Participation, Performance, and Perspectives in Medicaid and Medi-Cal Managed Care

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A synthesis of studies funded by the Medi-Cal Policy Institute and the Center for Health Care Strategies
Established in 1997 by a grant from the California HealthCare Foundation, the Medi-Cal Policy Institute is an independent source of information on the Medi-Cal program. The Institute seeks to facilitate and enhance the development of effective policy solutions with the interests of Medi-Cal recipients guiding this work. The Institute conducts and commissions research, distributes information about the program and its recipients, highlights the program’s successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, Medi-Cal beneficiaries, and other stakeholders who are working to create a more effective Medi-Cal program.
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I. Report Overview

This report focuses on efforts to examine and understand the wide range of experiences with Medicaid managed care through the review and synthesis of two recent studies. It first describes the purpose and approach of these two studies and summarizes their findings. Next, the studies’ commonalities and differences are discussed. The findings are further examined in light of plan participation and performance, as well as key factors previously identified as influencing the general experience of plans engaged in Medicaid managed care: program design, management, market context, plan characteristics, and contractual and rate considerations. Finally, it offers a summary and lessons pertaining to the future of Medicaid managed care.

Building upon earlier research by Hurley and McCue, the first study provides an update of trends in health plan participation and performance using national data. Using a model developed from previous research findings, this study then focuses upon the experiences in eight states, selected to represent different levels of program maturity and success. The second study explores the experience of Medi-Cal managed care in California, which is unique for its use of three distinct models of organizing managed care in a county. The California study also examines plan participation and performance, but within the state’s market, and also compares these findings with national data. Both studies rely upon interviews conducted with stakeholders from plans, programs, providers, and advocacy groups for further elaboration.

Common to both studies is recognition of marketplace turbulence, a changing political context, shifting and shrinking eligible populations, a preference for full-risk models, a varied mix of participating plans, and concerns about program management expertise and capacity. However, unique to the California study is a generally mature managed care market, three distinct managed care models, and the absence of meaningful plan withdrawals.

A synthesis of the findings from both studies finds participation growing among predominantly Medicaid or Medicaid-only plans. Of interest is the observation that while managed care plans have generally not been profitable in recent years, those participating in the Medicaid market place exhibit relatively stronger performance—on average, they incurred lower operating losses. Customizing program design to address local market needs, developing management expertise and partnerships with plans, and establishing rates that recognize the costs associated with additional contract requirements were emphasized.
Although several lessons are offered to enhance Medicaid managed care, one dominant theme emerges. Partnering between plans, programs, and providers pays: Through partnering, Medicaid managed care can go beyond its initial goals of enhanced access and cost containment to address quality performance.
II. Introduction

Medicaid managed care experienced a meteoric rise during the 1990s, with enrollment soaring from 3 million in 1991 to roughly 17 million by 1999. Virtually every state implemented some form of managed care for its Medicaid beneficiaries. Participation among health plans grew proportionately with this expansion. Overall, Medicaid programs seemed to mirror the methods and models of financing and delivery of medical services that were sweeping the private sector. By the end of the decade a number of states touted the success that Medicaid managed care had brought in the areas of access, cost control, and quality improvement.

Like nearly everything else about Medicaid, experience with managed care has varied across over 50 programs in the states and territories.

- Growth in managed care membership ranges from states moving rapidly ahead with statewide initiatives to slowed or stalled launches or expansions.

- Models include ambitious full-risk contracts with established health maintenance organizations to modest fee-for-service primary care case management programs, whose designs vary little from the initial wave of programs in the early 1980s.

- Levels of interest and participation among managed care organizations further reflect this variation: Some states rely solely on plans that serve both Medicaid and commercial populations, while others are unable to attract or sustain involvement among HMOs, particularly those with sizable private sector memberships.

- Evidence about the outcomes from managed care endeavors also differs across states, a function of different program experiences as well as the absence of credible data.

In recent years, Medicaid programs were buffeted by trends in the broader managed care market and a number of states saw participation among health plans decline. Because health plans experienced a distinct reversal of fortune across all of their business lines, it is difficult to identify whether declining participation among plans serving Medicaid is a cause or effect of plan difficulties. Again, no uniform pattern across states surfaces. Some states saw few withdrawals and continue to have
many participants. Others purposely limited participation to a carefully selected number of plans to avoid the instability associated with market withdrawals. A few states saw many plans withdraw and scrambled to maintain adequate numbers of plans to sustain their programs. Some states even witnessed all participating plans exit, and they had to discontinue mandatory programs because of their inability to maintain the required minimum of two plans.

Prior research has cast some light on patterns of, and perspectives on, participation. Since participation among plans nationally peaked in 1998, the number of plans continues to decline. The total number of Medicaid beneficiaries is also declining sharply, reducing the pool of potential members. States appear to be increasingly reliant on predominantly or exclusively Medicaid plans. Predominantly commercial plans, especially publicly traded plans with small Medicaid enrollments, are those most likely to withdraw from the market. State policies, practices, contracts, and rates all play a role in decisions to enter and exit the Medicaid market. In addition, while overall industry trends color the general appeal of Medicaid, local market conditions appear more significant in shaping plans’ decisions to sustain participation. Once again, however, significant exceptions to these findings are found across state Medicaid programs.

This report is a synthesis of two recent explorations of the Medicaid managed care experience undertaken using similar foci and frameworks. One study examines national trends in health plan participation and performance in Medicaid managed care, and offers a targeted examination of the experience of eight states. This study, funded by the Center for Health Care Strategies, explores how several factors influence the experience of states that operate diverse mandatory full-risk programs. The second study, funded by the Medi-Cal Policy Institute, examines variations across three different models of Medicaid managed care operating in California. Although the findings represent the experience of only a single state, the multiple models afford an opportunity to assess plans’ effectiveness in meeting state and county purchaser needs across three distinct design structures. In short, the cross-state and cross-county variations (in the California study) provide a unique opportunity to explore what states and localities can and have done to maintain viable Medicaid managed care programs.

The report initially describes the purposes and approaches of these two studies and summarizes their key findings. Next, the two studies’ findings are examined in light of their commonalities and their differences. The findings are further discussed in terms of plan participation and performance, and implications are related to factors previously identified as influencing the general experience of states engaged in Medicaid managed care: program design, management, market context, plan characteristics, and contractual and rate considerations. Finally, a series of broader lessons pertaining to the future of Medicaid managed care is detailed.
III. The Two Studies: Purpose, Approaches, and Summaries

Description of Purpose and Approaches

The two studies described here are an outgrowth of a 1998 research project conducted for The Center for Health Care Strategies by Robert Hurley and Michael McCue. This in-depth study of the Medicaid marketplace in the United States during 1992-1996 stimulated interest by both the Center for Health Care Strategies and the Medi-Cal Policy Institute to conduct additional research, one study focused nationally and one on California. These two studies, conducted collaboratively, attempt to understand the dynamics of the current Medicaid (referred to as Medi-Cal in California) marketplace.

