Medicaid Managed Care: Lessons From Five States

Site visits to California, Minnesota, New York, Oregon, and Tennessee illuminate how managed care is altering Medicaid.

By Marsha Gold, Michael Sparer, and Karyen Chu

Abstract: With Medicaid managed care enrollment accelerating, policymakers must quickly understand the lessons from the states so that the transition to managed care strengthens access and care systems and avoids problems. Our study of five recent state experiences shows that state objectives must be realistic and well planned. The experience of states with long histories of managed care underscores the conclusion that managed care is not a magic bullet for solving all access and cost concerns and that no amount of managed care can substitute for adequately financed programs that are well understood by beneficiaries, providers, and health plans alike. The results highlight ten lessons from the states.

Introduction

Medicaid is in the midst of fundamental change. Medicaid officials in nearly every state are encouraging or requiring beneficiaries to enroll in managed care. This trend is largely a response to the continued rise of Medicaid expenses as well as an attempt to address the ongoing problems of access to care. These remain, even though this federal/state insurance program accounts for much of the nation’s progress over the past thirty years in improving access to health care for low-income populations.

By 1994 forty-three states and the District of Columbia had a Medicaid managed care initiative. Between 1990 and 1995 Medicaid managed care enrollment more than quadrupled. Thirty-two percent of all Medicaid beneficiaries are now in managed care.

The shift to Medicaid managed care needs to be carefully monitored. For example, Medicaid managed care initiatives have had more problems than commercial managed care efforts have had, because of the unique nature of the Medicaid population (primarily low-income women and children, disabled persons, and the elderly) and sometimes inadequate state oversight.3 There is a fear that these problems may escalate with increased state flexibility. In this context, policymakers need to understand quickly how best to shape Medicaid managed care initiatives so that access and care systems for low-income persons are improved and transition problems minimized. Because of the pace of change, timely insights are critical, even if they are less conclusive than they ultimately could be with a longer and more thorough evaluation.

In this paper we draw on the insight developed through site visits to five very different states in late 1994 to early 1995 to identify

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issues and early lessons from the states’ experiences with implementing managed care. After a brief review of methods, we summarize the program features, the administrative and delivery issues raised, the effects on the health care system, our conclusions, and lessons.

**STUDY METHODS**

We selected the five study states—California, Minnesota, New York, Oregon, and Tennessee—to provide diversity in size, strategies, and experience. The study was based on site visits by a team of two or three people that lasted from four to five days.4 We interviewed state officials and others who are attempting to influence policy from the standpoint of consumers, providers, and insurers/health plans. Using interviews and, where available, documents, we prepared lengthy case studies for each state. These studies were circulated among diverse interviewees and revised using the comments we received. This paper compares the states and their experiences to identify common threads, cross-cutting issues, and general lessons. Our goal was to be well enough grounded in operational reality to catch the nuances but also general enough to see the “big picture.” Some findings or conclusions may seem obvious but bear repeating, particularly given the pace of change.

Our study draws on recent work to build a framework for looking at managed care and its relationships with the broader health system.5 Our focus on operations and effects in states leads us to expand on John Holahan’s three-part framework to consider diverse aspects of eligibility and enrollment, managed care plan and provider participation, and state oversight.6 Our focus is on access to care more than on financing, and we examine how the movement to managed care affects low-income persons and the safety net.

The strengths of the case-study method rest in its ability to provide timely, in-depth information from a variety of perspectives. The limitations are (1) the limited number of persons who can be interviewed; (2) the limited ability to go beyond identifying issues and problems to estimating their magnitude or empirical effects; and (3) the inherent subjectivity in interpreting complex and sometimes contradictory information. Programs are developed for operations, not for researchers. States vary in how they document policies, and many important facts and policies are not in writing. Thus, we rely heavily on interviews. We report facts that are supported by multiple sources and consistent with other information on hand. The systems we studied are evolving rapidly, so specific features may have changed since our visits.

**SUMMARY OF STATE INITIATIVES**

Exhibit 1 summarizes each state’s Medicaid managed care initiatives, the states’ history with managed care, and the implementation status of the initiatives. Briefly, the five initiatives are as follows.

- **CALIFORNIA.** The state is developing a managed care strategy within its Medi-Cal program (California Medicaid). The goal is to have half of the projected Medi-Cal enrollment in managed care by late 1996. This is to be accomplished through a variety of managed care models that are now in different stages of development across the state.

- **MINNESOTA.** Minnesota has several initiatives that eventually will be integrated under a federal Section 1115 research and demonstration waiver. The state is expanding mandatory Medicaid managed care statewide. MinnesotaCare, the state’s reform initiative, includes state-subsidized health insurance. Under the waiver, MinnesotaCare and Medicaid will be integrated under a managed care strategy, and MinnesotaCare will be supported in part with federal Medicaid funds.

