Medicaid Miracle in the Mountains

Can managed care serve Medicaid recipients and stay afloat? Here's one HMO that's done it for 20 years.

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CME COVERED IN *FPM* QUIZ

One of the biggest concerns many physicians have about health care reform is the seeming impossibility of successfully combining private practice, managed care and Medicaid. Let me tell you our story: The physicians of Mesa County, Colorado, in partnership with a local HMO, have successfully managed Medicaid care for 20 years.

Mesa County is a rural county on the western slopes of the Rockies. Its population of 95,500 clusters primarily in five small communities and in Grand Junction, a city of 30,500. The nearest urban center, Denver, is 250 miles away.

Beginning in 1974, Rocky Mountain HMO entered into an at-risk contract with the Colorado Medicaid program. Per member, the HMO is paid about 95 percent of what the Medicaid program costs in the non-managed rest of the state. By privatizing Medicaid, we have developed a program that is satisfactory to physicians, consumers and the government.

If you sign up for Medicaid in Mesa County and opt for the HMO plan, all physicians who are taking new patients will accept you in their practice. You are then tied into a tight gatekeeping system — tight in that you cannot bypass it, but loose in that virtually all local specialists participate and are available with an appropriate referral. Drop-in ER visits by Medicaid recipients may be unstoppable, but local

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SPEEDBAR

- Local hospitals were induced to give the HMO a 40 percent discount on ER rates.
- In addition, the hospitals provide the HMO with convenience rooms free of charge, for seeing patients that might otherwise end up in the emergency room.
- The HMO has retained the physician's withhold in only two of 20 years. In those years, legislative changes increased the HMO's costs unexpectedly.

hospitals, after some arm-twisting, have given us a 40 percent reduction on rates for these visits. Physicians are provided financial incentives for seeing these patients in their offices or in local convenience rooms (provided by the hospital free of charge), rather than seeing them in the emergency rooms (see Table 1).

Administrative hassles are greatly reduced because the individual doctor deals with the local HMO staff rather than the state Department of Social Services. Most physicians willingly participate.

For 20 years, physicians have been paid the same fees for Medicaid services as for other lines of HMO business (commercial and Medicare), less a withhold that varies from 25 percent to 40 percent, depending on utilization and total costs. At a 40 percent withhold, our fees are about the same as Medicaid payments outside this program. Most years, about half the withholds have been returned to the physicians, resulting in payments above the Medicaid schedule. Between 1986 and 1992, Medicaid payments to physicians in the HMO averaged 80 percent of their private fees.

Of the 20 years, there have been only two in which the 40 percent withhold has not protected the HMO from losses. In those years, 1990 and 1991, the state underestimated the medical costs of the new groups they added. When the state loosened income requirements those years, a large number of pregnant women were included. Payments to the HMO fell far short of the costs of caring for this group and their often high-risk newborns. Both years the doctors lost their 40 percent, and the HMO lost significant reserves (see Table 2).

Currently, the HMO covers 70 percent of the eligible Medicaid recipients in our area, all by patient election. The physician-controlled quality-assurance program remains confident that there is no care differential between private HMO patients and Medicaid HMO patients. A 1992 consumer survey conducted by the state Department of Social Services demonstrated

Table 1
Incentives to keep patients out of the ER

ER Visit - Intermediate Level
Code: 99283

Fee:	$39.55
Modifier for after hours:	+15.00
	$54.55

Convenience Room Visit - Intermediate Level
Code: 99283

Fee:	$39.55
Modifier for after hours:	15.00
Additional allowable for seeing patient in convenience room	+10.00
	$64.55

Emergency Seen in Doctor's Office - Intermediate Level
Code: 99213

Fee:	$35.52
Allowable for seeing patient in office rather than ER	10.00
Additional allowable for emergency service in office	+35.00
	$80.52

Table 2
Withhold return rates for Medicaid

Year	Total withhold	Withhold returned	Percent of withhold returned
1989	$607,725	$435,944	72%
1990	663,702	0	0
1991	1,058,948	0	0
1992	668,554	668,554	100

impressive consumer satisfaction with the Medicaid program the HMO administers (see "Results of a Medicaid patient satisfaction survey").

Why does it work here while the rest of the state struggles? The physicians, organized as an IPA that includes 85 percent of the local doctors, and the nonprofit HMO they started are committed to making it work. The two local hospitals have been reasonably cooperative on financial issues. When the Medicaid patient load is spread among all primary care physicians, albeit unevenly, the frustration and financial disincentives are tolerable.

Our system has achieved a fair balance in distribution of Medicaid patients. As outlined in Table 3, the physicians with higher percentages of Medicaid patients seem to be graduates of the local residency, particularly those who speak Spanish. The one physician who cares for 6 percent of all Medicaid patients seen by family physicians has a significant load, but to put that into perspective, it constitutes only 45 percent of his HMO practice, and in his part of the county, the HMO insures less than half of the population.

