

**Case Studies in Medicaid Managed Care**

**CONNECTING PUBLIC POLICY  
AND MANAGEMENT:  
THE ARIZONA HEALTH CARE COST  
CONTAINMENT SYSTEM EXPERIMENT**



**John Stuart Hall  
Melinda Snook Hollinshead**



The  
Nelson A.  
Rockefeller  
Institute  
of  
Government



**Case Studies in Medicaid Managed Care**

**CONNECTING PUBLIC POLICY  
AND MANAGEMENT:  
THE ARIZONA HEALTH CARE COST  
CONTAINMENT SYSTEM EXPERIMENT**

**John Stuart Hall**

*School of Public Affairs, Arizona State University  
and*

**Melinda Snook Hollinshead**

*School of Public Affairs, Arizona State University*

**The Nelson A. Rockefeller Institute of Government**

**411 State Street, Albany, New York 12203-1003**

**(518) 443-5522 / (518) 443-5788 (Fax)**

**<http://rockinst.org> (Home Page)**

**T**he Nelson A. Rockefeller Institute of Government, the public policy research arm of the State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

Based on a paper prepared for presentation at the 21st Annual Association of Public Policy Analysis and Management Conference, Washington, D.C., November 4 -7, 1999

The authors are grateful to the Rockefeller Institute, the Flinn Foundation, and St. Luke's Charitable Trust for their generous support of this research. We are also grateful for the insights of the several experts interviewed for this article. We are solely responsible for the interpretation and analysis that follows.

© 2000 by The Nelson A. Rockefeller Institute of Government.  
All rights reserved including the right of reproduction in whole or in part in any form.

Address inquiries to:  
The Nelson A. Rockefeller Institute of Government  
411 State Street  
Albany, New York, 12203-1003  
(518) 443-5522 (phone)  
(518) 443-5788 (fax)  
cooperm@rockinst.org (e-mail)  
<http://rockinst.org> (home page)

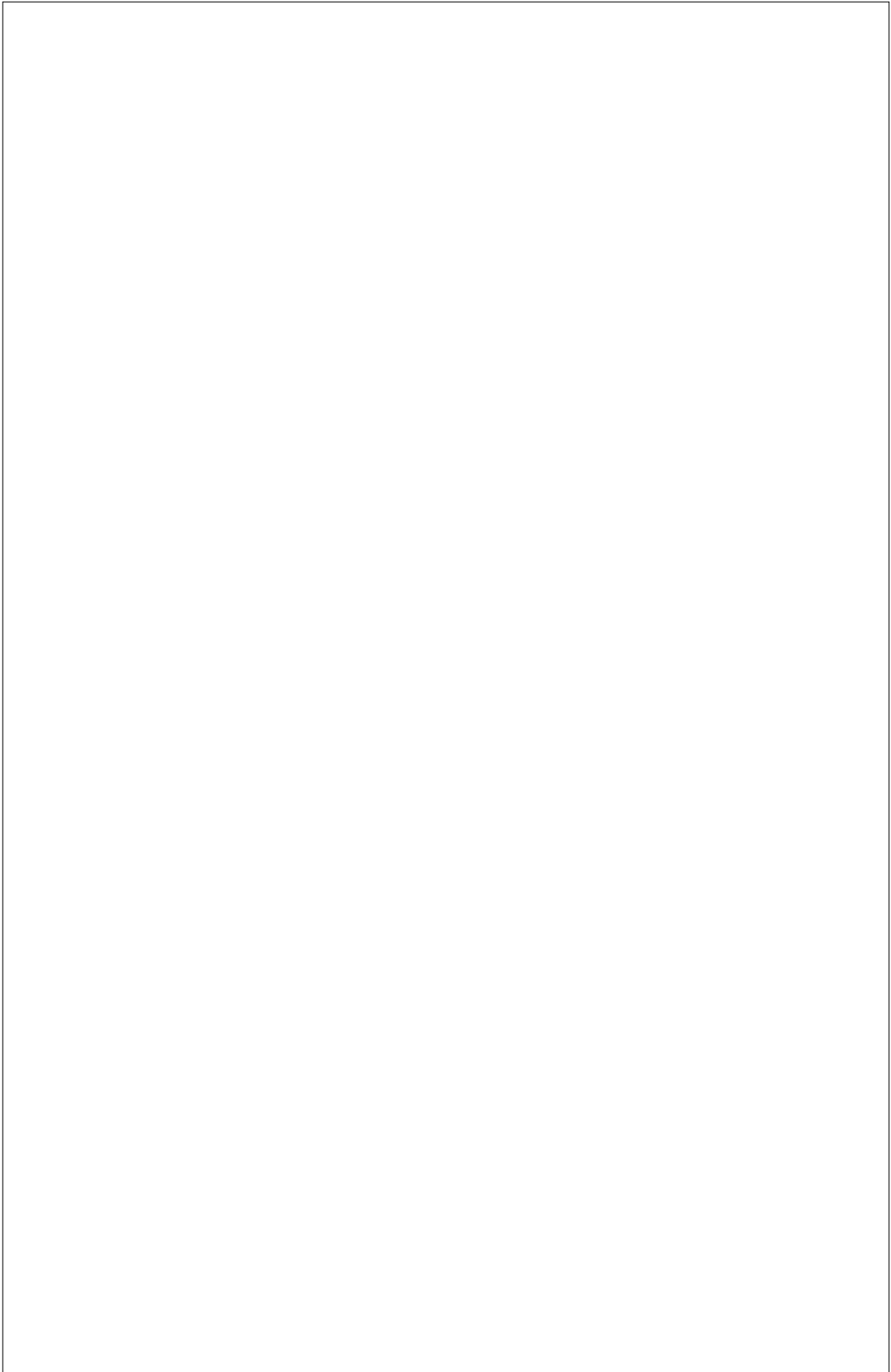
Manufactured in the United States of America

