

**Case Studies in Medicaid Managed Care**

**GETTING MORE THAN  
WHAT'S BARGAINED FOR:  
THE HIDDEN ADMINISTRATIVE COSTS  
OF WEST VIRGINIA'S MOUNTAIN HEALTH  
TRUST PROGRAM**



**L. Christopher Plein**



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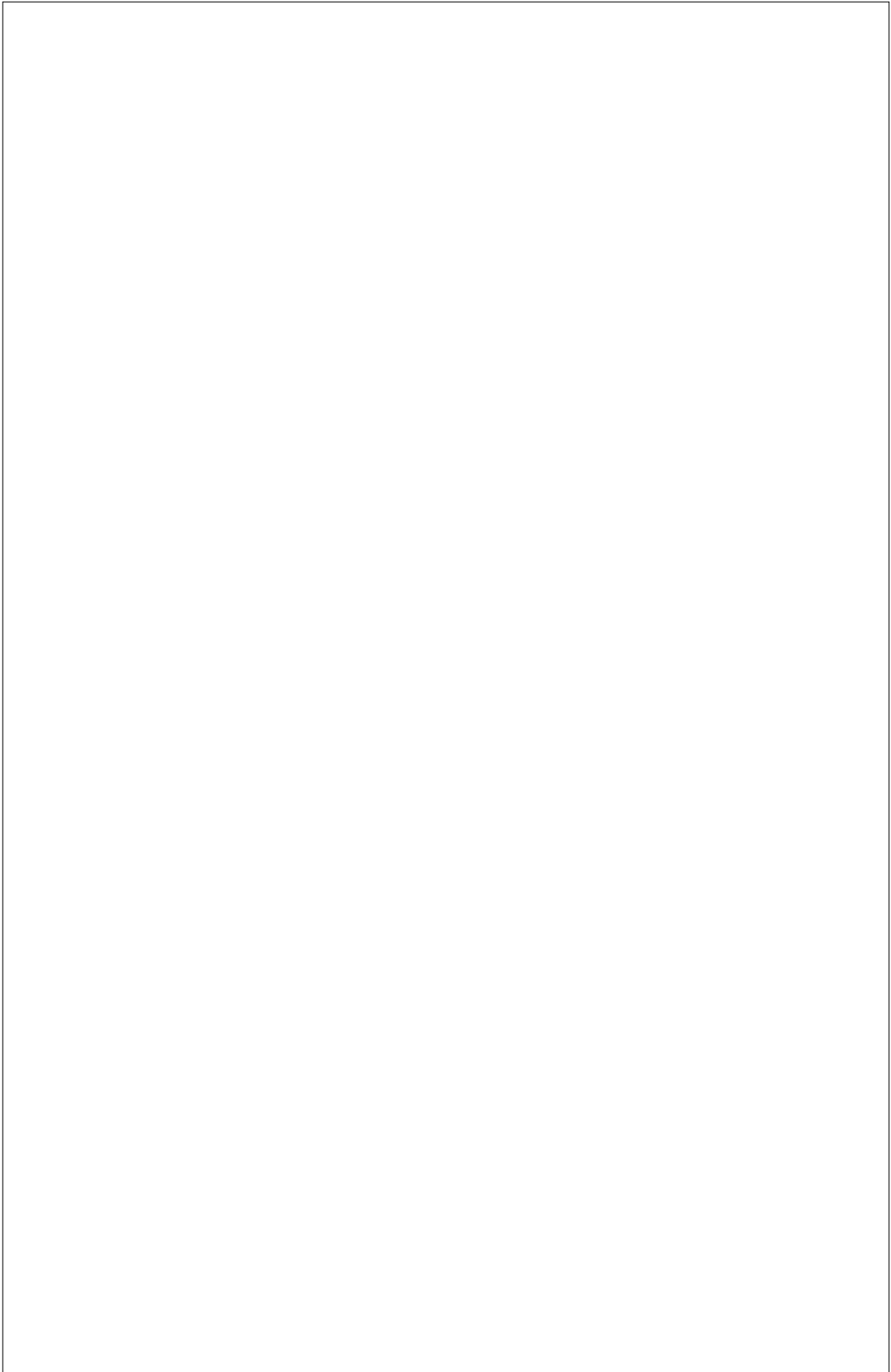
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## Introduction

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The expectations of policy decisions are not always realized. In the summer of 1996, the state of West Virginia initiated a managed care Medicaid program utilizing contracts with commercial health maintenance organizations (HMOs). Operating under a federal waiver, this demonstration program was intended to set the groundwork for a statewide conversion to Medicaid managed care. For the state, the attraction of the program was in the potential for cost control and containment. By entering into managed care contracts, program costs could be fixed and financial risks shifted from the state to contractors. Additional savings could be achieved by transferring administrative responsibilities and burdens from public agencies to nongovernmental organizations and consultants.

To date, West Virginia's experiment in HMO-based Medicaid managed care has not met with success. Existing conditions have not been amenable to the creation of the managed care market necessary for a competitive and effective program. The implementation of the program has been much slower than expected, and the numbers of those enrolled have failed to reach projected figures. Establishing the program has entailed substantial demands on the government, placing the state at a disadvantage in its relationships with HMOs. Managing the program has brought both administrative burdens and political costs as the state has had to balance various public policy needs against the pursuit of the Medicaid managed care program.

In short, the story of Medicaid managed care in West Virginia is one in which political expediency and the allure of a simple fix for the system clouded more reasoned assessments of the capacity of the state to pursue a new program regime. This paper examines this experience by first discussing the underlying political pressures for change in the face of program costs and budget constraints. Attention then turns to the popularity of HMO-based Medicaid managed care and how the state's Mountain Health

Trust program was designed along these lines. The paper then analyzes the administrative burdens of establishing the program and continuing costs and issues associated with maintaining the program.

## **Medicaid and West Virginia: A Legacy of Increasing Costs and Demands**

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Medicaid has been critical to improving health care access and quality in West Virginia. By leveraging federal dollars, the state has been able to expand health coverage to the medically needy, compensate hospitals that serve a disproportionate share of indigent cases, and help sustain rural clinics and public health departments. Approximately 308,000 West Virginians were covered by Medicaid in 1998 (Health Care Financing Administration, 1999a). This represents approximately 17 percent of the state's population. The program has been particularly important to the state's children. In 1995, 40 percent of West Virginia children under the age of 21 were Medicaid recipients — making up 56 percent of all beneficiaries. Between 1988 and 1994, 49.9 percent of the births in West Virginia were covered by Medicaid (Office of Maternal and Child Health, 1996). By compensating charity care and providing some of the financial underpinning of local health departments and rural clinics, Medicaid also extends support to the uninsured. In 1995, the number of uninsured West Virginians totaled about 276,000 (U.S. Bureau of the Census, 1997).

Among the states, West Virginia receives one of the highest Medicaid match rates. This match is on the order of three to one: For every 26 cents the state contributes to Medicaid, it receives a 74 cent match in federal funds. Yet even with this match rate the state has found it difficult to cover program obligations. Medicaid benefits have been expanded in recent years to cover more children and individuals with disabilities, increasing the scope of eligible beneficiaries. At the same time, health care costs, especially in long term care and prescription drugs, have increased (Office of Legislative Auditor, 1997).

In the past, reform was often driven by the desire to expand coverage and access. During the 1980s, the state sought to expand Medicaid coverage to the medically needy and poor, while at the same time developing reimbursement programs aimed at supporting hospitals providing a disproportionate share of indigent care and embarking on rural health initiatives. Due to frequent budget shortfalls, however, a sense of crisis has loomed over the state's Medicaid budget since the mid-1990s. This is evidenced in a change in attitude among policymakers. Policy preferences have shifted away from program expansion and toward cost containment strategies. Cost cutting priorities have helped lead the pursuit of managed care Medicaid options (see Plein, 1998).

There is a sense of immediacy to cost cutting efforts because of a fear that revenue is being exhausted. For a number of years, West Virginia has supplemented its general revenue funds with a health care provider tax in order to increase the pool of money available for accessing federal funds. The provider tax has been levied on doctors and hospitals regardless of whether they serve Medicaid recipients or not. Federal monies leveraged by this tax were largely distributed to hospitals that cared for a disproportionate share of indigent cases. In the spring of 1998, critics of the provider tax received support from recommendations offered by the Governor's Commission on Fair Taxation calling for a repeal of the provider tax ("Medicaid: Shift Tax Off Doctors?" 1998). Even without a cut in the provider tax, the future of the disproportionate share hospital (DSH) system has been cast in doubt due to changes in federal law. Building on legislation passed in 1991 and 1993, the Balanced Budget Act of 1997 further reduces the state's ability to allocate monies for DSH payments by placing specific limits on the amount of federal funds that can be applied to state matching funds for DSH payments over the next five years (Schneider, 1997).

