
Medicaid Confronts a Changing Managed Care Marketplace

Robert E. Hurley, Ph.D. and Debra A. Draper, Ph.D.

After two decades of concerted efforts, more than one-half of all Medicaid beneficiaries are now enrolled in managed care arrangements. Most States appear strongly committed to continued reliance on managed care, but the contemporary managed care marketplace is undergoing a number of significant changes. We describe how several of these developments are being revealed in commercial managed care and discuss implications for Medicaid purchasers and beneficiaries. State Medicaid agencies will have to adapt managed care strategies to respond to the evolving products and practices of managed care plans and their interest in public sector product lines.

INTRODUCTION

Throughout the 1990s, State Medicaid Programs undertook a major conversion of their acute medical services from a traditional fee-for-service (FFS) model into a variety of managed care arrangements. By the end of the decade, over one-half of all Medicaid beneficiaries were enrolled in these arrangements. While operational experiences and outcomes have been uneven, most States remain committed to maintaining models that have provided beneficiaries with a guarantee of a medical home, contractually specified performance standards, and the potential to promote,

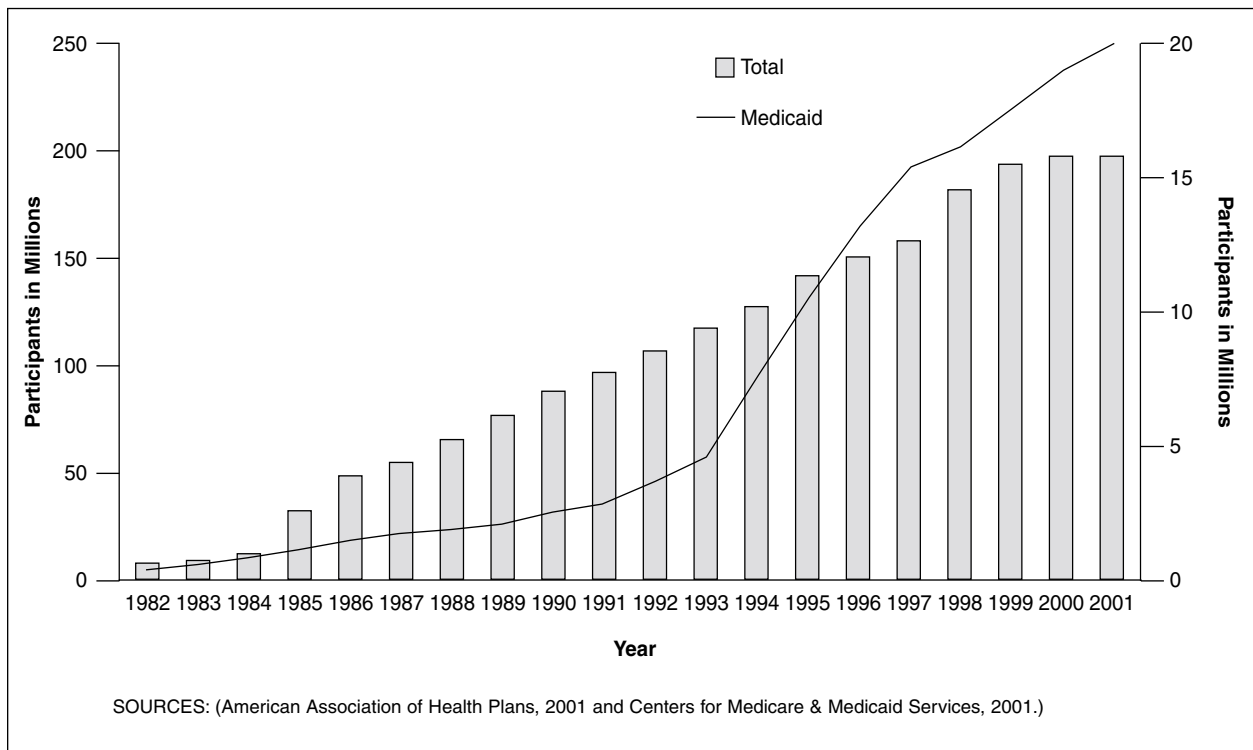
monitor, and document performance improvements. During most of this period, Medicaid rode the crest of the wave of private sector managed care expansion.

But several contemporary trends in the broader managed care marketplace are casting a shadow over Medicaid's ability to sustain its commitment to and momentum in expanding enrollment in managed care models. The trends include a significant backlash among providers and consumers, major changes in product design and features, and a growing sense that the cost containment capacity of managed care plans is slipping away. Commercial managed care products are retaining fewer and fewer of the features that originally distinguished managed care from conventional FFS payment method models, and plans are showing a declining interest in public sector markets. Taken together, these developments raise doubts about whether State Medicaid agencies can continue to get from managed care what they have sought and whether health plans and their providers will continue to participate in public sector lines of business.

In this article, we provide a brief review of the evolution of managed care in Medicaid. We then detail several recent developments in the managed care marketplace, particularly as they are being revealed in the commercial sector. The implication of each of these trends for Medicaid managed care is assessed. We conclude by examining a number of responses already evident among the States and offer an assessment of how

Robert E. Hurley is with Virginia Commonwealth University. Debra A. Draper is with Mathematica Policy Research. The views expressed in this article are those of the authors and do not necessarily reflect the views of the Virginia Commonwealth University, Mathematica Policy Research, or the Centers for Medicare & Medicaid Services.

