

RESTRUCTURING MEDICAID OFFICES TO DEAL WITH MANAGED CARE

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PREFACE

Throughout 1997, the Center for Health Care Strategies' Medicaid Managed Care Program (MMCP) has conducted Medicaid Managed Care Readiness Assessments with a number of state Medicaid agencies throughout the country. Our goals have been twofold:

1. To help states prioritize their activities in their Medicaid managed care developments, implementations, and operations; and
2. To offer technical assistance and grant opportunities to support efforts to make Medicaid managed care work in states that are demonstrating a commitment to vulnerable populations.

While we assessed states' levels of readiness to do rate-setting, quality assurance, enrollments, etc., we did not include "infrastructure" in our original list of Medicaid managed care capacities to be assessed. We quickly realized that the capacity for states to introduce Medicaid managed care programs was heavily dependent on the organizational capacities of the Medicaid agencies.

The U.S. Department of Health and Human Services Office of the Inspector General did an excellent job in shedding light on this challenge for states in its August 1997 report, *Retooling State Medicaid Agencies for Managed Care*. Jim Verdier, Director of State Health Policy at Mathematica Policy Research, Inc. and former Indiana Medicaid Director, provides further insights for Medicaid agencies in this policy report that summarizes the discussions of states' experiences with these issues in a session at the National Association of State Medicaid Directors Fall 1997 Annual Meeting. This short report is a practical and insightful inventory of challenges and recommendations that captures the experiences of four state Medicaid agencies that have made the transition to Medicaid managed care. It responds to the overall challenge for states, and to the Medicaid Managed Care Program's ultimate goal to make Medicaid managed care work, especially for vulnerable populations.

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EXECUTIVE SUMMARY

Managed care is fundamentally transforming the purchasing and delivery of health care. The challenges of operating in this new world of managed care are at least as great for state Medicaid offices as they are for the private sector, but Medicaid offices must also operate in the context of state government, with its built-in impediments to rapid change.

Medicaid office managers must change the way they organize and staff their offices to deal effectively with managed care, and the people in those offices must grapple with a new and often unfamiliar set of issues, concepts, and tasks.

This policy report reviews how Medicaid offices in Oregon, Rhode Island, Michigan, and Indiana dealt with these challenges, and develops some lessons, guidelines, and suggestions from those experiences. It builds on a workshop, moderated by the author, that was held at the October 1997 meeting of the National Association of State Medicaid Directors in Alexandria, Virginia, at which top officials from those states presented and discussed their experiences. The workshop panel members were Hersh Crawford, Oregon Medicaid director, Bob Smedes, Michigan Medicaid director, and Tricia Leddy, Rhode Island Medicaid managed care director. That workshop was in turn prompted by visits to states over the past year by the Center for Health Care Strategies, during which several states identified Medicaid office restructuring as one of their major concerns.

The report discusses restructuring issues in the order in which they are likely to arise in a state decision-making process: threshold planning questions, major initial challenges, and major longer-term challenges.

I. THRESHOLD PLANNING QUESTIONS

Medicaid offices should first list all the new responsibilities that managed care requires the Medicaid office to assume, and then determine which of those responsibilities existing staff may be able to assume, perhaps with some retraining. Those that are left will probably require some combination of new staff and outside contractors, to the extent state resources and purchasing, contracting, and staffing rules permit.

Some examples of how responsibilities might be allocated are illustrated in the table on the following page. As many of the responsibilities may be shared among current and new staff and outside contractors, the table in some cases shows primary (**X**) and secondary (*x*) allocations of responsibility. The allocations shown in the table are meant to be suggestive rather than definitive; individual states may have good reasons for allocating responsibilities differently, based on their own context. For managed care functions where various approaches have worked well, the table shows that either primary or secondary responsibility for a particular function may be appropriate (**X**, *x*).

Table 1. Illustrative Allocations of Managed Care Responsibilities

Managed Care Responsibility	Current Staff	New Staff	Contractors
Designing new managed care program	<i>x</i>	<i>x</i>	X
Coordinating with other agencies	X	<i>x</i>	<i>x</i>
Meeting with stakeholders	X	<i>x</i>	<i>x</i>
Developing RFPs and contracts	<i>x</i>	<i>x</i>	X
Actuarial rate-setting	<i>x</i>	<i>x</i>	X
Educating and enrolling beneficiaries	X, x		X, x
Monitoring complaints and grievances	X, x	X, x	X, x
Developing new data systems	<i>x</i>	<i>x</i>	X
Monitoring MCO quality, access, and solvency	<i>x</i>	X, x	X, x
Reorienting fraud and abuse surveillance	X, x	X, x	<i>x</i>
Independent external review of MCOs	<i>x</i>	<i>x</i>	X

Key: **X** = Primary responsibility; *x* = Secondary responsibility; **X, x** = Either primary or secondary responsibility; MCO = Managed care organization

II. MAJOR INITIAL CHALLENGES

The threshold planning issues discussed above often merge into initial implementation issues that top management in the Medicaid office must address. The major challenges at this stage include:

- **Assuring strong and committed leadership.** Strong backing from the governor and other top executive branch officials is necessary at this stage, when levels of controversy and anxiety are likely to be high. Support from key legislators is also important.
- **Getting adequate administrative resources and time.** Managed care is likely to require more administrative resources than fee-for-service Medicaid, especially in the early stages. Program budget savings are also likely to be substantially smaller and

less immediate than many governors and legislators expect. Keeping savings expectations realistic can help provide valuable flexibility for both program design and implementation.

- **Establishing a core managed care team.** Managed care requires people with a mix of skills and backgrounds, combined with energy, enthusiasm, eagerness to learn, flexibility, comfort with lots of unknowns, and a good sense of humor. Successful teams usually have a combination of new and current people, sometimes supplemented by outside consultants.
- **Recruiting new staff.** States have varying degrees of flexibility in recruiting and hiring. Since managed care requires some skills not commonly found in state government, and since turnover of key staff is likely to be high, states should anticipate spending a significant amount of time on recruiting.
- **Instilling a new organizational mission and culture.** Much of what managed care implementation teams must do requires a new orientation and new ways of doing business. The managers of these teams strive, usually successfully, to develop a sense of esprit and “specialness” in the managed care team. This may leave the rest of the Medicaid staff feeling like outsiders. Top Medicaid office managers face a continuing challenge in melding the old and new cultures.
- **Acquiring necessary knowledge and skills.** Because managed care is complex and rapidly changing, managers must establish an environment of continuous learning. There is extensive written information on managed care, and conferences abound. Managers should make sure that they and key staff members have the time and opportunity to take advantage of these resources. Managed care consultants can also be good resources for staff training.
- **Establishing a strong and comprehensive monitoring capability.** In managed care, the main focus becomes monitoring a program rather than operating it. States experienced with managed care have established a wide variety of ways of monitoring quality of care, access, and MCO financial performance. The 1997 Balanced Budget Act requires even more focus on quality assessment and improvement.
- **Coordinating with other state agencies, counties, and local governments.** Managed care widens the range of players that Medicaid offices must deal with. New ways of doing business require the development of new relationships with these entities and the re-negotiation of old ones. Experienced top-level Medicaid staff can play a key role in these efforts.

