



GA-U

Managed Care Pilot

Report to the Legislature

Chapter 518, Laws of 2005, Section 209 (19)

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Enabling Legislation:

The 2005 legislative session, under Laws of Washington Chapter 518, Section 209 (19), directed the Department of Social and Health Services to continue to operate the Medical Care Services (MCS) care management pilot project in King and Pierce counties and to deliver a report summarizing costs, savings, and outcomes.

Legislative Mandate:

Legislative Proviso 2003: “The department shall, within available resources, design and implement a medical care services care management pilot project for clients receiving general assistance benefits. The pilot project shall be operated in at least two of the counties with the highest concentration of general assistance benefits, and may use a full or partial capitation model. In designing the project, the department shall consult with the mental health division and its managed care contracts that include community and migrant health centers in their provider network. The pilot project shall be designed to maximize care coordination, high-risk medical management, and chronic care management to achieve better health outcomes.”

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EXECUTIVE SUMMARY

This report describes the pilot project using managed care to deliver Medical Care Services health coverage to General Assistance-Unemployable (GA-U) recipients.

THE POPULATION: GA-U recipients are low-income and share the following characteristics:

- They are adults with a physical or mental incapacity rendering them unemployable for at least 90 days but less than 12 months.
- Collectively, they are a very vulnerable group of people receiving health-care assistance from the state of Washington. They are disabled, low income and often homeless.
- In Washington State, 12,827 persons were on GA-U, as of September 2005.

MANAGED CARE:

- Managed care can increase access to a medical home, with better coordination of care and increased emphasis on preventive care.
- Under managed care, costs to payers become more predictable through the capitated payments, and the managed care environment promotes cost-effective care.

PROGRAMMATIC OUTCOMES:

- The pilot's model of partially capitated managed care is different from most managed care plans. This contributed to significant challenges in implementing the care and hinders full evaluation of the potential savings.
- Patients and providers in the pilot had a steep learning curve.
- Although there were a number of individual access problems, clients' reports indicated that access to care improved slightly overall.
- The pilot has provided a closer examination of how GA-U clients access care and reveals potential approaches to improved care management.
- A number of partnerships have developed, centering on improving services to GA-U recipients.

FISCAL IMPACT:

- Rate-setting occurred within existing funding, and any savings went to the contractor.
- Firm savings have yet to be calculated. Because of billing lag time, medical claims data is not yet available.
- Any savings that are produced would likely be the result of two factors: 1) the managed care organization's role in controlling costs, and 2) fewer hospitalizations in the wake of better access to preventive care.
- Expansion to a fully capitated model could further produce additional cost-savings with such services as disease management and case management.
- However, further analysis is needed to determine how these possible savings opportunities might extend to a statewide model.

BACKGROUND

A legislatively-mandated managed care pilot for the General Assistance-Unemployable (GA-U) beneficiaries began December 1, 2004, in King and Pierce counties – the two Washington State counties with the highest GA-U concentration. Medical Care Services (MCS) benefits are for clients who are on General Assistance (GA) through the Economic Services Administration (ESA) of the Department of Social and Health Services.

GA-U recipients receive up to \$339 per month in financial services. The health-care benefits they receive are funded solely from state funds with no federal contribution, except for some federal match for inpatient hospital costs. These individuals are low-income, and have a short-term disability (at least 90 days but less than 12 months). Collectively, they rank just behind those with long-term disabilities, such as Supplemental Security Insurance (SSI) recipients, as the most vulnerable group of people receiving health-care assistance from the state of Washington.

❖ GA-U Eligibility

To be eligible for GA-U, an adult must have a physical or mental problem that keeps him or her from performing substantial work for longer than three months. If the client has a disability expected to last longer than 12 months or result in death, the client is presumed to be going onto SSI and is switched to General Assistance-Expedited Medicaid (GA-X), a separate medical coverage with federal contributions. The GA-X clients are eligible for a more comprehensive medical benefit package than GA-U clients. For instance, the GA-U clients do not receive outpatient mental health benefits (except for mental health medication management), hospice services, or most dental coverage. Clients who go onto SSI also receive a higher financial grant (currently \$579 per month).

❖ GA-U Caseload Size and Characteristics

In Washington State, 12,827 persons are currently on GA-U, as of September 2005¹. Here is a typical cross-section of the population²:

- 60% are between ages 18 and 44, with the median age as 42;
- 45% have a diagnosis of mental illness in their medical records;
- Are predominantly Caucasian;
- Approximately 20% are homeless;
- More than 20% have been arrested in the past year; and,

¹ Economic Services Administration OPADA data

² Research and Data Analysis (RDA) Expenditures and Use of DSHS Services: Aged, Blind, and Disabled Clients, FY2001.

- On average, GA-U clients remain on medical coverage for 6.4 consecutive months.

Lapses in eligibility are a notable characteristic of this population, often interrupting care and seriously impeding the client's ability to obtain care. These lapses are often a function of a lack of transportation to obtain required program paperwork, mental health difficulties, frequent moves, or non-timely receipt of mail if homeless. While substance abuse is not a qualification for GA-U eligibility, it is likely that GA-U clients' medical conditions are exacerbated by substance abuse and absence of outpatient mental health care.

