned the transition. This chapter summarizes the experiences of several states as they worked to implement capitated managed care in their Medicaid programs under Section 1115 waiver authority—experiences that can be of potential help to states as they think about how to maximize their chances of successful managed care implementation. Information for this chapter comes from several reports written under the project; for more details on findings readers are referred to these reports.<sup>13</sup> Given the nature of our study states, our study findings provide a special focus on implementing Medicaid managed care in rural areas. We begin with Minnesota, which was ultimately successful in bringing Medicaid managed care to the state as a whole. We then discuss the experiences of New York, Kentucky, and Vermont, none of which has been able to implement capitation on a statewide basis. We finish with a brief review of lessons for other states to consider as they approach the task of introducing Medicaid managed care.

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<sup>13</sup>This chapter draws on the following reports: Coughlin, Marsteller, Rajan and Zuckerman (1997) “Expanding Medicaid Managed Care in Minnesota, 1<sup>st</sup> Site Visit Report;” Marsteller, Coughlin Long, and Rangarajan (1999) “Minnesota PMAP: 2<sup>nd</sup> Round Site Visit Report;” Coughlin, Long, Kasten and Goldenson (2000) “NY’s Partnership Plan: An Early Look at Program Implementation;” Long, Kendall, Coughlin and Ormond (2001) “Minnesota PMAP: 3<sup>rd</sup> Round Site Visit Report;” French, Bartocsch, Donoghue, Hoover, Walsh and Mitchell (2003) “Medicaid Managed Care in Kentucky;” Mitchell, Bartocsch and Haber (2004) “Evaluation of the Kentucky Health Care Partnership Program: A Comparison of the Managed Care Experiences in Regions 3 and 5;” and Coughlin, Long and Ormond (2004) “Rural Medicaid Managed Care: The Case of Four States.”

## **Minnesota's PMAP+**

Minnesota has long been a leader in promoting managed care for its Medicaid population, and in its health sector more generally. The state received its first 1115 Medicaid waiver in 1985, which it used to introduce its Prepaid Medical Assistance Program (PMAP). Ten years later PMAP had been extended to eight Minnesota counties, all but one of which were located in the Twin Cities metropolitan area--an urban catchment area that covered about one-third of all Minnesota Medicaid clients. In 1995, the state obtained another 1115 waiver to create PMAP+, a program to extend capitated Medicaid managed care to the remaining 79 counties, predominately rural counties of the state.

The PMAP+ plan was to introduce statewide mandatory capitation to all TANF and poverty-related populations, generally excluding the disabled. Prepaid health plans were to cover most acute and primary care services, including dental, drugs, and mental health. The plans (which are nonprofit by Minnesota state law) were to be paid a capitated rate based on age, sex, eligibility group, county of residence, and case mix.

The new waiver program was to begin its phase-in by geographic area in early 1996, and extend coverage to the whole state by 1997. By the end of 1996, however, the state had fallen far short of its goal, with PMAP+ covering only an additional 8 counties and 13,000 beneficiaries. While enrollees living in the new expansion areas expressed general satisfaction with the new system, the state faced significant resistance from a range of powerful stakeholders—including county officials, physicians and hospitals, and consumer advocacy groups.

Counties were the most prominent critics of PMAP+. Interestingly, state officials underestimated the opposition they would encounter from this quarter, even though similar tensions had emerged when the first managed care waiver went into effect 10 years earlier. The

counties had two major concerns. The first was that managed care would result in a cost shift to them, actually reducing access to needed care for some beneficiaries and forcing counties, as the legally obligated “payer of last resort,” to provide services at county expense that Medicaid was no longer covering. The second was that counties resented what they felt was the imposition of a single program model on all counties, when local authorities felt they knew what worked best for their communities. Providers echoed these concerns, feeling that imposition of PMAP+ in their areas would encroach on their ability to direct the provision of care. Some consumer groups also feared the effects of “rationing” care.

Stakeholders took their concerns to the Minnesota state legislature during the 1995-1996 session, which introduced two changes. The first was a 1996 redefinition (called “enhanced PMAP”) of the county’s role in the expansion, which included a voice in plan selection and in setting the timetable for implementation in their area. The second was the granting in 1997 of authority to design county-based purchasing (CBP) models as an alternative to PMAP. CBP granted counties the option of running their own Medicaid demonstration projects with advance payment from the state, as long as they accepted full risk and met state and federal requirements.

As of July 1998, 28 counties had implemented PMAP, with 38 counties proposing to adopt CBP by October 1999 (including some that had already transitioned to PMAP). Many observers questioned, however, whether CBP would in fact be viable for counties with little experience in assuming risk or managing care.

By October 2000, the state had successfully implemented enhanced PMAP in 60 counties, with a total enrollment of 183,000, with three more scheduled for 2001. The 24 counties that had not yet adopted it were still pursuing CBP options, although some observers continued to question the viability of these plans. CMS was raising concerns about allowing

counties to become the sole purchaser of health care without a competitive procurement process, for example. In addition, many counties felt that the state was being less than supportive of CBP, making them apprehensive about the likelihood of success. Provider support of CBP plans was also waning, calling into question CBP plan viability even if implemented. As of summer 2004, Minnesota had successfully implemented PMAP in 67 of its 87 counties, and entered into CBP arrangements with the remaining 20 counties.<sup>14</sup>

### **New York's Partnership Plan**

The motivation behind New York's 1115 waiver plan was to reduce Medicaid costs and improve access to care through enrollment of more than two million beneficiaries across the state into mandatory capitated managed care. Eligibility was to include TANF, poverty-related, and SSI populations, plus "special needs plans (SNPs)" for high need/high cost beneficiaries, and coverage of the state's Safety Net (SN) program, which allowed receipt of federal Medicaid matching dollars to cover health care for general assistance recipients. Project site visits in 1998 and 1999 documented early waiver program experiences.

Under the Partnership Plan, capitated health plans were to cover primary and acute care services, including prescription drugs (which were later withdrawn from the capitated benefit packaged and returned to FFS). Mental health and substance abuse services were included in the benefit package for the TANF populations but plans were subject to a stop loss provision for their enrollees. For the SSI population, these services were completely carved out. Finally, institutional and personal care services were excluded, and mental health and substance abuse services were largely carved out. Capitation rates were originally set by competitive bidding, but

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<sup>14</sup> It should be noted that the 1997 Balanced Budget Act (BBA), by allowing a single Medicaid plan in rural counties, helped move CBP forward.

were later set by negotiation to take into account managed care experiences, age, sex, eligibility group, and geographic region.

As of April 1999, New York had made substantial progress in implementing the Partnership Plan. All major urban areas in upstate New York had started mandatory managed care for their TANF/SN populations, with 140,000 recipients enrolled statewide. Implementation in New York City and implementation for non-TANF-related groups upstate had moved more slowly than planned, however. No mandatory enrollment of the SSI populations had taken place, for example, although several upstate counties were positioned to move forward with mandatory SSI enrollment under the waiver's terms and conditions and subject to CMS's approval. The state had also made only limited progress in moving forward with the SNPs. Those plans, which were intended to serve persons with HIV/AIDS and persons with serious mental illness (children and adults), were still in the development phase as of April 1999.<sup>15</sup>

What were the major barriers slowing progress, in addition to the problems inherent in any public program promoting wide-scale change? Four issues were particularly prominent. The first was similar to the situation in Minnesota—resistance by local government. New York has a strong local government structure, and counties pay about 25 percent Medicaid program costs. Officials in some upstate counties simply told the state they were unable to implement the Partnership Plan. Second, the strong state economy at the time, along with declining Medicaid enrollment, reduced the fiscal imperative for managed care, and there was no strong political or administrative voice speaking up for the waiver program at a critical implementation point.

Third, there was federal-state tension over how to handle the managed care provisions of the 1997 Balanced Budget Act (BBA)--with New York believing, contrary to CMS's

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<sup>15</sup> Eventually, authorizing legislation for SNPs for serious mental illness lapsed and these plans were never implemented.

interpretation, that the waiver exempted them from the BBA provisions. Finally, New York City hospitals, though not actively fighting the waiver, gave it lukewarm support at best, because they viewed Medicaid capitation rates as too low for viability.

As of January 2003, the Partnership Plan had been implemented in 21 of the state's 62 counties (three of which are rural) and in New York City. But only TANF-related populations are mandatorily enrolled.

### **The Kentucky Health Care Partnership Program**

Kentucky's 1115 waiver proposal, which was approved in October 1995, was also intended to introduce capitated managed care to its Medicaid program statewide. The state expected capitated payment systems and coordination of care to control or even reduce the rate of Medicaid expenditure growth, while improving the focus on preventive care and possibly improving quality of care. This discussion is based on two project site visits--the first in May 1999, the second in October 2000.

When the waiver was approved, most of the state's urban beneficiaries were already in a primary care case management (PCCM) program, which paid physicians a monthly case management fee but reimbursed all services on a fee-for-service basis. The intent was to build upon this system (called the Kentucky Patient Access and Care System or KenPac) to introduce capitated Medicaid managed care statewide and extend eligibility beyond the TANF-related population to the SSI population, excluding residents of nursing homes and psychiatric facilities. Most acute and primary care services were covered, including pharmacy, dental, and home health. Behavioral health was slated for capitation by separate organizations.

The waiver plan divided the state into eight Partnership regions with one Partnership entity to be formed in each region. The intent was to enable providers in a region (explicitly including academic medical centers, local health departments, primary care centers, and safety net clinics) to design a services delivery network tailored to the regional health care infrastructure and the needs of its Medicaid population. Thus, there would be no beneficiary choice of plan and the Partnership would bear the full risk of health services in its region, although it could negotiate different risk sharing arrangements with different provider groups.

At the time of the first site visit, Partnerships had been successfully implemented in two regions in the state—the areas in which KenPac had been successfully operating when the waiver was approved. These were the most urban areas in the state—surrounding the cities of Louisville (Region 3) and Lexington (Region 5). Their partnerships had begun enrolling TANF-related eligibles in November 1997 and the SSI population in April 1998. The six other regions—all predominantly rural—were in varying states of contract development and negotiation.

By October 2000, none of the other six regions had been able to form partnerships or initiate managed care contracts with the state. And only one of the two regions that had done so (Region 3) was still in operation. Region 5 decided to terminate its partnership after its third year of operation.

A brief discussion of the general problems with the Partnership experience highlights the challenges that such an ambitious approach brought with it. This is followed by a comparison of the experiences of the two regions that did form successful partnerships--highlighting why Region 3's partnership survived while Region 5's did not.

*General Opportunities and Problems.* Kentucky's innovative approach was designed to avoid certain potential problems. First, by encouraging providers and consumers to become

integrally involved in the development of a managed care entity they hoped to circumvented any tough political battles that might have accompanied a direct solicitation of commercial plans. They also hoped to diffuse distrust of managed care in the many areas that had had no experience with it. Second, contracting with a single entity in each region eliminated concerns about marketing practices and selection bias in plan enrollment. Third, the plans had a greater incentive to focus on preventive care, because they did not have to worry about enrollees switching to new plans.

Kentucky's approach came with its own set of challenges, however. Creating a monopoly plan in each region reduced the state's leverage in subsequent rate negotiations. In addition, many of the regions were so sparsely populated that they had difficulty generating the necessary capital to initiate a partnership agreement with the state—and might, in any case, have had a membership base too small to be financially viable. Several observers speculated, indeed, that the partnership concept might have worked if the state had been divided into fewer (larger) regions. Two of the more populous regions with some managed care experience (Regions 3 and 5) were able to implement capitated managed care. But Region 5 had problems that finally led it to abandon capitated managed care, making a comparison between Region 3 and Region 5 quite instructive about factors that importantly influence success.

*Region 3 versus Region 5.* Site visit informants identified a variety of factors that influenced the success of Region 3 and the failure of Region 5. First, payment rates were set higher in Region 3, and it is probable that Region 3 also had greater initial excess utilization, facilitating the achievement of savings. Second, Region 5 had a higher proportion of SSI enrollees—a group that both regions found difficult to serve at the rates that were set. Third, Region 5 chose to reimburse all providers on a FFS basis with a 20 percent withhold. Region 3

capitated primary care physicians and used FFS reimbursement with a 10 percent withhold for other providers. Although providers initially preferred the Region 5 system, they in fact bore more of the risk and ended up disenchanted with the system.<sup>16</sup> Fourth, although both regions had administrative problems in their first year, Region 3 (unlike Region 5) used an Administrative Services Organization and engaged managers with extensive Medicaid and commercial care experience to help them, and made successful efforts to cultivate good relations with politicians, providers, and beneficiaries. Fifth, providers in Region 3 had a long history of working together on indigent care giving them an advantage on forming a partnership. Finally, and perhaps most important of all, Region 5 is somewhat more rural than Region 3, which brought the inherent problems of smaller scale.

