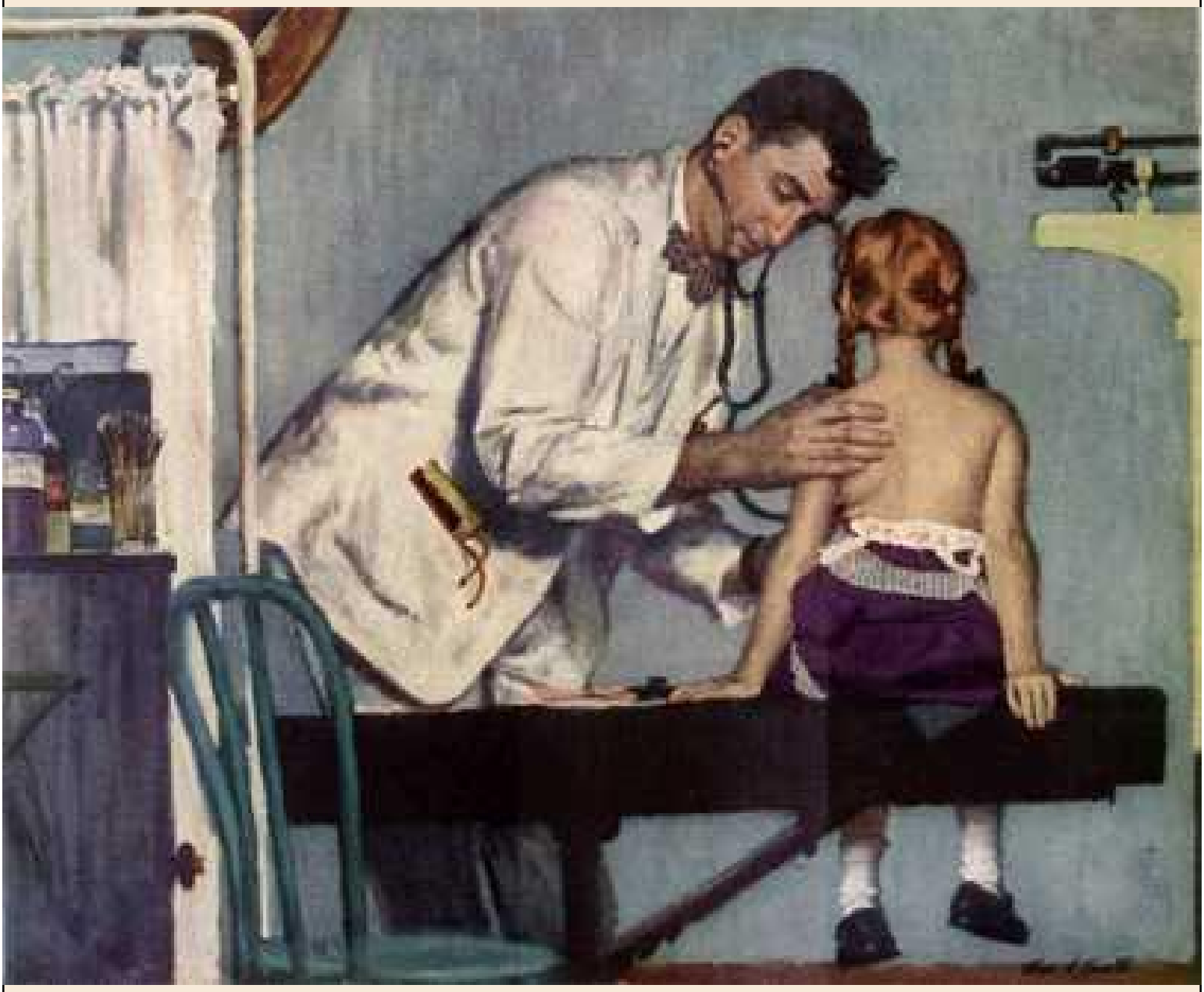
Looking Back at the Promises of Medicaid Managed Care



Medicaid managed care promised to improve access to doctors and increase continuity of care, all at a lower cost. Instead we have lost our ability to accurately track services provided, we cannot determine quality of care, and the state's savings figures don't add up.

Consumers Union Southwest Regional Office

April, 1999

Common Acronyms

FFS: Fee-for-service Medicaid
FQHC: Federally Qualified Health Centers
HEDIS: Health Employer Data and Information Set
HMO: Health Maintenance Organization
MCO: Managed Care Organization
NHIC: National Heritage Insurance Company
PCCM: Primary Care Case Management
PCP: Primary Care Provider
TANF: Temporary Assistance for Needy Families, formerly AFDC
TDH: Texas Department of Health
THQA: Texas Health Quality Alliance
UM Reports: Utilization Management Reports

Looking Back at the Promises of Medicaid Managed Care

In Brief

In 1993, Texas launched its first pilot project to enroll Medicaid recipients in commercial managed care organizations. Most people agreed that access to a commercial HMO should allow a Medicaid recipient to easily find a doctor (solving a major problem with the old fee-for-service system), while utilization management should lower program costs. In 1995, the state drafted an 1115 Waiver designed to cover more people through Medicaid, guarantee a period of continuous eligibility, and expand managed care across the state. While the 1115 Waiver failed, managed care expansion continued on a "pilot" basis.

Recently, the Texas Department of Health submitted its Texas Medicaid Managed Care Report (Summary Report)[1] to the Legislature. The report states that managed care has improved access to primary care providers and saved the state $35.6 million (for FY 1997).

The report cites the mandatory, independent evaluations of the managed care program, as well as data submitted to the Texas Department of Health (TDH) by health plans and Maximus, the program's enrollment broker. But do these sources really support the findings outlined by the Department?

