Section Three –
Medicaid Issues –

MANAGED CARE STRATEGIES FOR THE NORTH CAROLINA MEDICAID PROGRAM

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Issue Statement

In 1991, 32 states have in place a managed care plan for at least a portion of their Medicaid recipients. About 11 percent of all beneficiaries were enrolled in these managed care plans, covering 2.8 million recipients. The federal government and state governments continue to advance managed care plan initiatives to promote innovative service delivery and financial payment systems for rendering acute health care with the intent of containing costs and enhancing quality of care. Some states also moving toward managed care strategies to more cost-effectively manage long-term care services.

Managed care is one of the most successful strategies for overall control over the program. This paper assesses another option for North Carolina.

Background

Medicaid managed care programs vary significantly among the states. Some states have limited managed care programs, including North Carolina, which offers primary care case management in 12 of the State's 100 counties in addition to contracting with a Health Maintenance Organization (HMO) for a small percentage of the Medicaid population. Some states, like Arizona and Oregon, have developed broad-based capitation programs statewide. Lastly, some of the larger states, including California, Texas and New York, are phasing in managed care, capitation programs on a county-by-county basis.

There is no consensus as to the ideal managed care program model. A multitude of factors at the state and local community levels shape the scope, structure, and governance of a managed care program. Managed care is being adopted by government policymakers and administrators across the country as a comprehensive and coordinated system of medical and health care delivery. From a government perspective, there are seven principal reasons for embracing a managed care model for Medicaid recipients:

- Managed care is public-private partnership that draws on the strengths of the existing provider networks and organizations to mainstream recipients' care.

- Managed care emphasizes quality of care for its members by encouraging provision of prevention and wellness care, such as prenatal care, immunizations, and checkups, which are critical services for the women and children served by Medicaid.

- Managed care makes efficiency a cornerstone of the program by requiring coordination of care through a physician gatekeeper, prior authorization and utilization review by independent practitioners, and quality management reviews and studies of its contracting health care organizations.

- Managed care provides the economic incentives and oversight to promote the least restrictive, but most appropriate, level of care, thus containing cost.

- Managed care employs the competitive bid process for the purchase of care and to control the increase in rates for services.

- Managed care enables government to better plan and predict its budget for Medicaid by determining the capitation amount to pay prospectively for each member and to hold the contracting organizations at risk financially for the care of its members.

- Managed care reduces administrative costs for government because a prospective capitation payment is less labor intensive than processing and reconciling a tremendous claim volume. Additionally, the contracting managed care plans are responsible for coordinating the delivery of care instead of government employees.

Managed Care Models

Most managed care programs can be classified into one of four models:

1. Primary Care Case Management
2. Health Insuring Organization
3. HMOs - Voluntary Enrollment
4. HMOs - Mandatory Enrollment

The following section describes each of these classic managed care models. This section also discusses two less traditional managed care models, selective contracting and specialty population models.

- **Primary Care Case Management (PCCM)**

  North Carolina recently implemented a primary care case management (PCCM) managed care model in 12 counties, called Carolina Access. The State researched PCCM models in other states prior to development of Carolina Access, drawing on the strengths of other states' programs.

  In concept, the PCCM approach identifies a single provider responsible for coordinating and monitoring all care needed by a recipient. The primary care case manager is generally a primary care physician (PCP), who receives a case management fee, usually around $3, per recipient, per month. The PCP functions as a "gatekeeper" to control the flow of services. The PCP must provide primary care and except in an emergency, must authorize all other care provided to the recipient, including hospital and specialty care. The PCP must be available by telephone 24 hours a day, 7 days a week, to manage the care provided.

In the typical PCCM arrangement, recipients choose from a list of participating physicians (usually a general or family practitioner, pediatrician, obstetrician, or internist). Some states permit other health providers to enroll as PCPs, including outpatient hospital clinics, health clinics and nurse practitioners.

In Maryland, for example, access to primary care physicians has always been a problem. The State did not have a significant number of primary care physicians available to implement a PCCM. To remedy the situation, hospitals were allowed to enroll as primary care providers. The State is monitoring utilization to ensure hospitals are serving as "gatekeepers", and very preliminary findings suggest hospitals are serving effectively as gatekeepers. In North Carolina, outpatient hospital clinics are allowed to enroll as primary care physicians.

Recipient participation can be either voluntary or mandatory. Under many voluntary approaches, however, recipients are "locked in" to the physician they choose for a specific period of time, and can change primary care physicians only for certain specified reasons, for example, if they relocate.