ISBN 0-914341-78-2

## Table of Contents

---

States as Laboratories of Devolution . . . . .	1
AHCCCS: In the Beginning There was Fiscal Crisis . . . . .	2
A Political Partnership to Balance Cost Containment and Care. . . . .	3
Early AHCCCS: Private Management of Public Funds . . . . .	4
Crisis of Accountability: Who Should Manage the AHCCCS Partnership? . . . . .	6
Implementing AHCCCS: Learning to Work Together for Public Purpose . . . . .	7
Time and Political Resources . . . . .	8
Growing Healthy Plans . . . . .	10
AHCCCS Today . . . . .	11
AHCCCS as a Model . . . Of What? . . . . .	12
Raising AHCCCS in Arizona . . . . .	16
AHCCCS as a Performance Oversight Regime . . . . .	17
Performance Oversight Regimes and Governance Futures . . . . .	19
Endnotes . . . . .	20
References. . . . .	20



## **States as Laboratories of Devolution**

---

American federalism is based on a general premise that there is no optimal degree of centralization of political power (Zimmerman, 1992). However, the history of American government has been a long progression toward greater centralization at the national level. Only in recent decades have there been significant counter forces to devolve responsibility for social programs to the states from the federal government. Devolution has been a theme of an increasingly popular, still frequently questioned, political ideology that supports downsizing of government and increased privatization of public services (Fossett, 1999). One of the most important issues in the devolution development is state management capacity. With increased responsibility to devise and administer major social programs, how will states perform? In the example of indigent medical care, if states are given the responsibility, can they more effectively and efficiently provide health care for indigent populations (Thompson, 1998)?

One argument in particular in support of devolution suggests that states are the perfect laboratories in which to experiment with significant changes in policy. It is not a new argument: Supreme Court Justice Louis Brandeis is quoted as saying in 1932, "A federal republic benefits from a system in which a single courageous state may, if its citizens choose, serve as a laboratory, and try social and economic experiments without risk to the rest of the country" (Kincaid, 1995, 41). Recent devolution initiatives reinforce state opportunities to innovate and experiment for the good of their own constituency as well as for the benefit of other states that might choose to follow the same path. In health care programs for the poor and welfare policy, Arizona is one state that has, if accidentally, seized the opportunity to serve as a laboratory for policy change.

Taken together, several reports and articles tell the fascinating story of the Arizona Health Care Cost Containment System (AHCCCS) experiment (Babbitt and Rose, 1986; Intergovernmental

Health Policy Project, 1995; Christianson, 1997, 1999; Louis Harris, 1997; McCall, 1996; Schaller, Bostrom, and Rafferty, 1986). Those studies, for the most part, have focused on the effectiveness and efficiency of providing indigent health care using a managed care model. Important additional findings and lessons about public management of indigent health care are embedded in this literature.

We extract from and build on these earlier efforts as a part of our effort to tell the full and important story of the development of public policy and management infrastructure required to implement this complex example of devolutionary state experimentation. As a part of the larger Rockefeller Institute study of state capacity to manage devolution, we conducted numerous interviews with experts close to the AHCCCS experiment over its development, and examined existing program history, information, and evaluations. Our purpose in this research is to look closely at the ability of states to formulate and implement coherent, plausible, and broadly responsive Medicaid policy as a key ingredient of governing capacity (Thompson, 1998).

## **AHCCCS:**

### **In the Beginning There Was Fiscal Crisis**

---

Although Arizona has had indigent health care since its territorial days, by the end of the 1970s, Arizona was the last holdout in the national movement of states to implement federally approved Medicaid programs. Traditionally, the fifteen counties in the state had the responsibility for providing health care for lower income residents. As other states began instituting Medicaid programs and receiving the federal funds available to them, Arizona's counties continued to assume full financial responsibility, with some assistance from the state.<sup>1</sup>

After much discussion and debate, Arizona enacted but failed to fund the state share of Medicaid in 1974 (AHCCCS, 1998; Lockhart, 1998; Preisler, 1998). By 1981 however, because of

concerns about the growing cost of health care, Arizona began to look for ways to enter the Medicaid system and ease the financial burden on the counties. There were two primary facets to the Medicaid debate in Arizona: how to deliver services that met the federal mandates for Medicaid with respect to scope and quality, and how to do so while at the same time controlling the rising cost of providing health care. The level of service being offered in many of the counties fell below the federally mandated Medicaid guidelines. There was no consistency between counties as to services offered or eligibility for services; the state had never created overarching criteria to guide service in the individual counties (Preisler, 1998). The state eventually defined its choice as one of two possibilities: a traditional fee-for-service Medicaid system, or a managed care design that incorporated prepaid, capitated rates to control costs.

### ***A Political Partnership to Balance Cost Containment and Care***

---

In 1981 the political climate in Arizona made it difficult for the legislature and the governor to develop a plan for statewide indigent health care. The atmosphere in Arizona was, and still is, skeptical of large social programs and is one that supports principles of devolution, downsizing, and privatization. In the early 1980s politics in Arizona was in full support of the principles and policies advanced by the new Reagan administration to reform and decentralize major federal programs — fee-for-service Medicaid did not fit those principles (Lockhart, 1998; Schaller, 1998). The development of the Arizona Health Care Cost Containment System was the by-product of a strongly held belief by the leadership in the state legislature and the governor that to accomplish both cost containment and quality care in an indigent health care program, it was necessary to create a public/private partnership to administer a prepaid, capitated system.