III. MAJOR LONGER-TERM CHALLENGES

As Medicaid managed care becomes more broadly and firmly established, Medicaid office managers can turn their attention to some longer-term challenges:

- **Phasing down reliance on outside contractors and consultants.** Over time, as managed care becomes more routine and operational, outside consultants who helped

with initial program design, drafting RFPs, and the like should be less necessary. Enrollment broker tasks may be shifted to state or county staff as they become more familiar with managed care issues, and as the initial surges of new enrollment taper off. Some states, however, expect to rely on contractors for indefinite periods for enrollment brokering, monitoring, and other operational responsibilities.

- **Firming up relationships with longer-term contractors.** Some outside contractors will probably be necessary for the indefinite future, such as actuaries and independent external quality reviewers. Medicaid offices should strive to develop firm collaborative relationships with these longer-term contractors through open communication and other efforts to build up trust and commitment (keeping in mind that the roles of some contractors and state contracting and procurement rules may require a degree of independence from the office).
- **Dealing with staff turnover and redeploying fee-for-service staff.** Turnover among good managed care staff will be high, since they are much in demand in the private sector. Medicaid offices experienced with managed care respond to this by retraining and redeploying existing staff, ongoing recruitment of new staff, and reliance on longer-term contractors.
- **Avoiding fee-for-service administrative atrophy.** Fee-for-service Medicaid is not likely to wither away soon. Most states have taken only limited steps to enroll the elderly and disabled — who account for about 30 percent of all Medicaid recipients and 70 percent of all expenditures — into managed care. Traditional fee-for-service functions must remain in place and operating well to serve these vulnerable populations. Medicaid office managers should not become so distracted by managed care that they neglect these fee-for-service functions and the people who perform them.
- **Adapting to the changing health insurance marketplace.** The new state Children’s Health Insurance Program and state efforts to extend health insurance to the working poor present new challenges to state Medicaid programs, thrusting them into an even broader and more complex health insurance marketplace, and requiring greater focus on the relationships between Medicaid and commercial insurance programs.

INTRODUCTION

Managed care is fundamentally transforming the purchasing and delivery of health care. State Medicaid programs are in the middle of these changes, and in many states are leading them. They are doing so under many of the same financial pressures that are driving managed care in the private sector, but with less of the flexibility in purchasing, contracting, and staffing that allows the private sector to respond quickly to change. The public sector's requirements for due process and public accountability establish built-in limits to rapid change.

This policy report describes how some state Medicaid programs have restructured their Medicaid offices to respond to the challenges and opportunities of managed care. It outlines a series of issues and options for states to consider as they develop the changes in their own ways of doing business that Medicaid managed care will require. In presenting options, the report tries to take into account the constraints that most state governments face: limited fiscal and administrative resources, rigid personnel and contracting systems, relatively low pay, and — especially in managed care — strong competition from the private sector for talented people.

SOURCES

The report flows out of a workshop that was held at the annual fall meeting of the National Association of State Medicaid Directors (NASMD) in October 1997. Hersh Crawford (Oregon Medicaid director), Bob Smedes (Michigan Medicaid director), and Tricia Leddy (Rhode Island Medicaid managed care director) each made presentations. Jim Verdier, director of state health policy at Mathematica Policy Research, Inc., and Indiana Medicaid director from 1991–97, moderated the discussion. The workshop participants and reviewers of initial drafts of the report subsequently provided additional information and suggestions, which have been incorporated.

Because of the timeliness and importance of this topic for state Medicaid programs, the Center for Health Care Strategies (CHCS) has supported preparation of this summary of Medicaid office restructuring issues. The NASMD workshop that provides a partial basis for the summary was prompted by a series of assessments CHCS has conducted of states' readiness to design and implement Medicaid managed care programs. These assessments, conducted at the request of individual states, identified the issue of Medicaid office restructuring as a major concern of state officials.

The Department of Health and Human Services' Office of Inspector General has also identified this as a major issue for states. Its recent report, entitled *Retooling State Medicaid Agencies for Managed Care* (August 1997), is another significant source for this policy report.¹

APPROACH AND PREVIEW

This policy report discusses the issues in the order in which they might arise in a state decision-making process. States are obviously at various stages of this process, and decision-making does not always proceed in a neat linear fashion, but laying the issues out in this step-by-step way should help states locate where they are in the process, and help them think through how best to proceed in their own circumstances.

The policy report has three main sections:

1. **Threshold planning questions**, covering such issues as the new responsibilities that managed care requires Medicaid offices to assume, which of them can be performed by existing staff, which by new staff, and which by contractors or other entities.
2. **Major initial challenges**, including assuring strong and committed leadership, getting adequate administrative resources and time, establishing a core managed care team, recruiting new staff, instilling a new organizational mission and culture, acquiring necessary knowledge and skills, establishing a strong and comprehensive monitoring capability, and coordinating with other state agencies, counties, and local governments.
3. **Major longer-term challenges**, including phasing down reliance on outside contractors and consultants, firming up relationships with contractors who will be needed for the long term, dealing with staff turnover, redeploying fee-for-service staff, avoiding fee-for-service administrative atrophy, and adapting to the changing health insurance marketplace.

I. THRESHOLD PLANNING QUESTIONS

There are a series of threshold planning questions involving administrative and resource issues that states should consider before they decide how to proceed with managed care. The first step should be to inventory the new responsibilities that managed care will require Medicaid offices to assume, followed by consideration of how much can be done in-house with existing or new staff, and how much should be contracted out or delegated to other entities.

A. WHAT NEW RESPONSIBILITIES DOES MANAGED CARE REQUIRE MEDICAID OFFICES TO ASSUME?

As they move into managed care, state Medicaid offices must assume a wide array of new responsibilities, some of them similar to traditional fee-for-service functions, but others that are quite different and unfamiliar to most state government employees. The new responsibilities include:

- Designing the managed care program in accordance with Health Care Financing Administration (HCFA) requirements and state goals and capacities
- Coordinating with other state agencies, such as public health and insurance
- Meeting with stakeholders, including providers, recipients, advocates, and legislators
- Developing requests for proposals (RFPs) and contracts with managed care organizations (MCOs) and other entities, and revising existing contracts
- Working with actuaries to develop and/or negotiate capitated (per-member, per-month) payment rates
- Educating and enrolling beneficiaries and providers
- Receiving, tracking, and responding to complaints and grievances
- Overseeing and monitoring MCOs, other providers, and contractors
- Developing new data and information systems to collect, analyze, and report data on enrollment and disenrollment, complaints and grievances, services provided by MCOs and their networks (encounter data), and Health Plan Employer Data and Information Set (HEDIS) measures of quality and access
- Monitoring access, quality, and MCO solvency
- Modifying fraud and abuse surveillance to reflect the different incentives in managed care
- Providing for the external independent review of MCO quality and access that federal law requires

B. WHICH OF THESE RESPONSIBILITIES COULD EXISTING STAFF ASSUME?

Given the difficulties many states face in hiring new staff and procuring services from outside contractors, and the valuable experience and commitment that current employees can bring to managed care, the next step in planning should be to determine which managed care functions current employees could perform, with retraining as necessary and perhaps in partnership with new staff or outside contractors. This step should begin with an inventory of the experience, training, and interests of current staff.