Figure 1
Medicaid Versus Total Managed Care Organization Enrollment: 1982-2001



States' commitment to managed care models may be jeopardized by the transformation in managed care.

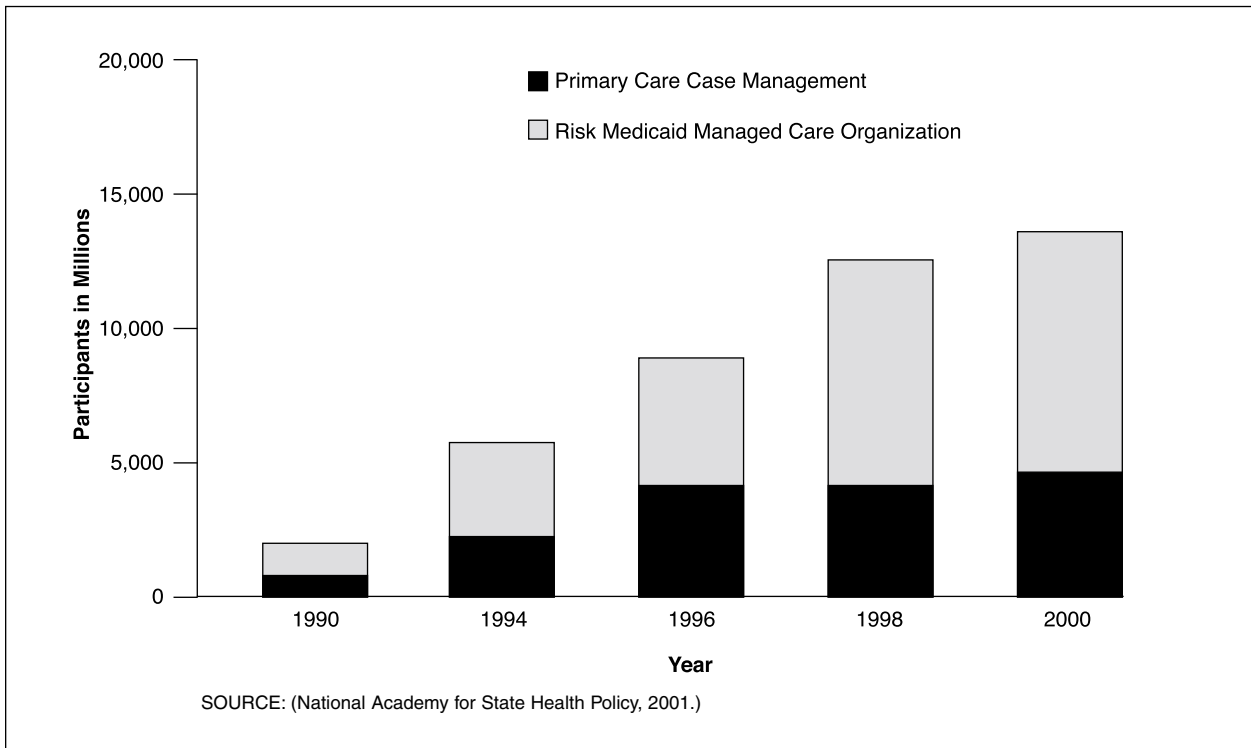
Medicaid Managed Care Background and Growth

Commercial managed care enrollment grew steadily from the late 1980s throughout the 1990s (Gabel et al., 2001). In comparison, Medicaid's rate of growth was initially slower and then more rapid as shown in Figure 1. Medicaid's first growth spurt occurred in the early 1980s as Arizona and a handful of other pioneering States sought to gain medical homes for beneficiaries and to achieve a measure of predictability in expenditure growth (Freund and Hurley, 1987). By 1989, enrollment had leveled off at about 2 million or approximately 10 percent of all Medicaid beneficiaries. Medicaid participation in health maintenance organizations (HMOs) lagged behind

the private sector at that time. In many States, HMOs were small, embryonic organizations centered in urban areas with little interest in participating in public sector programs of any kind.

Where there was a lack of development of or interest among prepaid health plans, other models of managed care were devised by States including, most notably, primary care case management (PCCM) (Freund, 1984). Initiated in Michigan and Utah in 1982 and 1983, these arrangements were built by recruiting primary care physicians to become gatekeepers and care coordinators and typically retaining FFS payments. For many States, the PCCM model was seen as a transitional arrangement that would suffice until fully formed prepaid health plans emerged and showed interest in Medicaid. Other States concluded the model gave them as much care management and assurance of access that they desired. The PCCM model had

Figure 2
Medicaid Managed Care Enrollment, by Model Type: Selected Years



the additional virtue of avoiding conflicts with traditional Medicaid providers reluctant to join health plan networks (Holahan et al., 1998). Reliance on PCCM models has remained relatively stable since the mid-1990s while HMO enrollment grew more rapidly, emerging as the dominant form of managed care with nearly three-quarters of all Medicaid managed care enrollees by 2000 (Figure 2).