### **The Vermont Health Access Plan (VHAP)**

The stated motivation behind Vermont's 1115 waiver plan was not primarily cost control. Rather it was to move toward universal health care coverage in the state.<sup>17</sup> Specific goals were to: increase access for the uninsured, move from a fee-for-service to a managed care delivery system, remove some of the stigma attached to Medicaid beneficiaries by enrolling them in plans similar to the non-Medicaid population, and to improve Medicaid cost predictability. This

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<sup>16</sup> As discussed in Mitchell Bartocsch and Haber 2004, Region 3 capped its PCPs for primary care services (adjusting for age, gender, and eligibility) and paid them 95 percent of the Medicaid fee schedule for lab and radiology. They also got FFS reimbursement for certain preventive services that the plan wanted to encourage (e.g. prenatal care, EPSDT, immunizations). Plus, they received bonuses for submitting encounter data. Region 3 specialists were paid FFS at 105 percent of the fee schedule with a 10 percent withhold, and hospital's were paid on a per diem basis with a 10 percent withhold. During Region 3's first year, none of the withhold was returned to hospitals or specialists. By 1999, 85 percent was returned. Region 3 was planning to return 100% in 2000. By contrast, Region 5 paid on a FFS basis using the current Medicaid free schedule with a 20 percent withhold. (PCPs were assigned to groups with budget targets that determined the portion of the withhold that would be returned.) After its first year, none of the providers received withholds, so PCPs were operating at 80 percent of their fee schedule. FFS reimbursement with a 20 percent withhold proved riskier than Region 3's reasonable cap for primary care. Initially, PCPs were attracted to the FFS system in Region 5, but the 20 percent withhold, which was never returned, ultimately angered them.

<sup>17</sup> In this section we focus on VHAP Medicaid managed care effort. In Chapter VI findings from Vermont's pharmacy assistance program for low-income Medicare beneficiaries are highlighted.

discussion is based on two project site visits—the first in October 1997, the second in November 1999.

VHAP managed care plans covered a full set of services, including long-term care services, prescription drugs, hospice, and mental health and substance abuse. Dental care continued on a fee-for-service basis and Vermont, as in New York, took over responsibility for pharmaceuticals soon after implementation. Vermont used a negotiated rate setting process with their plans with rates based on age, sex, and eligibility group. There was no geographic rate adjustment.

In August 1995, the state released their solicitation for Medicaid capitated managed care plans. After a significant delay, Vermont state was able to execute contracts with two plans later in that year –Community Health Plan (CHP) in May 1996 (which was acquired by Kaiser Permanente within the next month or so) and Blue Cross Blue Shield of Vermont in October 1996. CHP-Kaiser began enrolling both the traditional and expansion Medicaid populations in October of that year. Blue Cross followed suit in January 1997. Mandatory enrollment began in March 1997 and by May had extended to all areas in the state but one, the Brattleboro area. Both plans were paid on a fully capitated basis, with rates adjusted for age and sex and varying somewhat by plan.

Although fully implemented, Vermont's capitated system of Medicaid managed care proved unsustainable in Vermont. A key factor in the demise of Vermont's effort to develop a captivated managed care program for Medicaid beneficiaries was maintaining plan participation. For reasons unrelated to the Vermont waiver demonstration, Kaiser decided to exit the whole New England market in June 1999, leaving Blue Cross Blue Shield as the only private Medicaid managed care plan in the state as of the end of that year.

The state responded to the gap left by Kaiser by turning to its primary care case management (PCCM) program to take over the management of Kaiser’s enrollees. This program—PC Plus—reimburses most providers directly on a fee-for-service basis with an additional \$5 per member month going to primary care physicians for care management. The state eventually decided not to renew its contract with BlueFirst because they were unable to reach an agreement on capitation rates. Vermont then integrated the Blue Cross Blue Shield enrollees into PC Plus, just as it had for the Kaiser enrollees. PC Plus now serves all the traditional Medicaid and expansion population except for individuals whose primary care physician is not in the PC Plus network.

Another principal factor contributing to lack of success in Vermont’s capitated Medicaid managed care efforts was that there were few pre-managed care inefficiencies in the state’s health care system. Historically, Vermont has had a lower hospital use rate compared to the national average (American Hospital Association 1994). And Vermont had below average health care expenditures per capita (U.S. Bureau of Census 1993). Overlaying these is the lack of competition among Vermont hospitals. Each community is served by a single hospital. Almost all of the state’s 14 acute care hospitals are rural, and most are located 30 miles or more from each other. Together, these environmental characteristics offered few cost savings to managed care plans.

### **Key Lessons from Project Sites’ Implementation Experiences**

All four project states—Minnesota, Kentucky, New York, and Vermont—faced a range of challenges in implementing their Medicaid managed care programs. These can be encapsulated in the following considerations for states contemplating Medicaid managed care, particularly when it involves implementing capitated health plans in rural areas.

*Ensure that the area has a sufficient number of covered lives.* A key question is whether there are enough beneficiaries to support a capitated managed care program, especially in rural areas. New York's strategy (partially successful) was to set minimum population standards for counties to shift to managed care. Minnesota's successful experience "bundled" Medicaid beneficiaries with other publicly-covered groups (e.g. enrollees in MinnesotaCare, the state's public insurance program for low-income individuals) and required plans that wanted to serve public populations to serve all public programs in a county. Kentucky's strategy (ultimately unsuccessful except in one geographic area) was to divide the state into regions that combined several counties and to allow only one plan to serve each region. Vermont's approach (finally abandoned) was to solicit plans whose catchment areas were statewide.

*Be prepared to allow some flexibility for provider networks.* In an effort to have a sufficient numbers of providers (especially mental health providers) in rural areas and to meet state access requirements, Minnesota plans allowed some relaxation of provider credentialing. For similar reasons, Vermont relaxed standards for beneficiary travel time to providers. While Vermont's experience was too limited to determine whether the longer travel times was an effective strategy, there was a mixed assessment among Minnesota site visit respondents about the success of letting less credentialed providers serve Medicaid beneficiaries: On the one hand, plans were able to bring in new providers to their networks, especially specialists, that rural residents did not have ready access to. At the same time, though, plans were concerned about potential quality of care issues.

*Be realistic in assessing potential cost-savings.* If the primary motivation is cost savings, success will depend in large part on whether there are obvious places where resources can be cut without compromising quality of care. States make several assessments to determine if there are

ways to cut costs. For example, they can determine if their program has a heavy reliance on emergency room or hospital care? They can also ensure that the expansion area is large enough to support plan and provider competition to drive down costs. These are all pertinent questions. In the case of Vermont, for example, the system in place when the waiver demonstration was implemented was already comparatively cost-effective with a particularly low hospital use rate. Alternatively, Minnesota has been able to glean sufficient enough savings from moving to managed care statewide to finance coverage for an additional 130,000 individuals each year.

*Set feasible capitation rates.* Developing sound capitation rates is another important factor in making a successful managed care program. States need to consider and be prepared for all the various costs (including direct medical costs as well as administrative and reporting costs) that plans incur in serving Medicaid beneficiaries. Without sound rates, states run the risk of having trouble getting plans to participate in the Medicaid managed care as in the case of Vermont. States can use a range of strategies to help set practical capitation rates, including risk-adjusted rates (which Minnesota ultimately adopted), adding stop loss provisions and developing rate bands.

*Allow for local differences and local input.* In some areas, health care providers are core community participants. States need to be prepared to consider trading off some of the gains of capitation against the loss of key providers. They also need to be prepared to make operational and programmatic changes to accommodate the range of local areas and their governments that participate in the managed care initiative. Minnesota, for example, began its waiver program by implementing the same program statewide. Eventually, though, the state began to allow counties to customize its Medicaid managed care program to meet the needs of the local community. For Minnesota, this flexibility proved successful as PMAP+ or CBP programs are operating

statewide. By contrast, a central feature of Kentucky's waiver program was local control and input and this model proved to be largely unsuccessful at least in this state. Our findings suggest that state Medicaid programs need to critically assess their local communities to determine what would work and, equally important, what would not.

**CHAPTER IV**

**EFFECTS OF MANAGED CARE ON  
BENEFICIARIES AND HEALTH PLAN DECISIONS**

States embrace Medicaid managed care for a number of reasons, as evidenced by the 1115 waiver plans of our project sites, reviewed in Chapter III. Many states view managed care as a way to control Medicaid program costs while potentially improving beneficiary access to quality care. Care management and coordination is hoped to provide beneficiaries with a medical home where preventive care is promoted and primary care readily available. Having such care, in turn, is hoped to improve beneficiary continuity of care—reducing the use of such costly services as inpatient and emergency room care. Many states also hoped that managed care would provide medically vulnerable and low-income populations with access to mainstream health care providers as a way of eliminating a two-tiered system of care (where vulnerable populations are in the lower tier). The hope is that commercial plans, with provider networks broader than traditional Medicaid fee-for-service systems, will increase access to and quality of care for beneficiaries by moving them into the same care settings as available to those with private insurance.

This chapter discusses the extent to which Medicaid managed care has achieved these goals. Effects on beneficiary access and quality of care and cost savings are reviewed for the rural TANF population (adults and children in low-income households) in Minnesota and SSI recipients (beneficiaries with disabilities). We also examine access to care under Medicaid for rural beneficiaries. These discussions are followed by an analysis of changes in commercial plan activity in the Medicaid market nationwide. The final section focuses on policy lessons learned.

Information for this chapter comes from several reports written under the project; for more details on findings readers are referred to these reports.<sup>18</sup>

### **Managed Care Impacts on TANF and Poverty-related Beneficiaries in Rural Areas**

The effects of capitated Medicaid managed care on TANF and poverty-related beneficiaries (adults and children) reviewed here are based on a study of Minnesota's PMAP program. The experiences of rural beneficiaries under capitated managed care are compared with the experiences of similar beneficiaries under fee-for-service. The analysis is based on data from beneficiary surveys fielded in the state in 1998 and 2000. Changes in the health care access, use and satisfaction for a set of counties where Medicaid remained under fee-for-service in both years are compared with changes in the same outcome indicators for those counties where PMAP was introduced between 1998 and 2000, controlling for individual and area characteristics through multivariate regression.<sup>19</sup> The comparison is restricted to rural counties (the focus of Minnesota's 1115 waiver application) to maximize comparability.

*Access and Use.* Our regression analysis shows that introduction of PMAP+ had virtually no impact on beneficiaries' access to and satisfaction with care for either adults or children

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<sup>18</sup> This chapter draws on a number of project reports and publications. The project publications include: Coughlin and Long (1999) "Impacts of Medicaid Managed Care on Adults: Evidence from Minnesota's PMAP Program;" Long and Coughlin (2000) "Effects of Medicaid Managed Care on Children: Evidence from Minnesota's PMAP Program;" Long, Coughlin, and King (2003) "Estimating the Impacts of Medicaid Managed Care in Rural Minnesota;" Long and Yemane (2004) "Commercial Plans in Medicaid Managed Care: Understanding Who Stays and Who Leaves in a Changing Market;" Coughlin and Long (2004) "Estimating the Impacts of Medicaid Managed Care on Medicaid SSI Beneficiaries: A National Study;" and Long, King and Coughlin (2004) "The Health Care Experiences of Rural Medicaid Beneficiaries." The project publications include: Coughlin and Long (2000) "Effects of Medicaid Managed Care on Adults" *Medical Care*; Long and Coughlin (2001) "Impacts of Medicaid Managed Care on Children" *Health Services Research*; and Long, Coughlin, and King (2003) "Estimating the Impacts of Medicaid Managed Care in Rural Minnesota."

<sup>19</sup> For additional information on the regression models estimated as part of this analysis, see the report, Long, Coughlin, and King (2003) "Estimating the Impacts of Medicaid Managed Care in Rural Minnesota" or the article Long, Coughlin, and King (2004) "Capitated Medicaid Managed Care in a Rural Area: The Impact of Minnesota's PMAP Program," *The Journal of Rural Health*.

(Table IV.1).<sup>20</sup> This may not be very surprising given case study findings that revealed many of the physicians practicing in counties that switched to MMC continued participating in Medicaid after the transition to managed care. The share of adults and children with a usual source of care did not change. There were also no changes in the shares of adults and children linked to a physician as their usual source of care, and no change in continuity of care. Consistent with the lack of impact on access, there were no significant impacts on health care use for either adults or children, no increase in the proportion with a doctor visit in the past year, and no decrease in emergency room use. Unmet need remained high for both groups, as did the proportion rating different aspects of their health care experiences as fair or poor.

