

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Retooling State Medicaid Agencies
For
Managed Care**



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EXECUTIVE SUMMARY

PURPOSE

To identify the major organizational challenges State Medicaid agencies face as they shift their focus to managed care and to offer preliminary assessments of how the agencies are responding to these challenges.

BACKGROUND

At a rapid pace, most State Medicaid programs are shifting their enrollees from traditional fee-for-service health care to managed care arrangements. These still evolving arrangements include primary care case management (PCCM), comprehensive, full-risk managed care, and capitated carve-outs of particular services, such as mental health.

For the Medicaid agencies, this transition is fundamental. They are faced with retooling themselves, much like private corporations do when entering new markets or introducing new product lines. This inquiry defines the key challenges these agencies face in making this adaptation and offers feedback on how they are meeting them. It is based on a review of the experiences of 10 State Medicaid agencies strongly committed to managed care.

MANAGED CARE PENETRATION

The degree and type of Medicaid managed care penetration in the State has a major bearing on the organizational challenges facing a Medicaid agency. The more that Medicaid beneficiaries are enrolled in managed care of any kind and in full-risk managed care in particular, the more that agency management finds itself compelled to uproot its fee-for-service infrastructure and develop new organizational tasks, roles, and structures.

We have identified three stages of penetration. Stage III represents what we call the breakthrough point. At that point, nearly all Medicaid enrollees are in full-risk managed care. Staff redeployment is extensive. The fee-for-service sector no longer dominates. Only 1 of the 10 agencies has reached this stage. Among the others, five are in Stage I, four in Stage II.

CHALLENGES AND RESPONSES

We have identified five major organizational challenges. They are by and large sequential. Most States have considerable experience in addressing the first two, but have barely begun to address the last three challenges. Below we present the challenges and characterize the agencies' responses to them.

Establishing core developmental teams.

The agencies have experienced much success in establishing teams drawn almost entirely from staffs of Medicaid and other State agencies. A downside is that they tend to be isolated from the fee-for-service operations, making it more difficult at times to carry out budgeting and other agencywide functions.

Acquiring necessary knowledge and skills.

The agencies have made extensive use of consultants for ratesetting, computer modifications, and other functions. Few agency staff have experience in the managed care industry. With outmoded State personnel systems and minimal investments in staff training, the agencies face significant constraints developing sufficient staff expertise.

Instilling a new mission and culture.

In most cases, this challenge has barely been addressed, with staff concerns mounting. Some promising strategies, however, are apparent. One is to foster value-purchasing as a goal pertinent to both fee-for-service and managed care sectors. Another is to organize work units in ways that integrate roles across the two sectors.

Redeploying fee-for-service staff.

Once again, this challenge has barely been addressed. In nearly all States, the heaviest users of health care services remain concentrated in fee-for-service sector, thereby minimizing opportunities for staff redeployment. But pressures to move in this direction are building as managed care enrollment accelerates.

Avoiding a fee-for-service meltdown.

Some danger signs are apparent. Less innovation, lower morale, and slower responses in Medicaid fee-for-service sector jeopardize Medicaid service and oversight roles. These danger signs are especially apparent with respect to the following traditional fee-for-service functions: third-party-liability, surveillance and utilization review systems, and drug utilization review.

RECOMMENDATIONS

In State Medicaid agencies, State legislatures, and the Health Care Financing Administration, retooling has been a low-priority issue. In each sector, the focus has been on the substance of managed care efforts and on their effects on providers, beneficiaries, and taxpayers.

As Medicaid agencies approach and enter Stage III, they will be compelled to devote more attention to the retooling issue. The HCFA, as the Federal partner in the Medicaid

program, can encourage and help them to address this issue constructively. Our recommendations are made in that context.

The HCFA should provide forums to help State Medicaid agency managers take advantage of the opportunities managed care presents for retooling their agencies and to minimize the associated dangers.

These forums could be at the national level, through the establishment of a work group or technical advisory group, as well as at regional levels, through the efforts of regional offices.

The HCFA should revise its review and monitoring protocols so that they devote greater attention to how State Medicaid agencies are handling the organizational challenges associated with expanded managed care.

Particularly as agencies approach and enter Stage III, it is vital that the retooling issue be taken off the backburner, where it typically resides, and be given major attention. The HCFA can encourage such change by giving greater attention to the organizational challenges when it reviews State agency plans and activities.

The HCFA, in its ongoing reviews of State Medicaid agencies, should scrutinize possible adverse effects of managed care expansion on the performance of established fee-for-service functions.

This matter, we are suggesting, warrants special attention, especially as it relates to the third-party-liability, surveillance and utilization review subsystems, and drug utilization review functions.

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from HCFA, the Acting Assistant Secretary for Health (ASH), and the Assistant Secretary for Planning and Evaluation. The latter concurred with our recommendations without further comment. The complete text of the HCFA and ASH comments appear in appendix B. Below we summarize their comments and, in italics, offer our response.

The HCFA concurred with the first two recommendations and partially concurred with the third. It noted that ongoing activities and action taken in response to the first two recommendations would lessen the need for scrutinizing possible adverse effects of managed care expansion on fee-for-service functions. In addition, HCFA suggested that the States discussed in the report be given opportunity to comment on the report and that our reference to "danger signs" in the fee-for-service sector be changed to "concerns." *We decided to retain the former term because it more accurately reflects what we heard and found in the study States. At the same time, as we note in the report, we refer to danger signs in the context of early alerts that could emerge as significant problems if not adequately addressed. As for obtaining reactions from the States, we have received and*

taken into account considerable comment from the States in the course of framing our findings and recommendations.

The Acting Assistant Secretary of Health did not comment on the specific findings or recommendations in the report, but did offer four suggestions that could enhance the transition process to Medicaid managed care. They are helpful suggestions that warrant consideration by the States and HCFA. They concern the involvement of the State health departments in the managed care process, the need for broad stakeholder involvement in the process, the need to strengthen the integration of public health concerns into the change process, and the importance of strengthening compliance, monitoring, and evaluation at the State level.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION	
MANAGED CARE PENETRATION	3
CHALLENGES AND RESPONSES	5
Success in Establishing Core Teams	5
Some Concerns in Acquiring Necessary Knowledge and Skills	6
Limited Progress in Instilling New Mission and Culture	7
Minimal Efforts in Redeploying Fee-For-Service Staff	10
Danger Signs for Traditional Fee-For-Service Functions	11
RETOOLING AS AN ISSUE	15
RECOMMENDATIONS	16
COMMENTS ON THE DRAFT REPORT	19
APPENDICES	
A: Background on Medicaid Managed Care	A-1
B: Complete Comments on the Draft Report	B-1
C: Endnotes	C-1

INTRODUCTION

PURPOSE

Our purpose in this inspection is twofold: (1) to identify the major organizational challenges State Medicaid agencies face as they retool their agencies to support the growth of Medicaid managed care and (2) to offer preliminary assessments of how the agencies are responding to these challenges.

TRANSFORMATION OF STATE MEDICAID AGENCIES

Most State Medicaid agencies are undergoing rapid transformation. They are shifting from a traditional focus on fee-for-service health care to one increasingly defined by managed care. The managed care arrangements will involve any one or mix of the following: (1) primary care case management (PCCM), (2) comprehensive, full-risk managed care, and (3) capitated carve-outs of particular services, such as mental health, substance abuse, or dental services (see appendix A).

