Nothing Exceeds like Success: Managed Care Comes to Medicaid in New York City

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These men were not less brave than the others, merely more precise.
André Malraux,
Man's Fate

OVER THE LAST DECADE, MEDICAID POLITICS HAS featured state efforts to increase the number of beneficiaries enrolled in managed care. Federal officials had to respond to state requests to require beneficiaries to enroll. For-profit HMOs had to decide whether to compete for the Medicaid market. Safety-net health care providers (like public hospitals and community health centers) had to contract with health plans, or form their own health plans, or do both. State officials had to decide how quickly to proceed with managed care initiatives and how extensively to regulate their implementation. Each of these groups, along with consumer advocates and other analysts and stakeholders, had to develop strategies within a rapidly changing health policy environment.

We will review the politics of Medicaid managed care in New York City, concentrating on the transition from the policy of incremental growth that pertained during the early 1990s to its 1995 replacement, which was geared to more rapid implementation. We will examine the

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many problems that flowed from the decision to accelerate the transition, which, taken together, persuaded state officials to return to the earlier, more deliberate, approach. In pondering lessons learned from the episode, we compare New York's experience with that of other states.

New York Joins the Crowd: Incubating Medicaid Managed Care

Although managed care had become prominent, indeed preeminent, among Medicaid reform strategies in the 1990s, the states, like Tolstoy's unhappy families, fitted it to their problems in their own fashion and at their own pace. Ironically, New York State, which had the most expansive Medicaid program in the nation (the \$7,286 it spent per client was nearly twice the national average) was among the last states to mount the bandwagon (Sparer 1996a). However, to compound the irony, when it finally did so in 1991, its agenda—voluntary enrollment of half of its 2.4 million Medicaid clients within five years—was one of the most ambitious yet seen among the 50 states.

Until the 1990s, New York State had stood aloof from Medicaid managed care for several reasons. One is that it had long been infertile soil for managed care in general. State regulation of hospital rates limited the freedom of HMOs to build business by offering discounts to purchasers. The state's largest market, New York City, was dominated by academic medical centers, devotees of a costly, highly specialized, and institution- and technology-intensive practice style that made them appealing targets, but unpromising partners, for managed care plans. Two large payors—Empire Blue Cross and Blue Shield and the 900,000-member Health Insurance Plan (HIP), an HMO—were deeply entrenched in the health insurance market, and the potential for new HMOs to build market share was uncertain. Until 1985, the state discouraged for-profit HMOs, so it was late in attracting the HMO sector that was growing fastest and was best endowed with capital. Moreover, the business community, fragmented and unorganized around its health-purchasing role, rarely clamored for managed care or pressed the state to promote it.

Atop these "generic" obstacles were others specific to the introduction of managed care into Medicaid in New York State. By paying handsomely for institutional care and poorly for ambulatory services

(the state's \$11 fee for a new-patient office visit was the lowest in the nation), state rate setters seemed to rebuff HMOs, which substitute outpatient for inpatient care when possible (Sparer 1996a). (This fiscal issue had special salience for New York City's public hospital system, which drew extensive Medicaid payments for emergency-room care and would suffer from their reduction.) Talk of managed care in Medicaid elicited objections by advocates of the poor, who protested policies that would consign Medicaid clients to plans balked at by the middle class. Good managed care meant abundant primary care capacity: who would build it, and how, in the face of academic specialization and the reluctance of physicians to practice in poor areas? Further, managed care in Medicaid, especially in New York City, meant tackling problems that blurred medical and social conditions—mental illness, HIV infection, drug abuse, violence—in ways that defied efficient management.

Legislation

Given these complications, it is no surprise that the state's early steps to promote the policy of managed care (both in Medicaid and more broadly) were resolutely incremental. In 1976 New York enacted its own boilerplate version of the federal law of 1973 that encouraged HMOs. It further displayed its good will by allowing HMOs to pay the lowest ("Blue Cross") rate in its regulated hospital payment system. HMOs hardly took the state by storm, however. In 1984, for example, New York had only 13 licensed HMOs, with a total enrollment of approximately one million people (or 5 percent of the state's population). Moreover, few of these HMOs accepted Medicaid clients.

