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Prologue: With increasing frequency, the phrase “managed care” is appearing in the lexicon of individuals and organizations caught up in changing America’s traditional health care delivery system. Like any generic label, the phrase means a lot of different things to different interests, but it essentially combines delivery and financial dimensions of medical care in a variety of ways. Insurance companies consider us parts of managed care the employment of utilization review and preadmission certification to keep their beneficiaries medical costs—and premium rates—in check. Physicians and hospitals have become involved in the emerging phenomenon through case management and capitation agreements. The federal government has introduced managed care into Medicare by encouraging elderly beneficiaries to enroll in health maintenance organizations (HMOs) and by creating new economic incentives through its hospital reimbursement system—prospective payment. States, too, have incorporated managed care approaches in Medicaid as a way to constrain expenses. In this paper, Maren Anderson and Peter Fox of Lewin and Associates, Inc., a Washington, D.C.-based consulting firm, track the experience of several states with Medicaid managed care, in the form of both fee-for-service and partially capitated primary care case management, HMOs, and health-insuring organizations. Anderson, who holds a master’s degree in public policy from the University of California, Berkeley, previously worked at the Health Care Financing Administration (HCFA). Recently she completed a two-year study of California’s Medicaid selective contracting and preferred provider legislation. Her associate, Fox, holds a doctorate in business from Stanford University. Previously he worked at the Department of Health and Human Services in several policy-related positions within HCFA and the Office of the Assistant Secretary for Planning and Evaluation. He recently published a book for DHHS entitled Determinants of HMO Success—which some say is the In Search of Excellence of the HMO world.
Many state Medicaid programs have embraced managed care as a way to control costs and encourage competition among providers. As of June 30, 1986, twenty-nine states and the District of Columbia had enrolled more than 1.5 million people in some form of Medicaid managed care, including prepaid capitation arrangements, health insuring organizations, and primary care case management systems.\(^1\)

In this article we outline some of the lessons learned from Medicaid managed care programs, including the barriers to their successful implementation, experiences in various states, and limitations of prepayment. The lessons are drawn primarily from experiences with three of the seven Medicaid competition demonstrations, which began in 1982 under the sponsorship of the Health Care Financing Administration (HCFA).\(^2\) We also discuss the trend in the adoption of Medicaid managed care arrangements (including a brief overview of the seven demonstration projects), discuss the reasons for states adopting managed care, recount experiences with these programs to date, and list some of the limitations of managed care.\(^3\)

### The Trend Toward Medicaid Managed Care

As of June 1980, some sixteen states plus the District of Columbia had signed Medicaid contracts with health maintenance organizations (HMOs) or other types of prepaid plans, covering approximately 1 percent of all recipients.\(^4\) More than 85 percent of the enrollment was in four states: California, Michigan, Maryland, and New York. To increase state prepayment activities, the federal government mounted an initiative in the early 1980s to promote competition in state Medicaid programs and to encourage adoption of managed care approaches. HCFA's Medicaid competition demonstrations, which will be described in this article, were important products of this effort. In addition, passage of the 1981 Omnibus Budget Reconciliation Act stimulated Medicaid managed care programs by allowing states to contract with prepaid plans that met state requirements but were not federally qualified as HMOs. Further, the law permitted waivers of certain federal Medicaid requirements so that states could establish primary care case management programs.

**Types of managed care.** Since 1981, Medicaid managed care plans have proliferated. The four most common types of programs include HMOs, fee-for-service primary care case management, partially capitated primary care case management, and health insuring organizations (HIOs). HMOs that are either federally qualified, that is, meet the requirements of the Public Health Service Act, or that are defined in the state Medicaid plan but are not federally qualified, are paid a fixed peri-
odical fee per Medicaid enrollee (known as a capitation payment) for the
provision of comprehensive health services. (These plans are also re-
ferred to as prepaid health plans, or PHPs.) Enrollment in these plans
must be voluntary, and, within three years of formation, combined
Medicare and Medicaid enrollment in the plan may not exceed 75 per-
cent of total enrollment. According to HCFA, some twenty-five states
had contracted with over 130 HMOs as of June 1986 (Exhibit 1).

