

CHCS

Center for
Health Care Strategies, Inc.

Informed Purchasing Series

WORKING PAPER

Can Medicaid Managed Care Be Managed?

By James W. Fossett
The Rockefeller Institute of Government
State University of New York

Malcolm Goggin and Carol Weissert
Michigan State University

Jocelyn Johnston
University of Kansas

*Funded by the Center for Health Care Strategies, Inc.
under The Robert Wood Johnson Foundation's
Medicaid Managed Care Program.*

July 2002

IP231-702

TABLE OF CONTENTS

Executive Summary _____	3
Introduction _____	5
The Context for Managed Care _____	7
Organizational Capacity _____	13
Becoming a Prudent Purchaser _____	15
Developing Political Constituencies _____	17
Conclusion: Is Medicaid Managed Care Manageable? _____	19
Appendix _____	20

Executive Summary

This Working Paper examines the implementation of full-risk Medicaid managed care for the TANF population in ten states.¹ The paper assesses state success at achieving three interconnected management objectives:

- Developing the organizational capacity, either in-house or through contractors, to manage managed care effectively.
- Becoming a “prudent purchaser” of managed care by developing contractual standards for quality of care and other measures, collecting data to measure compliance with these standards, and rewarding or sanctioning health plans based on their performance.
- Developing political constituencies among governors, legislators, providers, plans, and advocacy groups to support and advance their programmatic objectives.

Our findings are mixed. States that operate in favorable market and political settings have made reasonable progress toward these goals; while states in less favorable circumstances have been less successful. A summary of findings follows:

1. The ability of states to manage managed care effectively is strongly influenced by the competitiveness of the local managed care market and the state’s ability to offer a commercially viable package to managed care plans. In states where the managed care market is competitive and the state’s rates and administrative costs are reasonably comparable with those in the private market, states are likely to have a strong position as a purchaser and can impose and enforce strong accountability provisions. Such conditions appear in Arizona, Michigan, and New Jersey, where the state has been able to adapt mandatory full-risk managed care for the TANF population statewide, and Florida, where the state has chosen to require “competition” between full-risk and primary care case management.
2. States with weaker positions as purchasers have more trouble establishing full-risk managed care on the scale desired and have experienced trouble getting adequate numbers of plans to participate in the program. Ohio, Kansas, and West Virginia were required to scale back the full-risk portion of their programs. North Carolina was unable to expand a pilot full-risk program beyond one county and Georgia eliminated its voluntary full-risk program. These states operate multiple forms of managed care for the TANF population.

¹The ten states are Arizona, Colorado, Florida, Georgia, Kansas, Michigan, New Jersey, North Carolina, Ohio, and West Virginia.

3. The political context within which managed care was debated and adapted also affects program management. In some states, elected officials' expectations for managed care are focused on budget savings, while in others program managers can pursue a broader set of goals which include improvements in quality and access.
4. Medicaid management systems in more "successful" states have undergone significant reorganizations, typically by relocating Medicaid to health agencies separate from traditional welfare departments. These new organizations have benefited from strong political support and resources, which have enabled them to attract skilled personnel and focus organizational structures around managing managed care.
5. In most states, the organizational shift to managing managed care has been more incremental. Typically these states operate more than one form of managed care or fee-for-service programs in addition to full-risk programs, and have been unable to redeploy significant resources to oversee managed care.
6. States have few performance standards in their contracts with plans and make only limited use of the data they collect from plans to encourage plans to improve the quality of care they provide to Medicaid clients or to "manage" their managed care programs. Most states' oversight regimes are focused on procedural compliance and rely more on complaints rather than analyses.
7. States have difficulties making use of data to manage health care programs for a variety of reasons, ranging from difficulty in attracting and retaining personnel with the necessary analytical skills to concerns over the political and public relations consequences of reports of unfavorable program results.
8. Many Medicaid agencies have experienced difficulties in developing effective political constituencies for their managed care programs. Some states have established effective relationships with governors, but states where the legislature is the dominant political force have more difficulty making a case for resources and support.
9. Most Medicaid agencies have made little effort to develop political support for their managed care programs. While all have consulted broadly with provider groups, plans, advocacy groups, and elected officials in developing and implementing managed care, this consultation has not typically translated into a willingness to support managed care in the political arena.

