

**Partnership Pays: Making Medicaid Managed
Care Work in a Turbulent Environment**

By Robert E. Hurley, Ph.D. and Michael J. McCue, D.B.A.

*Funded by Center for Health Care Strategies, Inc. under the
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Executive Summary

The experience of states involved in Medicaid managed care continues to vary greatly. A growing body of research describes Medicaid managed care as a complex undertaking implemented and operated in an unstable and uncertain managed care marketplace. While some states' programs fail, others succeed. Research suggests that Medicaid managed care rates alone do not determine success or failure. As concluded in an earlier study, *Medicaid and Commercial HMOs: An At-Risk Relationship* (Hurley and McCue, Center for Health Care Strategies, 1998), what seems equally important to success is how and how well a state designs, operates, and manages its Medicaid managed care program. To explore state variations, this study examined:

- patterns of entry and exit into Medicaid managed care on national and state levels, focusing on eight states with varied program results;
- interdependencies of critical program components in an original model of Medicaid managed care;
- features of state policies and practices that influenced program success; and
- implications of these findings for Medicaid managed care policy makers.

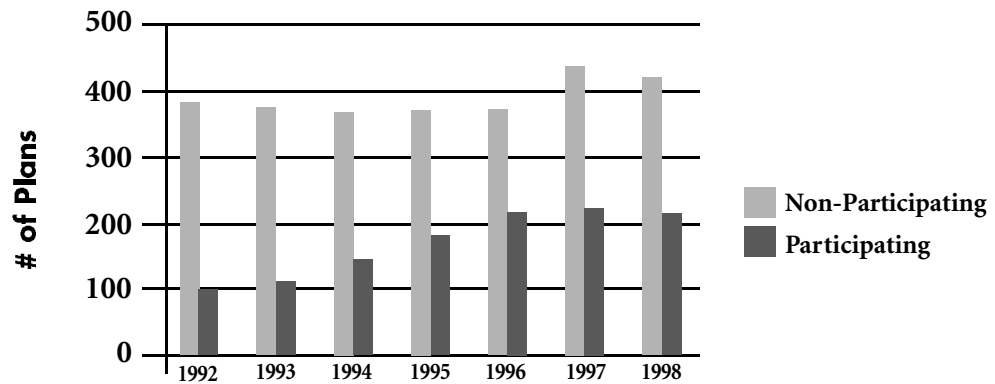
The study examined these issues by analyzing National Association of Insurance Commissioners (NAIC) data from 1992-1998, developing a general model of Medicaid managed care derived from previous research, and interviewing participants who represented different roles in Medicaid managed care in eight focal states. The data analysis built upon our previous study's examination of Medicaid HMOs and used similar comparisons. The eight states selected for analysis because of their diverse experiences with Medicaid managed care were Arizona, Maryland, New Jersey, Ohio, Texas, Virginia, Washington, and Wisconsin.

The findings highlight the high degree of variation in states' general program designs and implementation of Medicaid managed care, influenced in part by the general managed care environment as well as by an individual state's managed care marketplace. Additionally, the findings emphasize changes in the states' programs over time, suggesting that as state programs mature, the relationship between program management and participating managed care plans may become more collaborative.

Participation and Performance Trends

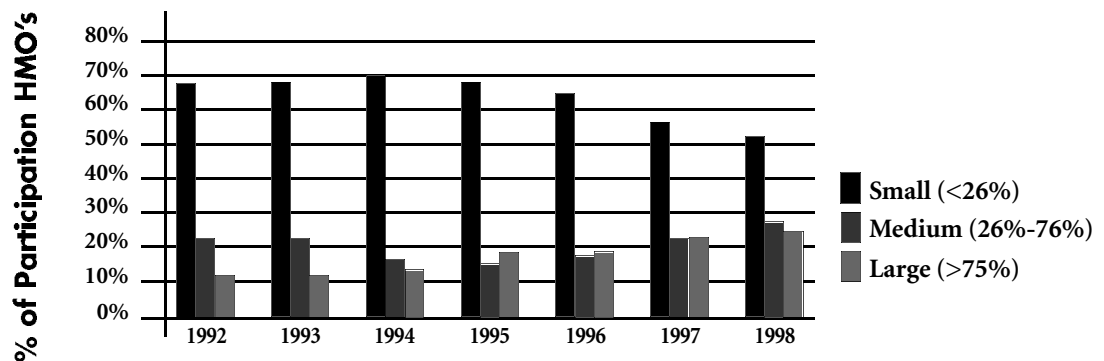
Our findings emphasize that plans currently participating in Medicaid are increasingly predominantly Medicaid plans. Moreover, our findings suggest that even though the average health plan in the United States is operating at a loss, these predominantly Medicaid plans tend to perform better than non-participating plans. An examination of both participation and performance trends provides possible explanations. Participation in Medicaid (see Figure 1) increased between 1992 and 1996, but leveled off in 1997 and 1998.

Figure 1
HMO Participation Status in Medicaid
Managed Care 1992-1998



Over time, the characteristics of plans participating in Medicaid managed care have changed significantly. Many of the larger plans with small Medicaid memberships as well as publicly traded plans previously in this market exited, possibly in response to insufficient enrollments to cover the administrative costs associated with Medicaid managed care coupled with the financial market pressures inhibiting for-profit plans from either entering or remaining in Medicaid. The trend toward predominantly Medicaid plans (see Figure 2) suggests that these participating plans can focus on expertise with this specific population while achieving the economies of scale necessary to spread the administrative costs associated with Medicaid over a larger enrollment.

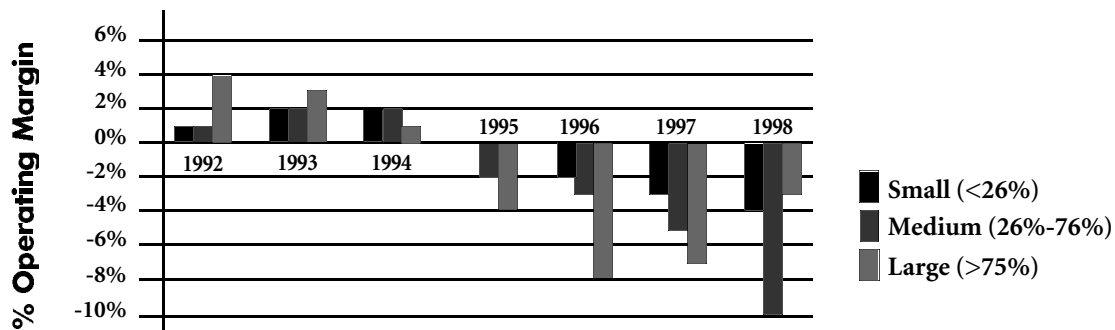
Figure 2
Participation by Medicaid Membership Size
1992-1998



Although data on Medicaid product lines and on Medicaid-only plans that are not licensed HMOs is not available, available data does demonstrate that plans not participating in Medicaid experienced greater financial losses than those participating (see Figure 3). In contrast, predominantly Medicaid plans, which are usually smaller plans, are performing better than those with no or limited Medicaid memberships. One explanation for these losses is the dramatic drop of commercial margins. The trend toward higher performance by predominantly Medicaid plans suggests that by concentrating on a single line of business these plans gained the expertise and operational efficiencies not found by those with low Medicaid enrollments.

Figure 3

Level of Medicaid Participation
% Operating Margin 1992-1998



A General Model

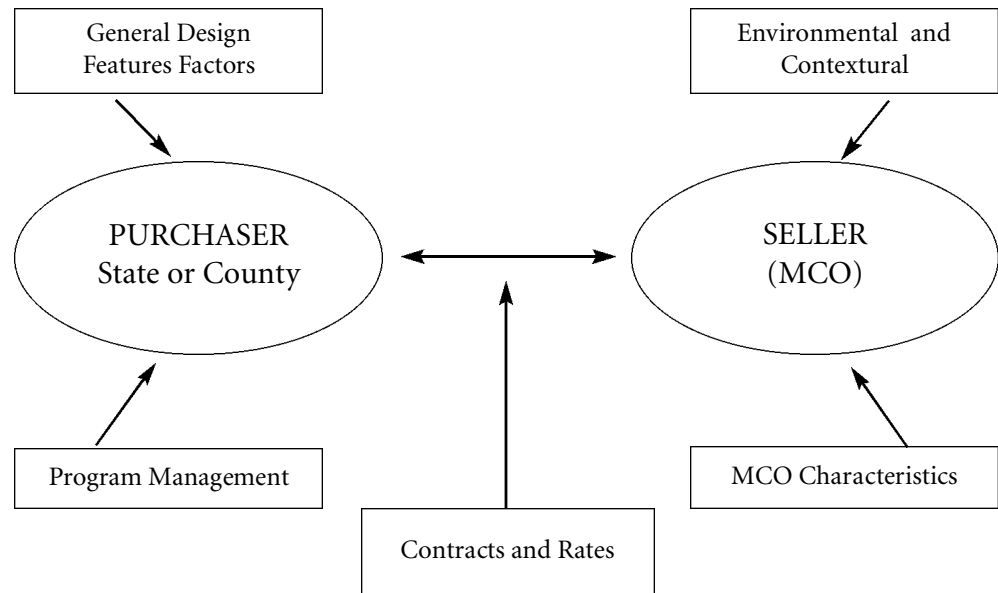
The earlier CHCS study of Medicaid managed care emphasized the complexities of program implementation as well as the diverse stakeholders and the numerous and often interrelated activities involved. For this study a multiple component model was developed and refined. Its five components are:

- General Design Features—the basic program goals as well as the state’s strategies in terms of models, covered population, and plan selection.
- Program Management—the state agency’s structure, expertise, program execution, and relationship with participating managed care plans.
- Environmental and Contextual Factors—the structure and maturity of the local managed care market, including the capacity and viability of plans.
- MCO Characteristics—specifically plan ownership, membership, experience, network, and financial status of participating plans.
- Contracts and Rates—the rate level and rate-setting process as well as the contractual terms and overall program monitoring and supervision.

Figure 4 suggests that the components can be examined individually; in fact, each component is directly or indirectly affected by other components. The General Model served as the basis of interviews with individuals having different roles in the eight states’ programs

Figure 4

Model of Medicaid-HMO Contracting

**Key Findings from Interviews**

Although diverse state experiences with Medicaid managed care were identified through interviews, some common patterns emerged.

- After often tumultuous program rollouts, most programs reached relatively stable operational states during which parties began to focus on long-term program refinement.
- Regardless of whether limited or unlimited bidding was originally initiated, the number of participating plans ultimately decreases, either by design or market competition.
- Those plans remaining in the Medicaid market will be determined by local managed care market conditions and by the configuration of traditional Medicaid providers.
- Concerns about rate adequacy are modified by greater understanding and cooperation between programs and plans in the rate-setting process; however, greater sensitivity to the costs associated with additional contract demands, particularly data gathering, is warranted.
- Although uncertain market conditions may continue to threaten Medicaid managed care programs, customizing program design and plan selection may achieve some market manageability.
- Stable and mature programs demonstrate the value of embracing managed care models and focusing attention on quality improvement.

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- Partnership pays. Mature programs are already experiencing some of the benefits of collaborative long-term relationships between Medicaid managed care programs and plans.

Regardless of the relative success of a particular study state, few representatives interviewed thought that the future of Medicaid managed care had stabilized. Noteworthy was the acknowledgement that many states were already looking ahead to consider the future forms that Medicaid managed care might take.

Introduction and Study Purpose

The experience of states involved with Medicaid managed care programs continues to vary greatly. Some states have experienced considerable success with their managed care initiatives, as evidenced by a diverse and stable set of participating plans. Other states have experienced disappointments and difficulties marked by declining viability and participation among health plans. A growing body of research indicates that Medicaid managed care is a complex undertaking that is being implemented and operated in an unstable and uncertain managed care marketplace. As we concluded in our 1998 report *Medicaid and Commercial HMOs: An At-Risk Relationship* (Hurley and McCue, 1998), it is difficult to ascertain if Medicaid's experience is specific to that public program, or if it is emblematic of the broader challenges that all purchasers face in relying on health plans to meet their needs.

This study updates earlier findings in terms of plan participation and performance in Medicaid and explores the variation in experiences among the states. Rate adequacy, which receives considerable attention in Medicaid managed care, clearly influences plan success and sustainability. However, capitation rates alone do not seem to determine success or failure. Our earlier study's interviews with health plan executives suggested that many other factors influence their decisions to enter the Medicaid market and determine the success or failure of their Medicaid endeavors. These factors include program design, implementation, and operational management, as well as larger market forces that affect the readiness and willingness of plans to enter or to remain in Medicaid. Perhaps even more significant is the extent to which states project a desire to develop long-term partnerships with contracting plans.

Based on our earlier findings, **we concluded that how and how well a state designs, operates, and manages its Medicaid managed care program is very important to its ultimate success.** By focusing on the experiences in a selected set of states, we have attempted to develop a more comprehensive picture of what factors are causing variation in the state experiences. Building on our previous study, we initially developed a conceptual model of Medicaid managed care implementation that incorporates a broad range of factors. We devised an instrument to explore and enrich this model through interviews with representatives in eight states. Interview results were then analyzed across the components of the model to understand how and why states' approaches were adapted to fit local conditions and state-specific program aims. These results were considered against the backdrop of descriptive information presented on plan participation and performance, on both a national and a focal state level. Finally, a discussion of the implications of this research is presented with the goal of aiding states in achieving greater success in their Medicaid managed care initiatives.

Relationship to Prior Research

Our earlier CHCS study, among the first to focus specifically on Medicaid managed care through the eyes and experiences of health plans, suggested that patterns of participation were changing significantly. In the early 1990s, interest in Medicaid among plans serving predominantly commercial members surged as states pursued federal waivers to expand mandatory managed care, creating a new and expansive pool of potential enrollment. This enthusiasm was short-lived and by 1996, this tide of new participation had ebbed, though the uneven implementation of managed care initiatives across the states made it difficult to isolate this trend. Subsequent work (most notably Felt-Lisk et al., 1999), presents a clear indication that the peak of participation has passed, an observation well supported by media accounts (Meyer, 1997; Langreth, 1998; Kilbreth, 1998). Several states found scheduled geographic expansion stymied by plan withdrawals. Other states discovered insufficient

numbers of plans willing to enter their markets. Some states have even found that their mandatory programs are unsustainable because of declining plan participation.

These trends are not unique to Medicaid. In many respects, Medicare withdrawals have gained more notoriety—despite the fact that Medicare HMO enrollment represents less than 15 percent of beneficiaries, as compared to Medicaid HMO penetration, which is more than twice as high. Likewise, the HMO industry has seen a significant reversal of fortune as demonstrated by:

- declining profitability;
- substantial declines in stock prices among publicly traded firms;
- major retrenchment efforts underway among bellwether not-for-profit plans like Kaiser and Harvard Pilgrim;
- frenetic mergers and acquisition activity in the HMO industry; and
- limited and often unsuccessful provider-sponsored forays into the managed care realm, despite high expectations.

