

Case Studies in Medicaid Managed Care

**IMPLEMENTING MEDICAID
MANAGED CARE IN KANSAS:
POLITICS, ECONOMICS
AND CONTRACTING**



Jocelyn M. Johnston



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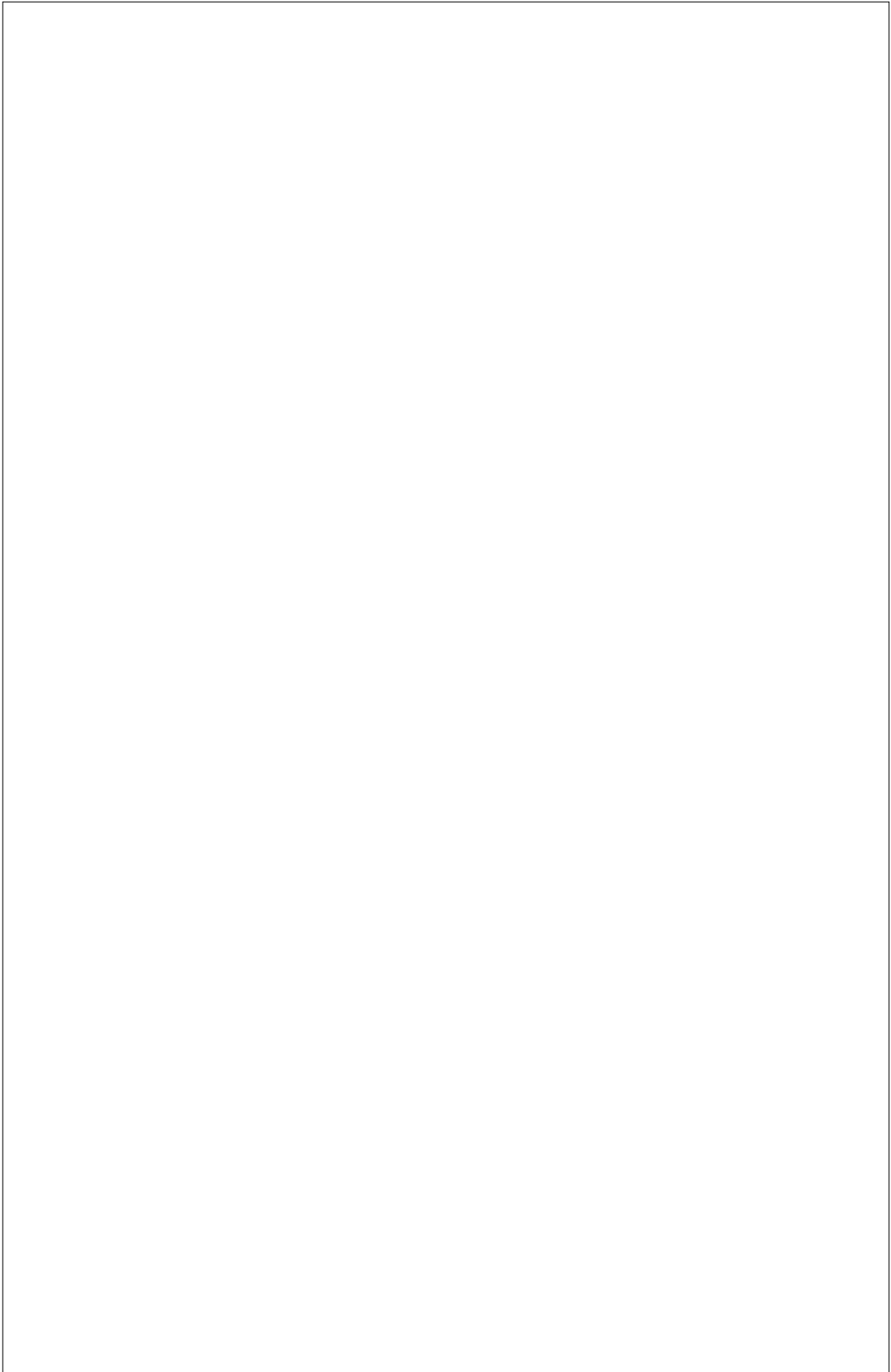
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Table of Contents

Background 2
The Kansas Managed Care Environment 4
Management Responses 6
Contract Management Strategies 7
Enforcing Contract Standards 10
Administrative Contracts 11
Managing with Tight Resources 13
Relations with Contractors 15
Conclusion 17
Endnotes 18
References. 20



The implementation of Medicaid managed care reforms in the State of Kansas has followed a rocky road shaped by a combination of political and policy imperatives and market conditions that often conflict with those imperatives. Medicaid managed care politics in Kansas are dominated by legislative distrust of the state's Medicaid agency, low Medicaid reimbursement rates, an inclination among state elected officials to embrace contracting out as a method to reduce the size of the social welfare bureaucracy, and legislative belief that capitated managed care is the best tool to hold program cost growth, legislative belief that capitated managed care is the best tool to hold program cost growth. Market factors, on the other hand, have hindered the development of capitated managed care for the state's Medicaid population. The state has been plagued from the outset by too few HMOs willing to participate in Medicaid, and by the resistance of physicians to managed care. Other implementation challenges include trust and morale issues resulting from conflicts between middle managers' efforts to strengthen program oversight, and the inclination of agency leaders to compromise these efforts in their responses to legislative objectives. The staff responsible for administration of Medicaid managed care is challenged by competing program needs within the agency, insufficient resources for staffing and management information, and limited preparation for the demands of managed care oversight.