With fee-for-service primary care case management, recipients must
select a primary care physician who assumes responsibility for providing
primary care and authorizing referrals to hospitals and specialists. Most
primary care case managers are paid a monthly case management fee
(usually $3) per enrolled patient. In addition, the case manager is paid
fee-for-service for all medical services, and Medicaid continues to pay
directly all specialists, hospitals, and other providers, who must submit
prior authorization forms documenting that the case manager approved
the care. According to the National Governors’ Association, at least
seven states have adopted these programs.5

Partially capitated primary care case management, a variation on the
fee-for-service case management program described above, entails capi-
tating the primary care physician for primary care services, including
laboratory work and x-rays. If the case manager approves, hospital serv-
ices, work done by specialists, and all other services are paid on a fee-
for-service basis. In some programs, the case manager may receive a bonus for
reducing hospital and specialty use. Approximately six states have these
partially capitated programs (Exhibit 1).

Finally, health insuring organizations (HIOs) feature a risk-
assuming intermediary, such as an insurance company or other public/private
agency, that assumes responsibility for delivering covered services to a
geographically defined population. Five states have HIOs (Exhibit 1). As
a result of provisions in the 1985 Consolidated Omnibus Budget Recon-
ciliation Act, new HIOs will be required to meet all federal requirements
for Medicaid HMOs. These restrictions mean that only existing HIOs
will be able to operate without becoming an HMO, effectively terminat-
ing the HIO as a separate approach.

Demonstration projects. In 1982, HCFA funded seven competition
demonstrations in six states: California, Florida, Minnesota, Missouri,
New Jersey, and New York. Each of the sites proposed to test innovative
health care financing and delivery approaches, including (1) competitive
HMOs/prepaid health plans (PHPs) (Florida, Minnesota, Missouri, and
New York); (2) fee-for-service and partially capitated primary care case
management (Missouri and New Jersey); and (3) HIOs (Monterey and
Santa Barbara counties in California and Minnesota).

The Florida Alternative Health Plan originally proposed to imple-
ment four models: (1) competitive bidding by HMOs; (2) case manage-
ment for recipients who consistently overutilize or underutilize medical care; (3) prepaid health plans for frail elderly patients; and (4) medical care vouchers offered by private insurers. The first and fourth models encountered opposition from key interest groups and were never imple-

### Exhibit 1
**States With Operational Medicaid Managed Care Programs, June 30, 1986 (Including Demonstrations)**

<table>
<thead>
<tr>
<th>State</th>
<th>HMOs</th>
<th>HIOs</th>
<th>PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Plans</td>
<td>135</td>
<td>5</td>
<td>NA</td>
</tr>
<tr>
<td>Total States</td>
<td>25</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Alabama</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Arizona</td>
<td>15</td>
<td></td>
<td></td>
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<tr>
<td>California</td>
<td>14</td>
<td>1</td>
<td>X</td>
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<tr>
<td>Colorado</td>
<td>3</td>
<td></td>
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<tr>
<td>Connecticut</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Florida</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Illinois</td>
<td>9</td>
<td></td>
<td></td>
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<tr>
<td>Indiana</td>
<td>1</td>
<td></td>
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<tr>
<td>Maryland</td>
<td>5</td>
<td></td>
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<tr>
<td>Massachusetts</td>
<td>7</td>
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<tr>
<td>Michigan</td>
<td>7</td>
<td>1</td>
<td>X</td>
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<tr>
<td>Minnesota</td>
<td>10</td>
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<tr>
<td>Missouri</td>
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<td>Nevada</td>
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<td>X</td>
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<tr>
<td>New York</td>
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<tr>
<td>North Carolina</td>
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<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>14</td>
<td></td>
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</tr>
</tbody>
</table>

Note: HMO = health maintenance organization; HIO = health insuring organization; and PCP = primary care plan.

1. In addition, California, Indiana, and Texas have capitated fiscal intermediaries, which pay claims for a fee-for-service program.
2. The number of plans/providers operating in each state is not available, thus the presence of a partially capitated PCP is denoted by an X.
3. Includes a plan that began operation shortly after June 30, 1986.
4. Missouri also has a small fee-for-service case-management program.

mented. The second model was partially implemented but quickly converted from a demonstration to an ongoing state program. At present, planning continues for the third model, which is intended to prevent the use of nursing homes through coordination of community based medical and social services. Florida hoped to implement this module in Miami during late 1986. Recently, having learned several important lessons from the failure of the demonstration, the Florida Medicaid agency revamped its approach to prepayment and embarked on a successful nonexperimental program of HMO contracting.

