

Medicaid Managed Care In Thirteen States

As more states make managed care mandatory for their Medicaid populations, questions persist about the quality of care and the effect on safety-net providers.

by John Holahan, Stephen Zuckerman, Alison Evans, and Suresh Rangarajan

ABSTRACT: This study examines the recent expansion of Medicaid managed care from the perspective of the thirteen states in the Urban Institute's Assessing the New Federalism project. States are moving to managed care for Medicaid both to improve beneficiaries' access and to control the growth in program costs. However, we find that despite dramatic growth in enrollment during this decade, few states are enrolling the elderly or the disabled—the most expensive Medicaid beneficiaries. We also conclude that cost-savings objectives are often at odds with goals of contracting with mainstream plans and protecting safety-net providers.

NEW FEDERALISM 43

MEDICAID MANAGED CARE is growing rapidly in the United States. Forty-nine states now rely on some form of Medicaid managed care, and enrollment has grown from 9.5 percent of total Medicaid enrollment in 1991 to 40.1 percent in 1996.¹ In addition, managed care is moving from primary care case management approaches to more comprehensive, fully capitated managed care systems. Understanding states' experiences with Medicaid managed care is important, not only because of the rapid growth in managed care enrollment but also because the Balanced Budget Act (BBA) of 1997 recently gave states a great amount of new flexibility in adopting mandatory managed care.

Managed care offers Medicaid programs the opportunity to improve access to and quality of care through established provider networks and greater provider accountability. Managed care also has shown some ability to contain Medicaid costs. However, there are growing concerns over the quality of managed care generally, and even more so over Medicaid managed care. There also are con-

John Holahan is director of the Urban Institute's Health Policy Center. Stephen Zuckerman is a principal research associate at the center. Both Holahan and Zuckerman have written extensively on federal and state health policy issues. Alison Evans, a former research associate at the center, is a doctoral student at the University of California, Berkeley. Suresh Rangarajan is a research associate at the center.

cerns over the financial threats that managed care poses for the traditional safety-net providers that care for a large number of the nation's uninsured persons. Finally, managed care also poses a threat to local government agencies, which often are the providers of primary care and mental health services to low-income groups.

Until recently, federal law did not allow states to require that beneficiaries enroll in managed care. To make managed care mandatory, states had to seek waivers from the Medicaid statutes.² The BBA allowed states to make managed care mandatory without waivers except for Medicare/Medicaid dual eligibles and children with special needs. In exchange for this flexibility, programs must meet requirements on enrollment procedures and choice of plans; at a minimum, they must establish standards for access and procedures for monitoring the quality and appropriateness of care.

This paper draws upon the case studies of thirteen states that were part of the Urban Institute's Assessing the New Federalism (ANF) project.³ States were not selected because they were innovators in Medicaid managed care. Rather, they were chosen for their extent of variation in health and welfare spending, fiscal capacity, and social and economic problems. We also aimed to achieve geographic diversity as well as balance in political leadership. The result is a mix of states that also vary in the extent to which they have embraced Medicaid managed care.

The states in this study vary in the extent to which managed care is mandatory, the degree of reliance on capitated managed care versus primary care case management, whether they include the Supplemental Security Income (SSI) population, whether managed care is statewide or limited to urban areas, and the maturity of the state's managed care program (Exhibit 1).

Why Are States Adopting Managed Care?

Earlier studies of Medicaid managed care suggest that states hope that it will enhance access for beneficiaries, improve quality of care, and reduce program costs.⁴ Although evidence on the success of this approach is mixed, our interviews with state officials, provider organizations, and advocates indicate that these are still states' objectives.⁵ Many studies indicate that low reimbursement rates and poor provider participation have made beneficiaries overly reliant on emergency departments and on clinics and physicians that see mostly Medicaid patients.⁶ However, policymakers often are reluctant to increase fee-for-service payment rates. They doubt that higher rates will increase the number of Medicaid providers. The state officials with whom we spoke see a greater likelihood of improved access if managed care plans are required to attract and

EXHIBIT 1
Overview Of Selected Medicaid Managed Care Plans, Thirteen Study States

State/program name	Waiver type	Model	Waiver enrollment (date)	State Medicaid enrollment (June 1996)
Alabama				498,000
Patient First	1915(b)	PCCM	73,000 (10/97)	
BAY Health Plan	1115	HMO	40,000 (projected)	
California				5,415,000
County Organized Health System	1915(b)	HMO	394,000 (7/97)	
Two-Plan Model	1915(b)	HMO	1,137,000 (7/97)	
Geographic Managed Care	1915(b)	HMO	139,000 (7/97)	
Colorado				260,000
Managed Care Program	1915(b)	HMO/PCCM	130,000 (7/97)	
Florida				1,538,000
HMO	1915(b)	HMO	396,000 (10/96)	
Medi-Pass	1915(b)	PCCM	667,000 (10/96)	
Massachusetts				654,000
MassHealth	1115	HMO/PCCM	377,000 (6/96)	
Michigan				1,148,000
Managed Care Program	1915(b)	HMO/PHP/PCCM	773,000 (8/97)	
Minnesota				477,000
Prepaid Medical Association Program	1115	HMO	159,000 (6/96)	
Mississippi				510,000
HealthMACS	1915(b)	PCCM	50,000 (2/97)	
New Jersey				707,000
New Jersey 2000	1915(b)	HMO	384,000 (5/97)	
New York				2,750,000
Partnership Plan	1115	HMO	2,400,000 (projected)	
Texas				1,986,000
State of Texas Access Reform	1915(b)	HMO/PCCM	384,000 (6/97)	
Washington				697,000
Healthy Options	1915(b)	HMO/PCCM	384,000 (6/96)	
Wisconsin				463,000
Managed Care Program	1915(b)	HMO/PHP	230,000 (1/97)	

SOURCE: Case-study interviews and state documents; and Health Care Financing Administration.

