THE POLITICS OF MEDICAID CONTRACTING AND PRIVATIZATION

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by

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DEDICATION

This dissertation is dedicated to my children:

Alexandra Kathryn Randall and Hannah Elizabeth Randall

May your lives be a constant journey in the pursuit and the use of knowledge.
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Finished!!!!

This is the one word that anyone who has endeavored to complete a doctoral dissertation is very happy to say and scream! But, the word means much more and is the result of countless hours, days, months and years of academic labor, sacrifices of friends and family and my own perseverance. My completion of this dissertation could not have occurred without the help of many individuals who assisted my development as a scholar. I would like to very sincerely thank my dissertation committee collectively: Dr. Renée Johnson, Dr. Daniel Hawes, Dr. Chris Banks, Dr. Steve Parente from the University of Minnesota and Dr. Susan Roxburgh who served as the Graduate Faculty representative. They all provided patient and informed guidance that greatly assisted the final manuscript and helped me to make it into a document I can always be proud. Next, I cannot even begin to thank my chair, Dr. Renée Johnson, for her help, guidance, friendship and patience in finalizing the dissertation. Without sounding cliché, she embodies everything a dissertation advisor should be!

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David J. Randall

May 1, 2012

Kent, Ohio
CHAPTER 1

Introduction

Walk into any state Medicaid agency in any state capital, and they will look very similar. Austere surroundings and an almost antiseptic décor match the equally somber attitude of the employees. The similarities end here, though. Medicaid programs utilize a range of contracting mechanisms and diverse contract schemes to deliver services to an increasing beneficiary population that has placed a fiscal strain on state budgets. The reliance on managed care contracting by states is largely driven by their ability to manage and coordinate health care to reduce patients’ use of and the cost of services. State Medicaid agencies’ reliance on managed care arrangements, specifically health maintenance organizations, is particularly interesting to policy observers since their use in relationship to the private market has decreased in the last decade; while use by state Medicaid agencies has increased (Kaiser, 2009; Duggan, 2004). Given that those persons with private health care coverage have gravitated towards health plans that allow greater freedom and flexibility rather than face the restrictions on provider choices and networks associated with managed care arrangements, and given the fact that Medicaid agencies choose to restrict freedom of choice and flexibility is both surprising and important.

The importance of understanding Medicaid contracting takes on even greater significance since an estimated 65 million Americans will be eligible for Medicaid in 2014. Principally responsible for the delivery of these health care benefits will be the states; many of which are struggling with their current Medicaid expenditures (Kaiser,
This dissertation examines the ways that state specific political and economic conditions influence the ways that states choose to deliver and contract their Medicaid services. As such, the research I present assists in explaining the complex policy dynamic associated with the largest and continuously growing state expenditure.

1.1 The Problem and Questions

Medicaid continues to be a challenge for states as policymakers are forced to deal with not only increasing numbers of beneficiaries, but also the costs associated with the state portion of the federal appropriation match. Equally as important, states are under increased pressure by providers, insurers and beneficiaries to expand and maintain health services for the program. This is juxtaposed against demands from other state centric constituencies for their piece of state spending, including education spending. In most states, state Medicaid appropriations constitute the largest single spending item and often surpass higher education spending (NGA, 2009). As states begin to plan for the proposed expansion of Medicaid as a result of Patient Protection and Affordable Care Act of 2010 (PPACA)\(^1\), the policy choices and the dynamics associated with how states choose to serve Medicaid beneficiaries for basic health services loom in state capitals.

As a result of the anticipated 30 to 40% increase in Medicaid beneficiaries in most states, a key question is how will states seek to deal with program expansion in 2014 and beyond? I suggest that examining past policy choices and discerning the factors that contribute to Medicaid contracting choices is appropriate and useful to predict how states

\(^1\) Public Law 111-148, also referred to as 2010 Health Care Reform Bill.
will deal with increasing beneficiary populations. In short, states have *many* choices they can make to serve Medicaid beneficiaries. They can choose to provide services directly by building, staffing and maintaining health care facilities akin to the Veteran’s Administration health system. Alternatively, they can choose to directly reimburse health care providers on a fee for service basis when health care services are provided, or they can contract with a wide variety of insurance entities (managed care organizations) to provide health care services to the population.

This study seeks to answer questions specifically about the choices states have made when they choose to contract with insurance entities (MCOs) to provide health care services to their Medicaid population. States also have choices about which types of MCOs they can use with their Medicaid systems, including not-for-profit and for-profit commercial MCOs. In addition, there is also great variation among states in the percentage of the Medicaid population that are served by MCOs. So, an important question I pose is what explains the variation and scope of state Medicaid contracting schemes? I suggest in this dissertation that there are varied, complex answers that help to explain the state variation in Medicaid policy choices.

Given the varied programmatic aspects of state Medicaid systems and the wide array of policy choices states can make, the factors that explain the choice are naturally complex. I suggest that there are core factors that help to explain why states choose to use differing forms of MCOs with their Medicaid programs. As I argue further in this study, the role of interest groups play an important role in explaining the choices as does the role of the state bureaucracy and its capacity to implement program choices made by state
policy makers. In addition, there are also other political, market and demographic factors that assist in explaining the variation in contracting choices made by the states.

