COMMERCIAL MANAGED CARE PLANS LEAVING THE MEDICAID MANAGED CARE PROGRAM IN NEW YORK STATE: IMPACT ON QUALITY AND ACCESS

PATRICK J. ROOHAN, MS, MARY BETH CONROY, MPH,
JOSEPH P. ANARELLA, MPH, JACQUELINE M. BUTCH, MBA,
AND FOSTER C. GESTEN, MD

ABSTRACT

To develop sufficient managed care capacity to accomplish the goal of transitioning Medicaid recipients into managed care, state policymakers have relied on commercial health maintenance organizations to open their panels of providers to the Medicaid population. However, while commercial health maintenance organization involvement in Medicaid managed care was high initially, since 1996 New York State has had 14 commercial plans leave the New York State Medicaid Managed Care Program. It has been speculated that the exodus of these commercial plans would have a negative impact on Medicaid enrollees' access and quality of care. This paper attempts to evaluate the impact of this departure from the perspective of quality and access measures and plan audit performance. Univariate and multivariate analyses were performed to evaluate the effect of commercial managed care plans leaving the Medicaid program. The overall performance of plans that remained in the program was compared to that of the plans that chose to leave for the two time periods 1996–1997 and 1998–2000. Access to care, quality of care, and annual audit performance data were analyzed. The departure of commercial health plans from the New York State Medicaid Managed Care Program has not had a statistically significant negative effect on the quality of care provided to Medicaid recipients as evaluated by standardized performance measures. In addition, there were no instances when there was a negative impact of the exit of the commercial plans on access to care. Managed care plans that chose to remain in Medicaid passed the Quality Assurance Reporting Requirements audit at a significantly ($P < .01$) higher rate than plans that chose to leave.

The authors are from the New York State Department of Health, Office of Managed Care, Bureau of Quality Management and Outcomes Research, Corning Tower, Empire State Plaza, Albany, NY 12237. Correspondence should be addressed to Mr. Roohan, Director.

Conclusions. A program consisting of health plans voluntarily participating and committed to Medicaid managed care can provide Medicaid recipients with appropriate access to high-quality health care. The exodus of commercial health plans from New York's Medicaid Managed Care Program during the time periods studied did not result in a detectable adverse impact on the quality of care for enrollees.

KEY WORDS Access to care, Commercial managed care, Health care delivery, Managed care, Medicaid managed care, Quality assessment.

INTRODUCTION

Many states have enacted programs to enroll Medicaid recipients into managed care plans as a means of improving access to high-quality health services, at the same time controlling spiraling costs. Enrollment in Medicaid managed care has grown significantly, from 11.6 million in 1995 to 21.2 million enrollees in 1998.¹ To develop sufficient managed care capacity to accomplish the goal of transitioning Medicaid recipients into managed care, state policymakers, including those in New York State, have relied in part on commercial health maintenance organizations (HMOs) to open their panels of providers to the Medicaid population. By encouraging commercial health plans to offer Medicaid product lines, government officials believed that Medicaid recipients potentially would have access to a greater range of providers, including those providers who had been unwilling to participate in Medicaid fee for service due to low reimbursement or bureaucracy.

While commercial HMO involvement in Medicaid managed care was high initially (24 of 28 commercial plans participated in Medicaid managed care in 1994), since 1996, a number of commercial plans (14) have left the Medicaid Managed Care Program in New York State. Currently, the majority (57%) of the state's Medicaid managed care enrollees are in plans only certified to serve Medicaid recipients; these plans are known as prepaid health service plans (PHSPs) in New York. The PHSPs represent 18 of the 30 plans certified by the state to serve Medicaid recipients.

Some policy analysts have expressed concern that the departure of commercial plans from the Medicaid market would jeopardize the state's Medicaid Managed Care Program by reducing or compromising the quality of care. This paper attempts to evaluate the impact of this departure from the perspective of standardized quality measures.