- **NEW YORK.** Working through localities, New York is expanding managed care enrollment in Medicaid voluntarily, for the most part. Its goal is to achieve 50 percent penetration by the year 2000. In 1995 New York submitted an 1115 waiver application through which nearly all Medicaid beneficiaries would be enrolled in managed care on a mandatory basis, but it has not yet been approved.

- **OREGON.** As part of its broader health
# EXHIBIT 1
Characteristics Of Managed Care Initiatives In five States

<table>
<thead>
<tr>
<th></th>
<th>California</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of state (1993)</td>
<td>31.4 million</td>
<td>4.5 million</td>
<td>18.1 million</td>
<td>3.0 million</td>
<td>5.1 million</td>
</tr>
<tr>
<td>Prior managed care experience</td>
<td>Extensive</td>
<td>Limited</td>
<td>Extensive</td>
<td>Limited</td>
<td>Extensive</td>
</tr>
<tr>
<td>Medicaid Mandatory programs</td>
<td>Extensive</td>
<td>Extensive</td>
<td>Limited</td>
<td>Extensive</td>
<td>Limited</td>
</tr>
<tr>
<td>Commercial</td>
<td>Limited</td>
<td>Extensive</td>
<td>One small program</td>
<td>Yes</td>
<td>None</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Extensive</td>
<td>Extensive</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Eligibility expansions</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Benefits/cost sharing</td>
<td>Traditional Medicaid</td>
<td>Traditional Medicaid</td>
<td>Priority list</td>
<td>Extensive cost sharing</td>
<td></td>
</tr>
<tr>
<td>Capitation</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Population focus</td>
<td>Families and children (SSI in a few counties)</td>
<td>Families and children with some others in demonstrations</td>
<td>Families and children</td>
<td>Those below poverty: disabled, aged, and blind being phased in</td>
<td>Comprehensive</td>
</tr>
<tr>
<td>Federal waivers</td>
<td>Freedom-of-choice waivers</td>
<td>1115 submitted, now approved</td>
<td>1115 submitted</td>
<td>1115 approved</td>
<td>1115 approved</td>
</tr>
<tr>
<td>Status at visit</td>
<td>Mandatory model in only some counties</td>
<td>Medicaid managed care expanding; MinnesotaCare not yet using managed care</td>
<td>Political transition; voluntary model except for one small demonstration project</td>
<td>One year's experience</td>
<td>One year's experience</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ research.

**NOTE:** SSI Is Supplemental Security Income.

* In its 1115 waiver application, New York proposes to add its Home Relief population to Medicaid, thereby generating federal matching funds for persons already covered by what previously was a program financed only with state funds.

* These are Section 1915(b) programmatic waivers that were established in 1981 to facilitate transition to managed care.

* Section 1115 waiver programs draw on the discretion of the secretary of health and human services to authorize statewide Medicaid managed care demonstrations that include eligibility, benefits, and service delivery charges.

reform initiative involving both private and public initiatives, the Oregon Health Plans Medicaid component expands coverage to all Oregonians below the poverty level. Savings are generated by managed care and by a benefit package that is defined by a “priority list” of covered condition and treatment pairs.

**TENNESSEE.** TennCare is an ambitious effort to rapidly revamp Tennessee’s Medicaid program. In TennCare’s first year enrollment increased from 770,000 to 1.1 million persons. Managed care enrollment is mandatory for virtually all TennCare insured persons. Subsidized, income-related coverage is available up to 400 percent of poverty, although new enrollment was limited after the first year. The system is financed through a complex structure that involves preexisting public and pri-
vate health expenditures.

Given the scope of the issues covered, it is not possible to provide details on all of them. The individual case studies provide these details as well as additional documentation for our findings and conclusions. Because none of the five states had much experience with managed care for disabled and other Supplemental Security Income (SSI) populations, who tend to be more vulnerable, this study provides little insight in this area.

**Administrative Issues**

**Enrollment and Marketing.** Shifting Medicaid beneficiaries from traditional Medicaid to managed care means that each beneficiary ultimately must be enrolled in an available plan. This process generally involves (1) informing beneficiaries of the change and the available choices; (2) explaining the procedures for making choices and helping beneficiaries understand the implications of those choices; (3) assigning those who do not make a choice to default options; and (4) notifying plans and beneficiaries of their choices in a timely manner so that enrollment cards and new-member materials can be distributed.

Administrative issues include determining who conducts the enrollment process (county, contractor, or health plan); whether enrollment is done in person or by mail, and how much, if any, direct marketing individual health plans may do. Additional tasks involve assuring that plans and accessible networks exist to serve the new enrollees.