It was not easy to overcome the negative attitude towards Medicaid held by many of Arizona's legislators, both conservative and liberal. However, as historian Dennis Preisler notes, "The

predicament faced by Arizona in the late 1970s was that fiscal pressures were on a direct collision course with ideological positions” (Preisler, 1998, 67). The leadership in the legislature continued to keep debate alive through various attempts to design a politically acceptable policy for indigent medical care. Ultimately, consensus was reached by developing a proposal that adhered to the ideological framework and culture of Arizona (Lockhart, 1998; Preisler, 1998). “Everybody knew each other. So even though they [the Legislature] may have postured, and . . . taken each other to task, they were all going in the same direction,” said Carol Lockhart, the acting director of the AHCCCS program at the time of implementation in 1981 (Lockhart, 1998).

The idea of a prepaid, capitated system to control the cost of medical services was palatable to Arizonans because it did not look like Medicaid (Kirschner, 1998; Lockhart, 1998). But, ultimately it was the element of privatization that helped make AHCCCS attractive to legislators. It is no accident that the state’s ultimate formal resolution of its indigent health care crisis makes no mention of Medicaid, that instead the focus was placed on cost containment. In fact, according to one state legislator and health expert, despite the eighteen years of experience and Medicaid funds, most Arizona state legislators believe that the state still does not participate in Medicaid.

### *Early AHCCCS: Private Management of Public Funds*

Because of political and cultural constraints, a goal evolved on the part of Arizona leadership to secure Medicaid funds without endorsing a formal Medicaid program with its dreaded fee-for-service financial commitments. In 1982 politics and management converged to make this goal achievable, with the election of Ronald Reagan, and an increasingly widely held faith in the cost cutting features of managed care. In 1982, with the bipartisan support of the legislature and the governor’s office, Arizona applied to HCFA, the Health Care Financing Authority, for a 1115 demonstration waiver granting the state its share of Medicaid funds and the authority to implement AHCCCS on trial basis. Central to the

AHCCCS proposal was the call for a public/private partnership between the state and the private physicians and health plans operating in the state. The opportunity to provide medical services to a large portion of the state's population previously seen only by the counties' medical centers, and to receive a guaranteed, up-front payment for providing those services, helped to garner the needed support of the provider community. As Don Schaller, first AHCCCS agency director, noted in an interview in 1998, "When we showed OB guys, guess what, 70 to 72 percent of all the pregnant women in the state are going to be covered by Medicaid. They signed up" (Schaller, 1998).

In establishing a public/private balance, the medical community worked with the state to create provider networks that would be able to bid for contracts. While this collaboration was necessary, it would also lead to some of the problems that made the first few years of AHCCCS difficult ones. While the medical community was willing, they had little experience with managed care. (Schaller 1998).

Relationships with providers were only part of the privatization plan put forth in the original AHCCCS proposal. Initially, program administration was also supposed to be privatized. The state would only maintain a small oversight office within the Department of Health Services, and a Joint Legislative Oversight Committee run by the legislature staff. "When AHCCCS was created, part of the sell job was that HMOs were basically a black box that you did not have to mess with inside, because they had built in incentives that were going to drive them in the right direction. So when they created AHCCCS, they created 25 employees to run it" (Lockhart, 1998). Nobody really understood what it was going to take to run a managed care program, or to balance a public/private partnership (Burns, 1998). Almost immediately, AHCCCS encountered problems associated with the early devolution of management responsibility to a private firm (Kirschner, 1998; Lockhart, 1998).

***Crisis of Accountability:  
Who Should Manage the AHCCCS Partnership?***

---

A private contractor, McAuto Systems, was hired in the beginning to take on the majority of the administrative responsibilities. The contractor was inexperienced in the operation of a public managed care organization, and with just 30 days notice, walked away from their agreement with the state in 1984. The state had to act quickly to insure that AHCCCS members would not experience an interruption in service during the period of transition. Following the termination of the contract with McAuto, the state created the state AHCCCS agency, since responsible for the administrative management and oversight of the AHCCCS program (AHCCCS, 1998).

The legislative leadership had sold AHCCCS to the legislature on the premise that it was to be essentially a privately administered and privately serviced program. “[C]onservative legislators specifically wanted privatization of the program to keep state bureaucrats out” (Preisler, 1998, 94). With the failure of the relationship with McAuto, it became clear that some degree of direct public oversight had to be developed if the program was to succeed. A bipartisan coalition of state policymakers from the legislative and executive branch had high stakes in the success of AHCCCS and quickly rallied to support the creation of a separate cabinet level department (also called AHCCCS) to manage the experiment. Ironically given the founders’ initial faith in privatized management, that department has continued to grow in size and stature since its invention in 1984 and remains very much an example of state government control of public policy to this day.

A large part of the ongoing challenge to the AHCCCS agency was to find and maintain an appropriate, workable balance between public and private sector objectives and actors. This balancing act occupied much of the effort of each of the agency’s directors. The agency continuously attempts to link public and private entities as well as bridge the two sectors. Its essential “publicness” involves garnering state and federal funding as well as developing public policy and regulations. It was necessary for

continued support to maintain a stable relationship with the legislature and state executive administration. On the other hand, the agency also had to work effectively with the private provider community, and understand the concerns and responsibilities of a private entity (Chen, 1999).

### **Implementing AHCCCS: Learning to Work Together For Public Purpose**

---

Balancing acts are often hard to sustain in the dynamic arena of intergovernmental politics. AHCCCS was no exception. In the late 1980s, the progressively strained relationship between AHCCCS, the legislature, and the governor's office reached its peak. Many of the program's core supporters from the early years were no longer in power, and AHCCCS had to cope with the perception of some, including key state officials, that it was simply another welfare program – an unpopular notion in Arizona. Through the 1980s, communication between AHCCCS and the legislature and governor's office became more guarded, as different economic times and increases in Medicaid rolls resulted in questions over AHCCCS expenditures (Burns, 1998; Brian McNeal, 1998). Arizona in the late 1980s and early 1990s faced economic recession and state budget cutbacks, and yet AHCCCS was continuing to grow, spend more money, and require large supplements to its budget (Burns, 1998; Kirschner, 1998; Brian McNeal, 1998). Focus was placed on the administration of AHCCCS as the cause for the increased expenditures, and AHCCCS did not respond well to the suggestions that the agency was spending too much on consultants and administrative procedures (Burns, 1998; Brian McNeal, 1998). During this period, information exchange became more limited and some legislative and executive staff, in part due to the strained relationship, saw the administration of AHCCCS as a "black box."