BACKGROUND

COMMERCIAL PLAN INVOLVEMENT IN MEDICAID MANAGED CARE

The departure of commercial plans from state Medicaid programs has received much attention recently. A Kaiser Family Foundation report states that: "In 1998,

about one commercial plan entered the Medicaid market for every six plans that exited. In 1997, the ratio was closer to one plan for every two plans exiting."^{2(p10)} In 15 high-volume Medicaid states, including New York, the number of plans participating in Medicaid managed care decreased from 153 to 126 between 1996 and 1998. The participation rate of commercial plans declined as well. For these 15 states, approximately 39% of the commercial plans participated in 1998 versus 51% in 1996. While the percentage of Medicaid enrollees served by these plans decreased slightly from 1996 to 1998 (66% vs. 60%), the number of Medicaid enrollees served by commercial plans increased by approximately 600,000 enrollees.²

There has been much discussion and speculation about the reasons for this exit. In a recent report by the Lewin Group, the overwhelming reason stated by HMO officials in New York is poor reimbursement and the administrative costs associated with Medicaid programs. The difficulty in attracting members to the voluntary program may also strain the HMOs if they cannot "weather the startup losses."³ Perceptions of unknown financial risk created by changing state policies have also contributed to the ambivalence of the HMO industry toward Medicaid managed care.⁴

A longitudinal analysis of the financial performance of Medicaid managed care plans performed by McCue et al.⁵ demonstrated that, in 1992 and 1993, plans with high Medicaid enrollment generally were more profitable than those with fewer enrollees. However, as expected, plans with large Medicaid enrollment incurred higher administrative expenses than plans with fewer enrollees. Since 1994, the profitability of plans with large Medicaid enrollment decreased, resulting in greater losses than for plans with smaller Medicaid enrollment. An increase in medical expenses does not seem to be the cause for these losses. The authors' interviews with stock analysts revealed that "rate inadequacy, substantial volatility and excessive administrative burden" contributed to a decline in financial performance. With plans experiencing a concurrent decline in the profitability of their "core" lines of business, many commercial HMOs made business decisions not to continue participation in Medicaid managed care.

NEW YORK STATE MEDICAID MANAGED CARE

New York has a long history of promoting managed care as an effective model for providing health services to Medicaid recipients. The Medicaid Reform Act of 1984 provided startup funding to provider-sponsored PHSPs. The PHSPs were established as managed care plans designed to serve the special health and service needs of the Medicaid population and eventually grew to 18 plans across the state. With the creation of the PHSPs came the first serious growth in Medicaid

enrollment, with over 62,000 Medicaid recipients voluntarily enrolled in managed care at the end of 1986.

By 1991, there were 90,000 Medicaid recipients voluntarily enrolled in managed care. That year, Medicaid Managed Care Reform Act legislation was enacted that required local social services districts to establish Medicaid managed care programs in each county. Enrollment targets for each county were established at this time, with a statewide goal of 50% of all those eligible for Medicaid becoming enrolled in managed care by 1995.

Throughout the 1980s, New York State used legislative and regulatory actions to achieve many of its health policy objectives. To promote involvement of commercial HMOs in Medicaid managed care further, New York enacted health care finance legislation in 1992 that required health maintenance organizations to pay a 9% surcharge on all inpatient hospital services rates* if they did not meet Medicaid enrollment targets established for them by the New York State Department of Health (NYSDOH).⁶ That year, nine new commercial plans applied to become eligible to enroll Medicaid recipients. Many of these plans enrolled very small numbers of Medicaid recipients, as described below.

By 1995, Medicaid enrollment in managed care had grown to over 653,000. There were 40 managed care plans, including 20 commercial plans, certified by the state to serve Medicaid recipients. New York submitted a 1115 waiver (The Partnership Plan) to the Health Care Financing Administration (HCFA) that, when approved, would allow mandatory enrollment by the state of 2.8 million of the state's Medicaid recipients into fully capitated managed care plans over a period of 5 years.⁷ The proposal was approved by the Health Care Financing Administration in 1997, and enrollment in upstate counties began in October of that year. The Partnership Plan was implemented in New York City in August 1999. Prior to the approval of the 1115 waiver, there were several local 1915b waivers operational in upstate counties and the southwest Brooklyn region of New York City.