Consumers Union Southwest Regional Office reviewed the independent evaluations of the Medicaid managed care program—focusing on two service areas and a series of specific questions about health care for women and children—and found that the independent researchers presented a much gloomier picture. Also, aggregate information about the program as a whole obfuscates critical problems in each of the service areas.

- Evaluators found serious problems with access to prenatal care and specialists, continuity of care, and delays in the enrollment process.
- Studies found significant inaccuracies in the state's data on managed care that undermine program evaluation.
- Two independent evaluations looked at the cost of the managed care program (as compared to fee-for-service Medicaid) and TDH used the most favorable figures. But the favorable evaluation excluded important cost factors that change the picture considerably. Taking all costs into consideration, there is little statistically significant savings due to managed care.

Until now, the state has rolled out managed care programs in one city after another, always focused more on the next implementation phase than the repercussions of the existing pilots for Medicaid enrollees and their doctors. The Department of Health, as both implementing agency and supervisor of the evaluation process, has a strong interest in demonstrating that the system works. While the new pilots rolling out in Dallas and El Paso may be too far along to halt, the Department should focus on fixing the existing problems quickly.

Consumers Union recommends that the state:

- stop and assess its progress addressing existing problems in the managed care program before contracting in any new expansion areas;
- create an accelerated enrollment process for pregnant women and newborns;
- enforce standards for data collection to ensure the state can assess quality of care and services utilized in the long term, including mandatory reporting from physician offices to managed care entities and to the state;
- increase TDH staff for contract supervision and compliance to ensure that HMOs and other state contractors address problems as they arise;
- make all independent evaluations, including actuarial studies of program costs, readily available to the public, including posting on the internet, and include adequate methodological information for advocates and the public to reasonably understand the information provided.

Consumers Union Review

Consumers Union reviewed the findings of studies by the Texas A&M Public Policy Research Institute (A&M)[2], the

> "Sixty-four percent of the HMO providers reported not knowing how many prescriptions per month recipients were entitled to and 46% of the traditional Medicaid providers said that the limit was three. Very few seemed to be aware of the fact that the three prescription per month limit was lifted for managed care recipients." (A&M, Travis, p. 3-4)

Texas Health Quality Alliance (THQA)[3], and Rudd and Wisdom, consulting actuary.[4] These reports, as well as the TDH report to the legislature, cover fiscal year 1997.

Texas A&M conducted the biennial program review required by the federal Health Care Financing Administration. Texas A&M researchers estimated savings to Medicaid due to managed care. In addition, they conducted a telephone survey of randomly selected health care providers in managed care and a parallel survey of providers in fee for service Medicaid. They also conducted a survey of Medicaid clients in both managed care and fee-for-service (FFS). They followed these phone surveys with on-site interviews with clients, nurses, doctors, physician assistants and billing staff.

The Texas Health Quality Alliance is the contracted External Quality Review Organization for the state of Texas. For each contracting HMO, the Texas Health Quality Alliance audited medical records, reviewed managed care organization focus studies, attempted to audit and validate managed care organization encounter data and utilization reports, and conducted on-site review of HMO compliance with the requirements of the TDH contract.

Rudd and Wisdom, a private firm, contracted to provide an actuarial estimate of the savings to Medicaid due to the managed care pilots. As part of that analysis, Rudd and Wisdom produced a separate analysis of the effect of the managed care pilots on the Vendor Drug Program.

CU reviewed existing studies on the cost of the program and access issues particularly affecting pregnant women and children, and limited our review of access and care issues to the Travis County Service Delivery Area (Travis) and Bexar County Service Delivery Area (Bexar) pilots. We elected to highlight issues relating to women and children because these are the largest population groups in the Medicaid program. We selected Travis because it hosts the oldest Medicaid managed care program, and Bexar because it is a large program that hosts both HMO and PCCM plans.

We did not re-evaluate underlying data or information incorporated into these studies, although we did consider cost information not incorporated into the cost analyses. Instead we merely read them, and report here many findings that we believe cry out for attention from the Legislature, the Department of Health, and the Health and Human Services Commission, State Medicaid Office. In cases where data problems outlined by the researchers clearly undermine the quality of the information, we note these problems.

Findings: Access and Quality of Care

TDH's report to the Legislature presents a rosy view of access to care in managed care areas. It seems obvious that access to a commercial health plan with a network of doctors should increase access to care for Medicaid patients, who have traditionally been rejected by many physicians. This potential benefit significantly increased political support for the shift to managed Medicaid. However, access may still be a problem today.

First, HMOs must incorporate into their networks all the doctors and facilities that have traditionally cared for Medicaid patients. This is a good provision designed to prevent massive disruption in the system and ensure enrollee continuity of care. But it also means that many Medicaid enrollees remain in the same provider networks as before. And like commercial HMOs, not all the doctors in a Medicaid HMO network are taking new Medicaid patients at any given time. Finally, patients who need immediate care—particularly women who become eligible for Medicaid at the time of their pregnancy—must go through a complex, multi-step enrollment process before they can see a doctor. For these patients, access may well have declined, and certainly is delayed at a critical time.

Citing the Texas A&M study, TDH reports, "most providers in traditional Medicaid, PCCM and HMO models perceived that access to and continuity of medical care either increased or was not affected by clients being in managed care." (Summary Report, p. 33) While this statement is true, it obscures the additional fact that a significant minority of physicians in HMOs stated that managed care actually decreased access, and HMO doctors were far more likely to say that managed care decreased access than PCCM or FFS doctors.