Current Medicaid Staff Backgrounds

Medicaid office staffs in most states have backgrounds and experience in the fee-for-service environment that fall into the following general categories:

- **Social services and social work.** Many staff members started their careers as eligibility workers or caseworkers, and have extensive experience helping recipients and providers work out problems on a case-by-case basis.
- **Claims processing and monitoring.** Especially in states in which claims processing is done in-house, a large number of staff people work with computer systems issues, provider and recipient enrollment and monitoring, and resolution of processing problems.
- **Clinical review, monitoring, and decision-making.** Medicaid offices frequently have nurses and physicians who work on medical policy issues (prior authorization, medical necessity determinations) and review of placements and services in nursing homes and other facilities.
- **Budgeting, auditing, and rate-setting.** These traditional fee-for-service financial functions are normally performed at least in part by Medicaid office staffs, with varying degrees of involvement by other state agency staff and/or outside contractors.
- **Fraud and abuse surveillance.** While the investigation and prosecution of fraud and abuse is usually handled by a Medicaid fraud unit in the state attorney general's office, Medicaid office staffs — especially those in surveillance and utilization review (SUR) units — generally work closely with these outside fraud units.

There are a number of managed care functions that people with these backgrounds could perform with relatively little retraining. Some examples include:

- **Coordination with other state agencies and meetings with stakeholders.** While this kind of coordination requires considerable understanding of managed care issues and options, experience of working with the actual human beings involved is often at least equally important. High-level and experienced Medicaid management and policy staff are likely to have personal contacts in other state agencies and with stakeholder groups that can facilitate coordination and consultation. Experience may well come with problematic baggage, however, so an outsider with a fresh view may sometimes be more effective. Contractors may bring this fresh view, along with managed care expertise, so melding them with existing staff can be especially

effective. Contractors can also help in coordinating and documenting activities and meetings.

- **Beneficiary and provider enrollment and education.** These are traditional fee-for-service functions. Medicaid staffs must learn the basics of managed care to perform them, but these are largely rule-driven tasks. Medicaid staffs have had to master a host of Medicaid rule changes over the past decade, so this should be a similar experience.
- **Monitoring access and quality.** Provided they have access to the right kinds of data, Medicaid SUR staffs should be able to do a good job on a number of managed care monitoring tasks, especially those that involve analysis of data. Medicaid staff with medical and nursing backgrounds may be able to play an effective role in on-site quality and access monitoring of MCOs, and in clinical quality of care reviews.

The table that follows lists the areas where current staff, usually with some retraining, may be able to assume or assist with new managed care responsibilities.

Table 2. Potential Links Between Current Staff Experience and Managed Care Responsibilities

Fee-for-Service Experience	Potential Managed Care Application
Social services and social work	<ul style="list-style-type: none"> • Educating and enrolling beneficiaries and providers • Handling grievances and complaints • Monitoring access • Meeting with stakeholders
Claims processing and monitoring	<ul style="list-style-type: none"> • Tracking grievances and complaints • Monitoring MCOs and other providers • Monitoring access • Helping to develop new data and information systems
Clinical review and monitoring	<ul style="list-style-type: none"> • Helping to develop new data and information systems • Monitoring quality • Monitoring clinical fraud and abuse
Budgeting, auditing, and rate-setting	<ul style="list-style-type: none"> • Working with actuaries • Helping to develop new data and information systems • Monitoring MCO solvency • Monitoring access • Monitoring financial fraud and abuse
Fraud and abuse surveillance	<ul style="list-style-type: none"> • Helping to develop new fraud and abuse monitoring systems • Monitoring access

C. WHICH OF THESE RESPONSIBILITIES ARE LIKELY TO REQUIRE NEW KINDS OF STAFF?

Medicaid fee-for-service staffs have generally not had extensive experience with tasks that require complex financial and organizational analysis, or negotiations with large private-

sector organizations. To the extent that these issues arise in a fee-for-service context, they usually involve individual transactions or audits of individual providers. More complex analytic tasks, such as the design of new provider reimbursement systems or audits of hospital cost reports, are usually performed by outside contractors. Medicaid fee-for-service staffs also generally do not have extensive experience in collecting, analyzing, and reporting large quantities of data. Budgeting and utilization review staffs are exceptions to some extent, but they tend to operate in specialized contexts with standardized rules and relatively narrow audiences.

Oregon Medicaid director Hersh Crawford makes a pointed comparison that emphasizes this staffing gap:

The managed care plans in your state already know more about rate-setting, contracting, building and maintaining a delivery system, and assessing provider capacity and financial solvency than you do.

Accordingly, the following kinds of managed care responsibilities will probably require new kinds of staff, or assistance from outside contractors:

- **Program design.** Experience in the managed care industry or familiarity with other state Medicaid managed care programs is usually necessary to design a credible and workable program.
- **RFP and contract development.** These crucial tasks are quite specialized, and require both legal skills and considerable familiarity with managed care operations. In addition, many current state staff people have spent much of their careers in contexts in which all the rules were set out in state regulations or statutes rather than in contracts. Carrying the regulatory mind-set into contracting can be problematic, leading in some cases to overly prescriptive and difficult-to-enforce requirements.
- **Rate development and negotiation.** States that try to do this without the assistance of outside actuaries are asking for trouble. “Hire the best actuary you can find,” Hersh Crawford says. “The managed care plans already have.” Relying solely on outside actuaries can also present problems, however. There should be people on the Medicaid office staff who know enough about what actuaries do to work with them effectively — answering their questions, making sure they have actually provided what the state has asked for, and explaining what they have done to other Medicaid staff, managed care plans, and fiscal staff in the legislature and other executive agencies.
- **Data and information system development.** Assistance from outside contractors may well be needed to evaluate existing data and information systems and design and implement new ones. Again, however, there must be at least some people on the Medicaid office staff who can help the contractors define report specifications and serve as translators to be sure the data being collected and reported meet the office’s management and policy needs, including HCFA reporting requirements.
- **Data-based monitoring of access and quality.** As noted above, Medicaid fee-for-service staffs can often be effective in monitoring roles, but they are accustomed to

operating in a case-by-case mode. New staff with data analysis skills will probably be needed to help the current staff identify patterns in the data that indicate potentially broader quality and access problems.

- **Financial solvency monitoring.** Medicaid fee-for-service staffs generally have little experience of analyzing the income statements and balance sheets of large, complex organizations like MCOs. State departments of insurance monitor insurance company and MCO solvency in most states and may continue to do so under Medicaid managed care. Nonetheless, Medicaid offices may need some independent capability in this area to work effectively with insurance departments, or to assume more of the monitoring responsibilities themselves.
- **Management of the state’s consultants and contractors.** If the state relies extensively on consultants and contractors for ongoing operational activities, such as enrollment brokering and recipient counseling, state staff must know how to hold contractors accountable for their performance. Current staff people may not have this kind of experience. Contractors can sometimes be used to help monitor other contractors. Enrollment brokers, for example, can help monitor a fiscal agent’s performance of enrollment-related functions. Enrollment brokers and external quality review organizations can help monitor many aspects of MCO performance.

D. WHICH FUNCTIONS SHOULD BE CONTRACTED OUT?

State Medicaid programs commonly use outside contractors for a wide range of managed care tasks, including program design, RFP and contract development, capitated rate-setting and risk adjustment, data and information system development, design of monitoring systems, enrollment and education of recipients and providers, quality and access monitoring, and independent external program evaluation.²

The basic threshold question is the extent to which state financial resources and procurement and personnel rules permit contracting out. Assuming some outside contracting is feasible, the following considerations should help states determine which managed care functions might be contracted out, given their own circumstances. In general, **a function is a candidate for contracting out if:**

- It requires technical skills that are difficult to attract and retain in state government, such as actuarial assistance
- Experience in other states or in other contexts may add significant value, such as program design and contract and RFP development
- It requires large numbers of additional staff initially, but fewer later on, such as beneficiary and provider enrollment
- A significant number of vendors provide the service, assuring at least a minimum level of competition and capability (actuarial assistance, enrollment brokering, quality monitoring)

- Federal laws or regulations require that at least some portion of the activity be performed by an independent entity, such as review of MCO quality and access
- Existing entities, such as other state or local government or private agencies, can provide the service and/or can make a strong public case that they should be allowed to

The final section of this report discusses ways of developing effective relationships with contractors over time, with a special focus on contractors who serve long-term managed care needs that state staff may not be able to meet.

