

Case Studies in Medicaid Managed Care

**FIRE, READY, AIM:
THE POLITICS AND IMPLEMENTATION
OF MICHIGAN'S MEDICAID MANAGED
CARE PROGRAM**



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**Carol S. Weissert
Malcolm L. Goggin**

*Department of Political Science
Michigan State University
303 South Kedzie Hall
East Lansing, MI 48824-1032
E-mail: weissert@pilot.msu.edu, goggin@pilot.msu.edu*

**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)**

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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)

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Understanding why and how political decisions are made is an important part of political science and public policy research. A less well known aspect of decision making relates to scope and speed of implementation of these decisions. Sometimes policymakers engineer a “crisis” to force tough decisions that otherwise might not be made (for example, Wisconsin’s law to discontinue participation in AFDC and Michigan’s statute doing away with school-based property taxes before there was a replacement for either the program or the funding). Other times policymakers, often state administrators, implement new programs statewide, eschewing the more typical incremental approach and following what one analyst has called a “politically driven implementation timetable” (Bonnyman, 1996).

Medicaid managed care has provided several cases of such expedited implementation. In 1982 Arizona became the first state in the country to launch an ambitious statewide Medicaid managed care program. TennCare, Tennessee’s 1994 managed care initiative to provide health care to all poor and near-poor in that state, is another example of a short-fuse implementation. The most recent example is Michigan’s launching of a new statewide Medicaid managed care program in 1997-1998. Following Governor Engler’s order to “fire, ready, aim,” Michigan’s ambitious managed care program was initiated and enforced statewide for over 700,000 Medicaid clients in the span of less than two years. Why these changes occurred and how they were implemented constitute the core of this analysis.

Michigan’s Managed Care System

Beginning in 1995, Michigan’s Medicaid program experimented with an early managed care approach, using three different “managed care” options: health maintenance organizations (HMOs), clinic plans, and physician sponsor plans (PSPs) under which physicians were paid a \$3 capitation rate per enrolled client to serve as “gatekeepers.” In clinic plans, physicians provided primary and most specialized care for a capitated rate, but the Medicaid

program paid hospital fees directly for inpatient hospital care. In early 1996, nearly 96 percent of targeted recipients were in either PSPs, HMOs, or clinic plans. By far the most popular plan was the PSP, which garnered 61 percent of the Medicaid enrollees. Some 34 percent were in HMOs; only 5 percent were in clinic plans (Harris and Kinney, 1998).

It was clear to Governor John Engler and others that the PSP approach was a very limited managed care system and that movement toward health maintenance organizations might be the best strategy. At issue were the costs of Medicaid. In 1995, Medicaid represented 20 percent of the state budget, with estimates of it reaching 30 percent by the year 2000. Medicaid expenditures in the state doubled from \$2.1 billion to \$4.6 billion in the seven years between 1990 and 1997 – a time when state revenues were growing by only about 3 percent annually. Alarmed by the magnitude of the rate increases, the Michigan Department of Management and Budget (DMB) pushed for a policy of shifting more Medicaid clients from fee-for-service to managed care.

In 1996, the governor's budget noted that, "while Michigan already is a leader in Medicaid managed care programming, it is clear that the state must move toward a comprehensive, capitated (fixed) managed care system if Medicaid costs are to be held to an acceptable level" (Harris and Kinney, 1998). Governor Engler announced plans to transfer all of the remaining eligible Medicaid recipients into managed care by the end of 1996.

To achieve this goal, on January 31, 1996, he issued Executive Order 1996-1 to create a new state health agency – the Michigan Department of Community Health (DCH). Shortly thereafter, the administration of the Medicaid program was transferred from the Department of Social Services to the Medical Services Administration within the Department of Community Health. The former state mental health director was named to head the newly formed health department; the new director of the Medicaid agency was someone with substantial experience on the provider side of the managed care industry.

Clearly costs were one concern and an impetus for the new program. The changes were also consistent with the political goals of smaller government and greater efficiency in government, as well as quality assurance and accountability, all of which have characterized the Engler administration. According to state officials, the consolidation that took place in 1996 was driven not so much by a desire to cut costs as it was by an attempt to find "a better way to manage our dollars."