The national study conducted by Hurley and McCue updates patterns of participation and performance through 1998 using HMO data from across the country. In addition to various national analyses, specific data on eight states, selected to provide a wide variety of program maturity and experience with full-risk managed care models, are also analyzed. A detailed model, one that conceptualizes the factors that appear to influence the overall experiences of states with HMO contracting, serves as the basis for a survey of multiple informants across the eight states to explore their perceptions about the Medicaid managed care program in their states. Interviewees included health plans, provider organizations, trade associations, advocacy groups, and Medicaid managed care officials. After summarizing and synthesizing interview findings, the relative importance of various factors and broader implications for Medicaid managed care programs across all states are highlighted.

The single-state study, *The Medi-Cal Managed Care Market*, conducted by Laguna Research Associates, focuses on the Medi-Cal market in California for 1996 through 1998. The California study offers the background and description of the three distinct models currently in use. It examines financial data from plans participating and not participating in the California Medi-Cal market and examines performance measures using California and national data. The study synthesizes the results.
of structured interviews with multiple informants representing health plans, state and county officials, and consumer and provider associations. Also included in the study are published and unpublished data, as well as personal communications.

Several caveats focusing on the data are emphasized: The data represent a relatively short time frame (1996-1998) and include unaudited financial reports that are neither verified nor corrected. Understanding the complete financial condition of a plan requires in-depth study of audited reports and on-site review with financial officers. In addition, commercial plans with both Medicaid and non-Medicaid enrollees report data for all their plan members. Thus, a plan’s overall performance may or may not reflect its experience with Medicaid beneficiaries or the practice of cross-subsidizing less profitable product lines with revenues from more profitable lines. Broader limitations pertaining to both studies are reviewed later in this report.

Brief summaries of the two studies that are the foundation of this integrated report follow. As syntheses, the summaries do not represent the complete body of information on which the remainder of this report is based. Interested readers are encouraged to examine the studies for a more comprehensive presentation and discussion of the findings.

**Summary of the National Study**

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 against a backdrop of instability and uncertainty in the managed care marketplace. While some states’ programs falter, others report significant success. Research suggests that Medicaid managed care rates alone do not seem to determine success or failure. As concluded in the earlier Hurley and McCue CHCS study, what is 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:

- recent patterns of entry and exit into Medicaid managed care on a national level and on a state level, using eight states with varied program success;
- the interdependencies of critical program decisions through an original model of Medicaid managed care;
- features of state policies and practices that influenced program success; and
- the implications of these findings for Medicaid managed care policy makers.

The study examined these issues using secondary data, National Association of Insurance Commissioners (NAIC) filings from 1992-1998; development of a general model of Medicaid managed care derived from previous research; and in-depth interviews with participants who represented different roles in Medicaid managed care in eight focal states. The data analysis
builds upon the authors’ previous study’s examination of Medicaid HMOs and used similar comparisons. The eight states, selected for the state analyses because of their diverse experiences with Medicaid managed care, include Arizona, Maryland, New Jersey, Ohio, Texas, Virginia, Washington, and Wisconsin.

The findings highlight the high degree of variation in states’ general program design 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**

The findings emphasize that plans currently participating in Medicaid are increasingly predominantly Medicaid plans. Moreover, the 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) escalated upward from 1992 to 1996 but plateaued in 1997 and 1998.

![Figure 1. HMO Participation Status in Medicaid Managed Care 1992-1998](image)

Over time the characteristics of plans participating in Medicaid managed care changed significantly. Many of the larger plans with a small Medicaid membership, as well as publicly traded plans previously in this market, exited. These exits were possibly in response to insufficient enrollment 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.
Although data on Medicaid product lines and on Medicaid-only plans that are not licensed HMOs are not available, available data do demonstrate that plans not participating in Medicaid experienced greater financial losses than those participating (see Figure 3). In contrast, predominantly Medicaid plans, which are generally 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 less Medicaid involvement.
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 include the following factors.

- **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 relationships with participating managed care plans.
- **Environment/Contextual Features**: the structure and maturity of the local managed care market, including the capacity and viability of plans.
- **HMO Characteristics**: specifically plan ownership, membership, experience, network, and financial status of participating plans.
- **Contract/Rates**: the rate level and rate setting process as well as the contractual terms and overall program monitoring and oversight.

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 participants representing different roles in the eight states’ programs.

**Figure 4. Model of Medicaid-HMO Contracting**

- **General Design Features**
- **Environmental/Contextual Factors**
- **MEDICAID State or County**
- **SELLER (HMO)**
- **Program Management**
- **HMO Characteristics**
- **Contract/Rates**
Key Findings from Stakeholder Interviews

The diverse state experiences with Medicaid managed care were clarified through interviews with the study participants and some clear patterns emerged.

- After often tumultuous program rollouts, most programs reach a relatively stable operational state during which parties begin to focus on long-term program refinement.

- Regardless of whether limited or unlimited bidding was originally initiated, the number of players ultimately shrinks either by design or natural selection.

- 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 are ways to achieve some market manageability.

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

- Stable and mature programs are able to demonstrate the value of embracing managed care models and to focus attention on issues such as quality improvement.

Regardless of the relative success of the observers’ study state, it was clear that few thought Medicaid managed care’s wild ride was over. Noteworthy was the acknowledgement that many states are already looking ahead to consider the future forms that Medicaid managed care might take.

Summary of California Study

As of December 1998, 2.4 million, or 48 percent, of California Medi-Cal beneficiaries were in managed care. More than 99 percent of those in managed care were served by one of the three models: County Organized Health Systems (COHS), Geographic Managed Care (GMC), or Two-Plan Model.

- The oldest California model, COHS began in the early 1980s and expanded in the mid-1990s. Under this model, the state contracts with the COHS in a county to provide a wide range of Medi-Cal services to a full range of eligibility groups. COHSs covered 358,000 beneficiaries in five communities (six counties) in December 1998.
First implemented in 1994, GMC includes multiple licensed HMOs selected through an RFA process, from which beneficiaries can choose. As of December 1998, thirteen HMOs were participating under the GMC model, covering 287,000 beneficiaries in two counties.

The newest and largest managed care model is Two-Plan, which was implemented in 1996 and 1997. Through Two-Plan, beneficiaries select services from a Local Initiative organized by the county or from a Commercial Plan selected by the state through a competitive process. Two-Plan models covered 1.7 million beneficiaries in 11 counties.

Across the three California plans are differences in eligibility groups, contracting entities, and rate and contract requirements. An understanding of these distinctions is helpful prior to examining participation and performance.

**Eligibility.** Although there is mandatory enrollment of all major Medi-Cal eligibility groups into COHSs, GMC and Two-Plan require mandatory enrollment for TANF-related groups only. Other eligibility groups, primarily the elderly and disabled, may voluntarily enroll. COHSs generally cover a broader range of services than GMC and Two-Plan, but coverage varies across the different COHSs.

**Contracting entities.** Contracting entities include both commercial HMOs and county-organized organizations, either COHSs or Local Initiatives, not-for-profit county-related organizations whose membership (with one exception) is entirely Medi-Cal beneficiaries. California HMO licenses are required for plans to participate in GMC and Two-Plan. The Two-Plan contractors include eight Local Initiatives and four Commercial Plans. The commercial insurers are all for-profit firms and one of the four, Blue Cross (owned by Wellpoint Health Networks Inc.), is publicly traded. One of the Commercial Plans’ membership is primarily Medi-Cal.