In this environment, the managers of State Medicaid agencies face an imposing new set of responsibilities that call for them to apply sound business practices and remain closely attuned to the health care marketplace. In both these respects, they find little guidance in the past policies and practices of their agencies.

In recent years, articles, books, and reports have been produced that explain these new responsibilities and that indicate how the States have been responding to them.¹ There has been much less attention to the organizational challenges the Medicaid agencies confront as they carry out their new managed care responsibilities.² Yet, the challenges are fundamental.³ They call for the agencies to reengineer themselves, much like private corporations would when entering a new market or developing a new product line. How well the agencies make this adaptation could well have a major bearing on the long-term success of their managed care efforts. It is a matter warranting further inquiry.

State Medicaid Agency Managed Care Responsibilities

- . *Defining types of managed care.*
- . *Developing health plan contracts.*
- . *Negotiating rates.*
- . *Educating beneficiaries.*
- . *Educating providers.*
- . *Ensuring patient access to providers.*
- . *Coordinating with other agencies.*
- . *Meeting with stakeholders.*
- . *Developing new data systems.*
- . *Overseeing health plans.*

THIS INQUIRY

This inspection focuses on the internal adjustments facing State Medicaid agencies as they move toward managed care. It starts out by addressing how these adjustments are influenced by the extent of Medicaid managed care in a State. It then identifies the major organizational challenges faced by the Medicaid agencies as they increase their commitment to managed care and addresses how they have been responding to those challenges.

In tackling this topic, we recognize that any generalizations about the Medicaid program that cross State boundaries can be hazardous. An often expressed adage among Medicaid directors is: "If you have seen one Medicaid program, you have seen one Medicaid program."⁴ Yet in a broad sense, currents of change are apparent among the States and are helpful to highlight, even if they do not adequately reflect what is happening in any individual State. In our synthesis observations, we focus on those currents. To reflect some of the diversity that exists and to minimize the danger of our becoming too abstract, we offer examples of developments occurring in particular States.

Our inquiry is based primarily on a review of the recent experiences of 10 State Medicaid agencies that have made strong commitments to Medicaid managed care. The States are diverse in terms of their location, size, and experience with managed care.⁵ They are clearly among the top half of States in terms of the proportion of their Medicaid beneficiaries in managed care. For each of the States, we interviewed agency officials and reviewed pertinent documents. In three, we conducted in-depth visits that also included interviews with representatives of health plans, advocacy groups, State legislatures, other State agencies, and Medicaid enrollees.

Our inquiry does not address the internal adjustments that the move toward managed care presents for other State agencies, such as those focusing on mental health, public health, mental retardation, elder affairs, and social services. These adjustments can be significant since Medicaid often serves as a major source of funding for their service operations and since managed care can lead to major changes in these operations. The organizational effects in these other agencies warrant attention. But with the reverberations of managed care likely to be most immediate and consequential within in the Medicaid agencies, we have decided to concentrate this inquiry on them.

We conducted this inspection in accordance with the Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency.

MANAGED CARE PENETRATION

The degree and type of Medicaid managed care penetration in a State has a major bearing on the extent of the organizational challenges facing the State Medicaid agency.

The challenges we are examining in this report do not occur in a vacuum. Both the extent and nature of the challenges are heavily influenced by numerous factors, many of which are beyond the control of agency management. Among the more important of these shaping influences are: the rapidity of the movement toward Medicaid managed care;⁶ the extent of managed care in the private marketplace;⁷ the extent of the agency's prior experience with managed care;⁸ the size of the State's Medicaid program;⁹ the complexity of the managed care program;¹⁰ and the extent and manner in which other State agencies regulate managed care organizations.¹¹

As important as these factors are, we learned that another factor is likely to have a more enduring effect on the challenges facing agency management as it seeks to gear up its organization to carry out managed care responsibilities. It involves the degree and type of Medicaid managed care penetration in a State. The more that Medicaid beneficiaries are enrolled in managed care of any kind and in full-risk managed care in particular, the more that agency management will find itself compelled to uproot its well-established fee-for-service infrastructure and develop new organizational tasks, roles, and structures.

Among the 10 States we reviewed, we identified three key stages of Medicaid managed care penetration (see table 1):

TABLE 1 STAGES OF MEDICAID MANAGED CARE PENETRATION				
Stage	Managed Care Enrollment	Full-Risk Managed Care Enrollment	Organizational Implications	States
I	Substantial. Can include majority of caseload.	Negligible to moderate.	Modest. Agency forms core managed care staff. Adjustments in computer systems, provider relations, and beneficiary education.	MA NY FL OH MO
I	Majority of caseload.	Dominant mode.	Substantial. Agency redefining itself as purchaser of health care. Major focus on enrolling beneficiaries and overseeing health plans.	CA RI MN UT
III	Nearly all of caseload.	Dominant mode.	Far-reaching. Agency reaches breakthrough point. Extensive staff redeployment. Fee-for-service sector no longer dominant.	OR

In Stage I, the Medicaid agency has made a substantial commitment to managed care--one that is likely to encompass most or all of the families with dependent children and perhaps even some of the aged, blind and disabled beneficiaries. Some of these individuals may be enrolled in full-risk managed care, but most are likely to be in PCCM and/or carve-out arrangements. This change calls for some adjustments in traditional agency operations. But the reverberations are relatively contained because the fee-for-service system remains essentially intact. Beneficiaries in PCCM and carve-out arrangements continue to receive much care from providers who continue to bill Medicaid for each episode of care.¹²

In Stage II, the critical difference is that full-risk managed care becomes mainstream. The agency begins to reposition itself as a purchaser of services from relatively few health plans rather than as a payer of bills from thousands of providers. In one way or another, more and more agency staff are involved in defining, supporting, and overseeing the work of health plans. The demands on the fee-for-service sector of the agency begin to diminish and staff accustomed to working on functions such as prior authorization or surveillance and utilization review must learn new roles. In this milieu, reorganizations are common.

In Stage III, full-risk managed care becomes even more dominant to the point where it encompasses many or even most of the aged, blind, and disabled beneficiaries. Although a minority of the caseload, they have accounted for a majority of agency expenditures and claims processed. As such, they have been instrumental in sustaining the fee-for-service sector of the Medicaid agency during Stages I and II. As these "high-user" beneficiaries join full-risk health plans, the foundation of the fee-for-service operation begins to give way. The agency reaches a breakthrough point that calls for far-reaching changes in its internal organization and in its use of agency staff.

CHALLENGES AND RESPONSES

Our review of 10 State Medicaid agencies revealed 5 major internal challenges they face as they adapt to managed care. The challenges, in essence, are generic ones that any kind of organization is likely to face in making a fundamental shift in its products and modes of operation. In this section, we explain the challenges and the agencies's responses to them. In large part, our discussion of the responses offers further illustration of the challenges by revealing the obstacles confronted in the implementation process.¹³

Challenge #1: Establishing a Core Developmental Team

To chart the course, the Medicaid agencies must assemble a leadership core that is committed to the managed care mission, energized by the conceptual and operational challenges it creates, and determined to persevere in the midst of complexity and uncertainty. This core must extend beyond the level of politically appointed officials into the career staff of the agency.