E. WHAT IF NO NEW STAFF OR CONTRACTING RESOURCES ARE AVAILABLE?

As discussed in more detail in the next section, it is very difficult to implement managed care with no new resources. States that have extensive experience with Medicaid managed care, such as Arizona and Oregon, report that managed care has higher administrative costs than fee-for-service Medicaid. In addition, states making the transition to managed care should not expect the traditional fee-for-service administrative workload to decline appreciably until managed care is broadly established.

Nonetheless, Medicaid offices must often play the hand that is dealt them, even if it is not an ideal one. In those circumstances, options include:

- Retraining or reassigning existing Medicaid office staff
- Borrowing or recruiting staff from other state agencies, such as public health, insurance, budget, and administration
- Relying to the extent possible on other state agencies, counties and other local governments, and advocacy groups

Oregon uses state prisoners to mail out managed care enrollment materials and handle phone inquiries from recipients and providers. Hersh Crawford says Oregon's prisoners "are dependable and reliable, and you always know where to find them."

A number of states rely at least in part on private consumer and recipient advocacy groups to assist with recipient education. Such groups can also be of considerable assistance in monitoring the performance of MCOs and other providers on dimensions of quality and access.³

Michigan's experience, described in the next section, illustrates what states can do when few or no new resources are available, but there is nonetheless strong support for change from the governor.

II. MAJOR INITIAL CHALLENGES

The threshold planning issues discussed in the previous section often merge into the initial implementation issues discussed in this section, as planning is superseded by learning-by-doing (Ready, Fire, Aim).

The challenges at this stage are primarily for the leadership and top management of Medicaid offices. They are both external and internal: obtaining the support and resources needed from the governor and the legislature, establishing a core managed care team, recruiting new staff, instilling a new organizational mission and culture in the Medicaid office, acquiring necessary knowledge and skills, establishing a strong and comprehensive monitoring capability, and consulting and coordinating with a wide range of interested parties.

A. ASSURING STRONG AND COMMITTED LEADERSHIP

Managed care represents an entirely new way of doing business. Medicaid's relationships with providers, recipients, and other state and local government agencies will be altered, to the disadvantage of some and the advantage of others. Those who perceive themselves as losers will probably seek relief from the governor's office, the legislature, and through the press. And, as discussed below, implementing managed care is likely to require more time and resources than governors and legislators expect or will be comfortable with.⁴

If those who oppose or are apprehensive about managed care perceive a lack of commitment or resolve by the governor or the top leadership in the Medicaid program, they will be encouraged in their efforts to stop or slow down managed care. Similarly, if the state budget agency, the personnel system, and the legislature perceive that managed care is not a high priority for the governor and the Medicaid agency, the additional resources needed to implement managed care effectively may not be forthcoming.

If, on the other hand, there is commitment and strong leadership from the governor on down to the Medicaid director, even limited resources are not likely to stand in the way of effective implementation.

In **Michigan**, for example, Medicaid director Bob Smedes says Governor John Engler was aggressively committed to expanding Medicaid managed care, but without substantial new administrative resources. Governor Engler established a new Department of Community Health by executive order to help facilitate the transition to managed care, bringing together in one agency the Medicaid office and the departments of public health and mental health. He gave the head of the new agency and the Medicaid director the authority to draw on people and resources throughout the state government, and to fill key positions with new people, despite Michigan's traditionally rigid civil service system. When faced with predictable opposition, the mantra of the new leadership was "don't blink."

Similarly, the **Oregon** Medicaid managed care program has benefitted from the strong support of former Governor Barbara Roberts and the current Governor, John Kitzhaber, who in his former position as state senate president was one of the main architects of Oregon's expanded managed care program. Jean Thorne, former Medicaid director and now a key person

on the governor's personal staff, and Hersh Crawford, the current Medicaid director and former long-time assistant director, have provided many years of effective and continuous leadership.

In **Rhode Island**, the RItE Care managed care program has had strong support from two governors — one Democrat and one Republican — and a Democratic legislature. Former governor Bruce Sundlen created a new Office of Managed Care in the Medicaid office by executive order in 1993. The new office was staffed by ten people transferred from the Department of Health and from other parts of the Department of Human Services (where the Medicaid office is located). Tricia Leddy, the head of the new Office of Managed Care, came from the Department of Health in 1993. The current Governor, Lincoln Almond, has continued to give strong support to RItE Care.

In **Indiana**, Governor Evan Bayh pushed the Medicaid office to develop and implement a statewide Medicaid managed care program, and made sure the office had the support and resources needed to do it effectively. No additional staff positions were created, but the Medicaid office had considerable flexibility in filling existing positions and bringing in outside contractors and consultants.

B. GETTING ADEQUATE ADMINISTRATIVE RESOURCES AND TIME

Governors, budget agencies, and legislatures usually do not appreciate that managed care may require more administrative resources than fee-for-service Medicaid, especially in the early stages with new managed care start-up costs and continuing fee-for-service administrative costs.

They also do not appreciate that setting up complex and unfamiliar new programs is not the work of a moment, and that rushing their implementation is likely to lead to mistakes, confusion, frustration, and many troublesome anecdotes.

Don't Exaggerate Potential Budget Savings

In part, some Medicaid offices bring these problems on themselves by holding out the promise that managed care will result in large and almost immediate budget savings. Political leaders, eager for the savings, understandably lack patience. Further, the message that increased administrative costs may exceed program savings in the early stages of implementation does not readily compute once expectations of quick savings have been established.

If it is at all possible, Medicaid directors should try to persuade governors and legislators that managed care may well *not* produce immediate savings, that it is neither cheap nor easy to put in place, and that it should be viewed as a longer-term investment in better and more cost-effective health care. It is not a quick fix for short-term budget problems.

If a Medicaid managed care program is especially well run, or if the existing fee-for-service system has unusually high utilization levels, managed care may indeed produce some early savings and some moderation in future growth rates. When it comes to budget savings, however, it is generally better to under-promise and over-deliver. Governors and legislators tend to be more forgiving of unexpected savings than of unexpected deficits.

Some of the factors that limit potential managed care savings in Medicaid, especially in the short term, include:

- The focus of most programs on the least costly part of the Medicaid population (mothers and young children)
- Already low fee-for-service provider payments in most states
- Insufficient investment in the actuarial, data analysis, and negotiating resources that are needed to capture managed care savings
- High initial administrative costs
- The limited ability of many MCOs to get beyond extracting price concessions from providers to actually managing the care they provide

In **Oregon**, Medicaid managed care was driven more by concerns about equity, access, and cost-shifting to hospitals and other providers than by short-term state budget pressures. The state took the time necessary to build the political consensus and the administrative capacity needed for effective implementation. Hersh Crawford notes that the delays in implementation caused by HCFA's initial reluctance to approve Oregon's 1115 waiver request ended up giving the state valuable extra time to bolster its administrative capabilities. While budget pressures have constrained the scope of Oregon's managed care initiative, its success did not depend on achieving quick budget savings.⁵

In **Michigan**, although the state faced budget pressures because of some major reforms in the financing of local education, the governor did not push for quick savings from Medicaid managed care. The governor and top officials of the Department of Community Health established an aggressive timetable for implementation of Medicaid managed care, and the program is achieving significant savings, but, Smedes says, the governor views managed care more as a longer-term investment in cost-effective care than as a major source of short-term budget savings.