NOTES: PCCM is primary care case management. HMO is health maintenance organization. PHP is prepaid health plan.

retain an adequate number of providers. States prefer this approach rather than simply increasing provider payment rates because the state's expenditure risk is limited. In addition, adequate access to providers can be monitored, although this is not always easy.⁷

Although access concerns are important, it is equally clear that managed care would not be so prominent without the potential for cost savings. Medicaid expenditures exploded between 1988 and 1992, mostly as a result of enrollment growth attributable to the economic recession, a number of federal eligibility mandates, and the growth of disproportionate-share hospital (DSH) payments.⁸ States saw managed care as a primary tool for controlling program

“States’ expectations for managed care are more modest than they were only a few years ago.”

costs. This may have been misguided, however, because neither the growth in beneficiaries nor DSH spending can be directly influenced by managed care plans’ actions. Although Medicaid spending growth has slowed since 1992, states have maintained a high level of interest in managed care.⁹

Moreover, states’ expectations for managed care are more modest than they were only a few years ago. Prior research showed that managed care, even without relying on capitated payments, could result in savings of up to 15 percent relative to fee-for-service care. Tennessee was even more optimistic, hoping to set rates at one-third below national average Medicaid costs.¹⁰ Now, most states anticipate saving 5–10 percent. The ANF case studies suggest that states understand that expected savings will depend on their current spending levels and other Medicaid managed care objectives.¹¹

Who Is Enrolled in Managed Care?

46

**MEDICAID
MANAGED
CARE**

All of the study states have enrolled Aid to Families with Dependent Children (AFDC) and related populations in Medicaid managed care, although not necessarily statewide.¹² The health care needs of these persons are the most similar to those of managed care plans’ commercial populations. Enrolling AFDC and related populations means enrolling the largest group of beneficiaries, which makes it more likely that plans will establish provider networks, set up administrative systems, and develop marketing strategies. However, this also is the group of enrollees with the lowest associated costs. The overall savings potential is less, because approximately 75 percent of Medicaid spending will still occur outside of managed care.¹³

The SSI population, the medically needy, and Medicare/Medicaid dual eligibles are the groups with the greatest per enrollee costs and most potential for care management. In 1995, for example, Medicaid acute care spending per disabled enrollee was \$4,646, compared with \$1,701 for nondisabled adults and \$1,099 for children. However, states face problems enrolling these groups because they are likely to have complex medical conditions, which make it difficult to establish contract provisions that ensure appropriate benefits, specialty care, and payment rates. This population also is more likely to have prior provider relationships, perhaps with multiple providers and suppliers of equipment, which some states hesitate to disrupt.

The study states vary widely in their treatment of SSI popula-

tions. Texas, Wisconsin, New Jersey, and Mississippi do not mandate enrollment of SSI beneficiaries but permit them to enroll voluntarily. In Minnesota they are excluded from participation in most counties. Washington intended to enroll SSI beneficiaries on a mandatory, capitated basis in 1996, but neither the state nor vendors were prepared to meet the more complex needs of this population; the state now intends to enroll this population in 1999. Colorado, Florida, Massachusetts, and Michigan enroll SSI beneficiaries mandatorily but permit them to choose between a noncapitated provider who acts as a case manager and a capitated health maintenance organization (HMO). Massachusetts also gives persons with severe disabilities or acquired immunodeficiency syndrome (AIDS) the choice of two HMOs specially designed for their needs. In New York mandatory enrollment for SSI beneficiaries and persons with special needs is planned under a waiver that will create by far the nation's largest mandatory managed care program for the disabled.

Enrolling medically needy beneficiaries in managed care is complex because they are a heterogeneous group. Some are eligible for Medicaid because their income and assets are only somewhat above the normal AFDC thresholds. Others, however, are eligible because they incur high medical costs and spend down to eligibility. This latter group is by definition "high cost." However, some states are beginning to include the medically needy in managed care. Michigan enrolls medically needy families but not those who spend down to medically needy income levels. In Minnesota counties that have a capitated managed care program, the state does not mandate enrollment but does allow both medically needy and spend-down groups to enroll voluntarily in HMOs. Washington enrolls the medically needy, including the spend-down population.

Dual eligibles typically are not included in the Medicaid managed care programs we studied. One exception, Minnesota, requires that aged beneficiaries enroll in managed care to receive non-Medicare acute care benefits.¹⁴ Some states would like to create managed care that extends across Medicare and Medicaid. In fact, both Minnesota and Colorado have waivers to develop new managed care programs that integrate acute and long-term care for dual eligibles. Interest in this group exists because states argue that different coverage and reimbursement rules lead to duplicative administration, fragmented care, bias toward institutionalization, and few incentives to use home and community-based services. A major barrier is that Medicaid has little financial leverage over physicians, who control health care referrals and costs to a significant degree.

What Role Will Auto-Assignment And Brokers Have?

Enrollment in managed care may be voluntary or mandatory. In a voluntary system, beneficiaries choose an HMO or a primary care case manager or stay in the fee-for-service system. This may lead to favorable or adverse selection from among the eligible population.¹⁵ These complex selection dynamics ultimately may make it difficult to set rates and estimate savings in voluntary systems. In this section we focus solely on the process of enrollment.

When managed care is voluntary, a state's primary role is to provide information to facilitate enrollment. For example, states often make extensive efforts to explain the mechanics of managed care to affected beneficiaries—for example, that emergency room and specialty care use may require prior authorization. States may rely on their own staff, managed care plans, or private enrollment brokers to assist with client education, marketing, and enrollment. If beneficiaries are enrolled in managed care plans and do not understand how they operate, public or private providers could be responsible for costs when sick patients “incorrectly” show up at emergency rooms or clinics for care.

When enrollment in managed care is mandatory, the state has a greater obligation to enrollees. Under most circumstances, the federal government requires that the state offer a choice of managed care plans. First, beneficiaries must be made aware that enrollment in a plan has become mandatory. Second, they also must be made aware of their plan choices and how best to make them. Mandatory managed care typically gives beneficiaries a period of time to select from among managed care plans.