Growth in prepaid arrangements including both HMOs and prepaid health plans (that typically assume less than full risk) was favored by the States as many of them pursued waivers to undertake ambitious eligibility expansion and restructuring of Medicaid financing and delivery systems (Holahan et al., 1995). An increasing number of States chose to make enrollment in managed care mandatory for certain beneficiary populations, thereby accelerating membership growth for plans. Prepaid arrangements offered States predictable

cost increases, promoted more extensive care management and coordination, and provided them with an opportunity to shift administrative efforts and expenses on to private plans. This strategy also dovetailed with the private sector's embrace of HMOs and allowed States to try to align their approach to the market with that of increasingly activist private purchasers. Commercially based HMOs also displayed interest in expanding their memberships by offering public sector products in both Medicaid and Medicare (McCue et al., 1999). State interest in cost control meant that they would accept restricted networks, preservice authorization, and other forms of care management in return for guaranteed access, comprehensive benefits, and no out-of-pocket expenses for Medicaid beneficiaries.

There were some areas of rough fit between Medicaid and commercial managed care suggesting adaptation would be

necessary (Hurley and Wallin, 1998). Limited access to care due to poor provider participation implied that there were unmet needs among Medicaid beneficiaries so enrollment in managed care arrangements might actually lead to increases in utilization. Low levels of provider payments under traditional Medicaid meant that participating plans would be hard pressed to reduce further payment rates to network providers, as they commonly did in commercial product networks. Plans also found that reducing payments to traditional Medicaid providers who provided substantial uncompensated care could destabilize local safety nets. Intermittent eligibility among beneficiaries led to high levels of involuntary turnover and increased administrative costs for plans. The high concentration of chronically ill and disabled persons in Medicaid presented major challenges to plans in those States that required these beneficiaries to enroll in prepaid health plans. Despite these impediments, by 1999 more than 15 million were enrolled in more than 300 prepaid plans nationally, and another 5 million beneficiaries were enrolled in PCCM arrangements (Centers for Medicare & Medicaid Services, 2001).

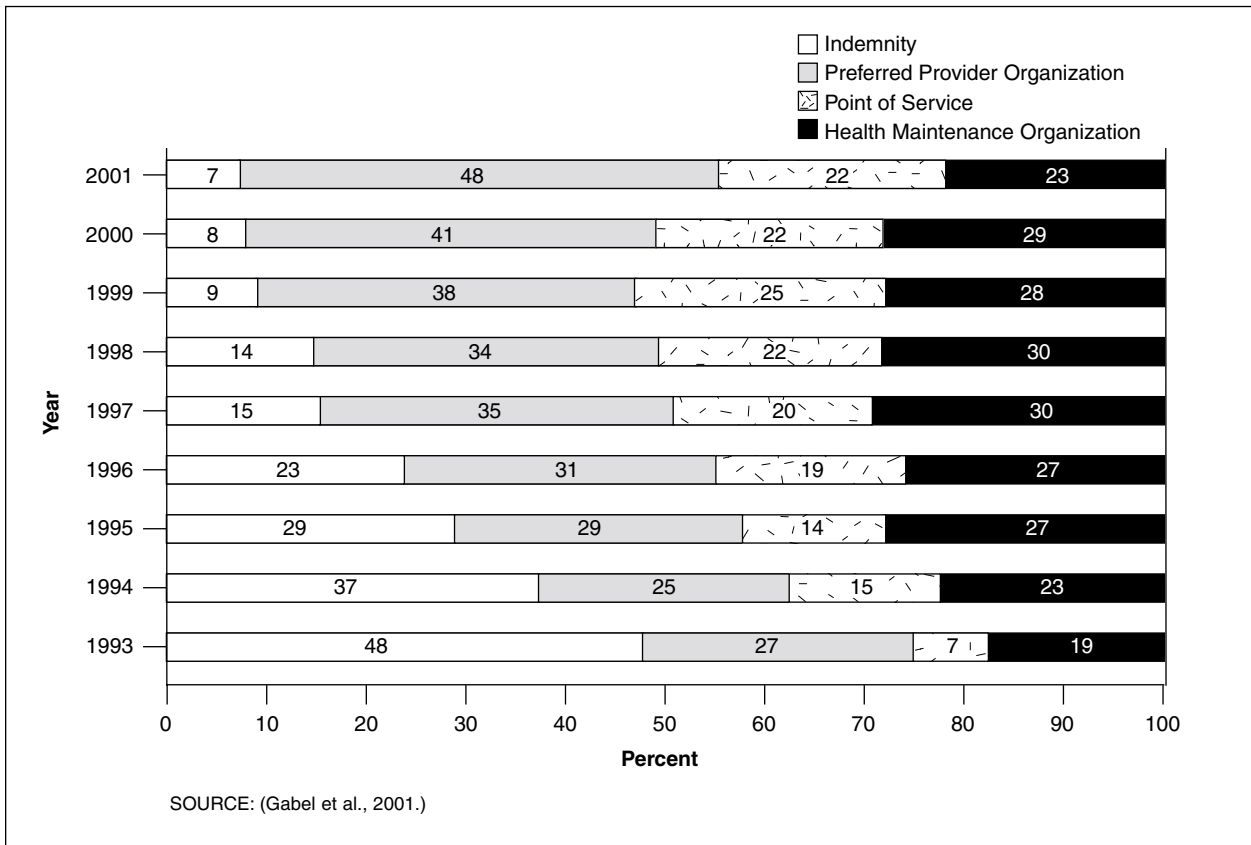
The degree to which Medicaid has transitioned into a managed care-based program is underscored by the landmark Medicaid managed care regulations that emanated from the Balanced Budget Act (BBA) of 1997 and were issued in spring 2002 (Centers for Medicare & Medicaid Services, 2002). The final regulations addressed many facets of Federal-to-State, State-to-plan, and plan-to-beneficiaries relationships that affect how States and plans operate and how beneficiaries are to be served. Among the most notable features of these regulations is the flexibility granted to States to enable them to adapt to a changing marketplace.