Despite the efforts of the Medicaid bureaucracy and the legislative imperative for capitated Medicaid managed care, the state today finds itself coping with a situation in which most areas of the state are served by only one financially unstable Medicaid HMO (known as Horizon).¹ For a brief period, Kansas contracted with three capitated plans in one area of the state. Now the state is struggling to sustain its contract with the only HMO willing to provide Medicaid managed care. That HMO has suffered financial hardship from the outset of its contract with the state, and its future is still uncertain. The state also continues to wrestle with the two organizations that provide managed care administration and oversight. Although the state has formulated a successful primary care case management (PCCM) program² that offers managed care

throughout most of the state, attainment of the legislative objective of widespread capitated Medicaid managed care is seriously threatened.

The challenges to state Medicaid administrators are enormous under the managed care paradigm, and as one analyst notes, “among these challenges, none are more pressing than those associated with contracting for health care services” (Thompson, 1998, 265). Kettl (1993, 1993a) has laid out several important conditions for successful social service contracting. The evidence from Kansas suggests that many of those conditions are absent. For most components of Medicaid managed care, there are too few potential contract providers. In addition, the state cannot realistically reassume the tasks performed by contractors; this is particularly true for many administrative oversight tasks currently contracted out to two nongovernmental organizations. Finally, training for Medicaid contract managers has been inadequate. The capacity of the state to successfully implement major Medicaid reforms is therefore inhibited by shortcomings in the policy design and the theoretical underpinnings of the reforms (Pressman and Wildavsky, 1984; Goggin et al., 1990; Van Meter and Van Horn, 1975; Mazmanian and Sabatier, 1981). These shortcomings have seriously compromised the capacity of Kansas’s administrators to oversee and enforce Medicaid contracts. The interest of state elected leaders in holding or reducing the state’s financial commitment to Medicaid may be incompatible with a managed care environment devoid of provider competition. Medicaid administrators are stuck between the competing forces of political interests and market realities.

Background

Kansas experienced high rates of Medicaid expenditure growth during the late 1980s and early 1990s. Between 1988 and 1993, Medicaid annual cost growth in Kansas exceeded the national average (Winterbottom et al., 1995).³ During this period, the state legislature was exasperated by requests from the state’s Medicaid

agency – the Department of Social and Rehabilitation Services (SRS) – for supplemental budget appropriations to cover unanticipated program cost growth (Davis, 1994; Johnston, Davis and Fox, 1998).⁴ The legislature was chronically skeptical of the agency, which administers most of the state’s social welfare programs, and which was perceived by lawmakers as inefficient and excessive in size. SRS suffers from the same prestige issues faced by “welfare agencies” in many states. There is strong gubernatorial and legislative support for SRS downsizing and for contracting out program services whenever possible.

In the spring of 1994, the Kansas legislature passed a bill, later signed by the governor, mandating the implementation of Medicaid managed care for the state’s welfare population. Anyone who qualified for Medicaid by virtue of receiving Aid to Families with Dependent Children (AFDC) or General Assistance was to be enrolled in a managed care program by July 1, 1997. When the managed care law was passed, Kansas operated a traditional fee-for-service Medicaid program, with the exception of a small managed care primary care case management (PCCM) waiver limited to a few counties. Fee-for-service reimbursement rates were notoriously low;⁵ physician office visits were reimbursed at a rate of \$8.50, which was roughly 20 percent of the private reimbursement rate. In November 1995, the Health Care Financing Administration (HCFA) granted SRS a waiver to expand its limited Medicaid PCCM managed care waiver and to move into capitated managed care. The broad objectives of this waiver were to assure adequate access to quality of care, prevent unnecessary utilization, reduce inappropriate utilization, and reduce cost growth for Medicaid beneficiaries. At that point, a newly designed PCCM program – HealthConnect – operated in just five of the state’s 105 counties, only one and a half years before the legislative deadline of July 1, 1997.

In effect, the state had just eighteen months to move from a system in which virtually all of the state’s Medicaid population was served through fee-for-service reimbursement to a statewide managed care system. By August 1997, SRS had complied and

managed care was available statewide through HealthConnect. Although HealthConnect technically met the objectives of the state legislative mandate, the legislature was pushing to expand the capitation approach to maximize cost saving. SRS responded, and by late fall 1998, capitated Medicaid managed care, known as PrimeCare Kansas (PCK), was available in 63 of the state's 105 counties, but only for Temporary Assistance for Needy Families (TANF) recipients and those who qualified for Medicaid by virtue of their poverty status (poverty level eligible, or PLE enrollees). In those 63 counties, recipients were required to enroll in a managed care program, but were able to choose between HealthConnect and PrimeCare Kansas. Choice among capitated HMOs has been minimal for Kansas Medicaid enrollees. For a short time, seven of the state's northeastern suburban counties offered a choice among either two or three Medicaid HMOs. But by December 1998, only one HMO continued to contract with the state for Medicaid managed care.⁶

The Kansas Managed Care Environment

The relationship between SRS and the legislature suffers from several years of conflict, but the agency's relationship with the governor appears to be more cooperative. Rochelle Chronister, who led SRS during much of this reform period, was a former state legislator who had worked closely with Governor Bill Graves to pursue many of his policy objectives (Johnston and Lindaman, 1999). Both the governor and the secretary espoused the "privatization" solution to many of the state's service delivery problems. This approach reduced the size of SRS by 35 percent during Chronister's tenure (Myers, 1997; Johnston and Lindaman, 1999).

Although most Kansas lawmakers want access and quality health care for the state's Medicaid population, cost control is clearly a top priority. While Kansas Medicaid administrators feel compelled to honor the political objective of cost control, they must also deal with the realities of the Kansas market for Medicaid managed care, particularly for capitated plans.