In general, GA-U clients have a high rate of hospitalization and emergency room visits. This may be directly related to a lack of a medical home and difficulty accessing physician and preventive care. Lack of access to mental health services and substance abuse treatment may also be a factor.³

❖ **Desired Outcomes of Pilot**

A basic premise of the managed care pilot is that clients will have better access to medical care and thus, have better health outcomes and more appropriate care than they received in the past through emergency rooms or hospitalization. Measuring access to care is a complex process, however. Prior to the pilot's implementation, planners selected several indicators related to access to measure the success of the project. Unfortunately, most of those indicators are not yet measurable:

1. An increased number of clients exiting public assistance due to improved health status
2. An increased number of clients transitioning to the GA-X or SSI program.
3. A decrease in emergency room visits.
4. A decrease in hospital admissions.
5. Improved pharmacy management.
6. No increase in medical costs for GA-U clients (cost neutral).

³ General Assistance Medical Care Management Project, Research and Data Analysis (RDA) 2003; Lerch, Steve PhD., "Avoidable Hospitalizations Among Medicaid Recipients in Washington State", WSIPP Document No. 02-08-3401 (URL: <http://www.wsipp.wa.gov>)

THE MANAGED CARE MODEL & ENROLLMENT

Differences between the GA-U managed care model and other state managed care programs had a significant impact on implementation of the new GA-U model.

❖ Similarities:

1. **Medical Home:** As with other types of managed care (primary care case management and contracts with managed care health plans), all enrollees have a medical home with a primary care provider (PCP) who sees the client for primary care, and who coordinates referrals to other medical services, such as specialists, tests, therapies, etc.
2. **Enrollment:** Mandatory enrollment is required in this pilot, as with DSHS' other managed-care program.

❖ Differences:

1. **One Contractor:** Federal funding requires a choice of health plans when locking clients into managed care, so more than one plan normally participates. A critical number of enrollees are required to offset startup and administrative costs, however, and the GA-U population was not large enough to divide between plans. In addition, the legislative mandate for this pilot specified certain contractor qualifications, and the Community Health Plan of Washington (CHPW) was the sole respondent to a request for information (RFI) and is the contractor for this pilot.
2. **Partial Capitation:** Most managed care contracts are fully capitated. This means all medical services to which the client is entitled are the responsibility of the health plan, with some exceptions (carve-outs) that are covered by DSHS. However, in the GA-U pilot, only primary care and prescription drugs are covered by CHPW, per CHPW's choice. The remaining covered services are paid on a fee-for-service (FFS) basis by DSHS.
3. **Two Claims Processing Sources:** With fully capitated managed care arrangements, the medical providers submit their claims (bills) to the health plan for payment. Because the GA-U pilot is partially capitated, CHPW is only processing claims for pharmaceutical drugs. CHPW pays its primary care providers a monthly lump sum based on the number of clients assigned to the clinics. All other claims are submitted to DSHS for payment.
4. **Expanded Network:** Normally, managed care plans contract with providers to form a provider network. Enrollees are required to use only the plan's network for

obtaining care. In the GA-U pilot, however, enrollees are required to use CHPW's primary care providers (PCPs), but may use other providers for other types of care, as long as the provider accepts GA-U clients. This was set up to preserve continuity of specialty care for these disabled clients. This "extended network" is not under contractual or credentialing oversight by CHPW.

5. Exemptions and Disenrollments from Managed Care: In the state's other managed care programs, clients may request to be exempted (not enrolled) or disenrolled from managed care. For example, American Indian and Alaska Native clients are allowed to request an exemption from managed care. In addition, if there are cases where the client's life or health could be jeopardized by enrollment into other managed care programs, clients may request that medical doctors review their situation on a case-by-case basis. However, the GA-U program's criteria for exemptions are more limited than the state's other mandatory managed care model (Healthy Options). For example, unlike Healthy Options, homeless and limited-English speaking GA-U clients are not allowed to exempt from managed care

❖ **Impacts:** The differences between the GA-U pilot and other managed care lines of business set a steep learning curve for providers, clients, and Community Services Office (CSO) staff. There were other impacts, too:

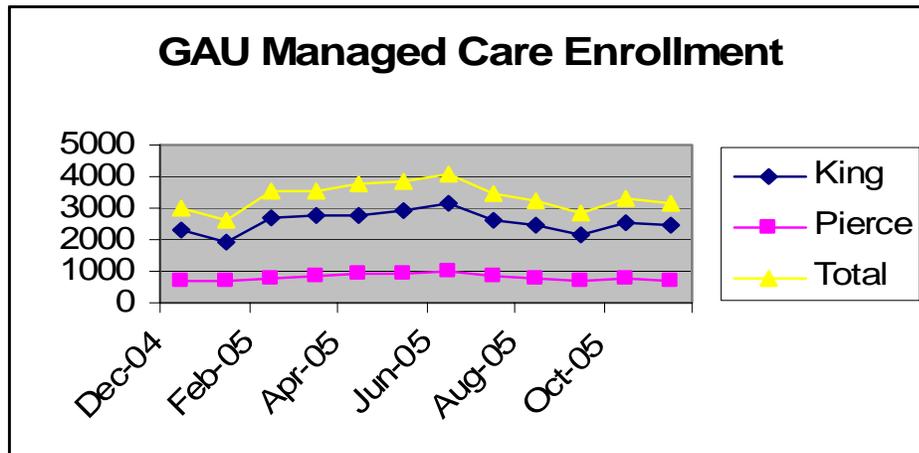
- 1. Provider Confusion:** Some specialty providers erroneously believed they must contract with CHPW in order to serve GA-U managed care clients. This has caused some delays in getting service and led some specialists to refuse to serve the clients. Another area of confusion was whether clients needed to obtain a referral from their CHPW PCPs in order to see a specialist. In fact, authorization (approval) to provide surgery, tests or specialty care is obtained from DSHS, not CHPW. These misunderstandings required special efforts to educate the providers and help the provider community understand this new model of care.
- 2. Women's Health Care:** The Office of the Insurance Commissioner (OIC) requires plans to give managed care clients access to a woman's health care provider without having to go through their PCPs. Some women's health care providers in the extended network of this model are PCPs but are not CHPW capitated providers. Since DSHS is paying the claims, there may be overlap in payment for capitated primary care and payments to these providers. Audits will be used to recoup overlapping monies.
- 3. Lack of Claims History:** Claims are a source of information about costs and utilization by clients. Without the ability to see what services are actually being used by its enrollees via the claims payment, it is difficult to manage care. DSHS does provide claims history to CHPW, but only after the fact. Other managed care

