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No discussion of the political controversy surrounding managed care can ignore Medicaid. A joint federal-state initiative born as a political afterthought to Medicare in 1965, Medicaid provides health insurance to from 35 to 40 million low-income people. The proportion of the population covered by Medicaid has almost doubled, increasing from 5.6 percent of the population under 65 in 1984 to nearly 11 percent in the late 1990s. Medicaid also provides support to nearly 10 percent of Medicare recipients. The number of Medicaid eligibles seems likely to increase over the next several years as previously adopted federal mandates requiring the coverage of poor children become operational and states use funds available through the new Children's Health Insurance Program that can extend Medicaid coverage to other low income children (National Center for Health Statistics 1998: 361–364).

This essay briefly traces the rise of Medicaid managed care in the 1990s. We argue that, although Medicaid has escaped the politics of backlash surrounding managed care more generally, forces are at work eroding the initial enthusiasm for placing Medicaid enrollees in managed care. This erosion will not trigger a major retreat from Medicaid managed care but it will prompt some states to back off from initiatives to extend capitated plans to ever larger segments of the Medicaid population. The technical and political issues involved in extending managed care to special-needs populations as well as the exit of commercial firms from Medicaid managed care have begun to slow its momentum.

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The Rise of Medicaid Managed Care

While small scale experiments with capitated prepayment and various forms of case management have been part of Medicaid in many states for over twenty years, the widespread use of managed care dates to the early 1990s. Three factors fueled the sharp increase in the popularity of managed care over this period (Fossett 1998).

First, many thought it would serve as a cost containment device. Medicaid expenditures exploded over the late 1980s and early 1990s, growing at a compound annual rate of over 19 percent between 1988 and 1993 (Boyd 1998: 60–63). Some of this growth stemmed from clever state manipulation of reimbursement rules for payments to hospitals and the shifting of program costs in mental health and mental retardation onto Medicaid, but much was also due to increased caseloads and high rates of medical inflation. Elected officials and budget bureaus trying to bring Medicaid expenditures under control embraced the idea of replacing fee-for-service payments for which the state was at unlimited risk with a single capitated payment that transferred risk to a managed care organization (MCO). Conventional means of reducing Medicaid expenditures—restricting eligibility, cutting payments to providers, or attempting to limit utilization—were politically unpopular and frequently ineffective. Under these circumstances, managed care could be presented as a responsible means for slowing Medicaid growth that did not require such onerous steps.

Second, many liberal advocates and agency officials saw managed care as a vehicle to overcome the chronic deficiencies of the existing Medicaid system in providing access to care of high quality to low-income people (e.g., Oliver and Oliver 1998). Medicaid enrollees have persistently faced problems in obtaining mainstream primary care, have relied too heavily on inappropriate care from hospital emergency rooms, and have far too frequently been hospitalized for problems that could have been successfully treated earlier with adequate primary care. By providing clients with reliable access to primary care, hopefully from a mainstream provider, and providing an organization that could be held accountable to contractual standards for access and quality, managed care offered the potential for improving prenatal and other preventive care and reducing unnecessary hospitalizations.

Finally, the Clinton administration was willing from the outset to apply pressure on the Health Care Financing Administration (HCFA) to grant states the waivers they needed to implement managed care on a

large scale. This represented a departure from the past, when HCFA had been reluctant to allow states to mandate participation of large numbers of Medicaid clients in aggressive forms of managed care. While state officials continued to complain that HCFA's waiver review process took too long, demanded too much detail, and responded excessively to the preferences of advocacy groups, almost all states succeeded in getting waivers to place some portion of their Medicaid population in some form of managed care during the 1990s.

As a result of this confluence of factors, the number of Medicaid clients enrolled in managed care increased dramatically in the 1990s from less than 3 million in 1991 to over 15 million in 1997—from just under 10 percent of the Medicaid population to nearly 50 percent. To be sure, managed care penetration varied greatly across the states. In 1997, for example, twelve states had 75 percent or more of their Medicaid population in managed care.[1] But in ten states, including such populous ones as Illinois and Texas, Medicaid penetration rates in 1997 amounted to 25 percent or less.[2] While managed care had come to dominate Medicaid operations in some states, in others it never had a "frontlash" (HCFA 1997).

