WASHINGTON STATE’S EXPERIENCE IN EXTENDING MEDICAID MANAGED CARE TO THE SSI POPULATION: A RETROSPECTIVE ANALYSIS

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By the
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I. INTRODUCTION

In April 1997, Washington State began enrolling Medicaid Supplemental Security Income (SSI) beneficiaries in a mandatory Medicaid managed care program in Spokane and 15 other eastern Washington counties. Beneficiaries were required to enroll with managed care organizations (MCOs), which would be paid on a capitated, full-risk basis. More than 10,000 SSI beneficiaries had enrolled by November 1997.

As the time approached for MCOs to sign new 1998 contracts with the state for the SSI program, however, plans began reporting that costs for the SSI population were substantially exceeding the per-member per-month (PMPM) capitated rates set by the state for 1997 (about $345 in the Spokane area). Because of federal regulations that limit total capitated payments to what Medicaid would have paid for care under the fee-for-service system (the upper payment limit), the state Medical Assistance Administration (MAA) was not able to increase capitated rates for 1998 to the levels MCOs believed were needed to cover their costs. Without significant rate increases and/or other changes in the program, such as risk-sharing arrangements with the state, the MCOs were not willing to sign contracts for 1998.

Therefore, despite considerable progress in implementation and early reports from beneficiaries of improved access to care, the state concluded that it was not feasible to continue the program. Accordingly, the state announced that the SSI managed care program would end as of January 1, 1998, and that the SSI beneficiaries who had enrolled in the program would be returned to the regular fee-for-service Medicaid program.

Evaluation of the SSI Managed Care Experience

Because of the amount of time and effort that MAA, participating MCOs, providers, consumer groups, and many others in state government and around the state had devoted to designing and implementing the new Medicaid managed care program for SSI clients, MAA decided to evaluate its experience with the program to see what lessons could be learned.

MAA staff completed an initial draft of the evaluation on December 26, 1997. This draft provides excellent background on the development of the program, and identifies some of the issues the state plans to explore. As part of the evaluation, the MAA invited the Center for Health Care Strategies, Inc. (CHCS) to provide an independent assessment of the SSI managed care program to Washington state officials, and ultimately to other interested parties in Washington and other states.

James Verdier, CHCS Senior Program Consultant and Director of State Health Policy at Mathematica Policy Research, Inc., Stephen A. Somers, President of CHCS, and Valerie Harr, CHCS Research Associate, visited Washington State from March 4-7, 1998. The report that follows is a revised version of a report on that visit that CHCS sent to state officials on June 15, 1998. It reflects comments and suggestions from state officials and Group Health Northwest, one of the MCOs that participated in the SSI program.

Sources

During the March 4-7 site visit, CHCS representatives met with MCO representatives in Spokane, Clark County, and Seattle, and with state officials in Olympia. A list of those with whom CHCS representatives met is in Appendix A. In addition, CHCS representatives reviewed written materials
II. SUMMARY OF FINDINGS AND RECOMMENDATIONS

Washington’s 1997 effort to extend Medicaid managed care to the SSI population was the outgrowth of a 1994 request by the state legislature. The 1997 effort was preceded by nearly three years of planning and consultation with stakeholders, including a pilot project in Clark County in 1995-97 that used a non-risk primary care case management (PCCM) model.

Despite this extensive preparation and consultation with stakeholders by the MAA, and despite the state’s successful experience since 1993 with Medicaid managed care for the AFDC and related populations, the state encountered significant difficulties in extending managed care to the SSI population. Major factors contributing to the difficulties included:

- the extensive and widely diverse care needs of the SSI population
- the dependence of many in the SSI population on social and other non-medical services provided through state and local agencies that had not previously worked closely with MAA and Medicaid providers
- the increased organizational and staffing demands placed on MCOs by the rapid enrollment of large numbers of chronically ill and disabled enrollees
- state confidentiality rules that limited the ability of MCOs to obtain information on individual enrollees’ diagnoses, functioning, and prior care and service utilization, which made care coordination and management more difficult and time-consuming
- the Medicaid upper payment limit, which limited funding for SSI managed care to the amount that Medicaid would have paid under a fee-for-service program
- exclusion of most mental health services from the SSI managed care program, which limited opportunities for coordination of mental and physical health services and increased opportunities for cost- and responsibility-shifting

Most of these factors are present to some degree in other states that are considering extending Medicaid managed care to the SSI population, which makes Washington’s experience especially valuable for other states.

Findings with Broader Applications

Several aspects of the Washington experience are especially relevant to other states that plan to extend Medicaid managed care to the SSI population:

- **The high degree of complexity involved in designing and implementing managed care for the SSI population, especially when the programs are mandatory and risk-based.** While the MCOs in eastern Washington recommended a risk-based model for the SSI population rather than the PCCM model the state initially proposed, the mandatory risk-based model ended up raising the stakes to uncomfortable levels for some MCOs, providers, beneficiary advocates and other stakeholders. Specific design and implementation decisions have greater consequences in a mandatory risk-based context, unexpected complexities can foster new uncertainties, and uncertainty breeds apprehension and anxiety, all of which probably contributed in some measure to the program’s early termination.
The role of MCO exceptional needs care coordinators (ENCCs) in screening new enrollees and helping to manage and coordinate their care. MAA specified ENCC responsibilities in considerable detail in the MCO contracts, including a requirement that a screening form for each new enrollee be filled out within 30 days of enrollment. This limited ENCCs’ ability to focus initially on beneficiaries for whom their efforts could make the greatest difference, and to experiment with different approaches and learn from their experience.

The approach used to develop risk-adjusted capitated rates for the planned second year of the SSI program. While the risk-adjustment system the state and its actuaries developed for the second year would benefit from further refinement, the state’s general approach to risk adjustment is one that could be a model for other states, especially if states are able to obtain eligibility-related diagnostic information on SSI beneficiaries.

The importance of developing linkages outside of the traditional medical community. SSI beneficiaries have needs for social and ancillary services such as transportation, personal care assistance, social support, and home modifications that usually cannot be met by traditional medical providers. Medicaid officials and MCOs must work together to develop linkages to other state agencies, service providers, and community resources if managed care is to be successful for the SSI population.

The importance of involving a wide range of stakeholders in program design and implementation. MCOs, health care providers, beneficiaries, advocates, providers of social and ancillary services, local governments, and other state agencies all have a stake in Medicaid managed care for the SSI population. Involving major stakeholders in program design can help highlight potential problems at the stage when they can most easily be corrected, and can help ease stakeholder apprehensions.

Continued stakeholder involvement following implementation can assist with mid-course corrections.