Difficult economic times were creating greater demands on safety-net programs such as AHCCCS (Burns, 1998; Kirschner, 1998; Brian McNeal, 1998). But probably the more important

contributor to relationship difficulties among key public sector actors during this period was the fact that AHCCCS was still maturing. The techniques that were being used by the budget office to project the expenditures and growth of AHCCCS were for a more mature, static program.

The program had been around for a few years, but in reality was still in its adolescence. As one AHCCCS executive described this period, "We were getting to our base Medicaid population, something that other states had done years before" (Brian McNeal, 1998). While AHCCCS was experiencing shifts in the needy population due to the recession, the agency was also still maturing and reaching out to the existing eligible population. Leadership changes in the governor's budget office and in the agency greatly helped to turn things around. As the legislative and executive budget offices made greater efforts to work with the agency, and toned down their public disapproval of the agency's administration, AHCCCS began to provide more constructive information (Burns, 1998; Brian McNeal, 1998). Both sides recognized that in order for AHCCCS to move forward as a successful program, greater collaboration and information sharing was essential.

### *Time and Political Resources*

In stark contrast to earlier rocky times, during much of the 1990s AHCCCS has been judged by many informed observers and experts as a model of innovative public policy. The first few years were trying and difficult, but because of the strong commitment of the legislators who had pushed AHCCCS through in 1981, the vital support was there to sustain development of the program.

The program's leading proponents forged this effective policy coalition at the outset. Following agreement on policy design, key legislators and the governor worked to get AHCCCS passed and signed into law. The state legislature passed the AHCCCS bill during a one day special session, November 9, 1981. It was signed into law by the governor on November 18, 1981, with a scheduled implementation date of October 1, 1982. Supporters of the program

believed that it was critical to the success of the program to get AHCCCS off the ground before the next legislature could interrupt implementation, as had happened in 1974 (Kirschner, 1998; Preisler, 1998). Although attempting to implement this massive program in such a short period of time had inherent difficulties, those backing AHCCCS believed speedy implementation was key to the program's success.

HCFA granted final approval for the demonstration waiver in the summer of 1982, just three months before the scheduled implementation date of October 1. The immediacy of the implementation was a challenge for the new program: capitation payments had to be ready to go at the onset of the program and members enrolled into the few health care organizations ready to accept AHCCCS patients. This required large-scale financial and patient forecasts and resultant preparation of contracts and capitation checks rather than simply gearing up to process fee-for-service claims in 90 days. It was a sink or swim environment, as much of the administrative structure needed was developed as the program was taking off. Requests for proposals (RFPs) for the private program administrator went out at the same time as the RFP for health care providers (Kirschner, 1998; Preisler, 1998).

The design of AHCCCS stipulated that contracts would be with health maintenance organization (HMO) and independent practice association (IPA) providers in Arizona, and that there would be a minimum of two per county from which enrollees could choose. However, the designers recognized that at the time there were not enough HMOs or IPAs in Arizona to meet the needs of AHCCCS. So, it was determined that AHCCCS would help providers write their RFPs. "Policy makers wanted AHCCCS to encourage physicians, hospitals, medical laboratories and pharmacies to join together into managed care operations and bid on AHCCCS contracts. For the most part, nobody in Arizona really understood the complexity of creating a prepaid health care network" (Preisler, 1998, 101).

### *Growing Healthy Plans*

From the beginning AHCCCS expected that providers would create IPAs to contract with AHCCCS and hire management firms familiar with managed care to provide program administration. However, in many cases this did not happen. The lack of understanding of managed care fundamentals, and the lack of existing structures or models meant that most of the initial IPAs were poorly managed financially and with respect to oversight of patient care (Kirschner, 1998).

Immediately following the reorganization of the administrative structure after the departure of McAuto, several plans began to experience difficulties due to financial insolvency. AHCCCS responded to the difficulties of those plans by terminating two of the health plans and asking the Arizona attorney general's office to proceed with criminal prosecution. Two other plans were sold and one reorganized under federal bankruptcy protection (AHCCCS, 1998). The lessons learned from the difficulties encountered with these initial plan contractors, although painful, were crucial to the development of the financial and programmatic requirements AHCCCS has since placed on plan performance. Over time, over a dozen home-grown managed care organizations have been created and have flourished in their relationship with AHCCCS. "People have to remember that when AHCCCS started there were really no effective carriers. The big interstate carriers like Blue Cross/Blue Shield didn't want anything to do with their own providers. They (new providers) would not have existed if it weren't for AHCCCS," said David Landrith, deputy director of Arizona Medical Association (Landrith, 1998).

Health plans wishing to contract with AHCCCS were subject to a competitive bidding process; sealed bids were submitted in response to RFPs. The idea of competitive bidding was part of the initial appeal of the AHCCCS proposal during legislative deliberations. The theory was that competitive bidding effectively restrains the chance of fee increases and encourages providers to develop more cost-effective methods for delivering care in an

effort to achieve a lower bid (Hillman and Christianson, 1984). The process was attractive to legislators both for its cost containment potential and, just as importantly, because it would force the public agencies that wished to continue to provide indigent health care into the private marketplace (Hillman and Christianson, 1984).