There are five components of Michigan's managed care initiative: the Comprehensive Health Care Plan, the Children's Special Health Care Plans, MICHild, MI Choice-Long Term Care, and Specialty Plans which subsume those persons with developmental disabilities, mental illnesses, and substance abuse problems.

The largest and most ambitious program is the Comprehensive Health Care Program (CHCP), which was launched in May 1997, when the state signed contracts with eighteen managed care plans to serve all non-waived Medicaid recipients (some 451,891 clients) in five counties in southeast Michigan. One year later, the state signed contracts with thirteen managed care companies to serve non-waived recipients in the remaining seventy-eight counties of the state. (Five more plans later signed contracts.) Enrollment in the new "outstate" plan, encompassing those counties beyond southeast Michigan, began August 1, 1998, and included approximately 330,000 clients.

As of December 1998, there were approximately 1.1 million beneficiaries in Michigan's Medicaid program; 754,516 of those were targeted for the managed care program. The remaining 345,000 were not eligible (they are dually eligibles, nursing home patients, mental health only patients, migrants, and a few other small categories). Approximately 87 percent of the targeted category were covered by a qualified health plan in December 1998. The remaining 13 percent or 98,067 were enrolled in primary sponsor plans. In early 1999 the state launched a "sweep" to enroll those patients in a qualified health plan. Patients had thirty days to voluntarily switch; during the second thirty days they were

automatically assigned to plans. By April 1, 1999, the state had nearly every client in a qualified health plan (QHP).

The four other components of the state's proposed managed care system are more targeted to recipient groups and are in varying stages of implementation:

- ❖ The Children's Special Health Care Services (CSHCS) program provides comprehensive health care and specialty services for children with special health care needs. In 1999, it was available only in southeast Michigan, with recipients provided service by two plans: Kids Care by Henry Ford Hospital System and the University of Michigan Health Care Services, and Children's Choice offered by the Detroit Medical Center/Children's Hospital of Michigan.

- ❖ MI Choice-Long Term Care was intended to provide long term care services in traditional nursing homes and home and in community-based waiver alternatives to nursing homes. The program hoped to select one managed care organization per region in a competition to provide for patients who need long term care or who are enrolled in state behavioral health or developmental disabilities programs. This initiative encountered political and administrative problems and delays. Administratively, there are no groups in the state offering a full range of long term care services and few Medicare-risk HMOs (Lipson et al., 1997). Politically, there are tensions between the state's long term care competitors such as nursing homes, home health agencies, and the Area Agencies on Aging. The legislature is involved as well. The FY 1999 DCH appropriations bill provided a series of directives to the department on issues such as consultation procedures, reimbursement methodology, and contract language. It also prohibited implementation of the program in 1998-99 and directed that the plan be voluntary for the first five years of implementation. In 1999, hearings were held across the state on proposals flowing from this initiative.

- ❖ Specialty plans including persons with developmental disabilities, mental illnesses, or substance abuse problems are “carve-outs” from the comprehensive health plan. The state’s community mental health service programs (CMHSPs) operate as prepaid health plans and are funded on a prepaid, capitated basis. The CMHSPs are required to subcontract with regional substance abuse coordinating agencies for management of the substance abuse benefits. The CMHSPs are expected to meet performance standards set forth by the state. Where the CMHSP performance is not meeting contractual requirements, the state agency may introduce competitive bidding to open the program to non-CMHSP organizations.

- ❖ MICHild, Michigan’s Children’s Health Insurance Program, is administered in the state’s Medicaid agency, the Medical Services Administration (MSA). The agency is contracting with health plans, health maintenance organizations, and preferred provider organizations to provide coverage for children in families with income of up to 200 percent of poverty. Children in families of four with an income of under \$24,000 a year are covered by the Healthy Kids Initiative under Medicaid. Families with an annual income between \$24,000 and \$32,000 are eligible for MICHild.

