The Collision of Economics and Politics in Medicaid Managed Care: Reflections on the Course of Reform in Maryland

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ALTHOUGH THE DRIVE FOR FEDERAL HEALTH CARE reform in the early 1990s stalled, restructuring of financing and delivery systems continues unabated in employer-sponsored health plans and state programs. As Paul Ellwood and George Lundberg (1996) suggest, we are on the verge of a new American health care system. One area of dramatic change is the passage of the Medicaid program toward a system of managed care and market competition.

Maryland has been one of the most active states in the area of Medicaid reform. During the 1990s alone, the state has initiated three different systems of managed care for the Medicaid population:

1. a primary care case management program
2. a combination of case management, support services, and integrated delivery systems for patients with severe and costly conditions (only partially implemented and then abandoned)
3. mandatory enrollment of beneficiaries in competing, capitated managed care organizations

This article will describe the recent evolution of the Maryland Medicaid program and the logic of the successive policy designs advanced by

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state officials. It will examine the central factors underlying the most recent reforms and the considerable sources of tension in policy formulation and implementation. Finally, it will explore lessons learned about the policy-making process and its impact on the design and performance of Medicaid managed care.

The Maryland experience illustrates several important features of public policy innovation. First, the specific impetus for change often comes from external factors that are independent of conditions in the existing program or policy area. Although states promote themselves as “laboratories” that can design and test model programs for other states or the federal government, innovations in health care financing and delivery are seldom left in place long enough to judge accurately the range of intended and unintended consequences. Pushed by external events, policy makers in Maryland did not formally evaluate the performance of one Medicaid initiative before formulating plans for the next one. Second, leaders can seize opportunities for reform, using very different skills and strategies—they may adopt a low profile and work with a select group of insiders, or they may create highly visible and inclusive mechanisms to design policy and build political acceptance. In either case, they typically must attract and maintain active support from very high-level officials in the political system. Third, successful adoption of a policy does not guarantee successful implementation. New programs are vulnerable to changes in leadership if crucial individuals and organizations inside and outside of government are not committed to implementing the policy.

The experience in Maryland is also a vivid reminder that managed care is a work in progress (Ellwood and Lundberg 1996). It demonstrates how different approaches might be developed to care for the complex health and social conditions of individuals entrusted to the Medicaid program. Indeed, although there is a near consensus across the states that Medicaid programs should adopt the techniques and incentives of “managed care,” there can be considerable variation in policy design. The most recent reforms in Maryland are distinctive because they devote an extraordinary amount of attention to serving the needs of patients with particular conditions, and to preserving a role under managed care for providers that have historically served Medicaid patients. Whereas other states have turned to managed care and converted the savings into broader insurance coverage, the new Maryland system emphasizes continuity and quality of care for persons who are currently

eligible for coverage. Policy makers have attempted to do more than create a new market for existing managed care organizations—they have taken on the challenge of reforming managed care itself.

The reforms in Maryland, as in most states, were triggered by pressures to reduce state spending and an assumption that managed care would deliver significant savings. An ironic outcome of the reforms, however, is that the estimated savings are fairly minimal. The design of the new managed care system reflects the distribution of power in a policy community where advocates seeking to protect Medicaid beneficiaries, as well as safety-net providers seeking to protect their patient base, have exerted considerable influence. Throughout the process of Medicaid reform, the economic expectations and practices associated with managed care and market competition have collided with the political accommodations necessary to make such a transition.

Reinventing Medicaid in Maryland

As midnight approached on April 8, 1996, the last day of the legislative session, the Maryland general assembly took its final actions for the year. By a unanimous vote in both houses, the conference committee report on senate bill 750 was enacted into law. With the signature of Governor Parris Glendening, Maryland joined the growing number of states planning major expansions of the risk-based capitation model of managed care in their Medicaid programs.

The new legislation authorized the secretary of health and mental hygiene to create a “research and demonstration” project under Section 1115 of the Social Security Act. (See Oliver and Paul-Shaheen [1997, 722–4] and Leichter [1997] on the shortcomings of states as “laboratories” to develop national solutions to social problems.) The Department of Health and Mental Hygiene (DHMH) promptly submitted its Medicaid demonstration proposal to the federal Health Care Financing Administration (HCFA) on May 3, 1996. HCFA gave its final approval to the Maryland waiver proposal on October 30, 1996. After a delay, state officials inaugurated the new HealthChoice program in June 1997, and they anticipated that within a year close to 75 percent of the Medicaid population would be transferred from the primary care case management program to their choice of managed care organization.

The unanimous support for the 1996 legislation reflected a consensus that managed care is appropriate for Medicaid as well as for employer-sponsored insurance, and that details of the plan had been sufficiently worked out from a technical and political standpoint. A similar policy consensus has emerged rapidly across most of the states, with surprisingly little variation in the basic policy due to the socioeconomic characteristics, political culture, or managed care experience in a given state (e.g., Grogan 1997). The superficial unanimity can obscure the contentious politics of managed care in Maryland, however. It is likely that without compelling forces outside the health policy community and considerable commitment from political leaders, legislators would have deferred action on the major reform package at least one year, and possibly longer.

The primary factor driving the Maryland Medicaid program toward managed care was an extended budget crisis during the early 1990s. Maryland was one of the states hit hardest by the national recession at the beginning of the decade. As Cold War levels of federal defense spending declined and its construction and service industries suffered setbacks, the state lost 109,600 jobs from 1990 to 1992, equivalent to 5 percent of its workforce. The economic slide caused both slower growth of state revenues and an increase in state spending (Maryland Department of Fiscal Services 1994, 3). In a span of less than three years, Governor William Schaefer, a Democrat, and the legislators struggled through seven rounds of cost containment to balance the state budget during regular and special sessions of the general assembly.

The Medicaid program helped to bring about that struggle, and, not surprisingly, it became a prime target of the effort to bring state spending into alignment with lower revenues (Maryland Department of Fiscal Services 1994, 8–9). Maryland Medicaid enrollment was fairly steady during the late 1980s at about 340,000. It then increased rapidly because of the recession and the expansions of eligibility under federal legislation. By fiscal year 1994, average monthly enrollment was 443,908, or about 9 percent of the state's population. The pattern of enrollment indicated wide economic and geographic disparities throughout the state, as the average enrollment rate ranged from 2.9 percent of the population in Howard County to 25.6 percent in Baltimore City (Maryland Department of Health and Mental Hygiene [MDHMH] 1994a, 2–4). The combination of rising enrollment and general health care inflation led to a doubling of the Medicaid budget between 1989 and

1994 (MDHMH–CHPDM 1996, 9). The fiscal year 1994 budget was \$2.02 billion, making it the largest single expenditure of state government. (About half was paid by the federal government.)

In Maryland and many other states, the tremendous growth in the Medicaid program has made its goals and performance almost permanent issues on the governmental agenda. Increasingly, Medicaid, like entitlement programs at the federal level, is as often treated as a fiscal issue as it is a health issue (e.g., Hoadley 1991; Oliver 1991).

Medicaid Managed Care Initiatives

Managed care was well under way in the state of Maryland and in its Medicaid program before the most recent reforms. As of 1994, 1.8 million people in Maryland, or 36 percent of state residents, were enrolled in HMOs. This proportion of HMO enrollment was third highest in the nation, only slightly behind California and Oregon (Group Health Association of America 1995). The state Medicaid program had contracted with HMOs for 20 years, primarily in Baltimore City. Between 1988 and 1995, an HMO option became available statewide, and enrollment increased nearly fourfold. By late 1995, over 126,000 beneficiaries voluntarily elected to obtain their Medicaid coverage through HMOs (MDHMH–CHPDM 1996, 10–11).

The trends in HMO participation suggest that continuing growth of managed care was likely in the Maryland Medicaid program. The rise in voluntary HMO enrollment, combined with program initiatives in the early 1990s, increased the technical and political feasibility of the current plan to institute mandatory managed care for Medicaid beneficiaries. The sections below will briefly describe the first initiative and then offer an in-depth analysis of why and how Maryland devised more complex approaches to manage its Medicaid services and budget.

The Maryland Access to Care Program (1991)

State officials who were ordered to reduce Medicaid spending initially responded by cutting back eligibility to the minimum required by federal law, eliminating coverage of some services, and reducing payments to some providers (Maryland Department of Fiscal Services

1994, 10). Further retrenchment in these areas became difficult or impossible for legal, political, or ethical reasons. To achieve still deeper cuts in the projected growth of Medicaid costs, policy makers needed more creative changes in the program.