Introduction

Medicaid managed care can be more complex for states to manage than traditional fee-for-service Medicaid. Advocates argue that managed care enables states to use market forces – competition between plans on price and quality – to improve the accountability of the health care system for Medicaid clients and to moderate growth in Medicaid spending. To realize these objectives, Medicaid agencies must develop technical, organizational, and political skills not required under the traditional fee-for-service program. Rather than paying bills as they come in, Medicaid agencies need to develop and negotiate contracts that include standards for packages of services to be supplied by managed care organizations; set the rates that will be paid for provision of the package; institute systems and procedures for measuring compliance with the standards; and take appropriate action in the event the standards are not met.

This Working Paper examines state success in managing Medicaid managed care for the TANF population of low-income women and children in ten states. Conducted in 1999 by researchers who examined a wide range of managed care management practices according to a standardized protocol,² this project examined state success at achieving three interconnected management objectives:

1. **Developing organizational capacity** – States should be able to develop the organizational capacity, either in-house or through contractual relationships, to manage managed care effectively.
2. **Becoming a prudent purchaser** – States should be able to develop contractual performance standards for quality of care and other measures; collect data adequate to measure health plan compliance with the standards; and sanction or reward plans based on their performance.
3. **Developing political constituencies** – States should be able to develop and maintain effective relationships with plans and other constituencies, including providers and elected officials in both executive and legislative branches.

While not a sample in any statistical sense, the ten states in this study represent a broad range of managed care program forms, sizes, and management strategies. Arizona is one of the few states in which all Medicaid clients are enrolled in managed care. The state's managed care program, known as the Arizona Health Care Cost Containment System, has been extensively evaluated and generally has received high marks. Michigan and New Jersey mandate full-risk enrollment for all TANF recipients, but retain fee-for-service Medicaid for other population groups. With the exception of Georgia, which relies exclusively on primary care case management (PCCM), the other states enroll TANF clients in combinations of voluntary and mandatory full-risk programs, PCCM, and fee-for-service Medicaid. At the time these data were collected in July 1999, Ohio and Colorado had the largest percentage – slightly over 40 percent – of their

²Field researchers in individual states are listed in the Appendix.

TANF-related Medicaid clients enrolled in full-risk managed care. Typically, full-risk programs are concentrated in urban areas and case management in rural regions, with no overlap between the two. The exceptions to this pattern are in Florida and Colorado, where the two forms “compete” for clients in the same areas.

Our results are somewhat cautionary. States’ ability to “manage” managed care, in the sense used here, is heavily dependent on the market and political context within which managed care operates. The states that have made the most progress toward effective management operate in market and political climates that support these objectives, while other states are required to operate Medicaid managed care programs under political and market conditions that make effective management difficult. This dependence of management success on the larger environment suggests that managed care may not be “manageable” in some states and only partially achievable in others.

The Context for Managed Care

States do not manage Medicaid managed care in a political or market vacuum. To the contrary, states' abilities to establish viable organizational structures, hold plans accountable, and develop politically advantageous relationships are shaped both by the managed care market in which they function as purchasers and the bureaucratic and political environment around both managed care and Medicaid. Two broad contextual factors are particularly important for states' abilities to manage managed care well – the state's position as a purchaser in the managed care market and the political context within which Medicaid managed care has been implemented.

States in the Managed Care Market

One contextual factor shaping the implementation of Medicaid managed care is the nature of the state managed care market and the state's relative strength as a purchaser. Health care markets vary widely in their competitiveness, the extent of managed care penetration, provider adaptation to managed care, and other factors that affect the competitive position of Medicaid agencies as purchasers. In more competitive markets, Medicaid clients may be more attractive to plans, and states may be able to enforce quality of care and other standards. In less competitive markets, states are limited in their choice of contractors and may be less able to insist on strong standards for accountability. In such markets, there may be areas where no plans are willing to enroll Medicaid clients and states may be required to rely on case management or fee-for-service arrangements.

A second factor that affects states' positions as purchasers is the commercial viability of Medicaid managed care for plans. Plans generally decide to participate in Medicaid if the revenue they receive from Medicaid premiums exceeds the cost of providing care to Medicaid clients plus whatever added reporting and other administrative costs are associated with accepting Medicaid clients. Plans that find that Medicaid rates are inadequate to cover these costs, either because premiums are low or the costs of contract compliance are high, are unlikely to participate or to remain participants.

The ability of state Medicaid agencies to set the premiums they pay at a commercially attractive level or the reporting and other administrative requirements associated with participating in Medicaid are frequently constrained by federal regulations or state budget requirements. The waivers under which states operate Medicaid managed care programs, for example, require that managed care be "budget neutral," or not cost any more than the same services would have cost under the state's fee-for-service Medicaid program. The requirement that premiums be constrained by such calculations, rather than by current market conditions, may make it difficult for states to pay commercially appropriate rates.

