STAYING THE COURSE: PURSUING VALUE IN THE MEDICAID MANAGED CARE ERA AND BEYOND

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INTRODUCTION

Medicaid, in the decade just completed, underwent a transformation that ranged in its implementation from blindingly swift to almost gently subtle. In 1992, there were 2 million Medicaid beneficiaries in managed care; less than 10 years later, we would probably see 20 million enrollees in managed care but for the precipitous decline in the overall number of Medicaid beneficiaries due to a strong economy and the states' somewhat uneven implementation of welfare reform.

States have transformed Medicaid as we knew it. Unmanaged fee-for-service Medicaid is a shadow of its former self, quietly receding from the scene except in the more remote rural regions or for special needs populations that are more difficult to serve, such as people with severe physical disabilities or rare and expensive diseases. The question now is, After all the early "stürm und drang" associated with its implementation, is managed care itself going to recede slowly from the Medicaid scene? It certainly seems to be under considerable pressure in other quarters, most notably Medicare. If this is so, what will be left?

If Medicaid managed care were an experiment conducted in a petri dish, would we be looking for further mutations of this particular species? This paper examines the notion that the current mix of historical, economic, and political conditions is conducive to the emergence of new forms of more politically viable managed care, which we loosely label "recombinant health maintenance organi-

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zations (HMOs).” While Medicaid beneficiaries are unlikely to generate the levels of political backlash against managed care seen among Medicare and commercial populations, various other issues, including combinations of marketplace dynamics, enrollment declines, and pressures from the community with disabilities, will generate changes in Medicaid managed care as we have come to know it.

MEDICAID: ON THE ROAD TO MANAGED CARE

The states that initially pursued managed care did so as a means of increasing access to care for Medicaid enrollees. But, in the early 1990s, cost control became a major driver for its expansion. While implementing managed care programs over the past decade, states have found that these programs also offered opportunities for improved access and quality of care and greater accountability. Although each state context is different, many states have found that managed care can

- Increase access of beneficiaries to providers and offer the beneficiaries greater choice.
- Create medical homes for Medicaid beneficiaries; reduce the inappropriate use of services, such as emergency and inpatient services; and increase primary and preventive care, such as prenatal care and more aggressive asthma care management.
- Integrate care for persons with chronic illnesses and disabilities by managing individual high-cost cases and coordinating care across medical and social needs.
- Introduce major improvements in the abilities of the states to measure outcomes and to provide accountability. Under managed care, states have access to more and better information about the care of their beneficiaries than under a fee-for-service system.

Medicaid has been evolving since its implementation in the late 1960s, beginning as a totally fee-for-service enterprise. Real experimentation with managed care did not begin until the early 1980s. Arizona refused to participate in Medicaid for its first decade, but ironically became the true pioneer of Medicaid managed care when it implemented a statewide managed care program in 1982. Arizona faced fewer obstacles than other states because it did not have the traditional Medicaid fee-for-service program to overcome. In the mid-1980s, other states also began to experiment with Primary Care Case Management (PCCM) models, in which a physician was paid a fixed case management fee per member

per month to coordinate care and manage utilization of services. PCCM programs helped reinforce the concept of creating a medical home for Medicaid recipients.

Enrollment, expenditures, and managed care organization participation grew precipitously during the period 1992 to 1996 (Fig. 1). Propelled in part by a 24% increase in Medicaid enrollment in a 2-year period (from 24 million beneficiaries in 1990 to almost 30 million by 1992), Medicaid expenditures grew from \$70.5 billion in 1990 to \$115 billion in 1992. This was a 63% increase over 2 years, and Medicaid began to look like a budget buster in many states. Because it was an entitlement, it was also viewed as largely uncontrollable. Having gone as far as possible to generate federal matching funds through aggressive Medicaid maximization strategies, states needed another answer.

Managed care entered as the potential mechanism to control growing costs. Enrollment in Medicaid managed care grew from 12% of total Medicaid enrollment in 1992 to roughly 50% in 1999. At the same time, the number of managed care organizations entering the Medicaid market rose from approximately 100 plans in 1992 to 225 in 1996 (Fig. 2). Growth in plan participation occurred predominantly among plans owned by publicly traded companies and other proprietary organizations, which had convinced themselves that they could profit handsomely from the huge number of potential "lives" in Medicaid in spite of capitation rates based on low fee-for-service Medicaid reimbursements.