In the Minnesota Prepaid Medicaid Competition Demonstration, Medicaid recipients are enrolling in HMOs and similar types of plans in three Minnesota counties: Hennepin (Minneapolis); Dakota, a suburban county south of St. Paul; and Itasca, a rural county in the central portion of the state. In Hennepin County, 35 percent of the eligible population is randomly assigned to the demonstration and required to enroll in one of seven participating plans; in Dakota County, enrollment in one of five participating plans is mandatory for almost all eligible people, including most aged, blind, and disabled recipients. In Itasca, the county functions as the prepaid plan, similar to an HIO: it is financially at risk, but in practice it passes much of the risk on to providers. The county accepts a capitated amount for enrollees and pays local providers fee-for-service, withholding 10 percent. At the end of the year, any surpluses or losses are largely assumed by providers.

The Missouri Managed Health Care Project in Jackson County, Missouri (Kansas City), requires approximately 23,000 recipients of Aid to Families with Dependent Children (AFDC) to enroll in managed care programs. Recipients select between financially at-risk plans or fee-for-service primary care physicians participating in what is called the Physician Sponsor Program. Most of the recipients have enrolled with five plans, that is, an existing independent practice association (IPA) HMO, which is sponsored by Blue Cross and Blue Shield of Kansas City, along with four plans that were newly formed for the demonstration, two by major teaching hospitals and two by neighborhood health centers. Approximately 16 percent of the population is enrolled with fifty-four physician sponsors, who provide basic medical care to enrollees, make all referrals to specialists, and manage all hospitalizations. They receive a case management fee of $1.50 per enrollee per month in addition to normal Medicaid fee-for-service payments for the services they provide.

In New York State, Monroe County created a separate authority known as MediCap, Inc., to administer an HMO contracting program. MediCap is responsible for administering the program, including marketing, rate setting, provider monitoring, and claims processing. The county is ultimately at risk for any cost overruns, but only after the participating HMOs and their affiliated providers have exhausted their
own resources. Approximately 64,000 Medicaid eligibles will be required to enroll in HMOs that have contracted with MediCap. At present, more than 34,000 AFDC and Home Relief (state-eligible indigent population) recipients have been enrolled, and MediCap is now preparing to enroll the aged recipients, who will be covered for long-term care. To date, two HMOs have agreed to participate—Rochester Health Network and the Genessee Valley Group Health Authority.

In the New Jersey Medicaid Personal Physician Plan (MP Plan), participating physicians in central and southern New Jersey counties, plus Newark, serve as case managers and are financially at risk for primary and referral specialist services. In return for a monthly capitation fee, they must provide routine primary care and authorize medical specialty, hospital, pharmacy, and other referral services. Moreover, physicians can benefit financially from controlling hospital utilization. Enrollment in the program is voluntary, and only 219 physicians and 9,500 recipients elected to participate as of June 1986.

From 1983 until 1985, Monterey County, California, assumed financial risk for a Medicaid primary care network, known as the Health Initiative. Approximately 28,000 recipients selected a primary care physician or the county hospital to serve as their case manager. The county paid the physician case manager fee-for-service at 10 percent above Medicaid rates plus a management fee of three dollars per enrollee per month. The hospital case managers were paid 100 percent of charges. Other providers were paid reduced charges. The program ended in February 1985 because the county lost money.

Under the Santa Barbara County, California, Health Initiative, the county created an independent authority that is financially at risk for 21,000 Medicaid recipients who must enroll with a primary care case manager. At present, more than 100 primary care physicians and the county health service serve as case managers. The county authority is capitated and receives 95 percent of Medicaid fee-for-service costs. It in turn capitates the primary care case managers for primary and specialty care and places them at risk for hospital care through a shared risk system. Also, the county health service is capitated for additional services, such as laboratory, x-ray, and pharmaceuticals. The remaining Medicaid benefits, such as long-term care, are reimbursed on a fee-for-service basis. Unlike its sister program in Monterey County, the Santa Barbara Health Initiative has been successful and continues to operate.