Transformations Underway

The implementation of Medicaid managed care in the 1990s triggered many controversies about program design, mandatory enrollment, and pace of implementation (U.S. General Accounting Office, 1987, 1990). These conflicts subsided as alternative managed care arrangements emerged as the standard approach to the delivery and financing of acute medical care. While there has been some attrition among plans participating in Medicaid, most notably among predominantly commercial plans, only a few States have not been able to retain sufficient participation to keep programs intact (National Academy for State Health Policy, 2001). The Medicaid experience contrasts sharply with the turmoil evident in the Medicare market and the widespread disgruntlement with the HMO product in the commercial market (Gold, 2001). Medicaid has not been immune to unfavorable trends, but it does appear that, to date, State Medicaid agencies have been more willing to accept some of the trade-offs associated with managed care arrangements that have not been acceptable in the Medicare and commercial sectors. In addition, States have also been willing and able to mandate managed care enrollment as contrasted with Medicare where enrollment may only be voluntary. But a closer look at how profoundly managed care may be altered by these trends is important to assess if Medicaid will be able to maintain its current level of support for managed care models.

The Center for Studying Health System Change has detailed a number of facets of the changing face of managed care that provide insights into the transformations underway (Draper et al., 2002). After reviewing the trends in the commercial sector, their implications for Medicaid are examined.

Figure 3
National Employee Enrollment, by Type of Plan: 1993-2001



Profitability Versus Growth—The mid-1990s were a period of low or no growth in health insurance premiums brought on in large part because of the desire of health plans to grow membership for market positioning purposes and to gain increased negotiating leverage with network providers. Plans paid a price for this buying of business strategy and saw profits decline as expenses rose faster than revenues. By 2000, this pattern had given way to retrenchment of plans that eschewed expansion as they raised premiums sharply to restore profitability and, in many cases, to respond to escalating shareholder dissatisfaction. For purchasers, the consequences have been profound. Premium increases have returned to levels not seen in over a decade, raising doubts about

whether managed care gains in cost control have now been exhausted (Benko, 2002).

Growth in Less Restrictive Products—Provider dissatisfaction and consumer disgruntlement increased as enrollment grew and exposure to restrictions and impositions of managed care, particularly embodied in the HMO product, became more troubling. Their concerns found voice in public policy arenas with vigorous expansion in mandates and aggressive regulation of managed care practices (American Association of Health Plans, 1998). Purchasers also responded by demanding that plans offer less restrictive products with more open networks and less interference in care delivery and consumption. Consequently, HMO enrollment growth leveled off and

then began to decline as the more user friendly preferred provider organizations (PPO) became the most rapidly growing product (Figure 3) (Gabel et al., 2001). This product essentially maintains conventional payment methods with providers, employs relatively limited cost control and care management requirements, and relies on differential levels of cost sharing with providers to encourage members to remain within the plan network.

Modified Efforts to Manage Utilization—Accompanying migration of membership to less restrictive network products such as PPOs, has diminished reliance on utilization control mechanisms like preadmission certification, prior authorization, and primary care gatekeeping. Plans have moved away from these practices to curb provider and consumer dissatisfaction, reduce administrative costs, and to redeploy resources to other care management activities such as disease management and intensive case management (Smith, Des Jardins, and Peterson, 2000). They are also giving members direct access to specialty care, though typically requiring higher copayments if the primary care physician does not make the referral. While evidence of the impact of these changes is limited, sharply rising premiums in the commercial sector suggest that alternative approaches to utilization management have not bolstered cost management and may have actually reduced plan capacity to control expenditures.

Consumer Cost Sharing—A variety of cost sharing mechanisms have become widespread in managed care arrangements, including HMOs which were once noted for comprehensive benefits and limited out-of-pocket costs. PPO products have long relied on cost sharing to promote cost consciousness in beneficiaries. Health plans and employers realized that enrollees are less dissatisfied if given a

choice of network providers, even if the choice may require higher out-of-pocket costs. HMOs responded to this competition for a time with point-of-service products that offered limited coverage for services provided by out-of-network providers, but now a number of these firms have added the PPO to their product portfolio. The use of multiple levels of cost sharing in the pharmacy benefit has grown dramatically in recent years to try to curb usage of more expensive products by creating tiers of drugs with differential copayments (Mays, Hurley, and Grossman, 2001). This design is now being extended by plans to other product features such as tiered physician and hospital networks with varying copayment levels between the tiers.