The A&M study found that a significantly greater number of HMO doctors than PCCM doctors in Bexar believed that managed care had decreased access to high quality medical care (14 percent of HMO doctors versus 4 percent of PCCM doctors). HMO doctors were also more likely to report loss of patient continuity of care

(27 percent of HMO doctors versus 15 percent of PCCM doctors and 5 percent of FFS doctors. (A&M, p. 4-23) In Travis, HMO providers were more likely to believe that state policies restrict medical services than providers in FFS (34% vs. 17%). (A&M, p. 3-40)

In particular, managed care providers in some areas report problems getting their Medicaid patients in to see specialists. While TDH claims that providers express the same level of satisfaction with ease of pre-certification, whether traditional, PCCM or HMO Medicaid (Summary Report, p. 33), A&M found that HMO (24%) and PCCM (28%) providers were much more likely to report pre-certification to be "difficult" than their FFS counter parts (10%).

"Within the HMOs, concerns about the availability of specialists were evident. Many providers, visited in the field, raised concerns about the numbers of specialists within particular plans being very problematic. They cited difficulty in locating colleagues who could meet with their patients in a timely manner." (A&M, 4-10) HMO providers were more likely (32%) to think it was difficult to make a referral to a specialist, than PCCM providers (24%) or FFS providers (18%).

Researchers detail many new barriers between patients and their care, particularly for pregnant women and their newborn children, who should be seen shortly after their eligibility is established. TDH does not compare prenatal care in managed care with FFS Medicaid. Instead, TDH reports "…access to prenatal care is evident in the HMO model, with more pregnant women receiving a prenatal visit within four weeks of plan enrollment, as compared to PCCM" (Summary Report, p. 4).

> "The number of recipients who could not identify their plan (37%) is somewhat disconcerting. PCA has been in operation since 1993 and both Foundation Health and HMO Blue ... since 1996. This lack of name recognition of the managed care plan suggests a lower level of information than would be desirable for an effective system."
> (A&M, Travis, p. 3-3)

This summary statement ignores critical insights about the managed care system as a whole in the underlying study. Texas A&M reported that in Travis, "a gap exists between the time eligibility is established and the time it takes for a participant to appear on an insurer's list…This is of particular concern to obstetricians who believe the lag in the system causes many pregnant women a delay in prenatal care. Physicians at times do not encounter participants until the end of the second trimester of their pregnancy." (A&M, p. 3-44)

This gap in the enrollment process exists for newborns as well as pregnant women. A&M researchers identified "a consistent pattern of concern raised about the cost associated with newborn services" in Bexar, and recommended an evaluation of the billing system for these services. (A&M, p. 4-52) This concern may relate to the period of time right after birth during which a newborn does not officially belong to any plan in the system.

Perhaps related to inadequate prenatal care, researchers also found that newborns cost more under both the Bexar and the Travis pilots, and pregnant women cost significantly less. (A&M, pp. 3-34, 4-39, 4-50) "While the cost analysis indicated a savings in cost for pregnant women, site visits to general practitioners and obstetricians indicate that the savings has been at a risk to pregnant women and the fetus." (A&M, 3-45) While TDH reports no overall increase in the percent of deliveries resulting in "complex" newborns (sick newborns who have to stay in the hospital more than four days or who die) (Summary Report, p. 22) its own graphs show that HMOs report increases in the number of complex newborns in both the Travis and Bexar areas. (Summary Report, p. 26)

In Bexar, among maternity care recipients, fewer HMO enrollees reported receipt of breast feeding instruction, postpartum visits and parenting skills training. Overall, HMO recipients were less likely to rate the medical care they received while pregnant as good or excellent (87 percent) relative to PCCM (92 percent) or FFS (94 percent). (A&M, 4-24)

Access to primary care, obstetrical care and other basic services for women and children were also compromised by the high level of default enrollments in 1997, according to A&M. In the Travis service area, more than a third (37 percent) of Medicaid recipients could not identify the plan they were in, although PCA, the dominant plan, had been operational since 1993. (A&M, p. 3-3) Asked whether they had selected their plan or been defaulted, 46 percent reported they had been defaulted. (A&M, p. 3-10) Researchers also identified high default rates in Bexar county.

It should be noted that NHIC started out as the enrollment broker for the managed care program, but in June 1997 the state switched to a new enrollment broker, Maximus. TDH reports to the Legislature that more than 80 percent of members select their own primary care provider and managed care plan (Summary Report, p. 4), but it is unclear whether this number refers to NHIC or Maximus results.

> "The eligibility process typically takes about 30 days. The enrollment step can add to the start-up interval and stretch it to as long as 90 days. This, however, appears to be a rare occurrence as about 60% of those in both managed care models received their Medicaid cards within three weeks."
> (A&M, Bexar, p. 4-7)

There has been no independent review of enrollment default problems since Maximus took over the program.

Citing NHIC data, TDH categorically states that "managed care has improved access to primary care providers." (Summary Report, p. 33) However, this is based on information from NHIC on the overall capacity of primary care providers in the system to serve Medicaid clients, assuming that each provider now open will take the full 1500 Medicaid patients allowed by TDH. Managed care providers may stop accepting new Medicaid patients at a level far fewer than 1500. Therefore this statistic does not clarify whether the types of providers and care patients need is available when they need it. According to A&M researchers, "Some providers go so far as to say that patients don't really have free choice because at the selection point many are told a particular provider is not taking new enrollments." (A&M, p. 4-9)

(Table 1) Encounter Data Audit finds significant problems tracking services delivered to Medicaid clients from physician office to state administrators

Encounter Data in Medicaid Managed Care: Do we know what services people are getting for our state dollars?			
County	Plan	% of encounters from the medical record matched to the HMO database	% of encounters from the medical record matched to the state's database
Travis	PCA	0.4%	0.06%
	HMO Blue	30.5%	12.99%
	Total	7.7%	3.2%
Bexar	PCA	0.0%	0.0%
	HMO Blue	34%	16.64%
	Community First	42.7%	28.75%
	Total	27.3	16.76%
Lubbock	FirstCare	36.5%	17.47%
	HMO Blue	28.8%	11.93%
	Total	33%	14.97%
Tarrant	PCA	1%	0.0%
	HMO Blue	31.3%	13.07%
	Harris Methodist	39.1%	16.84%
	Americaid	7%	4.2%
	Total	19.3%	8.6%
Statewide		20.3%	10.2%

Findings: Data Quality

The Texas Department of Health (TDH) does not discuss data quality problems in its Summary Report. However, both A&M and THQA focused a great deal of attention on the adequacy of the data used to evaluate service received through the managed care pilots.