FIGURE 1 Medicaid managed care enrollment.

FIGURE 2 Managed care organizations: participation in Medicaid 1991–1996.

The years after 1996 can be seen as the period after the gold rush. Health plans faced slower growth in premiums coupled with increased medical and administrative expenditures, resulting in lower overall profit margins. One study of 15 states with the largest number of Medicaid enrollees showed that commercial managed care organizations (health plans with less than 75% Medicaid enrollment) withdrew from the Medicaid market more often and entered less frequently in 1997 and 1998 compared with previous years.¹ Although withdrawals were not consistent across states, the impact had a dampening effect on Medicaid managed care nationally and created a sense that the peak of Medicaid managed care as a sound or profitable business proposition had come and gone.

Plans exited the Medicaid managed care market during this period because of a complex array of factors. Perceptions about the adequacy of the capitation rates were cited as one reason that health plans left the Medicaid market. However, other concerns about the overall design of the state's Medicaid managed care program, including program approach, implementation schedules, and larger market forces also contributed to the decisions of health plans to leave.²

Now, after the gold rush, many states are faced with a declining number and variety of managed care organizations with which to contract. Some states have had to limit planned expansions in their managed care programs. The impact of health plan withdrawals has taught states to be more prepared for an ever-changing marketplace. Based on their purchasing experiences, states are learning

to become more aggressive about managing the marketplaces in their own states. States have become better marketplace managers by analyzing market needs, creating incentives for new plans to enter the market, rewarding long-term health plan partners, or pushing for the use of alternatives to HMOs, like provider-sponsored organizations or disease management contracts.

The early impetus for the major expansion in Medicaid managed care may have come from the bottom line in the early 1990s—the need to control cost. However, in the more recent period of national economic prosperity, relatively stable medical costs, and declining Medicaid enrollment, states have continued to pursue managed care. Why? Because managed care is beginning to show results in improving access and quality of care. Further, it is providing accountability in a publicly financed system that previously had little, if any, way to measure its effectiveness.

The National Committee for Quality Assurance (NCQA) releases a Quality Compass report each year that reviews health plan performance across the country. In 1999, the Quality Compass report showed that health plans that publicly reported performance information had higher quality performance than those that did not. The National Committee for Quality Assurance concluded from this finding that “accountability drives quality.”³ Many states are becoming more aggressive about disclosing information on health plan performance to their beneficiaries. Only 22% of private employers provide health plan performance information to their employees.⁴ States are doing better. States are publishing information on health plan performance (including Health Plan Employer Data and Information [HEDIS] results), member satisfaction surveys, provider satisfaction surveys, and audit results. As they become more experienced with their Medicaid managed care programs, states are becoming purchasing leaders and are promoting innovations and accountability in the process. One reason states are more aggressive about disclosing information to consumers is that Medicaid consumers often have more health plan choices than commercial employees. As such, the need for comparative health plan information may be more acute and more useful in regard to Medicaid than in the private sector. States are rising to this challenge.

Implementing managed care within the “public fishbowl” of Medicaid is more challenging than is the case in the commercial sector. Governors, state legislators, safety-net providers, and consumer advocates all have strongly held views and expectations about managed care. Fortunately, the federal government, private foundations, and states themselves are creating mechanisms by which they can learn from each other or from the experiences in the private sector.