In addition to these structural factors, the market position of all ten states was weakened to some extent over this period by a recent shakeout in the managed care industry and the reduction in Medicaid caseloads stemming from the implementation of welfare reform in 1996. Over the late 1990s, many managed care firms were under severe financial pressure as a result of

increased costs and difficulties in raising premiums. A number of plans went bankrupt, others merged with larger plans, and others restructured their operations by eliminating unprofitable lines of business, including, for many, Medicare and Medicaid. In addition, Medicaid caseloads in almost all of these states fell, in some cases sharply, over this period, as a result of the improved economy and the implementation of welfare reform. Both of these factors may have made Medicaid clients less attractive to plans and weakened states' bargaining positions.

Table 1
HMO Penetration in Private and Medicare Markets
Sample States and United States
1999-2000

State	HMO Penetration Rate, 1999	Percent Medicare Enrollees in Managed Care, 2000
Arizona	29.2%	36.3%
Colorado	38.1	34.1
Florida	32.2	26.7
Georgia	16.6	6.1
Kansas	16.1	7.4
Michigan	27.4	29.2
New Jersey	30.6	14.3
North Carolina	18.4	4.1
Ohio	24.5	17.0
West Virginia	10.0	7.3
United States	29.2	17.2

Source: AARP, *Reforming the Health Care System: State Profiles 2000*.

The ten states in this study can be divided into three groups of differing market strength. As shown in Table 1, HMO penetration rates in these states in both the private and Medicare markets range from well above to well below the national average. Arizona, Michigan, New Jersey, and Florida have relatively well developed, competitive private managed care markets, particularly in urban areas. Arizona, Michigan, and New Jersey have established and maintained mandatory enrollment in full-risk managed care for TANF recipients statewide, while Florida has maintained a “competitive” system where clients may choose between full-risk plans and primary care case management arrangements. All four states have been able to attract sufficient numbers of plans interested in Medicaid without making significant concessions

Ohio and Colorado also have well established and competitive private managed care markets, but have experienced more difficulty in attracting plans to participate in Medicaid. Both were low payers under the fee-for-service program, but have been long-standing participants in managed care. Several plans left the Ohio Medicaid program, primarily as the result of a rate cut required to maintain budget neutrality. As a consequence, the state was required to eliminate mandatory status full-risk programs in three urban counties. Colorado has a relatively small number of Medicaid clients, and the state’s primary care case management program is popular with providers. As a result, the state has been compelled to maintain “competition” between full risk and case management in most areas and has persistent difficulties attracting plans.

The remaining four states – Kansas, Georgia, North Carolina, and West Virginia – have less competitive private managed care markets and have experienced difficulties in establishing and maintaining full-risk managed care. All four have managed care penetration rates well below the national average, all have had relatively restrictive Medicaid eligibility programs, and all were historically low payers under the fee-for-service Medicaid program. As a result, all four have experienced difficulties mounting full-risk managed care programs. On average, these states enrolled only 11 percent of their TANF population in full-risk arrangements, as compared to 45 percent in case management. North Carolina has established full-risk arrangements in only one county, and Georgia abandoned its full-risk program. Kansas and West Virginia also were required to eliminate their mandatory full-risk programs because plans dropped out of the program.

A state’s market position serves as a limiting factor in its ability to impose reporting and quality requirements and to develop adequate capacity to manage managed care effectively. States in a weak market position may find it difficult to press for strong accountability provisions or aggressively enforce existing provisions for fear of pushing plans out of Medicaid. States in a stronger market position may choose not to make accountability a high priority, but they are in a stronger position to hold plans accountable than states where Medicaid clients are unattractive to most plans. In similar fashion, states that must manage multiple forms of managed care as well as a fee-for-service program may have more difficulty getting enough resources and expertise to manage full-risk programs care effectively. By contrast, states that have been able to move sizeable numbers of clients into full-risk arrangements may be able to reconfigure their organizational structures to focus more resources on developing the necessary expertise.

The Political Context of Managed Care

A second related factor that influences the implementation of Medicaid managed care is the political context within which the program operates. States differ in their interest group configurations and the views of their citizens on the importance of Medicaid and other social programs, and these differences have consequences for states' abilities to implement managed care. In some states, social spending is unpopular and there is little organized support for attention to quality and access. Elected officials may be interested in managed care primarily as a means of reducing Medicaid expenditures, and may be unwilling to support complex changes in agency organization and staffing. Privatizing or downsizing government services have been popular political themes recently, which may complicate agency efforts to acquire the skills required to oversee managed care effectively. In states where social programs have broader political support, by contrast, elected officials may be more willing to support more complex objectives for managed care such as improvements in quality and access.