In the early 1980s, the state implemented its first Medicaid managed care initiative. One program, called the Physician Case Management Program (PCMP), offered primary care providers a capitated fee to cover primary care and gatekeeper services. State lawmakers also authorized development of a new kind of HMO, a Prepaid Health Services Plan (PHSP), which would be licensed to accept only Medicaid and other public assistance populations. The goal was to encourage community health centers and hospitals themselves to become managed care plans, a goal backed by start-up funds to half a dozen provider organizations to develop PHSPs (Sparer 1996b).

At the same time, state officials hoped to encourage traditional HMOs to enter the Medicaid market. The issue came to a head in 1985 in a dispute over the wisdom of allowing investor-owned HMOs to operate in New York. The state's health commissioner (David Axelrod) was eager to expand the managed care market and therefore was willing to permit investor-owned HMOs to operate in the state, but he also required them (and other HMOs as well) to "demonstrate a willingness" to accept Medicaid clients. The regulation offered no guidance, however, on how state officials should evaluate HMO compliance with this provision.

The entry of investor-owned HMOs into the state significantly enlarged commercial managed-care penetration. Throughout the 1980s, however, few of these plans pursued the Medicaid population, and the state did little to fortify their willingness to do so.

The disinterest of commercial HMOs in the Medicaid population, combined with the slow growth of the PHSP programs, consigned Medicaid managed care to slow growth. In 1988, for example, only 60,000 clients were enrolled. The legislature responded with new initiatives, which gave start-up funds to new PCMPs, established a program ("utilization thresholds") that sent clients who overused the medical system to a case manager, and authorized a mandatory managed care demonstration in Southwest Brooklyn. These measures, however, did little to accelerate enrollment. In 1991, only 75,000 Medicaid clients were in managed care, and the mandatory Southwest Brooklyn initiative would not even begin operation until late 1992.

In 1991, several evolving situations matured, converged, and convinced the state to embrace Medicaid managed care wholeheartedly. First, New York's Medicaid spending aggravated unusually intense political anguish over adoption of the annual state budget. A leading legislative protagonist remembered the scenario:

... a horrendous four or five months of budget fights. The 1990 budget didn't pass until June 1990. By election day that year the additional revenues we had counted on had evaporated. By Christmas we were trying to adjust to a big state budget deficit. In the middle of the fiscal year we were cutting money people had planned on. It was unpleasant to say the least.

And it concentrated policy makers' minds on doing something about Medicaid.

Second, the program's defenders were starting to doubt their power to stave off major departures in policy. Republican conservatives, a legislator noted, "wanted to take an ax to the program—cut eligibility, cut services." Those who were disinclined to do so rejoined that most clients then on Medicaid could not afford adequate medical care without it, that slashing benefits was a false economy ("You can cut out podiatry coverage but you don't eliminate feet," noted James Tallon, then majority leader of the state assembly), that payments to physicians were low enough already, and that Medicaid should be a full payor, not a cost shifter, to hospitals. These venerable arguments begged the pressing question, however: if not these measures, then what?

Third, even as the costs of traditional Medicaid loomed larger, its benefits looked smaller. Defenders and critics alike increasingly concurred that the status quo delivered inadequate value for money. Access to primary and preventive care was difficult in part because the state paid poorly for physician office visits. What good was free choice of physicians if many were called but few could be chosen? New York's generous payments to institutions had indeed kept hospital doors open to the poor, but emergency rooms and inpatient care were (correspondingly) overused. A fee-for-service (FFS), third-party-payment Medicaid program encouraged too many of the "wrong" types of services and too few of the "right" ones.

Fourth, managed care, increasingly prominent in a national health reform "movement" that gained ground daily, seemed to be precisely what the doctor ordered. It marked out middle ground between a defense of the status quo and the evisceration of eligibility and benefits. By assuring each client a "medical home" furnished with a primary care gatekeeper physician, managed care sought to ensure timely access to relatively inexpensive preventive and primary care services while reducing emergency room and hospital visits. Eligibility and benefits could be maintained, and providers who ran an efficient ship would fare well, perhaps even better, financially.

Finally, by 1991, managed care seemed to be not merely promising in theory but also plausible in practice. A legislator ticked off the empirical grounds for confidence. In New York, as elsewhere, the middle class was signing up for HMOs, which rebutted the old "second tier" objections. HIP had been a fixture of New York City's system for more than 40 years, had nearly one million members, and served approximately 30,000 Medicaid clients. The PHSPs were up and running (albeit slowly).

