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Health - Medicaid Managed Care

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

Health - medicaid managed care

August 6, 1998

MEMORANDUM FOR ERSKINE BOWLES

The President requested an evaluation of recent media reports which suggested that commercial health plans are withdrawing from participation in Medicaid managed care.

A review and evaluation of these reports have been completed as the President requested. Attached is Secretary Shalala's memorandum to the President advising him of our findings.

Elizabeth Sunny for
Mary Beth Donahue

cc: Podesta
Echaveste
Rahm
Bruce / Elena
Jennings
Cabinet Affairs

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 6 1998

MEMORANDUM FOR THE PRESIDENT

Recent media reports have suggested that commercial health plans (primarily for-profit HMOs) are withdrawing from participation in Medicaid managed care. At your request, we have evaluated these reports over the past several weeks by speaking to a wide variety of researchers, plan officials, and state and federal regulators and by reviewing research on this issue. Our review generally supports the conclusion that some commercial plans have withdrawn from Medicaid, but that their withdrawal has had little or no effect on access to managed-care coverage in most areas. The number of local and Medicaid-only health plans participating in Medicaid continues to grow, and for now these health plans are assuring adequate capacity for the continued expansion of Medicaid managed care. The growing dominance of Medicaid-only health plans, however, raises important policy issues about Medicaid beneficiary access to mainstream health care.

Below we discuss the participation of commercial health plans in Medicaid, the reasons for its decline, and some of the policy implications for beneficiary access and quality of care.

Commercial Plan Participation in Medicaid

Recent media reports of plans leaving the Medicaid market (including articles in the *Wall Street Journal* 4/7/98 and the *New York Times* 7/6/98) have focused on commercial health plans, plans whose primary business is non-Medicaid. Although we cannot yet confirm this trend with program data, anecdotal reports and our review of the issue generally support the conclusion that some commercial plans are pulling out of the Medicaid market. Some plans have left the market entirely while others have left states that they view as unreliable business partners.

The Medicaid managed care market is still evolving. Overall, enrollment in full-risk managed care plans was about 25 percent of all Medicaid beneficiaries in 1996, up from about 5 percent in 1991. Between 1993 and 1996, the number of managed care plans serving Medicaid beneficiaries more than doubled, with the largest increase occurring in Medicaid-only plans (plans in which Medicaid beneficiaries comprise 90-100 percent of total enrollment). Medicaid-only plans include those established by public hospitals and other Federally Qualified Health Centers, as well as those that are subsidiaries of commercial plans, provider-sponsored plans, and new plans that have been specifically created to capture the Medicaid managed care market. According to a 1997 survey by the National Association of Public Hospitals, approximately three-fourths of the urban safety-net hospitals surveyed have formed their own health plans, primarily to serve the Medicaid population.

The number of commercial plans serving Medicaid also grew rapidly during this period, increasing from 102 plans in 1993 to 199 plans in 1996. Commercial health plans initially viewed the Medicaid market as a complementary line of business to their other commercial operations. Many chose to expand into this market at a time when plans were vigorously competing for overall market share.

More recently, however, some commercial plans have begun to question the financial advisability of continued participation in Medicaid. Commercial plans that have left Medicaid (entirely or in selected states) have cited concerns over low payment rates, high administrative burdens, and high

volatility in enrollment as reasons for their declining interest in Medicaid. Perhaps more importantly, the market analysts that follow these publicly traded HMOs have begun to raise questions about the potential risk to plan profits posed by Medicaid participation. The understanding appears to be growing among plans that the Medicaid market is very different from the commercial market and that participation in Medicaid requires significant investments in developing new systems and new provider relationships that may not be rewarded by the low payment rates available in many states.

The pattern of withdrawals varies across the country. In some states, commercial participation appears to be stable. In other states, large commercial plans (predominantly those that are publicly traded) are beginning to question whether their future participation in Medicaid is viable. Specific examples of withdrawals of commercial plans over the last two years have been identified in at least 11 states (California, Connecticut, Delaware, Florida, Georgia, Maryland, Massachusetts, Missouri, New Jersey, New York, and Ohio). Precise numbers are difficult to obtain because of mergers and consolidation in the managed care industry.