The states in this study manifest three distinct patterns of managed care politics. The basic political parameters governing Arizona's program were set during the early 1980s, when the state's Medicaid agency was granted an unusual amount of administrative autonomy in order to prevent the program from collapsing. Program managers have been successful in preserving much of this autonomy and maintaining a largely bi-partisan base of support among elected officials. In Colorado, Kansas, Ohio, West Virginia, Georgia, and North Carolina, the political impetus for managed care focused primarily on the potential for cost containment, while in Michigan, Florida, and New Jersey, elected officials seem to have a more complex set of objectives.

Arizona is distinctive among the states in this study in that it never had a fee-for-service Medicaid program. The state received the first waiver from the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) for a large-scale capitated program in the early 1980s, which was developed with bi-partisan political support from both the legislature and the governor. The state initially contracted the administration of the program to a private contractor, which canceled the contract after less than two years of operation. The large number of officials with political stakes in the program who would be embarrassed if it completely collapsed led to unusual grants of authority to a new executive director who was brought in to reconstitute the program as a public agency. Subsequent managers of the state's Medicaid agency have been able to maintain much of its autonomy and political support.

A second set of managed care politics appears in Georgia, North Carolina, Colorado, Kansas, and West Virginia. Health politics in these states have historically been dominated by providers, particularly physicians, who typically are opposed to managed care. This opposition from powerful provider groups, together with the limited market opportunities for managed care plans, has produced a much heavier reliance on case management than on full-risk arrangements in these states. Medicaid is an unpopular program in these states, and managed care appears to have been attractive as a potential means of reducing growth in spending.

Colorado is an outlier in this group, since the legislature has been willing to devote resources to improve the state's managerial capacity.

By contrast, the larger more urbanized states in our sample – New Jersey, Michigan, Ohio, and Florida – have more pluralistic health politics. These states historically have paid better rates to hospitals and other institutions than to physicians, so hospitals have been more active players in Medicaid and physicians less influential. Job-based insurance is more common, and managed care has become better established in the private market, so insurance companies and HMOs are more active politically. All four of these states had prior experience with Medicaid managed care in some form, in some cases dating back to the early 1980s. These conditions tend to eliminate much of the political controversy associated with supporting full-risk in other states.

With the exception of Florida, managed care in these states was primarily an executive rather than a legislative initiative. Governors in Ohio, New Jersey, and Michigan are structurally and politically more powerful than in many others, and major policy initiatives have traditionally come from the executive. While Florida more closely resembles the other southern states in the balance of power between executive and legislature, both governors and legislative leaders have been strong supporters of managed care.

Program managers in these states have been able to pursue a more complex mixture of program goals than the other states in our sample. While cost containment has been a clear priority in all these states, there also has been political support for attention to quality and access as well. Michigan and New Jersey traditionally have had generous health and social service programs which have drawn bi-partisan support from both governors and legislators. While Medicaid agency managers in both states are expected to produce savings, and claim they have done so, there has been political support for improving quality as well. Similar support for a broad range of program objectives also appears in Florida. The state has been involved in managed care for some time, and there has been consistent political support for a broad range of program objectives.

Ohio's political position is more complex. While the state has been actively involved in managed care since the mid-1980s, the state's Medicaid program has been more conservative than other large industrialized states, and a series of Republican governors and legislatures appear to be mainly interested in cost containment than in quality improvement and less willing to invest resources in the development of oversight mechanisms. The agency has had difficulties establishing a strong political constituency for managed care, although governor and legislature have been willing to raise managed care rates in response to the exit of plans from the program.

Summary – Context and Management

These differences in market and political context indicate that states confront very different oversight and constituency building tasks. In Arizona, Florida, Michigan and New Jersey, state Medicaid agencies are in a relatively favorable position. Managed care is well established in the

private insurance market or is rapidly becoming so. State agencies are in strong positions as purchasers – state premiums have been reasonably competitive and there is, at least currently, a surplus of plans interested in competing for Medicaid contracts. Elected officials have been willing to support more complex objectives for managed care beyond cost control, so that agency officials have some political “slack” to pursue improvements in quality and access.

By contrast, Medicaid agencies in Kansas, Georgia, North Carolina, and West Virginia face a more difficult situation. Managed care is less well established in the private market than in other states, and there is significant opposition from providers, particularly in rural areas. State premiums are low, and both states have become dependent on a small number of plans to enroll Medicaid clients. None of these states have been able to move into full-risk managed care on as large a scale as planned, so that much of the TANF population remains in fee-for-service or case management. Elected officials are mainly interested in managed care as a means of saving money, so that Medicaid agencies have limited leeway or resources to pursue other objectives.

