

**MANAGING ACCOUNTABILITY IN  
MEDICAID MANAGED CARE:  
THE POLITICS OF  
PUBLIC MANAGEMENT**



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Nelson A.  
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## Foreword

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**J**ames W. Fossett is a perceptive, experienced political science observer of American state and local health programs and American federalism. In this report, written with colleagues studying five states, Fossett and company explore a crucial public policy subject that is not well understood or widely studied — the management of Medicaid managed care.

This pilot study is a component of the Rockefeller Institute of Government's 20-state field network evaluation of the implementation of welfare and related social programs begun by the Institute in 1997. Even though this is a pilot study, and our intention is to expand its scope both substantively and geographically, the report by Fossett and company is rich and informative in a way that we felt warrants distribution at this juncture.

Fossett and company assess the various purposes of the now-pervasive Medicaid managed care systems, focusing in a summary way on the capacity of state governments and their partners locally to be "prudent purchasers" on a basis that aids both the public fisc and the intended recipients of Medicaid services. Their conclusions are cautious. One state, Arizona, is far along in this endeavor and has been at it a long time. Others of the five states studied (the sample also includes Kansas, Michigan, New Jersey, and West Virginia) have made progress, but the challenges involved, as put under the microscope here, are immense and daunting. This is the case not just in the public sector, but as is well known from the larger national debate now underway — in the private sector as well.

On behalf of Thomas L. Gais, co-director of the Rockefeller Institute's State Capacity Study, and myself, we express appreciation to Jim Fossett and his colleagues for their thorough and timely exploration of this important subject. We also appreciate the assistance provided by many state officials and other respondents in the field research conducted for this report.

Richard P. Nathan  
August 15, 1999

## **Introduction**

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Once a rarity, managed care has become ubiquitous among state Medicaid programs. Enrollment has expanded better than fivefold since the early 1990s to the point where almost half of the Medicaid population is now enrolled in some form of managed care. Enrollment growth has been most rapid among the program's traditional "welfare" clientele — low-income women and children — rather than among the less numerous, but more expensive, elderly and disabled populations. Enrollments have also expanded most dramatically in more aggressively managed, full-risk forms of managed care rather than in less aggressive forms such as primary care case management, where providers are not at risk for the care they provide to clients.<sup>1</sup>

The popularity of managed care has been driven both by desire to save money on Medicaid and by the potential of managed care to enhance the accountability of the health care system in ways that were not possible under the fee-for-service system. Care under the fee-for-service system is provided by a host of independent providers and reimbursed one service at a time. There is no single entity that can be held responsible for the care provided to clients and little opportunity for states to influence the way care is delivered to Medicaid clients or establish standards for the appropriateness or quality of care. Managed care, by contrast, creates one organization — a health maintenance organization (HMO) or something similar — that accepts a single capitated payment for the entire range of services to Medicaid clients. This organization can, at least in theory, be held responsible for the entire range of health care received by its enrollees, and be sanctioned in various ways if it fails to comply with specified standards of care.

While managed care thus provides states with the opportunity to influence the care available to Medicaid clients, it also requires that states have the administrative capacity to exercise this influence effectively. If not implemented well, managed care may worsen the quality of care by concentrating the most

disadvantaged populations into care arrangements where there are strong incentives to under-treat families, while reducing or eliminating access to emergency rooms and other traditional sources of care. States' success at negotiating contracts with appropriate standards, prescribing information and other systems to measure compliance with these standards, and developing the political support to enforce the standards — how well they manage, in a word — is thus likely to be a critical determinant of the effects of managed care on Medicaid clients.

While there has been no shortage of academic and professional attention to Medicaid managed care, there has been surprisingly little systematic attention to states' experience with managing oversight on a large scale. The few studies that have explicitly addressed implementation issues have focused on the initial "conversion" of the Aid to Families with Dependent Children (AFDC) population from fee-for-service to managed care, particularly in states which attempted the largest and most aggressive expansions of managed care.<sup>2</sup> A number of organizations survey or monitor state policies and oversight practices in a variety of areas and offer frequently excellent advice for state managed care policymakers and program managers, but the reports of these surveys are frequently descriptions of "what states are doing" that make no attempt to assess the effectiveness of program implementation.<sup>3</sup> Many evaluations of Medicaid managed care have examined small-scale pilot or demonstration projects rather than the large-scale programs currently in place in many states. Most have focused on the effects of managed care on cost and utilization for different groups of clients and eschewed, frequently explicitly, the management and implementation issues involved in establishing and operating such programs.<sup>4</sup> Yet it is a reasonable supposition that management affects outcomes, and that better management may produce better outcomes. Management is one of the few variables affecting patients that is under the control of policymakers, and it is important to understand how management is being done so that the effects of differences in organization and oversight on what happens to patients can be understood.

An examination of the implementation of Medicaid managed care should also provide insight into the transferability of “best practices.” States that do things “better” may have advantages — sophisticated plans with cutting edge reporting systems, strong political support from elected officials, or well paid and unusually skilled staff, for example — that make best practices feasible in those states, but which are not present in other states. By comparing the implementation of managed care in “best practice” states with others, it should be possible to identify those factors that make best practices feasible in some states and the extent to which such practices can be transferred readily to other states.

This study assesses the implementation of Medicaid managed care to date in five states, focusing on the mechanisms states have put in place to oversee the operations of managed care organizations enrolling Medicaid recipients and states’ success at holding these organizations accountable for the care they provide clients. This study examines those portions of state managed care programs that enroll the women and children in the AFDC or TANF populations rather than the elderly and disabled populations, who are eligible for Medicaid through their receipt of Supplemental Security Income (SSI). SSI recipients in many states are enrolled in some of the same managed care arrangements as the TANF population; in others they are not, and most receive considerable Medicaid supported services either through a “carved out” specialized managed care plan for their particular disability (the most common arrangement is for mental health) or through the fee-for-service system.<sup>5</sup>

The five states examined in this study are listed in Table 1, together with descriptive information about active managed care arrangements for the TANF population during the fall of 1998. These states are not a sample in any statistical sense, but represent a broad range of managed care program forms, sizes, and management strategies. Arizona is one of the few states in which effectively all Medicaid recipients are enrolled in managed care. The state never had a traditional fee-for-service Medicaid program and has perhaps the longest running, best-established managed care

**Table 1**  
**Managed Care Arrangements for TANF Population, Fall 1998**

<i>State</i>	<i>TANF-Related Managed Care Enrollment, Fall 1998</i>	<i>Primary Care Case Management Enrollment</i>	<i>Full Risk Managed Care</i>		<i>Number of Plans</i>	
			<i>Mandatory</i>	<i>Scope</i>		
Arizona	332,130	0	Yes	Statewide	332,130	12
Kansas	84,550	70,633	Partial	2/3 of counties	13,917	3
Michigan	754,596	98,067	Yes	Statewide	656,529	31
New Jersey	380,000	0	Yes	Statewide	380,000	9
West Virginia	129,000	83,000	Yes	1/4 of counties	46,000	3

program in the country. The state's managed care program, known as the Arizona Health Care Cost Containment System (AHCCCS), has been extensively evaluated and has received uniformly high marks both for management and program outcomes.<sup>6</sup> It is included in this study as a "best practices" state. Michigan and New Jersey mandate full risk enrollment for all TANF recipients, but still retain fee-for-service Medicaid for other population groups such as the aged or disabled. Both are wealthy industrial states with strong traditions of nonprofit health care, generous Medicaid programs in both coverage and benefit levels, and well-paid, professional civil services. Kansas and West Virginia have mandatory full risk programs for TANF recipients in some urban areas, with primary care case management (PCCM) enrollment required for recipients elsewhere. Both are small rural states with traditions of less generous Medicaid programs and less well-paid employees.<sup>7</sup>

This study was conducted using the field network methodology, which has been successfully used to investigate the operations of a number of domestic programs.<sup>8</sup> This method, which combines intensive on-site investigation by locally based scholars with a common analytical framework monitored by a central staff, offers advantages over the multicase implementation study common in many domestic policy areas, which typically rely on site visits by outside investigators whose field time is short and whose local contacts may be limited. By relying on extended on-site research by locally based investigators with extensive knowledge of local political and market conditions and access to a broader range of local sources and evidence and a common analytical framework that allows comparison between cases, the field network method produces potentially replicable evidence on the operation of complex domestic programs such as Medicaid managed care.

This report is organized into four major sections. The first section describes the major conceptual differences between "accountability" in a managed care environment and in traditional fee-for-service Medicaid and presents the definitions and measures of accountability used in this study. The second section examines the market and political context within which managed

care was implemented in each state, and presents hypotheses on how differences in these conditions are likely to effect states' ability to implement managed care. The third section presents findings on how states have organized the oversight of managed care plans and the extent to which they have been successful in holding plans accountable. The final section presents our conclusions on the effectiveness of managed care as an oversight mechanism.

## **Accountability in Managed Care**

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Medicaid managed care represents a major change from traditional fee-for-service Medicaid in the management and oversight requirements it places on states. Accountability in fee-for-service Medicaid has been defined by the need to control expenditures and insure that all appropriate restrictions have been observed. Under this system, clients find providers who are willing to treat them, and providers provide treatment and submit a bill. The state pays the bill under a set of detailed federal rules governing the eligibility of clients, providers, and services. States may also restrict the "amount, duration and scope" of care by limiting the services a client may receive. States are also required to collect payments from insurance companies or other third parties who may be liable for a portion of the cost of care.

Under these arrangements, states have almost no control over the services provided to Medicaid clients and little leverage, apart from the fees paid to providers, over the quality and accessibility of care. Since payment is tied to the provision of individual services, no individual organization or provider can be held responsible for the quality or appropriateness of the care provided to individual patients. Rather, the state's primary responsibility is auditing and paying the bill after service has been provided. Most state Medicaid agencies have historically defined their role in terms of this bill-paying function and have not seen themselves as having any affirmative responsibility for setting or enforcing standards for gauging the appropriateness of care or improving the accessibility or quality of care to Medicaid clients. The management

information and other systems states have put in place to oversee fee-for-service Medicaid are oriented towards traditional command and control tasks – verifying the eligibility of clients, providers and services; detecting and preventing fraud, waste, and abuse; and documenting collections from third parties and the level of payments to particular providers in order to claim federal reimbursement.