This paper deals primarily with the design and implementation of CHCP, the statewide program covering over 700,000 beneficiaries. It is based on information provided by the Michigan Department of Community Health and on a series of interviews with DCH officials and other relevant actors. To put the Michigan experience in context, we compare Michigan’s implementation efforts and consequences with those of Tennessee and Arizona, the two states that adopted comprehensive statewide Medicaid managed care prior to Michigan. The Arizona Health Care Cost Containment System (AHCCCS), adopted in 1982, was the first mandatory statewide Medicaid managed care system in the country. TennCare, launched in 1994, covers nearly 800,000 Medicaid

clients and some 400,000 uninsured or uninsurable persons in a managed care system.¹

Implementing CHCP

The implementation of the CHCP had two components. The first, launched in May 1997, involved five counties in southeast Michigan, the most populous part of the state where HMO penetration was the highest. The state did little to encourage plan growth and involvement in southeast Michigan. In fact the rates provided to southeast Michigan plans were deliberately set low to save the state dollars. The capitation rates were less than 80 percent of the fee-for-service costs in most counties that were part of the first contract. In Wayne County the final bid prices ranged from \$135.35 to \$164 per member per month. The state saved some \$120 million in one-time savings from the lower rates in southeast Michigan. That money was returned to the state's general fund.

Rates for the second round — encompassing the 78 remaining counties in the “outstate” area — were higher, reflecting the state's desire to promote the emergence of new plans and to encourage existing plans to participate. “There was no capacity there; we had to grow the plans,” said one MSA official. “We now have seven new plans that didn't exist before the process and would not have acted on their own.” The outstate bids were based on nine regions, each with its own bid floors ranging from \$101.80 to \$121.80 per member per month. The state had no expectation of savings in the outstate round. The state also changed the bidding process to encourage firms in the second round. MSA worked with plans with perceived deficiencies to help them meet the requirements.

The task in the outstate was tougher than that in the more HMO-friendly southeast Michigan initiative. At the initiation of the mandatory managed care program in the nine outstate regions, only one-third of the Medicaid recipients there were enrolled in one of the twenty-three health plans that were named qualified health plans (Michigan's Children, 1998). By summer 1999, all eighty-three counties had at least two plans. In addition to

recognizing that the rates must be higher in outstate Michigan, the agency also made changes in the bidding process in the second round.

In August 1999, there were twenty-nine certified health plans serving Medicaid patients. Some mergers have occurred, as expected and encouraged by the state (in December 1998, there were thirty-one plans). “We realize that there are too many plans,” said one official. The state decided not to limit the number of plans designated as QHPs (especially an issue in southeast Michigan) because it saw what had happened in other states where “the states are still in court.” Rather, Michigan’s MSA established a threshold and any plan able to meet the threshold (and reach price agreements) was able to obtain a contract.

Changing the Medicaid “Market”

The market played an important role in the new approach that came out of the political orientation of the Republican governor and the conservative principles of the national and state Republican party. As one state bureaucrat observed, “The governor has made privatization a big issue.” According to another state official, “We all shared the values of the governor – privatization and devolution, and a belief in competition and the market.” Another state administrator echoed the market emphasis, saying, “We turned to the market, and we let the market sort things out.”

At the outset, the initiatives to move from fee-for-service to capitated managed care had political support from the governor and from a sympathetic state House of Representatives, which was controlled by a Republican majority at the time.² The first appropriations bill “boiler plate” had bipartisan support in the House. Democrats were concerned about access issues – making sure that people didn’t fall through the cracks. But once state legislators realized that \$120 million would be saved by going to managed care for Medicaid clients, members on both sides of the aisle in the state legislature lent political support to the idea. What was surprising to state officials was that there was initial support from the “health

lobby” as well. That first year there was a lot of dialogue between the state and the health plans, and between health plans and their providers, but little talk with or about beneficiaries.

Initially the state’s managed care plans were supportive of serving Medicaid clients. HMOs in the state realized that Medicaid managed care offered the potential for increasing market share and for making money off public clients. Even with somewhat lower payments, existing plans felt they could participate through the large volume of clients. What they did not count on, particularly in populous southeastern Michigan, was the entrance into the market of smaller, more entrepreneurial plans. For example, one large managed care plan based in Detroit reported that its initial bid was based on the expectation of 100,000 patients; the plan actually signed up only 32,000 patients, in large part because of the competition from eighteen plans, many of them new. The plan claimed it lost over \$40 million under the new CHCP program.