## **AHCCCS Today**

---

Always a political cornerstone of AHCCCS, competitive bidding remains central to its operation today. Plans are still selected based on an open bidding process; the most recent contract awards were increased from three to five year awards with an annual review and renewal process (AHCCCS, 1998; Hall et al., 1998; Potter, 1998). Prospective plans submit proposals responding to an open RFP. Plans submitting bids must include capitation rates and must segregate their bids by geographic service area for acute care services and by county for the long term care service. The capitation rates must specify a fixed per member, per month rate for various rate codes. In addition, AHCCCS evaluates plan proposals based on an assessment of the plan's ability to meet strict financial and operational requirements. Plans are required to demonstrate their ability to meet quality of service, provider network, and accessibility requirements, as well as information processing requirements (Hall et al., 1998; Branch McNeal, 1998).

After the first few tumultuous years, as AHCCCS began to learn and grow from the experiences of those difficult lessons, it became clear that to really make use of the financial and encounter data being required of the plans, AHCCCS would need to develop a new and better information system. Five years were devoted to the development of a Prepaid Medicaid Management Information System (PMMIS) that was implemented in 1991 (Chen, 1999; Hall, 1998; Kirschner, 1998). The PMMIS system is a statewide, automated managed care data system used by AHCCCS for the collection, retrieval, and reporting necessary to satisfy the information needs of AHCCCS, HCFA, other state and federal agencies, counties, health plans, providers, and eligible members (Hall et al.,

1998). The system generates payments, maintains member eligibility history, and preserves encounter data, as well as data for case management, information management, utilization, quality management, financial management and reporting, reinsurance and quality control analysis, as well as tracking for case management purposes and long term care eligibility (Hall et al., 1998).

AHCCCS has found a niche in Arizona, no longer an experiment, it is now imbedded as a mature, professionalized part of Arizona state government. It has accomplished what was originally intended: to provide cost effective health care to the indigent population being served by the counties at the time AHCCCS was implemented. In many instances AHCCCS staff was treading where no one had tread before, creating without any model to follow.

### **AHCCCS as a Model . . . of What?**

---

AHCCCS has often been referred to as a model for Medicaid managed care. Is it really a model? Can the lessons of AHCCCS be followed and the innovations of AHCCCS replicated in other states trying to shift from fee-for-service Medicaid to managed care? Or are the differences in Arizona, both in the beginning and even now, too stark for AHCCCS to be useful? During our research we found most informed observers considered AHCCCS to be a model for Medicaid managed care, but offered caveats about its unique and special conditions.

By many standards, AHCCCS is a successful agency: a public/private partnership that has stayed true to a commitment to provide health care, within a contained cost structure, to the indigent population in Arizona. It cannot be ignored, however, that part of what has allowed AHCCCS to be successful is that the program has never covered anything near 100 percent of the federal Medicaid eligible population. As David Landrith, long time observer of AHCCCS and deputy director of the Arizona Medical Association, noted, “. . . one of the great strengths is that we cover people well, and one of the great weaknesses is that we don’t cover enough people” (Landrith, 1998).

AHCCCS is judged to be a successful, cost effective program in part because its effective eligibility rate is just a fraction of federal poverty. According to a recent US Census Bureau report, Arizona is second only to Texas in percent of population without health insurance (24.2 percent). In part this is because AHCCCS limits eligibility to adults making less than 33 percent of the federal poverty level. This is in contrast to an average level among the states of 45 percent and some states with much higher income ceilings (Snyder, 1999, A2).

Arizona's relatively large share of poor, uninsured residents is not a new issue. Brought to the attention of state policymakers by the influential Flinn Foundation through a series of studies by Louis Harris, state policymakers have wrestled with the unpleasant side effect of rapid growth of population and poverty rates exceeding national norms throughout the 1990s (Sparer, 1999, 4). In partial response the state has developed a Child Health Insurance Program (CHIP, called "KidsCare" in Arizona), and two other small state programs designed to subsidize health insurance for low income people who are not eligible for AHCCCS and for small businesses. Relatively low enrollments in these programs combined with AHCCCS drop off associated with welfare reform have so far prevented the state from making significant dents in its high rate of uninsured citizens.

Since 1995, AHCCCS officials, the state's medical association, and other interests concerned with the state's high level of uninsured have attempted to expand AHCCCS eligibility. This has at times become highly contentious in state politics and intergovernmental relations. High points in the debate include legislative action blocking a 1995 AHCCCS waiver request of HCFA to expand enrollment, and a successful referendum in November, 1996 authorizing expansion of enrollment as long as federal funds were contributed to the cost. Somewhat ironically given concern about the uninsured problem in Arizona, HCFA officials have rejected this approach on the grounds that it is not "budget neutral," and that it imposed a cap on enrollment (Sparer, 1999, 8). Another referendum on the topic is on the state's ballot in November, 2000. If it

passes and is approved, AHCCCS will face program expansion challenges similar to, but certainly not as severe as those facing other states.

Some states that are currently trying to convert their Medicaid programs from fee-for-service to managed care are working with programs that currently cover 100 percent, 140 percent, even 200 percent of federal poverty, prompting one Arizona expert to suggest that “. . . they’re going to have a heroic problem trying to convert that many people into an AHCCCS style system.”

Most of the experts we talked to emphasize that AHCCCS started with a “blank slate,” a luxury that other states do not have. Accordingly it is probably more practically and theoretically productive to look most closely at AHCCCS responses to crises and problems. With that advice in mind, spanning the overall development of AHCCCS, we find several factors that contributed to its success. Some would seem to apply to other states attempting to shift to managed care for poor populations.

There is substantial agreement in many of the AHCCCS studies and among several of the experts that we interviewed about key lessons. Most agreed that the period of implementation required to make a successful transition was critical. Clearly, much of the trouble AHCCCS experienced in the first few years was due to the short period of time allowed to implement the program.