Provider Contracting Pressures—Growing tensions in plan-provider contracting have emerged in the past 2 years. Where many providers of various sizes and configurations were once intent on negotiating to have health plans delegate to them both more financial risk and care management responsibility, their appetite for risk was quickly met and then exceeded. More recently, a significant retreat from risk arrangements has been widely reported as provider groups encountered financial distress, saw expense growth exceed risk payment increases, failed to invest in administrative infrastructure, and experienced the bottoming-out of their ability to achieve further reduction in utilization (Hurley et al., 2002). Beyond rejection of risk, providers have displayed intensified resolve and militancy in their negotiations with health plans and have successfully extracted substantial payment increases in return. Some demonstrated this resolve by engaging in serious showdowns with major plans, contending that financial pressures on hospitals in particular were heightened by the BBA of 1997. In other instances, the countervailing leverage that has been accumu-

lated through local market consolidation among hospital systems and single specialty physicians has been unleashed with significant gains in provider market power (Strunk, Devers, and Hurley, 2001). The fact that (1) the managed care backlash has positioned providers to be the sentimental favorite in these negotiation battles and (2) purchasers have pressured plans to expand and keep broad networks intact, has made it very difficult for health plans to win these contracting disputes.

Consumer-Directed Products—Though the importance of what are characterized as consumer-directed products such as defined benefit plans remain largely theoretical and speculative, the number of private employers giving consideration to them is growing (Christianson, Parente, and Taylor, 2002). Likewise, a number of health plans are positioning themselves to participate in what might emerge as a market with explosive growth possibilities. The many new entrants poised to participate in this market mean plans cannot afford to ignore it. Health plans express concern, however, that such products could devastate existing risk pools by luring low-cost plan members out of comprehensive health plan products, leaving only costly beneficiaries in them, and driving premiums up even more rapidly than they are already rising. Some plan observers also contend these consumer-directed models are based on dubious assumptions about information availability and consumer sophistication.

Sharply Rising Premiums—Health plan premium increases in 2002 will approach the levels experienced in the early 1990s (Benko, 2002). The trends reflect a combination of substantial increases in payments to providers and pharmaceuticals, and a relaxation in managed care features that have eroded plans' ability to control cost growth. For commercial products, plans

have had to negotiate aggressively with employers to get them to accept these price jumps. While a portion of the increase can be offset by added offloading of costs to employees in private sector plans, virtually all employers have had to tolerate such increases, in part because of the lack of price competition among plans as previously discussed. Where such negotiation is not possible, such as in Medicare where health plan premiums are administered based on a legislated formula that has fallen far short of plan cost increases, plans can only reduce benefits, increase cost sharing, or exit the market. That is just what has happened among Medicare+Choice plans, resulting in substantial disruptions for beneficiaries and major disappointments for health plans (Gold, 2001).

Pressures on Medicaid Due to Transformations

Each of these recent trends in commercial managed care carries with it implications for Medicaid managed care (Table 1).

Plans Drop Poor Performing Product Lines—The renewed pursuit of profitability by plans has led them to evaluate carefully the performance of all of their products and purge low and no margin business. For many predominant commercial plans that entered the Medicaid market, membership growth has not increased negotiating leverage with providers because they have had to expand existing networks to incorporate traditional Medicaid providers to respond to State agency and consumer preferences (Hurley and McCue, 2000). In addition, plans that try to modulate their Medicaid exposure by keeping membership relatively modest discovered that the administrative costs associated with the program were disproportionately high relative to small scale membership and the limited profitability prospects Medicaid

Table 1
Trends in Commercial Managed Care and Medicaid Implications: 1982-2001

Managed Care Marketplace Trend	Commercial/Private Sector Implications	Medicaid Implications
Profitability Versus Growth	Greater selectivity in products offerings; profitability over growth	Low margin products at risk in pursuit of profitability
Growth in Less Restrictive Products	Broader networks; increased migration to preferred provider organizations	Preference for restricted networks to trade access for cost
Modified Efforts to Manage Utilization	Relaxation to reduce provider backlash	Tradition of prior authorization and oversight to control expenditures
Consumer Cost Sharing	More responsibilities for consumers to shape use (prescriptions) and product choice	Regulatory limits; practical impediments given low income beneficiaries
Provider Contracting Pressures	Responding to pushback with higher payments and reduced use of risk	Highly dependent on limited number of providers; low payments hard to raise
Consumer-Directed Products	Growth in interest in defined contribution, etc.	Unlikely development for Medicaid (vouchers)
Sharply Rising Premiums	Sharply rising premiums that purchasers are willing to pay thus far	Budgetary pressures in States make premiums increases hard to meet

SOURCES: Kaiser Family Foundation, 2002, and Centers for Medicare & Medicaid Services, 2001.

represented. As a result, recent evidence suggests that reduction in participation among predominantly commercial plans has continued since participation peaked in 1998. Consequently, the percentage of beneficiaries in predominantly or exclusively Medicaid plans continues to grow and now approaches the 50-percent level (Felt-Lisk, Dodge, and McHugh, 2001).