Commercial managed care is still relatively weak in Kansas. One study indicates that the HMO penetration rate in Kansas – 14.4 percent – is quite low compared to the national average of 28.6 percent. Most of the private managed care penetration exists in the state’s northeastern counties, which are located in or near the Kansas City metro area. The other major population center in the state – Wichita – has experienced much less private managed care activity.⁷ Kansas is primarily rural, and most of the state does not offer the competitive environment in which managed care ideally operates. This is especially true of full risk plans that avoid fee-for-service reimbursement for providers. Managed care dynamics outside the metropolitan area are plagued by problematic provider supply. Roughly half of the state’s counties have been defined as “critically underserved” by primary care providers. Nonetheless, the Kansas legislature continues to push for capitated Medicaid managed care whenever and wherever possible.

SRS Medicaid administrators are keenly aware that capitated managed care is an elusive goal in an environment with insufficient provider supply. Kansas physicians are resistant to managed care, particularly in rural areas; and commercial HMOs are dissatisfied with Kansas’s historically low Medicaid reimbursement rates, as demonstrated by the withdrawal of all commercial HMOs from the state’s program. Medicaid officials are not resistant to managed care per se: they are quick to note that the state’s PCCM program, HealthConnect, runs relatively smoothly and is overwhelmingly preferred by both Medicaid patients (according to patient satisfaction surveys) and providers. Yet Medicaid administrators are caught between the political mandate for a policy of expanded capitated managed care and the market environment that does not support that expansion.

This dilemma has been complicated by the recent legislative decision to require capitated managed care for all state Child Health Insurance Program (CHIP) enrollees. Although Medicaid managed care staff are not directly involved in many aspects of CHIP administration, they are skeptical that the legislature’s decision can be executed successfully. Each of the two CHIP HMOs

serving the state has exclusive coverage of the regions for which it contracts, but both are experiencing financial difficulties and their future participation is far from certain.⁸

The combination of the privatization and cost control objectives by state political leaders has also led SRS to contract out many of the administrative tasks associated with Medicaid managed care. The state has a major contract with Blue Cross and Blue Shield of Kansas (BCBS), which serves as the state's Medicaid fiscal agent and provides a variety of administrative and oversight services, and a smaller contract with the Kansas Foundation for Medical Care (KFMC), which supplies the state with regular quality and access studies.

Management Responses

The transition from traditional fee-for-service Medicaid to managed care has required major administrative adjustments nationwide (Fossett, 1998; Sparer, 1996; Landon et al., 1998). Kansas Medicaid administrators have devised strategies to deal with insufficient resources, difficult contracting conditions, and other implementation challenges. Downsizing pressure on SRS has led the agency to contract with two organizations to provide a wide range of program oversight and administrative services. The staff devotes a great deal of effort to keeping at least one capitated plan "in the game." Their motivation is straightforward: If all HMOs were to withdraw from the Medicaid market, SRS would be forced to report to the legislature that it was unable to deliver a viable capitated program. This is a position that top agency leaders want to avoid.

SRS is committed to inducing Medicaid HMOs to meet quality and access contract standards, but the agency is in a very weak position with regard to holding plans accountable. It appears that fairly drastic performance failures would have to be evident before SRS would terminate a contract. The state has been quite lenient with regard to financial viability, as evidenced by continuation of a contract with financially insecure Horizon. SRS has occasionally invoked mild corrective action when quality or access problems

surpass a threshold of acceptability, but in the case of Horizon, the only remaining Medicaid HMO, SRS has nearly bent over backwards to keep the plan afloat in the Medicaid market.

Mid-level Medicaid managers are motivated primarily by a desire to maximize access to quality care for the state's Medicaid enrollees. Higher level Medicaid officials, with more direct accountability to the legislature, are more responsive to the legislature's cost control imperative and the related interest in maximizing capitated Medicaid managed care. There is some evidence that the pressure from the legislature precludes SRS from being fully forthcoming with the legislature about the serious challenge it faces in managing a capitated program in a market with inadequate provider competition.

The implementation process for Medicaid managed care has differed substantially between the state's two managed care programs. While contract management for capitated Medicaid managed care is complex and fraught with difficulties stemming from an absence of willing providers, oversight of PCCM providers is relatively straightforward. A recent evaluation of the state's Medicaid managed care program found that the cost savings associated with the capitated program are moderate at best, and that quality and access are probably comparable (Fox et al., 1998). In view of limited managed care competition and the related contract oversight difficulties, the resources devoted to capitated managed care may be misplaced. Indeed, quality and access could worsen if Medicaid officials are forced to continue to overlook performance shortcomings by the state's one remaining Medicaid HMO.⁹

Contract Management Strategies

SRS (along with most Kansas state agencies) uses an "any willing provider" approach to soliciting proposals from contractors. Medicaid reimbursement rates are not negotiated. SRS publishes the reimbursement rates set by the agency and requests proposals from all providers willing to accept those rates in return for

specified services. Kansas, a “good government” state, has a history of “clean” contracting practices, with few incidents of corruption.

Medicaid managed care contracts with HMOs are exempt from the usual Kansas Department of Administration oversight of state contracts. While this exemption maximizes SRS’s flexibility in soliciting and finalizing contracts, it also makes Medicaid contracts less accountable to normal contractual supervision by the state’s top administrative agency. Potential Medicaid HMO contractors must meet the commercial health plan financial viability and licensure standards required by the Kansas Department of Insurance. These standards are generally consistent with those recommended by the National Association of Insurance Commissioners. Some SRS officials indicate that these standards may be too low for plans serving Medicaid clients in view of the financial challenges faced initially by providers serving this population. Accordingly, after the Department of Insurance has approved the plan, SRS conducts an additional review of the plan’s financial and corporate structure.