There are several types of information necessary to assess access and quality of service provided to Medicaid clients: encounter data, utilization management data, focused quality of care studies, and medical records. THQA formally audited each of these data types, while A&M reported numerous problems with access to the data necessary to complete their research. "Considerable energy should be invested," said the A&M team, "in improving the management information systems and databases that provide numerous opportunities for learning and oversight. This evaluation suffered immensely from the databases from which the evaluation team had to work."

Consumers Union reviewed the data audit performed by THQA (Encounter Report), and found that the significant problems with data about the services Medicaid clients are getting undermines any effort to establish whether access and quality have improved or declined in managed care areas. Probably the fundamental problem lies with the collection of "encounter" data.

Encounter data is the record of each service received or performed for a patient. It is the primary data necessary to know whether patients are being served and how often. A patient who visits the doctor has one "encounter." If the same patient revisits the doctor a week later for a follow-up, this is another "encounter." FFS Medicaid creates accurate encounter data, because providers bill for each service. HMOs find encounter data notoriously hard to collect, because doctors who are paid on a capitation basis (a certain amount per member per month) or hospitals paid on a per diem basis have little incentive to adequately report to the HMO each service they provide.

> "Accurate counts of patients served and services provided provide the basis for utilization analyses such as those conducted in HEDIS and HEDIS-like reporting environments. If this reporting is being done on the basis of electronic encounter files that bear only passing resemblance to the same picture illustrated from a review of medical records, then that reporting can be quite misleading." (TQHA, 1997 Encounter Validation, p. 26)

Prior to managed care, the state could track the amount and kind of service provided to children at every age, pregnant women, older adults, men or women. Although the NHIC system did not readily produce non-standard reports, the state used the data to project program needs and determine which populations were not adequately served.[5] Today, the FFS encounter data excludes information about the state's largest urban areas now under managed care, and the managed care program has not been able to create new encounter data to fill the gap.

According to THQA, only 20.3 percent of "encounters" found in patient medical records were recorded in the HMO administrative database. In the Travis service area, only 7.7 percent of encounters appeared in both the medical record and the database. Auditors determined that they could probably identify some additional partial record matches (records could be found for the same member on the same date of service but did not match for type of service provided, for example), and if you add those encounters, HMOs can find a total of 30.2 percent of medical record encounters in their database. PCA in Bexar had less than one percent of medical record encounters in its database, even using partial matches. The plan with the best data audit in the program, Community First, had less than half of its medical record encounters in its administrative database (Encounter Report, pp. 16-17).

The most common problem (42.5 percent of errors) was a "false negative"—a service that was provided and appears in the patient's medical records but did not appear in the HMO database. This indicates that Medicaid enrollees are getting more services than we know about (Encounter Report, p. 16, 25).

However, the degree to which existing data underestimates services is reduced significantly by the large number of "false positives"—services that appear in the administrative data but not in the patient's medical record (which would confirm that the services were actually received). The false positive rate was 23.8 percent across all plans. THQA attributed the high "false positive" rate in part to coding errors (Encounter Report, p. 18, 25).

To muddy the picture even more, TDH relies upon reports from NHIC, the claims administrator, to get a full picture of the Medicaid program. Managed care organizations submit data to NHIC, which edits the data for form and format problems. Any data that doesn't pass the edit is returned to the managed care organization. After editing and correction, NHIC produces a "history" file for use.

THQA compared the data submitted by the HMOs to the final NHIC history file, expecting the latter to be an audited version of the former. Instead, they found that more than a third of encounters in the final "history" file did not match encounters in the HMO data. Looking at these "extra" encounters along with the "false negatives" (encounters in the HMO file but not in the final NHIC file), and matching them generously, auditors determined that about 80 percent of the encounters in managed care organization administrative data could be found in the state's final "history" report. The other 20 percent could not (Encounter Report, p. 20-21).

More important to the state's quality assurance efforts, only about 10 percent of encounters in the patient medical record are identifiable in the state's "history" data. And almost two-thirds of the encounters recorded in the state "history" files could not be found in the available medical records (Encounter Report, p. 21, 23)

The clear conclusion from this audit is that neither the state nor the managed care organizations know, based on reliable data, the services being provided under the plans. THQA recommended that contract renewal should be linked to the accurate submission of encounter data, and the state should issue a unique provider ID number to be used by each plan to clear up some data coding problems.

Last year, TDH required managed care organizations to change the way they submitted data, in preparation for the completion of Compass 2000, an updated version of NHIC's existing claims database. Managed care organizations will be required to make a final set of changes to the data reporting formats this summer. The new state database should produce reports more flexibly than before, and it attempts to identify all managed care encounters as "claims" even if no billing statement is ever generated. These changes, however, do not address under reporting by doctors, or data coding problems within and among plans. It will take a concerted and long term effort backed by contract enforcement to give Texas the data it needs to manage the managed care program.

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Determining Utilization and Quality of Care in Managed Care Plans

In the absence of good **encounter** data about the services members get under a manged care plan, HMOs collect **utilization management (UM) data** and conduct **focused population studies** to assess the services provided.