Accountability in managed care is more complex. Rather than auditing and paying individual bills, states are now required to negotiate and oversee contracts with managed care organizations for packages of services to large populations covered by a single payment for each enrollee. Advocates have argued that these different arrangements provide states with the opportunity to improve the quality of care available to Medicaid patients in ways unobtainable under the fee for service system. By contracting with an organization that accepts payment for the entire range of services to Medicaid clients, managed care creates a means of defining standards for the quality of care to which plans can be held accountable and sanctioned if they fail.<sup>9</sup> The process of developing and applying such standards have come to be known in Medicaid argot as being a “prudent” or “value purchaser.”<sup>10</sup> One advocate has defined the basic elements of this strategy succinctly:

In order to obtain health care value, the prudent purchaser must define quality, measure it, seek to improve it, and exert market leadership. . . . The prudent purchaser must put into place the elements of a good quality management system – negotiated performance goals, member satisfaction surveys and focus groups, independent external reviews, continuous quality improvement systems, data reporting, and consequences for underachievers. Then the prudent purchaser must use these elements effectively, keeping in mind that the system should not be micro-managed, or made to respond to unrealistic expectations.<sup>11</sup>

State success at becoming a “prudent purchaser” thus means basically three things. One is the ability to state requirements for plan performance in contracts or regulations specifically enough so that compliance with these requirements can be measured. Particularly if differences in performance between plans

have financial consequences, what performance means and how it is to be measured must be stated explicitly and with sufficient clarity to withstand legal and political challenges from plans that do not perform well.<sup>12</sup> Second, the state should be able to tell with some confidence whether plans are complying with contractual requirements. States and plans should have clear common understandings both of what plans are expected to report and of appropriate standards for information systems and measures. Performance information should be collected and reported in such a manner that the state and other interested parties can be satisfied that they are valid, reliable, and reasonably comparable. Third, there should be consequences to plans for failure to comply with contractual or regulatory standards. States should be able to identify plans that are not performing at acceptable levels and take action to correct problems or apply appropriate sanctions.

This study examines two interrelated aspects of state performance to date in achieving these results. One is organizational. This study will examine how states have chosen to organize managed care oversight, including the division of labor between state agencies and outside organizations, and investigate the level of resources states devote to regulating plan activities.

The second major part of this study examines the processes that states have established to oversee plan activities. We focus on state oversight in four major areas — financial performance, quality assurance and improvement, access and network capacity, and consumer relations. We will apply a common framework to each area which assesses the specificity of state requirements, the information systems the state has established to measure compliance with requirements, and the state's ability to take action to enforce the requirements if plans are not compliant.

## **The Context for Managed Care**

States do not manage Medicaid managed care plans in a political or market vacuum. To the contrary, states' ability to put forth and insist on strong accountability standards is heavily shaped both by

the managed care market in which they function as purchasers and by the bureaucratic and political environment around both managed care and Medicaid. Two broad contextual factors appear to be particularly important for states' ability to function as "prudent purchasers" – the state's position as a purchaser in the local managed care market and the political context within which Medicaid managed care is implemented.

### States in the Managed Care Market

One broad contextual factor shaping the implementation of Medicaid managed care is the nature of the state's managed care market and the state's relative strength as a purchaser. Health care markets vary widely in their competitiveness, the extent of managed care penetration, provider adaptation to managed care, and other factors that affect the competitive position of Medicaid agencies as purchasers of services. In more competitive markets, Medicaid clients may be more attractive to plans, and states may be able to strike better bargains. In less competitive markets, where there are few plans, states may have more trouble insisting on strong accountability standards and may have trouble getting plans to bid.

A second factor that influences states' strength as purchasers are the capitation rates which they pay compared to those available from commercial purchasers. The waivers under which states operate Medicaid managed care programs require that managed care be "budget neutral" or not cost any more than the same services would have cost under the state's fee-for-service Medicaid program. In practice, this means that state rates 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 these calculations, rather than by current market conditions, may make it difficult for states to pay commercially appropriate rates. In addition, governors, budget bureaus, and legislators may

find the opportunity to realize savings from Medicaid irresistible and set rates below the UPL.

States can partially compensate for low rates by such devices as limiting the number of plans and guaranteeing a high volume of clients by “locking in” coverage for a minimum length of time rather than subjecting plans to the uncertainty produced by the high turnover within the Medicaid clientele. By increasing the volume of clients, these devices reduce the average cost to plans of providing care to Medicaid clients and insure stable revenue flows, thereby making Medicaid clients more financially attractive than they would be otherwise.

The five states in this study can be divided into three groups along these dimensions. Arizona has both an active commercial managed care market and has been able to pay rates sufficient to attract and retain a stable set of plans, many of whom have been long-term participants in Medicaid managed care. Michigan and New Jersey have newer and less well-developed managed care markets than Arizona. Both states were historically high fee-for-service Medicaid payers, however, particularly for hospital care, so that both have been able to attract significant numbers of plans interested in Medicaid contracts without making any concessions. Kansas and West Virginia have limited private markets, tend to pay below commercial payers, and been required to make concessions to attract plans, with limited success.

### Commercial Market Development

The five states in this study vary widely in their commercial health market development. As shown in Table 2, their HMO penetration rates vary from just above the national average to well below it, and the penetration rates of other forms of managed care shows a similar disparity. These and other data suggest that managed care is well established in Arizona, Michigan, and New Jersey, but less so in Kansas and West Virginia.

Among these states, the private managed care market is best developed in Arizona, where managed care of some form is

<i>State</i>	<i>Managed Care Penetration</i>
Arizona	30.30%
New Jersey	31.30%
Michigan	25.30%
Kansas	14.40%
West Virginia	10.70%
United States	28.60%
Source: Interstudy HMO Industry Report, 1998	

the dominant mode of health insurance for both public and private employers. By contrast with the other states in this study, managed care has also made substantial in-roads into the state's sizeable elderly population — almost 40 percent of the Medicare recipients in the state are enrolled in managed care, well above the national average. Several large national managed care organizations are active in the state, and providers are accustomed to dealing with managed care.

Managed care and the health delivery system are less well developed in Michigan and New Jersey.<sup>15</sup> While HMO penetration is about the national average for both states, it is below the average for other large urbanized states. The large-scale consolidations and other organizational changes in the health delivery system associated with managed care in such states as California and Minnesota have not occurred in either state. Both states have a strong tradition of nonprofit health care — Blue Cross and Blue Shield have historically been the dominant actors in the health insurance industry in both states, and the Blue Cross plan in Michigan is the state's largest HMO. Until 1992, New Jersey administratively set the rates hospitals were paid by insurance companies, including HMOs, so

that market competition for both hospital care and insurance coverage is a recent development compared to other states.

The commercial managed care industry is increasingly competitive in New Jersey and in the Southeastern part of Michigan around Detroit. While there are no national managed care companies active in Michigan, the number of plans has increased sharply since 1994. In the smaller urban and rural areas in “outstate” Michigan, managed care is less well established, and several counties had no active managed care organizations until the state’s entry into Medicaid managed care. National companies are more active in New Jersey, and consolidation among plans has already begun as a result of strong price competition.

By contrast, managed care is much less well established in Kansas and West Virginia. Both are small, predominantly rural states with few large employers and with shortages of providers in many areas – over half the counties in Kansas and two-thirds of those in West Virginia have been designated either in whole or in part as “medically underserved” in some fashion. There are few plans in either state, and most are small, frequently not capitated, not accustomed to aggressive price competition, and financially tenuous. Providers in both states, particularly in rural areas, are opposed to managed care and have been unwilling to participate in plans’ panels, making it difficult for managed care to become established. In Kansas, for example, only about one-fifth of the managed care enrollees in the state are enrolled with HMOs, as compared to almost sixty percent in preferred provider organizations (PPOs). Managed care activity in the state is also geographically restricted:

Kansas is primarily rural, and most of the state does not offer the competitive environment in which managed care ideally operates. Even Kansas’ urban areas have had only marginal experience with the managed care concept. . . . Most of the private managed care penetration exists in the state’s northeastern counties . . . in or near the Kansas City metro area. The other major population center in the state – Wichita – has experienced much less private managed care activity.<sup>14</sup>

Managed care in West Virginia is likewise limited in size and geographic scope. There are seven HMOs licensed in the state, but only four have more than 20,000 enrollees, and several have experienced financial problems. The largest stimulus to the establishment of managed care was the state government's entry into the market as a purchaser for its employees as well as for Medicaid:

In 1995, managed care covered only two percent of the state's population . . . (in large measure) because the state chose to allow its public employee insurance and Medicaid programs to enter into managed care arrangements, the number of West Virginians covered by managed care grew to . . . approximately 11 percent of the population. . . . As of 1997, the state as a payer made up 51 percent of the (managed care) market. . . . Given the state's low wage base, increasing dependence on service jobs, a small population that is not growing appreciably, and the large percentage of the population that is uninsured, the prospects (for future commercial growth) seem limited.<sup>15</sup>

### State Managed Care Rates and Policies

These states also vary widely in the competitiveness of the rates they pay compared to those available from commercial payers. Arizona sets managed care rates by competitive bid. The state prescribes rate corridors in its contracting materials and requires plans to submit bids within this range, giving preference to plans with bids that are lower than others, but higher than the rate floor. The state also manages the enrollment assignment process to insure that plans receive enough members for the contracts to be economically viable.

Arizona is also distinctive in that the state's Medicaid agency (known, like the program, as AHCCCS) has been successful in retaining effective political control over the rates it pays. In most states, including the others in this study, rates are effectively constrained by the UPL and the state's budget process. Since Arizona never had a fee-for-service program, it is not constrained by the UPL. For historical reasons, which will be discussed at length later in this report, the agency's staff is unusually sophisticated

financially and has command of a broad range of technical information which has allowed it to press its case through the state budget process with considerable skill. As a result, Arizona has been able to “follow the market” more effectively than many states and continue to pay competitive rates.