In addition to these competition demonstrations, several states have begun Medicaid managed care projects. For example, the Arizona Health Care Cost Containment System (AHCCCS) is a statewide program that requires both Medicaid eligibles and indigent families to select a prepaid plan. Also, Wisconsin requires AFDC recipients to choose from among fourteen participating HMOs in the Milwaukee and Madison areas. This
article focuses primarily on experiences of HMOs in the Florida, Minnesota, and Missouri demonstrations.

States have adopted managed care programs for differing reasons that reflect local politics, circumstances, and history. One thing they have in common, not surprisingly, is the desire to constrain state budgets. In addition to immediate budget savings, states may want to protect eligibility and benefits through more efficient use of available moneys, and many states want to move away from the spiraling inflation associated with a fee-for-service financing system. Other motivations for adopting managed care include improving access to mainstream medicine, testing policies and operating procedures that might be used nationally, and promoting the evolution of a competitive health care marketplace.

Lessons From Managed Care

Politics and the structure of managed care. Medicaid managed care programs are not designed in a vacuum. Rather, their structure must be responsive to the demands of various interest groups, including state legislatures, county governments, providers, and consumers.

In Missouri, the structure of the demonstration was greatly influenced by certain provider groups. As a result of pharmacists' efforts, prescription drugs were exempted from coverage by prepaid plans, and the medical society sought to assure that recipients could choose private, fee-for-service physicians. These changes meant that Missouri could not require enrollment in prepaid health plans as it had originally intended.

In Minnesota, provider and consumer groups representing chronically mentally ill, mentally retarded, and physically handicapped populations expressed the greatest concerns. These groups worried that the participating plans lacked experience in caring for these populations. Although they did not have significant impact on the structure of the demonstration, they did generate considerable discussion and also served to sensitize both the state and the participating plans to the special needs of chronically ill persons. They also made it clear that they would closely monitor the delivery of services.

Plans willingness to participate. Most states encourage established HMOs to participate in their Medicaid managed care programs, with mixed success. Among the important factors affecting willingness to participate are the competitive nature of selected local HMO markets and inducements offered by the states, particularly favorable rates, risk protections, and potential market share. States appear to have contracting problems in markets in which private payers and Medicare offer more favorable capitation rates than Medicaid. Further, HMO contract negotiations can be contentious, particularly in situations where the state has taken a tough bargaining position and issues of HMO competence
Florida illustrates the problems that can arise in a climate of mutual mistrust. The state was concerned about the track record of several Miami HMOs that previously catered to fee-for-service Medicaid recipients and, as a result, instituted several restrictive contracting provisions, such as capping the total number of potential enrollees at 10 percent of the county's Medicaid population and insisting upon formal and onerous competitive bidding. All but two Miami HMOs declined to submit bids. Their reasons were revealing—they objected to Florida's low Medicaid capitation rates and the cap on total enrollees. Also, the Miami plans found Medicaid less attractive than competition for commercial patients and Medicare enrollees (through HCFA's demonstration programs). Most important, they believed they were operating in good faith and were disappointed in the state's formal approach to negotiations. They were unaccustomed to government procurement processes, which are considerably more cumbersome than any imposed by the private sector. Subsequently, the state attempted to exclude one of the two HMO bidders on the grounds that it failed to meet the criteria for participation. The HMO sued, and, after considerable delay, the state ultimately decided to attempt direct negotiations. After the smoke cleared, however, none of the established HMOs were interested in participating, forcing the state to abandon its demonstration.

Florida learned several lessons from this process: first, many established HMOs will not compete for low-paying Medicaid patients, particularly when other attractive opportunities, such as Medicare HMOs, are available. Second, when a state does not have a particularly appealing "deal" to offer, it must cultivate plans' interest rather than dictating terms. Third, contract terms must be flexible and responsive to plan concerns—the state eventually bowed to the HMOs' objections and removed the 10 percent enrollment cap.