■ **Auto-assignment.** Beneficiaries who have not selected a plan by a cutoff date must be assigned to a plan (“auto-assignment”). Low rates of auto-assignment are considered signs that beneficiaries understand that they must make a choice and that they have selected a plan that meets their needs. Low rates of voluntary plan selection raise concerns that beneficiaries are not informed about managed care options, that they feel coerced, that they will seek care outside of the plan (for example, in emergency departments), and that plans will be paid premiums for beneficiaries who may not use their services. Although recent studies point out the limitations of using auto-assignment rates as indicators of a state's education and enrollment process, these rates appear to be the best available indicator.¹⁶ However, differences in how assigned enrollees are defined suggest caution in making comparisons across states.¹⁷

Although states would like to have as many beneficiaries as possible selecting plans on their own, they also are beginning to use

auto-assignment to achieve other policy goals.¹⁸ States may reward plans that score well on quality measures, offer lower prices, or have high enrollment prior to auto-assignment with a larger share of auto-assignees. New York plans to use both quality and price to reward plans, but price may not outweigh quality.¹⁹ In addition, certain Medicaid-only plans sponsored by safety-net hospitals and community health centers in New York will be guaranteed a certain proportion of the auto-assignees. Washington assigns most beneficiaries who fail to select a plan into the lowest-cost HMO.

Using auto-assignment to provide incentives is not always the model. In New Jersey auto-assignment is to be on an equal basis, with no plan favored over another. In the Alabama and Michigan primary care case management programs, beneficiaries are assigned to providers based simply on provider location rather than on beneficiaries' previous provider relationships. In addition to geography, the local initiative plans in California's two-plan model receive first preference in auto-assignment to limit potential reductions in Medicaid revenues for safety-net providers. Texas uses prior primary care provider, plans of other family members, and special needs to assign enrollees.

■ **Direct enrollment.** One of the surest ways to increase the number of beneficiaries selecting a plan without auto-assignment is to let plans market directly to beneficiaries. New Jersey, which permits a variant of direct enrollment, has experienced very high rates of voluntary enrollment in its new mandatory managed care program. However, New Jersey has contracted with an enrollment broker who does outreach and education. Although plans may conduct direct enrollment, the broker must ensure that each enrollee understands his or her plan choices before enrollment is approved.

Although direct enrollment may be most efficient from a state's viewpoint, it raises troubling issues. Aggressive marketing and enrollment tactics led to scandals in California dating back to the 1970s and to more recent media attention in Michigan and New York City.²⁰ Plans in New York City were found to have enrolled more beneficiaries than they could serve. The state then required social services offices to enroll beneficiaries, but enrollment came to a near halt as these offices were overwhelmed by applicants. Direct enrollment has since been reopened in New York City, but with greater oversight by the city and state. In Florida a 1994 press investigation revealed flagrant marketing abuses, which led to an enrollment freeze until the state could develop better oversight mechanisms.²¹

What Services Are Carved Out?

Medicaid programs historically have paid for a broader range of services than many private managed care plans normally provide.²² If

managed care plans contract for these Medicaid services and are either unable to deliver them or do not view them as medically necessary, the move to managed care could limit access. One way to deal with this is to treat some services as “carve-outs.” These services then would be provided on a fee-for-service basis or through a separate managed care program.

Carve-outs also may help states to reduce plans’ incentives to discourage enrollment of high-cost persons (that is, risk selection) that exist in both private and Medicaid managed care programs. For example, persons who use any behavioral health care services represent a greater risk to capitated plans because of their use of these services and the fact that they are often high users of other services.²³ Without the ability to adjust payments for the risks that these persons pose, managed care plans may seek to discourage their enrollment by underproviding behavioral health care services. Carving these services out, therefore, can reduce integrated plans’ risk with respect to behavioral health care costs and enhance their willingness to enroll users of the carved-out service.²⁴ In addition, carve-outs have been used to protect state and local government agencies that provide behavioral health care and whose budgets could be affected if managed care plans reduced their Medicaid payments.²⁵

50

**MEDICAID
MANAGED
CARE**

■ **Mental health services.** Because of these arguments, mental health services (and substance abuse treatment) are the most commonly carved out services. California, Colorado, Florida, Massachusetts, Michigan, and Washington all carve out mental health services. HMOs in Florida can choose to be capitated for inpatient and outpatient mental health services, but not for community mental health benefits, which are paid fee-for-service outside of the plan. Mental health services are carved out from the MediPass program in several Florida counties and are provided directly by Florida Health Partnership, a prepaid mental health program. In other counties primary care physicians refer patients for mental health services to fee-for-service providers. Massachusetts HMOs have the option to receive capitation for mental health and substance abuse services or receive a lower capitation rate; however, the state carves out mental health services from the primary care case management program. New Jersey HMOs receive fee-for-service reimbursement for all behavioral health care services that they provide. In Washington adult mental health services are carved out from HMO services and provided by regional service networks on a capitated basis.

■ **Carve-out issues.** If service responsibilities are not clearly defined under a health plan’s capitated obligation, there is an incentive for the plan to interpret its coverage narrowly and shift costs to the fee-for-service sector or carve-out plan. If carve-outs cause some

services to “fall through the cracks,” then the effectiveness of managed care to enhance access may be compromised.

Carve-outs also complicate the process of setting capitated payment rates. For example, if mental health services are carved out, Medicaid data must be analyzed in detail to allow a state to set appropriate rates for the basic services and the carved-out services. The risk obviously is overpaying one and underpaying the other, which can result in unwarranted profits and losses and, in the case of the latter, can create incentives for underservice.