Further, although a mandatory Medicaid managed care program in Rochester, launched in 1982, had disbanded in 1987 when providers protested payments they considered too low, the experiment left a bright legacy in one highly germane respect: more than 40,000 Medicaid clients had been enrolled smoothly and easily (and as mandated) in managed care plans. Anyone who clearly contemplated the state's fiscal crisis, the political precariousness of Medicaid, the loss of confidence in the status quo, the abstract appeals of managed care, and the reassuring record of managed care initiatives to date could hardly deny that, in 1991 in New York State, Medicaid managed care was an idea whose time had come.

The law produced by the legislature in 1991 was ambitious. The state's 58 social services districts (57 counties plus New York City) were to devise plans that would bring half the state's Medicaid clients into managed care within five years of onset of enrollment. Local districts would sign contracts with managed care plans. Departments within the state government would oversee developments within their domains: The Department of Social Services (DSS) would review, approve, and supervise the local managed care strategy. The Department of Health (DOH) would license managed care plans, set capitation rates, monitor quality of care, and perform other oversight functions. The Department of Insurance would work with DOH in regulating licensed HMOs. The Department of the Budget would review and approve Medicaid capitation rates.

Once contracts were in place, Medicaid clients would learn of the new managed care options from local social service workers. With the exception of Southwest Brooklyn's demonstration area, enrollment in managed care would be voluntary, although the law gave districts the authority to seek state and federal approval for mandatory enrollment should they wish to do so.

The careful crafting of the 1991 law—it was at once nonpunitive and a fundamental change in Medicaid's programmatic premises and, despite the incremental manner of its adoption, its intended outcomes were bold—facilitated its passage through the state assembly and senate with little controversy. Even on what had initially been the big issue—savings on state Medicaid spending—the legislators stayed relatively relaxed. One explained that he and his colleagues would be delighted if managed care achieved the 10 to 15 percent reduction in spending that the literature indicated was possible. "If we got that, plus better care,

fine. The basic idea was that if we're going to have to face these Medicaid problems year after year the least we can do is figure out how to spend the money better."

Incremental Implementation

Between early 1992 and early 1995, Medicaid managed care enrollment in New York City grew from 75,000 to just over 315,000 (18.7 percent of the city's 1.69 million eligibles). Beneficiaries were able to choose from a wide array of health plans, including commercial HMOs new to the Medicaid market, nonprofit networks formed by coalitions of safety-net providers, HIP, and a city-owned plan. State officials contended that the managed care initiative saved dollars (although firm figures were rarely forthcoming). Neither government regulators nor consumer advocates complained of marketing fraud (despite the intrinsic opportunities that were present in the ability of the health plans themselves to enroll beneficiaries). Perhaps most important was the fact that managed care enrollees were more satisfied with their care than were their FFS counterparts (Sisk, Gorman, Reisinger, et al. 1996). Medicaid managed care was a public policy success story.

One key to its success seemed to be the participation of the commercial HMOs. The state's decision to pay capitation rates set at 95 percent of FFS costs persuaded the HMO executives that significant profits awaited the savvy entrepreneur. After all, New York's FFS costs were so high that the capitation payments promised sizable returns to plans that aggressively shifted inpatient care to outpatient settings. At the same time, the plans sensed that latecomers to the gold rush risked losing ground they might not regain later. Managed care was now clearly the name of all the major purchasers' game; the prudent plan moved swiftly into promising markets, built up market share, and spread overhead costs. In this exercise, Medicaid money was as good as any other, especially given that the state, under pressure from consumer advocates, had "carved out" from the Medicaid managed care program such challenging services as chronic mental health care and substance abuse treatment.

To these carrots the state in 1992 added a formidable financial stick. In urgent search of revenue, the legislature imposed, as part of a broader package of provider surcharges, a tax (surcharge) of nine percent on the inpatient bills of HMOs that failed to enroll a specified number of

Medicaid clients. The plans grumbled (and sued, and lost) but complied. Mixing metaphors, a legislator characterized the surcharge as the “shock therapy” that persuaded commercial HMOs to “get their feet wet” in the Medicaid market much faster than they might have otherwise. It was, he chuckled, a “neat tax. In the first year nobody would comply so we’d get the revenue, and then we’d established good public policy beyond that.”

