DEVELOPMENTS IN MEDICAID MANAGED CARE

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Some of the most important developments in the health care system are occurring in the Medicaid program. Medicaid has a natural engine for innovation since it is administered by the states, each of which has developed its Medicaid program in distinctive ways and has the power and resources of a large purchaser. The population covered by Medicaid—low income and disabled adults and children—presents many challenges; in many ways, these individuals seem perfect candidates for managed care programs that provide a point of entry, coordination of services, and a locus of accountability. Almost all states have tried some version of managed care under federally approved waivers of the ordinary rules of the Medicaid program.

The challenges and opportunities resulting from the state-by-state nature of the Medicaid program provide one of the themes for this special section of the *Journal of Urban Health*. Medicaid operates in real time with real constraints, and states improvise their own solutions to the program's countless problems of design and administration. Yet, neither they nor the policy research community are well situated to draw lessons from their experiences. Sophisticated case studies, such as the paper of Gold and colleagues about Maryland and the safety net in this issue, are invaluable. Brodsky and Baron describe an innovative program at the Center for Health Care Strategies to enable states to learn from the experiences of each other. Somers and associates, whose work has made them familiar with developments in virtually all states, provide a broad synthesis regarding developments across the country.

Questions regarding cost and quality provide the other theme for this issue.

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The motives of states in moving to managed care are often mixed. Is the goal to improve access to care and accountability for the receipt of appropriate services? Or is it cost containment or even cost reduction, a goal that is implied by the common practice of setting rates for Medicaid health plans at less than (typically 95%) pre-managed care costs, even while expecting improved access to and utilization of services? Although goals of cost containment and quality improvement are not incompatible, it is also true that rates set too low are incompatible with good managed care and/or plan survival.

Two of the papers that follow shed light on various aspects of the cost/quality issue. Cebul and colleagues report on what happens to utilization and costs when the disabled SSI (Supplemental Security Income) population comes under Medicaid managed care. Billings and colleagues examine whether plans in New York benefit from favorable selection, enrolling a disproportionately healthy share of the population while receiving payment rates based on the past utilization experience of the whole population. Such a pattern would mean that the care-improvement aspects of managed care are not occurring for the most needy beneficiaries, and that the total cost of Medicaid would be increased, not decreased, by managed care.

The papers in this issue make clear that cost containment is not the only concern of those who design and administer Medicaid managed care programs. Four papers are concerned with aspects of the quality assurance and monitoring process. Felt-Lisk provides a comprehensive overview of quality monitoring in Medicaid managed care, and the previously mentioned paper by Brodsky and Baron on best practices also deals with quality concerns. The paper by Roohan and colleagues presents an innovative use of New York's Quality Assurance Reporting Requirements (QARR) data to access an important aspect of Medicaid managed care: Has the withdrawal of some plans from the Medicaid managed care program left the market to the poorest performing plans, or do the plan withdrawals improve the average performance level of the Medicaid managed care plans? Many of the plans that withdrew from Medicaid in New York State in recent years were commercial plans that had deep pockets and the ability to translate experience from other states and markets where they operate, and the plans that remained tended to be the home-grown plans sponsored by provider organizations. So, it was not obvious what the effects of market exiting might have been. Roohan et al. provide an answer. The paper by Fairbrother and colleagues reminds us that quality and quality reporting in Medicaid managed care are not just matters of states issuing regulations and health plans complying.

The plans, after all, do not provide the services directly to beneficiaries. They contract with provider organizations and individual providers, and the ability of plans to affect the care that beneficiaries receive depends on their success in dealing with some complex problems of interorganizational relations. The organizational element is often overlooked in discussions of quality monitoring and improvement in managed care in Medicaid and in general.

A third concern in Medicaid managed care—in addition to cost and quality—is the impact on the provider organizations that have been serving low-income populations and that have depended on the Medicaid fee-for-service program for a major share of their revenues. My colleagues and I have been studying one response of these providers—the invention of their own Medicaid managed care plans.^{1,2} The paper of Gold and colleagues in this issue reports on the effort of Maryland to protect the safety net providers in the context of the move of that state to Medicaid managed care.

The papers assembled here provide a good representation of the major themes of current research on Medicaid managed care: learning from the experiences of the states, understanding impacts on beneficiaries, and using regulation to mitigate the dangers and enhance the benefits of Medicaid managed care. This issue also includes three broad overviews that are very useful for such a complex program as Medicaid, with its state-to-state variability. Felt-Lisk's overview of quality is one such review. Somers and colleagues offer an overview of broad trends in Medicaid managed care nationally, emphasizing the search for value and the evolution toward partnership arrangements between states and plans. Finally, we offer a historic overview of the first 15 years of Medicaid in a standard feature of the *Journal*, the "classic" paper. Lewis, who was present at the creation of Medicaid, reflected on the evolution of the program in a 1983 conference at the Academy.

It has been a privilege to serve as guest editor of this issue and to work with many of the best researchers in the field. I am grateful to everyone who responded so positively to my inquiries regarding who was doing interesting and important work. I thank the researchers who contributed papers and also the 16 people who served as peer reviewers and whose suggestions resulted in improvements in all of the papers. They are acknowledged at the end of this issue.

The overall sense one gets from this set of papers is optimism in the face of difficult challenges rooted in the difficulty of doing managed care well, tensions associated with the goals of Medicaid managed care, and the politics of social welfare programs in the US. Notwithstanding the "muddling through" nature

of our policy-making process, important lessons are being learned from the experiences of our many states with managed care for the Medicaid population.

REFERENCES

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