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Health Care Strategies, Inc.

Resource Paper

*Understanding the Influence
of Publicly Traded Health Plans
on Medicaid Managed Care*

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The Center for Health Care Strategies (CHCS) is a national non-profit organization devoted to improving the quality of health services for beneficiaries served by publicly financed care, especially those with chronic illnesses and disabilities. CHCS works directly with state and federal agencies, health plans, and providers to design and implement cost-effective strategies to improve health care quality.

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Foreword

The Center for Health Care Strategies (CHCS) regards this study as an important contribution to our collective understanding of the dynamics of the Medicaid managed care marketplace. As the authors make abundantly clear, large publicly traded plans — including “the pure plays” as well as a few multi-line commercial plans — have emerged over the past five years as central players in a robust marketplace — a marketplace that, by most accounts, is delivering better access and better care to roughly 30 million low-income Americans than they would get in traditional, unmanaged fee-for-service Medicaid. In so doing, these health plans are offering states budgetary predictability and investors a measure of profitability that might, parenthetically, have its limits — both financial and political.

CHCS itself is particularly interested in improving quality in publicly financed care and in the degree to which these cross-state plans could present opportunities for standardizing provider performance and for spreading best practices to millions of consumers. CHCS also believes that the emergence and dominance of these plans can, and should, goad state purchasers to raise their contractual expectations for performance and for quality improvement. Although the jury still appears to be out on the willingness — and the capacity — of these plans to lead the market toward higher standards of care, the presence of the plans gives states a relatively stable set of infrastructure-rich organizations with which they can develop advances in *encounter data reporting and analysis, rate setting and risk adjustment, disease and care management for special-needs populations, and performance monitoring, transparency and disclosure*. In short, the presence of the pure play plans — and their large publicly traded siblings with multiple business lines — gives states the kind of capable national business partners available to Medicare and commercial purchasers. Indeed, because of the sheer size of Medicaid and the concentrations of these plans in certain markets, their presence could give Medicaid the opportunity to lead regional efforts to improve quality across the health care system.



Stephen A. Somers, PhD
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Executive Summary

Introduction

Publicly traded firms have increasingly exerted influence on Medicaid managed care over the past five years. In mid-2006, nine investor-owned, multi-state companies represented about one-quarter of all plans and about one-third of the beneficiaries in Medicaid managed care plans. Expanded presence of the publicly traded firms merits thoughtful, objective assessment. The activities of these firms, and their strong interest in growth, have bolstered the Medicaid market in several states by favorably influencing state policies and payment rates, by increasing the numbers of bidders and contractors, and by enabling some states to launch in, or expand programs to, new populations and new geographic areas. On the other hand, the magnitude of profits made by some of these firms has raised concerns in the policy community. A broader concern is the possibility that if this line of business does not demonstrate the growth in earnings expected by investors, the firms could fail and/or exit the Medicaid market, leaving states in a difficult position.

Study Approach

The influence of publicly traded or multi-state investor-owned plans (terms used interchangeably in this report) on Medicaid managed care was studied by performing four related tasks:

- Task 1.** Documenting market participation trends.
- Task 2.** Reviewing the most recent financial and non-financial performance indicators.
- Task 3.** Conducting interviews in seven states with substantial publicly traded firm participation.
- Task 4.** Interviewing 26 selected Medicaid policy and managed care experts.

Task 1: Plan Participation

From the CMS Medicaid web site, we identified 218 health plans that participated in Medicaid and insured more than 5,000 enrollees in 2004, the last year for which national data are available. In the entire population of 218 plans, the data indicated that “pure play” (investor-owned and Medicaid-focused), publicly traded plans accounted for 11% of the plans and that 26% were publicly traded. The total Medicaid enrollment for pure play health plans was 2,428,142, or 13% of the total Medicaid membership. Among all publicly traded plans, the total Medicaid enrollment was 5,634,427, or 32% of the entire Medicaid population. The percent of Medicaid managed care enrollees covered by publicly traded companies in five states — Indiana, Maryland, New Jersey, Washington, and Wisconsin — was between 50% and 58%. In two states, Texas and West Virginia, enrollment was 60% and 62%, respectively. In Connecticut, Illinois and Florida, enrollment was 82%, 87%, 89%, respectively. Publicly traded plans in Kansas had 100% enrollment.

Task 2: Financial and Non-Financial Performance Analysis

Financial Performance Indicators Summary

The analysis of financial data from 168 plans revealed three trends:

- Pure play publicly traded plans earned higher profit margins than non-pure play plans. Higher profits were driven by their significantly lower medical benefit ratios, rather than by lower administrative cost ratios.
- Publicly traded plans, both pure play and those with a commercial and Medicaid product mix, had higher administrative costs (plan salaries and benefits, marketing, claims processing, etc.) than plans that were not within these two categories.
- Publicly traded plans had significantly lower medical benefit ratios and higher administrative cost ratios than non-publicly traded plans. Lower medical benefit ratios contributed to their higher profitability.

Non-Financial Performance Analysis Summary

The results of this analysis must be viewed cautiously because of the small numbers of plans in the database relative to the financial indicators. The representativeness of self-reporting plans is problematic for both publicly traded and non-publicly traded firms. Some publicly traded firms are not included in any of these analyses because the plans did not publicly report data. The small number of non-publicly traded firms that permitted public reporting were larger, more well-established plans, and might not be typical of that sector of the market, either. Finally, the measures selected for presentation are only a subset of all available measures from the National Committee for Quality Assurance (NCQA) Quality Compass.

- CAPHS and HEDIS indicators do not indicate a consistent pattern of differences between publicly traded and non-publicly traded health plans. Satisfaction scores were slightly higher among the self-reporting non-publicly traded plans, but self-reporting publicly traded firms were equal to or slightly higher than the non-publicly-traded firms on some the HEDIS indicators. The indicators reported for both types of plans were comparable to those published as NCQA Medicaid benchmarks.
- The relatively small number of plans that voluntarily made available uniform non-financial performance information underscores the need for stronger requirements for transparency for all plans.

Task 3: State-Level Perspectives on Contracting and Performance

We conducted telephone interviews with state officials and health plan executives in seven states: Florida, Georgia, Indiana, Maryland, New Jersey, Texas, and Washington. We selected these states to include different regions and different stages of Medicaid managed care contracting. We also selected states with different numbers and types of Medicaid managed care plans, including multi-state investor-owned plans. The interviews covered many facets of plan operations and performance; the principal findings from these interviews are summarized below.

Task 4: National Perspectives

Twenty-six national experts on Medicaid policy and Medicaid managed care issues were interviewed regarding the growth of investor-owned plan participation and its implications. Approximately one-third of them had broad Medicaid knowledge, one-third had more detailed understanding of the Medicaid managed care market (including researchers and consultants), and one-third were senior executives from health plans and multi-state firms. The wide-ranging perspectives collected in the interviews are reported and major findings are also incorporated below.

Study Conclusions and Implications

Key findings from this study:

- Increased participation of publicly traded managed care companies has firmed up the Medicaid market, expanding and enhancing contracting options for states.
- Multi-state, investor-owned firms have brought financial stability to the Medicaid managed care market and provided options for local owners, especially provider systems, to sell plans that are either underperforming or not consistent with system goals.
- State experience in contracting and performance monitoring has not identified any strong systematic concerns about the performance of investor-owned plans.
- While publicly traded firms bring added capital, resources, and infrastructure into Medicaid, there is no clear evidence based on publicly available data that their non-financial performance differs from publicly traded firms.
- The superior financial performance of publicly traded firms is due to significantly lower medical loss ratios. These might be the result of delivering care more effectively, or could reflect less provision of necessary care — either of which would be consistent with the more aggressive medical management attributed to these firms. It is also possible that these firms attracted lower-risk members as a result of the composition of the provider networks.
- The profitability of a number of these firms has leveled off and might be trending downward as medical expenses grow, raising questions about investor enthusiasm for this sector over the longer term.
- The mobility of these firms, investor pressure to increase enrollment and earnings, and the volatility associated with being publicly traded stock companies represent legitimate — albeit tolerable — sources of anxiety for states that have grown reliant upon them.

The report concludes by discussing a number of implications that can be drawn from the study's findings related to the growing influence of publicly traded Medicaid managed care plans.

Introduction

Publicly traded firms have exerted increasing influence on Medicaid managed care over the past four years. Four firms — Amerigroup, Centene, Molina, and Wellcare — that conducted initial public offerings since 2001 now operate 30 individual plans with 3.8 million members in 18 states. In addition, another five publicly traded managed care companies with other lines of business — United Healthcare, Wellpoint, Coventry, HealthNet, and Humana — have four million Medicaid members in 30 plans in more than 16 states. In mid-2006, these nine investor-owned, multi-state companies represented about one-quarter of all plans and about one-third of all beneficiaries in Medicaid managed care plans.

The expanded presence of the publicly traded firms merits thoughtful, objective assessment. The activities of these firms and their strong interest in growth bolstered the Medicaid market in several states, favorably influenced state policies and payment rates, increased the numbers of bidders and contractors, and enabled some states to launch or expand programs to new populations or new geographic areas. In addition, they acquired struggling plans or enticed the sale of other plans, particularly those owned by provider systems, with attractive purchase prices. On the other hand, the magnitude of profits made by several of these firms raised concerns in the policy community. Other observers noted that stock analysts' scrutiny and expectations for continuous growth in revenues and income made it imperative for these firms to grow — and, perhaps, to overestimate their ability to serve the full range of lives they were accumulating. A broader concern lies with the possibility that if this line of business does not meet investor expectations, the firms could fail and/or exit the Medicaid market, leaving states in a difficult position.

Several recent developments make the need for a balanced exploration of this issue more urgent.

- Last year's bid awards in Georgia, in which the three winning bidders for all of the state's regions were Medicaid-focused publicly traded firms, suggest that there might be a pattern of state preference for specialized firms.
- The involvement of several of these firms in Texas, Ohio, and Indiana enabled all three states to move ahead with major program expansions. This allowed Ohio to return to mandatory enrollment in all major cities for the first time in several years.
- A number of provider-sponsored plans are openly exploring the sale of their plans to these firms, given the increasing value of their membership.
- After a prolonged run-up in stock prices, and high acclaim from many analysts, both Molina and Amerigroup badly missed earnings in the second half of last year and experienced immediate, steep drops in the value of their stock, which spilled over to the other firms.

Study Approach

This study of the influence of publicly traded or multi-state investor-owned plans (terms used interchangeably in this report) on Medicaid managed care was conducted by performing four related tasks:

- Task 1.** Documenting overview market participation trends.
- Task 2.** A review of recent financial and non-financial performance indicators.
- Task 3.** In-depth interviews in seven states with substantial publicly-traded-firm participation.
- Task 4.** Interviews with 25 national Medicaid and health policy experts.

- Some analysts have suggested that the stumbles of these firms could be the result of overly-ambitious expansions that taxed their capabilities to manage their medical costs and resulted in deployment of too many resources toward expansion.
- More recent experience suggests renewed investor confidence in the sector.

Task 1: Plan Participation

Composition of Markets

Focusing our analysis on 2004 data, the last year for which CMS reported data were available, we evaluated Medicaid health plans that were either owned by publicly traded companies or publicly traded companies with primarily Medicaid line of business or pure play focus. We also examined other plan traits that were reported in our 2003 CHCS study: Medicaid distribution, provider-sponsorship status, Medicaid-focused and multi-product status.

We identified 218 health plans from the CMS Medicaid web site that participated in Medicaid and insured more than 5,000 enrollees. Table 1 presents the descriptive characteristics of these traits for all 218 health plans that participated in the Medicaid line of business. The table also shows the characteristics of the plans included in our subsequent performance analyses. Table 1 shows that a total of 168 plans had usable financial data and presents the plan traits for the 55 plans that reported CAHPS¹ satisfaction measures and 71 plans that reported clinical and access HEDIS measures.