Medicaid officials have had to administer contracts with some HMOs that they feel are unable to maintain financial viability and services to enrollees (regardless of Department of Insurance approvals). On the other hand, Medicaid officials have urged some commercial plans to respond to the state’s “any willing provider” requests for proposals, despite the fact that the plans are quite skeptical that they can meet Medicaid performance requirements. The implication is that Medicaid officials make judgments about the viability of potential contractors, and sometimes engage in efforts to solicit proposals from plans that are not interested in Medicaid contracts, but which are seen by the agency as capable of providing high quality services to enrollees. In short, Medicaid administrators are actively seeking HMO competition.

Prior to December 1998, SRS used a number of strategies designed to maximize the retention of multiple plans. These efforts included the following:

- ❖ *Mandating enrollments:* Until December 1998, seven northeastern counties were served by more than one (capitated) HMO. In those counties, the state restricted all TANF/PLE beneficiaries to the capitated program, eliminating the HealthConnect (PCCM) option. This measure was designed to increase the number of enrollees available to the capitated plans. (The restriction was lifted in December 1998 when two of the three HMOs terminated their contracts with the state.)
- ❖ *Increased rates:* In 1998 the legislature authorized \$10 million to augment selected Medicaid reimbursement rates. However, Medicaid officials viewed this augmentation as a mere “drop in the bucket,” estimating that nearly \$100 million would be required to raise reimbursement rates to reasonable levels. Capitation rates for women of childbearing age and children were increased; this decision was reached after meeting with stakeholders (consisting primarily of the state, administrative oversight contractors, and plans) and assessing the most critical rate needs. In addition, flat fee reimbursements were instituted for maternal deliveries to alleviate plan problems associated with clients enrolling late in their pregnancies (i.e., with too few months of prepaid prenatal care).
- ❖ *Review of provider administrative burdens:* SRS has conducted a study of administrative oversight requirements (reporting, etc.) imposed on all managed care providers. In general, SRS officials indicate that most of their oversight requirements are required by HCFA, suggesting that SRS has little leeway to reduce provider administrative burdens. However, SRS may attempt to reduce plan financial reporting requirements, and is trying to streamline and reduce provider administrative burdens whenever possible.¹⁰
- ❖ *Facilitating provider financial health:* Horizon, the one remaining commercial HMO, has experienced substantial

financial difficulties. SRS continues to work with this plan to facilitate its financial health and its continued service to Medicaid patients.

- ❖ *Access to higher CHIP reimbursement rates:* Access to all CHIP clients is ensured in much of the state for the one current Medicaid HMO (Horizon) due to the state's configuration for CHIP coverage. Kansas established three CHIP regions, and decided to limit each of these regions to one CHIP HMO provider. (This policy was adopted in response to plan concerns. One official noted that "Plans wanted all the eligible [CHIP] population in their covered counties."). It was hoped that because Horizon has secured the bid to serve all CHIP clients in most of the state, the plan could benefit from higher CHIP reimbursement rates, which could serve to partially offset low Medicaid reimbursement rates.¹¹ However, Horizon continues to exhibit financial instability.

These efforts reflect the reality of administering contracts in an environment characterized by political and policy demands for capitated Medicaid managed care and market conditions that preclude competition and reduce oversight authority.

Enforcing Contract Standards

Medicaid managed care performance is reviewed at monthly meetings of the state's Peer Education Resource Council (PERC), which includes physicians, HMO plan representatives, pharmacy representatives, other providers, SRS officials, officials from the state's health related departments, and others. SRS has occasionally instituted "corrective action" plans with the Medicaid HMOs, primarily because of performance problems related to encounter data. Penalties typically involve temporary negative adjustments to capitation rates. However, in view of the relatively precarious financial position of the one current HMO, imposition of penalties may be difficult, and could prompt the HMO to withdraw from Medicaid. Thus far, SRS has attempted to help the plan through its difficulties. This plan is critical to the state, in part because it

provides the only care available to CHIP clients in two-thirds of the state's geographic area.¹² As one SRS official noted, "We have a dual role – we are partners with the plans in service provision. On the other hand, the plans are our contractors."

When Medicaid administrators are asked about their inclinations to invoke penalty provisions for contractual noncompliance in the areas of quality and access, they indicate that their options are limited.

From the perspective of these managers, the "higher-ups" in the organization may be too responsive to the legislative emphases on cost control and capitation expansion, sometimes at the expense of adequate access and quality for clients.

Administrative Contracts

In addition to its contracts with capitated managed care HMOs, Kansas's Medicaid agency also oversees contracts with two organizations that provide a variety of Medicaid administrative services, Blue Cross and Blue Shield of Kansas and the Kansas Foundation for Medical Care.

Blue Cross and Blue Shield of Kansas (BCBS) serves as the state's fiscal agent, performing the following functions:

- ❖ claims and encounter data administration for both the PCCM and capitated managed care programs.
- ❖ enrollment management, including tracking HMO enrollments and enrollee plan or provider assignments.
- ❖ Medicaid Management Information System (MMIS) administration.
- ❖ operation of the Medicaid customer help desk, which fields consumer complaints and grievances and provides responses to enrollee inquiries related to the managed care and fee-for-service programs.

- ❖ other administrative services, including provider recruitment management.

The Kansas Foundation for Medical Care (KFMC), the state's External Quality Review Organization (EQRO), contracts with SRS to provide a variety of Medicaid managed care oversight activities, including:

- ❖ monitoring of quality, access and patient satisfaction.
- ❖ utilization review (ER and hospital inpatient).
- ❖ focus studies around particular topics, such as immunization rates, EPSDT (Early and Periodic Screening, Diagnosis, and Treatment Programs), lead screening, asthma treatment, etc.

In addition, the state uses Lewin as an actuarial firm, and has contracted with a consulting firm in the past for advice on program start-up issues.