Utilization management data is collected by sampling administrative records to determine what services are used by members, and then the sample is extrapolated to a rate of use per 1000 members. TDH used this UM information in its Summary Report to show key information: emergency room and hospital visits are reduced under managed care, people have fewer complex newborns and average hospital stays are shorter (Summary Report, pp 23-26).

THQA attempted to audit the utilization management information by asking companies to provide the underlying source data, from which THQA reproduced the tables of ratios. They were unable to reproduce any table exactly, (Retrospective Review, Phase I, State Report, Americaid, p. 4, Community First, p. 4, FirstCare, p. 4, etc) and could not verify select reported information from many health plans.

- *"THQA was not able to replicate values reported by Americaid in the UM tables. ... Findings suggest that duplicate values may be present in the database or procedures may be listed under multiple service dates for one or more members." (RR, Phase I, State Report, Americaid, p. 5).*
- *"Foundation Health delivered UM spreadsheets, which was one element of the data request. Foundation Health delivered claims and enrollment information after an extended deadline, in an out-dated format, which was determined to be unusable. As files were not readable and others not received, replication could not be done." (RR, Phase I, State Report, Foundation Health, p. 5).*
- *HMO Blue provided no information on dates of enrollment for verification of the numbers of enrollees each quarter, and provided no dates of service after April of 1997, so THQA could not replicate the values reported. (RR, Phase I, State Report, HMO Blue Bexar, p. 6)*
- *PCA did not provide source data for membership and claims, so its report could not be verified. (RR, Phase I, State Report, PCA Bexar, p. 4, PCA Travis, p. 4-5).*

Overall, THQA found that "reporting criteria for formulas stated in the TDH instructions are subject to varying interpretation." As a result, plans incorrectly annualized procedures and applied the formulas inconsistently. In the behavioral health area, many plans submitted incomplete UM reports. In order to audit the UM reports, auditors required certain underlying data from plans, and many were unable to provide the required data elements. Finally, the auditors were unable to reproduce the tables exactly from the underlying data provided.

According to the auditors, UM administrative records are created from MCO encounter data. Therefore, the underlying problems with the encounter data cited elsewhere in this report will significantly effect the UM reports. Wherever TDH evaluates changes in the use of services due to managed care and bases its information on UM reports, this data cannot be verified and probably does not present an accurate picture of actual services delivered.

TDH requires HMOs to conduct focused studies of pregnancy, well child, asthma, behavioral health, and substance abuse treatment during pregnancy. These "studies" are similar to the UM data, but they generally target a narrower population and look for rates of specific treatments and followup. "By isolating care delivered to a small group of clients over time, TDH and MCOs can identify benchmarks for care, measure performance goals, and identify quality of care issues of concern," according to TQHA. If the audit confirmed that MCO's complied with state reporting requirements and their results could be validated, the focus study results could be used to compare plans on vital quality of care issues.

But, the auditors determined that "enough questions were raised ...concerning valid study methodology and the effect on findings" that the results of studies conducted by different plans could not be compared with one another. For example, plans reported a range of pregnancies with complications that varied from 11% to 85%, indicating that they did not conduct the study in the same way. Some studies were compromised by small sample size. Others were based on incomplete information. Seven plans identified information relating to outcomes of pregnancy and enrollment data (data that would identify the length of time between a woman's enrollment and her first prenatal visit) as difficult information to collect.

- *Community First collected no data regarding EPSDT visits (well child care). The four categories for immunization status were mutually exclusive and add up to 100%, but Community First's added up to 159%. TQHA calculations of the gestational age of infants at the time of enrollment in the health plan, an important piece of data for analysis of effective prenatal care, were different from the plan's report by 10%. (RR, Phase I, State Report, Com. First, p.6-8)*
- *Foundation reported inaccurate numbers in several sets of items related to asthma, and TQHA findings differed from Foundation by more than 10 percent on portions of the study relating to immunization documentation and lead levels. TQHA received no data to back up the pregnancy study or replicate it.(RR, Phase 1, State Report, p.7-8)*
- *HMO Blue, Bexar: The numbers reported in several measures related to pregnancy were different from calculations by THQA by more than 10%. (RR, Phase I, State Report, HMO Blue Bexar, p.7-8)*
- *PCA Travis: TQHA noted audit problems in both the pregnancy focus study and asthma-related inpatient admission and referral information. TQHA results differed from PCA by more than 10 percent on several items, including pregnancies with severe complications (RR, Phase I, State Report, PCA Travis, p.6-8).*

Conclusion

Focus studies and utilization management reports have been used as a surrogate for good data about the services provided under the Medicaid managed care program. But even this information does not pass an audit and should not be relied on to present an accurate picture of the services provided by health plans.

Findings: Cost to the State

The managed care pilots were predicated on the theory that the state could increase access to health care and reduce costs at the same time by enrolling Medicaid clients in HMOs. TDH's estimate of savings would appear to support this theory. But the underlying studies cited by TDH reveal the omission of significant cost factors that tend to reduce the savings attributable to managed care to a statistically insignificant level.

TDH reports FY 1997 savings due to Medicaid managed care of approximately $35.6 million, including $14.5 million paid to the state through profit sharing arrangements between TDH and the managed care organizations (Summary Report, p. 4). This is about 4 percent of total program costs in these areas. Intuitively, this makes sense because the state set the HMO capitation rate at a level 4 percent below the estimated FFS costs in each area. But several problems cloud this simple picture.

"If the FFS claims for managed care counties were overstated, as we believe they were, then the [HMO] premium rates were set at a higher level than would have been the case if the data were not in error...This has lead to a significant reduction in the estimated savings realized from managed care." (Rudd and Wisdom, p. 4)

First, the often cited 4% discount off FFS costs is not as straightforward as it appears. In its 1998 study, Rudd and Wisdom discovered that actual FFS costs in the managed care areas were significantly lower than they appeared from the NHIC data used as the basis for HMO capitation rates.