Some states believe that their carve-out programs have been successful (for example, the mental health carve-out in Massachusetts for enrollees in the primary care case management program); other states have not been satisfied. Several states have struggled with the interaction between their mental health and basic managed care plans. Michigan, which is just now designing a mental health carve-out, views this as a short-term strategy and hopes to integrate these services into comprehensive plans within five years.

What Types Of Plans Do States Use?

Medicaid managed care generally encompasses three types of approaches: primary care case management, full-risk HMOs, and prepaid health plans. The strategy behind a primary care case management program is to match beneficiaries with providers who will take primary responsibility for coordinating their care and approving and monitoring referrals. The goal is to manage utilization and reduce emergency room use and specialty care without putting the provider or plan at financial risk. Full-risk HMOs are fully capitated for a “comprehensive” set of services, ranging across preventive, primary, and acute care, and they have the greatest incentive to control utilization and medical costs.²⁶ Some prepaid plans, typically clinics or large group practices, do not bear full financial risk for a comprehensive service package. Instead, they typically are at risk for ambulatory services only, although some are essentially full-risk HMOs.

Where full-risk HMOs are available, states are turning away from primary care case management and prepaid health plans. Health Care Financing Administration (HCFA) data for 1996 show that nationally only about one-third of Medicaid managed enrollees are in primary care case management and prepaid health plan arrangements.²⁷ The former are a Medicaid program innovation from the 1980s and are not truly analogous to the managed care plans that have developed in the private sector in recent years.²⁸

Alabama and Mississippi sit at one extreme of the study states. They are only beginning to implement Medicaid managed care and have expanded primary care case management because neither has

“Some found so little interest among commercial HMOs that they created or fostered Medicaid-only plans.”

viable HMOs in most areas. Alabama also has recently begun contracting with a new HMO in Mobile County made up of traditional Medicaid providers. Washington State is at the other extreme, having since 1993 moved most of its AFDC-related beneficiaries from primary care case management to the nineteen HMOs with which the state contracts. Virtually all of Washington’s 377,000 beneficiaries in mandatory managed care were in HMOs.

Colorado, Florida, Michigan, and Massachusetts have a combination of primary care case management and HMOs. Three of the states are attempting to move more beneficiaries into HMOs. Colorado’s “rollover” policy that began in 1994 requires beneficiaries whose primary care physician was also on an HMO panel to enroll in the physician’s HMO or select another primary care physician. As a result, the number of Medicaid HMO recipients in the state increased dramatically. Between 1994 and 1997 primary care physician plan enrollment decreased from 135,000 persons to 60,000 persons, and HMO enrollment increased from 10,000 to 70,000.

Massachusetts will seek to shift approximately 300,000 patients in its primary care clinician program into HMOs. The state believes that in so doing it will gain much more control over use and will be free of the burden of managing its own primary care case management program. Michigan also planned to “roll over” all recipients in its provider-sponsored program into HMOs.

Contracting with commercial or “mainstream” HMOs has been difficult historically. Generally speaking, mainstream managed care plans could offer beneficiaries the advantage of mainstream providers. However, when states were first interested in promoting managed care, some found so little interest among commercial HMOs that they created or fostered Medicaid-only plans (such as Garden State Plan in New Jersey, Neighborhood Health Plan in Massachusetts, a variety of prepaid health service plans [PHSPs] in New York organized by community health centers and public hospitals, and more recently BAY Health Plan in Alabama).²⁹ Now that states are mandating managed care for more Medicaid enrollees, the greater volume is attracting more commercial plans. In addition, plans are more willing to accept Medicaid because the payments they receive may seem more attractive relative to declining private-sector payment rates.

Washington and Wisconsin seem to have had the most success in

enrolling Medicaid beneficiaries in mainstream plans. Washington's Health Options is focused on maintaining Medicaid beneficiaries' access through HMO choice. The state contracts with nineteen plans, which include 90 percent of the state's primary care physicians, and at least two plans operate in each county. Wisconsin has contracted with nineteen HMOs, all but three of which are mainstream plans. California has made a concerted effort to involve mainstream commercial plans; its two-plan model requires a mainstream plan as one option in each of the counties in which it operates.

However, some states feel that attracting mainstream plans may be in conflict with their cost containment objectives. Massachusetts would like to contract solely with commercial HMOs but finds them more expensive than the state's own primary care case management program. Although New York has also been successful in attracting commercial plan participation, recent reductions in capitation rates through competitive bidding are threatening to limit participation by many of these plans.

Greater participation from commercial plans may create problems for states with respect to the earlier Medicaid-only plans. The problem is that Medicaid-only plans include not only traditional providers for Medicaid but also providers that serve the uninsured and have relied on Medicaid revenues to do so. In mandatory programs in which competition is intense, Medicaid-only plans may be at a distinct disadvantage. Having no other clients, they may offer to contract at rates that are insufficient to cover their costs because if they are not selected they face almost certain extinction.

Many states are explicitly providing some protection to these plans. New York continues to foster its PHSPs and will favor them through auto-assignment. Some of these PHSPs are tied to fragile safety-net institutions that are valued by the state. California is fostering a type of Medicaid-only plan in twelve counties through its two-plan model. In each county the local initiative plan is required to contract with county and other traditional Medicaid providers and must meet state licensure requirements.

Excessive concern over protecting Medicaid-only plans may protect providers that serve the uninsured, but possibly at the expense of quality enhancement for the Medicaid population. For example, although the HMO run by the Los Angeles County Department of Health Services has performed poorly for several years in audits conducted by the state, it is being given special consideration as California expands Medi-Cal managed care.³⁰ Moreover, state agencies responsible for monitoring quality are still in the early stages of developing these strategies.³¹ Until these mechanisms are functioning, the best protection for Medicaid beneficiaries may be to enroll

them in managed care plans that also treat large numbers of privately insured persons.

Issues For The States

■ **Quality assurance.** The basic issue for states is that capitation provides financial incentives for plans to underserve their members. Therefore, states are establishing mechanisms to deter poor-quality care, monitor plan performance, and provide recourse in the event of complaints. Little is known, however, about the impact that these activities will have on the quality of care. Nevertheless, states continue and, in some cases, are expanding these requirements.