Exhibit 2 summarizes key features of each state’s approach to these issues. The processes functioned much more smoothly in two states (Minnesota and Oregon) than in others. Both states had much more experience to build on, and both also invested considerable time and resources in educating and communicating with beneficiaries. In Minnesota enrollees attend an educational session run by specially trained county staff when they come in for eligibility recertification. This eliminates extra steps for beneficiaries and almost does away with the need to assign beneficiaries to plans. In Oregon a contractor handles information dissemination and holds numerous information sessions (in eight languages). Beneficiaries enroll in person or by mail, unless they also receive cash assistance, in which case they must enroll in person.

The overall experience of the five states is that plans’ enrollment/selection processes are central to smooth implementation and that considerable attention must be paid to their design and funding. Problems arise even with good planning, especially when the volume of persons making the transition is high. For example, Oregon expected 5,000 calls in a month and received 4,000 in a day early in its program. Higher-than-expected telephone volume, illiteracy among beneficiaries, marketing abuses, low rates of plan selection, and inappropriate selections of plans because of poorly designed enrollment forms were among the problems states encountered.

TennCare’s experience illustrates the serious problems that can arise when timing is tight and experience is limited. TennCare used a mail-in enrollment process exclusively. In the first year the state, the plans, and individual providers were overwhelmed by the volume of telephone calls and the confusion generated by the initial mailing. The state received 50,000 calls in one day and finally resorted to pulling state staff from non-health care agencies into temporary telephone duty. Because enrollment occurred before provider networks were fully in place, eligible persons could not effectively consult with their providers, as instructed, to select a plan. As many as half of the beneficiaries had to be assigned to a plan, and those who selected a plan did not always get their choice. Because
## EXHIBIT 2
Enrollment And Marketing Features Of Each State Medicaid Managed Care Initiative

<table>
<thead>
<tr>
<th></th>
<th>California&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrollment</strong></td>
<td>Mail</td>
<td>In person</td>
<td>Mixed model (mail and in person)</td>
<td>Mixed model (mail and in person)</td>
<td>Mail</td>
</tr>
<tr>
<td><strong>Central beneficiary education</strong></td>
<td>Limited</td>
<td>Extensive</td>
<td>Limited</td>
<td>Extensive</td>
<td>Limited</td>
</tr>
<tr>
<td><strong>Use of contractor support</strong></td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>Direct marketing</strong></td>
<td>Yes</td>
<td>No</td>
<td>Yes&lt;sup&gt;b&lt;/sup&gt;</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Any Door to door</td>
<td>Yes</td>
<td>No</td>
<td>Yes&lt;sup&gt;b&lt;/sup&gt;</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Varies by county</td>
<td>No</td>
<td>Social Service District</td>
<td>No</td>
<td>No set policy</td>
</tr>
<tr>
<td>Voluntary selection rate in mandatory programs</td>
<td>86 percent</td>
<td>Virtually all</td>
<td>75-80 percent of subset at demonstration education sessions&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Over 90 percent</td>
<td>50-60 percent</td>
</tr>
<tr>
<td>Experience</td>
<td>Confusion</td>
<td>Smooth</td>
<td>Not applicable&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Smooth</td>
<td>Confusion</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ research.

<sup>a</sup> Applies to Sacramento except where noted.

<sup>b</sup> Suspended in New York City as of summer 1995.

<sup>c</sup> Of the approximately 38,000 enrolled in Southwest Brooklyn, about 9-12 percent were assigned to a plan, about 37 percent were enrolled by county workers after one-on-one meetings, and the remaining 51-54 percent were enrolled directly by health plan marketers.

<sup>d</sup> New York State had only a limited mandatory program; hence, experience with this feature was limited. New York allegedly experienced considerable marketing problems under its voluntary program, especially in New York City.

Of delays in notification, some patients apparently did not know which plan they were in for some time until after the system became effective, nor did they have new-member materials. Many persons appear to have continued their old care patterns despite the transition to managed care; fortunately, many providers responded with flexibility to this situation. For persons who were unsatisfied with the plan that was listed on their notification, the switch to another plan was difficult and often was not carried out in a timely manner. Meanwhile, at least one plan was totally overwhelmed by exceptionally rapid growth, partly driven by assignments made by the state. The plan’s enrollment grew from 35,000 to 275,000 overnight.

