

Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?

The hard reality of what it takes for states to take on the prudent-purchasing role, as seen in a five-state study.

by James W. Fossett, Malcolm Goggin, John S. Hall, Jocelyn Johnston, L. Christopher Plein, Richard Roper, and Carol Weissert

PROLOGUE: After turning to managed care to hold down costs, states found that they needed to shed their regulatory mentality toward Medicaid services and learn to implement policy through the contracting process. Theoretically, contracting relieves both states and service providers of a trying, micromanagement relationship and creates a conceptually satisfying single point of accountability.

In practice, states must build new capabilities to monitor and assess health plan performance. Their new role as hard-nosed purchaser has to be balanced with the traditional responsibility to protect and serve the disadvantaged, and plans can walk away if states push too hard. Nor does the “prudent purchaser” model provide much guidance for Medicaid departments in coping with political pressures brought to bear by stakeholders.

James Fossett is associate professor of public administration and policy at the State University of New York at Albany and a senior fellow at the Rockefeller Institute of Government. Malcolm Goggin is visiting professor of political science at Michigan State University. John S. Hall is professor of public affairs and public service at Arizona State University. Jocelyn Johnston is associate professor of public administration at the University of Kansas. Christopher Plein is assistant professor of public administration at West Virginia University. Richard Roper is president of the Roper Group, a consulting firm in Newark, New Jersey. Carol Weissert is associate professor of political science at Michigan State University.

ABSTRACT: This paper examines the extent to which five states are becoming “prudent purchasers” in their oversight of Medicaid managed care. Our conclusions are mixed. These states are making more sustained efforts along these lines than most private purchasers are and have improved the amount and quality of the data they collect on the experiences of Medicaid clients when compared with the traditional fee-for-service program. They have been less successful in ensuring data quality that is adequate to support contracting decisions and in developing the analytical or political capacity to use data to “manage” the managed care system. Becoming a prudent purchaser appears to be a complex task for states that may prove difficult to achieve.

ONE OF THE ARGUMENTS ADVANCED in support of Medicaid managed care has been its potential to improve the accountability of the health care system. The contractual relationship between states and managed care organizations (MCOs) makes it possible for states to enforce standards for accessibility and quality of care for which the contractor can be held accountable and sanctioned if standards are not met. The process of developing and applying such standards has come to be known as becoming a “prudent” or “value” purchaser.

This paper examines the extent to which states have realized managed care’s potential for improving accountability. It relies on field network studies of managed care arrangements for the Temporary Assistance for Needy Families (TANF) population in five states (Arizona, Kansas, Michigan, New Jersey, and West Virginia). Our conclusions are, if not entirely pessimistic, somewhat cautionary. These states generally have improved the amount and quality of the data they collect on the experiences of Medicaid clients when compared with the fee-for-service (FFS) program and are making greater efforts to measure quality than most private purchasers are. They have been less successful in ensuring data quality that is adequate to support contracting decisions and in developing the analytical or political capacity to use data to “manage” the managed care system. Becoming a prudent purchaser appears to be a complex task for states that may prove to be difficult for more than a few to achieve.

■ **What is prudent purchasing?** The combination of a vulnerable population and the need to account publicly for the spending of tax money makes the task of Medicaid agencies in overseeing MCOs more complex than that of private purchasers. Exercising such oversight requires states to develop administrative capabilities that are not required under the FFS Medicaid program. Most Medicaid agencies have historically defined their role primarily as bill payers. The management information and other systems put in place to oversee the FFS system have been oriented toward traditional command-and-control tasks, such as eligibility verification and prevent-

ing fraud, waste, and abuse.

Many advocates have argued that managed care enables states to improve the quality of care available to Medicaid clients in ways that the FFS system cannot. By contracting with an organization that accepts payment for the entire range of services to Medicaid clients, states can set standards for which plans can be held accountable and sanctioned if they fail. This process of developing and enforcing contractual standards for health care quality, access, and other aspects of plan performance in Medicaid is known as becoming a “prudent” or “value” purchaser. One proponent has defined the basic elements of this strategy:

In order to obtain health care value, the prudent purchaser must define quality, measure it, seek to improve it, and exert market leadership...The prudent purchaser must put into place the elements of a good quality management system—negotiated performance goals, member satisfaction surveys and focus groups, independent external reviews, continuous quality improvement systems, data reporting, and consequences for underachievers. Then the prudent purchaser must use these elements effectively, keeping in mind that the system should not be micro-managed, or made to respond to unrealistic expectations.¹

For states to become “prudent” purchasers requires three things. First, they must state their requirements for plan performance in a measurable form.² Second, they (and other interested parties) should be able to tell with some confidence whether plans are complying with the requirements. Third, plans must face consequences for failure to comply with standards.