Mandatory approaches require a panel of physicians large enough to serve the needs of the Medicaid population participants. Mandatory approaches require that the State obtain a waiver of freedom of choice.

In general, PCCM approaches include only the basic physician services. Alternatively, these approaches may be expanded to include laboratory and radiological services, as well as prescription drugs. While hospital services are normally not covered under PCCM contracts, some states have tried shared savings contracts. These allow PCPs to receive bonuses when inpatient and specialist use is less than expected.

Payment to providers under the PCCM model can be made on either a fee-for-service or capitation basis. Most PCCM programs, including Carolina Access, generally use fee-for-service reimbursement. The main advantage to fee-for-service reimbursement is that the State does not have to make any changes to its rate system or perform any rate calculations. Cost containment relies, therefore, on the reduction in utilization, although there are generally not penalties for failing to reduce utilization, or rewards for improving the appropriateness of referral.

Under capitation arrangements, the PCPs are paid a capitation amount to cover the basic primary care services. This option provides greater cost containment for the State because capitation payments are generally set at 95 percent of the fee-for-service rates.

PCCM arrangements have produced "significant effects on service use and delivery patterns in virtually all of the [demonstration] programs" according to investigators (Paul, Freund, et. al., 1987). In particular, many PCCM programs have demonstrated cost savings through the reduced utilization of the hospital emergency room. Growth in expenditures per eligible for outpatient hospital services was six percent lower in the twelve Carolina Access counties than comparison counties.

Some states have not experienced the same results. A mandatory PCCM in Maury County in Tennessee, for example, was not cost-effective. Although physicians were paid a $3 case management fee, they rarely turned away requests for specialist care. Paperwork alienated physicians. In Connecticut, a Primary Care Network resulted in increases in charges for physician, pharmacy, laboratory, radiology, and other services that were not offset by a drop in inpatient costs.

PCCM programs require considerable time and money to establish, and administration of the program can be difficult. Information systems at the PCP level are generally lacking, which hampers the gatekeeping function of the individual PCP and the monitoring and evaluating role of the State. As a result, this type of managed care initiative has been criticized for its failure to accomplish effective managed care controls.

Kentucky, Kansas, Michigan, Colorado and Utah have been using PCCM approaches for many years. Michigan's Physician Primary Sponsor Plan is one of the largest programs. Kentucky's mandatory statewide program has achieved considerable savings since its implementation, primarily from reduced physician and emergency room utilization. Kentucky estimated savings of approximately $125 million over a five year period. The Kentucky Program covers outpatient and acute inpatient care, physicians, certain nursing services, home health, lab work, durable medical equipment and pharmacy services.

- **Health Insuring Organizations (HIOs)**

Medicaid regulations describe a health insuring organization as an entity that accepts the risk for medical services for recipients and pays for the services in exchange for a premium from the Medicaid state agency. HIOs do not provide care.

A number of states have developed HIOs, and they differ by state in the extent to which they "manage" care. Some HIOs, such as HealthPass in Pennsylvania, operate with strong management controls which include selection and credentialling of participating providers and physicians. They operate as if they were an independent practice association form of HMO. Other HIOs, such as in Texas and Indiana, merely perform fiscal claims processing services under Medicaid with limited incentive features for controlling costs. (The Indiana HIO model is being

eliminated). North Carolina contracted with a private firm to act as an HIO in the early years of the program. The HIO arrangement in North Carolina was unsuccessful primarily because the contractor underestimated cost per recipient and no provisions were made for additional expenditures necessary to accommodate changes in the scope of services covered.

Implementation of new HIOs by Medicaid agencies was severely curtailed by COBRA 1985, which required HIOs to enroll a non-Medicaid population of at least 25 percent and permit disenrollment on demand. These requirements have virtually ended new HIO development.

- **HMOs - Voluntary Enrollment**

Medicaid agencies in a number of states, including North Carolina, contract with HMOs and other prepaid health plans on a capitated basis for Medicaid services. States must define in their State Plan what constitutes an acceptable prepaid health plan but have not been restricted to federally qualified HMOs since OBRA 1981. States have used OBRA to permit capitated contracts with community health centers (CHCs) and their organizations that meet the requirements of their State Health plan.

This managed care model permits eligibles to access comprehensive, coordinated delivery systems, and mainstreams recipients to the extent that the prepaid health plan also enrolls persons from the private sector.

