

Case Studies in Medicaid Managed-Care

**“MANAGING” MEDICAID
MANAGED-CARE:
A TEN-STATE COMPARISON**



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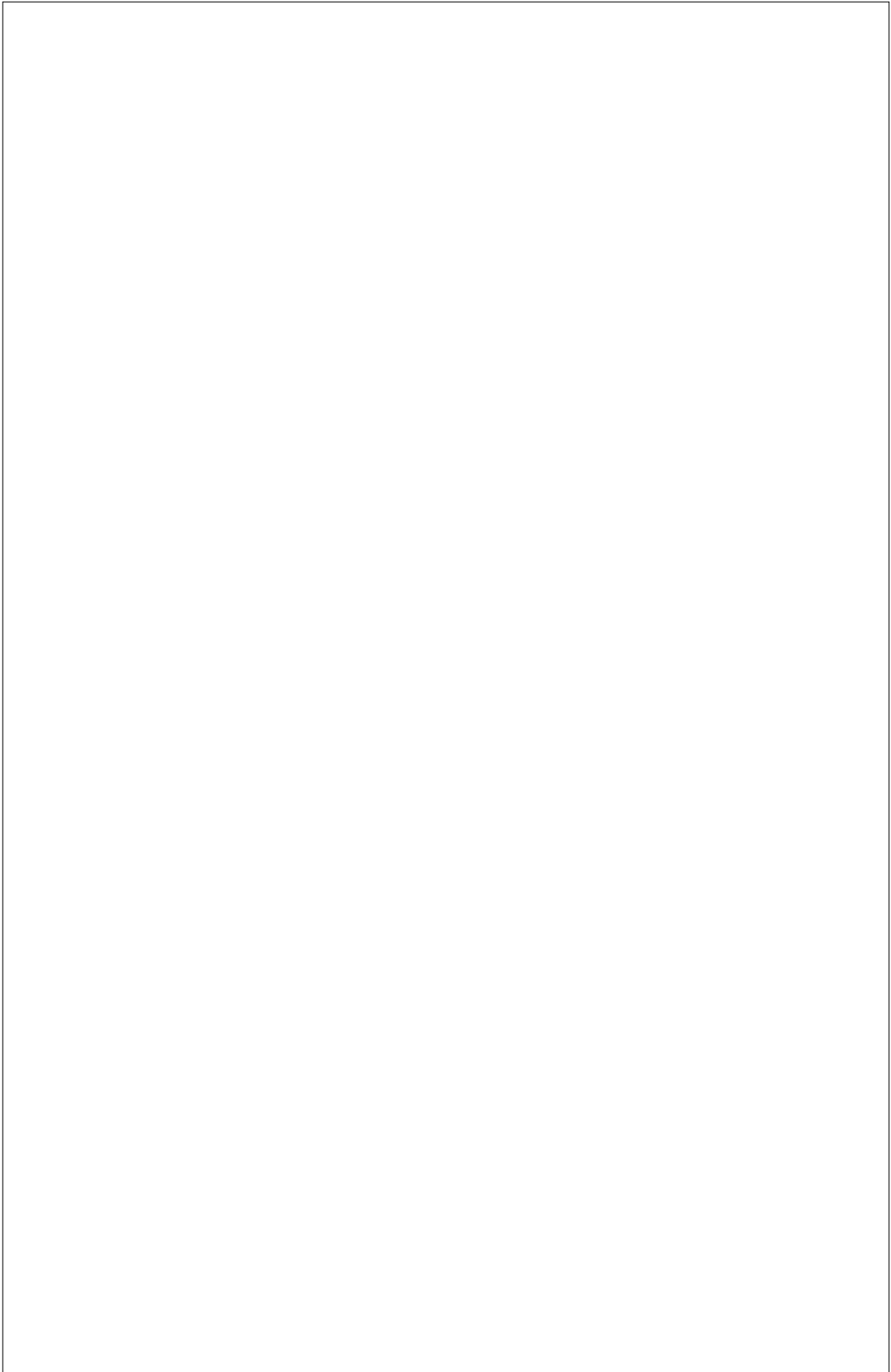
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In Brief

- ❖ The ten states in this study demonstrate varying degrees of success in managing Medicaid managed-care. The most successful management systems possess the capacity to effectively evaluate and improve health-care services by holding providers accountable for their performance.
- ❖ Three of the ten states — Arizona, Florida, and Michigan — exhibit effective management systems. Yet only one state — Arizona — meets the standards required for prudent state purchasing of Medicaid managed-care: rigorous analysis of managed-care provider performance *and* the political and managerial will to hold providers accountable by imposing penalties or sanctions for inadequate performance as needed.
- ❖ Management success is often determined by contextual factors beyond the control of administrators, including the extent of political support for adequate provider reimbursement rates and managed-care administration, and the degree of competition in the managed-care market.
- ❖ In states with the strongest political support for Medicaid managed-care and the most competitive health-care markets, managers are free to focus on program oversight and improvement. In states with the less political support and less competitive health-care markets, management resources are often diverted to crises and retention of managed-care providers.
- ❖ Medicaid management systems in effectively managed states have undergone fundamental reorganizations or reforms; all are located in health agencies separate from traditional welfare departments. These newly created or relocated organizations tend to benefit from high lev-

els of political support and an organizational culture that has facilitated the shift to managing Medicaid managed-care.

- ❖ In most other states, the shift to managed-care has been more incremental. Training is often minimal, and staffs tend to have Medicaid program experience, but little training in managed-care or contract management.
- ❖ “Downsizing” of state government is a frequent motive for these reorganizations and reforms. Several states contract out substantial portions of program oversight. Contract management skills are particularly important in these states. Two of the three most effectively managed states — Arizona and Florida — rely primarily on in-house oversight staff.
- ❖ The resources allocated to managing Medicaid managed-care vary substantially across the states. Low public-sector salary levels make it difficult for most states to attract and retain staff with the contract management and analytic skills essential to effective managed-care oversight.
- ❖ In states with low provider reimbursement rates, a significant portion of management resources is allocated to recruiting and maintaining sufficient numbers of participating providers; as result, Medicaid managers have fewer resources for evaluating performance and holding providers accountable for their performance.
- ❖ Some states operate both models of managed-care — full-risk (pre-paid HMOs), and primary care case management, or PCCM (through modest health management fees paid to independent primary care physicians). These states may require more resources to staff both program types, but managers have the flexibility to fashion solutions for needs that may differ

throughout the state – especially between urban and rural areas.

- ❖ Management systems in all ten states demonstrate a strong commitment to health-care quality, as demonstrated by the share of managerial resources allocated to quality oversight and the creation of organizational units dedicated to improving quality.
- ❖ Most states rely on centralized oversight systems, while a few — including Florida and North Carolina — operate relatively decentralized monitoring systems, typically through county governments or regional offices.
- ❖ Public-sector managers use both formal and informal information to monitor these programs; this is especially true in states that have had difficulty obtaining HMO performance data (often referred to as encounter data).
- ❖ Medicaid managed-care programs in these ten states rest on a fragile foundation. As states cope simultaneously with reduced state revenues, financial risks to HMOs experiencing growing health-care costs, and increasing Medicaid enrollments due to declining employment, management systems will require additional investment to sustain current oversight efforts.

Executive Summary

This report shares findings from a ten-state study of Medicaid managed-care, with a focus on state management systems and the organizations responsible for administering Medicaid. The transition from fee-for-service Medicaid to managed-care poses major new challenges to state administrators. Fee-for-service programs specialize in determining eligibility and paying claims. In contrast, effective managed-care managers must develop health-care standards, measure provider compliance with those standards, and hold providers accountable for their performance. This research, conducted in the summer of 1999, provides insights into how and why states have shaped their current management systems to adjust to this transition.

The Medicaid organizations in these ten states represent varying degrees of management “success.” But management does not operate in a vacuum. Managers in the most successful states benefit from strong political support and competitive managed-care markets. In these states, substantial investments in management systems have been made, political leaders have pushed major reorganizations to house Medicaid management systems in health agencies separate from welfare departments, reimbursement rates are high enough to sustain provider interest in state Medicaid contracts, and there are well-functioning managed-care markets. These conditions free managers to concentrate on program oversight and improvement.

This study suggests that only three of the ten states — Arizona, Florida and Michigan — have built the organizational capacity necessary to effectively manage the shift to Medicaid managed-care. And only Arizona has met the standards of “prudent purchasing” essential to a successful managed-care program — the capacity to rigorously analyze managed-care provider performance *and* the political and managerial will to hold providers accountable by imposing penalties for inadequate performance (Fossett et al. 2000).

In states with less political support and more reluctance on the part of HMOs and providers to serve Medicaid clients, managers typically find it difficult to hold providers accountable, and they must frequently devote resources to appeasing them. The retention of full-risk and Primary Care Case Management (PCCM) programs may act as a “safety valve” by allowing managers the flexibility to address needs that vary, especially between urban and rural areas.

Because the transition to Medicaid managed-care is typically driven by cost-containment and budgetary pressures, allocating resources for new, well-trained staff is often not a priority. This means that management staffs in some states have extensive Medicaid experience, but relatively little training in the skills necessary to oversee managed-care, manage contracts, or analyze managed-care performance. But regardless of the managerial context, most states in this study allocate a substantial share of management resources to the oversight of health-care quality, typically through centralized monitoring systems. In some states, this is accomplished with in-house expertise, but several states contract out significant portions of these oversight functions. In all states, and especially those with less managerial capacity, informal “through the grapevine” information serves as a critical supplement to formal provider performance reports.

Conditions in these ten states indicate that Medicaid managed-care rests on a fragile foundation. As states cope simultaneously with current state revenue shortfalls, financial threats to HMOs experiencing growing health-care costs, and increasing Medicaid enrollments due to declining employment, management systems will require additional investment to sustain effective managed-care oversight.