In 1996, the state legislature approved the Health Care Reform Act, which significantly deregulated the state's health care financing system and in the process removed the 9% surcharge on commercial plans. With financial penalties for nonparticipation in Medicaid managed care removed, a number of commercial plans notified the state that they were planning to leave the Medicaid market.

*For example, if a commercial plan had an enrollment target of 5,000 Medicaid recipients and only enrolled 1,000, they would be subject to the surcharge. An inpatient admission for a member of that plan, with a charge of \$1,000, would have a 9% surcharge of \$90 added to the total, which would be recouped by the state.

In 1999, NYSDOH contracted with the Lewin Group to investigate the reasons for the departure of New York's commercial plans from the state's Medicaid managed care program. As part of its analysis, the Lewin Group conducted a telephone survey of 17 plans that withdrew from the program either entirely or selectively. Of the plans contacted, 12 agreed to participate. Virtually all plans stated that "inadequate reimbursement rates" and "prohibitive and excessive" administrative requirements were the primary reasons for leaving the program. Consolidations and mergers and other business strategy issues were also contributing factors. The report states that, for 5 of the 12 plans, the surcharge was the primary reason for participation in New York's Medicaid managed care. One plan representative stated: "The penalties for non-participation were too severe to ignore."

Some speculated that the exodus of these commercial plans would have a negative impact on the access of Medicaid enrollees to care and, more importantly, the quality of that care. This paper compares the overall performance of plans that remained in the program to the performance of plans that chose to leave. Access and quality-of-care data were analyzed to determine whether the access of Medicaid enrollees to high-quality health care in fact has been affected adversely by the departure of commercial HMOs from New York's Medicaid Managed Care Program. Data taken from the Quality Assurance Reporting Requirements (QARR)⁸ of NYSDOH provided the basis for this analysis.

METHODS

Two analyses were performed to evaluate the effect of managed care plans leaving the Medicaid program. The first was a comparison over two periods of time of access to care and quality-of-care performance measures from QARR. Next, the ability to report reliable information in QARR was analyzed using the results of an annual audit of performance measures.

DATA SOURCES

The QARR is a series of quality, access, utilization, and plan management performance measures collected annually for Medicaid, commercial, and Child Health Plus enrollees in New York State. QARR measures are adopted largely from the Health Plan Employer Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA). QARR contains additional measures specific to New York State that address public health issues of particular importance in New York, including human immunodeficiency virus (HIV) testing of pregnant women, adolescent screening for tobacco or substance use, and lead screening of children.

Performance measures used for analysis were chosen based on three criteria. First, measures were selected that had been collected by managed care plans over a period of time and had little or no change in definition. Second, measures were selected that have been reported reliably over time. Last, measures were selected to incorporate the relevant age groups within Medicaid. Two access measures were chosen: adult access to preventive/ambulatory health services—aged 20–44 years and adult access to preventive/ambulatory health services—aged 45–64 years. The five quality measures chosen for analysis include: lead screening in the first 2 years of life, childhood immunization, adolescent well care visits, cervical cancer screening, and prenatal care in the first trimester. A description of the performance measures is given in Table I.

The first analysis used access to care and quality-of-care measures to examine two periods of time to compare the effects of commercial plans leaving the Medicaid program. The periods (1996–1997) and (1998–2000) were both chosen because a significant number of managed care plans left the Medicaid program in those time periods. Data collected in QARR for the 1996 reporting year were used to assess the 1996–1997 time period, and data collected for the 1998 reporting year were used for the 1998–2000 analysis.