The data indicate that pure play, publicly traded plans accounted for 11% of the 218 plans; 26% were publicly traded plans. The 168 health plans with financial data had similar traits except in two areas: they were overrepresented with publicly traded (31% vs. 26%) and pure play plans (13% vs. 11%). The plans with financial data were also weighted toward large Medicaid enrollment, with fewer plans in the bottom quartile of Medicaid enrollment (20% vs. 25%).

Table 1: CMS, Financial, CAHPS & HEDIS Data by Plan Traits

Plan Characteristics	CMS Number	Financial Number	CAHPS	HEDIS
Total Number of Plans	218	168	55	71
Total Medicaid Enrollment (median)	48,788	53,145	68,284	59,624
Sponsorship Status				
<i>Provider-sponsored</i>	32%	30%	36%	34%
<i>Non-provider sponsored</i>	68%	70%	64%	66%
Medicaid Focus Status (> 75%)				
<i>Medicaid Focused</i>	66%	63%	58%	62%
<i>Non-Medicaid Focused</i>	34%	37%	42%	28%
Pure Play Publicly Traded Status				
<i>Pure Play</i>	11%	13%	n/a	n/a
<i>Non-Pure Play</i>	89%	87%	n/a	n/a
Publicly Traded Status				
<i>Publicly Traded</i>	26%	31%	28%	27%
<i>Non-Publicly Traded</i>	74%	69%	72%	73%
Medicaid Distribution				
<i>Top 75th quartile</i>	25%	27%	29%	20%
<i>Median</i>	50%	53%	55%	55%
<i>Bottom 25th quartile</i>	25%	20%	16%	25%

¹ The CAHPS survey is technically a component of HEDIS, but will be identified separately in this report in order to distinguish it from the HEDIS non-consumer survey-based indicators.

Plans were assigned to one of three categories, based on their Medicaid membership distribution. Table 2 presents each category. Plans with Medicaid membership in the bottom 25th percentile had Medicaid membership less than or equal to 24,952. Medicaid plans with Medicaid membership in the top 75th percentile had Medicaid membership greater than or equal to 90,458.

Table 2: Level of Medicaid Membership by Size Categories

Level of Medicaid Membership Category	Medicaid Membership By Category	Median Medicaid Membership By Category
Top 75 th Percentile	>= 90,458	140,863
Median	Between 24,952 and 90,458	48,788
Bottom 25 th Percentile	<= 24,952	14,555

The majority of the publicly traded and pure play plans are accounted for in either the median or top 75th percentile. More than 95% of the pure play publicly traded plans were either in the median (54%) or top quartile (41%), while more than 83% of the publicly traded plans were in the median (46%) or top quartile (37%). The total Medicaid enrollment for pure play health plans was 2,428,142, or 13% of the total Medicaid membership. Among the publicly traded plans total Medicaid enrollment was 5,634,427, or 32% of the entire Medicaid population.

Investor-Owned, Multi-State Firms

In 2004, 28 states reported health plans owned by publicly traded plans that participated in Medicaid. United Healthcare Group, with plans in 12 states, had the highest number of plans participating in Medicaid. Eighteen states had health plans that were owned by pure play, publicly traded companies. Pure play firm Amerigroup had plans in six states and Centene, also pure play, had plans in seven states.

State Variation

The study aggregated health plan enrollment data to the state level in order to evaluate the influence of stock ownership and sponsorship status on Medicaid enrollment. Six states had more than 50% enrollment in pure play, publicly traded plans — Florida, Illinois, Indiana, Kansas Texas and Washington (Table 3). Five states — Indiana, Maryland, New Jersey, Washington, and Wisconsin — had between 50% to 58% enrollment; Texas had 60% and West Virginia had 62% enrollment. Connecticut (82%) Illinois (87%) and Florida (89%) and Kansas had the highest percent of enrollees in publicly traded plans.

Table 3: Sum Medicaid Market Share by Pure Play and Publicly Traded Plans

State	Non Pure Play Publicly Traded (%)	Pure Play Publicly Traded (%)	Non-Publicly Traded (%)	Publicly Traded (%)	Total Plans in State
Arizona	100.00	--	65.59	34.41	8
California	96.44	3.56	64.10	35.90	21
Colorado	100.00	--	100.00	--	2
Connecticut	91.55	8.45	17.93	82.07	4
Delaware	100.00	--	100.00		1
District of Columbia	56.05	43.95	56.05	43.95	3
Florida	25.36	74.64	11.36	88.64	10
Hawaii	100.00	--	100.00		4
Idaho	100.00	--	90.20	9.80	3
Illinois	41.80	58.20	12.64	87.36	5
Indiana	41.88	58.12	41.88	58.12	3
Kansas	--	100.00	--	100.00	1
Kentucky	100.00	--	100.00	--	1
Maine	100.00	--	100.00	--	4
Maryland	72.65	27.35	49.58	50.42	6
Michigan	89.78	10.22	71.38	28.62	16
Minnesota	100.00		100.00	--	8
Montana	91.41	8.59	51.88	48.12	8
Nebraska	100.00	--	--	100.00	1
Nevada	100.00	--	54.67	45.33	2
New Jersey	75.46	24.54	42.65	57.35	5
New Mexico	75.95	24.05	75.95	24.05	3
New York	96.63	3.37	90.69	9.31	23
North Carolina	100.00	--	--	100.00	1
Ohio	95.19	4.81	95.19	4.81	5
Oregon	100.00	--	100.00	--	10
Pennsylvania	100.00	--	87.15	12.85	8
Puerto Rico	100.00	--	74.28	25.72	3
Rhode Island	100.00	--	68.66	31.34	3
South Carolina	100.00	--	100.00	--	1
Tennessee	100.00	--	100.00	--	7
Texas	41.89	58.11	38.06	61.94	10
Utah	63.28	36.72	63.28	36.72	3
Virginia	100.00	--	57.36	42.64	7
Washington	47.30	52.70	47.30	52.70	5
West Virginia	100.00	--	39.95	60.05	3
Wisconsin	64.84	35.16	44.70	55.30	10

Task 2: Financial and Non-Financial Performance Analysis

Financial Performance Findings

Data Sources

Medicaid membership data were collected from the Centers for Medicare and Medicaid Services (CMS) web site, which lists plans participating in Medicaid and the Medicaid membership as of June, 2004 (Medicaid Managed Care Enrollment Report, 2004). Our population only included plans participating in Medicaid in 2004 that were located in 49 states (Alaska excluded) and Puerto Rico. Medicaid plans with CMS membership of fewer than 5,000 members were also excluded. Using these criteria, 218 plans were identified.

Licensed health plans' financial data were collected from National Association of Insurance Commissions (NAIC). Financial statements for unlicensed Medicaid health plans in Arizona, California, and New York were collected from state agencies. Arizona data were collected from the Arizona Health Care Cost Containment System. California data were collected from the California Department of Managed Health Care web site <http://wps0.dmhc.ca.gov/fe/search.asp>. New York data were collected from the Medicaid Managed Care Operating Report. The study included reliable and outlier-adjusted financial data on 168 of the 218 health plans.

The study used mean values to measure the financial performance and bivariate t-test comparisons to evaluate the mean differences among plan characteristics in the analysis of NAIC and state-collected financial data. The average value represents a mean value of a given trait across individual plans. Financial ratios were developed only from financial statements that complied with NAIC standards and the Medicaid line of business. As a result, these financial ratios might differ from the publicly released financial ratios of publicly traded companies, which are generated from 10-K files of the SEC and follow general accepted accounting principles (GAAP) of the Financial Accounting Standards Board (FASB).

Financial Performance Measures

Financial performance measures used three commonly-recognized and commonly-cited measures to evaluate the financial condition of health plans: operating margin, administrative cost, and medical loss ratios. These measures were computed only from financial data collected from the Medicaid line of business.

- **The operating margin ratio** measures the amount of Medicaid pre-tax operating income earned from Medicaid revenues. More importantly, it measures how well a plan controlled its medical and administrative expenses for the specific product line. The Medicaid operating income was computed by calculating the difference between Medicaid premium revenue and Medicaid medical and administrative costs. The profit margin ratio was computed by dividing Medicaid operating profits by Medicaid premium revenues.
- **The administrative cost ratio** measures the proportion of Medicaid revenue dollars paid for administrative expenses. The administrative cost ratio assesses how well a plan controls its administrative expenses relative to the revenue generated. Administrative costs include

the expenses incurred from salaries, marketing, rental, and related costs of operating the health plan, including claims adjustment expenses, which are primarily labor costs. The administrative ratio was computed by dividing Medicaid administrative costs by Medicaid premium revenue.

- **The medical benefits (loss) ratio** measures the proportion of revenue dollars paid for medical expenses. The medical benefits ratio gauges how well a plan controls its medical expenses relative to the revenue generated. The ratio can also be influenced by changes in the denominator (increases or decreases in Medicaid rates). The medical benefits ratio was computed by dividing Medicaid medical costs by Medicaid premium revenues.

The Overall Market

The average medical benefit ratio in 2004 was 86.5% among the sampled health plans participating in Medicaid. The average administrative cost ratio was 11.7%, and the average profit margin ratio was 1.8%. Our 2001 analysis of 183 health plans participating in Medicaid found an average medical benefit ratio of 84.1%, an average administrative cost ratio of 11.7%, and profit average margin of 4.2% — evidence that medical expenses for all the firms increased relative to premium levels. The finding is consistent with the effects of the recent recession, when states struggled to find resources to increase payments to plans.

Figure 1 compares the mean differences between publicly traded plans and non-publicly traded plans. At the .01 significance level, publicly traded plans reported significantly lower medical benefits ratios (84.9% vs. 87.2%) compared to non-publicly traded plans. Publicly traded plans also incurred statistically significantly higher administrative cost ratios than the non-pure play plans (13.0% vs. 11.1%). Publicly traded plans reported a slightly higher operating profit margin ratio (2.0% vs. 1.7%), which was not statistically significant. Higher administrative costs could have contributed to the lack of significant differences in operating profit margin ratios.