The complexity of the Medicaid program, the variation in contracting policy choices and the wide array of potential factors that may explain the policy choices demands a mixed methodological approach. As such, I use both quantitative modeling methods and qualitative interviews to discern which factors help to explain state Medicaid contracting variation over time. Before discussing the specific questions and methodologies I utilize in this study, I believe it is necessary to understand the evolution and devolution of state Medicaid systems and how the program has utilized contracting mechanisms since 1965.

1.2 Medicaid Contracting Explained

Ultimately, the choice to contract out Medicaid services is a result of several public policy goals that states seek to address through a managed care contract. The principal goal is to reduce costs by either entering into a contract with a Managed Care Organization (MCO) to manage the utilization of health care services or choosing to directly contract with health care providers. Most states choose to enter into contractual relationships with MCOs to deal with the complexities of controlling the usage of health care services and to control costs by shifting the risk of service delivery to a MCO (Daniels, 1998; Smith and Moore, 2008). Figure 1-1 shows the relationships among the parties involved and the rationale for why MCOs are used by state Medicaid programs. When MCOs are used by Medicaid programs, MCOs become the third party payer or ‘middle man’ between the health care providers and the Medicaid beneficiary and, thus,
shift the risk of providing services from the state to private insurance entities (aka MCOs).

**Figure 1-1**

![Diagram showing the flow from Health Care Providers to Managed Care Organizations-MCOs to Medicaid Beneficiaries](image)

*Note:* Created by the author from the Kaiser Family Foundation (2010).

Today, the seemingly simple contracting arrangement has become a complex maze of bureaucracy, oversight and a web of organized interests that are seeking to maintain or expand their piece of Medicaid spending. As an example, in California there are six distinct section bureaus that deal with oversight, management, contracting, and provider relations and benefits administration. Each of these divisions has its own task, along with a constituency, who are keenly interested in the outcomes of regulatory, spending and contract decisions. There are also many layers of management within the contracting bureaucracy that deal with program monitoring, policy and financial management, plan management, medical review, and operations support within the California Department of Health Care Services (CA DHCS, 2011). The bureaucracy is
designed to manage the contracting arrangement shown in Figure 1-1; while simultaneously adhering to the public policy goals of managing costs and promoting efficient delivery of health services to Medicaid enrollees.

However, state Medicaid bureaucracies are not all created equal. There exists variation in the size and specialization of staff who deal with the complex nature of Medicaid administration. In short, not all states have the bureaucratic specialization and capability as in the California example provided above. This study seeks to illuminate the differences in the bureaucratic capacity of state Medicaid agencies as being an important factor in helping to explain the variation in contracting methods states utilize to deliver Medicaid services. The importance of the capacity of Medicaid bureaucracy’s ability to deal with an estimated expansion of 16 million enrollees takes on a greater significance as the 2014 implementation deadline under the Patient Protection and Affordable Care Act of 2010 (PPACA) looms in state capitals.

1.3 Medicaid—Past and Present

In order to make sense of the market distortions brought on by decreased use of MCOs by private insurance and increased use of MCOs by Medicaid, it is useful to discuss both the program itself and states’ use of managed care arrangements in various stages of programmatic evolution. Medicaid was enacted by Congress and signed into law by President Lyndon B. Johnson in 1965 as part of the Medicare Act. The program

\[\text{2 Medicaid is the name given to the Medical Assistance Program contained in Title XIX of Public Law 89-97. The 1965 Act also created the Medicare program as part of the}\]
is designed to provide health care benefits to indigent people and those who cannot afford to purchase private health insurance coverage. Medicaid is funded by both the federal and state governments through matching grants to the states based upon a federal formulary that accounts for state demographic and economic characteristics. The federal match for the program ranges from 50% to 70% of the program costs (Daniels, 1998; Smith and Moore, 2008). Federal legislation initially limited Medicaid recipients to those eligible for federal welfare programs (primarily Aid to Families with Dependent Children [AFDC]), the blind and permanently disabled, and, at state option, the elderly indigent. Inpatient and outpatient services and pharmaceuticals were covered, and deductibles and co-payments were forbidden.

Since the 1965 enactment of both Medicaid and Medicare, Medicaid has been a shared state-federal program in which states have been given the flexibility to design their own programs subject to the minimum standards established by Congress. States can, therefore, choose to meet the diverse needs of their populations, thus giving rise to nationwide variations in eligibility standards, benefit design, and privatization schemes. Ironically, when the program was first established by Congress in 1965, it was viewed as an afterthought because there were no specific organized interests that lobbied Congress for the program; in contrast to the powerful range of interests associated with the Social Security Amendments of 1965. The Medicaid program is a means test based on adjusted gross income standards, and its policy origins can be traced to the Kerr-Mills state programs for the indigent (Smith and Moore, 2008, 1-17).
enactment of Medicare. The principal congressional authors, Ways and Means Committee Chairman Wilbur Mills (D-OK) and Senate Finance Committee member Senator Robert Kerr (D-OK), wanted to ensure that the indigent were not forgotten in the amendments to the Social Security Act of 1935. These congressmen used their powerful committee posts to insert provisions into what would become Title XIX of the Social Security Act of 1935 and the Medicaid entitlement provision (Smith and Moore, 2008, 21-50; Cohen, 1985).