Oversight Processes In Five States

To assess states’ progress toward prudent purchasing, we examined oversight methods and mechanisms in five states (Exhibit 1). These states are not a statistical sample but represent a broad range of managed care program forms, sizes, and management strategies. Arizona has the longest-running, best-established Medicaid managed care program in the country. Known as the Arizona Health Care Cost Containment System (AHCCCS), it has been extensively evaluated and has received high marks for both management and program outcomes.³ It is included as a “best practices” state.

Michigan and New Jersey are perhaps typical of the larger industrialized states in the Northeast and Midwest. Both have strong traditions of nonprofit health care, generous Medicaid programs in both enrollment and benefits, and well-paid civil services. Managed care is well established in the private health insurance market in both states. Both mandate full-risk enrollment for all TANF recipients but retain FFS Medicaid for other population groups.

Kansas and West Virginia are predominantly rural states with small populations, less generous Medicaid programs, and less well

EXHIBIT 1**Managed Care Penetration, Medicaid Liberality, And Managed Care Arrangements For The TANF Population, Five Selected States, Fall 1998**

State	Managed care penetration		Percent of poor population covered by Medicaid ^c	Medicaid spending per client ^e	Enrollment ^d	
	Private ^a	Medicare ^b			TANF related	PCCM
AZ	30.3%	38.7%	Low	- ^e	332,130	0
KS	14.4	5.1	Low	Low	84,550	70,633
MI	25.3	3.9	High	High	754,596	98,067
NJ	31.3	14.6	High	High	380,000	0
WV	10.7	- ^e	High	Low	129,000	83,000

State	Full-risk managed care ^d		Enrollment	No. of plans	Index of Medicaid managed care rates compared with Medicare AAPCC rates ^f
	Mandatory	Scope			
AZ	Yes	Statewide	332,130	12	1.01
KS	Partial	66% of counties	13,917	3	0.87
MI	Yes	Statewide	656,529	31	- ^e
NJ	Yes	Statewide	380,000	9	0.93
WV	Partial	25% of counties	46,000	3	0.96

SOURCES: See below.

NOTES: TANF is Temporary Assistance for Needy Families. PCCM is primary care case management.

^a *InterStudy HMO Industry Report, 1998* (St. Paul, Minn.: InterStudy Publications, 1999).

^b Kaiser Family Foundation, *Medicare State Profiles* (Menlo Park, Calif.: Kaiser Family Foundation, 1999).

^c D.J. Boyd, "Medicaid and Devolution: A Fiscal Perspective," in *Medicaid Devolution: A View from the States*, ed. F.J. Thompson and J.J. Dilulio (Washington: Brookings Institution, 1998).

^d Field research reports (unpublished).

^e Not available.

^f J. Holahan et al., "Medicaid Managed Care Payment Rates in 1998," *Health Affairs* (May/June 1999): 217-227. The index is the ratio of an index of standardized Medicaid premiums compared with the median Medicaid premium to an index of Medicare premiums paid in the state compared with the median of Medicare rates. Thus, a state that pays high Medicaid premiums compared with those of other states may have a lower index value than a state that pays lower rates but whose health care costs, as measured by adjusted average per capita costs (AAPCC), are relatively lower. New Jersey, for example, pays higher Medicaid rates than West Virginia, but has a lower index value because its AAPCC rates are even higher relative to the national median.

paid employees. Managed care is not as widespread in the private market as it is in the other three states. At the time of this study Kansas and West Virginia had mandatory full-risk programs for TANF recipients in some urban areas, with enrollment in primary care case management (PCCM) required for recipients elsewhere.