Figure 1: 2004 Financial Performance of Plans by Publicly Traded Status (168 Plans Reporting)

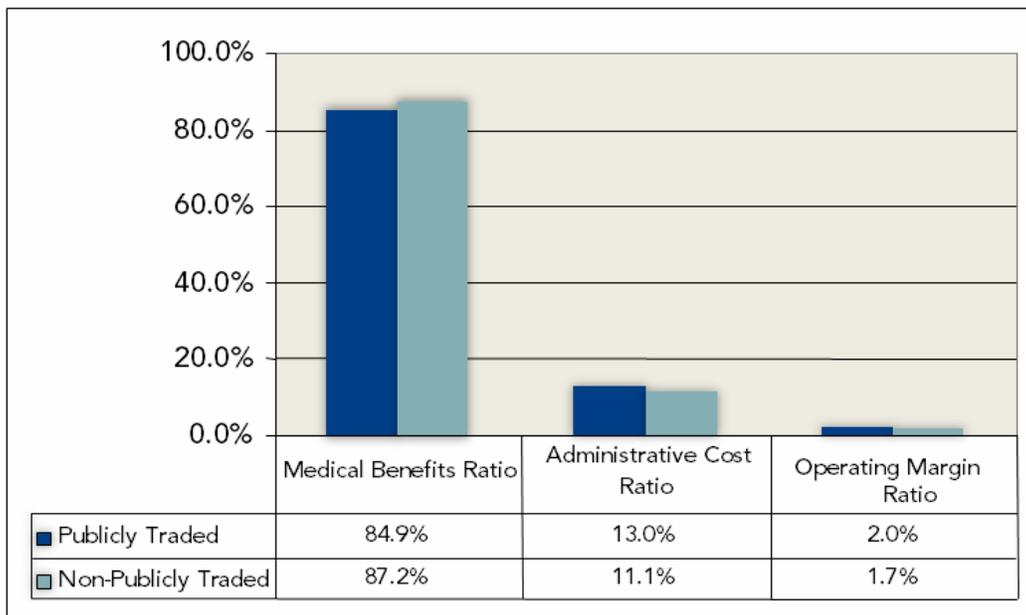
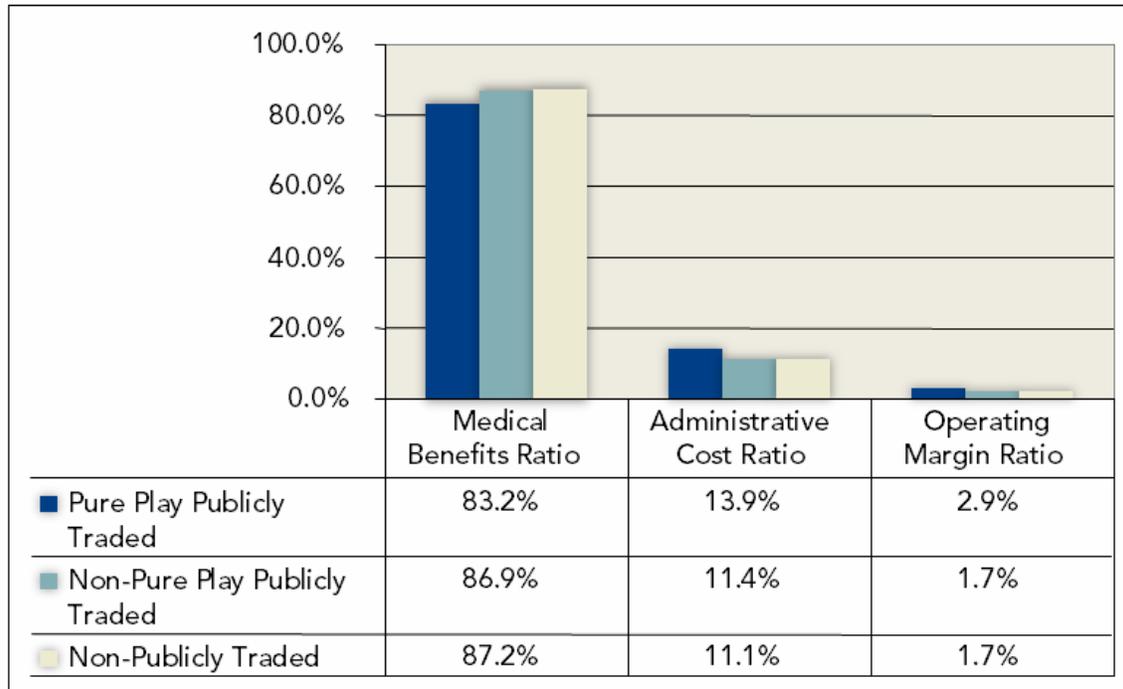


Figure 2 compares the mean differences between pure play publicly traded plans and non-pure play publicly traded plans. At the .01 significance level, pure play publicly traded plans reported a significantly lower medical benefits ratio (83.2% vs. 86.9%) than non-pure play plans. Pure play publicly traded plans also had statistically significantly higher administrative cost ratios than the non-pure play plans (13.9% vs. 11.4%). Pure play plans reported a higher operating profit margin ratio that was not statistically higher (2.9% vs. 1.7%).

Figure 2: 2004 Financial Performance of Plans by Pure Play Publicly Traded Status (168 Plans Reporting)



Financial Performance Indicators Summary

Our analysis revealed the following trends:

- Pure play publicly traded plans earned higher profit margins than non-pure play plans. Higher profits were driven by significantly lower medical benefit ratios rather than by lower administrative cost ratios.
- Pure play publicly traded plans and publicly traded plans incurred higher administrative costs (plan salaries and benefits, marketing, claims processing, etc.) than plans outside these two categories.
- Publicly traded plans incurred significantly lower medical benefit ratios and higher administrative cost ratios than non-publicly traded plans. Lower medical benefit ratios contributed to higher profitability.²

² Our financial ratios were developed from financial statements that comply with NAIC standards and the Medicaid line of business only. As a result, these financial ratios may not coincide with the publicly released financial ratios of publicly traded companies, which are generated from 10-K files of the SEC and follow general accepted accounting principals (GAAP) of Financial Accounting Standards Board (FASB). Accessing 2004 10-K data, average medical benefit, administrative and profit margin ratios for pure play publicly traded were as follows: 81.5%, 11.0% and 7.5%

Non-Financial Performance Findings

Data Source and NCQA Quality Compass Benchmark

The health plans from our initial population were merged with the health plans reporting quality of care indicators from the NCQA database. The measures are derived from the NCQA Quality Compass Edition 2005³ database, which includes member satisfaction and HEDIS 2004 clinical, access and utilization measures **for those plans that agree to allow their data to be attributed to them in public reports**. Fifty-five plans (one-quarter of all plans) from our initial database had reported satisfaction indicators, while 71 plans (less than one-third of all plans) had reported clinical and access indicators (see Table 1 for respondent characteristics). Given the small sample sizes, the study used median values to measure these indicators and median tests to compare differences among publicly traded health plans. Pure play publicly traded plans were not evaluated using these non-financial performance measures because of inadequate sample size.

NCQA data provide measures of quality of care that can be applied to Medicaid plan data. The measures include an overall rating of health, member satisfaction, access measures and selected clinical factors.

- **Health plan rating** measures the percent of health-plan enrollees' members who responded with a rating of 8, 9, or 10 to the statement, "We want to know your rating of all your experience with your health plan."
- **Satisfaction** measures, drawn from the Consumer Assessment of Health Plan Survey (CAHPS) include two indicators, the responsiveness of care and the accessibility of needed care.
- **Responsiveness of care**, defined by NCQA as "getting care quickly," assesses the ability of health plan enrollees to access necessary care at the provider level. This measure is scored by a composite index, reflecting the percent of members responding "always" or "usually" to a set of four questions (Table 1). Higher index scores indicate higher responsiveness and accessibility to plan services.
- **Accessibility of needed care** is defined by NCQA as "getting needed care." A composite index is used to measure the percent of members who responded "not a problem" to a set of four questions (Table 4) with a higher index indicating greater ease in obtaining plan services.

³ The source for data contained in this publication is Quality Compass[®] 2005 and is used with the permission of the National Committee for Quality Assurance (NCQA). Any analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for such analysis, interpretations or conclusions. Quality Compass is a registered trademark of NCQA.

Table 4: NCQA Quality Compass Composite Indicators

Responsiveness: “Getting Care Quickly”

1. When you called during regular office hours, how often did you get the help or advice you needed?
2. How often did you get an appointment for regular or routine health care as soon as you wanted?
3. When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
4. How often did you wait in the doctor’s office or clinic more than 15 minutes past your appointment?

Ease of Acquiring Necessary Care: “Getting Needed Care”

1. With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?
2. How much of a problem, if any, was it to get a referral to a specialist that you needed to see?
3. How much of a problem, if any, was it to get the care you or a doctor believed necessary?
4. How much of a problem, if any, were delays in health care while you waited for approval from your health plan?

Source: *User Guide NCQA Quality Compass, 2005.*

Clinical and access HEDIS indicators measure the provision of preventive child and adolescent health care. The six clinical measures used in this study include: (1.) Early initiation, the percent of women who delivered a baby who had received prenatal care during the first trimester of their pregnancies (prenatal care). (2.) The percent of women who delivered a baby and who had a postpartum care visit between 21 and 56 days after the delivery (postpartum care). (3.) The percent of children who by age two had received a specified group of immunizations (4 diphtheria-tetanus-pertussis, 3 polio, 1 measles-mumps-rubella, > 1 haemophilus influenzae type B, 2 hepatitis B vaccinations) (combination #1). (4.) The percent of adolescents who received the second dose of measles-mumps-rubella immunizations, three hepatitis B vaccinations, and chicken pox vaccination by age 13 (combination #1). (5.) The percent of diabetic patients who received the comprehensive diabetes care LDL-C screening (diabetes screening). (6) The percent of enrolled members 5 through 9 years old who were identified as having persistent asthma and were prescribed medication (asthma care use of meds 5-9).

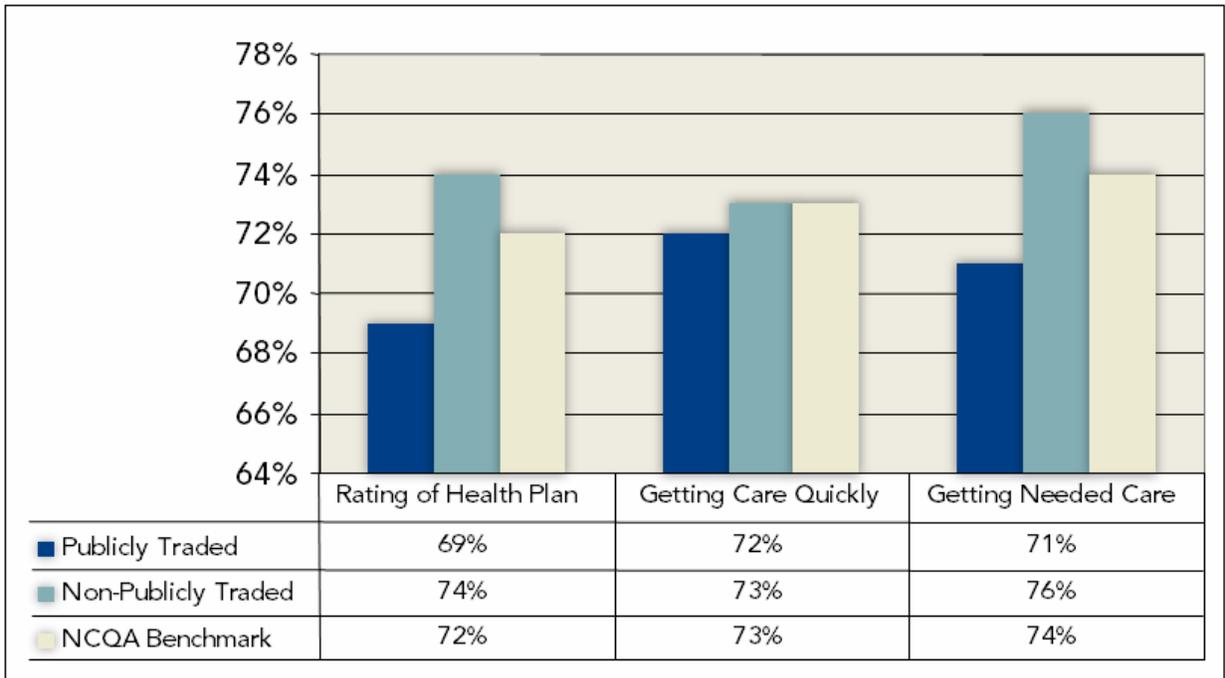
The access measures include (1.) the percent of adolescents who had at least one comprehensive well-care visit; (2.) the percent of children who had six or more well-child visits before they were 15 months old; (3.) the percent of children aged 3-6 years who received at least one well-child visit with their primary care doctor during the preceding year.

The NCQA Benchmark 2005 report, “State of Health Care Quality 2005” (http://www.ncqa.org/Docs/SOHCQ_2005.pdf) provided the benchmark indicators for these measures. The other data is based on both publicly reported and non-publicly reported data.