Not surprisingly, the approaches of both Arizona and Tennessee were similarly market-based. Bonnyman (1996) notes the importance of market forces in setting TennCare rates, notably that TennCare exploited favorable market conditions such as excess capacity and used the state’s dominant role as a volume buyer of health insurance. Amaral (1996) described the goal of TennCare as invigorating “a private market for Medicaid services, thereby improving the quality of care for low-income Tennesseans” (p. 34). In Arizona, the AHCCCS program has used competitive bidding to “harness” market forces and contain health costs (GAO, 1996). The framing of the issues in the market-based rhetoric served the program well in Michigan’s Republican-dominated legislature and executive branch.

Understanding Policy Change

Incremental change is the most common approach to altering policy direction. And in one sense, Michigan’s 1997-1998 Medicaid changes could be viewed as incremental. They clearly built on earlier, somewhat ineffective efforts at managing care in the Medicaid

program. However, in another important sense, the changes were different from incremental change. In Medicaid, changes are often undertaken in the form of demonstrations or initiatives in selected jurisdictions or with targeted populations (Coughlin, Ku and Holahan, 1994; Riley, 1995; Schneider, 1997). In the case of the 1997-1998 changes, the state made the decision to act statewide and quickly.

As one member of the DCH team designing the program put it, “We were affected by the bias of the Governor to pay attention to ‘ready’ and ‘aim,’ but you better be ready to ‘fire’.” The state announced the change and then set about implementing it. State officials did consult with health plans and other interests for several months but were also well aware of the executive imperative to move quickly. There was acknowledgment that if the decision to change had been made with public debate, the process would have been slowed considerably. As one official said, without swift action, “we would still be writing the RFP now.” Interestingly, the one aspect of the plan that was set to be launched after the basic plan — the long term care initiative — has been caught up in political crossfire and its implementation delayed, if not killed.

The decision to move comprehensively and quickly is not unlike recent state Medicaid decisions in Tennessee and Arizona. In each of these cases, the initial decision to act quickly led to some confusion, serious complaints over process, and readjustment of program particulars. Institutional decisions made early in the process were instrumental. Accountability was a major concern.

Institutional Changes

The first major institutional change in Michigan’s Medicaid managed care program was the consolidation of three state agencies — the Department of Public Health, the Department of Mental Health, and the state’s Medicaid agency within the Department of Social Services — into the new Department of Community Health. Symbolically, the change for the Medicaid agency, called the Medical Services Administration (MSA), was an important one,

separating the program from the social services/welfare domain to a new department designed to encapsulate state health programs and functions.

A second key change was the shift of focus of the Medicaid agency from a fee-for-service system under which the state paid provider bills and had little influence over the performance of those providers, and, thus, the quality of care, to a system wherein the state was a value purchaser with an emphasis on competitive billing and performance contracting. Before consolidation, MSA was much more a bill payer than an organization that felt responsible for the type and quality of care provided. A goal of the transfer was to change the organizational culture of the state Medicaid agency – from an organization described by one official as “the Bank of Medicaid,” which was purchasing health services but could not articulate a rational policy, to “a health organization preserving the state’s assets.” The new DCH leadership wanted to transform MSA from an agency that was a “transaction processor” that specialized in bill-paying to one that was “an informed purchaser of health services.”

While the DCH looked to other states such as Arizona for some ideas about how to proceed, especially with the long term care component, Michigan saw itself as a leader in managed care. As one DCH manager expressed it, although “we knew what HCFA [the federal Health Care Financing Administration] was up to and we knew what NCQA [National Commission on Quality Assurance] was up to, we started driving this train ourselves.”

One of the first tasks of the leadership of the new agency was to assemble a team of skilled managers, most of whom were already working in state government. The agency head recruited people to join the new team of managers by seeking out, through interviews, “radical thinkers” who were “frustrated” with the way the state Medicaid program had been working. Once assembled, these managers met routinely and, using the “team” approach to public management, planned the changes that would be necessary to reach the administration’s policy goals. At this point, the team used outside consultants, but only sparingly, that is, as content

consultants in a knowledge-based role. One administrative change that came out of the work of the teams and that added to the success of program implementation was the concept of “contract manager.” A contract manager’s main responsibility is to see how health plans are doing with respect to meeting the needs of Medicaid clients.