Some states are more strict than others about health plan marketing. Both Oregon and Minnesota prohibit any direct marketing by health plans. New York recently suspended door-to-door marketing in New York City, and California, too, is adopting this policy. Some small Medicaid-only plans expressed concern that restricted marketing could put them at a disadvantage because they have less name recognition and cannot take advantage of commercial advertising authority to circumvent Medicaid restrictions. Direct marketing by plans has been associated with some of the historic abuses in Medicaid managed care. 9
n ELIGIBILITY. Several states use simplified enrollment processes for newly eligible persons, thereby encouraging enrollment. However, these efforts have had unintended effects. Oregon’s attempt to simplify by considering only one month’s income generated negative publicity about potential fraud or abuse. In addition, the eligibility criteria in Oregon are apparently generous enough so that many persons chose to join the Oregon Health Plan directly rather than traditional Medicaid and welfare (along with its associated stigma and enrollment barriers). Thus, as of November 1994 approximately 21,000 more new eligibles than anticipated had signed up, but the number of traditional Medicaid eligibles fell about 23,000 short, primarily because of fewer Aid to Families with Dependent Children (AFDC) recipients than projected. This is consistent with other recent evidence that suggests that decoupling Medicaid from welfare can reduce reliance on welfare.10

Eligibility turnover is a major concern in many of the states because it limits a plan’s ability to amortize initially high marketing costs and new enrollees’ care costs over time. Extensive eligibility turnover also is inconsistent with a managed care model that focuses on prevention, early treatment, and continuity of care. Guaranteed eligibility is used less extensively than it could be because of concerns about its impact on cost. Minnesota, under its recently approved 1115 waiver, will use a “one-month rolling eligibility period” to address the problem of short-term eligibility turnover because of failure to meet administrative requirements.

Eligibility turnover also can occur when new and old eligibility processes are not completely coordinated, causing those who lose eligibility for Medicaid through AFDC to be disenrolled rather than being converted to other available options. This appears to have occurred at times under the Oregon Health Plan and possibly also under TennCare.

OVERSIGHT. The experience in all five states shows that effective oversight is essential. Each of the states, however, uses a different model, sometimes for historical reasons. Under TennCare, new organizations formed rapidly and could be authorized by TennCare as preferred provider organizations (PPOs) rather than going through the state health maintenance organization (HMO) licensure process. Yet TennCare’s process for overseeing these plans was not well developed in the first year: For example, marketing policies were not published during the first year, and few policies or procedures were put in writing. To respond to these and other problems, Tennessee recently increased the authority of the insurance department over PPOs.11 Similarly, California is phasing out its independent contracting with primary care case management programs regulated by the Medi-Cal agency, in favor of HMO licensure mechanisms regulated by the state’s Department of Corporations. In contrast, Oregon has a long history with regulating Medicaid managed care through the Medicaid program rather than through more general HMO licensure, which in Oregon is restricted to federally qualified HMOs.

Oversight requires state resources and staff. In California the lack of sufficient staff to oversee plans was cited by plan administrators and outsiders as creating serious constraints on implementation. In New York problems arose because administrative functions are fragmented and decentralized, which added to administrative costs and created confusion for health plans.12

None of the states had sufficient data to routinely monitor either baseline care patterns and access or the effects of the initiative; this is also a failing of traditional Medicaid. Virtually no state had information on care patterns and access to care for the uninsured before they were eligible for the program. Medicaid data could be used to monitor changes in care patterns and access for those who are continuously eligible, but states must manipulate eligibility, claims, and provider participation files to provide relevant information. This is not often done. Few states could tell us with statistics where Medicaid enrollees received care prior to the initiative.
care and capitation also is problematic, since claims are not submitted to the state.

Sacramento illustrates dramatically how data shortcomings influence policy development and evaluation. Virtually all stakeholders agreed that while initial implementation of managed care was rocky, the key issue is whether access to care improves. Unfortunately, the commission to assess the initiative is stymied by the lack of systematic information evaluating or even describing care patterns and access before the initiative. Some, for example, argue ex post facto that access to care was reasonably good before the initiative, at least for the average child or pregnant woman enrolled in Medicaid. But no one has data on this issue, at least not in a usable form.

DELIVERY AND COORDINATION

Managed care strategies require states to develop policies and procedures on (1) which managed care plans are eligible to participate; (2) which requirements these plans need to meet; (3) which benefits they should be required to provide, and which should be “carved out” and paid for separately on a fee-for-service basis; (4) what the rates should be and how they should be established; and (5) how, if at all, safety-net providers should be explicitly included in the initiative. All of these policies influence the delivery of care under the initiative. Exhibit 3 summarizes key features of each state’s approach.