For this study we examined states' oversight routines and processes in four major areas: financial reporting and performance, quality assurance and improvement, access and network capacity, and consumer relations. This study was conducted using the field network methodology, which has been used to investigate the operations of a large number of domestic programs. This method, which combines intensive on-site investigation by locally based scholars with a comparative analytical framework monitored by a central staff, offers advantages over the multicase implementation study common in many domestic policy areas.⁴

■ **Financial performance.** The financial performance and fiscal solvency of plans is an increasingly visible area of state oversight, as

the adequacy of rates has become a public issue in many states. Plans in some states have gone bankrupt; some commercial plans have withdrawn from the Medicaid market; and more have complained that rates are inadequate to support reasonable levels of care.

The financial oversight of MCOs has traditionally been the regulatory preserve of state insurance departments. The basic intent of these departments' reporting systems is to monitor MCOs' financial condition and performance, to ensure that income and other resources are sufficient to cover payments to providers. Plans report on operating results at specified intervals, with adverse results triggering more frequent reporting or corrective action, such as the drawing down of required financial reserves.

This focus on overall plan performance, while adequate for its primary purpose of protecting consumers and providers against plan default, may not provide information that is useful in managing a managed care program. Even if a plan's overall financial condition is sound, its Medicaid contracts may perform less well than its other lines of business. Plans' Medicaid enrollment may be too small to adequately spread the costs of providing care, leaving the plan vulnerable to unanticipated expenses. States that can monitor the performance of Medicaid contracts may be able to take corrective action, such as raising rates or increasing enrollment, and thereby prevent plans from leaving the program or defaulting on their obligations. Financial information also is important in the process of setting managed care premiums.

Among the states in this study, the most significant difference in financial oversight capability is between Arizona and the other four states. Because AHCCCS has been able to attract staff with good credentials in financial management and reporting, the agency has developed a Medicaid financial reporting system that is completely independent of the state insurance department's requirements. AHCCCS uses information from this system to develop rate corridors within which plans have to bid; to adjust rates between contracts; and to manage enrollment to provide adequate spreading of risks. For example, the state responded to a recent decline in enrollment resulting from welfare reform by increasing the size of several rural service areas to ensure that plans had economically viable enrollment levels.

The other four states remain much more dependent on state insurance departments to oversee plans' financial performance. All four require licensure or compliance with insurance departments' financial viability and reporting standards as a precondition of receiving a contract, and all require plans to submit periodic financial reports that meet department standards. Two states—Michigan and

Kansas—receive reports from the insurance department that provide analysis of plans' financial conditions, and all four rely on insurance department staff to identify plans that are experiencing difficulty.

These states have been less successful in developing the capability to monitor the performance of Medicaid contracts or to use financial information as a management tool, despite the fact that all four states receive separate financial reports from plans on the performance of Medicaid contracts. Michigan is the only state with any full-time staff devoted to financial oversight. Its insurance department remains the lead agency in dealing with plans over financial matters, however, and its Medicaid agency has yet to develop the capacity to use the information it collects to manage the program.⁵

This limited ability to gauge plans' management of Medicaid contracts deprives Medicaid managers of a useful tool for setting rates and managing enrollment. Such concerns are outside the mandate of state insurance departments' oversight, which is focused on aggregate financial position. States such as Arizona, which have the independent ability to gauge the financial performance of Medicaid contracts, can raise rates or enrollment to keep plans from dropping out of Medicaid or experiencing a decline in financial position that would spur insurance department action. States that lack this capability may lose plans or have to take politically controversial actions to sanction or prop up distressed plans.

■ **Quality assurance/improvement.** This oversight area has attracted the most attention from states and the Medicaid policy community. Central to most definitions of "prudent purchasing" or performance contracting in Medicaid managed care is the ability to define and measure quality of care and to tie financial rewards and continued contracts for plans to their achieving contractually specified performance standards.

Several factors can inhibit states' ability to promulgate and enforce performance standards. First, standards or benchmarks developed in the commercial market may not transfer well to the Medicaid population. Establishing these benchmarks for local use may require considerable negotiation. Second, quality reporting conventions and standards are only partially standardized, so states wishing to institute performance standards may need to invest considerable effort and money in systems development, negotiating over reporting conventions, and auditing to ensure that reported data are comparable and of reasonable quality.