HMO participation was not, however, the only reason for the early success. Careful public managers encouraged plans to enter the program and monitored the performance of those that did. New York City Mayor David Dinkins created a new Office of Medicaid Managed Care and appointed as its head Florence Frucher, a former administrator in the New York State Health Department. Managing a new “flat” bureaucracy with a small, handpicked staff assembled specifically with a mission to get Medicaid managed care off to a good start, Frucher walked plans through the requirements of the law and the criteria contractors needed to meet. Her insider’s familiarity with players in health policy in both the city and Albany, and the respect these players accorded her, enabled the agency to supply much needed technical assistance to plans.

Perhaps the most critical factor was the cautious and incremental pace at which the managed care initiative proceeded. The model was a state like Minnesota, which successfully phased in Medicaid managed care over a series of years, educating clients, treating health plans as partners, carving out (at least temporarily) the high-risk and disabled populations (Mathematica Policy Research 1996). The program administrators feared that phasing it in faster would replicate the problems incurred by Tennessee, which in one year jumped from one plan with 35,000 enrollees to 12 plans with 1.1 million enrollees, confusing clients, angering providers, and creating chaos in the state’s health care system (Gold 1997).

Acceleration

After defeating the Democratic incumbent, Governor Mario Cuomo, in the November, 1994, election George Pataki, a Republican, took office in January, 1995. A committed budget cutter, Pataki understandably trained a sharp eye on Medicaid and rapidly resolved to push managed care farther and faster. Working closely with the health commissioner,

Barbara de Buono, who had enthusiastically promoted Medicaid managed care while running the Rhode Island Health Department, the new administration proposed that the majority of state Medicaid clients be required to enroll in managed care plans by 1998. This heavier betting on the strategy of managed care for Medicaid clients touched several sensitive nerves.

First, mandatory enrollment meant, in essence, that Medicaid clients would no longer have the freedom to surrender their free choice of provider. Some private-sector employers had ceased to offer workers alternatives to managed care plans, but the practice had not (yet) grown so common that, when imposed on disadvantaged public clients, it failed to raise hoary ideological hackles.

Second, proposed inclusion of most of the state's Medicaid population in managed care plans highlighted lingering doubts about the industry's capacity to assure timely access to good-quality care. Dark prophecies about the inadequate number of primary care physicians in New York City seemed to be refuted by the enrollment of more than 300,000 clients in 19 plans, and although not much was known about the impact of primary care services and gatekeeping on these enrollees, negative anecdotal feedback was sparse. It remained to be seen whether a doubling of the enrollment target within a year or so was an invitation to trouble.

Third, critics protested that the state's oversight capacities were not up to the job: there was a big difference between overseeing a voluntary enrollment program with less than 500,000 beneficiaries and a mandatory program with nearly two million enrollees. The learning curve would be especially steep because the Medicaid bureaucracy was fragmented and decentralized: tasks were divided among the state's Department of Social Services, Health Department, Insurance Department, Budget Office, and 58 social services districts.

Fourth, mandatory enrollment meant that most Medicaid clients with special conditions and needs—the mentally ill, substance abusers, persons with AIDS, and more—would have to be integrated into managed care. Recognizing the exigencies of assuring—and pricing—such services, the state had carved out most of them in the maiden effort of 1991. The administration now promised to create “special needs plans,” but this was a theoretical postulate with no practical precedent. Meanwhile, the prospect mobilized a range of watchful and well-organized advocacy groups—the Gay Men's Health Crisis, the Legal Aid Society,

the Community Service Society, and others—who insisted that detailed local, state, and federal safeguards be installed before the program expanded.

Fifth, the policy-making style adopted by the Pataki administration for stepping up the pace of the program suggested a troubling proposition: even as the scope of policy conflict was expanding, the political system's capacity to manage it was eroding. Whereas throughout 1994 policy making for Medicaid managed care encouraged participation by, and the consensus of, the executive branch, the legislature, local officials, and groups with a stake in the outcomes, the new administration's initiatives were unilateral and, some said, high handed. Apparently the Pataki team planned to make Medicaid policy in the governor's office—or so it seemed to signal by applying for a crucial federal waiver in March, 1995 (which would allow mandatory enrollment to go forward), well before the conclusion of the legislature's budget deliberations, and by declining to negotiate in advance with groups that had a stake in the process. Players whose acquiescence had been crucial to smooth passage and successful implementation of the 1991 law were now, one complained, "out of the loop."