STRUCTURE OF DELIVERY SYSTEMS

The five states’ approaches vary but tend to be built around mandatory enrollment models using fully capitated plans where possible. Either full or partial capitation is used in each state for virtually all contracting between the state and health plans. Partial capitation or noncapitated models seem to be used mainly when an infrastructure in an area (especially a rural area) cannot support full capitation or when the available providers are poorly positioned to support the risk. Oregon has the most explicit policy of this type. The state ultimately wants to use only fully capitated plans, and it has assessed its ability to do this, by county. If the state decided that insufficient capacity existed in fully capitated plans, it used a mix of fully and partially capitated plans or (in very isolated rural counties) primary care case management models. Oregon has relied on fully capitated plans much more than was originally expected, in part because new plans formed for the initiative, and some commercial plans viewed it as a way to expand their base in rural areas.

The form of managed care used in each state reflects characteristics unique to its managed care infrastructure, the providers available in low-income areas, and the state’s prior experience. In Minnesota, for example, HMO penetration in urban areas is very high, and there is a well-developed HMO regulatory infrastructure. Thus, the state can require plans to obtain an HMO license to participate in the Medicaid managed care program. California could do the same thing, although historically it has used a variety of managed care plans. In contrast, New York, which has a heterogeneous population and a generally limited managed care infrastructure, relies on a much greater mix of managed care models.

CAPITATION RATES AND RISK ADJUSTMENT

States’ approaches to setting capitation rates vary. Three states set rates uniformly for all plans in an area, while two negotiate with plans. In most cases, the amount paid is restricted to a maximum of some percentage of fee-for-service experience. Although capitation rates are said to be below commercial rates in all of the states, the rates in Oregon and Minnesota are much less controversial with plans than those in Tennessee are, as the rates there are considerably below the historical fee-for-service experience. However, there is concern, at least in Oregon, about whether the states will be able to sustain the rates over time.

Risk adjustment is key to setting equitable rates, since the Medicaid population is diverse and plan costs may vary considerably, depending upon their enrollees. Risk adjustment facilitates equitable compensation when plans serve more expensive populations and protects against windfall gains by health
### EXHIBIT 3

**Medicaid Managed Care Features Of Each State Initiative**

<table>
<thead>
<tr>
<th>Planned focus</th>
<th>California</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited counties</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Many counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mandatory enrollment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Limited counties</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managed care structure</th>
<th>California</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitated plans</td>
<td>Full and partial</td>
<td>Full only</td>
<td>Full and partial</td>
<td>Mostly full</td>
<td>Full only, but risk status unclear for some plans</td>
</tr>
<tr>
<td>Eligible without state HMO license (Medicaid approval)</td>
<td>Yes, but being phased out</td>
<td>No, with minor exceptions</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefit package</th>
<th>California</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selected carve-outs (Sacramento)</td>
<td></td>
<td>Full Medicaid package</td>
<td>Negotiated carve-outs, open access to selected preventive services</td>
<td>Priority list, initial carve-out of mental health and chemical dependency</td>
<td>Carve-out of long-term care and Medicare crossover benefits</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate setting</th>
<th>California</th>
<th>Minnesota</th>
<th>New York</th>
<th>Oregon</th>
<th>Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan-specific negotiated rates with demographic adjusters; cap at 95 percent of FFS (Sacramento)</td>
<td>Regional rates with demographic adjusters (cap at 95 percent of FFS); adjustment for plans with teaching or disproportionate share hospital</td>
<td>Regional caps (95 percent) on FFS negotiated rates for demographic groups; plan specific negotiated rates</td>
<td>Actuarially based rates with assumed managed care savings; area and eligibility group adjustment; retrospective maternity/newborn adjustment</td>
<td>Statewide rates with demographic adjustments and offset; after withhold, payments are about two-thirds the estimated amount</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCES:** Authors’ research

**NOTE:** FFS is fee-for-service.

* a Currently only in Sacramento and in a limited number of other counties, but this is a key feature of the California initiatives being phased in.

* b In several counties, but many in the state (especially in rural areas) remain in fee-for-service.

* c Pending 1115 waiver application would modify this. Enrollment is now mandatory in one small demonstration project.

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plans when a healthier population is enrolled. Unfortunately, although risk adjustment is important, little is known about how to do it practically.\(^{13}\) The study states use relatively simple methods of adjustment: demographic, eligibility category, and geographic variables. Some states place more emphasis than others on the actuarial soundness of rates and the equity of the incentives. Oregon, for example, had an outside actuarial firm develop its rates. Different rates are set across a variety of geographic regions, and the state uses a creative approach to improve equity across plans with different maternity experience. Minnesota adjusts payments for what it perceives to be a more costly case-mix in some safety-net
plans. In contrast, Tennessee uses a single statewide rate for demographic groups that reflects only about two-thirds of anticipated fee-for-service costs.14

BENEFITS AND CARVEOUTS. Some benefits can be excluded (or carved out) from the managed care plan’s capitation rate, allowing enrollees to seek these services fee-for-service through traditional Medicaid. Minnesota and Oregon seem less likely to carve out benefits for persons enrolled in managed care. Because care is provided to persons, not conditions, any carving out of benefits can, at least in theory, create problems with coordination and burden-shifting. Yet not all plans and their providers, especially those with limited Medicaid experience, offer the full range of benefits and services typical of Medicaid. Carving these out can provide enrollees with access to providers who are more experienced with specific health problems or needs. We could not determine from the information available whether particular approaches work consistently better than others.