These state contracted entities, in turn, contract for services. Most contract with individual physicians and medical groups, often in different combinations. Most “downstream” the risk to medical groups and individual physicians through capitation, and most rely on contracted organizations for monitoring and care management activities. There are often multiple layers of administration between the health plan and the primary care provider. CalOPTIMA, the largest COHS, contracts with HMOs and Physician Hospital Consortia (PHC). PHCs have separate capitation for the physician organization and the hospital organization, and risk sharing arrangements between the two groups. L.A. Care, the largest Local Initiative, contracts with seven HMOs, which subcontract with medical groups and IPAs, which in turn subcontract with individual physicians.

**Rate and contract requirements.** The Two-Plan capitation rates, which are set by the state, are public. In GMC and COHS (with the exception of one county) rates are set through a negotiation process between the plans and the California Medical Assistance Commission. All GMC and COHS rates are confidential. Two-Plan and GMC models rely upon an enrollment broker, but COHS counties provide enrollment data directly to the state. The state has similar regulatory requirements across all models. Plans are required to supply DHS with information on quality, access, and financial status. Plans are also required to submit encounter data to the state.
Medi-Cal Participation Trends

Analysis of Medi-Cal participation trends for this period is shaped by the implementation of the Two-Plan model during this (1996-1998) timeframe. Seven new Local Initiatives serving Medi-Cal beneficiaries exclusively became licensed HMO participants in Medi-Cal during this period.

The overall participation rate of California health plans in Medicaid was relatively stable over the three-year period. Commercial plans often participated in several models. For example, in 1998 Blue Cross was a prime contractor in Two-Plan and GMC, and a subcontractor in COHS and Two-Plan; Health Net was a prime contractor in Two-Plan, GMC and PHP, and a subcontractor in Two-Plan. During this same period not-for-profit participation in Medi-Cal increased, fueled by the influx of the seven Local Initiatives, and participants saw an increase in their Medi-Cal membership relative to their total membership.

Performance Trends

Financial statements from the California Department of Corporations and California Department of Health Services (DHS) served as the basis for performance analyses. HCIA, Inc. provided the national data as well as information on some California HMOs for 1996 and 1997. Financial ratios, specifically the operating margin3 and the administrative cost ratio,4 were examined for participating and non-participating California plans, for participating plans in California by model, and for participating and non-participating plans in California and the United States.

Participating vs. Non-participating in California. By 1998 for each of the financial ratios examined, plans participating in Medi-Cal managed care outperformed those not participating. As Figure 5 shows, operating margins in all three years were better for California Medi-Cal participating plans than for non-participating plans. The operating margin was small and negative for participating plans in 1996, and became small and positive in 1997 and 1998. In contrast, non-participating plans' operating margin was negative in all three years. Administrative cost ratios were smaller for the Medi-Cal participating plans in all three years, with rates for both the participating and non-participating plans decreasing over the three-year period. However, the decrease was sharper for the plans participating in Medi-Cal than for those not participating.

Figure 5. Performance for Participating and Non-Participating Plans in California, 1996-1998

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<tr>
<td>Participating in Medi-Cal</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Operating margin</td>
<td>-.004</td>
<td>-.068</td>
<td>-.001</td>
</tr>
<tr>
<td>Administrative cost ratio</td>
<td>.156</td>
<td>.158</td>
<td>.125</td>
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**Medi-Cal Participating Plans by Model.** In all cases the financial ratios of the Medi-Cal participating plans were driven by the strong financial performance on all measures of the COHSs and the Local Initiatives after their initial implementation. In 1997 and 1998 operating margins improved for the Two-Plan model plans and COHS margins were positive (see Figure 6).

**Figure 6. Operating Margins of Medi-Cal Participating Plans by Model, 1996 - 1998**

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<th>Operating Margin</th>
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<tr>
<td>Two-Plan</td>
<td>-.066</td>
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<tr>
<td>GMC</td>
<td>.010</td>
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<tr>
<td>COHS</td>
<td>-.001</td>
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During the three-year period the administrative cost ratios decreased for Two-Plan participants to .101 and for GMC participants to .119. As Figure 7 reflects, COHS model participants’ administrative cost ratio, at .074, was the lowest. Note that COHS plans by definition incur no marketing costs; therefore, their lower administrative costs were expected.

**Figure 7. Administrative Cost Ratios of Medi-Cal Participating Plans by Model, 1996 - 1998**

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<th>Administrative Cost Ratio</th>
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<tr>
<td>Two-Plan</td>
<td>.291</td>
</tr>
<tr>
<td>GMC</td>
<td>.159</td>
</tr>
<tr>
<td>COHS</td>
<td>.077</td>
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**California and U.S. Data Comparisons.** Figure 8 displays the operating margins for California and national participating and non-participating plans. Operating margins were consistently larger for plans participating in Medicaid in California and in the U.S. Although at the national level, regardless of Medicaid participation status, operating margins were negative during 1996-1998, non-participating plans’ ratios were smaller than participating plans’ ratios. In California, the non-participating plans’ operating margins for all three years were also smaller than those of Medi-Cal participants, who had positive operating margins in 1997 and 1998.
Administrative cost ratios (see Figure 9) were consistently smaller for plans participating in Medicaid in California and in the U.S. Although these ratios decreased from 1996-1998 for both the participant and non-participant groups in California and the U.S., the decrease was more dramatic for those participating in California. By 1998 California Medi-Cal participants’ administrative cost ratio was 23 percent less than for U.S. Medicaid participants, and California non-participants had a ratio 6 percent less than U.S. non-participants.

Key Findings from Stakeholder Interviews
Although the diverse model experiences with Medi-Cal were clarified through interviews with different stakeholders, several common issues were emphasized. Among those issues highlighted were multiple managed care markets, movement to COHS, DHS management, provider participation, and capitation rates.

California’s multiple managed care models share many similarities but vary in terms of chain of authority, control, and responsibilities. Although commercial plans generally indicated interest in all three models, assuming that their total Medi-Cal enrollment (in all models) was sufficient, they prefer the GMC model because it may provide a more level playing field for competition. They are
less enthusiastic about participating in the other models, especially COHS, and oppose the current discussion of transforming Two-Plan and GMC counties to the COHS model.

Linked to the interest in moving to COHSs is the decrease in Medi-Cal enrollment because of welfare reform and improvements in the California economy. Several Two-Plan counties with relatively small Medi-Cal enrollments are considering requesting conversion of their counties to COHS, and current GMC participants anticipate the exit of currently participating plans that may not be viable with reduced county enrollments. Interest by the counties in the movement to COHSs is fueled, in some cases, by their interest in exerting community control over Medicaid and possibly Medicare resources in the future. This consolidation might offer COHSs the opportunity to fully coordinate care for the poor in their communities.