In addition to these industry observations, the Urban Institute's recent research comparing Medicaid capitation rates across states revealed, as expected, great variability (Holahan et al, 1999). Perhaps most striking is the finding that there is very little correlation between Medicaid payment rates and "market-based prices" (as measured by Medicare AAPCC rates). This is not necessarily surprising considering that Medicaid fee-for-service rates have, in many instances, been largely out of touch with market prices for similar services. The fact that plans participate in a product line where their payment rates may not be directly linked to the cost of the services that they are obligated to deliver provides some support for the contention that participation in Medicaid is influenced by factors other than rates. This conclusion is consistent with the findings of our previous CHCS study, which provided observations gleaned from interviews with health plan executives from 25 companies.

These findings motivated us to revisit and update past trends on HMO participation and performance in the Medicaid product line. They also provide the foundation for a broader frame of reference to understand the complex relationships among factors that affect the success of states that are engaged in Medicaid managed care. An original model guides this inquiry, with a series of interviews with participants in states with varied experiences with their Medicaid managed care programs. Those interviewed offer diverse perspectives and usually long-term involvement with their programs; thus, their observations reveal how states adapt and adjust to changing circumstances in managed care in general, and in Medicaid managed care in particular.

Another goal of this study is to examine its findings in conjunction with a parallel study of Medi-Cal managed care experiences being conducted by Laguna Research Associates for the MediCal Policy Institute of the California Health Care Foundation. This analysis of the three distinct models of managed care being implemented across California counties provides an opportunity to compare and contrast these programs with observations from the eight states included in the CHCS-supported study. The combined findings of these two projects will be incorporated in a forthcoming report.

Methodology

This study involved quantitative and qualitative data collection and the analysis and synthesis of data from both sources. Data was examined on a national level as well as on state level using eight states identified for specific study.

Quantitative Analysis

The quantitative analysis utilized 1997 and 1998 data from the NAIC filings that licensed HMOs provided to state regulatory bodies. The same data was used for the 1998 CHCS study. The HMO data was analyzed on a national basis to identify those participating in Medicaid and the extent of their participation. Plan characteristics selected for profiling plans were those characteristics used in the earlier study.

The database contains extensive financial performance indicators on individual HMOs at the aggregate level (i.e., across lines of business). Several measures and ratios of performance were created for each plan to assess how financial indicators varied across plans participating and not participating in Medicaid, and across those with limited, moderate, and extensive Medicaid membership. Combining the 1997 and 1998 data with the earlier data created a seven-year pattern of participation and performance. In addition to compiling this information on a national basis, profiles of each of the eight states selected for this study were constructed. Overall, this data forms a contextual picture of the managed care marketplace within which states have attempted to launch or extend Medicaid managed care initiatives.

Qualitative Analysis

The second component of the study involved development of a questionnaire to use in conducting interviews with individuals offering varied perspectives on Medicaid managed care implementation and participation in the eight focal states. An original model based on findings from the earlier study served as the foundation for a survey/interview protocol appropriate to use with multiple informants, including state Medicaid officials, health plan representatives, trade associations (HMO and hospital associations), and advocacy groups. Selected individuals received letters and follow-up phone calls to encourage participation and schedule interviews. All interviews were conducted by phone, and results were recorded in written form. These findings were then collated across states and interviewee classes to summarize according to the components of the model. Inferences drawn from the interview synthesis, coupled with descriptive participation and performance data, are summarized in this report.

States Included in the Analysis

The study focuses on eight states chosen for their wide range of experiences, including diversity within the state's markets and plan withdrawals. The focal states included some that rely exclusively on licensed HMOs and some with special Medicaid-created and regulated managed care organizations; most had a mix of Medicaid only and predominantly commercial plans in their programs. The focal states' experiences with mandatory HMO enrollment ranged from only 2 years to 15 years.

Arizona: Arizona has the most mature, state-wide HMO enrollment program in the country, the Arizona Health Care Cost Containment System (AHCCCS), dating from its original 1115 waiver issued in the early 1980s. The program weathered a turbulent start because of massive administrative programs and the loss of several early participating health plans, many of which were provider sponsored. After major administrative redesigns and management overhauls in the late 1980s, the program entered a lengthy period of stability and increasing sophistication that continues. The Arizona program is widely recognized as a model for success that other states seek to emulate. Both TANF and SSI beneficiaries are enrolled in plans that are selected through a carefully orchestrated competitive bidding process. The number of awards is limited so that participating plans garner sufficient membership. The AHCCCS believes competition should occur during the bidding process to ensure that only carefully selected, qualified plans may participate. Most of the health plans serve primarily Medicaid beneficiaries and Medicare members. Arizona collects and uses encounter data

extensively in program analysis and evaluation, though developing reliable data was a long-term project. Health plans now sign five-year contracts, with rates subject to annual adjustment. Although there have been few plan withdrawals or decisions to not re-bid in recent years, AHCCCS officials have encouraged other plans to enter the market and appear satisfied with the current level of interest shown in the program.

Maryland: Maryland operates a third generation managed care program implemented in 1996. This mandatory enrollment prepaid health plan for both TANF and SSI beneficiaries followed a mandatory PCCM program (Maryland Access to Care or MAC) and a longstanding voluntary HMO enrollment program. The state contracts with both licensed HMOs and with provider-sponsored managed care organizations which, compared to HMOs, face similar regulations but lower reserve requirements. The program, implemented on a statewide basis, experienced problems with both plan withdrawals and administrative difficulties, including rate-setting disputes over state administered rates. Major administrative and personnel changes have been made in the Medicaid agency, partially because of the managed care program. Maryland's program design includes a risk adjustment system that is dependent upon the submission of encounter data from the plans to distribute payment adjustments. Although this system is plagued by data submission difficulties, most parties still believe this is an appropriate requirement. Rate disputes have centered around initial rate setting and upper payment level calculations. Plan withdrawals, while introducing some instability, do not appear to be directly related to Medicaid rates, but several plans have indicated that their continued participation hinges on the next set of rates to be issued. A scandal related to initial contract awards and rate disputes resulted in legislative involvement, but the agency's new leadership appears to have broad-based support and credibility because of its efforts to address problems.

New Jersey: Although New Jersey's history with Medicaid managed care initiatives dates back to the early 1980s, its new initiative to enroll TANF beneficiaries in HMOs on a mandatory basis began with its sequential implementation in 1995. This program received a high level of interest among health plans and bids were awarded to all qualifying plans. Rates were administered by the state and the state attempted to maximize plan participation to ensure choices for beneficiaries. From the beginning, the state planned to make the program mandatory for SSI beneficiaries, but it purposely scheduled this to occur after the TANF-based program stabilized. Market instability, including plan failures and withdrawals, has created an atmosphere of uncertainty for beneficiaries and providers. While mismanagement, not Medicaid rates, is seen as responsible for plan failures, there is widespread concern that the rates are inadequate and that the future depends on retaining the remaining plans. The program's management has received favorable marks for its initial efforts at implementation, its efforts to promote participation, and its deliberate approach to extending the program to SSI beneficiaries (scheduled for mid-2000). However, the future of Medicaid managed care in New Jersey is clouded by an uncertain, troubled environment for managed care and by financial instability in the hospital environment.

Ohio: HMO enrollment in Ohio dates back to the mid-1980s, when a mandatory program was initiated in one metropolitan county and voluntary enrollment was permitted in several others. In 1995, the state obtained an 1115 waiver designed to expand eligibility and to enroll Medicaid TANF and AFDC-related beneficiaries on a mandatory basis in all metropolitan counties in the state. Interest among health plans appeared very high, and the state allowed all qualifying health plans to participate in a state administered rate based program. Entering plans included both predominantly commercial and Medicaid-only plans representing established plans, new entrants, and established plans that expanded to other markets across the state. Early in the program rates were reduced to increase state savings that were needed to finance plan eligibility expansion. When our earlier study was

conducted in 1997, some plans were already reconsidering participation. Subsequently, several plans have either failed or withdrawn from Medicaid, and a number of the urban areas in the state have experienced considerable instability. In addition, some of the failed plans left providers with substantial unpaid claims and there has been a degree of recrimination, particularly against the insurance regulators, for inadequate supervision. More recently, two urban areas (Dayton and Cincinnati) discontinued their mandatory HMO enrollment program when only one plan remained in the market. Currently the state is making a concerted attempt to attract new participants to bolster the program and has instituted rate increases to arrest plan exits. Observers remain unsure of the success of these remedial efforts, and some think the state may have to launch alternative contracting models, including PCCM or possibly sole source contracting, to restore mandatory enrollment in all metropolitan areas.

Texas: Texas has implemented an incremental, multi-model expansion for Medicaid managed care dating back to a pilot program in Austin in the mid-1990s and extended this to include several of the major metropolitan areas of the state. The program is primarily targeted toward TANF/AFDC related beneficiaries except in Houston where they have an ambitious risk-based program that serves SSI-beneficiaries including those with dual eligibility for both acute and long term care services. The state has relied on both a PCCM and HMO-based strategy, typically offered side-by-side. Health plans have expressed concerns that it is difficult for them to attract beneficiaries even in a mandatory enrollment environment when beneficiaries have the option to essentially remain with their existing primary care physician and experience few differences from fee-for-service Medicaid. The bidding process has been contentious in some markets as the state has made limited numbers of awards. Traditionally high volume providers like public hospitals have been concerned about inclusion in networks and some have chosen to sponsor their own plans. HMO participants represent a broad spectrum of plans. Some exits have been occurring in this market due to overall managed care trends, disappointing performance for provider sponsored plans, and concerns in some markets about rates that vary considerably among metropolitan areas in the state. Despite a somewhat hostile legislative and policy environment for managed care in this state, state Medicaid officials receive praise for their concerted efforts in promoting broad participation in program planning, adopting a reasonable approach to contractual demands, and maintaining an open dialogue with plans and providers. Plans, however, remain concerned about rate adequacy, the extensive reporting requirements associated with participation in Medicaid, and the state's continued commitment to maintaining the PCCM program.

Virginia: After implementing a statewide PCCM program, Virginia offered a voluntary HMO option to beneficiaries in 1994 in selected metropolitan areas where HMO interest existed. A mandatory program was implemented in eastern Virginia in 1996 and a similar program was implemented in central Virginia in 1999. Enrollment is mandatory for all TANF and SSI beneficiaries with some exclusions among the latter group. Both of these programs garnered substantial participation from predominantly commercial plans, with only one Medicaid-only plan participating in both markets. Rates now administered by the state after an unsuccessful effort with competitive bidding are generally viewed positively by plans and other observers. Notably, Virginia has no formal risk-adjustment scheme, but plans have not expressed concerns, believing that risk has been reasonably well distributed among plans. Data reporting has been problematic; reliable encounter data is not available despite the goal of using this data in future rate-setting efforts. Despite program successes in eastern and central Virginia, the state's two efforts to launch a mandatory program in northern Virginia failed because it could not attract the requisite two plans to participate. Rates have also been a concern in northern Virginia and in other regions where smaller numbers of eligible persons are not geographically concentrated. On a more positive note,

the state successfully persuaded health plans to cover rural counties in eastern and central Virginia where they previously had no commercial members. The Medicaid agency was motivated to do this because the state's CHIP program sought to contract with health plans that were serving these rural counties.

Washington: Like Maryland, Washington had some longstanding, but limited Medicaid managed care experience in a few locations in the state. This changed dramatically when the state implemented a variety of health reform measures in the early 1990s including a commitment to move the AFDC population into HMO enrollment eventually on a statewide basis. This was viewed as a reasonable approach to expanding access to mainstream providers and achieving greater cost control in a mature managed care market. Washington has also worked hard to align purchasing approaches for public employees, low income uninsured persons, and Medicaid beneficiaries. Participation among plans was very high initially, though broader marketplace changes, including declines in provider-sponsored plans and mergers among commercial HMOs, have caused some loss of participants. The state does not have any Medicaid-only plans, as plans have to also participate, at a minimum, in the Healthy Families program. The state also made an unsuccessful attempt to expand enrollment to SSI beneficiaries, but had to abort this after a variety of problems led plans and the states to decide this was not feasible. Washington uses a competitive bidding process for determining rates to health plans, and in recent years, rates have actually exceeded targets set by the Medicaid program. This has raised concerns about whether the program is achieving cost savings at this point and is likely to invite closer scrutiny from state policy makers. Plans believe that the state has become more proficient in program management, and note that this is apparent in a more sensible approach to contractual demands. Despite plan departures, the program remains stable, though concerns were raised about rural areas where it is becoming increasingly difficult for plans to negotiate rates with providers.

Wisconsin: A mandatory HMO enrollment program was implemented in Milwaukee for AFDC beneficiaries in 1984 and continues to the present time. Since then, the state has expanded enrollment in HMOs and has achieved a high level of health plan participation. It traditionally contracts with all qualifying licensed HMOs (currently 18), and has experienced few withdrawals. Managed care is well accepted in Wisconsin and Medicaid has made a concerted effort to include a broad spectrum of plans. Only one plan is a Medicaid-only plan. Rates are not a major source of conflict because rate increases are seen as necessary to retain desirable contractors. Recently concerns have centered around whether rates are approaching the UPL. Also, with the long history of mandatory HMO enrollment in the state, the fee-for-service base has lost meaning. Wisconsin requires plans to submit detailed utilization data, already used to audit plan performance and cross-plan comparisons. Ultimately, this data will support future rate development. Despite the high degree of success with the AFDC/TANF populations, there remains limited interest in making SSI enrollment mandatory. Although some pilot programs were implemented, the general sentiment is that human service programs in this state are already well-developed for this population and that currently it is not necessary to enroll these beneficiaries in HMOs. Wisconsin has been praised for its sustained effort to promote participation among all interested parties and to solicit input and feedback from a broad spectrum of community representatives.

PART I: Overview of the Medicaid Managed Care Market

This section describes the market trends in Medicaid managed care in terms of the characteristics and the financial performance of plans on a national level and in selected study states. The data sources and methodological approach are discussed first, followed by an analysis by plan characteristics and financial performance across all states. Finally, analysis of financial performance and plan participation is presented for the eight selected study states.

Data Sources

The HMO database of Health Care Investment Analyst Inc. (HCIA) provided the financial and operating information used to explore participation of the Medicaid market for the 1992-1998 periods. The total number of plans represented in the database increased from 471 in 1992 to 655 in 1998. Median values are used to offset the impact of outliers and extreme variations in financial measures. Caution must be observed when analyzing state data because of the limited number of licensed HMOs within each state. HCIA's database obtains the financial and utilization data from the filings supplied by the licensed health plans to their respective state insurance regulators. The data submitted to the National Association of Insurance Commissioners (NAIC) follows their recommended reporting format. Unfortunately, for the state of Arizona none of the licensed HMOs participate in Medicaid. Also, for each year we were unable to identify the profit status and chain affiliation for a small number of plans.

Methodology

HMOs vary on a number of significant dimensions. Understanding each of these dimensions provides insights into how the managed care industry has responded to the opportunities and challenges of Medicaid. More importantly, understanding these dimensions may show how the relative contribution of each industry segment serving Medicaid has changed during the seven years studied. The dimensions include plan characteristics (i.e., chain affiliation, profit status and Medicaid membership size) and market segment (i.e., Blue Cross for-profit and non-profit, publicly traded for-profit, and other for-profit, and non-profit HMOs and other non-profits). Within these dimensions, we analyzed the data by frequency and by financial performance on a national basis. For the eight selected study states, we evaluated financial ratios by participating and non-participating plans in Medicaid.