Michigan and New Jersey, where Medicaid managed care is a more recent development, have also been able to pay reasonably competitive rates without volume guarantees or other concessions. Both states were historically high payers under Medicaid fee for service, particularly for hospital care, which is the largest single component of managed care rates.<sup>16</sup> While New Jersey made no apparent attempt to realize immediate savings from managed care, Michigan’s procedure was more complex. Like Arizona, the state solicited bids within rate “corridors” that were set separately for the Detroit area and the remainder of the state. The first round of competitive bidding in the Detroit area set the corridors well below fee-for-service rates and produced bids as low as 80 percent of the UPL, saving almost \$120 million compared to fee-for-service costs. The state pursued a different strategy outside of Detroit to encourage the development of new plans:

Rates were higher — reflecting the state’s desire to promote the emergence of new plans and to encourage existing plans to participate. . . . The state had no expectations of savings in the outstate round. The state also changed the bidding process to encourage firms to participate. . . . The state has also been somewhat lenient in enforcing the requirement in the RFP that state risk-sharing would end after the first year. The plans were to become full risk and forced to become a licensed HMO. . . . Eighteen months into the contract, at least one-third of the plans are still (not licensed).<sup>17</sup>

By contrast with these three states, Kansas and West Virginia pay rates that are appreciably below commercial rates. Both were historically low payers under fee for service, and both have made appreciable efforts to make Medicaid clients commercially attractive. Kansas has adopted a wide range of measures to keep plans involved with Medicaid, including mandating enrollment, guaranteeing eligibility, increasing rates slightly, and reducing the administrative burden on plans. West Virginia has made fewer

overt concessions, but has resisted efforts by provider groups to allow so-called “Provider Sponsored Networks” (PSNs) to receive Medicaid contracts because of concern that existing plans would be adversely affected:

... (the state) is quite dependent on existing HMOs for the continuation and expansion of the (state’s) managed care program. . . . The state needs to be very sensitive to the conditions and needs of those HMOs operating in the program. . . . Because HMOs have such a tenuous foothold in West Virginia, the state does not want to undercut the market by allowing (provider sponsored) arrangements.<sup>18</sup>

### States as Purchasers

These differences in demography and state rates and practices have translated into differences in success at attracting and retaining plans. Arizona has been successful in developing and maintaining ongoing relationships with a stable set of “home grown” provider-owned plans which are reliant on Medicaid for a significant portion of their revenues. Several of these plans have had contracting relationships with AHCCCS for over fifteen years and have developed reporting systems and other administrative practices around state requirements. This familiarity with state requirements has given them an advantage in competing for contracts:

The existence of home grown plans has allowed AHCCCS to avoid making concessions to attract larger plans to the bidding process. (There has been) some involvement by larger managed care plans in more recent bidding cycles, but because AHCCCS is in the enviable position of having more plans bidding than there are contracts to award, the agency has been able to insist on high levels of performance without making concessions. In a couple of cases, the larger companies were not able to easily meet the state’s requirements and chose not to continue their contract. . . . The home grown plans . . . have grown with the needs of AHCCCS, while the new plans . . . must invest quite a bit of effort and resources to come up to speed.<sup>19</sup>

New Jersey and Michigan also currently have “excess capacity” in the sense that they have contracts with more plans than

required to maintain adequate choice for recipients in almost all areas. New Jersey initially had contracts with fourteen plans. Five have dropped out, but the state has made no contractual or rate changes; and state officials expect further consolidation as financially weaker plans are absorbed by larger organizations. Michigan currently has contracts with thirty-one different plans, some of which have small enrollments. The Detroit area, where the bulk of the TANF population is concentrated, has fourteen currently active plans. The outstate area is more unevenly served, with some rural areas having only the current legal minimum of two plans available.

Again, by contrast, Kansas and West Virginia have had considerable difficulty attracting sufficient numbers of plans. West Virginia currently has contracts with three plans, which is sufficient to maintain a choice of two plans in the fifteen counties where full-risk enrollment is currently mandatory. Attempts to expand the program to include additional counties and to incorporate the SSI population have as yet been unsuccessful, in some measure because of plans' unwillingness to expand. Kansas' problems have been even more severe. In spite of significant concessions, all of the state's commercial plans terminated their participation in Medicaid at the end of 1998, leaving only one plan willing to enroll Medicaid clients.

These differences in the state's market position serve as a limiting factor in the state's ability to impose reporting and quality requirements, particularly when those requirements are more stringent than those prevailing in the commercial market. States in a weak market position may find it difficult to press for strong accountability provisions or aggressively enforce existing provisions for fear of pushing plans out of Medicaid. States in a stronger market position may choose not to make accountability a high contractual or administrative priority for other reasons, but they are likely to be in a stronger position to hold plans accountable than states where Medicaid clients are unattractive to most plans.

## The Political Context of Managed Care

A second related factor which influences the implementation of Medicaid managed care is the political context within which the program operates. Medicaid agencies may fail to capitalize on a strong market position if they fail to develop political support among agency management, budget bureaus, and elected officials for maintaining competitive rates; the significant investment of time, effort, and resources required to function as a prudent purchaser, and rewarding or penalizing plans or providers based on performance. States differ in their interest group configurations and the views of their citizens on the importance of Medicaid and other social programs, and these differences have consequences for states' ability to implement managed care. In states where social spending is unpopular and there is little organized support for attention to quality and access, elected officials may be interested in managed care primarily as a means of reducing Medicaid expenditures, and may be unwilling to support complex changes in agency organization and staffing. Privatizing or downsizing government services have been popular political themes recently, which may complicate agency efforts to acquire the skills required to oversee managed care effectively. In states where social programs have broader political support, by contrast, elected officials may be more willing to support more complex objectives for managed care such as improvements in quality and access.

The states in this study manifest three distinct patterns of managed care politics. The basic political parameters governing Arizona's program were set during the early 1980s, when AHCCCS was granted an unusual amount of administrative autonomy in order to prevent the program from collapsing. Program managers have been successful in preserving much of this autonomy and maintaining a largely bipartisan base of support among elected officials. In Kansas and West Virginia, political support for managed care appears to have focused primarily on the potential for cost containment, while in Michigan and New Jersey elected officials seem to have a more complex set of objectives.

Arizona is distinctive among the states in this study in that it never had a fee-for-service Medicaid program and has been involved in managed care since the early 1980s. The state received the first waiver from HCFA for a large-scale capitated program that was developed with considerable bipartisan political support from both the legislature and the governor. The state initially contracted the administration of the program to a private contractor, which canceled its contract on thirty days notice after less than two years of operation. The large number of officials with political stakes in the program who would be embarrassed if it completely collapsed led to widespread support for unusual grants of authority to a new executive director who was brought in to reconstitute the program as a public agency. Among other things, the new agency was provided a direct reporting relationship to the governor, and allowed exemptions from the state's personnel and procurement systems, which allowed the agency unusual freedom in hiring and salary decisions and in structuring its contracting process according to its own desires. While some of these exemptions have since been repealed — the agency is no longer independent of the state civil service system, for example — AHCCCS has maintained much of its autonomy and political support. Thus, while Arizona was and remains a conservative state with a limited Medicaid program, the bureaucratic autonomy provided by the historical circumstances surrounding the formation of managed care has become institutionalized. The agency has been able to limit the growth of Medicaid expenditures to politically acceptable levels, so politicians have had little reason to alter existing arrangements.

By contrast, managed care was instituted in the other four states primarily as a response to the rapid growth of Medicaid expenditures in the late 1980s and early 1990s. Both as a result of increasing case loads and increasing unit costs, Medicaid expenditures increased sharply in all four states over this period. As in many other states, much of the political appeal of managed care appears to have stemmed from its potential as a cost-containment device. In Kansas and West Virginia, cost containment appears to have been the primary political motivation.

Medicaid has been an unpopular program in both states because of its cost, particularly after significant cost overruns in several years in the late 1980s and early 1990s. Medicaid agencies in both states have low bureaucratic status, and have had credibility problems in state legislatures. In West Virginia, for example, the legislature established a separate committee to oversee Medicaid and other human service programs and gave responsibility for the bulk of the new Children's Health Insurance Program (CHIP) to the agency that operates the public employee health insurance program rather than to the Medicaid agency, an assignment widely interpreted as reflecting a lack of legislative trust. Similar credibility problems were reported in Kansas:

(The agency which includes Medicaid) suffers from the same prestige issues faced by welfare agencies in many states. Gubernatorial and legislative support for . . . downsizing and for review of its activities to maximize service provision through contracts with non-governmental agencies whenever possible, demonstrate the pressures the agency faces. . . . The agency is under especially tight staffing scrutiny partly due to the perception of some legislators that it is a lumbering and inefficient agency . . . during the initial deliberations over managed care legislation, virtually no input was solicited from the agency.<sup>20</sup>

These problems of growth in Medicaid expenditures and legislative dissatisfaction with the Medicaid agency's limited success at keeping expenditures under control appears to have produced strong political support in both states for managed care primarily, if not solely, as a means of controlling costs. Elected officials may well be genuinely interested in the quality of care that Medicaid clients receive, but Medicaid agency managers perceive their primary charge to be reducing expenditures.

Political expectations around managed care have been more complex in Michigan and New Jersey. Both states have traditionally had generous health and social service programs which have drawn bipartisan support from both governors and legislators. Both states have historically had strong, politically active unions and Republican parties that have been moderate by national standards, making the political environment more liberal than in

Kansas or West Virginia. Governors in these states are structurally and politically more powerful than in many others, and major policy initiatives have traditionally come from the executive.

Consistent with these differences in political context, managed care in these states was put forward primarily as an executive initiative with a broader set of objectives rather than being focused on cost containment. In Michigan, where Medicaid expenditures doubled between 1990 and 1997, managed care was part of a larger set of gubernatorial entitlement reforms that included considerable reorganization of several state agencies, appointment of new senior management without traditional social service backgrounds, and a strong rhetorical emphasis on competitive bidding and performance contracting.

The state clearly wanted to stop the growth in Medicaid spending and saw managed care as the only way to do so without drastically cutting eligibility or provider payments. But many state officials go beyond the cost cutting rhetoric, emphasizing instead the need to remold the way health care plans and providers organize and do business. Also important is the state's desire to be cost-efficient while improving the quality of the product that is delivered . . . through competition and value purchasing.<sup>21</sup>

Medicaid managed care in New Jersey was part of a larger, market-oriented package of changes in the state's health care programs. The state had previously experimented with prepaid health programs on a small scale and even operated its own HMO in the late 1980s. Excluding payments to disproportionate-share hospitals, Medicaid spending in New Jersey grew by less than the national average during the early 1990s,<sup>22</sup> so there was less pressure to use managed care as a means of realizing short-term budget savings. Rather, broader use of managed care was part of a larger set of changes aimed at increasing the market orientation of the state's health care system, which had been heavily regulated and subsidized. New Jersey had been one of the few states that directly set hospital rates and had subsidized hospitals through payments for bad debt and charity care. Major legislation in 1992 eliminated the state's rate-setting system and reduced state subsidies for hospitals. State employees have also been moved into managed care and

there has been considerable reorganization of the state's human service agencies, though not, as in Michigan, with the intent of maximizing the state's purchasing leverage. Managed care was not an explicit gubernatorial priority as in Michigan, but both the governor and legislature have been broadly supportive and advocacy groups have not posed strong objections. Medicaid agency managers are expected to produce savings from managed care, and claim they have done so, but there has been political support for improving quality as well.

### Summary – Context and Management

These differences in market and political context indicate that states confront very different managerial tasks in overseeing plan performance. In Arizona, Michigan, and New Jersey, state Medicaid agencies are in a relatively favorable position. Managed care is well established in the private insurance market or is rapidly becoming so. State agencies are in strong positions as purchasers-state premiums have been reasonably competitive and there is, at least currently, a surplus of plans interested in competing for Medicaid contracts. Elected officials have been willing to support more complex objectives for managed care beyond cost control, so that agency officials have some political "slack" to pursue improvements in quality and access.

