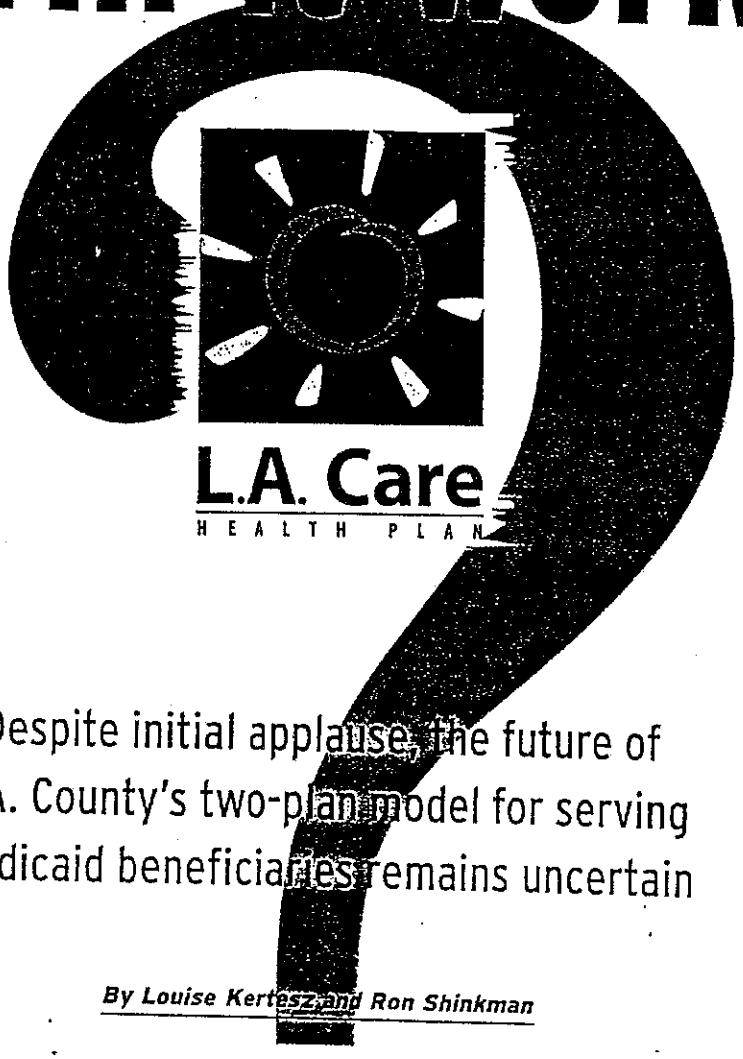
Will it work



Despite initial applause, the future of L.A. County's two-plan model for serving Medicaid beneficiaries remains uncertain

By Louise Kertesz and Ron Shinkman

There was much rejoicing in April when L.A. Care Health Plan, one of two managed-care plans that recently began serving Los Angeles County's 1.2 million Medicaid beneficiaries, finally received its HMO license from the California Department of Corporations.

L.A. Care, a combination of one public HMO and six commercial ones (See chart, p. 122), serves beneficiaries of Medi-Cal—the state's Medicaid program—alongside Foundation Health Systems and its two subcontractors.

It's Los Angeles County's version of the "two-plan" model already in place in 12 of California's 57 counties. When it's at full steam in Los Angeles County, the state is expected to spend about $1 billion a year on the program.

On the day L.A. Care received its license, Chief Counsel Cathy Kay whooped with joy, shouted good-natured expletives and high-fived everyone she encountered in the administrative offices, located in a nondescript high-rise building west of downtown Los Angeles.

After all, L.A. Care—whose focus is bringing safety-net providers into a managed-care system—expected its license last summer. The plan could not begin enrollment without it. Meanwhile, it was spending up to $1 million a month to remain operational, with little revenue coming in.

Amid the rejoicing, someone remembered L.A. Care's day of triumph also happened to be April Fools' Day. A phone call to the Department of Corporations confirmed the license was not a hoax.

Anxiety. But there continues to be real anxiety about L.A. Care's future, largely because many believe the two-plan model is inherently flawed. A report released in March by consumer organizations blasted the model for everything from chaotic enrollment procedures to impaired healthcare services.

"If the state had gone out of (its) way to design the system with the maximum amount of bureaucratic redundancy and overlap, to take the maximum amount out of healthcare and put it into administration, (it) couldn't have designed a better system," says an executive of one of L.A. Care's partner plans who wishes to remain anonymous. "They change the (two-plan) managers at the Department of Health Services faster than they move the dealers around in a Vegas casino."

The two-plan model works this way: In each county a quasi-governmental agency (such as L.A. Care) competes against a commercial HMO (FHS, in L.A. Care's case) for Medi-Cal enrollees. But in most examples, the agency usually subcontracts with other HMOs to provide services, and caps are placed on both the commercial HMO and the agency.