A number of cost saving measures have been put into place to hold down Medicaid expenditures. The state is lowering reimbursement rates for various health services, such as home health care, outpatient services, and home health and durable medical equipment. Efforts have also been undertaken to reduce payments

for prescriptions and long term nursing home care. In another cost cutting effort, the state is pressuring local health departments to cease direct medical services that can be billed under Medicaid. The one cost saving measure that has been most clearly embraced by the state is the conversion of the state's fee-for-service system of Medicaid to a managed care system. The foundation of this transition is contracting arrangements with commercial and comprehensive health maintenance organizations. To understand this move toward managed care, it is necessary to briefly explore the larger phenomenon of Medicaid managed care.

### **Medicaid Managed Care: A Quick Primer**

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West Virginia's budget problems are not unique. Across the United States, policymakers have become very concerned about the cost of Medicaid in recent years. The program is seen as a "budget buster" which consumes scarce state revenues. States are pursuing strategies to close the gap between program costs and revenues. They have done this through cost-containment measures aimed at reducing or limiting reimbursement for services and prescriptions, eliminating services that were once covered under Medicaid, and, perhaps most significantly, developing case management programs aimed at controlling patient utilization of, and provider referral to, medical services (for various discussions, see Daniels, 1998; Fossett, et al., 1999; Hurley and Wallin, 1998). In 1998, the number of those enrolled in Medicaid managed care programs across the United States stood at about 54 percent (Health Care Financing Administration, 1999b). Managed care has now replaced fee-for-service payment arrangements as the dominant form of service delivery for Medicaid.

The purpose behind managed care is to contain costs through better utilization practices and case management. In general, states rely on two variants of managed care: one approach involves primary care case management (PCCM), the other approach relies on contracts with managed care organizations. Under PCCM arrangements, a primary care physician is usually contracted to

serve as a gatekeeper for health care utilization by the Medicaid client. Services continue to be delivered on a fee-for-service basis. The second approach involves contracting with managed care organizations on a full-risk capitated basis. Under such arrangements, participating plans are given a set amount of money per patient and are allowed wide discretion in controlling the utilization of services. The plans usually bear the financial risk of coverage for a patient. States often pursue both approaches at once (Hurley and Wallin, 1998).

Under PCCM approaches, case managers are provided a monthly administrative fee and are not subject to financial loss or risk if patients inappropriately utilize services. Primary care case management programs (PCCM) are generally seen as a stepping stone from fee-for-service to full-risk capitated Managed care arrangements. Many states also see them as an alternative to HMO managed care arrangements for rural areas which do not have the resources to sustain full-risk plans. They may also provide the foundation for community health providers to join together to create provider sponsored networks and organizations. However, a drawback of PCCMs is that it is difficult for case managers to control utilization by patients. Financial risks continue to be born by

	<i>Enrolled</i>	<i>Percent</i>
Comprehensive MCO	7.2 million	34%
Medicaid-only MCO	4.6 million	22%
PCCM Plans	4.0 million	19%
Prepaid Plans	4.9 million	23%
Other	0.4 million	2%
Total	21.1 million	

Source: Health Care Financing Administration, 1999b. *Medicaid Managed Care Plan Type and National Enrollment – June 30, 1998.*

the state Medicaid program rather than by managed care entities (Hurley and Wallin, 1998).

As of June 30, 1998, about 19 percent of those enrolled in Medicaid managed care arrangements did so through PCCM plans (Health Care Financing Administration, 1999b). This represents a significant drop from a year before, when approximately 31 percent of the Medicaid managed care caseload was enrolled in PCCM plans.

Across the United States, most Medicaid recipients enrolled in managed care do so under managed care organizations. Most often, commercial or comprehensive health maintenance organizations (HMOs) participate. In addition to enrolling Medicaid recipients, these organizations contract with other public programs and private payers. Thus, for example, a comprehensive HMO might have contracts with private corporations and the state's public employee insurance program. In a number of states plans have developed that serve only the Medicaid population. As the designation implies, Medicaid-only HMOs are dedicated to a single purpose. They account for 21 percent of the managed care caseload in Medicaid in the United States (Health Care Financing Administration, 1999b). There are no Medicaid-only plans in West Virginia. This is due primarily to past regulatory restrictions on such arrangements. Some argue that these plans have shortcomings in that they tend to keep Medicaid patients out of the "mainstream" of the health system (see Hurley and Wallin, 1998).

Under the Medicaid managed care organization model, HMOs usually contract with a state under what are called "full-risk" arrangements. Under these arrangements, managed care organizations are given a monthly capitated fee per enrollee. If the aggregate cost of care is lower than the aggregate capitated fees received by the managed care organization, the entity profits. If the aggregate cost of care is higher, the managed care organization suffers a loss. Nationwide, as of June 1998, full-risk capitated plans cover over 56 percent of those enrolled in Medicaid managed care arrangements (Health Care Financing Administration, 1998b).

Federal policymakers have clearly endorsed managed care arrangements as a delivery model for health care. New federal provisions under the Balanced Budget Act of 1997 allow managed care organizations to contract Medicare services and give states greater power to establish managed care arrangements for Medicaid services. However, in some states, such as West Virginia, HMO-based managed care organizations are encountering challenges in establishing and sustaining operations. The viability of an HMO model of health care delivery depends on both the underlying structure of the health care market and the policy preferences of government.

West Virginia is a late entrant into the managed care arena. The HMOs serve the more populous parts of the state; their presence in rural areas is limited. Demographic factors such as a poor health population profile and low population densities in the state serve as impediments to the development of a managed care system based on commercial HMOs. A limited health care infrastructure also contributes to this slow pace of transition: A shortage of physicians and health delivery sites limits the capacity of HMOs to build networks and systems of contracted and participating providers in the more rural parts of the state. Only about 10 percent of the state's population is enrolled in managed care. As of June 30, 1997, about 63 percent of those in West Virginia enrolled in Medicaid managed care were participating in the state's PCCM program (Holahan, Rangarajan, and Schirmer, 1999, 4). A year later, these numbers had changed little.

### **The Mountain Health Trust Program**

West Virginia's managed care organization approach is known as Mountain Health Trust. The PCCM program is known as the Physician Assured Access System. The state's Mountain Health Trust program was approved under the Section 1915(b) waiver granted by the U.S. Department of Health and Human Services Health Care Finance Administration in April of 1996. Originally, recipients of Temporary Aid to Needy Families (TANF; formerly AFDC, or Aid to Families with Dependent Children) and Supplemental

Security Income (SSI) in twelve counties were to be enrolled in managed care organizations. The program has since been expanded to a total of eighteen counties. The state hopes to learn from this demonstration program and expand Medicaid managed care throughout West Virginia. However, there are substantial challenges to program expansion, including a lack of managed care providers in the state and resistance from public and private health providers to enter into contracts with managed care organizations (see Plein, 1998). Prior to November of 1999, the state had contracts with two managed care organizations in its Mountain Health Trust program. Since then, one of the plans has left the program, which has greatly complicated the administration of the Mountain Health Trust initiative.

The Mountain Health Trust program pays managed care organizations a capitated fee per Medicaid beneficiary. It is a risk-comprehensive plan, which means that managed care organizations will not be compensated if patient care exceeds capitated payments. The capitated rates were set at approximately 5 percent below the average monthly rate for Medicaid services to TANF and SSI recipients under the traditional fee-for-service reimbursement approach. The state anticipates that substantial cost savings will accrue through more effective case management, which will encourage preventative care and minimize improper or overutilization of services (Bureau for Medical Services, 1996; for a discussion see Plein, 1998).

To date, the demonstration program has been given mixed reviews. Establishing the program has been a drawn out process in those counties participating in the demonstration project. There have been delays in enrolling TANF populations in some counties due to a lack of managed care organizations and participating physicians. Recipients of SSI have yet to be included in the managed care system. For the past two years, enrollment figures have remained relatively stable in West Virginia's Mountain Health Trust program. As of April 1999, there were 45,454 individuals enrolled in the program ("Medicaid's Projected Budget Deficit Decreases," 1999). The peak enrollment to date was in December of 1998 when

approximately 49,000 individuals were enrolled (Plein, 1999a). These stable numbers are attributable to the fact that the program is limited to a relatively few counties. The total percent of the total Medicaid population enrolled in the PAAS and Mountain Health Trust program was about 42.5 percent as of June 30, 1998.