Introduction

Medicaid programs for poor women and children have undergone dramatic changes in the last fifteen years as states turn increasingly to the concept of managed-care. State policymakers view Medicaid managed-care as a crucial reform that offers the potential to contain costs while delivering high-quality health-care services. The shift from fee-for-service to managed health care has imposed major new demands on state Medicaid management organizations. In effect, state managers have had to transition from the relatively simple eligibility determination and claims payment demands of fee-for-service programs to full-blown managed-care management systems designed to improve individual client care, encourage preventive health care, construct effective client and provider financial and behavioral incentives, and continually evaluate provider performance — all while reducing cost growth.

Medicaid managed-care consists of two major designs. One design, sometimes referred to as full-risk managed-care, uses contracts for pre-paid health-care services, usually delivered by HMOs.¹ Full-risk contracts require HMOs to provide all stipulated health-care services for a fixed per-client per-month fee known as a capitation payment.² A second widely used design, known as a primary care case management (PCCM) program, involves the payment of modest monthly per-client fees to primary care physicians who “manage” the client’s health care.³ PCCM program management is more complicated than fee-for-service management — for example, under PCCM, managers must build and maintain provider networks — but these adjustments are less complex than those required for full-risk managed-care.

In either case, the state uses contracts to purchase health care. “Prudent purchasing” is therefore critical to successful Medicaid managed-care programs (Fossett et al. 2000). To meet the standards of prudent purchasing, states must develop realistic

health-care standards, measure provider compliance with those standards, and hold providers accountable when their performance is deficient. Prudent purchasing requires both adequate management capacity *and* favorable political and managed-care market conditions — political support that provides adequate management resources and a market with sufficient provider competition for state Medicaid managed-care contracts. Even the best-designed management systems cannot effectively administer managed-care programs in poor political or market environments.⁴

The ten states in this study have all made the shift to managed-care, with varying degrees of success.⁵ Their experiences provide insights into how and why states have adjusted their Medicaid management systems to meet the demands of managed-care. Three of the states — Arizona, Michigan and Florida — have created the organizational capacity to effectively manage Medicaid managed-care. These three states all demonstrate the capacity to evaluate their managed-care programs and make needed improvements. But they also benefit from competitive managed-care markets and strong political support for managed-care administration. Compared to the other states in this study, conditions in these three states facilitate confident and assertive management styles, with managers well positioned to negotiate with providers over performance issues.

Yet only one state — Arizona — truly meets the standards of prudent purchasing. Arizona is the sole state with both the capacity to rigorously analyze managed-care provider performance *and* the political and managerial will to hold providers accountable by imposing penalties for inadequate performance. Arizona managers are able to comprehensively evaluate the quality of managed-care health-care services, as well as patient access and service use. But importantly, they have the capability to correct deficiencies and fine-tune the program as needed by pushing providers to make required adjustments.

Although managers in the other nine states also impose penalties for deficient provider performance, they are far more

deferential to providers, and they tend to use penalties and sanctions irregularly and only as a last resort. For example, Michigan's managers demonstrate two styles. In the southern part of the state, where provider competition is strong, Medicaid managers are more aggressive with the plans. But in the rest of the state, where populations are more sparsely distributed and providers are less interested in serving Medicaid patients, management styles more closely resemble those found in North Carolina, Georgia, Kansas, and other states with similar market constraints. Florida falls somewhere in between; management is more assertive than in most other states in this study, but less assertive than in Arizona or southern Michigan.⁶

Colorado's experience illustrates the importance of the political and market contexts for Medicaid management. Colorado incorporates many of the elements necessary for effective management — good political support and adequate management resources to support qualified staff — but complications in the state's managed-care market diminish its capacity to evaluate and improve its program. Recent developments in the state's HMO environment — developments beyond the state's control, including premium increases driven by the commercial insurance market and HMO scarcity in rural areas — require managers to devote time and energy to soliciting and retaining providers, as opposed to evaluating and enhancing health-care services.

In some states, including Ohio and Kansas, state reimbursement levels tied to historically low fee-for-service rates continue to restrict program managers from holding managed-care providers accountable for their performance. Low reimbursement rates suppress HMO participation and several HMOs have terminated their Medicaid managed-care contracts. Even in states with more generous reimbursement rates, program managers must often devote time and other resources to convincing providers to remain in the market, sometimes because of anti-managed-care sentiments or reluctance to serve Medicaid clients. These dynamics divert management resources from performance oversight and improvement,

and make managers reluctant to invoke sanctions and other penalties, even in the face of clearly deficient performance.

State investments in Medicaid managed-care programs typically occur because of budgetary pressures and the desire to contain health-care costs (Fossett, 1998). As a result, the resources allocated to program administration may be insufficient. Contract management, essential to managed-care administration, requires significant investment in training because most public sector managers do not possess the skills or experience to oversee contractor performance (Sclar 2000; Johnston and Romzek 2000; Romzek and Johnston 1999; Kettl 1993).⁷ Low salaries mean that states often cannot attract staff with the management and analytic skills essential to effective program oversight. Among these ten states, only Arizona, Florida, Michigan and — to a lesser extent — Colorado, have succeeded in hiring and training the staff needed to fulfill the new demands of Medicaid managed-care; most others continue to rely on employees with extensive experience in Medicaid or other state departments but with little training in managed-care or contract management.

The experiences of these ten states yield several common themes. First, the Medicaid agencies in some states — including Arizona, Colorado, Florida, Georgia, and Michigan — benefit from reorganizations designed to move them into health agencies and away from the political and resource constraints associated with welfare agencies. Second, program designs have important consequences for management systems. If states restrict their programs to mandatory full-risk managed-care, they eliminate the need for oversight of PCCM programs. On the other hand, states that operate both full-risk and PCCM programs have more flexibility to serve geographically and demographically diverse Medicaid populations, especially in poor managed-care market environments. Third, many states have explicitly structured their management systems to “downsize” public agencies, often by contracting out substantial portions of program oversight. For these states, contract management skills are especially important, although all

states with full-risk programs require contract management skills to oversee HMO contracts.

These states vary more with regard to market conditions and political support — including reorganizations and the allocation of resources for management and provider reimbursement — than in terms of their organization of management systems. Most of the states operate highly centralized oversight and management systems, while a few depend on regional or county office staff to perform these functions. And despite a variety of managerial challenges, all ten states devote high proportions of management resources to analyzing and improving the quality of health-care offered through Medicaid managed-care programs. In fact, several of the states have created separate organizational units dedicated to managing health-care quality. Oversight in other program areas — including client access and satisfaction, and financial performance — is less formal and appears to attract lower levels of managerial attention.⁸

The common management themes — concentration of resources on oversight of health-care quality through centralized oversight systems — indicate that most administrators know what they need to do to manage, evaluate, and improve managed-care, but may not be able to do so because of factors beyond their control. For managers of Medicaid managed-care programs, these findings are somewhat discouraging. Despite their best efforts, the effectiveness of managed-care is often determined by political and market contextual factors.

Nonetheless, managed-care administrators are often able to rise above contextual constraints, often by working collaboratively with providers and by using both formal and informal information to assess performance and fashion modest adjustments to improve client services. These strategies may not meet the standards of prudent purchasing. But in view of the difficult environments in which many of these managers work, such strategies may be the best means available for enhancing Medicaid health-care services.

The Role of Program Design

The design of each state's Medicaid managed-care program — including the type of managed-care, whether enrollment is voluntary or mandatory, and the strategies used to establish contracts with providers — helps determine the demands on management systems and their effectiveness. States that maintain only one form of managed-care can concentrate their management resources on one program type and can standardize managed-care oversight. But in states with both types of managed-care — full-risk and PCCM — managers have greater flexibility to tailor programs to meet differing needs within the state.

As Table 1 indicates, five of the ten states rely on only one form of managed-care, while the others operate some combination of full-risk and PCCM care. Arizona, Michigan, New Jersey and Ohio restrict managed-care to the full-risk type, and Georgia relies solely on a PCCM program.⁹ Ohio, which has never had a PCCM program, has full-risk coverage in sixteen of its eighty-eight counties, and relies on fee-for-service care in the rest of the state. Colorado, Florida, Kansas, North Carolina, and West Virginia operate a combination of full-risk and PCCM managed-care and thus must maintain management infrastructures for two very different types of programs.

Six of North Carolina's counties offer voluntary HMO services, but enrollments are low and those counties continue to be dominated by PCCM. North Carolina mandates full-risk care in only one of its one hundred counties — Mecklenburg, which contains Charlotte. In the late 1990s, West Virginia moved to phase out its PCCM program in anticipation of statewide mandatory full-risk care.

Although management oversight may be more complicated in states with two types of programs, retaining a PCCM program may be worthwhile. For example, the recent withdrawal of West Virginia's largest participating HMO has crippled its full-risk program, and Medicaid managers are now trying to quickly rebuild

| Table 1. Elected Medicaid Program Design Features | | | | | |
|--|---------------------|---|---------------------------------------|-----------|---------------------------------------|
| | <i>AZ</i> | <i>CO</i> | <i>FL</i> | <i>GA</i> | <i>KS</i> |
| Full-Risk¹ | x | x | x | | x |
| PCCM | | x | x | x | x |
| Enrollment Strategies | Mandatory Full-Risk | Mandatory with Full-Risk/PCCM Choice ³ | Mandatory, with Full-Risk/PCCM Choice | Mandatory | Mandatory, with Full-Risk/PCCM Choice |
| Competitive Bidding | x | | | | |
| Agency Location | Health ² | Health | Health | Health | Welfare |

| Table 1. Elected Medicaid Program Design Features (Continued) | | | | | |
|--|---------------------|--|---------------------|--|--|
| | <i>MI</i> | <i>NC</i> | <i>NJ</i> | <i>OH</i> | <i>WV</i> |
| Full-Risk¹ | x | x | x | x | x |
| PCCM | | x | | | x |
| Enrollment Strategies | Mandatory Full-Risk | Mandatory, with Full-Risk/PCCM Choice in Six Counties ⁴ | Mandatory Full-Risk | Mandatory, but Only in Full-Risk Counties ⁵ | Mandatory, but Only in Two Full-Risk Counties; PCCM Is Voluntary |
| Competitive Bidding | x | | | | |
| Agency Location | Health | Welfare | Welfare | Welfare | Welfare |

1 Georgia terminated all full-risk HMO contracts by the end of 1999.

2 Arizona's Medicaid agency is "free-standing," administers only Medicaid, and was never located in a welfare department.