By contrast, Medicaid agencies in Kansas and West Virginia face a more difficult situation in overseeing plan performance. Managed care is less well established in the private market than in other states, and there is significant opposition from providers, particularly in rural areas. State premiums are low, and both states have become dependent on a small number of plans to enroll Medicaid clients. Neither state has been able to move into full-risk managed care on as large a scale as planned, so that much of the TANF population remains in fee for service or case management. Elected officials are mainly interested in managed care as a means of saving money, so that Medicaid agencies have limited leeway or resources to pursue other objectives.

We now turn to an examination of the consequences of these differences in political and market context for state oversight policies and practices. We first assess the organizational arrangements states have made for plan oversight, then examine the substance of plan oversight.

## **Oversight Organization**

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As many observers have argued, implementing Medicaid managed care on a large scale requires extensive and potentially expensive “re-tooling” of the operations of state Medicaid agencies.<sup>23</sup> Since most states retain fee-for-service Medicaid programs for substantial portions of their Medicaid population and many operate multiple forms of managed care, states have frequently been required to develop their managed care oversight structure without any reduction in other administrative obligations. The fixed costs of oversight systems are high compared to the variable costs associated with individual patients, so that administrative requirements for other parts of Medicaid are unlikely to decline much even if large numbers of clients are moved into managed care. Medicaid agencies have been traditionally staffed to pay bills, not purchase value, and the organizational cultures that have developed around these activities place heavy weight on regulatory compliance and catching cheaters, norms which do not transfer well to managed care. Managed care is more expensive to administer than fee for service because managed care attempts to regulate activities there were outside the scope of fee-for-service programs. Instituting managed care also requires that state Medicaid agencies acquire expertise in a variety of areas, ranging from business-style financial reporting to quality assurance, that were not required under fee for service. States can acquire these skills in a variety of ways, ranging from retraining existing Medicaid staff to hiring new staff to contracting with consulting firms or other specialized companies.

This section examines the manner in which the five states in this study have organized the oversight of plan activities. It

outlines the organizational arrangements states have developed for overseeing plan activities and assesses, albeit roughly, the level of resources states have invested in plan oversight.

## **Organizational Arrangements and Resources**

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State organizational arrangements are obviously influenced by the political and market context within which Medicaid agencies operate. States where market conditions limit the size of managed care programs continue to operate significant fee-for-service programs and may have to operate multiple forms of managed care. Managed care is thus competing for resources and policy makers' attention with activities that spend considerably larger amounts of money. In similar fashion, political attention and resources may be diverted from managed care by other, more visible, initiatives. The recently enacted Children's Health Insurance program and the recently publicized decline in Medicaid enrollments resulting from the implementation of welfare reform, for example, may consume resources and administrative effort that otherwise might have been invested in managed care. In similar fashion, gubernatorial and legislative support for managed care objectives beyond cost containment may manifest itself in higher levels of resources and support for organizational changes to improve the quality of plan oversight. It is thus not surprising that state strategies for organizing managed care oversight among the five states in this study are closely correlated with market and political conditions. Three broad sets of such strategies can be distinguished.

Arizona's AHCCCS program has pursued a consistent strategy of performing almost all oversight functions in-house. Unlike the other states in this study, AHCCCS subcontracts almost no significant oversight activity, including plan enrollment and financial oversight, which are almost universally contracted either formally or informally elsewhere, and has recently expanded its staff to allow consumer surveys, which had previously been contracted, to be performed in-house. The state contracts for actuarial

services and all plans undergo a federally mandated external review, but almost all on-going oversight is done by program staff.

This reliance on program staff, rather than contractors, appears to be the result both of a “standing decision” by agency officials to retain control over policy making and oversight and of the agency’s early independence from state personnel and procurement requirements. Since Arizona never had a fee-for-service program, the state was able to focus its oversight structure around managed care rather than being required to graft a new structure onto an established program. The agency also used its initial independence in hiring and pay to recruit staff largely from health plans, consulting firms, and providers rather than from other state agencies. The agency’s prestige has allowed it to continue to attract sophisticated and experienced staff:

Much of AHCCCS’ success is attributed to its ability to pay the necessary salaries to attract innovative, creative people . . . in the early years. While AHCCCS no longer has personnel procurement exemptions, the tone set in the beginning appears to have persisted. . . . The creative, innovative climate that was created became the draw.<sup>24</sup>

The state’s ability to attract a stable flow of staff with the necessary expertise in financial management, quality assurance, and management information systems limits the need to rely on contractors for these skills. Much of AHCCCS’s success in attracting unusually sophisticated staff, however, seems to be the result of a distinctive set of historical circumstances. The lack of a fee-for-service program and the initial exemption from state personnel requirements provided a considerable degree of management flexibility that is unlikely to be present in many other states.

A second set of organizational arrangements, perhaps more typical than Arizona, can be observed in Michigan and New Jersey, which both retain sizeable fee-for-service programs for Medicaid clientele other than the TANF population. Under these arrangements, the state Medicaid agency retains policy control over managed care and controls much of the program’s oversight, but relies more heavily on contractors and other state agencies for

technical and analytic advice and services and some oversight activities. Both states have large contracts with enrollment brokers to oversee or implement the enrollment process, and both have extensive contracts for data collection and evaluation in addition to federally mandated external reviews. Both rely heavily on state insurance departments for financial oversight of plans with Medicaid contracts, and New Jersey has largely delegated the oversight of consumer relations, including complaints and appeals, to the unit of the state health department that handles these problems for other HMOs.

While managed care in New Jersey was not a high political priority and was implemented without significant organizational change, Michigan reorganized its health-purchasing activities significantly. Managed care was part of a gubernatorial initiative with the announced intentions of moving all Medicaid clients, including the elderly and the disabled, into managed care and turning the state into a “value purchaser.” As part of this initiative, the Medicaid program was removed from the state welfare agency and placed into a new Department of Community Health with the former Departments of Mental Health and Public Health, the state’s primary “purchasers” of health services. There was also considerable internal reorganization away from the agency’s traditional functions towards a structure oriented towards competitive purchasing and contract oversight.

This reorganization was accompanied by considerable turnover in the agency’s upper-level management. The state offered voluntary retirement to a number of senior Medicaid managers and filled many of the new management positions with staff from outside the Medicaid agency, though usually from inside state government. The agency’s executives recruited individuals with strong market orientations and without strong attachments to the fee-for-service program, with the result that few of the senior managers involved in the oversight of managed care came from the “old” Medicaid program. Thus, while the agency received no new staff resources to implement managed care, there were

significant numbers of new managers selected for their commitment to this program direction.

A third set of organizational arrangements appears in Kansas and West Virginia. Managed care is small in both states compared to the fee-for-service program and both states operate large ongoing primary care case management programs as well as full-risk managed care. Neither state has invested significant staff resources into managed care oversight or made significant efforts to develop staff expertise in managed care. Rather, both have relied heavily on private contractors, as well as other state agencies, for both technical advice and much of the direct oversight of plans.

The most extreme case of delegation appears in West Virginia, where the state's Office of Medicaid Managed Care has only one professional employee. The office was provided several new positions to assist in program oversight, but these positions have not been filled, largely because of state officials' satisfaction with existing contractual arrangements. Other units within the Medicaid agency have responsibilities for oversight of data management and utilization review, and the state Insurance Commission is the primary agency involved in financial oversight. The bulk of on-going oversight of plans, however, has been delegated to several contractors. The state sees its role in these arrangements as management of these contracts rather than active participation in the oversight process:

. . . West Virginia opted to buy program components 'off the shelf' and tailor them to the state. This has been done by relying on private consultants and contractors to construct and manage the program . . . the primary qualification of agency staff rests in a knowledge of the political and policy contexts of program development and contracting. In other words, the priority is administrative ability rather than functional knowledge of the managed care arrangements.<sup>25</sup>

Kansas is more complex. By contrast with West Virginia, the state has attempted to retain a formal role in the oversight process and has received over a dozen new positions to do so. There is no "office" of managed care or other unit formally charged with

plan oversight, however, and the staff responsible for managed care has been assigned significant other duties:

Most of the staff hired to operate Medicaid managed care are not 'dedicated' exclusively to this program. Many are still involved with some aspects of fee for service, or other elements of Medicaid. More recently, most are involved in the administration and implementation of the Children's Health Insurance program. . . . As a result . . . the state is very dependent on contractors . . . significant authority has been delegated to (the contractors), particularly with regard to communicating with providers and plans.<sup>26</sup>

These differences in oversight organization translate into differences in the level of resources devoted to managed care oversight, both in Medicaid agencies and private contractors. Table 3 lists staffing levels in the organizational units most directly involved in managed care oversight for the TANF population in each state; while Table 4 lists major current contracts for plan oversight and their approximate value.

As measures of the resources invested in plan oversight for the TANF population, these figures are rough approximations at best. Many of the oversight units have significant responsibilities for other populations and functions, and several contracts include other Medicaid-related services as well as managed care. While more precise estimates are at least theoretically possible, developing such estimates would require an enormous amount of detailed data that may not be available in many states. Even if available, such estimates would not be particularly helpful in gauging the intensity or sophistication of state oversight processes since they would fail to account for differences in such factors as the qualifications of state oversight personnel, the sophistication of the reporting systems that are in place, or the ability to use the results of reporting systems to influence plan behavior. A direct examination of state oversight processes is likely to produce a defensible verdict on the success of states in functioning as "prudent purchasers."

**Table 3**  
**Employment in State Agency Units Directly Involved in Managed Care Oversight**

<i>State</i>	<i>Location of Medicaid Agency</i>	<i>Units Directly Involved in Plan Oversight</i>	<i>Positions (Approximate)</i>	<i>Other Responsibilities</i>
Arizona	Free-standing	Office of Managed Care Medical Director	100	Managed care for other populations – SSI/long-term care
Michigan	Department of Community Health	Plan Service Bureau Quality Assurance Bureau	125	Managed care for other populations and fee for service
New Jersey	Department of Human Services	Office of Managed care Managed Care Monitoring Bureau	25	None
Kansas	Welfare agency	No formal unit	13	Fee for service
West Virginia	Human Services Agency	Office of Managed Care	2	None

<b>Table 4 Major Contracts for Managed Care Oversight</b>			
<i>State</i>	<i>Number of Contracts</i>	<i>Total Outstanding Value</i>	<i>Services Covered</i>
Arizona	None		
Kansas	2	\$4.1 million	Data Management Enrollment Management Consumer Relations Evaluations – quality and access
Michigan	5	\$29.6 million	Enrollment Management Systems Development HEDIS audits Evaluation
New Jersey	3	\$28 million	All Medicaid data management Enrollment Management Evaluation
West Virginia	4	\$1.4 million	Program Management Data Management Decision support Enrollment Management Consumer relations

### **State Oversight Processes**

State Medicaid agencies contracting with managed care plans face many of the same administrative and contractual problems as any other organizational “principal” hiring an agent to provide health insurance or any other service. Purchasers typically wish to limit their health insurance expenses, but may also want to insure adequate care for their employees. Plans, by contrast, have objectives which may conflict with those of the principal with whom they contract. Plans receive a fixed payment for each enrollee and have to cover any care in excess of this payment from their own re-

sources. In order to insure their long-run financial survival, their average cost per patient has to be below the fixed payment. This payment arrangement may create an incentive for plans to under-treat patients or deny medically necessary care. Purchasers concerned about this possibility have to make provision to overcome the “information asymmetry” between themselves and plans about the costs of providing care and the level of care plans are providing to their enrollees. Thus states, or any other organization, wishing to insure that adequate care is provided to those for whom they are purchasing care are obligated to monitor plan activities by collecting and analyzing information about plan costs and the level and types of services plans provide. In order to function as a “prudent purchaser” along the lines proposed by many advocates, states are further obligated to define contractually adequate standards of care and penalize plans who fail to meet these standards.