One of the primary obstacles to extending managed care Medicaid in West Virginia has been the absence of a competitive managed care sector. West Virginia was relatively slow to embrace managed care. It was not until the mid-1990s that the state allowed commercial HMOs to contract with the state employee insurance program. At the same time, the state undertook an effort to place some of its Medicaid population into a managed care system that contracted with HMOs. The state's decision to contract with HMOs was a watershed event in the development of managed care in West Virginia. It was seen by many as a conscious effort to grow HMO managed care in West Virginia by opening a large enrollment base to nascent plans. Legislation and regulation have set a relatively high bar for HMO licensure in the state. This has made it difficult for other managed care organizations such as provider sponsored organizations (PSOs) or provider sponsored networks (PSNs) to get off the ground in West Virginia. As a result, through regulatory action and policy preferences, the state is currently committed to an HMO model of managed care. This burden of development and initiation has tested state administrative capacity.

### **Establishing Mountain Health Trust**

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Establishing an HMO-based Medicaid program requires substantial administrative effort and resources. It is a task that is made more difficult in a political climate that has created expectations of program success. The popularity of a privatized managed care system for Medicaid helped to propel the Mountain Health Trust initiative. But the desire to build a program such as this was not well grounded in the reality that managed care had made limited inroads into the state. Thus, the state found itself having to help build the managed care sector as well as make a transition in the

Medicaid program. A reorientation of the Bureau for Medical Services toward these program goals involved efforts to retain expertise from nongovernmental actors and organizations to provide assistance in program design and implementation. The persistence of a fragile HMO market in the state has made the implementation of the Mountain Health Trust program particularly daunting.

### *Responding to Political Demands*

From a fiscal standpoint, Medicaid is a very unpopular program area in West Virginia, primarily because of the financial demands of the program. In West Virginia, blame for cost overruns have often been placed at the door of the Bureau for Medical Services (see Plein, 1998; Plein, 1999a). In the mid-1990s, political interest in reforming Medicaid gained momentum. Governor Gaston Caperton, a Democrat, claimed ownership of the issue by advancing a model of Medicaid managed care based on contracts with commercial HMOs. The promise that financial risks could be minimized through full-risk capitated contracts proved alluring. In addition, administrative burdens and responsibilities could be shifted out of the public sector and into the participating HMO plans. Modeled after managed care Medicaid systems in other states, this plan embraced the notion that public problems could be solved through a private sector solution. The presumed efficacy of the HMO-based model of managed care went largely unquestioned by the state's policymakers (Plein, 1998). It was a policy idea that was framed as a simple and effective solution to a complex policy problem. Because other states had experimented with managed care, it was seen as familiar rather than unknown. Because the program relied on contracting arrangements, it was seen as complementary to the popular notion of privatizing government functions. This willing embrace of managed care has not been unique to West Virginia. As Hurley and Wallin (1998) have noted in regard to the national scene, "It is perhaps a testament to a near-blind faith in managed care that it has grown so rapidly with little convincing evidence as to its ability to provide states with more value for their expenditures" (3).

The popularity and attractiveness of policy ideas can lead to acceptance of a policy idea or approach with little thought about the implications of adoption. According to Moore (1988), it is this very image of a simple approach solving a complex issue which leads to the popularity of a policy idea. The rhetorical power of an idea or image may be enough to overwhelm more careful policy decision making. An ascendent image or policy solution also has the power to freeze out or de-legitimize other policy solutions (see Moore, 1988; Stone, 1988; McCurdy, 1995; Cobb and Ross, 1997). Richard Rose (1993) notes that failure to take into account the fungibility or transferability of a program can lead to policy failure. No program is completely fungible; some adaptation is required in adoption. Policymakers need to ascertain whether present conditions in their context are comparable to those from which a policy is being borrowed. Only then can a decision for adoption be warranted from a logical policy design perspective. But all too often, political considerations can intrude into the adoption of a policy. Emulation may not so much be the function of the technical and design attributes of a policy than what the policy stands for and who it is associated with. In a time of fiscal constraint and concern, Medicaid managed care stood for cost control and accountability. In a climate of doubt and distrust about governmental effectiveness, Medicaid managed care embraced private approaches to service delivery. In this way, an HMO-based model for Medicaid managed care gained ascendancy in West Virginia. And in this way, additional administrative burdens were placed on an already taxed bureaucratic structure.

The irony of the Medicaid managed care experience in West Virginia is that state administrators were relatively open-eyed about the difficulties of transitioning the program to an HMO-based model. In its application for a program waiver to the U.S. Department of Health and Human Services, the state noted:

HMOs have experience managing financial risk and are designed to address the challenges of providing well-coordinated, cost-effective, quality care. However, West Virginia's existing HMOs have little or no experience addressing the special needs of the Medicaid population. Simply moving the Medicaid popu-

lation into the HMOs' commercial structures is unlikely to overcome existing cultural, transportation, and other access barriers, nor will it automatically reverse habitual use of hospital emergency rooms as primary care delivery sites. Additional measures are needed to bring about a successful initiative (*W. V. Waiver Request*, 1995, 34).

Indeed embracing the HMO-model constituted an *about face* for the Caperton administration. Earlier in the decade, the Governor had appointed a task force on health care reform, which issued recommendations that the state foster the development of community based health networks that utilized public-private partnerships of health care providers and organizations. Part of the groundwork of such a system would have been the Medicaid primary care case management system that was already being put in place (see West Virginia Health Care Planning Commission, 1992). While the governor initially gave lukewarm support for these recommendations, this plan was soon abandoned in favor of a managed care arrangement that utilized commercial HMOs (see Plein, 1998). This placed the Department of Health and Human Resources and its Bureau for Medical Services into a position of having to change direction and "get up to speed" on managed care.

### ***Rethinking the Role of the State Medicaid Agency***

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The success of a Medicaid managed care system obviously depends on the financial viability of providers, plans, and arrangements in health care delivery. But the success of a program is also a function of government performance. The transition to Medicaid managed care arrangements poses substantial challenges for state agencies. Under traditional fee-for-service arrangements, the state Medicaid agency reimburses providers under an established payment plan. Traditionally, this process has been freighted with substantial regulation of federal and state origin. Under these arrangements, there has been a tendency for state Medicaid agencies to be seen essentially as fiduciary agents responsible for reimbursement and billing arrangements. As a result, Medicaid systems have often been encounter rather than case driven (see Fossett, 1998; Fossett et al., 1999). In other words, Medicaid

agencies have focused more on the services rendered rather than on patients. As Fossett (1998) notes:

Most state Medicaid agencies have historically defined their role in terms of this bill paying function and have not seen themselves as having any affirmative responsibility for setting or enforcing standards for gauging the appropriateness of care or improving the accessibility or quality of care to Medicaid clients (3).

The need for the Bureau for Medical Services to reorient itself toward more holistic program supervision has been acknowledged by senior state officials. Testifying before a legislative committee, the state's health and human resources secretary noted that, "West Virginia Medicaid historically has incorrectly been viewed only as a payer of claims. The new emphasis is toward promoting good health and purchasing quality care for those enrolled in Medicaid" (Ohl, 1999a). But what is expressed as a desire and what has been practiced have been two different things. The state has elected to reorganize its Medicaid agency, the Bureau for Medical Services (BMS), by retaining consultants for program design and oversight and by contracting out such services as data collection, analysis, and Medicaid client enrollment in the Mountain Health Trust program. In proposing its HMO-based managed care system, the BMS observed that a proactive administrative stance would need to be taken to guide the transition of Medicaid in West Virginia to a managed care system. The original waiver plan called for outreach efforts and holistic case management systems by participating HMOs, stressed the need for "experienced Medicaid providers" to be part of networks, and emphasized a role by the BMS to assist and educate existing Medicaid providers about their options for joining existing networks or creating new managed care arrangements (*W.V. Waiver Request*, 1995, 34). It has been difficult for the state to show leadership in developing managed care due to a lack of experience on the part of administrators. Instead of relying on an in-house knowledge base for developing the Mountain Health Trust program, the state has relied on outsiders.