Washington-specific Findings

There were some other aspects of the design and implementation of the SSI managed care program that are more specific to Washington, although they illustrate the kinds of issues other states should be alert to as they develop similar programs:

Inclusion of institutionalized individuals in the SSI managed care program. MAA decided as a matter of policy in 1995 to include over two thousand institutionalized persons in the SSI managed care program, about half of whom were living in facilities for the mentally retarded or developmentally disabled, and the remainder of whom were residents of nursing facilities. MAA made this decision at the urging of staff from the Developmental Disabilities Division and the Aging and Adult Services Administration, who believed managed care could be beneficial for these individuals. Currently, however, most MCOs have very little experience in managing the care of persons living in institutions. The institutions themselves may have pre-existing arrangements with physicians, hospitals, and other providers of acute health care services that may be difficult or inappropriate to disturb. MCOs may have difficulty obtaining ready access to institutionalized SSI beneficiaries. In addition, the most costly portion of their care—long-term residential services and the care provided by institution staff—was not included in the state’s SSI managed care benefit package, and thus could not be managed. In the end, MCOs enrolled very few of these individuals. Nonetheless, their planned inclusion in the SSI managed care program added to MCO concerns about the program’s workability.
• **Inappropriate pharmacy billing for mental health prescription drugs.** Almost all mental health services, including prescription drugs, were excluded from the SSI managed care program. Many pharmacies nonetheless billed MCOs for drugs prescribed for SSI managed care enrollees by community mental health center physicians, rather than billing the state as the program rules directed them to do. While MAA plans to make appropriate retroactive adjustments to correct these billing errors, the initial bills were another source of MCO disgruntlement. It is also an illustration of the many kinds of difficulties that can arise in drawing boundary lines between physical and mental health care, especially in the area of prescription drugs.\(^5\)

### Recommendations

If MAA’s evaluation of their experience with the SSI managed care program leads them and others to want to revive the program in some form, MAA may want to consider a voluntary risk-based SSI program in one or two urban areas, most likely Spokane and/or Seattle. A voluntary program would ease much of the apprehension and anxiety that surrounds mandatory managed care programs, and would focus the program on only those beneficiaries who believe managed care would be better for them than fee-for-service Medicaid.

At least three major issues would have to be addressed in a voluntary SSI program:

- **Risk adjustment and risk sharing.** Because the opportunities for biased selection by both enrollees and MCOs are much greater in a voluntary than in a mandatory managed care program, adjustment of capitated rates to reflect the widely varying costs of SSI enrollees is crucial for a voluntary program. Risk adjustment can increase the rates for high-cost beneficiaries to a level that could make enrolling them financially attractive to MCOs. Washington is fortunate in that it has already made extensive progress toward such a risk adjustment system. The risk-adjusted rate system could be supplemented by other forms of risk sharing, such as per-MCO risk corridors outside of which the state would share a portion of unanticipated gains and losses, and stop-loss provisions that would cap an MCO’s total loss for any individual enrollee.

- **Limited volume of enrollees.** The experience with voluntary managed care programs for SSI beneficiaries in other states indicates that initial enrollment will likely be small. MCOs may therefore not believe that the potential return will be sufficient to justify the up front investment in case management and care coordination staff, and the development of specialized networks. Some MCOs in the state have already made at least some of this investment, however, and some MCOs may also believe such investments warranted as a way of preparing themselves to better serve the broader Medicare market.

- **Role of ENCCs.** The role of ENCCs is crucial whether managed care for the SSI population is mandatory or voluntary. The state should build on its experience and that of Oregon and other states to better define the ENCC role and establish a framework that can permit it to evolve as experience grows.

Given the significant program planning and design effort that would be required for a voluntary program, the state may not want to pursue this option unless there is a significant possibility that the state will want to pursue a larger-scale mandatory program at some point in the future.
Other Options

Another possible option would be to use a non-risk primary care case management (PCCM) model for SSI managed care. Washington experimented with a variant of the PCCM model in the Clark County pilot project. MCOs received a capitated rate for establishing the provider network, coordinating care, managing utilization, and providing ENCC services, but the state continued to pay for services to providers on a fee-for-service basis. MAA officials say that “our experience with this model in Clark County was generally positive,” noting that “one of the two MCOs was able to save money during the contract period.”

Washington might also want to consider including the SSI population in the broader mandatory Medicaid managed care program that serves AFDC/TANF and related populations. The rate setting, risk adjustment, and risk sharing issues that arise in a separate program for the SSI population would largely remain in a combined program, since the predictably high and widely varying costs of the SSI population would still present significant risks of adverse selection for MCOs in a combined program.

III. PROGRAM DESIGN COMPLEXITY, CARE COORDINATION, AND CAPITATED RATESETTING

This section provides more detail on the findings that we believe have broader application beyond Washington State. The issues discussed in this section are closely interrelated, and all trace back to the fundamental difference between the Medicaid SSI populations and the AFDC/TANF and related populations: people on SSI have much more severe, chronic, and diverse health care and other support and service needs than do the generally young and healthy people in the rest of the Medicaid program. The managed care model—which so far has been used primarily to deal with the acute care needs of generally healthy people—requires substantial adaptation when applied to people who are disabled, elderly or both.

Program Design Complexity

Diversity of SSI Beneficiaries

People whose eligibility for Medicaid is based on their eligibility for SSI have a wide variety of chronic diseases and disabling conditions—from heart disease, lung disease, and cancer to AIDS, quadriplegia, schizophrenia, and mental retardation. The regular and predictable health care costs for these different diseases and conditions can range from $200 per month to $2000 per month. Their health care is provided by diverse and often highly specialized providers, from pediatric neurologists to psychiatrists, from durable medical equipment suppliers to dialysis centers, from wheelchair van operators to cancer specialists. They often depend on a variety of social and ancillary service providers: substance abuse counselors, physical therapists, psychiatric social workers, personal care attendants, and home health aides.

Many people on the Medicaid SSI program have managed to put together complex but workable personal care networks under the fee-for-service system that could be completely disrupted by managed care. Others are totally bewildered by the fee-for-service system—unable to find the right specialists, getting prescription drugs from a variety of different sources, appearing repeatedly in hospital emergency rooms, trying on their own to coordinate and manage their complex care needs.
Pressures on Program Designers

Thus, for people on SSI, managed care can be at once an alarming threat and a potential opportunity for better care. This puts substantial pressure on the designers of Medicaid managed care programs for the SSI population. Because the care needs of many in the SSI population are so great, and their condition so fragile, program designers often seek to anticipate every contingency and protect against every risk. Those beneficiaries and advocates who have seen how the fee-for-service system can be made to work for them encourage program designers to ensure that managed care is at least no worse than a well-coordinated fee-for-service system.

The result can be a set of requirements for managed care that are beyond the current capabilities of most MCOs and that, if implemented, would cost substantially more than the current fee-for-service system. Overly detailed requirements can also inhibit the ability of MCOs to restructure care more creatively within the limits on total expenditures that are inherent in managed care.