Profit Status

Although the for-profit (FP) or not-for-profit (NFP) status distinction appears clear, some exceptions exist. Some FP plans are wholly-owned subsidiaries of NFP organizations (e. g., some Blue Cross-sponsored HMOs) and do not meet the tax-exempt status of their parent. Similarly, many NFP hospital-sponsored HMOs are for-profit, with the HMO classified as an insurance product. In other cases, these HMOs are for-profit because of the presence of profit-sharing arrangements with physicians or equity partners.

Ownership

Ownership refers to whether a plan is publicly or privately held. Publicly held HMOs are owned by shareholders, and the stock is traded on an exchange. Privately held plans are not openly traded, and ownership may be limited to one or a limited number of owners (e. g., investors, hospital consortia). Note that FP plans are not always publicly held, including HMOs owned by mutual insurance companies. For example, plans held by Prudential and New York Life were once owned by their policy holders and were not openly traded. Both of these companies were subsequently purchased by Aetna US Healthcare, a publicly traded corporation.

The dimensions of profit and ownership have potential implications for Medicaid participation. FP plans, regardless of their ownership classification, are under pressure to demonstrate satisfactory returns to justify the capital investment. However, external scrutiny and appraisal by market analysts is aimed at publicly, not privately held plans. Although NFP plans' motivation for entering the Medicaid market may be "mission-driven," their need to remain financially viable and to generate excess revenues over expenses often mirrors FP plans.

Other Characteristics

Several basic attributes that may help to distinguish among HMOs are:

- *Chain.* Plans operating in a single market are dependent upon building membership from a cross-section of residents in their service area and must consider all possible market segments, including Medicaid. In contrast, chain or multi-market plans enter markets where they expect to succeed by building membership around their market niche, which may or may not include Medicaid. Chain or multi-market plans may also enter the Medicaid market to capitalize on potential economies of scale.
- *Membership Size.* Historically, most HMOs have had little Medicaid business, so their memberships were exclusively commercial or a mix of commercial and Medicaid. Although the past few years have seen a surge of plans into the Medicaid market, most aim to limit their exposure to Medicaid and still maintain a commercial orientation. A second, smaller group of plans serves predominantly Medicaid beneficiaries, accompanied by some public employees or public-assistance enrollees. This second group of plans is highly dependent upon Medicaid policies and payments and, until recently, provided the bulk of HMO enrollment. A small but growing number of entrepreneur-developed plans target Medicaid as a niche market.
- *Medicaid-Only MCOs.* An estimated 3 to 4 million beneficiaries are not included in this analysis because they are in exclusive Medicaid plans not under the purview of state insurance regulators (the data source for this study). Medicaid-only MCOs not licensed by insurance departments include some, but not all, of the capitated plans sponsored by high volume Medicaid providers (e. g., physician organizations, public hospitals or community health centers). Provider-sponsored Medicaid-only plans play a significant role in several states.

Financial Performance Ratios

A significant limitation of the financial performance data from HCIA is that it represents overall plan financial performance for all lines of business for the health plan, not only the Medicaid line of business. Financial performance data provides an objective evaluation and serves as the springboard for future financial assessments of the plans. Four key operating measures shed additional light on possible differences among plans in this market. The four ratios that signal financial stability are:

- *Operating margin ratio* - measures the amount of operating income earned from insurance revenues. The operating margin gauges how well a plan controls its medical and administrative expenses, and how well it earns a profit from its operations rather than from its investments. Plans with lower operating losses or smaller negative operating margins have better financial performance than plans with higher operating losses or larger negative operating margins.
- *Administrative cost ratio* - measures the proportion of insurance revenue dollars paid out in administrative expenses.
- *Medical loss ratio* - measures the proportion of insurance revenue dollars paid out in medical claims.
- *Equity ratio (net worth / total assets)* - measures the amount of equity cushion of the plan relative to its total asset base. This ratio measures the capital reserves of a plan as well as its financial solvency.

The operational definitions for each of these ratios appear in Table 1.

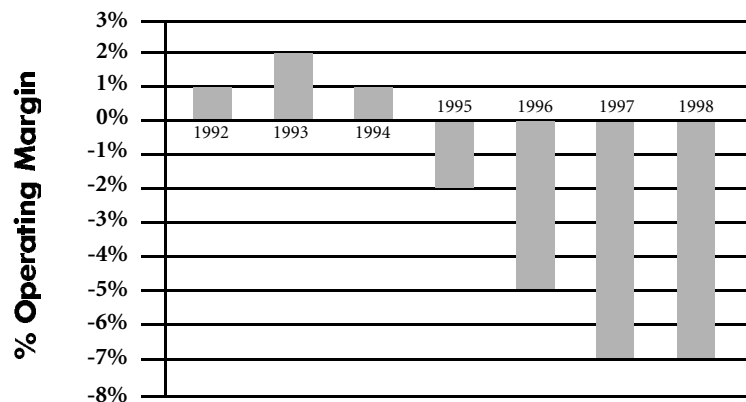
Table 1

Financial ratio	Operational Definition
Medical loss ratio	(Medical expenses + Hospital expenses)/ Insurance revenues
Administrative cost ratio	Administrative expenses / Insurance revenues
Operating margin ratio	(Insurance revenues-Total operating expenses)/Insurance revenues
Equity ratio	Net worth (equity) / Total assets
	Insurance revenues = (Fee-for-service revenues + Premium revenues + Medicare revenues + Medicaid revenues)

Financial Performance of HMOs for All States

Figure 1 provides a broad analysis of operating profits for health plans during the 1990s. The average health plan in the United States currently operates at a loss. While plans obviously aim for positive operating margins, those plans with lower operating losses are now outperforming the industry as a whole. For all HMOs in the database, operating margins decreased after 1994. The median operating margin declined from .02 in 1993 to -.07 in 1997 and 1998. Rising medical costs contributed to this decline in operating margins. In 1995, the medical loss ratio rose to .93 in 1998 from .85 in 1994. Conversely, the administrative cost ratio stabilized between .15 and .16 after 1996. Negative margins also contributed to the erosion of the capital cushion of health plans, with the equity ratio declining to .31 in 1998 from a high of .40 in 1995. In short, declining profitability among HMOs is attributable to increasing medical costs that diminish the capital reserves of health plans.

Figure 1
HMOs All Plans % Operating Margin
1992-1998



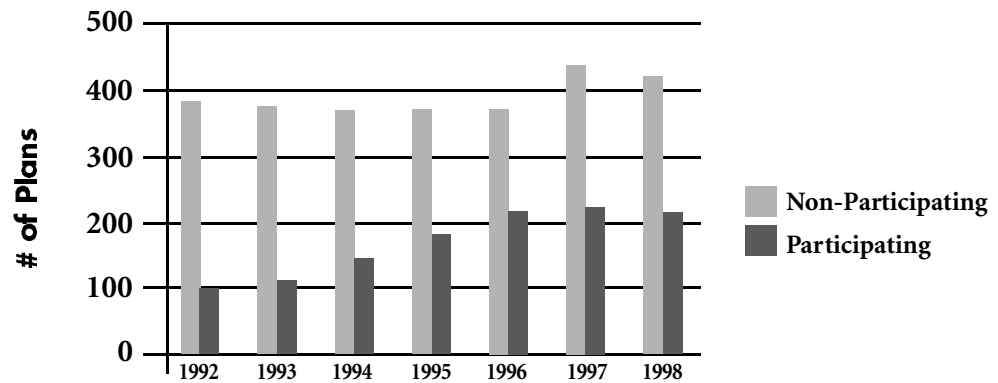
Participation in Medicaid HMOs by Plan Characteristics for All States

The HMO database of Health Care Investment Analyst Inc. (HCIA) provided the financial and operating information used to explore the Medicaid market for the 1992-1998 period. Further elaboration was provided by data from the American Association of Health Plans (AAHP). The total number of plans represented in the database increased from 471 in 1992 to 655 in 1998. Median values offset the impact of outliers and extreme variations in financial measures.

The number of plans participating in the Medicaid market steadily increased during the 1992-1997 period and leveled off to 226 plans in 1998 (see Figure 2). However, the characteristics of the participating plans varied across different types of plans. The percentage of participating plans associated with chains increased to 53% in 1995, declining to around 36% of all plans in 1998.

Figure 2

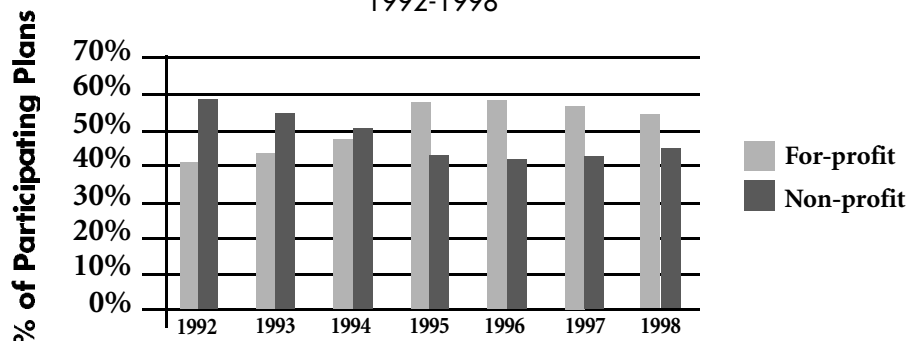
HMO Participation Status in Medicaid Managed Care 1992-1998



In the area of profit status, the number of FP plans participating in Medicaid increased sharply from 42% in 1992 to 58% in 1996, and remained above 55% for 1997-1998 (see Figure 3). During this same period the number of NFP plans participating in Medicaid decreased from 58% in 1992 to 42% in 1996, followed by a slight increase to 45% in 1998. Examination of plan ownership relative to profit status sheds light on these changes.

Figure 3

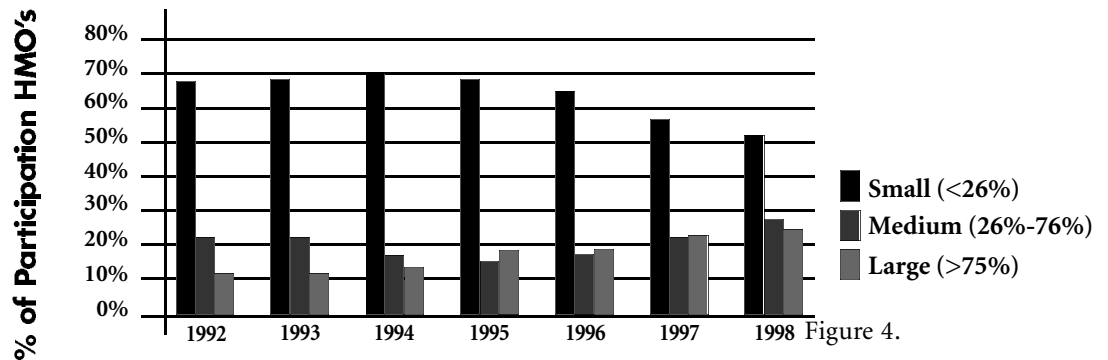
HMO Participation by Profit Status 1992-1998



HMO participation in Medicaid by Medicaid enrollment indicates that over the 1992-1998 period the majority of the plans participating in Medicaid were plans with small Medicaid enrollments. After 1994 a downward trend occurred for small Medicaid enrollment plans, while participation by plans with medium and large Medicaid enrollments increased (see Figure 4). In 1998, however, plans with small Medicaid enrollments declined while plans with medium and large enrollments increased. The small Medicaid membership category fell from 71% of all plans in 1994 to 51% of all plans in 1998, while plans in the large category more than doubled from 11% in 1992 to 23% in 1998. This trend verifies that a substantial number of new entrants either are entering the market as medium to predominantly Medicaid plans, or are moving rapidly from a small to large Medicaid membership. This shift in membership also verifies that plans with small Medicaid membership are leaving the Medicaid market.

Figure 4

HMO Participation by Medicaid Membership Size
1992-1998



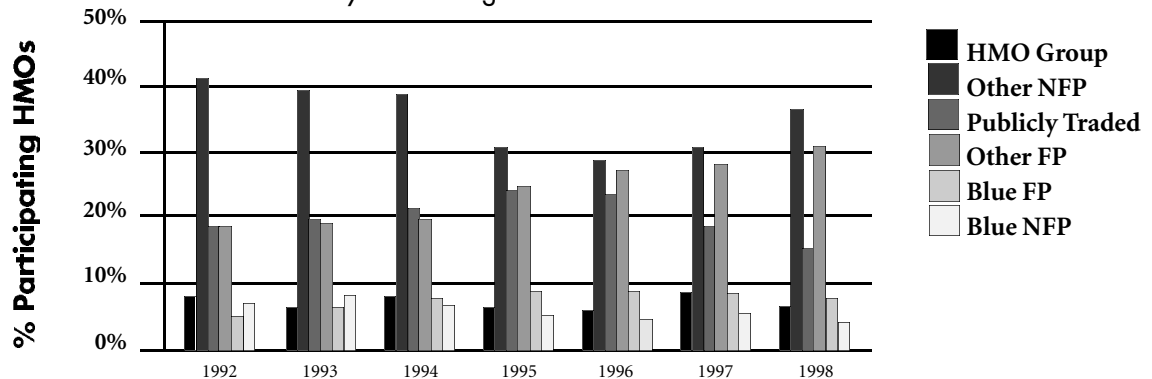
As Figure 5 shows, as early as 1992 the highest percentage involvement in Medicaid was Other NFP plans, with 44% participation. Other NFP plans declined to 29% in 1996, but increased to 37% participation by 1998. For publicly traded plans, participation rates peaked at 24% in 1995 and declined to 15% by 1998. From 1993 to 1998, Other FP plans increased each year to a high of 32% in 1998, which is the second highest participation rate.

In the HMO Group (now known as the Alliance for Community Health Plans), participation remained below 9% for each year, with a 6% participation rate in 1998. For Blue Cross NFP plans, Medicaid participation declined from 7% in 1993 to 4% in 1998; FP Blues also declined from 9% in 1996 to 7% in 1998.

The recent trend indicates that publicly traded plans and plans with small percentages of their enrollments in Medicaid are leaving the Medicaid managed care business. The growth in Medicaid managed care is occurring among plans that are either privately held, for-profit, or other non-profit plans, and among plans with large Medicaid enrollments.

Figure 5

HMOs Participation in Medicaid by Market Segment 1992-1998



Membership in Medicaid HMOs for All States

An important question is whether the change in the distribution of Medicaid membership is across all plan types or whether, despite its growth, most of the membership remains clustered around Other FPs and Other NFPs. Figure 6 provides part of the answer. Other FPs experienced the highest growth, accounting for 37% of the enrollment in 1998, compared to only 13% in 1992. Other NFPs increased slightly to 30% in 1998, while both FP and NFP Blues showed marginal growth to 15% in 1998, up from 11% in 1992. In contrast, publicly traded plans experienced the greatest decline, falling from 34% in 1992 to 13% in 1998. The inconclusive picture of plan tax status may reflect state licensure, rather than corporate mission.