The formative stage of managed care program design and implementation can extend over a number of years. It is a period of innovation requiring people at the helm who thrive in such environments. The feasibility and durability of the reforms are likely to be enhanced if the leadership team includes some individuals that have been part of the agency's career staff and that are well-steeped in the operational and policy landscape of the Medicaid program.

► **Each of the agencies has assembled a core of officials who are strongly committed to managed care reforms.**

In most of the Medicaid agencies we reviewed, there is a core managed care leadership that is highly committed to managed care reforms.¹⁴ The members of the team tend to see these reforms as vital not only for containing costs, but also for improving the access of beneficiaries to good quality care. They are curious about the dynamics of the health care marketplace and about how the agency can best relate to it. They seek to act as prudent purchasers of health care on behalf of their customers -- the Medicaid beneficiaries.

The core staff come almost entirely from the fee-for-service sector of the agency or from other State agencies. Staff in the Medicaid agency tend to see the managed care office as the place where the action is and as a good place to get ahead. Or at least to avoid losing ground. As one State official noted: "Everyone knows that the office of managed care will be the last place to suffer any downsizing."

► **For the most part, the core staff work in isolation from the fee-for-service part of the Medicaid agency.**

The fast pace and the frequent crises that characterize managed care offices may contribute to their isolation from staff operating the routine fee-for-service operations. A comment by one managed care official echoed by many of his counterparts was: "we are an island unto ourselves." Many managers indicated to us that such separation is necessary during the early developmental phases of managed care, but can become dysfunctional if still applicable as managed care becomes more established. For instance, in one agency, managers informed us that with fee-for-service and managed care staffs speaking very different languages, the job of budgeting had become very difficult.

Challenge #2: Acquiring the Necessary Knowledge and Skills

As Medicaid agencies become increasingly committed to managed care, they must have ready access to knowledge bases and skills that are different than those typically held by their fee-for-service staffs. They become particularly dependent on expertise in negotiating contracts with health plans, in developing and carrying out quality assurance systems, and in relating to stakeholder groups.

In the early period, developmental, planning, and public relations capacities are of great importance. Later, once managed care becomes more mainstream, monitoring and evaluation capacities become much more significant. Throughout, however, the agencies find themselves with a greater need for staff with broad backgrounds who can understand health care delivery systems and who can fit the pieces together.

► **In developing their managed care efforts, the agencies have been able to tap into considerable expertise.**

Most of the agencies have relied heavily upon consultants, both for technical assistance on matters such as ratesetting, contract development, and computer modification, and for ongoing service functions, such as pre-enrollment education and actual beneficiary enrollment. In Rhode Island, the Medicaid agency has turned to a consultant firm to carry out a central, ongoing leadership role for its overall managed care effort.

The other State agencies we reviewed have relied more fully on their own staffs to provide direction. In Massachusetts, the agency built up a core staff by bringing in many individuals experienced in the managed care industry, either directly with health plans or with employers purchasing services from the plans. This, however, has been the exception. In most of the agencies, few if any staff have industry experience. Yet, mainly through on-the-job training and trial-by-fire, many of them have gained considerable know-how about managed care. To date, more of that know-how seems to relate to purchasing and contract development than to health plan oversight. But that is changing as the number of Medicaid enrollees in full-risk health plans continues to increase.

► **In building up and maintaining their own staff expertise, the agencies face significant constraints that emerge from outmoded State personnel systems and from minimal investments in staff development.**

Medicaid agency managers routinely complained to us about State personnel systems that make it enormously difficult for them to recruit people with experience in the managed care industry, to rotate agency staff among different positions, and to give sufficient rewards based on performance.¹⁵ Every bit as much, they expressed concerns about the meager resources available for staff development. Rarely, for instance, could they even send an employee to an out-of-State conference.

California's "Broken" Civil Service System

"California's Civil Service System is broken. Today, there are no rewards for outstanding performance and no consequences for poor performance. It is difficult to hire outstanding applicants, and it is difficult to fire the 'bad apples.' Salary is based on longevity, not productivity. In a rapidly changing technological environment, workers lack adequate training. It is a topsy-turvy world characterized by perverse incentives. It must be changed."

(From "Competitive Government: A Plan for Less Bureaucracy, More Results, Office of the Governor," April 1996.)

Over time, many officials stressed, the consequences of this situation become troubling. Capable, experienced staff leave. Some career staff end up in roles for which they are ill-suited. Some become too dependent for day-to-day learning on the staff of the health plans which have contracts with the Medicaid agency. A number of plan representatives reminded us that they regularly educate Medicaid staff about how managed care works.

Challenge: #3: Instilling a New Organizational Mission and Culture

For Medicaid agency staff accustomed to the fee-for-service routines, managed care portends fundamental change. It means that they must reorient themselves to an agency that is beginning to focus on beneficiaries rather than on providers and to define itself more as a health care purchaser than a bill payer. Agency leadership must find ways of enabling staff throughout the organization to make this transition.

Toward the later part of Stage I and into Stage II, it becomes increasingly apparent that managed care represents more than marginal change affecting one sector of the Medicaid agency. In fact, it looms as a paradigm shift, recasting the role of the Medicaid agency and most of its workforce. A before and after analysis prepared by the Minnesota Department of Human Services reveals the extent of this shift (see table 2).

**TABLE 2
PARADIGM SHIFT FOR MINNESOTA DEPARTMENT OF HUMAN SERVICES**

Components	Old Approach	New Approach
Agency role	Service agency	Service agency for non-health care/purchaser for health care
Management approach	Mix of assistance, collaboration, regulatory, and contractual	Business contractual relations for health care purchasing; collaborative approach for non-health care
Areas of responsibility	Individual programs	Population based rather than program based
Approaches to responsibility	Regulation	Flexible strategies for contracting for specific results
Goal	Operating programs	Assuring value: access, accountability, and affordability
Purchasing strategy	Reimbursement of individual services	Managed competition
Eligibles	Recipients	Enrollees
Provider relationships	Individual service providers	Care delivery network
Managed care contractors	HMOs	Managed network care delivery systems
Accountability	State and provider	Individual, state, care delivery networks
Quality	Regulatory approach	Quality improvement systematic
Purchasing role	Through counties and tribes; directly with individual providers	Joint purchasing strategies

► **For the most part, the agencies have not yet addressed this challenge.**

The move toward managed care does not occur as surely and orderly as our sequential schema may suggest. Medicaid agencies carrying out PCCM and/or full-risk managed care efforts confront ongoing complexities that concern policy design, operational detail, and political controversy. These realities almost invariably reinforce a short-term perspective, with little time for cultivating strategies that will instill a new mission and culture in a successfully transformed agency.

In Stage II the consequences of such inattention begin to mount. Staff who are not yet part of the managed care effort become more concerned about what the effort will mean for them. For instance, with many third-party-liability (TPL) functions being passed on to health plans for their Medicaid enrollees, TPL staff wonder how their jobs will be affected. Will their skills be transferrable? Indeed, will their jobs be threatened? Left unanswered, such questions jeopardize staff morale and productivity.¹⁶

The consequences can also be worrisome for agency staff who have already been given managed care responsibilities. Some of them remain uneasy in their new situations, uncertain about the implications or merits of the paradigm shift noted above. Some find their instinctive way of viewing the Medicaid program remains rooted in the traditional fee-for-service program. They may find it difficult, for instance, to adjust to oversight roles that focus on the dangers of underutilization in managed care arrangements after years of contending with the overutilization biases of fee-for-service systems.

