Medicaid debate: Does managed care work?

Next week, a highly anticipated report on the Georgia Medicaid program's future is scheduled to be released.

The analysis, by the consulting firm Navigant, is expected to take a hard look at the way the state runs its managed care program. The program covers more than 1 million low-income Georgians, most of them children.

The biggest question surrounding the handling of Medicaid in Georgia is whether the state should maintain its current HMO-like structure, tweak it – or change it completely.

The Georgia Hospital Association is perhaps the most powerful group that wants the current set-up scrapped.

In a strongly worded December letter and report to Navigant and to the state agency that runs Medicaid and PeachCare, GHA said the current managed care program "has failed to achieve its intended purposes."

The hospital association said the "minimal savings" that the Medicaid managed care program has achieved have come at the expense of Georgia's medical providers.

GHA estimated that the state and medical providers have incurred a net loss of more than $700 million from 2007 to 2010 under the current program. It is run by three managed care companies, called "care management organizations," or CMOs.

The group also said hospitals have lost another $632 million in supplemental payments since fiscal 2007. Administrative costs for medical providers have increased significantly, and the quality of care provided by the three CMOs "has proven consistently low compared with other states' Medicaid managed care plans," the report said.

Are things getting better or worse?

The Dec. 6 report preceded an Atlanta Business Chronicle article that said the privatization of Georgia's Medicaid program has achieved significant savings.

Georgia spent $4,835 per Medicaid enrollee in 2009, down 2.7 percent from $5,532 per enrollee in 2004, according to the U.S. Centers for Medicare & Medicaid Services, which was the largest decrease in the country during that period, the Business Chronicle reported. The CMO program began six years ago in Georgia for Medicaid, which is jointly financed by the federal and state governments.

Representatives of Georgia doctors and hospitals told the newspaper that the cost cutting is contributing to low provider payments that are reducing access to quality health care.

The managed care companies have achieved cost savings "on the backs of a very vulnerable Medicaid population and on the backs of the provider community," said Kevin Bloye, a GHA vice president, in a recent interview with Georgia Health News. "The current system is broken and needs to be fixed."

GHN asked the three managed care companies to comment on the hospital association report. Virginia-based Amerigroup declined to comment, while officials at St. Louis-based Centene (which runs Peach State Health Plan in Georgia) and Tampa-based WellCare could not be reached for comment.

The state's Department of Community Health said Wednesday that it was preparing a response to the hospital association, and for that reason declined to comment.

Over the past decade, most states have turned over Medicaid to private health plans, with the goal of controlling costs and improving care. But Connecticut recently decided to drop the private health plans from Medicaid. (Here's a Kaiser Health News article on the state's decision.)

At the other end of the spectrum, Florida has decided to require all Medicaid recipients to enroll in an HMO or other tight network plan, beginning next year.

Looking at Georgia's bottom line

Georgetown University's Joan Alker said Wednesday that there is no good evidence, at least so far, that Medicaid managed care saves money or improves access to medical care.

"In general, the jury is still out,'' said Alker, co-executive director of the Center for Children and Families at Georgetown's Health Policy Institute. "In theory, managing care is like apple pie.'' Everyone wants to see better health outcomes and unnecessary treatments eliminated, she said.

The big question is whether the companies manage patients' care properly or create barriers to needed care, she said.

The Georgia Hospital Association, in its report, said a large share of the money paid by the state for its Medicaid managed care program has gone to corporate coffers.

"For fiscal year 2012 alone, between $360 million and $440 million could be paid by the state to the three CMOs for administration and profit,'' the report said.

Much of that money flows out of Georgia because the companies are all based in other states, the hospital association said.

Payments to medical providers declined by almost 5 percent from January 2007 to June 2011, even though state payments to the CMOs increased more than 16 percent during the same period, the hospital association's report said.

When all factors are weighed, the state's net loss is estimated to have surpassed $1.2 billion from 2007 to 2010, GHA said.

The report added that the three CMOs operating in Georgia rank in the bottom half nationally for well-child visits and children's access to primary care services. None of them reached a state target for reducing the number of emergency room visits by beneficiaries, GHA said.

The hospital association recommends the Medicaid model adopted by North Carolina, a public-private partnership run largely by physicians. It's a system that GHA says has delivered greater savings and better care.

Georgetown's Alker voiced similar sentiments, saying North Carolina "is an excellent model.''

States should have strong accountability and performance measures to make sure taxpayer dollars are well spent in their Medicaid programs, she said.

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