Medicaid agencies, along with other public purchasers, confront several structural problems not faced by private purchasers of care. First, because of their public nature, they are more “accountable” than private companies for their contracting decisions and are likely to be required to demonstrate to some external body, particularly legislatures, what the state received in exchange for the expenditure of tax funds. Private companies are not required to offer health insurance or to provide any particular package of benefits and are not required to pay attention to anything other than price in purchase decisions. Medicaid agencies, by contrast, are purchasing a mandated package of services for a population that has a legally enforceable right to receive them, and are likely to be under a variety of constraints imposed by state legislatures, audit requirements, and federal dicta to report on a wide range of matters that require the collection of information from contractors. As a result, public contracts almost inevitably require more reporting and other “red tape” than private ones.

These elevated levels of external accountability may also make it difficult for states to enforce performance requirements or sanction plans which fail to meet standards. Plans, providers, and

other public contractors involved in disputes with state agencies can appeal to courts, legislatures, and the media and get adverse state agency decisions overturned or significantly modified. State administrative procedures acts require that agencies be able to demonstrate the reasonableness of their actions to the satisfaction of a judge, and legislators may be swayed by campaign contributions or threats to providers that are major employers in their districts to intervene in such disputes. Aggressive demands on plans for improved performance or moves to terminate contracts or apply other sanctions may cause plans to drop out of Medicaid, litigate, or press demands in the political process and in the media that they are being driven to bankruptcy or unduly penalized for minor reporting problems. Even if these appeals are unsuccessful, terminating plans may require a considerable logistical effort to re-enroll large numbers of Medicaid recipients in other plans and deal with payment for any services they may receive in the interim. While states may be compelled to attach more “red tape” to their contracts than private purchasers, they may be more constrained in their ability to terminate or sanction delinquent contractors. The prospect of extended litigation or hostile political or media attention may cause state agencies to withhold sanctions in all but the most egregious cases. If there are few plans willing to accept Medicaid clients, states’ ability to insist that plans meet performance standards may be effectively eliminated.

These problems are accentuated by the immature measurement and reporting standards and technology associated with measuring the performance of managed care plans. Mature reporting systems, such as the financial reporting process, have developed a number of features that allow users to make use of the data these systems produce with some degree of confidence. There are explicitly stated and broadly understood sets of rules about the acceptable range of variations in reporting practices; a method, through the audit process, of enforcing compliance with these reporting standards and certifying companies as in or out of compliance; an established process for debating and promulgating changes in the standards; and a stable source of people trained in the rules and in the administration of the system. Methods for

using financial information to measure company performance are well established, and benchmarks for acceptable performance are widely circulated.

The measurement and reporting of health care quality and outcomes meets almost none of these standards. While there has been considerable improvement in the measurement of quality of care, the state of the art in this area is still widely argued to be relatively primitive, and there is still significant debate about the conceptual underpinnings of quality or outcome measurement. Most measurement standards for judging quality still focus on more readily measurable structural or process characteristics such as rates of immunization, mammography, and other disease screening rates rather than on the outcomes of care.<sup>27</sup> There is also limited standardization of reporting particulars and measurement conventions. The National Committee on Quality Assurance (NCQA) has emerged as the leading actor in the standardizing of plan reports and reporting systems through its Health Plan Employer Data and Information Set (HEDIS). Only about one-third of all plans, however, participate in NCQA's public reporting program for HEDIS data and member satisfaction surveys.<sup>28</sup> NCQA has recently announced plans to develop a coordinated measurement agenda with two major quality oversight groups for physicians and hospitals,<sup>29</sup> but it is not without competition and accreditation remains voluntary.<sup>30</sup> Both plans and providers continue to have considerable latitude in what they report, how they calculate what they report, and a fair number have chosen not to report anything at all. In similar fashion, the state of practice among plans is very uneven. While some plans have developed highly sophisticated data systems, others have more minimal systems and the quality of reporting varies widely. One recent large audit performed for the Health Care Financing Administration (HCFA) of the quality of HEDIS data submitted for Medicare managed care patients, for example, found considerable problems with the quality of much of the data and recommended that HCFA be "extremely cautious in using any unaudited measures for health plan comparison."<sup>31</sup> Measurement schemes for other areas of managed care

performance, such as the adequacy of provider networks or consumer satisfaction or complaint rates, are even less well developed.

This limited standardization in both standards and practice may complicate state efforts to develop or to enforce performance standards in many areas. Since there are no clear benchmarks for defining “adequate” performance in many areas, particularly for the Medicaid population, and many plans who are otherwise eligible and interested may lack the systems to reliably report performance measurements, states may be constrained in their ability to place performance standards in contracts or to hold plans to those standards that are contractually defined.

This section examines the success of these five states in addressing these agency problems. It first examines reporting and performance requirements in four major oversight areas and examines the processes states have developed for using the information plans are required to report. It then assesses the oversight routines and processes states have developed for overseeing plans and examines their likely success in applying sanctions to plans.

#### Oversight Processes – Reporting, Performance, and Use

This study examines state reporting and performance requirements and the uses states make of information that plans are required to report in four major areas. One is financial reporting and performance. The adequacy of Medicaid capitation rates has become an increasingly contentious political and managerial issue in many states, and the declared intention of many states to institute competitive bidding for managed care contracts makes the ability to gauge the adequacy of proposed rates increasingly important for states. The second area is quality assurance and improvement, the area that has attracted the most sustained attention both from states and the health policy community. Third, we examine access and network capacity requirements. The availability of sufficient physicians, particularly of primary care physicians, to provide adequate care to enrolled Medicaid clients was a particularly conten-

tious issue in waiver discussions between some states and the Health Care Financing Administration, and continues to be debated between state agencies and advocacy groups in a number of states.<sup>32</sup> Fourth and finally, we assess reporting and performance requirements around consumer relations. It may be difficult for Medicaid patients, many of whom may not be well educated, may not speak English, or lack access to adequate legal or other advice, to make effective use of available statutory protections governing service coverage, the ability to appeal plan denial or care, and other potential disputes. States' ability to oversee plan activities under these circumstances may be more important than it might be in a private insurance setting.

**Financial Performance.** Plan financial performance and fiscal solvency is an increasingly visible area of state oversight, as the adequacy of rates has become a public issue in a large number of states. Plans in some states have gone bankrupt, some commercial plans have withdrawn from the Medicaid market and more have complained that rates are inadequate to support reasonable levels of care. In other states, complaints about "excessive" profits by managed care companies have become visible public issues.

Financial management is an area where Medicaid agencies have had little expertise or experience. Historically, responsibility for financial oversight of managed care organizations, as well as other insurance providers, has been the regulatory preserve of state insurance departments, who are generally responsible for licensing managed care organizations and other providers of health insurance. While the particulars of insurance department oversight of managed care organizations varies widely in both breadth and depth, the basic intent of most reporting systems is to monitor the financial condition and performance of managed care organizations as a whole rather than of individual lines of business such as Medicaid. Typically, plans are required to maintain specified levels of particular types of financial reserves as protection against the possibility that income is insufficient to cover payments to providers. Plans report on operating results at specified intervals, with adverse results triggering requirements for more

frequent reporting or corrective action to remedy particular problems.

Given this focus on overall plan performance, insurance department reporting systems may not contain enough detail on individual lines of business such as Medicaid to provide an adequate picture of the financial performance of Medicaid contracts. Even if a plan's overall financial condition is sound, any of a number of reasons may cause its Medicaid contracts to perform less well than its other lines of business. States that can monitor the performance of Medicaid contracts may be able to take corrective action and prevent plans from leaving the program or defaulting on their obligations. Particularly in states that have competitive bidding rather than setting their own rates, the ability to monitor the financial performance of Medicaid contracts independent of the plan's overall performance is important to judging the reasonableness of bids and rejecting those that are too low.

Among the states in this study, the most significant difference in financial oversight capability is between Arizona and the other four states. Because AHCCCS has been able to attract staff with substantial credentials in financial management and reporting, including several CPAs, the agency has developed a Medicaid financial reporting system that is completely independent of the state insurance department's requirements. AHCCCS uses information from this system to develop rate corridors within which plans have to bid, to adjust rates between contracts, and to monitor the financial condition of plans:

AHCCCS staff generally know ahead of time when plans are having financial difficulties and can take appropriate action to help resolve difficulties . . . to help the plans attract an adequate number of clients in each area . . . [And] remain economically viable, AHCCCS limits the number of plans in some geographic areas. They also cap enrollment in some plans to avoid too rapid a growth that might lead to the plans exceeding their capacity. This also helps to control damage when plans are having difficulties. . . .

By contrast, the other four states remain much more dependent, either formally or informally, on state insurance

departments to oversee the financial performance of plans. All four require licensure or compliance with insurance department financial viability and reporting standards as a precondition of receiving a contract, and all require plans to submit periodic financial reports that meet insurance department standards. Two states — Michigan and Kansas — receive reports from the insurance department that provide analysis of plan financial conditions — and all four rely informally on insurance department staff to identify plans that are experiencing difficulty.