Medicaid managed care has, of course, assumed various forms. Early state initiatives tended to emphasize primary care case management (PCCM), a less aggressive form of managed care particular to Medicaid. Under PCCM, states assign Medicaid clients to a primary care physician who serves as a case manager, both providing care and authorizing all other services the client receives. States continue to reimburse on a fee-for-service basis and case managers are not at any financial risk for the care provided to their clients. Recent enrollment growth, however, has tended to occur in more aggressive forms of managed care, such as health maintenance organizations (HMOs), in which the states make capitated payments to managed care organizations, which then absorb the risk for care provided to Medicaid enrollees.

Whatever direction Medicaid managed care takes in the next few years, state governments rather than HCFA seem likely to be the driving force. The Balanced Budget Act of 1997 buttressed the authority of the states over the size and form of managed care (Fossett 1998). The act effectively eliminated the waiver process previously required to institute

1. The high-penetration states are Alabama, Arizona, Colorado, Delaware, Hawaii, Maryland, Michigan, Montana, Oregon, Tennessee, Utah, and Washington.

2. The low-penetration states are Alaska, Illinois, Louisiana, Maine, Mississippi, New Hampshire, South Carolina, Texas, Vermont, and Wyoming.

managed care and allowed states to mandate enrollment in such programs for all but a limited number of Medicaid beneficiaries. The new law also wiped out long-standing requirements that had sought to "mainstream" Medicaid recipients. In this regard, federal law no longer insists that state plans enrolling Medicaid clients have at least 25 percent of their membership from non-Medicaid sources (the so-called 75/25 rule); nor does it require states to provide recipients with an ample choice of plans and to permit them to switch enrollment on short notice for any reason. Although HCFA has preserved some authority to impose quality assurance provisions and other reporting requirements (including demands that managed care organizations collect and submit encounter data to the states), power over Medicaid managed care within the federal system has appreciably devolved to the states.

Back-Off

The increasingly pervasive use of managed care for the Medicaid population has not sparked an overt political backlash. The debate over whether states will or will not do managed care for poor, nondisabled women and children is largely settled in most states, and political attention has shifted to other issues. The significant decline in Medicaid spending growth over this period has reduced pressure on state budgets and lessened the perception of a Medicaid-driven "crisis" that demands immediate attention. The issues that have come to the forefront during the implementation of Medicaid managed care are complex, technical, and therefore hard to understand and be turned into dramatic "stories" that attract media attention. While advocacy groups in many states have continued to press complaints about the adequacy of provider networks, provision for chronically ill clients, and other problems, their demands get processed through a kind of insider, technical politics of Medicaid managed care that plays itself out in administrative forums such as managed care advisory committees. Many legislative staff members, reporters, policy researchers, and advocacy groups have shifted their attention to the design and implementation of the new Children's Health Insurance Program (CHIP) or the decline in Medicaid caseloads resulting from welfare reform. In the process, issues involved in implementing Medicaid managed care have moved further from the limelight.

Although the politics of Medicaid managed care has not featured a backlash, however, two forces beyond those suggested above have surfaced that could well slow the transition in many states from fee-for-

service to more aggressive forms of managed care. These are the technical and political obstacles involved in covering special needs populations and the exit of commercial firms from the Medicaid market.

Backing Off from the Special Needs Population

The growth of Medicaid managed care has been especially concentrated among nondisabled women and children—those qualified for Aid to Families with Dependent Children (now called Temporary Assistance to Needy Families [TANF]) and the growing proportion within this group ineligible for cash assistance but entitled to Medicaid. In contrast, state officials have faced more difficulties in extending managed care to the elderly and disabled populations who comprise about 30 percent of all Medicaid recipients but account for roughly 70 percent of program costs. This latter group largely qualifies for Medicaid through their receipt of Supplemental Security Income (SSI).

