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MEDICAID

Experience With State Waivers to Promote Cost Control and Access to Care

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to testify on the status of pending and approved statewide Medicaid waivers authorized by section 1115 of the Social Security Act (42 U.S.C. 1315) and on the effect these waivers have on access to and quality of care for Medicaid patients and providers. Our testimony is based on (1) numerous reports we have issued over the years on the Medicaid program and (2) states' experiences with Medicaid managed care programs.

The Congress has begun reexamining the $131 billion Medicaid program--one of the fastest growing components of both federal and state budgets. In 1993, Medicaid cost almost $100 billion more and served about 10 million more low-income recipients than it did a decade ago. To deal with this cost and enrollment explosion, many states are seeking greater flexibility in implementing statewide Medicaid managed care programs. Currently, the degree of flexibility being sought is available only through the waiver authority established by section 1115.

In brief, we found that while a large number of states have expressed interest in implementing waivers, only four states have waivers in place. Two additional states have received federal approval, but their plans still must be ratified by state legislatures.

As states move into managed care, they face significant challenges with this major shift in program focus away from the traditional fee-for-service system. More specifically, the emphasis that states place on program implementation and oversight may significantly affect the degree to which states' managed care programs are successful in containing costs while increasing access to quality health care.

BACKGROUND

Through section 1115 of the Social Security Act, the executive branch has been given broad authority to waive most requirements of the federal Medicaid statute to facilitate projects likely to further the objectives of the 30- year-old Medicaid program. The Health Care Financing Administration (HCFA) is the federal agency responsible for managing Medicaid. In 1993, in the midst of a national debate over eliminating barriers to health insurance, a handful of states sought section 1115 waivers from HCFA to simultaneously achieve two interrelated goals: (1) expand coverage to the uninsured and (2) contain the cost of publicly funded programs by shifting from fee-for-service to managed care delivery systems. The stated intent was to permit more individuals to be covered at little or no additional cost through more efficient delivery of medical services. The only prior use of section 1115 authority comparable to recent statewide waiver applications was the 1982 initiation of a managed care program in Arizona, a state that previously had not participated in Medicaid.

During 1994, the growing number of applications and the interest shown by many states has shifted section 1115 waivers from the fringes to the center of the debate over how the Medicaid program should evolve. The Clinton administration has favored linking managed care flexibility to expansion of Medicaid to previously ineligible groups. However, at least one recent section 1115 waiver applicant asked for greater flexibility to pursue managed care without expanding eligibility. This raises the question of whether states should be free or even mandated to adopt managed care as the standard for Medicaid.

The statewide section 1115 waivers, approved and pending, have certain common features. Most seek to expand Medicaid coverage to broader populations than those covered under the standard program. All of the states are seeking to use mandatory enrollment in capitated managed health care plans to better control program spending. While some states are limiting managed care to the Aid to Families with Dependent Children program (AFDC) and AFDC-related populations of women and children, others are expanding managed care to the aged and disabled, creating new challenges for these states and the participating health plans because these persons are not normally served by either public or private managed health care plans.

BARRIERS AT THE FEDERAL AND STATE LEVELS EXIST TO STATE USE OF SECTION 1115 WAIVERS

Since 1993, nearly half of the states have sought a statewide section 1115 waiver. However, only four states--Tennessee, Oregon, Hawaii, and Rhode Island--are actually implementing waivers today. (App. I shows the status of all approved and pending waivers; app. II summarizes the statewide demonstrations planned for each state with an approved waiver.)

The disparity between interest in obtaining and ability to operate under a waiver highlights an important aspect of the section 1115 phenomenon--implementing these enormously complex and often controversial demonstrations involves addressing issues beyond the formal federal review process. We found several of these issues at the federal and state levels that may create barriers to state use of section 1115 waivers.

Federal Issues

As more states seek federal approval of a section 1115 waiver, the time period between waiver submission and approval has lengthened. Five waivers were submitted between November 1992 and mid-1993, and each was approved before the end of 1993. Hawaii's waiver was approved in 3 months, the shortest period of time, and Kentucky's was approved in 7 months, the longest. In 1994, however, only one of nine waivers pending since the end of 1993 was

approved for implementation: Florida's approval took about 7 months of negotiations with HCFA.

This slowdown appears to be primarily caused by two factors: controversy about some of the implemented demonstrations and the increasing number of waivers requested.