These states have been less successful in developing the capability to monitor the performance of Medicaid contracts or to use financial information as a management tool. While all four states receive separate financial reports from plans on the performance of Medicaid contracts, none have yet developed Arizona's capability to use this information to manage enrollment or to establish and modify rates. Michigan is the only state besides Arizona with any full-time staff devoted to financial oversight. The state's insurance department, however, remains the lead agency in dealing with plans:

... this unit is just beginning to analyze the data it receives. In reality ... the first line of defense against financial trouble ... has been the Michigan Insurance Bureau. In fact, it was routine financial reporting to the insurance bureau ... that uncovered a problem at a (plan) operating in the Detroit area with 50 percent of its business in its Medicaid contract with the state. It was the Michigan Insurance Bureau, and not the Department of Community Health, that turned out to be the first line of defense against the contractor's financial collapse. Enrollment freezes and ultimately, the threat of canceling the contract forced (the plan) to sit down and work out a rescue plan with the state health department

This limited ability to gauge how plans are managing financially under Medicaid contracts deprives Medicaid managers of a potentially useful tool in setting rates and managing enrollment. Plans might be expected to lobby for higher rates and threaten to withdraw from the program if these demands are not met. A more sophisticated understanding of plan finances would

provide Medicaid managers with a basis for judging the legitimacy of these concerns and determining how to respond to them.

**Quality Assurance/Improvement.** Quality assurance and improvement has been the oversight area that has attracted the most significant attention from states and the Medicaid policy community. Central to most definitions of “prudent purchasing” or performance contracting in Medicaid managed care is the ability to define and measure quality of care and to tie financial rewards and continued contracts for plans to successful attainment of contractually specified performance standards.

States’ ability to promulgate and enforce performance standards is potentially limited by several factors. First, standards or benchmarks developed in the commercial market may not transfer well to the Medicaid population. Many pregnant Medicaid clients, for example, are not enrolled in Medicaid and assigned to a managed care plan until after the end of the first trimester of pregnancy, making it difficult to transfer commercial standards for early entry into prenatal care to this population. In similar fashion, many children are not continuously enrolled in Medicaid, making it difficult to transfer commercial pediatric standards for well child care or immunization rates. While benchmarks for the Medicaid population are likely to emerge from experience in time, deciding how to establish these benchmarks for local use may require considerable negotiation. Second, reporting conventions and standards in this area are only partially standardized, so that any given state may be unable to attract business from plans that can report on HEDIS measures or any other reasonable set of performance standards in a reliable fashion. Unless local plan reporting systems and practices are unusually sophisticated, states wishing to institute performance standards may be required to invest considerable effort and money in systems development, training, negotiating with plans over reporting conventions, and auditing to insure that reported data are comparable and of reasonable quality.

Given these difficulties, it should not be surprising that the states in this study have few formal performance standards in

contracts with plans or place plans at risk for failure to meet any given standard, a finding similar to that in other studies of managed care contracts.<sup>33</sup> These states vary widely, however, in the degree to which their quality reporting systems approximate the prerequisites for instituting such standards. The major difference within this set of states is, again, between Arizona and the other four states. While some of this difference is the result of Arizona's longer experience with managed care, it also reflects a qualitative difference in the level of investment in data quality and systems development. Arizona has developed an integrated, encounter-based reporting system that provides almost all the system's on-going information requirements in a variety of areas, while the systems in other states are in various stages of development.<sup>34</sup> While the Arizona system predates Medicaid HEDIS, it reports on a variety of HEDIS-like measures that apply to the TANF population, as well as a variety of measures focused on the elderly and the disabled. Two differences between the implementation of this system and those in other states are of particular note.

One major difference is the level of investment in data quality. Arizona initially implemented the system in 1991, and has spent the intervening period upgrading the quality of plan reporting. AHCCCS operates regular training programs for plan and provider personnel on data submission requirements, the only agency in this sample that does so. There is considerable formal and informal contact at the technical level between AHCCCS and plan personnel on definitional questions and other technical matters to insure comparability between plans. The state performs annual data validation audits to monitor the completeness and accuracy of encounter data, and must approve any changes in plan information systems. There are potential financial sanctions associated with failure to implement audit recommendations or for inadequate reporting, and the state authorizes reinsurance based on plan reports, so plans have significant financial incentive to maintain the quality of their reporting.

A second major difference between Arizona and the other states in this sample is the uses to which information is put. Most

states use quality reports for “monitoring” purposes — state personnel look at plan reports and may perform some limited analysis, note any disturbing changes or trends that may or may not be brought to plans’ attention, and may or may not follow up to note any change in plan practices in response to inquiries. Data reports are rarely distributed to plans or to consumers, and there is little explicit comparison of performance.

While Arizona does not distribute any information to consumers on a routine basis and has no formal performance standards, it has several mechanisms that have the effect of encouraging plans to compare their performance to other plans and provides limited awards for performance. The state regularly distributes comparative information on plan and provider performance to plans and providers, with a plan or contractor’s performance rated against the average of other plans or providers or unidentified data from all other organizations. AHCCCS is currently developing an initiative to provide some limited financial awards to high performers and provides some preference to high-performing plans in the contracting process:

If a plan/contractor has a good performance record, they are allocated a full score without filling out some sections of the RFP. If they have deficiencies, they must fill out all portions and sometimes they need to prepare more than a contract requires — they could be asked to propose a plan for addressing the area in which they are deficient.<sup>35</sup>

These processes, while not formal performance standards, may nonetheless exert some influence over plans’ behavior. The availability of comparative performance data, even without public distribution, has been shown to have a significant effect on the rates at which a wide variety of surgical procedures have been performed,<sup>36</sup> and it is not unlikely that this process has produced attempts by low scorers to improve their ratings.

The four other states in this study have quality improvement reporting and feedback systems that are at various stages of development. In line with its announced objective of becoming a value purchaser, Michigan has developed an aggressive system for

overseeing plan quality, although the system has not been in operation long enough to gauge its effectiveness. The state has articulated minimum standards for immunizations and several screening procedures that apply to continuously enrolled clients. There are no penalties associated with failure to meet those standards, however, although a bonus is planned for plans that meet immunization and well-child visit goals.

Michigan's oversight structure is more decentralized than Arizona's, but contains mechanisms intended to insure similar attention to data quality and comparative performance. Organizationally, quality has been given an elevated status. The unit charged with quality oversight reports directly to the Medicaid director rather than to a subordinate manager, and a clinical advisory committee composed of plan quality and medical directors has been established to define reporting frameworks and oversee plan quality improvement efforts. A staff member has been assigned to monitor plans' attention to quality improvement. The state has established an encounter reporting system, although only two-thirds of the plans were able to submit data as of early 1999. The state has let a large contract for auditing of plan encounter reporting and HEDIS submissions and plans a broad dissemination of plan performance results.

The other three states in this study have developed less aggressive approaches to quality oversight. All three have required plans to report HEDIS results or similar measures, but none have explicit performance standards and there has been less investment in data quality and less dissemination of results. Two of these three states – Kansas and New Jersey – have had difficulties getting all plans to report requested data. These problems have been particularly significant in Kansas, where only about half the requested measures have been available. West Virginia, where all plans are NCQA accredited, has had less trouble with reporting.

These results suggest that becoming a "prudent purchaser" is a complex organizational task that requires a considerable investment in systems development and data quality to achieve. It is difficult to envision a politically or legally viable

method for penalizing or rewarding plans for performance without a stable source of reliable, comparable data on all participating plans. Arizona's experience suggests that achieving this level of data quality requires considerable investment over an extended period of time. Given that several states have yet to establish stable reporting relationships with all participating plans and lack any structural means of insuring the quality of the data they receive, it would appear that "prudent purchasing" is currently beyond the reach of a number of states.

**Access and Network Capacity.** The availability of sufficient providers, particularly primary care physicians, to serve Medicaid managed care clients has been a persistent concern in debates over Medicaid managed care. TANF clients are residentially concentrated in depressed inner-city areas where there are few physicians, and the potential loss of access to public hospitals and other "safety net" providers under managed care has made the adequacy of plan network capacity of particular concern. Advocates have argued that managed care can potentially broaden the availability of mainstream providers to Medicaid clients, while detractors have expressed concern that clients may be limited to traditional high-volume "Medicaid mills" without the safety valve of access to hospital emergency rooms or public facilities.<sup>37</sup>

Insuring adequate access in managed care is complicated by the limited consensus around a variety of important conceptual and measurement issues in defining network adequacy. States commonly require plans to submit lists of providers in their networks and can compare them to any of a variety of staffing standards or benchmarks, but these standards vary widely.<sup>38</sup> In addition, there exists little consensus about how to address such common measurement problems as physician membership in multiple networks and feasible travel times.<sup>39</sup> Finally, methods for monitoring changes in accessibility to capture such common events as practices being opened or closed to new patients, retirements, and other changes that alter the availability of care from a particular network are not well developed.

Given these difficulties, it is perhaps not surprising that the states in this study follow the practice of requiring plans to document the adequacy of their networks in a more or less rigorous fashion initially upon contract receipt, but rely on other, generally more informal, means of monitoring access on an on-going basis. All states contracts contain minimum staffing requirements and require plans to report on staffing on a regular basis, but only Arizona requires that plans adjust their capacity reports for physician membership in multiple networks. In similar fashion, all states' contracts contain requirements for appointment availability, but only Arizona routinely collects data from plans on compliance with these standards. More typically, states rely on consumer complaints, surveys, and other informal means of identifying difficulties in getting care. In Michigan, for example,

Network capacity monitoring is largely informal and highly personal. The plans develop relationships with their . . . contract managers who both monitor their activities and provide assistance in dealing with some of the problems. The idea is that the plans had to meet certain formal standards to be certified and once certified, the informal system will be best to detect and solve any possible problems.<sup>40</sup>

Kansas has a detailed capacity monitoring system, but has experienced considerable difficulty in getting data from plans and timely analyses from the responsible contractor. As a result, particular access problems are typically resolved by informal means:

These problems are addressed in an *ad hoc* fashion, frequently through informal regular contacts between SRS and plan staff, and through monthly meetings of the state's Peer Education Resource Council. . . . There have been no sanctions in this area, although in some instances, informal action plans have been formulated to address particular access problems. SRS is much more concerned with retaining plans than with sanctioning performance with regard to network capacity.<sup>41</sup>

These results suggest that access and capacity is a relatively low oversight priority for these states. Unlike quality monitoring, where there is at least a minimal amount of standardization of reporting conventions and requirements, systematic

monitoring of the available capacity in a plan's network, particularly over time, is a complex task for which there are few established standards or reporting conventions. Consequently, states rely on a front-end screening of network capacity as part of the initial contract or certification process, and on other, more informal means of identifying and addressing on-going access problems.

