REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF THE PARTICIPATION OF ACADEMIC HEALTH CENTERS IN MANAGED CARE PROVIDER NETWORKS PURSUANT TO SJR 108

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Senate Joint Resolution (SJR) 108 of the 1998 General Assembly directed the Joint Commission on Health Care to study and analyze opportunities to enhance the ability of the Commonwealth's academic health centers (the Medical College of Virginia at Virginia Commonwealth University, University of Virginia Health Sciences Center, and Eastern Virginia Medical School) to participate in managed care networks.

The SJR 108 study was conducted in response to growing concerns among the Commonwealth's academic health centers (AHCs) that as managed care organizations (MCOs) seek to reduce health care costs for their enrollees through more aggressive provider contracting, the AHCs may be excluded from the managed care provider networks. The AHCs also are concerned that exclusion from managed care networks will cause a decline in third-party reimbursement making it increasingly difficult to maintain their traditional functions of medical education, research, and indigent care.

Based on our research and analysis during this review, we concluded the following:

- MCOs engage, to some degree, in "selective contracting" with the AHCs by excluding certain services (e.g., home health services) offered by the AHCs from the provider contract;

- the MCOs' contracting practices with the AHCs are similar to those used when contracting with other private hospitals;

- in some instances, MCOs negotiate an exclusive arrangement with one hospital or a limited number of affiliated hospitals to direct a greater number of patients to the hospital in return for lower costs per service;

- requiring the MCOs that contract with the state employee health benefits program to include the AHCs as fully participating providers in all managed care networks would help alleviate the practice of selective contracting; however, the insurance industry, other providers and the Department of Personnel and Training are opposed to this approach due to the potential impact on MCOs' ability to develop cost-effective networks and the potential negative impact on other community providers' ability to participate in MCO networks;

- retaining Medicaid patients is vitally important to the AHCs because of disproportionate share hospital payments and because Medicaid patients provide medical students with experience in treating a broader range of medical conditions;

- requiring Medicaid HMOs to include the AHCs in their provider networks would help ensure the AHCs retain their Medicaid patient base; however, MCOs and other Medicaid providers oppose mandating inclusion of the AHCs in the Medicaid HMO networks due to the potential adverse impact on the cost-effectiveness of the networks and the ability of other community providers to participate in the Medicaid HMO networks; and

- there are numerous financial and operational issues facing the Commonwealth's AHCs which are complex and much broader in scope than those discussed in this report; a more comprehensive study of these issues may be of significant value to the AHCs and the Commonwealth in determining how best to support these institutions.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 19-20.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments (Appendix B) provide additional insight into the issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Department of Medical Assistance Services, the Department of Personnel and Training, the Medical College of Virginia at Virginia Commonwealth University, the University of Virginia Health Sciences Center, the Eastern Virginia Medical School, the State Council of Higher Education in Virginia, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, and Trigon BlueCross BlueShield for their assistance during this study.

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Executive Director

February 19, 1999

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I.
Authority for Study/Organization of Report

Senate Joint Resolution (SJR) 108 of the 1998 Session of the General Assembly directs the Joint Commission on Health Care to study and analyze various opportunities to enhance the ability of academic health centers (AHCs) to participate in managed care provider networks. SJR 108 directs the Joint Commission to conduct its study in cooperation with the AHCs, the Department of Medical Assistance Services, the Department of Personnel and Training, and the Virginia Association of Health Maintenance Organizations.

Specifically, SJR 108 requires that the Joint Commission's study include, but not be limited to, a cost-benefit analysis of the feasibility of:

(i) requiring managed care organizations that bid on the state employee health benefits program to include the AHCs as fully participating network providers in all products offered by the managed care organization; and
(ii) assigning Medicaid recipients enrolled in a mandatory managed care program, such as Medallion II, to a health plan that includes AHCs as fully participating network providers in those instances when the enrollee has not chosen another health plan.

A copy of SJR 108 is attached at Appendix A.

This Report Is Presented In Five Major Sections

This first section discusses the authority for the study and organization of the report. Section II provides background information regarding the academic health centers (AHCs) and the competitive and financial challenges they face now and in the future. Section III presents information about the current contractual arrangements the AHCs have with managed care organizations (MCOs). Section III also discusses the potential impact of requiring MCOs which contract with the state employee health benefits program to include the AHCs in their provider networks for all products offered by the MCO. Section IV analyzes current Medicaid managed care programs and their contractual arrangements with MCOs and addresses the issue of "default" assignments of recipients to MCOs which contract with the AHCs. Lastly, Section V presents a series of policy options the Joint Commission may wish to consider in addressing the issue of AHCs' participation in MCOs' provider networks.

II.
Background: Current And Future Challenges Facing Academic Health Centers

Academic Health Centers Across The Country Are Facing Competitive Pressures That Threaten The Traditional Mission Of The Institutions

Historically, the nation's academic health centers (AHCs) have been at the forefront of medical and clinical innovations. Most of the nation's basic and clinical research advances are made at the 125 U.S. medical schools and their affiliated teaching hospitals. Over 50% of the National Institute of Health's extramural research grants go to medical schools. (Pardes, 1997.)

In addition to conducting cutting-edge research, the AHCs train health professionals, provide highly specialized patient care and treat a substantial portion of uninsured and indigent patients. A consequence of these traditional functions has been that AHCs' costs of providing care typically are higher than those of non-teaching hospitals. A non-teaching hospital's costs include those directly related to providing patient care and administrative support costs. The costs incurred at AHCs include not only the cost of direct patient care, but also medical education costs, higher indigent care costs, and higher costs associated with a greater concentration of specialists needed to provide highly specialized, tertiary care.