BACKGROUND: EXTERNAL EFFORTS TO ASSESS AND PROMOTE IMPROVEMENTS IN MEDICAID MANAGED CARE

In their landmark study on state Medicaid contracting with managed care organizations, Professor Sara Rosenbaum of George Washington University (Washington, DC) and colleagues characterized the shift from fee-for-service care to managed care as one of the most significant recent transformations in the US health care system.⁵ The tremendous variability of state goals, expectations, and capacity in the Medicaid arena led several nongovernmental funders with long-standing interest in health care issues for low-income and special needs populations to invest heavily in efforts to track, assess, and then promote improvements in the transformation. For example,

- The Kaiser Family Foundation and the Commonwealth Fund⁶ underwrote a series of early evaluations of Medicaid managed care in states like Tennessee, California, and Maryland, which parallel more intensive evaluations being underwritten by the Health Care Financing Administration.*
- Several major funders enabled the National Academy for State Health Policy to undertake a series of state surveys beginning in the mid-1990s to track the growth in managed care and changes in state purchasing strategies.⁷
- In 1995, the Robert Wood Johnson Foundation established the Medicaid Managed Care Program (MMCP), a multimillion dollar national program specifically designed to complement these tracking, evaluation, and policy analysis efforts by supporting operationally oriented training, technical assistance, and demonstration projects for states and health plans. The Center for Health Care Strategies (CHCS), which directs MMCP, placed early emphasis on quick turnaround studies of emerging policy issues.

Through such activities as supporting quick turnaround studies of emerging policy issues, identifying and shaping innovative purchasing practice, and investing in new models of managed care for special needs populations, CHCS has gained a window on many of the leading trends in state purchasing of Medicaid managed care.

PARTNERSHIP PAYS

As state purchasers place greater emphasis on quality, they are realizing that partnership pays. While early state Medicaid managed care contracts assumed

*After approval of initial Section 1115 Medicaid waivers in these states, the Health Care Financing Administration evaluated the effectiveness of these programs. These evaluations focused on whether managed care had improved quality and access of care while remaining budget neutral. For those states with eligibility expansions, the evaluations also focused on whether the state expanded Medicaid coverage with savings from managed care implementation.

a regulator/regulated relationship with contracting health plans, many states now work more cooperatively with their health plan partners and consumer advocates on joint quality improvement projects. For example, through the Healthier Babies project, Health Partners, Incorporated, a Medicaid HMO in Philadelphia, Pennsylvania, led an initiative in which competing health plans in the five-county Philadelphia area serving more than 500,000 beneficiaries created a common birth registry database.* The health plans also partnered with Pennsylvania's Departments of Public Welfare and Health, which agreed to make the state birth registry database available in electronic format. The purpose of this database is to centralize and link relevant prenatal and perinatal process and outcomes data so that the health plans can track the care provided to high-risk mothers and infants throughout the respective delivery networks. The plans now are using the data to improve outreach efforts and prenatal services.

In their research on safety-net health plans, Gray and Rowe,⁸ at the New York Academy of Medicine, found that many health plans sponsored by safety net organizations are struggling financially to serve low-income populations. As part of their research, health plans were asked what purchaser policies are most helpful to them. The health plans surveyed indicated that membership continuity is one of the important issues amenable to purchaser action. Policies that help membership continuity include eligibility "lock-ins," which allow members to keep their Medicaid benefits for a specified period of time, and autoassignment policies, which automatically give health plans a certain percentage of Medicaid members who do not choose a health plan. These policies help health plans control fluctuations in membership by ensuring that existing members retain their Medicaid eligibility and that new members will be assigned to plans fairly and consistently.⁸ Purchasers seeking to build long-term relationships with health plans should consider these policies that help health plans improve continuity in plan enrollment.

INEVITABILITY OF MEDICAID MANAGED CARE FOR PEOPLE WITH DISABILITIES ON SUPPLEMENTAL SECURITY INCOME

State purchasers are approaching the inevitability of Medicaid managed care for people with disabilities on Supplemental Security Income (SSI) with due deliberate speed amid fits and starts. Efforts to enroll people with disabilities into managed care have met with mixed success. Both Washington and Iowa have abandoned managed care initiatives for people with disabilities. Washington

*For more information, contact Healthier Babies, Inc., in care of Philadelphia Health Management Corporation, (215) 991-4005.

was forced to retreat from its program to enroll the Supplemental Security Income population after health plans refused to sign contracts, in large part because of significant financial losses sustained during the pilot phase of the project.⁹ Iowa recently abandoned its effort to enroll children and others with special needs into managed care because it was unable to attract significant health plan interest. Medicaid beneficiaries with complex health care needs are often in need of services that do not fall within the scope of traditional managed care, such as treatment for developmental disabilities and coordination with other publicly funded social service agencies, such as those dealing with mental health or special education. These services can be costly and administratively burdensome, and the health plans were not confident sufficiently that the rates being offered would cover all the costs associated with caring for these populations with more complicated issues.