plans get this information earlier, allowing them to detect a need for specialized care, disease management, case management, etc., closer to real time. CHPW is considering taking on the claims payment.

4. **Emergency room utilization:** DSHS pays for emergency room visits, both in true emergencies and possibly at times a client could be getting primary care from his or her PCP. Clients who do not want to use their CHPW PCP, or wish to get prescriptions their PCP will not prescribe, are able to inappropriately access care from an emergency room.
5. **Case Management:** As mentioned above, partial capitation and lack of claims processing capability hinders CHPW's ability to provide effective case management. That is a setback since the GA-U clients are disabled and often very complex — just the type of client who most needs case management.

❖ Managed Care Enrollment

The following chart shows the number of clients enrolled in managed care from December 2004 through November 2005:



The decline in managed care enrollment during the summer months mirrors a seasonal drop in GA-U caseloads (2003 and 2004 were exceptions, due to a weaker economy). Steady enrollment is important for managed care sustainability, with an average enrollment of 3,000 considered a minimum requirement to offset administrative costs and minimize overall financial risk of expensive clients.

PROGRAM OUTCOMES

A program evaluation in 2006 will compare an extensive baseline database to post-pilot data, including an analysis of a variety of access measures. It is not possible to thoroughly analyze the program earlier because complete data is not available. Providers have up to a year to submit their claims and there is additional lag time involved in paying or adjusting claims. Implementation also was marked by some understandable initial confusion and adjustment, as well as a gearing-up process among all parties, so data from the program's earliest phase may not reflect the true potential of managed care.

❖ Access to Care

A primary aim of the GA-U Pilot project is to increase clients' access to appropriate care. Access to care for low-income persons in the state is difficult, especially for specialty care. This is precisely the care many of the disabled GA-U clients need.

Access to Primary Care: Prior to the managed care pilot, many of the GA-U clients primarily used emergency rooms for health care. Access to general practitioners or family practitioners is important because they provide clients with a "medical home": a provider who knows the patient's medical background, who has handled the client's illnesses in the past, who can make effective referrals and who helps coordinate care.

Under managed care, all GA-U members have a plan-credentialed PCP, available 24 hours a day, a provider who can see them or consult with them according to the urgency of their medical needs. Many GA-U fee-for-service (FFS) clients do not have PCPs and often find themselves on waiting lists. This access to PCPs has been a very positive result of the pilot. GA-U clients on managed care are able to treat their disability faster than their FFS counterparts. They also do not have to go to emergency rooms for routine care. Under the pilot, clinic staff makes referrals and assists with appointments for specialty care, arranges for translators if necessary, and helps with transportation needs. Managed care often has additional resources for enrollees, such as case managers, social workers, disease management and preventative programs. A hotline or answering service can help patients get after-hours advice or contact with a provider.

However, there have also been some difficulties in this area, especially in the beginning of the pilot when large numbers of clients were new to managed care. Some of the clients were already being seen by CHPW providers, but the vast majority of the clients were new patients. This put a serious drain on the resources of the CHPW providers because of the extra work associated with new patients. On the plus side, the initial influx of new clients has subsided and the original group of patients has been transitioned. New patients are coming in today on a much more manageable basis.

The medical re-evaluation component of the GA-U application also had an adverse impact on providers. Once a client is on GA-U, the ongoing medical provider is responsible for documenting the client's need to remain eligible for GA-U. Filling out the re-evaluation form is perceived as time-consuming and not easily scheduled within state-required timeframes. Appointments to complete re-evaluations further taxed the PCPs' time, which is more focused on actual medical care.

The pilot has been instrumental in connecting the PCPs and the CSOs. A number of trainings and meetings have been held to alert providers to needed documentation and to provide contacts at CSOs. For example, one clinic now receives medical information from the CSO by fax prior to a client's appointment, something that helps the providers stay abreast of the paperwork. Efforts to revise the evaluation form also are underway, a change that will be well-received by the providers. Together, these actions helped ease some of the pressure on the clinics.

It is important to note that the clients now have a source of treatment. Under FFS, many GA-U clients might receive an evaluation but have trouble sustaining access to care since fewer providers are willing to see GA-U clients on an ongoing basis. One CSO noted that workers there have noticed GA-U clients getting increased continuity of care from a nearby provider. Before the pilot, the provider primarily saw GA-U clients just for evaluations.