The unsettling dynamics of acceleration in Albany were, meanwhile, reproducing themselves in New York City. In November, 1993, Democrat David Dinkins had lost the city's mayoral election to Rudy Giuliani, a Republican, who shared the budget cutter's eternal hope that managed care could wring savings from the voracious Medicaid program. As the Giuliani administration settled in and addressed its top priorities—law enforcement, education, and privatization of the City's Health and Hospitals Corporation—it was content to let Florence Frucher and her staff in the Office of Medicaid Managed Care run that program. Before long, however, the temptation of larger, quicker savings led the Giuliani team too to press for acceleration of comprehensive mandatory enrollment.

The fast lane suited the administration's policy style. A participant recalled "the Giuliani timetable," the determination to be "like the private sector, anti-bureaucratic. Quick, quick, quick was the idea." In this case, speed was of the essence for reasons that, as often happens in Medicaid policy, derived from concerns beyond the health arena itself. In the summer of 1994, City Hall discovered that the revenues on which it had based its plans to fund an earlier budget agreement with New York's public employee unions had fallen short. Unwilling to raise taxes, to cut top priority services, like education, policing, and fire protection,

or to seek “givebacks” from this potent union constituency, the administration searched urgently for extra monies and soon arrived, not surprisingly, at Medicaid—the “pot of gold,” as one player put it. Managed care was rolling merrily along in Medicaid; mandatory enrollment was less a question of “if” than “when”; and, before long, city officials and their labor advisors had resolved to seek federal waiver authority to enforce mandatory enrollment, if not overnight, at least in good time to reassure the unions.

As a “Dinkins person,” detached from these high-level “macro” policy decisions and standing outside the inner circle that made them, Frucher soon found herself fielding requests from City Hall to move these expansive plans along post haste. How to respond was not obvious. On the one hand, her office (and her job and the jobs of her staff) endured at the pleasure of the mayor. Incurring his displeasure could mean the end of her tenure and influence and could result in the office being abolished or entrusted to the wrong crowd. On the other hand, Frucher believed that a careful and measured effort was the only way to avoid overcommitment, underservice, doubtful quality, and other damaging downsides of badly managed care. In the end, Frucher opposed the acceleration policy, lost, and resigned.

By the summer of 1995, the incrementalism and consensus that had guided the Medicaid managed care program had dissolved into an intensive, controversial inflation of objectives. Then, as scandals in the program erupted into public view, the hitherto harmonious exercise suffered an acute attack of Murphy’s Law: plentiful issues in contention, abundant combatants entering the fray, and impaired political capacity to manage the conflicts.

The Marketing Scandals

In March, 1995, the Pataki administration requested federal permission to mandate Medicaid managed care enrollment. The next month, city officials announced that mandatory enrollment would be quickly implemented. One state legislator recounted: “The message was, ‘The race is on.’ And if I’m a competitor, I’m going to say that my ability to control market share will depend on what I do right now.” April, May, and June saw feverish marketing and the signing on of 150,000 new clients. The era of incrementalism was over. The new goal was to enroll

beneficiaries into managed care as quickly as possible—a major shift that soon caused major problems.

Critics of Medicaid managed care, who had feared all along that some plans would take the money and run and had been wondering why that unhappy outcome was overdue, now polished up their “I told you so’s.” Some plans apparently abused their right to market directly to clients by misrepresenting essential facts—for example, by telling clients they would lose their Medicaid eligibility should they decline to enroll immediately in the plan in question, or saying that clients could keep their own providers regardless of whether those physicians were members of the plan’s panel. It became clear as well that some plans had indeed enrolled more Medicaid clients than they were equipped to serve. Amidst a barrage of exposés in the media, city and state officials decreed that marketers in the city could no longer directly enroll beneficiaries or market health plans door to door. Moreover, five plans in the city (including the city-owned network) were prohibited from enrolling new Medicaid members until problems were fixed.