Designing a new managed care program for SSI beneficiaries requires an appreciation of how diverse and complex their care needs are, and how little is known about many of the people who are receiving care under the current fee-for-service Medicaid system. Program designers must approach their task with humility, flexibility, willingness to learn from experience, and in the expectation that they will not always get it right the first time. Frequent opportunities for refinements and corrections as the program evolves should be built into the design.8

Balancing MCO Flexibility with Enrollee Protection

What does all this mean in practical terms? One approach, which many states have adopted when extending Medicaid managed care to the SSI population, is to make enrollment voluntary. Only those who believe managed care will be better than fee-for-service will enroll, and those for whom managed care is not working can be allowed to disenroll easily. Eventually, as confidence in managed care builds, mandatory enrollment may become more palatable. This option is discussed in more detail later.

Even in the context of a program in which enrollment is mandatory, as it was in Washington in 1997, beneficiaries and MCOs can be given the flexibility needed to avoid the worst consequences of inappropriate program design choices. Especially in the early months of a mandatory program, extra resources should be devoted to educating and counseling beneficiaries about their choices, and relatively easy transfer to other plans should be allowed. Washington state officials report that the state, its community partners, and MCOs made a major effort to educate and counsel SSI enrollees in 1997, and that during implementation MCOs “routinely facilitated transfers to other plans to assure continuity of care.”9

Selection bias. The major potential problem with easy switching among plans is that MCOs may benefit or suffer from biased selection. MCOs could “encourage” the sickest and most costly beneficiaries to enroll in or switch to other plans, resulting in favorable selection to the MCO. On the other hand, MCOs that put together especially attractive and effective care networks could be flooded with high-needs and high-cost enrollees (adverse selection). With a system like Washington’s in 1997 that paid the same rate for all enrollees, the first MCO could profit unduly, while the second could suffer significant losses. However, a risk-adjusted system like the one Washington planned for 1998, or other forms of risk sharing that are discussed later, can reduce this selection bias problem. Washington MAA officials do not believe that client movement from one plan to another was a significant contributor to
selection bias in the SSI program in 1997, noting that changes were initiated by the client and approved by the state.

**Program requirements.** The Washington SSI managed care program included an especially revealing example of the tendency for program designers to be overly prescriptive in developing program requirements. In this case, it involved a critical feature of the program that—with more flexibility—could have provided both the state and MCOs with an opportunity to learn how best to balance the complex and diverse needs of Medicaid SSI beneficiaries with federal and state requirements for cost containment in managed care.

This key feature of the Washington program design—the role of exceptional needs care coordinators—is discussed in the following section on care coordination.

**Care Coordination**

Washington state required MCOs participating in the SSI managed care program to hire exceptional needs care coordinators—ENCCs—who were required under the MCOs’ contracts with the state to perform a wide range of functions and duties. This ENCC requirement was modeled after a similar feature in the Oregon managed care program for its SSI population, but Washington specified the ENCC role in much greater detail than Oregon did, with consequences that are detailed below. In part because of how the Washington ENCCs were required to perform their role in the initial stages of the program, health care costs for new enrollees were higher than MCOs anticipated, contributing to the anxiety that made them reluctant to sign contracts for the second year.

Perhaps more importantly, however, the detailed specification of ENCC duties in Washington made it difficult for the ENCCs to learn how to operate most effectively with a population whose care needs were not well known, and in an MCO environment in which the relationships among primary and specialty physicians, ENCC, enrollees, and social and ancillary service providers were not well developed. Time was needed for joint learning, experimentation, and development of mutual trust. Because of financial pressures, ENCC preoccupation with initial enrollment and screening duties, and the looming deadline for signing new contracts for 1998, that time was not available in late 1997.

**ENCC Requirements: Washington vs. Oregon**

ENCC requirements were much more detailed in the Washington SSI managed care program than they were in the Oregon program, which began two years earlier, and which Washington program planners had used as a model. Oregon MCOs had much greater flexibility in how they used their ENCCs than the Washington version permitted, and a greater opportunity to learn from experience. One key difference was that in Oregon ENCC services were to be provided at the request of patients or their representatives, while in Washington ENCCs were required to fill out a screening form for every SSI enrollee within 30 days of enrollment. In addition, as discussed further below, state workers in Oregon assumed many of the enrollment, screening, and counseling responsibilities that Washington placed on the MCOs’ ENCCs, freeing up the Oregon ENCCs to do more care management and coordination than the Washington ENCCs had time to do.

**Washington ENCC requirements.** MCOs participating in the Washington SSI managed care program were required to hire ENCCs, and their duties were spelled out in considerable detail in the contract with the state. ENCCs were required to, among other things:
- Fill out a screening form for each enrollee within 30 working days of enrollment in order to "identify and prioritize each member’s medical and allied social services needs . . . and to identify the appropriate agency or professional to provide services to meet those needs," and update that screening form at least every six months.
- "Coordinate with the member’s PCP [primary care provider] to assure the member receives medically necessary health care and that the PCP receives information about services provided under the terms of this agreement."
- "Provide reasonable assistance to members, and their families and representatives, to facilitate timely access to all medically necessary health services."
- "Acknowledge with a phone call or a letter to the member, all requests for services from a member by the end of the working day following the day of request."
- "Maintain a case file in the Contractor’s office for each member which documents all ENCC activities, including copies of the screening tool and any updates."

While these are all justifiable—even admirable—standards for an ideal Medicaid managed care system for people with special health care needs, they may have been too much to absorb all at once. This highly specific list of ENCC responsibilities had at least two major effects:

- ENCCs were so occupied with paperwork and administrative tasks—especially with the flood of new enrollees in the early months of the program—that they had little time to learn how to do their jobs creatively and cost effectively. There was little time for training or collaborative discussion about how to make managed care work for all involved.
- The ENCCs linked many new SSI enrollees to a range and level of medical services they had not received before in the fee-for-service system, driving costs for these enrollees well above prior fee-for-service levels.

Added to this was the fact that neither the ENCCs nor the medical and clinical staffs of the MCOs had good information on the prior Medicaid service utilization of their individual SSI enrollees, so they had no effective way of identifying potential fee-for-service overutilization in areas such as hospital emergency rooms, drugs, hospital inpatient services, and home health services. Potential savings in those areas could have offset to some extent the increased costs resulting from the ENCCs’ identification of unmet needs.

The ENCCs also had difficulty in getting information on SSI managed care enrollees’ use of social and other ancillary services, so they were often unable to identify other service providers who could assist with enrollees’ social and other needs (transportation, home visitation, day services, and the like). In some cases this could be merely an issue of care coordination and ensuring continuity of service, but in others—where a social or ancillary service might lead to less costly and more effective use of medical services—an MCO might want to include such a provider in its formal network.