► **Some agencies have undertaken what appear to be promising approaches to encourage staff acceptance of managed care.**

In various ways, some agencies are seeking to deemphasize the dichotomy between managed care and fee-for-service and to foster integrative perspectives that cut across these sectors. One such approach is to explain the agency's new mission in such terms. For instance, the Ohio agency stresses its aim to maximize its leverage in the marketplace and to get the best possible deal with respect to cost, quality, and access. It poses this overarching value-purchasing goal as one pertinent to both the fee-for-service and managed care sectors and to hybrid initiatives involving both.

Another depolarizing approach is to organize work units in ways that integrate roles across the two sectors. The Minnesota agency, for example, has developed what it terms "cross-cluster project teams" responsible for basic Medicaid benefits, continuing care for special populations, health care purchasing, and quality improvement. The Missouri agency has placed fee-for-service and managed care staff together in multiple units, with the intent to foster staff buy-in and to change the agency's mission.

Some agencies are also furthering staff buy-in by hiring consultants to help identify staff concerns and means of responding to those concerns. The Oregon agency, now in Stage III, used consultants to help it work on morale, relational and teamwork issues as it

expanded the scope of managed care. More recently, the Massachusetts¹⁷ and Missouri¹⁸ agencies have been doing the same.

Challenge #4: Redeploying Staff

Continued movement toward Stage III leads to a point where the fee-for-service workloads diminish and the agencies must redeploy significant numbers of the fee-for-service staff into managed care roles. Most of these individuals will have little preparation for their new roles.

In each State except Oregon, the fee-for-service sector still accounts for the great majority of Medicaid agency staff. In those States, agency leadership faces the enormous challenge of redeploying much of that staff into managed care while maintaining morale and operating both fee-for-service and managed care programs.¹⁹

► **Thus far, most of the agencies have not reached the point of redeploying major segments of their fee-for-service staff. In fact, many report that their staffing needs for managed care have increased faster than those for fee-for-service have declined.**

The fee-for-service sector caseload includes the sickest individuals generating the most claims. As long as most of them remain in this sector, they will continue to call for a disproportionately large share of agency staff support. This slows the pace at which the Medicaid agencies can phase down fee-for-service operations. So too do other largely unavoidable factors. One is what some claims processing staff describe as the "trailing effect," whereby fee-for-service claims for beneficiary services come in as much as 1 year after beneficiaries have shifted to managed care. Another is a temporary, but sometimes significant increase in inquiries to provider relations staff from providers seeking clarifications about the implications of new managed care policies.²⁰

In some States, continued pressures on the fee-for-service staffs appear to sustain a separation between fee-for-service and managed care staffs. One agency manager noted that those pressures prevent the agency from shifting staff as it would like and make it hard for the agency to come together. In other States, the agencies have developed explicit policies of gradually incorporating some managed care responsibilities into the work of fee-for-service staff. A manager in an agency that has taken this approach said that it has enabled more staff to be supervised by some in their own discipline and, as such, has led to a greater overall commitment to managed care.

► **In many of the agencies, the move toward major staff redeployment is imminent. Both internally and externally, pressures toward this end are mounting.**

One agency director said: "We are now at the point of making decisions of where to drop off fee-for-service pieces." Agency managers in other States made the same point. In a number of States, the fee-for-service claims volume has just recently begun to decline. This suggests some freeing up of fee-for-service staff. In some States, most especially California, legislatures are becoming increasingly aware of this development and

beginning to look for associated budget savings.²¹

In one traditional fee-for-service sphere--surveillance and utilization review (SURS)--the momentum toward staff redeployment appears to be gaining particular strength. In a number of the agencies, many SURS staff have been refocusing on quality improvement functions as opposed to the traditional fraud and abuse investigations. In some cases this has entailed transfers to new organizational units; in others, a realignment within existing units.

Pressing for Administrative Savings

In reviewing the Governor's Medicaid budget for Fiscal Year 96/97 budget, the California Legislative Analyst's Office recommended eliminating 48 field office positions and reducing the claims processing contract. These actions, it held, could save \$3.3 million, and were justified because managed care expansion was contributing to a declining fee-for-service workload.

The Governor's Office successfully maintained that such reductions were premature for that year. However, in its Fiscal Year 97/98 budget, it has proposed a reduction of \$3.1 million and 60 positions in Medicaid prior authorization staff because of the advance of managed care.

Challenge #5: Avoiding a Fee-For-Service Meltdown

In the shadow of managed care, fee-for-service often becomes viewed as the residual sector responsible for an outmoded product line. Yet, even into Stage III, it is likely to account for a majority of Medicaid expenditures and staff. Medicaid agencies must find ways of maintaining the effectiveness of this product line as they diminish its scope and continue to expand managed care.

One Medicaid agency manager framed the challenge well by asking these questions: "How do you manage two systems concurrently? You have people on both ends and people floating in the middle. How do you get people to change and get people who understand and have skills for both systems?"²²

► **Less innovation. Lower morale. Slower responses. These and other danger signs are becoming increasingly apparent in the fee-for-service sector of the agencies.**

Managers in most of the agencies we contacted indicated that the heightened attention being given to full-risk managed care was having some dysfunctional consequences on traditional fee-for-service operations. Although they did not see these consequences of great concern at this point, they believed that they could intensify as the move toward managed care accelerated. They indicated that the undesirable effects tend to be subtle and gradual, stemming from reduced program innovation and initiative on the fee-for-service side. Particularly common is reduced access to agency programming staff, who tend to be focused on managed care efforts and less available to help with efforts such as the development of new payment methodologies for various fee-for-service functions.

This situation, as one manager noted, could well require a greater tolerance for errors in the fee-for-service sector. For instance, reduced provider education efforts by provider

relations staff could (and some say do) contribute to a higher rate of erroneous provider claims which end up being denied.

In table 3, we address the effects of managed care on six selected fee-for-service functions. Our observations focus on the big picture that emerges when considering the 10 States we reviewed. In various ways and to varying degrees, of course, each State's own situation varies from the synthesis observations we offer.

TABLE 3 EFFECT OF MANAGED CARE ON TRADITIONAL FEE-FOR-SERVICE FUNCTIONS		
Function	Extent of Effect	Nature of Effect
Third Party Liability (TPL)	Moderate to Substantial	TPL role typically passed on to health plans. Leading to reduction in State agency TPL staffs and loss of agency expertise. Widespread concerns that health plan dollar recovery results will be less than those achieved by the agency.
Surveillance and Utilization Review Systems (SURS)	Moderate to Substantial.	Reductions in SURS exceptions and fee-for-service SURS staff. Refocusing on quality measurement and targeted studies. Decreased support for fee-for-service investigations. Little staff experience with managed care investigations.
Drug Utilization Review (DUR)	Moderate to Substantial.	Most States give DUR role to health plans. DUR staff have little connection with agency managed care staffs or with health plan DUR efforts. Most prescription drug expenditures still accounted for by aged and disabled fee-for-service population.
Provider Relations	Moderate.	Transition process triggers increase in inquiries. Signs in some States of dysfunctional effects such as longer response times, less attention to proactive provider education, and even an undermining of staff service ethic.
Claims Processing	Moderate.	Programming changes to accommodate managed care enrollments, payments, and encounter data. Five to 10 percent reduction in claims volume in some States. Some slippage in fee-for-service housekeeping tasks, such as correcting errors.
Prior Authorization	Minor.	Minimal signs of drop-off in workload as aged, blind, and disabled cases continue to sustain prior authorization efforts. But in a few States discussions already beginning about how to plan for substantial staffing reductions in next 2 to 3 years.