After pondering several models for Medi-Cal managed care, lawmakers and the California Department of Health Services say they embraced the two-plan model for the state's most populous counties because it would allow the purchase of healthcare at reasonable rates, give enrollees broad choices in health plans and create enough competition among the plans to ensure they would provide quality services. It would also provide a proper balance between private-sector management and government administration.

Yet just days before L.A. Care received its HMO license, HCFA decided the deluge of enrollment materials from L.A. Care was confusing to beneficiaries. HCFA halted the "default" method of enrollment until the plan straightens out its procedures.

Under the default system, enrollees who didn't pick one of L.A. Care's partner HMOs as of last summer were automatically enrolled in a plan. HCFA was concerned that, in their confusion, many enrollees were mistakenly defaulted.

L.A. Care administrators and state health department officials protested HCFA's action, contending problems have been largely worked out and the default delay would cause more confusion and strain the program's finances.

Many enrollment problems date from the state's previous Medicaid managed-care enrollment subcontractor, Portland, Ore.-based Benova, which lost its contract at the end of 1996 after relentless criticism for what detractors said were shoddy enrollment practices.

The state has since sued Benova for alleged billing discrepancies. Benova has filed for bankruptcy protection, claiming the state has not paid its bills in a timely manner.

L.A. Care's subcontractor, Fairfax, Va.-based Maximus, began handling enrollment Jan. 1. Anecdotal evidence indicates Maximus has been generating far fewer complaints, but HCFA remains concerned.

Informing beneficiaries. Other parties also are concerned. Mark Finucane, director of Los Angeles County's health services department and a member of the L.A. Care board of governors, believes L.A. Care is falling short of informing enrollees about all their choices.

"I don't want to be tagged by saying they're not up to the job. By the same token, I do think L.A. Care should be spending more time and money on educating consumers themselves, as opposed to letting their subcontracting plans do it for them," Finucane said in late March.

Two weeks later, Lynn Kersey, executive director of Maternal and Child Health Access, a Los Angeles-based advocacy group, announced the launch of the Medi-Cal Managed Care Education Project to inform consumers about the coming changes. "Too little has been done to date to prepare Medi-Cal beneficiaries for managed care," Kersey says.

L.A. Care officials support the project. Spokesman Keith Malone says L.A. Care once had a substantial educational budget, but the delays in becoming operational have drained much of it away.

Unfortunately, a lack of educational resources is not the only challenge facing L.A. Care. Its promise that it can stabilize costs and improve the health of hundreds of thousands of poor people through managed care has made it somewhat of a bureaucratic "Jerry Maguire"—starting out with lots of good intentions and very high hopes.

The program promises to assign the poor a primary-care doctor instead of leaving them to search for providers they must often locate through the Yellow Pages. This would increase the likelihood of them receiving preventive services.

In a mandated benefit beyond what enrollees of a commercial HMO enjoy, L.A. Care enrollees must be seen by a primary-care physician within 120 days of enrollment in a plan. The idea is to give them "a medical home," which they didn't have under fee-for-service.

Primary-care physicians—or their alternates in a medical group—must be available 24 hours a day. "It was often felt by (traditional Medi-Cal) providers that their obligation was 9 to 5, and after that the patient could find service in the emergency room," notes Don L. Garcia, M.D., FHS regional medical director for Southern California.

FHS was formed through the April merger of Foundation Health Corp. and Health Systems International. Foundation Health had been caring for Medi-Cal recipients in Los Angeles since it bought a plan in 1992.

Unlike enrollees in commercial health plans who are bound by annual open-enrollment periods, Medi-Cal beneficiaries have the right to change their HMO or primary-care doctor every 30 days.

Demands vs. money. But the demands L.A. Care must meet are overwhelming. It has been buried in pleas of "show me the money" from providers,

L.A. Care's HMOs by enrollment
(as of June 5)

HMO	Enrollment
Blue Cross of California, Woodland Hills	3,280
CareFirst, Los Angeles	20,829
Community Health Plan, Los Angeles	35,494
Kaiser Permanente Southern Region, Pasadena	23,149
Maxicare, Los Angeles	43,860
Tower Health, Long Beach	20,783
United Health Plan, Inglewood	50,96

Community is a public HMO; the others are commercial plans

Source: L.A. Care Health Plan

healthcare advocates and Los Angeles County officials.

Simply put, no healthcare provider interviewed for this article believes L.A. Care has the funding to properly treat its low-income charges.

Kersey, for example, believes L.A. Care will do a better job than the California Department of Health Services, the previous steward of the county's Medi-Cal program, in monitoring care and responding to consumer grievances. But overall, she considers its future "a real mixed bag.