Determining whether a growing number of Medicaid beneficiaries are being “mainstreamed” into fully regulated HMOs is also unclear from this data. Enrollment data (see Figure 7) shows that the number of beneficiaries enrolled in plans with a small Medicaid membership grew by 18% between 1992 (39%) and 1996 (57%). By 1998, however, small Medicaid membership plans dipped to 38% of total Medicaid enrollment. In contrast, the Medicaid membership in plans with large Medicaid enrollments more than doubled, increasing to 36% in 1998 compared to 14% in 1993. This suggests a decrease in participation in Medicaid by HMOs with small Medicaid enrollments. However, interpretation of this trend data is difficult because the data does not include the growing number of Medicaid-only plans in states with 1115 waivers.

Figure 6

Medicaid HMO Membership by Market Segment 1992-1998

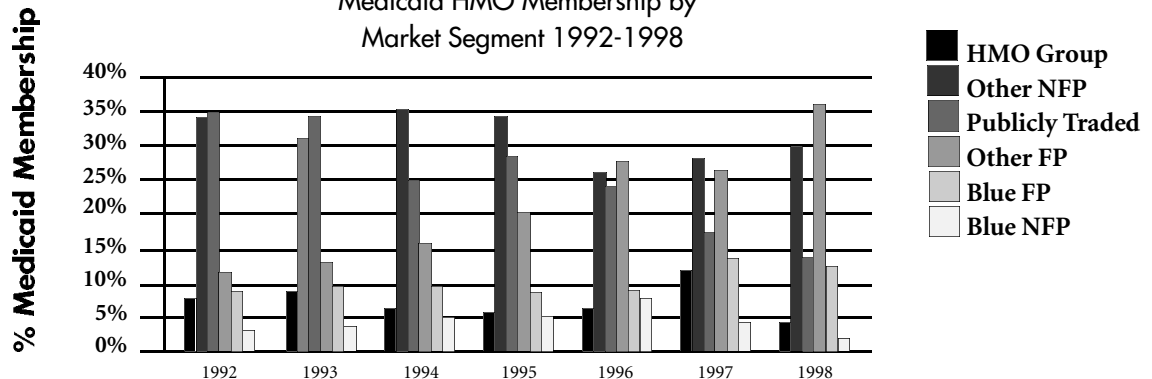
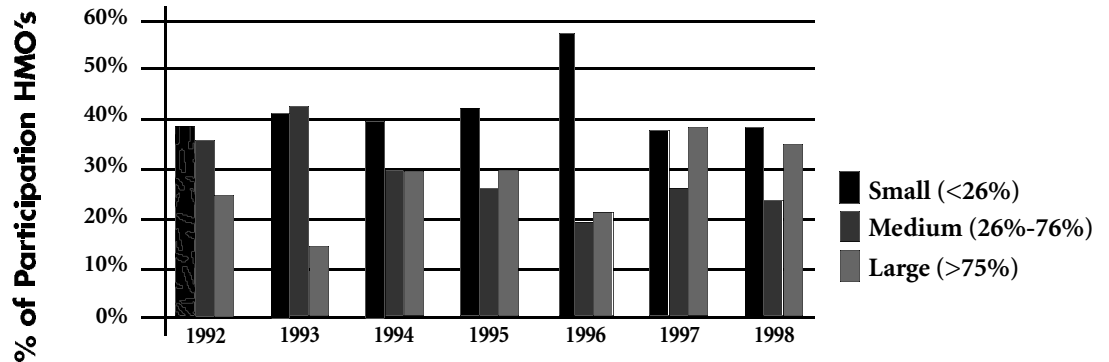


Figure 7
Medicaid HMO Membership by Plan Size
1992-1998



Financial Performance by Medicaid Participation and Size for All States

Figure 8 presents the financial analysis by Medicaid participation status. From 1992 through 1993, HMOs offering Medicaid products earned slightly higher profits. After 1994, both plans with and without Medicaid products incurred operating losses, although participating plans experienced operating losses that were less than half of those of non-participating plans. Slightly higher administrative cost and medical loss ratios appeared to result in higher operating losses for Medicaid non-participants. Operating losses eroded the equity cushion of participating plans at a greater rate than for non-participating plans. This suggests that the equity reserves of non-participating plans were preserved because of size and returns of their investment accounts. From 1992 to 1994, close to 70% of participating plans earned a profit, compared to only 55% of non-participating plans. A reversal occurred after 1994: Only 29% of participating plans earned a profit in 1996 and by 1998 this percentage dropped to 23%. In contrast, only 14% of non-participating plans earned a profit in 1996 and by 1998 this percentage increased only slightly, to 18%.

Figure 8
Medicaid Participation Status %
Operating Margin 1992-1998

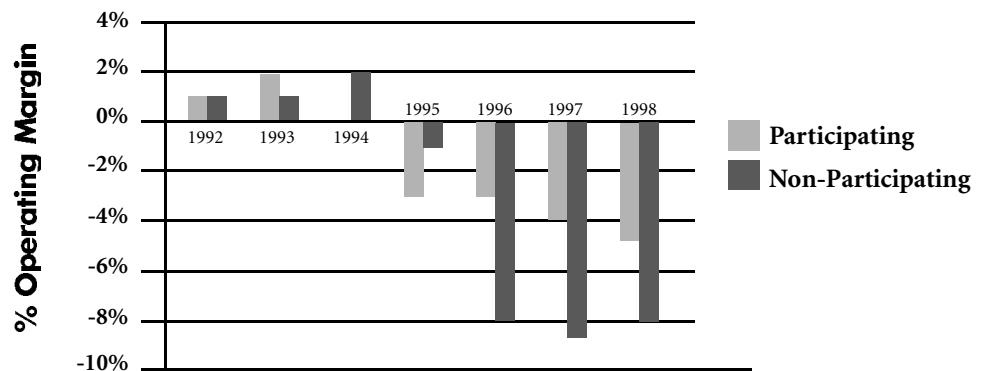
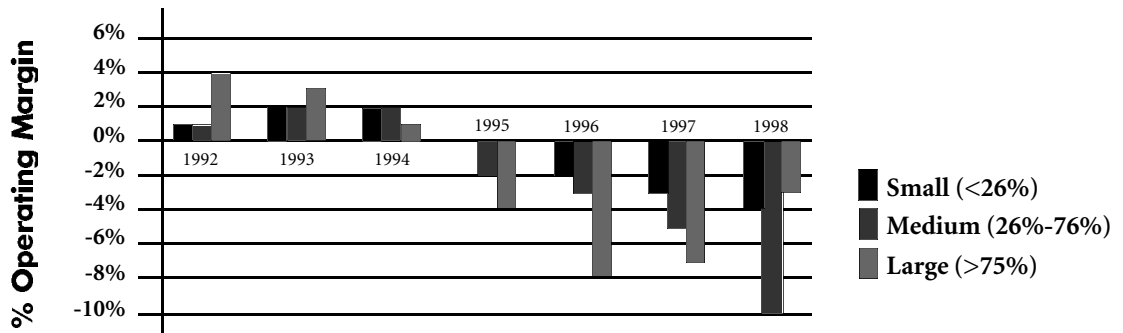


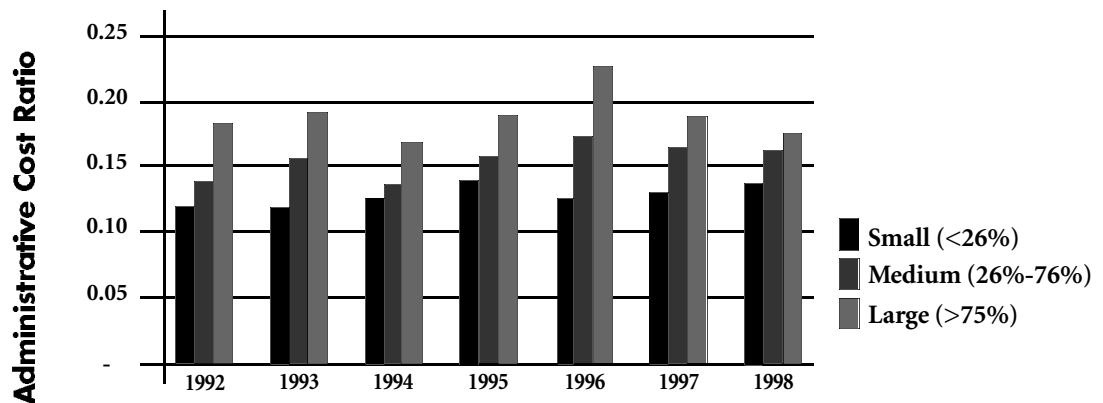
Figure 9 presents the financial analysis by size of Medicaid enrollment. Plans with higher percentages of Medicaid enrollees earned higher profits in 1992 and 1993 than plans with small or medium Medicaid enrollments. After 1994, operating profit margins for larger Medicaid plans declined considerably, from .01 in 1995 to -.07 in 1997. These operating losses stemmed from the higher administrative cost ratios of the larger plans, which reflects the administrative burdens of managing enrollees in this line of business, specifically the turnover among Medicaid enrollees and extensive contract and reporting requirements. In 1998, the trend reversed, and plans with larger Medicaid enrollments incurred lower operating losses than either smaller Medicaid enrollment plans or non-participating plans. Declining administrative costs contributed to these lower losses (see Figure 10); however, the administrative ratio of 18% for larger Medicaid plans is still higher than for plans in the other size categories. These predominately Medicaid plans are smaller in terms of overall enrollment—median enrollment of 45,500 compared to median enrollment of 142,600 for plans with a small Medicaid size enrollment. Smaller enrollments hamper the ability to achieve economies of scale in administrative costs.

Figure 9
Level of Medicaid Participation % Operating Margin 1992-1998



However, as noted in Figure 7, a greater percentage of total Medicaid enrollment shifted toward predominately Medicaid plans, which may be creating the critical economies of scale needed to spread fixed administrative costs and reduce operating losses. The medical loss ratio for predominately Medicaid plans grew at a slower rate (from .82 in 1995 to .89 in 1998) relative to small enrollment plans, which grew at a higher rate (.88 in 1995 from .93 in 1998) as shown in Figure 10. The equity cushion of predominately Medicaid plans declined significantly from .45 in 1993 to .27 in 1997, and then increased slightly to .29 in 1998. Conversely, non-participating plans reported higher equity cushions, which only declined to .34 in 1998.

Figure 10
Level of Medicaid Participation
Administrative Cost Ratio 1992-1998



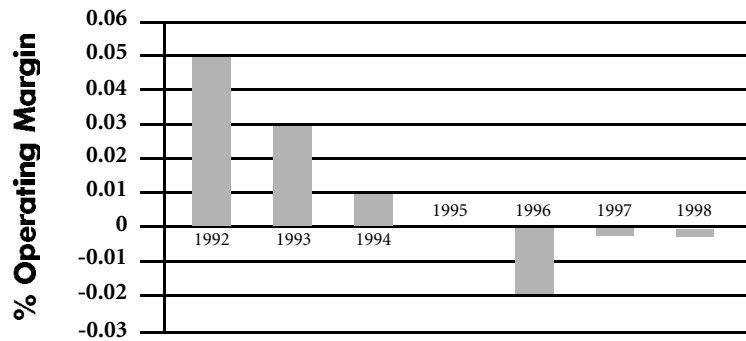
Analysis of Financial Performance and Plan Participation in Study States

As Figure 1 illustrated, in recent years the median profitability of HMOs throughout the U.S. declined dramatically. Of interest to this study is how our eight study states compare with this national trend.

Arizona: Medicaid data was not available for Arizona because all plans participating in Medicaid are not licensed HMOs. However, the general operating margin trend of Arizona's HMOs not in Medicaid (see Figure 11) suggests that these plans are financially stronger than comparable plans nationally. Arizona plans operated close to breakeven over the past two years.

Figure 11

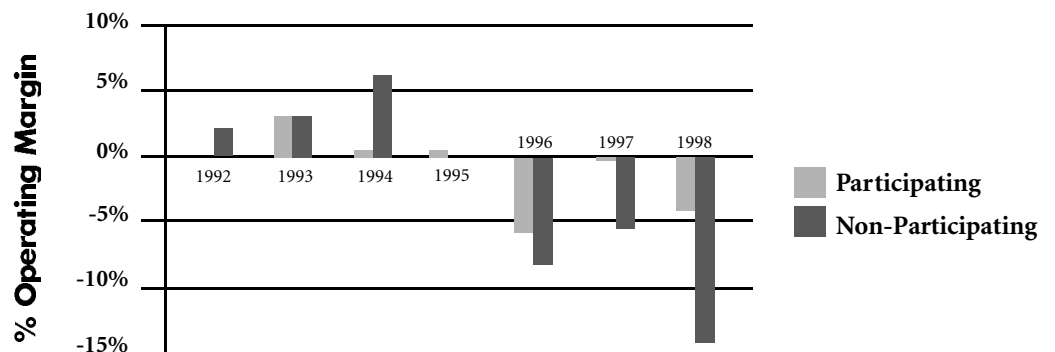
Arizona's HMOs
Non-Participating
% Operating Margin 1992-1998



Maryland: In Maryland, plan participation in Medicaid grew from 15% in 1992 to 33% by 1998. Maryland HMOs in Medicaid followed national trends and generated slight profits from 1992 to 1994 (see Figure 12). Conversely, non-participating plans had greater variation in profitability in 1994 through 1995. Following national trends, a downward trend in profit margins occurred for HMOs in Maryland. Non-participating plans incurred greater losses than those in the Medicaid market. Non-participating plans saw their operating losses increase to -.14 in 1998 from -.08 in 1996. A higher medical cost ratio, which grew to 1.00 in 1998 from .92 in 1996, was the main factor behind this operating loss.