TABLE I Description of QARR Measures Analyzed

Measure	Description
Adult access, aged 20–44 years	Adults aged 20 through 44 years who had one or more ambulatory or preventive care visit(s) during the measurement year
Adult access, aged 45–64 years	Adults aged 45 through 64 years who had one or more ambulatory or preventive care visit(s) during the measurement year
Lead screening of 2 year olds	Children aged 2 years who received at least one capillary or venous blood screening test for lead poisoning
Childhood immunization	Children who received the following combinations of antigens by their second birthday: 1996: four DTPs (diphtheria-tetanus-pertussis); three IPVs (inactive polio virus vaccine) or OPVs (oral polio virus vaccine); one MMR (measles-mumps-rubella); and one hepatitis B 1998: four DTPs; three IPVs or OPVs; one MMR; two Hib vaccines (<i>Hemophilus influenza</i> type B); and two hepatitis B vaccines
Adolescent well care	Adolescents who had one or more comprehensive well child visit(s) with a primary care provider
Cervical cancer screening	Women between the ages of 21 and 64 years who were enrolled continuously in their managed care plan for a year and who received one or more Papanicolaou tests some time in the last 3 years
Prenatal care in the first trimester	Women continuously enrolled for 10 months or more who delivered during the reporting year for whom prenatal care began in the first trimester (women who had an obstetrical visit 26–44 weeks prior to delivery)

The second analysis evaluated the ability of Medicaid managed care plans to produce performance indicators accurately. In 1995, NYSDOH contracted with NCQA to develop an audit methodology for QARR to ensure data reliability and validity. The audit consisted of a medical record review of targeted measures based on high-performance values, administrative data collection, and previous audit failures. Between three and seven measures were selected for each plan. This methodology was employed for the 1994 through 1997 reporting years. In 1997, NCQA developed the HEDIS Compliance Audit process, which is more comprehensive and contains a full information system review and a medical record review of selected measures. New York State adapted the NCQA Compliance Audit methodology for 1998 reporting. Therefore, to restrict the analysis to one type of audit, only audit results from 1994 through 1997 were used to determine if there was a difference in the ability of a managed care plan to report information correctly. Plans that left Medicaid were compared to those that remained in the program.

STATISTICAL ANALYSIS

For the first analysis, using QARR performance measures, we compared managed care plans that left the program to those that remained. Univariate *t* tests were calculated to determine significant differences in measure rates for each of the two cohorts being analyzed. Since the sample size for analysis is small (<50 plans per year), Wilcoxon rank sum tests were performed, but the results were similar to those obtained from the *t* tests. General linear models were developed to characterize the variation in rates, adjusting for whether the plan left the Medicaid program (left, remain) tax status (for profit, not for profit), location (New York City, rest of state, both New York City and rest of state), type of plan (HMO, PHSP), and Medicaid enrollment. The dependent variable was the performance rate for the selected access or quality-of-care measure from Table I.

For the second analysis, which evaluated the ability of the managed care plan to produce reliable data, chi-square tests of association were conducted on audit results to determine if the plans that left the Medicaid program differed significantly from those that remained in the program. All statistical analyses were performed using SAS software version 6.12.12 (SAS Institute, Cary, NC, 1996).

RESULTS

Table II describes managed care plans that left the New York State Medicaid Managed Care Program, including their Medicaid enrollment at the time they withdrew, their total enrollment, and the percentage of enrollment that was Medicaid. Of the 14 commercial managed care plans that left the Medicaid

TABLE II Commercial Managed Care Plans that Have Left the New York State Medicaid Managed Care Program