Within five years, all but one state had established a Medicaid program. Nevertheless, potential recipients did not always enroll promptly. Many received care at public hospitals and clinics, and many also patronized physicians who refused to participate because of low Medicaid reimbursement rates (Smith and Moore, 2008). As enrollment increased, however, urban Medicaid (and Medicare) recipients sought care at private hospitals, which forced many public hospitals to close or downsize. Urban Medicaid programs paid particular attention to African-Americans, as it was believed this population of minorities was more likely than whites to live in poverty in urban areas and to suffer ill health effects. Rural Medicaid programs offered community outreach programs and the provision of more health providers for the poor, but they were hampered by low state funding and small hospitals (Daniels, 1998; Smith and Moore, 2008).

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3 Smith and Moore (2008, 45) describe the legislative process surrounding the insertion of the Medicaid provisions in the bill (P.L. 89-97) as 'low profile' and a 'casual item,' and they 'doubted that it [the drafting of the provisions] took as much as an afternoon of their [Congress's] time.'
During the 1960s, public health departments refocused their attention from infectious diseases to social issues, including mental illness, drug abuse, child health, domestic violence, and teenage pregnancies. Around 100 community health centers were created in the early 1970s, which used Medicaid and Medicare funding to deliver integrated health services to the poor. Community mental health centers were also established. Neither type of community health center provided much support for integrated service delivery because of inadequate funding and staffing and poor administration (Smith and Moore, 2008).

When Medicaid was first implemented in 1966, the program closed the gap in the number of people who had no health coverage, but less than 40% of those eligible for Medicaid enrolled in the program (Hurley et al., 1993). States also enacted restrictive eligibility standards that were tied to welfare payments, including AFDC. While reducing the number of uninsured, the initial restrictive policies drove many Medicaid eligible individuals away from even enrolling in the first years of the program.\(^4\) As the program became more popular with states in the 1970s, enrollment increased; as did costs as a result of general health care inflation prevalent for most of the decade (Smith and Moore, 2008). In the 1980s, some states adopted new cost-control measures such as patient co-payments and Medicaid enrollment restrictions. Some states used health

\(^4\) Estimates of the number of uninsured during this period of time are not available and accuracy is disputed since the US Census Bureau did not begin a formal counting of households without health insurance until the 1980 census (Kaiser, 2010). Smith and Moore (2008, 23-28) suggest that perhaps 20% of the population did not have traditional health insurance coverage in 1965.
maintenance organizations (HMOs) to control Medicaid costs and integrate care. By 1981, participation rates had increased to almost half of all households below the poverty line (Daniels, 1998).

In the late 1980s and 1990s, Congress continued to expand Medicaid eligibility. The proportion of uninsured people in the United States reached 15% in 1990, even though state and federal Medicaid expenditures increased from $54 billion in 1988 to $120 billion in 1992. States varied widely in the amount of Medicaid funding they allocated in their state budgets, as well as in the amount they would reimburse for physician and hospital costs. In the early 1990s, states added more beneficiaries to Medicaid and utilized managed care to provide medical services as a tool to control costs and improve program efficiency (Daniels, 1998; Kaiser, 2010). As outlined below, managed care organizations contracted primarily with private hospitals; meaning public hospitals increasingly became the source of care for the uninsured poor.

Today, Medicaid covers a wide range of benefits to meet the diverse and often complex needs of the populations it serves. In addition to acute health services, Medicaid covers a broad array of long-term services that Medicare and most private insurance providers exclude or narrowly limit. Medicaid enrollees receive their care mostly from private providers, and over 70% receive at least some of their care in managed care arrangements (see Figure 1-2). Medicaid programs are generally required to cover: inpatient and outpatient hospital services; physician, midwife, and nurse practitioner

5 Census data show that the uninsured population had increased from 12 to 15% from 1980 to 1990 (Kaiser, 2009).
services; laboratory and x-ray services; nursing facility and home health care for individuals age 21+; early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21; family planning services and supplies; and rural health clinic/federally qualified health center services. In addition, states can elect to offer many “optional” services, such as prescription drugs, dental care, durable medical equipment, and personal care services (Kaiser, 2009).

Figure 1-2

Note: "Medicaid Managed Care Penetration Rates by State, 2008", Kaiser Fast Facts, The Henry J. Kaiser Family Foundation, July 2010; Source: Medicaid Managed Care Enrollment as of December 31, 2008. Centers for Medicare and Medicaid Services. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.
All Medicaid services, including those considered optional for adults, must be covered for children. Medicaid assists dual-eligible persons with their Medicare premiums and cost-sharing, and Medicaid covers key benefits not covered by Medicare, especially long-term care. Generally, the same Medicaid benefits must be covered for all Medicaid enrollees statewide. However, states have some authority to provide some groups with more limited benefits modeled on specified “benchmark” plans and to cover different benefits for different enrollees. Premiums are prohibited, and cost-sharing is limited for beneficiaries with income below 150% of the Federal Poverty Level (FPL). Less restrictive rules apply for others above the FPL, but no beneficiaries can be required to pay more than 5% of their income for premiums and cost-sharing (Kaiser, 2009; CMS, 2010). The cost of Medicaid’s health care services depends upon six factors:

1. The range of services available.
2. The type of reimbursement methodology used, such as direct reimbursement of health care providers through fee-for-service, or risk transfer contract through managed care arrangements.
3. Eligibility requirements that determine how many households are enrolled in Medicaid, which are largely set based on state income standards.
4. The number of total households below the poverty line in a state.
5. Amount of use and price of medical care in a state.
6. The number of elderly and disabled enrolled in the program.
Each of these factors also helps determine the range, type, and amount of health care services that a state provides its Medicaid eligible population (Aaron, 1991; Daniels, 1998; Smith and Moore, 2008).