To some extent these difficulties in providing information about enrollees to ENCCs were due to concerns about confidentiality. A September 15, 1997 memorandum from the state Attorney General’s office clarified these confidentiality issues by spelling out the circumstances under which ENCCs could get information without a signed release from the patient, and making it clear that a wide range of information could be obtained with such a release. Nonetheless, uncertainty about this issue impeded the early stages of SSI managed care enrollment. MCOs in particular cited these confidentiality restrictions as a major obstacle to coordinating care.
**Oregon ENCC requirements.** Oregon defines the responsibilities of the ENCCs in their Medicaid managed care program much more generally. The state’s contract with MCOs states that exceptional needs care coordination includes:

> [E]arly identification of those aged, blind and disabled OMAP Members who have disabilities or complex medical needs; assistance to ensure timely access to Contractor providers and Capitated Services; coordination with providers to ensure consideration is given to unique needs in treatment planning; assistance to providers with coordination of Capitated Services and discharge planning; and aid with coordinating community support and social service systems linkage with medical care systems, as necessary and appropriate.\(^1\)

Oregon reportedly has allowed MCOs considerable flexibility in how they use ENCCs. Annie Mockabee, Director of Government Programs for HMO Oregon—who has experience with both the Oregon and Washington ENCC approaches—emphasized that Oregon let MCOs determine how to use ENCCs most effectively. “We learned as we went along,” Mockabee said, citing monthly meetings in which ENCCs from all the plans get together to “compare notes and brainstorm.”\(^2\)

**Differences between Washington and Oregon**

There are a number of differences in the approaches the two states took to care coordination and in the structure of their care coordination programs that may account for some of the differences in results:

- **The Oregon ENCCs had fewer time-consuming reporting requirements placed on them.**
- **State agency case managers in Oregon facilitated the transfer to managed care by helping beneficiaries with their choices and identifying continuity of care needs, thus eliminating the need for ENCCs to screen everyone; the ENCCs had to contact only those with continuity of care needs.**
- **The Oregon approach permitted more collaboration among the ENCCs from the various plans (the monthly meetings, for example), resulting in a more collaborative process than Washington’s top-down approach allowed.**

There are a number of broader program and context differences between the two states that may also have played a role:

- **The possibility that Oregon’s SSI population may have had more of their needs met under fee-for-service Medicaid than was the case in Washington, lessening the pent-up demand for services**
- **The higher capitated rates in Oregon, which may have permitted MCOs to devote more resources to case management and care coordination than was the case in Washington**
- **The generally more favorable attitude toward managed care in Oregon, lessening the suspicions and apprehensions that ENCCs had to overcome**
- **The more gradual phase-in of SSI managed care in Oregon**

These differences in context, approach, and results between two generally similar states provide a valuable starting point for a fuller examination of the role of care coordination in managed care programs for the SSI population. Comparisons with other states, and with similar efforts in Medicare managed care, should lead to a better understanding of this crucial aspect of managed care for disabled and elderly populations.
Coordination with Mental Health, Developmental Disabilities, Aging, and Social Services Providers

A large portion of the Medicaid SSI population is dependent upon, or could be helped by, a wide range of providers whose service costs are not covered in the capitated rates paid to MCOs and who are generally not in MCO networks, including local providers of developmental disabilities, mental health, aging, social, and other ancillary services. Yet there are many cases, for example, in which the physical health problems of SSI beneficiaries are closely related to mental health problems, or in which personal care or transportation services are needed to help persons with disabilities function effectively and obtain access to needed medical services.

At a minimum, the MCOs in which such individuals enroll need information on past utilization of such non-covered services, and potential future needs. Because funding for these services was not included in the capitated rates in the Washington SSI managed care program, MCOs were generally not in a position to provide or pay for these services themselves. The MCOs had to rely heavily on communication, persuasion, and voluntary cooperation from the providers of these other services to ensure continuity of care and appropriate care coordination. Most of the responsibility for this fell on the already overloaded ENCCs.

The MCOs with whom we spoke believe they were hampered in their efforts to coordinate with other service providers by fears on the part of these other agencies that managed care represented a potential threat to their role, and by suspicions that their parent agencies in Olympia were not fully committed to managed care for the SSI population. The MCOs indicated that the confidentiality issues noted earlier were often especially problematic in their dealings with providers of non-Medicaid services. We were not able to pursue the coordination issue with the providers of these other services, or with representatives of their parent agencies, so we do not have their perspective.

There were differences in perception on the effectiveness of communication between MAA and others involved in the SSI managed care program. MAA representatives told us that the MCOs and a variety of state and local agencies were included in the planning process for the SSI program, and described extensive efforts MAA had made to assist with communication and coordination at both the state and local level.

Some MCO representatives we spoke with, however, perceived a lack of communication among MAA and other state agencies in Olympia, and further communication gaps between Olympia and the MCOs and providers of medical, social, and ancillary services in eastern Washington. The MCO representatives used the image of a ruined Greek temple with multiple columns but no connections at the top as a metaphor for how they thought the various parts of the Department of Social and Health Services and its local agencies worked. “MAA administration made a considerable effort to bring all players to the table,” one MCO representative said, “but based on the results there did not appear to be a concerted effort at the level of top management of the Department of Social and Health Services to get cooperation from all potential participants affected by mandatory managed care enrollment.” While acknowledging that MAA representatives met frequently with MCO representatives while the SSI program was being developed and implemented, some MCO representatives thought MAA officials conveyed a “we know best” attitude that did not invite full collaboration.

Difficulties in program coordination among Medicaid agencies and agencies responsible for mental health, developmental disabilities, aging, and social services are certainly not unique to Washington State. Differences in federal and state funding sources and rules, professional and bureaucratic styles and traditions, relationships with providers, and client characteristics and needs all combine to make
cooperation difficult at the state level. Personality and policy conflicts are not uncommon. Expecting managed care to achieve in a short time period a degree of coordination and cooperation that state government itself is rarely capable of may not be realistic.

Nonetheless, given time, managed care may be able to overcome some of the bureaucratic and other obstacles to coordination that exist in government agencies. Much of this will have to happen at the local level, but state officials can help. Some possible approaches state officials can take include:

- Encouraging MCOs to form care coordination teams with service providers at the local level, where the needs of individual clients for better integration of services may help push aside some issues of turf and authority
- Working aggressively at the state level to minimize bureaucratic obstacles to local cooperation, such as the confidentiality issue noted earlier
- Developing ways of integrating additional funding for social and ancillary service coordination into the SSI managed care system

Extra funding for care coordination. The last point warrants some elaboration. The Medicaid managed care upper payment limit prohibits states from paying capitated rates to MCOs that exceed what would be paid for the same population under the Medicaid fee-for-service system. In general, therefore, MCOs must fund care coordination out of savings in medical costs, just as they do much of their other administrative costs. It may be possible, however—if there is a favorable combination of political, bureaucratic, financial, and outside advocacy forces in a state—to obtain some additional resources for care coordination for the SSI population in managed care. In some states, for example, additional state-only dollars are used to fund home- and community-based services for the elderly and disabled beyond what is covered by Medicaid-funded waiver programs. The additional funding for care coordination could go to social and ancillary service providers, MCOs, or some combination, contingent on its being used to improve coordination of services for the SSI population in Medicaid managed care. While there are a number of potential obstacles to this approach, it may warrant further investigation if there is interest in Washington and other states.