The AHCs face a myriad of pressures on their traditional roles, including the rising costs of uncompensated care, leveling and targeting of research funding, new demands for health professional curricula, and the financing of graduate medical education. (Academic Health Centers: Getting Down To Business, 1998). In addition to these AHC-specific issues, there are continuing systemwide pressures for AHCs, as well as other providers, to control health care costs. The rising cost of health care across the nation has prompted individuals, businesses, and government to look for ways to control future cost increases. In response to market demands for greater accountability and cost controls, managed care has become the dominant form of health insurance.

While there are many pressures facing AHCs, it is the impact of managed care on the AHCs which is the primary focus of this study. More specifically, the focus is on the contracting practices of managed care organizations (MCOs) and how these practices affect the Commonwealth's AHCs.

As Managed Care Organizations Seek To Reduce Health Care Costs For Their Enrollees, There Is Concern That Academic Health Centers May Be Excluded From Provider Networks

As previously noted, the growth of managed care organizations (MCOs) has been in response to the demands of the health insurance market for greater control of health care costs. One of the key principles of managed care, in terms of controlling costs, is to have cost-effective provider networks in which quality care is provided in the least expensive setting. Accordingly, when developing provider networks, MCOs attempt to contract with providers (hospitals, physicians, etc.) who deliver quality services for the least cost.

The managed care marketplace imposes significant competitive pressure on the AHCs which have to compete with non-teaching hospitals for inclusion in MCO networks. As managed care becomes more and more dominant in the marketplace, it is imperative for the AHCs to participate in managed care networks in order to retain an adequate patient base. A robust patient base is critical not only for maximizing patient revenue, but also for the purpose of training medical students. When the number of certain types of patients (e.g., cardiac, pediatric, etc.) receiving medical services at the AHC is significantly reduced, the quality of medical education suffers because the students are not exposed to and are not able to treat the full range of conditions that may exist in that particular patient population.

Given the continuing pressure on MCOs to control health care costs, and the additional costs associated with an AHC (e.g., medical education, research, and high levels of charity care), there is growing concern among the AHCs that MCOs will be less and less willing to include the AHCs in their provider networks. Clearly, if an AHC is left out entirely from a managed care network, the patient base is reduced. However, "selective contracting" by MCOs also reduces the patient base. Selective contracting occurs when a hospital (e.g., AHC) is included in the provider network, but certain services are "carved out" (i.e., benefits are not provided for these services).

A complicating factor that has been cited by the AHCs is that they traditionally have provided highly specialized services, and that this leads to "adverse selection" as patients with higher levels of illness severity seek care at or are referred to these facilities. The concern here is that AHCs will attract higher risk patients to the health plans with which they participate. To the degree that this occurs, the AHCs worry that they will become even less attractive to MCOs as a network provider.

Another concern that has been identified is that even if AHCs are included in MCO provider networks, the reimbursement the MCOs are willing to pay for the AHCs' services may not be adequate due to the additional costs inherent with the full mission of the AHC (i.e., graduate medical education, research, and indigent care).

In sum, should there be an increasing trend of AHCs being excluded from MCO networks, the financial pressures on these institutions become even more problematic. Moreover, if third-party revenues decrease, states are going to have to find other sources of revenue to maintain the traditional functions and mission of the AHCs.

This Study Does Not Include A Comprehensive Analysis Of The Financial Condition And Operation Of Virginia's Academic Health Centers; To Do So Would Require Substantially More Resources, Expertise And Time

The current and future financial and operational status of the AHCs gave rise to the issues being addressed in this study. While the literature contains a number of articles and studies that clearly indicate AHCs across the nation are facing significant financial and competitive pressures, this study does not attempt to conduct a comprehensive fiscal analysis of the Commonwealth's AHCs. The financing and operation of the AHCs is extremely complex. A full-scale analysis of all the revenue streams, expenses, and operational issues associated with the AHCs would require substantially more resources, expertise and time than that available for this study.

A comprehensive study of these issues may be of significant value to the AHCs and the Commonwealth in determining how best to support these institutions in ways beyond those examined here.

AHCs Can Be Defined In Many Ways; For The Purposes Of This Report, AHCs Include The Medical College Of Virginia Hospitals, The University Of Virginia Health Sciences Center, And The Eastern Virginia Medical School

Senate Joint Resolution 108 did not include a definition of what constitutes an "academic health center" (AHC). There are different ways of defining an AHC. It would appear that under most any definition, the Medical College of Virginia Hospitals (MCV), the University of Virginia Health Sciences Center (UVA) and the Eastern Virginia Medical School (EVMS) would be considered an AHC. Of these three institutions, EVMS is unique in that it does not own or operate a hospital. In addition to its teaching mission, EVMS provides physician services through its faculty practice plan to a number of hospitals in the Tidewater area.

In addition to UVA, MCV and EVMS, there are a number of other hospitals across the Commonwealth which provide medical student training as part of their ongoing operation. Examples include residency programs at hospitals operated by INOVA Health System, Carilion Health System, Sentara Health System, and many other hospitals. Moreover, some of these hospitals also provide substantial amounts of charity care (e.g., INOVA Fairfax Hospital: $22.2 million in FY 1997; Sentara Norfolk General Hospital: $13.1 million). (Virginia Health Information, 1997.)

While there is no one right or wrong definition, for the purposes of this report, AHCs include MCV, UVA and EVMS. However, those hospitals with a teaching function and high levels of charity care may well argue that some of the issues addressed in this report apply to them and that consideration should be given to including them in any actions taken as a result of this study.

Also, for purposes of this report, references to the AHCs include both the hospital as well as the associated physicians (faculty practice plans) who provide medical services to patients in the hospital as well as in associated outpatient clinics.