The one notable exception is that parents in Medicaid families were significantly less likely to find it easy to obtain prescription drugs for their children in managed care than in fee-for-service counties. This is consistent with several changes that occurred under PMAP+. Some pharmacies that had supplied prescription drugs to Medicaid beneficiaries under fee-for-service were not included in managed care networks. In addition, some managed care plans required beneficiaries to use mail-order pharmacies for refills, and a few plans introduced drug formularies that restricted the specific drugs readily available under Medicaid. There was no increase in unmet need for drugs among children, however, implying that children under managed care were able to get the drugs they needed, even if obtaining them was more difficult.

*Program Costs.* State Medicaid staff maintained that program costs were lower under managed care than they would have expected under fee-for-service. Even though Minnesota has no hard data to support this finding, it is consistent with national findings from other studies.

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<sup>20</sup> An analysis that compared the experiences of rural beneficiaries living in Medicaid fee-for-service counties in 1998 with those living in PMAP counties in the same year yielded very similar findings.

Thus, the major achievement of Medicaid managed care in rural Minnesota may have been to maintain the same access to and quality of care as under fee-for-service but at lower cost.

Two major caveats to the generalizability of these findings to other states should be noted here. First, the cost savings attributed to managed care in the Minnesota study are limited to Medicaid program costs. Case study evidence suggests that some of the services provided to Minnesota beneficiaries may have been paid for by non-Medicaid sources (such as public health clinics) after managed care was introduced. Second, most of the Minnesota physicians who had participated in Medicaid continued to do so after the switch to managed care and were typically paid higher fees under managed care than under fee-for-service--providing little incentive to change practice patterns. The limited overall capacity of most rural health systems may have further limited the potential for change under managed care.

### **Rural Health Care Experiences under Medicaid**

Medicaid plays a vital role in rural America, yet little research exists on the health care experiences of low-income rural adults. In large part this is because of data limitations. This analysis of rural health care experiences under Medicaid is based on the 1997, 1999, and 2002 waves of the National Survey of America's Families, covering adults ages 19 to 64. This information was supplemented with health care provider supply data by county from the Area Resource File, and Medicaid managed care program status by county from CMS managed care summaries: *National Summary of State Medicaid Managed Care Programs* and *Medicaid Managed Care Enrollment Report, Medicaid Managed Care Summary* (available at [www.cms.hhs.gov/medicaid/managedcare](http://www.cms.hhs.gov/medicaid/managedcare)). For an individual on Medicaid through the Supplemental Security Income (SSI) program (which provides assistance to low-income

individuals with serious disabilities), he or she is coded as residing in a MMC county if the county operates any form of voluntary or mandatory MMC (e.g., capitated HMOs or primary care case management) for physical health care for its SSI population.<sup>21</sup> Similarly, for an individual on Medicaid through other routes, he or she is coded as residing in a MMC county if the county operates MMC for its Temporary Assistance for Needy Families (TANF) or poverty-related populations. It is important to note that individuals residing in a MMC county may not themselves be enrolled in MMC. Consequently, the comparisons reported here should not be interpreted as comparing MMC enrollees to FFS Medicaid enrollees, rather the comparison focuses on the environment in place in counties with MMC programs and FFS Medicaid programs.

For the population as a whole, it is well known that rural residents fare worse than their urban counterparts in securing access to care. Regardless of income, for example, the number of poor rural residents getting care, especially primary care, is notably lower than for the population as a whole and well below national targets. For Medicaid beneficiaries, however, we found rural-urban differences turn out to be much smaller than they are for either low-income privately insured individuals or those who are uninsured (Table IV.2). Further, when individual characteristics and the local supply of providers are held constant through regression models, the rural-urban differences among Medicaid beneficiaries totally disappear, unlike the case for those with private insurance and the uninsured.<sup>22</sup>

The national-level analysis reported on here also suggests that Medicaid managed care may hold promise for rural beneficiaries. When comparing rural beneficiaries living in counties

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<sup>21</sup> Managed care programs that are limited to mental health care services, dental care, family planning, long-term care, or other special services are not included in our measure of MMC.

<sup>22</sup> For additional information on the regression models estimated as part of this analysis, see the report Long, King and Coughlin (2004) "The Health Care Experiences of Rural Medicaid Beneficiaries."

under fee-for-service Medicaid with their counterparts under managed care, we found that beneficiaries under managed care were significantly more likely to have a usual source of care and to have had a doctor visit in the past year (see Table IV.3).<sup>23</sup>

### **Managed Care Impacts on Medicaid SSI Beneficiaries**

Increasingly states are shifting disabled Medicaid beneficiaries from fee-for-service Medicaid to Medicaid managed care. Our findings on the impacts of Medicaid managed care on SSI beneficiaries are based on multivariate regression models estimated using five years of the National Health Interview Survey (1997-2001).<sup>24</sup> This is an annual cross-sectional survey that provides detailed health and related data on individuals. Managed care status was determined by county of residence (as described in the previous section), which allows differentiation by type of managed care. We focus on capitated managed care programs and other forms of managed care versus fee-for-service Medicaid.

*Urban SSI Beneficiaries.* Regardless of type of managed care, this analysis shows that urban SSI beneficiaries under Medicaid managed care were significantly less likely than those under fee-for-service to report any contact with health care providers in the past year, and also less likely to report having had an office visit in the past year, after controlling for individual and family characteristics, county and state characteristics, and year of the survey (Table IV.4). Further, beneficiaries in counties with mandatory Medicaid HMO coverage were significantly less likely to have had a specialist in the past 12 months than beneficiaries under weaker forms of managed care or under fee-for-service. We find no effects of managed care on other

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<sup>23</sup> Unlike the estimates of the impacts of Medicaid managed care in Minnesota (above) and the estimates of the impacts on SSI beneficiaries (below), these comparisons should not be considered estimates of the impacts of Medicaid managed care since this analysis does not attempt to adjust for other factors (beyond Medicaid managed care) that could be driving the differences between the two groups of beneficiaries.

<sup>24</sup> For additional information on the regression models estimated as part of this analysis, see Coughlin and Long (2004) "Estimating the Impacts of Medicaid Managed Care on Medicaid SSI Beneficiaries: A National Study."

outcomes, including emergency room use: Urban SSI beneficiaries under all types of Medicaid coverage continued to report high levels of emergency room use. Nearly half reported at least one ER visit in the past year, and more than a quarter reported more than one visit. This evidence suggests that decision-makers and consumers need to be cautious in extending managed care to this population, at least in urban areas.

*Rural SSI Beneficiaries.* SSI beneficiaries living in rural areas appear to fare better under managed care than their urban counterparts (Table IV.5). Rural SSI beneficiaries under managed care were more likely to report contact with physician extenders such as nurse practitioners in the past year. While we observed no significant effects of mandatory HMO programs for this population, we find that under other types of Medicaid managed care rural beneficiaries were more likely to have a visit to a general physician and a visit to a physician extender in the past year.

### **Commercial Plan Choices in a Changing Medicaid Market**

If states are to keep commercial plans in the Medicaid managed care market, it is important for them to understand the factors that influence such plans' decisions to continue in or exit that market. This is of interest because the share of commercial plans participating in Medicaid has been declining since the mid-1990s (Felt-Lisk 1999). The findings discussed below are based on two years of InterStudy data on county Medicaid enrollment levels. Data for 2000 allow us to identify plans participating in a given county on January 1, 2000. Data for 2001 allow us to identify plans that were no longer participating in that county a year later.

*Potentially Important Factors.* Figure IV.1 illustrates the factors that can be expected to influence commercial plan decisions to participate in Medicaid managed care. The underlying assumption is that a plan will continue to participate so long as the financial returns from

participation allow the plan to meet its goals—which may be profit maximization, enrollment maximization, market share growth, market diversification, or some other objective. Whatever the objective, it obviously needs to be pursued within the constraint of at least breaking even, or the plan will fail financially.

Plan characteristics (top left-hand box) include structure, size, ownership, and market position. Plans that are more closely tied to the local health care market and plans that have an organizational mission to serve vulnerable populations, for example, can be expected to be more likely to continue participating in Medicaid, other things equal. Also relevant is the extent to which a plan has invested in the Medicaid market and its share of Medicaid enrollment. Higher investment and a greater share of Medicaid’s enrollment should make it less likely that a plan will leave Medicaid. Medicaid policies are also likely to be important (middle left-hand box). Higher capitation rates, for example, will make Medicaid participation more profitable. Local market characteristics (bottom left-hand box) that can be expected to influence plan decisions include the relative price of Medicaid managed care compared with the returns to alternative insurance arrangements—such as Medicare or private insurance. Also important are the degree of competition in the local managed care market and in the local provider market. More competition makes the market less attractive for a given plan.

*Findings.* Multivariate regression analysis allows estimation of the effect of a particular factor on the probability of exiting from Medicaid managed care, controlling for the impact of other factors (Table IV.6).<sup>25</sup> Plan characteristics, as expected, are significant predictors of plan decisions, other things equal. Plans with a large share of the local Medicaid managed care

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<sup>25</sup> Since the dependent variable in the model is a 0/1 variable, where an exit=1, we estimate a logit model. For additional information on the regression models estimated as part of this analysis, see Long and Yemane (2004) “Commercial Plans in Medicaid Managed Care: Understanding Who Stays and Who Leaves in a Changing Market.”

market, for example, and plans serving Medicaid enrollees in a greater share of the state are less likely to quit the Medicaid market. Provider-sponsored plans and non-profit plans are also less likely to leave the Medicaid market.

Medicaid policies also have a major influence on plan decisions, according to a majority of the indicators measured. Higher capitation rates reduce the likelihood that a plan will exit Medicaid, for example. And different carve-outs have different effects (with mental health carve-outs reducing the probability of exit and pharmacy carve-outs increasing it).

Local market characteristics have fewer effects on plan decisions. Exits are more likely in less populated counties. However, plan exits are less likely in counties where private capitation rates are high relative to Medicaid rates—a finding suggesting that higher rates in the private market may actually be subsidizing the costs of care in the Medicaid market, thus helping plans to continue in Medicaid managed care.

## **Lessons Learned**

As states consider moving their Medicaid programs towards managed care, several of the findings reported here can help them maximize the potential that their managed care approach will improve beneficiary access to care and to mainstream health plans.

*Beneficiary Impacts.* The Minnesota experience reported here applies to Medicaid managed care for TANF and TANF-related adults and children living in rural areas. Findings suggest that for this population, managed care may not have much effect on improving access to care or care delivery patterns compared with the situation under Medicaid fee-for-service. Medicaid officials in that state believe, however, that the managed care system did increase the cost-effectiveness of the care delivered to its rural beneficiaries.

Our national examination of access to care for SSI beneficiaries suggests that Medicaid managed care improves care for rural Medicaid beneficiaries with disabilities. This finding does not carry over to urban areas, however, suggesting that states should be cautious about extending managed care coverage to disabled Medicaid beneficiaries in urban areas. Access to care for this population is typically problematic under fee-for-service. And characteristics of the urban SSI population and/or the health care system in low-income metropolitan areas may make it harder for managed care to make improvements than in the more sparsely population rural areas. More research is needed to understand what role differences in beneficiary characteristics, managed care models, and local health care markets may play in the differences in the impacts of Medicaid managed care in urban and rural areas for SSI beneficiaries.

Overall, the findings from the studies summarized in this chapter suggest that the impacts of Medicaid managed care are not homogenous, rather the effects vary by Medicaid subgroup, geographic area and type of managed care. Medicaid policymakers should be mindful of these differences when developing managed care program policies. More research is needed to better understand the implications—including health outcomes—of Medicaid managed care and the factors behind the differences reported here.

*Impacts on Health Plan Participation Decisions.* Our analysis of factors influencing health plan decisions about whether or not to participate in the Medicaid program suggests that many of these factors are within the control of state policymakers and program administrators. Most importantly, states need to establish sound capitation rates that reflect the true costs of serving the Medicaid population enrolled in managed care, as well as to ensure that service carve-outs and similar policies are not interfering with the ability of plans to manage care in a cost-effective way. In addition, states should work to ensure that plans are able to enroll an

adequate number of Medicaid enrollees to operate effectively. This could be achieved by limiting the number of plans that are awarded contracts within a county and/or by contracting for care for groups of counties within the state.