3 Eligible Medicaid recipients (TANF-related) are required to enroll in a managed-care program, but they may choose between a full-risk and a PCCM program.

4 PCCM enrollments are mandatory in North Carolina. Full-risk enrollment is mandatory in Mecklenburg County. In six other counties, managed-care is mandatory, but enrollees may choose between PCCM and full-risk.

5 Sixteen of Ohio's eighty-eight counties offer full-risk care. In seven of those counties, full-risk enrollment for all eligible Medicaid recipients (TANF-related) is mandatory; in the remaining nine counties, full-risk enrollment is optional. There is no PCCM program, so all other recipients receive fee-for-service Medicaid.

the PCCM program. In Ohio, on the other hand, recent HMO losses have sent many Medicaid recipients back to the fee-for-service system, as the state has no alternative to the full-risk program.

Retaining both program types allows states to address stark differences between rural and urban needs. In 2000, Colorado's legislature acknowledged that "full-risk managed-care organizations were unable to adequately serve Medicaid clients who live in rural parts of the state," but lawmakers continue to maintain a full-risk enrollment goal of 75 percent of eligible Medicaid participants (Goggin 2000, p. 3). This directive puts strong pressure on Medicaid managers, many of whom feel that the goal may be unattainable. Similarly, in Kansas, the legislature wants to see full-risk care in as much of the state as possible. However, the combination of low reimbursement rates and low population densities in rural Kansas has created serious barriers to this objective. Michigan has adopted a more realistic policy, relaxing HMO eligibility requirements in rural sections of the state by shifting less risk to the HMOs and extending their deadlines for complying with state license standards. However, it remains to be seen whether rural Michigan providers will be able to meet these standards.

Florida and Colorado give managers the most flexibility for tailoring managed-care options to varying conditions within the state. Among these ten states, Florida has made the strongest commitment to both types of managed-care, and to the staffing required to oversee both PCCM and full-risk programs.

These differences in program design lead to variations in the effectiveness of Medicaid managed-care oversight and management. In Georgia and other PCCM dominated states, provider reimbursement claims give managers ready access to information they can use to evaluate and enhance health-care quality, and client access to and use of services. However, in a dedicated full-risk state such as New Jersey, the state's oversight focuses on reviewing HMO encounter data to assess quality and service use. In many states, encounter data has frequently been late, incomplete, or inaccurate (Landon et al. 1998). North Carolina, which relies heavily on its strong county structure (counties pay 5 percent of the

non-federal share of Medicaid costs), offers three different varieties of PCCM, complicating oversight and management.¹⁰ And the state must retain some full-risk expertise to oversee Mecklenburg County's program.

States also differ in the strategies they use to enroll Medicaid clients in managed-care programs. All designated Medicaid recipients in Arizona, Michigan, and New Jersey must enroll in a full-risk plan.¹¹ In Colorado and Kansas, recipients can choose between PCCM and HMOs in counties with both types of programs, but PCCM enrollment is mandatory in counties without HMO coverage. Many states use formulas to automatically assign (or "auto-assign") clients to various managed-care options, and the formulas vary based on state priorities. In Colorado, the system is skewed to bolster HMO enrollments, while in Florida a rotation system requires that "assignments shall be divided equally between" the HMOs and the PCCM program (Crew 2000, p. 18). Michigan's complex auto-assignment system uses an algorithm designed to direct clients to HMOs "that perform above average for important health status indicators" and that excel in performance reporting. The formula incorporates detailed performance factors such as "well-child visits, cervical cancer screening, and immunizations," as well as the "timeliness and completeness" of quarterly and annual reports (Weissert 2000, p. 40). Michigan recalculates its system each quarter.

Finally, management requirements are somewhat unique in Michigan and Arizona, where competitive bidding is used to award HMO managed-care contracts. In the remaining states, all of which use some variation of the "any willing provider" approach, a bid management infrastructure is not necessary.

These distinctly crafted program designs affect the demands on managers, and they require different resource commitments. Ultimately, issues of design influence states' ability to oversee and improve Medicaid managed-care programs and meet the standards of prudent purchasing. But other factors — including politically driven reforms, contracting decisions, the levels and uses of management resources, and the organization of management

systems — also play an important role in shaping the capacity of states to effectively manage Medicaid managed-care.

The Foundations of Medicaid Management Systems

Reorganizations and reforms, usually driven by political forces, have had an important impact on management infrastructures and capacities of states' Medicaid systems. Some states have pursued substantial government reforms intended to re-create Medicaid agencies while others have modified existing organizations only incrementally. Arizona — which created an entire new management system for its unique Medicaid program — best represents the “substantial” end of the continuum. Florida, Michigan, and Colorado also adopted fairly rigorous reforms designed to improve the management and performance of Medicaid managed-care. At the other end of the spectrum Kansas, North Carolina, Ohio, and West Virginia made relatively minor changes to existing Medicaid agencies; these states geared up for managed-care simply by reallocating staff or creating a new managed-care sub-unit within the traditional Medicaid agency.

Reforms and reorganizations often reflect the strength of policymakers' commitment to managed-care for Medicaid clients. The location of the Medicaid agency — an important feature of these reforms — provides important clues about the potential for adequate management resources, effective program management and managed-care performance.

Reforms and Reorganizations

In 1982, long after other states had adopted Medicaid programs, Arizona created its own version of Medicaid known as the Arizona Health-Care Cost Containment System (AHCCCS). AHCCCS has always required Medicaid clients to enroll in full-risk managed health-care plans. Although the state originally transferred all management functions to a private organization, after eighteen

months management was delegated to a newly created free-standing agency exempt from some civil service constraints and with “a separate moniker and an organizational mission (overseeing private sector contracts) different from other agencies” (Hall 2000, p. 26).

None of the other states in this study undertook such major reforms upon adopting managed-care. However, Florida embraced a series of rigorous government reforms in the 1990s aimed partly at improving the state’s growing health-care problems. Key among those reforms was the creation of the Agency for Health-Care Administration (AHCA), an agency that reflected then-governor Lawton Chiles’ designation of health care as a priority.

In 1996, Michigan’s Governor John Engler issued an executive order creating the Department of Community Health (DCH), which consolidated all public health, mental health, and Medicaid functions. The primary impetus for Engler’s reform was to “enable the state to become a more effective purchaser of health-care services” (Weissert 2000, p. 18). This reform was buttressed by civil service reforms that enhanced staffing and organizational flexibility. In Colorado, the General Assembly authorized a new Department of Health-Care Policy and Financing (HCPF) in 1994 with an intent to make this agency “the insurance company for the State of Colorado” (Goggin 2000, p. 41).

Reforms in Florida and Michigan were driven by enterprising governors, while Colorado’s more modest reforms reflected the legislature’s need to live within new tax and spending limits. (A voter initiative known as the Taxpayers’ Bill of Rights, or TABOR, amended Colorado’s constitution in 1992 by limiting annual growth in state tax revenue to population growth plus inflation.)

Like most of the rest of the states in this study, Kansas, New Jersey, and Ohio prepared incrementally for the shift to managed-care. The most common approach was to create a new unit or sub-unit within the existing Medicaid management infrastructure. Ohio formed a new bureau within its pre-existing Medicaid

agency over ten years ago, and has done little to reform its management system since. However, the state recently moved to merge its social service and labor departments, which will bury the Medicaid agency even further within a larger organization.¹²

West Virginia was the least willing to adjust its existing state management infrastructure. Although its PCCM program required some staffing to supplement the fee-for-service system, the full-risk staff consists of one bureau director and a secretary (five positions are vacant). The state contracts out nearly all management functions to consulting firms.

The Significance of Agency Location

The three states judged to be the most effective managers of Medicaid managed-care house their management infrastructures in health-oriented agencies rather than social service departments. Location appears to serve as an important symbol of political and resource support for Medicaid management.

However, the experiences in states in this study suggest that although autonomy from a social service department may be necessary to purchase and manage Medicaid managed-care successfully, autonomy is certainly not a sufficient condition. For example, Medicaid agencies in Colorado and Georgia are not located in social service departments, but their purchasing capacity is constrained by other forces such as insufficient provider competition or weak political support. Still, it is probably no accident that the remaining states, which all experience difficulty in Medicaid managed-care purchasing and management, retain their agencies within social service departments.

The importance of location arises from legislative and gubernatorial perceptions of social service organizations as unnecessarily large, unresponsive, and excessively bureaucratic. The experiences of the three “successful” states suggest that if and when state policymakers fully commit to investing in Medicaid managed-care, they may do so by removing management infrastructures from the political and resource constraints of social

service departments. Health-related departments are likely to face more hospitable political conditions than those managing “welfare” functions such as cash assistance and other poverty-related programs.