III.
Academic Health Centers' Participation In Managed Care Organizations' Provider Networks

Senate Joint Resolution (SJR) 108 directs the Joint Commission to examine ways of enhancing the academic health centers' (AHCs) participation in managed care networks. This section describes the current status of the AHCs' participation in managed care networks and analyzes the feasibility of requiring those managed care organizations (MCOs) which participate in the state employee program to include the AHCs in all products offered by the MCO.

Selective Contracting By MCOs Has Been Raised As A Concern By Some AHCs

As noted in the previous section, some MCOs contract with hospitals only for selected services and "carve out" other services. When a service is "carved out," the MCO's enrollees receive either reduced or no benefits when the particular service is received at the hospital. As a result, the "selective contract" results in the hospital providing these services to fewer patients. The concern over the impact of such "selective contracting" on AHCs was one of the principal reasons SJR 108 was adopted by the General Assembly.

Information Provided By Two Of The Three AHCs Indicates That Selective Contracting Is Occurring; In Some Instances The Contracting MCO Provides Coverage Only For Selected Services And Does Not Contract With Any Provider For A Comprehensive Package Of Services

To ascertain the degree to which AHCs are being affected by selective contracting, staff requested information from the three AHCs regarding their current contracts with MCOs. MCV and UVA were able to provide specific, although somewhat different, data regarding their contracts with MCOs. Data was not immediately available from EVMS; however, EVMS officials stated that selective contracting (i.e., services being "carved out") had not yet become a serious problem for the institution.

MCV Managed Care Contracts: Information provided by MCV indicates that it has contracts with 11 different MCOs, including nearly all of the major HMOs and preferred provider organization (PPO) plans in the area . The MCOs contracting with MCV include Aetna, CIGNA, Trigon, MAMSI, NYLCare, Prudential, and Southern Health. The 11 MCOs with which MCV has a contractual relationship offer a total of 35 separate plans or products, some of

which have different contract provisions. The MCV data shows that all 35 managed care plans/products have carved out at least one type of service. However, 27 plans/products carve out only one or two services, mostly home health services and mental health/substance abuse services. In many of these instances, particularly mental health/substance abuse and home health services, the MCO typically subcontracts with another MCO to provide these benefits. Accordingly, the MCO would not include these services in its contract with the AHC. While the majority of carve outs apply to only one or two services, 6 plans/products carve out 3 or more services, and one plan carves out seven types of services.

Mental health/substance abuse services are the most frequently carved out services (23 plans). The other services most frequently carved out are:

- home health services (18 plans);
- vision services (12 plans); and
- occupational, physical and speech therapy services (10 plans).

Orthopedic services and cardiology services were carved out by only three and two plans respectively.

UVA Managed Care Contracts: The managed care contracting information provided by UVA was in somewhat of a different format than MCV's data. The UVA data was more specific with respect to whether the contract included the medical center and/or the health services foundation (i.e., faculty practice plan) and whether the contract was for "general services" or "carve-out." However, there was no specific information on which services were "carved out."

UVA included information on a total of 74 managed care contracts. The data included a number of contracts that UVA has with national insurance programs (e.g., BC/BS National Pediatric Cancer Network), specialty programs (e.g., Trigon Partial Day Psychiatric), and employer benefit programs (e.g., Lakeland Tours, LLC, and General Electric). While UVA has contracts with several major MCOs (e.g., Trigon, CIGNA, MAMSI, and Travelers), it also has contracted with a number of less recognized MCOs (e.g., One Call Medical, American Health Plan, and Multiplan). Many of the contracts are limited to only a specific type of service because the MCO is only interested in procuring these services. For example, the BC/BS National Transplant Program contracts only for organ transplant services; accordingly, the contract carves out other services.

As previously noted, UVA provided data on whether the contract pertains to physician services only, medical center services only, or both. Of the 74 total

managed care contracts, 41 include both physician and medical center services; 33 contracts are for either physician services only or medical center services only. With respect to whether certain types of services are carved out (e.g., mental health /substance abuse, home health , etc.), 44 of the 74 contracts have no services carved out; 30 contracts carve out certain service(s). Twenty-eight of the 74 plans contract for both physician and medical center services with no carve outs.

MCOs Indicate That, In Many Circumstances, The Services That Are "Carved Out" Of AHC Contracts Also Are Carved Out Of Other Contracting Hospitals' Contracts

Representatives of several MCOs indicated that in many instances the services that are carved out of AHC contracts also are carved out of other hospitals' contracts as well. As previously noted, these services often are carved out because the MCO has a subcontract with another MCO to provide benefits for these services.

Another reason for some of the carve outs is because the MCO has negotiated an exclusive arrangement with either one hospital or a limited number of affiliated hospitals (e.g., Columbia or Bon Secours) to provide the service(s). In these instances, while the AHCs are affected by the carve outs, other private hospitals are affected similarly. By having an exclusive contract with one or a few hospitals, MCOs indicate they are able to direct a greater number of patients to the hospital(s) in return for a lower cost for the service(s). MCOs maintain that such arrangements enable them to hold down costs and provide their customers with lower premiums.

Requiring MCOs Which Contract With The State Employees Health Benefits Program To Include AHCs As Fully Participating Providers In All Of Their Managed Care Products Is One Action That Would Alleviate The Impact Of Selective Contracting; However, MCOs Oppose This Action

Through its state employee health benefits program, the Commonwealth provides health benefits to over 100,000 persons. One action that has been suggested to alleviate the impact of selective contracting on the AHCs is for the Commonwealth to require those MCOs which contract with the state's health benefits program to include the AHCs as a fully participating provider (i.e., no carve outs) in the networks that serve all of their products. This would include not only those products offered to the state program, but all other products offered to employer groups, etc.

In this scenario, MCOs submitting proposals to participate in the state program would include a certification in its bid/proposal stipulating that, if selected, it would include AHCs (which are located in its service area) in its provider network(s) as a fully participating provider for state employees and all other products.