At the contracting stage, states require managed care plans to show that their strategy for serving Medicaid enrollees meets some minimum standards. Standards frequently relate to the adequacy and appropriateness of provider networks, provider credentialing, linguistic and cultural competency, appointment availability and telephone systems, hours of operation, consumer appeal structures, and internal quality control procedures. The adequacy of a network is documented through patient-to-provider ratios. This issue has been especially contentious in New York and California. In fact, concern over provider adequacy has led to delays in the implementation of mandatory managed care in Los Angeles County.

States realize, however, that up-front documentation of plan characteristics does not necessarily translate into acceptable performance and high-quality care. Therefore, plans are often required to provide states with reports based on the Medicaid Health Plan Employer Data and Information Set (HEDIS) system for assessing performance. Massachusetts will even require plans to report HEDIS indicators for its commercial patients, for the sake of comparison. In New York a state-specific variant of HEDIS was developed that requires all HMOs to report more data than is commonly required by large employers. Member surveys also are seen as a way to help states identify problems associated with access to care and patient satisfaction; for example, questions often pertain to telephone and appointment waiting times or perceived quality of provider/patient relationships.

To monitor utilization and contrast it with prior fee-for-service experience, states also are trying to collect encounter data from plans. However, collecting and auditing encounter data has been a challenge for most states that have tried it.

Although many of these quality requirements are spelled out in contracts, it is not clear to what extent they are being enforced. Some states were thought not to have enough staff to monitor quality for current levels of enrollment, much less for a large managed

care expansion. This challenge is not limited to Medicaid. However, state Medicaid programs that have had difficulty recruiting plans may be reluctant to sanction them. Furthermore, some plans may be highly dependent on Medicaid and tied to safety-net providers. Here, financial sanctions could compromise already weak plans.

■ **Setting capitation rates.** States are using various approaches to determining capitation rates for payment of managed care plans; these include administrative rate setting, negotiations, and competitive bidding. All contain a basic link to existing fee-for-service payment levels. States assume that they can save about 5–10 percent off of existing fee-for-service levels. States also are very aware of their need to build capacity and do not seem to be making major attempts to slash rates. Methods of adjusting for risk also seem quite rudimentary.

Administrative rate setting. Minnesota and Colorado set rates administratively for all plans. Minnesota pays the same rate for all beneficiaries in a given rate cell and sets capitation rates based on fee-for-service costs, with a 10 percent downward adjustment to reflect expectations of savings for managed care. Colorado sets capitation rates at 95 percent of the average historic fee-for-service cost of services for each eligibility group. Rates are adjusted to account for paying federally qualified health centers (FQHCs) 100 percent of reasonable cost for those HMOs that have such providers in their network.

California also sets rates administratively in its two-plan model. The plans receive capitation payments based on fee-for-service-equivalent costs with adjustments for eligibility category, age, sex, geographic area, and other factors. DSH payments are excluded from the rates. Rates are low because fee-for-service rates in California have been low. Local initiative rates are increased to reflect the requirement that they contract with the traditionally more expensive providers, including FQHCs and disproportionate-share hospitals.

Negotiations. Massachusetts pays HMOs by negotiating rates individually with plans. The state calculates upper payment limits for each rating category based on fee-for-service experience. The state negotiates with plans that submit bids above the upper payment limit, and the state has brought HMO rates down by 10 percent per year over the past two years. Until 1995 HMOs were finding Medicaid contracts profitable; there is some question whether this remains true. However, HMOs are thought to be more expensive on a risk-adjusted basis than the state's own primary care case management program, which pays providers fee-for-service rates below those of HMOs (which tend to pay providers the same for all enrollees).

Competitive bidding. New York, Michigan, and Washington use competitive bidding, but in each case there is a clear link to existing fee-for-service rates. In addition, the states feel constrained by con-

cerns over maintaining participation of commercial plans, developing managed care capacity, providing incentives for quality of care, or protecting the viability of safety-net providers.

In November 1995, as part of its health plan procurement, New York instituted a competitive bidding process. The state established acceptable rate bands based on fee-for-service expenditures for comparable populations, adjusted downward for expected managed care savings. To facilitate competition, plans were not informed of the rate bands. The state accepted all plan bids in the rate range; those that were below the range were brought up to the bottom of the range, and those that bid too high were given the opportunity to contract at the highest acceptable rate in the range. Through this process, the state believes that it has achieved savings of approximately 10–12 percent off previous rates paid to capitated plans.

The process did not end with the results of the bidding but continued to be debated because of political pressures applied by the plans. When bidding took place, HMOs faced a 9 percent penalty applied to hospital charges if they did not serve Medicaid patients. The HMOs assert that they accepted what they believed to be very low Medicaid capitation rates, in order not to be precluded from Medicaid business or face the 9 percent penalty.³² Some commercial insurers felt that they had been unduly influenced by the potential penalty, and some have since limited their participation in Medicaid, which could create further capacity problems for the state. PHSPs believed that they were under significant pressure to submit low bids and be selected, since they serve exclusively Medicaid clients and contract with providers that serve primarily Medicaid clients and thus are highly dependent on Medicaid contracts. In response to these concerns, the state contracted for an independent analysis of the rates and ultimately raised capitation rates by 2 percent in New York City and 7 percent upstate; debate continues in the legislature on further upward adjustments.³³

In November 1996 Michigan released a request for proposals (RFP) for competitive bids from HMOs to provide care in the county that surrounds Detroit. Before prices would be considered, plans first had to have acceptable proposals for complying with quality measurement criteria. If their price fell within the established bid corridors, plans would receive contracts at the bid price. If the bid price fell below the corridor, plans would be awarded contracts at the low end of that corridor. Health plans that scored the highest on the quality measurement criteria will receive the highest share of auto-assigned clients, which Michigan believes to be less costly than average. Plans also were given extra points in the bidding process if they contracted with school-based clinics, local

health departments, and other safety-net providers. Payment rates appear to be about 90 percent of estimated fee-for-service costs.