The first breakthrough came in 1991 in the form of the Maryland Access to Care (MAC) program. The MAC program, which operated under a Section 1915 waiver from HCFA, did not change any Medicaid eligibility requirements or covered services. Instead, it restricted the freedom of choice normally allowed under the traditional Medicaid program by assigning each beneficiary to a primary medical provider—an individual physician or clinical group serving as the “medical home” for primary and preventive services and as a “gate-keeper” to specialty services. Emergency rooms and other specialty service providers needed to obtain a referral or authorization from a patient’s primary medical provider to receive payment from the Medicaid program. Under MAC, primary medical providers were paid on a fee-for-service basis, and fees for most services were increased to encourage provider participation.

All Medicaid beneficiaries were assigned to MAC except those eligible for Medicare, voluntary HMO enrollees, individuals in institutional care, foster care, or hospice care, and participants in special programs for diabetes, sickle cell, and corrective case management. By December 1992, 12 months after its inception, the program covered 300,000 individuals, or 70 percent of the Medicaid-eligible population.

The goals of the program were to improve access to primary and preventive services, encourage more appropriate use of services, improve continuity of care, increase provider participation, and reduce Medicaid expenditures. A preliminary evaluation found that the early performance of the MAC program was consistent with its initial goals. The study showed greater access to health care and lower overall expenditures. It found there was greater access to Early Periodic Screening, Diagnosis and Treatment (EPSDT) and other preventive services for Medicaid-eligible children. There was little impact on the frequency of inappropriate emergency room visits, although there was some evidence that the number decreased with length of time that patients were enrolled in the MAC program. Finally, the evaluation estimated that the MAC program saved approximately \$35 million on patient services during its initial year of operation, compared with predicted Medicaid expenditures without the new program (Schoenman et al. 1994, vii).

The Limits of Primary Care Networks. Primary care case management programs like MAC have been widely adopted as a method of introducing more continuity and responsibility into the traditional fee-for-service system; as of 1994, 24 states had initiated such a program (Grogan 1997, 819). The innovation is relatively simple and requires little restructuring of the overall system of Medicaid benefits, payments, and regulatory oversight.

With the inception of the MAC program, Medicaid beneficiaries no longer had a “Gold Card,” as one official put it, to seek any provider and service of their choice. Yet the MAC program, even if it worked properly, was an imperfect solution for achieving predictable improvements in cost containment and health services delivery. Although primary care providers received higher fees, there were no rules or direct incentives to in turn limit their own volume of services or referrals; nor, because Medicaid still made payments on a fee-for-service basis, was there any incentive for hospitals and specialty providers to limit the volume of services.

Many patients still suffered from poor continuity of care and supervision because their primary care provider often did not follow them into the hospital. Furthermore, even conscientious primary and specialty providers were unable to prescribe support services for Medicaid patients who repeatedly cycled through the health care system because inadequate housing, nutrition, counseling, supervision, or multiple health conditions affected their compliance with medical orders and the efficacy of treatment plans. Those deficiencies harmed their health and generated additional program costs as well (Mary Stuart 1996: personal interview).

It was to the needs of those individuals and other Medicaid patients with intensive needs that Maryland officials turned next. They sought to introduce both nonmedical services that would prevent costly medical complications and management procedures and incentives to provide more efficient care once high-risk patients entered the medical care system.

The High-Cost User Initiative (1994)

The High-Cost User Initiative was predicated on the knowledge that a very small proportion of patients generate the vast majority of health care costs, and the prospect that the state could design interventions to

improve treatment outcomes and reduce costs for patients with chronic or catastrophic illnesses.

In 1992, Secretary of Health and Mental Hygiene Nelson Sabatini requested an analysis of Medicaid expenditures from his Medical Care Finance and Compliance Administration. The subsequent report indicated that, in a given year, 5 percent of Medicaid beneficiaries accounted for roughly 50 percent of program spending, and 10 percent of beneficiaries accounted for 70 percent of the costs. A few cases each year were extraordinarily costly: in fiscal year 1993, 784 Maryland Medicaid patients each incurred costs of more than \$100,000 (MDHMH 1994b, 7). Most of them suffered from chronic or multiple ailments related to conditions such as low birth weight, AIDS, drug and alcohol dependence, mental illness, respiratory illness, and severe disabilities.

Conception and Design of High-Cost Patient Management Systems. Sabatini called upon Mary Stuart, the director of the Health Policy and Statistics Administration in the Department of Health and Mental Hygiene, to design a system that would improve the management of services for high-cost Medicaid patients. Sabatini wanted the new system to perform four functions:

1. identify current and potential high-cost patients
2. give providers greater flexibility in prescribing the most appropriate combination of medical and nonmedical services
3. offer providers financial incentives to deliver and coordinate care for seriously ill patients, with the savings to be shared by providers and Medicaid
4. monitor patient outcomes to guarantee the quality of care (Stuart 1995: personal interview)

Stuart and her staff could not find any readily available models that met Sabatini's criteria; even just a few years ago, the health policy community had not worked out the underlying technical issues of how to assess patient risks, organize an integrated set of health and social services, or establish procedures to assure appropriate quality and cost outcomes. Thus Sabatini's request had no immediate results, but instead set off a lengthy search for a viable set of program components. It would take nearly two years to translate the basic idea into a concrete policy proposal.

The High-Cost User Initiative emerged out of a combination of activities involving state health agencies, foundations, local hospitals, and researchers (Oliver 1996). The chief activities in this process and the ensuing reforms are listed in table 1. The ultimate design of the High-Cost User Initiative called for two basic interventions: "enhanced case management" and "integrated care management systems." These interventions were designed to save money by reducing hospital readmissions through better discharge planning and use of community-based services, and by maintaining patients in the lowest-cost setting of care appropriate to their needs (MDHMH 1994b, 3). The plan was to screen almost all Medicaid patients upon hospital admission. Those whose medical history, diagnosis, complexity of illness, or demographic makeup indicated they were likely to end up in the top 6 percent of cases based on treatment costs were then referred to one of the two interventions (MDHMH 1994b, 2).

First, some patients would enter into an enhanced version of case management similar to that used by some private health plans. Teams of nurses and social workers would review Medicaid patients identified as high-cost cases within 24 hours of hospital admission and work up discharge plans. Pending the approval of the federal government, the state planned to pay for a wide range of supplemental "waiver services" that could enhance the quality and efficiency of the treatment. These services included acupuncture, chiropractic services, behavior management, occupational and physical therapy, outpatient addiction therapy, dental care, nutritional supplements, assisted living services, respite care, hospice, assistive equipment, family training, transportation, environmental modifications, and others (MDHMH 1994c, 3).

Second, the initiative called for placement of certain patients in an integrated care management system (ICMS). This was essentially a specialty HMO that would receive partial or full capitation payments for the comprehensive care of patients who fit into "clinically focused groups" with a history of high-cost episodes, based on studies of Medicaid claims. Plans suggested that different ICMSs would be organized for patients with a primary diagnosis of uncontrolled hypertension, complications from diabetes, chronic obstructive pulmonary disease, congestive heart failure, high-risk pregnancy, premature birth, pediatric asthma, mental illness combined with medical problems, traumatic head injury, spinal cord injury, late-stage cancer, and AIDS (MDHMH 1994b, 20–1). The ICMSs would use interdisciplinary teams to develop treatment plans for

TABLE 1
Chronology of the Maryland Medicaid Reform Process

Winter and spring 1994

- Pilot study of high-risk patient management under grant from the Robert Wood Johnson Foundation
- Development of Department of Health and Mental Hygiene budget proposal for the High-Cost User Initiative under Secretary Nelson Sabatini
- Approval of High-Cost User Initiative by the general assembly in Governor William Schaefer's final budget bill

Summer 1994

- Creation of the Center for Health Program Development and Management at the University of Maryland Baltimore County (UMBC)
- Submission of Section 1115 waiver proposal for High-Cost User Initiative to the Health Care Financing Administration (HCFA)

Fall 1994

- Development of proposed regulations for implementing Integrated Care Management Systems
- Election of Governor Parris Glendening
- Republican majorities elected to the U.S. Senate and House of Representatives

Winter 1995

- Development of Integrated Care Management Systems suspended by the new secretary of health and mental hygiene, Martin Wasserman
- Decision to pursue Section 1115 waiver for a new, systemwide Medicaid managed care program
- Introduction of senate bill 694 by Senator Paula Hollinger, with the support of the Department of Health and Mental Hygiene (DHMH)

Spring 1995

- Adoption of senate bill 694 by the general assembly, directing the secretary of health and mental hygiene to formulate plans for comprehensive reforms in the state Medicaid program

Summer and fall 1995

- Public hearings throughout the state to receive preliminary input and identify prominent issues
- Appointment of Waiver Advisory Committee and Technical Advisory Group, which conducted a series of issue-oriented meetings
- Community forums with Medicaid beneficiaries
- Development of recommendations by the UMBC Center for Health Program Development and Management in consultation with the Department of Health and Mental Hygiene
- Approval of the High-Cost User Initiative waiver proposal by HCFA

Winter and spring 1996

- Submission of legislative proposal for Medicaid reform by the Department of Health and Mental Hygiene to the general assembly

(continued)

TABLE 1 *Continued*

• Executive and legislative modifications to the DHMH proposal
• Passage of house bill 1051 and senate bill 750 and appointment of conference committee to resolve differences
• Adoption of senate bill 750 by the general assembly and approval by Governor Glendening
• Submission of new waiver proposal to HCFA
Summer and fall 1996
• Development of Medicaid regulations for implementing systemwide managed care reforms
• Approval of waiver proposal by HCFA
Winter and spring 1997
• Scheduled implementation of the Maryland HealthChoice Program
Summer and fall 1997
• Implementation of the Maryland HealthChoice Program

a patient's primary condition and his or her other medical needs, coordinate the provision of health and social services, and monitor patient progress.