In contrast, the situation in Minnesota was cooperative and mutually supportive. Although their eagerness varied, most HMOs in the Twin Cities were willing to participate in the demonstration for several reasons. First, the Twin Cities area historically has been a hotbed of HMO development, with some 50 percent of the population enrolled in prepaid plans, and Medicaid was viewed as the major untapped market. Further, Medicaid rates were regarded as reasonable, and it made financial sense to participate. Another important factor was the spirit of cooperation in which planning for the demonstration occurred. The Minnesota state government has a tradition of consulting with HMOs as well as other concerned parties, making it possible for the plans to resolve many of their concerns. However, the consensus development process was time-consuming and delayed project implementation by more than a year.
Unlike Florida, where attempts to exclude HMOs were met with a lawsuit, Minnesota was able to exclude a newly formed plan that failed to meet several conditions of participation (for example, evidence of ability to manage the delivery system and adequate financial reserves), even though the organization had considerable community support. A couple of lessons can be derived from this experience. First, the state felt that having explicit selection criteria was helpful in making the decision "stick" in the face of political pressures. Second, staff were permitted latitude in interpreting these criteria and making subjective judgments about plans' viability.

In Missouri, the state wanted to contract with HMOs while encouraging traditional Medicaid providers to participate. Thus, the neighborhood health centers and the two hospitals with heavy Medicaid volumes were given the chance to compete with the two HMOs in Kansas City. Ultimately, only one HMO participated—Prevention Plus, a subsidiary of Blue Cross and Blue Shield’s IPA; the other plan, Prime Health, declined because it viewed the state’s capitation amount as inadequate, and it could not convince its network of hospitals to accept Medicaid rates. Thus, four out of five of Kansas City's Medicaid plans are new to prepayment and unaccustomed to accepting financial risk. As a result, several plans felt unprepared to monitor utilization and manage capitation, and they would have liked technical assistance from the state.

**Nature of competition.** Medicaid managed care programs, especially those that entail contracting with prepaid health plans, are often expected to produce the same competitive dynamics found in the private sector. However, each state’s Medicaid program has attributes that will modify, and potentially mute, the amount of competition that actually occurs.

HMOs compete for private enrollees in a number of ways, particularly in price and scope of benefits. Competition in services (such as provider location and choice, waiting times for appointments, physical layout of the office) and quality also is common. While it is not known how much weight prospective enrollees attach to individual competitive factors, price and benefits are generally believed to influence choice strongly. However, Medicaid enrollees may be immune from this form of competition. Whereas most private enrollees face premium differentials when they select from among various health plans, Medicaid coverage is available to eligible persons at no cost. Furthermore, since Medicaid benefits are comprehensive in many states, plans have little opportunity to improve benefits. Minnesota, with its broad benefit package, is a case in point, although the plans in the demonstration can offer a few services such as contact lenses that are not part of the regular Medicaid program.

Of course, competition for Medicaid recipients does occur but primarily on the basis of services, such as convenient access to providers,
short waiting times, and large numbers of participating physicians. However, if plans are reluctant to participate in the program in the first place, even this form of competition may be limited. Thus, when price is no longer a competitive factor, when plans are restricted in their ability to add benefits, and when some participants wish to limit their Medicaid enrollment, the effect may be to protect plans’ profit margins. The resulting level of competition may be analogous to that in the airline industry before deregulation, when the Civil Aeronautics Board (now defunct) set fares. The airline industry was competitive then, but far less so than it is now.

**Medicaid populations with special needs.** The Medicaid populations enrolling in HMOs differ considerably from typical private sector enrollees. As a result, states must be concerned about whether prepaid plans are equipped to serve the special needs of Medicaid patients, particularly pregnant women, children, and patients with chronic conditions. For example, early and continuous prenatal care for pregnant women and ongoing pediatric care for infants and children can provide significant long-term payoffs in improved health. While established HMOs have been more willing than private insurers to cover preventive services and prenatal and infant care, anecdotal evidence indicates that most plans are not developing special maternal and child health programs for Medicaid populations.

Moreover, most established HMOs have limited experience with patients who suffer from mental and physical handicaps, mental retardation, and chronic medical conditions. Many of these patients need more continuous medical supervision and nursing home care than HMOs ordinarily provide. To date, HMOs reportedly have not made special arrangements for the provision of chronic medical or mental health care. Further, HMOs have little experience with direct provision or contracting for long-term care, but this problem may diminish over time as more plans gain experience with Medicare and Medicaid populations. In the interim, states need to monitor prepaid plans to ensure that the chronically ill receive the medical services they need.

