

GAO

Report to the Ranking Minority Member,  
Subcommittee on Health and the  
Environment, Committee on Commerce,  
House of Representatives

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April 1995

# MEDICAID MANAGED CARE

## More Competition and Oversight Would Improve California's Expansion Plan







United States  
General Accounting Office  
Washington, D.C. 20548

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**Health, Education, and  
Human Services Division**

B-257569

April 28, 1995

The Honorable Henry A. Waxman  
Ranking Minority Member, Subcommittee  
on Health and the Environment  
Committee on Commerce  
House of Representatives

Dear Mr. Waxman:

The Medicaid program was established to make health care services more accessible to the poor. However, in many communities throughout the nation, Medicaid beneficiaries' access to quality care is far from assured. Too few physicians and other health care providers choose to participate in the Medicaid program because of low payment rates and administrative burdens. In an attempt to address the access problem, as well as rising costs and enrollment in its \$15 billion Medi-Cal program which serves about 5.4 million beneficiaries, California intends to increase its reliance on managed care delivery systems.

California, with about two decades of Medicaid managed care experience, has approximately 890,000 Medicaid beneficiaries in managed care plans. This number would almost quadruple to 3.4 million as California expands the managed care program, beginning in December 1995. According to state officials, the purpose of California's managed care expansion is to improve access and the quality of health care. The state expects that, in the long run, managed care will also contain Medicaid costs by reducing unnecessary services and delivering care more efficiently. A number of observers and participants, however, believe that the state's expansion plan will not achieve its goals of improved access or reduced costs.

Recognizing the significance of California's planned expansion and the value the state's experience may have for other states' Medicaid managed care programs, you requested that we review California's current and planned Medicaid managed care programs. Our objectives were to (1) describe California's current Medicaid managed care program, (2) review the state's oversight of managed care contractors with a focus on financial incentive arrangements and the provision of preventive care for children, (3) describe the state's plans for expansion, and (4) identify key issues the state will face as it implements the expanded program.

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In doing this work, we interviewed California and federal Medicaid officials, managed care contractors, and advocacy group representatives. We also reviewed documents related to managed care, including California's laws, regulations, policies, and procedures; California's strategic plan for expanding managed care; and general literature on financial incentives for providers of managed care. More detailed information on our scope and methodology is in appendix I.

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## Results in Brief

California plans a major expansion of its Medi-Cal managed care program in selected counties. By the end of 1996, over 3.4 million enrollees will receive health care through managed care plans—almost four times the number now enrolled. In selected areas, enrollment will be mandatory for women and children, who will choose to receive care from one of two plans. This is a significant change from the predominantly voluntary program the state currently administers that allows beneficiaries to choose between fee-for-service and managed care.

Problems identified to date in a primarily voluntary enrollment program could be significantly magnified in a much larger program with mandatory enrollment. We are concerned about whether the state will monitor managed care plans effectively enough to minimize any adverse effects on the availability and quality of health care provided to Medicaid enrollees placed in mandatory managed care. A vital factor in the success of the program will be the capabilities of the state's contract management staff. The state has said it intends to improve its monitoring and strengthen its staff capabilities through enhanced contract requirements and the hiring of more staff. We are also concerned that the state does not give enough attention to the extent that providers have financial incentives to limit needed care and that the state has difficulty verifying whether services it pays for are actually provided, including preventive care for children.

The state believes its expansion plan will improve Medicaid beneficiaries' access to care and is a major improvement over the current fee-for-service environment. However, we believe that any benefits of competitive managed care will be lessened by the state's decision to limit beneficiaries in selected areas to choosing between two health plans. Several areas of the state could support more than two health plans, giving beneficiaries more choices and the state more latitude in dealing with plans that do not meet their commitments.

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## Background

Enacted in 1965 as title XIX of the Social Security Act, Medicaid is a federally aided, state-administered medical assistance program. At the federal level, the program is administered by the Health Care Financing Administration (HCFA), an agency within the Department of Health and Human Services. Within broad federal guidelines, each state designs and administers its own Medicaid program, which HCFA must approve for compliance with current law and regulations. HCFA is also responsible for providing program guidance and oversight to the state programs. Nationwide, Medicaid served approximately 34 million low-income people in fiscal year 1994, with combined federal and state expenditures of \$143 billion.

California established its Medicaid program, named Medi-Cal, in 1965. The cost of the Medi-Cal program was estimated to be about \$15 billion in federal and state funds in fiscal year 1994, serving about 5.4 million people. The California Department of Health Services (DHS) is the agency responsible for administering the Medi-Cal program. It determines policy, establishes fiscal and management controls, contracts with managed care health plans, and reviews program activities.

California has over 20 years of experience with Medi-Cal managed care programs. DHS began contracting with Prepaid Health Plan (PHP) pilot projects in 1968. Abuses and scandals plagued the early years of PHP contracting, resulting in beneficiaries being denied access to care. This led the California legislature to pass the Waxman-Duffy Prepaid Health Plan Act in 1972, which established standards for California Medicaid PHP contracts and for program administration. Controls have been continually strengthened over the years through amendments to the Waxman-Duffy Act. The Knox-Keene Health Care Service Plan Act of 1975 gave the California Department of Corporations authority to license and regulate fully capitated PHPs in the state. One Waxman-Duffy amendment made Knox-Keene licensure a prerequisite to obtaining a Medi-Cal PHP contract. With the advent of the Waxman-Duffy and Knox-Keene acts, the majority of then-contracting PHPs had to leave the Medi-Cal program because they failed to meet the new standards.

Beginning in the 1980s, the state enacted several pieces of legislation authorizing the development and testing of alternative ways to deliver managed health care services to Medi-Cal beneficiaries. The first legislation, in 1981, authorized the development of pilot Primary Care Case

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Management (PCCM) programs.<sup>1</sup> Subsequent legislation, in 1982, authorized County Organized Health Systems (COHS) and a Geographic Managed Care (GMC) program, and also permitted routine PCCM contracting.

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## California's Current Medicaid Managed Care Program

Medi-Cal managed care is currently built on a foundation of PHPS and PCCMs. Contractors are all paid on a capitated basis for the services they provide; that is, the state pays the managed care plan a monthly fee for each enrollee, and the plan assumes responsibility for the full cost of the services it has contracted to provide.<sup>2</sup> PHPS are capitated to provide all basic benefits covered by Medi-Cal, excluding a few selected services such as organ transplants, chronic renal dialysis, long-term care, and dental care. The capitation fee is intended to equal DHS' cost of providing the same services on a fee-for-service basis to an actuarially equivalent population.

PCCMs are operated by physicians and other primary care providers who are capitated to provide all outpatient physician services and to manage all of the services provided to their enrollees. They may elect to provide certain additional services for an increased capitation fee. The capitation fee for PCCMs is set at 95 percent of the fee-for-service equivalent. All services not capitated are available to the PCCM enrollee on a fee-for-service basis.

DHS rewards PCCMs for effective case management by paying them a percentage of the amount by which the state's costs for the noncapitated services fall below the projected costs for an equivalent non-case-managed population.

California also uses other managed care delivery systems. COHSS deliver health care to Medicaid beneficiaries in three counties—San Mateo, Santa Barbara, and Solano. A COHS is a local agency that contracts with the state Medicaid program to administer a capitated, comprehensive, case-managed health care delivery system. The COHS is responsible for administering claims, controlling utilization, and providing services to all Medicaid beneficiaries residing in the county. Beneficiaries in the COHS area must enroll in the COHS. They have a wide choice of managed care providers but cannot obtain services under the traditional fee-for-service

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<sup>1</sup>PCCMs are entities that contract with the state to provide enrolled beneficiaries with physician and outpatient services on a capitated basis.

<sup>2</sup>DHS' excess risk limitation arrangements can provide partial indemnification to plans for any individual's health care costs in excess of a specified risk limit per contract year. Contractors may also purchase commercial insurance for some of their risk.

system unless authorized by the COHS. All Medi-Cal services are arranged for by COHSS through subcontracts with providers. The state plans to have COHSS in two more counties—Orange and Santa Cruz—in 1995.