Although the state legislature did not provide new resources to the newly-organized Medical Services Administration, the management team headed by the DCH and Medicaid directors was helped by three administrative changes: 1) reforms in the civil service system gave them a lot more flexibility in hiring; 2) the Medical Service Administration did not have to replace 50 to 60 people because they contracted the job of enrolling clients to Maximus, a private corporation that specialized in enrollment; and 3) the state offered early retirement to all state employees, and many of the Medicaid agency’s top and middle managers took advantage of the Engler administration’s offer of early retirement.

Early retirement was offered and taken by six senior Medicaid managers, many of whom, according to one member of the management team, were “locked into the old style of management.” This style was built on “authoritarian rule, where employees were terrorized and frightened.” According to this same state administrator, this “old guard” had created the Medicaid program in Michigan, and resisted proposed changes; they had difficulty adopting and embracing new ideas. There were others – both inside the state bureaucracy and in the state legislature – who were suspicious of managed care, seeing it merely as a way to save money at the expense of the Medicaid client.

Institutional changes were also important to managed care initiatives launched by Tennessee and Arizona. Both states’ programs were administered by new agencies, and staff were encouraged to “break out of the box” and think broadly about expanding access and improving the quality of care. In Arizona, the new agency was exempted from the state’s personnel rules so that the very best staff could be hired from the private sector.

Accountability

Key in any change to privatization is state oversight. Michigan officials are very concerned about these issues and have put in place data collection efforts to assure there are no “surprises” to agency staff or the public.

A 1996 state law allowed the DCH to increase enrollment in capitated health plans if a contract is in place for an independent evaluation to measure cost, access, quality, and patient satisfaction. The contractor is collecting information on such issues as provision of 24-hour on-call service seven days a week, accessibility and waiting room times, physician-patient ratios, appropriateness of provider networks, and authorization and coordination of services. Medical records are reviewed to determine if preventive measures, interval and medical histories, medication review, follow-up, and appropriateness of treatment standards are being met. In addition, information is collected from CHCP providers on the number of enrollees being seen for prenatal care, enrollees with insulin-dependent diabetes mellitus and newly diagnosed hypertension, those referred to selected medical specialists, those with HIV infection, those who received services in the emergency room, and those who had elective hospitalizations. Finally, the contractor is conducting a survey to determine the level of enrollee satisfaction. The contractor is also examining state expenditures before and after the launching of the program.

The MDCH requires plans to meet certain standards for financial soundness and monitors plans regularly. If the health plans do not comply with these requirements, the state can terminate the contract. However, the first step is to pursue remedial or corrective action to resolve the outstanding requirements. If this is not successful, enrollment freezes and/or capitation withholding will be implemented. The sanctions will be a matter of public record. However, the state is reluctant to impose harsh sanctions. “If we punish plans, we have to do it carefully,” said one MSA administrator. One reason for the caution is that the plans might fail if

sanctions are employed. It is in the best interest of the state, the plans, providers, and the clients if the plans survive.

In one case in Michigan, a plan began to have financial problems. The MSA and the state insurance bureau worked with the plan to try to achieve a more stable financial position. The MSA froze their new enrollments but did not withhold payments. If the MSA did take away their payments, they would almost certainly fail (Medicaid accounted for 50 percent of their business). The agency felt it was important it 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. The plan with financial difficulties is still not “out of the woods” but the state is committed to working with them within reason to achieve a stronger financial base.

Finally, to assure quality, the state requires quarterly reporting as well as an annual report – in the form of a NCQA Health Plan Employer Data and Information Set (HEDIS) report – from each qualified health plan. Initially, there was some grumbling about the report deadlines, which have now been changed so that health plans have more time to prepare the reports. The state plans to do away with the quarterly report and move to an annual report once it has relevant data. The overall objective is to provide information to the state legislature, the consumers of health services, and state residents about just how well each health plan is doing with respect to performance. Armed with this report, each consumer can make “an informed decision.”