**Rate setting.** Most Medicaid HMOs/PHPs receive a capitation rate set at 90-95 percent of what the state would have paid per enrollee per month without the program (that is, in its traditional fee-for-service system). Estimating the prior year fee-for-service base is usually not difficult. Rather, controversies arise in predicting future expenditures to establish a prospective premium. For example, Missouri has twice reduced its capitation amount to adjust for lower fee-for-service expenditures than its actuary predicted. In Minnesota, the base year is 1982, a period that becomes questionable as projections are made for increasing numbers of years into the future. In particular, the projections for the current year reflect estimated state budgets, which in turn incorporate...
allowable changes in fee-for-service reimbursement levels but may not adequately reflect changes in use and service intensity. Other rate-setting problems include lack of cost data when the state changes benefits, difficulties imputing administrative costs, and decisions about how to accrue interest earned from investing the capitation payments. Biased or adverse selection is a major issue with implications for the accuracy of the rate-setting process. Biased selection means that a plan attracts a disproportionate number of either healthy or unhealthy enrollees. States that retain a fee-for-service option must be concerned about the potential for certain plans to attract healthier enrollees on average, leaving the less healthy patients in the fee-for-service system. In Missouri, where this was a concern, funds were set aside to pay for hospital days in excess of a target level. At the plans’ request, the state also created two additional risk protection funds: (1) to protect plans from financial exposure for high-risk deliveries and neonatal intensive care, and (2) to protect plans from excessive numbers of births.

In states with mandatory enrollment, the primary issue is whether high-risk patients are distributed evenly among plans. Of particular concern to some plans in Minnesota are women who become eligible for Medicaid after they are pregnant, commonly late in the pregnancy. A significant percentage of these women are believed to lose eligibility within a few months of delivery. As a result, they are members of a plan for a brief period only, during which time they incur significant medical expenses. This situation would not be problematic were these women proportionately distributed among the participating plans. However, it is believed that they tend to enroll in the IPA-type plans that have broad physician participation, often with the physician they previously used if they had one, and are less likely to enroll in group or staff model plans that have fewer physicians.

Plans may be at a competitive disadvantage vis-à-vis the regular Medicaid program because they pay more than Medicaid for some services. Individual plans, particularly if they are new or small, typically do not have the purchasing clout of the state Medicaid program and are not able to obtain as favorable rates. One example cited earlier is that of Prime Health, a prominent HMO in Kansas City, Missouri, which declined to participate in the demonstration in part because it pays hospitals more than does Medicaid, and this excess would not be incorporated in the rates. (However, some states have arranged for HMOs to pay hospitals at Medicaid rates for Medicaid enrollees.) Also in Missouri, the two neighborhood health centers that sponsor prepaid plans have little leverage to obtain discounts. At the same time, many providers, particularly physicians, often favor Medicaid capitation precisely because they are reimbursed at higher levels.

**Provider and consumer reactions.** After some initial skepticism, we
have found that most providers and consumers accept Medicaid managed care, and some even support it. In Florida and Missouri, Medicaid physicians initially greeted managed care programs with hostility because they feared losing patients. However, their concerns were largely dispelled by the state, which went to great lengths to ensure that Medicaid physicians had a chance to participate in the managed care experiment. Eventually, most physicians supported the demonstration because they saw an opportunity to retain their professional autonomy, avoid the extensive paperwork required under the regular program, and potentially increase their revenues. In Missouri, for example, the Medicaid physicians initially insisted on a fee-for-service alternative, but after considerable education on the part of the state, the majority decided to join a prepaid plan. In Minnesota, where almost all providers had experience with HMOs and supported the concept of competitive strategies, there was widespread—if not always enthusiastic—acceptance of prepayment.

Similarly, consumer groups initially opposed managed care because they objected to limitations on recipients’ freedom of choice. Eventually, however, they accepted the advantages of better access to care and improved continuity. While the consumer surveys that are part of the Research Triangle Institute (RTI) evaluation have not been completed, early indications are that consumers are satisfied with the program.