According to Rudd and Wisdom: "If the FFS claims for managed care counties were overstated, as we believe they were, then the [HMO] premium rates were set at a higher level than would have been the case if the data were not in error. Our claims adjustment methodology has resulted in a reduction of the historical FFS claims and a corresponding reduction in the projection of FFS claims that would have been incurred had managed care not been implemented. This has led to a significant reduction in the estimated savings realized from managed care" (Rudd and Wisdom, p. 4).

Second, the cost of the managed care organization itself (the capitation rate and NHIC administrative expenses multiplied by the number of enrollees) is not the only cost in the managed care system. New costs—like the cost of the enrollment broker—have been introduced into the system. Old costs—like the cost of the Vendor Drug Program or the amount the state reimburses Federally Qualified Health Centers (FQHCs) for services—may have changed.

And the major FFS cost savings program—selective contracting—no longer applies to the areas where managed care rolls out. Plus, some services in the managed care areas remain under the FFS system, including the Vendor Drug Program and the costs of individuals who first present themselves to Medicaid for enrollment at the time they enter the hospital. While each of these individual items may not represent huge additional costs or lost savings, taken together they can eat up the amount TDH projects the state to have saved.

Two available studies compare the cost of managed care with the cost of traditional Medicaid. Each one addresses these external costs and their effect on savings differently.[6] Rudd and Wisdom included few external factors (see table 3), and determined that managed care saved the state $28.1 million in FY 1997. Since Rudd and Wisdom assumed no profit sharing from managed care organizations, their savings estimate increases to $42.7 million with profit sharing added. This is the most optimistic figure available, so we use it as the starting point to see whether the savings are really there.

(Table 2) A small nunber of voluntarily enrolled blind and disabled clients account for half of the Rudd and Wisdom savings estimate

Enrollment Group	Rudd and Wisdom Savings Estimate	Savings due to Group as Percent of Total Savings
AFDC kids	$1,115,141.00	2.6%
AFDC adults	$5,926,026.00	13.9%
Pregnant Women	$3,650,820.00	8.5%
Newborns	-$6,474,989.00	-15.2%
Expansion kids	$2,212,465.00	5.2%
Federal mandate kids	$59,018.00	0.1%
Disabled and Blind	$21,624,672.00	50.6%
All Risk Group Total	$28,113,153.00	
HMO profit sharing	$14,600,000.00	
Total Rudd and Wisdom Savings Est.	**$42,713,153.00**	

"The inclusion of Vendor Drugs into the computations did not effect the savings or costs of the individual risk groups except for Disabled and Blind. The estimated saving was reduced by approximately $4.8 million for that particular group due to the addition of Vendor Drugs in the computations"
(A&M, Tarrant, p. 6-37)

Vendor Drug and the Blind and Disabled Population

According to the Rudd and Wisdom study, more than half of the savings ($21.6 million) is attributed to lower costs for the voluntary enrollment of a relatively small number of blind and disabled people. In fact, Rudd and Wisdom predicted that in FY 1997 the state saved $10.2 million serving about 1,800 blind and disabled Medicaid enrollees in Tarrant HMOs alone.

(Table3) Two major studies include different program costs

Total Medicaid FFS area costs include:	**A&M FFS cost includes:**	**Rudd and Wisdom FFS cost includes:**
Vendor drug	X	
Form 650 and 750 claims	X	X
NHIC admin fee	X	X
TDH admin costs	X	
FQHC cost-based reimbursement payments		
Total Medicaid Manged care costs include:	**A&M managed care cost includes:**	**Rudd and Wisdom managed care cost includes:**
FFS costs of "delayed enrollment effect" (including FFS costs of recipients retroactively eligible for Medicaid)	X	X
Vendor drug	X	
HMO premium times # members	X	X
1997 MCO profit sharing back to the state	X	
FQHC cost-based reimbursement payments		
Birch and Davis (PCCM administrator)		
Maximus (enrollment broker contract)		
Lost "savings" from selective contracting		

Statewide, disabled/blind Medicaid clients accrue costs averaging about $6,460 annually[7]. Rudd and Wisdom estimates that FY 1997 costs in Tarrant for blind/disabled clients without managed care would have been about $6000, while the costs for individuals enrolled in managed care dropped to $2600 (57% less). No medical management program could claim to have so severely cut back costs for a high utilization group without affecting quality of care, unless the costs were shifted elsewhere in the program.

And this may be exactly what is happening here. Rudd and Wisdom did not include Vendor Drug program costs in its projections, although the three prescription limit is lifted for managed care enrollees and utilization might be expected to increase. In a separate study of the Vendor Drug Program under managed care, Rudd and Wisdom concluded that managed care reduces Vendor Drug costs, but the actuary elected to study all populations except blind and disabled—those individuals most likely to benefit from access to additional prescriptions. It is possible, in fact, that access to additional prescriptions is one of the biggest advantages attracting blind and disabled Medicaid enrollees to join an HMO. Rudd and Wisdom recommended that TDH apply its findings conservatively (that TDH assume no cost effect), in part because an analysis from the Bureau of Budget and Support Services (reviewed by Rudd and Wisdom) indicated that the average Vendor Drug cost for managed care clients is actually higher than that for FFS clients. This is logical, because one way to appropriately reduce emergency room and hospital utilization is to ensure that patients get the medications that will control their condition outside of a hospital

setting.