Access to Specialty Care: As mentioned before, access to specialists is difficult for many low-income clients. For example, many GA-U clients require orthopedic care in order to return to work, but few orthopedic physicians accept Medicaid patients and those who do usually have long waiting lists. Further analysis will be needed to see how much the pilot changed this problem, but the pilot clearly offers a number of advantages for clients. This includes referral coordinators at each CHPW clinic – a major improvement since many specialists require referral from a PCP before they will see a client. In addition, the CHPW provider relations department actively recruits specialists and keeps lists of specialist providers who will accept clients.

CLIENT SURVEYS

Surveys of GA-U clients about their access to care were conducted by the Health and Recovery Services Administration⁴ (HRSA) in Pierce and King counties before and during the GA-U pilot project. Because most GA-U clients are only on the program for a short time, different clients were surveyed for the two time periods. The post-implementation survey was conducted by phone, a less expensive method but one that probably resulted in fewer homeless respondents than the previous survey, which was

⁴ Preliminary findings of Medical Eligibility Quality Control (MEQC) Project #40

conducted mostly by home visits. This change in data collection methodology may have introduced a bias in the results. It is not advisable to make concrete conclusions based upon the results, since there may be a variety of reasons for the results. However, some key results are below:

- **Access to PCP:** Prior to the pilot, a majority of clients reported having a PCP (80% in King County; 75% in Pierce). That number increased in the follow-up survey (83% and 85%, respectively). It is possible that the number of actual PCPs was exaggerated in the first survey. “Primary care provider” was defined as a “personal doctor or health provider who knows them best”, and clients may think of their specialist that way, even though their specialist may not consider themselves to be responsible for preventive care. Pierce County clients reported more problems finding a PCP after implementation than before. That has raised concern that at least some clients do not understand that they have a PCP in managed care. If so, this may point out the need for additional education of clients.
- **Visits to PCPs:** The frequency of patient visits varied between the two counties, but tended to drop after implementation. So did phone calls to providers in Pierce County, although calls substantially increased in King County. Clients reported few problems with wait times for appointments, and clients in King County reported an improvement in PCPs’ understanding of their problems.
- **Access to Specialists:** Fewer clients reported seeing a specialist after implementation of the pilot, and fewer clients thought they needed a specialist. After implementation, significantly fewer clients reported problems seeing a specialist. The respondents who said seeing a specialist was no longer a problem rose from 29% to 70% in King County and from 56% to 71% in Pierce County. This may indicate the PCPs are assisting the clients getting access.
- **Prescription Drugs:** The majority of all clients said they needed a prescription under managed care and had no problem getting it. However, in King County the percentage of clients saying they had no problem getting their prescriptions increased (from 52% to 68%), and in Pierce County, the number dropped from 76% to 68%.
- **Urgent and Emergent Care and Emergency Room Utilization:** In the post-implementation survey, the need for urgent/emergent care increased for respondents in King County and decreased in Pierce County. The King County increase may be linked to the increase in clients calling their PCP for help or advice. However, a large percentage also reported more problems getting urgent care and emergent needs met at the clinic under managed care. Meanwhile, the number of clients who reported no trips to the ER increased under the pilot. In

addition, while more of King County clients made at least one trip to the ER after implementation, the same group made significantly fewer trips overall.

TRIPS TO ER	KING		PIERCE	
	Before	After	Before	After
Don't know	0% (1)	0	1% (1)	3% (4)
None	48% (72)	59% (89)	52% (80)	55% (83)
1 time	21% (31)	29% (43)	26% (41)	26% (39)
2 times	11% (16)	9% (14)	12% (19)	7% (11)
3 times	5% (7)	0	1% (2)	4% (6)
4 times	4% (6)	2% (3)	4% (6)	1% (2)
5-9 times	5% (7)	1% (1)	3% (4)	3% (5)
More than 9	7% (10)	0	1% (2)	0

- **Health Status:** Most clients, both before and after implementation, rated their health Poor or Fair, but there was a significant shift for post-implementation Pierce County clients who improved from Poor to Fair. There was also a significant shift in the second survey among clients who said they had experienced a lesser degree of bodily pain after implementation. In addition, other health conditions were addressed. There was a significant shift upwards in the number of clients who have been offered help quitting smoking and reduction in smoking. The following table is illustrative:

Smokes...	KING		PIERCE	
	BEFORE	AFTER	BEFORE	AFTER
...every day	62% (61)	45% (68)	74% (85)	37% (55)
...some days	13% (13)	3% (5)	7% (8)	11% (17)
...not at all	25% (25)	51% (77)	19% (22)	51% (76)

- **Mental Health:** Even though mental health treatment is not a covered benefit for GA-U clients, mental health status is a problematic issue. At least 40% of the clients have “mental disorders” listed by ESA as their primary incapacity issue, and more than 10% of clients in the post-implementation survey had a secondary mental incapacity in addition to a primary medical incapacity. Just prior to implementation of the pilot, mental health services at the community mental health services for GA-U clients were reduced. A number of the CHPW clinics do have limited access to social workers and mental health workers. But it is not known immediately whether this accounts for the surveys’ improved rating of mental health services. On a scale of 1-10, ratings were up from a median score of 1 in King County to 8 and from 4 to 8 in Pierce (despite increased problems for Pierce clients in problems getting care).

- **Overall Health Care:** Clients rated their own health care before getting on managed care at a median of 7 on a 10-point scale in both counties. The rating stayed at 7 in Pierce County after implementation but rose to an 8 (statistically significant) in King County.
- **Help from CHPW:** The majority of clients in both counties said after implementation that CHPW had helped them get medical care they needed to treat the problems that made them eligible for GA-U. The percentage was much higher in King County (84%) than in Pierce (52%).