**Limitations Of Managed Care Programs**

Whatever the merits of managed care programs, they are not a panacea. The limitations and problems include the following: (1) the impact on the non-Medicaid poor and near-poor; (2) coverage of populations needing long-term care; (3) assuring access to “mainstream” medicine; (4) converting demonstrations to ongoing prepaid plans; (5) the role of the county government; and (6) administrative cost problems.

**Impact on the non-Medicaid poor and near-poor.** Ironically, when states adopt managed care programs, they may be compromising the ability of providers to serve the non-Medicaid poor and near-poor who lack health insurance. Further, they may undermine the financial stability of the provider infrastructure that serves the medically indigent. Public and private sector cost-containment efforts, including the adoption of managed care, have constricted providers’ revenues, thereby reducing the money available for discretionary spending and uncompensated care. Although the shift results in new funds becoming available to participating prepaid plans, many HMOs have not traditionally cared for unpaid populations, nor do they have clear obligation to do so, any more than commercial insurance companies do. Whether Medicaid HMOs should provide uncompensated care becomes particularly impor-
tant if some plans earn high profits as a result of the constraints on competition discussed above.

Managed care may also squeeze institutions that the poor tend to use, including public hospitals and health clinics. These institutions have difficulty competing in a managed care environment. The costs of uncompensated care, coupled with traditionally high operating costs, make it difficult for public institutions to offer significant discounts, increasing the likelihood that they will be excluded from public and private managed care plans. If they decide to discount heavily in order to be included, these institutions may weaken their financial condition and further compromise their ability to provide uncompensated care. This raises the question of whether the state and counties should bear some responsibility for financing these facilities through other means.

Coverage of populations needing long-term care. As a practical matter, enrollment in most Medicaid HMOs is limited to non-spend-down AFDC recipients because they most closely resemble the employed populations enrolled in established HMOs. These restrictions mean that Medicaid HMOs are only addressing a small portion of most states’ expenditures. Indeed, AFDC recipients account for only 25 percent of total Medicaid expenditures.7

In Minnesota, Medicaid expenditures for aged, blind, and disabled groups are among the highest in the nation (81 percent in 1982).8 As a result, the state wanted to include all services provided to these groups in the capitation payments. However, it soon found that it could only partly realize its objective because it was unable to capitate the plans for long term nursing home care.

Access to mainstream medicine. Although managed care programs are intended to improve access to mainstream medicine, the results are mixed. The ability to achieve this objective depends on whether (1) mainstream organizations will participate in the program, and (2) institutions and physicians that traditionally have cared for the poor can be encouraged to join the mainstream, by offering ongoing rather than episodic care. Unfortunately, this has not been typical of hospital outpatient departments. Of the three state demonstrations that are the focus of this article, only Minnesota has attracted large numbers of established HMOs. The remaining states encouraged traditional Medicaid providers, that is, hospitals, physicians, and neighborhood health centers, to develop prepaid plans. As a result, most competition demonstrations, particularly those in Missouri, New Jersey, and Santa Barbara, have failed to attract new physicians to Medicaid. Rather, the physicians that already treat Medicaid patients are being reimbursed through a different mechanism. The experience to date suggests that Medicaid managed care has difficulty improving access to a broader array of mainstream physicians.
Moreover, some plan sponsors, notably the teaching hospitals, have institutional barriers that prevent them from operating like established private HMOs, at least in the short term. In these hospitals, the teaching curriculum takes precedence, and thus prepaid enrollees are likely to use physician specialty care and ancillary services at a higher rate than in private plans. Further, the hospitals have difficulty introducing new utilization review and patient management procedures, and they often do not devote additional administrative resources to the demonstration. As a result, it is “business as usual” for most plans operated by teaching hospitals. Recently, however, the participating teaching hospitals in Missouri have begun to change their patient management practices, and the state is confident that the program’s incentives for efficiency will produce higher quality mainstream medicine for the patients over the long run.

