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Medicaid's Implication on State and Local Health Department in the United States

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I. Introduction

The United States is focusing on health care reform as a means of controlling the costs of health care while at the same time, expanding access to services. The federal and state governments are in various stages of reforming the health care infrastructure. Health care reform represents both an opportunity and a threat to population-based health care activities and the public health arena.

As of this writing in November 1995, under "Contract with America" pledge, the Republican-U. S. Congress presented $ 170 billion cut of Medicaid program (health insurance for the poor) over seven years. The President of the United States and also the American Public Health Association (APHA) consider that these cuts would be devastating to 36 million for Medicaid.[1)]

Medicaid managed care has been a precursor to health care reform heralding a new set of rules to play by in the delivery of preventive, primary, and acute care to women, infants, children, and adolescents. Despite its having becoming part of the health care delivery landscape in recent years, a concise standard definition of managed care has yet to emerge. Managed care reflects the marriage of financing and delivering health care services to control health care costs and improve access to services. Covered services and the cost of care have challenged State Medicaid programs as never before to find the most efficient and effective strategies for providing access to high quality health care at controllable cost. Presently, all states are expected to have at least some degree of managed care in place.[2)]

As Medicaid populations are shifted into managed care arrangements, public health programs are increasingly affected. States health agencies have been asked to identify public health issues and their impact in the context of Medicaid managed care initiatives.

Local and county public health agencies are also expected to establish a range of roles Medicaid managed care environment.

It was estimated that by june 30, 1994, total enrollment in all types of managed care

arrangement reached 7.6 million, a 57 % increase in Medicaid managed care enrollment in just one year. As a result, nearly one-fourth of Medicaid enrollees are in some form of managed care.[3]

Ⅱ. Overview of Medicaid Managed care

The 1965 Social Security Amendments, that established Medicare, also created Medicaid under Title 19.[4] Medicaid is a State and Federal medical assistance program that pays medical bills for eligible, needy people.

All payments are made directly to the providers of medical and other health care services. The Medicaid-eligible person does not pay the health care provider for services. The only exception is a patient in a Medicaid-approved nursing facility who may be required to contribute part of his/her income toward the cost of care.[5]

Aid to Families with Dependent Children (AFDC) recipients make up a large proportion of Medicaid recipients (71.2%), yet account for a much smaller share of total Medicaid expenditures (29.4%). This is largely explained by the fact that nursing home and other long-term care services, representing 69.55 of Medicaid expenditures, are predominantly used by the aged and disabled, rather than the younger AFDC populations. Long term care services rarely included in managed care programs. Most Medicaid managed care programs include only the AFDC and related groups.[3]

Medicaid eligible criteria are; recipients of Aid to Families with Dependent Children (AFDC), pregrent women who meet the income guideline, certain public assistance recipients under age 21, persons 65 & over who receive monthly Supplemental Security Income (SSI), and blind or disabled persons who receives SSI.[5]

As of September 1995, only two states (Alaska and Wyoming) have no Medicaid managed care program operating or plans for initiating one. This shift towards managed care has great implications for public health agencies which have historically provided services to the Medicaid population.[3]

Over the past decade, health care costs rose dramatically as states and the federal government extended Medicaid to more needy people to the total of 36 million low income individuals.[6] Medicaid expansion has substantially raised the program costs, increasing at an annual rate of 6.2 % since 1968 and now accounting for 36.4% of all state health care spending.[7]

In an effort to control rising Medicaid costs while assuring quality and access, many states have turned to managed care approaches for solutions. Presently, nearly a quarter of all Medicaid recipients are enrolled in some form of managed care setting.

Ⅲ. Managed Care Criteria

The principles and practices of managed care are hardly new. The first group practice in the United States was established in 1887 at the Mayo Clinic and the first capitated plan was set up in Elk City, Oklahoma in 1929. The Kaiser-Permanente Health Plan began in 1933 for employees, and went public in 1947 as the first group-model HMO. By the end of 1955, approximately 56 million Americans are anticipated to have registered in HMOs*, half of these in IPA-HMOs**.[8)]

"Managed care" is a term that came into general use in the early 1980s to refer to a wide range of programs and types of health plans, including HMOs and PPO (Preferred Providers Organization) etc. A managed care approach includes a wide range of utilization and reimbursement strategies that are designed to encouraged cost containment while promoting quality of care.[9)] Managed care techniques lower the annual rate of rise of health insurance premiums by about 5 percent, e. g. 15 percent vs 20 percent.[11)] Key elements of the "managed care" approach include the following:

a) encouraging use of "selected" or "network" providers by:
   * creating financial incentives for enrollees to use "preferred" or "in-network" providers; and/or
   * requiring referrals from a designated primary care provider, known as "gate-keepers", for use of a specialty;

b) restructuring providers' financial incentives through mechanisms such as risk sharing, and prospective payment on a per capita basis.

c) creating delivery systems that:
   * monitor and coordinate care to reduce unnecessary or duplicate care,
   * assure that appropriate care is delivered in the lowest cost setting, and
   * focus on preventive and early primary care.