Michigan’s motivation illustrates this dynamic. A leading objective of the 1996 Michigan reorganization, which moved Medicaid from the social service department to the Department of Community Health, “was to change the corporate culture of the Medicaid agency — from an organization that was perceived by many as ‘the Bank of Medicaid,’” to one that could function as a “transaction processor” and “an informed purchaser of health services” (Weissert 2000, p. 19). In Florida, the social service department was viewed as unable to “drive policy changes through the legislature and to implementation” (Crew 2000, p. 5), so Medicaid was moved out in 1992. Similar concerns drove Colorado’s 1994 reorganization (Goggin 2000). And AHCCCS is physically located in a new building unattached to the capitol, and “seems to citizens to operate on a plane separate from other state government agencies” (Hall 2000, p. 26).

These states used these reforms to revitalize and redirect Medicaid management, to alter organizational culture, and to jump-start the changes needed to transition from fee-for-service management to Medicaid managed-care.

The Impact of Agency Contracts on Management Systems

States vary substantially in their reliance on contracts for management and oversight. Some contracts are federally required, such as external independent evaluations typically outsourced to area universities or consulting firms, and contracts with external quality-review organizations (EQROs). States also typically contract out PCCM fee-for-service reimbursements to “fiscal agents.”¹³

One common motivation for contracting is “downsizing.” Kansas, for example, has faced strong pressure to contract out as

many management functions as possible, partly because of a state-wide push for smaller government. Colorado, West Virginia, and Michigan also report downsizing pressure. Arizona's Medicaid agency was created amid calls to minimize the growth of government and expand the use of private organizations. Ironically, Arizona ultimately decided to scrap its "private" Medicaid management organization by creating a state organization to fill its place and to build and retain in-house expertise. The downsizing imperative therefore works differently in different environments.¹⁴

Table 2 provides an inventory of major state managed-care-related contracts, excluding those with full-risk HMOs.¹⁵ Arizona, Florida, and Ohio appear to be least reliant on contracts while Michigan, North Carolina, and Kansas depend heavily on outside agencies for program management and oversight. West Virginia relies almost entirely on outside agencies. Although two of the three most effectively managed states — Arizona and Florida — rely least on contracts, it is difficult to say whether this strategy enhances management. But these states are clearly committed to building in-house capacity, and this commitment may help explain their relatively effective management systems.

Most states use contracting for functions that are irregular (such as specialized health-care studies) or that require highly specialized technical skills (such as actuarial analysis). Many also use contracts for activities that rely on complex information systems (such as paying claims and managing encounter data). For example, Florida uses contracts to give the state "flexibility in completing irregularly required tasks, to bring credibility to the findings, and to provide expertise...not present in the agency" (Crew 2000, p. 8).

Nine of these ten states contract for the management of client enrollment and PCCM provider networks, as the large firms that specialize in enrollment management can do so more cheaply.¹⁶ But states have created a wider variety of arrangements to oversee areas such as health-care quality and use. West Virginia, which is near consulting firms with extensive program experience (many in the Washington, DC area), contracts out nearly all aspects of

| Table 2. Management and Oversight Contracts for Medicaid Managed-Care Programs | | | | | | | | | | |
|--|---------------|---|---------------------|---------------------|-------------------------------|--------------------------------|---|---|------|---|
| | AZ | | CO | | FL | | GA | | KS | |
| Contracting Emphasis? | Low | | Moderate | | Low | | Moderate | | High | |
| Contracts: | | | | | | | | | | |
| Enrollment | No | | Yes | Maximus \$1.8 M | Yes | Benova \$13 M ¹ | Yes | | Yes | BCBS (also the fiscal agent) \$13.2M ² |
| Actuarial | Yes | Mercer \$100-200, 000 | No | | No | | Yes | | Yes | Lewin \$12,000 ³ |
| Other | AZ State U | Satisfac- tion Surveys (expired) | Bid Con- sulting | Mercer \$131,000 | FL State U, Westat Inc. | Satisfac- tion Sur- veys | GA Medi- cal Care Founda- tion | Grievance hot-line, pre-author iz services | BCBS | Provider network manage- ment for PCCM |

| Table 2. Management and Oversight Contracts for Medicaid Managed-Care Programs (Continued) | | | | | | | | | | |
|---|-----------|--------------------|--------------|------------------------------|-----------|----------------------|--------------------------------|---|-------------------------------|--|
| | <i>AZ</i> | | <i>CO</i> | | <i>FL</i> | | <i>GA</i> | | <i>KS</i> | |
| | | | CAHPS survey | Health-care Research Systems | | | GA State University | Patient satisfaction surveys, Encounter data validation | Tucker-Allen \$75 M (expired) | Assistance with managed-care start-up. |
| | | | | | | | | | KFMC (EQRO) | Discretionary quality studies |
| Fiscal Agent | No | | Yes | Consultec \$10 M | | | Yes (includes auto-assignment) | EDS | Yes | BCBS (see above) |
| Required: | | | | | | | | | | |
| EQRO ⁴ | Yes | HSAG \$200-300,000 | Yes | FPRC | Yes | FMQA \$1.1 M | | | Yes | KFMC \$490,000 |
| Independent Evaluations | Yes | | | | Yes | FL State U \$100,000 | | | Yes | U of KS \$52,000 |

| Table 2. Management and Oversight Contracts for Medicaid Managed-Care Programs (Continued) | | | | | | | | | | |
|---|---|-------------------------------|-------------------------|--|--------------|-------------------------------|--|--|------------------------------|--|
| | <i>MI</i> | | <i>NC</i> | | <i>NJ</i> | | <i>OH</i> | | <i>WV</i> | |
| Contracting Emphasis? | High | | High | | Low | | Low | | High | |
| Contracts: | | | | | | | | | | |
| Enrollment | Yes | Maximus \$7 M | Yes | PCG (Mecklen- burg only) | Yes | Maximus | Yes | Auto- mated Health Systems \$1.4 M | Yes | Auto- mated Health Systems \$800,000 |
| Actuarial | No | | Yes | Coopers & Lybrand | Yes | | Yes | Mercer \$300,000 | | |
| Other | Healthcare Research Affiliates \$291,353 | Audits of HEDIS data | EDS (see be- low) | Provider training, service pre- authoriz | PRO of NJ | Satisfac- tion Sur- vey | Benova \$2 M | Consumer hot-line | Lewin \$500,000 | Program design and over- sight |
| | MarketFac ts \$935,746 | Satisfac- tion Sur- vey | NCQA | HEDIS and CAHPS data pro- cessing | | | Macro In- terna- tional \$278,000 | Satisfac- tion Sur- vey | Delmarva (see be- low) | PAAS re- design |

Table 2. Management and Oversight Contracts for Medicaid Managed-Care Programs (Continued)

| | MI | | NC | | NJ | | OH | | WV | |
|--|--------------------|-------------------------------|--------|--|-----|--------------|-----|----------------|--------------------------------|-----------------------------|
| | Bull HN \$4.3 M | Man- aged-care Start-up | MRNC | In-patient pre-author iz; quality reviews | | | | | Pacifica Con- sulting | General consulting |
| | | | Codman | Utiliza- tion re- views | | | | | WV Med- ical Insti- tute | Service pre-author iz |
| Fiscal Agent | | | Yes | EDS \$24M | | | | | Yes | Consultec |
| Required: | | | | | | | | | | |
| EQRO | Yes | MPRO \$994,525 | | | Yes | PRO of NJ | Yes | PRS \$1.3 M | Yes | Delmarva \$400,000 |
| Independ- ent Evalua- tions | Yes | Keystone PRO \$600,000 | Yes | UNC Charlotte \$402,000 | | | | | Yes | Mike Madelena Inc |

* Emphasis based on author's evaluation of field research reports. Unless otherwise noted, blank cells indicate no available information.

FA refers to fiscal agent.

1 Benova provides "choice counseling" to potential enrollees, and counsels enrollees desiring to change providers. The state has a third-party contract for this service.

2 The \$13.2 M figure includes fee-for-service claims processing and several non-managed-care functions. However, BCBS also collects and analyzes encounter data.

3 The Lewin reimbursement was \$180,000 in the first year of the contract (1996) and \$12,000 annually in subsequent years.

4 External Quality Review Organization.

full-risk oversight, including day-to-day management. Ohio, in contrast, has explicitly minimized contracting because of a clear desire to build internal management capacity and because policymakers concluded that “the complexity of the Medicaid program is frequently not well understood by those outside the system.” Ohio also found contracts too costly and until very recently, like Arizona, retained in-house responsibility for enrollment functions.

For many states, reliance on contracts is consistent with the shift to prepaid managed-care — states see “privatization” and private markets as a means to improve program performance and budgetary discipline. Michigan and West Virginia had long histories of relying on private, more market-like organizations for a wide variety of health-related functions. Michigan’s Governor Engler encourages contracting as an explicit privatization strategy. Colorado’s legislative leaders viewed “privatization as ideal for the health-care policy domain and competition, as long it did not put anyone out of business” (Goggin 2000, p. 23). In Georgia, contracting allows Medicaid managers “to know exactly how much they are spending” for a service or function; in addition, “the amount of money spent is predetermined and can be budgeted.” In Kansas, one official noted that the legislature will usually allocate resources for contracted management functions but almost never for new in-house management staff. This dynamic reflects the belief that nongovernmental organizations manage more effectively.

How Management Resources Affect Medicaid Oversight

With the exception of Arizona, which devoted substantial financial resources to creating and implementing its management infrastructure, the states in this study allocated minimal new resources to Medicaid managed-care.¹⁷ Because Medicaid managed-care was typically adopted as a cost-containment strategy, states tended to invest as little as possible in program management.