The suspension of enrollment in five plans put a sizable dent in the city’s disputed capacity to serve a larger Medicaid population in managed care. The end of direct enrollment meant a slower, more cumbersome process as clients learned about, and signed up for, plans through the mediation of case workers in income support offices.

A few months later, the ban on direct enrollment was lifted, but government oversight remains strict. Managed care supporters—including executives of managed care plans themselves—understand the political imperatives of responding firmly to “scandal,” but they argue that the summer’s unhappy developments had thrown government–industry relations seriously awry. The state proceeded as if a few unscrupulous exceptions negated the generally conscientious “rules” within the industry. Even as the state and city laid plans for mandatory enrollment, the program’s growth stopped in its tracks. Between September, 1995, and June, 1998, enrollment in New York City fell from 480,065 to 378,000.

The Controversy over Rates

Before 1995, state and city officials treated the health plans gingerly, even as partners: capitation rates were relatively high, government reg-

ulation was modest, and policy changes were made only after consultation and consensus. The Pataki administration traded this pattern for a more adversarial approach. One example was the decision to implement a new competitive bidding process that would presumably weed out plans that cost too much and (or) offered too little. The request for proposals (issued in November, 1995) imposed various new mandates but did not indicate how much the state would pay for the additional work. Instead, the state informed plans that bids above an undisclosed rate-band maximum would be rejected and that unsuccessful bidders would either receive the lowest rate bid by any other plan or be eliminated from the program.

From a cost perspective, the competitive bidding process was a policy success: capitation rates were reduced by 10 to 30 percent, with state officials arguing that the rate cuts were between 10 and 12 percent and health plan managers declaring that the cuts fell into the 17 to 30 percent range. (We did not have enough data to evaluate these competing claims.) The new approach generated extraordinary ill will and controversy, however. One large HMO (Aetna/US Healthcare) withdrew from the program. Others scaled back their marketing. All the health plans now claim to be losing money and intimate that beneficiaries will eventually suffer worse care. Consumer advocates, worried about quality, have lobbied for higher rates, and the legislature has ordered the Health Department to increase them (although the required increase was far less than the plans had requested).

New York is not the only state to reduce rates and cope with health plan defections: recent reports from Arizona, Illinois, and Ohio suggest a similar pattern (Anders and Winslow 1997). Most states, however, are more eager to build capacity than to slash rates, especially as they work to expand managed care initiatives (Holahan, Zuckerman, Evans, et al. 1998). In New York, in contrast, state officials have run the risk of health plans' exiting precisely as the transition to mandatory managed care begins. The state's goal is not to be the plans' "partner," but rather to be a smart and tough purchaser.

Reassessment

New York's Medicaid managed care program is still struggling to reconcile policy makers' quest for expanded enrollment and savings with

the need to avert the scandals and outcries that hurt the program in 1995. Accelerating the pace of the program to one that is appreciably faster, while concurrently fine tuning standards and safeguards of the plans, is not easy.

Managed care plans can no longer pursue Medicaid clients with little regulation and oversight, market themselves aggressively, and profit handsomely from state rates that are set high in hopes of energizing Medicaid managed care. At the same time, however, a relatively few state officials are now shouldering a larger number of regulatory tasks and are trying to acquit them in ways that are at once sufficiently flexible to satisfy the industry and sufficiently rigorous to reassure the advocacy groups. Acquiring and analyzing the data needed to assess quality and access in diverse plans are big jobs in themselves; translating data analyses into coherent regulatory policies is no simpler. When mandatory enrollment goes forward, these tasks and strains will increase. Nor is management within DOH by any means the whole administrative story: DSS, the Department of Budget, the Department of Insurance, state mental health agencies, and local social service districts all retain important pieces of authority over parts of the program.

Second, the expected advent of “special needs plans” to incorporate hard-to-serve populations will create strains for the developers and administrators of these plans: the organizations that now serve special groups and face an uncertain future role; state officials; advocates; and, of course, the special populations themselves. The medical arrangements that now accommodate the mentally ill, substance abusers, people with AIDS, and the disabled are often fragmented and discontinuous, so the promise of a medical home with comprehensive care may be even more valuable to these groups than to more “manageable” Medicaid clients. But fulfilling that promise—and especially striking a defensible balance between orderly gatekeeping by primary care providers and timely access to specialists—may be much harder than for the general population. Outcries over the insistence of some managed care plans that mental health providers substitute a limited number of outpatient visits for long-term therapy insofar as possible may reflect mere temporary pains of adaptation or may be harbingers of mounting conflict.