Other prominent themes of the “lessons learned” category may be summarized as follows:

- ❖ The role of the leadership in the agency is crucial. The leadership needs to have an energy and stature that draws qualified people into the organization. We were often told by insiders and outsiders that high quality individuals recruited as management staff at AHCCCS were often attracted by the opportunity to work with the creative, energetic, and innovative leadership of the agency. The leadership personnel are the champions for the agency.

- ❖ A managed care organization requires different kinds of personnel than a fee-for-service agency. A higher skill level is necessary to monitor and regulate the actions of the contracted providers. AHCCCS was allowed exemptions to the state personnel hiring procedures in the first few crucial years. This provided AHCCCS the necessary opportunity to recruit skilled employees with the experience in managed care necessary to guide AHCCCS in the initial stages. The snowball effect mentioned above with respect to leadership was begun because of the caliber of people attracted to AHCCCS in those first few years.
- ❖ A triangle of core support, including the legislature, the executive branch, and the agency, is crucial to the success of the agency in the first few difficult years of transition. The agency must have the necessary support to enforce unpopular actions, such as the removal or sanctioning of plans.
- ❖ The ability to record, process, and interpret a broad range of financial and encounter data is critical to not only the oversight responsibility of the agencies, but also the continued success of the plans. The financial difficulties experienced by some plans in the early years of AHCCCS were as a result of insufficient information being provided in a timely fashion to the plans by the providers. Incurred But Not Reported (IBNR) claims, special services ordered for patients by their provider but not reported to the plan, created serious financial difficulties for plans that did not have the ability to track such claims. Those plans found themselves in trouble financially as those claims started to surface.
- ❖ The state Medicaid managed care agency, in an effort to encourage plans to bid for contracts, especially in the beginning when the number of plans is more limited, should not overlook the undercapitalization of plans wanting to bid for contracts. Undercapitalization is one

of the primary factors associated with plan financial difficulty.

## **Raising AHCCCS in Arizona**

---

What accounts for this distinctive development of devolution called AHCCCS? Several elements of theory are useful in understanding the evolution and should be examined as the AHCCCS case is considered for potential heuristic and predictive benefit. These include political culture (Elazar, 1972) and various offshoots of the notion of “privatization” superseded by such concepts as “public-private regardingness” (Wilson and Banfield, 1964) and “private cities” (Salamon, 1977).

Arizona’s political culture values privatization of public functions as evidenced by many aspects of state public policy, including Arizona’s long term reliance on nonprofits for delivery of many social services, the well known City of Phoenix competitive bidding experiment for refuse collection, the current state experiment in privatization of welfare-to-work in one region of the state, and state facilitation of charter school experiments, making them more widespread and accessible in Arizona than most other states.

AHCCCS, as we have noted, is a sustained public-private partnership that has gone through distinctive phases. Its success is in part attributable to public management response to the initial crises associated with privatizing the administration of the program. Yet despite that initial crisis and continued vexing issues associated with ongoing public management of multiple plans and providers, few Arizona experts doubt the essential benefit of governing this important public policy matter through a public-private partnership, with heavy reliance on the private sector to deliver the public service. But there is more to understanding the development of this form of governance than knowing that the state’s political culture looks favorably on public-private partnerships.

A relatively new, powerful, and effective public agency with clout is not what many observers of Arizona politics would predict as flowing from the state's political culture. Yet strong public management is an Arizona reality, a corollary to its many adventures in privatization. Why? Because prudent fiscal management is another value held highly important in Arizona. So is avoidance of corruption. To have private service delivery and accountability of public funds requires professional and committed public management. Those values, in response to the circumstances described above, required building a new, well-staffed, and relatively highly paid state agency. Almost amazingly, AHCCCS today is the result of a substantial state investment in bureaucracy at a time of general intergovernmental contraction and shrinking federal aid (Wright, 1988), and in Arizona one of the most sustained tax reduction efforts of any of the states. From 1992 to the present, while the AHCCCS budget grew, Arizona implemented over \$2 billion in state tax cuts (Hall et al., 1997).

How could Arizona develop this new level of public management capacity — particularly for such a “liberal” cause as indigent health care, given its well known conservative political culture? The answer may lie in understanding more precisely the way in which values from the political culture connect management and policy. Regime theory helps to make that connection.

### *AHCCCS as a Performance Oversight Regime*

Regimes incorporate the informal rules and coalitions as well as the formal institutions that represent the reality of governance. They are closer to reality than policy proclamations and institutional mission statements. As leading regime theorist Clarence Stone has described them, regimes should be understood as: “(1) who makes up the governing coalition and (2) how the coalition achieves cooperation” (Stone, 1989, 241) That is, regimes are about who actually governs and how governance is achieved. Regimes frame management capacity, and management decisions reflect culture, history, past arrangements, and agreements of the polity.

The Arizona political system and its political and public management subsystems have long operated in a reality that can be described as a “performance oversight regime.” Elected officials at state and local levels have long articulated conservative themes, including ones about holding the line on taxes and government expansion just as the state’s spectacular growth has demanded much more public service. Under these conditions, professional staff of state and local governments along with civic leaders from the private for-profit and nonprofit sectors often have coalesced to build programs that meet needs, quietly. AHCCCS is one beneficiary of this tradition, but not the only one.

This not the place for a cataloging of public management experiments that appear to follow from the performance oversight regime, but state staff have developed effective partnership programs in several other areas of social and human services, just as local government staff are well known nationally and internationally for innovations in public management. Growth has provided the resources. The tax structure is strong and diversified enough to provide sustained revenue increases in recent years despite politically motivated tax cuts. Conservatism has limited discussion, and therefore criticism, of many public expansions. And the rock solid Arizona values of fiscal prudence and avoidance of fiscal corruption have led to high levels of attention to financial outcomes. In this way, state leaders have stressed partnerships, in part to be effective, in part to implement public programs, in a place that often seems to relish criticism of the role and function of government and public policy.