CAHPS Satisfaction Findings by Publicly traded Plans

Publicly traded plans reported slightly lower consumer satisfaction scores than plans that were not publicly traded (Figure 3). In the case of “overall rating of the health plan” and “getting needed care,” publicly traded plans received scores of 69% and 71%, respectively, compared to non-publicly traded plans, which received scores of 74% and 76%, respectively. Publicly traded plans’ ratings were also below the NCQA Benchmark data, which reported a value of 72% for rating of the health plan and 74% for “getting needed care.” In terms of responsiveness to care, “getting care quickly,” publicly traded plans reported only a slightly lower score (72% vs. 73%) than both the non-publicly traded plans and the NCQA benchmark.

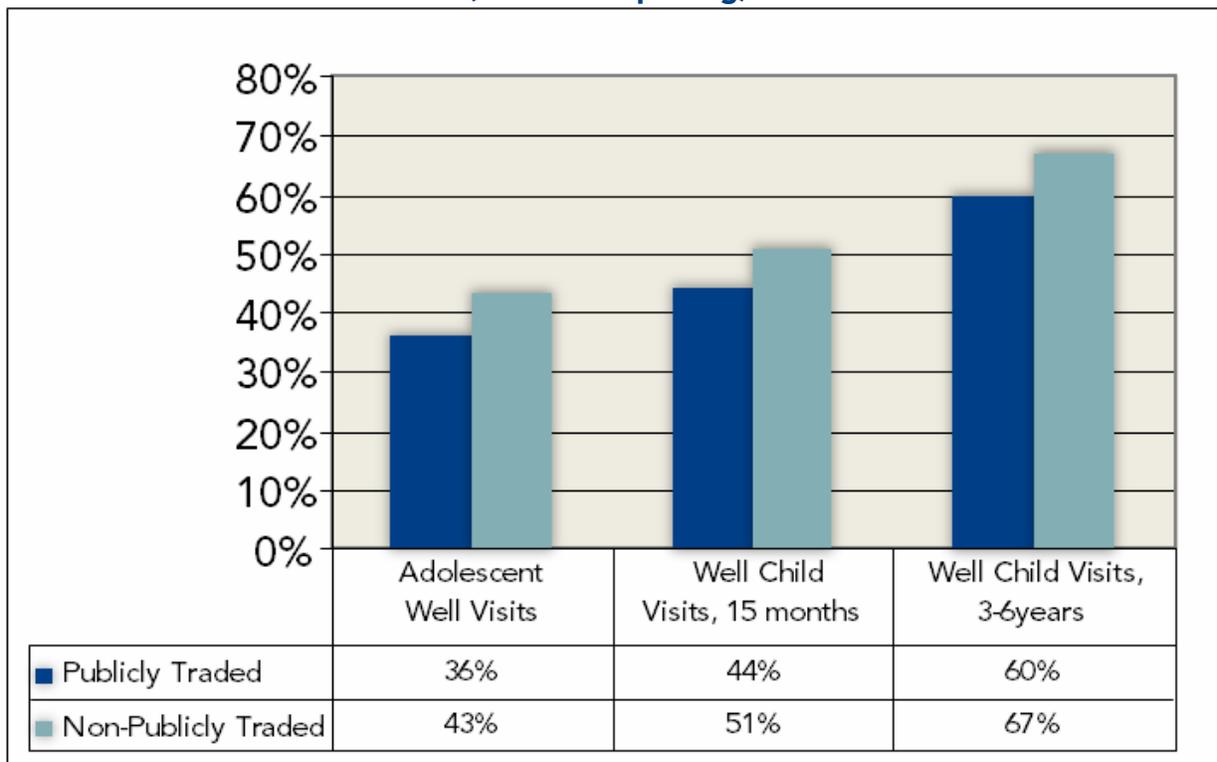
Figure 3: 2004 CAHPS Satisfaction Measures by Publicly Traded Status (55 Plans Reporting)



Findings of HEDIS Access Measures by Publicly Traded Plans

Figure 4 shows that publicly traded plans reported that only 36% of adolescents had at least one comprehensive well-care visit, compared to 43% among non-publicly traded plans. Forty-four percent of the children in publicly traded plans had six or more well-child visits before they were 15 months old, compared to 51% among non-publicly traded plans. In the case of well-child visits for three- to six-year-old children, publicly traded plans reported a significantly lower percent of children receiving well child visits (60%) than non-publicly traded plans (67%). No benchmark data were reported for these access measures. Overall, publicly traded plans reported lower scores on access measures than non-publicly traded plans.

Figure 4: 2004 HEDIS Access Measures by Publicly Traded Status (71 Plans Reporting)



HEDIS Clinical Measures by Publicly traded Status

Using HEDIS clinical measures (Figure 5), publicly traded plans had significantly lower proportions of women receiving prenatal care and postpartum care (78% and 56%, respectively) than non-publicly traded plans (85% and 61%, respectively). Publicly traded plans also reported a significantly lower proportion of children and adolescents receiving immunizations (65% and 57%, respectively) compared to non-publicly traded plans (71% and 69%, respectively). Across all the reported values for these measures, the publicly traded plans' scores were equivalent to NCQA benchmark data.

Figure 5: 2004 HEDIS Clinical Measures by Publicly Traded Status (71 Plans Reporting)

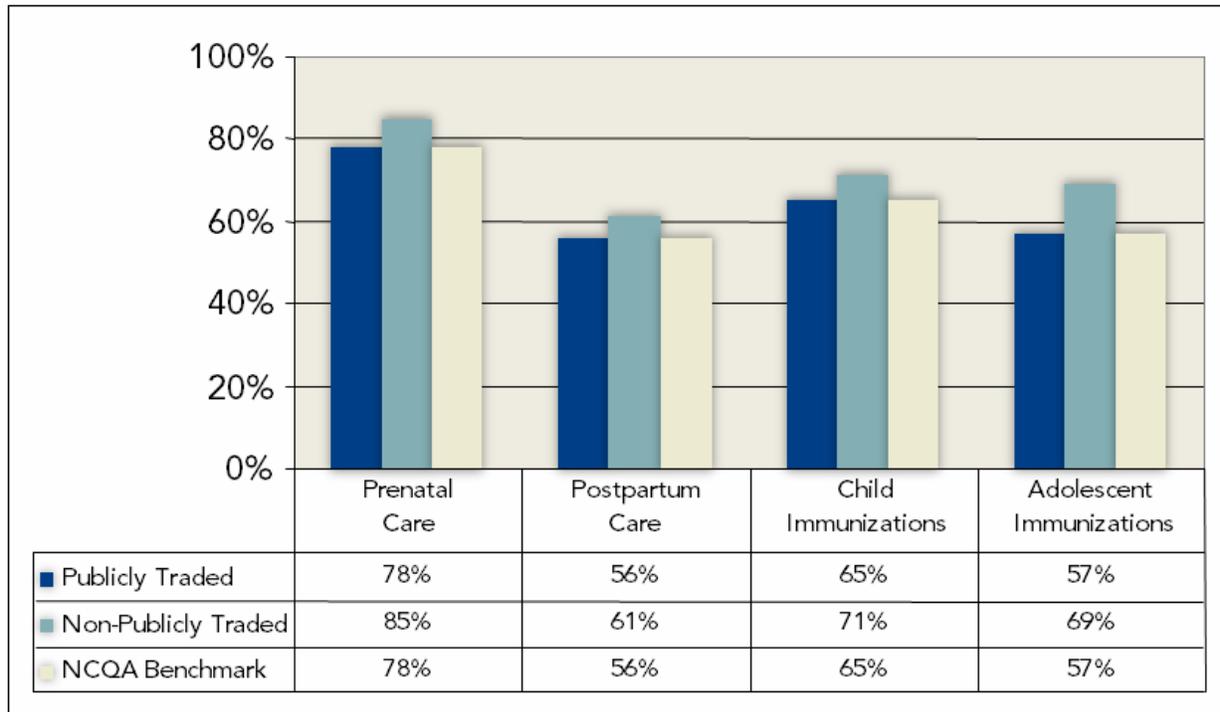
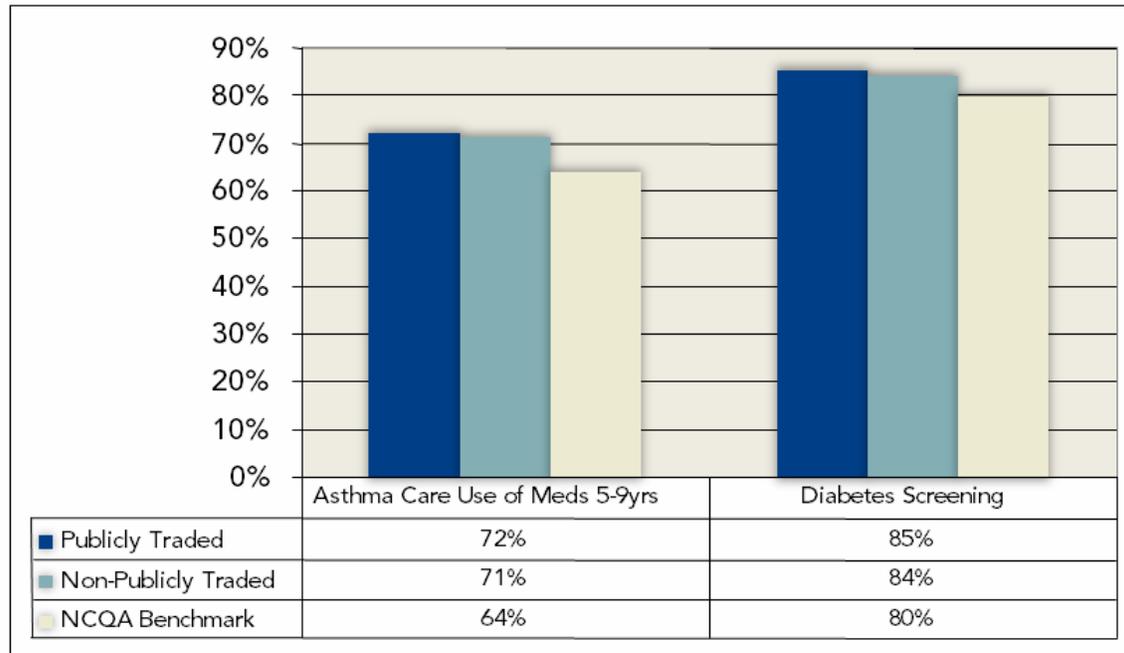


Figure 6 shows a somewhat different pattern of care for members with asthma and diabetes; the performance levels of the publicly traded firms were slightly higher than the levels of the non-publicly traded firms, and both types of firms had scores above the NCQA benchmarks.

Figure 6: 2004 HEDIS Clinical Measures by Publicly Traded Status (71 Plans Reporting)



Non-Financial Performance Analysis Summary

The results of this analysis must be viewed with caution, because of the small numbers of plans in the database. Moreover, the representativeness of plans is problematic for both publicly traded and non-publicly traded firms. Some publicly traded firms are not included in any of these analyses because they do not publicly report data. Likewise, non-publicly traded firms that permit public reporting are the larger and more well-established plans, and might not be typical of that sector of the market, either. Finally, the measures are only a subset of all available measures from NCQA's Quality Compass.

- CAPHS and HEDIS indicators do not indicate a consistent pattern of differences between publicly traded and non-publicly traded health plans. Satisfaction and access scores were slightly higher among the self-reporting non-publicly traded plans, but self-reporting publicly traded firms were equal to or slightly higher than some the HEDIS indicators. The indicators reported for both types of plans were generally comparable to those published as NCQA Medicaid benchmarks.
- The relatively small number of plans that voluntarily choose to publicly report uniform non-financial performance information prevents drawing definitive conclusions and underscores the need for stronger requirements for transparency for all plans.

