

GAO

Report to the Honorable
Cardiss Collins, House of
Representatives

September 1993

MEDICAID MANAGED CARE

Healthy Moms, Healthy Kids—A New Program for Chicago



Human Resources Division

B-253840

September 7, 1993

The Honorable Cardiss Collins
House of Representatives

Dear Mrs. Collins:

Medicaid is intended to make health care more accessible to the nation's poor. Yet in Chicago, like other communities in our nation, the number of primary care providers treating many of the pregnant women and children receiving Medicaid assistance is inadequate. Changes are needed in Chicago's health care delivery system to help combat high infant mortality and inadequate immunization from early childhood diseases. Chicago's infant mortality rate in 1990 was 15.6 per thousand births, as compared with 10.7 for the state and 9.8 for the nation.

To begin addressing the problems faced by pregnant women and children, Illinois is implementing a Medicaid primary care case management program in Chicago called "Healthy Moms, Healthy Kids." Since the 1970s, Chicago Medicaid beneficiaries have had the option of joining a health maintenance organization (HMO)¹ or remaining in a fee-for-service program. Beginning in May 1993, pregnant women and children eligible for Medicaid can continue to enroll in HMO programs. However, they also can choose the new Healthy Moms, Healthy Kids program. This program is similar to traditional fee-for-service arrangements except that providers, excluding hospital-based clinics, receive a per capita management fee to coordinate a client's care. Beneficiaries must choose a primary care provider that serves as the patient manager and is responsible for rendering the needed health services or arranging for any specialty care services. Community-based organizations and federally qualified health centers (FQHCs)² will provide case management services to children under 6 years of age and pregnant women.

The goal of the Healthy Moms, Healthy Kids program is to improve access and continuity of health care for about 400,000 women and children in Chicago. The program employs a private corporation to assist with the overall implementation of the program, including enrolling Medicaid beneficiaries, contracting with community-based agencies to deliver case

¹A prepaid health plan that receives a per capita amount each month to arrange or provide for all covered services.

²These centers include community health centers, migrant health centers, or health care for the homeless programs. Also included are clinics that meet the standards of these programs but are not receiving Public Health Service funds. States are required to pay 100 percent of their reasonable costs for providing covered services.

management services, and maintaining a beneficiary tracking and reporting system. In June 1993, the Health Care Financing Administration (HCFA) approved the state's waiver request for the new program.³

In a previous report to you and subsequent congressional testimony,⁴ we identified problems relating to the adequacy of the Illinois Department of Public Aid's (IDPA) management controls and oversight of Chicago-area HMOs that serve Medicaid beneficiaries. Because of these problems, you requested that we follow up to (1) determine if the Healthy Moms, Healthy Kids program has adequate controls to preclude the recurrence of such problems and (2) identify challenges to successful implementation of the program. The results of our work are summarized below. A discussion of our methodology is in appendix I.

Results in Brief

In our 1990 report, we found that Chicago's largest Medicaid HMOs serving Medicaid beneficiaries and IDPA (1) used incentive payment methods that could jeopardize the quality of care provided to program beneficiaries, (2) lacked adequate quality assurance programs to assess the care provided, (3) did not gather and analyze utilization data to detect potential underserving of program beneficiaries, and (4) performed little follow-up to correct quality-of-care problems. In our March 1993 report on Medicaid managed care programs, we found that program success often depends on the ability of states to adequately plan their programs, develop staff expertise and a community base of support, encourage provider participation, and monitor the quality of services provided to beneficiaries.⁵

Our recent work indicates that the Healthy Moms, Healthy Kids program plans include management and oversight controls that address prior weaknesses. As presently conceived, the Healthy Moms, Healthy Kids program would

³HCFA is responsible for approving state waiver applications. The waiver exempts the state from the usual Medicaid program requirements regarding statewide implementation of the program and beneficiary freedom-of-choice in plan selection. The waiver also allows Illinois to contract with a private corporation to enroll Medicaid beneficiaries into the program.

⁴Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990); and Quality of Care Provided Medicaid Recipients by Chicago-Area HMOs (GAO/T-HRD-90-54, Sept. 14, 1990).

⁵Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993).