The low-income women and children covered by Medicaid tend to be healthier than other recipients and have less need for long-term care of various types as well as other "nonmedical" services. This similarity in demography and usage to the private managed care population has meant that existing managed care entities could more readily adapt to their needs. In addition, the TANF population and the providers that typically serve them tend to be more geographically concentrated and less politically powerful than those associated with other Medicaid populations, making it more difficult for these enrollees to resist state efforts to mandate their participation in managed care.

In comparison to the nondisabled poor, the SSI population is much more heterogeneous with a much broader range of medical and other needs. Many in this group of recipients suffer from such conditions as AIDS, severe and persistent mental illness, substance abuse, or a range of developmental disabilities. These conditions often require treatment by specialized providers and may involve considerable institutional care. Private managed care organizations have little experience with this set of clients and providers, so that there are few readily transferable models that can be applied to them. For example, organizations known as behavioral health firms manage capitated mental health services for private employers, but these firms typically lack experience with the severely and persistently mentally ill clients who are eligible for SSI. To add to the complexity, much of this population is "dually eligible" for both Medicaid and Medicare. The gravity of their health problems and

the congeries of disparate providers and regulations involved in serving these enrollees make "managing" care for them in the conventional sense almost impossible.

In addition, advocacy and provider groups that serve the SSI cohort tend to be better organized and more politically potent than those that represent the TANF population or other low-income women and children. The TANF population congregates disproportionately in urban areas, which limits the number of legislators with constituents affected by managed care. It is largely served by providers—public hospitals, public clinics, and high-volume private practices—with low professional prestige. The elderly and disabled populations and the providers that serve them have more political resources. They are more broadly dispersed geographically, increasing the number of interested legislators; clients and advocate groups are better organized; and providers are larger employers in more communities than those providers who serve the TANF population. This combination of complex technical design problems and the greater political clout of advocates and providers has made it more difficult for states to move the SSI population into managed care. Providers and advocates have strongly resisted their inclusion in mainline managed care plans and insisted on specialized "carve-outs" with separate gatekeepers, networks, and funding from the TANF population. Some providers, such as state institutions for the mentally ill and mentally retarded, are typically excluded from managed care, as are some services such as those for substance abuse. While there are exceptions in such states as Oregon and Massachusetts, managed care for the elderly and disabled is typically partially rather than fully capitated, voluntary rather than compulsory, and less aggressively implemented than managed care for nondisabled women and children. Absent financial crises that would allow states to frame aggressive managed care as superior to a range of other economizing options, this pattern seems likely to persist.

Backing Off from the Medicaid Market

If special needs populations have placed barriers in the way of expanding Medicaid managed care, so too has the behavior of commercial managed care organizations. Commercial plans responded favorably to the initial expansion of Medicaid managed care in the early and mid-1990s, particularly in the large industrial states of the Northeast and Midwest (Winslow 1995; Hurley and McCue 1998). Because officials in these states calculated premiums on the basis of their experience with Medic-

aid fee for service, which incorporated relatively high hospital rates and greater use of hospital and emergency services than the population as a whole, these premiums tended to be competitive with those available from private employers. Potential enrollments in many states were also large making Medicaid clients attractive. As a result, a wide range of commercial plans aggressively recruited Medicaid beneficiaries.

More recently, however, commercial plans in many states have scaled back or terminated their participation in Medicaid. While systematic data are hard to locate, a recent survey reports that one-third of the states saw commercial plans withdraw from Medicaid in 1998, most visibly in the Northeast, where several national plans dropped out of Medicaid in multiple states (*State Health Watch* 1998a; Langreth 1998). Other commercial plans have scaled back Medicaid enrollment or dropped out of Medicaid programs in some locales, such as rural counties, while remaining in others. As a result, the rate of growth of commercial enrollment in Medicaid has declined since 1996 in spite of continued overall growth in Medicaid managed care participation (*State Health Watch* 1998a). The most rapidly growing category of plans enrolling Medicaid clients are "Medicaid only" plans, some of which are owned by community health centers, public hospitals, and other providers. Data from 1996 indicate that over 40 percent of Medicaid managed care enrollees were in plans where Medicaid clients comprised more than 75 percent of total enrollment (Felt-Lisk and Young 1997).