Task 3: State-Level Perspectives on Contracting and Performance

We conducted telephone interviews in seven states: Florida, Georgia, Indiana, Maryland, New Jersey, Texas and Washington, which we selected to include states in different regions and in different stages of Medicaid managed care contracting. We also selected states with different numbers and types of Medicaid managed care plans, including multi-state investor-owned plans. All seven of these states had at least half of their Medicaid managed care enrollment in publicly traded firms (Figure 7). We considered the 2004 Medicaid HMO enrollment information on the CMS website as well as what we knew about changes in enrollment and plan participation since 2004.

Figure 7: Plan Characteristics

State	# Medicaid Plans with Enrollment > 20,000	# Of These Plans That Are Investor-Owned Multi-state Plans	Total Medicaid HMO Enrollment as of June 2004
Florida	6	6	512,210
Georgia	3	3	0
Indiana	5	3	294,014
Maryland	5	2	469,849
New Jersey	5	4	355,413
Texas	7	2	472,762
Washington	4	1	427,612

All of the states except Georgia (which was just preparing to implement its new managed care program when we conducted the interviews) had operational Medicaid managed care programs. Texas and Indiana also had large Medicaid managed care procurements within the past two years and Florida was preparing to implement its newly approved Medicaid reform waiver program in two counties.

In each of the seven states we interviewed a senior state Medicaid agency representative with responsibility for managed care programs and HMOs participating in the Medicaid managed care program. We also conducted interviews with independent stakeholders in two of the states. In the health plan interviews, we typically spoke with the chief executive officer or executive director. In multi-state plans, we requested interviews with local executive staff, rather than national plan representatives. Altogether 19 plans were interviewed. In general, multi-state investor-owned plans were more likely to decline to be interviewed than community-based plans, although all types of plans did participate in the interviews. Some of the investor-owned plans declined to participate in the state-level interviews but did participate in the national interviews described in the next section of this report. All interviews were conducted using structured instruments and generally took between 45 minutes and one and one-quarter hours to complete. Comments are not attributed to individual states or plans in order to protect confidentiality of the respondents' identities.

State Purchasing Strategies

States vary in their approach to Medicaid HMO contracting. We observed three approaches. First, some states competitively procure and limit the number of HMOs that are awarded contracts. Second, some states competitively procure but award a contract to every bidder that meets a minimum threshold. Finally, some states have an ongoing open application process that allows any qualifying HMO to enter the market at any time.

All states seek an adequate number of financially stable contractors of acceptable quality. States with competitive procurements were among the most assertive in describing their interest in well-performing plans with demonstrated competence serving Medicaid members. We specifically asked if states with competitive Medicaid managed care procurements were designing their requests for proposals (RFPs) to attract certain plans or types of plans. In no case did a state report that it designed its procurement strategy specifically to target certain plans or types of plans, such as provider-sponsored or investor-owned plans. As one state Medicaid agency noted, “We wanted to have bidders and we wanted to have plans with both capitated Medicaid experience and financial stability. We did not make specific policy decisions to try to attract certain types of plans, other than qualified plans.”

A few states described specific steps that they had taken to facilitate the entry of new Medicaid HMO contractors, and reported that those efforts had proven successful. Steps included providing a clear opportunity for significant enrollment volume for new plans and making it possible for provider entities without HMO licenses to enter the market in certain circumstances. In some cases, states have encouraged market entry in order to assure that they do not become too dependent on any particular HMO contractor. One state reported writing letters to certain investor-owned multi-state plans informing them of the procurement opportunity.

In other cases, states have developed procurement strategies that could limit their dependence on any single managed care plan. Federal rules generally require states to have a choice of at least two health plans in order to operate a mandatory managed care program. Depending on the number of Medicaid managed care members in a given geographic region, some state procurements identify the minimum and/or maximum number of plans with which a state intends to contract. States with competitive Medicaid managed care procurements may require bidders to bid by state-defined regions and then make plan awards separately by region. This approach offers states the possibility of having multiple managed care plans, including plans serving less urban regions, while potentially limiting the state’s dependence on any one plan.

In Georgia, for example, the state defined six regions and determined the contract awards by region. Georgia’s RFP also required that no plan have more than 50% of the eligible Medicaid managed care membership in the Atlanta region and no more than 65% of the managed care membership in each of the other regions. Like Georgia, some states face a tradeoff between dependence on a few large plans and limiting the number of plans participating to make the Medicaid managed care program more viable and attractive to bidders, particularly in rural areas. The Georgia Medicaid managed care procurement limited awards in regions outside Atlanta to two plans. The RFP also required that only plans winning in at least two other regions of the state could be awarded a contract in the Atlanta area.

In one state without competitive procurements, the state indicated that they thought that the market would serve to limit the number of plans without the state having to explicitly limit the number of plans.

Medicaid HMO RFP Responses

We asked states with recent procurements about the relative success of the investor-owned, multi-state plans in the competitive Medicaid managed care procurements and the possible reasons for it. Some states with competitive procurements reported that the multi-state investor-owned plans were more likely to deliver polished, well-organized proposals compared to local, non-profit plans.

A number of states noted that the publicly traded plans have relatively good data and broad experience which might help them in drafting credible RFP responses. Some states speculated that the more consistent and higher-quality RFP responses from multi-state investor-owned plans might reflect the fact that these plans are more experienced in drafting proposals than community-based plans that might only need to respond to a single state RFP every few years. Other interviewees speculated that the publicly traded plans might have been more likely to have RFP writing units or to use subcontractors to assist in responding to Medicaid RFPs.

While examples of excellent proposals prepared by community-based plans were cited, the quality of the proposals from plans that were not publicly traded appeared to be much more variable than the quality of the proposals from multi-state investor-owned firms. Two state representatives indicated that local, non-profit plans sponsored by providers submitted some of the poorest RFP responses.

No state indicated that the proposals submitted by investor-owned plans were of poor quality. However, two state representatives cited some possibly negative aspects of the more routine proposal writing of multi-state, investor-owned plans. These states noted that in some cases the investor-owned plans clearly had a template that they were using to respond to RFPs. These state representatives felt that certain publicly traded plan proposals were not sufficiently responsive to state-specific RFP or Medicaid program requirements. One state representative expressed concerns that some investor-owned plans appeared to be using an “off-the-shelf” approach to developing Medicaid managed care proposals.

Attractiveness of the Medicaid Managed Care Marketplace

Most plans described the Medicaid managed care market in their states as attractive to managed care plans, with some exceptions. In most cases, health plans cited the commitment of the state Medicaid agency and of the legislature to Medicaid managed care. States were also often applauded for their inclusion of HMOs in policy development, and their willingness to listen to plan input and to respond accordingly. Several plans observed that state Medicaid agencies have become savvier over time in their approach to purchasing Medicaid managed care. While this sometimes resulted in more rigorous performance requirements, interview respondents felt that the increased sophistication benefited both the plans and the programs.

There were exceptions, however, and when there was plan dissatisfaction with Medicaid managed care programs, it was often linked to perceived inadequacy of state reimbursement rates. While the vast majority of the plans that we interviewed stated that they were profitable, albeit sometimes with quite modest margins, a few had financial losses or were fearful of them in the near future. These tended to be the plans that found their state Medicaid managed care market less attractive. Overall, however, most of the HMOs in the studied states were profitable, and

had been so for several years. This had created significant stability in most of the studied markets.

HMOs sometimes noted that the attractiveness of the Medicaid market in their state and the quality of state-HMO relations sometimes changed with gubernatorial administrations and state agency staffing, or with Medicaid budgets relative to the overall state budgets.

Financial Solvency and Financial Performance

We asked both state agencies and health plans about the financial solvency and performance of Medicaid managed care plans and the variation in these factors across plans. In our interviews, both states and plans reported relatively stable Medicaid managed care markets and solvent plans. A few states and plans noted the reduced earnings of some of the multi-state investor-owned firms and acknowledged that this was beginning to have an operational impact on certain plans in certain markets.

Many states did not provide specific details on the financial performance of their Medicaid plans, other than to note that the plans were solvent. Most state agencies were not able to or not willing to comment on specific trends in financial performance across different types of plans. In addition, both states and plans indicated that this type of Medicaid-specific financial performance data at the plan and state level is not publicly available.

Based on our interviews, at least three of the seven states' Medicaid managed care staff members that we interviewed appeared to have detailed understanding of the financial performance of their Medicaid plans. The remaining staff had some general knowledge of the financial performance of Medicaid plans, but did not have detailed information. In some cases, other state agencies or staff monitored the financial performance of health plans. One state required detailed expense reporting of contracted health plans and required Medicaid plans to return profits over a certain threshold to the state. Another state noticed a correlation between plan financials and the relative risk of enrolled Medicaid managed care populations. Since implementing risk-adjusted rates, two investor-owned multi-state plans were identified as having lower-risk populations. These plans' rates and profit margins had decreased since the risk-adjusted rate process was established. A third state reported that the Medicaid managed care staff, as well as hired consultants, regularly monitored plans' financial reports to the state. According to one respondent, "The state staff ask good questions and let plans know the state is carefully following financials." Only a few states reported having and enforcing limits on plan profits or floors on medical loss ratios. While other states indicated this could be an approach they would pursue if they identified significant issues with plan financial performance, states generally felt that their rate development and financial oversight process was sufficient protection for the present.

States referred to improved tools to ensure a higher level of financial stability from Medicaid HMOs than in the past. States with a longer history of Medicaid managed care contracting were more likely to make these observations. One state noted that Medicaid HMOs licensed by the state department of insurance are more financially stable and perform better than in the past when provider-sponsored Medicaid managed care plan requirements were allowed to be exempt from certain state insurance requirements. At the same time, a few plans complained about what they perceived of as excessive plan solvency requirements in certain state insurance regulations that apply to Medicaid managed care programs.

Medical Management

We asked plans about their medical management philosophy for Medicaid managed care. The responses fell into three groups. The first group contained specific and focused medical management strategies. These respondents tended to emphasize the need for care coordination involving both nurses and social workers and addressing not only medical issues, but also providing non-medical support, including helping members link with other agencies and community resources. These plans also emphasized (1.) management of emergency department use; (2.) management of high-risk obstetrical cases; (3.) vigilant tracking of hospitalizations; (4.) detailed measurement and interventions to address aberrant utilization patterns; (5.) formation of medical homes for each member; and (6.) home visit strategies for special needs populations, such as children with asthma. Publicly traded plans fell into the group of plans emphasizing these medical management strategies more often than did non-profit community-based plans.

The second group of respondents described their medical management program as “provider-friendly” or “loose.” These were often hospital-owned plans that placed a priority on maintaining good provider relations, and that prioritized access and/or quality over medical management. These plans maintained standard utilization-management and case-management programs, but described themselves as not overly restrictive. In at least one case, we were told that a hospital board specifically did not want its health plan to manage utilization aggressively. Non-profit community-based plans fell into this group more often than did publicly traded plans.

The third and smallest group of respondents comprised HMOs with primarily commercial enrollment. These plans made little or no medical management distinction between commercial and Medicaid members. They acknowledged that this was a strategic flaw, and that Medicaid-specific strategies were required to succeed in the Medicaid managed care market.

While none of the plans described themselves as being demanding with their utilization management functions, there were multiple indications that the investor-owned plans (single-state and multi-state) managed utilization more aggressively than their provider-sponsored competitors. Investor-owned plans reported that they consistently used utilization-management, case-management and disease-management programs. One provider-based plan executive, talking about the investor-owned plans in his state, observed, “They are tougher with their rules.” This approach might contribute to better financial margins as well as poorer provider relations, as we discuss later.