¹⁸Most of these states authorized new full-time-equivalent (FTE)

staff for the transition to managed-care, but resource levels vary, primarily because of the systems in place before managed-care took effect. For example, compared to other states, high-salary states like Michigan exhibit relatively generous levels of resources despite little new investment in management.

Arizona and Florida have the largest staff to client ratios in this ten-state group. Together with Michigan, these states are best able to attract employees with the skills essential to effective program oversight. And perhaps most importantly, reimbursement rate levels in these three states have given managers the power they need to hold providers accountable and to induce the changes necessary for program improvement. In most of the other states, managers may be able to identify the steps needed to improve health-care services, but their relatively weak position vis-à-vis providers reduces their capacity to implement those improvements.

For the most part, staffing Medicaid management systems entails shifting employees from fee-for-service programs to managed-care. Although these employees have extensive program experience, they are typically unprepared for the demands of managing managed-care, and states have devoted few resources to training and upgrading staff and importing managed-care specialists with the analytic and contract oversight qualifications needed for effective management.

Half of the states in this study emphasize either the PCCM or full-risk approach and have attempted to eliminate the other, thereby streamlining their Medicaid management staffs. Florida is an exception; its dual program — and the attendant flexibility for Medicaid managers — reflects a commitment of the resources required to maintain strong management infrastructures for both types of managed-care.

Staff Size

The number of FTE employees assigned to Medicaid managed-care ranges from over 1000 in Arizona and Florida to fewer than 10 in West Virginia. Arizona maintains some 30 staff per

10,000 managed-care enrollees, while comparable ratios for Florida and Colorado are 14 per 10,000 and 7.5 per 10,000. All of the remaining states have fewer than 3 staff per 10,000 managed-care enrollees. (Because some FTEs are not fully dedicated to managed-care, these ratios are only estimates.¹⁹) West Virginia and Georgia have the lowest ratios, but the implications are very different in the two states because West Virginia has extensive contracted management support while Georgia performs a greater share of its management functions in-house.

Of the three states judged to be effective managers of managed-care, two — Arizona and Florida — enjoy comparatively large staffs. Arizona's large staff is particularly unusual because of its restriction to the full-risk design, which removes the need for PCCM oversight staff. In Florida and Colorado, on the other hand, which support both managed-care designs, the larger staffs reflect the need for a full contingent of both full-risk and PCCM oversight personnel.²⁰

Michigan, which falls into the low staff to enrollee ratio category (less than 3 FTE per 10,000 enrollees), is a harder case to explain, but three points are noteworthy. First, Michigan uses contractors for a large share of its program management and oversight, which reduces the need for in-house staff. Second, program oversight has been facilitated by a competitive environment in which HMOs are eager to tap into the large numbers of Medicaid clients in the southern urban areas; HMOs that serve this part of the state are motivated to perform up to the state's standards. Third, the governor and legislature have also strongly backed Michigan's managers, who "will not retreat in any sense" from controversy or complaints from the urban HMOs (Weissert 2000, p. 15). This allows managers to focus on core management functions and avoid some of the "firefighting" to retain plans that saps management resources in many other states.²¹

Staff resources in the remaining states are far less generous, and program management and oversight is less effective. This is especially true in those states — Georgia, Kansas, North Carolina, Ohio, and West Virginia — that face economic and political

barriers to successful managed-care such as low reimbursement rates, few willing providers, and executive and legislative leaders whose focus on cost savings comes at the expense of needed investment in management.

Staff Qualifications

Staffs in the most successful states possess the strong analytic skills deemed essential to effective program management. Both Michigan and Arizona have tried to fashion a management culture strong on efficiency and management expertise. Michigan's staff is widely respected, and its Medicaid agency was able to increase staff credentials by taking advantage of civil service reforms and an early retirement program to bring in new blood with more relevant skills. In Arizona and Florida, staff qualifications are rated as excellent, and both states emphasize financial training. Florida's core managed-care staff "come almost exclusively from financial professions: accountants, actuaries, etc." (Crew 2000, p. 9).

Most other states have relied at least partly on staff from other state departments such as budget, aging, and health policy, and from within the traditional Medicaid agency. Ohio, like most other states, tries to attract and keep trained clinicians — especially nurses — to lead quality management efforts. The staff is also trained in such areas as computer science and health service management. However, Ohio's staff is relatively weak in financial management and analytic skills.

Most state managers are not well prepared to manage contracts, yet these staffs oversee some of the largest of all government contracts. In Michigan, for example, constraints of the civil service system mean that "the state views these slots which oversee the \$1.5 billion program as it would contract managers for much smaller (much less important) programs" (Weissert 2000, p. 20).

The level of resources devoted to staff training is quite low for most states. In Kansas, training for managed-care consists primarily of attendance at conferences and new subscriptions to managed-care journals, along with periodic training sessions by staff

from the federal Health Care Financing Administration. In New Jersey, four years after the state implemented its managed-care program, managers still note that they must “shift the focus of existing staff into managed-care through retraining and reeducating” (Roper 2000, p. 15).

Staff Hiring and Retention

While most state managers recognize the need to strengthen the analytic capacity of their staffs, they typically cite inadequate resources as the primary reason for their failure to attract and retain highly skilled managed-care professionals. Nearly all states experience the “revolving door” phenomenon in which individuals move between state employment and managed-care plans. However, the door opens disproportionately to the private sector, where higher salaries prove attractive to state employees.

Civil service rules and compensation packages often discourage potential state recruits from the private sector. This is especially true in states with traditionally low civil service salaries such as Kansas and Georgia. Florida is an exception: state employees who leave government are prohibited from taking jobs with HMOs, and Florida benefits from the state’s role as a leading employer in a state capitol with a well-trained work force and relatively little competition from the private sector. In Michigan, New Jersey, and Ohio, where salaries are more competitive, turnover is not a major problem.

Arizona has a unique staffing challenge. AHCCCS attracts highly qualified staff, but sees substantial turnover, perhaps because the agency appears to serve as a “training ground or a transition post” for staff who “often move on for more lucrative positions in the private sector” (Hall 2000, p. 34). However, this dynamic probably increases innovation in the agency, and staff who do leave tend to be “strong supporters and vocal advocates of” AHCCCS in their new positions.

A mix of recruits from the private managed-care market and seasoned Medicaid staff may be ideal. Experienced program staff

offer familiarity with the Medicaid system, the actors, and critical sources of informal information. These Medicaid professionals are more likely to have connections with staff in regional and local offices, and local eyes and ears can often provide important information about client and provider trends and provider performance.

Reimbursement Rates and Management

States unwilling or unable to pay the prevailing market capitation rate to reimburse full-risk providers face serious barriers to successful Medicaid purchasing, management, and oversight. In states without adequate reimbursement rates, a great deal of management time is consumed by recruiting and maintaining sufficient numbers of participating providers; as result, Medicaid managers devote less energy to holding providers accountable for their performance. Managers in several states report that they are reluctant to impose penalties and other approved contractual sanctions for unsatisfactory performance. This dynamic exists even in states with relatively generous rates but is especially evident in Kansas, Ohio, and West Virginia, which have all lost substantial portions of their full-risk provider bases due in part to low rates.²²

In Arizona and Florida, rates are sufficient to attract providers and they want to keep their Medicaid contracts. Thus, rates in these states support effective managed-care oversight and offer greater potential for managers to hold providers accountable for performance. Florida managed-care providers find Medicaid rates more favorable than those for Medicare or commercial clients. Arizona, which has one of the highest HMO penetration rates in the country, offers very competitive rates, and oversight is further facilitated by plan satisfaction with the reimbursement process. Arizona providers note that “the timeliness of AHCCCS provider/plan payments is ... a cut above many of the commercial plans” (Hall 2000, p. 51).

In Colorado, rates have traditionally allowed both PCCM and full-risk providers to gain financially from their Medicaid contracts, at least in urban areas with higher enrollments. But the recent loss of two HMOs, combined with 25 percent HMO premium

increases in the last three years, have had an impact on Colorado's competitiveness as a purchaser of Medicaid managed-care. The state has emphasized full-risk managed-care, and hopes to move to competitive bidding, but market conditions, including low provider interest in rural areas, have not supported these objectives. As a result, Colorado Medicaid managers, like those in many states in this study, increasingly find that they must restrain some of their oversight authority and treat providers — especially HMOs — with “kid gloves” (Goggin 2000, p. 21).

Similarly, until very recently, Michigan's management infrastructure has enjoyed a competitive Medicaid managed-care provider environment, despite setting rates at deliberately low levels. In southern Michigan, HMOs were attracted by the lure of large numbers of Medicaid clients, and the state was able to hold rates to 80 percent of pre-existing fee-for-service rates. This strategy generated a one-time savings of \$120 million. However, recent urban HMO complaints about losses suggest that this situation may change. Officials at one urban plan claim that they lost “over \$40 million in their bid based on a patient base that did not materialize” (Weissert 2000, p. 25), and rate complaints and withdrawal threats could weaken the state's purchasing power. And in the remainder of the state, Medicaid officials, conscious of the difficulties of maintaining full-risk managed-care in rural areas, have been very conciliatory with providers.

Reasonable rates in Georgia and North Carolina have not enhanced managed-care administration, but that may be due to the fact that both are southern states located in a region inhospitable to capitated managed-care. Despite fairly successful HMO penetration in urban Georgia, HMOs are finding it increasingly difficult to operate in the state. Industry losses, combined with recent legislative requirements for expanded HMO liability and patient choice, are likely to weed out many HMOs in the commercial sector. And Georgia has effectively abandoned full-risk Medicaid managed-care owing to the withdrawal of all participating plans by late 1999. Conditions are similar in North Carolina, where only

Mecklenburg County has been able to sustain full-risk managed-care.

