Medicaid Case Management Update

Despite the problems encountered by a number of Medicaid case management systems, states continue their enthusiastic support of these systems, which limit Medicaid enrollees' freedom of choice. What follows is a brief case management update. For more detailed information on how these systems work, see articles in the July 1983 and July 1984 Clearinghouse Review.

Some of the programs now being implemented appear to be improving access to care for Medicaid recipients; unfortunately, other programs provide less than satisfactory care and may be endangering the health of Medicaid enrollees. Much of the information in this update was obtained from legal services attorneys around the country.

Arizona: Arizona continues to have problems with the Arizona Health Care Cost Containment System (AHCCCS). A district judge ruled in a legal services case that the state would have to improve its enrollment procedures for AHCCCS or pay each recipient eligible for the program but not enrolled $50 a month. Apparently, this approach was effective. According to Community Legal Services in Phoenix, the state's Department of External Affairs has put enough people on the problem to improve the system. Meanwhile, a second AHCCCS provider, Western Sun, has declared bankruptcy and is now in Chapter 11 reorganization. Western Sun provided care in Yuma County.

In addition, pregnant women may not be getting the care they need under AHCCCS. According to Dr. Doug Campos-Outcalt, Director of Preventive Services for Maricopa County, preventive care is suffering under the system. A recent Maricopa County survey found that fewer women were obtaining prenatal care early in their pregnancies than previously.

California: The California Medical Assistance Commission (CMAC) has chosen two areas of the state—San Diego County and the San Fernando area of Los Angeles County—to try the capitated case management system, named "Expanded Choice." These two areas have a combined Medicaid enrollment of 250,000.

CMAC plans to begin enrolling recipients in January 1986, although details of the plan have not yet been finalized. Three months before start-up, the state has still not decided which groups will be exempted from the system, which services will be provided, how utilization will be studied, and what type of grievance system is needed.

Legal services advocates in Santa Barbara have received few complaints about the county's case management program. Monterey's system closed on February 28, 1985, due to high cost overruns.

Colorado: Colorado's mandatory case management system has been implemented smoothly. The program recruits individual physicians who it pays a fee-for-service and case management fee. Legal services advocates, however, are concerned about a decline in the number of EPSDT screenings and are trying to discover the cause of this decline.

Connecticut: A newly formed, nonprofit organization, Hartford Health Network, is proposing to establish a case management system for the city's AFDC population. The program would be administered by a nonprofit Health Insuring Organization (HIO). Few details of the proposal are available, but Hartford Health Network's Board of Directors includes a legal services attorney and other representatives of the low-income minority Hartford community.

1. Dallek & Wolsin, Limits on Medicaid Patients' Rights to Choose Their Own Doctors and Hospitals, 17 CLEARINGHOUSE REV. 280 (July 1983).
2. Dallek, Parks, & Waxman, Medicaid Primary Care Case Management Systems: What We've Learned, 18 CLEARINGHOUSE REV. 270 (July 1984).
5. Turk, supra, note 3, at 12.
Kentucky: Kentucky sent its waiver request to HCFA on July 5, 1985, for a new case management system called "Ken PAC." The system will pay physicians a $3 case management fee plus fee-for-services fees. Approximately 2.5 million AFDC and AFDC-related recipients will be enrolled for an "estimated" savings of $3.1 million a year.

Michigan: Preliminary cost data has just been released on the Physician Primary Sponsor Plan (PPSP) program in Wayne County. Analysis shows some cost savings resulted from the PPSP system, primarily from a decline in ambulatory physician utilization for the high-user population (persons with 42 or more prescriptions, 16 or more office visits, or 18 or more lab procedures a year). This population showed no significant decline in either emergency room or inpatient hospital utilization.

Preliminary results also show that the PPSP system did not appear to increase access to care for the most underserved Medicaid population; Medicaid recipients who did not see a doctor before they were enrolled in PPSP still did not see a doctor after they were enrolled.

The program continues to have problems due to the lack of an adequately staffed hot line. A telephone busy study was done to follow up on the study conducted a year ago. The first study found that over 12,000 calls during a one-week period did not get through to the hot line because the lines were busy. In May, when the study was repeated, there were 3,000 calls that could not get through. One of the reasons for the continued inability of enrollees and providers to get assistance is the lack of hot line workers, called "problem solvers."