- remove financial incentives to underserve patients by combining the gatekeeping concept of managed care with fee-for-service reimbursements (paying providers a fixed amount per medical service provided) and a fee for patient management;
- address quality assurance issues, through a peer review process, to identify needed patient services and performance indicators to assess patient outcomes;
- require collection of patient and provider utilization data; and
- conduct periodic patient surveys, establish a grievance system, and set up a hotline to identify quality-of-care problems.

While the Healthy Moms, Healthy Kids program proposes oversight and quality controls, the successful implementation of the program is not assured. Key elements of the program are not yet resolved. A primary concern is the limited funds appropriated by the state to implement the program. The fiscal year 1994 funding is about 30 percent less than IDPA requested from the state. This could hamper the case management component of the program, affect the quality of health care services provided, and limit the staff resources needed to implement the program.

IDPA must also attract and retain a sufficient number of health care providers—which is a major objective of the Healthy Moms, Healthy Kids program. By offering several inducements, such as increased payment rates, selection of patients, access to health care specialists, and better patient treatment compliance through case management, IDPA officials believe that they have attracted a sufficient number of providers. This is important because experience with previous programs in Illinois has shown that many providers who signed up for the programs never actually provided services to beneficiaries, while others dropped out when IDPA was late in paying for services.

Background

Since 1974, IDPA has contracted with HMOs to provide comprehensive prepaid health care to Medicaid beneficiaries receiving cash assistance under the Aid to Families With Dependent Children (AFDC)⁶ program in the Chicago area. From the start of the HMO program, Illinois experienced problems common to HMO programs in general, and Medicaid HMO programs in particular. Some of the problems included allegedly using high-pressure sales tactics, providing poor-quality services, and limited monitoring of the quality of care for beneficiaries. According to IDPA

⁶AFDC is a federal/state program that provides cash welfare payments to certain low-income families—particularly those with an absent parent.

officials, they have taken steps to address these problems, including internal and external quality assurance reviews, compliance audits, and investigations of marketing complaints.

In 1990, we reported that controls IDPA adopted for Chicago-area HMOs were inadequate. From that time, IDPA continued to have problems with MedCare, the second largest HMO serving Medicaid beneficiaries in Chicago. These problems included the failure to pay providers, poor documentation of services provided, and incomplete and late submission of required reports. IDPA attempted to terminate its contract with MedCare on April 1, 1992. However, according to IDPA officials, MedCare obtained a court-ordered injunction to block the termination action. As a result, IDPA was forced to continue working with MedCare through MedCare's eventual bankruptcy, sale, and closure in November 1992.

In December 1992, IDPA requested that HCFA waive title XIX, section 1902(a) of the Social Security Act to allow for the implementation of the Healthy Moms, Healthy Kids program in Chicago for a 2-year period. HCFA approved the waiver in June 1993. Essentially, the waiver allows IDPA to contract with a private corporation to enroll Medicaid beneficiaries in the program and implement the case management component. The waiver applies only to Chicago, limits program participation to about 400,000 pregnant women and persons under 21, and restricts participants' ability to switch primary care providers at will.

The Medicaid beneficiary is required to stay with the selected primary care provider for 6 months but can change providers at any time thereafter or may change before 6 months with cause. Although IDPA is implementing the program statewide for pregnant women and children, a Medicaid waiver is not needed for areas outside of Chicago because participation is optional. According to IDPA officials, county health offices or FQHCs will provide case management services statewide.

The Healthy Moms, Healthy Kids program combines primary care with case management. Under the program in Chicago, pregnant women and children under age 6 are enrolled with community-based case managers. If beneficiaries do not enroll in an HMO, they must choose as their primary care provider either a physician who is participating in the Healthy Moms, Healthy Kids program; a federally qualified health center; or other state-approved health clinic. IDPA officials estimate that all eligible pregnant women and children will be enrolled in about 14 months.

In November of 1992, IDPA awarded a contract to First Health Services Corporation to assist with the overall implementation of the Healthy Moms, Healthy Kids program. Under the contract, First Health is responsible for the following:

- educating beneficiaries about the program,
- enrolling beneficiaries with primary care providers and case managers,
- subcontracting with community-based organizations and FQHCs to deliver case management services,
- monitoring subcontractor performance,
- maintaining a case management information and tracking system,
- submitting required reports to IDPA to monitor program performance, and
- developing and maintaining a system that allows providers access to beneficiary eligibility and prior health care records.