The exit of commercial plans has affected state initiatives to expand mandatory enrollment into different areas and populations. Many states which had initially enrolled TANF clients in PCCM had hoped to move these clients into full-risk capitated programs. While this transition has often occurred in urban settings, where the bulk of the TANF population lives, many states have found it difficult to attract commercial plans to rural areas. The small potential enrollment in rural locales and the resistance of providers in these areas to managed care make them unattractive to commercial plans. A number of predominantly rural states, such as Arkansas, appear to have concluded that moving rural clients out of case management into full risk care is no longer feasible.

Difficulties in attracting commercial plans have also encouraged states as diverse as New York and West Virginia to scale back or postpone initiatives to move the elderly and the disabled populations into mandatory managed care. New York has shifted from a mandatory to a voluntary design for its mental health managed care program. States as experienced and sophisticated as Washington have been compelled to terminate SSI

managed care programs due to the bankruptcy of managed care organizations or to the MCO's unwillingness to sign contracts (Verdier 1998).

Recent developments in the larger managed care market and as well as state policies and practices in implementing managed care have also undercut commercial interest in Medicaid. The financial position of many commercial plans worsened significantly in the mid-1990s, following several years of positive earnings. Increased competition, particularly in larger urban markets, kept premium revenues flat while medical costs continued to increase. Plans have responded to these financial pressures by dipping into capital reserves, raising premiums sharply, and reducing or eliminating unprofitable lines of business (Hurley and McCue 1998; Hau 1998). Plans with more Medicaid members may well have lost more money than those with fewer members and stagnant revenues in the commercial market have reduced the ability of these plans to cross-subsidize Medicaid losses (McCue et al. 1999). Under these conditions, at least some plans have chosen to eliminate lines of business, such as Medicaid, that do not pay their own way.

State rate-setting and regulatory policies may also have contributed to a decline of commercial interest in Medicaid. The waivers under which states initially implemented Medicaid managed care required that such care be "budget neutral" or not cost more than Medicaid would have paid for the same services to the same population under the fee-for-service system. In practice, this means that state premiums have been tied to the "upper payment limit" (UPL), an estimate drawn primarily from existing fee-for-service utilization data, of what Medicaid would have paid under fee for service, converted to a per member per month basis. This requirement that premiums be constrained by UPL calculations, rather than current market conditions, may make it difficult for states to pay commercially appropriate rates, particularly if the fee-for-service and the managed care populations differ in health status and utilization. States that have historically paid lower amounts may find it particularly difficult to provide inducements even roughly comparable to those of private purchasers. In some states, governors, budget bureaus, and legislatures have also seized the opportunity to realize savings from Medicaid and have set rates below the UPL. New York, for example, enacted an almost 30 percent rate cut, and Michigan took over $100 million out of the base compared to the UPL. Ohio, Florida, and Pennsylvania also approved sizeable rate reductions (McCue et al. 1999). As a result, many states pay premium rates well below the average for commercial purchasers.

This disparity between public and private rates seems likely to grow. Most projections envision substantial increases in the rates of growth in health care costs over their depressed levels in the mid-1990s, particularly for prescription drugs. Employer health insurance costs rose by over 6 percent in 1998 after several years of stable prices, and certain large national managed care companies have already secured premium increases in the high single digits from employers for 1998–1999 (Winslow 1998; Rundle 1998). In addition, membership in more restrictive forms of managed care declined in 1998 for the first time in favor of more loosely organized and more expensive, point-of-service plans and preferred provider organizations (Winslow 1999). Quite clearly, the managed care premiums paid by private employers and employees are likely to increase more sharply in the immediate future than in the recent past.