Most of the plans complain about DHS program management, specifically lack of feedback, inability to keep time schedules, limited staff expertise in managed care, and inconsistent and unreasonable requests. Subcontracting arrangements in some counties complicate the relationship further because plans do not deal directly with the state; thus, reporting requirements are interpreted through the eyes of the intermediary between the plan and the state (i.e. a COHS, a Local Initiative or other Commercial Plan) and may result in inconsistent and duplicative requirements. Generally plans are not questioning the usefulness of the required data, but the thoughtfulness with which the regulations are promulgated and the ability of the state to use the data constructively.

Almost all plans indicated no current problems with the participation of primary care providers, but reported some difficulties with specialist participation. Identified as possible future problems were the willingness of providers to participate and the viability of participating medical groups. In both the commercial and the Medi-Cal markets, managed care shifted financial risk to medical groups, IPAs, and individual physicians who, as price takers, carry much of the burden of low rates. Several interviewees warned that 60-90 percent of the medical groups in California are in financial distress.

All of the plans claim the capitation rates are too low (“the lowest in the country”), particularly in light of the cost of complying with the state’s regulatory requirements. However, no one is exiting Medi-Cal because of this and Medi-Cal is perceived as a profitable business by most, but not all, plans. Several suggested that Medi-Cal is more profitable than the commercial market in California, assuming there is a sufficient number of beneficiaries to support the program’s administrative requirements.
IV. Studies’ Commonalities and Differences

Caveat on Comparing the California Experience to That of Other States

Given the pervasiveness and long-standing nature of commercial managed care in California, as well as some of its more distinctive features (including widespread shifting, or “downstreaming,” of risk from health plans to organizations of providers), it is hazardous to make unqualified comparisons between that state and others. This caution applies to Medicaid managed care as well even though, in terms of the amount and length of experience with mandatory managed care models, California has not been a leader. The fact that Medicaid managed care was implemented on a foundation and against a backdrop of a mature managed care marketplace affords an opportunity to examine what other states may experience as private sector managed care grows and matures. To put the comparisons into context, the commonalities and differences between California and other states are described.

Commonalities

The two studies found many similarities among states, including marketplace turbulence, the political context, eligible populations, preference for full-risk models, a mix of commercial and Medicaid-only plans, program management competence, and concern regarding rate adequacy.

Marketplace Turbulence

In recent years health plans in California and elsewhere endured considerable turbulence and instability. Mergers and acquisitions have become common as has declining profitability, which is now manifested in operating losses for the majority of plans. While plan failures appear to be less frequent in California, downstreaming of risk has added considerable instability at the provider group and IPA level, and these entities are failing in growing numbers. Consumer and provider disgruntlement has precipitated a backlash in virtually all states, leading to extensive legislative intervention in the managed care market. Private purchasers appear increasingly concerned about rising premiums after several years of remarkably low rate increases. Plans in all markets contend that provider consolidation, increasing labor and technology costs, and rising prescription drug prices prevent them from continuing to curtail premium increases.
Political Context of Medicaid/Medi-Cal
Although current rates of increase in Medicaid expenditures pale in comparison to those of the early 1990s, this program remains a significant part of every state’s budget. Record budget surpluses have failed to generate support for substantially increased state investment in Medicaid programs. State policy makers continue to manifest great ambivalence toward managed care as they struggle with their decisions to simultaneously buy it and bash it. Moreover, this ambivalence is further demonstrated in Medicaid by the debate over whether any and all profits generated by plans are invariably the result of “overpayment.” The experience in California, where rates are arguably among the lowest in the country, is quite typical: There is little public support to raise rates as long as plans are accepting and apparently profiting from them.

Eligible Populations
California implemented mandatory managed care for only low-income women and children (the five county operated systems are an exception), which mirrors many states’ programs. Like other states, California appears reluctant to extend mandatory enrollment to special need populations and uses carveouts and exclusions to achieve these aims. In addition, in California and elsewhere the number of persons eligible for enrollment has plummeted as Medicaid rolls have shrunk, raising concerns among plans that rely on this membership as a major line of business. New enrollment from CHIP-eligible children affords only a minor offset to these losses.

Preference for Full-Risk Models
California’s three managed care models are all full-risk arrangements, reflecting a commitment to buying a comprehensive delivery system and to shifting financial risk to this system. Nearly 75 percent of all Medicaid beneficiaries in managed care across the country participate in plans with this arrangement. The use of capitated payments is designed to encourage plans to become more efficient and to invest in promoting health and prevention among enrollees. Such models also conform Medicaid’s purchasing strategy with that of most private sector buyers, sending clear signals to providers that affiliation with managed care organizations is essential if they wish to continue serving their Medicaid/Medi-Cal eligible patients.

Mix of Commercial and Medicaid-only Plans
Virtually all states that require beneficiaries to enroll in full risk managed care plans offer a mix of plans with various ownership and membership composition. In some instances this is the outgrowth of conscious policy decisions, as in the case of California’s Two-Plan Model. In other cases, the participation may result from market forces, which leads to diverse plans’ participation. Clearly, local market conditions play a significant role in the configuration of participating plans and may lead policy makers to craft special strategies to launch distinctive programs, as in the case of California’s COHs, which are predominantly or exclusively Medicaid. In addition, California, like many other states, has purposely fostered safety-net provider sponsored plans by encouraging their development and awarding them contracts.

Program Management Competence and Capacity
Although the talent pool for managed care expertise may be deeper in California because of the state’s long and varied experience with managed care, the concern that public agencies have not attracted sufficient expertise is as common there as in other states. Some of these concerns reflect the difficulties that public programs face when they attempt to both purchase in, and regulate,
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private markets. As previously noted, the problem is exacerbated in an era of open hostility toward managed care by many elected officials. Because Medicaid is jointly administered by the federal and state governments, additional tensions ensue when state officials are required to follow policies and procedures over which they have no control. However, there is a skill and experience deficit across the country as Medicaid agencies still struggle to reconstitute themselves as “value-based purchasers” after nearly 30 years as a claims-processing bill-payer.

Concerns Regarding Rate Adequacy and Contract-related Demands
Like their counterparts throughout the country, plans and providers in California are preoccupied, if not consumed, with rate adequacy. Initially the concerns were an outgrowth of the difficulty in negotiating discounts with network providers when, historically, the fee-for-service Medicaid rates were already very low. More recently the increased demands placed on plans by purchasers have spurred increased concern that Medicaid rates fail to compensate plans for the increased costs associated with meeting these additional demands. Some of these issues, such as cultural competence, are of special concern in California; others, like encounter data reporting, are almost universal.

Differences
California appears to differ from the national findings in three main areas: marketplace dynamics, the design of the models, and lack of commercial withdrawals from Medi-Cal, despite rates that are among the lowest in the nation.

Marketplace
The California marketplace has a much higher level of managed care penetration than most other parts of the country. With the exception of Medicare beneficiaries, HMOs dominate the market, especially in the counties in which Medi-Cal managed care has been implemented. HMOs in California, both in the commercial and Medi-Cal markets, generally “downstream” the risk to provider groups (IPAs and medical groups). Medical groups and IPAs are generally capitated and have or share responsibilities for quality assurance, utilization management and providing required financial, access, quality and utilization data.