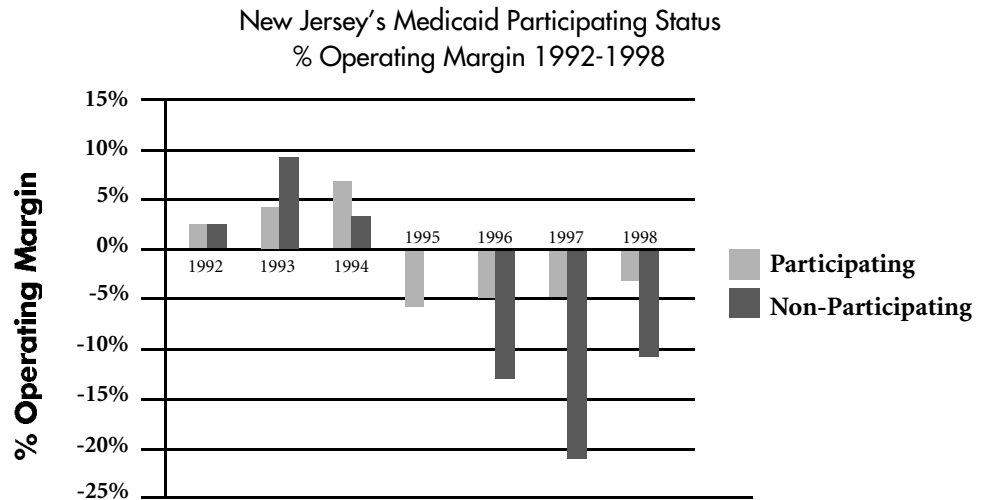
Figure 12

Maryland's Medicaid Participating Status
% Operating Margin 1992-1998



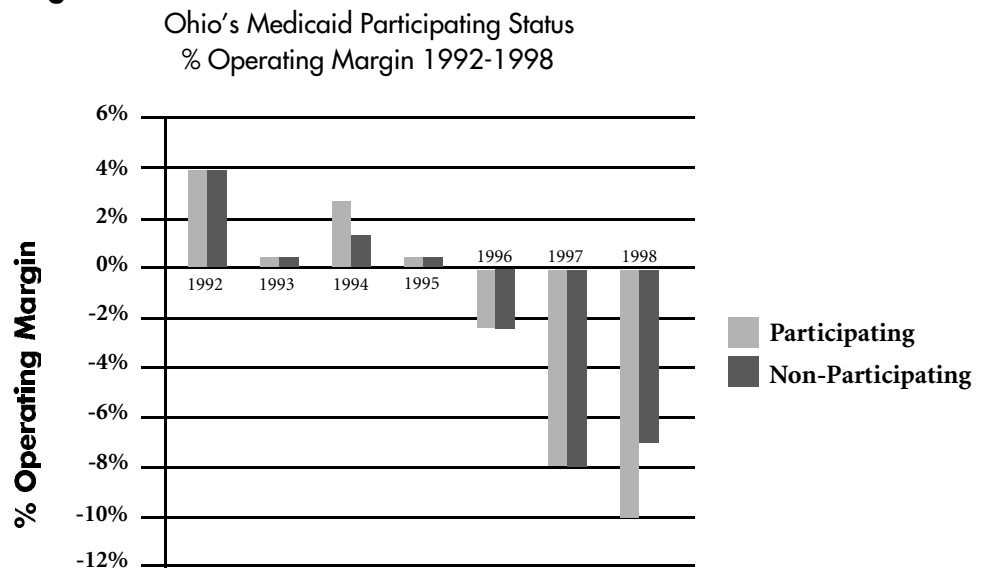
New Jersey: In New Jersey, plan participation in Medicaid increased from 14% in 1992 to 38% in 1998. The operating margin ratios for participating and non-participating plans fluctuated significantly during this study period (see Figure 13). In contrast to the national median operating margin, HMOs participating in Medicaid saw their operating margin ratio more than double from .03 in 1992 to .07 in 1994. After 1994, the operating margin ratio for these plans declined dramatically to -.05 in 1997. In contrast to the national norms, HMOs participating in Medicaid lowered their operating losses to -.03 by 1998, while non-participating plans' operating losses remained close to the national median. Declining margins among participating plans are attributable to the rise in the administrative cost ratio.

Figure 13



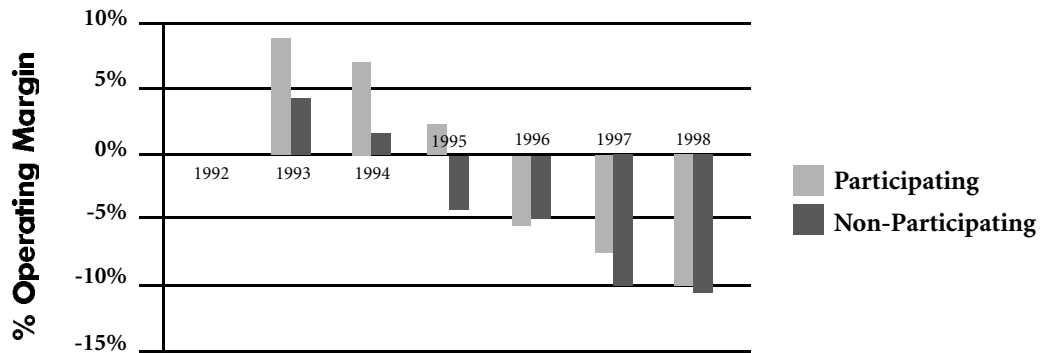
Ohio: In Ohio, plan participation in Medicaid declined from 41% in 1992 to 32% in 1998. From 1992 to 1995, the profitability of plans in the Medicaid market was slightly higher than the national median operating margin (see Figure 14). After 1995 the trend reversed dramatically, with plans in and out of the Medicaid market incurring operating losses. Participating plans experienced greater declines in their operating margins than comparable plans nationally. For participating plans, the operating losses grew to -.10 in 1998 from -.03 in 1996; for non-participating plans, the operating losses declined to -.07 in 1998 from -.11 in 1997. Higher medical costs led to the higher operating losses for plans in and out of Medicaid.

Figure 14



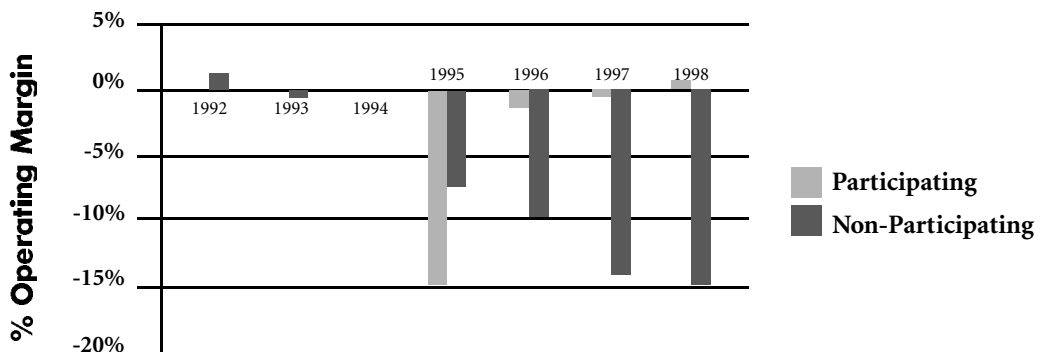
Texas: In Texas, plan participation in Medicaid increased from 5% in 1993 to 26% in 1998 (see Figure 15). The profitability of participating plans exceeded national averages until 1995, when plans in and out of the Medicaid market operated at a loss. By 1998 operating losses rose significantly to -.12 for non-participating plans and to -.10 for participating plans, exceeding the average losses incurred by HMOs nationally. These significant losses stem from rising medical and administrative costs.

Figure 15
Texas's Medicaid Participating Status
% Operating Margin 1992-1998



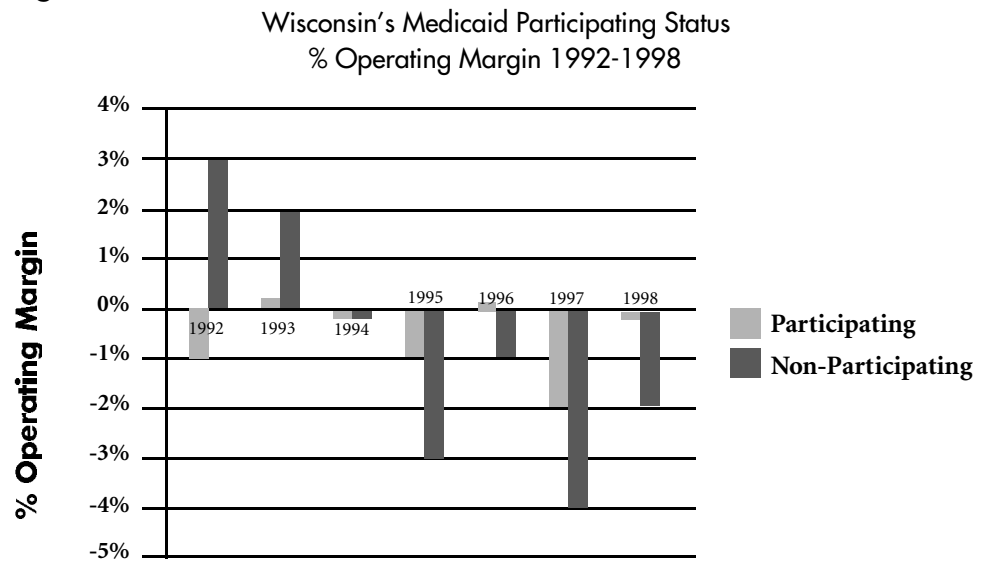
Virginia: In Virginia, plans did not participate in Medicaid until 1995. By 1998, 38% of the plans participated in Medicaid. Plans in the Medicaid market incurred operating losses that significantly exceeded the national averages. However, from 1996 to 1998, participating plans improved to a breakeven point (see Figure 16). In contrast, non-participating plans saw their operating losses fall to -.15. Participating plans improved their profit positions by controlling their medical loss ratios.

Figure 16
Virginia's Medicaid Participating Status
% Operating Margin 1992-1998



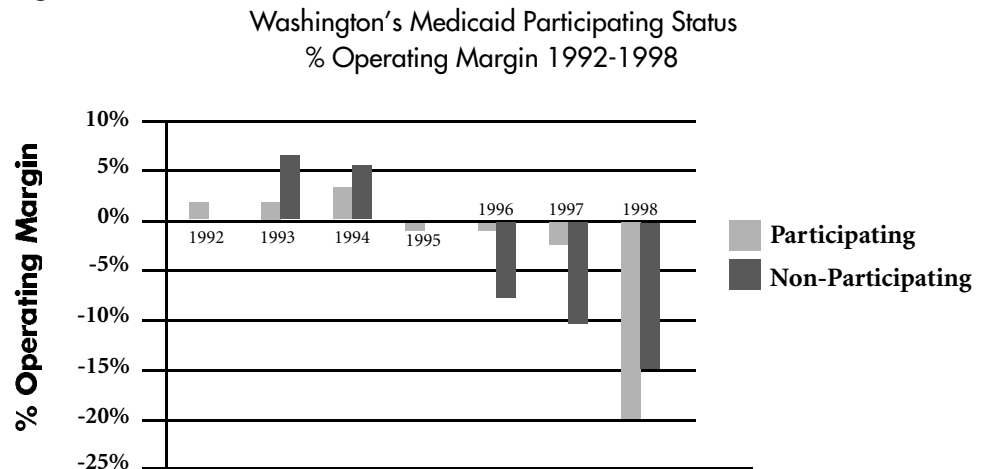
Wisconsin: In Wisconsin, plan participation in Medicaid increased from 22% in 1992 to 70% in 1998 (see Figure 17). Participating and non-participating plans showed only slight variations in their operating margin ratios over the study period. With the exceptions of 1992, 1995, and 1997, the operating margins of plans in Medicaid remained at or slightly below the breakeven points for each year. Non-participating plans followed national patterns by showing a downward trend in operating profits from 1992 through 1994. After 1995, non-participating HMOs incurred operating losses that were less than the national standards.

Figure 17



Washington: In Washington, plan participation in Medicaid increased from 22% in 1992 to 50% in 1998 (see Figure 18). Both participating and non-participating plans experienced significant reversals in profitability. In 1993 and 1994, non-participating plans earned higher profits than those in Medicaid. After 1996, plans in and out of the Medicaid market lost money, with participating plans experiencing greater losses than non-participating plans. The operating margin for plans in Medicaid dropped to -.20 in 1998. Higher medical expenses contributed to these operating losses.

Figure 18



Summary Analysis of State Data

The analysis of HMO participation in Medicaid in these eight states found participating plans in only two states operating at or above a breakeven point. However, while participating plans in the remaining states are incurring operating losses, their losses are comparable or less than those reported by non-participating plans.

In 1998, plans participating in Medicaid in Virginia and Wisconsin operated at or above breakeven. However, non-participating plans in Virginia incurred operating losses, while participating plans in Wisconsin operated close to breakeven. Both participating and non-participating plans in Ohio, Texas, and Washington incurred significant operating losses in 1998. Those plans participating in Medicaid in New Jersey and Maryland operated at losses, but at lower levels than non-participating plans. For all the states except Maryland and Wisconsin, plans participating in Medicaid reported lower equity cushions than non-participating plans. Lower equity indicates that these plans may lack the capital reserves to cover shortfalls in profitability. Thus, both the financial stability and the risk of failure for plans participating in Medicaid are or should be concerns for state policy makers.

PART II: A General Model Of Purchaser and Seller Contracting In The Medicaid Market

Previous research has demonstrated that the implementation of Medicaid managed care programs is a complex and often contentious process involving many stakeholders and numerous activities. To examine this process, a multiple component model was constructed and, through subsequent iterations, refined. Figure 19 illustrates that the decisions of purchasers (state and/or counties) and sellers (managed care organization) are shaped by five general factors:

- General Design Features
- Program Management Attributes
- Environmental/Contextual Factors
- MCO and Contractor Characteristics
- Contractual Terms and Rates

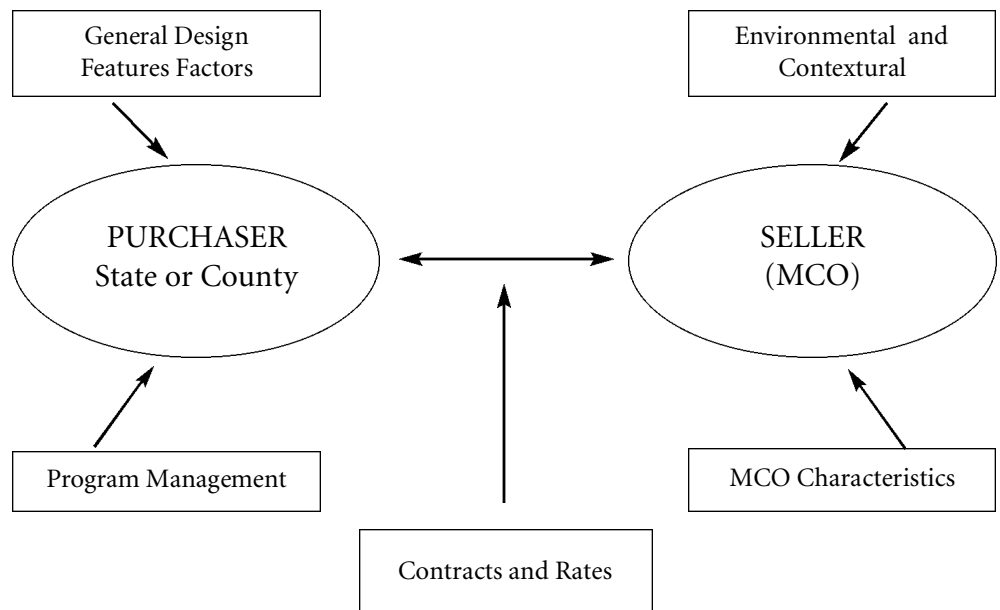
No single factor can be studied by itself. Each is affected directly and indirectly by other components of the model. Nonetheless, focusing on how the purchaser-seller transaction is affected by the other factors highlights the many decision points and considerations that impact the success of a purchaser's efforts to buy high quality managed care services for its beneficiaries.

General Design Features

These include the basic goals of the state's Medicaid managed program: for which and how many beneficiaries is managed care enrollment sought, and what model or models of managed care it plans to adopt. These decisions are commonly influenced by past state experience with managed care programs, the extent to which program design affects or is affected by other public programs (such as mental health or public health), and whether the state is planning a program with or without carveouts. In addition, General Design Features include the strategic planning for procurement and solicitation of plan participation: what plans (including traditional HMOs and perhaps non-traditional plans) will qualify to participate, how they will be selected, and if the number of awards will be limited, or made to all qualifying bidders.