The ICMS concept reflected Sabatini's insistence on creating new systems with a broader scope of services, financial risk sharing with providers, and continuous responsibility for patient management. It was assumed that short-term case management alone would be insufficient for many patients with chronic conditions; yet few general HMOs had the expertise, and none had the financial incentives, to establish long-term relationships with high-risk patients under the existing Medicaid program. The ICMS provisions also gave academic health centers and other institutions with established expertise and commitment to these specialized populations an opportunity to make the transition from fee-for-service medicine toward prospective payment and managed care.

Another notable feature in the initiative was the decision to create the Center for Health Program Development and Management (CHPDM) on the campus of the University of Maryland Baltimore County (UMBC). The new center was to develop the state's application to HCFA for the waivers needed to implement the interventions. It would then operate the High-Cost User Initiative and serve as an ongoing source of technical assistance to the state health department and Medicaid program in the following ways:

1. supervision of patient screening, assessment, and referral to case management and ICMSs
2. administration of the case management program
3. construction and refinement of data bases that would track patient utilization, costs, and outcomes
4. development of payment methods and establishment of rates for different types of high-cost patients
5. evaluation of provider performance

The connection to UMBC was a pragmatic way to enhance the analytical resources available to Medicaid and to exercise good political relations. Sabatini was introduced to the UMBC president, Freeman Hrabowski, and the provost, Jo Ann Argersinger, in a meeting with Governor Schaefer, during which it was agreed that a relationship between the state and the university would be mutually beneficial. Sabatini was impressed by the willingness of UMBC officials to let DHMH determine the research agenda and to work within budgetary, political, and time constraints. They agreed to create a direct reporting line from CHPDM to the provost in order to lessen the risk that the normally complex governance of the university would interfere with the accountability required in the Medicaid program.

Stuart initially had tried to run most of the research and development work through a consulting firm that created the pilot high-cost screening instrument (Tillman et al. 1992), but this approach was dropped when the state attorney general ruled that a consulting contract would have to go through a competitive bidding process. With UMBC, the contract for program operations could be developed through an inter-agency agreement rather than having to undergo the usual nine-month procurement process required for private-sector contractors. Sabatini could have attempted to hire additional staff within DHMH, but he believed that the legislature would not create an exception to a state hiring freeze and approve new permanent civil service positions (Coburn and Booth 1995; Nelson Sabatini 1996: personal interview). The university would have greater flexibility than DHMH in personnel decisions and setting staff salaries and, in addition, the academic setting might help attract a higher-quality staff (Sabatini 1996: personal interview).

An Inside Strategy for Policy Adoption. At its inception, the High-Cost User Initiative was not controversial and did not have a high

profile in the political process. When the legislature enacted house bill 1359 in the spring of 1993 to reform small-group health insurance and strengthen data collection on health care use and costs, Sabatini asked to insert language that would enable the state to initiate capitated payment programs with health care providers that were not licensed to operate either as regular insurance companies or as HMOs. This language, which was added to an uncoded section of the bill during the conference committee, established the statutory basis for creating ICMs under the High-Cost User Initiative the following year.

As work progressed on the technical details, Sabatini met with Governor Schaefer in the fall of 1993 and received permission to include the initiative in the administration's budget proposal for fiscal year 1995. Sabatini had used this strategy for other program changes and understood its advantages over independent legislation. The executive branch has an unusually strong constitutional position on budgetary matters in Maryland: the general assembly can only reduce the amount proposed for appropriations by the governor; it cannot add or transfer funds from one program to another. Thus, the initiative could not be held hostage to other legislative priorities.

The spending plans in the initiative also contributed to its success. The DHMH proposal called for a reallocation of program funds rather than additional appropriations; it was advertised as a way for Medicaid to put taxpayer dollars to better use. Even though its creators hoped the initiative would improve the quality of care and patient outcomes, they were required to save the state at least as much money as it cost to run the initiative. The waiver proposal to HCFA actually projected that the High-Cost User Initiative would save \$114 million over its first five years (MDHMH 1994b, 4). A large proportion of the reallocated funds—several million dollars each year—was to go to program staff and operations based at UMBC. In 1994, the state senate took initial action on the budget bill and Barbara Hoffman, a Democrat, who represented parts of Baltimore City and Baltimore County and took a special interest in the UMBC budget, was vice chair on the Senate Budget and Taxation Committee. Hoffman had long been active on education and health issues and was one of the core group of legislators who were credited with smoothing the way for the DHMH budget proposal and monitoring the subsequent performance of CHPDM.

After a routine legislative hearing, the High-Cost User Initiative passed the general assembly as part of Governor Schaefer's final budget

in the spring of 1994. Mary Stuart and her staff in the Health Policy and Statistics Administration initially supervised program implementation for DHMH. After legislative enactment, more of the daily management passed to officials responsible for Medicaid operations and to newly hired staff at CHPDM. Working on a tight timeline, the small CHPDM contingent and DHMH officials completed a waiver application to HCFA within a few weeks. The proposal sought federal agreement to pay for the supplemental services needed to replace or prevent higher-cost care and to allow mandatory reassignment of potentially high-cost patients from MAC providers to ICMSs. The Maryland proposal went to HCFA on July 7, 1994. That same day, UMBC hosted a news conference to formally announce the creation of CHPDM and details of the new Medicaid reforms.

Implementation Successes and Failures. In the summer and fall of 1994, the screening and case-management components of the program got under way in earnest. From the outset, CHPDM staff believed that the case management was only a second-best strategy to improve the efficiency of patient services and that the greatest program savings would come from ICMS services. Before a single ICMS was organized, however, case management revealed how inefficient the existing system was for high-risk patients. Even though only a fraction of eligible Medicaid patients was being screened and referred to case management, the early implementation produced enough estimated savings to more than offset the cost of all CHPDM operations. For fiscal year 1996, Medicaid saved an estimated \$8.6 million, or \$2.30 for every dollar spent on the CHPDM operations (CHPDM 1996). These savings were based on the case managers' estimates of what their care plans would have cost compared with unmanaged delivery, but these estimates have not been validated by a claims analysis of the amount actually spent by Medicaid.

External Opposition to ICMS Development. The waiver proposal submitted to HCFA called for a full year of ICMS planning and implementation of services beginning in July 1995. The ICMS was the hallmark innovation in the High-Cost User Initiative and, indeed, had no organizational counterpart either in the private sector or in other states. These specialized systems of managed care promised a lot: better care at lower cost for an extremely needy segment of the population. The program designers believed that instituting ICMSs would immediately benefit the Medicaid population and, over time, information from ICMSs

might have improved disease management in virtually all managed care programs.

The potential significance of this innovation did not guarantee its survival, however. By the start of 1995, plans for ICMS development were dead. The High-Cost User Initiative lost political momentum in its first few months, and the seeds were sown for a much broader, less specialized system of managed care for the Medicaid population. A number of factors contributed to the early demise of ICMS development and the eventual death of the entire initiative.

The first sign of strain was external resistance from health care organizations that were expected to establish and operate ICMSs. The Maryland Association of Health Maintenance Organizations expressed concern that physician and hospital groups that sponsored an ICMS could effectively form their own managed care organizations without review by the state insurance department and without having to meet the same financial and quality assurance requirements as regularly licensed health plans (Geni Dunnells 1995: letter). Even with the built-in advantages of their existing provider networks and experience with capitation payments, HMOs saw the ICMS plans as an entry point for unfair competition.