In Ohio, declining rates – which were low to begin with – have seriously reduced the state’s inventory of HMOs willing to serve Medicaid patients. The state’s purchasing power has diminished substantially, and oversight authority has suffered. In New Jersey, by contrast, three years of rate reductions have not curtailed the state’s purchasing power. The common declining rate factor in these two states is overwhelmed by the differences in provider competition and pre-existing fee-for-service payment levels, which heavily favor New Jersey and work against Ohio.

West Virginia and Kansas are also “stuck” with capitation rates tied to very low historic fee-for-service rates. The combination of low rates and fairly low HMO penetration rates seriously restrict program management, oversight authority, and purchasing power. Most HMOs are unwilling to serve West Virginia’s Medicaid population, despite an ambitious state plan to institute mandatory full-risk managed-care statewide, and the state is scrambling to reinvigorate its PCCM management system. For the past three years, Kansas has struggled to retain the only HMO serving Medicaid patients. For these states, management resources have been increasingly devoted to troubleshooting and scrambling to retain providers, as opposed to program oversight.

Staffing Full-Risk and PCCM Programs

States tend to focus more on financial analysis skills for full-risk management staff, and utilization-review skills for PCCM programs. Full-risk programs are more staff-intensive. For example, in 1998 Georgia assigned one-quarter of its managed-care staff to the full-risk program, but only 14 percent of its enrollees. This is somewhat inconsistent with the prevailing notion that full-risk HMOs have built-in quality and utilization management, thereby offering the potential for reduced staff oversight, while PCCM programs require state management of these functions.

For states operating both types of managed-care, only Florida purposely allocates management resources equally between full-risk and PCCM programs. Colorado, Kansas, and West Virginia have all devoted substantial shares of management resources to full-risk programs in hopes of eliminating PCCM or at least increasing full-risk enrollments. For West Virginia, this strategy has backfired, and the state is now dealing with an understaffed PCCM management team unprepared for the failure of the full-risk program.

How States Organize Medicaid Management Systems

Medicaid management systems represent structural adaptations to unique sets of circumstances, including managed-care program designs and political and policy environments. The states in this study vary not only in the location of their managed-care agency, but also in the way they distribute management resources across the quality, access, client satisfaction, and financial components of managed-care. The most effectively managed states have concentrated their resources on the oversight of health-care quality and provider financial performance, often with organizational designs that emphasize these two program components.

Common management themes across the ten states include relatively centralized oversight structures, and a combination of formal and informal monitoring strategies, especially regarding client access to and satisfaction with health care. Informal information is especially important to managers that have difficulty obtaining timely and accurate performance reports. In most states, financial oversight consists of reviews by departments of insurance — which typically regulate and license full-risk plans — supplemented by Medicaid staff analysis.

As noted earlier, several of these states lodge their Medicaid managed-care staffs within a traditional Medicaid agency, which is often one of several “bureaus” or “commissions” within a large

social service agency. Ohio provides a typical example of a Medicaid agency buried several levels deep within a state social service agency, despite its control over a budget of \$6 billion, one of the state's largest. This means that the Medicaid agency has limited formal power, although it relies on informal — and not always reliable — power to argue for resources. New Jersey, Kansas, and West Virginia exhibit similar patterns. Yet even agencies with more favorable organizational locations do not necessarily exercise greater power and control over resources. In 1999, Georgia's freestanding Medicaid department was subsumed into a newly consolidated department responsible for a wide variety of health-related functions.

Colorado and Ohio provide typical examples of the Medicaid managed-care organizational structures used in this group of states. Detailed descriptions of the organizational structures for these two states, including organizational charts, are provided in Appendix 1.

Oversight Structure

Nearly all these states operate with a centralized oversight structure, although a few — including Florida and North Carolina — maintain decentralized systems in which counties or other state sub-units are responsible for program management and performance oversight. Florida uses a combination approach. The centralized Division of Managed-Care and Health Quality oversees the full-risk program, which houses nine plan analysts charged with direct HMO oversight, assisted by five analysts who collect and analyze data on quality and access. The state's PCCM oversight, in contrast, occurs principally through regional offices, where coordinators serve as primary contacts for providers and clients and oversee health-care quality and client access and satisfaction.

In North Carolina, where counties have a strong incentive to control Medicaid costs because they must cost-share with the state, county staff serve as front-line program contacts for enrollees and

providers. Within the Department of Health and Human Services, the Division of Medical Assistance uses six “regional consultants” to train, supervise, and provide technical assistance and support to county managed-care representatives (MCRs). The MCRs are employees of their respective county social service organizations but their salaries are funded by the state. In two counties, including Mecklenburg (which operates the only mandatory full-risk program), the state contracts out many of the functions that the MCRs perform in all other counties.

Quality Management

The organizational structures in many of the states include separate units responsible for health-care quality oversight. Many are identified by name with “quality,” although the unit is sometimes integrated into a larger division with broader responsibilities. In fact, quality appears to be the most important program emphasis in most of these states. For example, in Michigan, “the commitment of the state to quality assurance” is demonstrated by the fact that within the Medicaid agency, “one of the three bureaus deals specifically with quality improvement; ... the symbolism of a bureau should not be understated” (Weissert 2000, p. 41). In Florida’s Agency for Health-Care Administration, the Division of Managed-Care and Health Quality, responsible for the full-risk program, is one of the two major managed-care sub-divisions; the other is the Division of Medicaid, which administers the PCCM program.

Quality is also prominent in Arizona’s management structure. Arizona maintains intensive in-house capacity, and a sub-unit of the Office of Managed-Care (one of seven divisions of the state’s Medicaid agency), oversees quality. Like many other states, Arizona’s quality oversight emphasizes preventive strategies such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and reductions in chronic diseases such as asthma and diabetes. Arizona’s quality managers review Health Plan Employer Data and Information Set (HEDIS) data, focusing on health-care outcomes to assess quality; they also examine

information on access and patient satisfaction. Teams, which include representatives from three of AHCCCS' seven divisions, conduct on-site quality reviews which are "collaborative, coordinated, and designed to promote an integrated approach that allows AHCCCS to maintain a comprehensive understanding" of health-care quality (Hall 2000, p. 63).

Most of the other states dedicate lower-level sub-units to quality management and oversight, and most depend on the expertise of clinically trained staff such as registered nurses. The intensity of oversight varies, based in part on whether any tasks are contracted out.

In several states, including Colorado, Kansas and Ohio, quality management is constrained by difficulties in collecting encounter data. Managers in these states are deeply committed to quality oversight, but demonstrate less capacity to collect and analyze the data required to draw firm conclusions about health-care quality, probably because of weak provider competition. For example, Kansas found it difficult to push reluctant HMOs to meet reporting requirements, and because encounter data reports were still not flowing smoothly after two years of full-risk care, managers had to depend increasingly on an External Quality Review Organization (EQRO) contract to produce quality studies.²³ Providers in full-risk programs are reimbursed on a per-patient basis and so have little incentive to submit data that details the services they deliver. In contrast, PCCM providers must submit detailed claims to generate reimbursements, so managing quality is more straightforward because patient data is readily available. PCCM quality managers tend to be clinically trained (often as registered nurses), and their oversight is supplemented to some extent by staff or contractors responsible for monitoring patient access, use of services, and satisfaction.

Like many other states, Kansas also uses informal information to keep abreast of quality performance (as well as access and patient satisfaction), in part by staying in touch with staff in regional offices who are most likely to hear client complaints. Managers also review problems during monthly meetings of the Health

Programs Advisory Committee, which includes providers, advocacy groups, clients, and staff from related state agencies.²⁴

Kansas is not alone in its reliance on external advisory committees. Florida convenes a similar panel to address quality and other types of grievances. In contrast, Michigan's clinical advisory committee meets only "two hours a week, four times a year," and the committee "lacks expertise in many details of Medicaid and the state has not provided education to its members" (Weissert 2000, p. 15).

Despite these variations, quality is clearly the most important component of Medicaid managed-care oversight in these ten states. In states with weaker oversight capacity, managers do their best to monitor and improve quality, often by combining formal evaluations with informal information. To the extent that managers can push providers, they are inclined to push hardest on quality issues.

Access and Utilization

In most of these states, the oversight of access and utilization does not warrant a separate bureau. For example, Michigan monitors access through its Customer Services Bureau, while Colorado does so through its Division of Managed-Care Contracting.

Some states manage and oversee patient access to health-care services in-house, often with staffs that are also responsible for provider enrollments; their familiarity with provider networks facilitates their scrutiny of patient access to providers through such measures as geographic proximity of providers and enrollees. Other states rely on contractors. Kansas incorporates both approaches, using a contractor to handle most formal provider enrollment functions (for both the full-risk and PCCM programs), and internal staff for maintaining and expanding PCCM provider networks and provider relations as needed. Ohio, Michigan and Florida rely on their contract managers for most network management functions, and North Carolina's individual county MCRs are responsible for access oversight.

Most HMO contracts establish provider-to-patient-ratio standards as one means of enhancing client access. However, compared with quality oversight, nearly all states monitor patient access and network capacity relatively informally, relying on “through the grapevine” information. Many administrators also conduct random phone calls to providers to verify access standards such as weekend coverage and the availability of timely appointments.

For full-risk programs, utilization oversight is typically closely associated with quality oversight and data analysis units, which review encounter reports. But for PCCM programs, several states rely on external evaluators to analyze utilization patterns, supplementing their own staff analyses. Utilization oversight merits greater attention from PCCM managers because there are no built-in HMO incentives to foster cost-effective service utilization.²⁵

Client Relations

Some states dedicate separate units to the oversight of client satisfaction, such as New Jersey’s Office of Beneficiary and Provider Network Support and Colorado’s Customer Service Section. But in contrast to quality oversight, most states do not highlight this function in their formal organizational structures.