Comments from the clients reflect difficulties adjusting to new providers and managed care rules, as well as other problems in the program that need to be addressed. Overall, however, it seems clear that access to care has not suffered -- and indeed, in some areas it has improved.

❖ **Changes in Clients' Eligibility Status**

There are systemic advantages to putting clients into a medical home. One is that it gives the program a more complete picture of the patient's medical and mental health condition. Some clients are actually more seriously impaired than is ascertained. As such, they may be eligible for GA-X. The PCPs, by nature of seeing the patients for all their care, may be in a better position to pick up undetected problems and to treat patients on a more comprehensive basis than before. With that in mind, the pilot offered training to help PCPs determine who is qualified for the SSI program. Changing GA-U clients' eligibility to GA-X or SSI is a measure of success, because these programs cover more medical benefits, the clients' receive a higher living stipend, and the state receives federal funding to offset state costs.

To evaluate the impact of the pilot on the changes in eligibility, rates of returns to work and switches to GAX/SSI were compared.

- The number of clients who returned to work has been too small to evaluate, either before or after the pilot.
- The rate of GA-U clients in the pilot areas switching to GA-X also did not change significantly during the first two months of the program (most current data, allowing for retroactive changes), compared to elsewhere in the state and to 2004 rates.⁵

⁵ Office of Financial Management, Office of Forecasting, special report V. Schiebert

PARTNERSHIPS

A number of partnerships have been developing among different systems under the pilot that will better serve GA-U clients. At this point, the relationships are still in the beginning stages, but the pilot has paved the way for their formation, and it is anticipated they will continue to strengthen. They include:

1. **CSOs and Medical Providers:** The DSHS CSOs and the clinics are working together toward a better understanding of the GA-U and SSI programs. The partnership is fostering improved contacts, effective trainings, and better working relationships overall. Each clinic and CSO has a different arrangement, and some unique practices have been set up to streamline the exchange of information. The increased understanding of the GA-U program by providers is also starting to produce better documentation of GA-U clients' eligibility and potential for reclassification in GA-X/SSI.
2. **Mental Health Connections:** While GA-U clients are not eligible for mental health coverage with their medical benefits, some of the CHPW clinics employ social workers or have special mental health arrangements for their patients, including GA-U clients, albeit on a limited basis. CHPW is actively pursuing a state grant for mental health dollars that could serve GA-U clients. Many providers and DSHS social workers feel that more GA-U clients would return to work if outpatient mental health services were available. Another benefit would be better access to mental health medications. Mental health drugs can be prescribed, but the initial evaluation and monitoring the drugs is problematic for most PCPs. Consultation and training of PCPs may assist in this area.
3. **Better Understanding of Chemical Dependency Services:** Navigating the chemical dependency system is somewhat confusing for most clients and providers. Links between county Alcohol and Drug Addiction Treatment Support Act (ADATSA) and case managers at CHPW have been established and referral mechanisms clarified. Information on new ADATSA funding and referral guidelines has been distributed to many of the providers, as they have voiced a concern about many of their patients' use of addictive products.
4. **Homeless Programs and Grants:** A national program for assisting homeless clients to obtain SSI has selected Washington as one of its grantees. DSHS is a major participant, with CSO and HRSA staff representatives developing action plans, including educating CHPW providers.
5. **Emergency Rooms and CHPW:** CHPW and some of its outreach workers have been working closely with Harborview and Tacoma General to reduce the need for emergency care by diverting care to PCPs and other efforts.

6. **Veteran's Association:** A list of GA-U clients not previously linked with Veteran's Affairs (VA) has been matched against Washington's Department of Veteran's Administration; it was found that 21.7% are veterans, and potentially eligible for VA benefits. This information will be distributed to CHPW clinic outreach workers so they may help inform clients of this resource (particularly when mental health needs are identified).
7. **Vocational Rehabilitation:** Resources for vocational rehabilitation are decidedly limited, but initial steps have been taken to utilize this resource where available and appropriate.
8. **Labor and Industries:** Putting workers back on the job is a goal for both Labor and Industries (L&I) and the GA-U program, and DSHS has begun efforts to align the programs where applicable -- such as identifying providers with occupational specialty, reviewing authorization guidelines, etc.
9. **Family Planning:** CHPW providers are a natural vehicle to provide family planning information. Planning has begun to strengthen their ability to do so.

It is expected that program costs for GA-U clients will decline as these partnerships strengthen each other. Planners anticipate that under managed care more clients will be able to return to work, transfer to other federally funded programs, and use services more appropriately.

FISCAL IMPACT

GA-U medical costs have been increasing over the years. The legislative proviso requiring the GA-U Managed Care Pilot stipulated the pilot not cost more than what would be expended on FFS GA-U clients. As a result, the pilot's focus has been on improving client access to care and improved medical outcomes, as well as familiarizing clients and providers with managed care, and producing cost experience needed to set rates for fully capitated managed care. With the goal of cost neutrality, no funds were allocated to manage this program.

❖ Rate-Setting and Savings Methodologies

Rate-setting for GA-U managed care has been somewhat problematic. Historical costs have varied to such an extent that the contractor did not feel comfortable accepting a full-risk, fully-capitated managed care model. The rate-setting model for the partially capitated pilot utilized historical baseline per member per month (PMPM) primary care and FFS prescription costs, adjusted forward, without discount, to the program year.