According to A&M, blind and disabled clients account for the majority of vendor drug utilization, and the inclusion of the Vendor Drug Program in the cost savings equation reduces the estimated savings in Tarrant, Bexar, and Travis by a total of $11.9 million. Consumers Union supports continued access to adequate prescription care for all managed care enrollees, because this is a critical tool to prevent hospitalization. But any program cost analysis should include all aspects of the Medicaid program that might be effected by managed care. Given the potential for cost shifting, Consumers Union questions all the savings attributed to the blind and disabled population, but particularly the large savings estimated in Tarrant, Travis, and Bexar SDAs.

More inclusive analysis

Texas A&M attempted to incorporate many of the external costs (including vendor drug and TDH additional administrative costs), and concluded that managed care resulted in no statistically significant savings in Travis, Bexar and Tarrant service areas (see table 4). In fact, A&M researchers found that managed care may have cost the state more in Bexar than traditional Medicaid. In all five service areas together, A&M reported a total potential savings of $13 million—less than a third the savings reported by Rudd and Wisdom and probably not statistically significant for the billion dollar managed care program (in these areas)

(Table 4)

Managed Care adds significant new administrative costs, may increase vendor drug utilization, and reduces the savings from selective contracting

(the effect of these factors on the bottom line varies depending on which estimate you use)

	A&M savings estimate	Rudd and Wisdom December 1998 savings estimate	Rudd and Wisdom March 1999 savings estimate[1]
Travis	$147,956	$2,061,019	$2,061,018
Bexar	$(7,575,298)	$(3,683,931)	$3,311,037
Southeast	$11,697,030	$13,252,545	$13,252,545
Lubbock	$6,928,878	$5,534,892	$5,534,892
Tarrant	$1,777,822	$3,953,662	$3,953,662
Estimated savings	$12,976,388	$21,118,187	$28,113,154
Profit sharing	included already above	$14,500,000	$14,500,000
Total Savings	**$12,976,388.**	**$35,618,187**	**$42,613,154**
Lost "Select" savings	$(9,905,097)	$(9,905,097)	$(9,905,097)[2]
Maximus costs	$(847,642)	$(847,642)	$(847,642)[3]
Birch and Davis costs	(Request sent to AG)	(Request sent to AG)	(Request sent to AG)[4]
TDH administration	included already above	$(2,670,0270)	$(2,670,027)[5]
Blind/Disabled Vendor Drug	included already above	$(11,900,000)	$(11,900,000)[6]
Revised savings estimate	**$2,224,000**	**$10,295,421.00**	**$17,290,000**
Savings as % of projected FFS costs	**0.22%**	**1.02%**	**$1.71%**[7]

1. Texas A&M and Rudd and Wisdom initially produced similar estimates of savings in all areas. Since Texas A&M included certain administrative costs and costs for the Vendor Drug program that were excluded by Rudd and Wisdom, this might account for the somewhat lower A&M savings estimate in all areas. When Consumers Union asked for detail tables on the December Rudd and Wisdom cost estimates, we were told that the department had asked for a new cost estimate, in part because the Bexar numbers (finding losses) seemed wrong. The new run shows no losses in Bexar.
2. Lost savings to the "Lonestar Select" selective contracting program (Lewin, May 29, 1998).
3. Actual funds paid to Maximus for first three months of their contract, FY 1997. The state paid Maximus **$113.6 million in** FY 1998, and will probably pay somewhat less in FY 1999.
4. Consumers Union requested the Maximux contract last fall. TDH refused to release it and sent the request to the Attorney General. Since the contract has been let, the AG ruled it public. Subsequently, Consumers Union limited its request for Birch and Davis information to the amounts actually paid under the contract for each fiscal year. TDH sent this request to the AG also. The AG's opinion as to whether this is public is pending.
5. The TDH "Texas Medicaid Managed Care Report FY 1997" is the only source we have seen for the costs of an expanded state administration. This figure is the sum of the administration costs for PCCM (p. 16) and for the HMO program (p. 17). In its Methodology, A&M stated that it included administrative costs for TDH for managed care in its calculations, but we do not know what figure they used.
6. Since neither Consumers Union nor Texas A&M itself were given copies of a written methodology for the R&W actuarial estimates of fee for service (had managed care not been implemented), any effort to determine problems in the study and offer suggested corrections is by its nature a shot in the dark. Texas A&M specifically noted that for Travis, Bexar, and Tarrant service areas, inclusion of Vendor Drug in the cost estimate reduced the potential savings by a total of $11.9 million. We adopted this figure knowing there may be other significant differences between the two studies that would affect this estimate.
7. FFS program estimate from Rudd and Wisdom March 1999 report ($895,538,800) plus vendor drug program costs as estimated by Texas A&M ($115,057,517) equal $1,010,596,317. Cost savings of this magnitude in the billion dollar managed care program may not be statistically significant.. A&M noted that its finding of a 2% additional cost in Bexar County was probably not statistically significant. A&M considered its finding of a 7% savings in Tarrant to be statistically significant.

given margins for error in the study as a whole (see footnote 7 to table 4).

But, both the A&M study and the Rudd and Wisdom study omitted important cost factors, including the lost savings due to selective contracting, and the cost of the enrollment broker and the PCCM administrator. Consumers Union reviewed available information about the selective contracting program and the costs associated with new administrative tasks (see table 3) and attempted to assess whether these additional costs actually offset predicted savings (see table 4).

Selective Contracting

Prior to the implementation of managed care, the state initiated a program called LoneSTAR Select, designed to reduce hospital inpatient costs under traditional Medicaid by introducing price competition among hospitals. According to a 1998 Lewin study, hospitals negotiated FY 1997 discounts with the Medicaid program averaging 3 percent. More than 40 percent of Medicaid dollars pay for hospital care.