Colorado and Ohio occupy an intermediate position. Both states have well developed private managed care markets and considerable experience with Medicaid managed care, but both have experienced difficulties in taking advantage of their potentially favorable market position. Ohio has experienced problems with plans dropping out because of low rates and declines in Medicaid enrollment. While Colorado’s agency has had more political support, it has had difficulty attracting plans to participate in the program. It also has the touchy problem of encouraging the enrollment of clients in full-risk arrangements without alienating the providers who participate in the state’s case management program.

These differences in politics and markets suggest that different states have to manage managed care in very different ways. State agencies that are purchasing care in competitive managed care markets, pay reasonable rates, and have strong political support can manage programs in ways that are not available to states with less competitive markets, lower rates, and little political support.

The next sections of this Working Paper examine the success of states in “managing” managed care, as defined here, given these political and market factors. Our findings suggest that while some states have experienced difficulty in implementing effective management systems for operating Medicaid managed care, others have successfully adapted to the political and market conditions under which they operate. These adaptations are not consistent across states, suggesting the need to be modest about prescriptions of what constitutes “best practices.”

Organizational Capacity³

One basic management problem for states is developing the organizational capacity to manage managed care. Managed care requires different organizational competencies than fee-for-service Medicaid and primary care case management, which are primarily oriented around auditing and paying bills. Dealing with plans about packages of services requires different skills and different organizational arrangements than dealing with providers about bills for individual services.

As might be expected, states' abilities to rearrange the organizational structures of their Medicaid agencies to oversee managed care effectively has been largely determined by their ability to move Medicaid clients from fee-for-service or primary care case management into full-risk arrangements. Four states – Arizona, Florida, Michigan, and Colorado – have been reasonably successful at this transition. All four operate managed care through centralized organizational arrangements that are separate from the state's welfare agency, which is the traditional location for Medicaid programs. Colorado, Michigan, and Florida's Medicaid programs are housed in health-related agencies, while Arizona's Medicaid agency is a free-standing department. Colorado and Florida still operate case management programs, which are operated as sub-units of the larger health agency.

While hardly sufficient to ensure management "success," separation from welfare agencies offers political advantages. Creation of a new agency allows political officials to send a strong "signal" about their political priorities and allows them to appoint senior managers who are sympathetic to their goals. Being lodged in a separate agency may also give agency managers more prestige and higher rank than their counterparts in larger human service or welfare agencies. This greater visibility may make communication with governors and legislators easier and provide an advantage in the budget process. It may also avoid the "stigma" of association with unpopular welfare programs, and may make resources easier to attract.

Separate managed care agencies also appear to have had more success attracting qualified personnel than other states. Arizona has developed a reputation as an agency that can attract well qualified applicants from providers, plans, and other private health care agencies. Florida's agency benefits from the state's strong hiring position as the largest employer in an area with large numbers of well-educated residents and almost no private sector. Michigan is among the better paying state governments, and took advantage of a major reorganization to staff the Medicaid agency with senior managers without ties to the traditional Medicaid program and with strong commitments to managed care. Colorado pays less well and has had more problems with turnover and retention, but the close ties between the governor, the agency head, and their former colleagues in the legislature have made it easier for the agency to secure resources. These favorable conditions, and the more favorable market and political conditions that support them, have made it possible for these states to reorient their organizations around the oversight of managed care.

³ The analysis in this section relies heavily on Johnston, J. *Managing Medicaid Managed Care: A Ten State Comparison*, available on the Rockefeller Institute of Government web site at http://www.rockinst.org/publications/federalism/medicaid_managed_care/managing_medicaid.doc.

In most of the other states in our sample, Medicaid managed care remains housed in larger agencies, frequently at a low level, and organizational change has proceeded more incrementally. New Jersey and Ohio's managed care programs, for example, remain part of human service umbrella agencies. While both states pay well and have some experience with managed care, neither has been able to attract substantial new resources to make investments in the specialized analytical and financial skills required to operate managed care effectively. While governors in both states have been supportive of managed care, it has not been a high political priority in either state.

In the southern and smaller midwestern states in our sample, managed care is subsumed under the existing Medicaid agency. Case management and fee-for-service remain the dominant mode of delivering care to Medicaid clients in these states, and the persistence of multiple forms of Medicaid has made it difficult to make major organizational changes or to redeploy existing personnel in any dramatic way. While most states have received at least some new resources to implement managed care, these resources typically have been limited. As a result, most managed care oversight units have been staffed from within state agencies rather than by new hires and new positions have not been filled by staff with backgrounds in managed care.