California began a GMC pilot in Sacramento County in 1994. Under this project, the state contracts with several managed care plans to serve that county's recipients of Aid to Families With Dependent Children (AFDC) population on a mandatory basis and other Medicaid beneficiaries on an optional basis. The state is planning an additional GMC project in San Diego County.

Presently, approximately 890,000 Medicaid beneficiaries are enrolled in managed care plans in 20 of the state's 58 counties. Table 1 shows enrollment by type of plan.

**Table 1: Statewide Medi-Cal Managed Care Enrollment by Type of Plan (Dec. 1994)**

Type of plan	Enrollment
Prepaid Health Plans	476,041
Primary Care Case Management programs	147,835
County Organized Health Systems	136,086
Geographic Managed Care programs	130,423
<b>Total</b>	<b>890,385</b>

Most of the managed care enrollments are voluntary; that is, each beneficiary may choose to receive care through either a managed care plan or the traditional fee-for-service system. In addition, in some counties, Medicaid beneficiaries have a choice of managed care plans.

## Monitoring and Oversight

DHS monitoring and evaluation of Medi-Cal contractors consist of annual medical and periodic financial audits of all Medi-Cal managed care plans. DHS also performs periodic monitoring and oversight, including quarterly site visits to managed care plans by DHS contract management staff. Managed care plans are reviewed for compliance with federal and state regulations, with plan contract requirements, and with plans' own procedures.

The DHS Audits and Investigations Division conducts the annual medical quality assurance audits and the periodic financial audits (approximately every 2 years) of all Medi-Cal managed care plans. The medical audit focuses on plan performance in areas such as accessibility, continuity of

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care, quality assurance, personnel licensure, preventive services, grievances, and facilities and equipment.

DHS contract management staff's monitoring of managed care plan performance in terms of access and quality of care includes (1) investigation of complaints from beneficiaries, county welfare departments, beneficiary advocate groups, and providers; (2) review of disenrollments from plans; (3) review of emergency room visits by plan members; (4) follow-up of contractor corrective action plans for deficiencies identified in medical and financial audits; and (5) reviews of plan capacity and access. At the time of our review, DHS employed 17 contract managers. Each contract manager was responsible for one to three health plans.

In addition to DHS' periodic financial and medical audits, health plans involved in Medi-Cal managed care must undergo several other types of audits on a regular basis. These include the state Department of Corporations' medical and financial audits of all health maintenance organizations (HMO); annual certified public accountant audits of health plans; and HCFA-sponsored biennial independent cost, access, and quality assessments of PCCMS and COHSS.

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## Monitoring and Oversight Could Be Strengthened

Effective monitoring and oversight activities are critical to the success of any state Medicaid managed care program to ensure that beneficiaries have access to quality health care.<sup>3</sup> However, a 1992 HCFA review found that DHS was not always able to manage and monitor its managed care program well enough to ensure that the health plans it contracted with were meeting all their responsibilities or that beneficiaries were receiving needed services in a timely fashion.<sup>4</sup>

Our review found three areas for continued concern. First, although DHS monitors managed care plans for compliance with their Medicaid contracts, it provides little guidance and training to those responsible for this important task. Second, the state does minimal review of plans' provider financial incentives to ensure that they do not encourage inappropriately withholding health care services. Third, the state does

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<sup>3</sup>See Medicaid Managed Care: Healthy Moms, Healthy Kids—A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993); Medicaid: States Turn to Managed Care to Improve Access and Control Costs (GAO/HRD-93-46, Mar. 17, 1993); and Medicaid: Oregon's Managed Care Program and Implications for Expansion (GAO/HRD-92-89, June 19, 1992).

<sup>4</sup>HCFA Region IX, Review of California's Administration of Its Managed Care Program (1993).

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little monitoring to ensure that services are actually provided through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, which focuses on preventive services for children.

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## DHS Contract Managers Lack Specific Guidance and Training

After its 1992 review, HCFA criticized DHS' monitoring of managed care plans. Representatives of advocacy groups we interviewed also criticized DHS' contract management capabilities and lack of enforcement activity. Although DHS often cites managed care plans for noncompliance with contractual obligations, advocacy groups said effective enforcement is not undertaken.

A December 1994 study by the Center for Health Care Rights in Los Angeles concluded that Medi-Cal health plans with a history of poor care had not been penalized or forced to make improvements.<sup>5</sup> The Center reviewed a sample of health plans' medical audits over time and DHS activities after deficiencies were discovered. In its report, the Center expressed concern with the inconsistent application of deficiency ratings and the lack of DHS and health plan follow-up for serious quality of care problems found during an audit.

Contract managers we interviewed expressed concerns of their own, including their inability to monitor managed care health plans on a proactive basis. They said that they dealt with problems brought to their attention but did not have time to anticipate, identify, and resolve emerging problems. Heavy workloads are one reason for this problem. After its 1992 review of DHS, HCFA cited the agency's lack of staff as one reason for DHS' inadequate monitoring, and an advocacy group we spoke with also said contract managers' heavy workloads had an adverse effect on Medicaid beneficiaries' access to quality health care. Although the state has added staff, a HCFA official told us that DHS has just enough people to keep current programs running and that heavy workloads remain a HCFA concern.

Another factor involved in DHS' inadequate monitoring that HCFA found in its 1992 review was a generally low level of contract manager experience and technical expertise. Our review also indicated that DHS could improve its monitoring and management of health plans by giving contract managers more training and guidance. In our discussions with DHS officials and contract managers, we found that only on-the-job training and ad hoc

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<sup>5</sup>Center for Health Care Rights, *State Oversight of Medi-Cal Managed Care Plans: How Well Does California Protect Poor Families?* (Los Angeles: Dec. 1994).

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workshops were provided. Only one of the five contract managers we interviewed said enough training was provided.<sup>6</sup> Other contract managers wanted additional training on topics such as how to interpret a contract, how to review plans' cost and utilization reports, and what to look for during site visits.

We also found that DHS had not provided contract managers with written policies and procedures on how to perform their duties. For instance, contract managers said they did not have adequate guidance regarding what they should do when contractors fail to comply with state requirements. They believed that DHS policy on the use of sanctions for noncompliance was vague and, therefore, not easily implemented. DHS agreed contract managers could use more guidance and training.

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## DHS Does Minimal Monitoring of Financial Incentive Arrangements

Managed care plans that are paid on a capitated basis, such as PHPS and PCCMs, often give incentives to their providers to encourage them to control costs. If the costs of the services these plans provide are higher than the capitation payments they receive, the plans must make up the difference.<sup>7</sup> As a result, primary care physicians in managed care plans typically serve as "gatekeepers" who must preapprove certain services for their patients. Financial incentive arrangements adjust the compensation paid to primary care physicians to discourage them from providing health services such as inpatient hospital care, referrals to specialists, and certain diagnostic tests when the services are unneeded. While there are no reliable current data on the extent to which managed care plans use financial incentives, evidence suggests that most HMOs use some incentives.

All three Medi-Cal PHPS we spoke to regarding their financial arrangements do use incentives. One plan, which has salaried primary care physicians, pays them a bonus of up to 20 percent of salary partly on the basis of the cost of individual physician referrals for specialty and hospital care. A second plan pays a medical group on a capitated basis to provide virtually all medical services in-house except inpatient care. Any surplus or deficit up to a specified limit in the inpatient hospital budget is shared equally

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<sup>6</sup>We interviewed 5 of the 17 contract managers, which represents a judgmental sample of those who work with different types of plans and report to different unit supervisors.

<sup>7</sup>Financial incentives are only one of a number of methods capitated managed care plans may use to limit service provision. Others include requiring physicians to obtain the plan's preapproval when ordering expensive procedures, educating physicians regarding cost control, reprimanding and possibly terminating the contracts of physicians who exceed utilization guidelines, and screening out physician applicants who do not share the plan's cost-control goals.