While selective contracting with hospitals resulted in a $47.9 million savings to the state in FY 1997, this was down from a savings of $57.4 million in 1995. Lewin attributed the nearly $10 million decline in annual cost savings primarily to the increased enrollment in managed care pilots (Lewin pp. 41-42). LoneSTAR Select discounts end when managed care rolls out for managed care enrollees (contracted discounts continue to apply to Medicaid recipients remaining in FFS) (Lewin, p. 21). This is important because, given the marginal nature of the projected savings due to managed care, the Lewin report indicates that much of the savings would have occurred anyway if all hospitalized patients were covered by traditional Medicaid under selective contracting.

A statewide, legislative reassessment of the managed Medicaid program is needed to determine whether access has improved, whether the new system is cost effective, whether expansion should continue, and what should be done to ensure the state's capacity to monitor and operate the program.

Administration

Medicaid managed care creates new administrative tasks, and the costs must be included in any assessment of savings. TDH has expanded its managed care bureau in order to administer the complex system of new contracts. And, the multiple plan system creates the need for a new middle man—the enrollment broker, Maximus—to guide people through the much more complicated process of picking an HMO and a primary care doctor. TDH paid Maximus $13.6 million in FY 1998, the first full year of the Maximus contract. In the three initial contract months for FY 1997, the state paid $847,642. Additional TDH administrative costs amount to another $2.6 million. Consumers Union asked TDH for the amounts actually paid to Birch and Davis, the PCCM administrator, for FY 1997, but TDH refused to release the information and forwarded our request to the Attorney General for a determination as to whether it is public.

Taken together with the other ajustments, these administrative costs whittle away the savings estimated by Rudd and Wisdom (see table 4) to a level that is probably not statistically significant in the $1 billion dollar managed care program in these service areas.

Managed care was introduced in this state in order to increase access and quality of care at a reduced cost. Years later, we don't know if it has done either. The state has already started rolling out the Dallas and El Paso area pilots. These are the last of the very large metropolitan areas, and pose new and different problems even as the old problems remain. Now is the time to halt any new contracts for a while and look at what we are doing and where we are going.

Recommendations

In order to address existing problems, and ensure the quality of health care provided by the Medicaid program, Consumers Union recommends:

- Before contracting in any new expansion areas, a statewide, legislative reassessment of the Medicaid managed care program to determine whether access has improved, whether the new system is cost effective, whether expansion should continue, and what should be done to ensure the state's capacity to monitor and operate the program. It is possible that an HMO-based private health insurance system cannot provide the wide array of services needed by the Medicaid population in a cost effective manner. While evaluations of individual HMOs, using patient and doctor surveys, can provide some information about the effectiveness of care as experienced by those individuals, it cannot provide a systemic overview of whether the program as a whole is working—from DHS enrollment to the doctor's office.
- Legislation to implement an expedited process for determining eligibil-

ity and enrolling pregnant women and newborns to ensure immediate access to prenatal services.

- Assessment of savings that could be achieved with 12 month continuous eligibility, to include an analysis of the costs of reenrollment to plans and physicians, and the effect on quality of care and access for patients.
- Immediate public dissemination, including posting on the Internet, of all evaluation reports of the Medicaid managed care program, plans and other entities.
- Substantial improvements in data collection and data quality—enforced under the contracts—including verifiable encounter data for each doctor visit and service provided by an HMO. Contracts need to specify that full encounter data must be provided by physicians when HMOs delegate responsibilities to independent physician networks, or if the Medicaid program contracts directly with independant physician networks. De-identified encounter information should be publicly available for independent analysis. Contract renewal should hinge on the results of the audit verifying encounter data completeness and accuracy.
- A review of existing data and reports collected from HMOs and Maximus to identify data that reveals quality of care and access and ensure that these reports are accurate, while eliminating information that is not useful (this process is already underway in the TDH Bureau of Managed Care).
- Increased staffing at TDH for contract supervision and compliance to ensure that HMOs and other state contractors address problems as they arise.

Footnotes

[1] Texas Department of Health, Texas Medicaid Managed Care Report, FY 1997, December 1998.

[2] Blakely, Craig et al, Texas' Medicaid Managed Care Waivers Study: A Final Analytical Report, Public Policy Research Institute at Texas A&M University, June 1998. Hereinafter "(A&M)".

[3] Texas Health Quality Alliance, Texas Medicaid Managed Care, Retrospective Review, FY 97 State Report, (no date). And Texas Health Quality Alliance, Plan Report, Texas Medicaid Managed Care, FY 1997 Encounter Validation, February 5, 1999.

[4] Rudd and Wisdom, Estimated Financial Impact of Managed Care on the Texas Medicaid Program, November 2, 1998; Rudd and Wisdom, Impact of Managed Care on VDP Costs, December 3, 1998; and Rudd and Wisdom, Texas Department of Health, Cost Impact of Managed Care, March 12, 1999.

[5] National Heritage Insurance Company (NHIC), the state's claims administrator for Medicaid, has had significant data problems of its own. The NHIC system, while relatively complete, has never been flexible and researchers (including A&M) could not readily access the data for non-standard reports. However, before managed care the Form 2082 data produced from NHIC's claims database represented a complete picture of Medicaid program expenditures by type of recipient, recipient demographics, and basic service categories. That information is now unavailable for managed care populations.

[6] It must be noted here that we asked for documentation detailing the Rudd and Wisdom actuarial method for the FFS cost projections, including information about the underlying trend assumptions, and TDH told us that no such documentation exists. According to Texas A&M researchers, who used the Rudd and Wisdom method as the basis for their own analysis, no written reports of this method were available to them either. (A&M, Cost Analysis Methodological Report, p. 4)

[7] Form 2082, statewide fee for service cost figures for blind and disabled enrollees excluding vendor drug and long term care services.

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