Trading Off Choice Restriction for Guaranteed Access—State Medicaid agencies have long displayed a resignation toward accepting restricted networks as a means to achieve cost control. In effect, FFS Medicaid functioned much like a tight PPO network product for many years—contracting with a limited set of providers willing to accept deeply discounted prices and to tolerate other administrative requirements like prior authorization of selected services (Zuckerman, 1987). Geographic maldistribution of providers in areas with major concentrations of Medicaid beneficiaries further constrained access. As a result, the priority placed on full freedom of choice of providers is far less sacrosanct in Medicaid compared with commercial

coverage. This has meant that Medicaid agencies have fewer qualms about embracing tight network managed care products as long as they can meet required access and capacity standards that were not achievable in the traditional Medicaid FFS program. This is particularly evident in an area like dental care in which 26 States have put health plans at financial risk for dental services in the hopes that they will achieve more success in improving access to care beyond that of Medicaid’s own dental program (National Academy for State Health Policy, 2001).

Reassessing the Value of Utilization Management—Medicaid agencies have traditionally relied on mechanisms like prior authorization to impose utilization and cost controls on providers and beneficiaries. While they understand the dissatisfaction these have engendered, they also value their contribution to promoting appropriate service delivery and have not advocated for their modification as strongly as private purchasers. Medicaid agencies’ perspectives toward primary care gatekeeping is even more at variance with private sector

buyers as enrolling beneficiaries with a primary care provider has made the concept of a medical home a reality (Hurley, Freund, and Paul, 1993). It also extends to beneficiaries the virtues of a designated care coordinator and a source of advice and consultation on a 24-hours-a-day and 7-days-per-week basis. Many States that have enrolled chronically ill and disabled beneficiaries in managed care have maintained the gatekeeper model, but have commonly permitted specialty physicians to play this role. Consequently, discontinuation of primary care gatekeeping as a core element in managed care plans is not a welcome development in the eyes of many Medicaid purchasers.

Cost Sharing Constraints—Medicaid regulations severely limit the ability of States to employ copayments for most services and where such arrangements are permitted, such as for drugs, the permissible levels are nominal. Some States have employed these mechanisms with expansion populations as with their 1115 waivers or for their children's health insurance programs in which a number of States include partial premium contributions as well. But the yield from employing these mechanisms is unclear and there are significant risks associated with imposing them too aggressively on low-income populations. Recent research suggests that even very modest copayments for drugs can represent impediments to access (Cunningham, 2002). Classic studies have indicated that the services most likely to be foregone in the face of copayments are preventive and maintenance services that may contribute to increased costs over a longer term (Lohr et al., 1986). Unlike private insurance, where cost sharing is used to steer consumers to low cost plan options or to encourage them to spend their own income for discretionary services, Medicaid agencies find it difficult to rely on managed care

products that use extensive cost sharing to control cost and service use.

Narrow Provider Base—The push for broader networks and improved payments to providers is a sentiment that Medicaid purchasers might share with their private counterparts, but practically speaking this is beyond the reach of most State Medicaid Programs. The tradition of low provider participation and dependence on those providers that, by virtue of mission, tradition, and location, have served Medicaid beneficiaries, has conditioned Medicaid purchasers and beneficiaries to accept narrow networks. Efforts to enroll beneficiaries in predominantly commercial health plans have generally not succeeded in expanding access to more mainstream providers, in part because these plans typically have different (lower) payment schedules for the Medicaid product relative to commercial products (Gold et al., 2002). Beneficiary preference also plays a role, as they may prefer to see providers that are familiar and geographically closer to their places of residence. In cases in which States have made special efforts to enable beneficiaries to seek care from different providers, Medicaid agencies have been criticized by traditional Medicaid providers. These providers feel threatened, by loss of patients and revenues and accuse States of short sightedness because their actions may destabilize the local safety net (Institute of Medicine, 2000). Taken together, these factors indicate that Medicaid agencies will not be strong supporters of broader provider networks.

Consumer-Directed Products Unlikely—The contemporary interest in consumer-directed products with potentially high levels of cost participation or the overt trading off of benefits for lower costs seems unlikely to make much headway in the Medicaid Program. Operationally, some sort of voucher program would be required to

implement a mechanism to provide beneficiaries with more involvement and a greater economic stake in what plans they choose and which benefits they want to purchase. Beyond the administrative complexities are genuine concerns that a model that converts benefits to cash for low-income persons would encourage them to spend money on other basic, near-term needs and neglect health care coverage. In this instance, providers may be at risk for sharp increases in uncompensated care if beneficiaries forego comprehensive coverage, but erroneously assume they have access to comprehensive services when needed. While these concerns are perhaps true for all populations with access to product designs like defined contribution, their suitability for persons with limited resources seems even more dubious.