Figure 19

Model of Medicaid-HMO Contracting



Program Management

Interviews with health plan executives in our earlier study suggested that states vary dramatically in experience and competence in implementing managed care initiatives. Because most Medicaid agencies were largely fee-for-service claims-processing entities until very recently, realigning functions with the new responsibilities accompanying the Medicaid program requires major restructuring. New skill sets and new initiatives require an extensive commitment of resources to planning, organizing, and executing time-sensitive implementations. False starts, schedule slippage, or failure all have adverse implications for plans. Outsourcing functions to external parties (e.g., enrollment brokers/benefits counselors) may offset expertise and resource deficiencies and impact market entry and exit. Overall, the quality of the relationship between Medicaid staff members and health plan representatives appears to significantly influence the willingness of plans to stay committed to the Medicaid product line.

Environmental and Contextual Factors

Decisions about design and implementation are influenced by the relevant managed care market, particularly its structure and competitiveness. By understanding the relevant managed care market, purchasers hoping to introduce Medicaid managed care can assess the potential interest and readiness of HMOs to enroll Medicaid beneficiaries. The market's maturity and life cycle stage reflect whether established plans in highly penetrated markets perceive Medicaid as an opportunity for growth, or whether new entrants see Medicaid as an opportunity for initial membership build-up. In either case, assessing plan capacity for new enrollment growth is critical. The provider market structure reflects, to some extent, providers' willingness to participate in managed care networks serving Medicaid beneficiaries, and whether rates and other terms are attractive enough to allow plans to build sustainable delivery systems. The design decisions that shape plan qualifications determine whether provider-sponsored plans will become integral parts of managed care initiatives. Traditional Medicaid providers are a critical consideration because of interest in protecting them, easing their transitions into managed care arrangements, or possibly promoting the development or sponsorship of their own health plans.

MCO Characteristics

A number of health plan characteristics appear to influence the long-term viability and stability of a managed care program. Previous research found that different rates of participation across different types of ownership (local versus chain) and different membership composition (ranging from entirely Medicaid membership to overwhelmingly commercial membership) may influence expectations and decisions among Medicaid program managers. Although state Medicaid agencies may not explicitly promote or avoid Medicaid-only plans, they are likely to be attentive to this dimension. Plans also vary in terms of their maturity and experience in local markets and across varied product lines. A number of respondents to this study recommended that state Medicaid agencies use plan maturity and experiences to assess the likely commitment of plans to stay in markets. Finally, the financial conditions of the plans with which Medicaid agencies are contracting is critical, particularly the extent to which they are dependent on Medicaid rates to remain viable. Plans highly reliant on Medicaid revenues could become vulnerable given unexpected or dramatic rate cuts. On the other hand, plans incurring substantial losses in commercial or other lines of business may be unwilling to remain in a low or no margin line of business like Medicaid in the long run.

Contracting and Rates

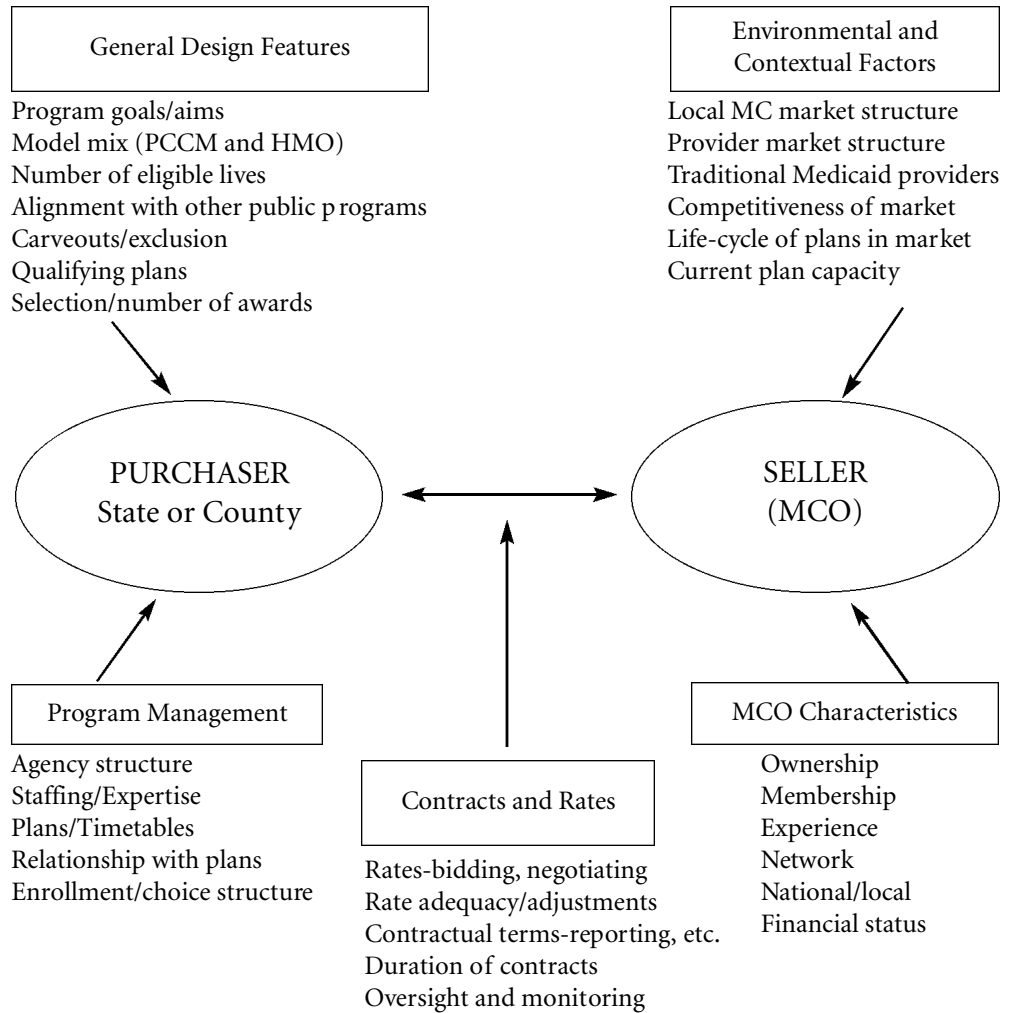
Ultimately, the relationship between purchasers and sellers is formalized by the contract, which sets mutually binding commitments. The rate development process is also critical in influencing this relationship, including the extent to which plans are involved in and informed about this process. The method of rate determination is also significant. Whether states have adopted risk adjustment methods or other techniques to mitigate or limit risks also influences plan satisfaction.

The non-financial terms in the contract are increasingly important as states become more detailed and demanding. This may lead to a misalignment between demands and expectations, and to an unwillingness to pay commensurately with those requirements. Supervisory and reporting activities, especially encounter data reporting, are frequent sources of conflict between state agencies and health plans. The duration of contracts was also identified in our earlier survey as an important issue, with plan managers contending that by cultivating longer term relationships with health plans, state Medicaid agencies could create a climate of collaboration and partnership.

Figure 20 presents the full model. This full model served as the foundation for the telephone survey instrument used in this study. Interviews with individuals from eight states were designed to test the model and to explore the interrelationships among its components.

Figure 20

Model of Medicaid-HMO Contracting



PART III: Key Perceptions of State Medicaid Managed Care

The previously described model of Medicaid managed care was explored and enriched by interviews with key observers representing different roles (state program, provider, advocate, plan executive, trade association) in the eight focal states. The telephone survey instrument that guided the interviews appears in the Appendix. In general, there was a high degree of confirmation within states on many issues. Stakeholder perspectives were less likely to be uniform across states, reflecting the fact that state-level programs vary substantially and participant viewpoints are shaped by practical experience, not theoretical preference. The interview findings are discussed according to each component of the model.

General Design Features

Program Aims

Respondents overwhelmingly identified the primary and secondary aims for their states' Medicaid managed care programs as the familiar dual goals of cost savings and access enhancement. Most thought that over time, cost savings had become a less prominent goal, in part because state agencies' expectations became more modest or because they discovered that their pursuit of excessive savings could jeopardize their programs. The relative importance of access as an explicit aim depended on how problematic access had been prior to implementing the Medicaid managed care initiative.

Most observers thought that over time, cost savings had become a less prominent goal, in part because state agencies' expectations became more modest or because they discovered that their pursuit of excessive savings could jeopardize their programs.

In some mature programs, sentiment is shifting toward quality improvement as a priority. The emphasis on quality improvement usually is associated with a relatively stable state program, the availability of quality data, and the development of reasonable performance benchmarking. Although few differences among stakeholders within states emerged from the inquiry about state program aims, there was one exception: Plan and provider representatives tended to see cost savings as more important than Medicaid officials did.

Model Selection

All of the focal states had a mandatory HMO enrollment strategy operating in at least part of their state. The opportunity to move toward full-risk contracting to obtain more predictability in payment was the most common reason cited for embracing a Medicaid managed care program. Respondents perceived HMOs as growing rapidly in the private sector and as a more advanced form of managed care relative to primary care case management (PCCM) programs; thus, it was a desirable model to promote. In some states the opportunity to offload administrative costs to plans was noted as appealing to state agencies, especially when contrasted with the administrative burdens of a PCCM program.

The maturity of the managed care market, coupled with the presumed level of interest among HMOs to serve the Medicaid population typically signaled the market readiness desired for states to initiate mandatory programs. Many respondents were surprised by the initial enthusiasm of plans, which was directly proportional to the size of their potential Medicaid enrollments. However, because of changing market conditions, some states had to modify schedules and target implementation, often delaying plans to enter some markets by

several years. Many observers, including those from both plans and state agencies, found that having a single point of accountability was a substantial improvement over fee-for-service, and they genuinely thought HMOs could improve quality. By contracting with only licensed HMOs rather than some other types of partially or fully capitated plans, the states' programs could rely on another state agency for supervision and avoid development of a regulatory apparatus themselves.

Many observers, including those from both plans and state agencies, found that having a single point of accountability was a substantial improvement over fee-for-service, and they genuinely thought HMOs could improve quality.

Carveouts, Exclusions, and Exemptions

States vary substantially on the extent to which their programs include groups other than TANF (AFDC) women and children. The reasons for carving out, excluding, and exempting other populations reflect many considerations, most beyond the scope of this study. However, this study did explore whether decisions to include or exclude special need populations had an impact on the readiness and willingness of plans to participate in the Medicaid managed care program. Two distinct perspectives were articulated. Many states and plans thought that initially serving only the TANF population on a mandatory basis

...some respondents thought that all entering plans should be expected to serve the full spectrum of Medicaid beneficiaries; these individuals also argued that special need populations could benefit more from managed care than healthy women and children.

was sensible and prudent. Extension of the managed care program to more needy populations would risk creating additional problems for beneficiaries, special need service providers, and advocates, as well as complicating the administrative difficulties associated with rates and the selection criteria. The consensus of those endorsing carveouts was clear: including these additional groups could jeopardize the entire managed care effort.

In contrast, however, some respondents thought that all entering plans should be expected to serve the full spectrum of Medicaid beneficiaries; these individuals also argued that special need populations could benefit more from managed care than more healthy women and children. Faced with the expectation of serving special need clients, those plans not prepared to make bona fide commitments to the Medicaid market would be less likely to enter. State officials in some states agreed, though they understood that accelerating enrollment to include special need populations required an administratively sound program and raised the stakes if such a program failed. At the time of the interviews, a number of the participating states still did not have firm timetables for extending mandatory HMO enrollment to large blocks of SSI (ABD) beneficiaries.

Qualifying Plans

As noted above, several states contracted with only licensed HMOs, a step that simplified supervision by placing responsibility for monitoring on another state agency. However, some states allowed the qualification process to be shared, at least in part, with the agency responsible for Medicaid managed care; in these instances other types of managed care organizations could qualify to contract on a full-risk basis. This alternative approach allows traditional provider organizations to participate on a full risk basis in the form of a provider-sponsored organization, either permanently or on a transitional basis, until they

obtain full HMO licensure. This is one of several strategies states employed to protect traditional Medicaid providers. It is also a strategy that is re-emerging as an option following HMO withdrawals from some state markets, and as the long-term viability of the conventional HMO is questioned

Soliciting Bids or Proposals and Making Awards

One of the most significant differences among respondents centered around the value of making the bidding process competitive, including setting pre-determined limits on the number of awards. Shared perspectives emerged within states, not within roles.

One of the most significant difference among respondents centered around the value of making the bidding process competitive, including setting predetermined limits on the number of awards.

The argument for making awards to all qualifying bidders sought to maximize choice opportunities for beneficiaries and to encourage extensive plan participation, particularly among new entrants into Medicaid. These goals could potentially enhance credibility and political support for the program by involving a large number and broad spectrum of health plans. However, this approach risks allowing more bidders than the market can sustain, thus creating potential instability and dislocation for beneficiaries. With unlimited awards, plans lacking commitment might enter the Medicaid market temporarily. With unlimited awards plan membership could be diluted, thereby undermining plan commitment to investment in this product line. In addition, the supervisory process would be burdened by an increased number of participating plans.

The argument for limiting the number of awards assumes that the bidding process is a more reliable and reasonable site for competition, and that less qualified plans will be eliminated at this point. Rigorous selection criteria can require evidence of commitment and anticipated viability. By limiting awards, winning plans receive more substantial memberships, thus increasing the value of their bid, and the larger membership may reduce the state's need to offer higher rates to attract preferred plans. This, in turn, leads to longer-term relationships, more stability for members, and a greater likelihood that investments in genuine quality improvement will be made. Plan monitoring and supervision are also enhanced because less qualified plans are excluded.

The argument for limited awards received more support in theory than in practice for two reasons. First, in evaluating market instability, most states contend that awarding a limited number of awards places them in precarious positions and gives surviving plans disproportionate leverage in their relationships with the state agency. This was the particular concern among state officials; some had planned to trim the number of participating plans as their programs matured, but found that plan exits had left them with too few surviving plans to risk further reductions. The other reason for not limiting the number of awards was the anticipation of political pressure or judicial appeals if certain plans failed to receive awards. Complicating the reality of limiting bids were serious questions about the states' expertise to make valid decisions about qualifying plans, particularly in the initial stages of their programs.

Program Management

Implementation and Operations

Because the focal states had experience with one or more mandatory program rollouts, inquiries about implementation and timetables were viewed as appropriate. Despite many early problems, more recent implementation tasks were performed reasonably well, subject

to the state agencies' resource limitations. While our earlier study found plans very critical of delays and slippage in program initiation, the current appraisals were more tolerant or acknowledged improved performance by the state staff. Respondents claimed the state agency had more realistic assessments of the time and effort needed to launch programs, as well as a more stable environment than during the numerous Section 1115 waivers in the mid-1990s.

Another factor influencing perceptions about the pace of implementation was the recognition that extending mandatory programs to special need populations is a more challenging process than implementing programs for TANF women and children. It is also apparent that a number of Medicaid agencies are now undergoing major structural modifications to align their functions more fully with the managed care strategies they are implementing. Among the focal states, only Arizona currently manages its program in an entirely separate agency, due in part to the very different origins of Medicaid in that state.