Quality Improvement

The states reported that their analyses of plans’ performance, usually using HEDIS and CAHPS measures, did not reveal any consistent patterns by plan size or ownership status. Based on their data, state staff could not generalize about what types of plans were superior performers in the area of quality, and noted that frequently some plans did better on some measures and worse on others.

State representatives cited tools aimed at ensuring higher performance quality from Medicaid HMOs than in the past, including detailed Medicaid HMO contract requirements, state regulations, and oversight of contracted plans’ performance. States that had longer histories of Medicaid managed care contracting were more likely to make these observations. Some states used

detailed Medicaid HMO contract requirements, while other states wrote many of their managed care requirements into regulations.

Plan executives offered a broad range of responses when asked about strategies for providing quality care. The more sophisticated approaches included:

- *Member outreach:* A few HMOs cited the need for a “high-touch” strategy involving member outreach, education, and assistance with making links to community organizations and local and state agencies regarding food, shelter and utilities.
- *Disease state collaborative:* One HMO has worked with its provider network to create a collaborative to implement evidence-based guidelines for certain diseases.
- *Comprehensive initiative:* Another HMO described a multi-faceted approach to prenatal care, involving member outreach, and both member and provider incentives.
- *Data:* A few plans noted that good data analysis and reporting infrastructure is essential to measuring and improving quality.

A few executives appeared to know little about what their plans were doing to provide quality care, and did not know what quality measures the plan was using. These plans and a number of others did not appear to have placed a high management priority on quality and quality improvement. The interviews created the impression that quality improvement is typically not a top organizational priority, which might reflect insufficient state agency emphasis on quality improvement. In some plans quality care and quality improvement, while considered desirable, were not described as essential to continued plan success.

Less than half of the plans described having quality incentive programs in place with their providers, and some of these programs were quite new. Usually these were “pay-for-performance” programs involving added compensation for certain behaviors. The incentive payments were applied in one of three ways: (1.) retrospective bonus payments basis on an assessment of population health (usually HEDIS) measures; (2.) payments for member completion of a health risk assessment or of a high-risk pregnancy program; or (3.) mini-grants for deserving provider quality improvement initiatives. Most of the remaining HMOs said that they were considering such strategies for the future.

NCQA or URAC Accreditation

Almost all of the interviewed plans had not been accredited by NCQA or URAC, and many had no intention of becoming so. Half of the non-accredited plans said that there would be no value to the plan in becoming accredited. These plans sometimes mentioned the already-extensive state requirements. Others said that they simply saw no value in accreditation for a Medicaid HMO. Some non-accredited plans indicated that they were considering obtaining NCQA accreditation. The balance of the HMOs felt that NCQA accreditation did hold some value, but had not pursued it. In order to explain their actions, they cited (1.) the cost and manpower effort associated with pursuing accreditation; (2.) the fact that the state already had a stringent set of requirements; and/or (3.) their current inability to initiate such an effort.

Disease Management

Almost every one of the surveyed HMOs had disease management programs. The programs usually addressed between one and five conditions, in part depending upon the population served (i.e., Temporary Assistance for Needy Families Program (TANF)-only vs. TANF and Supplemental Security Income (SSI). Conditions that had commonly been addressed through disease management programs included asthma, diabetes, congestive heart failure and high-risk obstetrics; one plan included obesity. Most of these were internally-managed programs, although a few plans outsourced a portion of their disease management programs. A few other HMOs recently brought their disease management programs in-house or said they would be doing so soon. One plan explained that having the program outsourced led to a loss of control.

While a few plans reported that they had calculated a positive return on investment (ROI) from their programs, most stated that they had not been able to do so, sometimes citing the newness of their program or the difficulty of documenting an ROI due to the high level of membership churning in Medicaid managed care membership.

The interviews did not reveal significant differences in how publicly traded and non-publicly traded plans delivered disease management services.

Cost Management

Plans of all sizes and ownership status acknowledged that cost management was a constant struggle. Many of those interviewed felt that there was nothing in their plans' approaches to cost management that differed other plans' approaches. Respondents cited the need for daily and weekly measurement of utilization, with a focus on high-risk cases, data analysis to isolate cost drivers, and good contracting. While some plans were more structured and aggressive than others in their approach to managing costs, our impression was that the available tools for managing costs were relatively well-known, and there was little innovation that distinguished one plan from another. It is possible, however, that as this is a sensitive competitive issue, there was less willingness to speak as openly as on other topics.

States and plans did, however, perceive that Medicaid-focused investor-owned plans might have some important advantages in managing the costs of Medicaid managed care based on their Medicaid focus, multi-state operations, and access to information technology, as well as actuarial and medical resources

Provider Contracting

In some Medicaid managed care markets all plans appear to contract with all willing providers within their geographic service area. This is not the case in all markets, however. Some plans selected narrower networks, and there were a few examples of plans "pruning" their networks, particularly when faced with deteriorating margins and providers who were perceived to be non-compliant. Some interviewees described this as a rational approach — electing to work with providers who best understood persons served by Medicaid, and who were "good partners" with the health plan in that they cooperated with the plan's medical management program and contracted at a competitive rate.

Others, however, argued that some HMOs had narrowed, or were narrowing, their networks in order to attract a more favorable mix of enrollees. For example, in one market a publicly traded plan dropped two hospitals serving very poor areas. This decision, coupled with the fact that the major urban safety-net hospital was already unwilling to contract with the HMO (it offers its own plan) resulted in the publicly traded plan having a network and membership drawn from comparatively higher-income areas. As in this instance, the decision to narrow the plan network is not always made by the HMO — hospitals sponsoring their own health plans sometimes choose to not contract with competing health plans, creating something of a monopoly in non-metropolitan regions. We heard anecdotally that investor-owned plans that are new to an existing Medicaid managed care region sometimes face challenging negotiation positions with the providers in the region.

Some of the plans that have open networks do so for purely political reasons. One executive told us “we have included the whole world” to avoid political grief, but admitted that this was probably to the plan’s detriment. Most plans contract with all available Federally Qualified Health Centers. While there is a contractual requirement for new plans to do this for the initial years of the contract in some states, most plans continue to do so because, as one plan executive told us, “You ain’t gonna get members if you don’t have safety-net providers.” Finally, we observed that HMOs that maintained narrower networks than their competitors within specific markets tended to be investor-owned.

Provider Relations

While most of those interviewed cited strong relationships with their provider networks as essential to success, the multi-state investor-owned plans appear to have had more problems with these relationships. Their more aggressive approach to utilization management sometimes angered physicians, particularly when contrasted with the approaches of non-investor-owned competing Medicaid HMOs. Investor-owned plans’ billing requirements were reportedly also more prescriptive, resulting in higher volumes of pended and denied claims. All of this contributes to what physicians refer to as “the hassle factor.” The provider community was also attributed with bias against the multi-state investor-owned plans simply because they are investor-owned, and because they are not community-based.

A few interviewees reported that the multi-state investor-owned plans did not reach out to providers as much as the community-based plans, and did not give local providers equal opportunities for input.

Provider-owned plans, conversely, were described as trusted and supported out of an understanding that hospitals needed to create HMOs to hold onto their patients, and because hospitals are often perceived as cornerstones of their communities. One multi-state investor-owned plan acknowledged the benefit community-based plans realize from having a strong local presence. A provider-based plan told us, “They [multi-state investor-owned plans] are not as good with providers ... the community trusts us, but the for-profits are more knowledgeable.”

Perspectives on Impact of Multi-State Investor-Owned Plans on Medicaid Markets

Most of those interviewed, including state managers and the executives of competing HMOs, felt that multi-state investor-owned plans had had a positive impact on their markets. Strengths of these plans were identified:

- **Most multi-state investor-owned plans focus exclusively on the Medicaid population, creating both expertise and efficiencies.** The few plans that continued to serve Medicaid while focusing primarily on a commercial membership conceded that a lack of strategic focus on Medicaid limited their performance effectiveness, and made it difficult to make their Medicaid business financially viable.
- **Their size gives them economies of scale and financial stability.** Some believed that this allowed multi-state investor-owned plans to perform better than smaller plans in Medicaid managed care. The CEO of a community-based plan told us, “I feel like the local hardware store with Wal-Mart built around the corner.”
- **Their capitalization allows multi-state investor-owned plans to invest in systems and infrastructure in a way not possible for other Medicaid health plans.** One plan told us, “The additional overhead [required to serve a Medicaid population] is exorbitant for programs that are not well financed.” States frequently referenced the superior information technology infrastructure that the investor-owned plans offered, compared to some of the smaller provider-sponsored plans.

Some state representatives were emphatic about how essential multi-state investor-owned HMOs were in their states. Typically, these representatives were from states that had no Medicaid participation from their state’s leading commercial insurers. Without the multi-state investor-owned plans, the states would have had only a small number of provider-sponsored plans, some with limited geographic service areas. One state agency senior manager told us, “The investor-owned multi-state firms are critical to us.” Another stated that her state was “dependent on the multi-state investor-owned firms,” adding that “these firms generally have raised the bar in terms of performance of plans in the state.”

Some interviewees noted a few differences in how the multi-state investor-owned plans competed:

- **Multi-state investor-owned plans were reported to conduct more extensive marketing through advertising and sponsorship of community events.** (One plan executive referred to this as the “mass-market approach,” versus her own plan’s “grass-roots approach.”) Some community-based plans had modified their marketing strategies in response to the competition.
- **Multi-state investor-owned plans tended to be assertive in their lobbying efforts, both with legislatures and with Medicaid agencies.** These plans sometimes hired high-profile, high-priced local lobbyists. Some community-based plans drew on sponsoring hospitals’ histories, reputations and political influence within their states to gain support for the HMO’s interests. However, other community-based plans told us that they simply lacked the resources to devote to lobbying and to managing state agency relations as intensively as the investor-owned plans.

While most interviewees were respectful of, if not complimentary about, the impact of investor-owned plans in their markets, there were some who voiced words of caution and concern.

- **A few states expressed concern that multi-state firms were sometimes not as focused on the state's particular approach or model for Medicaid managed care.** They didn't want a standard national product, but one customized to their state, and aligned with the Medicaid agency's philosophy.
- **Some states worried that multi-state plans did not create sufficient partnerships with providers and other community organizations.** One state expressed concern about a certain multi-state investor-owned plan, noting that "Its level of commitment to [the state] is not as solid as the local plans whose mission is tied to their communities."
- **Out-of-state administrative functions have been a source of problems for some states.** One state manager told us that providers were frustrated when told that claim payment problems were the result of actions taken by corporate offices in another state over which the local HMO personnel had no control. Another state manager described problems with member service telephone lines being handled by out-of-state call centers that did not understand the Medicaid managed care requirements of the client state. This state required the HMO to move its member services operations to the state in order to solve the problem.
- **Profit levels of investor-owned firms can become a lightning rod.** Some states described actions that had been taken by states in response to public or legislative outcries about high margins, as well as contemplated actions. For example, states were concerned over the level of administrative expenses contained within the premiums of some investor-owned plans. One state hired an independent auditing firm that reported that it believed that at least one multi-state investor-owned plan was using corporate expense charges to move profit to its parent. Another state was considering setting a cap on administrative expenses included in the capitation rate.

The magnitude of multi-state investor-owned HMO profits can also spark debate. We were told that in one state, there was worry about large profits being taken out of the state rather than reinvested within it. In another state, low medical loss ratios in investor-owned HMOs were seen as reflecting poorly on the efficiency of provider-based plans, which had much higher medical loss ratios.