Most states have supplemented their in-house capacity building efforts by relying on consultants and other private contractors to perform a variety of analysis and oversight activities. Some states have "sub-contracted" oversight functions to other state agencies. Reliance on contractors, whether public or private, varies widely. Arizona, Ohio, and Florida subcontract almost nothing beyond federally mandated quality reviews, while other states rely more heavily on contractors. The extreme case is West Virginia, which subcontracts the management of its' full-risk program and has only one professional employee in its managed care office. More typically, states have subcontracted enrollment management and more complex technical activities such as rate setting and information system design and management.

Most states have invested their most substantial organizational resources in monitoring and improving quality. States are required by federal regulations to establish contracts with External Quality Review Organizations and to contract for external evaluations with some independent organization, usually a local university or consulting firm. Almost all states with sizeable full-risk programs have established separate organizational units with full-time staff. Markedly fewer resources have been devoted to other oversight areas such as plan finances or access and utilization of care.

Becoming a Prudent Purchaser⁴

Prudent purchasing has become the informal gold standard for state Medicaid agencies in their dealings with plans. Becoming a prudent purchaser requires states to incorporate measurable performance standards into contracts with plans, collect data that will indicate whether plans are complying with these standards, and take action to penalize or reward plans according to their compliance.

State progress in meeting these goals has been uneven. There are few formal performance standards in managed care contracts that put plans at any financial risk, and the use of contractual sanctions has been limited. While federal regulations require states to collect large amounts of data from plans, collecting and using this information as a tool to manage managed care remains problematic for many states. Some states are still experiencing difficulties collecting information from plans, and the capacity to analyze and use the information submitted by plans in program management and policy decisions is limited. Not surprisingly, those states with favorable market conditions, support from political leaders, and with the most experience with full-risk managed care have had the most success to date in developing effective oversight systems. Plans in these states are likely to have more sophisticated reporting systems that can produce data that meets state reporting requirements, and states can be more aggressive in pressing for compliance with these standards. In states where managed care markets are less competitive and plans may be struggling financially, complying with elaborate state reporting requirements may be expensive. States may have difficulty collecting data from plans and may be unwilling to press plans for fear of causing their withdrawal from the program.

Given these considerations, it is perhaps not surprising that only Arizona currently meets reasonable standards for a fully functioning oversight system that permits “prudent purchasing.” The state initially implemented its system in 1991, and has spent the last decade upgrading the quality of plan reporting. The state performs annual data validation audits to assess the completeness and accuracy of encounter data, and must approve any changes in plan information systems. There are financial sanctions associated with failure to implement audit recommendations or for inadequate reporting, and the state authorizes reinsurance based on plan reports, so plans have significant financial incentive to maintain the quality of their reporting. Arizona distributes performance data to plans (though not to consumers), rewards high performing plans in the contracting process, and is planning a modest performance bonus system. While not formal performance standards, these processes create an incentive for plans to worry about the quality of the information they submit and to pay attention to the results.

Several other states are well along in developing reporting and oversight systems. Michigan’s oversight structure is more decentralized than Arizona’s, but contains mechanisms intended to ensure similar attention to data quality and comparative performance, though without financial consequences. Colorado has similar plans to institute prudent purchasing practices. Florida and

⁴ The analysis in this section draws heavily on Goggin M. *The Uses of Data in Medicaid Managed Care: A Ten State Comparison*, available on the Rockefeller Institute of Government web site at http://www.rockinst.org/publications/federalism/medicaid_managed_care/uses_of_data.doc.

New Jersey have adopted more reactive oversight models in which administrative and compliance problems are identified and pursued, but without any particular agenda for improving the quality of care. Other states rely on plan reports to monitor compliance with procedural and other contract requirements or to identify problems, but typically are more responsive to complaints than to the results of analyses. While most states distribute some form of “report card” on consumer satisfaction with individual plans, there are few penalties or rewards attached to performance on these measures. Few states use data to reward or sanction plan performance or to guide the selection of plans in subsequent contracts.

States also vary widely in the level of analysis they apply to the data collected from plans and their investment in developing analytical capacity. While all states have made at least some investment in monitoring the quality of care in managed care plans, these efforts range from significant investments in sophisticated staff to smaller units whose primary responsibility is reviewing reports from contractors. Arizona, Michigan, and Florida have made significant investments in data quality and oversight capacity, while other states have invested fewer resources. Most states’ analyses of the data submitted by plans are limited to descriptive statistical reports, with little investment in more sophisticated analyses that might be useful in policy or management decisions. This under analysis of data is most marked in the case of information on the financial condition of plans. Most states lack staff with the requisite training and skills to analyze and use complex financial information and are dependent on state insurance departments for financial analyses.