Michigan is applying for a year’s continuation of its waiver, which is expected to be approved.

New Jersey: New Jersey is now expanding its voluntary case management program to the entire state and, thus far, few complaints have been voiced.

New York: Suffolk County is the site of a pediatric demonstration project comparing the regular Medicaid fee-for-service program, a Medicaid fee-for-service system that reimburses physicians at a rate approximating the physicians' private fees, and a capitated system. Under the latter system, doctors receive a capitated rate per AFDC enrollee, plus a portion of any surplus in a separate referral fund. Doctors are partially at risk for any referral fund shortfall.

Preliminary data on the first year's operation of the project show that both the augmented Medicaid program and the capitated systems saved the state money. The regular Medicaid program cost $35.00 a month per recipient for primary and specialty physician care, the augmented fee-for-service Medicaid program cost $26.95 a month for these services, and the capitated prepayment system cost $20.45.

The American Academy of Pediatrics, which published "The Failure of Kentucky's First Case Management System," concluded that "without additional data and analyses, it cannot be said for certain whether the actual savings are large enough to warrant implementing similar efforts elsewhere."

Oregon: Oregon's case management system is enrolling AFDC Medicaid recipients in two counties. Enrollment is being phased in slowly; new Medicaid recipients are enrolled when they become eligible for the program, and all other recipients are enrolled when they are recertified every six months. In Multnomah County (Portland), about 1,000 families have been enrolled. The plan is being expanded to two neighboring counties. Thus far, the program has been smoothly implemented.

Pennsylvania: HCFA has still not approved a case management system for Philadelphia. In June, HCFA sent the state a second request for more information. Because HCFA has delayed granting the waiver for lack of information, the state has pushed back implementation of the program until December 1986.

The 10-page HCFA request contains detailed questions on cost, access, and quality. HCFA found that Pennsylvania's response did "not contain sufficient information on which to approve the waivers" and asked the state to provide added documentation on administrative costs, capitation rates, the number of providers expected, utilization standards, emergency procedures, quality standards, medical protocols, etc.

Community Legal Services of Pennsylvania has submitted to HCFA two lengthy briefs pointing out the potential problems of the system.

South Carolina: HCFA responded to South Carolina's waiver request to enroll high-risk, pregnant, medically needy recipients in a case management system with an eight-page request for more information. Apparently, HCFA is concerned that South Carolina's proposal for an expanded package of prenatal care services will not really save money. In general, South Carolina legal services advocates think the case management proposal will enhance care to eligible enrollees.

Utah: Within two years, Utah plans to require all Medicaid recipients to enroll in an HMO. Presently, in the Wasatch Front area of the state (which contains the state's three...
major cities—Ogden, Provo, and Salt Lake—and most of the state’s population), Medicaid recipients are given a choice of fee-for-service or an HMO. The state’s Medicaid agency promises that it will not restrict freedom of choice until Medicaid recipients have at least three HMOs to choose from.

**Wisconsin:** Wisconsin’s system of enrolling all AFDC beneficiaries in Milwaukee and Madison in HMOs has faced some major problems. Most troubling is the lack of contract specifications requiring HMOs to subcontract with ambulance companies to provide services to HMO enrollees. This has led to confusion about the circumstances under which HMOs will pay for ambulance services. Sometimes an ambulance company calls requesting permission to transport a Medicaid enrollee to a hospital only to wait 45 minutes for prior authorization. Often, these situations are quite serious. In many instances, HMOs refuse to reimburse ambulance companies that, in turn, say they are going bankrupt.\(^{10}\)

Other problems with Wisconsin implementation include inadequate referrals to EPSDT, maternal and child health, and WIC providers; lack of education causing confusion about how to use the new system; the state’s unwillingness to support the continued existence of a community advisory committee; and poor utilization data. This last issue is especially serious. Although voluntary enrollment in the system started last September and involuntary enrollment began last March, the state has collected little or no utilization data and is, in fact, fighting with the HMOs on what types of data need to be provided. Without utilization data, no measure of quality is possible.

Despite these problems, few complaints from clients (outside of the ambulance issue) have been received by legal services advocates, and there is no indication that significant underutilization is a problem.

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