Medicaid spending for services totaled about $339 billion in 2008; this amount is not distributed uniformly across all enrollees. Although the elderly and people with disabilities comprise one-quarter of Medicaid enrollees, they account for roughly two-thirds of Medicaid spending. This pattern reflects the higher per capita costs associated with these individuals due to their more intensive use of both acute and long-term services. In 2007, Medicaid expenditures were about $14,500 per disabled enrollee and $12,500 per elderly enrollee; compared to $2,100 per child and $2,500 per non-elderly adult. These aggregate and specific spending patterns are expected to grow as an estimated 16 million enrollees are added to the system in 2014 as a result of the passage of the Patient Protection and Affordable Care Act (PPACA) of 2010 (Kaiser, 2010).

Unfortunately, challenges come with this growth to not only enroll new beneficiaries, but also to make certain state budgets are not strained to a breaking point. As a result of these state budget constraints, managed care contracting comes into play both as a cost control strategy and as a management tool. The discussion below provides the necessary background and policy context regarding the use of managed care arrangements by state Medicaid programs.
1.4 Use of Managed Care by State Medicaid Programs—Evolution and Devolution

To understand the types of managed care arrangements state Medicaid programs have used over the last 30 years, it is important to examine managed care and the options available to states in making their contracting choices. Managed care is a type of prepaid health insurance plan in which the enrollees receive medical care in a coordinated manner in an attempt to reduce the use of services and costs. Enrollees usually have a primary care physician to coordinate care and to act as a ‘gatekeeper’ in order to reduce unnecessary use of health care services. The principal rationale for this type of service delivery is to control the utilization of services, coordinate care, and control costs (Daniels, 1998; Duggan, 2004; Smith and Moore, 2008).

Prior to the widespread use of managed care arrangements, the Medicaid program relied on a third-party payment mechanism with health care providers (Hurley et al., 1993). When the program was implemented in 1965, patients were used to selecting their own physicians directly and having the government (i.e., the states) reimburse providers on a fee-for-service basis. However, Medicaid required the state to pay in full and did not allow any co-payments or deductibles to be assessed to beneficiaries by either physicians or hospitals (Daniels, 1998). The inability of health care providers to charge Medicaid patients the same as their insured patients resulted in several criticisms of the program. First, Medicaid restricted patients’ access to health care providers. Second, there was a lack of coordination of care as a result of few physicians’ willingness to participate in the program. Finally, there was inappropriate use of certain types of care and excessive use...
of high-cost emergency room facilities because beneficiaries could not always find physicians who were willing to accept the low reimbursement rates from Medicaid. Together, these issues resulted in poor quality of patient care and high treatment costs (Hurley et al., 1993). Thus, the end result had undermined the goal of Medicaid.

States grew frustrated with the problems associated with administering the Medicaid program and sought new avenues to address concerns about quality of care and cost. The solution the states turned to was managed care, which organizes the use of services by patients and the delivery of services by all health care providers. Much of the activity of state Medicaid programs was a result of the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1981. OBRA allowed the states to experiment and design alternative programs to control Medicaid costs; while at the same time improving quality and access for patients. Since 1981, most of the states have sought and received approval for waivers from the traditional fee-for-service reimbursement methodology and have utilized a wide range of managed care arrangements to deliver health care services to the Medicaid population (Hurley and Freund, 1988). Typically, most managed care has been delivered through HMOs. HMOs are characterized as organized systems of care delivery designed to provide comprehensive health coverage on a fixed payment basis, usually a capitated amount. Private health care businesses found the model appealing because of their ability to control usage and costs, which led to its widespread adoption in the 1970s. The federal government favored HMO use with Medicaid under OBRA in 1981. In short, HMOs appeared to be a good model to control costs and to reduce unnecessary use of health care services (Daniels, 1998).
During the 1970s and 1980s, states saw rapid growth in Medicaid enrollment as shown in Figure 1-3. Accompanying this upturn was rapid growth in state and federal expenditures in the program. Notably, during this time state Medicaid expenditure growth rates also were dramatic, with many states seeing double-digit increases in year-over-year program costs. Figures 1-3 to 1-5 shows the spending, growth and enrollment trends that prompted state Medicaid programs to seek solutions to manage not only increased enrollment, but also escalating costs and utilization of services.