Providers in California are price takers, receiving whatever remains after the plan and medical group take their administrative expenses “off the top.” For a substantial percentage of the beneficiaries in Medi-Cal managed care, there are the additional administrative entities (HMOs, medical groups and IPAs) between the health plan capitated by the state and the physician actually providing services to the beneficiary. The medical groups and IPAs in California are widely thought to be experiencing substantial problems, with many in financial difficulty. Some plans are initiating efforts to directly contract with individual physicians. The difficulties may have an impact on future market stability, and they may raise questions about the value-added contribution of these types of intermediary entities.

Design of Managed Care Models
Through its multiple models California “manages its markets” in ways that attempt to preserve traditional and safety net providers and, at the same time, are sensitive to community differences and desires. The three models, described earlier in this report, provide services to California Medicaid
beneficiaries under capitated arrangements with health plans. Almost half of the five million Medi-Cal beneficiaries were served under such arrangements in December 1998.

These managed care models are, in and of themselves, a unique feature of the California market. Most states use an RFA model where multiple plans are selected in a geographic area and beneficiaries choose their service provider among them. While this is the case with California’s GMC model, the smallest of the three models, most Medi-Cal beneficiaries participate in Two-Plan and COHS, which depart from this design. In contrast to the RFA model, the COHS model is organized around county-based quasi-public entities and Two-Plan around a county-organized Local Initiative and one selected commercial HMO per county. Not only are there significant differences among the three models but also within each model. Specifically, L.A. Care, a Local Initiative, and CalOPTIMA, a COHS, combine elements of GMC into their structure.

The state has also purposely, through its design of the Two-Plan model, tried to promote the participation of traditional and safety net providers by assuring that at least one of the two plans in a county include them in their network of providers. The participation of eight not-for-profit county-related Local Initiatives and five COHSs that (except for one Local Initiative) serve only Medicaid beneficiaries stands in sharp contrast to other states. On the one hand, these entities increase total administrative costs to the extent that they contract with other HMOs or medical groups rather than individual physicians. In these “plan partner” relationships, the administrative costs of all the entities that stand between the COHS and the individual physician reduce the amount of money that can be allocated to direct medical services. On the other hand, they increase community involvement, participation, and control and may aid in developing community infrastructure for local problem solving. More communities are assuming responsibility for a range of local problems. A community infrastructure, developed to support health care for the poor, can extend to the solution of other local issues.

**Lack of Plan Withdrawals**

Unlike other states where commercial plans have withdrawn from Medicaid managed care, this is not an issue in California. Thirty health plans participated in Medi-Cal as of December 1998, including 26 of the 41 HMOs licensed in the state. California’s managed care program is also marked by stability, with the rate of participation relatively stable; during the 1996-1998 period, there were only two exits, both of them plans which lost their bids to be Two-Plan commercial contractors. Having losers in a bidding process is desirable if it provides incentives for plans to perform at higher than minimally acceptable levels.

In 1999, which falls outside of the California study’s timeframe, two HMOs exited the program. One experienced financial difficulties not related to its Medi-Cal line of business and is going out of business. Another, a COHS subcontractor that has a large commercial membership but a very small Medi-Cal membership, cited increased Medi-Cal requirements as the primary motivation for leaving the program. In short, these two exits do not appear to signal market difficulties. Both reflect the kind of market dynamics that are observed in and outside of a managed care environment.

On balance, despite complaints about rate adequacy and what is described as increasingly unnecessary and capricious regulation, many commercial insurers still express interest and even enthusiasm about participation. All the large participants interviewed expressed interest in continued and expanded participation. None of them seemed to think participation endangered their plan’s profitability.
V. Discussion of Findings and Implications

Findings from the Two Studies

The overall findings from both studies provide the foundation from which several conclusions can be drawn and they illustrate areas where interesting and puzzling questions remain. The following discussion examines the findings across the dimensions of plan participation and performance, and the five components of the general model that guided these studies: design, management, environment, plan characteristics, and contract and rate issues.

Plan Participation

The general picture of plan participation in Medicaid is a mixed one. Overall participation among HMOs is declining from a peak in 1996. A number of states, including Wisconsin, Virginia, Arizona, and counties in California have experienced relatively few plan exits in recent years, while others, like Ohio, New Jersey, and Texas, have faced a fair amount of instability. Relative to plan exits, Washington and Maryland fall somewhere in between, though both have concerns that other plans might leave in response to future rates. Plan participation profiles are quite mixed across these states. With exception of the COHS and Local Initiative plans in California, there are a limited number of Medicaid-only plans found in these states. Some of the states have a very broad spectrum of participating plans from among major commercial players, which include publicly traded companies. States that by design limited the numbers of their awards find they have less diversity of plans, but they usually have attracted a mix of participants. California’s Two-Plan approach exemplifies this approach, with one “mainstream” plan and one locally organized plan based on traditional and safety net provider systems.

Are plan participants typical or representative of the local HMO market? Generally they are, subject to the degree to which states limit the number of participants. In markets with mandatory programs, major local players are often significant participants. Blue Cross plans, which enjoy dominant positions in many markets, are deeply involved in several states and in a number of the counties in California. There are also a few multi-state Medicaid-only firms that are major players in several states. The presence of these companies—which have the opportunity to select the markets in which they choose to participate—may signal the states that operate sound and successful programs, including those whose rates may allow for a reasonable return.
In most instances the exiting plans have a relatively small Medicaid membership. If they were unable to grow successfully as a predominantly or exclusively Medicaid plan, they could not sustain participation. The overall decline in the number of Medicaid eligibles over the past two years has heightened risk for this type of plan. If they are predominantly commercial, their decision to withdraw may reflect an unwillingness to make the investments necessary to comply with Medicaid requirements (or to achieve economies of scale in meeting them). Clearly, deteriorating margins for the entire industry have motivated many HMOs to carefully review all their business lines and to make strategic withdrawals if opportunities for turnaround in the short run are limited.

**Plan Performance**

One of the most striking findings from the two studies is the relatively strong financial performance among the California plans participating in Medicaid. The performance is bolstered by COHS plans and Local Initiatives participating in the Two-Plan model. In both cases plans achieve profitability through essentially only Medicaid/Medi-Cal premium revenue. The strikingly low administrative costs in these organizations, despite their relatively small size, are particularly impressive. In addition, they are achieving profitability despite very low capitation rates relative to other states.

There are several possible explanations for the success of California plans.

- Their success may be the result of doing business in a more mature managed care market where provider payments from commercial products are low, and the spread between Medicaid and commercial payments may not be as great as that found in other states.

- The local and public nature of these plans may persuade providers to accept rates that commercial plans may not be able to negotiate.

- The extensive use of downstreaming of financial risk from plans to providers may improve overall financial performance for plans, while shifting the consequences of low capitation rates to provider groups. Left unanswered is whether risk-shifting is sustainable, given the reported instability among provider groups in California.