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*. Most state laws governing HMOs define them to be an organization capable of providing comprehensive medical care to a prepaid, enrolled population. Enrollment is usually is voluntary and is an alternative to conventional health insurance. Enrollees, who usually are employees and their families of organizations which offer HMOs as an alternative to the company health insurance plan, are thus financially tied to the HMO, i. e. They must personally pay any physician visits or other medical care obtained outside the HMO, except for emergency care and outside care approved by the HMO.[11)]

**. HMO is distinguished by 2 basic models; Prepaid Group Practices (PGPs) and Individual Practice Association (IPAs). Under the IPA model, the HMO usually contracts on a capitation basis with a separate entity formally known as an IPA which, in turn, contracts with a relatively large number of physicians or physicians groups in the community who draw only a minority of their patients from the HMO. The physicians generally bill the IPA on a fee-for-service basis, and the contractual agreement typically specifies fee levels and risk by the physicians.

Programs incorporating some or all of these "managed care' elements offer states the dual promise of controlling costs and increasing recipient access to primary care. Implementing a managed care program in Medicaid, however, is not a simple undertaking. For example, if a state makes managed care mandatory, under federal law it must give Medicaid recipients a choice among managed care plans. In many areas of the country, however, there are still few, if any, HMOs. States wanting to mandate managed care need to find more than one HMO or to "build" other managed care alternatives where multiple HMOs do not exist.

IV. Model of Medicaid Managed Care

There is a great deal of variation across the country in the models of Medicaid managed care that the states are choosing to implement. Three basic models are;[10)]

A. Full Risk Capitation Plan (Comprehensive Risk)

The State Medicaid agency contracts with HMO (Health Maintenance Organization) or Prepaid Health Plans (PHPs), like private employers, to provide Medicaid enrollees with comprehensive care. The plan receives a capitation payment for each enrollee, which is a set fee per patient per month. The capitation payment covers a specified group of services, and is paid to the plan regardless of whether those services are used. In addition, states may also contract on a full-risk basis with federally funded community health centers that have traditionally service medicaid and other low-income beneficiaries. Prepaid health plans (PHP) in federally funded health centers are unique to Medicaid managed care. Federal law now requires that a Medicaid-contracted HMO have at least 25% non-Medicaid enrollees. Arizona is the lead state in this approach.

Statistics are:

4.8 million (15%) of Medicaid recipients or 63% of all Medicare managed care enrollees as of 6/94; 6% of total Medicaid spending.
27 states using this approach (10 full-risk, 17 combinations of full and partial risk).

B. Partial Capitation Plan (limited risk)

This plan is in between two models (full-risk and primary care case management) and exhibits the most variation. The State Medicaid agency contracts directly with providers on a capitated basis for a sub-set of services and also pays providers for other, non-capitated services on a fee-for-services basis. Providers are reimbursed for a limited number of services on a fixed basis per person, per month, and paid for all other services on a

fee-for-service basis. This plan limits provider choice, shifts, some risk for care to providers and creates delivery system to coordinate care. There are two types of capitation;

a) Acute care program: establishes a contract with groups of physicians for a fixed capitation payment for all out-patient services.
b) Specialty "carve-out" program: pays specialty providers and / or organizations on a capitated basis for mental health, substance abuses, dental, etc.

Plans operated by states are similar to "network" model HMOs; HMOs contract with providers, some on a capitation basis and some on a discounted fee-for-service base. However, since payments to contractual physicians tend to be low, this plan generally does not seek further physician service discounts, and instead focus on coordinating care to achieve cost savings. Nevada is the lead state in this approach.

Statistics are:

* 800,000 (2%) of recipients enrolled by 6/94; 0.2% of Medicaid expenditure.
* 10 states are in this plan; enrollments grew 9% during 6/93-6/94.