Currently, the following MCOs are offered through the state employee program: Key Advantage and Cost Alliance (administered statewide by Trigon), Trigon HealthKeepers HMO (Eastern, Central, Northern, Western [Roanoke only] Virginia), Kaiser Permanente HMO (Northern Virginia), Partners HMO (Southwestern Virginia), Prudential Healthcare (Central Virginia), and Sentara (Eastern Virginia). This proposed action would mean that these MCOs would have to include the AHCs as fully participating providers in all products offered by the MCO. (This would apply only to those MCOs in which an AHC is located in their service area.)

Concerns Have Been Expressed By The MCOs, Other Community Providers, And The Department Of Personnel And Training About Requiring MCOs To Include The AHCs As Fully Participating Providers In All Products Offered By The MCO

Requiring that certain providers participate in a given managed care network raises serious concerns by MCOs that their ability to establish cost-effective networks will be jeopardized. MCOs express concern that if any provider, whether it is an AHC or any other type of professional or facility provider, is guaranteed entry into their networks, their ability to negotiate lower costs for their subscribers is hampered. MCOs questioned how they would be able to negotiate rates at all with an AHC when they are required to include the AHC in their networks. Another complicating factor identified by the MCOs is that UVA sponsors its own health plan, QualChoice. MCOs expressed concern that they would be required to include a hospital in their network that is associated with one of their competitors.

Some providers, both hospital and physician groups, also have expressed concern that such a requirement would place them at a competitive disadvantage. Requiring MCOs to include the AHCs in their networks for all products would limit the number of available "provider slots" in these networks and would lessen their chances of being included.

The Department of Personnel and Training (DPT), which administers the state employee program, expressed concern on two fronts. First, such a requirement may lead to increased program costs should the MCOs be required to include the AHCs in their networks in place of another provider which may be

able to provide certain services at a lower cost. Any increased cost would be borne by the Commonwealth and state employees. The second concern is that some MCOs may be less willing to participate in the state program if they are required to include the AHCs in all of their product networks.

One possible alternative to this proposed action would be to require the MCOs participating in the state program to include the AHCs as network providers in only those products offered to state employees. While the concerns of MCOs and other providers regarding the impact of this approach would be reduced, the concerns would still exist. The AHCs would benefit less from this approach, but would still be included in those products offered to state employees.

Based On Limited Information Available From The Literature And The Association Of American Medical Colleges, It Appears That Similar Actions Have Not Been Taken In Other States

Staff attempted to determine whether other states had adopted requirements that AHCs be included in the provider networks of the MCOs contracting with their respective state employee health benefits programs. A review of the literature pertinent to AHCs, primarily the Journal of Academic Medicine, was conducted. While this was not a comprehensive search of all health-related journals, no information was found that indicated such action had been taken in other states.

The staff of the American Association of Medical Colleges (AAMC) was contacted to see if they were aware of any similar actions being taken in other states. The AAMC staff could not indicate with certainty that no other state had taken this action, but they were unable to identify any state which had done so.

In sum, while it cannot be stated with certainty that other states have not taken this type of action, based on available information, it does not appear that other states have required MCOs contracting with the state employee benefits program to include AHCs in their networks.

IV.
Participation Of Academic Health Centers In Medicaid Managed Care Programs

Virginia's Medicaid Program Provides Coverage To Over 100,000 Persons Through Its HMO/Managed Care Programs

As with the state employee health benefits program, the Virginia Medicaid program provides health benefits to a significant number of Virginians through managed care programs. The Department of Medical Assistance Services (DMAS) reports that, as of August, 1998, 103,013 persons were enrolled in health maintenance organizations (HMOs) contracting with the Medicaid program. (This figure represents a one-time "snap-shot" view of Medicaid HMO enrollments.)

There are two Medicaid programs in which recipients are enrolled in HMOs: Options and Medallion II. In areas of the state where Options is available (Central Virginia and Eastern Virginia), recipients have a choice of whether to enroll in an HMO or receive benefits through the Medallion primary care case management program. In Medallion II areas (Tidewater), enrollees are required to enroll in an HMO. (DMAS reports that Medallion II is expected to be expanded into the Richmond area by April, 1999). The August, 1998 enrollment reports indicate that 13,580 recipients are enrolled in Options, and 89,433 are enrolled in Medallion II.

Retaining Medicaid Patients Is Vitally Important To The AHCs Because Of Disproportionate Share Hospital Payments; The AHCs' Teaching Function Is Also Enhanced Through A Greater Number Of Medicaid Patients

A critical source of funding for the AHCs has been disproportionate share hospital (DSH) payments which provide reimbursement to help offset the large amounts of uncompensated care provided by the institutions. As discussed below, the number of Medicaid patient days is a key factor in how the DSH payments are calculated. Accordingly, as the number of Medicaid patient days at the AHCs increases, so does the amount of DSH payments that the AHCs receive.

In addition to the significant financial advantage of retaining Medicaid patients (i.e., DSH payments), these patients also are important to the AHCs' teaching mission. By maximizing the number of Medicaid patients, the AHCs have a larger, more diverse patient base which provides medical students experience in treating a broader range of medical conditions.

Academic Medical Centers Receive Substantial DSH And Enhanced DSH Payments

In Virginia, hospitals become eligible for DSH payments when the percentage of their Medicaid inpatient bed days exceeds fifteen percent of their total inpatient bed days. For purposes of calculating DSH payments, hospitals in Virginia are divided into two types. The first type consists of the University of Virginia Medical Center (UVA) and the Medical College of Virginia (MCV) Hospitals. The second type consists of all other hospitals in the Commonwealth.