Capitated Rate setting

The capitated rates that Washington developed for 1997 were relatively low compared to those in Oregon and other states, but there appear to be no obvious ways in which the rates could have been significantly increased without violating the federal upper payment limit. For 1998, Washington had developed risk-adjusted capitated rates that held the promise of tying rates more closely to the predictable costs of beneficiaries with widely varying care needs. While some of the complexities of the planned 1998 rate setting system may have contributed to the anxieties of some of the MCOs in the SSI program, that system—with some refinements that Washington is in an unusually good position to achieve—could be a valuable model for other states.

1997 Capitated Rates

As noted earlier, a number of MCOs believed that the capitated rates for the SSI program—which were set at about $345 PMPM for the Spokane area—were too low to cover the costs they expected for the SSI population. That rate is about $100 PMPM lower than the comparable rates for the SSI managed care population in Oregon. There are a number of factors that may account for the relatively low Washington rates:

- Inpatient hospital utilization has historically been low in Washington, compared to other states
• *Fee-for-service utilization for the SSI population may have been higher in Oregon than in Washington, permitting a higher upper payment limit*

• *Oregon’s 1115 waiver permits greater flexibility in setting rates than does Washington’s 1915b waiver, possibly accounting in part for the 8 percent allowance for administrative costs in the Oregon rates, compared to 2.7 percent in Washington*

CHCS reviewed the 1997 rates and their development very carefully with MAA staff and the state’s actuaries. There did not appear to be any obvious ways in which the rates could have been significantly increased while still remaining within the upper payment limit.

**MCO concerns about rate adequacy.** One eastern Washington MCO representative indicated that MCOs in the SSI program “were convinced that there was a degree of cost-shifting to the MCOs from other provider entities” who had formerly provided services to chronically ill patients outside the managed care setting, including nursing services and providers of durable medical equipment. The Medicaid SSI capitated rates, she said, “were established by cost factors from fee-for-service claims but did not include services provided by other entities under contract to other state departments. Consequently, the rate was artificially lower than the actual costs of providing all care and services to this population.”

If the services provided by the “other entities” were actually funded by the Medicaid program, their costs could have been included in the Medicaid SSI capitated rates without violating the upper payment limit. If the funding came from sources other than Medicaid, however, including those costs in the Medicaid capitated rates would have been problematic. These MCO concerns about rate adequacy further highlight the complexities involved in pulling together and funding the full array of services needed by the SSI population in managed care.

**Planned 1998 Capitated Rates**

In 1997, MCOs in the same geographic area were paid the same capitated rate for all SSI eligibles, irrespective of age, sex, diagnosis, or health condition. Since enrollment was mandatory, however, and since the state was developing a system to adjust the rates for 1998 to take into account enrollees’ diagnoses and prior health care utilization, the risks of selection bias in the first year of the program were relatively minimal.

The system developed for 1998 was based on the “Disability Payment System” (DPS) developed by Richard Kronick and others for use in state Medicaid programs. The system derives enrollee diagnoses from inpatient hospital claims and some ambulatory claims, and so is able to produce diagnoses only for those SSI enrollees who are hospitalized in the preceding year or for whom there is an ambulatory claim with a diagnosis. In addition, since a year of claims data is needed in order to determine diagnoses, no diagnoses are available for new enrollees. In Washington, this meant that diagnoses were available for only a little over half of all potential 1998 SSI enrollees.

These diagnoses were linked to past Medicaid claims data to determine past Medicaid service utilization and costs. Based on past diagnoses and costs, the state’s Milliman & Robertson actuaries then projected likely 1998 costs for beneficiaries in 35 different diagnostic categories (cardiovascular disease, cancer, diabetes, mental retardation, AIDS, etc.) with varying degrees of severity.

The resulting ratesetting system was fairly complex, and it included some features for ongoing adjustment of rates throughout the year to maintain budget neutrality (“normalization”) that may have made some MCOs nervous. But the basic system promised to be a substantial improvement over the
1997 system of identical rates for all SSI enrollees in a geographic area, which took no account of widely varying enrollee care needs and predictable future costs. The risk-adjusted system, by contrast, would have paid much higher capitated rates for enrollees with predictably high future costs, and lower rates for those with predictably lower future costs.

**Potential future improvements.** As noted above, one of the significant gaps in the DPS approach to risk adjustment is the lack of diagnostic information on new enrollees in SSI, who represent nearly 10 percent of the SSI population in Washington. In addition, relying on claims for diagnostic information means that the system produces no diagnoses for people who are not either hospitalized or treated in an ambulatory setting that produces a claim with a usable diagnosis. Further, the diagnoses on hospital inpatient claims are not always accurate or relevant. (A person with diabetes who is hospitalized for a broken leg may not have the diabetes diagnosis noted on the hospital claim, for example.) Ambulatory claims are even less likely to have a usable diagnosis. In setting rates for 1998, the state’s actuaries determined that nearly 40 percent of the SSI population in Washington that was enrolled for three months or more during the year in which claims were examined did not have usable diagnostic information.

There is, however, a separate source of diagnostic information on SSI enrollees. The Social Security Administration (SSA), which administers the SSI program, determines a diagnosis for SSI enrollees as part of the process of determining initial eligibility for the program. These eligibility determinations are commonly done by state agencies under contract with SSA, but the diagnostic and other eligibility information is normally sent directly to SSA and not shared with other state agencies. SSA has been very reluctant to share this diagnostic information with states, citing workload and confidentiality concerns. In 1996, however, SSA did provide diagnostic information on SSI beneficiaries to two states: Massachusetts and Washington.

Washington received diagnostic information on nearly 90,000 SSI beneficiaries in the state who were determined eligible during the 1994-1995 period. Since then, MAA staff have been regularly receiving diagnostic information on new SSI enrollees directly from the state agency that makes the eligibility determinations for SSA. Washington thus has available from an independent source diagnostic information on almost all SSI eligibles that can be used to check the DPS diagnoses derived from inpatient hospital and ambulatory claims, and to provide diagnoses for both the new enrollees and prior enrollees with no claims-based diagnoses. With this rich database of diagnostic information, the state and its actuaries are in an excellent position to develop a system of risk adjustment for SSI managed care capitated rates that could be a model for other states.

If, as discussed below, Washington should decide to proceed with a voluntary managed care program for the SSI population, or to include the SSI population in a broader mandatory managed care program, this approach to adjusting the capitated rates for predictable risks could be important to the program’s success. Without risk adjustment of the rates or some form of risk sharing with the state, MCOs may perceive that the risks of adverse selection are too great.

**IV. POTENTIAL VOLUNTARY SSI MANAGED CARE PROGRAM**

If Washington state determines that another effort to extend managed care to the SSI population is warranted, the state may want to consider establishing a voluntary rather than a mandatory program, and limiting it initially to one or two major urban areas, such as Spokane or Seattle.