**Consumer Relations.** The relationship between managed care plans and their enrollees has been the subject of a much publicized backlash in recent years. In response to a variety of "horror stories" stemming from the denial of care and strong lobbying campaigns from patient advocates and physicians, nurses, and other providers, a number of states have recently enacted patient protection legislation limiting the ability of managed care organizations to restrict access to care and giving patients enhanced rights of grievance and appeal.<sup>42</sup> There has also been extensive discussion about the information plans should be required to disclose to current or potential clients on a wide range of matters, ranging from coverage to information on individual providers and performance information of various types. Patient protections similar to those in recent legislation have been explicitly extended to Medicaid patients by many state contracts and recently by executive order.<sup>43</sup>

As a reporting and measurement technology, consumer relations is generally better developed than the measurement of access and capacity, but less well developed than financial reporting. NCQA accreditation standards require regular surveys of consumer satisfaction and specify appropriate elements of a grievance and appeals process, which has contributed to at least a partial standardization of plan practices in these areas.<sup>44</sup> There are several validated survey instruments that are broadly used to measure consumer satisfaction, including one for Medicaid clients – the Consumer Assessment of Health Plans (CAHP), developed by the Agency for Health Care Policy and Research.<sup>45</sup> A variety of official and unofficial groups in addition to NCQA have issued guidelines for plan grievance and appeal processes that contain many common elements,<sup>46</sup> but there has been little attempt to standardize reporting requirements. Plans generally appear to keep track of

complaints and the use of formal appeals processes and to use this information to change procedures and replace providers. There is little standardization of definitions across plans, however, so that comparable information does not typically exist. It is also unclear what appropriate benchmarks would be. Plans differ in the sophistication of their members and their concern about member satisfaction, so that it is unclear that a low complaint rate would be unambiguously positive.

The five states in this study follow a roughly similar regime in regulating plan relationships with customers, although the organizational arrangements for oversight vary considerably. All five approve all plan marketing materials, and all but Arizona contract with an enrollment broker to enroll clients in plans. There were a number of widely publicized scandals involving direct marketing and enrollment by plans in the early 1990s, and most states have prohibited or significantly restricted plans' ability to market to and enroll clients directly. Arizona's enrollment arrangements predate these scandals, and the state was unaffected by the difficulties in other states, so enrollment continues to be handled by county eligibility workers.

All five states also monitor client satisfaction in roughly similar ways. With the exception of New Jersey and West Virginia, which have delegated oversight to other agencies, all have staff explicitly charged with overseeing this area. All conduct or commission patient satisfaction surveys and disseminate the results. All require plans to maintain a hotline to respond to client questions and complaints, and all require plans to designate a grievance or complaint coordinator to handle client and provider complaints and grievances, and specify timetables and processes for addressing complaints and grievances. All maintain other channels for clients to lodge complaints about plans, usually through a hot line operated by the state agency or a contractor. All require plans to report on client inquiries, complaints, and grievances on a regular basis. In almost every state, however, there appears to be a strong preference for resolving problems informally before they reach the grievance stage. In West Virginia, for example:

Consumer satisfaction and complaint issues are reported on a quarterly basis to the Office of Medicaid Managed Care . . . this area is distinct from other oversight areas as it focuses more on case-by-case concerns rather than on aggregate program performance . . . there has been very little use of the formal grievance process. . . . The practice appears to be to work out complaints and disputes within the HMOs, sometimes with the enrollment broker helping things along by informing higher levels of authority in the plan that problems are afoot.<sup>47</sup>

This emphasis on individual cases, rather than aggregate performance, and a preference for informal rather than formal resolution of particular problems likely increases the responsiveness of the system to individual complaints, but it may also limit the effectiveness of the reporting system in providing potential clients and purchasers with a reasonable picture of plan performance. Plans that are unresponsive to consumers unless they complain or threaten legal action may have a low formal grievance rate, but not because of the high quality of their service. Given that Medicaid clients may be less likely to complain than better educated, more efficacious private clients, reliance on individual initiative may be at best a partial substitute for effective formal state oversight, particularly in large states with many plans where state officials are unlikely to have detailed informal understandings of the internal activities of all contractors.

### Oversight Routines and Processes

As the above accounts suggest, these states vary widely in the processes and organizational routines they have developed to oversee plan activities and in the “signals” they send to plans about what constitutes acceptable performance. Among these five states, three distinct oversight styles can be distinguished.

**Proactive.** Arizona and, to a lesser extent, Michigan, manifest what might be labeled as a proactive oversight style. There are three major features of this oversight style. One is multiple formal reviews of plan operations. This typically takes the form of front-end screenings, or readiness reviews, before plans are allowed to begin

enrolling clients, followed by periodic regular reviews of overall operations. Arizona subjects new plans to a “readiness review” to insure compatibility of systems and procedures, then reviews plan operations and performance formally on an annual basis. Michigan has instituted a similar readiness review, and relies on contract managers to oversee on-going operations at individual plans. Contract managers receive all reports, reviews, and other material related to their assigned plans, and are responsible for insuring that identified problems are addressed. Quality measures and improvement plans are addressed through a high-level committee on which plans are represented and to which plans are required to present their improvement efforts. A separate staff member is also responsible for following through on quality-improvement measures. These review systems should minimize the likelihood that significant problems are unidentified or unaddressed.

Second, both states devote significant resources to insuring data quality. While many plans have improved the quality of their reporting systems, standards of reporting practice still remain very uneven. Arizona conducts training programs for plan personnel on reporting standards and AHCCCS staff conduct regular audits of plan reporting. Michigan has a sizeable contract to audit plans’ HEDIS submissions. This attention to the quality of reporting should increase the likelihood that plan performance is adequately reflected in plan reports and that data across plans is roughly comparable.

A third feature of these states’ oversight systems is the dissemination of data in forms that permit comparison of plan performance, either by the plans themselves or other parties. While neither state has contractual performance standards that plans are at financial risk for failure to meet, both distribute (or, in Michigan’s case, plans to distribute) performance information in a form that makes explicit comparison of plan performance possible. While past experience with similar reporting systems suggest that plans are likely to make more use of such information than are patients in choosing a plan, experience also suggests that the availability of explicitly comparative information is likely to lead plans

to take action to improve their rankings even if consumers make limited use of this information.

**Reactive.** A second oversight style, which might be termed reactive, appears in New Jersey and Kansas. Neither state conducted formal readiness reviews or other front-end screening of plans prior to commencing operations, and neither conducts any regular formal performance reviews. Both states interact regularly with plans about reporting requirements and respond to problems as they are identified, but appear to be less aggressive than Michigan or Arizona in pushing plans to function in any particular fashion or in focusing attention on the results of quality reporting systems. While both states require plans to report on a wide range of quality, access, and complaint measures, neither has made any significant investment in auditing or other data quality assurance efforts, and both have experienced difficulties of varying degrees of severity in securing plan compliance with reporting requirements. While both distribute information on performance or consumer satisfaction publicly – New Jersey more so than Kansas – the limited attention to data quality and the failure to focus attention on performance in any formal interaction may send the signal to plans that they are not at any particular risk for poor performance.

**Informal.** A third distinctive oversight style, which is more informal than those in other states, appears in West Virginia. The number of public and private actors involved in the program is smaller than in other states and has been stable since the program's inception; the contractors involved in the program have performed multiple tasks over an extended period rather than single discrete activities; and there is regular interaction between the various actors. Because getting an HMO license in West Virginia requires being accredited by an external body, the three HMOs involved in the program have sophisticated reporting systems and have been able to meet the state's reporting requirements, which are similar to those required for continued licensure. The program's small size, the stability of actors, and the regularity of contact over the life of the program has produced an oversight regime that relies more

heavily on informal contact and coordination than that in other states.

There are monthly strategy and review meetings that bring together principals from (the state's major contractors), participating HMOs and the Bureau of Medical Services. . . . With only three plans participating . . . keeping track of operations should not be a significant challenge. Informal procedures appear key to maintaining lines of communication and insuring quality control among the plans and program management.<sup>48</sup>

These differences in process send considerably different signals to plans about the importance of adequate reporting and performance. Arizona and, to a lesser extent, Michigan place considerable emphasis on data quality and deal with plans in contexts that focus attention on plan performance. While neither state has formal performance standards, Arizona provides a variety of incentives for plans to improve performance and maintain the quality of their reporting systems, and Michigan intends to institute similar incentives. The cumulative effect of these procedures and incentives is to raise the visibility of data quality and performance concerns in dealings with plans and to provide incentives for plans to address these issues.

The similar signal in other states is more ambiguous. There is less formal review of plan's reporting systems and less emphasis on data quality. Plans' reporting systems are not formally audited, and there are fewer forums in which plan performance is explicitly addressed. Under these arrangements, there are fewer incentives for plans to focus explicitly on the quality of care they are providing. Since two of these states — Kansas and West Virginia — are under some pressure to maintain existing plans in the Medicaid program, their ability to focus attention on these issues is very much limited by what plans are willing to tolerate.

### Sanctions

The ability to impose sanctions on plans who do not perform adequately is one of the critical elements to state success as a "prudent purchaser." Without the legal ability to penalize or terminate plans

whose performance is inadequate, and without the willingness and political support to invoke these sanctions if needed, plans may feel under no particular pressure to improve their performance and states will lack any leverage to compel them to do so. State ability and willingness to use sanctions, by contrast, may limit the need for their use by sending a strong signal to plans that compliance is expected.

Given the difficulties outlined earlier that states face in invoking sanctions, it is not surprising that the five states in this study have made minimal use of the sanctions available to them. While all five states have a range of sanctions available, ranging from requirements for corrective action to financial sanctions and termination of contracts, there have been few uses of these sanctions and no termination of plans for inadequate performance. State agencies appear to have a strong preference for informal resolution of problems, and invoke formal penalties only in the most egregious circumstances.

The reasons for this reticence are clearest in West Virginia and Kansas. Both states have only a minimal number of plans participating in Medicaid, and few available replacements if any should drop out. In this situation, plans clearly have the upper hand in disputes with state agencies, who are likely to be extremely reluctant to invoke formal sanctions. In Kansas, for example,

Absence of competition compels SRS (the agency that administers Medicaid) to actively pursue plan retention, at the expense of somewhat weakened contract enforcement . . . all a plan must really do to maintain the state contract is to continue to provide services to Medicaid clients. While SRS clearly seeks to impel the plans to meet contract standards, SRS is in a very weak position with regard to holding plans accountable. It appears that fairly drastic performance failures would have to be evident before SRS would terminate a contract. . . . SRS will invoke some corrective action if quality or access problems surpass a threshold of acceptability, but SRS has nearly bent over backward to keep the (remaining) plan afloat in the Medicaid market.<sup>49</sup>

The situation is more complex in the other three states. While all have a reasonable number of plans participating in the

program, all appear to perceive considerable political and administrative costs associated with using sanctions and appear to be reluctant to use them except in extreme cases, preferring to rely on more or less formal arrangements for correcting less severe problems. Thus, for example, in Michigan:

The agency can sanction plans . . . it can freeze enrollment, refer to an arbitrator, or withhold payment. However, the state is reluctant to use the harsher sanctions. . . . One reason for the caution is that the plans might fail if sanctions are employed. In one case, a plan began to have financial problems. . . . The MSA (Medicaid agency) froze new enrollments, but did not withhold payments. If the MSA did stop payments, the plan would almost certainly fail. The agency felt it was more important to work with the plan rather than shut it down. A second reason the agency was accommodating was political. The plan . . . had strong connections in the Michigan legislature. The ability and willingness of plans to go to the legislature for relief is a recurring happening in Lansing.<sup>50</sup>

Similar practices were reported in Arizona, where the state has established relationships with some plans that have been in place for as long as fifteen years. Given the considerable investment by both states and plans in these relationships, AHCCCS has a strong preference for corrective action rather than imposing penalties:

. . . there have been financial sanctions levied for poor quality performance. More often, however, AHCCCS works with the health plans to develop and monitor corrective action plans. Only if corrective action fails, do they resort to financial sanctions.<sup>51</sup>

These findings indicate there are significant practical constraints on states' ability to impose sanctions on plans for failure to comply with formal contractual requirements. Dependence on a limited number of plans, fear of political or judicial reversals, or the desire to avoid jeopardizing or straining long-standing relationships appear to limit states' willingness to use available sanctions and encourage them to rely on more informal means of encouraging plans to meet contractual commitments.