Given these difficulties, it should not be surprising that the states in this study have few formal performance standards in contracts with plans, a finding similar to that in other studies of managed care contracts.⁶ Contracts contain lengthy specifications of the data that

plans are required to submit and the quality improvement processes that they are expected to undertake. There are, however, almost no standards for such widely used quality benchmarks as vaccination rates, well-child visits, or access to prenatal care, for which plans can be penalized for failing to achieve. These states vary widely in the degree to which their quality-reporting systems approach the prerequisites for instituting such standards. The major difference within this set of states is, again, between Arizona and the other four states. Two particular differences are noteworthy.

First is the level of investment in data quality. Arizona initially implemented its reporting system in 1991 and has improved plan reporting in the years since then. The state performs annual audits to monitor the completeness and accuracy of encounter data, and it must approve any changes in plan information systems. Financial sanctions are associated with failure to implement audit recommendations and inadequate reporting, and the state authorizes reinsurance based on plan reports, so plans have a significant financial incentive to maintain the quality of their reporting.

A second major difference is the uses to which information is put. Although Arizona does not distribute any information to consumers and has no formal performance standards, it has several mechanisms that encourage plans to compare their performance with that of other plans and provides limited awards for performance. The state regularly distributes comparative performance information to plans and providers, with a plan's performance rated against the average of other plans or providers or unidentified data from all other organizations. AHCCCS is developing an initiative to provide financial awards to high performers and gives contract preference to them.

These processes, while not formal standards, may nonetheless affect plans' behavior. The availability of comparative performance data, even without public distribution, has been shown to have a significant effect on organizational behavior, and it is likely that this process has prompted low scorers to attempt to improve their ratings.⁷ External evaluations cited earlier suggest that AHCCCS has been able to limit spending growth without impairing access or utilization, so this approach may have been effective.

Quality improvement reporting and feedback systems in the other states we studied are at various stages of development. Michigan has developed an aggressive system for overseeing plan quality, although it has not been in operation long enough to gauge its effectiveness. The state has issued minimum standards for immunizations and several screening devices that apply to continuously enrolled clients, but without any penalties for failure to meet them.

Michigan's oversight structure is more decentralized than Ari-

“States rely on consumer complaints, surveys, and other informal means of addressing ongoing access problems.”

zona’s but contains mechanisms intended to ensure similar attention to data quality and comparative performance. The unit charged with quality oversight reports directly to the Medicaid director, and a clinical advisory committee, with state staff support, has been established to define reporting frameworks and oversee quality improvement efforts. The state has established an encounter-reporting system, has let a large contract for auditing of plan reporting, and plans a broad dissemination of plan performance results.

The other three states have developed less aggressive approaches to quality oversight. All three have required plans to report Health Plan Employer Data and Information Set (HEDIS) results or similar measures, but none has explicit performance standards, and there has been less investment in data quality and less dissemination of results. Kansas and New Jersey have had difficulties getting all plans to report requested data.

These results suggest that becoming a prudent purchaser is a complex organizational task for states, requiring a considerable investment in systems development and data quality. It is difficult to envision a viable method for penalizing or rewarding plans for performance without a stable source of reliable, comparable data on all participating plans. The experience of Arizona, the only state in this sample to have such a data system in place, suggests that achieving this level of data quality requires considerable long-term investment. Given that several states have yet to establish stable reporting relationships with all plans and lack any institutional means of ensuring the quality of the data they receive, prudent purchasing may be beyond the reach of many states.

■ **Access and network capacity.** Having enough providers, particularly primary care physicians, to serve Medicaid managed care clients has been a persistent concern. Advocates have argued that managed care can broaden the availability of mainstream providers to Medicaid clients, while detractors have claimed that clients may be limited to “Medicaid mills” without the safety valve of access to hospital emergency rooms or public facilities.⁸

Ensuring adequate access is complicated by the limited consensus around several conceptual and measurement issues in defining the adequacy of networks, for which staffing standards or benchmarks vary widely.⁹ Also, consensus is lacking on how to address such common measurement problems as physician membership in

multiple networks, allowable travel time, or changes in network capacity over time.¹⁰

Given these difficulties, it is not surprising that the states in this study require plans to document the adequacy of their networks in a more or less rigorous fashion initially upon contract receipt, but rely on consumer complaints, surveys, and other informal means of identifying difficulties in getting care. In Kansas, for example, “These problems are addressed in an ad hoc fashion, frequently through informal regular contacts between SRS [Social and Rehabilitation Services] and plan staff, and through monthly meetings of the state’s Peer Education Resource Council...There have been no sanctions in this area, although...informal action plans have been formulated to address particular access problems. SRS is much more concerned with retaining plans than with sanctioning performance with regard to network capacity.”¹¹

These results suggest that access and capacity are relatively low oversight priorities for these states. Systematic monitoring of the available capacity in a plan’s network, particularly over time, is a complex task for which there are few established standards or reporting conventions. Consequently, states only formally measure network capacity as part of the initial contract or certification process and rely on informal means of identifying and addressing ongoing access problems.