**Figure 1-3**
**Medicaid Expenditures**

**Figure 1-4**
**Medicaid Eligible Enrollment**

*Source: Author created charts from CMS (2010), National Health Expenditures Data Set.*
As many states opted to use HMOs to serve their Medicaid populations, different types of managed care arrangements emerged to principally deal with escalating expenditures, growth rates and enrollment. First, many states elected to use Preferred Provider Organizations (PPOs) in which care was delivered on a negotiated fee-for-service basis to a select population. PPOs have relied heavily on a Primary Care Case Management (PCCM) system in which the physicians in the network acted as ‘gatekeepers’ to control use and costs. PPO arrangements were also useful in rural areas where competition among providers had been limited, thus allowing a PCCM to control access to services in a cost-effective manner. Typically, PPO arrangements with Medicaid were negotiated at less than what providers were charging private insurance.
plans. Much of the success of these arrangements was determined by the types of providers recruited and discounts offered in the contracts (Daniels, 1998; Kaiser, 2010).

Other types of managed care arrangements have also emerged and are still in place today among state Medicaid programs. In some states, HMOs have entered into risk-sharing arrangements with primary care physicians wherein financial incentives are used as an inducement for Medicaid providers to control costs. The financial gains and losses associated with care are shared by both the physician and the HMO. In many states, the HMOs or MCOs assume all of the risk associated with the covered services offered by a state’s Medicaid program. In some states, there are different types of MCOs that contract with Medicaid, including for-profit and not-for-profit that only accept Medicaid enrollees.

MCOs are not the only risk transfer arrangements used by states. In some states, providers are allowed to form their own risk-bearing entities to treat specific and geographic Medicaid populations. These types of hybrid arrangements have emerged in recent years as an alternative to the MCO model that most states have used in order to control costs and deliver health care services. In addition, some states (e.g., California) have established risk-bearing entities at the county level to provide services through county-owned hospitals. Other states require Medicaid enrollees to use only county-owned and -operated hospitals as a means of providing revenue to county hospitals and as a cost control measure (Kaiser, 2010). It is clear that states use diverse delivery and financing mechanisms to serve the Medicaid population.
However, one fact bears repeating: during the last decade (1997-2007) managed care use in the private market has steadily declined from its peak usage period in the 1970s and 1980s. The decline in the use of managed care can be attributed to many factors, including the backlash by employees as a result of restrictions on provider choice, perceptions of arbitrary decision by HMOs over medically necessary care, and increasing co-payments that many plans instituted to control costs (Duggan, 2004; Kaiser, 2009). Conversely, state Medicaid programs, however, increased their use of managed care plans during this same period. Figure 1-6 provides a graphical representation of market trends from 1997 to 2007 for both private managed care market penetration and the use of all forms of managed care by the states. As the graph in Figure 1-6 shows, the percentage of managed care use in state Medicaid programs is also higher than that of the private insurance market. A key question posed by this study asks why states increased the use of managed care arrangements for Medicaid when private health care saw a decrease in enrollment in HMOs. Before suggesting reasons for this observation, it is useful to contextualize states’ Medicaid administration choices with respect to privatization.
1.5 State Choices Regarding Medicaid Managed Care

Since the enactment of OBRA in 1981, states have used a variety of managed care arrangements to serve the Medicaid population (Smith and Moore, 2008). Why do states differ in their contracting mechanisms? Specifically, why do we observe variation in the type and scope of contracting mechanisms that the states use to deliver Medicaid? In order to explore answers to these questions, it is important to list the types of managed care arrangements that states currently utilize. Also, relevant background on the risks associated with each contracting choice, the oversight and administrative challenges, and the political and economic ramifications of the policy choices need to be provided as well.
Managed care arrangements take many forms, as evidenced by the chart in Figure 1-7. Each form of managed care differs in how risk is shared between providers and the state Medicaid agency, as well as in the delivery of services to the Medicaid beneficiary. Before explaining the administrative challenges associated with differing plan types, it is useful to define the plan types and jumble of acronyms associated with the managed care arrangements that states utilize. Below is a list of managed care plan types that states use (Kaiser, 2010; CMS, 2010):

**Commercial MCO:** A Commercial Managed Care Organization is a health maintenance organization, an eligible organization with a contract under 1876 or a Medicare+Choice organization, a provider-sponsored organization, or any other private or public organization that meets the requirements of 1902(w). A Commercial MCO provides comprehensive services to both Medicaid and Medicare. Commercial MCOs are generally organized as for-profit and not-for-profit entities under state insurance laws, but some states do allow commercial MCOs to organize as non-profits. The data presented herein makes the distinction by designating commercial MCOs as for-profit entities. Table 3.1 and 3.2 distinguishes the difference between all types of managed care and commercial for-profit MCOs.

**Medicaid-only MCO:** A Managed Care Organization [that] provides comprehensive services to only Medicaid beneficiaries, not to commercial or Medicare enrollees.

**PCCM:** A Primary Care Management Provider is a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contract directly with the State to locate, coordinate, and monitor covered primary care and sometimes additional services). This category also includes those PIHPs that contract with the State as primary care case managers.

**PIHP:** A Prepaid Inpatient Health Plan provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services. There are several types of PIHPs that States use to deliver a range of services. For example, a Mental
Health (MH) PIHP is a managed care entity that provides only mental health services.

**PAHP:** A Prepaid Ambulatory Health Plan provides less than comprehensive services on an at-risk or other than state plan reimbursement basis and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

**PACE:** The Program for All-inclusive Care provides pre-paid, capitated, comprehensive health care services to the frail elderly.