Another dramatic finding complements the California results: In recent years, across the country, plans that are more reliant on Medicaid beneficiaries than on commercial members report stronger performance; that is, incurring smaller operating losses or larger operating gains. Although this observation is puzzling in light of the widespread concern about Medicaid rate adequacy, it suggests that the downward trends in commercial premiums eroded health plans’ most profitable line of business. When Medicaid rates were rolled back in a few states, as noted in the 1998 Hurley and McCue study, Medicaid rates may have stabilized. Plans more heavily invested in Medicaid appear posed to reduce their administrative costs (as a percent of premium) through economies of scale and focus. Plans less committed to Medicaid may contend that the costs associated with limited participation are not met by the modest rates Medicaid programs pay. If this market dynamic can be more fully documented, it may provide a strong endorsement for managing the Medicaid market by limiting participation, as demonstrated in California, or by restricting the number of awards to ensure that participants obtain sufficient membership size, as demonstrated in Arizona. This finding also suggests that in the future, more multi-state, Medicaid-focused plans can be attracted to this market if it appears rewarding.
Overlapping life cycles are probably at work in the pictures of performance presented here. California’s program, with the exception of COHSs, is relatively new in a number of markets and a second procurement for the Two-Plan model had not yet occurred. But the program appears to be in a steady state at this time and plan participation is not expected to change significantly in the near future. It is not possible, however, to determine what role downstreaming of risk to providers has on the participation and performance of plans, and whether difficulties in that area might have an impact in the future on Medi-Cal managed care.

**Program Design**

Among the study states, and within California, there is a broad spectrum of models. The COHS model is, for all intentions and purposes, found only in California, but interest in this design is surfacing in Ohio, where the state previously failed to sustain multiple plans in specific urban markets. The Two-Plan model is an equally distinctive California creation owing to the special role played by county sponsored health care delivery systems as providers of last resort, particularly for the large undocumented immigrant population. In reality, this model is emerging, albeit more subtly, in other states’ special accommodations to allow safety net provider sponsored plans to participate, sometimes giving them special concessions relative to their commercial competitors. Finally, California’s GMC closely approximates the market structure found in other states, with multiple plans with diverse sponsorship competing to enroll members.

One conclusion drawn from the evidence is that the degree to which California has purposely customized its models to its markets may explain the relatively successful performance of plans across all three types of arrangements. Other states with more carefully choreographed configurations of plans, such as Arizona and Texas, also lend support to this explanation. Other states, like Wisconsin and Virginia, have shown little interest in reducing the number of contractors, and their market exits are few. In contrast, some states have watched as the number of plans winnowed down by natural selection/market forces. In some instances, these forces have little to do with Medicaid; they reflect larger developments in the managed care industry, such as fallout from the Balanced Budget Act of 1997 and consolidation within the HMO industry. In other cases, Medicaid policies and practices spawned either an excessive number of initial awards, injudicious qualification of plans that subsequently proved themselves inadequate or uncommitted, or both. However, in these states there was little capacity or appetite for restricting initial awards when the program began.

At the other end of the design cycle is the looming concern in several states that attrition among plans could ultimately jeopardize the Medicaid program and its negotiating position with remaining plans. Interestingly, this does not surface as a major concern in California, where the state has effectively created monopoly and duopoly markets, or in Arizona, where bid awards are limited. This may be a function of market and plan maturity. It may also reflect a fundamentally different view of what constitutes competition, and where that competition should occur: namely, at the point of bid award rather than at the plan-to-consumer market interface. In addition, it illustrates that a long-term commitment to a relationship by both buyer and seller carries sufficient advantages that more than offset the potential risks of exploitation by either party.
In addition to program structure and plan procurement, the number and types of beneficiaries influence program success. The decision to defer extending the program to special need populations until programs are well established, or until key systems like risk adjustment are in place, is a course adopted in several states. In these states, most observers thought that more ambitious timetables to extend coverage beyond low-income women and children would discourage plans from participating or invoke the ire of beneficiaries, advocates, and providers. Most states are now becoming more venturesome, though California and Wisconsin stand out for their reluctance to expand mandatory enrollment to more challenging populations.

A significant development is the declining number of persons eligible for Medicaid across virtually all of the states. Plans that entered the Medicaid market based on projections of substantially larger numbers of enrollees are falling far short of their targets. This problem is exacerbated in states that do not limit the number of contractor awards and participating plans are competing for this shrinking population. Initially this will trigger further plan departures and more discontinuity for plan members, though exits may bolster surviving plans. Currently California’s Two-Plan and COHSs are experiencing declining numbers, which raises concerns about their ability to maintain a sufficient size to achieve the economies of scale needed to remain viable. Whether this trend can force major program redesigns merits careful monitoring.

Program Management

Most states’ programs still struggle to achieve status as value-based purchasers, a major makeover from the historical passive payer role of the typical Medicaid agency. However, most are acquiring the requisite skill sets needed to meet their responsibilities, through agency reorganization, new hiring, or use of external consultants. This improvement was recognized and applauded by health plans in most of the study states. The consensus is that program managers are performing more competently, particularly as programs move away from initial (and typically tumultuous) implementation to greater stability and predictability. Another frequently held view is that there are concerted efforts to promote more participation by plans and other stakeholders in program planning, program design, and rate and contract development. Tensions remain, in part, because state program managers are still subject to both legislative and political constraints in their local environments, and to federal requirements (including waiver policies and, most notably, proposed regulations related to the Balanced Budget Act of 1997 in such areas as quality monitoring and improvement).

Most encouraging, though, is the degree to which observers characterized the relationship between the plans and their state Medicaid staff as open and collaborative, reflecting a growing recognition of mutual dependence (at least in the states studied in these two projects). Experiences in more mature programs like Arizona, Wisconsin, and Washington underscore the degree to which a sense of partnership can flourish if assiduously cultivated over time. This type of relationship is critical for states that want to move beyond the goals of access enhancement and cost control, and to the more challenging tasks of quality improvement. In addition, only a long-term business partnership can yield the flexibility for both parties to weather and to adapt to unforeseen issues and developments.
Market Context

The turbulence in managed care markets is unlikely to abate in the near future, suggesting that state Medicaid agencies will continue to face unpredictable challenges. This project suggests that policymakers recognize these broader developments as shaping and constraining their opportunities and planning. This uncertainty is supported by the large number of states that acknowledge long range planning to uncover the next generation of managed care models. For some states this may mean a retreat to less ambitious, but more controllable, strategies like primary care case management. For others this may entail direct contracting with providers or emerging permutations of this approach.

Market structure and maturity influence how far and fast states can go with their managed care strategies. In states where prepaid managed care is the dominant form of financing and delivery for the private sector, it is relatively easy for Medicaid purchasers to attract and retain plans, and to expand to most urban areas of their states. Rural managed care, especially the prepaid variety, remains rare except in those instances where states can induce or compel urban-based plans to stretch their coverage, as occurred in Virginia, Maryland, and Washington. In mature managed care markets sufficient accommodation protects safety net providers by program design and operational features; less mature states still struggle with engineering this protection while promoting successful provider adaptation.