Our review reveals that the danger signs are particularly notable for three traditional fee-for-service functions. The first, and perhaps most pressing danger involves, the delegation of third-party-liability (TPL) responsibilities to the health plans.²³ These responsibilities involve identifying and obtaining payments from any other sources of insurance or coverage held by Medicaid beneficiaries. This is a process in which many Medicaid agencies have become quite adept and have used to achieve significant savings.²⁴ Most health plans, in contrast, have little experience with TPL tracking and recovery techniques. As long as prior fee-for-service TPL savings are reflected in capitated rates, the potential financial risks to Medicaid are contained. The enduring

challenge will be to ensure that capitated arrangements do not erode the incentives and expertise needed to maximize TPL recoveries.²⁵

The second concern centers around signs of a diminishing focus on fraud and abuse investigations in the fee-for-service sector at a time when that sector is still the dominant one in the great majority of State Medicaid agencies. This concern is reinforced by a recent Office of Inspector General report documenting a decline in the number of suspected fraud referrals to State Medicaid Fraud Control Units.²⁶ As important as it is to gear up to handle the new oversight responsibilities associated with managed care, a reduced scrutiny at this point on the fee-for-service side would seem to be an unacceptable price.

Finally, delegating DUR responsibilities to health plans raises concerns about how fully DUR programs are being used to oversee the adequacy of drug therapy regimes of Medicaid managed care enrollees. In accord with the requirements of the Omnibus Budget Reconciliation Act of 1990, State Medicaid agencies have developed DUR programs geared to their fee-for-service beneficiaries.²⁷ But, as we stressed in a prior report addressing the lessons learned by those programs, the infrastructure and insights they developed become increasingly irrelevant as beneficiaries are enrolled in health plans.²⁸ Thus far, the agencies report that they have little information about the thrust or effects of the plans' own DUR efforts. Adding to our sense of concern are findings in one of our more recent reports that most health plans contract with pharmaceutical benefit management companies to manage their prescription drug benefits and conduct only minimal oversight of the performance of these firms.²⁹

These concerns, we emphasize, are put forth as danger signs - as early alerts to what could emerge as significant problems if not adequately addressed. At the same time, we recognize that with proper guidance fee-for-service management can actually be strengthened as managed care expands. To some degree, this may in fact be happening in some States, especially those with large PCCM programs.³⁰

► Notwithstanding the danger signs, the fee-for-service sector of Medicaid agencies is not moribund. Within it are some creative stirrings that could contribute significantly to reinvigorated Medicaid agencies in the years ahead.

Particularly promising are those initiatives that seek to introduce a value purchasing approach to that sector. The Ohio agency, for example, has engaged in selective contracting for home and community based services and has negotiated a contract with a single provider for vision care services. Other agencies have taken similar approaches, which represent a significant contrast from the traditional bill-payer orientation of Medicaid agencies, but yet are not capitated managed care.

Many agencies are also actively involved in managing the care of certain high-cost beneficiaries who continue to be served within the fee-for-service sector. For instance, the California agency has been carrying out a medical case management program directed to patients who have had multiple hospital admissions and/or complex treatments. Under

the program, agency nurses work with the providers and patients to facilitate care in home settings and to avert preventable hospital readmissions. For Fiscal Year 1994-95, the agency documented savings of \$11.2 million for 2,349 cases.³¹ The State legislature was impressed enough to authorize funding for 46 new positions to support the program; this at a time when the agency's capitated managed care program was moving full speed ahead.

Finally, within individual fee-for-service sectors, one can find some efforts to minimize the adverse effects associated with downsizing. Striking in this regard is the Oregon agency's initiative in using prisoners to respond to basic telephone inquiries by providers and beneficiaries. Facilitated by a Statewide referendum that called for prisoners to be engaged in training or employment, this initiative has enabled a downsized provider relations staff to focus on more complex inquiries and to reduce its backlog of billing exceptions.

RETOOLING AS AN ISSUE

Retooling of Medicaid agencies for managed care has been a low priority issue.

This has been true for Medicaid agencies' leadership, the State legislatures, and the Health Care Financing Administration of the U.S. Department of Health and Human Services. In each of these settings, the focus of those concerned with managed care is on the substance of the effort as it affects providers, beneficiaries, and taxpayers. In the States we reviewed, even in those where managed care is well advanced, the emphasis on program design and implementation has been nearly all encompassing. Further, although important work has been done in developing conceptual frameworks, overall missions, and long-term plans, agency managers find themselves compelled to concentrate on near-term actions, often in a reactive rather than proactive mode. "Long-term around here," said one agency manager, "is about 2 months."

In this environment, agency leadership from time to time has given substantial attention to reorganizations intended to position the agency more effectively for the transition to managed care. But the thorny particulars of reorienting, retraining, and redeploying staff for new roles typically have remained on the backburner. And State legislatures to this point have expressed little interest in these particulars.

The Health Care Financing Administration (HCFA) has indicated some concern about these administrative issues. Its Medicaid monitoring guide for regional office officials raises some general questions that bear on the Medicaid agency's organizational readiness to carry out a managed care program. More notably, in its guide intended to help HCFA reviewers assess the readiness of States to carry out Section 1115 waivers, it has a section on State administration that poses some pertinent "retooling" questions to address. It asks for instance: "...what problems does the State foresee in running two parallel Medicaid programs? How will the two programs be coordinated?" It also asks: "Have key staff been hired and trained....?"

These and a few other such questions posed by HCFA address important issues concerning how Medicaid agencies equip their organizations. At times, they have led to communications with State officials about the adequacy of administrative resources being devoted in support of managed care efforts. But they typically are overshadowed by hundreds of other questions and communications focusing on the programmatic content and processes of managed care.

RECOMMENDATIONS

Our review indicates that during Stage I and even well into Stage II, State Medicaid agencies have not found it necessary to give major attention to the retooling challenges addressed in this report. In part, this is because the agencies' managed care initiatives have not yet had a substantial effect on their fee-for-service operations and staff. It is also because they have been able to assemble a core of talented staff who have been fast learners and have assumed the lion's share of design and early implementation responsibilities. Some of the agencies have been more aggressive than others in tackling and anticipating the internal organizational changes that will be necessary as they increase their commitment to managed care, but even in these cases, the efforts are more appropriately characterized as backburner rather than frontburner matters.