There are several reasons for the limited uses of analysis in program management and the limited uses of performance sanctions and rewards more generally. One is political. Distributing information publicly on the performance of private contractors may be controversial, and attempts to use such information as a basis for sanctions or preference in the contracting process may result in litigation from plans who are sanctioned or excluded. Medicaid managers may be concerned that they will be blamed in the media and by elected officials if plans do not perform well or there is controversy about plans’ performance. Managers also may be concerned that the use of formal sanctions or penalties may disrupt relationships with plans or lead them to consider withdrawing from Medicaid. Under these conditions, Medicaid agencies have a strong incentive to rely on informal persuasion rather than formal sanctions as a means of improving plan performance and avoid focusing attention on potentially unfavorable analytical results.

A second reason for limited state use of analysis is the considerable cost of developing an adequate analytical capacity for both plans and states. The states that have been most effective in developing this capability have made considerable investments in data development and quality control and in trained personnel to make adequate use of the data. Plans in these states also have made significant investments to collect and provide information. Other states have found it difficult to acquire the resources to make these investments and may have had to deal with plans that lack the sophistication or the resources to collect and report data in a timely fashion. Several states have had considerable difficulty attracting and retaining professional staff knowledgeable in the appropriate analytical techniques or managers able and willing to use complex information to manage relationships with plans.

Developing Political Constituencies⁵

Effective management of Medicaid managed care has an explicitly political dimension. In order to manage managed care effectively, state Medicaid agencies have to cultivate support from elected officials, both executive and legislative, and develop effective working relationships with the major constituencies for managed care – providers, plans, and advocacy groups. Medicaid agencies need adequate budgets to manage the program effectively and the ability to pay adequate rates to attract a sufficient number of plans, and also may need political support for potentially controversial actions such as sanctioning plans.

Developing a constituency always has been difficult for Medicaid agencies, particularly around services to the TANF population. While health care providers, particularly physician and hospital associations, are powerful actors in state politics, Medicaid has had difficulty developing a constituency among providers. Many providers do not accept Medicaid clients, and there has been recurring controversy around the adequacy of Medicaid fees. Medicaid agencies have cultivated relationships with provider groups with some success, but pressures on Medicaid agencies to hold spending down have frequently made these relationships uneasy and antagonistic.

State success in broadening the constituency for Medicaid and managed care beyond this less than stable base can be traced to the pluralism of the health politics environment and the relative political strength of the governor as compared to the legislature. In states such as Michigan, New Jersey, Florida, and Ohio, physicians are less dominant as political actors, hospitals are more significant, and managed care plans or associations may have established themselves in the political process. Full-risk managed care is less controversial and the stronger managed care market that prevails puts state agencies in a stronger position as purchasers.

Under these conditions, governors may find investing political “chips” in supporting managed care attractive. A reputation for running innovative and successful programs can elevate a governor’s visibility on the national political scene and increase his or her chances of being considered for higher political office, and many governors may find managed care’s reliance on the “private market” politically attractive. Legislatures in these states are typically less powerful than elsewhere, so agencies that can enlist gubernatorial support may be able to secure resources and support for organizational changes to operate managed care more efficiently. Governors in Michigan and Florida, for example, were strong supporters of separating Medicaid from welfare agencies, and in the case of Michigan, were willing to support early retirement for senior Medicaid executives in order to staff the new agency with managers sympathetic to the new approach.

Gubernatorial support, however, does not guarantee either adequate resources or amiable relations with providers. Ohio governors, for example, while supportive of the expansion of

⁵ This section draws heavily on Weissert C. *State Medicaid Agencies as Key Actors in Medicaid Managed Care*, available on the Rockefeller Institute of Government web site at http://www.rockinst.org/publications/federalism/medicaid_managed_care/medicaid_managed_care.doc.

managed care, historically have viewed the program as a means of saving money and have been unwilling to invest either in new resources for the agency or in mechanisms to attract or retain plans to the program. In similar fashion, even strong political support has not altered Medicaid agencies' tenuous relationships with providers. In Michigan, for example, hospitals and physician groups have loudly blamed hospital closures on Medicaid managed care, prompting a strong response from state Medicaid officials that hospitals were overstating their financial problems and that managed care rates were not to blame in any case.