Marketplace consolidation is a significant concern in several states because it jeopardizes program stability and, in extreme cases, the state’s capacity to maintain a mandatory program. However, consolidation can strengthen the remaining plans, as occurred in New Jersey and Texas. In other cases, plan failure is accompanied by defaults in provider payments, loss of continuity of care for beneficiaries, and a general loss of credibility for the entire program, as observed in Ohio. In recent years major national players like Aetna purchased several smaller companies (US Healthcare, NYLCare, and PruCare) and, in some instances, eliminated current or potential Medicaid contractors.

Health Plan Characteristics

As noted earlier, the managed care organizations with which states contract reflect the diversity found in the marketplace as a whole. The preponderance of participating plans have major commercial memberships, though enrollment is growing faster in Medicaid-only plans. Declining interest among some major publicly traded managed care firms continues, with only United Healthcare displaying a strong multi-state commitment to Medicaid among the national players. In addition, some large not-for-profit plans like Kaiser, Henry Ford, and Harvard Pilgrim purposefully limit their participation and exposure in Medicaid. On the other hand, Blue Cross plans are expanding their involvement in Medicaid, with major roles in nearly all of the states and a particularly strong position in California across all three models. This suggests that state-based plans have natural advantages in terms of large, geographically dispersed networks and brand name recognition. Some states also value their participation because they bolster program credibility with elected officials. Correspondingly, many plans contend they have an implicit obligation to participate in high profile legislatively sponsored initiatives.

Predominantly Medicaid plans play an integral role in several states—either by virtue of original design, as in California, or as a result of market evolution and shakeouts. Policymakers in most states are relatively unconcerned that a drift toward predominantly Medicaid plans may signal a retreat from the goal of mainstreaming.
Several explanations may account for policy makers’ lack of concern.

- The predominantly Medicaid plans with which they contract have to meet standards that are comparable to those of the predominantly commercial plans.

- These plans are often more committed and, in some instances, more competent to serve Medicaid beneficiaries.

- Many commercial plans serving Medicaid do so by creating separate product lines with distinct provider networks and contractual terms that produce the same effect as creating a Medicaid-only plan. Some plans suggest that their separate product lines still gain the benefits of being part of an overall product portfolio and that programs, systems, and administrative infrastructure built for commercial members enhance the ability of the plans to serve Medicaid beneficiaries.

Medicaid-only plans comprise three distinct groups. The first group, the community-based quasi-public health plan unique to California, is represented by the COHSs and most of the Local Initiatives. A second group includes the provider-sponsored entities formed to allow providers more control over their destinies and premium dollars. This group is represented by plans formed by alliances of community health centers or by high volume Medicaid hospitals, including public facilities and academic health centers. In some markets these plans form the backbone of the Medicaid managed care program. While there is little evidence to assess how well these plans manage care relative to their competitors, recent research by both Brad Gray and Sue Felt-Lisk paints a troubling financial picture for these entities, one that corresponds to a trend seen for provider sponsored (especially hospital) HMOs overall. Coupled with the impact of BBA-related Medicare cuts for several of these provider groups, concerns about their long-term viability are not unfounded, particularly if sponsoring providers enter periods of severe retrenchment. On the other hand, some observers believe that disproportionate share payments to high volume Medicaid hospitals may enable them to sustain participation, because they have the effect of subsidizing some hospital-sponsored plans. The third group of Medicaid-only plans is multi-state for-profit companies competing in a Medicaid or public sector managed care niche. By strategically selecting favorable state Medicaid markets, consolidation of administrative functions, judicious partnering with indigenous providers in local markets, and selective acquisitions of the membership of exiting firms, some multi-state for profit plans are achieving substantial Medicaid membership growth. Whether this translates into long term viability is still unclear, but this sector of the managed care market clearly merits tracking.

**Contracting and Rate Issues**

Rates and contracts are the flashpoints of most of the conflicts between plans, Medicaid policy, and program personnel, as states pursue maximum value for their plan premiums. In virtually all states, the contracts increasingly demand more detail and specificity as states become more assertive in their purchasing roles. The specificity reflects the goal of enforceable standards and accountability. As policy makers discover they can be far more explicit in their demands in a managed care environment than was possible in a fee-for-service world, they often intensify their desires to remedy Medicaid’s past shortfalls. Plans express serious concerns about whether Medicaid purchasers (including both state and federal) are too aggressive in these remedial efforts—setting expectations and standards of performance at unreasonable and unrealizable levels. Thus, they characterize this
These studies found that states are increasingly more cognizant of the administrative costs associated with complying with their growing demands. This issue is partially absorbed into the broader concern about rate adequacy because plans assert, not disingenuously, that they can satisfy the states’ demands if they are adequately compensated to do so. Thus, there are growing disputes over the appropriateness of the Upper Payment Limit (UPL) as a reasonable ceiling for capitation payments, when the expectations for health plans exceeds those required in the fee-for-service arena from which the UPL is derived. Many stakeholders contend that inclusion of a reasonable administrative component in the rate base is essential to focusing attention on the extent to which additional demands are not cost-less; unless rates are adjusted as administrative requirements are increased, health plans are increasingly forced to absorb these costs. In light of growing problems in controlling medical costs, particularly spiraling pharmacy costs, many health plans contend that uncompensated administrative costs may eventually drive them out of the Medicaid business.

The contentiousness surrounding encounter data submission also illustrates the link between contractual demands and rate concerns. Though the debate over encounter data is longstanding, it is brought into sharper focus as most states now require submission of these data and impose sanctions for noncompliance. In short, as fee-for-service data become more remote and unreliable for future rate setting, states see reliance on encounter data a valid substitute. In addition, some states like Maryland have adopted risk-adjustment methodologies based on encounter data. Although plans generally applaud efforts at risk adjustment, they balk at the technical and administrative approaches used to collect and process encounter data, contending it adds substantial additional costs with little evidence that it will be used constructively. Of the several states studied in these projects, only Arizona and Wisconsin apparently have encounter level data systems that function as intended, but Maryland is apparently close to achieving its goals.

Another implication of data requirements cannot be ignored. For states to fully appraise whether they are getting value from their managed care initiatives, they ultimately need detailed quality data on access and outcomes to track changes over time and across plans. Without these data, states cannot document whether managed care programs are superior to simply maintaining a fee-for-service program, and they cannot arrive at valid measurements of performance. Mature programs have reached this point, and this may explain why they have more stable contracting environments: They know what they are getting, and what they might lose, if they are unable to retain high performing plans. It is no surprise, then, that the goals and aims of these state Medicaid managed care programs have shifted from access enhancement and cost control to quality improvement.

**Limitations and Recommendations for Future Research**

Beyond reiterating the earlier caveat about the need to qualify comparisons between California and other states when examining managed care issues, other limitations of the two studies and their conclusions merit attention. A number of these limitations invite additional research and investigation.
Data Limitations
The performance data used in both studies are drawn from unaudited information from submissions to regulatory bodies. In addition, the data for the national study include information only on licensed HMOs. Thus, the research does not include data from plans that are not subject to insurance commission regulation; some states do not require that Medicaid-only plans be licensed HMOs. Data on these plans could be obtained from state Medicaid agencies or directly from plans to build a comprehensive database of all plans participating in Medicaid managed care.