In **Indiana**, the state had already achieved major savings in projected Medicaid expenditures before managed care was implemented (mostly by bringing Indiana's inflated provider reimbursement rates in line with those of other state Medicaid programs), so the Medicaid office was under no budgetary pressure to achieve additional savings from managed care. This enabled the state to phase in mandatory managed care over three years, beginning in July 1994, and to allow recipients and providers the choice of either a primary care case management (PCCM) program or risk-based MCOs. Medicaid office officials stressed repeatedly and publicly that the main goal of the managed care program was to improve quality and access, not to achieve budget savings.

In **Rhode Island** as well, budget savings were not a goal of the managed care program — the goals were to expand access and improve quality of care.

C. ESTABLISHING A CORE MANAGED CARE TEAM

Medicaid managed care is complex, rapidly changing, and filled with uncertainty. As discussed earlier, it demands financial, policy, evaluation, organizational, and negotiating skills

that are not commonly required by fee-for-service Medicaid programs. Medicaid managed care also requires extensive dealing with HCFA, providers, and other state and local government entities with whom existing Medicaid office staff have probably had considerable interaction in the past. Establishing teams with a mix of existing and new staff is therefore usually an effective strategy.

The core managed care team should include people with managed care experience (or at least great interest in managed care), analytic, negotiating, and communication skills, familiarity with the state environment, energy, enthusiasm, eagerness to learn, flexibility, comfort in dealing with lots of unknowns, and a good sense of humor. They must also be willing to work long hours for low state salaries.

It is possible to recruit people like this in the early stages of a new program — from either inside or outside state government — since the opportunity to have a major impact on an important new initiative can make the Medicaid office more attractive than other potential opportunities. People with these skills — especially when they are enhanced by experience in building a new Medicaid managed care program — quickly become highly attractive to the private sector. It can therefore be difficult to retain them in the Medicaid office for more than a relatively short period. In addition, as discussed further in the next section, people who are stimulated by the challenge of developing a new program may become bored and restless once the program is up and running and the major focus turns to day-to-day operational issues.

While the enhanced future attractiveness of people on the core managed care team to the private sector can be helpful when recruiting new managed care staff — especially those who are at a relatively early stage in their careers — the obvious down side is the turnover and loss of experience that occurs as they are recruited away. This potential turnover problem further underscores the importance of including experienced long-term Medicaid office staff who are eager to get involved in a new area, but who are more likely to stay on as the managed care program stabilizes and matures.

In **Michigan**, as noted earlier, Department of Community Health and Medicaid office leaders had to implement Medicaid managed care with few additional resources, and within a state civil service system that traditionally had been quite rigid regarding new hires and movement of existing staff between and within agencies. Governor Engler was successful in bringing new leadership to the state civil service commission, laying the groundwork for some greater flexibility in staffing the Medicaid managed care program.

Medicaid director Smedes and other top department officials recruited 25 to 30 new people from throughout state government and within the Medicaid office. (The Medicaid office had about 350 staff people, most of whom were involved in fee-for-service claims processing and related activities.) They looked for people who were regarded by their peers as leaders, and who had energy,

enthusiasm, and creativity. Most of the people they recruited were staff analysts rather than managers, and so tended to have less of a vested interest in preserving the current system.

Some top managers were recruited from elsewhere in state government, however, and a number of existing Medicaid managers chose to leave state government under a newly liberalized state early retirement system. The new Medicaid office deputy director and the three top bureau chiefs all came from other positions in state government. (Smedes himself came to state government in 1995 following a career in the private health care sector.)

Smedes and other department leaders formed several teams to design and implement the new Medicaid managed care program. Each team had one leader from among the new people recruited from other agencies, and one recruited from within the Medicaid office. Each team also had a “coach” from another agency in state government, including some from the Department of Management and Budget. The new people in these teams, Smedes says, were the real drivers and catalysts for change.

In **Rhode Island**, the core managed care team was made up of the ten people transferred to the new Office of Managed Care from elsewhere in state government, plus consultants who were brought in to help design the program. A different set of consultants was brought in later to play an ongoing role in program management and health plan oversight and monitoring. The office has adopted a “merged staff” model, with the consultants working in the same office as state staff, and functioning as an integral part of the managed care team.

In **Indiana**, the core managed care team was headed by the deputy director of the Medicaid office, who had more than a decade’s experience in private-sector managed care and was a top executive in the state’s largest MCO before coming to the Medicaid office. Others on the team included the Medicaid office’s medical director — a physician who had done extensive research on managed care — and a small number of recently hired policy analysts, one of whom had several years experience working on managed care for a major private consulting firm. Because the regular Medicaid office program staff was deeply immersed at the time in the design and implementation of a new claims processing and management information system, it was difficult to involve them in managed care. There have been two transitions in the leadership of the core managed care team since 1994. In both cases, the new top manager was promoted from within the core team.

The turnover problem and the corresponding need to bring more of the experienced fee-for-service staff into managed care is discussed further in the last section of this report, which deals with longer-term challenges.

D. RECRUITING NEW STAFF

States have varying degrees of flexibility in recruiting and hiring. The Michigan approach described earlier indicates what can be done when there is strong top-level leadership, even when state civil service rules are fairly rigid and there are limits on new hires from outside state government. Michigan, Oregon, Rhode Island, and Indiana all brought in some new people — from elsewhere in state government, from the private sector, or as consultants. Because many of the skills needed for managed care may not be available in state government, and because

people with those skills are much in demand in the private sector, it may be difficult to hire key managers and staff through traditional state government routes. One supplementary approach is to advertise the positions in local newspapers and trade journals, emphasizing the uniqueness and the challenge of the opportunity.

Another is to recruit at graduate schools of public policy, public health, health administration, and business. This is an especially good source of people with data, analysis, and financial skills. More generally, it can be a good way to find people who are enthusiastic, eager to learn, flexible, and comfortable with rapid change, risk, and uncertainty. The best time to start recruiting is around February, when the graduating class starts seriously looking for jobs. If state personnel rules permit and if resources are available, hiring graduate students for the summer between their first and second years in a master's degree program is a good way of getting extra staff to work on shorter-term managed care projects, while at the same time laying the groundwork for later full-time hires after graduation.

E. INSTILLING A NEW ORGANIZATIONAL MISSION AND CULTURE

Because managed care represents such a major change from traditional ways of staffing and running a Medicaid office, top managers must be prepared to spend major amounts of their time establishing a fresh sense of mission and a new culture in the office. This can be an especially difficult and delicate task since, as discussed in the last section, major fee-for-service functions must continue to be performed at the same time. The esprit and sense of "specialness" that the core managed care team must develop should not come at the expense of the rest of the staff. Some potential ways of striking this balance are discussed both here and in the final section.