Health care providers had quite different concerns and constituted a more formidable source of opposition to ICMS development. Most providers, including those whose staff had worked closely with DHMH on the preliminary design and planning grant, expected there would be a trial period to test the feasibility of the ICMS concept and of different payment arrangements. The original budget proposal, in fact, called for a year of pilot testing in three Baltimore hospitals—but, by the fall of 1994, CHPDM was planning to begin statewide implementation of ICMSs in mid-1995 without a smaller-scale trial.

The atmosphere became contentious after CHPDM and DHMH officials announced the draft regulations for ICMS operations and payments in September 1994. The ICMS guidelines stated that Medicaid would negotiate capitation rates for the different patient groups. This worried hospital officials, who believed that full capitation should be phased in based on several years of experience with the new patient categories and range of services. CHPDM staff had not completed its risk-adjustment methods and provider data to simulate the likely impact on individual providers. In addition, it was not clear how ICMS payments would cover the “social costs” of graduate medical education

and charity care, which, since 1977, have been calculated into the hospital-specific rates set by the state Health Services Cost Review Commission for all payers. CHPDM provided no assurance that Medicaid would cover the actual social costs for particular providers; academic medical centers and other teaching institutions were concerned that if adjustments were included in the basic capitation rate, Medicaid would still have a financial incentive eventually to compress capitation payments toward the lowest negotiated rate or to direct patients away from institutions with teaching programs or high volumes of uncompensated care (Gerard Reardon 1996: personal interview). These institutions have proposed that the social costs be spread across the rates of all hospitals in the state, arguing that the resulting rates would more accurately reflect the true efficiency of patient care and would make academic institutions more attractive to managed care plans.

This fear of a preference for providers with lower rates was compounded because DHMH and CHPDM would be in charge of screening patients and referring them to an appropriate ICMS. In fact, the draft regulations and a subsequent letter of clarification stated that ICMSs with lower capitation rates would be rewarded with a higher volume of patients (MDHMH 1994d, 26; John Folkemer and Louis Hays 1994: open letter). The two academic medical centers in Baltimore were particularly concerned that a selective contracting process would emerge, which would result in many patients being referred to lower-cost providers without regard to geographic location or historical service to the Medicaid population.

The staff from CHPDM and DHMH held a public meeting, on October 25, 1994, to discuss concerns with the draft regulations. The state response, on December 16, 1994, listed "several important proposed changes" in the regulations. It expressed a willingness to consider risk-sharing arrangements beyond the negotiated capitation rate, such as a stop-loss mechanism, whereby the state would pick up individual patient costs above a certain amount, or "risk corridors," whereby Medicaid and the ICMS would share a specified proportion of the difference between the capitation rate and the actual costs incurred for patient services (Folkemer and Hays 1994: open letter).

Official documents and CHPDM staff confirmed that Medicaid was to move quickly away from fee-for-service to capitation for ICMS patients. The stated goal was a capitation rate of not more than 90 percent of equivalent fee-for-service payments. They argued, however, that there

was never any intent to impose pure capitation without additional adjustments for unpredictable patient costs. They also argued that there was no plan to introduce competitive bidding or selective contracting, despite the wording of the proposed regulations (Louis Hays 1996: personal interview).

The misunderstandings between providers and Medicaid staff appear to reflect differences in both substance and style. The High-Cost User Initiative was founded out of a desire to create a more organized system of health services for seriously ill individuals; at the same time, it was clearly designed to make the state a more prudent purchaser of services and encourage market forces in the larger health care system. This latter policy aim put Medicaid officials at odds with providers struggling to maintain the relatively collaborative, anticompetitive culture that has distinguished Maryland health policy for decades. These substantive differences were exacerbated by poor communication as program development moved from DHMH to CHPDM. Many of the CHPDM staff were newcomers to the state's health policy community and did not sense the importance of consulting with its most influential leaders and organizations before recommending options for implementation. The questions and objections raised by providers did not stop the initiative outright, but they made it easier for subsequent developments to sidetrack its progress. The initial policy cycle also showed CHPDM staff that they would have to open up channels of communication and create a foundation of trust in the next round of reform.

Ambivalence inside the Medicaid Bureaucracy. While discontent grew on the outside, there were divisions within DHMH as well. Some Medicaid officials questioned whether an experimental program concentrated on a small number of beneficiaries was worth all the technical and political difficulties. There was a sense that the High-Cost User Initiative was "pie in the sky," devoted more to research and development than to solving immediate problems in Medicaid operations. It was spending too much time and money on identifying potentially high-cost patients, planning new organizations, and offsetting medical services with social services; some program administrators believed it might be better to focus on reducing unnecessary or overpriced health services for patients who were already identified as high-cost cases (Lawrence Triplett 1996: personal interview). The argument for establishing the growing staff, data systems, and other departmental operations at UMBC was not universally accepted. Finally, some officials felt that

limiting the initiative to a small, high-risk population put excessive pressure on DHMH to estimate accurately the necessary services and capitation payments. They came to prefer a broader initiative, not because they admired managed care organizations, but because it would avoid another unique administrative and financial structure for Medicaid operations. Enrolling most patients in larger health plans would spread the actuarial risk more broadly than in the ICMSs and presumably would create more economic slack for providers, health plans, and the Medicaid program (Joseph Millstone 1996: telephone interview).

The ambivalence and dissent surrounding ICMS development might have made little difference had the Maryland waiver proposal already been approved by HCFA. The federal waiver did not arrive until December 1995, 17 months after the original request, and HCFA officials were surprised to learn that ICMS development was no longer part of the plan. Some CHPDM staff felt that the Maryland proposal, because it dealt with only a portion of the Medicaid population, was treated as a “small” waiver and put at the end of the queue while HCFA devoted itself to proposals from other states with broader policy and political implications (although a major waiver proposal from New York, for example, was under review for over two years).

Turnover in the Political System. John Kingdon (1984, 160–2) argues that turnover of key officials often opens a window of opportunity for policy change. Indeed, while the controversy within the state health policy community was necessary to prompt reconsideration of the High-Cost User Initiative, its demise and the subsequent course of the Maryland Medicaid program are most easily traced to political events in November 1994. The national election swept Republicans into majority control of both houses of Congress for the first time in two generations. The results of that turnover in leadership would be felt a few months later. Of more immediate consequence was the narrow victory of Democrat Parris Glendening in the race to succeed retiring Governor Schaefer. He selected Martin Wasserman, a physician-attorney and career public health officer, as the new secretary of health and mental hygiene. Nelson Sabatini arranged to leave DHMH and have his successor appointed in December 1994, even before the new governor took office. The High-Cost User Initiative lost its champion with his departure. Within weeks, word passed from DHMH to CHPDM to the health care community that ICMS development would be suspended and the state would undertake a new managed care initiative.

Maryland Medicaid Managed Care Program
(1995–96)

The change in administration provided an opportunity to review the entire Medicaid program. Even though the MAC program was a modest success, DHMH officials believed it would not produce major cost savings. With Sabatini gone, the state trade associations for HMOs and hospitals appealed to Wasserman to reconsider the scope and timing of the High-Cost User Initiative (Dunnells 1995: letter; Cal Pierson 1995: letter). There was already support within DHMH, as noted above, to stop tiptoeing into managed care through conventional HMO contracts and specialized programs. Medicaid officials argued that HMOs were overpaid under the existing system (a small discount of average per capita expenses under fee-for-service), an assertion that supported a move to a more sophisticated system of capitation payments that more accurately predicted resource use. The Glendening transition team report included a recommendation to move additional components of the Medicaid program from fee-for-service into managed care. It did not specify the form “managed care” was to take, but argued that Medicaid patients’ access to traditional providers, including academic health centers, should be protected (*Maryland Forward* 1995).

Wasserman, who most recently had headed the public health departments in two Maryland counties, Montgomery and Prince George’s, was not especially knowledgeable about Medicaid financing and delivery systems. He was receptive to new ideas, however, and had established a reputation as a successful “bureaucratic entrepreneur.” He won a Ford Foundation award for innovations in state and local government after creating Project Deliver, a public–private partnership to improve obstetric services to indigent women in Montgomery County (Levin and Sanger 1994). As he prepared to take office, Wasserman attended a conference that discussed Medicaid managed care initiatives in other states. Thus he was vaguely aware of Section 1115 waivers when Democratic state senator Paula Hollinger urged him to consider a new round of Medicaid reform based on mandatory enrollment in managed care organizations (MCOs). The new governor had other agenda priorities and was not ready to take the lead on health care, but he was willing to let Hollinger and DHMH go forward.