Adjustments using utilization trend factors from the DSHS Medical Forecast Per Cap Report were made to bring past years' costs in line with expected experience for the year. By trending GA-U baseline PMPM costs forward and using DSHS forecast utilization figures, planners calculated the equivalent of what would have been spent under the FFS system.

CHPW is paid a monthly PMPM premium, based on the number of clients enrolled that month. The rates differ by county of residence, but unlike Healthy Options, not age or sex. To estimate cost savings, the trended baseline expenditures, when they become available, for GA-U clients will be compared to the premiums paid to CHPW, added to the DSHS FFS medical expenditures.

❖ Preliminary Results

Findings at this time are extremely limited because of the lag time medical providers have to bill DSHS. Therefore, full claims data is not currently available. If there are reductions in costs, they may be due to a variety of causes, including improved care management by PCPs, a shift in more expensive clients going to GA-X, fewer claims submitted due to the hassle factor, denied claims due to providers unaware of managed care, and other factors.

➤ Premium Costs

The following chart shows the expenditures in monthly premiums paid to CHPW for primary care and prescription drugs:

GA-U Managed Care Premium Payments		
	Payment count	Premium amount
December 2004	2,961	\$506,985
January 2005	2,186	\$375,976
February 2005	3,488	\$595,332
March 2005	3,530	\$603,136
April 2005	3,726	\$642,270
May 2005	3,833	\$657,420
June 2005	4,085	\$690,282
July 2005	3,454	\$548,678
August 2005	3,188	\$505,878
September 2005	2,830	\$449,273
October 2005	3,346	\$534,936
November 2005	3,136	\$499,079
TOTAL		\$6,609,243

➤ **Potential for Savings**

The pilot was set up to operate within available resources, so the rates for the capitated services were set at FFS equivalents. No startup or administrative costs have been built into the rates. It was agreed that any savings from such non-capitated services, such as hospitalizations or emergency room visits, due to better management by CHPW, are contracted to go to CHPW. Transferring savings to the contractor serves as an incentive to provide preventive and more cost-effective care, and to compensate for additional primary care visits used in the pilot not reflected in the rates. This outcome will be determined after DSHS pays all claims for the enrollees, later in 2006.

If savings are achieved from this partially capitated model, it is anticipated a fully capitated model will be able to better manage the program with its more comprehensive system.

CONCLUSIONS

Sound medical arguments and practices support the effort to provide a managed care “medical home” for this population and offer better, more consistent and more appropriate care. On the other hand, the GA-U circumstances present managed care with many challenges. This is an extremely fragile population – many with physical disabilities, others with mental problems, all of them low-income, and too many homeless.

The pilot thus required a steep learning curve for all involved parties—clients, DSHS staff, primary and specialty providers. Although it is difficult to draw conclusions about the “success” of the GA-U Managed Care Pilot without concrete utilization data, these preliminary findings seem apparent:

- The full potential of managed care is handicapped by the partial capitation arrangement.
- The client access survey reveals some problems, but overall, the pluses and minuses of managed care seem to balance out. Clients generally report increased access to primary care providers, they appear to be using the emergency room more appropriately, and they seem better able to access specialists when they need them.
- The pilot did not assume savings, but the move toward more appropriate care would seem to predict lower costs – a logical result. Nevertheless, ongoing reviews are needed to compare actual costs to projected costs for GA-U pilot

clients and non-pilot GA-U clients. Fiscal data to determine savings is expected to be completed in approximately one month.

- The pilot has created and fostered a number of partnerships between caregivers, clients, program sponsors and stakeholders. One especially noteworthy bond has developed between the CSOs and health-care providers. These relationships have benefited both state staff and health-care professionals – and because of that, the clients.
- The pilot has brought DSHS a better understanding of the GA-U population and its needs. This improved information will clearly enhance services, update policies and improve procedures to better effect; it also will continue to inform the agency’s efforts to move clients to SSI or GA-X as they become eligible for that status.
- Overall, this closer look at the GA-U medical program has already identified many potential areas for better management.
- Next steps:
 - 1) The GA-U program under the partial capitation model has been extended through February 2006. We hope to apply what we learn about the first six months of the program to the re-negotiation of the contract. Moving to full capitation would resolve many of the current system difficulties and allow improved care management for these clients.
 - 2) Based on the first year evaluation, consider expanding the program. The decision will be made in context of other managed care efforts, such as initiating an SSI managed care program.

APPENDIX

GA-U Pilot Clients Compared to Other GA-U Clients Clients on GA-U at least 1 month in December 2004 to February 2005 period Demographics, Baseline Criminal Justice Involvement, Baseline Diagnoses, and Baseline Pharmacy SOURCES: DSHS Research and Data Analysis Division Client Services and Client Outcomes Databases	GA-U Pilot Clients	Other GA-U Clients
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DEMOGRAPHICS		
Number of Clients	3,905	9,556
Age		
18-24	7.9%	11.7%
25-34	16.0%	17.0%
35-44	28.6%	27.6%
45-54	35.4%	32.9%
55-64	12.0%	10.8%
65 and over	0.1%	0.1%
Gender		
Male	60.5%	58.8%
Female	39.5%	41.2%
Single Race		
Asian/Native Hawaiian/Other Pacific Islander	5.2%	2.2%
Black	24.5%	6.4%
Hispanic	6.2%	8.3%
American Indian/Alaska Native	1.6%	4.3%
Other	3.3%	2.0%
White	59.2%	76.9%
CRIMINAL JUSTICE INVOLVEMENT		
Percent Arrested in CY 2004	20.6%	20.8%
Percent Convicted in CY 2004	15.9%	17.6%

DEFINITION OF CLIENT GROUPS: There were 3,905 clients who were enrolled in the GA-U Managed Care Pilot for at least one month in the December 2004 to February 2005 period. Pilot clients were identified by the presence of a GA-U capitation payment in MMIS medical claims. There were 9,556 other clients who were on GA-U medical coverage for at least one month in the three month period (but not enrolled in the GA-U managed care pilot).