C. Primary Care Case Management Plan (PCCM)

The State Medicaid agency contracts directly with primary care providers to act as "gate-keepers", approving and monitoring all covered services for the patient. For this "case manager" service, the primary care providers are paid a "per-patient per-month case management fee" (usually around $3 to $5 as an incentive); in addition, the providers are reimbursed by the state on a fee-for-service basis for all services provided. The "case manager" is usually a primary care physician, but may be a clinic or an HMO. The enrollee must go to the "case manager" for all covered services or for authorization to obtain other providers' services, except in a true emergency. Many states' Medicaid programs have traditionally paid physicians only a fraction of their normal fee, many physicians do not accept Medicaid patients or limit the number they do accept. This plan technically limits choice of provider and enrollees' access to specialist without prior approval, but greater overall primary access for care is achieved. Kentucky id the lead state in this plan.

Statistics are:

* 2.4 million Medicaid recipients (or 8% of all recipients).
* Enrollment grew 59% from 6/93 to 6/94.
* 19 states using this approaching in 1993 and 31 states in 1994.

Of the total Medicaid program, "non-managed care" still remains as the major portion (77%) and "Managed care" has captured about one-fourth (23%). Medicaid managed care by types are; 63% full capitation, 32% PCCM, and 5% partial capitation. [3)]

V. Federal Waivers for Medicaid Managed Care

In order to enroll Medicaid population in managed care plans, states must obtain waivers of current federal Medicaid law of the Social Security Act.[3),4),9)]

A. Section 1915 (b) Waivers (Freedom-of-Choice Waivers or Pragmatic Waivers)

Authority for section 1915 (b) waivers of the Social Security Act was designated by the Omnibus Budget Reconciliation act (OBRT) in 1981, to facilitate state implementation of Medicaid manage care and other innovative approaches. This is most frequently obtained by states. Waivers are granted for 2 years, but renewable. The most common use of section 1915 (b) is to mandate enrollment of certain Medicaid populations into HMOs or other prepaid plans, a PCCM, or a combination of both. Each of these options would involve obtaining a waiver under section 1915 (b), which allows "gate keeping" and the denial of payment for services not authorized by a patient's primary care provider. If the state elects to mandate enrollment into health plans only, it essentially seeks to eliminate the fee-for service environment for the specified recipients group and replace it with an exclusive range of capitated plans under contract with the state.[4)] As of February 1995, 38 states and washington, D. C. are under this waiver and 6 states are pending including the States of New Jersey. The following approaches are permitted.[9)]

* plans must be statewide with service comparability;
* implementation of a primary care case management system must be implemented;
* localities must be allowed to act as a central broker;
* sharing of program cost savings through the provision of additional services; and
* permits selective contracting with a ,limited set of providers.

B. Section 1115 Waivers (Demonstration Waivers)

Section 1115 of the Social Security Act, in place since 1962, allows states to conduct research and demonstration projects involving Medicaid and other social security program i. e. AFDC, Title XX Program. This waiver, prior to 1993, involved small, limited, pilot, and experimental projects. in 1993, waiver process was revised from the former policy of granting only true search waivers to test truly innovative delivery system. Granting period for waivers has been limited to 5 years. Now, waivers may be granted for a sufficient duration for a fair test. It has been used in the past to establish innovative capitated programs such as the statewide Arizona Health Care Cost Containment System (AHCCCS) and the Minnesota Prepaid Medicaid Demonstration Project, both of which were launched in 1982 and remain in operation today. Section 1115 waivers have increasingly become a popular tool used by states to reform their Medicaid programs. under these waivers,

certain title XIX requirements can not be waived. For example, a state can not impose co-payment arrangements unless it meets several strict tests after an opportunity for notice and comment, nor can a state waive or alter medical assistance for certain eligible pregnant women and children. The exception are minor, through, in comparison to the wide range of federal Medicaid requirements that can be obviated under the Section 1115 authority.[4] Currently, 23 states are involved (4 states including N. J. are in application process, 6 states are under review, and 13 states won approval).
Major features are;[9]

* allows beneficiaries to enroll in partial or full risk plans.
* provides financial coverage for individuals previously eligible for Medicaid
* HMOs which previously did not meet federal requirements, i. e. at least 25% of enrollees are non-Medicaid, may now participate Medicaid managed care.
* eliminates cost based reimbursement.