These withdrawals do not appear to be causing problems for access to managed-care coverage in most areas, although no systematic quantitative data have been collected to date. (In one state, Georgia, some managed-care enrollees will have to shift to fee-for-service Medicaid, at least temporarily.) Even as some large commercial plans leave the Medicaid managed care market, local health plans and plans serving primarily Medicaid beneficiaries are replacing them in most areas, and the overall number of these plans has been growing. Many of these plans have developed outreach programs, networks, and management systems that may be more appropriate for the Medicaid population and have shown a willingness to meet the special Medicaid requirements imposed in some states. The potential implications of the growing dominance of these Medicaid-only plans is discussed later in this memo.

Reasons for Decline in Commercial Plan Participation

Although the Medicaid population has health and behavioral characteristics distinct from the general population, many commercial HMOs believed they could provide coverage by expanding their existing business and building on their infrastructure and organizational systems. Rates would typically be set by the government rather than the market, but health plans believed that Medicaid was plagued by inefficient utilization patterns that, if corrected, would allow them to make a return on investment.

Large managed health plans withdrawing from the Medicaid market over the past year or two cite several reasons for their decisions:

- better understanding of the business;
- low capitation rates; and
- burdensome contract requirements.

Commercial health plans have learned that covering the Medicaid population is not simply an expansion of current business, but rather a new and different line of business. The health and

behavioral needs of the population and the nature of the program (e.g., monthly eligibility) require distinct systems to be successful. Participation in Medicaid often also requires health plans to form relationships with new groups of providers (including safety-net providers) that have traditionally served Medicaid patients. As a result, the cost of covering the Medicaid population can be much higher than many health plans had initially projected.

Many health plans contend that when states set capitation rates, they do not reflect costs or demand, (although they sometimes involve competitive bidding). Under federal law, capitation rates in the Medicaid managed care market cannot exceed the amount of money that would have been spent to provide a comprehensive benefit package in Medicaid fee-for-service (FFS). This constraint has two components, each of which may contribute to suppressing capitation rates. The first is the low reimbursement rates the Medicaid program has historically paid in FFS. A 1991 study by the Physician Payment Review Commission showed that average Medicaid physician fees were about 62 percent of Medicare's (which in turn were lower than those in the private sector). The second is any under-utilization of services in FFS, resulting from both low physician participation in Medicaid and the less organized system of care delivery characteristic of FFS medicine.

Over time, plans have perceived Medicaid capitation rate increases as inadequate. In fact, in about half the states where we have information, rates have been cut, in some instances up to 10 percent to 15 percent over several years. A number of health plans argue that capitation rates (or least the annual adjustments after rates are first calculated) are often arbitrary; they do not reflect an actuarial analysis of an organization's true costs of serving this population. A number of HMO officials and financial analysts view states' rate-setting procedures as primarily "political." Plans are doubtful of their ability to raise capital or to make an adequate return on their investment over the long run.

Health plans also perceive Medicaid contracting requirements as more onerous than those imposed by private employers and Medicare. As purchasers, Medicaid agencies are looking both to ensure access to the range of Medicaid benefits and to monitor quality. As states learn how to design comprehensive contracts, their contracts with health plans increasingly include provisions for services particularly relevant for the Medicaid population – such as screening for elevated lead levels, medical and mental health care for children in the child welfare and juvenile justice systems, and asthma management programs and assessment. In addition, Medicaid agencies purchasing a managed care benefit package seek to ensure that adequate, quality health care is delivered to beneficiaries through various reporting requirements such as: utilization/encounter data, including hospital inpatient days; quarterly quality assurance reports; and patient satisfaction surveys. While there is significant overlap in requirements between Medicaid and either Medicare or large employer health plan contracts, there are a number of provisions unique to Medicaid. Although these differences appear largely to be the result of Medicaid managed care contracts conforming to the Medicaid benefit package, health plans believe that some of the requirements are arbitrary or poorly thought out.

