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Review Essay

Making Sense of Medicaid Reform

Mark R. Daniels, ed. *Medicaid Reform and the American States: Case Studies of Managed Care.* Westport, CT: Auburn House, 1998. 320 pp. \$49.95 cloth.

Stephen M. Davidson and Stephen A. Somers, eds. *Remaking Medicaid: Managed Care for the Public Good.* San Francisco: Jossey-Bass, 1998. 320 pp. \$45.95 cloth.

Over the past decade, state governments fundamentally reshaped the delivery of health care to the poor by shifting Medicaid beneficiaries from a cost-based, fee-for-service system to a variety of managed care arrangements. The scope and rapidity of this change is striking. As recently as 1993, only 14.4 percent of the total Medicaid population was enrolled in managed care (HCFA 1999b). With encouragement from the Clinton administration, a growing number of states received comprehensive demonstration waivers permitting states to change federal Medicaid eligibility criteria, benefits, and mandate enrollment in managed care plans. As a result, the number of Medicaid beneficiaries enrolled in managed care plans more than tripled in five years, from 4.8 million in 1993 to 16.5 million in 1998, or 53.6 percent of all Medicaid enrollees (*ibid.*). Ten states also used Medicaid demonstration waivers to expand access to care for more than 800,000 uninsured and the "medically needy" individuals (HCFA 1999c).

The rapid transformation of state Medicaid programs presents several important challenges for policy makers. The devolution of policy making to the states focuses new attention on the capacity of state health bureaucracies to design and implement cost-effective delivery systems that protect the needs of vulnerable populations. Protecting the interests of special needs populations imposes new burdens on state officials who must exercise renewed vigilance to ensure that patients in capitated health plans are not underserved. Finally, the implementation of Medicaid managed care plans creates new winners and losers among patients and providers; states need to preserve safety-net providers to serve the poor and disabled while simultaneously introducing new competitors to challenge traditional modes of financing and delivering care to program enrollees.

The two volumes discussed in this essay seek to expand our knowledge of how states designed and implemented Medicaid managed care reforms over the past decade. Mark R. Daniels's edited collection of essays, *Medicaid Reform and the American States*, reviews the prospects and pitfalls of Medicaid managed care by presenting case studies of sixteen states that developed demonstration waiver programs in the 1990s. These cases offer an interesting snapshot of these waiver initiatives, but the absence of a shared intellectual agenda handicaps the book. Many contributors adopt a "black box" approach to the development of Sections 1915 and 1115 waivers and offer little discussion of the representation of affected interests and groups in framing waiver applications and few insights into the decision-making process (e.g., whether to use anticipated savings to expand enrollment for the uninsured). For students of comparative Medicaid policy, more comprehensive treatments such as Frank J. Thompson and John J. DiIulio's (1998) discussion of federalism and Medicaid reform offer a wealth of data coupled with analyses of difficult issues facing reformers (e.g., protecting safety-net providers in a competitive marketplace).

In *Remaking Medicaid: Managed Care for the Public Good*, Stephen M. Davidson and Stephen A. Somers "want readers to recognize the great potential of Medicaid managed care, yet also recognize and respect the challenges that must be met for it to reach that potential. We also want to convey the difficulties inherent in these challenges even when the strategy is well conceived and public officials implement it with skill and determination, so that managed care will not be seen as a magic bullet [that] can be simply forgotten once aimed and fired" (4). The editors largely succeed in their goal of providing a comprehensive and accessible overview of the challenges facing public officials and MCOs as they seek to implement Medicaid managed care programs. The contributors explore many issues in depth, including the intricacies of contracting, designing health-based payment systems, assuring access to quality care for special-needs populations, measuring the quality of care provided by participating MCOs, and the obstacles and opportunities associated with fully capitated financing systems.

A Question of State Administrative Capacity

The rapid transformation of state Medicaid programs raises important questions about the administrative capacities of state health bureaucra-

cies. Creating and sustaining competitive markets for health services places new demands on state governments and requires different policy-making skills than traditional cost containment initiatives such as rate-setting or utilization review (Morone 1992). The characteristics of an effective claims processing organization in a fee-for-service reimbursement system are quite different from the actuarial and managerial skills required to negotiate benefits coverage for special-needs populations, design effective enrollment and patient education systems, monitor the quality of care provided to beneficiaries, and sanction plans that provide substandard care.