It seems unlikely that many Medicaid managed care programs will be able to keep up with these trends and remain competitive purchasers. States are still constrained by the UPL, which in lower paying states imposes particularly formidable constraints on the ability of states to match practices in the commercial market. In addition, building political support for any significant increases in Medicaid premiums will be difficult. While Medicaid caseloads have declined slightly and state financial conditions seem likely to remain reasonably strong, budget bureaus and legislators are likely to have other uses for available funds even within Medicaid.

The commercial appeal of Medicaid contracts has been further attenuated by "red tape"—Medicaid reporting and monitoring requirements that exceed those common in private commercial contracts. Other than a small number of highly visible companies and purchasing consortia, most private purchasers appear to make only limited demands on plans for information on utilization and the quality of care provided to enrollees, do not systematically discriminate in favor of plans with accredited quality reporting systems, or provide their employees with information on the quality of care provided by plans (Commonwealth Fund 1998; Meyer, Rybowski, and Eichler 1997). It appears that most plans in most states are accustomed to performing consumer surveys and providing financial information on contract performance to commercial purchasers, but doing little beyond this to gauge quality or access.

By contrast, Medicaid imposes substantial reporting requirements on managed care organizations. Federal waiver and statutory requirements, pressure from advocacy groups, legislative interests, and agency desires to ensure adequate care or be a "prudent purchaser" have fueled demands

that plans submit quality and access information in excess of that typically required by other purchasers. While particulars vary considerably, most states insist that plans demonstrate the adequacy of their network of primary care physicians and notify states of significant changes in the availability of care. Almost all states require plans to submit quality information, largely based on the Health Plan Employer Data and Information Set (HEDIS) reporting system of the National Commission on Quality Assurance (NCQA), which documents such measures as prenatal care timeliness and adequacy, and rates of mammography and other screening procedures (Partridge and Torda 1997). Recently proposed rules implementing the Balanced Budget Act mandate the reporting of "encounter" data and a number of other particulars (*State Health Watch* 1998b; HCFA 1999). Most states also require plans to assume responsibility for "third party liability," or collecting payments from other insurance which Medicaid clients may have; and some states demand that plans demonstrate "cultural competence" by employing interpreters and distributing marketing materials in several languages. The cost of these additional requirements is difficult to quantify. Plans with predominantly Medicaid enrollees, however, report administrative loss ratios as much as 50 percent higher than those with smaller Medicaid contingents (McCue et al. 1999), suggesting that the financial burden of state red tape may be considerable.

Finally, a conflict between the cultures of state Medicaid agencies and those of the commercial plans has frequently impeded the establishment of productive working relationships based on trust of each other's motives and competence (Hurley and McCue 1998). The staffs of state agencies and those of private plans typically differ in their training and experience as well as their values and ideologies. Agency personnel frequently hold public health or social work degrees, place a high value on enhancing the accessibility and quality of care available to low-income groups, and are accustomed to acting as regulators. Agencies often have little experience with the type of contractual relationship required in managed care, which is more collaborative and cooperative than the regulatory oversight aimed at the prevention of fraud and abuse that has characterized Medicaid's dealings with fee-for-service providers. Agency staff tend to suspect commercial firms of being more interested in profits than health care and more willing to cut corners and hide behind contractual fine print. These suspicions may lead them to insist on lengthy, detailed contractual language, scrupulous adherence to requirements, and, generally, to assume the worst in dealings with plans. This posture

strikes plans as unduly adversarial (ibid.). Plan staff are more likely to be trained in business than public health and to give commercial considerations greater weight in decisions. They often have little experience with the political environment in which public agencies operate, and frequently view agency staff as unfamiliar with the specifics of managed care, hopelessly liberal, and prone to make unreasonable demands without awareness of their financial or logistical consequences.