The voluntary enrollment prepaid health plan model is perhaps the easiest for a state to implement and can be initiated without obtaining federal waivers. Because the program is voluntary, recipients select between fee-for-service and available HMOs or other plans, and states do not have to seek a waiver of freedom of choice regulations. Enrollment is frequently limited to AFDC recipients, due to their somewhat more stable eligibility, patterns of utilization, and acceptability to HMOs.

A major issue for contracting HMOs under a voluntary program is the expense of marketing to eligibles and the limited eligibility of recipients, which necessitates a continual and extensive effort in this regard. HMOs may be less willing to participate in a voluntary enrollment program, as they will have to support the marketing expenses, have fewer enrollees than under a mandatory program, and may suffer from biased selection of certain high cost enrollees, particularly pregnant women in their third trimester.

Recipients may also have limited incentives to voluntarily enroll in HMOs unless access to care in the fee-for-service environment is severely compromised. To

overcome this reluctance, Illinois has added the negative incentive of copayments in the fee-for-service sector to encourage recipients to enroll in HMOs.

Other states are experimenting with offering guaranteed eligibility of six months to recipients who enroll. Ordinarily, states are required to redetermine Medicaid eligibility monthly. Often, Medicaid recipients lose eligibility several times during the course of a year's entitlement. Section 1902 (e)(2)(A) of the Social Security Act allows state Medicaid programs to adopt six-month extended eligibility for Medicaid recipients who enroll in either federally qualified or state-approved HMOs or prepaid CHCs. Many states have not adopted this policy, however, because of the additional costs to the Medicaid program, and because of the recordkeeping necessary on the part of state eligibility workers.

States utilizing voluntary HMO enrollment approaches include Illinois, New York, Maryland, Ohio, Florida and Iowa. Based on enrollment in states that have used this approach, only approximately 10-20 percent of the eligible Medicaid population can be expected to enroll in HMOs under a voluntary approach.

- **HMOs-Mandatory Enrollment**

The mandatory enrollment of Medicaid eligibles in qualified HMOs or other prepaid health plans is another approach being used by Medicaid agencies. Steps in implementing a mandatory enrollment program are more complicated than in a voluntary program, but there are also benefits to be gained.

Mandatory programs require that all eligible recipients select, within a given period of time, or be enrolled in, an HMO to receive Medicaid benefits. The Federal government requires that states wishing to establish mandatory programs seek a waiver of freedom of choice requirements. State agencies must waive the statewideness requirement if HMO enrollment is mandated only in specific areas of the state. Additionally, state agencies must waive the rule which requires non-Medicaid enrollment of 75 percent or greater, if they allow certain HMOs without extensive private enrollment to participate.

HMOs contract with a state Medicaid agency to assure the provision of a comprehensive set of Medicaid benefits, and agree to enroll a certain number of enrollees. Mandatory HMO enrollment programs are targeted to primarily urban areas where certain market and Medicaid criteria are met. The criteria include:

- A concentrated number of Medicaid eligibles, primarily AFDC recipients

- Considerable HMO or other prepaid health plan activity and growth

- Competitive market for HMOs, hospitals and physicians

The presence of competition and the availability of several plans to choose from is considered a critical quality control feature.

This alternative presents the potential for larger savings than the voluntary approach based on the number of enrollees and preference for running a one-tiered system of care. HMOs may prefer mandatory to voluntary enrollment of Medicaid recipients for several reasons:

- They are assured a greater number of enrollees, thereby gaining a solid population base and source of revenue.

- The typically high costs of marketing to a voluntary program are reduced, although not eliminated.

- The mandatory nature of the program reduces the potentially adverse selection of a small but costly group of eligibles. While there may still be biased selection within the HMOs available, the effect is mitigated by the large number of enrollees and by the random assignment of persons who fail to select an HMO.

Savings from these approaches is generally greater, because of the larger number of eligibles involved and the assurance that biased selection will not occur (for the program as a whole, although it may occur from plan to plan). Capitation rates are usually established at 90 to 95 percent of the fee-for-service level of expenditures. In addition, this approach allows for greater budget predictability.

States utilizing mandatory HMO enrollment include Minnesota, Wisconsin, New York, and Arizona. The Arizona Health Care Cost Containment System (AHCCCS) provides an example of a fully capitated and managed Medicaid program -- even long term care services are included.

■ Selective Contracting

Selective contracting does not fit the general typology of managed care, but it can be considered an approach to "manage care." This concept is discussed also in the inpatient hospital services issue paper.