In **Michigan**, Bob Smedes says, the leadership of the new Department of Community Health moved aggressively to change the mission and culture of the Medicaid agency. Instead of the traditional focus on efficient transaction processing, guarding the Medicaid bank, and maintaining smooth political relations with providers, the new managed care leadership sought to focus the agency on a broader mission: maintaining and improving the health of Michigan citizens, especially the most vulnerable ones. To accomplish the mission, they emphasized measurement of outcomes, impact on populations, smart purchasing, and use of market incentives.

As noted earlier, new people were brought in from all over state government, in some cases replacing senior managers who chose early retirement or transfer. The new people worked in a number of functional teams with existing Medicaid office staff. Top managers worked closely with the new teams.

The Medicaid office transition to managed care was more gradual in **Oregon**, but over time the office went from having only about 5 percent of the staff working on managed care in the late 1980s, to the current situation in which about two-thirds of the staff work on some aspect of managed care. Hersh Crawford says that, although no special effort was made to instill a sense of mission and purpose in the managed care staff, "the constant pressure of always being in the

middle of a storm (providers, plans, legislators, governor's office, safety net providers, local public providers, HCFA) certainly caused this group to pull together and stick together." Crawford notes, however, that the intense and growing focus on managed care has led some people on the fee-for-service side to feel like "outsiders."

In **Rhode Island**, the new Office of Managed Care was established as a separate entity within the Medicaid office, and continues as a distinct unit. The office's relatively small size (only about two dozen people, half of whom are consultants), with everyone located in the same place, has facilitated the development of a sense of mission and cohesion.

In **Indiana**, the five people working on managed care were part of a staff of 60 people in the Medicaid office who were all working on intense, high-pressure, and high-visibility tasks (fee-for-service reimbursement reform and program restructuring for virtually every provider category, plus design and implementation of a new claims processing and management information system). Managed care was therefore just one part of a larger program restructuring mission.

Massachusetts Medicaid director Bruce Bullen, commenting on an earlier draft of this report, wrote:

I have found that it is important for the entire Medicaid agency to become part of the "purchasing" enterprise. We used a TQM-inspired process to define our core business and our customers, and we use cross-functional teams to make sure that we are improving our products and services. This involves everyone, not just the "managed care" unit. Internal expertise and morale improves. It makes it easier to farm out certain responsibilities and keep others in house.

F. ACQUIRING NECESSARY KNOWLEDGE AND SKILLS

Because managed care demands so many skills that are not required in fee-for-service Medicaid, and because it continues to change so rapidly, top management in Medicaid offices must foster a climate of continuous learning. Staff should be encouraged to attend conferences, seminars, and training sessions that will enable them to learn what other states are doing in Medicaid managed care, and, if possible, to obtain a private-sector perspective. There should be opportunities for staff to learn from each other, and from outside consultants. The teams that Michigan set up provided an opportunity for this kind of joint learning. Rhode Island's Tricia Leddy characterized her managed care office as being like "a little university-affiliated research team."

There are many good written sources on Medicaid managed care, and managed care in general. The National Academy for State Health Policy's *Medicaid Managed Care: A Guide for States* (3rd edition, 1997) is perhaps the best starting point. Peter R. Kongstvedt's *Essentials of Managed Health Care* (2nd edition, 1997) is a good source for the private-sector perspective on managed care. The Center for Health Care Strategies' Web page (www.chcs.org) contains a wide range of managed care information sources, as well as links to other Web sites.

Fostering a learning culture in the Medicaid office is a good way to integrate the fee-for-service staff into managed care. Those who want to learn and who value the opportunity for

professional growth will be valuable additions to the managed care team. Bringing them onto the team will also reduce some of the barriers that might otherwise exist between the managed care and the fee-for-service staffs, a topic that is discussed further in the next section.

Emphasizing the opportunities for learning is also a good way of recruiting some of the kinds of new people who are needed to run managed care programs, and who normally might not consider a position in state government. That was a strong part of the appeal in Indiana, where state government salaries are unusually low.

G. ESTABLISHING A STRONG AND COMPREHENSIVE MONITORING CAPABILITY

Hersh Crawford emphasizes that in managed care the main focus becomes monitoring rather than operating a program. Quality assurance and access monitoring is crucial. **Oregon's** monitoring program has the following components:

- Satisfaction and health status client surveys
- Review of plan medical records, policies and procedures
- On-site visits to observe plan operations and quality improvement programs
- Review of client and provider complaints
- Client hearing process
- Regular meetings with plan medical directors to review best practices and guidelines
- Hotlines to help clients and providers, and answer benefit questions
- An ombudsperson for seniors and persons with disabilities who need help with managed care

Rhode Island also has invested substantial resources in program monitoring and evaluation. Tricia Leddy says that these are the two major functions that the state decided to contract out, because they require a level of technical expertise and experience that is difficult to find and retain in state government staff. The state has a contract with Birch & Davis Health Management Corporation for oversight and quality assurance, and a separate contract with MCH Evaluation, Inc., a small private research firm that works with the Office of Managed Care and the Department of Health to perform research studies of the RIte Care managed care program. The research studies use public health data (e.g., birth outcomes, smoking during pregnancy, interbirth intervals, preventable hospitalizations) as well as Medicaid claims and administrative data. The office also contracts with an external quality review organization to do focused clinical studies.

The RIte Care program regularly makes public the results of this monitoring and evaluation activity. Some of the results:

- Per-enrollee physician visits rose from two per year before RIte Care (1993) to five per year in RIte Care's first year

- The number of women on Medicaid who began prenatal care in the first trimester rose from 76 percent in 1993 to 82 percent in 1995
- The number of low-birthweight infants born to Medicaid-enrolled mothers dropped from 9.1 percent in 1993 to 8.5 percent in 1995
- Ninety-five percent of the 1,009 respondents to a December 1996 RItE Care member satisfaction survey were “very satisfied” or “satisfied” with RItE Care

The Appendix shows more of these RItE Care program results.

Indiana has also established extensive monitoring processes and systems. Before an MCO can begin enrolling recipients, it must go through a “readiness review” that is conducted by Medicaid office staff and the external quality review organization the state has contracted with for Medicaid managed care monitoring. This process identifies areas that need improvement before any enrollment occurs. The state also conducts ongoing quarterly reviews of MCOs for which the MCOs submit information on what they are doing in areas such as network development, quality improvement initiatives, and other readiness review categories.

With the assistance of its enrollment broker, Indiana systematically tracks why people call a central hotline, and why they change doctors or delivery systems. This provides an early warning of potential problem areas.⁶

The Medicaid office also convenes regular meetings of three different monitoring, advisory, and oversight groups to identify policy and operational problems, and clarify and improve policies:

- A Quality Improvement Committee, made up of representatives from the MCOs, the state department of health, and practicing physicians not affiliated with the MCOs (monthly meetings)
- A Clinical Advisory Committee, made up of practicing primary care physicians from around the state who participate in either the state’s risk-based managed care program or its primary care case management program, and representatives of the state department of health (bimonthly meetings)
- A Managed Care Policy Meeting, with representatives of the MCOs and their major subcontractors, and the state’s enrollment broker, fiscal agent, and external quality review contractors (monthly meetings)

Sharon Steadman, Indiana’s Medicaid managed care director, emphasizes the importance of following up on problems identified through the various monitoring and review processes: “States can monitor managed care until the cows come home, but to be effective they must *do* something with what they find during their monitoring.”