SRS officials estimate the combined annual cost for the BCBS and KFMC administrative contracts at nearly \$5 million. The contract with BCBS, in effect from November 1996 through November 2001, entails reimbursement on a per enrollee basis. Because of lower than anticipated enrollments (due in part to drastic TANF caseload reductions), the per enrollee reimbursement rate is currently under review.¹³ The contract with KFMC was renewed at the end of 1998. KFMC is compensated by the state on the basis of the number of active capitated plans. SRS officials estimate that annual compensation to KFMC approximates \$350,000.

SRS's capacity to oversee the performance of BCBS and KFMC is clearly related to its ability to enforce contracts with providers. Most reporting from providers and plans goes directly to the oversight contractors (BCBS and KFMC). The contractors then use that information to prepare reports for SRS. If providers and plans fail to submit required information, or if that information is somehow inadequate, then the oversight contractors may be unable to perform their management tasks. While this dynamic

explains some of the problems SRS has encountered in managing its oversight contracts, it doesn't explain everything. BCBS took months to become "operational" after its contract took effect in November 1996; many officials blame information system problems for this delay. Others suggest that BCBS underbid on the Medicaid contract and ran into compliance difficulties as a result. At this stage, SRS seems relatively satisfied with BCBS's performance, though electronic information exchange is still problematic. Currently, SRS is engaged in extensive "data verification" for a variety of BCBS reports, including encounter data reports. BCBS only began receiving regular streams of encounter data in early 1999, and some difficulties, including data quality problems, persist.¹⁴

Similar complications have been encountered by KFMC. One SRS official noted that KFMC often "just doesn't seem to be able to do what we ask them to." Data problems, some of which stem from provider and plan reports, limit the capacity of KFMC to comply with required SRS reporting. KFMC reports also require "data verification" by SRS.

The state is very dependent on these contractors, primarily because of SRS staffing constraints imposed by the legislature. While the state is "in charge" of these contractors, significant authority has been delegated to BCBS and KFMC, particularly with regard to communicating with providers and plans about required reports. Nonetheless, SRS has limited capacity to penalize the administrative contractors, partly because of a classic issue with some government contracts: the inability of the state to quickly reassume responsibility for tasks that have been contracted out. SRS would be very hard pressed to handle even a small fraction of the BCBS tasks. In the case of the KFMC contract, SRS is considering conducting those oversight activities in-house, but that is possible because only one capitated plan currently provides Medicaid managed care.

Managing with Tight Resources

Many of the complications faced by public administrators implementing Medicaid managed care in Kansas are directly

attributable to resources that are either inadequate or unavailable to Medicaid officials. From the perspective of mid-level Medicaid administrators and providers, Kansas political actors are unwilling to commit the resources needed to enhance dismally low provider reimbursement rates. Provider interest groups have not actively engaged in the rate issue; consequently, the legislature has felt free to discount administrative concerns over rates (Sparer, 1996). Low reimbursement rates, combined with inadequate provider supply, weaken the oversight capacity of Medicaid contract management staff.

An additional implementation constraint stems from tight resources for agency staff. SRS is under especially strong staffing scrutiny because of the perception among some elected officials that it is a lumbering, inefficient agency. To paraphrase one SRS official, "We can get any funds we need for [oversight] contracts, but we can't get funds to hire staff." Gubernatorial and legislative support for "downsizing" (especially downsizing of SRS), and for "privatizing" as many state activities as possible has led SRS to rely on outside contractors for most managed care oversight. Although the legislature authorized fourteen SRS employees for managed care in 1994, over time other Medicaid program needs have reduced staff attention to managed care oversight. Many are still involved with some aspects of fee-for-service programs or other elements of Medicaid. More recently, many of them are at least tangentially involved in the administration and implementation of CHIP.

Efforts to downsize and limit staff growth are not restricted to Medicaid programs for the TANF/PLE populations. One other major component of Medicaid was recently transferred from SRS to the Department of Aging: In 1997, SRS transferred administrative responsibility for several components of Medicaid services for the elderly through a HCFA waiver.¹⁵

Most of the SRS staff assigned to Medicaid managed care were program staff promoted from within SRS, with little or no experience with managed care or with private sector health organizations. Most have bachelor's degrees; several also have

master's degrees in such areas as nursing, health services administration, business, and public administration. (Staff qualifications among the contractual agencies providing administrative services are similar.) One staff member was hired in the early 1990s from outside SRS; this person had experience with an actuarial firm and with the state's legislative post-audit department. But for the most part, the staff had to take the "learn as you go" approach.

Thus, training has been negligible. Most training for the managed care staff has been obtained informally, often from the capitated managed care plans. Some staff attend professional conferences, where they are able to obtain management information from the staffs of other states. Periodic HCFA regional training conferences share "best practices" among the states in the region. In addition, funds have been authorized to subscribe to some professional publications and journals that serve managed care professionals. However, officials are unable to cite any formal state-conducted training activity.

Despite these difficulties, agency capacity to oversee plans has generally improved over the years. Moving from a very small managed care pilot program to statewide mandatory coverage in a short time frame was a major accomplishment. Simply by virtue of time and experience, SRS officials have become more adept at contract management. Yet, like Medicaid administrators in other states, they are plagued by continued information challenges and difficulties with evaluating the work they have done (Fox et al., 1998; Landon et al., 1998).

Relations with Contractors

Administrators of the Medicaid HMOs in Kansas, like managers of many government contracting agencies, are often unprepared for the level of regulation and scrutiny involved (Romzek and Johnston, 1999). This can be especially difficult for social welfare programs, many of which demand high levels of intergovernmental accountability. In Kansas, Medicaid HMOs were frequently

unprepared for their new roles; plan officials indicated that they had “no clue” what they were getting into. The HMOs consistently complain that SRS’s reporting requirements are excessively burdensome compared to those in the private sector. Despite the desire of state Medicaid officials to reduce the administrative burdens of capitated managed care, much of the provider reporting is needed to fulfill state reporting requirements to HCFA. The HMOs have also been exasperated by requirements to report to three organizations – SRS, BCBS, and KFMC. HMO officials also cite low reimbursement rates as an additional barrier to continued program participation. Plan officials indicate that regardless of their respect for the Medicaid staff with whom they interacted, and regardless of the motivation of some plans to provide “community service,” they felt compelled to terminate their contracts with the state.