■ **Consumer relations.** Amid a much-publicized anti-managed care backlash in recent years, several states have enacted patient protection legislation limiting MCOs’ ability to restrict access to care and giving patients enhanced rights of grievance and appeal. Many of these protections have been extended to Medicaid patients by state contracts and executive order.¹²

As a reporting and measurement technology, consumer relations is generally better developed than is the measurement of access and capacity, but less well developed than financial reporting. National Committee for Quality Assurance (NCQA) accreditation standards and guidelines issued by other groups require regular surveys of consumer satisfaction and specify the elements of a grievance and appeals process; this has contributed to at least a partial standardization of plan practices in these areas. Several validated survey instruments are broadly used to measure consumer satisfaction, including one for Medicaid clients.¹³ Plans generally keep track of complaints and the use of formal appeals processes and use this information to change procedures and replace providers. There is little standardization of definitions or reporting across plans, so comparable information does not typically exist. It is also unclear what appropriate benchmarks would be. Plans differ in the sophis-

tication of their members and the degree to which they solicit and heed member concerns; thus it is unclear whether a low rate of complaints would be unambiguously positive.

The five states in this study follow a roughly similar oversight regime in regulating plan relationships with customers, although their organizational arrangements for oversight vary greatly. All review plans' marketing materials, and all but Arizona contract with an enrollment broker to enroll clients. All conduct or commission patient satisfaction surveys and disseminate the results. All require plans to adopt procedures for responding to clients' questions, complaints, and grievances and to report regularly on client contacts. In almost every state, however, there is a strong preference for resolving problems informally before they reach the grievance stage. In West Virginia, for example, "this area is distinct from other oversight areas as it focuses more on case-by-case concerns rather than on aggregate program performance...The practice appears to be to work out complaints and disputes within the HMOs, sometimes with the enrollment broker helping things along by informing higher levels of authority in the plan that problems are afoot."¹⁴

This emphasis on informal resolution of individual cases may increase the system's responsiveness to particular complaints, but it limits the extent to which the reporting mechanisms provide a reasonable picture of plan performance. Since Medicaid clients may be less likely than private-pay clients are to complain, reliance on individual initiative may be at best a partial substitute for effective formal state oversight.

Are States Becoming Prudent Purchasers?

These findings indicate that by and large the states examined here are not functioning as "prudent purchasers," in the simplest meaning of that term. Few explicit performance standards for plans are embodied in state managed care contracts. Performance data are universally required but unevenly collected, analyzed, and used. States have a wide range of contractual sanctions available to them, ranging from requirements for corrective action plans, to freezing enrollments or payments, to terminating contracts. They have been reluctant, frequently for sound political or market reasons, to use these sanctions, preferring to rely on more informal solutions.

Arizona is the only state we examined that can claim to have a fully functioning oversight system that meets reasonable standards for prudent purchasing. AHCCCS has invested significant resources and energy over an extended period of time in improving the quality of plan reporting and has only recently begun to consider disseminating performance information beyond plans. Given Arizona's con-

siderable advantages—sophisticated staff and plans and a favorable political and market setting—the extended time it took to establish reporting systems to support performance judgments suggests that becoming a prudent purchaser will take even the most sophisticated states considerable time to achieve.

A more realistic comparison might be between states' performance under managed care and their awareness of patient care and outcomes under FFS Medicaid. States are still having problems acquiring and using quality and other data on managed care. Almost every state, however, has better information about the experience of Medicaid clients under managed care than under FFS, and the direction of change is generally positive.