These tacit understandings about public programs as necessary but, from a political perspective, not necessarily desirable and/or affordable can be viewed as dangerous in a democracy because they sometimes result in limiting public debate and discussion. Yet the assumption that major public purposes are best accomplished by sharing burdens, blame, and credit among the public and private sector, and by assigning much of the implementation responsibility for partnerships to staff, has led to an understanding of the role and purpose of government that is different

and, by measures of public performance, sometimes very effective. AHCCCS and its customers have benefited enormously by these understandings and allies.

## **Performance Oversight Regimes and Governance Futures**

---

In the foreseeable future, many state and local governments will face the same apparent paradox that has impacted Arizona governance for some time. Devolution and tax reduction movements call for conservative politics while public demand and reality result in pressure to increase public services. The ultimate answer that satisfies political and management demands is for the public sector to monitor and measure performance whenever it succumbs to the temptation to shed services. There will, because of politics, be more privatization. Accordingly the public role, the scope and method of public management, and definitions of public management capacity will have to change to make sure that public purposes are being achieved. Most public entities have to think carefully about their role in the future, and the type of information, evaluation and feedback, contracting, and monitoring that will be needed. Arizona's AHCCCS program provides some insights into what may be the future of state policy and management in many places and policy arenas. As one expert on Arizona government and AHCCCS put it.

AHCCCS is kind of at that place. We don't deliver health care. We go out and hire organizations, and we monitor them. (AHCCCS does) operational reviews and financial reviews. That's a different nature of an organization than the old Medicaid agency that used to just pay claims. That's the model where state government, or all government has to go (Peter Burns, Budget Director, Office of the Governor, 1988-96, Interview, July 1998).

## Endnotes

---

- 1 The increasing financial burden of indigent health care was often passed onto the state in the form of bailout requests made by the counties to the Arizona legislature.

## References

---

Arizona Health Care Cost Containment System, (AHCCCS). August 1998.

ARIZONA: Overview of the Arizona Health Care Cost Containment System (Agency promotional booklet). Phoenix, AZ: author.

Babbitt, Bruce and Jonathan Rose. (Spring, 1986). "Building a Better Mousetrap: Health Care Reform and the Arizona Program." *Yale Journal on Regulation* 3, 243-281.

Busby, Kathy. General Counsel, APIPA. Interview, September 17, 1998.

Burns, Peter. Consultant, Wakonda Group. Interview, July 10, 1998.

Chen, Mable. Vice President-Operations, Express Scripts/VALUEX. Interview, January 6, 1999.

Christianson, Jon, et al. (1997). "Health System Change in Phoenix, Arizona." Report for the Center for Studying Health System Change. Available online: <http://www.hsc.com/communityrpt/reports/communities/phoenix-01.html>.

\_\_\_\_\_. (1999). "Ownership Changes Set Market in Flux." Report for the Center for Studying Health System Change. Available online: <http://www.hsc.com/communityrpt/reports/communities/phoenix-01.html>.

Dunton, Lynn. Assistant Director, Office of Policy Analysis and Coordination, AHCCCS. Interview, December 18, 1998.

Elazar, Daniel. (1972). *American Federalism*, 2nd ed. New York: Crowell.

Fossett, James, et al. (1999). *Managing Accountability in Medicaid Managed Care: The Politics of Public Management*. Albany, NY: The Nelson A. Rockefeller Institute of Government.

Hall, John, et al. (Eds.). (1997). "Balancing Acts: Tax Cuts and Public Policy in Arizona." *Arizona Policy Choices*, Vol. 1. Phoenix, AZ: Arizona State University, Morrison Institute for Public Policy.

Hall, John, Melinda Snook and Pat Jones. (1998). "Accountability in Medicaid Managed Care: The Arizona AHCCCS Experiment." Report for the Rockefeller Institute of Government. Albany, NY: The Nelson A. Rockefeller Institute of Government.

Hillman, Diane and Jon Christianson. (Fall 1984). "Competitive Bidding as a Cost-Containment Strategy for Indigent Medical Care: The Implementation Experience in Arizona." *Journal of Health Politics, Policy and Law* 9(3), 427-451.

Intergovernmental Health Policy Project. (April, 1995). "Applying the Lessons of Arizona's Medicaid Managed Care Program, AHCCCS." Report from the Henry J. Kaiser Family Foundation and the Flinn Foundation of Arizona Conference. Washington, D.C.: author.

Jasinski, Len. Medical Director, AHCCCS. Interview, December 21, 1998.

Kincaid, John. (Spring 1995). "Values and Value Tradeoffs in Federalism." *Publius: The Journal of Federalism* 25(2), 29-44.

Kirschner, Len. Vice President, State Health Care, EDS. Interview, July 1, 1998

Landrith, David. Deputy Director, Arizona Medical Association. Interview, May 29, 1998.

Lockhart, Carol. President, Lockhart Associates. Interview, July 9, 1998.

Louis Harris & Associates. (February 1997). 'Arizonans and Managed Care.' (Results of a study of health care in Arizona commissioned by the Flinn Foundation of Arizona). Phoenix, AZ: The Flinn Foundation.

McCall, Nelda. (July 1996) "The Arizona Health Care Cost Containment System: Thirteen Years of Managed Care in Medicaid." (Report to the Henry J. Kaiser Family Foundation). Menlo Park, CA: The Henry J. Kaiser Family Foundation.

McNeal, Branch. Assistant Director, Office of Managed Care, AHCCCS. Interview, December 8, 1998.

McNeal, Brian. Deputy Director, Department of Health Services, Interview, July 21, 1998.

Potter, Rick. Deputy Director, AHCCCS. Interview, November 10, 1998.

Preisler, Dennis. (1998) "A History of the Arizona Health Care Cost Containment System Policy: AHCCCS as a Medicaid Alternative 1981-1987." Dissertation, Arizona State University, Tempe, Arizona.