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with physicians. The third plan, which passes along almost all the financial risk, compensates each of its medical groups on a capitated basis for nearly all medical services, including services for which patients must be referred outside the group. It also uses bonus incentives for low hospital utilization. Appendix II contains a more detailed discussion on the use of financial incentives.

Ideally, financial incentives operate to reduce unnecessary medical procedures, but they also have the potential to deny patients beneficial and necessary services. Although there are few data on whether financial incentives actually reduce the quality of medical care, the American Medical Association, the Department of Health and Human Services, advocacy groups, academic experts, and our past reports have commented on the potential of incentives to impair quality. Among the factors cited as influencing how much of a hazard incentives may pose are (1) the extent to which a physician's compensation is placed at risk for services approved by, but not directly provided by, the physician; (2) whether the incentives are based on the service utilization patterns of individual physicians or of a group of physicians in the aggregate; (3) whether a physician's risk is spread over a large patient pool and the duration of the period used for computing a bonus or deficit; (4) whether the managed care plan provides stop-loss insurance to limit a physician's risk; and (5) whether the plan has an effective quality assurance program that attempts to counteract any adverse effect the incentive may have on patient care.

Although DHS reviews financial incentive arrangements, officials told us they have no criteria or guidelines regarding the types of financial incentives that are acceptable. Their auditors, who review the Medicaid managed care plans' financial statements, use their individual professional judgment when analyzing financial arrangements between the plans and their subcontractors. The auditors focus primarily on whether the compensation a plan pays to a subcontractor is adequate to protect the financial viability of the subcontractor, not on whether the compensation arrangements threaten quality of care.

DHS relies primarily on the Department of Corporations' licensing process to uncover unsatisfactory financial incentive arrangements. A Department of Corporations official told us that the only general rule applied when reviewing financial incentive arrangements is that a provider or provider group that does not provide hospital or other institutional care may not be

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capitated for such care.<sup>8</sup> Apart from applying this rule, the Department of Corporations reviews financial incentive arrangements on a case-by-case basis. In general, though, it does not examine the arrangements closely because the managed care plan is responsible for ensuring that its subcontracting arrangements meet the state's quality assurance requirements.

Pursuant to the Omnibus Budget and Reconciliation Act of 1990 (P.L. 101-508), HCFA is currently developing standards for imposing restrictions on the financial incentive arrangements that managed care plans contracting under Medicare and Medicaid can enter into with their physicians. The final regulation is undergoing internal review and is scheduled to be published in 1995.

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## Assurance Needed That EPSDT Services Are Provided in a Capitated System

EPSDT strives to improve low-income children's health by providing a framework for the timely detection and treatment of health problems. However, research shows that the percentage of eligible children participating is low,<sup>9</sup> indicating that the program has not been entirely successful. Under managed care, the success of an EPSDT program depends largely on the capitated providers who are generally responsible for furnishing most primary and preventive health services.

Though DHS contracts with managed care plans to provide EPSDT services to Medi-Cal enrollees, DHS does not know to what extent the services are provided because of inadequate data and monitoring. In addition, in violation of federal and state requirements, the state does not require that all eligible children be periodically notified of available services.

HCFA requires states to ensure that Medicaid-eligible children, from birth through age 20, are provided preventive health services under the EPSDT program. EPSDT services consist of screening services;<sup>10</sup> vision, dental, and hearing tests; diagnostic services; and other medical services needed to correct conditions discovered during screenings. Problems with

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<sup>8</sup>The Department of Corporations established this rule because it believed that capitating a group or provider group for hospital or institutional care gave the group too great an incentive to deny patients this care. The Department believes this rule may be out of date and is considering rescinding it because the arrangements it prohibits are becoming increasingly widespread in the industry.

<sup>9</sup>U.S. Department of Health and Human Services Office of Inspector General, Final Report: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)—Performance Measurement, OEI-07-90-00131 (Aug. 1992).

<sup>10</sup>Screenings, also called health assessments in California, consist of a comprehensive health and developmental history, a comprehensive unclothed physical examination, appropriate immunizations, laboratory tests, and health education and guidance.

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California's EPSDT data and monitoring were noted by HCFA in its 1992 review. HCFA reported that plans kept poor medical records that made it impossible to determine whether children received appropriate services. HCFA recommended that the state adopt procedures to track Medicaid providers' activities and to validate that children received necessary diagnostic and treatment services in accordance with EPSDT requirements.

We found continuing problems in the current program. Specifically, DHS (1) allowed plans to submit aggregate data regarding their provision of EPSDT services that allow for little or no analysis or verification; (2) did not comply with federal and state requirements by periodically notifying, or ensuring PHPS periodically notify, all eligible children of available services; and (3) could not ensure that all children referred for diagnosis and treatment actually received it.

PHPS may report EPSDT services to the state on an encounter level (Form PM-160) or monthly aggregate basis. According to DHS officials, most report aggregate data. From these aggregate data, it cannot be determined how many children actually received at least one screening, whether eligible children were receiving all required screenings, or whether children referred for diagnosis and treatment because of screening results actually received treatment. Aggregate data are also difficult to verify, making validation of reported services impossible.

HCFA's policy had been that PHPS can be "deemed" to have met EPSDT requirements because they are assumed to emphasize preventive care. According to a DHS official, this policy gives DHS no incentive, for HCFA reporting purposes, to track or verify whether plans actually provided EPSDT services. HCFA recently revised its reporting requirements and no longer allows "deeming." As a result, in September 1994, California changed its reporting requirements and now requires PHPS to submit encounter-level reports (Form PM-160). The state, however, admits that implementation will be slow and incremental.

Federal and state requirements say DHS must notify EPSDT-eligible children through age 20 of upcoming screenings and of the availability of assistance with transportation and scheduling appointments, and must record the response to this notification. DHS issues notices for children under age 3 except for those enrolled in PHPS that submit aggregate data to the state. However, the state does not determine whether PHPS issue notices except through annual audits, in which issuance of screening notices may not be

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reviewed. Furthermore, DHS neither issues notices nor requires PHPS to issue notices to children aged 3 and older.

Federal law requires the state to provide diagnostic and treatment services for children with conditions discovered during screenings. To determine whether children referred for diagnosis and treatment actually received it, follow-up is needed. DHS conducts follow-up for children enrolled in PCCMS through county Child Health Disability Prevention offices. However, it does not do follow-up for children in PHPS because the task is considered to be case management, a role PHPS are required to perform. The state does not verify whether PHPS perform follow-up as required.

DHS' Medical Review Branch does annual medical quality assurance audits of managed care plans to determine if the plans comply with federal and state regulations, contract requirements, and the plans' own procedures. If any problems or deficiencies related to EPSDT happened to be noted in the annual health plan audits, contract managers should determine if managed care plans corrected them. However, the DHS audits are designed to assess the quality of services rendered to beneficiaries in general. They are not designed to assess or estimate the number of children who received screenings or to determine the rate at which health plans provided diagnosis and treatment to children who needed it based on screening. In addition, unless children had at least three visits to a provider during the year, their records are not audited.

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## California's Expansion Will Significantly Change Program

Movement toward the expansion of managed care in the Medi-Cal program began in 1991 with the passage of state legislation that emphasized managed care as a means for delivering health care services. After considering different models of managed care, including using a single plan organized by a local agency with broad representation in each county, the state decided to use two plans per county. A draft plan was released in January 1993. Public hearings followed and, based on the testimony of interested parties, the state revised its plan for expansion. It was published in final form in March 1993.

By December 1996, California intends to have approximately 3.4 million Medicaid beneficiaries enrolled in managed care—a majority of the estimated 6 million Medi-Cal beneficiaries. Most of these beneficiaries will be enrolled as part of the state's 12-county expansion plan. Figure 1 shows the counties with Medi-Cal managed care programs by type of enrollment after the expansion has occurred.



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California sees managed care as the solution to many of the access and quality problems of its current, largely fee-for-service program. These problems include difficulties in finding physicians who accept Medicaid patients and the lack of a quality assurance system for Medicaid beneficiaries in the fee-for-service program. State officials believe the expanded managed care program will bring a greater number of providers into the program and give beneficiaries greater continuity of care. In addition, they believe that managed care offers better opportunities for controlling costs than a fee-for-service environment.