Steep Cost Increases Intolerable Given Tight Budgets—Sharply rising premiums present a problem for all purchasers and, depending on the extensiveness of cost sharing, consumers as well. The problem is magnified in Medicaid given fiscal constraints in general and the more severe limitations encountered during budget crises (Smith, 2002). If States administer payment rates rather than negotiate them, they may simply find no plans willing to accept rates that fall well short of cost increases or are substantially lower than what can be negotiated with private payers. This is largely the fate of the Medicare+Choice Program at the current time (Gold, 2001). If States engage in negotiation or competitive bidding with negotiation, as many of them do, then such negotiations become increasingly difficult in periods of economic downturns when reduced tax revenues restrict payment increases. New regulatory requirements that rates must be “actuarial sound” appear to give States added flexibility in ratesetting, but States can only avail themselves of this flexibility

based on their ability to pay such rates. Plans with limited commitment to the Medicaid product line are the first to flee when payment falls short of expectations. But even those with strong commitment to and investment in Medicaid are sorely tested because they have limited control over their input costs. For example, while they may be able to negotiate commensurately low increases in provider payments, they must still pay market prices for other inputs such as pharmaceuticals that are a major portion of the Medicaid benefit package. This is precisely the predicament many State Medicaid agencies find themselves in at the current time.

Medicaid’s Response Options to Marketplace Trends

Because managed care has delivered value to Medicaid agencies and beneficiaries, the decline and transformation of the industry is cause for serious concern and strategic and tactical responses to preserve these gains. While commercial purchasers and the Medicare Program may choose to return to reliance on conventional FFS payment-based models, Medicaid managers have little to be nostalgic about. The prospects of losing progress made in guaranteed access, improved care management and coordination, contractually based performance guarantees, and data for monitoring and measuring change, motivates State Medicaid agencies to devise a variety of responses.

A number of States remain committed to maintaining a prepaid health plan based program, reaffirming their belief that the traditional HMO product is the preferred arrangement for their beneficiaries. Medicaid could actually become the last bastion of the pure HMO model because State agencies are willing to accept the constraints associated with a closed delivery system in

return for assured access and cost predictability and control. It is likely, however, that such a commitment will lead to expanded reliance on predominantly or exclusively Medicaid enrollment plans. While some Medicaid specialized plans sponsored by safety net providers have failed or cease to exist, especially those sponsored by hospitals, there remain vibrant provider-sponsored plans including several that have formed an organization called the Association for Health Center Affiliated Health Plans (2002). Investor-owned Medicaid focused plans including Amerigroup and Centene represent another important segment that is filling the gap left as commercial plans exit from Medicaid (Elliott, 2002). Although concerns have been raised about the sustainability of Medicaid specialized plans, as this sector continues to evolve, the surviving plans appear to be stronger, more operationally sophisticated, and accumulating larger memberships. As these plan make greater investment in this line of business and Medicaid agencies are more reliant upon them, their mutual dependence should contribute to greater stability in the market.

Key challenges to sustain prepaid health plans lie in the areas of maintaining adequate and appropriately adjusted payment rates and devising incentive-based payment arrangements to promote and reward efforts to improve quality and member well-being. While ratesetting remains a contentious issue made more difficult by State revenue shortfalls, many States have made substantial progress in ratesetting methodologies including the incorporation of risk adjustment (Kronick and Dreyfus, 1997). Increasing sophistication in this area is essential to achieve the oft-cited goal of “making sure the money follows the member.” Incentive-based payments that encourage and compensate for superior or improved performance mea-

asures are receiving heightened attention by States (National Academy for State Health Policy, 2001). Many States have realized that contracting with prepaid health plans puts in place a foundation for measuring and motivating continuous quality improvement in ways never possible in the traditional unmanaged FFS Medicaid Program. Increased emphasis on the importance of actuarial soundness in the ratesetting promoted by the 1997 BBA regulations should provide added momentum for further progress in this area.

Full risk prepaid programs are not likely to be sustainable or even desirable in States with undeveloped managed care markets or in States that are rural in character. Other States may find that full risk prepayment is not feasible when rate increases fall short of medical cost trends for plans and they cease to participate. Reducing the scope of services for which health plans accept risk could attenuate some of these problems as has already been done in States that have been contracting with prepaid health plans that may not assume risk for inpatient care or other core services. A number of States also do this with passthroughs for certain high-cost services (drugs for human immunodeficiency virus/acquired immunodeficiency syndrome members, transplant services), while others use stop loss provisions or exemptions of certain populations from prepayment to shield plans from unmanageable or unacceptable risk (National Academy for State Health Policy, 2001). Still other States have carved out the pharmacy benefit from the capitation paid to HMOs and managed this benefit as a statewide Medicaid pharmacy benefit program (Holahan and Suzuki, forthcoming). More States may opt for this approach if plans feel they cannot meet their drug expenses with the payment increases obtained from States. Partial risk arrange-

ments with physicians or groups of physicians, characterized as prepaid ambulatory health plans in the 1997 BBA regulations, are also likely to grow if inpatient cost increases continue to soar and further reductions in inpatient use become unobtainable, as has become common for commercial managed care products.

PCCM programs have expanded in recent years to about 25 percent of all managed care enrollees, particularly in States that have lost confidence in or participation among prepaid health plans (National Academy for State Health Policy, 2001). Other States have opted for mixed models of managed care including both HMO and PCCM arrangements to maximize statewide enrollment while reflecting local market differences. The limitations of PCCM models clearly lie in the fact that they do little to alter conventional patterns of care or delivery system structure, typically retaining FFS payment. Not surprisingly, their minimal impact on providers has been seen as a virtue in some cases because this makes them more acceptable to providers than prepaid health plan contracting.