Hollinger was a nurse by profession and a prominent legislative advocate of better health services for the poor. During the second Schaefer

administration, she had become persona non grata at DHMH because of her protests against budget cuts for AIDS services. The arrival of Glendening and Wasserman gave her renewed access to administrative policy circles. She was a member of the health committee on the governor's transition team and, in January 1995, she energetically pursued discussions with DHMH leadership and staff. Over the preceding few years, Hollinger had met periodically with officials from other states who were active in health care reform. In the immediate wake of the Clinton administration's failed attempt at national reform, she believed that states could still achieve modest but important gains through Medicaid reform.

The Rationale for a Comprehensive Managed Care Program. One reason for Wasserman's interest in a new initiative was administrative simplification. It was an opportunity to consolidate the MAC program, existing HMO operations, and several specialized waiver programs that predated the High Cost User Initiative for conditions like diabetes, sickle cell anemia, and lead paint poisoning into a single managed care program to serve all Medicaid beneficiaries. As the process moved forward, he emphasized quality improvement as the essential goal of the new reforms.

Hollinger sought a new system for different reasons. Many states had initiated Section 1115 demonstrations under the premise that managed care would yield cost savings that could be used to expand Medicaid eligibility to populations that were previously uninsured or underinsured (Alpha Center 1995). In Oregon and Tennessee, for example, major expansions of Medicaid managed care allowed those states to cover hundreds of thousands of additional residents. Hollinger originally hoped to pursue the same strategy in the 1995 legislative session. She introduced senate bill 694 as an act concerning "expansion of eligibility through managed care plans." For a brief time, Medicaid managed care was still thought of as a progressive tool of health care reform (Paula Hollinger 1996: personal interview).

Those aspirations were short-lived, however. Any plans to expand insurance coverage disappeared in the face of congressional proposals to restrict severely the growth of federal contributions to the Medicaid program in the spring of 1995. Once Congress turned from the largely rhetorical actions on the "Contract with America" to a spending plan necessary to reduce the federal deficit and finance tax cuts, state policy makers were forced to think of Medicaid in very different terms. As

Hollinger observed the proposals emerging in Washington, she began to focus on ways that Maryland might avoid ill-considered reductions in Medicaid eligibility or services. The threat was sufficiently serious that the proud liberal and staunch advocate of a single-payer health insurance system became the leading voice in the legislature for building a new Medicaid system around capitated managed care organizations.

Neither DHMH nor UMBC gave any formal indication that the implementation plans announced for the High-Cost User Initiative in September 1994 might be delayed or reconsidered. In January 1995, however, Wasserman "suspended" ICMS development and laid plans for a new Section 1115 Medicaid waiver. According to officials at DHMH and CHPDM, the two decisions were basically linked together and driven by the pursuit of a new waiver; it was only logical to put ICMS development on hold and include high-cost patients in a systemwide managed care program. The opposition of health care organizations to ICMS plans appeared to be a supporting, not a determining, factor in Wasserman's decision to suspend implementation. None of the parties outside of DHMH received either the official documentation of this change in policy or the precise rationale for it.

With strong support from DHMH, the general assembly passed senate bill 694, and Governor Glendening signed it on May 25, 1995. It directed the secretary of health and mental hygiene to formulate plans for comprehensive reforms in the state Medicaid program and submit them to the legislature for action during the 1996 session. The statute endorsed an effort to place the great majority of beneficiaries in capitated managed care plans. Upon legislative approval, DHMH would develop a new Section 1115 demonstration proposal to the federal government.¹

A Model Process of Public Input and Policy Formulation? To receive HCFA approval for their Medicaid waiver applications, states must meet the following criteria: appropriateness of the proposal's design to achieve its stated goals for coverage, cost savings, and other outcomes; ability to provide accessible, quality care for Medicaid beneficiaries; budget neutrality or savings; health care system capacity to implement the proposal; and evidence of local commitment (Voelker 1995). The issue of local commitment was closely monitored in light of problems that emerged after Tennessee implemented its new waiver program in

¹ Annotated Code of Maryland, Health General §15–101.

January 1994. In that state, after endorsing the general goals and authorizing a waiver application to HCFA, the legislature delegated the actual design of TennCare to state health officials, who were not required to submit final plans for legislative approval. As a result, many groups—providers, beneficiaries, and the legislative community—felt left out of the process, prompting HCFA to review more carefully how states notify and include interested parties in the waiver development process (Mirvis et al. 1995; Bonnyman 1996; Brown 1996).

During the 1995 deliberations over senate bill 694, Wasserman met with representatives of several advocacy groups and promised that, once the bill passed, they would be consulted on the design of the upcoming waiver proposal. They would then have further input after the proposal was returned to the legislature for approval. In retrospect, it is clear that Maryland officials took considerable precautions to create a supportive political environment. The formulation of the new plan was a delicate technical and political exercise that consumed a full year. Medicaid program documents contend that Maryland used “the most extensive and inclusive public process for developing the waiver of any state in the country” (MDHMH–CHPDM 1996, 5).

In the spring of 1995, DHMH set up a new contract for technical assistance with CHPDM. Because its staff and operations were already covered by the Medicaid budget, CHPDM could simply shift much of its analytical work from the High-Cost User Initiative to development of the new, systemwide managed care program. The center was to run meetings and develop preliminary recommendations to DHMH for design of the new system. In addition, CHPDM was to help state officials draft program regulations and the waiver application to be sent to HCFA upon approval by the general assembly.

In an effort to gain a broad base of input and also to secure political support for the Medicaid reform proposal prior to the legislative process, Wasserman directed that public hearings be held to solicit information and gain a preliminary sense of the central issues to be addressed in policy development. Eleven public hearings were conducted in every region of the state in June and July 1995. Over 1,000 people attended the hearings, and CHPDM and DHMH staff heard testimony from 228 individuals (MDHMH–CHPDM 1996, 6).

To follow up on that general base of input, Wasserman appointed a 131-member advisory committee and created a highly organized process to identify and deliberate on issues and policy options. The

1115 Waiver Advisory Committee (Advisory Committee) included elected officials and representatives of MCOs, medical care providers, Medicaid beneficiaries, state and local governmental agencies, and a variety of advocacy groups. Wasserman sent personal letters of invitation to members, asking them to collaborate on improving the overall quality of care for the Medicaid population and curtailing rising costs in the program (CHPDM 1995a).

The secretary relied on a group of 45 state agency experts within the Advisory Committee for proficiency on certain policy and administrative issues. The Technical Advisory Group was to help develop policy options for the Advisory Committee, conduct research, and track federal legislation affecting the Medicaid program.

Medicaid beneficiaries were invited to small community forums to discuss their priorities for the new system. CHPDM staff organized six forums in September 1995 in the most populous counties in the state. The privacy of these forums made them a useful supplement to public meetings during which “consumer” input was solicited by policy makers. This approach required CHPDM staff to augment their role as technical analysts and consultants, and it gave them the new responsibility of identifying and representing beneficiary interests.

Advisory Committee Deliberations. The Advisory Committee began a series of weekly meetings in July 1995. CHPDM and the Technical Advisory Group developed policy options papers to guide committee discussion of critical issues in designing the new program. The first meeting addressed health plan enrollment and service “carve-outs,” which were categories of services or types of beneficiaries that should not be covered by regular MCOs. In subsequent meetings, the committee considered the designation of essential community providers, the delivery of mental health and substance abuse services, the expansion of coverage and benefits, quality assessment and improvement, encounter data, capitation and risk adjustment, and access to care. The issues that generated the most debate were carve-outs, essential community providers, and mental health and substance abuse services. The final scheduled committee meetings in September allowed open comments and debate.

Despite the emphasis on inclusion and representation, most stakeholders were reacting to an agenda established by the state health department and the legislature in senate bill 694. While its input influenced the ultimate design of the waiver proposal, the committee took no formal votes and exercised no authority over the specific provisions or

the overall proposal. Louis Hays, director of operations for CHPDM, set the political tone at the first committee meeting by stating that Secretary Wasserman and the center assumed that most Medicaid beneficiaries would be enrolled in managed care and few, if any, services would be carved out (CHPDM 1995b, 2).

The participation and solidarity of legislators on the Advisory Committee also helped members to focus on system performance and cooperation. Chief among them were state senators Hollinger, the primary legislative sponsor, Hoffman, and Larry Young, chair of an important health subcommittee. The elected officials demonstrated that they would not oppose the move to managed care and insisted that no option would be adopted unless it improved the integration of health services and made financial sense for the state. They were generally opposed to carve-outs because, in their view, the new system ideally should work seamlessly for beneficiaries—that is, they should not be shifted from one specialized system to another because of a change in their medical condition.