The potential benefits of a voluntary program are:
• **Only those who believe they would benefit from managed care would enroll.** This should minimize the concerns of advocates and potential enrollees, and ease the initial outreach, education, and evaluation burden of ENCCs, MCOs, and the state.

• **MCOs could focus initially in those areas where they have special competencies for treating the SSI population.** Building entire networks to treat the highly diverse SSI population may be difficult for MCOs to do at the outset, but starting with certain subsets of the SSI population—people with heart disease, lung disease, asthma, diabetes, developmental disabilities, or AIDS, for example—may be less daunting. MCOs would have to be paid high risk-adjusted capitated rates based on diagnoses for this to be feasible, however.

• **The financial and health care risks are lower for all parties.** The existing fee-for-service system would remain as a fall back for beneficiaries, and MCOs, providers, and the state could be reasonably confident that the program would not grow rapidly and unpredictably. Again, allowing fee-for-service as a fallback could present unacceptable selection bias risks to MCOs, the state, or both, without adequate adjustment of the rates for risk or some form of risk sharing.

• **The state, MCOs, providers, and potential enrollees would have an opportunity to learn gradually how best to do managed care for the SSI population.** This would lessen the time and volume pressures that are common in mandatory programs.

Two major concerns would have to be addressed before this approach would be feasible, however:

• **Selection bias.** In a voluntary program, it is very difficult to predict the kinds of persons who will enroll. MCOs may end up enrolling primarily low-cost, low-need persons (favorable selection), or they may attract primarily enrollees with very high costs (adverse selection), especially if the MCOs choose to specialize in persons with high-cost diseases or conditions. Adequate risk adjustment and risk sharing systems are therefore even more important in voluntary SSI managed care programs than they are in mandatory programs.

• **Limited enrollment.** While limited and slow-growing enrollment has the advantages outlined above, it has the major disadvantage of limiting the number of enrollees over whom fixed care coordination, case management, network development, and other administrative costs can be spread. These costs can be substantial for the SSI population, especially at the outset.

**Risk Adjustment and Risk Sharing**

As discussed earlier, Washington’s access to SSA diagnostic information on the SSI population, in combination with the extensive progress the state and its Milliman & Robertson actuaries have made in adapting the DPS risk adjustment system to Washington’s SSI population, has positioned the state to develop a system of risk adjustment that could be a model for other states. With such a system of risk adjustment, persons voluntarily enrolling in an SSI managed care program would bring with them a capitated rate that accurately reflected the predictable costs of their health care over the upcoming year. MCOs would therefore not be systematically under- or over-reimbursed for those who choose to enroll.

Only a portion of any individual’s future health care costs are predictable, however, even with good data on diagnosis and past health care costs. Even the best risk adjustment systems can predict no more than about 20-25 percent of actual future costs.25 Risk adjusted rates are therefore often supplemented by other forms of risk sharing. Stop loss protection can limit an MCO’s total spending on any single individual during a year to a fixed dollar amount, such as $100,000, with the state assuming costs above
that level. Actuaries commonly reduce state-paid capitated rates by a standard amount to reflect this kind of risk sharing, or MCOs can purchase stop-loss protection on the private market. Stop-loss protection is a more likely approach when the number of enrollees in each MCO is small.

Another common approach would be to use risk corridors for an MCO’s total annual cost for all SSI enrollees. If total costs for a year exceed an amount previously agreed upon by the state and the MCO—the high end of the risk corridor—the state would assume some agreed-on portion of the MCO’s loss. Unexpected gains, which would occur if total costs were less than the low end of the risk corridor, could be shared in the same way. If the sharing of risk above and below the corridors is symmetrical, this approach would normally not lead to a reduction in the capitated rate (as is the case when the state provides stop-loss protection), since both the state and the MCO would have an equal risk of gains and losses. Risk corridors and sharing of risk for total enrollee costs are most applicable when the volume of enrollees is relatively large.

Limited Volume of Enrollees

Unless MCOs view managed care for the SSI population as a good investment for the future, they are unlikely to be interested in a small-scale voluntary SSI managed care program. The total Medicaid SSI population in Washington State is only about 60,000, with fewer than 10,000 in the Spokane area, and fewer than 20,000 in King County. The Medicaid SSI population therefore represents a relatively limited longer-term opportunity, even if the program were eventually to become mandatory.

The Medicare market is much larger, however, and is likely to require over time the same kinds of internal case management and care coordination resources and the same kinds of provider networks as the Medicaid SSI market. There are over 700,000 Medicare beneficiaries in Washington, and over 180,000 of them are currently enrolled in HMOs. Spokane County has nearly 60,000 Medicare beneficiaries, with 16,000 currently enrolled in HMOs. King County has over 200,000 Medicare beneficiaries, with over 60,000 in HMOs.26

There are also about 70-90,000 lower-income “dual eligibles” in Washington state who are eligible for both Medicare and Medicaid. While they are difficult to include in managed care, and were therefore excluded from the Washington SSI managed care program, they could potentially be included in future managed care programs.27

If MCOs view the Medicaid SSI population as part of the broader Medicare market, there may well be significant interest in a voluntary SSI managed care program as a way of developing capacity and experience for that broader market. The table below shows the HMOs in Washington that had either Medicare or Medicaid enrollment in January 1997, as reported by InterStudy:

<table>
<thead>
<tr>
<th>HMO</th>
<th>Medicare Enrollees (1/1/97)</th>
<th>Medicaid Enrollees (1/1/97)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Health Plan of Washington</td>
<td>18,656</td>
<td>17,724</td>
</tr>
<tr>
<td>Group Health Cooperative of Puget Sound</td>
<td>57,032</td>
<td>66,015</td>
</tr>
<tr>
<td>Group Health Northwest</td>
<td>5,216</td>
<td>34,926</td>
</tr>
<tr>
<td>PacifiCare of Washington</td>
<td>40,784</td>
<td>5,747</td>
</tr>
<tr>
<td>NYLCare Health Plans Northwest</td>
<td>--</td>
<td>22,491</td>
</tr>
<tr>
<td>QualMed Washington Health Plan</td>
<td>3,176</td>
<td>--</td>
</tr>
<tr>
<td>Virginia Mason Health Plan</td>
<td>7,338</td>
<td>--</td>
</tr>
</tbody>
</table>

Other Considerations

If Washington is interested in developing a voluntary SSI managed care program, there are other considerations that should also be addressed:

- **Significant budget savings in the short term are not likely.** As state and HMO experience in 1997 suggests, the initial start-up costs and the amount of time necessary to identify and achieve savings in medical care utilization mean that neither the state nor participating MCOs should anticipate significant short-term budget savings or profits. Thus, unless the program is viewed by both sides as a longer-term investment, with the possibility of mandatory enrollment in the future, it may not be worth pursuing. On the other hand, the risks of significant short-term losses are relatively low for both the state and MCOs in a small-scale voluntary program.