## **Conclusions: Can States Be Prudent Purchasers?**

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The combination of a vulnerable population and the need to account publicly for the expenditure of tax money places particular weight on the ability of states to oversee the operation of managed care organizations effectively as compared to private purchasers. Compared to the fee for service system, managed care provides states with the opportunity to improve the accountability and quality of the providers that serve Medicaid clients, but it also requires that states develop the administrative capacity to influence the care clients receive. “Prudent purchasing” has become a widely cited shorthand term to describe the package of contractual standards, management and other information systems, and enforcement mechanisms deemed necessary for states to exercise this influence.

These findings indicate that few of the states examined here are functioning as “prudent purchasers” in the simplest meaning of that term. There are few explicit performance standards for plans embodied in state managed care contracts; performance data is universally required, but unevenly collected and analyzed; and states have been reluctant, frequently for sound political or market reasons, to use the contractual sanctions that are available to them. Such devices as “performance guarantees,” where plans put a portion of their premium payments at risk for meeting specified performance targets, are unknown.<sup>52</sup>

Among the states examined in this study, Arizona is the only state which can currently lay claim to a fully functioning oversight system that meets reasonable standards for “prudent purchasing.” Michigan’s oversight system contains many of the same organizational and process elements, but has not been in place long enough to allow a firm verdict on its performance. While Arizona has no formal performance standards that place plans at financial risk, it has oversight and information dissemination processes that make plans aware of their comparative performance and provide them with advantages if their performance is

superior. AHCCCS has invested significant resources and energy over an extended period of time in improving the quality of plan reporting, and has only recently begun to consider disseminating performance information beyond plans. Informal reports from other states considered leaders in managed care indicate that similar investments of energy, time, and money have been required to establish reporting systems of reasonable quality. Given Arizona's considerable advantages — sophisticated staff and plans and a favorable political and market setting — this extended time to establish reporting systems that will support performance judgments suggests that becoming a “prudent purchaser” is a goal that will take even the most sophisticated states considerable time to achieve and that some states may be unable to reach.

A more favorable comparison, and perhaps a more realistic one, is between state performance under managed care and state awareness of patient care and outcomes under the fee-for-service Medicaid program. While states collected enormous amounts of data on the services provided to Medicaid clients via the bills submitted by providers, almost no states made the considerable investments of time and resources required to turn claims data into usable information that could be used to monitor or evaluate the care provided to Medicaid clients. In spite of several federal initiatives to mandate the use of claims data in program reporting and provide examples and technical advice on how to turn such data into useable evidence, few states wanted such evidence badly enough to make the effort required to develop it. The findings here indicate that there are still significant problems in state attempts to acquire and use quality and other data on managed care. Almost every state, however, has significantly more and better information about the experience of Medicaid clients under managed care than under fee for service and the direction of change is generally, if not uniformly, positive.

States are also making more sustained efforts to monitor and improve the quality of care available to Medicaid beneficiaries than most private purchasers. With the exception of financial reporting and recipient surveys, Medicaid oversight requirements in

every area were reported to be more substantial than those required by local private purchasers. While a limited number of large companies and purchasing consortia have attracted considerable press for their innovative purchasing and quality measurement practices, the limited available evidence suggests that most private purchasers invest far less effort in benefits purchasing and focus almost exclusively on price.<sup>53</sup>

These heavy reporting requirements make Medicaid contracts more expensive, and hence less attractive, to private plans. Because of this elevated expense, they place a premium on states making effective use of the information they collect, both in fact and in the perception of plans. Plan complaints about excessive reporting requirements may be neutralized by states' ability to demonstrate that information is being used in a sensible and mutually beneficial ways. Thus, in Arizona, for example:

Plans may find requirements for non-financial data troublesome at times . . . but the plans acknowledge that when AHCCCS does ask for information, they use it in a productive way that is visible to the plans. . . . Occasionally, complaints from plans will cause AHCCCS to review their requirements (as they did in a recent hospital utilization study) and drop the request. . . . This keeps the plans from viewing requests from AHCCCS as exercises in futility that will not yield any useful information. Consequently, plans oblige without many complaints.<sup>54</sup>

Other states have been less successful to date in establishing a comparable relationship with plans or in making effective use of the information they collect. Several states collect data of which they currently make little use, particularly financial reports, and do not disseminate quality or other information in a fashion that encourages plans and other parties to pay any attention to the results. This limited ability to make productive use of the data collected suggests that many states may be in the unenviable position of imposing an expensive reporting burden on plans without securing any of the improvements in quality or access that the data are intended to produce. While this situation may improve in states that are able to upgrade the quality of the data they receive from plans to an acceptable level, the experience of Arizona and

other successful states suggests that it may be some time before many states have data of adequate quality to support contract decisions.

These findings also suggest that successful state oversight is heavily influenced by the market and political environment in which Medicaid agencies operate. States such as Kansas and West Virginia have little or no choice about the plans with which they will contract, making the imposition of strong performance standards backed by the credible threat of sanctions or contract cancellation effectively impossible. Managed care is only marginally established in private markets in these states, and there is little political support for the spending on either rates or staff required to establish more elaborate oversight systems. Improvements in performance or oversight are very much limited by what plans are willing to accept and the persuasive skills of oversight staff.

By contrast, the more elaborate oversight structures in place in Arizona or Michigan are largely the result of more favorable political and market conditions. Managed care is well established in these states, and there has been political support for a more complex set of objectives around managed care than saving money. Plans are on the whole more experienced and better able to comply with sophisticated reporting requirements. In Arizona, AHCCCS executives have been able to capitalize on the unusual degree of autonomy initially granted the agency to establish a stable flow of sophisticated staff and to maintain effective control over the rates the agency pays to plans. In Michigan, gubernatorial actions to reorganize the state Medicaid agency and elevate new management to important positions appear to have been critical to establishing the state's oversight structure.

This dependence of management on politics and markets suggests the need for successful managed care programs to be able to adapt to changes in these external circumstances. Supportive governors, legislators, and senior managers frequently leave office for other positions, and their replacements may be less sympathetic to agency goals. To be successful over the long run, managed care managers must develop a broad base of political support that

is not dependent on relationships that individual managers have been able to develop with individual legislators or gubernatorial staff. Among the states examined here, only Arizona has thus been able to “institutionalize” its managed care arrangements. Programs in the other four states are newer and less well established politically.

In similar fashion, managed care markets change over time, so that states may see whatever market advantage they enjoy deteriorate if they are unable to pay rates at least roughly competitive with those in the commercial market. Many states have experienced a significant loss of commercial plans over the last year in response both to changes in the larger managed care market and to unfavorable initial experiences with Medicaid.<sup>55</sup> Private managed care premiums have risen sharply recently, suggesting that states who are unable to raise rates may lose both plans and the ability to meaningfully enforce performance requirements on those who remain, who may be less sophisticated than those who departed. The need to follow the commercial market may conflict with the political requirements of state budget processes, which may be less than receptive to requests for significant increases in Medicaid expenditures. The TANF population and the providers who serve them are disproportionately concentrated in urban areas and typically are lacking in prestige, numbers, and other political resources by comparison with other Medicaid constituencies such as the elderly or the disabled, who are more broadly dispersed and command more significant political resources.<sup>56</sup> Without the ability to set the rates they pay, Medicaid agencies may find their ability to establish or enforce compliance with performance standards to be compromised.

These findings also suggest the limited transferability of so-called “best practices” between state settings. The small number of states with well-paid, sophisticated staffs, nationally accredited plans, reasonable rates, and strong political support from governors and legislators can develop any number of carefully crafted, innovative procedures that address a variety of Medicaid management problems and attract the attention of foundations,

professional associations, and policy researchers. It is doubtful in the extreme, however, that these procedures can be readily transplanted to the larger number of states that lack these advantages. Among the states in this study, for example, it is highly unlikely that any of the oversight practices followed by Arizona or Michigan could be transferred to Kansas or West Virginia, which lack the political and market advantages that made enhanced oversight possible. At a minimum, recommendations about “best practices” ought to be more pluralistic and more sensitive to variations in the circumstances in which states are required to implement managed care.

Perhaps more importantly, these findings suggest that doing Medicaid managed care “right” may be beyond the managerial and political reach of more than a few states. If Arizona’s experience is a reasonable guide, establishing oversight systems that produce reliable data of reasonable quality is an expensive, extended process for both state agencies and plans. Establishing the capability within state agencies to make effective use of such data once collected and provide incentives to plans to improve the care they provide to Medicaid clients is an equally complex process. Some states are making progress toward these goals, while others have been less successful. In states that are effectively dependent on a limited number of plans, Medicaid agencies’ ability to insist on any standards is minimal and the need to retain plans is likely to take precedence over improving performance. The complexity of these tasks and the need for supportive political and market conditions to support their effective performance suggests that some states may find less aggressive and more incremental methods of improving the quality of care available to Medicaid clients more achievable and effective.

## Endnotes

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- 1 There are two primary types of Medicaid managed care arrangements. Primary care case management requires each client to be assigned to a primary care physician (internist, pediatrician, or family practitioner) who must provide or approve all the client's care. The state continues to pay for all the client's care on a fee-for-service basis and the case manager is under no risk for the cost of the care of his/her clients. Full-risk programs, by contrast, require the client to enroll in a health maintenance organization, who accepts a capitated payment for each enrollee and must provide all medically necessary care for all enrollees from these capitation payments. If more care is required, the health maintenance organization is "at risk" for the excess, or must pay for it from its own resources.
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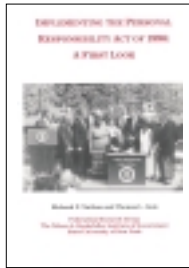
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