The Mountain Health Trust program is an experiment in "vertical" privatization in which key administrative and management

functions have been outsourced in a variety of ways (see Plein, 1998; 1999a). Program design was led by consultants who brought their expertise and experience in designing state Medicaid managed care programs to West Virginia. Applications for federal review were assembled by these same consultants. The role of these contractors continues in the day-to-day operation of the program and in the review and future planning of the program. Thus, policy and program decision functions have essentially been delegated to these private interests. In program management, the reliance on consultants extends to support staff as well. In the field, much of the program is administered by a contractor who is responsible for enrolling Medicaid recipients in HMOs and maintaining “customer” relations. Finally, the private plans themselves and their contracted providers are the front line in service delivery. In this vertical structure, the only direct state role is at the local welfare office where Medicaid eligibility determinations are initially made, and in the Office of Medicaid Managed Care where one senior public employee engages in contract management and program review (Plein, 1999a).

### ***The Administrative Burdens of Working with the Market***

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High expectations coupled with poor market conditions pose daunting challenges to program success. By adopting an HMO-based approach to Medicaid managed care, West Virginia placed itself at a disadvantage in negotiating with and working with the plans participating in the Mountain Health Trust program. Well known for having a poor health profile for its population, the enrollment base for managed care was not seen as particularly attractive for managed care organizations. Coupled with this was a shrinking enrollment base for the most attractive Medicaid clients due to smaller welfare rolls. In turn, a lack of competing plans in the state gave the advantage in negotiation and bargaining to the HMOs. The limited prospects for market development in the health industry in general and the Medicaid population in specific have conspired to make it difficult to encourage new entrants and competitors into the system. Continuing

dependence on a few plans means that if the state overcommits to the Mountain Health Trust program, its fortunes will be wrapped up with those of the managed care industry. This is a particularly poor position to be in when renegotiating contracts and adjusting program goals and objectives.

In order to get Medicaid managed care arrangements under way, HMOs have benefitted from state practices that limit enrollment to those receiving TANF. Because the health profile of these individuals tends to be in the range of the general population, it is this portion of the Medicaid client base that is attractive to HMOs that contract under full-risk, capitated arrangements (Fossett, 1998). The dilemma for state policymakers and administrators is that most Medicaid costs are associated with the elderly, people with disabilities, and people with chronic conditions. These individuals account for approximately 70 percent of expenditures under Medicaid. For the most part, Medicaid managed care arrangements do not currently involve these individuals (Hurley and Wallin, 1998). While the numbers of those with disabilities who are enrolled in Medicaid managed care arrangements are growing (see Regenstein and Schroer, 1998), HMOs tend to shy away from these populations. Significant concessions must be made before these populations can be enrolled — such as higher capitated payments and stop-loss insurance arrangements that limit the financial risks of the host plan.

Another attraction of the population of TANF recipients is that it comprises the largest segment of those receiving Medicaid (Fossett, 1998). For managed care organizations seeking to become established in a state or region, these individuals can help to build an enrollment base necessary for effective economies of scale. Recent changes in welfare law are working against this stable base. The decline in welfare rolls has meant a decline in Medicaid recipients and a softening of the enrollment base due to shifting eligibility and program requirements. In West Virginia, the Medicaid population was seen as particularly attractive to HMOs. Though the state might not be the best payer through its Medicaid program, these enrollees coupled with public employees and others

can help establish a base of both providers and patients. Thus, in general, Medicaid is a stage of development for a managed care organization. But it is less of a building block as it is a temporary support for the construction of the plan.

As a late adopter of the Medicaid managed care approach, one might expect West Virginia to have a distinct advantage from learning from the lessons of others. But changing conditions, especially in the attitude of HMOs toward managed care for entitlement programs, tend to cancel out any advantage. In general, it appears that commercial HMO interest in participating in Medicaid managed care arrangements, as well as Medicare arrangements, is beginning to wane. The exit of managed care organizations from participating in the Medicare program has generated considerable attention.<sup>1</sup> Though perhaps not as noticeable, there is diminishing interest among firms in participating in Medicaid managed care arrangements as well. This has certainly been the case in West Virginia, where there has been no movement from other HMOs to enter into Medicaid contracts. Commenting on the national scene, Holahan, Rangarajan, and Schirmer (1999) observe:

States have found the transition to capitated managed care more difficult than expected. After a wave of interest by mainstream plans in the early 1990s, commercial plans have been hesitant to enter the Medicaid market, and a number of plans have either ended or limited participation in existing Medicaid managed care programs. Many plans leaving the market have cited increasing frustration with Medicaid managed care, namely, inadequate capitation rates coupled with the administrative demands of state Medicaid programs (3).

Because West Virginia is a relative newcomer to managed care, commercial HMOs in the state have already felt the chill prior to entering into the Medicaid managed care arena. Of the seven licensed HMOs in the state, only two now participate in the Mountain Health Trust program. The participating plans are Carelink and the Health Plan of the Upper Ohio Valley. Carelink operates in the southern parts of the state, while the Health Plan operates in the northern part of the state. In only two counties do these plans

compete head-to-head. Recently, the Optimum Choice plan withdrew from the program. Like the other plans, it had been involved in the program since its inception. Not only did the Optimum Choice plan account for the largest share of enrollment, it was also a competitor with the two remaining plans in the southern and northern parts of the state. The remaining plans have also recently experienced financial difficulties (Plein, 1999a). As we discuss shortly, this loss of competition and choice is forcing the state to re-configure its Medicaid managed care system.

	<i>Enrolled</i>	<i>Percent</i>
Carelink	12,246	25%
Health Plan	17,871	36%
Optimum Choice	19,247	39%
Total	49,364	

Source: Figures provided to the author by the Office of Medicaid Managed Care, West Virginia Department of Health and Human Resources.

For all practical intents and purposes, the state is engaged in sole source contracts with the HMOs participating in Mountain Health Trust. In no one county of the state have more than two plans competed against each other. And given the practical realities of transportation and access, in many counties the markets are geographically distinct for providers so that each has its own turf. In his discussion of privatization and contracting arrangements, Gormley (1994) warns that sole source contracting poses dangers to maintaining leverage and control by the purchaser of products and services. Gormley notes that sometimes competitive bidding is not an option. This is true once a decision to contract out has been made. But in the case of West Virginia, this situation may have been avoided with more careful policy design and program development. The state elected to pursue Medicaid managed care before a general managed care market was established.

As one state official explained in an interview for this research, the plans participating in the program did not have to go through a competitive bidding process. Given the paucity of HMOs in the state and limited interest in the program by these plans, an RFA or request-for-application, rather than an RFP, or request-for-proposal, was utilized. Those that could make it over the bar of eligibility were allowed to participate in the program. Ideally, the state would like to engage in competitive bidding for contracts under the Mountain Health Trust program, but the future prospect of this is dim. Instead, the state finds itself in a dependent relationship with the HMOs. Since signing on to Mountain Health Trust, these plans have been actively engaged in program development and design and enjoy influence over the direction of the program. This is done largely through informal lines of communication involving regular interaction between Bureau for Medical Services staff, consultants, and the plans (Plein, 1999a).

### *Discussion*

In its relationship with participating HMOs, the state is at a distinct disadvantage. Over the course of Mountain Health Trust only three plans have participated in the program and now one of these has withdrawn. Only the TANF/AFDC qualified population has been enrolled. While the state tends to have negotiated capitated payments with the plans that are well within national averages (see Holahan, Rangarajan, and Schirmer, 1999), the HMOs are protected by many carve-outs for services that otherwise might increase the financial risk of carrying Medicaid recipients. Most notably, those in the Medicaid population who are the most expensive to care for are still in the fee-for-service program. The state's administrative burden is complicated by the fact that it is not running one Medicaid system, but three: the traditional fee-for-service program, the Mountain Health Trust program, and the Physician Assured Access System primary care case management program.

A number of observers have identified various points to consider in deliberating whether to and when to enter contracts (see

DeHoog, 1984; Gormley, 1994; Wallin, 1997). As these scholars point out, there are many dimensions to contracting. They also note that political pressures can intrude on the decision making process. The popularity of an idea, and pressure to act on it, may be one contributing factor. For policymakers, the allure of commercial HMO models of managed care is that the state, in theory, is relieved of many of the administrative challenges and fiscal risks of running the Medicaid program. In an era of contracting and privatizing government services, commercial HMOs that bear the full risk of operating health plans are seen as very palatable. The state is able to cost-out expenditures and transfer risk to the plans under contract. In practice, however, this has not been the case.

As purchasers of managed care, states have the ability to exercise leverage as customers. However, in states where there are few competing plans, it is possible that the state, having invested resources into new systems and commitment to new approaches, will become dependent on the plans themselves. In these situations, the state may find itself subsidizing or sustaining plans in the fear that the failure of any one plan would substantially upset the market. If the state is dependent on a few plans to carry out a Medicaid managed care plan, then it has little leverage to exercise control. The threat of a plan pulling out may be enough to temper demands. The irony of market creation may be that the state's choices as a customer may be constrained by new arrangements (see Plein, 1999a).