Most states had no immediate or significant concerns about their dependence on multi-state investor-owned health plans. Some states noted that their investor-owned plans had been operating in the state for years and would be unlikely to exit quickly. It is possible that this was not a major concern for states because most plans have been consistently profitable in most of the studied states. In addition, many state agencies were aware of the number of multi-state investor-owned plans bidding on recent Medicaid procurements, and they could have confidence in their states' ability to attract new entrants. State concerns about the investor-owned plans appeared to be limited to certain plans and regions, not with the overall industry. Only a few state Medicaid agencies wondered how certain plans that were facing financial challenges might react to a financial downturn.

It was primarily competing community plans and stakeholders who questioned how multi-state investor-owned plans will act when there is a downturn in the profitability of investor-owned plans' operations in a given state. Competing plans and stakeholders characterized investor-owned plans as prioritizing stakeholder return above all else, felt that such plans might leave their markets or compromise their services to members should they incur even temporary losses.

Variation Across States and Across Plans

While a fair amount of attention has been given in this section of the report to how multi-state investor-owned plans have influenced Medicaid managed care markets, another important observation concerns variation in Medicaid managed care markets across states. We found that the community-based plans in some states consistently described sophisticated models for managing care and improving quality, while in other states the community-based plans appeared to have much less mature management and improvement systems in place. We did not conduct enough interviews or obtain enough information to determine why this variation occurred. It did appear, however, that some states were obtaining much greater value from their contracted HMOs than were others.

A second observation on variation concerns the apparent variation in community-based plans. Our interviews, while limited to seven states, seemed to suggest that the variation in performance by community-based plans (provider-sponsored and investor-owned) might be much greater than the variation in performance among multi-state investor-owned HMOs. The community-based HMOs appeared to range from poorly-capitalized, barely-managed health plans to sophisticated best-practice models of Medicaid managed care. This variation seemed to exist not only among states, but within states as well.

Task 4: National Perspectives

Twenty-six national experts on Medicaid policy and Medicaid managed care issues were interviewed to gather their perceptions regarding the growth of investor-owned plan participation and its implications. Approximately one-third had broad Medicaid knowledge, one-third had more detailed understanding of the Medicaid managed care market (including researchers and consultants), and one-third were senior executives at health plans and multi-state firms. The findings are summarized by each of the questions from the interview protocol.

1. Why has Medicaid become such an attractive market for these firms?

The most frequently cited explanation for the attractiveness of the market was that the investor-owned firms discovered that specialization in challenging lines of business like Medicaid could be financially rewarding. Unlike multi-line firms that dabbled in Medicaid in the mid-1990s, the multi-state, Medicaid-focused firms made the necessary adjustments and accommodations to respond to the demands of this business line. Repeal of the 75/25 rule in the Balanced Budget Act (BBA) of 1997 opened the way to fully specialized firms. But even multi-line firms that remained in the market developed separate units that concentrate on public programs serving low-income members. Sharper focus on Medicaid enabled these plans to develop the systems and skill sets necessary to outperform what many saw as underperforming local plans, a disproportionate number of which were provider sponsored.

A number of observers referenced changes in the broader marketplace, including stalled growth opportunities in the commercial sector and the deterioration in the Medicare market after the BBA of 1997, which left Medicaid as one of the few expanding markets. Others pointed to the publicly traded status of these firms, suggesting that collapsing investment opportunities in other sectors in the early 2000s created a chance for Medicaid-focused firms to launch surprisingly successful initial public offerings (IPOs). Likewise, pressures from Wall Street to sustain enrollment growth encouraged continued expansion, while at the same time promoting entry into multiple states to diversify revenue sources.

Several respondents noted that business conditions in a maturing Medicaid managed care market were particularly favorable for these firms, including substantial inefficiencies in fee-for-service Medicaid, the ability to work with a single large and relatively stable purchaser, opportunities to enroll a large population at a pre-determined date, low administrative costs (due to constraints on marketing), and an environment that is less competitive than commercial markets.

2. To what do you attribute their success/profitability?

These firms cited a strong focus on Medicaid as integral to their success in the market — financially and otherwise. The firms garnered some economies of scale and standardized a number of processes and systems that produced operating efficiencies. In addition, they developed targeted skills in contracting and medical management, though there were mixed views as to whether they outperformed local Medicaid-focused plans in these areas. Some observers suggested that, as outsiders, these firms were more aggressive and less fettered by provider and political constraints in network development and contracting. They suggested provider-affiliated plans were likely to pay providers “excessively,” resulting in higher medical loss ratios than the publicly traded firms. Others commented that these firms were able to pay certain types of providers (i.e., primary care physicians) better than other plans and thus achieve greater provider

participation. Overall, there was a strong sense that state rate setting improved (in part due to the actuarial-soundness requirement on states) and that the diffusion of risk adjustment techniques provided more firms with the assurance that they would be paid appropriately.

The financial strength and access to capital clearly differentiated these firms from local ones, particularly provider-sponsored plans. They had more resources to invest in information and other technologies and in expansion. All of the firms used capital to undertake mergers and acquisitions, though this was an expensive way to grow when opportunities still existed for organic growth through new solicitations and extension of managed care to new populations. By the same token, some of the new state solicitations demonstrated a preference for these firms because of their financial wherewithal, rapid response capacity, and their multi-state experience. The mobility of these firms and their ability to choose the states in which they wished to participate — compared to local plans — was also seen as conferring significant advantage. An important qualifier to these generalizations was that these firms were not all alike — even among the pure plays — as they had different structures, strategies, and approaches to the market.

A number of observers professed surprise at how financially successful these firms have been. A few openly questioned if their good fortune was either a transitional phenomenon, largely due to revenue growth outpacing expense growth during a period of enrollment expansion, or, more sinisterly, the result of success in garnering favorable selection through calculated network composition and other means. Countering these views were suggestions that at least some of these firms were successful in educating (some said “lobbying”) states on how to be better purchasers, including ensuring that states paid fair and adequate rates.

3. What impacts — positive and negative — have these firms had on Medicaid managed care?

Positive Impacts. The most prominent positive impact noted was that the desire of these firms to participate and to grow allayed state concerns about sufficient plan involvement to launch and maintain mandatory, full-risk programs. Recent solicitations have produced a plethora of bidders, and the financial difficulties of some firms in the past year had no apparent impact on this activity. Other commentators suggested that investor-owned, multi-state firms have proven influential in convincing states of the value of full-risk managed care contracting and the potential savings to the state, which benefited all plans in the market. In part, this reflects a stronger commitment to political activism, at least for some firms, and successful appeals to elected officials who might be ideologically disposed toward privatization. For states aiming to make managed care statewide, these firms demonstrated their willingness to enter markets not previously served by managed care plans.

Other responses highlighted the contributions of managed care firms by allocating more expertise and commitment to care management, compared to many provider-sponsored plans. This raised the bar in terms of Medicaid managed care performance expectations, and led to increased competitive pressure on local plans to either improve or exit, sometimes by selling out to multi-state investor-owned firms. Some interviewees concluded that these firms had helped move Medicaid managed care to a new plateau, shifting it away from health-system-sponsored plans that were more committed to maintaining market share than managing care. Others contested this view, contending that many provider-affiliated plans — most notably those that have survived and grown — also increased in sophistication and equaled or surpassed multi-state investor-owned plans. In addition, these provider-affiliated plans were seen as more likely to reinvest profits locally than publicly traded firms.

Negative Impacts. Chief among concerns about the growing influence of investor-owned firms is the risk of plans exiting markets after states have grown dependent on them, which could jeopardize state Medicaid program sustainability. In these markets, firms potentially could extract undesirable terms and conditions from states as the price of avoiding their market exit. Another worry voiced by interviewees was that the mission of investor-owned plans — profitability — is at variance with the Medicaid program, although some thought this perspective too narrow and one that could conceivably exclude Medicaid from doing business with any vendors, including individual physicians. Some concerns focused on whether plans earned their profits, whether plans engaged in “street-level underwriting” (promoting favorable selection via network composition), or whether plans put safety-net providers in jeopardy because they resisted contributing to cost-shifting and cross-subsidies embedded in local communities.

A more general issue raised by some respondents was that increased reliance on these plans — and any managed care plan, for that matter — reduces the state’s control of Medicaid because the agency is no longer contracting directly with care providers. Thus, efforts to reduce spending or alter programs must deal with intermediary organizations, which could increase complexity and expense without increasing value. Another respondent perspective was that publicly traded firms face powerful pressures from investors and analysts who are essentially competing with states for the commitments of these firms and who, if dissatisfied with returns, could desert these firms and ultimately undermine their ability to meet their commitments to the states.

4. What implications do these firms have for other plans in the Medicaid market?

Most respondents anticipate continued growth of these firms, in part through consolidation of existing plans, mainly those that are provider-affiliated, within local markets. Health plan consolidation, now widely evident in the commercial market, is likely to occur in the Medicaid market for the same reasons: economies of scale, capacity to make major capital investments in information technology and elsewhere, ability to recruit and retain superior personnel, and opportunities to enter new markets. Although provider-sponsored plans have survived longer in Medicaid than in commercial markets, they continue to struggle to compete for internal investment. For many health systems, the opportunity to sell off a plan — whether struggling or successful — provides a substantial infusion of needed cash.

While states might find less competition and fewer contractors under this scenario, observers suggest that the states’ rising demands and expectations are the impetus for some consolidation, which then could favor multi-state, investor-owned plans. Some observers contended that new solicitations in states like Georgia and Ohio reveal such preferences. But, despite these trends, most respondents did not expect a high level of concentration in all Medicaid markets, in part because of the costliness of mergers and because the financial difficulties of some of the Medicaid-focused firms slowed their desire to expand. This also suggests “lumpy” patterns of growth, given the opportunistic nature of acquisitions, rather than a rapid, progressive rollup of small firms. Another perspective is that new firms — multi-state, privately-held firms that currently might be positioning themselves for future IPOs — could contribute more market entrants in the future.

5. How would Medicaid managed care programs be affected if these firms stepped back or withdrew from markets?

Although there were notable exceptions, most observers believed that in a number of states the desire to maintain full-risk managed care programs would be seriously jeopardized if these firms retreat from Medicaid participation. In many cases, the local plans remaining in the market lack the capacity to absorb substantial numbers of new lives, and there are often no new sponsors likely to develop replacement plans. Moreover, in markets where local plans have already been sold to these firms, there are no candidates at all. There is little indication that multi-line firms not *already* in Medicaid see it as a priority market and, if existing firms are exiting due to profitability concerns, there is no financial motivation for new investor-owned plans to enter. States could be faced with either reverting to traditional fee-for-service or primary care case-management models, or, as already is occurring in some states, to embracing alternative models (i.e., disease management or intensive case management) to fill the gap.

A concern of many Medicaid policy observers was that, given this possibility, states must realistically assess what kind of contingency plans are needed to avoid finding themselves in difficult bargaining/rate negotiations with very small numbers of contractors who could threaten to withdraw. Plan perspectives on this same scenario suggest that this possibility should encourage states to maintain a hospitable contracting climate with sound payment rates. An alternative view, consistent with what a number of states are now doing in new and renewal solicitations, is more careful structuring of bidding and awards to ensure that there are sufficient numbers of competing plans in sub-state regions, avoiding excessive dependence on one or a few plans.

6. Do you anticipate these firms will be successful in the future?

Views about future prospects were mixed because of uncertainty about Medicaid, and because many predicted that the larger than expected profits of previous years cannot be sustained over time. Growth in Medicaid, in terms of numbers of persons covered and in the continued desire of most states to enroll beneficiaries in managed care arrangements, bodes well for firms in this market. However, budgetary pressures associated with further Medicaid growth suggest that state efforts to control spending will only intensify, probably making payment rates to health plans increasingly contentious. Other policy observers underscored the cyclical nature of Medicaid and contended that plans in this market must anticipate ups and downs, because Medicaid is tethered to state budgets that are tied to larger economic conditions. Because the fluctuations vary across states, plans doing business in several states could be better positioned to partially cushion this impact.