As Medicaid agencies approach and enter Stage III, this situation will have to change. As the decline in fee-for-service workloads accelerates, agency managers will be compelled to give high priority to how they redeploy most of their workforce into very different roles, orient them to a new mission, train them to develop new skills, and at the same time make certain that remaining fee-for-service operations continue to perform adequately. In the midst of all this, some, and perhaps most, of the agencies will also have to engage in significant downsizing of their staffs. A transformed agency focused on full-risk managed care and prudent purchasing typically will not require the staffing levels of traditional Medicaid agencies.

This transition presents major opportunities. The inevitable disruption provides management with a chance to reengineer their agencies in ways that enhance their overall productivity. In fact, given the scope of the internal changes necessary, Medicaid agencies could well serve as pioneers for workforce reforms for all of State government. Moving in this direction, however, will call for substantial support from both State governors and State legislatures. In particular, they would have to be willing to allow for and even urge changes in State civil service systems that now impede agency efforts to make most effective use of their human resources.

At the same time, the transition presents major dangers, particularly if the agencies are not adequately prepared for them. In the fee-for-service sector, lower levels of priority, innovation, and morale could erode service to beneficiaries and providers still dependent on that sector, and could weaken important oversight activities. In the expanded managed care sector, poor staff training, motivation, and organization could undermine the transition to capitated health care arrangements that State government is counting heavily upon to help contain Medicaid costs and improve the beneficiaries' access to good quality services.

The lead role here is that of the States. But given the partnership nature of the Medicaid program, the Federal government and State governments should work cooperatively in

finding effective ways of dealing with these challenges. Toward that end, we direct the following recommendations to the Health Care Financing Administration:

The HCFA should provide forums to help State Medicaid managers take advantage of the opportunities managed care presents for retooling their agencies and to minimize the associated dangers.

These forums could be convened at the national level, through the establishment of a work group or technical advisory group, as well as at regional levels, through the efforts of regional offices. State environments are too varied to expect that the development of a set of explicit national guidelines would be feasible. However, written analyses and discussions of lessons learned and promising approaches identified by State officials themselves could be quite useful. It could be particularly useful to tap into the experiences of those States where Medicaid managed care penetration is well advanced.

This kind of activity is especially important in view of our finding that State officials rarely get to attend conferences to become exposed to lessons learned by other States in moving from fee-for-service to managed care environments.

The HCFA should revise its review and monitoring protocols so that they devote greater attention to how State Medicaid agencies are handling the organizational challenges associated with expanded managed care.

These issues are too complex and too rooted in the distinctive characteristics of State political and organizational cultures to be conducive to checkmark certifications by federal reviewers. But in the course of its efforts to monitor State agency managed care initiatives, to review Section 1915 and 1115 waiver requests, and, most especially, to evaluate Section 1115 research and demonstration projects, HCFA (and its contractors) should incorporate greater discussion, inquiry, and assessment of retooling issues into its reviews. For agencies approaching and into Stage II, these reviews should devote particular emphasis to agency plans and activities involving the redeployment of fee-for-service staff. At the least, this process could help generate more attention to these issues at the State level. Beyond that, it could well yield insights that are helpful to State agency managers.

The HCFA, in its ongoing reviews of State Medicaid agencies, should scrutinize possible adverse effects of managed care expansion on the performance of established fee-for-service functions.

In these reviews, HCFA should give special attention to possible danger signs we noted concerning third-party-liability, surveillance and utilization review subsystems, and drug utilization review.

With respect to third-party-liability (TPL), HCFA has been well aware of the dangers that we note. For some time it has been working with State representatives and the American Public Welfare Association through a technical assistance group addressing the dangers

and how to address them. Most recently, these efforts have led to (1) the design and distribution of a survey to obtain up-to-date information on how States are handling TPL for beneficiaries in managed care, (2) the restructuring of State data reporting requirements to ensure that States report to HCFA third-party collections made by health plans, and (3) joint agreement that the American Public Welfare Association will prepare for the State Medicaid agencies a technical assistance piece that will offer guidance on how to incorporate TPL responsibilities in contracts with health plans.³² These are constructive initiatives. Our recommendation is intended to reinforce their significance and to encourage State Medicaid agency leadership to be fully alert to the most cost-effective ways of pursuing third-party-liability in managed care environments.

In regard to surveillance and utilization review subsystems (SURS), HCFA's Program Integrity Group has been undertaking initiatives that could help improve the effectiveness of State SURS units.³³ In response to the recent OIG report on these units, for instance, HCFA noted that it plans for these units to be users of its recently developed fraud investigation database. However, the intent of this initiative would be undermined if the remaining fee-for-service SURS units in the States lack sufficient staff resources or expertise to take full advantage of this database. This matter may warrant some attention by the Program Integrity Group.

For drug utilization review, finally, State Medicaid agencies and HCFA look to the collection and analysis of encounter data from plans as a way of overseeing their performance on drug management issues and minimizing the kind of danger we note in this report. However, with such efforts being in their very early stages, additional measures could be warranted. In that context, HCFA could work with the Medicaid agencies to identify ways of using the health plan contract as a vehicle for holding plans more fully accountable for how they manage drug therapies. These could involve the incorporation into the contracts of: (1) performance measures concerning prescription drugs that are set forth in the Health Plan Employer Data Information Set developed by the National Committee for Quality Assurance and (2) specific assurances that plans would obtain in their subcontracts with PBMs.³⁴ It could also involve, as we have noted in a previous report, increased State review of pharmacy practice in its on-site monitoring of the plans.

COMMENTS ON THE DRAFT REPORT

We solicited and received comments on the draft report from the Health Care Financing Administration, the Acting Assistant Secretary for Health (ASH), and the Assistant Secretary for Planning and Evaluation (ASPE). The ASPE concurred without elaboration. The HCFA and ASH comments appear in full in appendix B. Below we summarize them and offer our response in italics.

The HCFA concurred with our first two recommendations. It reinforced the importance of using existing mechanisms to help States learn from one another as they move from fee-for-service to managed care arrangements. It also agreed with the importance of reviewing and revising HCFA monitoring protocols so that they are sufficiently sensitive to the organizational challenges associated with expanded managed care.

With respect to our third recommendation calling for the State Medicaid agencies to scrutinize possible adverse effects of managed care expansion on the performance of established fee-for-service functions, HCFA offered a partial concurrence. It noted that actions taken in response to the first two recommendations could alleviate the need for such scrutiny and that HCFA, as our report indicates, is already doing a good deal to monitor possible adverse effects.

In line with the above comment, HCFA suggested that our reference to "danger signs" in the fee-for-service sector be changed to "concerns." It also suggested that the States discussed in the report be given the opportunity to comment on it.

We considered HCFA's suggestion on characterizing the possible problems in the fee-for-service sector as "concerns" rather than "danger signs." We decided to retain the latter term because it more accurately reflected what we heard and observed in the study States. At the same time, as we note in the report, we present the danger signs as early alerts that could emerge as significant problems if not adequately addressed.

Concerning HCFA's other comment about obtaining feedback from the States reviewed, we have received considerable comment from them during the course of framing our findings and recommendations. We are distributing the report widely among the States, and, as is our custom, will include with it a user feedback form inviting further comment.