BCBS and KFMC also cite coordination problems. Much of their reporting is contingent on information from either the HMOs or another administrative contractor. For example, the bulk of KFMC reporting to SRS relies on data from BCBS (which in turn relies on encounter and other data from the managed care providers) or from the plans. The dearth of encounter data has hampered the efforts of BCBS and KFMC to comply with their contractual requirements.

Most – if not all – of these complications in relationships with contractors are linked to resources. If reimbursement rates were higher, and if the Medicaid agency was adequately staffed and trained, it is likely that the state would be more successful in inducing capitated managed care providers to supply required information. This would ease the plight of the administrative contractors. Likewise, if more resources were directed to reimbursement rates, providers would feel less pinched by administrative burdens and the required adjustments involved in government contracts. To paraphrase one contract agency official, “We can’t continue to subsidize the state’s under-funding of Medicaid.” The state’s PCCM primary care providers are also dissatisfied with reimbursement rates. However, they are required to

do far less in terms of administering managed care. Consequently, they avoid the double whammy (faced by administrative and HMO contractors) of low rates and high administrative burdens.

Conclusion

Although Medicaid bureaucracies have a great deal of influence over the outcome of program reforms (Fossett et al., 1996; Schneider et al., 1997; Schneider and Jacoby, 1996), the implementation of reforms as daunting as managed care poses significant challenges to public administrators. The data collected for this study indicates that most Kansas Medicaid administrators are driven by a mission of providing quality service to the state's poor families. Yet their mission is hampered by a combination of often conflicting forces consisting of political and policy imperatives from the state's political leaders that are inconsistent with the managed care environment that exists in the state. That environment hinders the ideally competitive conditions required for effective government contracts.

Like policymakers in other states, Kansas lawmakers "tend to neglect and underestimate issues of administration," eschewing the often "dreary and dull" details in favor of hoped for short-term gains (Thompson, 1998, 279). In addition to this typical implementation problem, the "theory" behind capitated Medicaid managed care in Kansas is shaky at best. Potential capitated managed care providers express virtually no interest in Medicaid contracts. Low reimbursement rates and high administrative burdens present further barriers to provider participation and competition for the state's business. Only one financially unstable HMO currently serves the state's Medicaid population. Meanwhile, the state's PCCM program hums along, experiencing relatively minor problems with regard to access, quality, and patient satisfaction. Despite these problems, the legislative interest in capitated care persists, as evidenced by the recent mandate to cover all CHIP clients through capitated programs.

The legislative imperative for capitated Medicaid coverage, combined with low interest among commercial plans for Medicaid business, weakens SRS's oversight authority. At the same time the executive/legislative imperatives for contracting and agency downsizing constrain the capacity of SRS to conduct oversight in-house, requiring them to rely on administrative contracts over which they have limited enforcement power. Tight resources continue to stymie efforts to enhance the program. As Fossett (1998) notes, the financial squeeze that prompted Kansas and many other states to move to Medicaid managed care inhibited the investments necessary for effective program administration and oversight. In the words of Robert Hurley, a leading Medicaid analyst, "the great lesson of Medicaid is you don't get what you don't pay for" (Meyer, 1997).

In short, Kansas Medicaid administrators, like administrators in many states, are stuck between political imperatives and the reality of implementing a policy under less than ideal conditions. SRS must restrict contract oversight because the agency is under serious pressure to retain its contracts. Medicaid administrators remain frustrated by the failure of capitated managed care to live up to its expectations. There is additional disappointment that plans have not provided some of the supplemental services that SRS had hoped its Medicaid clients would receive (i.e., smoking cessation programs, etc.). To paraphrase one official, "our utopian belief that our clients would actually be treated like everybody else" in the Kansas health care community has not been met.

Endnotes

- 1 In spring 1999, FirstGuard purchased Horizon, an HMO that contracted with Kansas to provide capitated Medicaid managed care services. Horizon had been owned by the Kansas Medical Society. Horizon had substantial financial difficulties, and had been seeking a purchaser for several months. Most of the information in this paper refers to the HMO's performance prior to its purchase by FirstGuard. The purchase is not yet finalized.
- 2 A primary care case management program pays providers a small case management fee (\$3 per enrollee per month is typical) to serve

as a primary care provider and “gatekeeper” to specialty services. Services are not capitated.

- 3 The high proportion of aged Medicaid recipients in Kansas – a portion which is growing quickly compared to the average state – is partly responsible for Kansas’s relatively high cost growth. However, the reforms discussed in this paper do not address the elderly Medicaid population.
- 4 It is important to note that a major component of Kansas Medicaid cost growth in the early 1990s consisted of health care services for the elderly and disabled. While the legislature’s focus on capitated managed care for the state’s “welfare” population may be understandable, the welfare portion of the Medicaid population generates the lowest per participant cost.
- 5 In 1993, for example, only twelve states had lower ratios of Medicaid maximum fees to Medicare fees for primary care, and only five states had lower ratios for hospital care. See Winterbottom et al. (1995).
- 6 Many state Medicaid programs have lost HMOs recently (Pear, 1998; Smart, 1998; Abelson, 1998; Steinhauer, 1998). In Kansas, this trend is complicated by the fact the state never had many HMOs to begin with.
- 7 To paraphrase one managed care expert in the state, “Wichita had a very bad experience with HMOs – they basically took dollars from the community, and then left town.”
- 8 For CHIP, SRS carved the state into three regions, each of which is limited to coverage by one HMO. The one remaining Medicaid HMO has the contract for two of the three state CHIP regions.
- 9 For most contracts, requests for proposals include reimbursement rates. Once the agency has selected the contracting agency, negotiation continues until both sides have agreed to final terms with regard to rate details, contract compliance conditions, etc.
- 10 This may happen by default: SRS is currently reviewing one of its oversight contracts. If that contract is terminated, and the oversight activities are conducted by SRS in-house, there is some evidence that plan burdens may diminish simply as a result of staffing pressures within SRS.
- 11 Horizon provides CHIP services in the largest geographic areas of the state. But in the eastern and most populous region of the state, CHIP clients will be served by a plan that does not participate in Medicaid managed care, and which has indicated that it may not continue to serve CHIP enrollees.
- 12 Because the legislature has insisted on capitated plan coverage for all CHIP clients, SRS has a strong interest in keeping the CHIP plans functioning. In a comment that validates the common problem faced by a purchaser in a market with inadequate supply, one SRS