**HIO:** A Health Insuring Organization is a managed care entity which, by law, is exempt from certain rules governing MCO program operation such as the requirement for beneficiaries to have a choice of at least two managed care entities in mandatory programs.

**Other:** When the structure of the managed care plan is not considered a PCCM, PIHP, PAHP, Commercial MCO, Medicaid-only MCO, HIO, or PACE.

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**Figure 1-7**

*Medicaid Managed Care Enrollment, by Type. Total for All States*

<table>
<thead>
<tr>
<th>Managed Care Plan Type</th>
<th>Number of Enrollees</th>
<th>Number of States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial MCO</td>
<td>10,284,082</td>
<td>22</td>
</tr>
<tr>
<td>Medicaid-Only MCO</td>
<td>13,176,581</td>
<td>31</td>
</tr>
<tr>
<td>PCCM</td>
<td>7,275,241</td>
<td>30</td>
</tr>
<tr>
<td>PIHP</td>
<td>8,593,773</td>
<td>21</td>
</tr>
<tr>
<td>PAHP</td>
<td>8,162,741</td>
<td>24</td>
</tr>
<tr>
<td>PACE</td>
<td>17,091</td>
<td>30</td>
</tr>
<tr>
<td>Other</td>
<td>2,113,534</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total Enrollment</strong></td>
<td><strong>49,623,043</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

*Source:* Kaiser Family Foundation, 2009
The differences in the managed care types used by states are principally a function of who bears the risk to manage the health care services required of Medicaid beneficiaries. Commercial and Medicaid MCOs both accept capitated or per beneficiary payments per month to manage the care for a defined population of enrollees. The goal of the state Medicaid agency in entering into the contract is to transfer the risk to the MCO to efficiently and effectively manage the health care of the enrollees for the amount of money they have accepted from the state. The MCOs are licensed insurance entities and authorized to bear risk by state insurance regulators. The challenge for the state Medicaid agency is making certain that the MCOs can effectively manage the Medicaid population within the revenue provided under the contract. Medicaid-only MCOs also have added issues; they are constrained by only accepting Medicaid beneficiaries, which provide unique challenges in finding providers that will accept contracts with them due to historically low levels of reimbursement (Kaiser, 2009).

In the case of PCCM arrangements, these organizations also bear risk similar to Commercial MCOs, but the ownership and management of PCCM is restricted by statute to physicians. The theory behind the establishment of PCCMs is that health care providers will be more efficient in the delivery of services since they are the ‘middle man,’ in much the same way as an insurance entity such as a MCO. However, one of the challenges for state Medicaid agencies is that PCCMs do not have the same efficiency and effectiveness criteria as Commercial MCOs to manage the health care utilization of the Medicaid population since they directly benefit from delivering the service. PCCMs counter this argument by suggesting that they can deliver services more efficiently owing
to their ability to reduce administrative costs when providers are directly bearing risk (Kaiser, 2009).

Each type of contract requires specific types of data to make sure certain managed care contractors are meeting their duties to serve Medicaid beneficiaries. As an example, PCCM contractors require extensive documentation on how physicians are meeting the health needs of enrollees and how health care use is affected by their management. Each contracting choice, even if customized by a state, requires the collection of data and administrative oversight by state Medicaid officials. State officials are required to monitor the marketing of managed care plans to enrollees, enforce standards for provider network capacity and quality of care, and develop management information systems to make certain managed care organizations are adhering to contract requirements (Fossett, 1998). All of these functions require the use of state Medicaid personnel and resources in order to make certain contractors are adhering to the standards prescribed by the state and federal governments.

Medicaid managed care arrangements of all types have two simple goals: to bring efficiency to the program and to save money. As state use of managed care arrangements has matured, the hybrid system we have today developed as a result of a variety of institutional and economic factors. Medicaid providers have been historically underpaid, and this fact has created administrative challenges for state agencies. As a result, many commercial managed care plans withdrew from state Medicaid programs and set up Medicaid-only managed care arrangements (Draper et al., 2004). Also of importance, is the inherent conflict between the managed care plans’ goal of managing risk and
Medicaid’s mission of being an insurer of last resort. This fact has forced many states to customize their managed care arrangements and to negotiate with one or a few entities to serve a vulnerable population. The lack of competition traditionally associated with private sector managed care arrangements has created unique challenges for state officials seeking to make the Medicaid program more efficient and has directly resulted in the range of managed care arrangements we observe today (Smith and Moore, 2008).

The contracting choices states make can be best represented as a simple matrix between utilizing for-profit or not-for-profit firms and using either a managed care arrangement or a direct fee-for-service payment method with health care providers. The matrix represented in Figure 1-8 shows how each type of contracting mechanism states use fits within this typology and provides a useful way of categorizing state Medicaid contracting choices.

![Figure 1-8](image)

In each of the contracting arrangements contained in the above matrix, one can classify winners and losers. The use of fee-for-service arrangements is characterized as the best method for providers to use. Data suggest that these arrangements have resulted in higher payments and increased utilization of services by health care providers (Smith and Moore, 2008; Fossett, 1998). The state and MCOs can be construed as winners
under a managed care contracting arrangement since data suggest that use of capitated payment methodology bring greater cost savings to the state as opposed to traditional fee-for service arrangements; thus, limiting health care provider reimbursement (Kaiser, 2010).