This combination of lower than average Medicaid premium rates, higher than average reporting and administrative requirements, and occasionally adversarial working relationships tends to dampen the appeal of Medicaid clients to commercial plans. Given that these factors show no sign of abating and may well be increasing, Medicaid clients may become even more unappealing to commercial plans in the near future. This may result in the increased concentration of low-income clients in Medicaid-only plans, and cause more states to postpone or cancel plans to move additional groups into managed care.

Conclusion

The politics of managed care backlash has in many respects been galvanized by those who benefit from mainstream medical care. To address the concerns of consumers and providers about managed care, policy makers have proposed a package of incremental reforms—better access to specialists, wider coverage of emergency room care, mandated outside review when care is denied, greater confidentiality of medical records, the right to sue managed care organizations under state malpractice law, freedom for physicians to discuss expensive treatment options with their patients, and more. For most Medicaid enrollees and the providers that serve them, these mainstream politics must at times look like a debate over what flavor of frosting to put on a cake. Medicaid enrollees have throughout the life of the program tended to face a much more basic set of problems, such as finding physicians in their neighborhoods willing to treat them, getting providers to give them the same quality of care as more affluent patients, dodging the excesses of Medicaid mills, and surviving the eligibility recertification processes conducted by welfare bureaucracies.

To be sure the politics of mainstream managed care has some relevance for Medicaid. It probably makes it a little more difficult for policy makers to portray managed care as *the* answer to all of Medicaid's problems. It may slightly buttress the position of those who argue for vigor-

ous oversight of managed care organizations to assure that they deliver on their promises of access and quality. On balance, however, the politics of Medicaid managed care differs appreciably from its more mainstream counterpart. It tends to be a less visible and more technical kind of politics that plays out in administrative forums well off the main political stage. Although the federal government in general and HCFA in particular continue to play a part, the impetus toward devolution puts players from the states at center stage. The resulting dynamics, especially those associated with special needs populations and state relationships with commercial managed care firms, may well yield a backing off from Medicaid managed care in some states.

The full implications of these politics on efforts to promote a better balance among cost containment, quality assurance, and access in the Medicaid program remain to be seen. Clearly, states face major challenges in realizing the fruits of managed care for Medicaid recipients. As states strive to become prudent purchasers, they must acquire expertise in a host of areas ranging from business-style financial reporting to sophisticated information systems for quality assurance—areas not very salient to them under the old fee-for-service model. Meeting this challenge requires state agencies to develop political support for expensive investments in personnel and systems and to deal creatively with the "immature" technology associated with defining, measuring, and reporting about health care quality.

Persuading governors and legislators to make the kinds of investments in administrative capacity needed to hold managed care organizations accountable for efficient and effective performance has been difficult. Individuals with the requisite skills in financial analysis, quality assurance, and the design of management information systems exist, but not in large numbers. The salaries required to attract and retain them are frequently beyond the reach of all but the best-paying states. Many states have found that plans hire away technically qualified staff almost as fast as they can be recruited. As a partial remedy, many states, especially smaller ones, have become increasingly dependent on consultants and other private sector contractors. States are spending large sums to procure managed care advice, analyses, and services such as rate setting, enrollment brokerage, quality assurance, and auditing. In some cases, these private contractors have been delegated decisions that greatly affect who gets what, when, where, and how from the Medicaid program. This raises intriguing and complex questions of administrative accountability.

The leverage of the states in managed care arrangements ultimately depends on their ability and willingness to penalize, fire, or replace contractors who fail to perform. Unlike private purchasers of care, state agencies operate in a political environment in which plans involved in disputes with the state can appeal to the courts, state legislatures, and the media. State agencies face the threat that their demands on managed care firms to speed up the pace of systems development or data collection for quality assurance may cause these plans to drop out of Medicaid, or to litigate, or press complaints in the political process that they are being driven to bankruptcy. This threat looms especially large in states that, due to low payment rates or other factors, already have only a limited number of plans willing to participate in Medicaid. If the scenario we have outlined is correct, the number of states in this unfavorable position may well increase.

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