official noted that “we don’t have a fall back for CHIP if the plan fails.”

- 13 The reimbursement rate is set at \$4 per enrollee per month. Some SRS officials note, however, that the initial BCBS bid for the administrative contract was viewed as a “low-ball” bid, and that as a result, BCBS is now requesting a reimbursement rate increase.
- 14 Most states have faced substantial difficulties in collecting good encounter data from capitated Medicaid providers. According to Landon et al. (1998), twenty-two states reported collecting encounter data in 1996, but many “lacked the ability to analyze meaningfully encounter data from multiple health plans,” indicating that the capacity to engage in access, quality, and utilization comparison among plans continues to elude most state Medicaid administrators.
- 15 A number of the contract oversight issues discussed in this paper have also been experienced in the newly configured Medicaid program for the elderly. See Johnston and Romzek (1999), Romzek and Johnston (1999), and Romzek and Johnston (forthcoming).

References

- Abelson, Reed. (1998, August 12). “Oxford Health Posts Big Loss for 2nd Quarter.” *New York Times*.
- Davis, Raymond G. (1994). “Public Health Policy: Perplexing Problems and Proximate Policies.” In H. George Frederickson (ed.). *Public Policy and the Two States of Kansas*. Lawrence, KS: University of Kansas Press.
- Fossett, James D. (1998). “Managed Care and Devolution.” In Frank J. Thompson and John J. DiIulio, Jr. (eds.). *Medicaid and Devolution: A View From the States*. Washington, D.C.: The Brookings Institution.
- Fossett, James W., Carol Ebdon, and Norman Brier. (1996). “When Is Growth Not Growth? The Curious Case of Mental Budgeting in New York.” *Public Budgeting and Finance* 16 (4), 82-95.
- Fox, Michael H., Jocelyn Johnston, Raymond Davis, Robert Lee, Mary Zimmerman, Janice Moore, and Kara Lindaman. (1998).

"An evaluation of the Medicaid managed care program in Kansas." Report to the Kansas Department of Social and Rehabilitation Services, June.

Goggin, Malcolm, Ann O'M. Bowman, James P. Lester, and Laurence J. O'Toole, Jr. (1990). *Implementation Theory and Practice: Toward a Third Generation*. Glenview, IL: Scott, Foresman/Little, Brown.

Johnston, Jocelyn M. and Kara Lindaman. (1999). "Kansas Carves Out a Middle Ground." In Carol S. Weissert (ed.). *Learning From Leaders: Welfare Reform Politics and Policy in Five Midwestern States*. Albany, NY: Rockefeller Institute Press.

Johnston, Jocelyn M. and Barbara S. Romzek. (1999, September/October). "Contracting and Accountability in State Medicaid Reform: Rhetoric, Theories, and Reality." *Public Administration Review*.

Johnston, Jocelyn M., Raymond Davis, and Michael Fox. (1998). "Medicaid Reform in Kansas: A Cautious Approach." In Mark R. Daniels (ed.). *Medicaid Reform and the American States: Case Studies On The Politics Of Managed Care*. Westport, CN: Auburn House.

Johnston, Jocelyn M. and Kara Lindaman. (1998). "Implementing Welfare Reform in Kansas: Moving, But Not Racing." *Publius* 28 (3), 123-142.

Kettl, Donald F. (1993). *Sharing Power: Public Governance and Private Markets*. Washington, D.C.: The Brookings Institution.

Kettl, Donald F. (1993a). "The Myths, Realities, and Challenges of Privatization." In Frank Thompson (ed.). *Revitalizing State and Local Public Service*. San Francisco, CA: Jossey-Bass.

Landon, Bruce, Carol Tobias, and Arnold Epstein. (1998). "Quality Management by State Medicaid Agencies Converting to Managed Care." *JAMA* 279 (3), 211-16.

- Mazmanian, Daniel and Paul Sabatier. (1981). *Effective Policy Implementation*. Lexington, MA: D.C. Heath & Co..
- Meyer, Harris. (1997, November 20). "Medicaid: States Serve Up A Real Turkey." *Hospitals and Health Networks* 71 (22), 22-27.
- Myers, Roger. (1997, July 23). "SRS Is Losing Its 'Monster' Image." *Topeka Capital-Journal*.
- Pear, Robert. (1998, September 14). "Sharp Rise Predicted in Health-Care Spending in Next Decade." *The New York Times*.
- Pressman, Jeffrey and Aaron Wildavsky. (1984). *Implementation*. 3rd Edition. Berkeley, CA: University of California Press.
- Romzek, Barbara S. and Jocelyn M. Johnston. (In press). "Reforming State Social Services Through Contracting: Linking Implementation and Organizational Culture." In Jeffrey Brudney, Laurence O'Toole, Jr., and Hal B. Rainey (eds.). *Public Management: New Developments in Theory, Methods, and Practice*. Washington, D.C.: Georgetown University Press.
- Romzek, Barbara S. and Jocelyn M. Johnston. (1999). "Reforming Medicaid Through Contracting: The Nexus of Implementation and Organizational Culture." *Journal of Public Administration Theory and Research* 9 (1), 107-140.
- Schneider, Sandra K., William G. Jacoby, and Jerrell D. Coggburn. (1997). "The Structure of Bureaucratic Decisions in the American States." *Public Administration Review* 57 (3), 240-249.
- Schneider, Sandra K. and William G. Jacoby. (1996). "Influences on Bureaucratic Policy Initiatives in the American States." *Journal of Public Administration Research and Theory* 6 (2), 496-522.