Information Systems

As discussed earlier, data-oriented monitoring can be difficult to do without new kinds of staff or assistance from contractors. Further, the management information systems designed for a world of fee-for-service claims processing are generally not adequate for managed care. Managed care requires information systems that can show trends over time, comparisons among types of providers and services, and relationships between inputs (prenatal care) and outcomes (number of low-birthweight babies). While there are a number of vendors that are eager to provide such systems, Hersh Crawford cautions that “information systems will take longer and deliver less than promised.”

Nonetheless, the investment of time and resources needed to obtain good information systems can have major payoffs in improved program performance and accountability. In addition, good information systems can enable Medicaid fee-for-service staff to make significant contributions to managed care. Their experience in dealing with recipient and provider problems on a case-by-case basis can help provide explanations for trends and patterns in the data that less experienced staff may have trouble interpreting. If, for example, there is a puzzling change in a trend, fee-for-service staff may be able to point to a change in rules, procedures, or practices that could explain it. Without the trend data, the magnitude of the change would not be apparent, but without the contribution of experienced staff the reason for the change might remain a mystery.

Encounter Data

Encounter data (claims-level data equivalent to the data used for claims payment in the fee-for-service system) are an especially important component of managed care monitoring systems. States that do not require these data from their MCOs and use them for monitoring and reporting will soon lose the ability to effectively operate and oversee their managed care programs.⁷

Independent External Reviews of MCO Quality and Access

Federal law requires independent external reviews of MCO quality and access, and provides 75 percent federal matching funds (as opposed to the normal 50 percent) for these activities.⁸ This requirement gives states an opportunity to add to their capacity to monitor managed care access and quality at a cost to the state that may be less than if the state used its own staff. External quality review organizations (EQROs) have assisted state Medicaid programs in monitoring managed care for a number of years, focusing primarily on clinical reviews and studies. Many EQROs have now developed broader data analysis capabilities that can assist states in monitoring a wide range of quality and access measures. Oregon, Indiana, and Rhode Island all use EQROs as an important part of their managed care quality and access monitoring.⁹

H. COORDINATING WITH OTHER STATE AGENCIES, COUNTIES, AND LOCAL GOVERNMENTS

Depending on how states divide up Medicaid managed care responsibilities, there may be a substantial need for consulting and coordinating with other state agencies (public health and

insurance, for example) and with counties and other local governments who may play a role as providers, MCOs, administrators, or advocates. This consulting and coordinating requires a combination of technical managed care skills and knowledge, plus the experience, sensitivity, personal relationships, good judgment and negotiating skills that long-time state employees may have. It is usually not a task that can be left to new and inexperienced managed care staff. As noted earlier, contractors may bring a fresh perspective and experience from other states and other managed care contexts, and can therefore provide valuable support for experienced state staff. Contractors can also help with scheduling, preparation of background papers, and meeting documentation.

III. MAJOR LONGER-TERM CHALLENGES

Over the longer term, Medicaid offices may want to phase down their reliance on outside contractors and consultants for those functions that state staff can perform. They should firm up their relationships with those contractors for whom the state has a continuing need, be prepared to deal with staff turnover, and consider redeploying more of their fee-for-service staff to managed care. They must also be concerned about the potential for atrophy of fee-for-service administrative capabilities as managed care consumes more and more time and resources, while major fee-for-service responsibilities remain. The new state Children's Health Insurance Program and state initiatives to extend health insurance to the working poor present additional challenges to Medicaid managed care programs.

A. PHASING DOWN RELIANCE ON OUTSIDE CONTRACTORS AND CONSULTANTS

Over time, as managed care issues become more routine and operational, outside consultants may be less necessary. Enrollment broker tasks, for example, could be taken over by state or county staff as they become more familiar with managed care issues, and as the initial surges of new enrollment and new questions taper off.¹⁰

In **Rhode Island**, existing state and local staff have been responsible from the outset for managed care beneficiary enrollment, education, and counseling. Beneficiary and provider information lines were staffed by people transferred from the Department of Health and the Department of Human Services. Tricia Leddy concluded early on that these were functions that did not have to be contracted out, since the work is quite similar to what state staff were doing in the fee-for-service environment. They are doing "a terrific job" in their new managed care roles, Leddy says. Rhode Island's relatively gradual implementation of managed care meant that they did not face the heavy front-end pressures for enrollment and counseling staff that have led many states to turn to enrollment brokers.

Consultants with expertise in program and system design will also be less necessary as programs become better established. This transition can occur more quickly if Medicaid office managers encourage regular interaction between these consultants and a broad range of Medicaid staff. Managers should also arrange for consultants to conduct regular briefing and training sessions for Medicaid staff so that the state's investment in consultants has the greatest possible payoff in terms of organizational learning and staff professional development.

As discussed below, some specialized tasks, such as actuarial rate-setting, quality and access monitoring, data systems design and operation, financial monitoring, and program evaluation may require continuing reliance on outside contractors, but even there the increasing experience of state staff may reduce the amount of outside contractor time required. As state staffs become more familiar with their actuary's data needs, for example, the data can be supplied in ways that reduce the amount of expensive actuarial time needed for reformatting and other data cleanup tasks.

B. FIRING UP RELATIONSHIPS WITH LONGER-TERM CONTRACTORS

As noted above, states will probably need to maintain relationships with some kinds of managed care consultants and contractors for an indefinite period. Actuaries are the obvious example, but Indiana and Rhode Island also rely on contractors for a number of other ongoing managed care functions. Indiana, for example, has continued to rely on its enrollment broker for beneficiary enrollment and counseling, as well as for provider recruitment and a wide range of program monitoring tasks.

Rhode Island's Birch & Davis Health Management Corporation (BDHMC) consultants are an integral part of the Office of Managed Care's staff, concentrating on specialized oversight, monitoring, and financial tasks, including work with the state's outside actuary. As noted earlier, state staff do the majority of the work in the area of recipient enrollment, education, and counseling, serving as unbiased enrollment counselors. However, Tricia Leddy notes, BDHMC staff have provided substantial assistance with these functions:

For example, BDHMC provides bilingual enrollment counselors at local [Department of Human Services] offices (who work under the auspices of State staff) and has done so from the beginning of the program. This augments the State staff assigned to this function, who are all English-speaking. In addition BDHMC has provided training for enrollment counselors, as well as answers/clarifications to issues/questions raised to the Office of Managed Care by enrollment counselors. Finally, BDHMC has coordinated our mail-in enrollment function (a follow-up to families who do not choose a Health Plan when they meet with an enrollment counselor).

Oregon, Rhode Island, and Indiana all rely to varying degrees on outside contractors to monitor quality and access and to perform periodic evaluations of the managed care program. Some degree of independence from the Medicaid office is necessary to maintain the credibility of these activities, so bringing them entirely in-house is generally not feasible. Indeed, as noted in the last section, federal law and regulations require that at least some of the evaluations of quality and access must be done by an independent entity.

For those contractors with whom the state expects to have a long-term relationship, and for whom the degree of independence required of outside evaluators is not necessary, Medicaid office managers should, to the extent possible, treat them as integral members of their staff. The open communication and collaboration that can build trust and commitment in the regular Medicaid office staff should be extended to them. Rhode Island's merged staff model is a good example, but these relationships can be built up even when contractors are not physically located in the Medicaid office.

State laws and regulations usually require that contracts be rebid periodically, so Medicaid office managers should make sure that their relationships with long-term managed care contractors do not adversely affect the integrity of the state procurement process. This is usually just a matter of being aware of the rules and following them, however.