Selective contracting is a method of establishing payment rates through the use of a competitive bidding process. In this approach, hospitals or other providers serve as contractors to the Medicaid program for the provision of services. This process may be used to set reimbursement rates regardless of the underlying form of payment

(per diem, per case, capitation, or fee schedule) and it may be used to determine all-inclusive inpatient and/or outpatient rates, or it may be applied to select services only.

Selective contracting programs may cover all recipients for a specific service (e.g., California's selective hospital contracting system). Or, selective contracting may apply to special groups of recipients (e.g., Virginia selectively contracts with providers who provide care to patients in need of ventilation therapy services).

- **Use of Managed Care for Special Needs Populations**

Generally, managed care initiatives have been targeted at the AFDC population. Specialty needs populations are generally not included in standard managed care initiatives because of the difficulties of setting capitation rates. Because stop-loss insurance protection for Medicaid recipients is either prohibitively expensive or impossible to obtain commercially, HMOs are further discouraged from providing care to these recipients. In addition, other populations, such as the elderly, physically handicapped, mentally ill, special needs children, and high-risk pregnant women are difficult to reach and often require specialty care which may not be readily accessible.

Managed care programs for specialty populations are most often developed for reasons other than cost containment. The South Carolina High Risk Channeling Program, for example, provides additional prenatal services to pregnant women. The Diabetes Care Program, implemented July 1991, in Maryland, is targeted toward diabetic patients. The program covers standard services as well as additional benefits, such as education courses and nutrition counseling, coordinated through select primary care physicians.

There have been limited efforts by states to serve Medicaid disabled eligibles in their managed care demonstration programs; those that have, encountered difficulties. In California, New York, and Minnesota, efforts to include the disabled population in demonstration projects were unsuccessful.

Another option made available to states through COBRA 1985, designed to improve the way they deliver services to their special needs patients, is to offer case management services as an optional Title XIX service. The legislation describes case management as helping recipients "gain access to needed medical, social, education, and other services". A National Governor's Association survey concluded, however, that "case management lacks a precise conceptual or operational definition. In the absence of a definition, case management typically describes a range of activities that can vary from routine, minimally professional referral

services, to primary nursing, to comprehensive care plan development, oversight, and monitoring."

Findings

Finding 1: North Carolina lags behind other states in its development of managed care programs.

The North Carolina public and private sectors are in the early stages of employing managed care programs for the delivery of health services. Nationally, 14 percent of the population is enrolled with health maintenance organizations, compared to 5 percent in North Carolina. Attitudes and perceptions of policymakers, providers and patients regarding managed care concepts combine to affect the development of managed care programs in the State of North Carolina.

Finding 2: Carolina Access is a positive step toward managed care.

Through Carolina Access, the North Carolina Medicaid program has taken steps to introduce managed care concepts to providers and patients. Carolina Access does not put providers at risk for the cost of care delivered to enrollees. Nevertheless, mechanisms within the program encourage the appropriate utilization of health care services. Carolina Access enrolls primary care physicians to coordinate the care of Medicaid patients. Patients are required to contact their primary care physicians prior to obtaining all non-emergency health care. Carolina Access has produced savings for the Medicaid program due to reduced utilization of services. The Division of Medical Assistance estimated a $3 million savings over a five-month period in the twelve counties enrolled in the program.

Finding 3: Managed care programs offer several advantages over traditional fee-for-service arrangements.

A managed care program in North Carolina would address the following objectives:

1. Promote early diagnosis and treatment for preventive health
2. Shift care from hospitals to physician offices and clinics
3. Stabilize and contain the escalation of Medicaid costs
4. Enable clients to form primary care contact with physicians
5. Ensure patient access to care
6. Improve the quality of care

Recommendations

Recommendation 1: Expand Carolina Access statewide and introduce elements of risk-sharing.

Due to the early success of the Carolina Access in the twelve participating counties, North Carolina should move to implement Carolina Access in all counties as quickly as possible. Additionally, the State should introduce elements of risk-sharing by implementing any of the following policies:

- Savings-sharing policy, whereby primary care providers share in the savings which result from appropriate and cost-effective utilization of other health services, including physician specialty services, prescription drugs and outpatient hospital services. The savings sharing provision could replace the $3 per recipient case management fee.

- Capitate payments for physician services to guarantee certain savings levels (generally, 5 percent of fee-for-service payments).

- Capitate payments for physician services, outpatient hospital services and prescription drugs to guarantee greater savings than those identified above.