Finally, the Acting Assistant Secretary of Health did not comment on specific findings or recommendations in the report, but did offer four suggestions intended to enhance the transition process to Medicaid managed care. They are helpful suggestions that warrant consideration by the States and HCFA. They concern the involvement of the State health departments in the managed care process, the need for broad stakeholder involvement in the process, the need to strengthen the integration of public health concerns into the change process, and the importance of strengthening compliance, monitoring, and evaluation at the State level.

APPENDIX A

BACKGROUND ON MEDICAID MANAGED CARE

Medicaid Expansion into Managed Care Programs

Over the past 15 years, States have increasingly used managed care to provide medical services for Medicaid beneficiaries. This trend has accelerated in the past few years: in 1991, 2.7 million Medicaid beneficiaries were enrolled in managed care, by 1993, that number grew to 4.8 million, and in 1996, 13 million. As of June 1996, 39 percent of all Medicaid beneficiaries were enrolled in some kind of managed care arrangement.

To date, States have primarily enrolled adults and children in low-income families into managed care, whereas aged or disabled beneficiaries remain under fee-for-service systems. By 1996, over 500 managed care organizations were providing services to 13 million Medicaid beneficiaries.

The movement to enroll Medicaid beneficiaries in managed care began in earnest in the early 1980s, as States experienced significant fiscal pressures due to rising Medicaid costs. While States viewed managed care as a way to contain Medicaid costs, they were constrained by Federal standards required for Medicaid enrollment in managed care.

In response to mounting concerns, Congress allowed States greater flexibility to deviate from those standards through amendments to the 1981 Omnibus Budget Reconciliation Act.³⁵ For example, the amendments allow States to pursue freedom-of-choice waivers (under section 1915 of the Social Security Act) that release them from certain Federal provisions, such as the free-choice-of-provider provision. To date, 42 States have freedom-of-choice waivers.

States also can receive research and demonstration waivers under section 1115 of the Social Security Act. Since 1992, many States have aggressively pursued such waivers. States implementing or pursuing 1115 waivers often extend, as a part of their demonstration, insurance benefits to those not otherwise eligible for Medicaid, such as the working poor and their families. As of this writing, HCFA has approved 18 research and demonstration waivers. Of those, 12 States have implemented their programs, 5 are pending implementation, and one has no plans to implement.³⁶ The HCFA is currently reviewing nine States' applications.³⁷

Defining Managed Care

Although managed care organizations vary, they generally feature a focus on primary, preventive health care and care coordination. That focus is believed to improve care and access for enrollees. It is also thought to promote cost containment, thus slowing the rate of increase in health care spending.

The managed care organizations enrolling Medicaid beneficiaries can generally be defined as fitting into one of two basic types: health maintenance organizations and fee-for-service primary care case management (PCCM) programs. Both types feature coordinated care. But each carries a different level of financial risk. Health maintenance organizations (hereafter referred to as health plans or plans) are full-risk plans that contract with Medicaid for a fixed fee per person and provide comprehensive services.³⁸ PCCM programs comprise providers, usually primary care physicians, willing to serve as gatekeepers and take responsibility for approving and coordinating enrollees' care. Medicaid pays PCCM providers on a fee-for-service basis, but they receive a case management fee to cover their added responsibilities. Thus PCCM providers are at no financial risk.

Some agencies also contract with plans separately for certain aspects of care, such as mental health, substance abuse, and dental care. The arrangements for these "carve-outs" vary in terms of the services included and the level of financial risk the plan assumes.

APPENDIX B

COMPLETE COMMENTS ON DRAFT REPORT

In this appendix, we present in full the comments of the Health Care Financing Administration and the Acting Assistant Secretary for Health.

APPENDIX C

ENDNOTES

1. See, for examples, General Accounting Office, *Medicaid: Data Improvements Needed to Help Manage Health Care Program*, (IMTEC-93-18), May 1993; General Accounting Office, *Medicaid: Experience with State Waivers to Promote Cost Control and Access to Care*, (T-HEHS-95-115), March 1995; Kaiser Commission on the Future of Medicaid, *Medicaid and Managed Care: Lessons from the Literature*, Washington, DC, March 1995. John K. Iglehart, "Health Policy Report: Medicaid and Managed Care," *New England Journal of Medicine* (322) 25, June 22, 1995, 1727-1731; Joel Schendler, "Implementing a Managed-Care System in a Fee-for-Service Environment," *W Memo*, vol.7, no.7, July 1995, pp. 29-31; Physician Payment Review Commission, *Annual Report to Congress, 1995*; General Accounting Office, "Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan," (HEHS-95-87), April 1995; National Academy for State Health Policy, *Medicaid Managed Care: A Guide for States*, Portland, Maine, 1995; and Michael S. Sparer, *Medicaid Reform and the Limits of State Health Reform*, (Philadelphia: Temple University Press, 1996).
2. In this report, we use the term "organizational" challenges in reference to those internal issues affecting the productivity of the agency. They center around how agency management relates to agency staff and defines their missions, roles, and tasks. These challenges are of course related to, but yet distinct from those focusing on the design, implementation, and assessment of managed care efforts.
3. The National Academy for State Health Policy has given some attention to these challenges. See its chapter on administrative issues in *Medicaid Managed Care Guide: A Guide for States*.
4. Donna Checkett, "A State Medicaid Director on Medicaid Managed Care," *Health Affairs* 15 (3), Fall 1996, 172.
5. The States are California, Florida, Ohio, Massachusetts, Minnesota, Missouri, New York, Oregon, Rhode Island, and Utah. Our in-depth visits were to California, Minnesota, and Massachusetts.
6. Nowhere, it seems, has Medicaid managed care been ushered in more quickly than in Tennessee. See G. Girden Bonnyman, Jr., "Stealth Reform: Market-Based Medicaid in Tennessee," *Health Affairs* 15 (2) Summer 1996, 306-14; Jim Cooper (former congressman), "TennCare: Tennessee's Medicaid Experiment," Letter to the Editor in *Health Affairs* 15 (4), 282; and David M. Mirvis, et al., "TennCare--Health System

Reform for Tennessee," *Journal of the American Medical Association*," (274) 15, October 18, 1995, 1235-1241.

7. In an extended discussion, *Medicine and Health* reports on four basic stages of health care market development as delineated by the American Practice Association. See Christina Kent, editor, "Perspectives," *Medicine and Health*, April 17, 1995, 1-4.

8. California, for instance, has undertaken some major Medicaid managed care efforts in the early 1970s. They turned out to be largely unsuccessful, but provided a body of lessons learned experience to draw upon in framing the more recent initiatives. See Sparer, *Medicaid and the Limits of State Health Reform*.

9. The California Medicaid program covers about 5.5 million enrollees. In contrast, the Rhode Island program covers a little more than 100,000. Clearly, the dimensions of the retooling challenges are very different in these two settings.

10. The complexity is greatly influenced by factors such as the number and type of carve-outs; the number and scope of relationships with other State agencies, with county governments, and with local service providers (such as community health centers); and the number of linguistic groups being served (about 40 in California)

11. In particular, these would involve State health departments and State departments responsible for licensure of insurance entities.

12. Given that our categories are general and that the pace of change in the States is often quite fast, any assignment of individual States to particular Stages, as we have done, can be risky. Perhaps the most difficult assignment in this regard is Massachusetts. At this writing, PCCM remains as the dominant mode of managed care in Massachusetts. However, the Medicaid agency has a substantial number of disabled enrolled in PCCM arrangements and the agency leadership has infused throughout much of the agency a purchaser orientation much like that we describe for Stage II or III States.