Keeping One Eye on Washington. As the summer progressed, the Advisory Committee was increasingly attuned to potential changes in federal policy. Members received repeated reminders that proposals for federal budget cuts and block grant caps meant that expanding Medicaid eligibility was not an option. John Folkemer, deputy director of the Medical Care Policy Administration in DHMH, reported that Congress had adopted a budget resolution cutting \$181.6 billion from the federal Medicaid budget over seven years. Growth would be limited to 7.2 percent the first year, 6.8 percent the second year, and 4 percent every year after that. Although Congress had not produced final budget legislation at that point, Folkemer said the proposed cuts could result in an estimated \$2.8 billion of lost revenue to Maryland over a period of seven years (CHPDM 1995e, 25). The prospect of sizable funding cuts was the final ingredient needed to ensure that a majority of committee members continue to accept the basic concept of mandatory managed care for Medicaid beneficiaries; it was now seen as a necessary way simply to maintain current levels of eligibility and benefits.

The federal deliberations represented a new type of “policy club,” which was cited as instrumental in propelling passage of other state health care reforms when credible threats of worse alternatives help instill political commitment and facilitate cooperation among potential opponents (Brown 1993). In Maryland, the “club” was wielded from

outside the state rather than by an internal coalition—and conservatives, not liberals, applied the pressure that facilitated reform.

Controversy over Provider Participation in MCOs. Apart from which groups of beneficiaries should be carved out of the new managed care system, the most controversial problem the Advisory Committee faced was setting the terms of provider participation. Should Medicaid require MCOs to contract with certain providers or allow providers to organize MCOs on their own? Most providers wanted assurance that, if the state was to enroll Medicaid beneficiaries into managed care, then the physicians, clinics, and hospitals that had served this population in the past should be able to do so in the future.

The Maryland debate took as a starting point the provisions for “essential community providers” in the Clinton administration plan for national reform. These providers were later labeled as “historic providers” in the Maryland legislative language and waiver proposal to HCFA. They included individual physicians, Federally Qualified Health Centers, Maryland Qualified Health Centers, rural health clinics, school-based health centers, local health departments, and family planning clinics (CHPDM 1995c). Medicaid funding is a large part of the operating budget for many of these providers, who often render care in poorer areas of the state. It was incumbent on planners of the new managed care system, therefore, to assure access to care in those areas.

In contrast to states like Tennessee—where providers had to be induced to accept Medicaid patients (Mirvis et al. 1995)—the majority of Maryland providers who participated in the waiver development process sought inclusion in the system. In particular, African-American physicians described difficulties negotiating with MCOs to join their networks, and local health departments and Federally Qualified Health Centers believed that MCOs would resist contracting with them (CHPDM 1995d, 23). Participation in Medicaid was also crucial for the two academic medical centers in the state, at Johns Hopkins University and the University of Maryland at Baltimore, which together received almost one-third of all Medicaid general hospital revenues under the existing system (MDHMH 1994a, 59). Medicaid accounted for about one-fifth of all patients at Johns Hopkins (Salganik 1996).

The heavyweight interests in this battle were hospitals and existing health plans. The Maryland Hospital Association favored including any organization with a proven track record of delivering care to the Medicaid population. It argued that the state should support the formation

of entities similar to HMOs with rigorous solvency and capitation requirements. These entities could provide coverage for general or special populations. The position adopted by Maryland Association of HMOs, that no provider was essential, would allow MCOs to develop their networks with maximum flexibility and the lowest costs. It would consider a compromise, whereby the state offered MCOs incentives to contract with certain providers but did not require such contracts (CHPDM 1995d, 9). Ultimately, policy makers would have to choose between two disparate views regarding historic providers. The first view was that the state should focus on identifying necessary services and ensuring access to those services; the second view was that it was truly important which providers render the services.

CHPDM Recommendations. On September 21, 1995, the Advisory Committee held its last formal meeting to develop recommendations for the 1115 waiver application. That input served as the basis for CHPDM to draft a preliminary reform plan for Secretary Wasserman. The CHPDM plan set the stage for several innovations in the Maryland reforms, and many of its major recommendations carried through to the final reform plan in 1996. CHPDM staff projected that the overall plan would save the Maryland Medicaid program a total of \$1.3 billion over six years.

Dozens of members of the Advisory Committee reconvened in downtown Baltimore three weeks later for a review of the draft proposals. The CHPDM recommendations introduced several trial balloons into the policy process and allowed DHMH officials to observe the reaction of interest groups before adopting the recommendations as their own. According to Medicaid documents, "The reaction of the Committee was very positive, and members expressed satisfaction about the extent to which their positions and concerns were reflected in the draft" (MDHMH-CHPDM 1996, 7). The staff at CHPDM and DHMH conducted an additional six public hearings and two consumer forums to review the draft waiver proposal. These formal and other informal sources of feedback led to revisions presented at a final meeting of the Advisory Committee on November 8, 1995. The committee's comments were weighed as DHMH converted the proposal into legislative language.

State and Federal Approval of Systemwide Managed Care. The legislative proposal by DHMH was announced on January 11, 1996. Shortly thereafter, it was introduced as house bill 1051 and senate bill 750 in

the general assembly. During legislative hearings in late February and early March, many members of the Advisory Committee offered testimony supporting a systemwide expansion of Medicaid managed care. Many interested organizations and groups, including some represented on the committee, offered amendments calling for major or minor modifications to the DHMH proposal.

The large number of proposed amendments indicated that, although there was little opposition to the basic policy, there was still considerable disagreement about critical details of organization and financing. Still at issue was who would be allowed to organize managed care plans and what solvency standards they would have to meet; what, if any, guarantees would be made to historic Medicaid providers for participation in MCOs; how payments to MCOs would be determined; and whether and when the Medicaid program might initiate selective contracting with MCOs to encourage greater competition and cost savings. Another heated debate centered on the role of MCOs in the delivery of mental health services. There was also strong pressure to require MCOs to devote a minimum amount of Medicaid payments to direct patient services, based on widespread concern that a significant proportion of revenues would be siphoned off for administrative expenses and profits. As would be expected, health plans wanted to avoid micromanagement of their operations while provider and patient advocates wanted stronger regulatory controls.

Officials in DHMH worked with interest groups and incorporated many of the proposed amendments into revised bills in January, prior to legislative hearings. Nonetheless, individual groups and coalitions pushed forward into legislative deliberations many amendments not supported by DHMH. Many of the controversial provisions continued to be debated as the bills from each house went to conference committee. After a drawn-out conference, agreement was reached on a modified version of senate bill 750 and sent back to the floor of each house at the very end of the legislative session. Medicaid officials commented that this had been an extraordinarily difficult process and that, in ordinary circumstances, legislation containing so many contested amendments would be rejected or returned to the summer session of the legislature for further study and development of consensus (Joseph Millstone 1996: phone interview).

The final version of senate bill 750 was passed by unanimous vote in both houses of the general assembly on the final day of the session and

was signed into law by Governor Parris Glendening on May 14, 1996.² Within weeks of enactment, CHPDM and DHMH polished the final details of a new section 1115 waiver proposal and sent it to HCFA. The proposal received a favorable review, and HCFA sent notice of the final terms and conditions for approval on September 19. U.S. Secretary of Health and Human Services Donna Shalala announced final approval on October 30. According to Barbara Shipnuck, deputy secretary at DHMH, officials at HCFA have praised the Maryland proposal for its clarity and conciseness and consider the public process prior to its adoption to be a model for other states to follow.

Key Features of the Systemwide Managed Care Program. The new Maryland Medicaid Managed Care Program includes several notable features, which are summarized in table 2. If the system operates as planned, it will integrate and strengthen services for most, if not all, beneficiaries. It will also cost less to operate than the existing set of programs. Although the projected savings subsequently dropped sharply, the waiver application to HCFA estimated that the new program will save \$541 million over five years from 1997 to 2001 (MDHMH-CHPDM 1996, 129).

The only major improvement in access is a guarantee of six months' coverage once beneficiaries become eligible for Medicaid. The draft proposal included some expanded benefits, such as adult dental coverage, but the legislature rejected any expansion of benefits in order to meet projected savings and directed that MCOs cover only the current benefits under the fee-for-service MAC program (MDHMH-CHPDM 1996, 57).

Beneficiaries may receive family planning services and certain services performed at school-based health centers without advance approval of their MCO. Also, patients diagnosed with HIV/AIDS may self-refer for an annual diagnostic and evaluation service, and women may keep their current obstetrician if their pregnancy preceded Medicaid enrollment. MCOs are required to reimburse out-of-plan providers for these services.

To assure that most Medicaid beneficiaries can remain with their current provider if they so wish, DHMH will designate providers with a demonstrated history of providing services to Medicaid beneficiaries before July 1995 as "historic providers." Providers who meet the Med-

² Annotated Code of Maryland, Health General §15-101.