State officials face numerous challenges in building provider networks, developing materials to educate beneficiaries about managed care, enrollment procedures, and setting capitated rates for participating MCOs. The shift to capitated financing brings to the forefront the administrative competence of state agencies designated to implement Medicaid managed care programs. As Robert Hurley notes in *Remaking Medicaid*, “Buyer performance has been critical to the origins and evolution of managed care—both in pursuit of greater value for money and in stimulating the formalization of organized delivery systems capable of meeting buyer requirements and demonstrating adequacy of performance” (33). Whereas earlier efforts at cost containment often relied upon cutbacks in payments to providers, low capitation rates may provide financial incentives for MCOs either to underserve Medicaid enrollees or to refuse to participate in the new system altogether.

Devolution raises more questions for policy makers than it answers. A basic question facing state policy makers is whether contract negotiations, building provider networks, enrolling beneficiaries, and developing new payment methodologies should be handled “in house” or subcontracted to private vendors or consultants. The shortfall between the administrative capacity of existing state Medicaid programs and the demands of the new medical marketplace led many states to hire outside consulting firms to draft Medicaid managed care waiver applications. The use of specialized consultants only serves to highlight the importance of building the bureaucratic capacity of state Medicaid agencies, however, since the need for specialized expertise in developing managed care contracts and assessing patient outcomes is ongoing, not episodic. In addition, as John Holahan, Alison Evans, and Stephen Zuckerman note in *Remaking Medicaid*, states may either capitate payments for nonacute services such as mental health care, case management, and home care to participating MCOs or “carve out” separate managed care or fee-for-

service contracts with specialty providers. How might states accommodate safety-net providers who have traditionally served the needs of the poor in a capitated delivery system? In answering these questions, state officials may choose from a variety of policy tools: some states have assigned such tasks to existing state agencies, while others embraced privatization for routine program operations.

Unfortunately, few of the cases presented in *Medicaid Reform and the American States* systematically explore the question of whether state governments possess the expertise and administrative competence to nurture new medical markets. In particular, a variety of organizational questions remain unasked. Did states seek to assist community health centers and other safety-net providers in their transition to managed care by fostering the development of Medicaid-only HMOs or other organizational forms? If so, were these efforts successful? How did state waivers seek to measure patient satisfaction with the quality of services provided by MCOs and/or provide due process for patients who were dissatisfied with the services they received? Who was responsible for implementing these tasks? With the notable exceptions of Eric Jacobson and Amy Droskoski's discussion of Delaware's Diamond State Health Plan and Thomas and Karen Oliver's of Maryland's Section 1115 waiver proposal, the cases shed little light on the policy-making context of developing and implementing Medicaid reform proposals.

The Health Care Financing Administration (HCFA) has encouraged the development of information systems to monitor the quality of patient care under Medicaid (Jencks 1995), but existing fee-for-service-based Medicaid information systems are ill-equipped to facilitate quality improvement in a managed care environment. In a fee-for-service payment system, utilization review programs focused on the identification of outliers; in a capitated system, state officials must design and implement monitoring systems to assess patient outcomes and satisfaction. In most states, such initiatives must be designed from the ground up. In this context, the bureaucratic capacity and professionalism of state health bureaucracies is a crucial explanatory variable in predicting the success or failure of Medicaid reforms.

Some have claimed that Medicaid managed care programs promise to end the two-tiered system of care that has characterized Medicaid since its inception. Implicit in this argument is the assumption that mainstream providers will be able to offer more consistent, higher quality care than traditional safety-net clinics and physicians. To assess this claim, however, state officials must gather data on the nature of patient interactions

with MCOs. As several contributors to *Remaking Medicaid* note, however, such an undertaking requires a considerable investment in capacity-building, as the data sets, specialized personnel, and computer systems needed for ongoing outcomes assessments do not currently exist in most state Medicaid bureaucracies. In addition, a lack of education, political efficacy, and resources (e.g., Internet access) limits the ability of many Medicaid beneficiaries to become “prudent purchasers” of health care. How can states ensure that Medicaid managed care beneficiaries have an opportunity to make an informed decision in choosing their MCO? Should states employ enrollment brokers to contact and educate enrollees about their plan options?