HOW TO INTERPRET THE TABLE: 60.5% of GA-U pilot clients were male, compared to 58.8% of other GA-U clients; 20.6% of GA-U pilot clients were arrested at least once in FY 2004, compared to 20.8% of other GA-U clients.

DISEASE CATEGORIES CDPS Disease Categories Present in CY 2004 MMIS Claims		
	<i>Sample Diagnoses</i>	
Cancer, high	Lung cancer, ovarian cancer, secondary malignant neoplasms	0.5% 0.6%

Cancer, medium	Mouth, breast or brain cancer, malignant melanoma	1.3%	1.2%
Cancer, low	Colon, cervical, or prostate cancer, carcinomas in situ	0.5%	0.8%
Cardiovascular, very high	Heart transplant status/complications	0.2%	0.3%
Cardiovascular, medium	Congestive heart failure, cardiomyopathy	2.4%	2.3%
Cardiovascular, low	Endocardial disease, myocardial infarction, angina	9.1%	6.6%
Cardiovascular, extra low	Hypertension	17.1%	13.5%
Cerebrovascular, low	Intracerebral hemorrhage, precerebral occlusion	1.5%	1.1%
CNS, high	Quadriplegia, amyotrophic lateral sclerosis	0.0%	0.0%
CNS, medium	Paraplegia, muscular dystrophy, multiple sclerosis	1.4%	1.1%
CNS, low	Epilepsy, Parkinson's disease, cerebral palsy, migrane	16.7%	15.6%
DD, medium	Severe or profound mental retardation	0.0%	0.0%
DD, low	Mild or moderate mental retardation, Down's syndrome	0.0%	0.0%
Diabetes, type 1 high	Type 1 diabetes with renal manifestations/coma	0.2%	0.1%
Diabetes, type 1 medium	Type 1 diabetes without complications	2.6%	3.0%
Diabetes, type 2 medium	Type 2 or unspecified diabetes with complications	1.3%	1.2%
Diabetes, type 2 low	Type 2 or unspecified diabetes w/out complications	7.4%	6.2%
Eye, low	Retinal detachment, choroidal disorders	0.6%	0.5%
Eye, very low	Cataract, glaucoma, congenital eye anomaly	1.9%	1.8%
Genital, extra low	Uterine and pelvic inflammatory disease, endometriosis	3.3%	3.3%
Gastro, high	Peritonitis, hepatic coma, liver transplant	0.6%	0.4%
Gastro, medium	Regional enteritis and ulcerative colitis, enterostomy	5.2%	4.5%
Gastro, low	Ulcer, hernia, GI hemorrhage, intestinal infectious disease	14.7%	12.7%
Hematological, extra high	Hemophilia	0.0%	0.0%
Hematological, very high	Hemoglobin-S sickle-cell disease	0.0%	0.0%
Hematological, medium	Other hereditary hemolytic anemias, aplastic anemia	1.0%	0.8%
Hematological, low	Other white blood cell disorders, other coagulation defects	2.0%	1.5%
AIDS, high	AIDS, pneumocystis pneumonia, cryptococcosis	1.5%	0.7%
HIV, medium	Asymptomatic HIV infection	0.2%	0.1%
Infectious, high	Staphylococcal or pseudomonas septicemia	0.3%	0.2%
Infectious, medium	Other septicemia, pulmonary or disseminated candida	0.4%	0.6%
Infectious, low	Poliomyelitis, oral candida, herpes zoster	2.1%	1.7%
Metabolic, high	Panhypopituitarism, pituitary dwarfism	1.1%	1.4%
Metabolic, medium	Kwashiorkor, merasmus, and other malnutrition, parathyroid	0.9%	0.7%
Metabolic, very low	Other pituitary disorders, gout	2.5%	2.1%
Psychiatric, high	Schizophrenia	2.7%	1.8%
Psychiatric, medium	Bipolar affective disorder	5.5%	4.8%
Psychiatric, low	Other depression, panic disorder, phobic disorder	26.4%	21.8%
Pulmonary, very high	Cystic fibrosis, lung transplant, tracheostomy status	0.1%	0.1%
Pulmonary, high	Respiratory arrest or failure, primary pulmonary hypertension	0.5%	1.1%
Pulmonary, medium	Other bacterial pneumonias, chronic obstructive asthma	1.5%	1.1%
Pulmonary, low	Viral pneumonias, chronic bronchitis, asthma, COPD	13.7%	13.2%
Renal, very high	Chronic renal failure, kidney transplant status/complications	0.4%	0.6%
Renal, medium	Acute renal failure, chronic nephritis, urinary incontinence	2.1%	2.7%
Renal, low	Kidney infection, kidney stones, hematuria, urethral stricture	3.8%	3.9%
Skeletal, medium	Chronic osteomyelitis, aseptic necrosis of bone	0.6%	0.4%
Skeletal, low	Rheumatoid arthritis, osteomyelitis, systemic lupus	3.8%	3.9%
Skeletal, very low	Osteoporosis, musculoskeletal anomalies	10.6%	9.7%
Skeletal, extra low	Osteoarthritis, skull fractures, other disc disorders	16.3%	16.3%
Skin, high	Decubitus ulcer	0.3%	0.2%
Skin, low	Other chronic ulcer of skin	1.4%	1.1%
Skin, very low	Cellulitis, burn, lupus erythematosus	12.1%	9.6%
Substance abuse, low	Drug abuse, dependence, or psychosis	11.8%	8.0%
Substance abuse, very low	Alcohol abuse, dependence, or psychosis	5.8%	6.3%