The state intends to contract with two health plans in each of 12 counties—one would be a “local initiative” and the other would be a “mainstream” plan. The local initiative could take different forms. County governments were given the first opportunity to establish local initiatives. If a county government chose not to, a local initiative could have been formed by a consortium of local stakeholders.<sup>11</sup> However, all 12 counties submitted a formal letter of intent to establish local initiatives. The mainstream plan will be a single private plan selected through a bidding process; joint ventures will be considered. All health plans within the new program will have to meet federal and state requirements for access and quality for managed care plans.

Under the state’s proposal, only AFDC and AFDC-related Medicaid beneficiaries (who together make up approximately 67 percent of the Medicaid beneficiaries statewide) will be required to enroll.<sup>12</sup> Other categories of eligibles such as Supplemental Security Income (SSI) and SSI-related Medicaid beneficiaries will not be required to enroll in managed care plans, but they may do so if the plans in their areas have the capacity to serve these groups and their coverage is provided for in the plans’ Medicaid contracts.<sup>13</sup>

DHS set the minimum enrollment level at 22,500 for each plan. DHS believes this number will ensure the viability of the mainstream plan and the safety-net providers participating in the local initiative. Safety-net

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<sup>11</sup>DHS did not specifically define the term “stakeholders” in its plan. It appears to refer to any interested parties that will be affected by the Medicaid program in a county—including providers and beneficiaries.

<sup>12</sup>AFDC includes families receiving cash assistance. AFDC-related women and children are those who are not receiving cash assistance but are eligible for Medicaid based on family income relative to the federal poverty level.

<sup>13</sup>SSI beneficiaries are people who are aged, blind, or disabled and receive cash assistance. SSI-related beneficiaries include people who meet SSI requirements but have too much income to qualify for SSI supplemental payments but not enough income to cover their health care costs.

providers include community health centers and hospitals that provide charity care and serve relatively high numbers of Medicaid beneficiaries. Maximum enrollment levels, still to be determined, will be established to moderate the effect the enrollment of beneficiaries in the mainstream plan will have on disproportionate-share payments to safety-net hospitals, which have partially compensated them for their volume of charity care and Medicaid services. The state expects to set a maximum enrollment for the mainstream plan at approximately 30 to 40 percent of the total Medicaid managed care enrollees in most counties.

To implement several provisions of the program, the state will have to seek a waiver of certain federal requirements that set minimum standards for state Medicaid programs. For example, to require a beneficiary to join a managed care plan, the state must obtain a waiver of federal Medicaid requirements that allow beneficiaries a choice of providers.<sup>14</sup>

## Improvements Proposed for Expanded Program

In an effort to improve program operations and oversight, DHS has proposed several enhancements to the Medi-Cal managed care program. These changes are described in the state's September 1994 "Request for Application" that solicited health plan applications for the mainstream plan contracts in the 12 counties. The request for application also forms the basis for agreements with the local initiatives. These initiatives are based on input received from interested parties throughout the state. Proposed changes include the following:

- Increasing access to, and coordination of, care through promoting the integration of public health and specialty services within managed care—The expansion will include traditional and safety-net providers, including community clinics and family planning in managed care networks. Health plans will be expected to enter into memorandums of understanding with local health departments for the provision of specified public health services, for example, immunization, family planning, and detection and treatment of sexually transmitted diseases.
- Improving the health status of the Medi-Cal population through strengthening and standardizing the definition of preventive health care services—Contracting plans will notify members of the availability of an

<sup>14</sup>In June 1994, the state announced a delay in its implementation schedule of up to a year; implementation is now not anticipated until December 1995. The primary reasons for the delay are to (1) consider comments raised on the state's draft request for application and its decisions on recommendations made by the Medi-Cal managed care Expansion Work Group, (2) ensure sufficient time for the counties involved to develop information systems, and (3) allow enough time for local initiatives to plan.

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initial health assessment and will be required to complete the assessment within 120 days of enrollment. The plans will be required to meet other requirements consistent with the EPSDT periodicity schedule.

- Strengthening quality assurance efforts through expanding monitoring and data reporting capabilities—Contracting plans will report encounter-level data to DHS that will allow the state to identify all of the diagnoses and procedures performed by the health care provider during an interaction with a patient.
- Removing barriers to accessing care through the development of standards for cultural and linguistic services.

In addition, once the request for application procurement process is completed, request for application requirements will be developed into a standardized program manual for training and use by DHS staff.

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### Better Monitoring and Oversight Are Needed in Expanded Program

On the basis of our review of the current program operations, we believe the state must improve its monitoring and oversight activities to avoid problems in the expanded program. Although the proposed changes in contract requirements with health plans may improve the program, these provisions must be implemented, monitored, and enforced. As was described before, under the current program, the state's monitoring of managed care plans has not been sufficient to determine whether beneficiaries received EPSDT services that plans had contracted to provide. Problems identified to date in a primarily voluntary enrollment program could be significantly magnified in a much larger program with mandatory enrollment.

In addition, the state needs to provide better guidance and training to its contract managers and to expand oversight to include reviews of financial arrangements and EPSDT programs. In recognition of these needs, DHS has requested an additional 102 positions for the managed care program.

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### Expansion Raises Some Important Questions

While the state seeks to benefit from competition, we believe that by allowing only two plans to serve an area, California is limiting beneficiaries' choices and may be reducing its ability to deal with plans that do not fulfill their contractual requirements. Limiting mandatory enrollment to AFDC and AFDC-related beneficiaries seems reasonable as the program is first implemented, but the state should reconsider including the SSI population once the expanded program is running smoothly. How the traditional and safety-net providers fare under the expansion plan remains

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to be seen, but the state's plan attempts to strike a reasonable balance between protecting traditional and safety-net providers<sup>15</sup> and moving them toward a competitive managed care system.

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## The Two-Plan Model Raises Questions About Competition

Representatives of private managed care health plans that currently have Medi-Cal contracts have voiced concerns over the two-plan model. They believe that the limit on private contractors is unnecessary and that it eliminates meaningful choice for beneficiaries. In addition, they have challenged the state's contention that the two-plan model will create a competitive environment. For example, private plans that are normally competitors may need to work together in the larger counties under the two-plan model to form large enough entities to handle the enrollment requirements. This would put them in the awkward position of sharing confidential information with their competitors.

The California Association of Health Maintenance Organizations believes that without competition, Medi-Cal contractors will not be responsive to market demands for increased quality of care. According to an analysis done by the California Legislative Analyst's Office, having two plans in a county—a local initiative plan that does not have to compete and a mainstream plan—does not represent a competitive market. The analysis said that once the mainstream plan has been selected, the state will feel compelled to continue existing contracts regardless of how poorly plans may perform because of the major disruption that would occur if enrollees were forced to change plans.

DHS officials stated that the primary reason for the two-plan model is that the state lacks the resources to administer and oversee more plans. They said another major reason is that having multiple plans would force the state to lower the minimum enrollment levels set for each plan (now set at 22,500 enrollees).

DHS officials believe that the initial bidding process for the mainstream plan and subsequent rebidding will provide adequate competition among private sector plans. With regard to choice, DHS officials pointed out that

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<sup>15</sup>The state defines traditional providers and safety-net providers in general terms. A traditional provider is one that has historically delivered services to Medicaid beneficiaries. The term includes medical and hospital providers that provide services to relatively high numbers of Medicaid beneficiaries. Safety-net providers are clinical providers that provide comprehensive primary care and hospitals that provide acute inpatient services to the medically indigent and special needs segment of the state's population. They are providers of charity care. Most safety-net providers also provide services to Medicaid beneficiaries. Examples of safety-net providers include community health centers, hospitals that receive so-called disproportionate-share payments from Medicaid, and public and university hospitals.