Smart, Tim. (1998, September 16). "Humana to Scale Back HMO Plans; Move Will Affect Some Medicare and Medicaid Patients." *The Washington Post*.

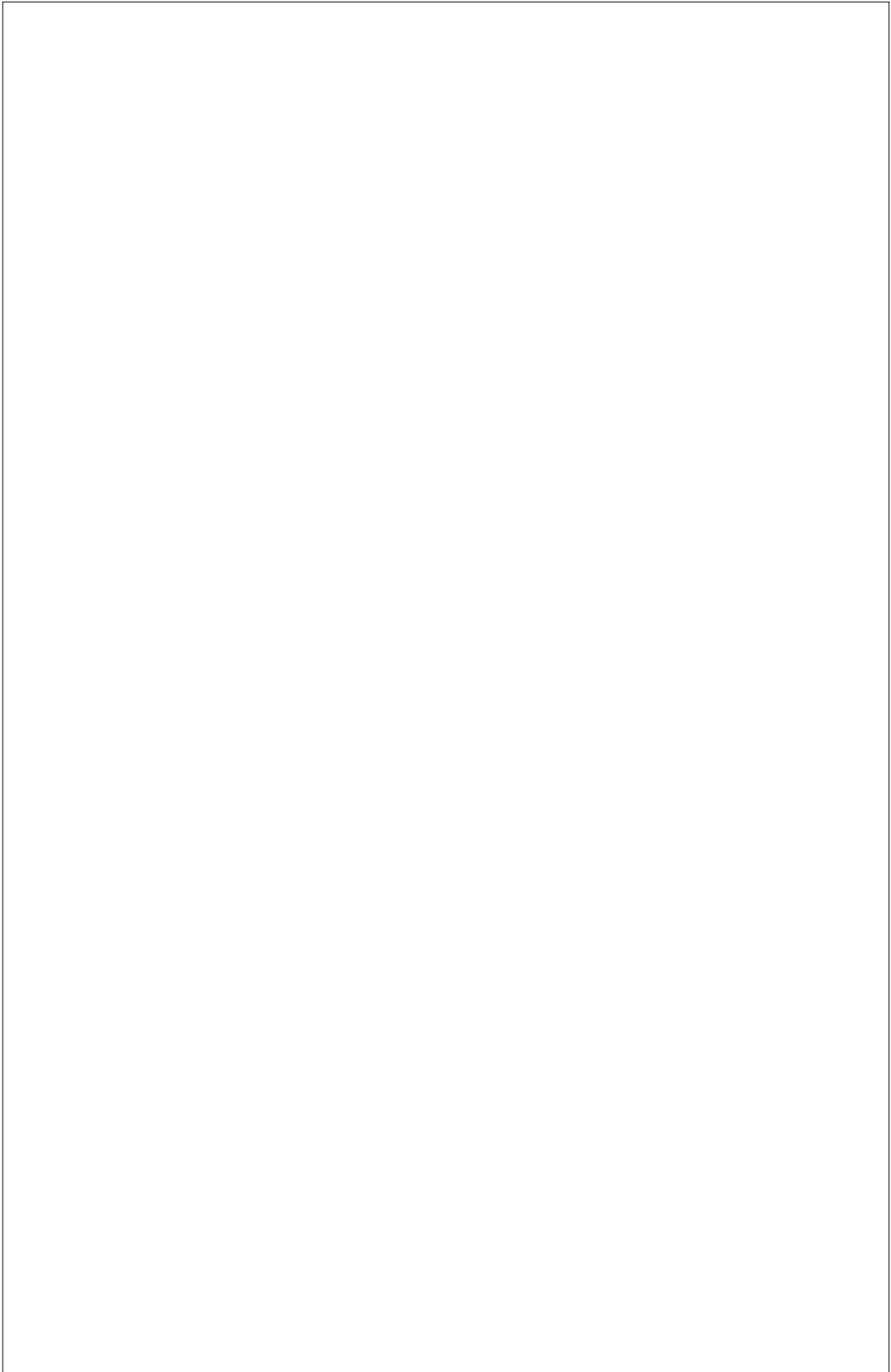
Sparer, Michael S. (1996). *Medicaid and the Limits of State Health Reform*. Philadelphia, PA: Temple University Press.

Steinhauer, Jennifer. (1998, October 7). "New York Bracing for Medicaid Managed Care." *The New York Times*.

Thompson, Frank J. (1998). "Federalism and the Medicaid Challenge." In Frank J. Thompson and John J. DiIulio, Jr. (eds.). *Medicaid and Devolution: A View From the States*. Washington, D.C.: The Brookings Institution.

Van Meter, Donald and Carl Van Horn. (1975). "The Policy Implementation Process: A Conceptual Framework." *Administration and Society* 6 (4), 445-88.

Winterbottom, Colin, David Liska, and Karen Obermaier. (1995). *State-Level Databook On Health Care Access And Financing*, Second Edition and Supplement. Washington, D.C.: The Urban Institute.





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