Managed care politics have been more complicated in the remaining states in our sample, which operate in less favorable market and political circumstances. Physicians are more dominant in health care politics, and opposition from these groups, as well as limited private market development and rates that are constrained by federal requirements at a fairly low level, has made it difficult to establish full-risk managed care on a large scale. Legislatures are typically more powerful than in other states and exercise more control over programmatic details. Establishing supportive relationships with legislatures is problematic for managed care agencies. Many state legislatures are part-time, have high turnover, and few professional staff or other resources, making it difficult for legislators to stay informed about the complex particulars of managed care. Becoming a managed care or a Medicaid expert has little political value for the average state legislator in his or her home district. Under these circumstances, agency managers are likely to find it difficult to convince legislators of the need for resources.

A more general finding of interest is the limited attention paid by most Medicaid agencies to date to cultivating and developing a political constituency analogous to teachers or labor unions. In spite of the frequent hostility to Medicaid – or perhaps because of it – state Medicaid agencies appear to have made few efforts to “sell” their programs to legislators. Medicaid agencies consult widely with providers, plans, and advocates in the design and implementation of managed care, but have been less than successful to date in developing these potential allies into political supporters. Of the states studied here, only Arizona has made any sustained effort to cultivate legislative support for its efforts. The Medicaid agency relies on legislative leadership to designate a “Gang of Four” – a Republican and a Democrat from each house – to be the main legislative experts on Medicaid. Agency management stays in contact with these members and briefs them on program operations and legislative needs. The agency actively works with interest groups – particularly providers and plans – to develop a united front around legislative issues. Ohio has established a network of county level advisory committees that function in part as interest groups by meeting with state legislators to talk about the implementation of managed care. Apart from these two examples, there is almost no attempt to publicize managed care's successes or to inform legislators or the public of trends in the program's performance.

These findings suggest the continued need for state Medicaid agencies to develop constituencies for their managed care programs that can defend these programs in the political arena. While many state agencies appear to have secured at least nominal support from governors and all have made efforts to consult broadly with interested parties in the design and operation of their managed care programs, almost none have made sustained attempts to develop a legislative or overtly political constituency for their efforts. Arizona's strategy of identifying and cultivating

individual legislators, perhaps those with major concentrations of Medicaid clients or large providers in their districts, or Ohio's embryonic advocacy groups, might serve as useful models.

Conclusion: Is Medicaid Managed Care Manageable?

These findings indicate that states are capable of managing full-risk managed care for Medicaid populations, but only in a limited range of political and market circumstances. Compared to traditional fee-for-service Medicaid, managed care has a high "degree of difficulty" — it requires states to acquire a variety of complex organizational skills and competencies and function in political and market environments more constrained than those faced by private purchasers. Most private purchasers of managed care control the coverage they offer, the rates they pay, and the reporting requirements they impose on plans, and can alter these factors in response to market conditions. State managed care agencies have only limited control over these factors, and lack the flexibility to adapt rates and reporting requirements to changing market environments. Managed care also is frequently unpopular with powerful interest groups, and elected officials may be unwilling to support managed care agencies or provide adequate resources. Under these circumstances, it is perhaps not surprising that many states have had difficulty managing managed care effectively.

These findings also suggest that recent changes in both managed care markets, federal regulations, and state budgets may make it difficult for more states to operate managed care programs effectively. Recent increases in health care prices may raise private premiums dramatically, and sharp deteriorations in budget conditions in many states may make it difficult for Medicaid programs to follow market rates effectively. In similar fashion, the final implementation of regulations stemming from the Balanced Budget Act of 1997 may increase the cost to plans of participating in Medicaid. As currently composed, these regulations impose significant additional reporting burdens on plans. This downward trend in revenue and increase in the administrative cost of serving Medicaid clients may cause more plans in many states to withdraw from Medicaid.

This likely deterioration in market position suggests that many states may be faced with the need to develop alternative arrangements to full-risk managed care for which the management and political requirements are less severe. Primary care case management, which was initially seen as a transitional arrangement between fee-for-service and full-risk managed care, may become more popular in many states.

Appendix

Field Researchers

Arizona– John S. Hall, Arizona State University

Colorado- Malcolm Goggin, Michigan State University

Florida– Robert Crew, Florida State University

Georgia– Michael Rich, Emory University

Kansas– Jocelyn Johnston, University of Kansas

Michigan– Carol Weissert, Michigan State University

New Jersey– Richard Roper, The Roper Group

North Carolina– William Brandon and Hunter Bacot, University of North Carolina-Charlotte

Ohio–Robert J. Casswell, Ohio State University

West Virginia– Christopher Plein, West Virginia University