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each of the contracting plans will contain large networks of providers, giving beneficiaries a choice of providers within each plan. Finally, state officials said that they will act aggressively against plans when problems with access and quality are identified—even if that means terminating a contract.

We believe that California’s two-plan model will restrict competition and beneficiary choice. For example, competition will be restricted in Los Angeles County where several health plans appeared ready to compete for the mainstream contract.<sup>16</sup> While beneficiaries may have a choice of many providers, the plans’ policies and practices are a controlling factor in the care that providers give. Selecting a different provider will not solve a problem that arises because of plan decisions, such as to restrict the availability of high-cost specialized services.

Relying on only two plans could also reduce the state’s willingness to cancel a contract and thus weaken its ability to make plans comply with contract provisions. Each plan will have a large number of enrollees, making canceling a plan extremely disruptive to many people. This will be especially true in large metropolitan areas. In addition, because DHS has already had difficulty ensuring access, quickly finding alternative sources of care for large numbers of enrollees could be very difficult.

While the state’s ability to administer and oversee the program is important, administrative limits are not a persuasive argument for restricting the number of plans to two. The number of plans may not have as much effect on DHS’ administrative workload as the total number of providers or number of enrollees in the managed care program.

DHS officials were also concerned that having multiple plans would force the state to lower enrollment levels. However, DHS could keep the minimum and maximum enrollment levels that it established for both the local and mainstream plans, but use the maximum enrollment number for the mainstream plan in each county as a “global cap” for multiple participating plans.

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**Optional Enrollment of SSI  
Population Appears  
Reasonable**

As in other states, California’s decision not to require the aged and disabled of the SSI and SSI-related population to enroll was the culmination of weighing the potential benefits of including the entire Medicaid

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<sup>16</sup>Six health plans in Los Angeles have announced their intention to form a joint venture to compete for the mainstream contract.

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population in the managed care program versus the uncertainties of how to implement and manage such a program. There have been diverse views from several parties in assessing the decision by California.

In our March 1993 report on state managed care efforts, we noted that although some states had included other population groups in their managed care programs, most states targeted their Medicaid managed care programs to AFDC and AFDC-related beneficiaries. They did this because AFDC and AFDC-related populations (1) most closely resemble patients in existing primary care practices and generally do not require the same specialized health care services as the SSI population, (2) are more likely to benefit from the types of preventive services that are the hallmark of a managed care delivery strategy, and (3) have the greatest problems getting access to care.

Officials in two California counties operating COHSS have stated that the way to achieve the maximum benefits from managed care is to have the entire Medicaid population, including the SSI recipients, enrolled. They attributed some of the financial savings of their programs to the mandatory enrollment of the SSI population in their counties. They said that including SSI beneficiaries increases the COHSS ability to spread risk and to achieve savings.

In contrast, after its 1992 review, HCFA officials recommended that instead of including more beneficiaries as the COHS officials suggest, California limit the size of its program by targeting its managed care effort to specific high-risk/high-cost beneficiary groups, rather than enroll the entire AFDC and AFDC-related population in so many counties. Given the state's limited administrative resources, the expansion effort could be improved by targeting managed care on groups that would benefit the most from case management while, at the same time, controlling costs, HCFA officials believe. Administering a managed care program of over 3 million AFDC and AFDC-related beneficiaries will create an even greater administrative strain on the state than it is now experiencing, HCFA officials said.

However, DHS officials point out that the primary goal of the new program is to improve Medicaid beneficiaries' access to health care services while controlling costs. They believe that enrolling the entire AFDC and AFDC-related population in the designated regions is the best way to increase access for the largest number of people at this time. DHS officials also point out that the state is dealing with problems associated with high-risk/high-cost beneficiaries through the design and implementation of

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special projects. The state is expanding its Programs of All-Inclusive Care for the Elderly that provide a continuum of care from primary and acute care to long-term care. In addition, the state has begun a medical case management program for high-risk/high-cost beneficiaries.

We believe that excluding the SSI population from the expanded program may limit the potential for cost savings. However, at the same time, leaving out the SSI population during the implementation of the program may be a prudent decision with such a large expansion. Administering this program is going to be a major challenge for the state. The state can reconsider the desirability of enrolling the SSI population once the expanded program is running smoothly.

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### Impact on Safety-Net Providers Could Affect Access

Counties in California are financially responsible for providing health care to those who are medically indigent but do not qualify for Medi-Cal. To do so, some counties administer and partially fund their own health care systems that include hospitals and clinics. These county systems, which also provide care to Medi-Cal beneficiaries, are recognized as traditional and safety-net providers. Critics, including Los Angeles County officials and some advocacy groups, believe that the two-plan model may harm the financial viability of safety-net and traditional providers, diminishing their ability to provide care for the medically indigent and for undocumented aliens.

With few exceptions, counties have little or no experience in running managed care systems. County hospitals and clinics receive their revenues from a variety of sources, including county appropriations and third party payers such as private insurance, Medicare, and Medicaid. These third party payers primarily reimburse on a fee-for-service basis. Although Medicaid does not reimburse for all the health care expenses a county incurs, it has been a reliable source of substantial revenue.

Medicaid disproportionate-share payments—supplemental payments to hospitals that serve large numbers of Medicaid and other low-income patients—also have become an important revenue source for California’s county hospitals, particularly to subsidize the care of the uninsured. If county hospitals lose Medicaid patients to other managed care providers, county revenues to fund health care will be affected in two ways: (1) direct Medicaid reimbursement for services provided will be lost and (2) disproportionate-share payments will decline as the number of Medicaid beneficiaries they serve drops.

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The state's managed care expansion model extends participation to safety-net and traditional providers to ensure that the hard-to-serve populations will have access to health care. The local initiative must include all safety-net providers that agree to the terms and conditions required of similar providers affiliating with the initiative. The local initiative will also be required to submit standards for including traditional providers. Furthermore, DHS will encourage mainstream plans to include safety-net and traditional providers in their networks by assigning favorable weighting to mainstream plan proposals that provide for the inclusion of traditional and safety-net providers.

Most of the counties involved in the expansion program have asked to be allowed to set up COHSS with no competition from mainstream plans. County officials believe that these arrangements are the best way to provide for the Medicaid population as well as the indigent and the undocumented alien populations. COHSS would eliminate the competition of the private plan and, therefore, minimize the potential financial losses and risk safety-net providers face.

However, Los Angeles County health care officials believe that even if plans contract with safety-net providers, the state's plan for expanding managed care will lead to a loss of essential revenues for their health care system because many Medicaid beneficiaries who now obtain care in county facilities will enroll in mainstream plans. They fear this will destroy the viability of some safety-net providers, resulting in reduced access to care for the remaining Medicaid beneficiaries and the indigent uninsured. County officials are also concerned that the mainstream plans will enroll the healthier beneficiaries, leaving the sicker and more costly beneficiaries in the county system. In addition, according to the California Association of Public Hospitals, because traditional and safety-net providers lack experience running managed care plans, they may be at a disadvantage competing with experienced private plans.

State officials told us that there are no plans to establish COHSS beyond the ones already operating or scheduled to start in 1995. The officials believe that assurances have been built into the strategic plan so that counties will receive adequate revenues to ensure the financial viability of safety-net providers. Specifically, the state has put in place safeguards to reduce bias selection between health plans. For example, beneficiaries who do not choose plans will be equitably distributed between plans. Furthermore, the expansion plan protects disproportionate-share payments in three ways:

- The enrollment floor for the local initiative is based on total disproportionate-share hospital days in the county and is designed to protect disproportionate-share hospital payments flowing to that county.
- A 2-year implementation period and a 2-year data lag<sup>17</sup> will allow disproportionate-share hospitals time to make the transition to the new managed care environment.
- Safety-net providers will play a significant role in the local initiative and therefore will be able to arrange admissions to hospitals in a way that protects their disproportionate-share supplemental payments.

Despite these efforts to protect some of the revenue sources for counties, however, state officials believe that county facilities could operate more efficiently. They believe more efficient operations by the county, and by safety-net providers in general, will lead to better care for Medicaid beneficiaries because care will be provided in more appropriate settings, such as physicians' offices rather than hospital emergency rooms.