HOW TO INTERPRET THE TABLE: Chronic disease conditions were identified by applying the Chronic Illness and Disability Payments System (CDPS) to clients' fee-for-service medical claims in CY 2004. Counts are hierarchically unduplicated within the disease group. For example, a client with diagnoses of schizophrenia and depression will be counted only once in the "Psychiatric, high" category. Thus, percentages can be added within a disease category (e.g., Psychiatric) to produce the unduplicated percentage of clients in that disease category. Clients with diagnoses in multiple categories (e.g., Cardiovascular and Psychiatric) will be counted once in each broad category represented in their medical claims diagnoses. For more information about the CDPS, see Kronick R, Gilmer T, Dreyfus T, et al. *Improving health-based payment for Medicaid beneficiaries: CDPS*. Health Care Fin Rev 2000; 21:29-64.

PRESCRIPTIONS | Medicaid-Rx Drug Categories Present in CY 2004 Pharmacy Claims

Summary Drug Descriptions

Alcoholism	Disulfiram	0.3%	0.4%
Alzheimers	Tacrine	0.1%	0.0%
Anti-coagulants	Heparins	2.4%	2.0%
Asthma/COPD	Inhaled glucocorticoids, bronchodilators	16.4%	16.6%
Attention Deficit	Methylphenidate, CNS stimulants	0.5%	0.7%
Burns	Silver Sulfadiazine	0.7%	0.4%
Cardiac	Ace inhibitors, beta blockers, nitrates, digitalis, vasodilators	32.1%	28.0%
Cystic Fibrosis	Pancrelipase	0.4%	0.2%
Depression / Anxiety	Antidepressants, antianxiety	42.5%	40.1%
Diabetes	Insulin, sulfonylureas	5.7%	4.7%
EENT	Anti-infectives for EENT related conditions	15.9%	13.8%
ESRD / Renal	Erythropoietin, Calcitriol	0.2%	0.1%
Folate Deficiency	Folic acid	1.5%	0.9%
Gallstones	Ursodiol	0.0%	0.0%
Gastric Acid Disorder	Cimetidine	10.0%	10.1%
Glaucoma	Carbonic anhydrase inhibitors	0.4%	0.4%
Gout	Colchicine, Allopurinol	0.8%	0.8%
Growth Hormone	Growth hormones	0.0%	0.0%
Hemophilia/von Willebrands	Factor IX concentrates	0.0%	0.0%
Hepatitis	Interferon beta	0.0%	0.0%
Herpes	Acyclovir	1.6%	1.8%
HIV	Antiretrovirals	0.7%	0.3%
Hyperlipidemia	Antihyperlipidemics	9.5%	8.7%
Infections, high	Aminoglycosides	0.1%	0.1%
Infections, medium	Vancomycin, Fluoroquinolones	9.3%	7.7%
Infections, low	Cephalosporins, Erythromycins	38.8%	39.8%
Inflammatory /Autoimmune	Glucocorticosteroids	10.6%	10.1%
Insomnia	Sedatives, Hypnotics	3.0%	2.5%
Iron Deficiency	Iron	2.1%	1.8%
Irrigating solution	Sodium chloride	0.2%	0.3%
Liver Disease	Lactulose	0.3%	0.4%
Malignancies	Antineoplastics	1.2%	1.0%
Multiple Sclerosis / Paralysis	Baclofen	1.2%	2.5%
Nausea	Antiemetics	10.2%	10.8%
Neurogenic bladder	Oxybutin	0.4%	0.6%
Osteoporosis / Pagets	Etidronate/calcium regulators	0.6%	0.8%
Pain	Narcotics	46.5%	49.0%
Parkinsons / Tremor	Benzotropine, Trihexyphenidyl	1.1%	1.0%
PCP Pneumonia	Pentamidine, Atovaquone	0.0%	0.0%
Psychotic Illness / Bipolar	Antipsychotics, lithium	13.6%	11.0%
Replacement solution	Potassium chloride	5.0%	4.2%
Seizure disorders	Anticonvulsants	15.2%	15.4%
Thyroid Disorder	Thyroid hormones	2.1%	3.5%

Transplant	Immunosuppressive agents	0.2%	0.2%
Tuberculosis	Rifampin	0.4%	0.3%

HOW TO INTERPRET THE TABLE: Pharmacy groups were identified by applying the Medicaid-Rx system to clients' fee-for-service medical claims in CY 2004. Clients with prescriptions in multiple categories (e.g., Pain and Depression/Anxiety) will be counted in both two categories. For more information about Medicaid-Rx system, see Gilmer T, Kronick R, Fishman P, et al. *The Medicaid Rx Model: Pharmacy-based risk adjustment for public programs*. Med Care 2001; 39:1188-1202.