The management and oversight of Medicaid managed care in its many forms has created challenges for states in a variety of ways. Because of the lack of competitive markets and the lack of participating providers, state Medicaid agencies have been forced to customize their contracting arrangements to serve the population. States have used ‘carve outs’ of benefits, risk-adjusted payments, and a variety of state-specific mechanisms to meet beneficiary demand and to promote efficiency in their respective programs. Many programs have evolved into a negotiated price for service as opposed to the traditional insurance model of risk-sharing. With these adaptations come managerial challenges for states in their administration of Medicaid (Smith and Moore, 2008).

In the traditional management of Medicaid, providers would bill the state agency directly for providing services to beneficiaries. In the current environment, however, states must develop complex management and oversight capabilities such as information systems to track and monitor provider payments and program eligibility. By using third-party contracting mechanisms, this responsibility largely shifts to the managed care contractors. The states thus shift from becoming bill payers to negotiating and implementing contracts and making certain those contractors have adequate provider networks to meet the needs of the Medicaid population. Additionally, states must set up monitoring mechanisms to make certain that contracts are being properly executed to
deliver services. Management of the process becomes more efficient by using managed care arrangements, thus bypassing the thousands of providers that would have been paid under the traditional fee-for-service (Fossett, 1998; 2004).

The use of managed care arrangements by the states has also become a political and legal issue as evidenced by the occasional scandal associated with program management. Providers are often at odds with managed care plans who are tasked with managing the care and treatment of beneficiaries; state lawmakers, the governor, and the Medicaid agency are often at odds over funding levels. These factors mean Medicaid tops the list of issues that state elected officials have to tackle (Fossett, 1998; NGA, 2009). There are diverse sets of interests associated with Medicaid policy and implementation, and the political pressure that accrues to state policymakers is great, especially when budgetary pressures mount and the state must produce savings in program costs.

Because of the political pressures to achieve budgetary savings, state officials have increasingly viewed managed care arrangements as a ‘quick fix’ to plugging budget shortfalls (Fossett, 1998). Budget savings take precedence over quality of care concerns and other health related investments. Additionally, state officials are reluctant to invest in increased management tools and oversight capability to monitor programs and make necessary adjustments to improve program quality and efficiency. Questions of management capacity in the states have taken on added significance as a result of reduced
federal involvement in the managed care contracting process, which gives additional relevancy to issues of state management capacity to oversee Medicaid contracting.\(^6\)

The choices that states make with Medicaid managed care can be summed up as a range of risk-sharing arrangements based on the degree to which providers participate in the risk. With this fact in mind, one can generally classify the winners and losers in the contracting process. For the most part, providers end up being the losers since they are forced to contract with managed care organizations whose primary task is to control the use of their services. State officials generally can be perceived as winners since they will often tout the use of managed care arrangements as a means of reducing costs and promoting system efficiency. States can also be losers in the contracting process if they are left with few contracting options and end up having to pay higher prices as a result of a lack of competition. MCOs can be perceived as winners if they are able to receive favorable contracts from the state based on competitive market forces or even political influence.\(^7\) However, each of these generalizations should not be taken at face value, since there are ramifications for both winners and losers in the contracting system. Thus, it becomes important to understand the many factors associated with the contracting choices states make and to understand their ramifications.

\(^6\) The Balanced Budget Act of 1997 gave states administrative flexibility in designing managed care programs, thus limiting direct federal agency involvement in state contracting decisions (see Fossett, 1998, and Draper et al., 2004).

\(^7\) The generalization of winners and losers is supported by empirical data showing how changes in contracting methods results in reduced Medicaid costs and decreased provider utilization by beneficiaries. See also Smith and Moore, 2008 and GAO, 2007.
1.6 Privatization: A Choice—Government-Run or Private Market?

State governments utilize a diverse set of contracting arrangements to essentially privatize public health care services. States’ use of private organizations to provide Medicaid services is best defined as a choice between directly reimbursing providers (i.e., hospitals, physicians, and ancillary providers) and contracting for providers’ services through licensed managed care organizations that bear risk (MCOs, which include HMOs, PPOs, or insurers). This choice is ultimately a reflection of policy decisions that state officials make to improve efficiency, reduce costs, and provide quality care to Medicaid beneficiaries (Smith and Lipsky, 1993; Duggan, 2004).

Analogous to the choices state governments make to deliver health care services is the United States Veteran’s Administration (VA). The VA is the largest integrated health care system in the United States and provides public-sector care for honorably discharged veterans of the U.S. armed forces (Evans, 2005). The VA is financed mostly from general taxation, offers a broad range of health care services to meet veterans’ needs, and can be characterized loosely as a veteran-specific national health service (Oliver, 2007). The VA also can be categorized as a publicly run, funded, and administered health care system, with the federal government owning, operating, and providing the necessary health care personnel to administer care to veterans.