Experience and Expertise of State Staff Members

Judgments about the competence of persons (or individuals) responsible for managing Medicaid programs varied significantly among states. Most state staff remain in transition from fee-for-service backgrounds. Hiring and salary limitations have impeded Medicaid agencies from attracting some of the necessary expertise. However, some key staff members in many of the state agencies are viewed as crucial to program success because of their competence and continuity. In several states, recent hires are bolstering internal capacity and assisting in the conversion process from a fee-for-service claims-paying agency. In addition, state agencies have relied extensively on consultants in some critical areas (e. g., actuarial services, contract development and negotiation, information systems) in part because money for contract services is often more readily accessible than for hiring permanent staff.

A number of respondents stressed that the competence with which state agencies manage their programs directly affects the extent to which legislative "interferences" can be avoided

An important but unanticipated issue that arose in discussions about staffing was the role that state legislatures can, do, and should play in the Medicaid managed care program. A number of observers stressed that the competence with which state agencies manage their programs directly affects the extent to which legislative "interference" can be avoided. This view was commonly shared by state staff and by most respondents, who tended to see risks in micro-management by elected officials. Some respondents, however, offered a slightly different view. They contended that elected officials need to "be in the loop" but in a purposely crafted role, such as a legislative supervisory body. This arrangement would ensure that legislators are engaged in what is inescapably a public process, in the event that plans need an avenue for recourse.

Relationships Among Stakeholders

In the eight focal states, the relationship between the state Medicaid staff and various stakeholders was generally characterized by a high level of interaction and, in some cases, collaboration. This contrasts with findings in the earlier study, which underscored many states' failure to pursue and achieve partnership relationships, particularly between plans and Medicaid agencies. Virtually every state had fostered the participation of multiple parties in program planning, implementation scheduling, contract crafting, and rate development—at least in terms of informing plans about the rate-setting process. Stakeholders recognized and appreciated these efforts and saw them as cultivating long-term relationships. A sense of

partnership was seen as particularly valuable for problem identification and resolution, early intervention to preempt potential crises, and fuller appreciation for rationales behind policies and practices.

In some states, respondents identified specific events that contributed to this emerging plan-program rapport: plan exits, the refusal of plans to bid on new areas, or impasses over rate negotiation. In other cases, new personnel in key positions launched concerted attempts to engage various stakeholders to address program problems. Because these comments came from respondents representing all perspectives, it is clear that the quality of these relationships significantly influences a state's ability to create an environment for constructive problem solving.

Enrollment and Choice

Respondents were asked about their experiences with enrollment brokers, the most commonly out-sourced Medicaid managed care function. Our earlier study found numerous concerns about the potentially adverse impact of enrollment brokers on health plans by either creating confusion or bias in the enrollment and auto-assignment processes. There was also concern about the competence of brokers at that time, fueled by some notable failed contracts between states and enrollment brokers. The sentiment toward the enrollment broker is becoming more positive. States officials contend that enrollment brokers have added value in the plan selection process and have met critical needs in terms of personnel and expertise, especially during periods of rapid expansion. Interviewees representing plans were also more supportive of the broker function and, while concerns remain about enrollment brokers creating another barrier to effective plan-to-beneficiary communication, most think the programs generally benefit from their use. However, the majority of those interviewed emphasized that regardless of the effectiveness of enrollment brokers, clients continue to need more and better education on how to navigate the managed care world. A few states are broadening the role of brokers to address this concern.

Environmental and Contextual Factors

Managed Care Market Structure

States pursuing mandatory HMO enrollment targeted those areas with established HMOs in the market, and with a minimum of two or more plans willing to participate. This has resulted in an urban-oriented strategy, at least initially, though several of the focal states successfully influenced plans to extend their service areas to locales where they previously had little or no commercial presence. Most respondents did not anticipate the level of interest in entering the Medicaid market by plans during the program implementation period in the early to mid 1990s. The previously discussed national trend illustrated the surge in entry which corresponds with the period of general prosperity in the HMO industry. At that time the prevailing industry consensus saw membership as crucial to achieving market standing and enhanced negotiating leverage with providers. The Medicaid market appeared to offer rapid growth with its promise of mandatory enrollment.

The ensuing years brought significant industry changes including dramatic losses, plan failures, provider consolidations and pushback, intense consumer backlash, and extensive regulatory impositions. The industry responded to these pressures by mergers and acquisitions and by a renewed interest in sacrificing membership growth for improved profit margins. Interest in entering new lines of business waned, and plans carefully evaluated those products and business lines with losses or low margins. Thus, as plan withdrawals from Medicaid participation occurred in several states, few new entrants came forward to replace them. In addition, as a result of mergers and acquisitions, the total number of plans available to enter the Medicaid market plummeted, further impacting program stability and retention.

Health Plan Maturity and Performance

By design, most states' selection processes encouraged plan participation in an effort to maximize choice opportunities for beneficiaries. As noted earlier, this sometimes meant attracting plans with limited experience with Medicaid or with the target markets. Given Medicaid's history of participation problems among providers, these efforts seemed sensible at the time. Several observers recognized that this could lead to an excessive number of participating plans, but over time market forces would reduce participants. We noted in our earlier report that the "survival of the fittest" approach was generally unpopular with established plans, especially those with longstanding interest in serving Medicaid members.

In retrospect, the sentiment in a number of states is that more selectivity during program initiation might have reduced market turbulence. But as discussed earlier, it is unclear that state agencies could have successfully denied participation to any but the most inferior of plans. In some states, after many firms entered the market, the financial picture deteriorated in unanticipated ways, and significantly so in states where rates were summarily reduced or where rate setting or bidding led to no increases. Also, as the financial performance of plans declined, even plans that initially had had a long-term commitment to Medicaid reconsidered their continued participation.

Plan Interest In and Capacity For Medicaid

The extent to which respondents saw maximizing participation from predominantly commercial plans as both a program goal and a realistic objective varied among states; in contrast, there was consensus on this issue within states. A number of states found broadly based interest in serving a Medicaid membership and, because many states were committed to a licensed HMO strategy, it was assumed that many plans would enter this market. Few states anticipated a surge of Medicaid-only plans when they launched mandatory programs. Notably, this has changed over time, and now there is a greater expectation that new entrants may be Medicaid-only plans, particularly provider-sponsored Medicaid plans. Expected enrollment also led states to believe that they would need to attract established plans with the capacity to absorb a large number of new members because, at that time, Medicaid-only plans were typically small and generally considered incapable of rapid expansion. Several respondents observed that many commercial plans did not understand the key differences between serving Medicaid members and serving their commercial customers, thus limiting their participation.

Readiness of Traditional Providers

An important dimension of capacity to serve Medicaid beneficiaries is the extent to which providers who traditionally serve this population are included in the participating plans' networks. Many of these traditional providers had limited managed care experience and some had unique payment arrangements that could be jeopardized by a Medicaid managed care contract. Likewise, some plans worried that the inclusion of these networks, particularly if mandated, might interfere with their ability to credential their network members as required by NCQA accreditation, or give these providers excessive negotiating leverage. Historically, in some states with PCCM programs, Medicaid agencies were tolerant of indigenous providers who struggled to meet staffing and coverage requirements. This left plans in the unenviable position of having to exclude key providers, in some cases even local health departments, from their networks.

These concerns have subsided across most of the states as plans and traditional medical providers have developed more positive accommodations. This has resulted from more subtle and operationally meaningful requirements, like geographic accessibility, rather than from mandates on inclusion. In fact, even plans with sizable commercial provider

networks have augmented their networks with traditional Medicaid providers to meet access standards and build membership. This may indicate that commercial HMOs have failed to integrate Medicaid patients into their broader commercial networks, though this issue is not explicitly examined here.

Payment amounts and payment timeliness are points of increased friction between Medicaid plans and traditional providers, a conflict which also mirrors plan-provider relationships outside of the Medicaid market. The adequacy of provider payment appears directly linked to capitation rate adequacy issues. Thus, in many states, plans and providers are aligned in their efforts to get state officials to address the rate issue.

Characteristics of Participating MCOs

Statistical profiles on plan participation appear earlier in this report and illustrate that participation has changed over time. Those interviewed from the eight focal states elaborated on these trends based upon their experiences.

Plan Ownership and Membership

Changes in the types of plans participating in Medicaid programs usually reflect plan exits. Plans with more limited Medicaid memberships were more likely to leave, often because they had failed to attract sufficient enrollments. Usually these plans were predominantly commercial HMOs that were slow or hesitant to enter this market, or they were plans that were not well known to beneficiaries, or plans that lacked familiar providers in their networks. There was also a sense that for-profit plans were under more pressure to maintain acceptable financial performance (especially publicly traded plans). Given declining profitability across the HMO industry as a whole, many of these companies retrenched, withdrawing from both lines of business and geographic markets. The end result was increased reliance by Medicaid programs on predominantly Medicaid plans, though within the eight focal states this was less evident than the national statistics reflect.

Locally headquartered plans tended to remain in the Medicaid markets, regardless of ownership type, justifying the view of some observers that these plans deserve more favorable consideration in the selection process. Alternatively, some multi-state plans that focus specifically on Medicaid have successfully entered markets by demonstrating their abilities to build local networks and to manage care effectively. A few states in this sample promoted, or at least supported, the development of provider-sponsored managed care organizations to facilitate provider transition into managed care, and to ensure an adequate number of contracting options.

In most instances these were Medicaid-only plans. The long-term retention of these plans is clouded by the expected adverse effects of the Balanced Budget Act of 1997 particularly related to increased supervisory demands that both plans and some states consider unneeded and burdensome. In summary, most observers saw withdrawals as both inevitable and, in many cases, advantageous by allowing the remaining plans to increase their memberships when exiting plan members were redistributed. In the past two years, membership growth through redistribution has become more significant as the number of eligible persons in Medicaid decreased.

In summary, most observers saw withdrawals as both inevitable and, in many cases, advantageous by allowing the remaining plans to increase their memberships when exiting plan members were redistributed.

Plan Commitment and Continued Participation

Those interviewed in the focal states think that plan withdrawals are plateauing and remaining plans appear relatively stable and committed to the Medicaid product line. A few states are experiencing friction arising from the extent to which Medicaid participation is linked to Children's Health Insurance Program (CHIP) participation, but this is not expected to result in plan exits. One point of contention is whether plans participating in Medicaid must also agree to be CHIP plans. In addition, some plans are concerned that the rates set for CHIP members may not adequately reflect their expected levels of utilization due to demand for services among previously uninsured persons. State Medicaid personnel are anxious that the further loss of plans could put them in a vulnerable position in negotiations, because remaining plans may seek more favorable terms by threatening to withdraw, possibly costing the state a mandatory program.

Many states, uncertain about the future design of managed care plans and the managed care marketplace, are looking at other options beyond full-risk HMO contracting. For some, this could mean moving to alternatives to risk-based arrangements, including direct contracting with provider networks. For others, it could mean initiating or expanding

Many states, uncertain about the future design of managed care plans and the managed care marketplace, are looking at other options beyond full-risk HMO contracting.

PCCM programs, especially to serve areas where HMOs are unlikely to venture. Still others are looking at more innovative risk or partial-risk arrangements with emergent entities and enterprises. Such planning seems both inevitable and desirable for forward-thinking purchasers to consider what form the next generation of managed care will take.

Financial Condition and Stability

Among the most notable developments since our earlier study of HMO participation and performance is the relatively sharp decline in overall industry financial performance. The managed care industry is significantly less profitable than it was in the mid-1990s, forcing plans to become more judicious in evaluating their market opportunities and leading some to drop unprofitable product lines. Plan withdrawals from Medicaid appear to reflect this trend. Although our data do not address this directly, one explanation is that commercial product line margins have experienced the greatest losses because of small or no premium rate increases. As a result, the difference between Medicaid rates and commercial rates may be less than in the past, at least in those states that have continued to increase Medicaid payment rates. In some states, Medicaid operating margins may be higher than commercial margins, though the higher administrative costs in the Medicaid program may offset these benefits.

In all of the states, there is a keen sense among all parties that fair and appropriate capitation rates are critical to maintaining viable programs in the future.

Some states in the survey experienced recent health plan insolvencies, though the extent to which Medicaid rates or other policies contributed to this is unclear. Most informants attributed these failures to poor management and/or weak supervision by regulatory authorities. The financial performance of Medicaid-only plans was not seen as a particular problem in the study states, possibly because these plans are generally stable and well-managed. It is more difficult to evaluate provider-sponsored plans because their financial situations are significantly influenced by their relationships with their sponsoring

organizations. Respondents from the states reported that there was little concern that special payment terms to protect or preserve these provider-sponsored plans were currently needed. In all of the states, there is a keen sense among all parties that fair and appropriate capitation rates are critical to maintaining viable programs in the future.

Contracts and Rates

Contract Content and Changes

A major concern raised by health plans is the perceived misalignment between what state agencies are seeking and what they are prepared to pay through their capitation rates. In recent years concern had increased as virtually all states increased the number and specificity of demands placed on health plans to enhance accountability and to systematically increase performance. Those interviewed found even more troubling contracted standards of performance that were perceived as unrealistic and significantly greater than the baseline performance they inherited from the Medicaid fee-for-service program (e.g., immunization and EPSDT screening rates). This kind of “hang another ornament on the Christmas tree” approach to contracts with HMOs was cited as a particularly undesirable feature of Medicaid managed care.

Despite this factor, some states provided more positive impressions. State officials are now recognizing the need to moderate contract demands and acknowledging the administrative burdens and costs associated with the additional requirements. In some states, particularly those with more mature Medicaid programs, the inclusion of a more reasonable “administrative component” in the rate-setting process is being addressed, a point plans see as both substantively and symbolically significant. This suggests that some states are recognizing formally that contractual terms are not cost-free, and that satisfying these demands cannot continue to be financed solely out of medical expense expenditures and savings.

Most Challenging Terms

The aforementioned performance standards were among the most difficult contractual problems cited. Other contract terms, including network composition, cultural competence, marketing prohibitions, and member appeals processes were less problematic, particularly for plans with serious commitments to entering and remaining in the Medicaid market. Program monitoring was seen as more intrusive and rarely well planned or coordinated. States also

The encounter data area continues to be a battleground over its reliability and value, its likely use by states, the nature of the specifications and submission process, and the level of effort plans must invest to collect useful source data.

acknowledged that staffing and skill set deficiencies had impeded their progress. Notably, all parties expressed concern about the federal mandates for program supervision that are included in the proposed regulations for the BBA of 1997. Many see these rules as usurping state program monitoring prerogatives and adding new and arguably redundant burdens on plans, particularly those that are already NCQA accredited.