All states in this study conducted regular client satisfaction surveys to supplement their information on health-care quality and access. Although managers prefer more systematic analyses of quality and access, these surveys allow them to address program weaknesses that they might not otherwise observe. This is true for both the full-risk and PCCM program models. Medicaid managers rely on both the HMOs themselves and external contractors to perform these surveys, which in-house managers then review.

Several states also create program advisory panels, which often include Medicaid clients who can provide their impressions of patient satisfaction. For example, in Ohio, each managed-care county maintains a Joint Advisory Council that “includes

consumer representatives who may bring concerns relating to overall satisfaction or enrollment issues” (Caswell 2000, p. 41). Similarly, Florida’s Statewide Provider and Subscriber Assistance Panel includes a client representative to convey patient views on quality, access, and other performance issues.

Informal information adds to the managers’ understanding of client satisfaction. Many of Ohio’s more experienced management staff “have their own informal networks of contacts that can supplement the formal reporting lines” on client satisfaction (Caswell 2000, p. 43). Kansas managers also rely consumer complaints, both formal and informal, as important sources of performance information. Other forms of client information such as enrollment and disenrollment patterns also permit managers to judge program and provider effectiveness.

Financial Performance

With the exception of Arizona (which has a top-notch in-house financial oversight staff), all state Medicaid managed-care administrators depend heavily on state insurance departments for full-risk financial oversight, supplemented by their own analyses. Michigan maintains an especially stringent financial oversight system, routing information from the insurance department to managed-care contract managers, whose familiarity with each plan facilitates their financial reviews. Similarly, Florida’s financial oversight staff are “exceptionally experienced” (Crew 2000, p. 14).

Financial oversight by insurance departments does not guarantee trouble-free performance. In Kansas, for example, Medicaid managed-care managers were relatively powerless in the face of the insurance department’s annual financial approval of the state’s only participating HMO, despite widely perceived financial instability. That approval was likely due partly to the fact that the state medical society owned the HMO and the potential political repercussions of corrective action, as well as to legislative imperatives for statewide full-risk managed-care even without willing HMO providers.

Similarly, despite duplicate oversight by both insurance and Medicaid managers, New Jersey was unprepared for the financial collapse of two of its managed-care HMOs. In Ohio, the “ambiguous assignment of administrative responsibility” for the financial performance of participating HMOs probably contributed to a recent lawsuit by unpaid providers in one failed network. Neither the insurance nor the Medicaid managed-care staffs were willing to take full responsibility for oversight, and neither predicted the HMO failure. The plaintiffs allege that they “should be able to assume that any plan approved and regulated by the state has met a basic test of viability” (Caswell 2000, p.31), regardless of the source of that approval.

In most states, the Medicaid management staff is aware of plans’ financial problems before they are reported. Managers are typically inclined to help the plans, especially in states where participating plans are scarce resources. But Medicaid staff members are typically unable to provide the highly skilled financial analysis that most states want, partly because state salaries don’t attract top financial analysts. For the most part, precise information about the cost-effectiveness of managed-care eludes Medicaid staffs. Again, Arizona, Florida, and Michigan are exceptions — their ability to attract and retain highly skilled financial oversight staff has enhanced program oversight and managers’ understanding of financial performance.

Conclusions

The ten states in this study exhibit varying degrees of success in building organizational capacity to effectively manage Medicaid managed-care. Three states — Arizona, Florida, and Michigan — have successfully constructed management systems to transition from fee-for-service programs, which focuses on eligibility determination and claims payment, to effective oversight of managed-care systems, complete with rigorous evaluation and continuous program improvement. However, only Arizona meets the standards of prudent purchasing, which requires both effective

management *and* the capacity to hold managed-care providers accountable by imposing sanctions for deficient performance as needed.

Despite the best efforts of state administrators, effective program management and program success are often determined by the state's political and market contexts. In the least successfully managed states, management systems are framed by low levels of political support and management funding, and insufficient competition among managed-care providers. The best-managed states benefit from competitive managed-care markets and strong political commitments to managed-care administration.

In the most effectively managed states, policymakers purposely located Medicaid administration in a health agency independent from the state's welfare department, thereby removing managers from the strict political scrutiny and low resource support that typify many state welfare organizations. These states are best equipped to attract and retain staffs that possess the analytic skills essential to effective program oversight and contract management. These states also enjoy competitive managed-care markets in which reimbursement rates are attractive and providers are motivated to contract with the state. As a result, administrators in these states can focus their management efforts on program oversight and improvement as opposed to "keeping plans in the game."

In states such as Florida, where policymakers clearly recognize the different needs of urban and rural areas by fully supporting both full-risk and PCCM systems, managers have the flexibility to fashion programs to serve different geographic areas. In states without this flexibility, managers are often dealing with crises driven by HMO exits or provider financial problems often related to low population densities or other rural managed-care complications.

Most of these states use highly centralized oversight and management systems, while a few depend more on regional or county office staff to perform these functions. All states demonstrate a strong commitment to the oversight of health-care quality,

devoting a substantial share of management resources to this function, whether conducted in-house or through contracts. Quality management typically combines formal performance reports with informal information available to experienced Medicaid staff familiar with providers and clients. Informal information is particularly important to managers that have difficulty obtaining timely and accurate quality performance reports. The most effectively managed states can push providers on quality issues because they have the political and managerial capacity to hold providers accountable for their performance.

Most of these states have failed to attract staff with the management and analytic qualifications essential to successful managed-care administration. Yet managers are often able to skirt some of the most troublesome political and market constraints by working collaboratively with providers. Whether a collaborative approach to a contracting relationship fosters prudent purchasing is open to question. But in the current context, managers often have no other option.

Conditions in these ten states indicate that Medicaid managed-care rests on a fragile foundation. The future will pose substantial challenges to management systems throughout the states. Increasing Medicaid HMO exits, combined with rising health-care premium costs in the public and private sectors, will tax all Medicaid managers, including those in successfully managed states. States that have enjoyed good management conditions, such as Michigan, are beginning to encounter resistance from providers. Current economic conditions are reducing state income and could prompt rising Medicaid enrollments, putting increased burdens on state budgets. The National Association of State Budget Officers and the National Governors Association recently reported that "Medicaid expenditures have escalated and are consuming a greater portion of states' budgets. The pressure from escalating Medicaid costs coincides with the revenue slow-down in the states" (National Association of State Budget Officers 2001).

These trends have the potential to jeopardize the favorable conditions that have facilitated effective management systems in

Arizona, Florida, and Michigan. Indeed, some of these dynamics have already eroded management effectiveness in Colorado. Economic strains are likely to coincide with the need for stronger oversight systems, as states cope simultaneously with revenue shortfalls, financial risks to HMOs experiencing growing health-care costs, and increasing Medicaid enrollments due to declining employment. This combination begs for more — not fewer — management resources. But state budget pressures could lead to layoffs or lengthy staff vacancies, just as conditions may require intensified program oversight. It remains to be seen how adaptable these management systems will be, and whether and how policymakers and managers will respond to future economic, political and market forces.

Endnotes

- 1 HMOs, or health maintenance organizations, dominate as providers of full-risk health-care plans. “Plans” and “HMOs” are used interchangeably in this report.
- 2 Under this arrangement, the HMOs bear the financial risk. If the costs of the stipulated health-care services exceed the capitation payment, the HMOs suffer the financial loss.
- 3 Under PCCM programs, health-care providers bear no financial risk. They are reimbursed on a fee-for-service basis, and clients are free to seek specialists on their own. Nonetheless, the PCCM primary care physicians are responsible for managing the client’s health-care needs.
- 4 The question of whether a state becomes a “prudent purchaser” is different from the question of whether a Medicaid managed-care program demonstrates success, although the two are related. The ultimate objective of Medicaid managed-care is to provide high-quality health care while holding cost growth; prudent purchasing, which requires effective management, facilitates program success. For some of the states in this study — especially those that have lost purchasing power due to such developments as the withdrawal of HMOs from the Medicaid market — there are certainly legitimate doubts about program success. However, program success is beyond the scope of this study. Instead, the focus here is on state Medicaid managed-care management systems and their capacity to evaluate and improve managed-care programs.

- 5 The ten states are Arizona, Colorado, Florida, Georgia, Kansas, Michigan, New Jersey, North Carolina, Ohio, and West Virginia. This study, based on research on conducted during the summer of 1999, focuses primarily on Medicaid managed-care for poverty-related clients — mostly low-income women and children.
- 6 New Jersey is an interesting case because it benefits from favorable political and market environments, yet does not demonstrate the capacity necessary to aggressively push plans to correct deficiencies. The management style in this state is quite benign relative to that found in states with similarly supportive political and market contexts, and analytic capacity is still not well developed (Roper 2000).
- 7 Kettl (1993), Sclar (2000), and others point out that contract management requires substantial financial investment — in staff, information systems, and other components of management — yet governments often overlook this investment as they seek potential cost savings through private sector contractors.
- 8 Managed-care oversight is spread across several related program components: client access to health-care, patient utilization of health-care services, client satisfaction with health-care services, the quality of health-care services, and the cost-effectiveness of managed health care. Client access and satisfaction are often evaluated through patient surveys, and through administrative reviews of such indicators as waiting time for appointments, weekend coverage, and geographic proximity to providers. But quality, utilization, and financial oversight is dependent on the analysis of the relationship between provider “encounter” data (detailed information on patient encounters designed to simulate reimbursement claims data) and health-care outcome measures (such as reductions in preventable child asthma hospital admissions).
- 9 Although Georgia still operated a full-risk program in July 1999, by the end of the year all HMO contracts had been terminated (Rich 2000).
- 10 The three PCCM programs, known as ACCESS I, ACCESS II and ACCESS III, are variants on the standard PCCM model. ACCESS I is the traditional PCCM program, in which a primary care physician gatekeeper receives a small monthly case management fee for each enrolled patient and fee-for-service reimbursement for all medical services provided. ACCESS II involves “limited networks” of key providers who have agreed to coordinate care management systems. ACCESS III builds on the ACCESS II concept, but creates a countywide coordinated network.
- 11 In most states, some categories of Medicaid clients, such as the elderly or disabled, are exempt from managed-care enrollment mandates. For the most part, this discussion is restricted to poverty-related clients.