Table IV.1: Estimates of the Impacts of Medicaid Managed Care on Access to and Use of Care--Adult and Child TANF and Poverty-Related Beneficiaries, Minnesota

Outcome	Adults		Children	
	Baseline: MMC Counties in 1998 (%)	Change Under MMC	Baseline: MMC Counties in 1998 (%)	Change Under MMC
<b>Access to Care</b>				
Has a usual source of care (other than emergency room) <sup>1</sup>	99.1	-0.7	98.9	0.3
For those with a usual source of care:				
Usual provider is a doctor	60.4	-2.1	72.2	2.4
Sees same provider at all or most visits	59.0	0.0	73.1	-3.6
Travel time to doctor is more than 30 minutes	15.2	-5.9	19.9	6.0
Able to talk to provider right away when need medical advice	91.0	-6.3	92.5	-8.4
<b>Health Care Use</b>				
Had hospital stay in last year (excluding stay for delivery)	16.3	-6.0	8.3	1.9
Had ER visit in last year (excluding falls and accidents)	22.0	-6.5	24.5	-4.5
Had visit to doctor/other provider in last year	68.6	-4.7	82.8	-1.1
Had dental visit in last year	70.9	6.6	85.7	-9.0
<b>Unmet Need</b>				
Had any unmet need for health care in last year	62.3	-9.6	24.5	-0.6
Had unmet need in last year for:				
Hospital care	3.8	-1.2	2.5	-3.8
Doctor care	44.4	-10.3	11.9	1.8
Specialist care	12.0	-2.4	4.3	-2.2
Mental health care	5.6	-4.2	3.7	-1.1
Dental care	42.5	-10.0	9.9	1.2
Prescription drugs	6.2	4.1	2.9	-1.5
<b>Rating of Care</b>				
For those who used health care services over the past year, the share rating as good, very good, or excellent (versus fair or poor):				
Amount of time spent with doctors	82.9	8.7	92.8	0.3
Explanation of medical procedures/tests	89.0	1.6	95.3	1.6
Ease of getting evening/weekend care	61.8	-4.4	63.8	1.8
Ease of getting emergency care	84.9	3.7	86.7	5.1
Ease of getting prescription drugs	90.8	-6.4	96.2	-7.6 **
Sample size	208	904	273	1358

Source: 1998 and 2000 Surveys of Medicaid Beneficiaries in Minnesota. The table is drawn from Long, Coughlin, and King. 2004. "Capitated Medicaid Managed Care in a Rural Area: The Impact of Minnesota's PMAP Program," The Journal of Rural Health.

<sup>1</sup>Because all children with an impairment or health problem that limits their daily activities or their ability to attend school have a usual source of care, the estimates for this variable are based on a regression model that excludes those

\* (\*\*) Significantly different from zero at the .05 (.01) level, two-tailed test.

**Table IV.2: Simple and Regression-Adjusted Differences in Access to Care in Rural and Urban Areas Among Low-Income Adults--by Insurance Status, United States**

	Private Insurance			Uninsured			Medicaid		
	Non-MSA	MSA	Difference	Non-MSA	MSA	Difference	Non-MSA	MSA	Difference
<b>Simple Differences</b>									
Usual source of care	88.5%	84.6%	3.9***	64.0%	51.6%	12.4***	84.6%	84.1%	0.5
Doctor visit	67.1%	71.7%	-4.6***	39.9%	38.3%	1.6	78.5%	76.6%	1.9
Pap smear	58.2%	62.1%	-3.9*	36.6%	43.4%	-6.8***	57.4%	62.3%	-4.9*
Dental visit	62.6%	66.8%	-4.2***	35.4%	35.6%	-0.2	45.1%	54.0%	-8.9***
ER visit	24.3%	23.9%	0.4	27.1%	21.3%	5.8***	44.2%	44.0%	0.2
Hospital stay	3.1%	3.0%	0.1	2.2%	2.0%	0.2	8.3%	7.5%	0.8
Unmet need for medical care	6.4%	5.9%	0.5	14.9%	13.3%	1.6	10.8%	9.0%	1.8
<b>Differences Controlling for Individual Characteristics</b>									
Usual source of care	88.1%	86.2%	1.9	64.6%	55.0%	9.6***	86.0%	85.1%	1.0
Doctor visit	67.1%	74.3%	-7.2***	40.4%	41.4%	-1.0	77.5%	77.9%	-0.3
Pap smear	59.2%	63.0%	-3.7*	39.8%	43.0%	-3.2	60.2%	62.7%	-2.5
Dental visit	62.9%	68.7%	-5.7***	36.4%	37.4%	-1.0	49.9%	54.5%	-4.6*
ER visit	25.0%	24.4%	0.6	24.7%	22.8%	1.9	42.8%	44.3%	-1.5
Hospital stay	3.5%	3.7%	-0.2	2.3%	2.3%	-0.1	8.7%	8.3%	0.4
Unmet need for medical care	6.7%	6.6%	0.1	13.4%	16.4%	-3.1***	10.0%	10.2%	-0.2
<b>Differences Controlling for Individual Characteristics and the Local Supply of Providers</b>									
Usual source of care	88.3%	86.2%	2.1	63.0%	56.0%	7.0***	86.8%	84.9%	1.8
Doctor visit	68.9%	73.4%	-4.5**	40.0%	41.4%	-1.4	79.1%	77.5%	1.6
Pap smear	60.2%	62.7%	-2.6	39.2%	43.0%	-3.8	61.1%	63.1%	-2.0
Dental visit	64.3%	68.4%	-4.0**	37.6%	37.1%	0.5	53.2%	55.0%	-1.8
ER visit	25.0%	24.3%	0.7	26.4%	22.4%	3.9*	42.4%	44.4%	-2.0
Hospital stay	3.3%	3.8%	-0.5	2.6%	2.2%	0.4	7.5%	8.3%	-0.8
Unmet need for medical care	6.4%	6.7%	-0.3	13.7%	16.6%	-2.9**	10.2%	9.7%	0.5
Sample size	5,473	14,303		3,647	9,836		2,130	7,018	

Source: 1997, 1999, 2002 National Survey of America's Families.

\* (\*\*) (\*\*\*) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

<b>Table IV.3: Access to Care in Rural Areas for Adult Medicaid Enrollees-- Managed Care versus Fee-for-Service</b>			
<b>Outcome Measure</b>	<b>Living in County with Medicaid Managed Care</b>	<b>Living in County with FFS Medicaid</b>	<b>Difference</b>
Usual source of care	89.6%	80.2%	9.4 ***
Doctor visit	81.9%	73.8%	8.0 **
Pap smear	57.9%	58.8%	-0.9
Dental visit	47.6%	45.1%	2.5
ER visit	41.5%	47.3%	-5.8
Hospital stay	9.3%	6.5%	2.8
Unmet need for medical care	10.1%	10.3%	-0.2
Sample size	1,235	895	

Note: Regression estimates, adjusted to control for individual characteristics and local provider supply.

Source: 1997, 1999, 2002 National Survey of America's Families.

\* (\*\*) (\*\*\*) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Table IV.4: Estimates of the Effect of Medicaid Managed Care--Adult SSI Beneficiaries in Urban Areas, United States					
Outcome	Assuming All Under FFS (%)	Model 1	Model 2		Sample Size
		Change Under MMC	Change Under Mandatory HMO	Change Under Other MMC	
Has usual source of care other than the ER	91.2	0.5	2.8	-0.1	1606
Over the last 12 months					
Any contact with any health care provider	96.4	-3.6 **	-4.7 **	-3.4 **	1589
Any office visit to any provider	94.1	-5.2 ***	-6.5 ***	-4.9 **	1565
Over the last 12 months, contact with					
Physician	48.4	5.6	5.5	5.6	1573
Specialist	42.3	-3.8	-8.8 *	-2.7	1595
Nurse practitioner, physician's assistant or midwife	10.4	3.4	2.2	3.7	1595
Hospital stay in last 12 months	20.5	2.8	-0.5	3.5	1615
ER visit in last 12 months	46.2	-4.7	-1.4	-5.4	1620
More than 1 ER visit in last 12 months	26.6	-2.9	3.5	-4.3	1620
Flu shot in last 12 months	34.5	-6.1	-10.3	-5.2	1583

Source: 1997-2001 National Health Interview Survey

\* (\*\*) (\*\*\*) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Table IV.5: Estimates of the Effect of Medicaid Managed Care--Adult SSI Beneficiaries in Rural Areas, United States					
Outcome	Assuming All Under FFS (%)	Model 1	Model 2		Sample Size
		Change Under MMC	Change Under Mandatory HMO	Change Under Other MMC	
Has usual source of care other than the ER	90.8	-0.3	1.0	-0.7	513
Over the last 12 months					
Any contact with any health care provider	93.5	1.6	3.8	0.7	511
Any office visit to any provider	91.4	1.3	-0.1	1.8	508
Over the last 12 months, contact with					
Physician	39.0	7.1	-2.9	11.3 *	513
Specialist	34.2	0.3	6.3	-2.4	517
Nurse practitioner, physician's assistant or midwife	10.0	9.3 **	9.7	9.1 **	513
Hospital stay in last 12 months	25.1	3.0	2.3	3.3	517
ER visit in last 12 months	49.9	-7.8	-7.7	-7.9	519
More than 1 ER visit in last 12 months	24.1	3.4	6.8	1.8	519
Flu shot in last 12 months	28.3	-4.2	3.9	-7.9	511

Source: 1997-2001 National Health Interview Survey

\* (\*\*) (\*\*\*) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Table IV.6: Factors Associated with Commercial Plan Exits from Medicaid Managed Care, United States

Variable	Odds Ratios	Change in the Predicted Probability of Exit <sup>1</sup>			
		With a Change in Value from 0 to 1	With an Increase of 1/2 Standard Deviation (STD)	Mean	STD/2
<b>Medicaid payment and other policies</b>					
Medicaid capitation rate	0.985 **	--	-3.1	146.99	31.20
Growth in Medicaid capitation rates (standardized)	0.550 ***	--	-2.4	1.00	0.51
State carves out mental health services	0.508 ***	-9.9	--	--	--
State carves out pharmacy services	2.324 ***	12.8	--	--	--
Poverty-related population required to enroll in HMO in county	1.322	--	--	--	--
SSI population required to enroll in HMO in county	1.827 **	9.5	--	--	--
<b>Plan characteristics</b>					
Age of plan	0.990	--	--	--	--
Plan's total number of enrollees in county (thousands)	0.995	--	--	--	--
Plan uses closed managed care model	0.515 **	-8.5	--	--	--
Plan is affiliated with BCBS	1.345	--	--	--	--
Plan is independent firm	1.349	--	--	--	--
Plan is provider sponsored	0.291 ***	--	--	--	--
Plan is for profit	1.657 **	7.0	--	--	--
Plans share of county MMC market	0.089 ***	--	-3.3	0.17	0.20
Share of counties in state in which plan has MMC enrollment	0.134 ***	--	-4.6	0.58	0.35
<b>Market characteristics</b>					
Private capitation rate/Medicaid capitation rate	0.551 **	--	-3.3	4.20	0.82
M+C capitation rate/Medicaid capitation rate	0.977	--	--	--	--
Median operating profit margin in area (standardized)	0.882 ***	--	-2.5	-0.88	2.31
Competitiveness of HMO market in county (HHI)	0.596	--	--	--	--
Competitiveness of hospital market in county (HHI)	1.194	--	--	--	--
Total number of physicians per 10,000 population in county	1.008	--	--	--	--
County population in lowest quartile	1.702 **	8.3	--	--	--
County population in higher quartile	0.821	--	--	--	--
County is urban	2.306 ***	11.3	--	--	--
Sample size	1155				
Chi-square (df=24)	188.120				

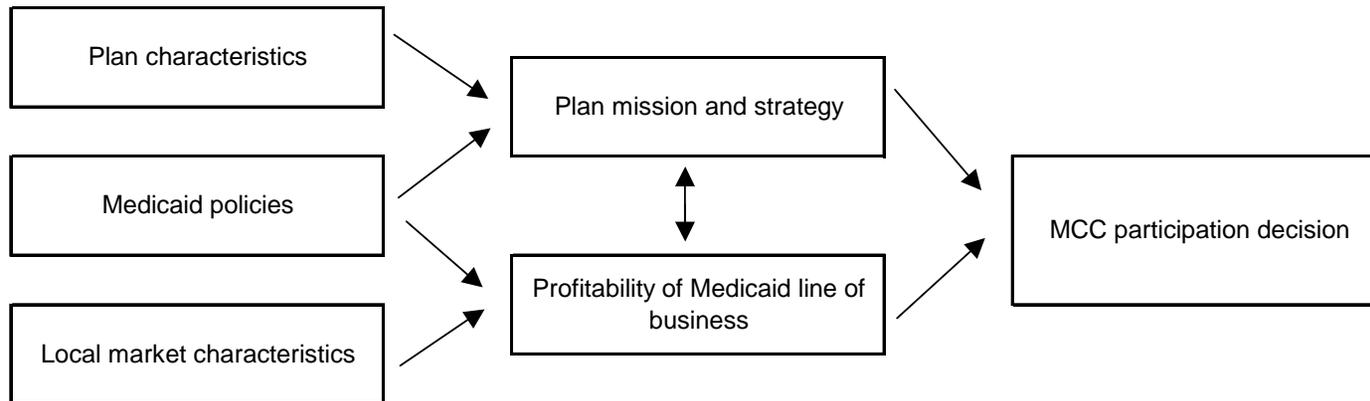
Source: Urban Institute tabulations using InterStudy and other data.