Third, the onward march of Medicaid managed care may deeply depress the Health and Hospitals Corporation, other safety-net institutions like community clinics, and the 20 percent or so of New York City’s population that lacks health insurance. Although HHC depends

heavily on Medicaid revenues, it has the cumbersome character of a large municipal bureaucracy, leaving it with much slower reflexes than those of the managed care plans that compete for Medicaid clients. Federal, state, and local cuts in Medicaid (and Medicare), coupled with stricter service requirements, could tighten the vise further. HHC's critics—including Mayor Giuliani—would be pleased to see the city opt out of the hospital business, but the politics of closing public hospitals and clinics in poor communities would be controversial. Moreover, HHC uses Medicaid revenues partly to subsidize the care it delivers to the city's uninsured population. Will the nonprofit hospitals be willing and able to fill this gap, even as they face other obstacles: pressure from private purchasers and plans to discount prices, lower payments from Medicaid itself, and an assault on excess capacity?

Fourth, the cumulative force of these several stressors on public and private stakeholders may cause state political leaders to pine for the good old days, when "managed care" triggered images of harmony among access, quality, and cost. If these tensions in the Medicaid managed care program play out in a larger context of consumer and provider rebellion against the managed care juggernaut and dogged media coverage of abuses, real and alleged, policy makers may have a lot of conflict to manage. That conflict over Medicaid managed care increased inversely with the political system's adeptness at handling it is hardly reassuring. Whether the system is rediscovering the ways and means of consensus building, and whether the policy outcomes of political fire fighting end in the enhancement or the evisceration of the promise of Medicaid managed care, will grow clearer—with luck—in time.

Conclusion

Despite various rude shocks, incrementalism surely remains the most familiar "general theory" of the U.S. policy process. The fragmented structure of political power, the omnipresence of veto points for disturbed interests, and the cultural aversion to bold government assertions and intrusions combine to reward extensive legislative–executive bargaining, consultations with a wide range of affected groups in order to build a consensus, and the billing of policy innovations as modest departures from the status quo. If incrementalism can stay its course

over time, proponents contend, society reaps the benefits of genuine change without suffering the costs of jarring conflict.

Not everyone buys the incrementalist line, however. Analysts and politicians alike sometimes denounce “slow but steady” as indefensibly lethargic. On this view, incrementation abjures and hobbles “real” leadership by doctrinal fiat. Electoral shifts may reflect the public’s wish for a broad spectrum of change; those granted power have a brief honeymoon period, a short-lived window of opportunity, in which to make their mark on policy before the brutal grinding of the political gears enforces deadlock. Too solicitous a concern for legislative sensibilities spoils the coherence of executive plans. Too earnest a quest for consensus among special interests whittles innovations into pathetic lowest common denominators. Setting out in advance to win half a loaf means settling for crumbs when the dinner bell tolls, thus frustrating the popular will.

The abstract points at issue between the two models of innovation come vividly to life when overlaid onto the case of policy making for Medicaid managed care in New York. The law of 1991, though ambitious in its objectives, honored the basic norms of incrementalism. The Democratic executive and the legislature (including its Republican senate) cooperated closely and willingly. Major groups had a hearing, and political leaders tried to address their concerns. Proponents emphasized that managed care merely supplemented a traditional system that was serving the poor poorly with another option that was becoming the middle-class mainstream. This approach, which dominated policy through 1994, produced sizable voluntary enrollment with little controversy.

Rudy Giuliani, who became New York City’s mayor in January 1994, and George Pataki, who entered New York’s governor’s office one year later, preferred the “big bang” style of leadership. A city and state strapped for revenues might realize big savings by putting nearly all Medicaid clients into managed care plans as soon as possible. Implementation of the 1991 law proved that Medicaid managed care did not make the sky fall, so why go on dithering over whether to exploit its potential? “Partnership” with the legislature (especially its Democratic assembly) invited ideological and parochial pressures that could hamstring mandatory managed care. Advocacy groups would never be satisfied with less than a barrel full of broad exceptions and exemptions for their clientele, so why extend an olive branch before the battle began? And why treat the timidity of those who argued that incremental growth

and voluntary enrollment were virtues in themselves as an excuse for not seizing a great occasion for bold leadership?