Medicaid Product-Line Performance
Financial performance information specifically related to only the Medicaid line of business within all participating plans would strengthen this analysis. These data are now being reported by plans on the NAIC standard reporting form, but they were not reliable for their first year of availability (1998). Some Medicaid agencies require plans to submit such data, but the cost and reliability associated with collecting this on a national basis, including apportioning costs across different lines of business, are daunting. However, this information is necessary to fully understand the performance of Medicaid plans and the relative contribution that Medicaid products make to health plan profitability and loss.

Administrative Costs of Medicaid Products
The very low administrative cost experience of COHS and Local Initiative plans in California is impressive. The declining administrative costs reflect a relatively short start-up period resulting in smaller than expected start-up expenses, as well as the achievement of economies of scale. More in-depth research is needed to understand the components of administrative costs for Medicaid plans and to ascertain if design features in California may enable plans to avoid certain costs (e.g. marketing) or shift these costs to downstreaming risk partners.

Extent and Implications of Downstreaming of Risk
Little research addresses whether the shifting or sharing of financial risk with provider organizations, including multi-specialty groups, IPAs, or integrated delivery systems, is as extensive in Medicaid as it appears to have become in commercial and Medicare managed care. However, it does appear widespread in California and may be a factor in understanding how and why plans are achieving profitability despite low Medi-Cal rates. Although evidence suggests that many at-risk provider entities in California are experiencing financial distress, Medi-Cal’s contribution to this situation is unknown. On a broader scale, fragmentary information gleaned in the eight state interviews suggests that downstreaming of risk is not common in Medicaid managed care arrangements, reportedly much less so than it is for other lines of business. Additional research is needed in this area to gain a more complete picture of how providers are compensated and what long-term implications these arrangements may have for health plan stability.

More Refined Information on Rates and Rate Adequacy
The landmark Urban Institute study conducted in 1998 established a previously unavailable benchmark with which to make capitation rate comparisons both across states and over time. The study itself had a number of acknowledged limitations that will be refined in further iterations. A particularly pertinent element missing from the study was a comparison of Medicaid rates with local

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market commercial rates. Comparisons made to Medicare capitation rates did provide some illumination in this area, but it would be useful to know the spread between the rates Medicaid is paying for comparable individuals who are in private groups. The California situation appears to imply that what may seem to be very low rates relative to other states are not really that low, when compared to the commercial rates in the same markets. Another metric that would be of interest is the effective percentage of the Upper Payment Limit (UPL) that a state’s capitation represents. While some states appear to be very close to 100 percent of the UPL, others have taken fairly deep discounts in health plan premiums relative to the fee-for-service equivalent. It would be helpful to know if these states are experiencing difficulty in retaining participating plans.

**Absence of Clinical Quality and Outcome Data**

Both of the studies focused on participation and financial performance indicators, rather than on how well health plans are meeting access, use, and quality goals. These questions are beyond the scope of these studies, but are of critical importance in evaluating overall Medicaid managed care strategy as well as in appraising individual plan behavior. This remains a problematic area on two levels:

1. National summary data are not being collected in a standardized format nor collated to support comprehensive cross-state comparisons; and

2. Many states are still struggling with basic data collection and reporting from plans, and are far from obtaining meaningful performance data in these areas.

In general, states have grossly underestimated the amount of specialized resources and senior leadership required to implement and operate a successful encounter data collection program.
VI. Lessons Learned

Summary

The two studies discussed here represent a wide range of experiences with Medicaid managed care, often from distinctly different contexts. The first study provided an update of trends in participation and performance using national data. Building on a comprehensive model developed from previous research findings, this investigation then focused on the experiences in eight states, selected as representing different levels of program maturity and success. The second study explored the experience of Medicaid managed care within California, which is unique for its use of three different models. The California study also examined participation and performance within the state’s market, and also compared these findings with the national experience. Both studies relied upon interviews conducted with stakeholders from plans, programs, providers, and advocacy groups for further elaboration. A discussion synthesizing the findings of these two studies emphasizes observations made about plan participation and performance, as well as the components of the general model that guided these studies.

Lessons Learned

This report closes by listing several lessons that reflect the collective conclusions from these studies. These lessons provide practical suggestions aimed at enhancing state Medicaid managed care programs effectiveness in reaching their varied goals. Medicaid managed care, like its core components—Medicaid and managed care—can only be understood by appreciating the political, economic, and social variability across and within states. As such, states can learn much from their sister states, but emulation must be undertaken with considerable caution.

- State Medicaid agencies should design and manage their programs with an eye to larger market conditions, but they should customize to local conditions. Broader managed care trends are relevant to state experiences, but states can buffer themselves to some degree by sensibly customizing their strategies to local conditions.

- Managed care program managers must accept instability in the managed care industry as a given while pursuing long-term relationships with organizations that can best meet their needs. Medicaid officials should recognize that their design and management
decisions significantly influence plan success and retention, and they should prudently
exercise their power to cultivate partnerships that meet mutual needs. Maintaining
adequate enrollment in participating plans is critical to their survival.

- Value-based purchasing is more than just rhetoric: States must be prepared to “walk the
talk” of buying value. This means having in place qualification, selection, contracting,
and monitoring processes that focus on doing business with plans that can demonstrate
that they are providing services that are worth what the Medicaid program is paying
them.

- Data collection, especially encounter data collection, has to improve in Medicaid
managed care. Encounter data is necessary for state Medicaid programs to effectively
monitor utilization and access, conduct financial analysis and rate setting, measure
quality improvement, and identify future planning needs. If this situation is not reversed
soon, states will forego their ability to effectively manage their programs.

- Successful Medicaid managed care programs will have to commit to payment rates
commensurate with contractual demands. This means they must ultimately recognize
that administrative requirements are not cost-less, and that plan profits are not
necessarily the same as overpayments.

- Effective program management requires states to recruit or otherwise build the skill sets
necessary to operate in a fundamentally different context from claim processing and bill
paying. These new skill sets will assist in promoting a stronger commitment to
purchaser-plan collaboration and cultivating greater credibility with all constituencies.

- Managed care program management requires flexibility and adaptive strategies to
respond to continuing changes in the numbers of persons eligible for Medicaid, plan
participation, and evolving models of managed care. Even the most mature and
experienced states with relatively stable market situations are considering future models
and contingency plans to deal with future developments.
Notes


3 Operating margin is a measure of plan profitability. It is the amount of operating income earned from capitation payments and other insurance revenue, independent of profit earned from investment income. The operating margin thus takes account of how well a plan controls both its administrative and its medical and hospital expenses. A positive and large operating margin is desirable.

4 The administrative cost ratio is an expense measure that indicates the amount of capitation and other insurance revenues that go to support the administrative costs of a plan. Plan administrative costs support the plan’s infrastructure, i.e., their monitoring, quality assurance, information management, and general administrative activities. While administrative costs are not in themselves bad, especially if they result in overall cost savings, in general smaller administrative costs result in more money being available to support other activities, specifically medical services costs.