\* (\*\*) (\*\*\*) Significantly different from zero at the .10 (.05) (.01) level, two-tailed test.

Note: Logit model correctly predicts exit status for 81 percent of all observations. Looking at the accuracy of predictions by exit type, 95 percent of plans that actually remained in Medicaid were accurately predicted as not exiting Medicaid and 35 percent of plans that actually exited were accurately predicted as exiting Medicaid. The lower rate of accurate predictions for exiting plans is an expected result of logistic regressions when they are trying to predict an event that occurs less frequently.

<sup>1</sup>We estimate changes in the predicted probability of exit for variables that have a significant effect on the probability of exit.

**Figure IV.1: Factors Influencing the Medicaid Managed Care Participation Decision by Commercial Plans**



Source: Modified from Lake, T. and R. Brown. 2001. Medicare+Choice Withdrawals: Understanding Key Factors. Menlo Park, CA: The Henry J. Kaiser Family Foundation.

## CHAPTER V

### **RECONFIGURING THE SAFETY NET: THE EXPERIENCE OF LOS ANGELES COUNTY**

Los Angeles County, with 9.8 million people and covering over 4000 square miles, has the largest county population in the nation and covers more than 13 times the area covered by the five counties that make up New York City. Over one-fifth of the county's population lives below the poverty line, one-third of its non-elderly population lacks health insurance, and another fifth is covered by California's Medicaid program (Medi-Cal). The county's state-mandated burden of serving as the health care provider of last resort, therefore, is massive (Long et al. 1999; Zuckerman and Lutzky 2001).

By 1995—shortly before the county's 1115 waiver application was submitted and approved—years of shrinking revenue streams, health service demand increases, and the cost of maintaining the county's deteriorating health system infrastructure had culminated in a funding crisis for the Los Angeles County Department of Health Services (LACDHS). This crisis was so severe that the deficit for the department had grown to over 28 percent of its operating budget, accounting for about half of the total county deficit. The budget-cutting proposals that were the inevitable result of this state of affairs varied in detail, but all involved closing parts of the county's extensive network of hospitals and clinics—which provided a large share of the health care for the county's uninsured and Medicaid population.

The county was awarded a five-year financial relief package of about \$1.2 billion in federal Medicaid funding, in return for which it agreed to fundamentally restructure the LACDHS and the delivery of health care to the indigent. This chapter reviews LAC experiences

under its 1995-2000 1115 waiver, based on two case-study site visits—one in 1997, the second in 2001.<sup>26</sup>

## **Waiver Outcomes**

The waiver provisions focused on four major objectives: (1) to improve access to county-funded ambulatory care, (2) to make hospital care more efficient, in part by reducing beds in county hospitals, (3) to foster cultural change, and (4) to bring financial stability to the LACDHS. Progress has been made on the first three fronts, but these restructuring efforts had not achieved the fourth objective by the end of the first waiver period in 2000. (Because of continuing financial instability, the waiver was renewed for an additional five years).

### Restructuring Ambulatory Care

One of the primary goals of the waiver was to rebuild and expand the county's indigent ambulatory care system. The three major components of this effort were (a) a public-private partnership program (PPP), which the planners hoped would lead to a 50 percent expansion in the number of ambulatory care visits through extending county-funded indigent care provision to private facilities, (b) better integration of the system of care, and (c) cultural change.

*The PPP Program.* These partnerships were universally considered one of the big successes of the waiver program. Over the waiver period LACDHS contracted with more than 81 private partners to deliver primary care at over 100 sites. The initial act in the PPP program was to offer private providers the opportunity to take over six public clinics slated for closure in

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<sup>26</sup> This chapter draws on two project reports and one project publication. The project reports are: Long, et al. (1999) "A Case Study of the Medicaid Demonstration Project for Los Angeles County;" and Zuckerman and Lutzky (2001) "The Medicaid Demonstration Project in Los Angeles County, 1995-2000: Progress, but Room for Improvement." The project publication is: Long and Zuckerman (1998) "Urban Health Care in Transition: Challenges Facing Los Angeles County." *Health Care Financing Review*.

1995. Three took up the offer, taking responsibility for two public clinics each. To fully appreciate the importance of the change brought about by the PPP, one needs to remember that there was little or no coordination between the public and private providers before the waiver. Beyond increasing ambulatory care access, the program seems to have improved communication across both public and private safety net providers—giving, among other benefits, more flexibility to the LACDHS to contract, expand, or shift the distribution of providers depending on perceived need.

These successes have led to only modest expansion in the number of ambulatory care visits, however—in the neighborhood of 8-10 percent as of 2000, rather than the 50 percent planned. Constraints included problems with reimbursement levels and the method of establishing total payment (which may result in clinics providing greater access to visits being penalized), and inadequate monitoring, in the early waiver years at least, of provider performance.

*Integrating the System of Care.* Key to this effort was the transformation of the county's fragmented and hospital-based system of care into a linked system of community-based primary, specialty, and preventive care. Initiatives included relocating some hospital-based outpatient specialty care into the county's clinics and providing both primary and public health services in the same clinics.

Creation of a system of referral centers is cited as the major contribution of the integration effort. Prior to the waiver, all access to specialty care for the county's indigent came through the emergency room, regardless of whether the referring primary care physician was at a public health center or private clinic. To reduce emergency room use, LACDHS created referral centers at each of its five acute care hospitals, as a gateway for primary care providers to access

specialty and inpatient services in the network. The primary care provider submits a request to a referral center, which, if it approves the request, schedules an appointment date and sends a notification card to the patient. These referral centers are viewed as a significant step toward improving specialty care, and the flow of patients and information between primary and specialty care providers.

### Increasing the Efficiency of Hospital-Based Care

Increased efficiency of hospital-based care was to be achieved by (a) reducing inpatients beds and admissions, and (b) hospital “reengineering”.

*Reducing Hospital Use.* Waiver plans envisioned reducing the number of hospital beds over the waiver period by nearly 40 percent. This was to be achieved by downsizing the county’s major medical center and privatizing two of its other hospitals. Privatization did not materialize, however, due to a lack of interest among potential buyers and strong resistance by unions and some LAC Board of Supervisor members. Downsizing of the major medical center was achieved, however, with budgeted beds reduced by 29 percent, inpatient days by 27 percent, and average length of stay from 6.4 to 6.1 days during the waiver period. These reductions were accompanied by a drop in full-time positions of about 16 percent.

*Hospital Reengineering.* This effort focused on four major areas: (a) more prudent purchasing of supplies, equipment, and pharmaceuticals, (b) standardizing, centralizing, and outsourcing services; (c) improving clinical efficiency and service use by Clinical Resource Management (CRM); and (d) redesigning health services administration. There were over 450 individual reengineering projects over the waiver period, with initial projections of cost savings of over \$250 million. These efforts produced estimated cost savings of only about \$110 million.

The greatest share of the savings (over 20 percent) came from purchasing improvements and participation in a public health service drug discount program.

Does the fact that savings were less than expected mean that reengineering was not a success? Not necessarily. After a slow start, the savings grew more in line with the original projections. But even this level of savings was unlikely to guarantee future financial viability for LACDHS, particularly given the fact that county auditors were not certain that all the areas of savings could be maintained into the future. With respect to CRM, although savings were uncertain (given the likelihood of substantial losses in federal and state revenues because of the decline in inpatient days, discussed further below), it was generally agreed to be a significant step toward improving management and quality of care, because it moved the focus of the system to outcome-based measures and quality-of-care standards for inpatient and outpatient services alike.

### Cultural Change

Although assessments of waiver implementation varied, there was universal agreement that the county was better off as a result of the waiver because it had caused a cultural change among stakeholders in the indigent health care system. Examples given included more focus on meeting patient needs, becoming more culturally and linguistically sensitive, and redesigning processes to do more with the same or fewer resources. The waiver experience also led to recognition that other county departments may need reorganization, particularly human resources and other support departments.

## Bringing Financial Stability

The financial package that accompanied the waiver included some components that were clearly one-time solutions to the crisis. But others were included to foster longer term system change with an eye to restoring its financial stability. The one-time components included a supplemental Medi-Cal payment, an increase in the county's Medicaid DSH payments, and a Public Health Service grant. The longer term relief effort included making the county eligible to receive a federal match for indigent patient services in non-hospital settings; allowing LACDHS to claim DSH funding for private hospitals as uncompensated care expenses when computing DSH payment caps; and a supplemental project pool (SPP), funded equally from federal and local funds, that allowed the county to receive federal matching funds for care to indigent patients (whether inside or outside the hospital), once the number of clinic visits had reached a certain level.

Of the longer term relief provisions, only the indigent care match actually provided a clear incentive to move indigent care out of the hospital. The DSH provision provided the opposite incentive, with revenues slated to fall if the county was successful in moving patients out of the hospital (dubbed the "catch-22 effect" by some case study respondents). On paper, the SPP provided some incentive to move patient care out of the hospital. But because it was a lump-sum payment, and because the number of clinic visits already exceeded the threshold level to qualify for the full payment, the intended incentive was in fact nonexistent.

## **Lessons Learned**

The major lesson to be learned from the waiver experience of Los Angeles County is that substantial financial relief and a serious restructuring effort is unlikely to be enough to restore

financial viability to a Medicaid system on the brink of collapse. Waiver efforts did succeed in expanding geographic access to non-hospital indigent care; cutting the number of inpatient beds, inpatient days, and average length of stay; and implementing a hospital reengineering system that produced some savings through better purchasing of supplies, equipment, and prescription drugs. Observers also agreed that the culture of indigent care provision had improved, bringing more attention to patient care quality and communication among providers throughout the system.

But the large number of uninsured in the county has not been reduced and the obligation to meet their health care needs remains. The new waiver provides about \$1.6 billion over five years. The federal government is providing \$900 million in funding over the 2001-2005 period, scheduled to phase out over that period. The state is providing an additional \$300 million in combined state and federal matching funds through cost-based reimbursements to all county clinics and private clinics with county contracts for Medi-Cal ambulatory care. The county has committed \$400 million. Whether or not actions under the new waiver will stimulate enough additional financing and operational reforms in the LACDHS system to make it financially stable remains an open question. But if past is prologue, it is hard to be optimistic.

## CHAPTER VI

### EVALUATION OF THE VERMONT PHARMACY ASSISTANCE PROGRAMS FOR LOW-INCOME MEDICARE BENEFICIARIES<sup>27</sup>

This chapter summarizes two sets of analyses to evaluate Vermont's state pharmacy assistance programs for low-income disabled and elderly beneficiaries. Two of Vermont's three publicly subsidized drug programs for low-income elderly and disabled beneficiaries were incorporated into the state's 1115 Medicaid waiver and are, therefore, eligible for federal matching dollars. The first study was based on a longitudinal analysis of medical (Medicare) and pharmacy (Medicaid) claims data and is publicly available on the CMS Website. The second study was based primarily on information collected from a survey of enrolled and eligible or near-eligible but nonenrolled beneficiaries in Vermont conducted between March and June 2004. A more complete presentation of study findings is available in the full report.<sup>28</sup>

The two sets of analyses provided an opportunity to consider the implications of enrollment in a voluntary publicly subsidized prescription drug program for the soon-to-be implemented Part D Medicare drug benefit. The findings from these analyses only apply to low-income, aged Medicare beneficiaries who are not dually eligible for Medicaid and, therefore, are not generalizable to the entire Medicare population. However, the low-income population covered by Vermont's pharmacy assistance programs is the group most likely to lack prescription drug coverage and to have difficulty paying for medications. As such, they are a key target of the Part D program. Furthermore, a program adopted by a single state, particularly

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<sup>27</sup> This chapter was written by Boyd Gilman, Barbara Gage, Susan Haber, Sonja Hoover and Jeremy Green.

<sup>28</sup> Gilman, BH, B Gage and JB Mitchell. "Evaluation of Vermont's Pharmacy Assistance Programs for Low-Income Medicare Beneficiaries: First Round Evaluation Report," Contract No. 500-95-0040, Centers for Medicare and Medicaid Services, February 28, 2003. Gilman, B, B Gage, S Haber, S Hoover and J Greene. "Evaluation of the Vermont Pharmacy Assistance Programs for Low-Income Medicare Beneficiaries: Findings from the Enrollee and Nonenrollee Surveys," Contract No. 500-95-0040, Centers for Medicare and Medicaid Services, September 24, 2004.

a small one such as Vermont, does not have the potential of a program like Medicare Part D to exert profound influences on the health care market. Nonetheless, the experience in Vermont may provide important lessons for Medicare as it moves toward implementing the Part D benefit.