Concerns have been raised about the rapid approval and implementation of Tennessee's waiver and that state's acknowledged failure to consult with all affected stakeholders, especially physicians. In June 1994, the National Association of Community Health Centers went to court to stop the implementation of statewide section 1115 waivers, arguing in part that approval was arbitrary and capricious because it failed to consider the views of all interested parties.

HCFA responded to these concerns by publishing principles and procedures governing section 1115 waivers, including guidelines designed to ensure that communities affected by a demonstration project would have adequate opportunity to comment. Another indication of HCFA's intention to respond to these concerns was its November 1994 conditional approval of South Carolina's section 1115 waiver. HCFA sanctioned the "framework" of South Carolina's waiver with the understanding that HCFA would approve implementation only after the state reached a number of milestones related to the adequacy of service delivery and capitation rates. The methodology used to develop and the adequacy of capitation rates have been a major and continuing criticism of the Tennessee waiver.[1]

In addition, the number of waivers now pending--ten as of mid-March 1995--has undoubtedly tested HCFA's review capacity. Furthermore, this backlog is likely increase: according to HCFA, as many as five additional states are considering potential waivers or are already drafting waiver concept papers. HCFA is establishing an office of state health reform that, together with HCFA regional offices, should more effectively support the development and implementation of statewide section 1115 waivers.

State Issues

HCFA approval of a waiver, however, is often only an intermediate step to a state's program implementation because consensus on the waiver design begins at the state level. For example, Florida asked for federal permission to implement its section 1115 program before obtaining waiver approval from the state legislature. Though approved at the federal level in September 1994, the waiver is only now being debated by the Florida

[1]We will address these and related financing issues in our forthcoming report on the Tennessee waiver program.

legislature, and the outcome is uncertain. In Kentucky, state legislators doubted that managed care savings would be sufficient to expand coverage to additional groups, and they ultimately refused to authorize implementation of an approved waiver. Kentucky officials told us that they felt caught in a "catch 22" because the legislature demanded demonstrated savings before approving planned coverage expansions, and HCFA refused to allow the state to proceed with managed care initiatives unless Kentucky gave a specific date for expanding coverage to new groups. Ohio must also get state legislators' approval before implementing its recently approved waiver.

A relatively new hurdle to waiver implementation is the close link between demonstration waiver designs and comprehensive state health reform initiatives--initiatives that are increasingly being reexamined in the aftermath of the 1994 health care reform debate, the November 1994 elections, and state budgetary uncertainties. For example, Washington is delaying drafting and submitting its section 1115 waiver.

TWO FACTORS AFFECT SUCCESS OF TRANSITION TO MANAGED CARE

Two factors significantly affect the degree to which a state's Medicaid managed care program succeeds in meeting its goals of controlling costs while improving access to quality care:

-- implementation: how much time the state allows for planning and execution, and

-- oversight: how much effort the state devotes to quality assurance, information gathering, and financial review.

Operating a wide-scale managed care program differs significantly from the traditional fee-for-service programs. Implementing a program more slowly allows time to acquire staff expertise; develop a community base of support; create an organizational structure and administrative operation; and properly educate staff, providers, and beneficiaries. A state with widespread managed care in the private sector should have an easier time with planning and implementation because the members of the community, particularly providers, are already familiar with managed care.

The second factor that contributes to the success of a state's managed care program is the degree to which appropriate oversight mechanisms are in place and utilized. Quality assurance systems are particularly important to ensure that beneficiaries are receiving sufficient care of acceptable quality. Financial incentives to underserve are inherent in managed care and may lead to problems. Large private sector employers have recognized the importance of oversight in this area and are demanding strong

quality assurance systems in health plans throughout the country. For the vulnerable Medicaid population, no less should be expected.

State oversight of a managed care program cannot be effective, particularly in the area of quality assurance, without good data collection efforts and information systems to report on beneficiaries' experiences. Information systems are generally new because the information needs of a state with a managed care program are different from those for a fee-for-service program. We have found that states are more likely to have a successful program and fewer problems in transition if they take the time to develop and test their information systems.

Another important oversight function is the financial review of health plans' solvency and allocation of revenues. The financial condition of a plan can have a strong impact on the access to and quality of care. Moreover, the plan must ensure that program dollars are used primarily for health services and that management and administration expenses are limited.