To date, there is little indication that network capacity, access, and utilization data are being analyzed and used in any systematic fashion, but interviews with MSA administrators indicate that progress is being made and reports are being readied. Plans are a bit more skeptical. One plan administrator complained that the MSA might ask fifty questions but use only three or four in their analysis. Furthermore, plans don't yet trust the data. For example, one report noting a 15 percent change in the cancer rate was

discounted by a plan administrator who said that the questions were defined too broadly to be valid. Further, plans note the difficulty in getting providers to provide timely, accurate reporting, especially for those Medicaid patients the physician does not see.

Clearly, enhanced accountability is one of the goals of the MSA managed care effort. In a presentation before newly elected state legislators, Michigan's MSA director made the point that under a fee-for-service system the various providers were operating independently and without coordination. With managed care, the provider jigsaw pieces fit together in an approach that enhances accountability. In the MSA's value purchasing strategy, accountability is the first of nine elements.

Tennessee and Arizona struggled with accountability issues. In both states, programs were implemented before data systems could be designed to track costs and quality of care. A 1984 GAO analysis found that AHCCCS had not generated the information necessary to evaluate issues of quality or reasonableness of payments to providers. In 1986 the state launched a prepaid management information system that is viewed as highly successful in assuring accountability (Amaral, 1996). Tennessee initially struggled with the basic systems and administrative procedures to process applications. Patient encounter data from the plans in the state were often woefully inadequate or inaccurate (Bonnyman 1996).

Rapid Implementation

The rapid implementation in Michigan led to problems with the enrollment broker and the bidding process in the first round of bidding.

In Michigan the problem with enrollment in the new program apparently resulted from the speed in which the contract was implemented. In July 1, 1996, by state law the qualified health plans stopped marketing for clients. A few days later the contract with Maximus was signed. Enrollment began on September 1. The plans then went for two months without any enrollments. There were

large back-ups. In addition, in the outstate contract, the state would not let Maximus talk to the plans until the plans had signed the contract. The state is now conducting an external evaluation of the enrollment process.

There were also problems with the bidding process in southeast Michigan. The state set a floor and ceiling (unknown to bidders) and negotiated prices with several plans, resulting in accepted bid prices below their initial bids. Plans were able to initially bid "high," knowing that the state would work with them to bring the bid to the desired bid corridor. In the second phase, there was no negotiation and the plans could no longer "game" the system by adjusting their bids after the other plans' bids were in.

Another problem that flowed in part from the quick implementation and in part from the rather low rates provided to southeast Michigan plans was a great deal of acrimony in the early months of the program. Meetings were noisy and unpleasant. Some plan leaders still refer to state leadership as "whimsical." While MSA officials think the relationship with plans has improved, some plans, particularly those involved in the southeast Michigan bidding, are still unhappy.

In Arizona, the state canceled the contract with a private firm hired to administer the AHCCCS program because of disputes. The program then terminated two health plans due to insolvency. Another plan was reorganized under federal bankruptcy statutes (GAO, 1996). In Tennessee, a hotline maintained by the state was often overwhelmed by the volume of calls and was not always adequate. Toll-free hotlines maintained by managed care organizations were "grossly inadequate" (Thorne, Bianchi, and Bonnyman, 1995). Interestingly, one of the GAO recommendations after several studies of Arizona was that states use a transition period "to make the dramatic shift from third-party payor in a fee-for-service system to health plan overseer monitoring costs, access, and quality of care" (GAO, 1995, 4).

Working with Plans, Advocates

When the plans in Michigan realized that there was a gap between the contract rate per enrollee and a lower effective rate, they often cut their reimbursement rates to their network doctors. This did not sit well with physicians, and in some cases the cozy relationship between the plans and their network providers began to change. The plans and providers started to complain loudly, often about items that were included in the rates such as transportation costs and services formerly covered by other state-funded maternal and child health programs. "They complained to us constantly," said one MSA official. "We still get a regular laundry list of complaints." State officials were not persuaded. One state official said that "the reality was that in the southeast the plans were fat and happy" – thus could absorb the cuts.