However, other states have been more successful in implementing Medicaid managed care programs for special needs populations. With MMCP funding, Tennessee's Centers of Excellence for HIV/AIDS care have improved the delivery of care significantly for all Tennessee residents who are HIV+.¹⁰ The Centers of Excellence have developed clinical protocols, criteria for designation as an AIDS provider, and accessible, expert provider networks with which all TennCare health plans must contract. This approach is a potential model for other states that hope to improve quality of care for beneficiaries with HIV/AIDS and other chronic disabilities.

Missouri is working with a care management organization to implement a managed care model for children with serious behavioral health needs who are in, or at risk of being in, state custody.* Enrollment in pilot sites began in early 1999 and is expected to reach up to 1,000 children. The state intends to compare functional outcomes of children in the pilot program with outcomes of children in the traditional fee-for-service system.

These projects should add considerably to the growing reservoir of best practices expertise across the country in how to provide managed care for people with special health care needs. Specific best practices to note from these grants

*A care management organization (CMO) coordinates comprehensive care for individuals with complex medical and/or social service needs. CMOs generally do not have the insurance functions of typical health plans, but usually have a contractual relationship with traditional health plans. CMOs focus exclusively on improving care for individual clients by designing treatment plans, coordinating with multiple providers, and acting as the client's advocate to improve care delivery. For more information, contact Keith Krueger, Ph.D., at (573) 751-8215.

are the involvement of consumers in the planning process and the integration of care and financing streams for people dependent on multiple public programs. We believe that most states eventually will follow the lead of Arizona, Tennessee, Pennsylvania, Missouri, Oregon, Maryland, and others in extending managed care techniques into acute care for the disabled and, ultimately, long-term care for Medicaid beneficiaries in need of those services.

**STATE PURCHASER ADJUSTMENT TO AND SHAPING OF
THE MEDICAID MANAGED CARE MARKETPLACE**

State purchasers are adjusting to and, indeed, beginning to shape the Medicaid managed care marketplace. Faced with growing uncertainty about the willingness of health plans to participate in Medicaid managed care, states also are experimenting with models of managed care that fall on a continuum somewhere between traditional fee-for-service medicine and full-risk capitation. Strategies being considered by states include

- Enhanced primary care case management models, in which a provider is given a larger monthly case management fee than in the traditional PCCM model to ensure that greater attention is paid to both prevention and continuity of care.
- Provider service organizations (PSOs), in which risk is accepted by a provider or a group of providers; these organizations operate similar to health plans, but may not be licensed as health plans by the state.
- Chronic disease management (CDM), in which a state targets specific high-cost/high-volume diseases (e.g., HIV/AIDS, heart failure, high-risk pregnancy) and contracts with vendors to design specific treatment programs for enrollees with these conditions.

While some have viewed many of the original PCCM programs as “managed care light,” other states are beginning to use enhanced versions as viable alternatives in markets in which plans are unwilling or unable to take on significant risk for populations scattered across rural areas or with complex care needs.

North Carolina has developed an enhanced PCCM program. Its initial PCCM program, Access I, has existed since 1991. In recent years, the state launched two new complementary programs, Access II and III, which are enhancing services provided to Medicaid beneficiaries in the PCCM program. Additional services to enrollees in these programs include health risk assessment screenings, case management of high-risk enrollees, care coordination with enrollee participating

primary care providers, and identification of enrollees eligible for disease management programs.*

Another option states have for purchasing care for Medicaid beneficiaries is to contract with PSOs. Generally, PSOs that contract directly with Medicaid are plans affiliated with hospitals and/or health centers based on safety nets. PSOs sometimes may not be licensed fully as HMOs, yet function much like HMOs.† They receive capitated payments from the state, perform health risk assessment of members, provide case management services, contract with providers, and are subject to similar reporting requirements, eligibility rules, and enrollment guidelines as HMOs. Some purchasers have encouraged the formation of PSOs by offering enhanced capitation payments to safety-net providers, while others have agreed to contract with non-HMO licensed PSOs, thus enabling the PSO to avoid the costly, time-consuming licensure process.¹¹