First Health contracted with 42 community-based case management agencies and FQHCs in Chicago to deliver case management services. According to IDPA officials, First Health began enrolling beneficiaries at local IDPA offices on May 24, 1993, targeting new applicants, pregnant women, infants, and children up to age 5.

Healthy Moms, Healthy Kids Program Plans May Address Prior Concerns

The Healthy Moms, Healthy Kids program plans include oversight and quality control initiatives that should address the weaknesses we identified in our 1990 report. However, the program is just being implemented and sufficient program data to assess the program's quality controls will not be available for many months. In our earlier report, we found financial incentives to underserve beneficiaries, inadequate quality assurance programs, inadequate and untimely utilization data, and little follow-up to correct quality-of-care problems.

Reduced Financial Risk to Providers Proposed

Healthy Moms, Healthy Kids employs a primary care case management model, which combines the concept of managed care with fee-for-service reimbursements. These reimbursements are virtually free from the financial risk that providers assume under capitated managed care models like HMOs. In the past, the largest Chicago-area HMOs serving Medicaid beneficiaries used payment methods to help control the use of health care services. Under these methods, individual primary care physicians or small groups of physicians were paid fixed amounts to provide all covered services to enrollees.

In 1990, we reported that the incentive payment funding mechanism for Chicago-area HMOs could result in physicians either limiting or reducing medical services provided to program participants because much of the financial risk was shifted onto physicians with small practices. Physicians could be forced to pay the cost of some care themselves if the cost exceeded the amount they were paid to care for the patient. By assuming the financial risk of treating Medicaid patients, the small physician practices risked insolvency if their beneficiary population required more medical services than the payment rate covered. IDPA and HCFA officials disagreed that incentive payment funding mechanisms would lead to reductions in medical services to Medicaid beneficiaries.

Unlike previous HMO programs that paid a per capita amount for each beneficiary, Healthy Moms, Healthy Kids pays providers for each medical service delivered. Providers participating in the program also receive a monthly patient management fee of \$5 for each beneficiary. Moreover, additional services are covered, such as payment for performing a risk assessment on pregnant women and children, a \$400 increase in the reimbursement rate for deliveries, an 8-percent increase in the reimbursement rate for follow-up office visits for children, and a \$10 increase in the early periodic screening, diagnostic and treatment (EPSDT) services rate, which includes immunization screening for children.

**Quality Assurance
Proposal Appears to
Address Quality-of-Care
Issues**

The Healthy Moms, Healthy Kids quality assurance proposal includes components to assess quality of care and whether needed services are provided. In 1990, we reported that the Chicago-area HMOs' quality assurance programs were inadequate. Reviews conducted by HCFA and a private contractor concluded that the quality assurance programs were so fragmented that the Chicago-area HMOs could not assure that Medicaid beneficiaries were receiving quality medical care. The reviews concluded that IDPA's oversight was inadequate and that HMOs reviewed few, if any, outpatient services for quality of care or patient outcomes.

IDPA is proposing to form a quality assurance committee that will develop a quality assurance plan. A peer review process and performance indicators to identify services and patient outcomes will be included in the proposal. According to IDPA's proposal, the quality assurance committee should consider the following indicators for pregnant women and children: the number of prenatal, child, hospitalization, and emergency room visits; birthweight of infants; immunization status of children; and neonatal deaths.

IDPA officials told us in July 1993 that they are in the process of identifying potential quality assurance committee members, which will include physicians and public health and IDPA officials. In part, the committee would determine the specific clinical and health service delivery areas the state should monitor as well as the most useful performance indicators.

Plans Require Utilization Data

The Healthy Moms, Healthy Kids program plans call for collection and submission of utilization data. In 1990, we reported that IDPA did not initially require participating HMOs to submit utilization data and when IDPA added the requirement to the HMO contracts it did not include provisions for accurate data. IDPA will require the case management contractor, First Health, to submit routine and timely reports in an approved format for continuous program monitoring and evaluation.