The three principal objectives of both studies were:

- to identify the primary determinants of enrollment, including an examination of the evidence of adverse selection and crowd out;
- to assess the impact of enrollment on the use and cost of drugs, as well as unmet drug needs; and
- to analyze the impact of enrollment on the use and cost of non-drug medical services.

In both studies, we compared the major outcomes between enrollees and non-enrollees. The comparison group in the claims-based analysis included all non-dually eligible Medicare beneficiaries who were not enrolled in any of the state pharmacy assistance programs. The comparison group in the survey-based analysis included nonenrolled beneficiaries with incomes below 300 percent of poverty who lacked prescription drug coverage. We also investigate the differences between enrollees in each of the three state pharmacy assistance programs. Finally, in the survey-based analysis, we examine the differential effects of drug coverage for selected chronic conditions.

### **Vermont's Pharmacy Benefit Programs**

Vermont currently offers three pharmacy benefit programs to its low-income elderly and disabled residents. The first, called *VScript* was started in 1989 as a state-funded program to offer low-income Medicare beneficiaries a subsidy on maintenance prescription drugs. The second, called *VHAP Pharmacy* was introduced seven years later under the state's 1115 Medicaid waiver. It employed both state and federal dollars to provide a more generous drug

benefit package with less enrollee cost-sharing to seniors and disabled residents with slightly lower incomes. In 1999, VScript program became absorbed into the Medicaid waiver as well and, as a result, the state-funded portion was extended to a higher income population. The expanded state-only program is referred to as *VScript Expanded*.

The eligibility and cost sharing rules have changed quite dramatically during the course of study.<sup>29</sup> During the most recent year under review, VHAP Pharmacy included beneficiaries with incomes up to 150 percent of the Federal Poverty Level (FPL), required a nominal two-tier copayment based on the cost of the prescription, and covered all drugs. Expenditures were eligible for federal matching dollars. The VScript program included beneficiaries between 150 and 175 percent of poverty, also used a nominal two-tier copayment, and covered only maintenance drugs. Expenditures under VScript were also eligible for the federal match. The third program, VScript Expanded, included beneficiaries between 175 and 225 percent of poverty, required a \$275 deductible and a 41 percent coinsurance payment, and covered only maintenance drugs. Money spent under VScript Expanded was not eligible for federal matching dollars.

## **Methodology and Data**

The initial study was based on an analysis of medical claims from Medicare and pharmacy claims from Medicaid, plus an assessment of VHAP Pharmacy and VScript enrollment data between 1993 and 2000. VScript Expanded had not yet been implemented at the time of the initial evaluation and was excluded from the analyses. Descriptive analyses were

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<sup>29</sup> In summary, Vermont expanded the income eligibility threshold for the 1115 waiver component from 100 percent to 175 percent of poverty and, subsequently, expanded the income eligibility threshold for the state-only component from 175 percent of poverty to 225 percent of poverty. At the same time, the state replaced the high coinsurance rate with a lower two-tier copayment structure for VHAP Pharmacy and VScript, but maintained the coinsurance rate for VScript Expanded. More recently, however, the state eliminated all enrollee cost sharing and introduced a sliding scale monthly premium for all three programs.

used to examine program enrollment patterns and changes in the Medicaid spend-down rate over time. Descriptive analyses were also used evaluate the use and cost of prescription medications for both enrollees and beneficiaries who were also eligible for full drug benefits under Medicaid. Descriptive and multivariate regressions analyses were also used to compare the use and cost of Medicare-covered services for enrollees and non-dually eligible nonenrolled beneficiaries.

The follow-up analysis was based primarily on a 2004 telephone survey of two groups of Medicare beneficiaries: those enrolled in the state pharmacy assistance programs; and those who met or nearly met the programs' income eligibility criteria, but who were not enrolled in either these programs. Beneficiaries who were younger than 65 years of age, diagnosed end-stage renal disease; under hospice care; and dually eligible for full Medicaid benefits were excluded from the sample. The survey responses were merged with Medicare claims data for the medical offset analysis.

## **Major Findings**

The major findings for each of the three principal research questions are summarized below.

*Findings on Enrollment.* Nearly 16 percent of the roughly 93,000 Medicare beneficiaries in Vermont received some form of outpatient drug coverage through the state pharmacy assistance programs in 2000. Of the 14,659 enrollees, 9,748 (66 percent) were in VHAP Pharmacy, 2,892 (20 percent) in VScript and 2,019 (14 percent) in VScript Expanded. An additional 17 percent of the state's Medicare beneficiaries received outpatient drug coverage through Medicaid. The longitudinal analysis of state eligibility data suggests that the Vermont pharmacy assistance programs helped lower the rate at which low-income beneficiaries spend down to full Medicaid benefits. The proportion of Medicare beneficiaries who were dually

eligible for full benefits under Medicaid fell from nearly one-quarter in 1994 to less than 20 percent in 2000. During the same period, the proportion of newly enrolled dually eligible beneficiaries who spent down to full Medicaid benefits was reduced by half, from 2.9 percent to 1.4 percent.

Evidence further suggests that Vermont's pharmacy assistance programs are enrolling the most vulnerable individuals among the population eligible for coverage. Compared to people who are eligible for, but not enrolled in the program, enrollees are more likely to be older, have less education, have lower income, and live alone. Sicker individuals are also more likely to enroll in the programs. People who report themselves as being in fair or poor health have 75 percent greater odds of enrolling than those in excellent or very good health. Having certain chronic conditions, including hypertension, heart disease, and arthritis also increases the likelihood of enrolling. This adverse selection suggests that the programs enroll people with higher than average needs for prescription drugs and, potentially, higher than average costs. Although VScript and VScript Expanded target drugs for selected chronic conditions, there are few differences in health status across programs. This is consistent with the claims-based findings that showed little difference between programs in the types of medications purchased.

Further, people for whom purchasing prescription medications poses the greatest financial burden are substantially more likely to enroll in the pharmacy assistance programs. Having to forgo basic needs such as food or heat triples the odds of enrolling, while needing assistance from family or friend to pay for medications more than doubles the odds of enrollment. Descriptive analyses show that people with higher out-of-pocket expenses prior to enrollment are more likely to enroll, but the level of out-of-pocket spending was not significant in multivariate analyses. Surprisingly, greater utilization of prescription drugs prior to enrolling

does not increase the likelihood that a person will join the programs. Given their poorer health status, lower pre-enrollment utilization may indicate greater unmet needs in the enrollee population, whereas people with high levels of prescription drug utilization may have found ways to access needed medications without this assistance.

Crowd-out does not appear to be a problem in Vermont's pharmacy assistance programs. Having prescription drug coverage dramatically reduces the likelihood of enrolling and people with coverage have 85 percent lower odds of enrolling compared to people without coverage. Only 20 percent of enrollees had any type of prescription drug coverage in the year prior to enrolling and 60 percent had never had coverage. Given the low levels of prior prescription drug coverage among enrollees, there is minimal potential for crowd-out. We estimate that the maximum potential crowd-out is only about 7 percent of enrollees. This includes all people who said they voluntarily dropped their Medigap or employment-based insurance to join the pharmacy assistance program or who said they involuntarily lost their employment-based coverage.

Enrollment in the pharmacy assistance programs is very stable and more than two-thirds have been enrolled two or more years. A variety of factors drive the decision to enroll in the pharmacy assistance programs. Nearly all (90 percent) said they wanted the future protection provided by drug coverage. Many people enroll because they have no alternative for receiving coverage. Over 80 percent said they enrolled because they did not have prescription drug coverage and close to 80 percent indicated that they could not afford other forms of coverage. For three-fifths of the enrollees, the decision to apply was precipitated by a specific medical need, either the diagnosis of new condition or a change in treatment for an existing condition.

Like other public assistance programs, lack of awareness is a barrier to enrolling people in the pharmacy assistance programs, although 43 percent of eligible nonenrollees were familiar with the program. Unlike many other public assistance programs, the pharmacy assistance programs appear to have widespread acceptance among the potentially eligible population and two-thirds said they would apply if they were eligible. Most people who would not apply either already have coverage or do not feel they need it. Burdensome application procedures and welfare stigma are not significant deterrents to applying.

*Findings on the Impact of Enrollment on Use and Costs of Prescription Drugs.*

Enrollment in one of the state pharmacy assistance plans is associated with an increase in the number of outpatient prescription drugs purchased. Following enrollment in the state's pharmacy assistance programs, enrollees were almost twice as likely to have more than 20 prescriptions filled per year compared with nonenrollees, although the finding was not statistically significant at the 10 percent level. Further, 65 percent of enrollees had more than 20 prescriptions filled within the year. While the survey did not allow us to compare the change in the total number of prescriptions filled before versus after enrollment, pre-enrollment evidence on the number of *unique* prescriptions filled nonetheless suggests that the state pharmacy assistance programs greatly improved access to outpatient prescription drugs.

In addition to higher prescription drug purchases, enrollees had lower out of pocket costs. Enrollees were 82 percent less likely than nonenrollees to have out of pocket costs of 200+ /month. This effect varies across the three pharmacy assistance programs with VHAP Pharmacy enrollees being 90 percent less likely than nonenrollees to have those high costs, VScript enrollees 85 percent less likely, and VScript Expanded only 48 percent less likely than nonenrollees. These findings are consistent with the structure of the enrollee cost sharing rules

between the three programs, with VHAP Pharmacy being the most generous program and VScript Expanded being the least generous. Restrictions on the types of drugs covered under VScript and VScript Expanded may also have led to greater out-of-pocket spending relative to VHAP Pharmacy enrollees.

Enrollees were also less likely to have unmet needs than nonenrollees. In the 12 months before the survey, enrollees were 48 percent less likely than nonenrollees to have skipped drugs or taken fewer than prescribed, although this finding was mostly attributable to VHAP Pharmacy enrollees who were 65 percent less likely than nonenrollees to answer yes to either of these questions. Similarly, enrollees were 62 percent less likely to not fill a prescription item because of cost. Again, this effect is greatest for VHAP Pharmacy enrollees who were 77 percent less likely to not fill a prescription because of cost. However, VScript enrollees were also less likely to have unmet needs, with the enrollees being 55 percent less likely to not fill a script.

The earlier analysis of pharmacy claims data for prescriptions purchased in 1999 revealed that the total cost of the Vermont pharmacy assistance programs, including both state and federal dollars, was \$13.3 million. Of that amount, 82 percent was incurred by the VHAP Pharmacy program (\$10.9 million) and 18 percent by the VScript program (\$2.4 million). An additional \$33.5 million was spent on outpatient drugs for dually eligible Medicare beneficiaries under Medicaid. Moreover, over 83 percent of the 9,598 VHAP Pharmacy enrollees submitted an outpatient drug claim, resulting in average drug payments of \$1,131 per enrollee and \$1,358 per user. A total of 79 percent of the 3,001 VScript enrollees submitted a claim, with an average payment of \$809 per enrollee and \$1,024 per user. In comparison, 89 percent of the 16,809 dual eligible beneficiaries submitted a drug claim, with an average cost of \$1,935 per dual eligible and \$2,176 per user. The claims analysis further showed that VHAP Pharmacy claimants

submitted an average of 35 claims. Claimants in VScript, which covers only longer-term prescriptions for chronic diseases, submitted an average of 18 claims. In comparison, dual eligible beneficiaries who purchased drugs submitted on average 50 claims.

The types of drugs most commonly purchased under both VHAP Pharmacy and VScript were used to treat chronic conditions such as stomach acids or ulcers, cholesterol, heart disease, diabetes and mental disorders. In contrast, Medicaid prescriptions were dominated by treatments for mental health and related disorders. Three drugs used for treating stomach acids and ulcers (Prilosec, Prevacid and Pepcid) accounted for over ten percent of total expenditures. Another seven percent of spending was for two cholesterol drugs (Lipitor and Zocor), four percent for two heart disease drugs (Norvasc and Vasotec), three percent for two mental disorder drugs (Zoloft and Prozac), and two percent for one diabetes drug (Glucophage). Total expenditure on these drugs is driven by both high numbers of users and high costs per pill. The drug with the highest number of users was Furosemide, a diuretic that is essential for treating congestive heart failure and kidney and liver disease. However, despite its high use, it ranked 48<sup>th</sup> in terms of total VHAP Pharmacy expenditures because of its low cost per pill. The similarity in drug use patterns between the programs, despite differences in coverage, was supported by findings from the survey as well. The survey showed few statistical differences in the prevalence of selected chronic conditions between the three programs.