The biggest obstacles in this process have been the state and federal governments. Settling on contract terms was time-consuming and frustrating in the early years. For many years, we were unable to get a contract for all Medicaid eligibles and were forced to treat only the sick ones — a significant negative selection process. Finally, in 1993, we acquired an opt-out rather than an opt-in arrangement with the Department of Social Services. This means that Medicaid patients are automatically enrolled in the HMO program unless they elect not to be in it. We still have been unable to obtain the necessary federal waiver to charge copayments. The Medicaid population needs this type of disincentive to modify its expensive utilization habits. So far, Colorado has been unable to help us.

Several things need to change before this type of cooperation can become more widespread. State governments can help by minimizing regulatory restraints. They must recognize that if money is to be saved, some providers will lose business or be excluded entirely. In Mesa County, we selected one pharmacy chain with whom we negotiated major cost-savings. The excluded pharmacies subsequently caused the HMO major turmoil by effectively lobbying the state legislature that this policy was "unfair." If legislatures want Medicaid to succeed, they must take a second look at the traditional attitudes about distribution of federal and state funds. Waivers for innovation need to be available. The exclusion of patient financial participation (copayments) makes any management scheme less than ideal. Plans must be able to limit benefits responsibly. Somehow there has to be a trade off between altruism and effectiveness. So far, altruism is winning in Colorado.

Hospitals need to help. If we had to pay full fare locally, the Medicaid population's penchant for emergency room visits might have tipped us out of that

Results of a Medicaid patient satisfaction survey

Of Rocky Mountain HMO Medicaid patients surveyed,

- 96.7 percent were satisfied with the medical care from their doctor.
- 95 percent felt their doctor spent enough time with them in office visits.
- 71.2 percent felt it was not hard to get an office visit "right away."
- 93.8 percent were pleased with the referrals they received from their PCPs.
- 88 percent felt the waiting time for referral appointments was acceptable.
- 96.7 percent were pleased with their pharmacy service.
- 95.3 percent reported "good medical care" and "personal attention" when hospitalized.
- 96.6 percent had not considered changing from the HMO to the non-managed form of Medicaid health coverage.

Results are based on responses from 714 Medicaid HMO enrollees (8.5 percent of total enrollment).

SPEEDBAR

- The Rocky Mountain HMO scored well on a Medicaid patient satisfaction survey.
- Medicaid patients are automatically enrolled in the HMO unless they specifically elect not to be.
- The state government, hospitals and insurers must do what they can to enable the HMO to treat Medicaid patients efficiently.
- Physicians on the HMO panel need to share the load of Medicaid patient care.

Table 3

Medicaid patient distribution within Rocky Mountain HMO

Percentage distribution by specialty of primary care physicians	
Family practice (43 + 18 residents and faculty)	76%
Pediatrics (7)	22%
General internal medicine (9)	2%
	100%
Percentage distribution among family physicians	
18 family practice residents and faculty	20% total *
1 physician	6%
5 physicians	4% each
5 physicians	3% each
13 physicians	2% each
19 physicians	1% each

**Expressed as a percentage of all patients selecting family physicians as primary care providers. (Note: Because of rounding, percentages do not add up to 100.)*

business. The financial incentives we established to encourage physicians to guide patients to the office have helped, as have the rate reductions for emergency room charges we negotiated with the hospitals. In negotiating with the hospitals, we were at the point of establishing a walk-in clinic that included lab and X-ray before they agreed to the 40 percent reduction.

Involvement in Medicaid needs to become a priority for medical insurance companies. Such involvement, however, makes no business sense in the current environment. In Colorado, it now appears to make political sense. The state and federal government may need to stimulate that activity, but physicians can apply some pressure. The doctors of Mesa County are very appreciative of Rocky Mountain HMO for its willingness to manage Medicaid. As a result, the HMO has a panel of physician providers that includes almost everyone. This panel is a major marketing tool for the HMO in Mesa County. It now insures 41 percent of the commercial business in the area and 55 percent of the Medicare eligibles. In addition, physicians have been willing to make some financial concessions in their contract with the HMO that they might not have made otherwise. Physicians know the Medicaid line of business is often a headache for the HMO. It would seem appropriate in the future for physicians to refuse to participate with medical insurance companies that will not consider contracting with Medicaid. Then they might listen.

Physicians need to work together to encourage Medicaid involvement. All need to do some of the patient care, for it can be cumbersome if only a few do it all. Some Medicaid patients and their families can be trying for physicians and their staffs. Physicians groups need to be understanding of the quality physicians who, for whatever reasons, accumulate large numbers of Medicaid patients. These physicians should be favored financially.

Physicians need to apply pressure on the managed care companies, the hospitals and the government to make such programs succeed. And, in turn, the physicians need some antitrust relief when they work in concert.

I do not deny that health care reform will demand difficult changes from all of us, and yet I know from our experience that Medicaid can be managed if physicians work together and demand that it happen. FPM

Mesa County Physicians IPA is a 150-member organization that includes 85 percent of the physicians in Mesa County. Rocky Mountain HMO is a nonprofit, federally qualified HMO with 55,000 enrollees — including 40,000 in Mesa County. Rocky Mountain Health Management Corporation has managed Rocky Mountain HMO since its inception in 1974.