Florida has implemented a CDM model for Medicaid beneficiaries served in its PCCM program. This statewide pilot project is a two-phase, 3-year program. In the first phase, CDM vendors will provide case management and care coordination for Medicaid beneficiaries with HIV/AIDS, diabetes, hemophilia, or asthma. The state expects that, in addition to improving care for beneficiaries with these conditions, the amount spent on case management fees plus current medical expenditures will be less than medical expenditures under the PCCM model prior to CDM.¹²

THE FUTURE OF MEDICAID MANAGED CARE: REACTIVE OR PROACTIVE RESPONSES?

Purchasers of Medicaid managed care will continue to face many challenges due to developments in the general marketplace and within Medicaid in particular. Medicaid purchasers are becoming increasingly adept at designing and building their permutations of managed care to meet their goals for access, cost, and quality. Indeed, some state Medicaid agencies are beginning to behave more like innovative private purchasers by creating new administrative and risk arrangements with providers and health plans. Medicaid purchasers lack the significant tool of beneficiary cost-participation, yet their leadership is not so surprising

*For more information, contact the North Carolina Foundation for Advanced Health Programs, Inc., at (919) 821-0485.

†The main differences between PSOs and HMOs are that PSOs are not required to have the same level of insurance risk reserves and do not have to go through the HMO licensure process. This allows many provider organizations to accept risk for their Medicaid enrollees without having to meet the same levels of insurance risk reserves and HMO licensure procedures as traditional HMOs.

when one considers that state Medicaid agencies are often (1) the biggest single purchaser in many regions and (2) the most experienced purchaser of fully capitated managed care. Sophisticated state purchasers already are well ahead of most private purchasers in terms of using data for accountability purposes in managing contracts, setting rates, and assessing quality.¹³

When it comes to purchasing managed care for populations with chronic illnesses and disabilities, Medicaid is almost by definition ahead of the pack. The most widely cited model for special needs plans across the country, the Community Medical Alliance (now part of Neighborhood Health Plan/Harvard Pilgrim Health Care in Boston, MA) was built essentially under the watchful auspices of the Massachusetts Medicaid agency.¹⁴ Massachusetts Medicaid provided Community Medical Alliance with extensive care and feeding via technical assistance. It also protected the entity through narrow risk corridors that limited the amount of loss (or profit) the plan could experience during any payment period. Massachusetts is also upgrading its PCCM program so that the state itself becomes, in effect, a managed care organization, contracting out for various administrative and clinical services, while closely monitoring provider networks, performance, and consumer satisfaction.

According to a recent report for CHCS by Health Management Associates, a number of other states are pursuing a "build your own" approach to PCCM.¹⁵ As indicated above, North Carolina and Florida are developing forms of PCCM that go well beyond simple utilization management by primary care providers paid \$2 to \$3 per member per month. The disease management organizations in Florida are variations on the theme of case management focused on care enrollees with high-cost/high-volume illnesses. States with extensive managed care experience, such as Arizona, are watching these developments closely. Part of being an effective purchaser is having contingency plans in place in case health plans threaten to exit the market, as has occurred recently in Ohio, Massachusetts, and other states.

ENVISIONING AND SHAPING THE NEXT GENERATION

Medicaid managed care will face some of the same challenges besetting Medicare and private purchasers of managed care. Buyers who want to sustain a managed care strategy because they have concluded that it can yield improved value will have to adapt to marketplace changes and be innovative in bolstering the participation of managed care organizations that are meeting the needs of beneficiaries. States can enter partnerships with plans they want to keep in the market by ensuring a sufficient number of beneficiaries and rewarding good performance. In

some regions or for some populations, states need to be prepared to implement other integrated care options if such plans are not present or they cannot be kept engaged in Medicaid.