Most states' experience with Medicaid managed care is only a few years old. As a result, they are still learning, for example, what contract requirements are an effective means of ensuring quality or access. A recent foundation-funded study of contract requirements, along with growing experience

nationwide, has the potential to bring some stability. But in the meantime, the uncertainty plans often face in negotiations adds to the perception that states are inflexible business partners.

We should note that HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act. Whether commercial plans view these provisions as an added burden or as an impetus toward greater uniformity among states remains to be seen.

Medicaid's structure also creates challenges for health plans. The most frequently cited example is the "churning" in Medicaid enrollment, that is, beneficiaries cycling on and off Medicaid. Churning hinders health plans' ability to provide comprehensive care, particularly cost-effective preventive services such as prenatal care, as Medicaid beneficiaries may not be enrolled in a health plan for a sufficient period of time for outreach and managed care education to take place. For example, one plan recounted the experience of Medicaid beneficiaries enrolling in the seventh month of their pregnancy. This problem is partially addressed in the Balanced Budget Act through requirements for guaranteed eligibility. Another complexity is created in states where Medicaid contracts are written at the county level, generating additional management and reporting obligations for health plans. These structural challenges may contribute to the perception that Medicaid managed care is an arduous undertaking for commercial plans, particularly those with no previous Medicaid experience.

For all plans, there is a substantial investment associated with succeeding in Medicaid managed care (particularly if there is broad choice). Plans will not make that investment without reason to believe they will be able to form a long-term business relationship with a state. State practices that plans perceive to be arbitrary or political discourage that investment, particularly for commercial plans for which this population is not critical to their market share. Other practices that appear on their face to be reasonable also may discourage commercial plans, because they do not assure adequate return on investment. Examples of such state practices include permitting a large number of plans to compete in each area (which may lead to inadequate enrollment in any one plan), or establishing auto-assignment methods, used when beneficiaries fail to choose a plan, that favor certain plans (usually public plans operated by safety-net providers).

Policy Implications

States have two central and sometimes competing goals for Medicaid managed care. First, they are looking to control their costs, expecting that plans will use resources more wisely. Second, states may view managed care in Medicaid as a means of improving access, which may mean either more utilization or better providers. The second goal might be addressed in two different ways – by seeking to mainstream Medicaid beneficiaries and by requiring contracting plans to address the special needs of the Medicaid population and the unique benefits and other requirements of the program itself.

Recent experience in Medicaid, however, suggests that these goals are difficult to achieve simultaneously. For example, ensuring that payments to safety-net providers are sufficient to maintain their financial status sometimes conflicts with efforts to reduce costs. The withdrawal of

some commercial plans, if it continues, raises questions about whether Medicaid managed care can provide access to mainstream providers.

Mainstreaming as a Policy Goal

For years, a key debate in fee-for-service Medicaid has been whether beneficiaries have access to an adequate range of providers and, specifically, to the same providers that serve other Americans. Research suggests that so-called "Medicaid mills" have arguably contributed to poorer health outcomes.

This same issue now arises in Medicaid managed care. Some argue that having the same health plan card as anyone else can be empowering to the beneficiary and avoid the stigma of welfare status. The concern raised by reports of commercial plans leaving this market is that mainstream plans (particularly national plans) will not participate in Medicaid managed care unless conditions are favorable – thus jeopardizing the goal of mainstreaming.

At the same time, there is an issue of whether commercial plans, for which the Medicaid population is only one line of business, in fact make the same effort to serve the special needs of this population as plans created specifically to serve this population. In addition, there is evidence that some commercial plans essentially operate a separate, smaller provider network within their plans for Medicaid beneficiaries – achieving the goal of mainstreaming in name only.