Both sides of the argument have their points, but if the eating proves the policy pudding, the incrementalist recipe would seem to be the more digestible—at least in this time, place, and policy circumstance. The dramatic acceleration of Medicaid managed care the state and city sought ran afoul of one grave, probably inevitable, problem: it set off a range of external public and private dynamics the bold leaders did not desire but could not control. State and local proclamations that the market would more than double before long triggered aggressive grabs for market share by managed care plans, which led to scandals that drew intense media attention and inflamed New York's skillful advocacy community, shook the confidence of the public and potential enrollees alike, left legislators believing that their careful handiwork had been destroyed, and moved federal officials to fortify their reviews of state and city waiver requests.

Once these forces were unleashed, leaders in Albany and the City had little choice but to pledge new allegiance to old incrementalist virtues of consultation and consensus. They slammed regulatory brakes on plans that marketed dishonestly and enrolled clients they could not serve properly; explained to the media that abuses were episodic and exceptional and that safeguards and protections were newly in place; negotiated with advocates on a range of legal and policy issues; and assured legislators, the public, and the federal government that a fundamentally healthy program had merely developed a few minor, merely temporary, maladies. The political hardball that had preceded these conflicts made their political management that much more difficult, however—a hidden cost of the aggressive leadership model. The policy costs were sizable too: the program lost momentum (and enrollment), even as the Pataki and Giuliani administrations were prepping it for major expansion.

What "larger lessons" might one extract from New York's travails? Some may contend that the unsteady state of Medicaid managed care portrayed here is not particularly novel, dramatic, or instructive. States that introduce managed care into Medicaid often get off to a stormy start but then pick themselves up and soldier on. Arizona's early misadventures with its Health Care Cost Containment System (AHCCCS) (better chronicled, alas, than its subsequent corrections and successes) and Tennessee's upheavals after launching TennCare, a huge and quick infusion of Medicaid and uninsured citizens into managed care plans,

are cases in point. In New York, too, the problems that bedeviled the program in 1995 have been addressed, the federal government is (at long last) apparently satisfied that the state and city are ready to inaugurate a responsible mandatory program, abuses were arguably all along exceptions more than rules (although information about what transpires within the managed care black box is so spotty that no one really knows), and meanwhile hundreds of thousands of enrollees may well be enjoying easier access to better care than they had previously.

New York's case merits a long second glance, however, because it is, in a sense, the opposite of those of Arizona and Tennessee. These latter started out fumbling and grew steadily better, whereas New York traded successful incremental program building for a very different leadership style that increased conflict and decreased enrollment. Every state that declares its intentions to go mandatory risks setting off a land rush for market share, but most steered clear of direct marketing by plans, preferring instead to rely on county Medicaid workers or enrollment brokers recruited by the state itself (as New York City itself now does). All states scrutinize the rates they pay for Medicaid managed care with an eye to savings, and some select plans by competitive bidding. However, few have forced rates down as quickly and sharply, or used competitive bidding as aggressively and antagonistically, as did New York. A measure of regulatory tension between government and plans goes with the policy territory in any state attempting Medicaid managed care, but seldom have conflicts over data requirements, quality monitoring, and client education generated the bitterness found in New York.

New York seems to be an outlier, whose peculiarity highlights important political patterns and lessons. Some states had early problems with Medicaid managed care and then corrected them, whereas New York's program started smoothly and went sour, and for one and the same reason: the values that political leaders bring to implementation and the strategic choices they make can have an immense influence on policy outcomes. Most states have remembered what New York's leaders temporarily forgot, namely, that Medicaid managed care is a complex exercise that demands consultation and consensus building, not only among governors, budget makers, and health commissioners, but also among legislators, several species of regulators, providers, reporters, local officials, and, not least important, managed care plans. Any stakeholder, elected chief executive, or other official who wants to call the policy tune must grapple realistically with a richly pluralist cast of

characters. This populous and stubborn institutional universe does not preclude “big bang” leadership a priori, but it may foredoom initiatives in which the political will to innovate is not properly fortified by political skill in bargaining and implementing policy departures.

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