The savings-sharing provisions do not have the cost containment potential of the two capitation options, but they may be more appealing to physicians who are generally adverse to risk. The capitation options should, however, be a goal of the Medicaid program.

Implications:

- The Medicaid Program must continue to work with physicians to educate them regarding the importance of these managed care programs as they can improve quality as well as achieve cost savings.

- Savings sharing provisions may require enhanced management information reports on utilization of services. The Medicaid Management Information System must track utilization of groups of services used by specific recipients assigned to primary care physicians. Some of these reports are being generated now to monitor Carolina Access.

- Under a savings sharing provision, physicians would give up the $3 case management fee. Savings potential is greater, however, for the State; physicians' savings sharing amounts are likely to be higher.

- Utilization review is necessary to ensure that underutilization, i.e., inappropriate withholding of services, does not occur.

Recommendation 2: Develop a statewide managed care program by contracting with existing provider networks.

More than fifty rural hospitals and health clinics exist in the State of North Carolina. These hospitals play a key role in the community with regard to the delivery of all types of health care. These facilities would be excellent candidates to serve as contractors for the provision of all health care services. As contractors, the facilities would receive a capitated payment per Medicaid patient per month.

The facilities would have financial incentives to coordinate and manage the care of Medicaid patients. The State may limit the financial risk of the contractors by implementing a stop-loss provision, whereby each contractor's losses are limited to a fixed percentage of aggregate capitation payments.

Under this scenario, Carolina Access providers would be encouraged to participate through they're inclusion in provider networks.

Implications:

- Developing managed care options with rural hospitals and health clinics circumvents arguments that managed care is not viable in North Carolina because of rural health issues and lack of physician willingness to participate in the Medicaid program.
- Significant cost savings, improved quality and greater access can be achieved.
- This builds an existing network of providers who have demonstrated commitments to the North Carolina Medicaid program.

Recommendation 3: Evaluate the feasibility of statewide managed care programs for certain populations and certain regions of the State.

While the experiences of other states and research findings on managed care cannot replace an impact analysis that is specific to North Carolina, they can provide some guidance as managed care options are developed and evaluated. First, it is clear that no single model can accommodate all populations or geographic areas. Further, current research findings indicate that:

- No managed care program can be successful without physician and hospital acceptance and involvement.
- The greater the financial risk borne by the managed care program and providers, the greater the success in controlling utilization and cost.
- Long-term care should not be excluded from the feasibility study.

- States and counties must make investments in establishing the appropriate administrative systems for internal operations and external oversight.

While the feasibility study of managed care programs applicable to the North Carolina Medicaid environment requires additional up-front expenditures, evidence from other states is conclusive that saving can occur.

Implications:

- A strong message must be delivered to the provider community that managed care alternatives are viewed as the method to contain Medicaid program expenditures in the long-term. In the absence of managed care, the State may find it necessary to make the more arbitrary, painful changes to scope and eligibility described in Issue Paper 1.

- Short-term expenditures must be viewed as the trade-off to long-term care cost containment.

Overall Implementation Considerations

The detailed regulatory role of a fee-for-service system must change significantly with a managed care approach. In exchange for accepting financial risk, the provider is given considerable flexibility in decision-making. This freedom is essential to attract additional provider participation. This does not mean, however, that State abdicates its regulatory responsibilities. Regulatory oversight moves from an individual provider review to a more sophisticated organizational review with financial transactions and contractual compliance being the main focus. In short, the relationship between government and provider becomes more similar to private sector contractual relationships.

Risk definition sets the framework for the managed care model. The State must define a preliminary maximum expenditure per recipient, or budget cap. The model will require refinement in order to develop capitation amounts for each service and eligible type covered under the model. The State should determine in detail:

- How many eligibles will be enrolled in each managed care component during the contract period
- How many risk groups will be defined
- How "excess risk" will be defined and treated
- How risk and incentives will be shared

Capitation will reflect the per recipient cap based on provider bids. The providers will receive the capitation monthly per enrolled recipient by respective risk class. It is likely that the State will retain a portion of the risk for enrollment increases above counts anticipated. Once these questions are fully answered, program implementation can begin.

North Carolina officials must determine whether the interested provider organizations are qualified to serve the members and manage the financial risk. A qualified provider organization must meet the following conditions:

- Deliver all program covered services
- Demonstrate quality management techniques
- Establish a strong and accessible provider network
- Offer sufficient financial resources and reserves
- Establish managed care processes and controls
- Report utilization data and costs timely
- Administer an accurate financial reporting system

Provider organizations fail for financial and/or management system reasons. Financial reasons include undercapitalization, improper pricing of the risk, and erroneous reserve calculations. Management reasons include the absence of prior authorization and utilization review controls, and inadequate tracking and reporting of medical costs and utilization. These reasons for failure are important evaluation criteria for North Carolina to consider in qualifying a provider organization and in monitoring it once a contract has been executed.