We believe the state's plan attempts to reasonably balance the need to protect traditional and safety-net providers, while moving them toward a competitive system. To insulate them completely from competition would preclude gaining any of the benefits of competition.

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## Observations

California has devoted considerable effort to its proposed expansion of Medi-Cal managed care. It has involved the public in its planning process, modified its plan based on the comments of interested parties, and adjusted its schedule for implementation when problems have been encountered. The expanded program will attempt to improve Medicaid beneficiaries' access to care and control costs. However, given incentives to control costs by limiting services, the state will need to provide effective oversight to ensure that managed care plans provide beneficiaries with high-quality comprehensive care. This is especially important for EPSDT and other preventive services where outreach efforts are often required.

The state's decision to exclude the SSI population from mandatory enrollment is consistent with the practices of other states and seems reasonable at this time. However, we believe that California may want to consider mandatory enrollment of the high-cost SSI population once the expanded program is running smoothly.

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<sup>17</sup>Statistics used to calculate disproportionate-share payments are 2 years behind the year in which such payments are received.

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Insulating county health systems and other traditional and safety-net providers from competition to avoid any risk would eliminate the benefits of competition. The state's plan to protect these providers attempts to strike a reasonable balance between protecting their viability and fostering competition.

The success of California's planned expansion is largely dependent on its ability to increase access by creating competition and choice. We believe that the two-plan model will unnecessarily restrict both competition and beneficiary choice. In addition, it may limit the state's ability to take action against plans that do not comply with contract provisions.

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## Agency Comments

We obtained official comments on this report from HCFA and DHS. We have incorporated their views where appropriate. Specifically, HCFA agreed with our conclusion that more competition is desirable in the proposed expansion.

In its comments, DHS (1) emphasized the improvements that the new Medi-Cal managed care contracting program will bring under the expanded program; (2) provided additional information and top management's perspective on DHS monitoring and oversight activities; and (3) acknowledged that while competition will be limited under the expansion plan, DHS believes that the expanded access and choice for beneficiaries are major improvements over the current fee-for-service environment.

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As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 14 days from its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of HCFA, the Director of the Office of Management and Budget, the Director of DHS, and other interested parties. We also will make copies available to others upon request.

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Please call me on (202) 512-4561 if you or your staff have any questions about this report.

Sincerely yours,

A handwritten signature in black ink that reads "William J. Scanlon". The signature is written in a cursive style with a large, prominent initial "W".

William J. Scanlon  
Associate Director,  
Health Financing Issues

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## Abbreviations

AFDC	Aid to Families With Dependent Children
COHS	County Organized Health System
DHS	Department of Health Services
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
GMC	Geographic Managed Care
HCFA	Health Care Financing Administration
HMO	health maintenance organization
PCCM	Primary Care Case Management
PHP	Prepaid Health Plan
SSI	Supplemental Security Income

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# Scope and Methodology

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To obtain general information on California's Medi-Cal managed care program and plans for expansion, we interviewed state officials from DHS; the Departments of Finance, Corporations, and Personnel; and the California Medical Assistance Commission. We also interviewed federal officials from HCFA's headquarters and Region IX office, contractors, advocacy groups, and associations. We reviewed documents related to the Medi-Cal managed care program and plans for expansion, including the following:

- federal and state program laws, regulations, policies, and procedures;
- HCFA Region IX's Review of California's Administration of Its Managed Care Program for fiscal year 1993; and
- California's strategic plan for expanding the Medi-Cal managed care program.

To obtain specific information on contract administration, we interviewed DHS Medi-Cal Managed Care Division officials, including contract managers and supervisors, as well as contractors and advocates. We also reviewed documents related to contract management, including contract manager duty statements, state contract administration job series requirements, and managed care contracts.

To better understand the financial incentive arrangements between managed care plans and their physicians, we interviewed officials from HCFA, the state Department of Corporations, the American Medical Association, Group Health Association of America, experts, advocates, and contractors. We also reviewed documents regarding physician incentive arrangements, including a 1990 Department of Health and Human Services report, legislative provisions, proposed HCFA regulations, our previous reports, and journal articles.

To assess how adequately managed care plans provide EPSDT services to children, we interviewed officials from DHS' Children's Medical Services Branch, its Medi-Cal Managed Care Division, its Audits and Investigations Division, policy consultants, and contractors. We also reviewed documents related to the federal EPSDT program and the state Child Health Disability Prevention Program.

Our work was performed between May 1993 and December 1994 in accordance with generally accepted government auditing standards.

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# Financial Incentive Arrangements Between Health Maintenance Organizations and Their Physicians

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Financial incentive arrangements may be loosely defined as compensation arrangements between a health maintenance organization (HMO) and its physicians that are intended to encourage physicians to control the services provided to plan enrollees. HMOs often assume responsibility for providing services to their enrollees for a fixed, predetermined capitation fee. Thus, they are at risk for the difference between the capitation fee and the cost of the care they provide.<sup>18</sup> Although precise figures are unavailable, it is believed that most HMOs use financial incentives in their compensation arrangements with physicians.

While financial incentives may operate to reduce unnecessary or inappropriate services, many analysts believe they also have the potential to reduce the quality of medical care by denying patients beneficial treatments. As a result, in our prior reports, we, like others, have called for increased oversight and quality assurance monitoring.<sup>19</sup> Pursuant to a congressional mandate in the Omnibus Budget and Reconciliation Act of 1990 (P.L. 101-508), HCFA is developing regulations to restrict the financial incentive arrangements which HMOs that are Medicare or Medicaid contractors can use.<sup>20</sup>

Financial incentives are only one of several means an HMO may use to control the amount of care its physicians provide. Other methods include requiring physicians to obtain the HMO's preapproval when ordering expensive procedures, educating physicians regarding cost control, reprimanding and possibly terminating the contracts of physicians who exceed utilization guidelines, and screening out physician applicants who do not seem to share the plan's cost-control goals.

A number of factors counteract the tendency of financial incentives to impair the quality of care. These include the professional ethics of the medical profession, concern about malpractice liability, the desire of HMOs to attract and retain patients, HMOs' quality assurance programs, and

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<sup>18</sup>As we stated in an earlier report, all other things being equal, the fewer services a capitated HMO provides, the more money from the fixed fee it retains as earnings. Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988), p. 8.

<sup>19</sup>Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 17, 1990), pp. 32-33; and Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988), pp. 29-30.

<sup>20</sup>The Congress first enacted legislation aimed at regulating the financial incentives used by HMOs that are Medicare or Medicaid contractors in 1986. However, because of subsequent congressional revisions and postponements of the effective date, no regulatory action was taken before the enactment of the Omnibus Budget and Reconciliation Act of 1990.

quality assurance reviews by external entities, such as government regulatory agencies.

In addition, the structure of a managed care plan may affect the financial incentive arrangement it uses. In two-tier HMOs, the plan contracts directly with individual physicians. Examples of two-tier plans are (1) staff model plans, which provide care through physicians they employ, and (2) independent practice association plans, which contract with physicians to provide care through their independent practices. In three-tier HMOs, the plan contracts with one or more medical groups or associations, which in turn contract with individual physicians. Thus, in a three-tier HMO, the contract between the plan and the group and the contract between the group and its physicians may each contain financial incentive arrangements—and the arrangements may differ significantly.