TABLE 2
Key Features of the Maryland HealthChoice Program

-
- Beneficiaries guaranteed eligibility for six months
 - Guaranteed participation for historic providers
 - Risk-adjusted capitation rates using Ambulatory Care Groups (ACGs)
 - Special capitation payments for (1) Centers for Disease Control–defined AIDS patients and (2) pregnancy and delivery services
 - Stop Loss Case Management
 - Rare and Expensive Case Management
 - Mental health services carve-out administered by the Mental Hygiene Administration in conjunction with local Core Service Agencies
 - Additional quality standards for seven special populations
 - Self-referral provisions for family planning, school health services, and HIV/AIDS diagnostic and evaluation services
 - State-administered enrollment and prohibition of direct marketing by MCOs
 - MCO mandate for patient outreach
 - Local ombudsman program for relations between Medicaid beneficiaries and MCOs
-

icaid quality standards are entitled to be assigned by the state to at least one MCO provider panel if they have unsuccessfully attempted to join the panels of all MCOs in their service area. This category of providers includes both health care institutions and individual professionals who have participated in the MAC program (MDHMH–CHPDM 1996, 72). In addition, providers will be allowed to establish their own MCOs if they meet state guidelines for quality and financial security. Thus, Maryland joins other states in offering providers a chance to maintain autonomy rather than be integrated into conventional MCOs that have not demonstrated a commitment to underserved populations (Sparer 1996; Schauffler and Wolin 1996; Lipson 1997).

In contrast to current Medicaid HMO operations, MCOs will not be permitted to engage in direct, face-to-face marketing to beneficiaries. To reduce the likelihood of risk selection practices, DHMH will distribute comparable information on health plans and administer enrollment. In addition, MCOs will be required to contact enrollees who are difficult to reach or who miss appointments and attempt to bring them in for care. MCOs may enlist assistance from local health departments if their documented attempts for patient outreach are unsuccessful. DHMH will also contract with local health departments or other community

agencies to run an ombudsman program to assist beneficiaries and handle disputes with health plans.

The legislation sets limits on MCO administrative expenses. DHMH may adjust capitation payments if it determines that an MCO has a loss ratio under 80 percent during 1997 and under 85 percent thereafter. This means that managed care plans must use at least 85 percent of the money they receive from Medicaid for patient care and no more than 15 percent for administration and profits. This level of efficiency should be easier to accomplish because of the rules prohibiting direct advertising campaigns.

The new Medicaid program will coordinate with a novel mental health services “carve-out” designed and promoted by the leadership of the Mental Hygiene Administration (MHA). MHA, which is assuming a new role as manager of Medicaid mental health services, will operate a “specialty mental health system” in partnership with local Core Service Agencies. The program will manage care for all publicly funded mental health services, blending together funds from Medicaid, Medicare, MHA grants, forensic care appropriations, self-pay, and private insurers. It will use a private behavioral health company for administrative services only: claims payment, data systems, and utilization review. The full continuum of mental health services—except treatment for substance abuse—is managed within the carve-out, so opportunities for MCOs to “dump” patients into the public sector are reduced (K.A. Oliver, *in press*).

Special patient populations will receive additional attention in the new managed care system. Advisory groups of clinical experts, advocates, beneficiaries, and MCO representatives will develop new access and quality standards for seven categories:

1. children with special health care needs
2. physical disability
3. developmental disability
4. pregnant and postpartum women
5. the homeless
6. HIV/AIDS
7. substance abusers

The MCOs may be required to submit treatment protocols and demonstrate the adequacy of their provider network for serving these special

populations. As described below, capitation rates will be adjusted for higher-cost patients. In addition, a small number of patients with specific "rare and expensive conditions" will receive care through a case management program run for Medicaid by CHPDM.

Maryland Medicaid will use innovative methods to set new capitation rates. It will phase in the Ambulatory Care Group (ACG) case mix system developed at Johns Hopkins University to set adjusted rates for beneficiaries with at least six months of claims data in the fee-for-service program. For other beneficiaries, rates will simply be adjusted for eligibility category, age, gender, and region. There will be special capitation rates for AIDS patients and a lump sum payment for maternity services, including delivery. Because mental health services will be delivered in a separate system of care, MCOs will not receive payments for these services in the regular capitation rates. This is a substantial change for HMOs that currently serve the Medicaid population, and one that they strongly resisted, as mental health expenditures currently represent 10 to 12 percent of the total Medicaid budget (K.A. Oliver 1996).

Secretary Wasserman has assigned CHPDM to operate two case management programs under the new Medicaid plan. The Rare and Expensive Case Management (RECM) program provides specialized services for patients with conditions like pediatric AIDS, congenital anomalies like cleft palate and spina bifida, metabolic diseases like cystic fibrosis, selected degenerative diseases, and hemophilia. Rare and expensive diagnoses were determined by claims analysis and input from clinicians familiar with the treatment needs. The program makes fee-for-service payments for services authorized by case managers. It is essentially a small population carve-out, as RECM patients are not enrolled in regular MCOs.

An MCO qualifies for protection under the Stop Loss Case Management program if the inpatient hospital costs of an enrollee exceed \$61,000 in one contract year. Beneficiaries above the stop loss threshold enter into case management, and subsequent care must be deemed medically necessary and appropriate. Medicaid will pay 90 percent of inpatient hospital charges above the stop loss limit for the year, using an established fee-for-service schedule. Stop loss patients continue to be enrolled in their MCO, which must cover the remaining 10 percent of inpatient hospital charges and 100 percent of all other services in the Medicaid benefits package.

The Next Steps in Program Development

The state originally planned to implement the new Maryland Medicaid managed care program during the first seven months of 1997. Delays in administrative tasks and continuing controversies led Secretary Wasserman to announce that enrollment in the new system, renamed Health-Choice, would begin in June 1997 (MDHMH 1997a).

A critical problem was assuring that there would be a sufficient number of participating health plans of adequate quality. Before receiving state certification, several new MCOs were required to correct deficiencies “to guarantee high quality programs and assure that Medicaid clients maintain continuity of care with their personal family physicians or other health care providers” (Martin Wasserman 1997: memorandum). As the final regulations were drafted, the legislative committee charged with oversight of executive agencies mandated that DHMH make “a number of additional detailed changes . . . increasing the complexity of performance demands on the new Managed Care Organizations [and] making it more difficult to meet requirements as quickly as originally anticipated” (Martin Wasserman 1997: memorandum). State officials were eventually successful in persuading most existing HMOs to continue under the MCO provisions of the new system: only one of six plans that had previously served Medicaid patients elected to leave the program.

The new program is intended to be only the first step toward a comprehensive system of managed care for all Medicaid services. Senate bill 750 directed DHMH to establish a “long term managed care advisory committee” to develop a proposal to cover the Medicaid population excluded from the first phase of reform (mainly patients eligible for both Medicare and Medicaid and those receiving institutionalized care). The long-term-care committee was to hear public testimony, conduct public meetings around the state, and prepare a report by November 1996.

The legislation required Secretary Wasserman to use the new advisory committee report as the basis for a long-term managed care proposal to the governor and the general assembly. Wasserman issued a plan for Phase II of Medicaid reform on January 30, 1997. The recommendations were cautious, suggesting only that the state encourage greater voluntary enrollment of Medicaid–Medicare dual eligibles in managed care; develop pilot projects to integrate acute- and long-term care; and

promote long-term-care planning and insurance for state employees and the general public (MDHMH 1997b). The assembly did not take any action on Phase II during the 1997 session, and it appears that new proposals will be delayed until at least 1998 to give legislators time to observe how well the HealthChoice program is working.

Reflections on the Evolution in Maryland: The Connections between Health Politics and Policy

I now turn to examine what lessons might arise from the recent evolution of the Medicaid program in Maryland. First, I identify some of the important features in the process of policy innovation. Then I consider how the process shaped policy design in Maryland and how the new system reflects the emerging politics of managed care in Medicaid and other parts of the health care system.

Opportunities for Policy Innovation

It is reasonable—indeed, desirable—to view public policy as a long-term process of problem solving (Wildavsky 1979). One of the most notable characteristics of the process, however, is that the factors that create opportunities for significant policy change often have little or nothing to do with the substantive problems that concern most policy experts (Cohen, March, and Olsen 1972; Kingdon 1984; Polsby 1984).

In Maryland, the onset of a state budget crisis pushed Medicaid officials to develop the MAC program, which promised to help contain costs associated with increasing program enrollment and inappropriate use of emergency and other specialty services. Recurring shortfalls in the state budget forced all agencies to identify new sources of savings; within a year of putting the MAC program into operation, Nelson Sabatini began pressing hard for the development of what became the High-Cost User Initiative.