Another line of discussion — related to the states' increased sophistication — was rate setting and contract demands, which can pressure plan margins. Coupled with a push toward increased performance transparency and aggressive plan oversight, profitability for the sector as a whole could decline. Also threatening these firms are growing indications of provider pushback in contracting, to which some of the publicly traded firms in Medicaid have attributed recent missed earnings. However, other commentators cautioned against overreaction to these stumbles and suggested that they are characteristic of an adolescent industry, where even the most mature firms have less than a decade of experience. A few interviewees were much more skeptical and indicated that they doubted the longevity of a number of these firms, once “easy profits” disappeared, and suggested that states must prepare for abrupt departures by firms that sell out or purge their portfolios of state markets that are a drag on their bottom lines.

Two specific areas of new opportunities and challenges for these firms were discussed with respondents: enrollment of aged, blind, and disabled (ABD) beneficiaries and state interest in so-called “consumer-directed” (CD) designs. Many respondents suggested that the ABD populations will test whether these firms have sufficient expertise to serve high-need populations that are markedly different from the healthy women and children now enrolled in most of these plans. Because ABD premiums are much higher, representing substantial revenue growth prospects, some analysts have encouraged these firms to pursue these opportunities. Moreover, access to resources to invest in information systems, specialized programs like disease management, and highly-skilled personnel positions could create distinct advantages for these firms compared to local plans. Many of them also have some experience with either Medicare products or are developing special needs plans for dually-eligible persons. While these indicators suggest promising possibilities for these firms with ABD enrollment, there are doubts about whether the plans have adequate relationships and commitments from community-based providers currently caring for these persons to become proficient. In addition, as non-local, investor-owned enterprises, they are likely to engender some resistance from advocates who play prominent roles in the implementation of ABD managed care.

Respondents displayed more consensus about the CD-based waivers (and the flexibility embedded in the Deficit Reduction Act), and the opportunities and dangers they represent to these firms. In principle, several factors favor such opportunities for these plans: their mobility, their desire for growth, their espousal of the value of innovation, and their ideological compatibility with privatization strategies. But expectations about whether these developments will yield a windfall were muted, even among firm representatives interviewed. Currently there is considerable uncertainty about the actual designs of these initiatives, including who will be covered, what will and will not be covered, where risk for uncovered care will be borne, and who will be responsible for denying care that is not covered. More broadly, there were widespread doubts about the suitability of extending the commercial analog of consumer-directed products with health savings accounts and high deductibles to Medicaid eligibles. Some openly suggest the “political gimmickry” of these models seems designed to either reduce enrollment in Medicaid, or to shift the responsibility to deny care from public to private entities. Add to this the administrative complexity and the cost of devising multiple new benefit designs, for what is probably a relatively small qualifying population, and some observers predicted a short life span for this spate of new CD innovation. It was viewed as unlikely to have much impact on multi-state, investor-owned firms.

7. Does the prominence of these firms necessitate any particular policy intervention?

The final question posed related to what policymakers should or should not be doing in light of the growing presence of these firms in Medicaid managed care programs across the country. Several respondents, across the three interviewee categories, suggested that no specific actions are justified at this time maintaining a level playing field is both fair and desirable to ensure healthy, legitimate competition among plans and clear opportunities for different types of plans to participate in this market. All plans should be accountable for meeting reasonable contractual terms and, if some do this by paying less for medical benefits and/or administrative expenses, this should be acceptable. These observers felt that if profit margins are viewed as unreasonable or politically unpalatable, then states should focus on refinement of rate setting or raise the bar in terms of plan performance, not necessarily resorting to profit or medical loss ratio (MLR) limits — though there was some support for the latter, especially as a performance monitoring measure.

A more pervasive view was that states should be more assertive in maximizing the transparency of uniform plan performance information — both financial and non-financial — so different stakeholders can evaluate plan activities and performance. With respect to multi-state firms, several respondents contend it is essential to ensure that state-level plan reporting and cost allocation guidelines have the precision to gauge plan performance in each state, on both financial and quality indicators. Transparency also includes developing the capacity to perform provider network comparisons to ensure that plans are not purposely avoiding risk through the construction of networks. More directly, such concerns can be addressed, as they now are in few states, by adequate risk adjustment methods to equalize the consequences of attracting favorable or unfavorable risk profiles. Another point raised by a few observers is the need for more readily available timely, reliable national level data (such as HEDIS and financial indicators) so that states can more accurately benchmark their plans' performance. Uniform reporting requirements would be particularly useful in carrying out cross-state comparisons of multi-state firms.

Several respondents believed that states need to be more sensitive to the long term business opportunities that they should be creating. That would mean stabilizing relationships with plans; putting performance metrics like medical loss ratios into a multi-year time frame; developing plan-specific performance improvement targets; and embracing pay-for-performance/quality improvement models that are coming into vogue in both commercial and Medicare markets. Among those interviewed, this final recommendation — pay-for-performance/quality improvement models — enjoyed broad support because it benefits from a strong push to greater transparency and because it creates an opportunity to move beyond punitive or regressive approaches to changing health plan behavior. It is designed to reward results and explicitly creates opportunities to ensure that all plans, including the multi-state investor-owned plans, are earning their money.

Conclusions and Implications

Summary of Key Findings

Key findings from this study:

- Increased participation of publicly traded managed care companies has firmed up the Medicaid market, expanding and enhancing contracting options for states.
- Multi-state, investor-owned firms have brought financial stability to the Medicaid managed care market and provided options for local owners, especially provider systems, to sell plans that are either underperforming or not consistent with system goals.
- State experience in contracting and performance monitoring has not identified any strong, systematic concerns about the performance of investor-owned plans.
- While publicly traded firms bring added capital, resources, and infrastructure into Medicaid, there is no clear evidence based on publicly available data that their non-financial performance differs from non-publicly traded firms.
- The superior financial performance of publicly traded firms continues to be due to significantly lower medical loss ratios. These could result from more effectively delivered care or less provision of necessary care, either of which would be consistent with the more aggressive medical management attributed to these firms; and/or to the attraction of lower risk members as a result of provider network composition.
- Profitability for a number of these firms has leveled off and may be trending downward as medical expenses grow, raising some question about investor enthusiasm for this sector over the longer term.
- The mobility of these firms, investor pressure to grow enrollment and earnings, and the volatility associated with being publicly traded stock companies represent legitimate, albeit tolerable, sources of anxiety for states that have grown reliant upon them.

Implications of Study Findings

A number of implications can be drawn from the study findings and the principal ones are discussed briefly below.

1. It is incumbent on states to monitor closely the *performance of all plans* and to continue to promote greater public transparency on pertinent financial and non-financial indicators. For many of the most astute observers interviewed in the study, the best response to concerns about the impact of publicly traded or multi-state investor-owned plans is for state Medicaid officials to intensify efforts to make all facets of performance information on participating plans more credible and publicly available. Expectations of timely, full disclosure on performance can have powerful effects on individual plan behavior and will ensure that states will have the information needed to assess whether any and all plans are performing at levels that justify the profits

that are being generated. The disappointing level of public reporting by Medicaid plans in the NCQA Quality Compass suggests that more should be done to gather such data via the Medicaid program as a means to ensure that individual plan and industry-level benchmarks are available. Plans offer many valid reasons for not embracing NCQA accreditation and reporting — including its costliness, data demands, and lack of recognition of accreditation in state oversights — and these should be addressed as part of efforts to standardize public reporting. Additionally, financial reporting by multi-state firms creates important challenges to ensuring that a complete, accurate picture is available. Beyond making information public, states need to embrace more proactive purchasing strategies that drive meaningful performance improvement among contracting plans.

2. States’ perspectives on plan selection, contracting, and payment policies should be focused on maintaining long-term stability to maximize the promotion of sustained improvements in the well-being of beneficiaries. As the Medicaid managed care market matures and state purchasing sophistication grows, attentiveness to longer-term goals becomes more prominent. Not only are states looking for stability in the contractors they select, but at least some are incorporating multi-year goals and expectations into their contracts to encourage progress and sustainability of effort. Only a few states (for example, New York and Michigan) are financially rewarding in meaningful ways the progress plans are making in improving the health and well-being of their members. Much more could be done to send unequivocal signals to plans that this is what states want and value. Conversely, most plans have displayed — especially during the recent state budget crises — recognition that stable business partnerships will experience inevitable ups and downs. By implication, as budgets and payment rates improve, performance expectations should also be expected to rise. The current level of interest in market participation among so many plans gives states unprecedented opportunities to do so.

3. Rate adequacy consideration must include appropriate risk adjustment techniques to ensure that plans compete and are rewarded on a level playing field, especially given the movement toward high-cost enrollment populations. As risk adjustment techniques have become more refined and somewhat more widely employed, states and (most) plans have grown to expect that “the money follows the person” and that risk variation among plans will be largely counteracted by payment adjustments. For many reasons, provider networks are likely to continue to vary across plans and to exert subtle and not-so-subtle influences on member mix, and such variability will almost certainly grow as more seriously disabled and chronically ill beneficiaries are enrolled in plans. States that fail to adopt such techniques do themselves, their beneficiaries, and their plan contractors a disservice.

4. Concerns about profit margins and payouts for medical benefits are best addressed through careful rate setting and negotiations, but should also stimulate attention to more forward-looking policies, including pay-for-performance incentives. Medical loss ratio or profit margin standards or screens have a useful role for program monitoring purposes, according to many observers, including even some plan executives. But they should not receive excessive attention when more and better means to promote desirable behavior exist or when they are largely reflecting poorly-calibrated rates or inadequately-negotiated contracts. Several observers at the state and national level suggested that states are now well-positioned to develop contract specifications that promote and reward performance improvement over multiple years and to communicate clear, actionable incentives to plan contractors to show how they can earn more money. Medicaid agencies can either lead by their own pay-for-performance initiatives or can dovetail their efforts with other payers in their states and localities.

5. It is likely that many states will grow more reliant upon publicly traded firms and thus need to be *attentive to reducing exposure to disruptions to the extent possible either through contracting strategies or development of fallback options*. Based on the comments of state-level respondents reported here and the proliferation of new opportunities in additional states, there is little reason to doubt that states will continue to turn to investor-owned multi-state firms to meet their needs. States are attentive to the uncertainty that contracting with these firms can represent, as witnessed by the careful contracting strategies many of them are devising. But it is likely that in addition to these strategies of regionalization and redundancy in contract awards, other states will explore various models of non-full-risk arrangements as alternatives, including gradations of administrative services only options, disease management for sub-populations, and preservation of some level of primary care case management. Others will continue to make concerted efforts to keep local plans viable, including those sponsored by safety-net providers, in hopes that they could fill part of the gap that might be created if publicly traded firms were to retreat from participation.

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In the final analysis, sustained growth opportunities for these firms will be dependent on enrolling higher-risk, higher-need populations, including developing models for the ABD population in general, and duals in particular, that will seriously test their ability to manage care and costs. The test of the capability and durability of publicly traded firms in Medicaid in this realm can be seen as a special case of determining whether prepaid managed care models can be made to meet the needs of high-cost and high-use beneficiaries in both the public and private sectors. Pressure is now building from states on these firms to step up to this care management responsibility, at the same time investors (and their analysts) are encouraging the companies to pursue the greater revenues these populations represent. Based on past history and current observations, it is not yet clear whether the potential advantages these firms have to be successful in this area will be realized or not. But they do have a significant opportunity to be the leading edge of boldly taking Medicaid managed care where few other plans have gone before.