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## Methods of Compensating Primary Care Physicians

The manner in which HMOs compensate primary care physicians and physician groups for the services they provide is the starting point for an analysis of financial incentive arrangements. Financial incentives commonly take the form of adjustments to primary care physicians' compensation. In addition, the method of compensation employed can itself have incentive effects. HMOs generally pay primary care physicians in one of the following three ways:

- **Fee-for-service:** It has been estimated that about 40 percent of HMOs pay primary care physicians by the traditional fee-for-service method, compensating them for each unit of service they provide. The fee-for-service rate is usually lower than the fees the physicians would charge nonplan patients.
- **Capitation:** About half of individual primary care physicians also are paid in this manner. Most three-tier HMOs pay the middle-tier medical group or association on a capitated basis, whereby a fixed monthly fee per enrollee is deemed payment in full for all services provided to that enrollee.
- **Salary:** About 15 percent of HMO primary care physicians are paid a salary for their primary care services. But an estimated 80 percent of staff model HMOs pay their primary care physicians in this manner. Salaried physicians cannot increase their income either by providing additional services, as physicians paid on a fee-for-service basis can, or by providing fewer services in order to increase the number of patients assigned to them as capitated physicians can. As a result, salary is widely regarded as having the most "neutral" incentive effects of any of the three modes of compensation.

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**Types of Financial  
Incentive Arrangements**

Financial incentive arrangements take many forms. Typically, however, they consist of mechanisms for adjusting the compensation of primary care physicians or groups to encourage them to limit service utilization. Although the incentives may be designed to limit the services provided by the primary care physicians themselves (“direct services”), it is believed that they more commonly target services preapproved by the primary care physicians but provided by others (“referral services”). Primary care physicians in HMOs usually serve as “gatekeepers” who must authorize all or most nonprimary care, including inpatient hospital care, visits to specialists, and diagnostic tests and other forms of ancillary care. The following are four commonly used financial incentive arrangements.

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**Shared Deficit**

In a shared deficit arrangement, the HMO may establish separate budgets for primary care, inpatient hospital, specialty, and ancillary services. If there is a deficit in any of the referral funds, primary care physicians are required to absorb a portion of it. Those physicians with the highest referral costs are sometimes required to contribute the most. Primary care physicians who are compensated on a fee-for-service basis may also be required to absorb a portion of any deficit in the primary care fund to discourage them from providing too many services themselves. Often a portion of the physician’s compensation, usually not exceeding 20 percent, is withheld to be applied against a possible deficit. Some HMOs limit the physician’s liability to the amount withheld. Others require the physician to make up deficits beyond that amount through direct repayment, deductions from future compensation, or increased withholding rates.

The following describes a typical shared deficit arrangement: A primary care physician is paid \$20 per patient per month for providing direct services (and for providing administrative services, such as serving as a gatekeeper for nonprimary care). Of the \$20, \$4 is withheld to cover a possible deficit in the inpatient hospital care fund. If there is a deficit in that fund, some or all of the \$4 will not be returned to the physician, depending on the physician’s hospital referral rate. In addition, the physician may be liable for additional amounts beyond the \$4.

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**Shared Surplus**

Shared surplus arrangements operate much like shared deficit arrangements, except instead of being penalized if there is a fund deficit, physicians are given a bonus if there is a surplus. Bonuses are widely used in staff model HMOs, to reward salaried primary care physicians for holding down referral costs.

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**Appendix II**  
**Financial Incentive Arrangements Between**  
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**Physicians**

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The following is an example of a shared surplus arrangement: A primary care physician is paid \$16 per patient per month for direct services. If there is a surplus in the specialty care fund, the physician can receive an additional amount based on the physician's specialist referral rate. Often, the additional amount is limited to a percentage of the physician's compensation. Thus, in this case, the maximum bonus might be \$4 per patient.

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**Shared Surplus and Deficit**

In a shared surplus and deficit arrangement, if there is a deficit in a fund, primary care physicians are required to contribute toward it. Conversely, if there is a surplus, they receive a bonus. If money was withheld from the physicians and there is a surplus, they receive the amount withheld plus a bonus.

The following illustrates how a shared surplus and deficit arrangement might work: A physician is paid \$20 per patient per month for direct services. Of the \$20, \$4 is withheld to cover a possible deficit in the ancillary services fund. If there is a deficit in that fund, the physician may forfeit the \$4 and possibly be liable for additional contributions as well. If there is a surplus in the fund, the physician may receive the \$4 withheld plus a bonus.

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**Capitation for Referral Services**

When physicians are capitated to provide not only primary care but also referral services, the physicians' compensation for the services they render directly can be reduced by 100 percent of the cost of the referral services. This is a more potent incentive to deny patients referral services than the deficit/surplus arrangements under which the physicians bear only a portion of the cost. It is also an arrangement that can impose a considerable financial risk on the physicians, depending on the scope of the referral services for which they are capitated. The risk can range from being responsible only for the costs associated with processing in-office tests performed by the primary care physician to being responsible for the cost of all patient care—including inpatient hospitalization.

The following example illustrates how a capitation-for-referral-services arrangement might work: A physician group is paid \$100 per patient per month to provide all primary care, specialty, and ancillary services. The group consists exclusively of primary care physicians and must contract with others for specialty services. Since the group must absorb the entire cost of specialty care, it could potentially pay out a significant share or

even more than the entire compensation it receives for treating its patients.

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## Prevalence of Financial Incentive Arrangements

There are no reliable current data regarding the extent to which HMOs use financial incentive arrangements or the prevalence of the different types of arrangements. The best available data are derived from surveys conducted in the late 1980s by the Group Health Association of America, an HMO trade association; by a consulting firm under contract to HCFA, and by Alan Hillman, a leading academic expert on financial incentives.<sup>21</sup>

According to the Group Health Association of America's 1987 survey, 85 percent of HMOs used financial incentive arrangements. The study by HCFA's consulting firm, conducted in 1988, found that incentives were used in 95 percent of HMOs. In a 1990 journal article, Hillman stated that the great majority of HMOs use incentives.<sup>22</sup> Although the data are not conclusive, there is evidence that HMOs are increasingly using financial incentive arrangements that shift more risk to providers.

There is also evidence that it has become increasingly common for HMOs to capitate physicians, or (more typically) physician groups, for all medical services—including inpatient hospital care. This type of arrangement obviously places the physician or group at unlimited financial risk, unless, as is often the case, the plan provides stop-loss insurance.

It is not a new development for primary care physicians to be capitated for some referral services. A 1987 study by Alan Hillman found that primary care physicians were capitated for the cost of outpatient lab tests 40 percent of the time.<sup>23</sup> The Group Health Association of America's 1987 study found that capitation fees paid to primary care physicians usually covered not only primary care services, but also referrals to specialists and ancillary services. However, they rarely covered inpatient hospital care. Officials at both HCFA and California's Department of Corporations told us

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<sup>21</sup>The Physician Payment Review Commission reported to the Congress in March 1995 on the results of a survey on HMO physician payment arrangements that it conducted in 1994.

<sup>22</sup>Mark V. Pauly, Alan L. Hillman, and Joseph Kerstein, "Managing Physician Incentives in Managed Care," *Medical Care*, Vol. 28, No. 11 (Nov. 1990).

<sup>23</sup>Alan L. Hillman, "Financial Incentives for Physicians in HMOs—Is There a Conflict of Interest?" *The New England Journal of Medicine*, Vol. 317, No. 27 (Dec. 31, 1987).

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they believe this is changing and that the capitation of medical groups for all medical services, including inpatient care, is becoming widespread.<sup>24</sup>

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## Factors Affecting the Power of Incentives

Many factors can affect the likelihood that a financial incentive will influence a physician's practice decisions.

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### Extent of the Risk

The extent of a physician's risk is the physician's maximum possible financial gain or liability under an incentive arrangement. In the case of a deficit or a capitation-for-referral-services arrangement, the physician's liability is potentially unlimited. In the case of a surplus arrangement, the physician's potential gain is limited because the amount by which costs can be constrained below the HMO's budget is finite.

HMOs may limit the extent of a physician's potential liability or gain to a percentage of the compensation the physician is paid for direct services.<sup>25</sup> For this reason, extent of risk is sometimes defined as the maximum possible percentage increase or decrease in a physician's compensation for direct services that an incentive can produce.<sup>26</sup> Obviously, the more a physician is placed at risk for a type of service, the greater the incentive for the physician to limit the use of that service.