Health Plan	Date Plan Completed Medicaid Withdrawal*	Medicaid Enrollment Prior to Withdrawal†	Total Enrollment‡	Percentage Medicaid Enrollment
Aetna Health Plans of New York, Inc.§	May 9, 1996	1,464	131,303	1.11
CIGNA HealthCare of New York	March 1, 1997	2,429	49,058	4.95
Community Health Plan/Kaiser	December 31, 1999	15,391	238,339	6.46
Empire Blue Cross/Blue Shield¶	May 1, 1999	9,144	258,792	3.53
Health Services Medical Corporation	August 1, 1997	2,944	97,395	3.02
HMO Blue	June 30, 1997	4,117	22,855	18.01
HMO-CNY	December 30, 1996	1,236	35,407	3.49
Independent Health Association—Hudson Valley	December 31, 1996	3,708	37,791	9.81
Mohawk Valley PHP	March 26, 1997	18,617	302,734	6.15
NYLCare	January 1, 1999	2,271	88,758	2.56
Oxford Health Plan#	December 31, 1999	36,877	1,356,885	2.72
Partner's Health Plans	July 1, 2000	6,036	34,001	17.75
Prudential Health Care Plan	March 26, 1997	3,916	68,387	5.73
US Healthcare	April 30, 1998	22,996	715,415	3.21

*Source: NYS DOH Office of Managed Care Bureau of Managed Care Program Planning, internal correspondence.

†Source: NYS DOH Office of Managed Care Quarterly Enrollment Reports. Total Medicaid enrollment of quarter preceding notice to withdraw from Medicaid.

‡Source: NYS DOH Office of Managed Care Quarterly Enrollment Reports. Total enrollment of quarter preceding notice to withdraw from Medicaid.

§Merged with US Healthcare.

||Acquired by Capital District Physicians Health Plan; withdrew from the Northeast market.

¶Acquired by Neighborhood Health Providers.

#Acquired by Managed Healthcare Systems.

Managed Care Program, 12 had a relatively small Medicaid enrollment, accounting for less than 10% of the total enrollment of each plan. For 8 of these plans, Medicaid enrollment was even smaller, less than 5% of total enrollment. Only 4 plans had more than 10,000 members at the time of withdrawal from Medicaid. Of the 4 plans, three either merged with or were acquired by other managed care plans.

Table III includes univariate comparisons of QARR access and quality measures for commercial managed care plans that remained in Medicaid managed care compared to those that chose to leave for the two time periods, 1996–1997 and 1998–2000. Comparisons were made for the two access measures and five quality-of-care measures. For the 1996–1997 time period, there is no statistical difference in access to care for both age groups (20–44 and 45–64 years; $P = .95$,

TABLE III Univariate Analysis of Performance on QARR Access and Quality Measures for Commercial Plans that Remained in the New York State Medicaid Managed Care Program Compared to Plans that Left, 1996–1997 and 1998–2000

Measures	Plans that Remained		Plans that Left		Statistical Significance
	N	Rate	N	Rate	
Plans in Medicaid managed care in 1996–1997					
Adult access, ages 20–44 years	30	76	7	76	NS
Adult access, ages 45–64 years	28	76	6	75	NS
Lead screening of 2 year olds	23	74	6	59	NS
Childhood immunization	24	73	6	61	NS
Adolescent well care	28	37	6	32	NS
Cervical cancer screening	28	61	5	56	NS
Prenatal care in the first trimester	25	62	6	64	NS
Plans in Medicaid managed care in 1998–2000					
Adult access, ages 20–44 years	28	76	4	74	NS
Adult access, ages 45–64 years	27	82	4	77	NS
Lead screening of 2 year olds	30	70	3	46	NS
Childhood immunization	30	63	3	37	<i>P</i> < .05
Adolescent well care	28	37	4	25	<i>P</i> < .05
Cervical cancer screening	29	70	4	69	NS
Prenatal care in the first trimester	25	62	2	65	NS

Note: For this analysis, 30 plans remained in Medicaid managed care and 8 plans left in the period 1996–1997. For 1998–2000, 30 plans remained in Medicaid managed care and 4 plans left. Measure-specific sample sizes may not reflect these figures as measures with audit failures or small sample sizes were omitted from the analyses.

Rate = percentage of eligible members achieving the measure; NS = no statistically significant difference.

$P = .85$, respectively). For all five quality measures, there are no statistically significant differences between plans that remained in the Medicaid managed care program and those that left. Rates for plans remaining in Medicaid managed care are higher for four of the five measures, but due to small sample size, the analysis does not have the statistical power to differentiate from the rates of plans that left Medicaid managed care.