"Some providers are only going to be offered four or six dollars per patient visit. They're banging their heads against the wall because the rates are unlivable," she says.

Kersey's concerns boil down to simple mathematics. The California Department of Health Services, which acts as an intermediary in dispensing funds from the Medi-Cal program, pays L.A. Care $74.61 per month per enrollee. Rates are higher for certain enrollees, such as the aged and disabled. L.A. Care is allowed to retain 9% of that for administrative purposes in its first year of operation and 6% in the second year. The subcontracting health plans are allowed to retain an additional 15% for administrative costs and their own profit.

That leaves between $55 and $57 per month for patient care, an amount most interviewed for this article believe is about half the sum required to do a proper job. Also, the costs for administration and profit retention give L.A. Care a medical-loss ratio—the amount of premium revenues actually devoted to patient care—of 76% to 79%. Most HMOs in California have a medical-loss ratio of about 85%, meaning only 15% is profit and administrative expenses. Those with ratios lower than 85% usually encounter sharp criticism from consumer groups.

"This is going to be a frightening prospect. I'm deeply concerned this is going to work against the patient, reduce access and potentially erode the quality of care," says Mel Marks, M.D., executive director of Memorial Miller Children's Hospital in Long Beach. "At this rate, I think some traditional Medi-Cal providers will no longer be able to see patients."

Instead, Marks believes $100 a month is more in line with what it would cost to treat a child.

"There are very few providers around the country that don't complain about capitation rates under Medicaid," says Richard Chambers, associate regional administrator for HCFA's Medicaid division in San Francisco.

"Once we get utilization data, the actual experience in Los Angeles, we believe we can go back to the state and say, 'Based on what is a reasonably mature Medi-Cal market, these rates are inadequate.'"

—John A. Sarles, L.A. Care CEO

Capitation crunch. The crux of the problem is that, under the federal waiver allowing managed care in Medicaid, capitation rates can't be higher than their fee-for-service equivalent, Chambers says.


Rodgers

The state has negotiated rates that are about 3% to 5% below fee-for-service payments, which in California are among the most frugal in the nation. The fee-for-service rates haven't changed since the mid-1980s, Finucane points out.

"They need to recalculate those rates, and come up with something that is more current and reflective of what's going on in the current healthcare environment," Finucane says.

"The capitation rate is absolutely ridiculous," says Mandy Johnson, executive director of the Community Clinic Association of Los Angeles County, an advocacy group for small, independent clinics, many of which treat large numbers of Medicaid recipients. "At that rate, the system will collapse within a few years unless the rates are changed."

James Drinkard, M.D., medical director for Adventist Health's Southern California division, says: "I think the capitation rates we have been told about seem inadequate in our organization, both on the physician and hospital side. It's going to be a struggle." Drinkard operates a medical group with about 200 Medi-Cal physicians.

Meanwhile, L.A. Care is optimistic about the possibility of increasing its capitation rates. A spokesman said the plan anticipates a 3% increase in capitation rates effective in October.

As for an overall increase in the state's fee-for-service equivalent rate, Joe Kelly, chief of the state Department of Health Services' Medi-Cal managed-care division, says the possibility in the near term is very low.

"The Legislature and governor would have to (concur) on a general tax increase, and in this environment I see that as very unlikely," Kelly says.

The Healthcare Association of Southern California, an influential lobbying group for the region's hospitals, has spent $25,000 on a preliminary actuarial study—by consulting firm Milliman & Robertson—of L.A. Care's capitation rates.

"The results confirm that, in comparison to 10 other states, the capitation rates being paid in Los Angeles County are woefully inadequate," says Jim Lott, the HASC's senior vice president. Lott asserts that the current capitation rates will lead to a "meltdown" of the current system.

Lott adds that the HASC is considering spending an additional $275,000 for an extensive study, then possibly lobbying HCFA with the results if they're favorable to its cause.

And if HCFA doesn't want to listen?

Lott hints that legal action may be inevitable. It would not be the first time Los Angeles providers have sued over Medi-Cal reimbursement. A lawsuit filed by Orthopaedic Hospital in Los Angeles against the state health services department over its low rate of reimbursement won a recent victory in federal appellate court.

"Orthopaedic's case may help us out, but the state has been very expert in making all of Medi-Cal a zero-sum game," Lott says.

The state is supported by HCFA in this regard. Chambers says HCFA did an "extensive review" of Medi-Cal capitation rates and certified their actuarial soundness in 1996.

"I don't know if a lot of people know that traditional providers whose patient population has been made up of regular Medi-Cal have had no oversight."

—Marsha Olivier, L.A. Care's executive director of operations

But to help in the transition, Woodland Hills-based Blue Cross of California—an L.A. Care partner plan—is paying its capitated Medi-Cal providers 5% over fee-for-service rates. Blue Cross providers have a choice of fee-for-service or capitated reimbursement.