However, among the contract terms mentioned, data requirements were the most highly criticized. A growing number of states require encounter-level data from health plans to support ongoing program monitoring, consumer information, and in some cases rate setting and risk adjustment. In addition, states with 1115 waivers are required to collect this data to support federal evaluation efforts. The encounter data area continues to be a battleground over its reliability and value, its likely use by states, the nature of the

specifications and submission process, and the level of effort plans must invest to collect useful source data. Only two focal states are confident enough with the reliability and validity of their data to use it in program monitoring. The remaining states think that progress is being made, but data remains incomplete. Plan representatives remain skeptical about the long-term utility of this data, and express sentiments ranging from frustration to outrage over the poor execution of encounter data design, collection, and analysis. Even those HMOs in states with explicit plans for using encounter data for rate setting and risk adjustment remain uncertain that these efforts will succeed.

Rate Setting

Some of the focal states have experimented with competitive bidding both with and without subsequent negotiation. But most are currently administering rates or making awards wherein bid rates only vary within pre-determined ranges. There appears to be little enthusiasm in most of these states for competitive bidding because either the level of interest among plans is not high enough to support this, or because the state does not want to introduce more uncertainty into the process. In some states the bids have been above rate limits and reduced expected savings. In our earlier study competitive bidding was criticized by established plans that thought this might increase entry among plans without long-term commitments. However, some of the more mature states are now so far removed from a credible baseline of fee-for-service (at least in those markets where they have long-standing programs) that they are uncertain about how future rates can be reasonably set.

Rate Adequacy and Adjustments

Virtually every respondent identified rate adequacy as a central point of concern, particularly in light of the overall decline in health plan margins. The absence of reliable fee-for-service or encounter data from prepaid plans, makes it increasingly difficult for states to establish and justify their rates. In addition, there is the long-standing belief that Medicaid fee-for-service rates are below market levels for most providers, so capitation rates drawn from this base will be suspect. For some states the Upper Payment Limit (UPL), which is based on historical fee-for-service payments, is seen as a barrier to adequate rates because this limits payments to HMOs. However, it is likely that HCFA will provide states with more rate flexibility.

Considerable activity in terms of risk adjustment and implementation followed our earlier study. Even more notable is the widespread acceptance of the essential need for adjustments as states attempt to extend prepaid enrollment to special need (SSI/Aged, Blind, and Disabled) beneficiaries. All but one of the focal states are engaged in examining or experimenting with approaches to align payment with member needs beyond age, gender, geography, and eligibility category. These developments are welcomed by plans and providers alike, who contend that risk-adjusted rates are appropriate and necessary to promote quality care. However, the one reservation about risk adjustment revolves around data requirements, as more sophisticated payment and risk adjustment systems are based on more detailed information, which can only come from well-designed and implemented encounter data systems.

Summary Observations from Interviews

In addition to the detailed inquiries about the elements of the model of Medicaid managed care, interviewees discussed the major accomplishments and disappointments of their states' Medicaid managed care initiatives. They also elaborated on the major challenges facing Medicaid managed care in the future.

Accomplishments

The majority of those interviewed viewed their states' Medicaid managed care experiences favorably, regardless of their respective roles. Nearly all observed marked improvement over time, though many could recall painful or disappointing experiences during implementation. In some states, current crises or pending negotiations bred some negativism, but none of the respondents was interested in returning to fee-for-service. Responses suggest that once states have weathered the distinctive challenges of program development and rollouts, most of them have moved to a period of program maturity during which the relationship of the plans with the state agencies improved. In some instances, plan exits contributed to this sense of maturity, as state officials had to address factors that adversely affected participation. Most plans observed that states have gained an awareness of how broader changes in the managed care marketplace influence plan interest and participation in Medicaid.

The creation of a successful collaborative relationship between plans and purchasers appears to be most critical in developing a successful long-term MMC program.

In the focal states, access to care was identified as the major accomplishment of MMC, regardless of whether the states' programs are viewed as wholly successful or not. Other major accomplishments cited were improved tracking, improved care, and effective management, all factors that ultimately contribute to improved quality of care. Many state officials found that they have a much stronger sense of accountability in their Medicaid managed care arrangements than they had in their fee-for-service Medicaid arrangements. The creation of a successful collaborative relationship between plans and purchasers appears to be most critical in developing a successful long-term MMC program. Those from states with well-established programs and plans were more apt to express this viewpoint than those from states with less experience, implying that this sense of partnership takes time to develop.

Disappointments

Many of the specific disappointments cited relate to failures to fully take advantage of some of the opportunities that managed care affords, especially maximizing access to care. Issues and obstacles contributing to access concerns were excessive use of carve outs, reluctance to extend managed care programs to special need populations, intermittent eligibility, and declining numbers of Medicaid beneficiaries, all of which contribute to greater uncertainty. Those interviewed were also disappointed by the exits of plans from the Medicaid market, though many thought this was not only inevitable but desirable for a number of the reasons discussed earlier. However, there was concern that in some states additional plan exits could jeopardize their ability to sustain mandatory programs.

Operational disappointments included the failure of states to develop effective performance systems, in part because of their inability to collect adequate or reliable data. Contract demands on plans continue to increase, especially as plans try to include more needy clients. The widely varying levels of state staff expertise and inconsistent program supervision were other problems cited by critics. In a number of states, managed care backlash was seen as adversely affecting managed care; this led some legislators to become more involved with Medicaid managed care than critics found desirable. Others saw this as a reflection of lack of confidence in the leadership of the Medicaid managed care program. In contrast, a few observers claimed this involvement was necessary and appropriate because legislators need to be aware of, and concerned about, whether plans are being paid adequately to do what they are contracted to do.

Future Challenges

The future challenges identified were fairly evenly divided among expanding access, program refinement and execution, and defining effective legislative roles. Expanding benefits to incorporate new groups was deemed as potentially problematic. Overall, groups to be included require more care and more expensive care, and also require additional coordination among a number of different providers. This will be difficult and delicate work to accomplish successfully. Developing reliable performance indicators that can be used as a basis for planning and evaluation by both policy makers and providers was identified as critical to the long-term success of Medicaid managed care.

Most respondents believe that better quality-related data needs to be gathered and used in a timely fashion to promote quality improvement. However, this will mean additional costs for plans anticipating that they may not be paid adequately to cover these costs. By implication, this means much will depend on how adequate capitation rates are in the future. States have made progress in developing a more public and participatory process for establishing their capitation rates, and this is welcomed as an important step forward. However, whether they will commit to supporting rates that are reasonable and commensurate with the expectations placed on plans remains undetermined.

PART IV: Implications For Policy Makers

Partnership Pays

The experience of the states with established and mature managed care programs attests to the fact that interactive and collaborative relationships between Medicaid agencies and health plans are mutually beneficial. In some instances, the sense of partnership was evident from the program's beginning; in other cases it emerged as both parties discovered their interdependency. The common goal of developing a Medicaid-financed delivery system that is superior to a fee-for-service system can unite these potential adversaries, particularly as programs begin to demonstrate that beneficiaries receive improved care with prepaid managed care. States that have ongoing constructive dialogue and interaction with plans are more likely to focus on program improvement and enhancement. Reaching this point is particularly important because of broader marketplace instability and the possible decrease in plan participation.

Data Trends - Participation

Over time, the number of plans associated with national chains that participate in Medicaid managed care has decreased. For-profit plans continue to have slightly higher participation rates than non-profits. Plans leaving Medicaid are larger plans with small Medicaid enrollments and publicly traded plans. Evidently, the lack of sufficient enrollment to cover the administrative costs of Medicaid managed care and the financial market pressures of Wall Street may inhibit plans from entering or remaining in Medicaid. Conversely, participating plans are increasingly predominantly Medicaid plans. This may enable them to focus their expertise on serving this population and also achieving the economies of scale necessary to spread the administrative fixed costs of the Medicaid product line over a greater enrollment base.

Data Trends - Performance

The average health plan in the United States is operating at a loss; superior performance is achieved by plans with lower operating losses or small operating profits. Reliable data on the Medicaid product line is not widely available, but recently plans not participating in Medicaid have experienced greater financial losses than those participating, possibly due to the dramatic decrease of commercial margins. It also appears that plans that are predominantly Medicaid are actually performing better than those that have limited Medicaid memberships, even though these higher performers tend to be somewhat small plans. One explanation is that concentrating on a single line of business, like Medicaid, enabled these plans to gain unique expertise and operational efficiencies beyond those with only slight involvement. Because our data do not include Medicaid-only plans that are not licensed HMOs, it is not possible to describe the experience of Medicaid-only managed care organizations.

Post-Implementation Stabilization

Our interviews were conducted with representatives of states that have completed major mandatory implementations and achieved relatively stable operational environments. The findings confirm the obvious; following an often tumultuous rollout, all parties can turn to longer term issues, increased program refinement, and management sophistication. That is not to say that major challenges do not arise. They do. Programs expand to other geographic areas or other demographic groups, and broader market developments intervene. Establishing a sound and credible foundation, however, appears to be critical in the life cycle of all state programs. One important note is that observers acknowledge that reaching a point of stability enables them to focus on long-range challenges, such as improving the quality of health care.

Decrease in Participation Inevitable

All parties, including state officials, seem reconciled to the fact that the number of contractors will decrease either by design or by market forces. In some respects, this reflects a belief that initially more plans than were necessary or appropriate participated in most states or, for some, that the “illusion” of competition-based choice for beneficiaries among many plans is neither reasonable or desirable. There are differences of opinions about whether more forethought and careful selection would have reduced the instability and dislocation due to plan withdrawals. Regardless of the reasons for withdrawals, many states are genuinely concerned about whether further plan withdrawals could undermine efforts to sustain mandatory HMO enrollment. But, consistent with the earlier theme of partnership, it is apparent that achieving this degree of constructive mutual dependence is more likely when the number of plans is limited to those with demonstrated competence in, and commitment to Medicaid.

Who Will Remain?

The types of plans that will remain in this market appear to be largely determined by the local managed care market conditions and the configuration of traditional Medicaid providers. The level of commitment made to participate in Medicaid, as measured by membership, appears to be an important predictor of durability. Ownership per se is not a clear predictor. Broader trends indicate an expanding role for predominantly Medicaid plans, but in some states and some markets, commercial plans remain the backbone of Medicaid managed care programs. Notably, state officials see participation by commercial plans as important to sustaining program credibility, even if not necessary to achieve the explicit goal of mainstreaming beneficiaries. Our findings are not able to address directly a related important question: To what extent are plans that remain in Medicaid built on or around traditional Medicaid providers? The state interviews reveal considerable variation on this topic and some concern about the long-term viability of these types of plans.

Rate Adequacy

Concern about rate adequacy is a primary concern about Medicaid managed care. For states that once anticipated achieving significant discounts from expected fee-for-service costs, the past few years have been disillusioning. There is now greater sensitivity to rate adequacy, fairness, and “actuarial soundness.” States appear more committed than before to communicating to plans how their rates are set, and why rates are not higher. There is also greater awareness of how the administrative demands placed on plans exceed those expected in a fee-for-service program, on which most capitation rates are largely or solely based. It is likely that this awareness will lead to efforts to balance rates and demands, as states conclude that they can get more value from managed care if they are prepared to pay for it. On a less positive note, the loss of a fee-for-service base creates new challenges to establishing what reasonable rates should be. Many of these challenges can be met successfully only if more and better data can be collected and reliably employed.

To What Extent Can This Market Be Managed?

Medicaid managed care will likely continue to be vulnerable to broader managed care market developments, particularly as state programs attempt to rely on plans with major commercial commitments. It is possible to reduce some of this uncertainty by careful program design and plan selection. Simply reducing the number of contractors may create more stability, although it leaves states vulnerable to countervailing leverage from the smaller number of contracting plans. Many states are already considering a future where the current forms and models of managed care are themselves transformed. This type of vision and leadership suggests that Medicaid managed care programs can not only survive but also thrive.

Conclusion

This study builds on earlier research that documented declining participation in Medicaid by managed care plans and reported on the perspective of health plans and other market-place observers. The new research presents an update of patterns of plan participation and performance on both a national basis and within eight focal states. Multiple interviews were conducted across these states using an interview protocol derived from a conceptual model of the Medicaid managed care market. The findings indicate that states continue to see plan withdrawals; although efforts to slow or reverse these trends were taken, larger market trends like decreasing HMO profitability make a reversal challenging. The interviews revealed that more established and mature programs have developed a variety of means to nurture and sustain participation while promoting overall improvement in plan performance. A commitment to fostering a genuine partnership between health plans and Medicaid purchasers appears essential to Medicaid managed care success. Medicaid managed care programs that are proactive and nurture a collaborative relationship with plans are best prepared to respond to future developments.

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APPENDIX: Survey Instrument

GENERAL DESIGN QUESTIONS

1. What do you think were the original aims for Medicaid managed care (prompt: cost savings, access, quality improvement)? Do you think these are still the principal aims? Why/why not?
2. What were the major factors that influenced the selection of the model(s) the state used (e.g., HMO and/or PCCM)?
3. To what extent did the maturity of the managed care market affect the design of the Medicaid MC program in your state?
4. What services and populations were initially carved-out and/excluded? Why were they carved-out/excluded? Are they still carved-out/excluded?
5. How did the state initially structure plan qualification and selection? Do you think the process was fair/was perceived as fair by all parties? Why or why not? Has this changed over time? Have the changes been for the better or worse?
6. Did the state limit the number of awards/contracts? Do you think the approach was a wise one? Why or why not? Has this strategy changed over time?

PROGRAM MANAGEMENT

7. How well has the state implemented and managed its managed care program over time? Has it set and stuck to timetables; have the schedules been reasonable; have they attempted to include multiple parties in planning and development?
8. How would you characterize the Medicaid managed care staff relationship with health plans (collaborative; accessible; distant; adversarial)? Does this staff have the requisite experience and skill sets to managed the program effectively? Have they used outside consultants (including actuaries) successfully?
9. Has the state chosen to use an enrollment broker/benefits counselor? How would you assess the value that this organization has added to the program?

MANAGED CARE ENVIRONMENT

10. How mature would you describe the relevant state (or local) managed care market? How accepting of managed care are the principal hospitals and doctors?
11. Would you characterize the managed care market as competitive? How much interest did commercial plans show in Medicaid when managed care was introduced? Has this changed over time?
12. How well have traditional Medicaid providers transitioned into Medicaid Managed Care? What special accommodations have been made for them? Was there opposition to these accommodations?

MCO CHARACTERISTICS

13. Did the MMC program have explicit goals to attract commercial HMOs?
14. Was the selection and implementation schedule designed to give traditional providers an opportunity to prepare for MMC? Was this a successful strategy?
15. Has reliance on predominantly Medicaid plans (>50 or >75 percent) changed over time? Have any plans withdrawn and for what reasons?

CONTRACT/RATES

16. Have contracts become more specific and demanding over time? In what ways? How have plans responded to these changes?
17. What terms/requirements have plans found most challenging to comply with? How has the nature and extent of state oversight changed over the life of the program? How well do you think the state is currently doing in terms of program monitoring and oversight?
18. How would you assess the adequacy of rates and the appropriateness of the process by which the state has set/negotiated rates? Has risk adjustment of rates been an issue or a concern in your state, and how responsive to these concerns has the state been?

GENERAL APPRAISAL

19. How would you gauge the success of Medicaid MC in your state thus far? What have been its major accomplishments and disappointments?
20. What do you see as the two or three most important challenges facing your state's Medicaid managed care program over the next few years?
21. Are there any additional comments about your state's Medicaid managed care experience that you would like to share with us?