C. DEALING WITH STAFF TURNOVER AND REDEPLOYING FEE-FOR-SERVICE STAFF

“Turnover among good staff will be high,” Hersh Crawford says, “so plan to spend a lot of time recruiting.” The turnover problem tends to be greater in managed care Medicaid than in fee-for-service Medicaid. States are consciously modeling their Medicaid managed care programs on programs in the private sector. Private MCOs, providers, enrollment brokers, consultants, and other service providers are actively competing for state Medicaid business. All of this provides more opportunities in the private sector for state Medicaid staff than was generally the case in the past, when there was relatively little demand in the private sector for the kinds of skills and experiences that people developed in state Medicaid offices.¹¹

In addition, as Crawford notes, “Operating a program is different from implementing one. Implementation is new and exciting; operating can be boring but still stressful.” Part of the solution to the turnover problem may lie in making more effective use of Medicaid fee-for-service staff, who usually have extensive experience in an operating environment.

This redeployment will require staff retraining and managerial creativity and sensitivity. As noted earlier, managed care requires new skills, new knowledge, and new ways of thinking. Some people will have difficulty making the transition. “Don’t assume,” Crawford warns, “that budget staff can just figure out what the actuary does, how capitated rates are set, and what risk adjustors, withhold payments, and overlapping costs are.”

Nonetheless, as noted earlier, through a combination of new hires and redeployed fee-for-service staff, about two-thirds of Oregon’s Medicaid office staff are now working on managed care, compared to only about 5 percent a decade ago.

D. AVOIDING FEE-FOR-SERVICE ADMINISTRATIVE ATROPHY

Fee-for-service workloads are not likely to decline as rapidly as managed care requirements increase, putting strains on both fee-for-service and managed care staffs. “Running a fee-for-service *and* a managed care system is more than twice as hard as running either one alone,” Crawford says.

Fee-for-service Medicaid is not likely to wither away anytime soon. While states are moving quickly to enroll their TANF populations and low-income pregnant women and children in managed care, most of the elderly and disabled — who account for approximately 30 percent of all Medicaid recipients and 70 percent of all expenditures — will be likely to remain in the fee-for-service system in most states for some time to come. There will thus still be a need for traditional fee-for-service functions such as claims processing, auditing, rate-setting, third-party-liability (TPL) collections, surveillance and utilization review (SUR), drug utilization review, provider relations, and prior authorization.

These important functions may suffer from managerial inattention and declining staff morale as managed care becomes more predominant. Given the total volume of expenditures for the elderly and disabled population, their vulnerability, and their greater need for care, Medicaid offices must continue to devote significant administrative resources to serving them.

While a number of states have begun to enroll the elderly and disabled populations into managed care, mostly on a voluntary basis, the program design and implementation challenges

involved in doing so are substantially greater than those states have faced with the mostly young and healthy populations that are currently enrolled in managed care. Complete enrollment of these more vulnerable populations in managed care will not come quickly. For the foreseeable future, therefore, most states must continue to be concerned about maintaining a well-functioning fee-for-service capability.

As managed care is extended to the elderly and disabled populations, the office restructuring lessons learned in providing managed care to mothers and young children will prove valuable. As an example, just as the skills and experience that caseworkers and enrollment staff have developed in a fee-for-service world can be extended to beneficiary counseling in managed care, the case management skills that state staff and contractors have developed in home- and community-based waiver programs could be brought to bear in managing the care of elderly and disabled MCO enrollees.

E. ADAPTING TO THE CHANGING HEALTH INSURANCE MARKETPLACE

The new State Children's Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997¹² presents yet another set of challenges for Medicaid programs, as do other state efforts to extend health insurance coverage to the working poor. These initiatives can thrust Medicaid managed care programs into an even broader and more complex health insurance marketplace, and require greater focus on the relationships between Medicaid and commercial insurance programs. Massachusetts Medicaid director Bruce Bullen outlined some of the challenges in commenting on an earlier draft of this report:

As we all begin to purchase on behalf of the working poor, we need to think about coordinating benefits, about "crowd-out," about insurance reform, about outreach and advertising, about market clout, about group purchasing — about a lot of things that Medicaid directors traditionally don't think about. When it was just a welfare fringe benefit, you didn't need to.

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ENDNOTES

1. Copies of the IG report (OEI-01-95-00260) can be obtained by calling the Inspector General's Boston Regional Office at 617/565-1050.
2. For an excellent discussion of the use of enrollment brokers and other approaches to beneficiary enrollment and counseling, see Mary S. Kenesson. "Medicaid Managed Care Enrollment Study: Report of Findings from the Survey of State Medicaid Managed Care Programs," (Princeton, NJ: Center for Health Care Strategies, December 1997).
3. For a summary of such activity, see Jane Perkins et al., "Making The Consumers' Voice Heard in Medicaid Managed Care" (National Health Law Program, December 1996).
4. For a discussion of some of these issues, see James M. Verdier, "Implementing Medicaid Managed Care Amid Skepticism, Anxiety, and Controversy: Suggestions for Program Design, Monitoring, and Reporting," and "Suggestions for Dealing with the Media, Legislators, Providers, Recipients, and Advocates," (Princeton, NJ: Center for Health Care Strategies, November 1997).
5. For more on this and other lessons from the Oregon experience, see Marsha Gold, Michael Sparer, and Karyen Chu, "Medicaid Managed Care: Lessons From Five States," *Health Affairs*, Vol. 15, No. 3 (Fall 1996), pp. 153–166.
6. For more on Indiana's use of data to monitor Medicaid managed care, see Verdier, "Implementing Medicaid Managed Care: Suggestions for Program Design, Monitoring, and Reporting," esp. pp. 12–13 and the Appendix.
7. For more discussion of the importance and uses of encounter data, see Verdier, "Implementing Medicaid Managed Care: Suggestions for Program Design, Monitoring, and Reporting," pp. 13–15; National Academy for State Health Policy, *Medicaid Managed Care: A Guide for States*, 2nd ed. (1995), Vol. IV, Ch. 5, "Collection and Use of Encounter Data in a Capitated Managed Care Environment"; and Embry M. Howell, "Medicaid Managed Care Encounter Data: What, Why, and Where Next?" *Health Care Financing Review*, Vol. 17, No. 4 (Summer 1996), pp. 87–95.
8. Social Security Act, Sections 1932(c) and 1903(a)(3)(C)(ii), as added by Sections 4705 (a) and (b)(2) of the Balanced Budget Act of 1997 (Public Law No. 105-33).
9. For a discussion of how Washington, Minnesota, and Ohio used EQROs in a recent demonstration project, see Suzanne Felt-Lisk and Robert St. Peter, "The Quality Assurance Reform Initiative (QUARI) Demonstration For Medicaid Managed Care: Final Evaluation Report," Vol. II: Technical Report, pp. II-58–65. Prepared by Mathematica Policy Research for the Henry J. Kaiser Family Foundation, November 1996.
10. As of mid-1997, 37 of the 40 states that offer managed care plan choices had established some form of independent enrollment counseling program, with 26 states contracting with private-sector enrollment broker companies and 11 states relying on agency staff. Kenesson, "Medicaid Managed Care Enrollment Study," p. i.
11. For a discussion of private-sector needs, see Center for Studying Health System Change, "An Inadequate Supply of Qualified People Will Slow the Pace of Health System Change," Issue Brief No. 7, March 1997.
12. Public Law 105-33, Section 4910(a), adding a new Title XXI to the Social Security Act.