States also are making more sustained efforts than most private purchasers are to measure and improve the quality of care available to Medicaid beneficiaries. The limited evidence available suggests that most private purchasers focus almost exclusively on price in purchasing health coverage.¹⁵ With the exception of financial reporting and recipient surveys, Medicaid oversight requirements in every area are more substantial than those required by local private purchasers in every state. These heavy reporting requirements make Medicaid contracts more expensive and less attractive than commercial contracts. To justify this elevated expense, states must make effective use of the information they collect, both in fact and in the perception of plans. Plans' complaints about the requirements may be neutralized by states' ability to show that information is being used in sensible and mutually beneficial ways.

Not all states have made effective use of the information they collect. Several states collect data of which they make little use and do not disseminate information in a fashion that encourages anyone to pay any attention to the results. This suggests that many states may be imposing an expensive reporting burden on plans without securing any of the improvements in quality or access that the data are intended to produce. This situation may improve in states that can upgrade the quality of the data they receive from plans, but the experience of Arizona and other successful states suggests that it may be some time before many states have data of adequate quality to support contract decisions.

These findings also suggest that successful state oversight is heavily influenced by the market and political environment in which Medicaid agencies operate. Establishing a strong oversight posture is difficult in states such as Kansas and West Virginia, where managed care is only marginally established in private markets and there is little political support for spending to establish more elaborate oversight systems. Both pay relatively low rates. Medicaid agencies

“The need for states to follow the commercial market may conflict with the political requirements of states’ budget processes.”

in both states have low bureaucratic status and have had credibility problems with state legislatures. Legislatures in these states support managed care primarily as a means of controlling costs. These states thus have little choice about the plans with which they will contract, effectively ruling out the imposition of performance standards backed by the credible threat of sanctions or contract cancellation. Improvements in performance or oversight are very much limited by what plans are willing to accept and by the persuasive skills of oversight staff.

By contrast, the more elaborate oversight structures in Arizona and Michigan are largely the result of more favorable political and market conditions. Managed care is better established in these states, and plans there are better able to comply with sophisticated reporting requirements. There also has been political support for managed care objectives that are more complex than saving money. In Arizona AHCCCS executives have been able to maintain the unusual degree of autonomy they got in the mid-1980s, when the private contractor hired to manage the program cancelled its contract with thirty days’ notice. The new agency was given a direct reporting relationship to the governor and exemptions from the state’s personnel and procurement systems. While some of these exemptions have since been repealed, AHCCCS has maintained much of its autonomy and political support.¹⁶ Unlike the other states in this sample, which are required to provide contracts to “any willing provider,” AHCCCS can deny contracts to willing plans, alter plan service areas and enrollments, and regulate plans’ administrative arrangements.

In Michigan, Medicaid managed care was part of a larger set of gubernatorial entitlement reforms intended to turn the state into a “value purchaser.” Medicaid was removed from the state welfare agency and placed in a new Department of Community Health. Management positions were filled by persons with strong market orientations and no prior attachment to the FFS program.

Political and organizational support for oversight of plan activities has been reinforced by market conditions. Managed care markets in both states are competitive, particularly in Phoenix and Detroit, where the TANF-related populations are concentrated. Both states pay adequate rates and have been able to attract a “surplus” of plans interested in Medicaid business. Under these conditions, assertive oversight regimes stand a better chance of success.

THESE FINDINGS SUGGEST SEVERAL CONCLUSIONS about the extent to which states are capable of becoming prudent purchasers of Medicaid managed care and whether this notion is useful as a benchmark for state performance. First, they suggest that doing Medicaid managed care “right” may be beyond the managerial and political reach of many states. Establishing reporting systems that produce data of reasonable quality and the capacity to make use of such data is an expensive, extended process for both state agencies and plans. Some states are making progress toward these goals, while others have been less successful. In states that are dependent on a limited number of plans, Medicaid agencies’ ability to insist on any standards is minimal, and the need to retain plans is likely to take precedence over improving performance.

Management’s dependence on politics and markets also indicates the need for successful managed care programs to adapt to changes in these circumstances. To be successful over the long run, managers must develop a broad base of political support that is not dependent on the relationships that individual managers have been able to develop with individual legislators or gubernatorial staff. Among the states examined here, only Arizona has thus been able to “institutionalize” its managed care arrangements.

In similar fashion, managed care markets change over time, so states may see their market position deteriorate if they are unable to pay rates that are roughly competitive with those in the commercial market. The need to follow the commercial market may conflict with the political requirements of states’ budget processes, which may be less than receptive to requests for significant increases in Medicaid spending. Unable to set the rates they pay, Medicaid agencies may find their ability to establish performance standards or enforce compliance to be compromised.