Meanwhile, an L.A. Care task force is studying the capitation rate. "Once we get utilization data, the actual experience in Los Angeles, we believe we can go back to the state and say, 'Based on what is a reasonably mature Medi-Cal market, these rates are inadequate,'" says John A. Smits, L.A. Care chief financial officer.

Getting breaks. One thing often missed by critics of the capitation rate's inadequacy is that the risk providers will assume is minimized by the expensive services "carved out" of the program. For example, Medi-Cal providers will be referring the sickest patients—such as children with long-term illnesses—to their regular specialist providers outside the two-plan system, notes Sean O'Brien, director of FHS' Medi-Cal operations. Mental health and dental care also will be covered by conventional means.

Additionally, L.A. Care and the commercial HMOs working with traditional Medi-Cal providers say they will give them the training and the tools to provide better care while containing costs.

"I don't know if a lot of people know that traditional providers whose patient population has been made up of regular Medi-Cal have had no oversight," says Marsha Olivier, L.A. Care's executive director of operations. Many of them have no hospital privileges and have never been part of a peer-review process, she points out.

"When these same physicians enter a Medi-Cal managed-care environment, they have a huge number of requirements they never had before. No one ever looked over their shoulder," Olivier says.

If managed care can be made to work well in California, it will be "a superior delivery system," Chambers says. Fee-for-service Medi-Cal was "not that hot of a system" and, since it was tied to low provider rates, enrollees had a very tough time getting access, he says.

David Friedman, vice president of Medi-Cal operations at FHS, points out that because HMOs credential their physicians and perform medical audits, their enrollees haven't been subject to "Medi-Cal mills." Those physicians and clinics that dispense shoddy treatment to beneficiaries in volume still operate in Los Angeles, he says.

Garcia asserts that managed Medi-Cal enrollees enjoy not only better access but access to better quality care.

FHS executives note that the credentialing process will help the traditional safety-net providers move into mainstream medical practice. HMOs will conduct training programs to help providers do that.

Monumental task. Judging from some providers' reaction, HMOs have a monumental task ahead. Agop Aintablian, M.D., a cardiologist serving Medi-Cal pa-

tients, says after an L.A. Care information seminar, "HMOs are just intermediaries" that want to make a profit from the system, taking money from physicians and giving nothing in return.

People inclined to look for hopeful signs for L.A. Care can consider Blue Cross of California's experience in a Medi-Cal managed-care program in Sacramento. Last year, Blue Cross received top ratings for the care it provides in all 10 categories reviewed by the state. Just a year before, its ratings were mediocre to poor.

"Sacramento is probably the best learning experience we could have had" for L.A. Care, says John Monahan, general manager of Medi-Cal programs.

Blue Cross, which has been awarded Medi-Cal managed-care contracts in several counties, is tailoring programs for each one. "The low immunization rate and teen-age pregnancy is what we're concentrating on in L.A.," Monahan says. As the plan gets more information about county demographics, it will hone its targeting of healthcare services, he says.

HCFA's Chambers points out that "Blue Cross was not a plan option in L.A. County prior to the two-plan model. Medi-Cal beneficiaries did not have Blue Cross as an option." With L.A. Care plan partners and FHS and its two subcontractors to choose from, "there's a wider range of options for beneficiaries" than under fee-for-service, Chambers says.

Among the other advantages L.A. Care intends to bring its beneficiaries—and to providers caring for them—is to monitor the disease states of various ethnic populations by following their healthcare utilization patterns, says Anthony D. Rodgers, chief executive officer. "It is our intent to actually go into those communities to proactively assess what's going on." Meanwhile, regional community advisory committees, which will elect members to L.A. Care's governing board, will act as their community consumer advocates.

L.A. Care is also trying to persuade legislators to create a long-term financing mechanism to help get computers and other upgrades into physician offices, Rodgers says.

Clyde Oden, president and CEO of Los Angeles-based Watts Health Foundation, acknowledges that Watts' United Health Plan—an L.A. Care partner—has a "vested interest" in the program's success. He adds, "I think we can expect that with any massive change in membership and enrollees there's going to be early problems and that judgment too soon about the effectiveness of this change would be a disservice to everybody involved. I am convinced, however, that within 12 months of operations the people of California will enjoy the benefits of this change."

Says HCFA's Chambers: "There isn't a state that has implemented Medicaid managed care that hasn't had a transition problem."

Despite these reassurances, the bitter warnings and suspicions continue. The two-plan model is "the trickle-down theory at its worst," says Jim Gonzalez, managing partner of Jim Gonzalez and Associates, a legislative advocacy firm. The poor have no power, so they're relegated to inferior healthcare, he says. ❑