There is no statistical difference in access to care for both age groups (20–44 and 45–64 years; $P = .74$, $P = .67$, respectively) for the 1998–2000 time period. Rates for childhood immunization are statistically higher for plans that remained in the Medicaid managed care program (63%) compared to those that left (37%). Similarly, the rate for adolescent well care visits for plans that remained (37%) is higher than for plans that left Medicaid managed care (25%). For lead screening

of 2 year olds, cervical cancer screening, and prenatal care in the first trimester, there are no significant differences between the plans that left Medicaid and those that remained.

The results of the multivariate analyses are presented in Table IV. Adjusting for tax status, location, type of plan, and Medicaid enrollment, managed care plans that remained in the Medicaid program had childhood immunization rates over 20% higher than plans that left in 1996–1997. No other access or quality measures were statistically significant during this time period.

Plans that remained in Medicaid managed care after 1998–2000 had significantly higher risk-adjusted rates of lead screening (21.9% higher, $P < .05$), childhood immunizations (27.2% higher, $P < .05$), and adolescent well care visits (13.3% higher, $P < .05$) than the plans that chose to leave Medicaid managed care. There are no significant differences in both access measures, cervical cancer screening

TABLE IV Multivariate Analysis of Performance on QARR Access and Quality Measures for Commercial Plans that Remained in the New York State Medicaid Managed Care Program Compared to Plans that Left, 1996–1997 and 1998–2000

Measures	Parameter Estimate*	Statistical Significance
Plans in Medicaid managed care in 1996–1997		
Adult access, ages 20–44 years	3.6	NS
Adult access, ages 45–64 years	–4.6	NS
Lead screening of 2 year olds	11.0	NS
Childhood immunization	20.7	$P < .01$
Adolescent well care	1.2	NS
Cervical cancer screening	3.2	NS
Prenatal care in the first trimester	4.7	NS
Plans in Medicaid managed care in 1998–2000		
Adult access, ages 20–44 years	8.7	NS
Adult access, ages 45–64 years	7.5	NS
Lead screening of 2 year olds	21.9	$P < .05$
Childhood immunization	27.2	$P < .05$
Adolescent well care	13.3	$P < .05$
Cervical cancer screening	7.8	NS
Prenatal care in the first trimester	0.4	NS

*Parameter estimate is the increase in the rate of a measure due to a managed care plan remaining in the New York State Medicaid program, compared to plans leaving, adjusting for tax status, plan location, type of plan, and Medicaid enrollment.

NS = no statistically significant difference.

TABLE V Ability of Managed Care Plans to Report Data Reliably, Commercial Plans that Remained in the New York State Medicaid Managed Care Program Compared to Plans that Left, 1994–1997

Measurement Year	Percentage Passing Rate		Statistical Significance
	Plans that Remained	Plans that Left	
1994	74.0	57.6	NS
1995	73.8	72.7	NS
1996	85.2	68.1	$P < .05$
1997	87.6	84.2	NS
All years combined	82.3	68.9	$P < .01$

NS = no statistically significant difference.

rates, or the prenatal care in the first trimester rates for managed care plans remaining in Medicaid managed care compared to plans that left.*

The abilities of managed care plans to report reliable information are summarized in Table V. For 1994, 1995, and 1997, plans that remained in the Medicaid program had higher rates of passing audits, but these differences were not statistically significant. In 1996, plans that remained in the Medicaid program had a passing rate of 85.2%, statistically higher than the passing rate of 68.1% for plans that left ($P < .05$). When the 4 years are combined, managed care plans that remained in Medicaid passed the QARR audit at a rate of 82.3%, statistically higher than plans that chose to leave (68.9%, $P < .01$)

DISCUSSION

FINDINGS

The analysis presented in this paper reveals that the departure of commercial health plans from the New York Medicaid Managed Care Program has not had a statistically significant negative effect on the quality of care provided to Medicaid recipients as evaluated by standardized performance measures. In fact, for some measures, such as immunization and lead screening, performance actually is higher among plans that remained in the program. In addition, there were no instances for which there was a negative impact on access to care by the exit of the commercial plans. While the focus of this paper was on the effect of commer-

*Multiple regression models were used that included Medicaid enrollment as an independent variable. Using a weighted regression model with Medicaid enrollment as the weight yielded similar results.

cial plans leaving the Medicaid program, when the analysis was expanded to include all plans that left (including Medicaid-only plans), the results of the analysis did not change.