*Findings on the Impact of Enrollment on Use and Costs of Medical Services.* The results of the survey analysis provide evidence that consistent and timely access to outpatient prescription drugs among Medicare beneficiaries may serve as a substitute for acute inpatient services. Enrollment in Vermont's state pharmacy assistance programs was associated with a 17 percent reduction in annual expenditures for inpatient services, although the offset at the overall

program level was statistically insignificant at the 10 percent level. The results further suggest that drug coverage among the elderly may be a complement to outpatient services, particularly those administered in a physician's office. Enrollment in the state pharmacy assistance programs was associated with a 19 percent increase in annual expenditures for professional services and this result was significant at the ten percent level. While access to prescription medications may help prevent avoidable hospitalizations, they may also require regular monitoring of drug treatment regimes and carry potential side effects that require the services of a physician or other professional health care provider.

The complementarity effects appear strongest among beneficiaries who suffer from particular chronic conditions. Enrollment in VScript and VScript Expanded, programs whose benefits are limited to maintenance medications for chronic conditions, was associated with a statistically significant 35 percent increase in annual expenditures for professional services. Enrollees in VScript Expanded also exhibited a statistically significant 25 percent increase in facility costs for services administered in an outpatient setting. These results suggest that, despite the higher cost sharing required under VScript and, in particular, VScript Expanded, complementarities between drugs and outpatient services may be more likely among beneficiaries who suffer from chronic conditions requiring consistent and timely use of outpatient medications. In contrast, the offsets observed on the inpatient side were higher among VHAP Pharmacy enrollees, but the results were not statistically significant.

The enhanced effects of drug coverage on medical service use and costs among beneficiaries with chronic conditions are further evidenced when the models were estimated over subgroups with specific diseases. Enrollment in a state pharmacy assistance program was correlated with lower inpatient spending for people with two of the three conditions we

examined in survey study: hypertension and arthritis. However, none of the inpatient offsets for the disease-specific analyses was statistically significant. In contrast, annual expenditures for professional services increased 19 percent for enrollees with hypertension and 24 percent for those with a heart condition. Both of these complementarities with services covered under Part B were statistically significant at the ten percent level or higher. However, it should be reiterated that earlier analyses using pharmacy claims data indicated a remarkable similarity in both the types and amounts of drugs purchased by VHAP Pharmacy and VScript and enrollees. The eight most commonly purchased drugs in terms of both number of prescriptions and expenditures were the same for VHAP Pharmacy and VScript. As noted above, these included drugs for such common chronic conditions as stomach acids or ulcers, cholesterol, heart disease, diabetes, and mental disorders.

Given the opposing relationship between drug coverage and the use and cost of outpatient versus inpatient services, the net effect of drug coverage on total medical spending is difficult to ascertain and depends on the magnitude of the individual service-level effects. The only total effect from the survey analysis that was statistically significant was for beneficiaries who reported having heart disease. For people with heart disease, drug coverage was associated with higher medical spending for inpatient, outpatient and professional services. The net effect was a statistically significant \$1,266 increase in annual medical expenditures.

In contrast, the first-round longitudinal claims-based analysis using a non-dually eligible nonenrolled beneficiary control group found no significant association between drug coverage and use of non-drug medical services. The lack of a statistical difference was due in part to the inability to control fully for selection and the drug coverage status of the nonenrollee group. The results from the longitudinal analysis, however, suggested that beneficiaries are most likely to

enroll in a voluntary prescription drug program without late enrollment penalties following an acute illness. Average Medicare spending for inpatient, outpatient and physician services increased by nearly \$1,000 during the initial year of enrollment in VHAP Pharmacy or VScript compared to the spending trend amount non-enrolled beneficiaries. Inpatient expenditures increased by \$850, outpatient expenditures by \$72, and physician payments by \$62 for VHAP Pharmacy enrollees and by comparable amounts for VScript enrollees during their first year of enrollment. These findings were statistically significant at the one percent level. However, following the initial spike in expenditures, average spending amounts among program participants returned to pre-enrollment levels during the subsequent VHAP Pharmacy and VScript enrollment years. This pattern held true for both programs and for all types of services. The relative changes in spending during subsequent years of participation were largely not statistically significantly different from zero, suggesting a regression to the mean.

## **Lessons Learned**

Our analyses of Vermont's pharmacy assistance program provides important insights regarding who is most likely to enroll in the Medicare Part D program and the program's potential for serving people with the greatest needs.

*Implications for Enrollment.* The Vermont pharmacy assistance program serves those individuals within the eligible population that have the greatest need and that can most benefit from publicly-provided prescription drug coverage. The enrolled population is in poor health and likely expensive to serve. Although it is a voluntary program, it is not clear whether the Part D program will be subject to the same adverse selection. Because Congress was cognizant of the potential adverse selection in Part D, the Medicare Modernization Act requires a penalty for late

enrollment in Part D to discourage individuals from delaying enrollment until they become ill and have high prescription drug needs.

Like other public assistance programs, lack of awareness is a barrier to enrolling people in the pharmacy assistance program. Unlike many other public assistance programs, Vermont's pharmacy assistance program appears to have widespread acceptance among the potentially eligible population and two-thirds said they would apply if they were eligible. While plan complexity and benefit design under Part D may make it more challenging to enroll potentially eligible, low-income beneficiaries, Vermont's experience provides encouraging evidence that low-income people who can benefit most from Part D will be successfully enrolled.

*Implications for Use and Costs of Drugs and Non-Drug Medical Services.* The analyses show that the provision of a publicly subsidized outpatient prescription drug benefit among the low-income elderly has a profound and beneficial effect on access to prescription medications. Subsidies provided under Part D for non-dually eligible low-income beneficiaries will be important for maintaining access among this vulnerable population.

The study further shows that the Part D drug benefit may help lower Medicare spending under Part A. At the same time, the Medicare drug benefit may lead to higher spending under Part B. The medical spending effects (both Part A offsets and Part B complements) of a Medicare drug benefit are likely to be most pronounced among selected populations, particularly those suffering from chronic conditions requiring the regular use of effective maintenance medications. Substantial savings may, in fact, be realized among beneficiaries with certain chronic conditions where outpatient prescription medication is particularly effective for avoiding illness and preventing unnecessary medical service use. It may, thus, be useful to consider

condition- and drug-specific factors when Part D and Medicare Advantage plans develop their drug formularies and cost sharing rules.

## CHAPTER VII

### LESSONS LEARNED AND DIRECTIONS FOR FUTURE RESEARCH

The Evaluation of Medicaid Health Reform Demonstrations project produced a wide range of analyses based on case studies of specific sites, state-specific beneficiary surveys, Medicare and Medicaid claims data, national probability sample survey data, and data from managed care plans. Findings, and therefore lessons learned, fall into five major categories:

- Implementation and operations under managed care
- Impacts on beneficiaries
- Impacts on health plan decisions about Medicaid participation
- Potential for reconfiguring the safety net
- Prescription drug use and costs under a Medicaid drug program for low-income seniors

This chapter's review of lessons learned from project findings is divided into sections that correspond to these major issues. The chapter concludes with suggested directions for future research. We begin with a brief review of the potential for Medicaid managed care to improve health care delivery.

#### **Potential for Managed Care to Improve Medicaid Services**

For adults and children on Medicaid via TANF or poverty-related expansions in Minnesota, our findings indicate that fee-for-service Medicaid is generally doing an adequate job in many areas in providing health care to beneficiaries. The major areas where an effective managed care system might achieve cost-effective improvements appear to be: reducing emergency room use for non-immediate needs, particularly for adults; following up to ensure

preventive care appointments are made and kept; reducing travel times to care and wait times in the office before being seen; and reducing unmet need for doctor and dental care.

The situation is more complex for disabled beneficiaries. This is a highly vulnerable and costly population about which relatively little is known, particularly in a managed care context. Project data indicate a wide diversity in the types of health conditions among this population, both adults and children--from physical afflictions such as muscular dystrophy, cerebral palsy, and HIV/AIDS to mental retardation and such mental health conditions as schizophrenia and paranoia. Our findings indicate that there are many opportunities for improvements in access to care under fee-for-service Medicaid for this population, and that managed care can potentially help, if based on a sound understanding of the issues to be confronted.

### **Implementation and Operations under Medicaid Managed Care**

All our project states (Minnesota, New York, Kentucky, and Vermont) made efforts to introduce Medicaid capitation, with three of the four states concentrating their efforts primarily in rural areas of the state. Their implementation experiences can be encapsulated in five key lessons for states considering Medicaid capitation.

*Ensure that the area has a sufficient number of covered lives.* A key question is whether there are enough beneficiaries to support a capitated managed care program, especially in rural areas. New York's strategy (partially successful) was to set minimum population standards for counties to shift to managed care. Minnesota's successful experience "bundled" Medicaid beneficiaries with other insurance groups. Kentucky's strategy (ultimately unsuccessful except in one geographic area) was to divide the state into regions that combined several counties and to

allow only one plan to serve each region. Vermont's approach (finally abandoned) was to solicit plans whose catchment areas were statewide.

*Be prepared to allow some flexibility for provider networks.* In an effort to have a sufficient numbers of providers (especially mental health providers) in rural areas and to meet state access requirements, Minnesota allowed some relaxation of provider credentialing. For similar reasons, Vermont relaxed standards for beneficiary travel time to providers. While Vermont's experience was too limited to determine whether the longer travel times was an effective strategy, there was a mixed assessment among Minnesota site visit respondents about the success of letting less credentialed providers serve Medicaid beneficiaries: On the one hand, plans were able to bring in new providers to their networks, especially specialists, that rural residents did not have ready access to. At the same time, though, plans were concerned about potential quality of care issues.

*Be realistic in assessing potential cost-savings.* If the primary motivation is cost savings, success will depend in large part on whether there are obvious places where resources can be cut without compromising quality of care. To determine this, states will need to assess a number of issues. Is there heavy reliance on emergency room or hospital care? Is the area large enough to support plan and provider competition to drive down costs? Or is there, in contrast, pent-up demand for care that could lead to initial cost increases? In the case of Vermont, for example, the fee-for-service system in place when the waiver demonstration was implemented was already comparatively cost-effective.

*Set feasible capitation rates.* Developing sound capitation rates is another important factor in making a successful managed care program. States need to consider and be prepared for all the various costs (including direct medical costs as well as administrative and reporting

costs) that plans incur in serving Medicaid beneficiaries. Without sound rates, states run the risk of having trouble getting plans to participate in the Medicaid managed care as in the case the Vermont.

*Allow for local differences and local input.* In some areas, health care providers are core community participants. States need to be prepared to consider trading off some of the gains of capitation against the loss of key providers. They also need to be prepared to make operational and programmatic changes to accommodate the range of local areas and their governments that participate in the managed care initiative.

### **Impacts of Managed Care on Medicaid Beneficiaries**

As states consider moving their Medicaid programs towards managed care, several project findings can help them maximize the potential that their managed care approach will improve beneficiary access to care.

For TANF and poverty-related Medicaid beneficiaries, findings from our formal impact evaluation for rural Minnesota suggest that managed care may not have much effect on improving access to care or care delivery patterns compared with the situation under Medicaid fee-for-service. Medicaid officials in that state believed, however, that their managed care system did increase the cost-effectiveness of the care delivered to its rural beneficiaries under Medicaid.

For Medicaid beneficiaries with disabilities (i.e., the SSI population), we found that Medicaid managed care does lead to some improvements in access to care for rural beneficiaries with disabilities. This finding does not carry over to the SSI population in urban areas, however, suggesting that states should be cautious about extending managed care coverage to urban

disabled Medicaid beneficiaries. Access to care for the disabled beneficiary population, as noted, is typically problematic under fee-for-service. And differences in the characteristics of the urban SSI population, the version of Medicaid managed care implemented in urban areas and/or the health care system in urban areas may make it harder to make improvements in care than is the case in rural areas.

Overall, the findings summarized here suggest that the impacts of Medicaid managed care are not homogenous, rather the effects vary by Medicaid subgroup, geographic area and type of managed care. Medicaid policymakers should be mindful of these differences when developing managed care program policies. More research is needed to better understand the implications of Medicaid managed care and the factors behind the differences found in the research reported here.

### **Impacts on Health Plan Participation Decisions**

Participation of commercial health plans in Medicaid managed care is an objective for many policymakers and program administrators wishing to increase access to and quality of care for beneficiaries by moving them into the mainstream health care delivery system. Our analysis of factors influencing health plan decisions about whether or not to participate in the Medicaid program suggests two major lessons for state policymakers and program administrators as they seek commercial plan participation.

The first lesson is that states need to establish sound capitation rates that reflect the true costs of serving the Medicaid population enrolled in managed care, as well as to ensure that service carve-outs and similar policies are not interfering with the ability of plans to manage care in a cost-effective way. Second, states should work to ensure that plans can enroll an adequate

number of Medicaid enrollees to operate effectively. This could be achieved by limiting the number of plans that are awarded contracts within a county and/or contracting care for groups of counties within the state.