VI. Public Health Implication

As Medicaid populations are shifted into managed care arrangements, public health programs are increasingly affected by the implication of State Medicaid implementation process. State health agencies have been asked to identify public health issues and its impacts in the context of Medicaid managed care initiatives and local and county public health agencies also expected to establish a range of roles in Medicaid managed care environment.

The power of the state to carry out functions such as protecting the heakth of its citizens "is generally referred to as the state's police power...i. e., the power 'to enact and enforce laws to protect and promote the health, safety, morals, order, peace, comfort, and general welfare of the people'... and local agencies, including state and local public health departments and agencies, derive their power by delegation from the state legislature''.[12]

A. Public Health Strategies for States

In a managed care environment, according to the Association of State and Territorial Health Officials (ASTHO), state health agencies may have new roles focusing on 1) quality assurance, 2) Direct Access to Public Health Services, and 3) Services for Children with Special Health Care Needs. The following categories are the 3 primary strategies;[13]

a) Quality Assurance: state health agencies, as the purchaser of services, have greater leverage in specifying process and outcome measurements for managed health care systems in terms of both quality and cost containment strategies. State health agencies

have regulatory and licensing responsibilities for managed care organizations and can influence system development.

b) Direct Access to Public Health Services: Public health "carve outs" or direct public health access services are distinguished from other non-population based services either because of communicable disease control implications or because of their preventive health service nature. some states carve out public health services for tuberculosis (TB), sexually transmitted diseases (STD), human immunodeficiency virus(HIV), woman, infant and children (WIC), family planning, and immunizations, etc. Some states allow public health activities on an in-plan basis for managed care. States must balance the needs for services and costs in protecting public health and possibly avoiding higher costs of adverse outcomes due to a lack of service. States have approached carving out certain public health services differently. Option include mandatory contracting with local health departments by managed care organizations, allowing patients to self-refer to the health departments for specific services paid for on a fee-for-service basis.

c) Services for Children with Specific Health Care Needs: Children and pregnant women will be significantly affected by managed care process, particularly as Aid to Families with Dependent Children (AFDC) populations are the target of this shift to managed care. Even though EPSDT (Early Periodic Screening, Diagnosis and Treatment) is an approved services under Medicaid rule, some providers are inexperienced in working with low income populations. Managed care organizations may be hesitant to enroll patients considered to be a higher risk and more costly. This may be detrimental to high risk/high cost children with chronic condition. Some states have enacted a separate legislation to cover this gap.

B. Public Health Participation for Local Health Department

The push for Medicaid managed care is a nationwide trend in an attempt to increase access and control health care costs for the Medicaid population. This trend has many implications for local health departments.[14] Managed care arrangements primarily seek to meet the medical care needs of individuals, while population based public health services strive to protect the health status of the community.[15]

During July 1933-July 1994, the University of Nebraska Medical Center conducted a nationwide survey to learn the status of city and county health departments and maternal and child health (MCH) in the managed care arena.[16] The study team of the University targeted 176 U. S. city and county health departments with populations greater than 100,000 or the largest city in the states not otherwise represented, among over 3000 local health departments in the nations. One hundred thirty seven (137) health departments responded from 47 states and territories, including District of Columbia and Puerto Rico.

Nearly two thirds (61%) of the urban health departments, that responded, had Medicaid

managed care in place, being implemented, or to be implemented within a year. The survey also indicated that an additional 16% of urban health departments were considering Medicaid managed care in the future, only 12% were not being considered for Medicaid managed care and 11% unknown and other categories.

The survey revealed that urban health departments play a wide range of roles in an Medicaid managed care environment, roles which mirror the core function of local public health; assurance, monitoring, assessment, and policy development. In many cases, city and county health departments continue to be direct primary care providers either as a designated medicaid managed provider or under contract with HMOs or other capitated systems, especially in family planning. immunization, STD/HIV/TB communicable disease control, lead screening, well child care, environmental health, and other preventive care services.

Non-clinical services, such as health education, home visitation, case management, and referral continue to be offered by urban health department, increasingly through contractual arrangement with Medicaid managed care providers. The health departments continue to offer health services to uninsured, underinsured, and undocumented population.