In addition to the regular DSH payments available to any hospital exceeding the 15 percent threshold, UVA and MCV both receive enhanced DSH payments. The purpose of these payments is to both compensate for the cost of serving low-income patients and to subsidize the teaching and research missions of the academic medical centers. DSH payments to the two academic medical centers are calculated using the following formula:

- the hospital's Medicaid utilization percentage in excess of fifteen percent, times 11, times the hospital's Medicaid operating reimbursement, times 1.4433 and (ii) the hospital's Medicaid utilization percentage in excess of thirty percent, times the hospital's Medicaid operating reimbursement, times 1.2074.
- The product of the hospital's low-income utilization in excess of 25 percent, times the hospital's Medicaid operating reimbursement.

For FY 1997, enhanced DSH payments to UVA totaled $35,102,339. The enhanced DSH payments to MCV for FY 1997 totaled $76,886,504. Figure 1 shows DSH payments to these two academic medical centers from FY 1992 to FY 1997.

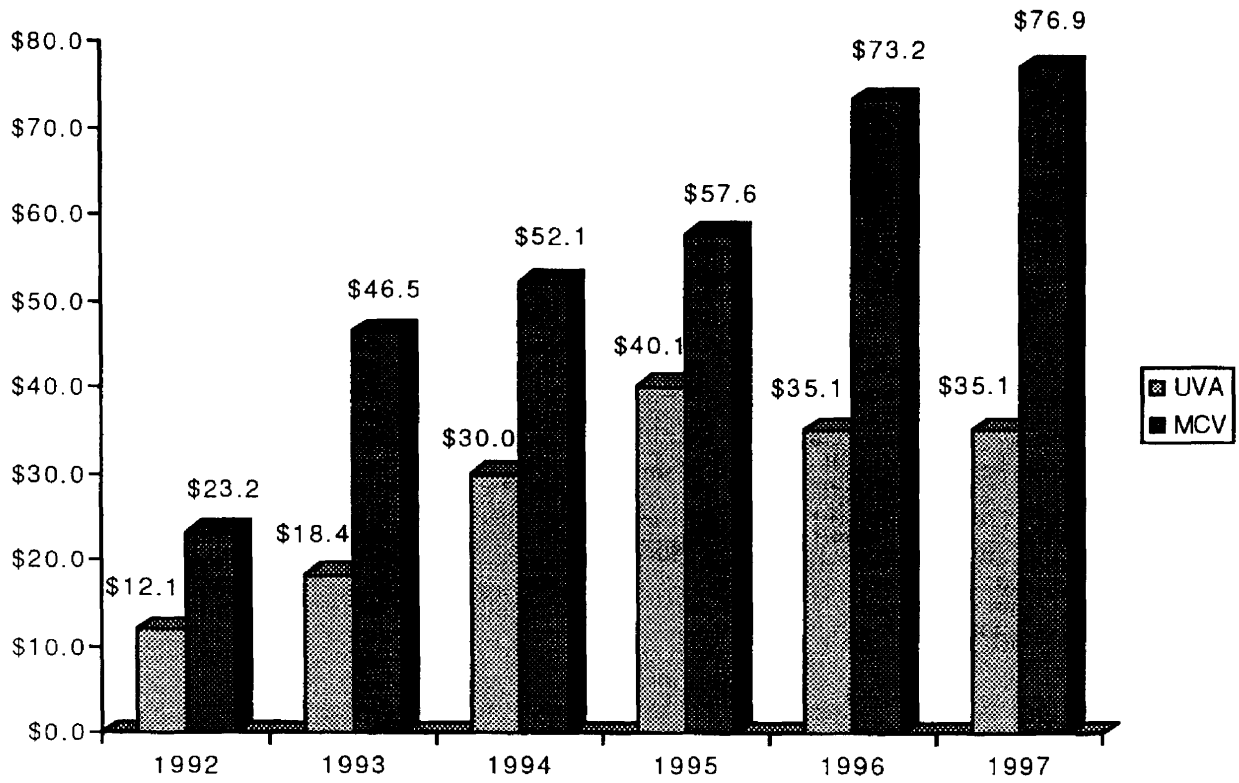
To Draw Down DSH And Enhanced DSH Payments, AHCs Must Maintain A Certain Level Of Medicaid Utilization

The 1998 Appropriation Act appropriates $40,788,000 (general funds) and $43,422,000 (nongeneral funds) to UVA in FY 1999, and $40,753,000 (general funds) and $43,447,000 (nongeneral funds) in FY 2000 for Medicaid payments, including DSH and enhanced DSH amounts. The appropriation for Medicaid payments to MCV is $71,355,000 (general funds) and $75,981,000 (nongeneral funds) in FY 1999 and $71,311,000 (general funds) and $76,025,000 (nongeneral funds) in FY 2000.

As previously noted, DSH and enhanced DSH payments are vitally important to the AHCs. To draw down these funds, they must achieve a certain level of Medicaid utilization. If Medicaid utilization drops below a given level, the AHCs cannot draw down their full Medicaid payment amounts included in the Appropriations Act. Even with the enhanced DSH payments received by the AHCs in FY 1997, UVA and MCV still reported $30.2 million and $42.6 million respectively in unreimbursed charity care in FY 1997. If Medicaid utilization is not maintained at the AHCs, the level of enhanced DSH payments decreases and the amount of unreimbursed charity care increases.

Figure 1

Enhanced DSH Payments to Academic Medical Centers: FY 1992-FY 1997 (in Millions)



Source: Statistical Record of the Virginia Medicaid Program, State Fiscal Year 1997

Increasing The Number Of Medicaid Recipients Who Enroll In HMOs That Include The AHCs Would Help Ensure The AHCs Retain Their Medicaid Patient Base

Senate Joint Resolution 108 directs the Joint Commission to determine the feasibility of assigning Medicaid recipients enrolled in a mandatory managed care program, such as Medallion II, to a health plan that includes AHCs as fully participating network providers in those instances when the enrollee has not chosen another health plan.