**FEATURES OF MEDICAID AND STATE CHILDREN'S
HEALTH INSURANCE PROGRAM MANAGED CARE
ORGANIZATIONS IN THE FUTURE**

What will the integrated models of Medicaid and State Children's Health Insurance Program (SCHIP) managed care organizations look like? Are they indeed "recombinant HMOs"? What will states have to do to spawn and nurture their development? While some noteworthy prototypes of these new forms of Medicaid managed care have been developed on a pilot or demonstration basis, as a starting point, it may be easier to visualize these entities as having certain features or attributes, including

- Stable, committed sponsorship responsive to beneficiary needs
- Flexible financing and delivery systems that integrate services through blending of funding and/or placing a premium on care coordination
- Capacity to develop and to accommodate innovation

Stable and committed sponsorship Many state agencies are worried about the staying power of commercial HMOs in Medicaid. States also have found many HMOs unwilling to make some of the changes needed to serve populations that differ from their commercial members. Some plans have been reluctant to make administrative accommodations needed to respond to Medicaid-specific purchasing demands.

At the same time, however, many states that believe in the goal of gaining access to *mainstream* plans for their beneficiaries are not yet ready to give up and to rely solely on predominantly Medicaid-only plans. They continue to look for plans that will make a long-term commitment to Medicaid and SCHIP beneficiaries. Some states are prepared to reduce the number of contractors to ensure that remaining plans gain sufficient volume. Provider-sponsored plans, especially those of hospitals, have proven to be relatively unstable—both for Medicaid and other markets—so states are limited in the options they can pursue.

If they cannot find and buy these managed care services from established organizations with a commitment to serving publicly financed populations, states will have little recourse but to create new models or stimulate the development of new configurations of providers to fill this void. Whether this means eschewing the goal of mainstreaming remains to be seen since states may be able to dovetail their strategies with some private purchasers who are going to be engaged in

similar initiatives. For example, through the Buyers Health Care Action Group in Minnesota, self-insured employers have crafted a direct contracting model with groups of providers (called "care systems") that is a general alternative to HMOs in that market.¹⁶ A number of other business coalitions currently are planning similar ventures.

Flexible financing and delivery systems On the one hand, confidence in full-risk capitation has diminished in recent years due both to concerns about perverse incentives for providers and to the desire of purchasers to buy certain administrative functions or services from entities outside the prepaid health plans. On the other hand, risk-based systems remain attractive because of the ability for buyers to shift risk and the incentives for prevention, primary care, care coordination, and more cost-conscious care delivery. States and their contractors probably will continue to develop models that forego or limit risk (e.g., stop-loss provisions or shared savings models), better adjust for it (risk adjustment methods), or tie bonus incentives directly to performance measures. Established health plans may profess some difficulty in accommodating these arrangements, but many of them currently have administrative services only (ASO) contracts with self-insured private employers that have similar financing flexibility. If health plans cannot meet state needs, other arrangements built around providers or combinations of providers and third-party administrators or network managers may emerge. Administrative services only arrangements seem to be growing in popularity within the behavioral managed care arena.

Flexibility in service delivery entails the capacity to meet both generic and specialized needs of beneficiaries. This may mean full-service plans with special subnetworks for special populations, just as some plans now use centers of excellence for specialized high-cost/high-intensity services. The subnetworks may complement or be the source of targeted disease management programs.

Again, if existing health plans are unresponsive, states may seek customized delivery systems by increasing the capacity of existing health care providers to incorporate desired components of quality care delivery. In many respects, state Medicaid agencies could be creating models that have many elements commonly found in established HMOs, but these "recombinant HMOs" presumably will be able to respond to specific requirements and expectations of their Medicaid developers. It is also likely that experimentation with special need plans will continue on a parallel track, though such plans almost certainly will not be full-risk ones given their inability to achieve economies of scale and scope due to the small sizes of the populations to be served.