Ross, Diane. Assistant Director-Division Member Services, AHCCCS. Interview, November 10, 1998.

Salamon, Lester M. (1977). "Urban Politics, Urban Policy, Case Studies and Political Theory." *Public Administration Review* 37: 422-434.

Schaller, Don. Schaller Anderson. Interview, July 16, 1998.

Schaller, Donald F., Albert W. Bostrom, and John Rafferty. (1986). "Quality of Care Review: Recent Experience in Arizona." *Health Care Financing Review* (Annual Supplement), 65-74.

Snyder, Jodie and Pat Kossan. (October 5, 1999) "Uninsured Struggle to Get Aid: Working Poor Rules Lock Out AHCCCS." *The Arizona Republic*. A1-A2.

Sparer, Michael S. (December, 1999). *Health Policy for Low-Income People in Arizona*. Urban Institute. Available on-line at: <http://newfederalism.urban.org/html>.

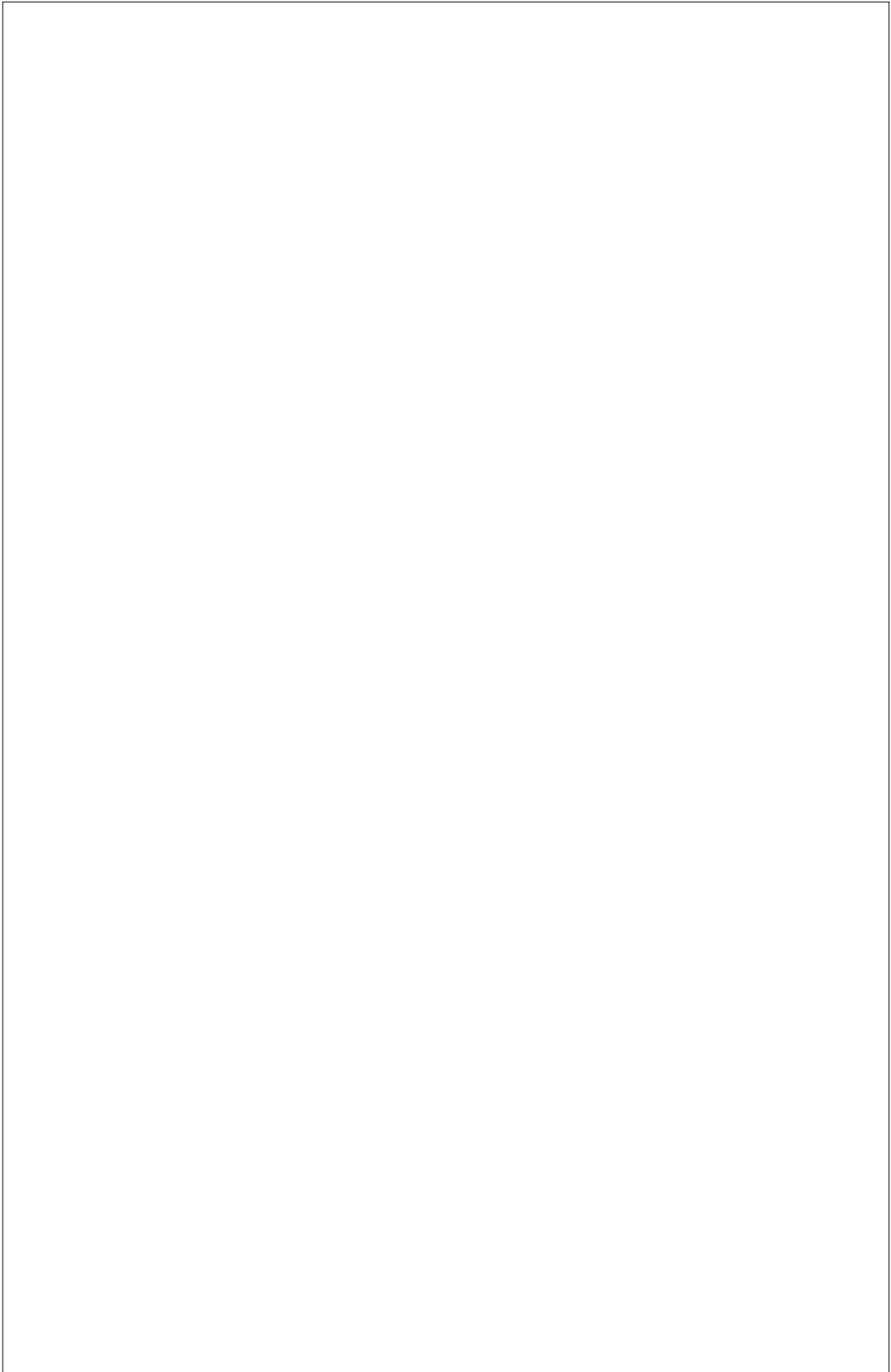
Stone, Clarence. (1989). *Regime Politics: Governing Atlanta, 1946-1988*. Lawrence, KS: University of Kansas Press.

Thompson, Frank J. (1998). *Federalism and the Medicaid Challenge*. Rockefeller Institute Bulletin. Albany, NY: The Nelson A. Rockefeller Institute of Government, 12-24.

Wilson, James Q. and Edward C. Banfield. (1964). "Public-Regardingness as a Value Premise in Voting Behavior." *American Political Science Review* 58.

Wright, Deil. (1988). *Understanding Intergovernmental Relations*. 3rd ed. Pacific Grove, California: Brooks/Cole Publishing Company.

Zimmerman, Joseph. (1992). *Contemporary American Federalism: The Growth of National Power*. New York: Praeger.





**The  
Nelson A.  
Rockefeller  
Institute  
of  
Government**

411 State Street  
Albany, New York 12203-1003

<http://rockinst.org>