### **Potential for Reconfiguring the Health Care Safety Net**

Project findings on this issue come from a study of the 1115 waiver experience of Los Angeles County, which (in return for a major federal subsidy) agreed to fundamentally restructure the county's delivery of health care to the indigent. The major lesson to be learned from the waiver experience of Los Angeles County is a sobering one. Substantial financial relief and a serious restructuring effort may not be enough to restore financial viability to a safety net health care system on the brink of collapse. Waiver efforts did succeed in expanding geographic access to non-hospital indigent care; cutting the number of inpatient beds, inpatient days, and average length of stay; and implementing a hospital reengineering system that produced some savings through better purchasing of supplies, equipment, and prescription drugs. Observers also agreed that the culture of indigent care provision had improved, bringing more attention to patient care quality and communication among providers throughout the system.

Despite these successes, the large number of uninsured in the county remained, along with the obligation to meet their health care needs. The county received a new waiver with additional subsidy for the 2001-2005 period. Whether actions under the new waiver will stimulate enough additional financing and operational reforms in the LA County system to make it financially stable remains an open question. But if past is prologue, it is hard to be optimistic.

## **Implications of Vermont Drug Analyses**

Our analysis of Vermont's pharmacy assistance programs has important implications, especially for the recently enacted new drug benefit under Medicare. First, state pharmacy assistance programs and, ultimately, Part D, play an extremely important role in providing outpatient prescription drug coverage to one of the most vulnerable and least insured groups of Medicare beneficiaries. Subsidies provided under Part D to the non-dually eligible low-income population will be crucial for building on the achievements made by states and ensuring continued access to outpatient prescription drugs among the near-poor.

Participants in publicly subsidized drug programs also tend to be those with the greatest needs. However, late enrollment penalties imposed under Part D should help limit the deleterious impact of adverse selection on future plan costs. Finally, while the new Medicare drug benefit may help reduce the number of unnecessary hospitalizations and lower inpatient expenditures, Part D may conversely lead to higher outpatient and Part B expenditures. The potential for savings is likely to be greatest among beneficiaries with chronic conditions where outpatient prescription medication is particularly effective for avoiding illness and preventing unnecessary medical service use. It may, thus, be useful to consider condition- and drug-specific factors when Part D and Medicare Advantage plans develop their drug formularies and cost sharing rules.

## **Suggestions for Future Research**

The Evaluation of Medicaid Health Reform Demonstrations addressed a number of issues related to state 1115 waiver initiatives, providing new information on a range of issues. As with any research project, the findings from those research efforts raise new questions. Areas that would benefit from additional work include:

- Exploring the impacts of Medicaid managed care for TANF and poverty-related populations in states beyond Minnesota. In particular, what is the impact of MMC for populations in rural areas in states without a strong health care system and a generous Medicaid program (for which Minnesota is known)?
- Expanding the analysis of the impacts of MMC on disabled populations. How do the effects of MMC on disabled beneficiaries vary in different states (with different MMC programs) and for different populations of disabled persons? What is driving differences in the effects of MMC for this population in urban and rural areas?
- Baseline studies of access and use for beneficiaries with disabilities under fee-for-service Medicaid. Much of the policy concern has focused on how Medicaid managed care may affect these beneficiaries, but little is known about how these beneficiaries are faring under the current fee-for-service delivery system.
- Expanding the analysis of commercial plan participation in Medicaid managed care to consider quality of care and plan entry. How does the quality of care provided by commercial plans compare to that of Medicaid-dominated plans? How can states attract additional commercial plans into county MMC markets?
- Expanding the analysis of the impacts of new safety net funding to look at the effects on beneficiaries as well as providers in Los Angeles County. Expanding the analysis of the health care safety net to other urban markets that have received substantial safety net funding as part of 1115 waivers (e.g., New York City).
- Exploring the impact of Part D implementation on the design of state pharmacy assistance programs, who enrolls, and the costs of these programs. Do states eliminate their pharmacy assistance programs and, if so, why? Do states that continue offering such programs change the benefit to wrap-around Part D or do they continue to offer independent programs? Does enrollment in state programs decline following implementation of Part D? How do total and per enrollee program costs change following the implementation of Part D?
- Understanding the impact of Part D on low-income individuals previously eligible for state coverage. What is rate of enrollment in Part D among low-income populations previously eligible for state coverage? Do out-of-pocket costs change following implementation of Part D for people previously eligible for coverage through a state program? Do patterns of utilization change? Do individuals change drugs (either within a therapeutic class or between brand-name and generic) after they enroll in Part D? Are there changes in access to prescription drugs and unmet need for low-income individuals who enroll in Part D plans?
- Investigating the impact of Medicare Part D on Medicaid spend-down, on prescription drug needs and out-of-pocket spending, and on use and cost of prescription medications and non-drug medical costs.

Finally, the findings from the Evaluation of Medicaid Health Reform Demonstrations highlight the challenges states and communities face in transforming their health care systems, whether that transformation involves switching from fee-for-service to Medicaid managed care or, as in the case of Los Angeles County, trying to reconfiguring a complex urban health care safety net system. In-depth case studies of program change are needed whenever states make system changes, both to document what has been changed and to understand the process of change. Information on the challenges and successes that are faced by states as they implement change is critical to policymakers and program administrators in other states as they contemplate reforms to their Medicaid program or health care safety net.

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**APPENDIX A**

**LIST OF PROJECT REPORTS,  
PUBLICATIONS AND PRESENTATIONS**

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## **APPENDIX B**

### **PROJECT EVOLUTION AND CHANGE**

In September 1995 CMS, then HCFA, awarded the Urban Institute (and our subcontractors Mathematica Policy Research (MPR), Inc. and Research Triangle Institute (RTI), then Center for Health Economics Research, a contract to evaluate five Section 1115 State Health Reform Demonstrations. It was expected that each demonstration would involve two primary features: an expansion of eligibility to new populations not previously covered by Medicaid and the movement of most of the state's Medicaid population into Medicaid managed care (MMC). Our original design involved detailed case studies and assessments of the impacts of managed care on access, use and satisfaction with health care, using both encounter data and beneficiary survey data.

In the early part of the evaluation we experienced a number of delays and false starts, primarily related to numerous switching of states to be included in the evaluation. Indeed, our roster of states was not finalized until more than two years into the five-year contract. Our five sites are Kentucky, Los Angeles County, Minnesota, New York and Vermont. In addition to the changing roster of states, the character of the demonstrations also changed. Among our study states, Minnesota, New York, and Vermont undertook true eligibility expansions, but they were small. Further, indications from preliminary data explorations by the Urban Institute and from the experiences of Mathematica Policy Research, Inc. in the first 5-state contract (HCFA contract number 500-94-0047) suggested that it would be quite optimistic to assume that quality encounter data would be available to use as part of this evaluation. Finally, our assigned states have encountered delays in implementing various parts of their waivers. New York experienced considerable delays in implementing mandatory managed care in New York City. Kentucky is no longer pursuing fully capitated managed care in much of the state. Vermont is no longer

pursing fully capitated managed care at all. These delays have affected the implementation of our research plans.

Because of these and other developments the project was redesigned. The final project included a number of studies, some of which were based on a single state or compared several states, and some with a national focus. The project also included a survey methodology analysis.

## **I. STATE-SPECIFIC STUDIES**

### Minnesota

- Conducted case studies in 1996, 1998, and 2001
- Beneficiary surveys—completed in 1998 and 2001
- Impact analyses based on matched county study using the 1998 survey
- Impact analyses based on pre/post and difference-in-differences design using the 1998 and 2001 surveys

### New York

- Conducted case studies in 1998 and 2000
- Beneficiary surveys—completed in New York City and Westchester County in 2000
- Analyses of Medicaid beneficiaries' health care experiences under FFS using 2000 surveys

### Los Angeles County

- Conducted case studies 1998 and 2001

### Vermont

- Conducted case studies 1998 and 1999
- Beneficiary surveys—completed in 2004
- Evaluation of the state's pharmacy assistance programs using the 2004 survey and claims data

### Kentucky

- Conducted case studies in 1998, 1999 and 2000
- Beneficiary survey completed in 1999
- Analyses of Medicaid beneficiaries' health care experiences under FFS using 1999 survey data

## **II. CROSS-STATE STUDIES**

- Analysis of how states crafted their MMC programs to accommodate rural areas based on the state case studies

- Comparison of access to care for the SSI population in Kentucky to access to care by similar individuals in New York, Oregon, and Tennessee using survey data collected in each state

### **III. NATIONAL STUDIES**

- Analysis of how managed care, relative to fee-for-service, affects access to care and use of medical services among disabled Medicaid beneficiaries using the National Health Interview Survey (NHIS)
- Analysis of commercial plan participation in Medicaid managed care using InterStudy data
- Analysis of the health care experiences of rural Medicaid beneficiaries using data from the 1997 and 1999 National Survey of America's Families (NSAF)

### **IV. STUDIES OF SURVEY METHODOLOGY**

- Assessment of the use of telephone interviews of SSI beneficiaries to evaluate access to and use of care by disabled Medicaid beneficiaries

**APPENDIX C**

**EXECUTIVE SUMMARY  
FOR**

**“REMOVING THE BARRIERS:  
MODIFYING TELEPHONE SURVEY  
METHODOLOGY TO INCREASE  
SELF-RESPONSE AMONG PEOPLE  
WITH DISABILITIES”**

This report is based on Mathematica’s first telephone-only interviews with individuals with disabilities.<sup>30</sup> Data were collected from over 4,200 adults with disabilities solely by telephone. The groups that were interviewed included adults with physical or sensory disabilities (including blindness and deafness), mental retardation, and severe and persistent mental illness.

The Americans with Disabilities Act brought with it a shift in thinking regarding the level of participation that individuals with disabilities have in decisions that affect their lives. Out of this shift has come the self-directed care model, which puts forth that people must have the option of shaping their own lives and determining what types of services they receive. Further, there has been a move toward ensuring full participation by individuals with disabilities in their lives. These changes have brought about an increase in the choice and control people have over meeting their support needs, increasing independence and social inclusion.

Individuals with disabilities can face three broad categories of challenges when completing an interview: communication barriers, stamina barriers, and cognitive barriers. Because of these challenges, survey researchers often have to rely on proxy respondents or administrative data when conducting studies of this population. However, data collected through proxies or administrative records are often not of the highest quality, as research indicates that the best data are collected directly from people who are being affected by the policy change or program under study.

To overcome the challenges and to promote full participation people with disabilities in the study, we made minor modifications to the design of the questionnaire design and survey procedures to increase accessibility. Questionnaire design modifications included short recall periods, concrete questions, elimination of high frequency sounds, inclusion of breaks to

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<sup>30</sup> This is the executive summary from Ciemnecki and CyBulski (2004) “Removing The Barriers: Modifying Telephone Survey Methodology To Increase Self-Response Among People With Disabilities.”

overcome fatigue, neutral encouragement, and structured probes. Procedural modifications included sensitivity training for interviewers, compassion fatigue support for interviewers, and modified expectations regarding time to administer questionnaires.

The overall response rate for these surveys was 66 percent. The one notable source of non-response was the inability to locate sample members. Once sample members were located, however, they were quite willing to participate in the telephone interview, as demonstrated by a cooperation rate of 95 percent. Further, the majority of individuals with disabilities did not need a proxy to complete the interview (83 percent). Even among individuals with mental retardation or a developmental disability, the group that required the most proxy response, three-fourths of these individuals were able to respond for themselves.

The telephone interviews produced data that were relatively complete and accurate, with slight variations by disabling condition. Overall, item non-response was less than 3 percent. Qualitative comparisons of patterns of answers across pairs of questions found that responses were consistent at an aggregate level. Respondents were best able to answer salient items, such as health status and demographics. The most difficult questions to answer were about the choice of managed care organizations and primary care physicians.

To test the reliability of the telephone data, two smaller studies were conducted. The first was an in-person interview with a sub-sample of respondents, and the second was a telephone interview with a family member. These follow-up questionnaires contained some of the same questions as the telephone questionnaire given to disabled respondents. The items that were selected to be included in the follow-up questionnaire were those that would not change over time or for which changes could be accounted for in a follow-up item. We found that the

information collected through the telephone questionnaire of persons with disabilities was consistent with that collected through the in-person interviews and the family interviews.

In sum our findings suggest that it is feasible to interview large samples of disabled beneficiaries over the telephone. Not only did the vast majority of respondents answer for themselves, but nearly all were able to answer more than three-fourths of the questions in nearly all topic areas. By implementing several innovative methods for overcoming the barriers that this population faced when being interviewed, we were able to demonstrate that telephone surveys of people with disabilities are not only feasible, but produce high-quality data as well.