### **Sustaining Mountain Health Trust: New Administrative Burdens and Risks**

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The transition to Medicaid managed care creates rather than relieves the state of administrative burdens. While day-to-day administrative functions can be off-loaded to hired consultants, enrollment brokers, and the plans themselves, ultimate accountability rests with the state. In the case of West Virginia, much of the burdens are political in nature as the state finds itself having to respond to concerns and demands placed upon it by established

stakeholders who feel threatened by new arrangements. Though not yet manifested in West Virginia, additional burdens may emanate from concerns over enrollee management and client rights issues. These, in general, are part of concerns about the imperfections of the managed care market. Moreover, additional burdens emanate from efforts to sustain and grow the Mountain Health Trust program in a state where the prospects for program success are less than assured.

### *The Demands and Concerns of Health Care Interests and Stakeholders*

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Change is not without consequence. The transition of health care delivery to managed care arrangements may not bode well for those in the health care system who have traditionally served the poor or have served populations with limited access to health care. Specifically, there is considerable concern about “safety net” providers who have been a resource for the uninsured as well as those on Medicaid. The development of managed care may signal a fundamental change in those areas where health care resources are most limited – namely, rural areas. Transitions to Medicaid managed care arrangements may amplify these effects. However, these effects or consequences are not necessarily determined. They may be forestalled or mitigated by policy actions. Just as legislation and regulation have helped to create current conditions, so too can they be used as a tool to minimize the transition to a managed care dominated health care infrastructure.

Over the years, the Medicaid program has helped to subsidize health care services for those not directly covered by the program. Through cross-subsidization and cost-shifting, many health services have been made available to the poor and uninsured by hospitals, clinics, and local health departments. As noted by Hurley and Wallin (1998), local health and human service agencies were encouraged by state governments to enter into direct service providers and bill Medicaid. Recent reforms, however, are reversing this trend. At both the state level and the federal level new laws and regulations are being implemented that

are aimed at cutting the opportunities for direct and indirect subsidies to health care providers through Medicaid funding (see Schneider, 1997).

Without public policies aimed at smoothing the transition to managed care health care delivery, Medicaid cost containment strategies that focus on contracting with HMOs may have negative consequences for “safety net” providers. Controlling the flow of dollars into the medical system through the use of HMOs may diminish the ability of Medicaid dollars to be used to help underwrite services to those not in the program — such as rural health clinic services, charity care in hospitals, and direct patient services provided by public health departments (for discussions, see Norton and Lipson, 1999; Bovbjerg and Marsteller, 1999). As Norton and Lipson (1999) observe:

The implicit cross-subsidy of care for the uninsured is eroding as a result of the federal, state, and private payers’ aggressive approach to seeking low-cost care for a defined population that excludes the uninsured. At the same time, the number of uninsured persons continues to increase, because of reductions in employer-sponsored coverage or declines in Medicaid rolls resulting from welfare reform (27-28).

Norton and Lipson (1999) note that states can take action to protect “safety net” providers by requiring Medicaid managed care firms to contract with public health departments, rural clinics, and the like. In West Virginia, HMOs participating in the Medicaid managed care program are not required to contract with public health departments but are offered financial incentives to do so. In addition, the state has committed itself to a “transitions” project aimed at assisting the exit of local health departments from direct health service delivery (Plein, 1999a).

In essence, Medicaid dollars are an important underpinning of the health care system. Those who are particularly dependent on these funds, such as teaching and rural hospitals, local health departments, and rural clinics, have champions in state legislatures, the medical and health services community, and the welfare rights arena. In such an environment, Medicaid state agencies are subject

to cross-cutting pressures from established players and must carefully weigh contending demands (see Hurley and Wallin, 1998; Fossett, 1998; Plein, 1998). As Hurley and Wallin (1998) note, "In fact, much of the recent history of Medicaid managed care illustrates the delicate balance of the program trying to be an aggressive buyer on behalf of its beneficiaries, without colliding with many other roles that Medicaid agencies have assumed or been assigned" (2).

The concerns that are expressed for "safety net" providers are reflected and amplified in issues surrounding the future of rural health in an era of managed care development. In general, there is fear that managed care may weaken the availability of health care in rural areas. In regard to Medicaid, cost containment efforts may further erode the base of health care in rural areas. There are also concerns that HMO models of managed care may not be successful in rural areas. Abandonment of service areas or plan failure may place hardship on those in rural areas who are unable to travel and access health care services. A number of advocates and observers advise that in order to preserve health care in rural areas, it will be necessary to develop alternatives to HMO-based managed care models. Community based initiatives that involve partnerships between public organizations and private providers are seen as one strategy for adapting managed care for rural areas. Provider sponsored organizations and networks, in which providers rather than an insurance company bear the risk of service, are also seen as a viable option for rural areas (see Mueller and McBride, 1999; National Rural Health Association, 1995, 1998). Such arrangements have been suggested for West Virginia by health reform advocates and task forces (see Plein, 1998) and demonstration projects in rural managed care are under way in the state (see West Virginia University Office of Rural Health, 1998).

But existing state regulations and perceived policy preferences are seen as working against managed care alternatives. The state's licensing standards have been criticized by some as being geared to the traditional HMO model of managed care. For example, in West Virginia, insurance regulations require that managed

care organizations have \$2 million in cash reserves to be licensed in the state. Provider sponsored organizations and networks are ill-positioned to raise these reserves. But without being licensed as HMOs, they cannot participate in the Mountain Health Trust program. The Bureau for Medical Services claims that it has no say in this matter, arguing that it is an issue for the legislature and insurance commissioner to resolve. A coalition made up of rural health advocates and the West Virginia Hospital Association would like to see these licensing arrangements change to allow PSOs and PSNs into the Medicaid managed care market (see West Virginia Hospital Association, 1997; Plein, 1999a).

Medicaid is a distributive policy issue (for a discussion, see Plein, 1998). For this alone, any efforts at policy reform will tend to be checked by established interests that derive benefits and revenues from the program who feel threatened by change. The Bureau for Medical Services has played an uncertain role in positioning itself in distributive conflicts emanating from Medicaid reform. Though high level political officials have long stressed the role of the state as a payer in helping to create a managed care market in West Virginia (see, for example, McElhinney, 1995), the Bureau for Medical Services has traditionally exercised caution in this regard (see, for example, Owens, 1995). This is especially the case now as the consequences of both Medicaid managed care reform and other reforms are cutting into the revenue streams of established public and nongovernmental interests. In the battle over provider sponsored networks, the Bureau risks the dangers of collateral damage. It is an issue to be decided by a legislature that must balance the demands of PSO interests against those HMOs that feel threatened by the prospect of new competition. But nonetheless, pressures will continue for the Bureau for Medical Services to allocate resources and determine through regulatory policy the relative winners and losers in the Medicaid arena. As is frequently noted in the literature (for discussions, see Kerwin, 1994; Schoenbrod, 1993), there is a tendency for elected officials to shift such decisions to administrators.

### *The Need for Regulation in an Imperfect Market*

It has long been established that health care is an imperfect market that requires regulation to protect the interests of participants and to correct or mitigate inequities between participants (see Feldman and Zeckhauser, 1978; Starr, 1982; Evans, 1997). One of the market imperfections of the health system is that the patient is usually at a disadvantage in the provider-client relationship. As Feldman and Zeckhauser (1978) note, "In this industry, with the asymmetry of information, the producer rather than the consumer tends to determine what kind and how much care will be delivered" (96-97). In an era of managed care, the producer is now largely the health plan rather than the specific physician or care provider. With Medicaid managed care systems, states have sought to design safeguards for clients. Following the lead of other states and the requirements of federal guidelines, West Virginia has pursued a number of approaches aimed at protecting client rights and interests.<sup>2</sup> Some rely on the logic of the market, in the guise of competition and choice. Others are rooted in the belief of regulatory safeguards through public authority. The failure of the former will increase administrative burdens for public agencies. The effective implementation of the latter rests on such issues as to whom authority has been delegated and to what level resources have been committed to ensuring protections.

The design of West Virginia's Mountain Health Trust program reflects the widely held assumption that consumer choice is the ultimate arbiter of quality and satisfaction in market arrangements. Current federal law dictates that patients have a choice between two or more plans. It also mandates that clients can change plans after thirty days. However, the ideal of this safeguard is not matched with reality. Choice only works if there are options, and a lack of competition in West Virginia limits choice. In practice, enrollee shifting has not been a noticeable trend in West Virginia. Added to this is the fact that counties are often geographically divided between one plan or the other. Transportation factors and opportunity costs may make it infeasible for a client to change plans. They may essentially be locked into one plan.