Oregon’s effort to structure its benefit package through a formal priority-setting process has garnered considerable national interest. Our interviews suggest that health plans do not have major problems with the prioritized list of covered services. Some providers find it valuable; others report confusion as to what is covered. Contributing to the acceptance of the list are (1) the provider-led and “consultative” way in which it was developed, (2) the level at which the cutoff is set, (3) the fact that the state provides a benefit hotline staffed by registered nurses and runs a monthly meeting of plan medical directors to address coverage questions, and (4) the willingness of the state and health plans to be flexible in responding to physicians’ concerns. For example, the state moved treatment of hernias in children under age eighteen “above the line” on the priority list in response to providers’ concerns. Anecdotal evidence suggests that some “below-the-line” services continue to be provided for nonmedical reasons. For example, some providers perform nonmedically indicated circumcisions in response to cultural or religious norms. Other services—especially when they are viewed as inappropriate, need to be scheduled, or are expensive—are most likely not provided.

ENABLING SERVICES AND MEDICAID. States vary in the extensiveness and form of their requirements for “enabling” services such as translation, outreach, and transportation. For example, California requires new enrollees to be assessed within 120 days, whereas Oregon has no such requirement and generally tries to avoid what it views as micromanaging plans. Some plans see a philosophical conflict between a single standard of care (which they prefer) and structuring services around the needs of particular payer populations. Plans that place more emphasis on providing such enabling services perceive that they are at a disadvantage relative to their competitors that do not emphasize such services. Plans in Minnesota say that now, after years of experience, they appreciate the specific care issues associated with certain Medicaid groups. One plan provides cellular phones to high-risk pregnant women who do not have telephones at home. Another subsidizes tuition for child enrollees to attend an asthma camp.

COST SHARING. TennCare has the most expansive eligibility definitions but also uses the most extensive cost sharing for those who are not traditionally eligible for Medicaid. Enrollees above the poverty level are supposed to pay premiums on a sliding scale, although these were not often collected in the program’s first year because of administrative problems. TennCare requires enrollees with incomes above poverty to pay deductibles and coinsurance. Recently, Tennessee also proposed cost sharing for enrollees below the poverty level who are not otherwise eligible for Medicaid, although this was not federally approved. TennCare adjusts the plan’s capitation rates downward to reflect anticipated recoveries from cost sharing. However, some plans absorb these costs. Deductibles seem to be particularly problematic. They can serve as barriers to persons...
who need maintenance drugs because low-income beneficiaries cannot pay the up-front cost of the deductible. At least one plan paid for drugs, even if the deductible was not met, because it feared the costs of not doing so.

PARTICIPATION BY COMMERCIAL HMOs. The extent to which commercial HMOs are involved in Medicaid managed care initiatives varies by state. All commercial plans in Oregon have participated; plan participation in California is more mixed. Both Minnesota and New York show that making participation in Medicaid financially advantageous to plans increases Medicaid participation by commercial HMOs that once were reluctant to enter the market. Medicaid participation is made more attractive by making it a condition for other kinds of eligibility, such as participation in the state employees’ plan, or for desired exceptions, such as various taxes or surcharges.

Although the states vary in whether they require managed care plans to be licensed as HMOs, none relies exclusively on commercial plans. All five states contracted to some extent with plans formed primarily in response to the particular state initiative or to previous Medicaid managed care initiatives, for at least two reasons. First, traditional providers for low-income persons wanted to continue in this role, and some formed their own managed care plans to do so. Second, new plans were important to generate sufficient capacity, particularly when commercial plans were not interested in aggressively expanding to pursue the Medicaid market.

TRANSITIONAL ISSUES. TennCare tied to move rapidly from traditional Medicaid to managed care. Experience suggests that this is difficult to do, especially when there is only a limited managed care infrastructure and little time to plan. Tennessee was unable to change in so short a period to a system of well-organized, effectively configured managed care plans. Provider networks in the first year were not fully developed. For example, a plan could have in its network a hospital with a plan-affiliated surgeon but no anesthesiologist. Alternatively, the structure of the network could result in referrals to specialists who were far from an enrollee’s residence. Phone systems for patients were often inadequate; as a result, responses were delayed, or patients were connected with persons who were not familiar with the TennCare population. We heard reports of difficulties with drug formularies and exceptions processes; it is not clear whether this was because they were poorly developed, because physicians did not understand them, or because pharmacists resented them.