According to IDPA officials, data specific to the Healthy Moms, Healthy Kids program will be collected from paid claims. IDPA plans to use an existing data subsystem to compile Medicaid data into beneficiary and provider utilization profiles for use in identifying cases of underutilization or overutilization of program services. In addition, First Health is developing a case management information and tracking system. The system will utilize beneficiary health profile information from IDPA's existing management information system and specifically track patient health assessments, screening and medical appointments, medical services provided or not provided, EPSDT services, and case management services.

To monitor and evaluate the program, First Health is required to submit to IDPA monthly reports on primary care provider enrollments, complaints and grievances, problems and resolutions, and EPSDT services as well as quarterly case management reports on subcontractors and services. According to IDPA officials, the report formats are being developed.

Quality-of-Care Problems to Be Reviewed

As proposed, the Healthy Moms, Healthy Kids program-monitoring efforts should identify access and quality-of-care problems and initiate appropriate follow-up action. In 1990, we found that IDPA did not take effective follow-up action when potential quality-of-care problems were identified. For example, IDPA did not conduct a survey to determine whether beneficiary dissatisfaction caused widespread HMO disenrollment. Under Healthy Moms, Healthy Kids, IDPA plans to conduct patient surveys, establish a patient grievance system, and set up an inquiry and complaint hotline to identify access and quality-of-care problems.

IDPA plans to monthly send randomly selected participants an explanation of medical benefits, which will include a survey to identify quality-of-care issues. The survey questions will be designed to capture data relating to access problems and program utilizations. According to IDPA officials, First Health is in the process of developing the client survey process, including the survey questions, method of random sampling, the forms to be used, and the process to be used for follow-up and corrective action.

The Healthy Moms, Healthy Kids program proposes two methods for handling beneficiary grievances. First, IDPA has grievance procedures established for the existing Medicaid program to handle beneficiary disputes against medical providers. Second, First Health is responsible for resolving disputes between case management agencies and beneficiaries. According to IDPA officials, First Health has drafted grievance procedures as a part of the client education and enrollment manual, which IDPA is in the process of reviewing. The contractor is also responsible for maintenance of the inquiry and complaint line. IDPA plans to follow up on complaints and take corrective action if warranted.

Challenges to Healthy Moms, Healthy Kids Program Implementation

The state faces major challenges in implementing Healthy Moms, Healthy Kids in Chicago—implementing the program with limited funding and retaining a sufficient number of primary care providers. Local community organizations question whether IDPA has sufficient resources to implement the program. Local community organizations also fear that without a sufficient number of primary care providers patient access and quality of care could be compromised.

Limited Funding to Implement Program

A major challenge IDPA faces is implementing the program with limited funding. The state appropriation for the Healthy Moms, Healthy Kids program is about 30 percent less than IDPA's fiscal year 1994 budget request. IDPA officials said that in the Chicago area the reduced funding will cause some delays in enrolling program beneficiaries and result in a portion of the target population not being initially enrolled in the program. Local groups are also concerned that case management services may be underfunded because of the limited resources.

IDPA officials said that, for fiscal year 1994, about \$81 million was requested statewide, which included a 50-percent federal match, to implement the Healthy Moms, Healthy Kids program. About \$56 million was designated for Chicago. On July 14, 1993, the state legislature

appropriated \$57 million for the program or \$24 million less than IDPA requested. IDPA officials are in the process of determining how the reduced funding will be distributed statewide. As a result, the amount of funds available for the Healthy Moms, Healthy Kids program in Chicago has not yet been determined.

According to IDPA officials, the reduced funding will result in (1) an extension of the beneficiary enrollment period from 12 to 14 months; (2) a phase-in of beneficiaries starting with new applicants, pregnant women, infants, and children up to age 5;⁷ and (3) postponement of redetermination of Medicaid eligibility for enrollment into the program. From the fiscal year 1994 budget, about \$8 million is for First Health to develop and administer case management contracts, beneficiary tracking and information systems, and beneficiary education and enrollment. Additional funds will be used to pay for contracted case management services, the increases in physician and EPSDT rates, and a monthly patient management fee.

Community groups expressed concern that the quality of care delivered through case management services could be compromised because of underfunding and limited staff resources to provide case management. According to IDPA officials, the ratio of cases to case manager will be 155 to 1. Some community groups believe this is high given the intensity of case management services necessary as well as other outreach service requirements. Case management can include developing family service plans, arranging or delivering needed assistance for scheduling appointments, transportation or child care, and referral to social service agencies to eliminate barriers to seeking and obtaining primary care health services.