The experiences of two states, Oregon and Tennessee, show how investment in implementation and oversight appear to influence the degree to which states realize their program objectives.

Oregon's Program Has Avoided Problems

Thus far, Oregon's managed care program appears successful. The state began planning its current section 1115 waiver program more than 5 years ago. State planners held community meetings and consulted providers, some of whom were already participating in the state's partially capitated managed care program, which began in 1985. The state learned lessons from the first program that have helped in implementing the much larger managed care program.

Oregon also implemented an array of safeguards designed to ensure access and quality. It requires plans to limit the financial pressure felt by any one provider in an effort to guard against underservice. The state also adopted an extensive quality assurance program, which requires plans to maintain internal quality assurance programs, and annually contracts with a physician review organization for an independent review of medical records. Finally, Oregon uses client satisfaction and disenrollment surveys, and a grievance procedure to further monitor quality.

Oregon is, however, facing some challenges. The state had operated a managed care program in the more populous parts of the state. But as the state expected, creating prepaid capitated systems in the more rural areas has been difficult. In some areas where neither the state nor the private sector had been operating managed care systems, the state has relied on a mixture of fee-for-service and managed care plans to establish a program. Also, the

state is just beginning to enroll the elderly and disabled in managed care.

Tennessee Had Start-Up Problems

In contrast to Oregon, the more recent TennCare program has encountered a number of difficulties resulting, in part, from its rapid implementation. Before beginning its managed care program last year, Tennessee had almost no experience with managed care in its Medicaid program. In fact, the state's private sector had only a limited amount of managed care compared to the rest of the country. Despite this lack of familiarity, the state moved rapidly and began operating its statewide managed care program fewer than 9 months after announcing the plan.

This quick transition created a number of problems. First, providers have generally been critical of the state for not being included in the planning and development of the program. Beneficiary advocates, however, were a part of the planning process and have generally been supportive of the program.

Even state officials admitted there was confusion among beneficiaries. For example, beneficiaries were required to select a health plan before the plans had completely identified which physicians would be participating, resulting in some beneficiaries not knowing if their physician would be available in particular plans. Further, beneficiaries received little education about how managed care works. The state, however, has since partnered with the advocacy groups to help educate beneficiaries and resolve their problems.

The quick implementation also affected the participating health plans. Their information systems had not been fully developed and tested by the time the program began, and this significantly delayed the payment of many bills. Problems with the implementation of information systems also delayed health plans' provision of data on service use so that the state could assess the quality of care provided. Only recently have such data been available and begun to be analyzed.

The state has adopted an extensive quality assurance program similar to Oregon's, including beneficiary satisfaction surveys, a hotline, and a grievance procedure. It remains critical, however, that the quality assurance program is operated in an effective manner over time.

CONCLUSIONS

Widespread state interest in section 1115 waivers foreshadows a major shift in the Medicaid program. In particular, the mandatory enrollment of the bulk of the Medicaid population in managed care may become much more the norm than the exception.

However, while interest in restructuring Medicaid is great, experience to date has been very limited because only a handful of states have implemented their section 1115 waiver programs. Our prior work, though, consistently suggests that successful Medicaid managed care programs depend on allowing adequate time for planning and implementation and putting appropriate oversight mechanisms in place. As states continue to pursue statewide managed care programs, particular attention needs to be given to these factors to ensure access to quality care for the large populations involved.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or the other members of the Subcommittee may have.

For more information on this testimony, please call Richard Jensen, (202) 512-7146. Other major contributors were Walter Ochinko, Cheryl Williams, and Michael Gutowski.