It is extremely unlikely that plans for yet another major initiative would have been mounted had Sabatini stayed in office. However, other external events combined to trigger the process leading to the new systemwide managed care program, HealthChoice. The change of administration in Maryland brought in Martin Wasserman as the new

secretary of health and mental hygiene and opened the door for Paula Hollinger to regain her influence in state health policy. Their pursuit of a new Section 1115 waiver was greatly aided by an even more dramatic change in the political system—the Republicans' takeover of Congress and their bold (and ultimately unsuccessful) plans for capping federal contributions to Medicaid.

When opportunities for innovation arise outside the health policy community, they often create pressure to alter fundamental aspects of a program well before solid evidence about the current design or proposed alternatives is available. In Maryland, the series of three major initiatives in five years is a strong reminder that policy makers do not rely on formal evaluations before approving one approach or abandoning another.

Leadership Styles and Strategies

Regardless of its origin, the conversion of an opportunity for policy innovation depends on skilled leadership. Leaders clarify goals, recognize opportunities, search for feasible alternatives, and generate political resources in the policy-making process. The course of Medicaid reform in Maryland is inextricably tied to the vision and energy supplied by Nelson Sabatini and Mary Stuart to the High-Cost User Initiative, and Martin Wasserman and Paula Hollinger to the new systemwide Health-Choice program.

The Maryland experience demonstrates a variety of potential styles and strategies for exploiting opportunities for innovation. The leadership styles at DHMH differed dramatically: Sabatini operated as a consummate insider, using the knowledge of programs and procedures he gained as deputy secretary and director of overall Medicaid operations during the first Schaefer administration before his appointment as secretary. Wasserman, who was new to the state health department, operated as a rhetorical leader and principal sponsor of the broad-based process he established to support the systemwide reforms. The relatively inclusive and visible deliberations were a savvy response to the criticisms levied not only at the formulation of the High-Cost User Initiative, but also at the Clinton administration during its abortive attempt at national reform and the much-discussed "stealth reform" of Medicaid in Tennessee (Bonnyman 1996).

Although Sabatini and Wasserman each devised a successful strategy for policy adoption, their chosen strategies had different implications for policy implementation. The fate of the High-Cost User Initiative illustrates the critical importance of high-level political support—and how even a modest reform may be undone when leaders and priorities change before its advocates are able to cultivate strong internal or external constituencies (Downs 1967; Doig and Hargrove 1990; Oliver and Paul-Shaheen 1997). The insular process created by Sabatini was less risky for initiating reform; but when Medicaid officials themselves did not strongly support the premises and design of the new program, there was little reason for higher-level leaders to press for its completion in the face of outside resistance. In contrast, the far more cumbersome process established by Wasserman had a greater risk at the outset of not producing legislation; but once the process gathered momentum, it attracted far higher expectations, and a broader political constituency was invested in its success.

The Economics and Politics of Managed Care—Toward Collision or Synthesis?

In its general design, the new Maryland Medicaid system could be regarded as part of a copycat phenomenon among the states. As of January 1995, 37 of the 48 states that had submitted or were developing a Medicaid waiver program chose to build their systems around mandatory enrollment in capitated health plans (Grogan 1997, 819). The details of the Maryland system, however, reveal how the general design can be significantly shaped by the process of policy formulation and the balance of power in the health policy community.

In many places in the United States, an alliance of what Robert Alford (1975) calls “corporate rationalizers” in business, government, and health plans has taken firm control of health policy. In contrast, the course of Medicaid reform in Maryland reflects policy making under a “negotiated regime” (Hackey 1993), where local providers are still at least as influential as public and private purchasers of health services. The power of the health care establishment manifested itself in the death spiral of the High-Cost User Initiative. A few leading institutions reacted to uncertainties in patient assignment and payment methods by first demanding accommodation, then undermining the initiative when

the official responses did not fit their customary expectations. Even though the financial threat from the 1995 congressional budget proposals caused all parties to accept systemwide enrollment in managed care, historic Medicaid providers exerted a strong influence in writing the rules regarding provider participation, sponsorship of MCOs, prohibition of selective contracting, and limits on administrative expenses and profits.

Karl Kronebusch (1997) argues that providers and beneficiaries have traditionally been competitors for funding and service priorities in the Medicaid program. The Maryland experience suggests that, with the rise of managed care, providers and beneficiaries are increasingly likely to find themselves on common ground in the policy process. In the latest round of reform, the large advisory committee and community forums strengthened the position of traditional providers of Medicaid services and patient advocates relative to managed care organizations. There was extraordinary weight given to discussions of how to preserve existing patient-provider relationships in order to assure the accessibility and appropriateness of services rather than to consideration of mechanisms for improving efficiency and containing costs. In addition, considerable discussion was devoted to protecting "special populations."

Overall, there were sufficient doubts in Maryland about the motives and capacities of MCOs to warrant dozens of requirements for their clinical and administrative practices. Together, providers and advocacy groups successfully pressured politicians to adopt what one might regard as heroic measures to manage the managers. Indeed, MCOs could reasonably feel that they were modern-day Gullivers being strapped down by the Lilliputians. If the idea was to create a more streamlined and efficient system of services, why all the micromanagement?

In the death of the High-Cost User Initiative and the birth of Health-Choice, the fundamental premises about managed care and competition have regularly collided with political concerns about managed care. The reforms in Maryland are distinctive because policy makers have not simply turned over the care of Medicaid patients to the existing managed care industry. The detailed oversight of managed care has some tradeoffs, however. First, some of the major health plans in the state—including one of the HMOs in the old voluntary system—have decided that the dose of regulation is too heavy and thus far are not participating in the new system.

Second, there is a sizable gap between the original economic expectations for the new system and its likely performance. The main factor underlying governmental endorsement of managed care and market competition was, after all, the perception that those policies will slow budget growth and reduce the pressure for tax increases or cutbacks in other state services. Subsequent developments have raised the question of whether major savings are possible. The High-Cost User Initiative was supposedly aimed at the greatest areas of inefficiency; yet it would have shaved only about 1 percent off the annual program budget. It appears that the systemwide managed care program will not produce substantial savings, either. The huge variation in estimates offered throughout the policy process suggests that the estimates themselves are highly speculative; nonetheless, the anticipated savings dropped from \$1.3 billion over six years in the CHPDM recommendations to \$541 million over five years in the final proposal submitted to HCFA. By the time the waiver was approved in October 1996, Secretary Wasserman suggested that the annual savings to the state and federal government will be \$56 million, less than 3 percent of a Medicaid budget that now exceeds \$2.3 billion (Goldstein 1996). Some of the reduction in projected savings is due to slower growth of health care costs in general; this means that the state will be spending less overall and the net savings from the shift to managed care are correspondingly lower (John Folkemer 1996; personal communication).

In summary, the initial intent of policy makers to capture budgetary savings through Medicaid managed care has met with two major constraints: concern for the quality and appropriateness of care, and the motivation of safety-net providers to conserve their professional and economic status in the health care system. These challenges to Medicaid managed care are emerging in a number of settings (General Accounting Office 1997; Lipson 1997; Rosenbaum 1997) and are part of a general trend, as uncertainty about managed care now extends to market restructuring outside of Medicaid (Kassirer 1997; Declercq and Simmes 1997; Hilzenrath 1997).

The apparent collision between economic premises and political responsiveness, however, may point the way to a constructive synthesis—a system of managed care that balances economy with important community, professional, and personal values. The process and ultimate design of the new system in Maryland is actually a fair reflection of the state of knowledge about managed care for the Medicaid population:

while enrollment in managed care creates the promise of a better system for many Medicaid beneficiaries (Sisk et al. 1996), studies continue to find evidence that managed care produces worse outcomes than fee-for-service medicine for vulnerable groups—the chronically ill, elderly, and poor (Schlesinger and Mechanic 1993; Ware et al. 1996). Secretary Wasserman ultimately justified the Maryland approach, in fact, as a way to improve the quality and coordination of services for the state's most vulnerable groups and provide them with a "medical haven" (Goldstein 1996).

The shape of the new American health care system is still unfinished. Managed care is a work in progress and, like any important innovation, it generates a variety of concerns (Ellwood and Lundberg 1996). The ongoing challenge for policy makers, then, is to channel legitimate skepticism about managed care into a more patient-centered, accountable health care system. The result of a long debate in Maryland is a new program that may not produce the significant savings associated with managed care in the past, but could produce a significantly improved version of managed care for individuals in the most difficult of medical and social conditions.

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