Another possible action would be to direct the Department of Medical Assistance Services (DMAS) to require HMOs participating in the Medicaid managed care programs to include the AHCs in their provider networks as fully participating providers.

DMAS currently pre-assigns all Medallion II enrollees to an HMO according to the following procedure:

1. clients previously enrolled in an Options HMO are assigned to that HMO; previous Medallion clients are enrolled in the HMO selected by their Medallion primary care physician, if applicable;
2. clients not assigned under condition 1 are assigned to the HMO of another family member, if applicable; and
3. clients not assigned under conditions 1 or 2 are assigned to an HMO on an equal, random basis.

Clients have 45 days to change their pre-assigned HMO if they prefer to enroll in another plan. (DMAS indicates that Options clients will be assigned to HMOs in a similar fashion once a waiver is approved by the federal Health Care Financing Administration (HCFA).)

Based on DMAS records for the period of February through August,1998, a total of 21,619 clients were pre-assigned to an HMO. Of this total, 8,473 (39%) were assigned under condition 1 (previous plan); 3,009 (14%) were pre-assigned under condition 2 (family history); and 10,137 (47%) were pre-assigned under condition 3 (random).

If the HMOs contracting with DMAS for the Medallion II program were required to include the AHCs as fully participating providers (assuming the AHC was in the HMO's service area), all of the Medallion II clients ultimately would enroll in an HMO which included the AHCs. If DMAS was directed to pre-assign those clients who currently are randomly assigned under condition #3 only to those HMOs which included the AHCs as fully participating providers, based on DMAS' data, only about 47% of the enrollees would be affected.

There are two variations of directing "default" assignments to HMOs which include AHCs in their provider networks. The first would be to let the appropriate AHC select the HMO. The HMOs do not favor this approach. The second variation would be for DMAS to assign these Medicaid recipients to the HMO which has the highest percentage of admissions at the AHC. The advantage of this approach for the AHCs is that it would increase the likelihood that if a Medicaid recipient was going to be admitted to a hospital, the admission would be at the AHC rather than another hospital in the network.

In The Options And Medallion II Areas Of The State, The AHCs Currently Are Included In Most Provider Networks; AHCs Are Concerned About Future HMO Provider Networks

Currently, the AHCs are included in nearly all of the Medicaid HMOs which are operating in their service area. This issue has less of an impact on UVA at this time because there are no Medicaid HMOs operating in their service area. MCV currently participates in each of the three Options HMOs (Virginia Chartered Health Plan, Optimum Choice, and Southern Health Services) in Central Virginia. The only services carved out of these contracts are vision services under Southern and home health from Optimum Choice. EVMS provides physician services to a number of hospitals in Eastern Virginia, but does not own or operate a hospital as do MCV and UVA. EVMS officials indicated that while there was a serious concern regarding access to certain Medicaid patients when Medallion II was first implemented, this issue has been resolved. However, EVMS officials indicated concern about possible reductions in Medicaid patients in the future.

Future HMO Networks: The chief concern expressed by the AHCs with respect to retaining Medicaid patients is that they may be left out of future HMO networks. As Medallion II areas expand resulting in HMOs providing services to more Medicaid clients, and as the competition among the HMOs for covered lives increases, the AHCs fear that they will be excluded from these networks. To the degree they are excluded, the amount of enhanced DSH payments likely will be reduced creating further financial problems.

MCOs And Other Medicaid Providers Have Some Concerns Regarding Actions To Require Inclusion Of AHCs In Medicaid Networks

The HMOs have less concern regarding actions to increase the AHC's Medicaid utilization than they do regarding any action to include the AHCs in the networks of HMOs participating in the state employee health benefits program. While the AHCs currently participate in most Medicaid HMOs, there is still some concern on behalf of the managed care organizations that restrictions

on network development may hamper their efforts to develop cost-effective networks in the future. Also, other Medicaid providers, some of whom have treated the Medicaid population for many years, likely would be concerned that such a provision would reduce the number of Medicaid patients they treat.

Another Potential Action Identified By MCV Would Be For The Medicaid HMOs To Reimburse The AHCs At A Rate No Lower Than The Highest Negotiated Payment Level For Any Similar Physician Or Hospital

MCV has suggested that another means of supporting the AHCs would be to include a provision in the Medicaid HMO contracts that would require the AHCs to be reimbursed at a rate no lower than the highest negotiated payment level for any similar physician or hospital. This would provide the AHC with a type of "most favored nation" level of reimbursement.

This provision ultimately may have an impact on the cost of the Medicaid program. Currently, the capitation rates paid to the HMOs are based on historical claims data irrespective of the reimbursement that HMOs pay to providers. However, if paying the AHCs a level no less than the highest rate paid to other providers increases the HMOs' costs, they likely will come to DMAS for an increase in their capitation rates.

Other providers not entitled to this level of reimbursement likely would be opposed to taking such an action. Also, the HMOs would argue this reduces their ability to develop cost-effective networks.

Based On Limited Available Information, It Does Not Appear That Similar Actions Have Been Taken In Other States

A review of the literature pertinent to AHCs, and discussions with the staff of the American Association of Medical Colleges (AAMC) did not identify any other state which had taken similar actions to require the inclusion of AHCs in their Medicaid HMOs. However, it should be recognized that this finding is based on limited information.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue. Also, in some instances, the policy options may not be mutually exclusive of one another; combinations of certain options can be implemented.