The ideal of choice in Medicaid managed care has been severely tested. Early experiences with managed care in Florida and Tennessee demonstrated that direct marketing by HMOs to enroll Medicaid recipients created serious problems for program quality and effectiveness. Bombarded with inducements and encouragement, it is doubtful that clients were able to make informed decisions. As a result, many states now prohibit plans from directly recruiting Medicaid recipients. However, states often lack the administrative capacity to coordinate the enrollment process. As a result, nongovernmental organizations are often retained to carry out this function. These enrollment brokers are responsible for providing Medicaid recipients with information about plans and assisting in their choice of plans. Increasingly, these brokers also provide guidance and assistance to clients once they are enrolled in plans. For example, Automated Health Systems, which is the enrollment broker for the Mountain Health Trust program, tracks client assignment, assists in customer complaints, and participates in program development and assessment (Plein, 1999a). In essence, these nongovernmental actors provide some regulatory assurance that the interests of clients will be protected.

Shifting enrollment functions to nongovernmental actors does not absolve the state of responsibility. Indeed, a number of scholars and observers have expressed concern that the delegation of the responsibility might be made without adequate procedural safeguards – protections that are all but taken for granted in the design and operation of public agencies (for discussions, see Gilmour and Jensen, 1998; Sullivan, 1987). Evaluations of the enrollment function in West Virginia have been mixed. In the early stages of the Mountain Health Trust program, criticism was aired in the media citing confusion and frustration among clients seeking to enroll in the program (see Plein, 1998). Research conducted for this project suggests that the enrollment broker has not worked as closely with field offices of the Department of Health and Human Resources in coordinating client intake as was intended (see Plein, 1999a). The transfer of responsibilities is of concern in other states, as well. For example, Romzek and Johnston (1999) document the difficulties of contracting out Medicaid case management

services for the elderly in Kansas. They note the difficulties of establishing working relationships between agencies and nongovernmental actors involved in case management.

### **Expanding Mountain Health Trust: An Uncertain Future**

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In 1996, the state announced that the Mountain Health Trust program would cover up to 95,220 people in a twelve county region by March of 1997. These goals have not been achieved. Total enrollment stood at less than 45,000 in August 1999 – about 4,000 less than a peak of approximately 49,000 in January, 1999. Most significantly, the SSI population has yet to be brought into the system. As for geographic expansion of the program in the state, performance has not met expectations. The state received permission to expand the Mountain Health Trust program to five additional counties making for a total of eighteen counties covered. But growing the plan has been difficult. It was anticipated that HMOs could use the promise of a Medicaid patient base as a lever to encourage hospitals and providers to enter into contracts and arrangements with the plans. Instead, HMOs have often met stiff resistance from the health care community. In these cases, providers and hospitals either distrust HMO arrangements or desire to create their own networks and systems for managed care. The fact that enrollments in the Mountain Health Trust program have not increased significantly since 1997 tells us that gaining federal approval to operate a Medicaid managed care in a geographic area and actually getting one up and running are two different matters. The state must now consider possible options and the attendant political and financial costs for expanding Medicaid managed care.

One option would be to protect the existing HMO market by excluding other managed care competitors and by carving up the rural market among the HMOs. Although the Balanced Budget Act of 1997 gives permission to the states to contract with provider sponsored organizations and other networks, the Bureau for Medical Services in West Virginia has not signaled a desire to do this.

Instead, there are indications that the state would like to protect the HMO market by electing to pursue a provision in the act that allows states to contract with a single plan in a rural area. Under the act, states may contract with as few as two managed care organizations or primary care case manager entities. In rural areas, the contract can be with as few as one entity, as long as Medicaid recipients are entitled to a choice of two or more primary care providers or case managers (National Governors' Association, 1997; Schneider, 1997). Final federal rules have not yet been issued on this provision, so the state is in a wait and see posture. There is a certain irony built into this option. Arguments that competition between managed care organizations will lead to service effectiveness and fiscal efficiency hold little relevance where monopolistic arrangements result. Further, the lack of competition will increase the regulatory burden on the state to oversee these arrangements. Rather than encouraging competition to achieve efficiency, the state could find itself back in an oversight role with all the attendant hazards and problems that champions of privatization and public choice have been warning about for years.

Another option is for the state to hedge its bets by revitalizing its primary care case management system. The Physician Assured Access System (PAAS) still is the largest managed care program in the state. But as noted previously, PAAS fell out of favor as the Mountain Health Trust program was embraced as the managed care system of the future. But, there are indications that the state is acknowledging that the Mountain Health Trust program may not be the sole path of Medicaid managed care. In recent months there has been an effort to reinvigorate the PAAS program. In those counties that cannot sustain HMOs, the PAAS program provides an opportunity for the state to manage Medicaid care. Of 3,700 licensed physicians in West Virginia, approximately 500 participate in the PAAS program. Recruitment efforts have recently been stepped up (see Ohl, 1999b). Most significantly, the state is reconstituting the PAAS program in sixteen Mountain Health Trust program counties to provide a choice for Medicaid enrollees.

Until recently, the PAAS program had been suspended in those counties where the Mountain Health Trust program operates. Some state officials believe that allowing both programs to operate would satisfy requirements for competition and choice that are now part of federal rules governing Medicaid managed care programs (Plein, 1999a). The exploration and limited pursuit of this option suggests that the state is uncertain about what path to take. Without a clear sense of direction, any of these choices might be explored without committing resources and priority to any one option. This places further demands on administrative resources. Requests are made to develop plans and possibilities, while other ideas and initiatives must be deferred until a path for program maintenance and expansion opens. These uncertainties cloud other areas of responsibility and concern to the state, such as those involving the fate of “safety net” providers, rural health service delivery, and the enrollment of the disabled and chronically ill in managed care.

A successful system of privatized Medicaid managed care in West Virginia relies on establishing the keystone of the system — a system of viable health maintenance organizations that can provide coverage to affected populations. As the biggest payer in West Virginia, the state has been able to create a managed care market through virtue of a decision that released its public employees to HMO enrollments. Establishing a viable HMO market in West Virginia may prove elusive and may be bought at a price that is too dear. The lure of state contracts was sufficient to bring HMOs to West Virginia, but it is questionable whether they are enough to sustain their presence. Because of the fragile condition of HMOs in West Virginia, the state is exercising caution regarding the licensing of provider sponsored networks and organizations. Advocates of PSNs and PSOs argue that these managed care systems hold the solution to providing Medicaid services and controlling delivery costs in the rural areas of the state. Tempting as this might seem, the state is reluctant to allow new competitors into the managed care market out of fear that existing HMOs will fall in the face of competition. In order to protect existing HMOs and thus protect its base of managed care Medicaid enrollees, the state appears to be

foreclosing, for now, some options for expansion. As a result, the state appears to be temporizing on the choices of expanding the program. As two years of experience with Mountain Health Trust has amply demonstrated, HCFA approval for expansion does not necessarily translate into success in implementation. Public efforts aimed at market creation that fall short of expectations can place policymakers and governments in an awkward position.

### *Discussion*

The development of the Mountain Health Trust program has tended to follow the path of least resistance. Those in the population who pose the least risk to programs have tended to be the first to be enrolled. For Medicaid managed care, this means that those who qualify because of economic status have been moved into HMO arrangements. Those qualifying for Medicaid because of disabilities or medical needs have yet to be enrolled in the program. The program has also been implemented in those counties that have been most amenable to the formation of managed care arrangements. The growth of the program has been slow and expansion appears to have hit a wall. As the situation now stands, the Mountain Health Trust program is in stasis.

Ultimately, the efficacy of the Mountain Health Trust program must be judged on both expressed and tacit objectives behind the program — cost containment. If the program is limited only to the AFDC/TANF population, it will never deliver on the larger promise of cost containment for Medicaid. Since most costs are associated with the care of those with disabilities and chronic conditions, the purposes of managed care systems are best tested and accomplished with coverage of these populations. Early on in the design of the program, skeptics in the legislature warned that a program aimed only at welfare recipients would not be addressing core areas of program expense — namely coverage for those who are disabled and those needing long term care (see Owens, 1995). Inclusion of the SSI population in the program was originally aimed at addressing this area of cost. Though granted authority by the federal government to extend the program to the SSI

population, West Virginia has not pursued this option. The state has repeatedly delayed the enrollment of these individuals since the inception of the program. Enrollment of the AFDC/TANF population should be seen as a proving ground for the viability of Medicaid managed care, rather than an end in itself.