STATEWIDE SECTION 1115 MEDICAID WAIVERS SUBMITTED SINCE 1991

Approved			
	Date submitted	Date approved	Start date
Oregon	November 1992[a]	March 19, 1993	February 1994
Hawaii	April 19, 1993	July 16, 1993	August 1994
Kentucky	May 1993	Dec. 9, 1993	Suspended--not approved by state legislature
Tennessee	June 16, 1993	Nov. 18, 1993	January 1994
Rhode Island	July 20, 1993	Nov. 1, 1993	August 1994
Florida	Feb. 9, 1994	Sept. 15, 1994	Awaiting state legislative approval
Ohio	March 2, 1994	Jan. 17, 1995	Awaiting state legislative approval
Provisionally approved			
South Carolina	March 1, 1994	Nov. 18, 1994	
Pending			
	Date submitted	Status	
Massachusetts	April 12, 1994	Negotiations on-going	
New Hampshire	June 1994	HCFA awaiting state response to questions	
Missouri	June 30, 1994	HCFA awaiting state response to questions	
Minnesota	July 27, 1994	Negotiations on-going over finance issues	
Delaware	July 27, 1994	Negotiations on-going over finance issues	
Illinois	Sept. 14, 1994	HCFA reviewing finance issues	
Louisiana	January 3, 1995	HCFA reviewing proposal	
Oklahoma	January 6, 1995	HCFA reviewing proposal	
Vermont	Feb. 22, 1995	HCFA reviewing proposal	
New York	March 20, 1995	HCFA reviewing proposal	

[a]Oregon's initial waiver proposal, submitted in August 1991, was denied in August 1992. After revising certain sections, the state resubmitted its proposal in November 1992.

MAJOR FEATURES OF APPROVED SECTION 1115 DEMONSTRATION WAIVERS

Oregon	Demonstration expands Medicaid eligibility to all persons with incomes up to the federal poverty level (FPL) while limiting health care services provided by ranking them in order of importance. Shifts delivery of services into fully and partially capitated plans and primary care case management programs. Aged, blind, and disabled persons were initially excluded. However, in September 1994, HCFA approved an amendment allowing inclusion of noninstitutionalized aged, blind, and disabled persons in the waiver demonstration.
Hawaii	Demonstration expands Medicaid eligibility to all persons with incomes up to 300 percent of the FPL. Shifts delivery of Medicaid services into a managed care system. Aged, blind, and disabled persons are excluded from the demonstration and managed care requirement. Requires cost sharing from most residents with incomes above the FPL.
Kentucky	Demonstration expands Medicaid eligibility to all persons with incomes up to the FPL. Medicaid services are delivered through the existing statewide primary care case management program with a gradual move into capitated managed care delivery. Aged, blind, and disabled persons are included in the demonstration and its managed care requirement.
Tennessee	Demonstration expands Medicaid eligibility to all persons without regard to income level. Cost-sharing requirements increase with income level. Medicaid services are delivered through capitated managed care plans. Aged, blind, and disabled persons are included in the demonstration and its managed care requirement.
Rhode Island	Demonstration expands coverage to pregnant women and children up to age 6 with family incomes at or below 250 percent of the FPL. Medicaid services to AFDC recipients and new

APPENDIX II

	beneficiaries will be delivered through prepaid health care plans.
Florida	Demonstration expands Medicaid eligibility to uninsured residents with incomes at or below 250 percent of the FPL. State will subsidize health insurance for those newly eligible through its existing system of 11 health purchasing cooperatives. Benefits package for the expansion population is more restrictive than that provided to traditional Medicaid beneficiaries. Both AFDC and aged, blind, and disabled Medicaid recipients are required to enroll in managed care.
Ohio	Demonstration expands Medicaid eligibility to all residents with incomes below the FPL. Medicaid benefits, including mental health and drug and alcohol addiction services, are delivered through prepaid managed care providers. Aged, blind, and disabled persons are excluded from the demonstration and its managed care requirement.

RELATED GAO PRODUCTS

Medicaid Managed Care: Healthy Moms, Healthy Kids--A New Program for Chicago (GAO/HRD-93-121, Sept. 7, 1993).

Medicaid: HealthPASS--An Evaluation of a Managed Care Program for Certain Philadelphia Recipients (GAO/HRD-93-67, May 7, 1993).

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

Medicaid: Factors to Consider in Managed Care Programs (GAO/T-HRD-92-43, June 29, 1992).

Medicaid: Oregon's Managed Care Program and Implications for Expansions (GAO/HRD-92-89, June 19, 1992).

Medicaid: Factors to Consider in Expanding Managed Care Programs (GAO/T-HRD-92-26, Apr. 10, 1992).

Managed Care: Oregon Program Appears Successful But Expansion Should Be Implemented Cautiously (GAO/T-HRD-91-48, Sept. 16, 1991).

Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area (GAO/HRD-90-81, Aug. 27, 1990).

Medicaid: Early Problems in Implementing the Philadelphia HealthPASS Program (GAO/HRD-88-37, Dec. 22, 1987).

Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987).

Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans (GAO/HRD-86-10, Nov. 22, 1985).

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