These findings also suggest the limited transferability of best practices between states. The few states that have well-paid, sophisticated staffs; nationally accredited plans; reasonable rates; and political support can develop innovative management systems that attract the attention of foundations and professional associations. It is doubtful, however, that these procedures can be transplanted to states that lack these advantages. For example, few of the oversight practices followed by Arizona or Michigan could likely be transferred to Kansas or West Virginia, which lack the political and market advantages that make enhanced oversight feasible. At a minimum, recommendations about “best practices” ought to be pluralistic and sensitive to variations in state circumstances.

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NOTES

1. B. Bullen, "What Is a Prudent Purchaser?" (Speech presented at HCFA/NASMD Medicaid managed care meeting, 1998).
2. S. Rosenbaum et al., *A Nationwide Study of Medicaid Managed Care Contracts* (Washington: George Washington University Medical Center, Center for Health Policy Research, 1998); and R. Pear, "Administration to Set Down New Protections for HMO Medicaid Patients," *New York Times*, 15 September 1998, A24.
3. See N. McCall, "Lessons from Arizona's Medicaid Managed Care Program," *Health Affairs* (July/Aug 1997): 194-199; and U.S. General Accounting Office, *Arizona Medicaid: Competition among Managed Care Plans Lowers Program Costs*, Pub. no. GAO/HEHS-96-2 (Washington: GAO, 1996).
4. Field researchers' analyses are structured by a common protocol or "report form." Field researchers then analyze local programs relying on extensive interviews, program reports and other documents, observation of meetings, media coverage, and other locally available evidence. See R. Nathan, "The Methodology of Field Network Evaluation Studies," in *Studying Implementation: Methodological and Administrative Issues*, ed. W. Williams (Englewood Cliffs, N.J.: Chatham House, 1982); and I. Lurie, "Field Network Studies" (Unpublished paper, Rockefeller Institute of Government, 1999).
5. C. Weissert and M. Goggin, Michigan field report, 25-26.
6. Rosenbaum et al., *A Nationwide Study of Medicaid Managed Care Contracts*.
7. W. Gormley and D. Weiner, *Organizational Report Cards* (Cambridge, Mass.: Harvard University Press, 1999). For a more informal recent example, see T. Burton, "HMO Rates Hospitals; Low Scorers Don't Like It, but They Get Better," *Wall Street Journal*, 22 April 1999, A1, A13.
8. J. Perloff and J. Fossett, *The New Health Reform and Access to Care: The Problem of the Inner City* (Washington: Kaiser Commission on the Future of Medicaid, 1997).
9. See J. Perloff and J. Fossett, "Physician Supply and Network Capacity: Staffing Medicaid Managed Care in New York City" (Working paper, SUNY Albany School of Social Welfare, 1997).
10. See J. Billings et al., *Analysis of Primary Care Practitioner Capacity for Medicaid Managed Care in New York City* (New York: NYU Health Research Program, 1998) for a comprehensive description of these problems.
11. J. Johnston, Kansas field report, 25-26.
12. Rosenbaum et al., *A Nationwide Study of Medicaid Managed Care Contracts*; and Pear, "Administration to Set Down New Protections."
13. See GAO, *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent*, Pub. no. GAO/HEHS-98-119 (Washington: GAO, May 1998); and J. De Sa, *The Market for Accountability: Measuring and Managing Plan Performance* (Washington: Alpha Center, 1998).
14. C. Plein, West Virginia field report, 57.
15. See J. Meyer et al., *Theory and Practice of Value-Based Purchasing: Lessons from the Pioneers* (Rockville, Md.: Agency for Health Care Policy and Research, 1997); "Employers Underutilize NCQA Data on Plans," *Commonwealth Fund Quarterly* (Summer 1998): 1-2; and R.A. Berenson, "Beyond Competition," *Health Affairs* (Mar/Apr 1997): 171-180.
16. See J. Hall and M. Hollinshead, "Connecting Public Policy with Management: The Arizona Health Care Cost Containment System Experiment" (Paper prepared for presentation at the Association of Public Policy and Management Conference, Washington, D.C., 4 October 1999).