The plans, through their state association, organized a managed care consortium that worked with the legislature to increase the payment levels and "de-link" certain activities from the Medicaid contracts. They succeeded in getting more money for transportation costs (the initial contracts included mandatory transportation in the overall rate) but were not successful in separating maternal and infant programs. They were only moderately successful in raising the rates. The FY 2000 state budget included a 4 percent increase in rates.

The MSA established a clinical advisory committee (CAC) to collaborate with each health plan on quality improvement. There are fifteen members, including quality improvement directors and medical directors, and they meet quarterly. Although this committee was included in the waiver, it had held only two meetings as of December 1998. One of the plan spokesmen praised the establishment of the committee but complained that it took the MSA "three years to get around to this." There is also a Health Plans Advisory Committee, but it is similarly ineffective at this point. It meets two hours a week, four times a year. Its membership, representatives of plans, providers, and consumer groups, lacks expertise in many

details of Medicaid and the state has not provided education to its members.

The dialogue became somewhat heated in winter 1999 when the Michigan Health and Hospital Association (MHHA) published a report critical of Michigan's Medicaid program entitled, *No Margin, No Mission*. DCH director James Haveman responded with a press release titled, "Haveman to Hospital Association: Start Telling the Truth about Medicaid." Haveman took issue with the hospitals' claims that they had been forced to lay off employees, close clinics, and decrease charitable contributions to the community (MPHI, 1999). Fireworks also erupted in the legislative hearings in May, with the executive director of MHHA asserting that "community hospitals are closing programs as the direct result of government's failure to finance Medicaid and federal Medicare." The MHHA spokesman called the situation a "tragedy in the making" (Gongwer, 1999a). Again, the DCH chair minced no words, saying that the state had successfully provided more care to more individuals while controlling cost growth through the Medicaid managed care program. "We can't be in a managed care environment and act like it's a fee for service environment," he told a Senate subcommittee on April 27th. "It is not in the state's interest or to the benefit of patients to add hundreds of millions of dollars to the system and not achieve any different outcomes" (Gongwer, 1999b).

Thus, the state agency, supported by the governor and a Republican-led legislature, was somewhat surprisingly unresponsive to the pleas of plans and health providers. Their faith in the market system seemed undaunted. They were willing to allow the market to "shake out," including having some large plans freeze the number of Medicaid clients they would take. Politically, some of these HMOs felt they could not retreat from the Medicaid market, but they did want to reduce their liability to the Medicaid program. Several large Medicaid-dominated plans dominated the market, particularly in southeast Michigan. In recent months, some larger plans have stopped offering services in some counties

and have refused to take on new Medicaid patients. Clearly the market is continuing to adjust.

Tennessee and Arizona also heard the complaints from providers – especially Tennessee, where almost one-third of the doctors in the Blue Cross and Blue Shield network initially refused to join TennCare (Gleick, 1995). Arizona’s early experiences with providers were equally chaotic, with delays in payments and corrupt and incompetent managed care partnerships (Gleick, 1995). However, Arizona’s problems were relatively short-lived and over 80 percent of the state’s providers now participate in the program (GAO, 1995). TennCare’s initial adversarial relationship with providers continues (Alpha Center, 1999).

While there are certain safeguards built into the contracts with qualified health plans to assure consumer satisfaction and provide mechanisms for grievances and complaints, the MSA has done little to obtain the input of consumers in the implementation of the program. The MSA hopes to produce a “report card” which will be widely distributed among Medicaid recipients as a way to help them make decisions about plans. The state has installed a toll-free number and put in place a number of consumer satisfaction surveys. TennCare was widely criticized for similar issues and has worked to include an advocacy coalition more closely in the program (Thorne, Bianchi and Bonnyman, 1995).

Readjustments

Like Arizona and Tennessee, Michigan has learned from its early mistakes. It is reassessing the role of the enrollment broker and working with plans to collect information useful to both the agency and the plans. However, the MSA remains steadfast in its support of managed care and its belief that if forced by economic incentives, plans will structure their organizations more efficiently and thus the health care system will be improved. The MSA director would like to see organizations develop “best practices” for managed care entities. Other administrative changes could lead to

greater efficiency, and, thus, more profits, but these have yet to be implemented.