Washington State also uses competitive bidding of rates for each of several eligibility groups. Because the state is more interested in building capacity to provide Medicaid managed care than in achieving savings, the state let it be known that it would accept all rates that were comparable to fee-for-service levels. Most of the bids were at or near these levels, and the state did not achieve much savings through competitive bidding. There remains considerable interest in a “lowest bidder takes all” strategy. Proponents argue that the state could save 20 percent per patient. The argument against is that many HMOs would be driven out of business altogether and that competitive forces would be weakened over the long run.

Risk adjustment. Risk adjustment has become a major issue in managed care because of the possibility of serious over- or underpayment and resulting impacts on HMOs’ behavior. In general, methods of adjusting for differences in risk seem quite crude. Massachusetts negotiates separate rates for five groups: AFDC, severely disabled, AIDS, other SSI, and dual eligibles. Other states establish rate cells based on factors such as age, sex, pregnancy status, region, eligibility category, and institutionalization. Colorado has moved to a more sophisticated mechanism, whereby risk adjustment is based on prior utilization in high-risk diagnostic code groupings to set rates for AFDC and disabled beneficiaries.

■ **Protecting safety-net providers.** There is concern in most states over the impact of managed care on safety-net hospitals and community health centers. These providers often are more costly, and managed care plans often want to avoid contracting with them. It is expected that safety-net providers will either form managed care plans or join existing ones. In either case, the providers must accept lower payments than they had under fee-for-service and consequently reduce costs to compete for managed care patients.³⁴ Ultimately, they could lose volume and receive lower revenues from Medicaid because of managed care.

In Texas it is expected that local health departments will move away from direct care provision to concentrate on public health functions and that county hospitals that provide much of the uncompensated care will have to operate with lower revenues. In New York there is concern that increased Medicaid enrollment in commercial HMOs will hurt PHSPs and in turn hurt the safety-net providers that depend on them. The state, in response, has given preference to the PHSPs in assignment of Medicaid enrollees who do not directly choose plans. The New York Section 1115 waiver also has provided New York City public hospitals with approximately

“Safety-net providers argue that managed care plans will increase the amount of uncompensated care they must bear.”

\$250 million in additional funding for each of the next five years to prepare for the transition to managed care.

Safety-net providers in several states have formed managed care entities to retain Medicaid funding. A Minneapolis-based HMO (Metropolitan Health Plan) that is organized around the major county hospital has been operating since the mid-1980s. Colorado Access was formed recently by several safety-net providers in response to the state’s “rollover” of primary care physician plan beneficiaries into HMOs and favorable HMO payment rates.³⁵ The newly formed HMO retained its current Medicaid population and continued to direct those people to its facilities.

In Massachusetts the Neighborhood Health Plan (recently purchased by Harvard Pilgrim Health Care), which cares for approximately 35 percent of the state’s Medicaid HMO enrollees, was formed with the support of the Medicaid agency and community health centers. Massachusetts is directly addressing the needs of Cambridge Hospital and Boston Medical Center, which provide a large proportion of indigent care, by allocating funds from its bad debt and charity care pool and providing them with \$70 million of federal funding (under an 1115 waiver) to develop prepaid health plans.

In some states there was concern that safety-net hospitals might lose access to DSH payments if these payments were included in managed care rates, but most hospitals have argued successfully to keep DSH out of the rates. Additional protection is provided by the 1997 BBA, which prohibits states from folding DSH payments into HMO rates.³⁶ Furthermore, DSH payments to safety-net hospitals could be reduced if managed care gives beneficiaries better access to mainstream providers. This could be particularly serious in states that use intergovernmental transfers (IGTs) from public hospitals to finance DSH (such as California and Texas), if these hospitals become unwilling to put up their share of the DSH financing.

There also is concern that managed care will increase uncompensated care. For example, in Michigan the fear is that if beneficiaries do not receive timely care from Medicaid managed care plans, they will go to safety-net hospitals. The care provided there will not be approved by the plan, and the hospital’s costs will not be reimbursed. Thus, safety-net providers argue that managed care plans will increase the amount of uncompensated care they must bear.

■ **Nonmedical services.** States have used Medicaid to fund a broad set of services and providers, in part to bring in federal funding for these services. Over time, services in schools, case management, and other social services and public health programs have become increasingly supported by the Medicaid program through a variety of “maximization” strategies. Medicaid managed care plans often do not provide these services. If these services are to be provided, states will have to find other means to support them. Advocates in some states raise concerns that these nonmedical services are simply no longer being provided.

Conclusions

Based on this review of states’ experiences, several conclusions emerge. First, Medicaid managed care is growing rapidly. States are moving to mandate enrollment in managed care and are becoming increasingly reliant on fully capitated HMOs. Primary care case management plans are still important in states with relatively little managed care for the general population, but where possible they are being phased out. The movement toward shifting risk to physicians and other providers is proceeding somewhat more slowly, with most physicians (and other providers) still being paid fee-for-service even within capitated HMOs.

Second, although contracting with mainstream HMOs rather than predominantly Medicaid plans is becoming more common, mainstream plans tend to be more costly and appear to limit managed care’s cost-saving potential. Moreover, a shift away from Medicaid-only plans, which often are linked to safety-net providers, may reduce revenues that have been used to support care for the uninsured. Both of these issues place serious limits on the likely growth of mainstream HMO contracting by Medicaid programs.

Third, Medicaid managed care is still primarily limited to AFDC and related populations. Enrollment of the disabled under managed care is widely discussed but limited to very few states. Many mainstream HMOs are not prepared to address the needs of the disabled. Furthermore, it is proving difficult to establish contract provisions that assure appropriate benefits, specialty care, and payment rates for the disabled. There is growing interest in enrolling dual eligibles because of their high cost, but administrative issues are complex.