A number of States have aspired to enhance and augment their PCCM programs by adding additional features such as nurse call advice systems, provider profiling, and case management and other care coordination support personnel (Smith, Des Jardins, and Peterson, 2000). Some States even hire network managers who managed the program on behalf of the State as a third party administrator. In some instances, States produce health plan employer data and information set-like performance measures on their PCCM plan, which enable them to compare the performance of this model with their HMO contractors. Other States have used the PCCM platform as a base for introducing targeted disease management programs for a number of chronic conditions among Medicaid

beneficiaries including asthma, diabetes, congestive heart failure, hemophilia, and human immunodeficiency virus/acquired immunodeficiency syndrome. The programs include data-driven case identification, intensive member education, liaising with primary care and specialist physicians, and service usage monitoring including pharmaceuticals. In some cases, disease management contractors may actually be paid in part based on performance indicators designed to promote improved outcomes for beneficiaries (Connors, Highsmith, and Croke, 2001).

Policy Implications

There are several significant policy implications of the current challenges faced by State Medicaid agencies as the managed care industry undergoes transformation.

Rate Adequacy—Fiscal distress in the States will make providing rate increases to plans problematic in the near term offsetting much of the flexibility gained by the implementation of actuarial soundness as embodied by the BBA regulations. An economic recession with 40 percent of beneficiaries in prepaid health plans is unprecedented. States with positive experience and relationships with their health plan contractors will make concerted efforts to encourage plans to endure this difficult period with the promise of better payments in the future when the general economic picture improves. Plans in turn will have to engage in this same type of temporizing behavior with their network providers, petitioning for their forbearance during a difficult period. Whether these delicate negotiations will succeed is uncertain.

Contractual Requirements—Armed with additional flexibility provided by new Federal regulations, States may be able to grant health plan contractors some relief in

the form of less onerous administrative requirements or less aggressive enforcement of terms or targets. As with rate adequacy, these modifications will need to be the subject of negotiations and be undertaken in a spirit of deferring compliance until a more normal relationship can be restored. It may also mean delaying further geographic expansions or forgoing inclusion of beneficiary subpopulations that would represent additional effort and expense to plans. One reason why States have objected to Federal efforts to impose added managed care contracting requirements is their belief they need more, not less, flexibility to maneuver and to maintain plan participation. The final 1997 BBA regulations appear to have recognized and responded to these concerns.

Reconsidering and Rescoping Risk—A special case of contract modifications is a reduction in the scope of services for which health plans accept financial risk. As previously discussed, there are already a number of circumstances in which this is currently being done and it appears that more of this rescoping will occur, especially in those areas where risk is seen as excessive or associated costs are viewed as unmanageable. There is precedent for this in so-called downstreaming of financial risk from health plans to provider organizations in the commercial and Medicare markets (Hurley et al., 2002). In a sense, State Medicaid agencies are effectively choosing to return to a larger measure of self-insuring for a portion of the benefit package just as many private purchasers have chosen to do.

Eschewing Mainstreaming—One apparent casualty of the current trend toward increased reliance on predominantly Medicaid plans is a desire to use managed care to promote more access to mainstream plans and providers. It seems that, if States persist in trying to contract with

prepaid health plans and commercial plans continue to show declining interest in this market, then Medicaid agencies will grow more dependent on Medicaid-focused plans. A key question will be whether these Medicaid-focused plans have the resources and commitment to continue to develop sound and credible care management strategies and comply with the contractual demands States may place on them. Efforts to enroll beneficiaries with more extensive needs, including the severely disabled or chronically ill, may be particularly challenging for these plans because of the added resources and specialized providers needed to serve them. If they can demonstrate that they are delivering good and improving outcomes, this will offset concerns that plans for the poor are at risk of being poor quality health plans.

Medicaid as Managed Care's Final Bastion

Because State Medicaid agencies embraced managed care more slowly and, in some instances, more skeptically than commercial purchasers, it would be ironic if Medicaid remains one of the few niches in which managed care, and the HMO product in particular, flourishes. But this is not necessarily surprising because the basic principle underlying managed care—accepting some restrictions on care seeking in return for a more comprehensive benefit package at a modest cost—comports well with the design and philosophy of Medicaid. In fact, it may be that only in a program like Medicaid that is vividly aware of its limited resources and prepared to accept the need to ration them carefully that managed care can find a fertile and sustainable foundation in this country.

CONCLUSION

Managed care in Medicaid has reached a point in which more than one-half of all beneficiaries now participate in such arrangements. At the same time, commercial managed care plans, particularly HMOs, are undergoing a number of changes reflecting loss of purchaser support, provider participation, and consumer enrollment. This transformation represents an important threat that State Medicaid agencies must address and respond to in order to maintain the gains that managed care has provided to them and their beneficiaries.

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Reprint Requests: Robert E. Hurley, Ph.D., Department of Health Administration, Virginia Commonwealth University, 1008 East Clay Street, Richmond, VA 23298. E-mail: rhurley@hsc.vcu.edu