In addition, many patients continued to use their previous providers either because they did not know what plan they were in (state notifications were late), were dissatisfied with the plan to which they were assigned, or did not understand the system. The second-largest plan did not have a billing system that was even partly operational until mid-1994. Participating providers were not paid or were paid lump sums that they could not associate with services, leaving them dissatisfied, especially those who were paid fee-for-service.

HEALTH CARE SYSTEM EFFECTS

ACCESS TO CARE. The states’ experience highlights the fact that Medicaid initiatives affect persons who are already insured or covered by Medicaid in a different way than they affect persons who gain coverage through a new initiative. The former have the most to lose (especially if benefits and access are already relatively good), and the latter, the most to gain. Although Oregon lacks data on these issues, most stakeholders perceive the effects of Phase I to be generally positive because the uninsured are better off, and those previously receiving Medicaid are essentially in the same position. In fact, some previous enrollees gamed through minor expansion and coordination of benefits despite confusion associated with the transition. Surveys in Tennessee show similar patterns, but both groups had a less positive experience overall, probably because of the disruption and confusion in TennCare’s first year. In Minnesota innovative features such as loaner telephones are
perceived as having improved access for those who already were covered.

Most concerns we heard about care were more likely to focus on the chronically ill and those with special needs than on the average enrollee. Persons become eligible for Medicaid because of either low income or sickness and disability. The latter group, generally adults, is more likely to have special needs, chronic illnesses, or other problems that cause them to function less effectively in traditional, mainstream care systems. Research suggests that those in poor health are more vulnerable to delivery system problems or disruptions associated with the start of a new initiative. Unfortunately, most techniques for monitoring and evaluation focus more on averages than on distributions. Thus, they are not particularly sensitive to measuring effects that apply only to a subpopulation.

The states’ experience also indicates that managed care on its own will not remedy access problems related to provider shortages, especially in the short run. For example, low provider supply constrained the development and adequacy of managed care networks in rural and some inner-city areas of Tennessee. This generated access problems even as the initiative prompted the state to expand the authority and supply of nurse practitioners.

SAFETY-NET PROVIDERS AND THE UNINSURED. Participation in a state’s Medicaid managed care program does not seem to be a good proxy for safety-net protection.

Some safety-net providers were in a stronger position than others to respond more actively to their state’s program. A plan based around the public hospital system in Minneapolis is thriving. However, the Memphis public hospital has been severely stressed by TennCare, which led to a major reduction in Medicaid revenues. Some providers, especially those that are experienced, are large, and have established plans, appear likely to survive and grow. Access to capital and expertise is a constraining factor for some safety-net systems.

The size and role of the safety net also vary across communities. Stress on the safety net is more likely to have a negative effect in cities such as Los Angeles, New York, and Memphis, which historically have relied on large public systems, than in communities such as Sacramento and Orange County, where the safety net is much more limited.

The most serious concern is that a weakening of the safety net will reduce standby protection for those who remain uninsured or become so if the state’s initiative fails. This is especially a concern to the extent that public subsidies for such services are being independently reduced by other changes in federal, state, or municipal policies. This may not be a Medicaid or managed care responsibility, but it is an important public policy concern.

When coverage is expanded, but not universally, funding once used for cross-subsidization is now used to support eligibility expansion. Thus, safety-net providers are less able to tap such sources as disproportionate-share hospital payments and cost-based payments to federally qualified health centers to cover indigent care. In theory, the result should be positive to the extent that state initiatives reduce the number of uninsured persons and demand for uncompensated and subsidized care. However, some providers said that the volume of such care has not
CONCLUSIONS AND LESSONS

CONCLUSIONS. The conclusions from the five states we studied contain both positive and negative messages. States such as Minnesota and Oregon have moved a large share of their low-income populations into relatively well-designed managed care programs. Other states, such as Tennessee, have had major problems, at least in the early stages of implementation. Still others, such as California and New York, illustrate how long and complex the implementation process can be, particularly in large and diverse states. Both positive and negative effects on access to care appear likely in all five states. Thus, it is particularly disturbing that so few of the states had good baseline data on access, to judge whether the effort was worth it, both for persons already covered by Medicaid and the newly enrolled. In a previous study we suggested that a national Medicaid survey generating timely, state-specific estimates is feasible and should be implemented. This is an important issue, whether or not managed care exists.