Fourth, the breadth of the Medicaid benefit package means that few managed care plans can provide all services; this creates problems for Medicaid programs in establishing plan contracts. The broad range of benefits stems from both the range of services that states can choose to cover under federal rules and states’ efforts to maximize federal revenues by bringing state-funded health and so-

cial services into Medicaid to obtain federal matching funds. One consequence is the carving out of certain services to be paid through separate capitation arrangements or on a fee-for-service basis. Carve-outs are designed to protect certain groups, such as the disabled, who are reliant on services that the managed care plans are often unable to offer, and to insulate state and local agencies, particularly those responsible for mental health care, from the revenue-reducing effects of Medicaid managed care. Experience with carve-outs seems mixed, however, because incentives exist to shift costs between basic and carve-out plans or to Medicaid fee-for-service, which could affect access and cost savings.

Fifth, regardless of whether states establish capitation rates administratively, through negotiations, or with competitive bidding, expectations of savings from managed care tend to be on the order of 5–10 percent relative to fee-for-service. These savings expectations in part reflect the historically low Medicaid payment rates, which make it difficult to achieve the kinds of savings often seen in the private sector. States seem to be increasingly reluctant to attempt to achieve greater savings, because of growing concerns about the need to maintain a large Medicaid managed care capacity to promote access and competition in the long run.

A major unanswered question is, “How will Medicaid managed care plans achieve savings?” Given that Medicaid has not always been a generous payer, how can plans accept capitation rates that are below states’ expected fee-for-service costs and still cover administrative expenses? Although there was not uniformity of opinion among state officials with whom we spoke, the general sense was that plans would have to both control provider payment rates and reduce utilization. States were optimistic that plans could reduce hospital rates, because they would not be constrained by federal laws concerning Medicaid fee-for-service rates. In addition, states expect that excess capacity among hospitals and specialists and recent declines in private rates will make both types of providers much more willing to accept Medicaid patients at lower rates.

While lowering these payment rates, Medicaid policymakers also expect managed care plans to reduce inpatient utilization and inappropriate emergency department visits, become less reliant on specialty care, and shift patients to more efficient providers. (This latter strategy may mean that urban public and teaching hospitals will face curtailed patient flows.) To achieve these goals and still provide high-quality care, plans must make primary care more available to Medicaid beneficiaries. Many plans expect to use the savings they achieve on other services to increase primary care payment rates above those in Medicaid fee-for-service as a way to build capacity.

There was concern, particularly from advocacy groups, that managed care was limiting access to many of Medicaid's social services. Many states have been extremely adept at funding many social or nonmedical services, such as case management, substance abuse services, personal care, and public health services through Medicaid maximization. When states contract for managed care, plans often limit access to these services. To the extent that states or local governments have to provide the social services that managed care plans no longer provide, directly support public hospitals, or initiate other efforts to provide care to the uninsured, costs are simply being shifted rather than being reduced. The result is that the 5–10 percent savings that states are expecting from Medicaid managed care may overstate the true savings to the public sector.

.....
The Assessing the New Federalism project is supported by funding from the Annie E. Casey, Henry J. Kaiser Family, W.K. Kellogg, John D. and Catherine T. MacArthur, McKnight, Robert Wood Johnson, Charles Stewart Mott, and Weingart Foundations and the Commonwealth Fund and the Fund for New Jersey. Additional support is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through grants to the University of Wisconsin-Madison. Opinions expressed are those of the authors and do not necessarily reflect the positions of the Urban Institute or its funders.

NOTES

1. Data from the Health Care Financing Administration Web site, "Medicaid Managed Care Trends," www.hcfa.gov/medicaid/trends1.htm (August 1997).
2. The Section 1915(b) freedom-of-choice waiver allows states to mandate managed care for Medicaid enrollees into either primary care case management or HMOs, but beneficiaries still must have a choice of plans. Section 1115 research-and-demonstration waivers allow states even more flexibility, because the federal government can approve states' requests to test new approaches to benefits, services, eligibility, delivery systems, and program payments. Section 1115 waivers have been designed to make managed care mandatory for current enrollees and, in some cases, use any savings that develop to expand eligibility. These waivers also allow states to limit the types of plans available to beneficiaries to a greater degree than 1915(b) waivers do.
3. For details of the ANF project, see A. Kondratas, A. Weil, and N. Goldstein, "Assessing the New Federalism: An Introduction," in this volume of *Health Affairs*.
4. U.S. General Accounting Office, *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*, GAO/HRD 93-46 (Washington: GAO, March 1993).
5. R. Hurley, D. Freund, and J. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).
6. See, for example, J. Mitchell, "Physician Participation in Medicaid Revisited," *Medical Care* (July 1991): 645–652; J. Cohen, "Medicaid Policy and the Substitution of Hospital Outpatient Care," *Health Services Research* (April 1989): 24–33; J. Cohen, "Medicaid Physician Fees and Use of Physician and Hospital Services," *Inquiry* (Fall 1993): 281–292; and J.W. Cohen and P.J. Cunningham, "Medicaid Physician Fee Levels and Children's Access to Care," *Health Affairs* (Spring

