

MHPA Fact Sheet

July 2011

Responding to the Commonwealth Fund Issue Brief “*Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide*”

Medicaid Health Plans of America (MHPA) represents both nonprofit and for profit Medicaid health plans. We urge policymakers to reject the conclusions of the Commonwealth Fund Issue Brief, “*Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide*” for the following reasons:

Poor Research Methodology

- **The small sample size makes statistical interpretation difficult and results suspect.** The authors relied on financial and quality data for a limited number of plans from different and inconsistent sources. For example, the authors had preventive and chronic condition data from only one-third of plans that met the criteria for their analysis. For quality data, publicly traded plans were underrepresented, and were disproportionately located in south and Atlantic states. The analysis relied on administrative and medical expenditures which are calculated differently across states and types of plans.

Failure to Explore Alternative Explanations for Differences

- **The authors did not adjust for the effect that geographic location can have on quality data.** The publicly traded plans reporting quality data were disproportionately located in the south and Atlantic states which can skew results.
- **The authors did not adjust for the effect that differences in enrollees could have on costs or quality data.** They failed to analyze whether certain populations (i.e., low income vs. higher income children, disabled, elderly), are more likely to enroll in certain types of plans and how that might impact cost and quality data.
- **The authors did not explore the impact of differences in state Medicaid policies.** They did no analysis on how differences in payment rates or mandatory/non-mandatory enrollment might influence costs or quality.

Results Inconsistent with Study Previously Conducted by Same Author Using Similar Data

- **The author’s previous study used a superior research methodology.** Author Robert McCue conducted a study in 2006 which explored a similar topic with similar data. In that study, given the acknowledged data weaknesses, the authors prominently disclosed study weaknesses and attempted to strengthen the data by conducting interviews with state policymakers.
- **The author’s previous study arrived at more cautious conclusions about costs and quality comparisons.** The authors explained that the small sample size made comparison difficult. Lower medical loss ratios of publicly traded plans were not unexpected and were consistent with the more sophisticated medical management of such plans. Quality indicators showed no consistent pattern of differences across plans. States did not identify any strong systematic concerns about the performance of investor-owned plans.
- **The author’s previous study acknowledged that the increased participation of publicly traded plans firmed up and brought financial stability to the Medicaid market.**

Other Studies Have Not Reached Same Conclusion

- Patricia Born and Carol Simon (Health Affairs, 2001) found for profit status was not a major factor in observed differences in plan performance.
- Bruce Landon et. al., (Journal of American Medical Association, 2007) found the type of health plan less determinant of quality than the demographics of the population being served.
- Landon and Arnold Epstein (Health Affairs, 2001) found non-profits and for-profit Medicaid plans to have only subtle differences in management practices, quality and utilization review.

MHPA strongly advises that state policymakers seek out more balanced information when evaluating potential health plan contracts for their Medicaid programs. We note the following:

Quality of Care in Medicaid Managed Care and Commercial Health Plans

Bruce E. Landon et. al., Journal of the American Medical Association, 298, no. 14 (2007):1674-1681.

“We found little difference in the quality of care provided to the Medicaid population served by Medicaid-only plans compared with the quality of care provided to the Medicaid population served by commercial plans that also served Medicaid enrollees.”

“These findings suggest that the type of health plan enrolling the population (commercial, Medicaid/commercial, or Medicaid only) is a less important determinant of the quality of care than differences in the characteristics of the population being served, the local provider networks in which they receive care, access to care, patterns of care seeking, and adherence to treatment recommendations.”

Patients And Profits: The Relationship Between HMO Financial Performance And Quality Of Care

Patricia H. Born and Carol J. Simon, Health Affairs, 20, no.2 (2001):167-174.

“For-profit status, in our analysis, is not a major factor in observed differences in plan performance. Other economic and market factors explain, in a statistical sense, a significant amount of the variation we observe. Competition and the nature of the health care marketplace are important.”

“Quality measures are generally higher when plans operate where there is greater managed care presence and where the structure of the hospital market gives opportunities for more competition.”

“Our findings suggest that plans may not be making a choice between profits and quality but, rather, that plans need to generate profits to enable quality. While this is not new to economists, it is hardly a conventional notion in health policy circles.”

For-Profit And Not-For-Profit Health Plans Participating In Medicaid

Bruce E. Landon and Arnold M. Epstein, Health Affairs, 20, no.3 (2001):162-171.

“Our data suggest that for-profit and not-for-profit health plans are similar in their management practices and capabilities, and there appear to be only subtle differences in their quality and utilization management practices.”