The adoption of Medicaid managed care arrangements also reveals the hidden administrative costs of transition. Reorienting a state's Medicaid program toward managed care requires a substantial investment of resources and effort in administrative arrangements. Policy design and oversight activities in the development and implementation of programs place demands on already stretched state Medicaid bureaucracies. Medicaid managed care requires that the state develop expertise and dedicate resources to contract management, quality control, provider relations, and consumer protection (Fossett, 1998; Hurley and Wallin, 1998). Further, since states continue to run fee-for-service programs in conjunction with new managed care approaches, they must maintain existing systems as well (Fossett, 1998). Administrative burdens are intensified as reform creates or amplifies numerous issues relating to trade-offs between vested stakeholders in the health care community, concerns about client welfare and rights, and uncertainties about sustaining a program over time.

## **Conclusion**

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The state's expectations for the Mountain Health Trust program have not been fulfilled. Current conditions suggest that the promise of a Medicaid managed care system based on contractual arrangements with commercial HMOs will not be realized. As the largest payer of medical insurance in West Virginia, the state essentially created a managed care market by allowing the public employee insurance program and some of the Medicaid program to establish contracts with HMOs. But by pursuing this path of reform, the state has created additional burdens and responsibilities that tax the state's administrative capacity. Political expediency and unrealistic policy preferences prompted the adoption of the

Mountain Health Trust program. The difficulties of fulfilling expectations have been demonstrated in both establishing and administering the program. West Virginia has gotten much more than it has bargained for in terms of new and continuing regulatory burdens and gnawing uncertainties about the viability of the Mountain Health Trust program.

## Endnotes

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- 1 For example, once attracted to managed care arrangements for Medicare that were provided under the Balanced Budget Act of 1997, HMOs are now backing out of this program. They have found that the costs of caring for a geriatric population coupled with the burdens of establishing networks of health providers to be too taxing. In July, 1999, the federal government estimated that the exit of HMOs would affect 327,000 Medicare beneficiaries — adding to the some 407,000 who had lost their plans in the previous year (Pear, 1999).
- 2 The scope of this presentation does not allow for a discussion of the broad set of issues associated with quality of care and access issues in managed care arrangements. For a general discussion of these issues see Fossett et al. (1999).

## References

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Bovbjerg, Randall R. and Jill A. Marsteller. (1999). *Health Care Market Competition in Six States: Implications for the Poor*. (Briefing Paper.) Washington, D.C.: Urban Institute. Accessed on-line at: [newfederalism.urban.org/html/occ17.html](http://newfederalism.urban.org/html/occ17.html).

Bureau for Medical Services, Office of Medicaid Managed Care, Department of Health and Human Resources. (1996). *Mountain Health Trust*. (Briefing Handout). Charleston, West Virginia: Author.

Cobb, Roger W. and Marc H. Ross. (1997). "Agenda Setting and Denial of Agenda Access: Key Concepts." In Roger W. Cobb

and Marc H. Ross (Eds.), *Cultural Strategies of Agenda Denial*. Lawrence, KS: University Press of Kansas, pp. 3-24.

Daniels, Mark. (Ed.). (1998). *Medicaid Reform and the American States: Case Studies in the Politics of Managed Care*. Westport, CT: Auburn House.

DeHoog, Ruth H. (1984). *Contracting Out for Public Services: Economic, Political, and Organizational Perspectives*. Albany, NY: State University of New York Press.

Evans, Robert G. (1997). "Sharing the Burden, Containing the Cost: Fundamental Conflicts in Health Care Finance." In Theodore Litman and Leonard S. Robins (Eds.), *Health Politics and Policy* 3rd Ed. Albany, NY: Delmar Publishers, pp. 265-287.

Feldman, Penny H. and Richard J. Zeckhauser. (1978). "Some Sober Thoughts on Health Care Regulation." In Chris Argyris, et al. (Eds.), *Regulating Business: The Search for an Optimum*. San Francisco: Institute for Contemporary Studies, pp. 93-123

Fossett, James W. (1998, November). *Managing Accountability in Medicaid Managed Care: A Pilot Study*. (Rockefeller Reports). Albany, NY: The Nelson Rockefeller Institute of Government.

Fossett, J, with J. Hall, J. Johnston, L.C. Plein, R. Roper, C. Weissert. (1999). *Managing Accountability in Medicaid Managed Care: The Politics of Public Management*. Albany, NY: The Nelson Rockefeller Institute of Government.

Gilmour, Robert S. and Laura S. Jensen. (1998). "Reinventing Government Accountability: Public Functions, Privatization, and The Meaning of 'State Action.'" *Public Administration Review* 58(3), 247-258.

Gormley, William. (1994, Autumn/Winter). "Privatization Revisited." *Policy Studies Review*, 215-231.

Health Care Financing Administration. (1999a). *Medicaid Managed Care State Enrollment – June 1998*. Accessed on-line at: [www.hcfa.gov/medicaid/mcsten98.htm](http://www.hcfa.gov/medicaid/mcsten98.htm).

Health Care Finance Administration. (1999b). *Medicaid Managed Care Plan Type and National Enrollment – June 30, 1998*. Accessed on-line at: [www.hcfa.gov/medicaid/plansum8.htm](http://www.hcfa.gov/medicaid/plansum8.htm).

Holahan, John, Suresh Rangarajan, and Matthew Schirmer. (1999). *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey (Occasional Paper Number 26)*. Washington, D.C.: Urban Institute. Accessed on-line at: [newfederalism.urban.org](http://newfederalism.urban.org).

Hurley, Robert E. and Susan Wallin. (1998). *Adopting and Adapting Managed Care for Medicaid Beneficiaries: An Imperfect Translation (Occasional Paper Number 7)*. Washington, D.C.: The Urban Institute. Accessed on-line at: [newfederalism.urban.org](http://newfederalism.urban.org).

Kerwin, Cornelius. (1994). *Rulemaking: How Government Agencies Write Law and Make Policy*. Washington, D.C.: Congressional Quarterly Press.

McCurdy, Howard. (1995). "Fiction and Imagination: How They Affect Public Administration." *Public Administration Review* 55(6), 499-506.

McElhinney, Brad. (1999, January 18). "PEIA Choice May Make Medicaid Managed Care Move Easier," *Charleston Gazette*, 5A.

"Medicaid's Projected Budget Deficit Decreases." (1999, May 10). *Focus*. Newsletter of the West Virginia Hospital Association, 2.

"Medicaid: Shift Tax Off Doctors?" (1998, July 29). *Charleston Gazette*, 4A.

Moore, Mark. (1988). "What Sort of Ideas Become Public Ideas?" In Robert B. Reich (Ed.), *The Power of Public Ideas*. Cambridge, MA: Harvard University Press, pp. 55-84.

Mueller, Keith and Timothy McBride. (1999, February). "Taking Medicare Into the 21st Century: The Realities Of The Post-BBA World and Implications for Rural Health Care." Columbia, MO: Rural Policy Research Institute.

Mueller, Keith J. (1998). "Provider Sponsored Organizations for Medicare Managed Care: What Is Next for Rural Providers?" (Working Paper 98-1). Omaha, NE: Nebraska Center for Rural Health Research, University of Nebraska Medical Center.

National Governors' Association. (1998, September). "State Challenges And Opportunities In Rural And Frontier Health Care Delivery." Accessed on-line at: [www.nga.org](http://www.nga.org).

National Governors' Association. (1997). "Medicaid Managed Care." Accessed on-line at: [www.nga.org/MCH/medicaid.htm](http://www.nga.org/MCH/medicaid.htm).

National Rural Health Association. (1998, February). "A Vision for Health Reform Models for America's Rural Communities" (Issue Paper). Accessed on-line at: [www.NRHArural.org](http://www.NRHArural.org).

National Rural Health Association. (1995, May). "Managed Care as a Service Delivery Model in Rural Areas" (Issue Paper). Accessed on line at: [www.NRHArural.org](http://www.NRHArural.org).

Norton, Stephen A. and Debra J. Lipson. (1999). "Public Policy, Market Forces, and the Viability Of Safety Net Providers" (Briefing Paper). Washington, D.C.: Urban Institute. Accessed on-line at: [newfederalism.urban.org](http://newfederalism.urban.org).

Office of the Legislative Auditor, West Virginia Legislature. (1997, December). *State of West Virginia Full Performance Evaluation of the Department of Health and Human Resources Medicaid Eligibility: Eligibility Decision Error Rate*. Charleston, WV: December. Author.