- 1995): 255–262.
7. GAO, *Medicaid Managed Care: Challenge of Holding Plan Accountable Requires Greater State Effort*, GAO/HEHS 97-86 (Washington: GAO, May 1996).
 8. The number of Medicaid beneficiaries enrolled grew from 22.0 million in 1988 to 34.8 million in 1992. DSH payments grew from virtually nothing in 1988 to \$17 billion in 1992. Some of this was initiated by states, but nonetheless, to many observers Medicaid expenditures appeared to be out of control. Growth in acute care spending per enrollee also was high in most states, increasing, on average, by 9.5 percent per year between 1988 and 1992. J. Holahan and D. Liska, “The Slowdown in Medicaid Spending Growth,” *Health Affairs* (March/April 1997): 157–163.
 9. *Ibid.* Most of the slower growth of Medicaid spending since 1992 was attributable to reduced growth in enrollment and cessation of growth in DSH expenditures. Although increases in spending per beneficiary also fell, they declined more for the elderly and disabled, who are largely not in managed care plans, than for adults and children. Thus, little of the slowdown in Medicaid growth is attributable to managed care.
 10. R. Hurley and D. Freund, *Primary Care Case Management Evidence from Medicaid: Synthesizing Program Effects by Program Designs*, Health Care Financing Administration (HCFA) Cooperative Agreement no. 18-C-99490/3-01 (Baltimore: HCFA, June 1991); and G.G. Bonnyman Jr., “Stealth Reform: Market-Based Medicaid in Tennessee,” *Health Affairs* (Summer 1996): 306–314.
 11. States with high acute care spending because of either rich benefits or limited controls have a greater potential to save money. Others whose spending is already low because of low provider payment rates and limited benefits have much less potential for saving. In addition, states recognize that improving access and quality may limit their savings potential.
 12. AFDC has been replaced by Temporary Assistance to Needy Families (TANF), but AFDC rules still apply for Medicaid eligibility.
 13. Acute care accounts for only about half of Medicaid expenditures. If Medicaid acute care spending could be reduced by 10 percent for all beneficiaries in managed care, spending would decline by 5 percent. It is difficult to enroll all beneficiaries in managed care. Most states rely on managed care for adults and children, who only account for 25 percent of Medicaid spending.
 14. New Jersey and Florida allow dual eligibles to voluntarily enroll in managed care for Medicaid-covered services. Massachusetts allows dual eligibles to receive benefits through an HMO if it is a Medicare risk-contracting plan.
 15. Healthy beneficiaries may opt to enroll in managed care because they expect to use fewer services and are willing to have fewer provider options. Alternatively, sicker beneficiaries may enroll as a way of ensuring their access to some providers that will treat Medicaid patients.
 16. GAO, *Medicaid: States’ Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO/HEHS 96-184 (Washington: GAO, September 1996); and J. Horvath and N. Kaye, *Enrollment and Disenrollment in Medicaid Managed Care Program Management* (Portland, Maine: National Academy for State Health Policy, December 1996).
 17. For example, states differ in how they count newborns enrolled in their mother’s plan (some consider them assigned, while others do not) and in the length of time they give beneficiaries to select a plan.
 18. Some believe that auto-assignees are above average in health status, less costly to health care providers, and therefore desirable. Others maintain that refusing to choose a plan means makes these patients difficult to deal with in managed care, that is, they are unlikely to follow the rules.
 19. State of New York, Assembly Bill 11329, 12 July 1996.
 20. GAO, *Better Controls Needed for Health Maintenance Organization under Medicaid in*

- California, B-164031 (Washington: GAO, September 1974); and J. Holahan et al., *Health Policy for Low-Income People in New York*, Urban Institute State Reports (Washington: Urban Institute Press, December 1997).
21. F. Schulte and J. Bergal, "Medicaid HMOs Face State Scrutiny," *Ft. Lauderdale Sun-Sentinel*, 16 December 1994, 1A.
 22. For example, Medicaid programs often provide extensive coverage for substance abuse treatment, mental health care, rehabilitation, home and personal care, and case management. This issue is further complicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, which requires broader service coverage for Medicaid-covered children than for adults.
 23. L.L. Morlock, "Recognition and Treatment of Mental Health Problems in the General Health Care Sector," in *The Future of Mental Health Services*, ed. C.A. Taube, D. Mechanic, and A.A. Hohmann (Washington: U.S. Government Printing Office, 1989).
 24. R.G. Frank et al., "Solutions for Adverse Selection in Behavioral Health Care," *Health Care Financing Review* (Spring 1997): 109-122.
 25. S. Bachman et al., *Medicaid Carve-Outs: Policy and Programmatic Considerations* (Princeton: Center for Health Care Strategies, Inc., March 1997).
 26. But even many of these plans still pay physicians and other providers on a fee-for-service basis.
 27. Data from the HCFA Web site, "Medicaid Managed Care Enrollment by Program Type," www.hcfa.gov/medicaid/plansum4.htm (August 1997).
 28. However, in thirteen states the only type of Medicaid managed care is primary care case management (Alabama, Arkansas, Idaho, Kentucky, Louisiana, Maine, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia, and Wyoming).
 29. Federal law imposed the 75/25 rule, whereby at least 25 percent of enrollment must not be Medicaid and Medicare. This was intended to counter the creation of "Medicaid mills." Some of these plans were exempt from this rule. Still others met the rule by counting their general medical assistance enrollees toward the 25 percent group.
 30. J. Yang and M. Litt, *Quality of Care in Medi-Cal Managed Care Plans: A Survey of the California Department of Health Services Medical Audits* (Los Angeles: Center for Health Care Rights, 1995).
 31. B. Landon, C. Tobias, and A. Epstein, "Quality Management by State Medicaid Agencies Converting to Managed Care," *Journal of the American Medical Association* (21 January 1998): 211-216.
 32. The 9 percent penalty was phased out with New York's rate-setting system and ended when the III5 waiver was approved.
 33. "The New York State Office of Managed Care Bureau of Managed Care Financing Actuarial Review" (Unpublished report, Arthur Andersen, Hartford, Connecticut, December 1996).
 34. Many states are continuing to assure that federally qualified health centers receive revenues consistent with the cost-based reimbursement requirements under Medicaid fee-for-service.
 35. The Colorado Access Network consists of the University Hospital, Children's Hospital, and Denver Health, as well as the Colorado Community Managed Care Network, which comprises many community and migrant health centers from around the state.
 36. However, exceptions are made for states that previously included DSH in their rates. For example, in Minnesota DSH payments are included in rates paid to plans, which are expected to pass them on to hospitals.