The mass migration of Medicaid enrollees to managed care occurs in the shadow of an ongoing national debate over the quality of care provided by MCOs. The managed care industry has been buffeted by criticism in recent years from physicians, policy makers, and the press. Policy makers and the public have been exposed to vivid stories of new mothers and babies being tossed from hospital beds by tight-fisted HMOs, or of patients whose longstanding relationships with physicians, pharmacists, and other providers were severed by selective contracting. The solutions fashioned by state policy makers to address such excesses of MCOs, however, have done little to augment the capacity of state Medicaid bureaucracies to monitor the quality of care provided to program beneficiaries. In recent years, most state initiatives to discourage MCOs from underserving their patients have been framed by anecdotes rather than hard data on patient outcomes under managed care (Rochefort 1998). New mandates such as legislation barring “drive through deliveries” and guaranteeing direct access to OB-GYNs did not require the development of extensive monitoring tools but rather prohibited “excessive” conduct by providers and health plans.

To fulfill the promise of managed care, states must hold providers accountable for caring for the needs of different segments of the Medicaid population. As Sara Rosenbaum notes in *Remaking Medicaid*, states must develop new ways to finance services that are not covered within the standard benefits package of participating MCOs. Medicaid agencies can either purchase the standard benefits package offered by MCOs, or issue requests for proposals to develop new products that fulfill traditional Medicaid coverage standards (200–202). States have less experience in designing managed care contracts that hold plans accountable for the quality of patient care, mandate standardized data collection, and assess the adequacy of provider networks, patient appeals processes, and

coverage of “medically necessary” services. The implication of Rosenbaum’s analysis is clear: Unless state Medicaid agencies actively recruit personnel who have prior experience in purchasing care from MCOs, states may be at a considerable disadvantage at the bargaining table.

Richard Kronick and Tony Dreyfus’s chapter in *Remaking Medicaid* argues for a risk-adjusted system of capitation in which “the payer seeks to adjust payments so that they vary according to the predictable element of risk associated with different individuals. In this system, plans can no longer make easy profits by avoiding individuals with predictably higher costs because a plan that enrolls disproportionately low risk members will be paid less than average” (226–227). Traditional approaches to setting capitation rates that pay providers a percentage of the average fee-for-service costs provide incentives for health plans to shun sicker than average patients; a reasonable system of risk-adjusted rates would encourage providers to enroll patients with chronic illness as long as the expenditures for patients could be predicted with a high degree of accuracy. As Kronick and Dreyfus point out, several diagnosis-based payment and classification systems now exist that could be used to construct risk-adjusted capitation rates, but many state Medicaid programs find themselves short of both the administrative and political resources needed to institutionalize new payment mechanisms.

Improving Care for Special-Needs Populations

Designing an effective managed care network for poor and underserved patients requires a fundamental shift in the relationship between state health bureaucracies and providers. Enrolling poor, disabled, and elderly beneficiaries in managed care raises a number of thorny implementation questions. As Hurley notes in *Remaking Medicaid*, states face challenges in preserving the full statutory benefits guaranteed to Medicaid beneficiaries, which in many cases exceed those offered by MCOs’ standard benefits packages. To ensure that all enrollees, and patients with special needs in particular, receive services that they are entitled to, states must conduct ongoing performance evaluations of HMOs, assess the quality of service coordination for patients with chronic conditions, and ensure that the capitation rates paid to MCOs are adequate to provide an appropriate level of care.

Managed care has significant advantages for patients with chronic conditions because of its emphasis on prevention, coordination of care-

givers, and periodic contacts with patients and their families. Indeed, successful HMO disease management programs can deliver more cost-effective care, producing better patient outcomes, higher patient satisfaction, and lower rates of hospitalization (Zelman and Berenson 1998: 94–99). Since the development of disease management systems requires a considerable investment, however, capitated rates of payment for chronically ill patients must take into account the special needs of the target populations. State efforts to develop capitated financing arrangements for the disabled and elderly must encourage participating MCOs to educate participating providers in the new treatment modalities, identify enrollees who would benefit from disease management, and empower patients and their families to actively monitor their condition. A capitated payment system encourages the use of innovative disease management approaches, but capitation rates, which are too low, may offer incentives for providers to withhold basic services.