Capacity to develop and accommodate innovation A hallmark of the next generation of managed care organizations will be their capacity to import and exploit new innovations in pharmaceutical products, medical devices, and eventually gene therapy, as well as many new developments in administrative technology. The cumbersome and often friction-ridden relationships that currently exist between health plans and providers already are proving to be impediments because of the failure of both parties to align their incentives satisfactorily. These tensions are exacerbated if payment rates are not adequate and if there simply is not enough money to satisfy either party. But, new technologies that can improve clinical outcomes for beneficiaries and potentially save money for purchasers and health plans may not be adopted if a suitable "platform" cannot be developed from which to launch them. CDM programs already are bumping into impediments in this realm. Likewise, Medicaid and SCHIP plans serve a membership that turns over frequently, primarily because of changes in eligibility. These plans are likely to have difficulties justifying investment in some of the new drug products and other interventions when the impact of these services may not be repaid for several years—long after Medicaid and SCHIP beneficiaries may have left plans. Given expectations that the next generation of managed care models will have to serve special need populations, these types of problems have to be considered as these new delivery systems are developed.

**FEATURES OF SUCCESSFUL MEDICAID AND STATE
CHILDREN'S HEALTH INSURANCE PROGRAM MANAGED CARE
PURCHASING IN THE FUTURE**

For managed care organizations with these desired attributes to arise, participate, and remain in Medicaid, states will have to think and act like enlightened, value-based purchasers and display the following characteristics:

- Commitment to adequate financing and performance-based monitoring
- Willingness to give contractors flexibility and discretion to be innovative
- Belief in promoting a spirit of long-term partnership with contractors

Commitment to adequate financing and performance-based monitoring Disputes over rate adequacy have plagued current and past generations of capitated Medicaid managed care and will not disappear in the future. However, there does seem to be a stronger appreciation for the fact that Medicaid programs cannot expect health plans to subsidize their Medicaid product with profits from other lines of business as long as plan participation is voluntary.

In addition, states have more reasonable expectations about the savings they can expect with managed care initiatives—savings that, unfortunately, have

diminished as the costs of health plans have increased in recent years. But, the differences between states like Arizona and Wisconsin that have demonstrated their willingness to maintain reasonable rates and states that have not are stark. Full-risk programs in states without adequate rates are in serious jeopardy and are unlikely to survive in the long term. These states will have to redesign their managed care models or return to less-effective fee-for-service approaches.

A critical feature of states that have committed to sustaining adequate rates seems to be a corresponding investment in gathering performance-based data to assess the value of the products they are purchasing. Presumably, if states decide they are not getting value in their full-risk programs or if they find they are still paying more for the program than they can afford, they will want to build performance-based monitoring into their next generation of programs. PCCM programs can support at least some measure of performance data collection and oversight, as can disease management or case management programs. However, such a commitment by states should rule out a complete return to traditional fee-for-service systems because of its notorious deficiency in assigning accountability and measuring performance.

Willingness to give contractors flexibility and discretion to be innovative The heightened attention to the contract between state agencies and health plans has been a mixed blessing. It has produced more accountability and made purchaser expectations and performance standards far more explicit. However, it also has taken on a role of a catchall document that has led many states to overload responsibilities out of proportion with payments or to attempt to remedy years of shortcomings in the Medicaid fee-for-service program by demanding that plans fix these problems immediately. The next generation of programs definitely will need strong, enforceable contracts that articulate responsibility clearly, irrespective of with whom states are contracting. It will be essential for the contracts not to be so demanding or overly prescriptive to deprive plan and model sponsors of the flexibility to maneuver in a turbulent marketplace or to develop new, nontraditional programs and initiatives to serve beneficiaries. If states have to customize their delivery systems more extensively in the future, they may use contracts that are more organic and adaptable.

Belief in promoting the spirit of long-term partnership with contractors One clear lesson gleaned from states that have had mature, successful managed care programs is that they have long time horizons with health plans. They see them as their strategic partners to craft programs jointly that will meet the needs of their beneficiaries better than an unmanaged fee-for-service model. They have few

illusions that health plans can work wonders in the short term in terms of either changing patterns of delivery and use or affecting outcomes. These states also understand that, to encourage contractors to be creative, and even to fail at times, there must be a modicum of trust between both parties. They see managed care initiatives as engaged in sustained re-education and redesign that ultimately can provide both the methods to improve care and the metrics to measure this improvement. They genuinely appear to be prepared to walk the talk of continuous quality improvement—a process that is fundamentally a collaborative one among purchasers, plans, providers, and the people they all serve.

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