- **A cooperative partnership relationship between the state and participating MCOs will be necessary.** State staff indicated that they had made major efforts to work with MCOs and other stakeholders in developing the SSI managed care program, and spoke highly of the commitment and effort of many of the MCOs. Some of the MCOs with whom we spoke, however, complained of a somewhat adversarial “us vs. them” relationship with state officials in the 1996-97 design and implementation period, with insufficient opportunities for joint communication. Managed care for the SSI population is a new and difficult experience for both sides, so it is worth devoting extra effort to communication and cooperation. This suggests, for example, that a program in the Seattle area might prove to be a better joint learning experience than one in Spokane, where the distance from Olympia may make regular communication difficult.

- **Additional effort will be needed to enlist the cooperation of other state agencies and local providers of social and ancillary services.** As discussed earlier, the SSI population is much more dependent on social and ancillary services than are the AFDC/TANF and related populations, and MCOs participating in a voluntary program will need help in establishing these relationships, particularly from state agency leadership. Again, however, some of these relationships with local support service providers will likely also be helpful for the MCOs’ Medicare enrollees, and some of the MCOs may already have established them.

V. OTHER OPTIONS

Washington MAA officials do not believe that a voluntary SSI managed care program is feasible, given the concerns about selection bias and limited enrollment discussed in the previous section. They therefore recommended discussion of two other options: a PCCM model, and including SSI beneficiaries in the regular Medicaid managed care program as a separate eligibility group.

Group Health Northwest, one of the eastern Washington MCOs, also expressed skepticism about the voluntary SSI option:

Unless there are sufficient safeguards built into the reimbursement rates, risk adjusters, coordination between the various departments of DSHS, greater recognition of the MCOs’ expertise in caring for chronically ill patients with multiple needs, [and] resolution of the conflicting confidentiality regulations, . . . a voluntary program under managed care will be difficult to implement.
Accordingly, this section contains a brief discussion of the two other options suggested by MAA officials.

**Primary Care Case Management (PCCM)**

Washington used a variant of the PCCM model in the 1995-1997 pilot program in Clark County. The two MCOs with whom the state contracted for this pilot program assumed more responsibilities than the managing entity normally does in a PCCM program. In most PCCM programs, states pay primary care physicians a fee of $2 or $3 per month for each beneficiary they agree to be responsible for, plus regular fee-for-service reimbursement for the medical services they provide. In exchange for the monthly per-beneficiary fee, PCCM physicians normally agree to some care screening, availability, and reporting requirements, but do not assume any major administrative or care coordination responsibilities.

In the Clark County pilot, by contrast, the two MCOs were responsible for establishing provider networks, coordinating care, managing utilization, and providing ENCC services. One of the MCOs, Clark United Providers, had difficulty maintaining financial viability under this version of the PCCM model, in part because it did not have the administrative infrastructure needed to perform all of the required care management functions. It also had relatively little influence over its network of providers.

The other MCO, HMO Oregon, had more success with this model and was able to save money for the state during the contract period by controlling fee-for-service expenditures, according to MAA officials. HMO Oregon officials report that a major reason for their success was that—as a long-established and experienced HMO—they already had the infrastructure in place that was needed to manage care. Further, even though they were not financially at risk for the medical services provided to their enrollees, they acted as if they were.

Large organizations structured and staffed to operate in a particular way do not normally change the way they behave in response to temporary differences in financial incentives, such as those in the Clark County pilot program. It is not clear, however, that MCOs would continue to manage care effectively into the indefinite future without financial incentives to do so. The SSI population requires substantially more resources for care coordination in managed care than do the AFDC/TANF and related populations. Those resources must come from somewhere. If they cannot come from savings achieved through better management of health care services (as they might in a capitated program), the state must pay for them directly in the PCCM management fee. Those fees will likely have to be substantially higher than the monthly fees of $3 or so per month that are common in PCCM programs for AFDC/TANF and related beneficiaries.

Thus, if a state is willing to pay higher case management fees, the PCCM model may work for the SSI population. States may have to devote more resources to monitoring the effectiveness of PCCM management and care coordination for the SSI population than they are accustomed to with PCCM for AFDC/TANF and related populations, since more administrative dollars would be at stake and the consequences of inadequate care coordination are likely to be more serious for SSI beneficiaries.

**Inclusion of SSI Populations in Broader Risk-Based Managed Care Programs**

Instead of having a separate risk-based managed care program for the SSI population, SSI beneficiaries could be included in the same risk-based programs that serve AFDC/TANF and other Medicaid beneficiaries, using the same contracting process and MCOs. Unless capitated rates are substantially higher for the SSI population to reflect their predictably higher costs, however, it is not likely that MCOs would be willing to bid for such contracts.
MCOs are willing to cover the higher costs of a few disabled enrollees in their commercial populations when those higher costs are confined to a relatively small number of randomly occurring cases in a large enrollee population made up of generally healthy people, many of whom require little or no medical care during the course of a year. The Medicaid SSI population, by contrast, is made up almost entirely of people who have disabilities and chronic illnesses that will result in predictably high annual medical costs for the indefinite future. No MCO could remain financially viable for long if it had to cover the higher costs of the Medicaid SSI population primarily out of savings from AFDC/TANF and related populations.

The SSI capitated rate system that Washington used in 1997 would probably work reasonably well if the SSI population were included on a mandatory basis in the same risk-based managed care program as the AFDC/TANF and related populations, since the SSI rates were set at a level that covered the predictable average costs of SSI enrollees. Without the kind of more sophisticated risk adjustment Washington planned for 1998, however, or some form of risk sharing with the state, MCOs might nonetheless be apprehensive that they would suffer from adverse selection in such a program.

Enrolling SSI beneficiaries in risk-based managed care programs covering broader populations does not by itself solve the rate setting, risk adjustment, and risk sharing problems with which Washington and other states have been struggling. It just shifts them to another context.

VI. RECOMMENDATIONS

Issues for Further Study

The CHCS visit to Washington State and our subsequent analysis has identified several major issues that warrant further investigation by the state in its own evaluation of the SSI managed care program, and by other states considering such programs. CHCS plans to explore some of these issues in more detail in order to assist states with design and implementation of managed care programs for the elderly and disabled SSI population:

- **Care coordination and management.** There are a number of lessons to be learned from how ENCCs performed their roles in Washington and Oregon, and how similar care coordination and case management functions have been handled in other state Medicaid programs, and in Medicare. CHCS has funded Mathematica Policy Research to prepare a best practices manual on care coordination in Medicaid managed care, based in part on case studies of care coordination in five states, including Washington and Oregon.

- **Risk adjustment using SSA diagnostic information.** As discussed above, using SSA diagnostic information for the Medicaid SSI population could substantially improve the ability of states to adjust capitated rates to reflect the wide variations in predictable costs for this population. Washington is further along on this approach than most other states, and so could provide a test of its value and feasibility.