Option I. **Take no action.**

Option II. **Introduce legislation to require that managed care organizations participating in the state employee health benefits program include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out") for all products offered by the MCO.**

- An alternative course of action would be to require the MCOs to include the AHCs as fully participating providers only in those products offered through the state program.

- This requirement would apply only to those managed care organizations whose service area includes an academic health center.

Option III. **Introduce a budget amendment directing the Department of Medial Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out").**

- This requirement would apply only to those HMOs whose service area includes an academic health center.

Option IV. **Introduce a budget amendment directing the Department of Medical Assistance Services to implement a procedure wherein Medallion II clients currently assigned to HMOs on a random basis be assigned to an HMO which includes the academic**

health centers in their networks as fully participating providers (i.e., no services to be "carved out").

- This requirement would apply only to those HMOs whose service area includes an academic health center.

- A variation of this option would be to direct DMAS to make the assignments to the HMO which has the highest percentage of admissions at the AHC.

- This action could be expanded to the Options program if DMAS' waiver is approved by the federal Health Care Financing Administration.

Option V. **Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to reimburse the academic health center(s) at a rate no lower than the highest negotiated payment level for any similar physician or hospital.**

- This requirement would apply only to those HMOs whose service area includes an academic health center.

Option VI. **Introduce a joint study resolution directing the Joint Commission on Health Care, in cooperation with the House Appropriations and Senate Finance Committees, to conduct a more comprehensive study of the academic health centers. The focus of the study would be to analyze the current and future financial and operational issues affecting the AHCs in a competitive marketplace, and to identify strategies that the Commonwealth and the AHCs could take to improve their long-term viability.**

APPENDIX A

SENATE JOINT RESOLUTION NO. 108

Directing the Joint Commission on Health Care to study the participation of academic health centers in managed care provider networks.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the health insurance marketplace continues to change at a rapid pace in response to market demands for quality health care services at reasonable costs; and

WHEREAS, managed care has become the dominant form of health insurance coverage in the United States and Virginia as evidenced by the number of employers offering managed care plans to their employees and the transition of many government-sponsored programs, such as Medicare and Medicaid, to managed care plans; and

WHEREAS, there has been significant growth in recent years in the number of Virginians with health insurance coverage through health maintenance organizations; and

WHEREAS, market trends indicate that there will be continued growth in managed care plan enrollments; and

WHEREAS, academic health centers (AHCs) often are viewed primarily as tertiary care providers in managed care provider networks due to their prominence as referral centers, their specialty composition, research expertise, and the socioeconomic status of the patients located near the centers; and

WHEREAS, the selective contracting practices of many managed health care organizations have resulted in the Commonwealth's AHCs being included in a number of managed care provider networks only as tertiary care providers; and

WHEREAS, the state Medicaid program and the state employee health benefits program contract with managed care organizations to provide insurance coverage and health care services to a large number of Virginians; and

WHEREAS, there may be opportunities for the state Medicaid program and the state employee health benefits program to include provisions in their contracts with managed care organizations to enhance the ability of the AHCs to participate more fully in managed care provider networks; and

WHEREAS, there may be other strategies and actions that can be taken to improve the ability of the AHCs to participate more fully in managed care provider networks; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study the participation of academic health centers in managed care provider networks. The Commission shall, in cooperation with the academic health centers, the Department of Medical Assistance Services, the Department of Personnel and Training, and the Virginia Association of Health Maintenance Organizations, identify and analyze various opportunities to enhance the ability of the AHCs to participate more fully in managed care provider networks. The study shall include, but not be limited to, a cost-benefit analysis of the feasibility of (i) requiring managed care organizations that bid on the state employee health benefits program to include the AHCs as fully participating network providers in all products offered by the managed care organization and (ii) assigning Medicaid recipients enrolled in a mandatory managed care program, such as Medallion II, to a health plan that includes AHCs as fully participating network providers in those instances when the enrollee has not chosen another health plan.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: PARTICIPATION OF ACADEMIC HEALTH CENTERS IN MANAGED CARE NETWORKS STUDY (SJR 108)

Individuals/Organizations Submitting Comments

A total of 5 individuals and organizations submitted comments in response to the draft issue brief on participation of academic health centers in managed care provider networks.

- Virginia Commonwealth University/Medical College of Virginia (VCU/MCV)
- Jill Hanken, Virginia Poverty Law Center
- Virginia Association of Health Plans
- Virginia Hospital and HealthCare Association
- Trigon, BlueCross BlueShield

Policy Options Included in the Academic Health Centers Issue Brief

Option I. **Take no action.**

Option II. **Introduce legislation to require that managed care organizations participating in the state employee health benefits program include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out") for all products offered by the MCO.**

- An alternative course of action would be to require the MCOs to include the AHCs as fully participating providers only in those products offered through the state program.

Option III. **Introduce a budget amendment directing the Department of Medial Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to include the academic health centers (hospital and faculty practice plans) in their provider networks as fully participating providers (i.e., no services to be "carved out").**

Option IV. **Introduce a budget amendment directing the Department of Medical Assistance Services to implement a procedure wherein Medallion II clients currently assigned to HMOs on a random basis be assigned to an HMO which includes the academic health centers in their networks as fully participating providers (i.e., no services to be "carved out").**

- A variation of this option would be to direct DMAS to make the assignments to the HMO which has the highest percentage of admissions at the AHC.

Option V. **Introduce a budget amendment directing the Department of Medical Assistance Services to include a provision in their contracts with health maintenance organizations (HMOs) that requires the HMO to reimburse the academic health center(s) at a rate no lower than the highest negotiated payment level for any similar physician or hospital.**

Option VI. **Introduce a joint study resolution directing the Joint Commission on Health Care, in cooperation with the House Appropriations and Senate Finance Committees, to conduct a more comprehensive study of the academic health centers. The focus of**

the study would be to analyze the current and future financial and operational issues affecting the AHCs in a competitive marketplace, and to identify strategies that the Commonwealth and the AHCs could take to improve their long-term viability.