Furthermore, as Hurley and Debra Draper note in *Remaking Medicaid*, efforts to “mainstream” persons with disabilities into commercial MCOs are likely to encounter significant resistance from organized advocacy groups and providers that have traditionally served special needs populations. Reshaping the payment system by enrolling sizable numbers of chronically ill and disabled beneficiaries into capitated delivery systems requires both political entrepreneurship and administrative resources that are unlikely to be present in all states.

The Politics of Mandatory Enrollment in Managed Care

The extraordinary variation in state managed care enrollment raises a crucial question for comparative research: What can account for the willingness of public officials to first embrace, and then successfully implement, managed care programs for Medicaid? By 1998, managed care penetration in state Medicaid programs ranged from a low of 0 percent (Alaska, Wyoming) to a high of 100 percent (Tennessee). Although eleven states had enrolled more than 80 percent of their Medicaid caseload in managed care, seven other states reported managed care enrollments of less than 20 percent (HCFA 1999a).

Medicaid Reform and the American States misses an opportunity to explore the politics that accompanied the development of state waiver applications. Why, for example, did most states opt to enroll only poor women and children in managed care on a mandatory basis? Did these deci-

sions reflect the political clout of nursing homes and other health providers, or the relative difficulty of designing capitated payment systems for patients in institutional settings and persons with chronic disabilities (e.g., AIDS)? While more than 60 percent of Medicaid enrollees are young families, this group only accounts for less than 30 percent of program expenditures in most states. The average cost for elderly and disabled beneficiaries and the rate of spending growth for these populations are much higher than for AFDC/TANF eligible enrollees (Thompson and DiIulio 1998). Although the real potential of Medicaid managed care to control costs and improve patient outcomes will remain unrealized until states shift elderly and disabled patients to capitated settings, the contributors to *Medicaid Reform in the American States* do not discuss the political obstacles that accompany mandatory enrollment in managed care for these groups.

Too many chapters in *Medicaid Reform and the American States* seem divorced from the political context that shapes Medicaid policy decisions. This is unfortunate, for the book includes case studies of many states that have not received much attention in the scholarly literature (e.g., Alabama, Delaware, Kansas, and Oklahoma). Many of the cases could offer a richer analysis of how Medicaid reform reached the formal policy agenda if there had been greater discussion of how the proposals were defined by issue expanders and containers in legislative debates, and how governmental actors, institutions, and organized interests sought to advance their interests through the policy-making process. This is a difficult but not impossible task, as illustrated by Michael Sparer's (1996) study of Medicaid policy in New York and California. Had the case studies in *Medicaid Reform in the American States* followed a similar logic, the book would be a significant addition to both the literature on state politics and policy making and to our knowledge of the politics of Medicaid and state-level health care reform.

Drawing upon national data, case studies, and practitioners' reports from the field, one of the real contributions of *Remaking Medicaid* is its discussion of *which* policy decisions will be devolved to the states. Many recent discussions of managed care have been characterized by either strident criticism or unabashed enthusiasm, but the contributors to *Remaking Medicaid* provide a balanced assessment of the circumstances under which managed care can meet policy makers' expectations.

Conclusion

Over the past decade, state officials have reinvented how Medicaid provides acute care services to the poor. State governments must play a vital

role in building markets as both purchasers and regulators. As purchasers of health care, Medicaid agencies must use their market share to negotiate cost savings while ensuring that MCOs have the resources necessary to deliver cost-effective care to vulnerable populations. A capitated delivery system also imposes new responsibilities on the state to advocate for the interests of Medicaid enrollees and monitor the behavior of MCOs. If past experience is any guide, many states will rise to the tasks before them, while others will falter. States that are able to build their internal policy-making capabilities have a remarkable opportunity to improve the quality of care for underserved populations and to restore predictability and order to the budgetary process. In the absence of the specialized expertise and administrative competence required to monitor patient outcomes and plan performance, however, state Medicaid managed care programs are likely to disappoint both policy makers and patients.

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