- **Contracting for social and ancillary services.** ENCCs and other MCO care coordinators can help establish the linkages to social and ancillary services that may be needed by SSI managed care enrollees. Without additional financial resources, however, MCOs must rely largely on voluntary cooperation by these other service providers to obtain the needed services. Further exploration of other potential funding sources and mechanisms that would permit MCOs to contract directly for these additional services is warranted. A review of state- and Medicaid-
funded home- and community-based services programs may provide some insights into how this could be accomplished.

**Voluntary SSI Managed Care Program**

As discussed above, a voluntary managed care program for the SSI population would provide Washington State with a valuable learning opportunity that could also assist other states. Such a program would require a significant investment of time and resources for planning and development, however. It should probably be undertaken only if state officials believe there is the potential for a mandatory program in the future, and that such a program could improve access and quality of care for SSI beneficiaries and help to contain Medicaid cost growth.

**Other Options**

Enrolling the SSI population in PCCM programs or risk-based managed care programs that include a broader range of Medicaid beneficiaries are also options that may work for Washington and other states. Many of the care coordination, financing, and rate setting issues that Washington had to deal with in its effort to extend managed care to the SSI population remain present in some form in these other options.
Appendix A

Site Visit Participants

Center for Health Care Strategies, Medicaid Managed Care Program
Stephen A. Somers, PhD, President
James M. Verdier, JD, Senior Program Consultant
Valerie Harr, MA, Research Associate

Medical Service Corporation
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Kathy Mace, RN, Care Management

Group Health Northwest
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Deborah Richey, MSW, Care Resources Department

Community Health Plan of Washington
Robin Pfohman, ENCC Program Coordinator
Betsy Plastino, ENCC Program Manager

Clark United Providers
Beth Barker, CPA, Vice President
Carl Dobbs, Operations Administrator
Monica Knapp, RN, Utilization Review
Cindy Orth, Provider Relations and Contracting Representative
Sheriann Okawa, Medical Management Program Manager
Bonnie Peterson, RN, ENCC

Washington Department of Health and Social Services
Medical Assistance Administration
Carolyn Adams  David Hanig
Tom Bedell  Frankie Jorgenson
Jane Beyer, Assistant Secretary  Alice Lind
Cathy Cochran  Julie Martenson
Kathleen Connor  Michael Paulson
D. Andrea Davis  Janice Shineman
Susan Fleskes  Margo Westfall
Gaylan Gaither  Pat White
Roger Gantz  Peggy Wilson
Karen Brodsky of the Center for Health Care Strategies and Margo Rosenbach of Mathematica Policy Research provided valuable comments and suggestions on earlier versions of this report. The report also reflects detailed comments and suggestions made in a July 22, 1998 letter to Stephen A. Somers from Jane Beyer, Assistant Secretary of the Medicaid Assistance Administration, and July 15 comments from Group Health Northwest that were included with the Beyer letter.


MAA officials’ July 22, 1998 letter to CHCS takes some issue with this point, saying that “It is not clear to us that inclusion of this group significantly contributed to problems in the program,” and noting that there would have been difficulties in identifying institutionalized beneficiaries through the state’s record system in any event. Their letter goes on to say that “during implementation we heard very few complaints about the inclusion of nursing home or ‘supervised living’ clients in the project. Further, Oregon has also included this population in their program.”

For more on this issue, see Trish Riley, Joanne Rawlings-Sekunda, and Cynthia Pernice, “Transitioning to Managed Care: Medicaid Managed Care in Mental Health.” National Academy for State Health Policy, June 1997.

The Washington MAA Quality Control Team is currently analyzing the results of pre- and post-implementation surveys of SSI beneficiaries that should reveal a good deal about their characteristics and care needs, and their attitudes toward and experience with the SSI managed care program. The results of this analysis should be available in early Fall. James Verdier telephone interview with Janice Shineman, MAA, July 31, 1998.

For a discussion of some of the complexities involved in designing managed care programs for this population, see Peter D. Fox and Teresa Fama (eds.). Managed Care And Chronic Illness: Challenges and Opportunities. Gaithersburg, MD: Aspen Publishers, Inc., 1996.

Oregon Department of Human Resources, Oregon Health Plan, Fully Capitated Health Plan Model Contract, October 1, 1997, p. 50.

One MCO representative from eastern Washington noted that “Although the local providers attempted to coordinate care and share information, this was prevented at the state level by varying degrees of support from the departments involved and confidentiality regulation interpretations.” Jean Kindem, Group Health Northwest. Included in July 22 Jane Beyer letter to Stephen A. Somers.

The upper payment limit is a federal regulatory requirement, initially promulgated in 1978 and revised in 1983, that provides that under a risk contract “Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the agency of providing those same services on a fee-for-service basis, to an actuarially equivalent nonenrolled population group. (42 CFR sec. 447.361).

Some Medicaid section 1115 managed care waivers allow states to meet “budget neutrality” requirements over five years rather than in every year, as Washington’s section 1915(b) waiver requires. Additional funding for care
coordination might therefore be easier to provide in the context of an 1115 waiver, especially if it were provided primarily in the first year or two of the program.

19 Preliminary rates for the Seattle area were about $7 PMPM higher than in Spokane. The rates set for some rural areas were as low as $300 PMPM.

20 Jean Kindem, Group Health Northwest, included in July 22 Jane Beyer letter.


22 Many physically disabled SSI enrollees, for example, may have very high costs for wheelchairs, other durable medical equipment, transportation, physical therapy, and other services, but do not have medical problems that require hospitalization. The claims for their ambulatory services may or may not include a usable diagnosis.

23 The Division of Disability Determination Services (DDS), which is organizationally within MAA, but is located in a separate office building.

24 Indiana has developed a rate setting system for its voluntary managed care program for persons with disabilities and chronic diseases that is based on diagnoses developed as part of the state’s own eligibility determination process. (As a 209(b) state, Indiana determines eligibility itself, rather than relying on SSA/SSI determinations.) Indiana has approximately the same kind of information on primary and secondary diagnoses that Washington is able to get from SSA and DDS, but the diagnoses are not cross-checked and updated using inpatient hospital and ambulatory claims, as is done in the Washington DPS rate setting system. Indiana’s current rates were developed by the Indiana office of Milliman & Robertson, the same actuarial firm that develops Washington’s rates.


27 For an excellent summary of some of the issues involved in extending managed care to dual eligibles, see Maureen Booth, Julie Fralich, and Paul Saucier, “Integration of Acute and Long-Term Care for Dually Eligible Beneficiaries through Managed Care.” Prepared for the Medicare/Medicaid Integration Program, University of Maryland Center on Aging, August 1997.


30 July 22 Jane Beyer letter, p. 3.

31 James Verdier telephone interview with Annie Mockabee, Director of Government Programs for HMO Oregon, April 14, 1998.