Ⅶ. Conclusions

Medicaid managed care enrollment has grown rapidly over the last several years, enrollments now represent almost one-fourth of all recipients, 93% of Medicaid expenditures are still paid on a fee-for-service base, not on a capitation basis. while 17.2% of Medicaid recipients are enrolled in full or partial capitation programs, only 6.7% of program expenditures are paid in capitation. This is primarily because existing managed care program that tend to focus on the lower cost of AFDC (Aid to Families with Dependent Children) population and not on long term care services, such as nursing home care. Long term care is a much tougher financial nut to crack. Many managed care system emphasize the need for a gate-keeper in order to prevent overuse and misuse of services. Medicaid managed care plans, however, should assure that patients are brought into the system, and that services are accessed and used enough. In other words, these plans should encourage "gateways" to appropriate services for populations presently undeserved. Managed care providers should report a set of uniform data for assessment of the availability, accessibility and utilization of health services.

States seek to manage care to increase access at reduced costs. Two recent reports revealed that those aims have generally been archived. The two studies by Hurley and Freund concluded that; a) emergency room utilization rate is reduced, b) inpatient use is lower, and c) costs to states are lower.[10),11)]

Managed care plan enrollees may continue to "seek out of the plan" care for a number

of reasons, ie. inaccessible location, transportation problem, language barrier, waiting times, and unfamiliarity with the system, etc. States are responsible for an adequate and orderly transition, including outcome monitoring plan utilization. Local health departments should be designated and funded to assist in this role.

Within the Medicaid managed care framework, quality control of health care deliverly is another concern. "fee-for-service" payments give providers financial incentives to provide unneeded services to beneficiaries. In contrast, capitation payments can give financial rewards to providers in a short term, but this may cause too few services to be rendered. Thus, State Medicaid authorities and local health departments must establish a "check and balance" system.

Ⅷ. REFERENCES

1. APHA opposes Medicare Reform Plan That Could Hurt Senior's Health, The Nation's Health, American Public Health Association, Washington, D. C., Nov. 1995.
2. Peck M. Hubert E; Changing the rules: Medicaid Managed Care and MCH in U.S. Cities (Special Report 1), City MatCH at the University of Nebraska Medical Center, Department of Pediatrics, Omaha, NE, July, 1994.
3. States as Payers: Managed Care for Medicaid Populations (the States and Private Sector: Leading Health Care reform), the National Institute for Health Care Management, Washington, D. C., February, 1995.
4. Gage L, Von Oehesen W; Managed Care Manual; Medicaid and State Health Reform, Clark-Boardman-Callaghan, NY, 1995.
5. Medicaid Brochure (PH-1, What is it?), Division of Medical Assistance and Health Services, Trenton, NJ, Dec., 1994.
6. Medicaid; The move to Managed Care, the National Institute for Health Care Management, Washington, D. C., February, 1995.
7. Zimmerman M, et al.; Medicaid States Expand Coverage for Pregnant Women, Infants and Children US General Accounting Office, Washington, D. C., 1989, GAO/HRD 89-90.

   Congressional Research Service, Medicaid Source Book: Background Data and Analysis, US Government Printing Office, washington, D. C., 1988.
8. Lundberg D, Managed Care in JAMA and the Archives Journals- A call for papers for Coordinates Theme Issues (Editorials), JAMA, Oct. 25, 1995; 274 (15): 1309.
9. Medicaid Managed care: A Handbook for Public Health Agencies (unpublished draft), the National Association of Country and City Health Officials, Washington, D. C., Oct. 1995.
10. Hurley, Robert E. and Freund, Deborah A.; A Topology of Medicaid Managed Care, Medical Care, August, 1988; 26 (8)

    Hurley, Robert E., Freund, Deborah A, and Paul, John. Managed Care in Medicaid: Lessons for Policy and Program Design. Health Administration Press, Ann Arbor, MI. 1993.
11. W. Wilson; Unpublished Papers on Medicaid Managed Care, 1993.

12. Willium Shonick. Government and Health Services; Government's Role in the Development of U.S. Health Services 1930-1980. Oxford University Press, 1995.
13. Special Edition: Public Health Strategies for Medicaid Managed Care (an information brochure), Access Report of the Association of State and Territorial Health Officials, Washington, D.C., Sept., 1995.
14. Medicaid Managed Care Arrangement and Local Health Depts.- A Case Studies of Experience with Medicaid Managed Care (an information brochure), National Association of County and City Health Officials, Washington, D. C., 1993.
15. Managed Care, Medicaid, and Public health System (an information brochure), National Association of County and City Health Officials, Washington, D.C., July, 1993.
16. Peck M. Hubbert E; Changing the rules: Medicaid Managed Care and MCH in U.S. Cities (Special Report 1), City MatCH at the University of Nebraska Medical Center, Department of Pedeatrics, Omaha, NE, July, 1994.