The information presented in Table II reveals that, for the majority of these plans, their Medicaid product lines represented less than 10% of their total enrollment. This tendency of some commercial plans toward small enrollment and divestiture may reflect a limited long-term commitment to Medicaid managed care. With respect to data collection and performance measurement, plans without a long-term commitment to the Medicaid managed care business may have been less likely to devote resources to meet the administrative requirements of the program. This may also help to explain why plans that exited the state's Medicaid Managed Care Program were significantly more likely to have failed the audit of their QARR data than plans that remained.

LIMITATIONS OF THE STUDY

The limitations of this study include the relatively small number of plans included in the analysis and the selected measures available for study during the years examined. While these measures do not represent the entire set of measures reported by health plans during this period of time, they do represent measures that are reflective of the populations enrolled in Medicaid—women and children.

Also, this study did not measure other benefits that commercial health plans may contribute to Medicaid programs. These benefits could include expanded provider networks, greater competition for rate proposals, and improved coordination and continuity of care as individuals change insurance type based on income. By having greater access to capital, commercial plans may also be positioned better for program developments such as expansions, investment in information systems, and new technology.

POLICY IMPLICATIONS

These findings are not consistent with the speculation by some that the departure of commercial health plans from Medicaid programs would compromise the quality of care for enrollees. The Medicaid-only plans and those commercial plans that remained in the Medicaid Managed Care Program subsequent to the elimination of the 9% surcharge have expressed a long-term commitment to serving Medicaid enrollees. This therefore may explain partially why statewide Medicaid performance was not affected adversely by the departure of commercial plans between 1996 and 1997.

This analysis suggests that a program consisting of health plans (commercial and Medicaid only) voluntarily participating and committed to Medicaid man-

aged care can provide Medicaid recipients with appropriate access to high-quality health care. The exodus of commercial health plans from New York's Medicaid Managed Care Program during the time periods studied did not result in a detectable adverse impact on the quality of care for Medicaid enrollees.

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REFERENCES

1. Health Care Financing Administration. Medicaid Managed Care Enrollment Report. Available at: <http://www.hcfa.gov/medicaid/>. Accessed June 6, 2000.
2. Felt-Lisk S. *Kaiser Commission on Medicaid and the Uninsured. The Changing Medicaid Managed Care Market—Trends in Commercial Plan Participation*. Menlo Park, CA: The Henry J. Kaiser Family Foundation; May 1999.
3. Robbins R. HMO defections slow Georgia's Medicaid effort. *Atlanta Business Chronicle*. July 24, 1998;21:5A.
4. Bailit M. *Purchasing in a Turbulent Market: an Assessment of Medicaid Managed Care in the Mid-Atlantic States*. Princeton, NJ: Center for Health Care Strategies; October 1999.
5. McCue MJ, Hurley RE, Draper DA, Jurgensen M. Reversal of fortune: commercial HMOs in the Medicaid market. *Health Aff*. January/February 1999;18(1):223–230.
6. New York State Public Health Law, Chapter 41, 1992.
7. New York State Department of Health. The Partnership Plan. Available at: <http://www.health.state.ny.us/nysdoh/mancare/mcmain.htm>. Accessed June 6, 2000.
8. New York State Department of Health. Quality Assurance Reporting Requirements, a Report on Managed Care Plan Performance 1998. Available at: <http://www.health.state.ny.us/nysdoh/mancare/mcmain.htm>. Accessed June 6, 2000.