Overall Summary of Comments

Virginia Commonwealth University expressed strong support for Options II, III, IV and V citing financial and market pressures which continue to threaten the traditional missions of the academic health centers (AHCs). Jill Hanken commented that reasonable steps should be taken to assist the AHCs retain their patient base which is needed for disproportionate share hospital (DSH) payments and their teaching mission. However, she expressed concern that Medicaid recipients must retain the right to choose a managed care plan that meets their particular needs and desires.

The remaining three commenters expressed recognition and understanding of the pressures facing the AHCs, but recommended either Option I or Option VI (further study) rather than taking any of the steps proposed in Options II, III, IV, and V.

Summary of Individual Comments

Virginia Commonwealth University/Medical College of Virginia (VCU/MCV)

Sheldon M. Retchin, M.D., Associate Vice President for Clinical Enterprises, commented that while all providers face similar threats from a competitive marketplace, VCU/MCV and the other AHCs carry the vast majority of responsibilities for indigent care and education. Dr. Retchin summarized many of the unique challenges the AHCs face with respect to the financial burden of indigent care, the impact of adverse selection of sicker patients to the AHCs, and selective contracting by managed care organizations (MCOs). Dr. Retchin also commented that VCU/MCV has taken a number of steps to remain competitive and responsive to patient care needs, including: (i) reducing costs wherever possible and a reduction in its workforce by more than a 1,000 positions, (ii) providing increased

access to care through satellite clinics; (iii) increasing access for uninsured patients; and (iv) improving the quality of care provided at the hospital.

Dr. Retchin responded to several of the issues included in the staff report that were raised by MCOs, including (i) contract "carve-outs;" (ii) exclusive contract arrangements; (iii) the impact of requiring AHCs to be included in MCO networks; and (iv) "most favored nation" reimbursement requirements.

Dr. Retchin commented that VCU/MCV strongly supports Option II and that it would endorse a proposal that limits the inclusion of the AHCs only in those MCO networks used in the state employee health benefits program. VCU/MCV also strongly supports Options III, IV and V. Dr. Retchin suggested that Option IV be modified such that Medallion II clients currently assigned to HMOs on a random basis would be assigned to HMOs proportionate to the admissions to MCV Hospitals.

Jill Hanken, Virginia Poverty Law Center

Jill Hanken, Staff Attorney, commented that it is appropriate that Virginia take steps to assist the AHCs. She indicated that reasonable steps should be taken to help the AHCs retain the patient base needed for disproportionate share hospital (DSH) payments and their teaching requirements. Ms. Hanken noted a concern that Medicaid recipients must retain the right to choose a managed care plan that meets their particular needs and desires. She further noted that the opportunity to select alternative providers must be preserved. She commented that a modified Option IV would be a reasonable step. Her suggestion would be that Medallion II clients who are assigned on a random basis would be assigned to an HMO which includes the AHC; however, limited carve outs would be permitted.

Ms. Hanken also commented in support of Option VI for further study of this issue.

Virginia Association of Health Plans (VAHP)

Mr. Mark C. Pratt, Executive Director, commented that the VAHP is opposed to the policy options (Options II, III, IV, and V) that would have

the effect of impeding the ability of health plans to negotiate provider contracts in the open market. Negotiating provider contracts in the competitive market enables MCOs to hold down costs and provide purchasers with lower premiums. Mr. Pratt noted that some MCOs may be less willing to participate in the state employees' health benefits program if they are required to include the AHCs in all of their product networks.

VAHP supports Option I or, in the alternative, Option VI. Mr. Pratt suggested that should a comprehensive study of the AHCs be undertaken, the impact of the various policy options presented in the issue brief also be evaluated before Virginia pursues such a course of action.

Virginia Hospital and HealthCare Association

Catherine C. Hammond, Vice President, commented that because of the complexity of these issues the VHHA recommends Option VI. Ms. Hammond, noted that, in general, the VHHA questions whether state action dictating the inclusion of the AHCs in managed care networks would complement existing state policy to promote managed care plans. VHHA believes that competing health plans should be required to demonstrate they offer reasonable access to quality health services and that they should be held accountable for performance. But once a health plan accepts the responsibility of offering quality services, the VHHA believes it is unwise for the purchaser to dictate the inclusion of any particular subset of providers. Lastly, Ms. Hammond expressed concern over replacing market-based contracting with a noncompetitive method of assuring the participation of AHCs in managed care networks.

Trigon BlueCross BlueShield

Leonard Hopkins, Vice President, Public Policy Officer, commented that Trigon opposes policy options (Options II, III, IV and V) which inject government into the competitive marketplace and hamper the ability of MCOs to negotiate freely with providers. He noted that ultimately the consequences of such policies could be to increase the cost of health care and limit consumer choice. Mr. Hopkins also noted the complicating factor that UVA sponsors its own health plan and that MCV apparently plans to do the same. He noted that, under these proposals, MCOs would be

required to accord preferential treatment to hospitals that are associated with competitors.

Mr. Hopkins commented that Trigon supports Option I. In the alternative, Trigon believes a study (Option VI) should be completed before consideration of any of the other specific policy options.

JOINT COMMISSION ON HEALTH CARE

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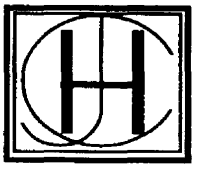

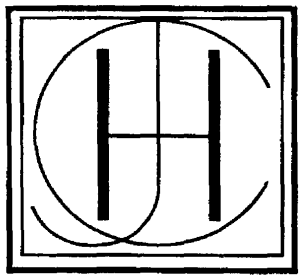

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