Managed care operations require more than "minor" internal changes to the existing fee-for-service system program administration. Examples of new and far-reaching administrative directions and staff skills required under Medicaid managed care programs are described below.

- Recipient health plan enrollment will entail many of the functions involved in the Carolina Access program. In addition to assigning eligibles to a managed care contractor, the process in place for Carolina Access enrollment will be complicated under a full managed care program. Recipients must be tracked over at least the six-month guaranteed enrollment period.

- Recipient and provider grievance investigation and adjudication, including eligibility appeals and oversight of the appeals programs which the health plan contractors will implement, will be required.

- Developing the automated system will prove substantial. In addition to development of rates and tracking of assigned recipients' experience and provider care patterns, stop-loss reinsurance and multiple risk levels (children, pregnant women, aged, blind, handicapped) will be involved. Provider data, case management and health plan performance data also will require support.

- The Medicaid administration will need to focus oversight on under-utilization of prepaid services as opposed to the traditional concern regarding service over-

utilization. New policies and procedures for quality review and utilization review, as well as related systems support, will be required.

- Provider contracting and monitoring will become the a core Medicaid administrative activity. The development and maintenance of at-risk contracts, the competitive bidding process and incentive sharing will require implementation and on-going activity.

Once most of the managed care program policy decisions are resolved, the Medicaid administrators will begin to seek federal regulatory approval. The North Carolina Medicaid program has been successful in securing federal waivers. Four operating criteria for a managed care program require waivers. They are listed below.

- Guaranteed six-month program eligibility and lock-in of members to a managed care plan enabling the State and contractor to more accurately set capitation rates

- Federal contract qualifications for a health care provider organization and the State's interest to modify them

- Restriction of recipient freedom of choice to the providers within a contracting health plan

- A capitation reimbursement methodology and flexibility in the payment scheme

These waivers plus others have been granted to states seeking to operate Medicaid managed care programs.

In addition to federal regulatory approval, the mandatory managed care scheme and the capped Medicaid budget will require the approval of the North Carolina legislature.

Cost Savings

Actual cost savings for implementing a managed care program will vary depending on the payments for services, utilization of services by recipients and the number of individuals who will participate in the managed care program. However, other states' experience with managed care has resulted in:

- Five percent reduction over fee-for-service expenditures for medical and long-term care services

- High implementation costs the first two years on the program due to increases in recipients and administrative costs

- Phasing in population groups over a five year period is preferred versus attempting to include everyone during the first year of implementation.

Based on other states' experience, North Carolina would experience an initial expenditure of $800,000 in the first year of implementation. However, by year three, actual State savings would be approximately $47.9 million. The estimated savings over the ten-year period would be $2.5 billion.

Exhibit 1 presents estimated savings that would result from a statewide managed care program, including statewide expansion of the Carolina Access program. Savings results from immediate expansion of Carolina Access are present in the physician services issue paper.

EXHIBIT 1

NORTH CAROLINA MEDICAID EXPENDITURES (In Millions)

Managed Care	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current System Expenditures	$670.0	$804.0	$964.8	$1,157.8	$1,389.3	$1,667.2	$2,000.6	$2,400.7	$2,880.9	$3,457.1
Managed Care System Expenditures	$670.0	$804.0	$918.4	$1,074.5	$1,246.0	$1,457.8	$1,705.6	$1,995.6	$2,334.8	$2,731.7
Implementation Costs	0.8	1.2	1.5	1.5						
Savings Per Year	($0.8)	($1.2)	$47.9	$84.8	$143.3	$209.4	$295.0	$405.2	$546.1	$725.3
Cumulative Savings	($0.8)	($2.0)	$45.9	$130.7	$274.0	$483.4	$778.4	$1,183.6	$1,726.7	$2,452.0

Assumptions

- Implementation date, non long-term care: FY95
- Implementation date, long-term care: FY97
- Managed care model will achieve a five percent reduction over fee-for-service expenditures for non long-term care in FY95
- Managed care model will achieve a five percent reduction over fee-for-service expenditures for long-term care in FY96
- Assumes twenty percent annual growth under current system, seventeen percent under managed care model