13. Our typology of five challenges omits one that might normally be regarded as one of the most prominent: the adequacy of staffing levels to carry out managed care responsibilities. In our presentation, that challenge is to some degree subsumed under some of the others, which we found more compelling. For instance, the challenges of establishing a core team and acquiring the necessary knowledge and skills clearly involve obtaining adequate numbers of staff.

None of this is meant to minimize the danger of managed care initiatives being jeopardized by having too few staff associated with their implementation. Indeed, in a recent review of five Section 1115 Medicaid managed care demonstration projects, the authors offer the following warning: "New programs need to have enough administrative resources." They add: "At least in the short term, states may require more administrative capacity, particularly if they are continuing to use fee-for-service for some populations or services." See Mathematica Policy research, Inc. and the Urban Institute, *Implementing State Health Care Reform: What Have We Learned From The First Year?*

The First Biannual Report of the Evaluation of Health Reform in Five States. Submitted to Office of research and Demonstrations, Health Care Financing Administration, December 18, 1996.

14. In Florida, responsibility for managed care is split between two offices. The full-risk component is led out of the Bureau of Managed Care in the Division of Quality Assurance. The PCCM initiative is run out of the fee-for-service operation in the Division of State Health Purchasing.

15. Of course, this complaint is not unique to managers in the Medicaid agency. Managers in other State and Federal agencies regularly express similar concerns about the lack of flexibility afforded by personnel systems. But for an agency seeking to introduce a fundamental shift in its mission and operations, such inflexibility can present particularly serious problems.

16. Although perhaps a bit dramatically, one agency manager conveyed the seriousness of the situation as viewed by many Medicaid program staff: "Change is coming too fast to adjust employee perceptions. It's like stages of death. It's like a corporate merger. It's a rough transition. It's like mourning for a loss."

17. In Massachusetts, consultants from the University of Massachusetts interviewed staff and conducted focus groups involving staff. The effort identified some communication problems within the agency and led to a series of initiatives addressing them. These included an agencywide newsletter, regular off-site meetings with senior staff to discuss benefit plan progress, a survey of training needs, and some field reorganization.

18. In Missouri, after interviewing about 75 agency staff, a consultant developed a four-phase process to prepare the agency for the internal changes necessary to carry out expanded managed care responsibilities. It involved two retreats as well as consultant-facilitated task groups and technical assistance to help agency management and staff "make the necessary adjustments to the new structures and systems. . . ."

19. As the State Medicaid agency that has gone the furthest in transforming itself from fee-for-service to managed care, the Oregon agency has a substantial body of experience to draw upon in further explaining the challenges of retooling and understanding the lessons learned in responding to them. Unfortunately, in our inquiry, our contacts with Oregon officials did not involve a site visit and were limited to brief telephone conversations; so in this report we are unable to draw substantially on the Oregon experience. It does, we believe, warrant further examination, in the context of the issues raised in this report.

Of course, there is a substantial literature on Oregon's Medicaid reforms. See, for examples, Mathematica Policy Research (for the Kaiser Foundation and Commonwealth Fund), *Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon*, July 1995; and John A. Kitzhaber, "The Governor of Oregon on Medicaid Managed Care," *Health Affairs* (15) 3, Fall 1996, 167-69.

20. This was a particular problem for the Oregon agency when, in 1994, it was substantially expanding the number of individuals served by the Medicaid program. The fee-for-service provider relations staff found itself faced with significant increases in telephone inquiries and billing exceptions. Before long a substantial backlog developed which added to frustrations.
21. A politically sensitive point not usually emphasized by the architects of managed care reforms is that for a time dual managed care/fee-for-service systems will actually be more expensive to administer than traditional fee-for-service systems. It is not until sizeable decreases occur in fee-for-service claims volume that significant opportunities for administrative savings are likely to emerge.
22. In those agencies that are increasingly oriented toward a prudent purchasing perspective and explain their mission in those terms (as does the Ohio agency), the distinctions between fee-for-service and managed care may become increasingly blurred. According to former HCFA Administrator Bruce Vladeck and health care consultant Lynn Etheredge, this, in fact, is happening in health care markets across the country. See Robert Cunningham, editor, "Perspectives: Government as Purchaser: Making Policy by Contract," *Medicine and Health*, October 14, 1996, 1-4.
23. Consultants hired by State Medicaid agencies often recommend that TPL be delegated to health plans to simplify administration for the agency. As long as the capitated rate reflects prior levels of TPL recovery on the fee-for-service side, this delegation tends to be attractive to the Medicaid agencies.
24. A California Medicaid official has estimated that "without TPL savings, California's Medicaid costs would be over 20 percent higher." See Barbara V. Carr, "Who Manages Third Party Liability when a State Contracts its Medicaid Program to Managed Care Plans," March 1995.
25. See Jane Horvath, "Third Party Liability in Risk-Based Managed Care: Issues and Options," in National Academy for State Health Policy, *Medicaid Managed Care: A Guide for States*, 1995, III-65-81.
26. Office of Inspector General, Office of Evaluation and Inspections, "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," (OEI-07-95-00030), November 1996.
27. The legislation exempted health plans contracting with Medicaid agencies from the requirements of the DUR program it set forth.
28. Office of Inspector General, Office of Evaluation and Inspections, "Medicaid Drug Use Review Programs: Lessons Learned by States," (OEI-01-92-00800), May 1995 (Draft Report).
29. "Experiences of Health Plans with Pharmacy Benefit Management Companies," (OEI-01-95-00110), December 1996.

30. In Massachusetts, for example, the Medicaid agency leadership treats its PCCM program as an internally managed health plan and manages its fee-for-service providers accordingly. This is reflected, for example, in its hospital contracting approaches and in its system of profiling "network managers" and providers.

31. California Department of Health Services, "Medical Case Management: A Successful Partnership," September 1995.

32. It also bears note that in May 1996, HCFA sent to the State Medicaid agencies a draft manual issuance that spells out various options available to the States in carrying out TPL responsibilities in managed care environments.

33. The Program Integrity Group has been established to address fraud and abuse issues affecting the Medicare and Medicaid programs.

34. This and the following recommendation were made in our aforementioned report entitled, "Experiences of Health Maintenance Organizations with Pharmacy Benefit Management Companies."

35. The 1981 amendments also allow States to enroll Medicaid beneficiaries in limited-risk managed care organizations (i.e., no risk for inpatient care) that fail to meet Federal qualifications.

36. The following States have implemented their 1115 waivers: Alabama, Arizona, California, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, and Vermont. The following States have approved 1115 waivers that are pending implementation: Florida, Illinois, Kentucky, Maryland, and Massachusetts. South Carolina has an approved waiver but no plans for implementation.

37. States with 1115 waivers under review are: Georgia, Kansas, Louisiana, Missouri, New Hampshire, New York, Texas, Utah, and Washington.

38. Federal regulations define comprehensive services as either inpatient hospital services and one other mandatory service or three or more mandatory services (42 CFR 434.21). Mandatory services are defined in statute as inpatient and outpatient care, physicians' services, and laboratory and diagnostic services, among others (42 USC §1396d(a)).