The Role of Medicaid-Only Plans

Given the apparent trend toward more reliance on Medicaid-only plans, it is important to understand the ability of these plans to serve the Medicaid population. Even if withdrawals by commercial plans do not persist, changes made by the Balanced Budget Act (i.e., elimination of the need to get a waiver if less than 25 percent of a plan's enrollment is non-Medicaid) may accelerate the growth of Medicaid-only plans. Little research has been done to date on these plans, although some work has been funded by private foundations.

Medicaid-only plans may have particular strengths. They can be designed to meet the specific needs of Medicaid enrollees and, because of their focus on Medicaid, can develop particular expertise in diagnosing and treating conditions that disproportionately affect the Medicaid population. They also may be more likely to invest in enabling services, such as transportation and translation services, that assist Medicaid beneficiaries in obtaining needed services.

Furthermore, Medicaid-only plans are likely to be operated by or contract with the same providers that have traditionally served beneficiaries under fee-for-service Medicaid. In particular, they often collaborate actively with – or are owned or sponsored by – safety-net providers. In short, these providers are located in the communities where beneficiaries live and have the cultural competencies appropriate for this population.

There are questions, however, about the long-range viability of Medicaid-only plans, specifically about their ability to cope with the same low payment rates and regulatory requirements faced by

other plans. These plans lack the ability to cross-subsidize from other lines of business, creating a potentially greater risk of insolvency. Some of these organizations may survive only as a result of special protections – for example, special tax status, lower financial requirements, or government subsidies – that can avert insolvencies or their consequences.

Medicaid-only plans also face other challenges. Because they tend to be smaller than other plans, they have a harder time spreading fixed costs, such as the investment in information systems that are important for internal management, Medicaid reporting requirements, and performance measurement. Their smaller size may also make them more vulnerable to fluctuations in the Medicaid rolls. Because they are often newer entrants to the market, some may lack administrative or other needed expertise.

Conclusion

Although we cannot yet quantify the magnitude of the drop-off in commercial health plan participation in Medicaid, there are certainly growing numbers of plans choosing not to participate in selected geographical areas. This trend may not affect significant numbers of Medicaid managed care enrollees, either because these plans have low enrollment or because other managed care options are available to affected beneficiaries. However, as the interest of commercial plans in Medicaid wanes, the prospects of using managed care to mainstream Medicaid beneficiaries clearly become more limited. Whether or not the Medicaid population can be better served by Medicaid-only plans is a question that remains to be answered.

Regardless of the type of plan, payment rates based on historically low fee-for-service payment may not provide adequate flexibility to improve access in ways that proponents of Medicaid managed care have envisioned. Ideally, additional services can be financed by savings due to greater efficiency and avoidance of unnecessary services, such as costly emergency room care. Whether this can be accomplished in practice is uncertain given the historical access deficiencies of Medicaid. These issues will become even more difficult as greater numbers of more costly populations (i.e., the disabled and the elderly) join Medicaid managed care. Further study of capitation rates (both methodologies and levels) will be important.

Viewed against the backdrop of all the concerns outlined here, the significant adjustments to managed care models that health plans are compelled to make to meet Medicaid program requirements and beneficiary needs must be recognized. HCFA will soon be promulgating a proposed rule to implement additional consumer protections, quality assurance standards, and other regulatory requirements stemming from the Balanced Budget Act, which may add to the administrative burden for health plans. This rule will amplify the difficult tradeoffs between the goals of assuring quality and protecting rights of beneficiaries on the one hand, and the objective of ensuring broad plan participation and choice on the other.

The Department will continue to analyze these issues further to ensure that decisions made by commercial health plans do not have an adverse impact on access to health care for Medicaid beneficiaries. One component of this effort will be increased surveillance, including factors such as what types of plans are participating, how much choice is available, and how these patterns vary by

state and market area. A second component will be research on some of the underlying issues discussed in this memo (e.g., plan capitation payments and the characteristics of Medicaid-only plans). Finally, additional consideration will be given to the overall goals of the Medicaid program and Medicaid managed care initiatives in particular, with attention to the tradeoffs between improving access, assuring quality, and saving money.

Donna E. Shalala