Office of Maternal and Child Health, Bureau for Public Health. (1996) *West Virginia Department of Health and Human Resources. Maternal and Child Health Block Grant Application, Fiscal Year 1997*. Charleston, WV: author.

Ohl, Joan. Secretary of the West Virginia Department of Health and Human Resources. (1999a, February 4). "FY 2000 Budget Presentation Before the Senate Finance Committee." Accessed on-line at: [www.wvdhhr.org](http://www.wvdhhr.org).

Ohl, Joan. Secretary of the West Virginia Department of Health and Human Resources. (1999b, April 10). "Address to the First Annual PAAS Conference." Accessed on-line at: [www.wvdhr.org/Speeches/paas.htm](http://www.wvdhr.org/Speeches/paas.htm).

Owens, Paul. (1995, July 11). "Managed Care Savings May be Slow to Show." *Charleston Daily Mail*, 1A, 7A.

Pear, Robert. (1999, July 16). "H.M.O.'s to Drop 327,000 Medicare Patients." *New York Times*, A15.

Plein, L. Christopher. (1999a). "West Virginia's Medicaid Managed Care Experience: The Mountain Health Trust Program." Report for the Accountability in Medicaid Managed Care Project. State Capacity Study, The Nelson A. Rockefeller Institute of Government, The State University of New York. Albany, NY: The Nelson A. Rockefeller Institute of Government.

Plein, L. Christopher. (1999b). "General Notes and Observations on the Political and Policy Context of Managed Care, Disease Management, Diabetes, and Medicaid in West Virginia." Report for the West Virginia Comprehensive Diabetes Control Project. Office of Health Services Research, West Virginia University.

Plein, L. Christopher. (1998). "Uncertain Prospects: West Virginia and Medicaid Reform." In Mark R. Daniels (Ed.). *Medicaid Reform and the American States*. Westport, CT: Auburn House, pp. 275-291.

- Regenstein, Marsha and Christy Schroer. (1998). "Medicaid Managed Care for Persons With Disabilities: State Profiles." Economic and Social Policy Research Institute, Kaiser Family Foundation. Accessed on-line at [www.kff.org](http://www.kff.org).
- Romzek, Barbara S. and Jocelyn M. Johnston. (1999). "Reforming Medicaid Through Contracting: The Nexus of Implementation and Organizational Culture." *Journal of Public Administration Research and Theory* 9(1), 107-139.
- Rose, Richard. (1993). *Lesson Drawing in Public Policy: A Guide to Learning Across Time and Space*. Chatham NJ: Chatham House Publishing.
- Schneider, Andy. (1997). "Overview of Medicaid Provisions of The Balanced Budget Act of 1997, P.L. 105-333" (Briefing Paper). Washington, D.C.: Center for Budget and Policy Priorities. Accessed on-line at: [www.cbpp.org](http://www.cbpp.org).
- Schoenbrod, David. (1993). *Power Without Responsibility: How Congress Abuses the People Through Delegation*. New Haven, CT: Yale University Press.
- Starr, Paul. (1982). *The Social Transformation of American Medicine*. New York: Basic Books.
- Stone, Deborah. (1988). *Policy Paradox and Political Reason*. Glenview, IL: Scott, Foresman, and Co.
- Stone, Greg. (1997, April 24). "Confusion Hinders Welfare HMO Program." *Charleston Gazette*, 1A, 9A.
- Sullivan, Harold J. (1987). "Privatization Of Public Services: A Growing Threat to Constitutional Rights." *Public Administration Review* 47(6), 461-467.
- U.S. Bureau of the Census. 1997. *Statistical Abstract of the United States*. Accessed online at: [www.census.gov/prod/www/abs/cc97stab.html](http://www.census.gov/prod/www/abs/cc97stab.html).

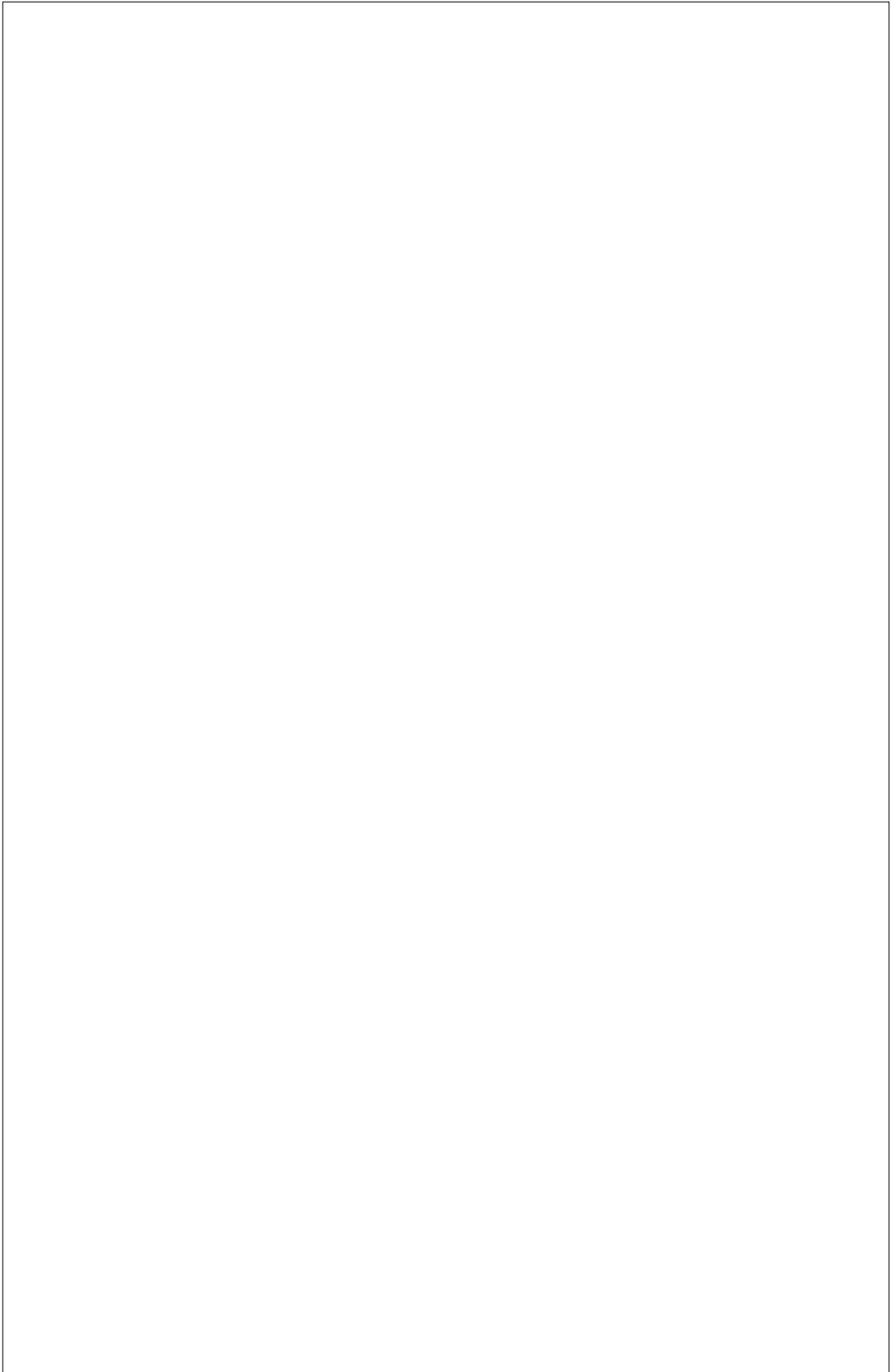
Wallin, Bruce A. (1997). "The Need for a Privatization Process: Lessons From Development and Implementation." *Public Administration Review* 57(1), 11-20.

West Virginia Health Care Planning Commission. (1992). *Health Care Reform in West Virginia: A Shared Responsibility*. Charleston, WV: author.

West Virginia Hospital Association, West Virginia University Office of Rural Health, and Center for Rural Health Development. (1997, February 11). *Provider Sponsored Networks and State Insurance Regulation*. Accessed on line at: [www.wvha.com/publicat/reports](http://www.wvha.com/publicat/reports).

West Virginia's Section 1915(b) Waiver Request to Implement a Medicaid Managed Care Program. (1995, August). Submitted to the Health Care Financing Administration, U.S. Department of Health and Human Resources by the Bureau for Medical Services, West Virginia Department of Health and Human Resources.

West Virginia University Office of Rural Health. (1998). *Managed Care and Rural Network Development in West Virginia*. Morgantown, WV: West Virginia University Office of Rural Health.







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