- 12 Georgia's management system was undergoing reform when this research was conducted. In July 1999, at the behest of the new "anti-managed-care" Governor Roy Barnes, health-care functions were being consolidated into a new Department of Community Health.
- 13 Contractual fiscal agents are most often used to approve and pay Medicaid fee-for-service claims.
- 14 The downsizing pattern is not always due to financial motives. In some states, political pressure to reduce government size is driven more by ideological than financial considerations.
- 15 This list is not comprehensive, as not all states submitted information on contracts with fiscal agents or actuarial firms.
- 16 Enrollment management may entail client enrollment and disenrollment (including electronic enrollment), and perhaps enrollment trend analysis.
- 17 Bear in mind that, comparatively speaking, Arizona started from scratch; it had no existing fee-for-service management system on which to build, as did all the other states.
- 18 For example, governors in North Carolina and Georgia earmarked managed-care savings for enhancements to public school funding, and Michigan's governor funneled over \$120 million in program savings to the state's general fund.
- 19 The ratios were calculated based on staff data reported in the 1999 research on which this study is based, and on 1999 total (TANF and other) Medicaid managed-care enrollments by state, as reported by the Health-Care Financing Administration. See www.hcfa.gov/medicaid/mcsten99.htm.
- 20 It is also unclear how "dedicated" the Colorado staff is to Medicaid managed-care, as the Colorado Department of Health-care Policy and Financing operates several smaller non-Medicaid health-care programs.
- 21 As noted earlier, this is more true in southern Michigan, where urban areas attract HMOs, than in the rest of the state, where managers have assumed a much less assertive position with providers.
- 22 In Kansas and Ohio, CHIP enrollees, who generate higher reimbursement rates than Medicaid enrollees, were seen as potential enticements to persuade HMOs to serve Medicaid patients. But this strategy has not worked. In Kansas, low Medicaid rates have not been offset, in the eyes of HMOs, by CHIP rates, and in Ohio, financial losses have overwhelmed any potential gains from CHIP enrollments.
- 23 All states are required to contract with an EQRO, which conducts independent analyses used to enhance quality oversight.
- 24 They also review grievance and patient satisfaction data, and CAHPS survey data.

- 25 Utilization reviews focus on the success of providers in inducing patients to use preventive health care (such as primary care physician visits), and on the relationship between preventive health care and subsequent use of avoidable services such as hospital admissions and emergency room visits.

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Appendix 1. Medicaid Managed-Care Organizational Structure in Colorado and Ohio

Colorado and Ohio have adopted organizational structures that help illustrate the manner in which many states design their management systems and their priorities on different components of managed-care. Like the other states in this study, they tend to focus most of their management resources on the oversight of health-care quality.

Colorado's Department of Health-Care Policy and Financing, which manages the state's second largest budget (\$1.8 billion), is divided into several offices, one of which is the Office of Medical Assistance. This office administers Medicaid and several other state-funded health programs, and contains three divisions. The Division of Health Plan Management is responsible for program monitoring and provider relations. The Division of Managed-Care Contracting develops, implements, and monitors contracts for several managed-care programs. Within the Division of Health Plan Operations, the Customer Service Section administers patient education and customer grievance procedures, the Eligibility and Enrollment Section directs eligible clients to appropriate programs, and the Quality Assurance Section oversees health-care quality and utilization.

Ohio's Medicaid agency — the Office of Medicaid — is one of 12 units in the state's Department of Human Services; it oversees an annual budget of over \$6 billion. The Office of Medicaid contains six primary units, including the Bureau of Managed Health-Care (BMHC); the other bureaus deal primarily with long term care and policy functions. BMHC is divided into four sections. The Contract Administration Section focuses on formal managed-care contracts and provides technical assistance to health-care plans as needed. The Enrollment Administration Section deals with enrollment activities. The Program Development and Analysis Section analyzes encounter data and feeds reports to the Performance Monitoring Section, which oversees plan

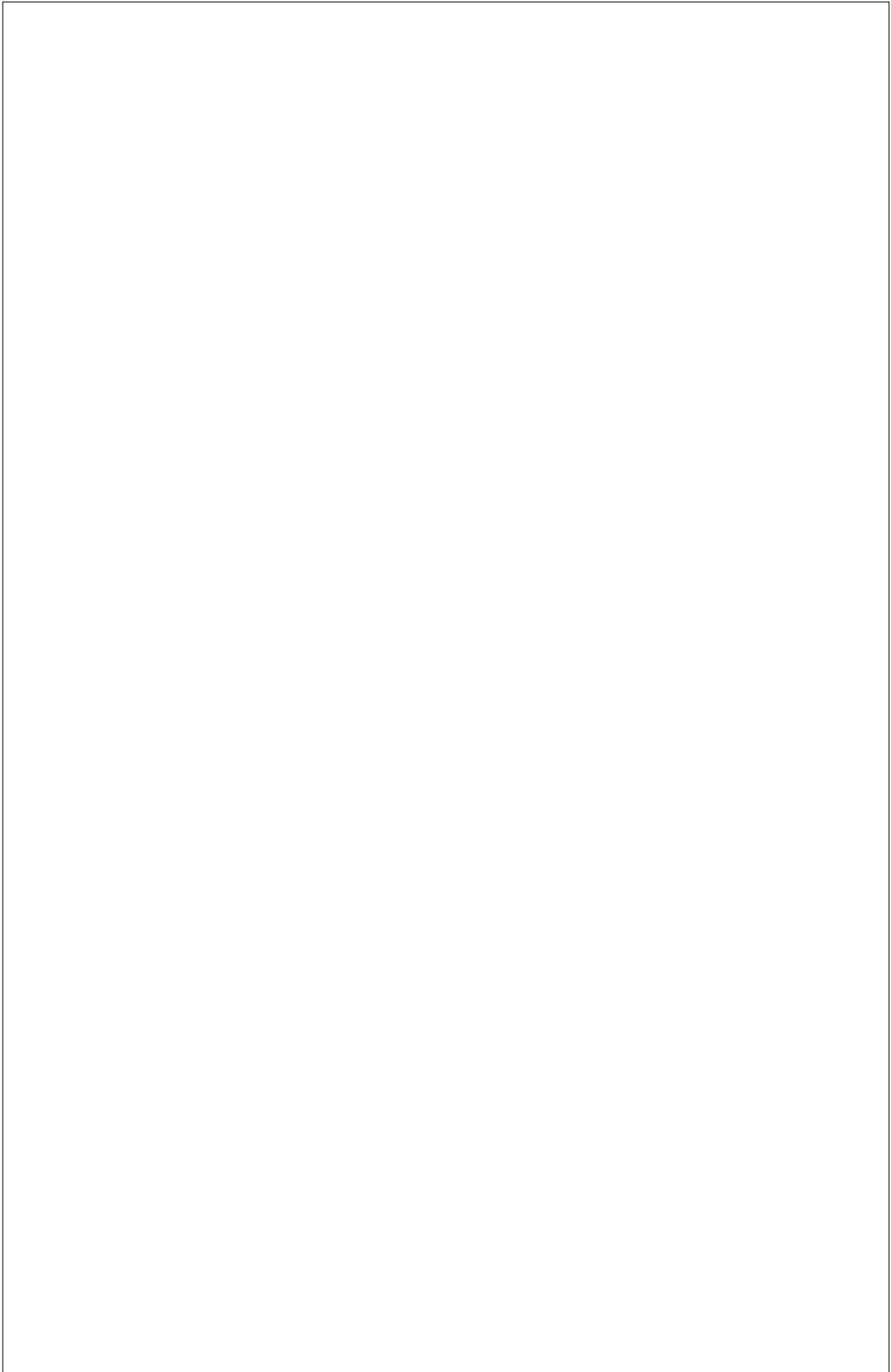
performance in terms of financial stability, quality, utilization, and – to some extent – access. This section monitors the “guts” of the managed-care program and maintains the most direct contact with the HMOs, but relies on the Analysis Section for systematic information. Similarly, the director of Colorado’s Quality Assurance Section works closely with the director of the Division of Managed-Care Contracting, noting that “whereas [the Contracting Division] monitors the contracts with the HMOs we are more of an auditor,” with an emphasis on the quality portion of performance (Goggin 2000, p. 80).

Colorado Department of Health-Care Policy and Financing

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|---------------|-------------------------------|----------------------------------|-------------------------------------|------------------------------------|--------------------------------------|------------------------------------|---------------------------|
| Budget Office | Office of Program Development | Office of Information Technology | Office of Accounting and Purchasing | Office of Medical Assistance | | | |
| | | | | Division of Health Plan Management | Division of Managed-care Contracting | Division of Health Plan Operations | |
| | | | | | Customer Service Section | Eligibility & Enrollment Section | Quality Assurance Section |

Ohio Department of Human Services

| | | | | | |
|----------------------|--------------------|---------------------------------|-----------------------------------|--|--------------------------------|
| Eleven other offices | Office of Medicaid | | | | |
| | Five other bureaus | Bureau of Managed Health-Care | | | |
| | | Contract Administration Section | Enrollment Administration Section | Program Development and Analysis Section | Performance Monitoring Section |





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