Provider Recruitment Essential to Program Success

Another major challenge in implementing Healthy Moms, Healthy Kids in Chicago is attracting a sufficient number of primary care providers and determining the proper provider-patient mix. IDPA officials recognize that without a sufficient number of primary care providers to serve 400,000 pregnant women and children in Chicago the program cannot be fully implemented. IDPA officials believe that they have enrolled a sufficient number of providers to serve the target population.

Under the program, physicians are expected to be the primary care provider. About 29,000 pregnant women and 366,000 children are expected

⁷The program was originally planned to serve pregnant women and persons under the age of 21.

to be enrolled in the program. IDPA officials estimate the ratio of physicians to pregnant women at 1 to 500 and to children at 1 to 1,500. As of July 1993, IDPA had enrolled over 900 physicians to serve pregnant women and children. According to IDPA officials, these providers can provide care to over 96,000 pregnant women and over 525,000 children.

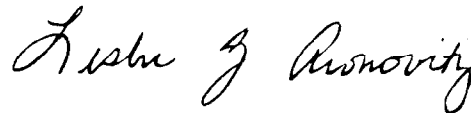
IDPA has experienced some problems with providers in the past. According to a 1989 IDPA Medicaid study, only two-thirds of the providers enrolled in the Medicaid fee-for-service program provided any health services to beneficiaries in fiscal year 1988. The study further reported that providers generally restricted their participation in the program to previous patients or a few referrals and concluded that a handful of providers delivered most of the services to beneficiaries.

IDPA officials said Healthy Moms, Healthy Kids offers several enhancements to providers, including increased payment rates, selection of patients, access to specialty referrals, and better patient compliance through case management, all of which are designed to keep providers in the program. Providers must commit to serving a specific number of Medicaid beneficiaries and must give written notice 45 days before withdrawing from the program. Further, IDPA officials said that expediting payments to Healthy Moms, Healthy Kids providers is a top priority; however, without sufficient state revenues payments may be delayed.

We discussed a draft of this report with HCFA Medicaid officials in the Chicago Region V office and IDPA officials. They generally agreed with the information presented on the Healthy Moms, Healthy Kids program. We have incorporated their comments where appropriate. We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, IDPA officials, and other interested parties. We also will make copies available to others on request.

Please call me on (202) 512-7104 if you or your staff have any questions about this report. Other major contributors are listed in appendix II.

Sincerely yours,

A handwritten signature in cursive script, reading "Leslie J. Aronovitz".

Leslie J. Aronovitz
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Abbreviations

AFDC	Aid to Families With Dependent Children
EPSDT	early periodic screening, diagnostic, and treatment services
FQHCs	federally qualified health centers
HCFA	Health Care Financing Administration
HMO	health maintenance organization
IDPA	Illinois Department of Public Aid

Objectives, Scope, and Methodology

Our objectives were to (1) determine whether the Chicago-area Healthy Moms, Healthy Kids program has adequate controls to preclude recurrence of problems we identified in 1990 and (2) identify challenges to successful implementation of the Healthy Moms, Healthy Kids program.

As agreed, we focused on the Healthy Moms, Healthy Kids program in Chicago. We performed our work at HCFA headquarters in Baltimore; HCFA Region V in Chicago; and IDPA and Illinois Department of Public Health offices in Springfield and Chicago, Illinois. We also visited Chicago and Cook County public health offices and several community-based organizations.

To address the first objective we reviewed IDPA's waiver request and program plans for the Healthy Moms, Healthy Kids program. We compared the state's proposed controls to the weaknesses identified in our 1990 report and associated testimony to determine if sufficient oversight controls were proposed. Because the program is just being implemented, performance and patient outcome data were not available to test the adequacy of the proposed controls.

To address the second objective we interviewed federal, state, county, and city governmental officials along with members of community-based organizations and statewide advocacy associations. We contacted community-based organizations because they are primarily responsible for providing case management services.

We performed our work between September 1992 and July 1993 in accordance with generally accepted government auditing standards.

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