The five states we studied illustrate sharply the diversity in population, managed care infrastructure, provider networks, and state infrastructure across the states. A program that works well in California may not work well in New York. The same program also will probably not work equally well in all of the different areas within a state. States also vary in political climate and styles in ways that influence both what is viable and the effects of change. It is hard to imagine, for example, that the process of consensus and consultation used in Oregon to establish its priority list would work as well in New York, which is considerably larger and more diverse and has a combative political style.

LESSONS FROM THE STATES. Although our study illustrates why states need to tailor approaches to their unique environments, it also suggests that there are things that any state needs to consider in developing effective initiatives for low-income persons. In brief, we draw ten lessons about how states can increase their potential success in restructuring Medicaid with managed care for low-income populations.

1. Invest in an effective enrollment process that anticipates confusion and questions. This includes well-designed written materials geared toward low-income populations, a toll-free telephone number with the capacity to address a large volume of questions, and some way to provide individual counseling in person.

2. Emphasize education about the system for both enrollees and providers. This is important both when previous managed care experience is limited and in established systems to address changes and resolve new problems.

3. Build a well-developed oversight system to minimize problems and monitor performance. Without this, marketing abuses and miscommunication are inevitable. Both access and quality standards for plans are important, particularly for new plans. The time and resources needed to establish an oversight system should not be underestimated.

4. Build managed care strategies that are sensitive to the configuration of existing plans and providers and to the experience they have had in accepting risk for medical delivery, particularly for low-income popula-
tions. Before transferring risk to a provider, assess their administrative capacity and their ability to absorb risk.

(5) Allow sufficient time for implementation and system development, so that any controversy, confusion, and potentially serious access problems may be addressed in the transition. Substantial lead time is needed to develop effective procedures, oversight, and education. States that are considering very rapid time frames, perhaps to avoid political opposition (as in Tennessee) or to address serious budget constraints, must recognize the controversy, confusion, and short-term transition-related problems that will arise with rapid implementation.

(6) Invest in administrative structures and assume that these will cost, rather than save, money, at least in the short term. New systems and administrative demands are generated by managed care. States typically will not be able to offset these with other administrative cost savings.

(7) Pay special attention to policies and systems for the chronically ill. This population is particularly vulnerable to the effects of managed care because such persons are likely to have special health care needs. New types of systems may be needed for chronically ill persons and other subgroups of the Medicaid population that have special needs.

(8) Set rates that are sensitive to the populations enrolled in managed care plans and the costs associated with treating them. The adequacy of the rates affects which plans participate and whether care is comparable to that received by others. Because the Medicaid population is diverse, risk adjusters that modify payments to plans based on the health care needs of and the expected costs for enrollees are needed to encourage equity and to avoid windfall gains.

(9) Minimize extensive and rapid eligibility turnover. Eligibility turnover and managed care do not mix well. The “on again/off again” cycle of eligibility under Medicaid adds to administrative costs and makes it hard for health plans to provide continuity of care.

(10) Set objectives that are realistic. Financing a Medicaid managed care program does not by itself resolve the access problems created by an insufficient or poorly distributed supply of providers. In creating a benefit package, it is important not to impose unnecessary barriers to care. It is unrealistic to expect Medicaid managed care alone to generate enough savings to cover all of a state’s uninsured residents. An adequately financed safety net is critical to maintaining access for those who remain uninsured.

In sum, establishing effective managed care programs for low-income populations requires work and time. A variety of diverse factors, policies, and procedures will influence outcomes. In short, the success of the initiative is “in the details” and depends on both the commitment and the financing available to support them.

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NOTES


2. D. Rowland and K. Hanson, “Medicaid: Moving to Managed Care,” Health Affairs (Fall 1996): 150-152.


4. California and New York are large states where initiatives are being phased in through collaboration with localities. We spent more time in these states (five days) and focused more on specific markets—Sacramento, Los Angeles, and Orange Counties in California and New York City and Albany/Rensselaer in New York.


8. When MinnesotaCare converts to managed care, they plan to have a mail-in selection process because that is how the enrollment process is carried out. Some are concerned that this could lead to problems.

9. GAO, Medicaid States Turn to Managed Care.


12. Since our visit, the state has attempted to address the issue by consolidating state commercial and Medicaid managed care oversight in a newly created Office of Managed Care within the state Department of Health.


14. This estimate is for initial capitation rates once the “withhold” is considered. The withhold reflects on offset held in reserve by the state to protect against losses.

15. To some extent, this reflects the low participation rates of some specialists, such as orthopedists, who were said to be boycotting the program, and general shortages of physicians, especially in inner-city and rural areas.

16. This plan had historically capitated its primary care providers, many of which were community health centers that viewed the capitation rates as considerably better than they could obtain through other plans paying fee-for-service. This plan also puts a priority on expediting payment to capitated providers, especially those whose circumstances made cash flow more critical.