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<sup>24</sup>Under the arrangement, termed "full integration" by a Department of Corporations official, the medical groups enter into contracts with hospitals to provide inpatient care. The hospitals may be paid on a fee-for-service, capitation, or other basis. Even if it is capitated, however, the medical group has an incentive to hold down referrals to keep down the capitation fee it pays the hospital in the next period.

<sup>25</sup>For example, as previously explained, many plans that use deficit arrangements limit the physician's liability to the amount of the physician's compensation that is withheld, which generally is no more than 20 percent of the physician's compensation for direct services.

<sup>26</sup>The extent of risk has also been defined as the breadth of the services for which the physician is at risk. For example, the physician may be subject to a deficit arrangement that covers specialty referrals but not hospital referrals. Obviously, an incentive that does not place a physician at risk for a particular type of service is unlikely to affect the physician's utilization of that service.

Extent of risk might also be defined as the portion the physician bears of the cost of the services the incentive is intended to limit. For example, if a physician is capitated for specialty services, the physician is liable for 100 percent of the cost of such services. If a physician is subject to a deficit arrangement with respect to specialty services, then (oversimplifying somewhat) the physician is liable for an agreed-upon percentage of the amount by which the cost of such services exceeds the budgeted amount. Even if a physician's maximum total liability under an incentive plan is limited to a specified percentage of the physician's direct compensation, the physician might be more reluctant to arrange for specialty care if he or she is capitated for it than if he or she is subject to a deficit arrangement under which the physician might bear perhaps 50 percent of the cost.

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**Stop-Loss Insurance**

In a deficit or a capitation-for-referral-services arrangement, the HMO may sometimes provide its physicians or physician groups with stop-loss insurance to limit their potential risk. Stop-loss insurance is typically provided on a per patient basis and is designed to protect physicians whose patients suffer catastrophic illnesses. Coverage usually begins at between \$1,000 and \$9,000 per patient per year for outpatient referral services and between \$10,000 and \$100,000 per patient per year for inpatient hospital services. If stop-loss insurance is not combined with a limitation on the physician's overall risk to a specified percentage of his or her direct compensation, and if the physician happens to have an unusually sick group of patients, then the insurance may not prevent the physician from having to pay out more than his or her entire direct compensation.

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**Distribution of Risk**

Deficits and surpluses can be distributed on the basis of the cost performance of either an individual physician or a group of physicians. Numerous researchers, including the American Medical Association, independent analysts, advocacy groups, and HMO industry representatives have stated that incentives based on group performance are less likely to influence a physician's behavior. When a physician's cost performance is aggregated with that of other physicians, the effect on the physician's income of each decision he or she makes regarding patient services is reduced. In addition, a physician with unusually sick patients would be less likely to reduce care provided to patients needing expensive treatments because the physician's performance would be aggregated with that of physicians with healthier patients. Some researchers have suggested, however, that peer pressure might actually make group performance incentives more potent than individual performance incentives.

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**Number of Physicians**  
**Sharing the Risk**

In instances where the distribution of a surplus or deficit is based on the performance of a group of physicians, it is generally believed that as the size of the group increases, the effect of the incentive on physician behavior may diminish. The greater the number of physicians, the smaller the impact of each physician's decisions on the physician's incentive payment.

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**Appendix II  
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**Number of Patients in a  
Physician's Patient Panel**

Numerous analysts have maintained that the more patients assigned to a physician, the less effect financial incentives are likely to have on the physician's behavior.<sup>27</sup> Having more patients increases the probability that a physician can recoup the cost of treating the sickest patients from the savings generated by healthier ones. As a result, the physician would be less inclined to withhold an expensive treatment from a sick patient.

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**Duration of the Risk  
Assessment Period**

According to many analysts, the shorter the period over which a physician's cost performance is assessed, the greater the impact the incentive is likely to have on the physician's behavior. A shorter period allows a physician less opportunity to recoup the cost of treating a very sick patient from healthy patients. Risk assessment periods generally range from 1 month to 1 year. According to the Group Health Association of America, at least one-third of HMOs assess financial incentive payments more frequently than annually.

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**Generosity of the  
Physician's Compensation  
for Direct Services**

The less the physician is compensated for primary care services, the more sensitive the physician will be to an incentive that would increase or decrease the physician's income on the basis of his or her referral service utilization rate.

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**Portion of the Physician's  
Income Derived From the  
HMO**

The greater the proportion of a physician's total income that comes from an HMO, the greater the likely effect of that HMO's financial incentives on the physician's practice pattern.

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**Generosity of Service  
Utilization Budgets**

In general, the lower the cost target a physician must achieve to obtain a bonus or avoid contributing towards a deficit, the more powerful the incentive to withhold services. An approach used by some HMOs that puts physicians under particular pressure is one that requires individual physicians to meet or beat a group average. This places the physicians in competition with each other.<sup>28</sup>

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<sup>27</sup>In the case of distribution based on group performance, the relevant variable is the number of patients assigned to all of the physicians in the group.

<sup>28</sup>In general, according to one expert, HMOs base their service utilization budgets on prior years' usage and anticipated changes. A spokesperson for one Southern California HMO told us that if the bonuses awarded to its member physicians for controlling hospital costs seem excessive, the HMO may reduce the hospital utilization budget in the next contract period.

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## **Financial Incentives Used by Three Southern California PHPs That Are Medi-Cal Contractors**

Three Southern California PHPs that are Medi-Cal contractors use the following financial incentive arrangements: One plan, which is a staff model, uses a bonus arrangement. The plan compensates primary care physicians at its 30 medical centers on a salaried basis. It seeks to control referral costs by providing a bonus to the physicians that is based in part on the extent to which they hold down specialty and inpatient hospital referrals. The bonus is linked to the referral rates of individual physicians and cannot exceed 20 percent of a physician's salary.

Another plan, which is a group model, uses a combination deficit and surplus arrangement. The plan pays its medical group a capitation fee as compensation for providing all medical services except inpatient hospital care. Since the group is staffed to provide virtually all of the services it is capitated for, the arrangement does not fall into the capitation-for-referral-services incentive category. To control hospital referrals, the plan establishes a budget for hospitalization and shares any surplus or deficit with the group. The amount that can be shared with the group is subject to a relatively modest cap. The group in turn divides its share of any surplus or deficit among its physicians equally, rather than on the basis of their individual referral rates.

A third plan, which is a network/independent practice association model, uses capitation for some referral services plus a bonus arrangement for others. The plan pays the medical groups and independent practice associations it contracts with a capitation fee that covers virtually all medical services except inpatient hospital care. Because the groups and associations contract out some specialty and surgical care, this arrangement amounts to a capitation-for-referral-services type of incentive. In addition, the plan uses a bonus incentive to reward groups and associations that keep hospital referral rates low. The plan believes that most of its groups and associations adjust the compensation of their primary care physicians to encourage them to control specialty and hospital referral costs.

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## **Effect of Financial Incentives on the Quality of Care**

Few data exist on the extent to which financial incentives affect physicians' service utilization patterns. A number of studies have shown that HMOs in general hospitalize patients at a significantly lower rate than traditional fee-for-service practices.<sup>29</sup> However, these studies did not assess whether the HMOs' lower rate was attributable to their use of financial incentives or to other differences between HMOs and

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<sup>29</sup>These studies have not found any consistent differences in the use of ambulatory services.

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**Appendix II**  
**Financial Incentive Arrangements Between**  
**Health Maintenance Organizations and Their**  
**Physicians**

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fee-for-service providers. There have been at least two studies of the utilization effects of different forms of compensation within the HMO setting. But in the course of our work, we were unable to find any systematic analyses of the effects of specific types of incentives on the utilization of the services the incentives are intended to reduce, such as the effect of a bonus for controlling specialty referrals on such referrals.

Even if the effects of financial incentives on service utilization were known, their impact on quality of care would not be readily ascertainable because there is currently no consensus about how quality of care should be defined and measured. If a financial incentive induced a physician to withhold a service that a patient did not need, then quality of care would not be impaired. The difficulty lies in determining which services are “needed.” Although the effect on patient outcomes is one measure of quality, efforts to measure the impact of care or outcomes are still in their infancy.

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