Not surprisingly, the Tennessee and Arizona models have made some changes in those states. Tennessee “catalyzed” the movement to managed care and the reorganization of health care delivery systems across the state, according to Gordon Bonnyman (1996). Among the related issues Bonnyman notes is the removal of long-standing barriers to the use of physician assistants and advanced practice nurses and a revamping of the state’s graduate medical education program to focus more funding on the training of primary care physicians. Arizona’s AHCCCS program has served as a model for many states wishing to harness competitive forces to control costs while improving access and quality.

Differences of Note

While this analysis has highlighted the similarities in the implementation efforts of the three states, there are some notable differences as well. First, unlike Michigan, managed care was not widespread in either Arizona or Tennessee when their Medicaid programs were launched. In Tennessee, none of the twelve managed care organizations that originally contracted with TennCare had experience in managed care practices outlined in the program (Amaral, 1996). In contrast, Michigan’s HMO penetration rate in July 1997 was 24 percent, only slightly below the national average of 27 percent. (InterStudy, 1997). The market was especially vibrant in southeast Michigan, the target of the 1997 effort.

A second difference is that the media coverage provided in both Arizona and Tennessee was vibrant, if often critical. In Michigan, there was little media coverage and little attention to the new program outside the state agency, plans, providers, and consumers. Unlike the state’s innovative welfare program which was a high priority to the governor, who continues to issue monthly press releases on the progress of the program, the Medicaid reforms garnered little gubernatorial attention or visible support. (It is important to note, however, that the DCH director did

apparently have strong behind-the-scenes support from Governor Engler, and the program portrayed much of the governor's philosophy toward government programs.)

Finally, the Michigan plan does not have the strong incentives for participation that the Tennessee model has. Tennessee's "cram-down" provision prohibited any physician who opted out of participating in TennCare from participating in the large Blue Cross and Blue Shield network, thereby losing a huge amount of business from state and local employees and teachers. This provision, although widely declaimed by physicians, was viewed as an important incentive for physician participation in the fledgling program. Michigan's plan is relying on a competitive market system in which plans will compete for Medicaid and other clients.

No Return Possible

No one in Michigan talks of returning to the fee-for-service or modified managed care system. The managed care effort in southeastern Michigan saved \$120 million in 1998 which was returned to the state treasury and is gone. There is no going back. As Bonnyman noted in describing TennCare, the "reform process . . . once initiated, is difficult to reverse." The reforms in Tennessee and Arizona have withstood enormous criticism and political party leadership changes and Michigan's reform is expected to do so as well.

Yet, there are concerns that expectations have been raised too high and that tough times may be ahead in meeting those expectations without additional resources. The state's major accomplishment has been simply to go statewide with a managed care program in less than eighteen months. The state now has contracted with twenty-nine health plans to serve over 700,000 people. Another major accomplishment has been accountability. The state has been serious in pursuing its efforts to get qualified health plans to meet the state's expectations with respect to quality. The Medical Services Administration is no longer trying to "befriend" the plans. It has a vision and a set of goals for its customers and it is prepared to do what it needs to pursue the vision and meet the goals.

So far, the Medicaid agency is succeeding politically with the governor, the legislature, interest groups, and (reluctantly) the plans. However, there will be more changes ahead. In 2000, the contracts will be rebid and the legislature is expected to adopt procedural reforms supported by providers.

In implementation of Medicaid managed care, Michigan has encountered the start-up problems, disgruntled providers and plans, and the sheer instability of the market endemic to major change so quickly implemented. Like Tennessee and Arizona, Michigan's short-fuse change was dramatic and fraught with potential problems. Also like theirs, it may well work.

Endnotes

- 1 The literature on AHCCCS and TennCare is extensive and includes Alpha Center (1999), Amaral (1996), Gleick (1995), GAO (1984, 1995), and Thorne, Bianchi, and Bonnyman (1995).
- 2 Both houses of the Michigan legislature were controlled by the Republicans in 1995-1996. In 1997-1998, the Democrats were in the majority; following the November 1998 election, the Republicans again controlled the House. The Michigan Senate has had a Republican majority since 1983.

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

411 State Street
Albany, New York 12203-1003

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