Converting the demonstrations to ongoing programs. In some states, such as Missouri, the participating plans are neighborhood health centers and public hospitals with little experience in prepayment. These plans face considerable administrative challenges if they are to remain financially solvent. They must put into place utilization review mechanisms designed to control health care delivery and financial accounting systems designed to manage capitation payments. Given the investment many of these providers have made, they want to convert to ongoing Medicaid HMOs. Unfortunately, most will have difficulty complying with the federal requirement that at least 25 percent of plan enrollees be other than Medicare or Medicaid beneficiaries. HCFA may grant a three-year waiver of this requirement and exemptions may be granted for prepaid plans based at federally funded community health centers and public HMOs. For the plans that do not qualify for exemptions, a key issue for the future is whether they can manage their risk and attract private-paying patients. If not, their long-term viability is questionable.

Role of the county. Several states rely on the counties for aspects of administration, usually eligibility determination, which is performed along with determining eligibility for cash welfare payments. Historically, these states found it convenient to rely on the counties for these activities rather than creating their own local bureaucracies. However, county administration reduces state flexibility and creates both political and administrative problems for the movement to managed care.

The situation in Minnesota is illustrative. For the demonstration to be large enough to be worth undertaking, the state deemed it essential to include one of the two large urban counties: Ramsey (which includes the city of St. Paul) and Hennepin (which includes Minneapolis). Ramsey early declined to participate, a refusal that the state accepted with little questioning. Hennepin ultimately agreed, but only after significant delays and program modifications. One of the county’s concerns was the
demonstration’s potential to reduce revenues to its large medical center, reflecting the county’s role as a provider rather than a purchaser.

In theory, the counties in states such as Minnesota are contractors of the state. However, they are also independent and proud units of government that are not readily replaceable through competitive bidding or other types of selection. Furthermore; these governmental entities have their own political clout. Minnesota was prepared to mandate, through legislation, the participation of Hennepin County if need be, but doing so is hardly a comfortable position for any state to be in.

**Administrative costs.** If states believe that Medicaid managed care will eliminate most of their administrative responsibilities, they are sadly mistaken. Complex and sophisticated monitoring and management are required when a state adopts prepayment. For example, states must maintain eligibility and enrollment files for the prepaid plans. In Missouri, it took the state’s fiscal intermediary more than a year and considerable expense to develop the-software modifications necessary to track prepaid enrollment. Another concern should be having a quality assurance system to detect underservice. To conduct quality assurance reviews, the state needs medical data and personnel capable of interpreting them. Thus, reducing administrative costs is not a good reason to undertake prepayment or other managed care programs. Furthermore, the administration of such programs may require staff with new skills and, if anything, greater levels of sophistication in finance and health services delivery.

**Conclusions**

Despite many of the limitations described above, states continue to be attracted to managed care for the Medicaid population. State officials believe that these programs offer predictable budgetary increases while promoting quality and continuity of care. Whether the Medicaid competition demonstrations actually achieved these objectives will be answered by the evaluation team headed by RTI. In the next few years, the researchers will report empirical data on cost savings, quality of care, and provider and consumer reactions, all of which will contribute to a better understanding of the impact of managed care.

While empirical results are not yet available, the experiences of the Medicaid competition demonstrations have provided important insights into the nature of these programs. These projects have shown that once plans agree to participate, they remain committed. Further, despite original opposition, both consumers and providers appear comfortable with the concept of Medicaid prepayment. Some states have successfully extended their managed care plan beyond AFDC to include aged and disabled populations but are finding that coverage of long-term care
poses problems that are difficult to overcome. Finally, prepaid plans are conscientious about providing care to Medicaid patients, but states need to strengthen their monitoring efforts and to improve the skills of their administrative staff. Given the successful implementation of many of these programs, we can expect that Medicaid managed care will continue to expand over the next few years.

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NOTES

1. Office of Prepaid Health Care, Health Care Financing Administration.

2. In early 1983, HCFA awarded a contract to evaluate these demonstrations to a consortium headed by the Research Triangle Institute (RTI), which includes the University of North Carolina as well as the Medical College of Virginia. In addition, Lewin and Associates and the American Enterprise Institute (AEI) were subcontracted to prepare case studies in each of the participating states over a four-year period. Lewin and Associates is responsible for the case studies for Florida (jointly with AEI), Minnesota, and Missouri; AEI is responsible for California, New Jersey, and New York.


6. Personal communication with member of demonstration evaluation team.


8. Ibid.