The choices that states make to serve the Medicaid population can best be described as either direct contracting with health providers or a contract with an organization licensed to bear the risk of providing the service on a fixed or capitated basis. Several researchers have classified this choice as one of efficiency and as a means
of reducing costs (Halverson et al., 1998; Duggan, 2004). States can also choose to run state hospitals and employ physicians and other health care personnel to serve the Medicaid population, which was common in the early period of Medicaid implementation. However, few states have retained that delivery mechanism as a result of the high fixed costs associated with maintaining a physical infrastructure (hospitals) and the personnel costs associated with direct delivery of services (Smith and Moore, 2008). Figure 1-9 shows the trend since 1965 in contracting choices. In the early years of Medicaid, there was direct provider reimbursement on a fee-for-service basis, but the currently favored mechanism is reliance on for-profit commercial managed care arrangements.
There are many reasons governments may choose to privatize a service such as health care. Various scholars suggest that efficiency is a principal motive (Kettl, 1993; Gormley, 1989). Others suggest that vested interests play a vital role in shaping the choices that state agencies make regarding Medicaid programs (Gold, 1997; Johnston and Romzek, 1999). Finally, Duggan (2004) suggests that private markets play an important role in shaping the contracting choices made by Medicaid agencies. Substantial research by numerous scholars has found multiple political, economic, and institutional factors in state policymaking to explain a policy choice such as Medicaid contracting. Additionally, there is extensive theoretical scholarship that provides a basis for understanding the
process of both privatization and contracting and also assists in explaining the observed variation in contracting schemes the states have used over time. All of this research points to the conclusion that there are multiple rationales behind a government’s choice to privatize health care services. This study will shed light on the factors that shape the policy choices of one of the most complex state programs.

1.7 The Theoretical Puzzles

The fact that there are striking differences in the type, scope, and variation in contracting choices states have made over time drives the questions posed by this study. First, it is important to understand the various factors that can explain the policy choices made by the states for Medicaid contracting in order to establish a baseline of state policy decisions. Building on this foundation, the main research questions of this study focus on observed variation in Medicaid contracting choices and the relationship between these choices and bureaucratic capacity, interest groups, health insurance markets, as well as the political conditions in the states. Understanding the factors that influence Medicaid contracting choices are important for many reasons; not the least of which includes the scope of the program: over 46 million beneficiaries (soon to be over 65 million) and over $300 billion spent annually by the state and federal government.

Ideally, variation in contracting mechanisms should be viewed through a structural choice lens since state contracting choices are arguably a result of how state Medicaid agencies are structured. Administrative structures can and do influence the outcomes of policy and are often the result of the political choices made by political leaders (Moe, 1989; Cassell, 2002). In the interviews this researcher conducted in
California, West Virginia, North Carolina, and Indiana, political principals purposefully structured the agencies to influence the outcomes that led to administrative decisions to choose certain types of contracting vehicles. Thus, the structural choices were ‘stacked’ in the beginning of the policy process and resulted in the contracting choices. Moe (1989) further suggests that structural choices that arrange the tasks of bureaucracies are a result of the competing interests of political principals. In the case of Medicaid, there are many political principals, such as the governor, state lawmakers, and the bureaucracy itself, who are competing for power and attention. The resulting conflicts among these principals cause the bureaucratic structures to be complex, vague, and incompatible with stated public policy goals. Medicaid agencies in the states evolve as a result of the conflict between the principals. These structural issues therefore become an important factor in the Medicaid contracting choices that states make.

The concept of ‘deck-stacking’ that Moe (1989) suggests is of particular interest in looking at Medicaid contracting choices and the mechanisms that have developed in state bureaucracies. I argue that many factors influence the structures of Medicaid agencies, but that organized interests are the most influential factor. Additionally, political principals, such as state lawmakers, contribute to the structural choice argument by understaffing Medicaid agencies, thus limiting their ability to implement the program. As a result of the structural choices made by political principals and organized interests, I expect to see a strong correlation between structural choices, such as agency staffing levels, and the contracting choices. This variation can be observed in Medicaid over time.
However, Medicaid policy choices could be a result of the dominance of pluralistic interests engaged in rent seeking activity, as Gray and Lowery suggest (1996; 2001). I suggest that solely relying on the importance of pluralism to explain a program as complex as Medicaid ignores the structural choice arguments advanced by scholars such as Moe (1984) and Cassell (2002). I suggest that interest group involvement, while an important factor, only tells part of the story about why we observe variation in state Medicaid contracting choices.

1.8 Explaining Policy Variation in the States: Interests, Bureaucracies, and Politics

Various research supports the importance of interest groups in the state policymaking process and the visible impact of vested interests in seeking favorable policy outcomes. The make-up, diversity, and strength of interest groups explain, in part, why and how states make expenditures and enact specific types of policies (Gray and Lowery, 1999; Heinz et al., 1993; Jacoby and Schneider, 2001; Nice, 1984). Interest groups play an important role in the formulation, development, and implementation of state government policy and programs for their own financial benefit by influencing policy choices (Morehouse, 1981; Gray and Lowery, 1996). They have grown in number and influence in state capitals in recent years; largely as a result of the federal government’s devolution of programmatic responsibility and implementation to the states. In addition, there is a great deal of variation in the scope and influence of interest group populations in the states (Gray and Lowery, 1996). The size and influence of
vested interests in state capitals are important factors for understanding the variation in contracting mechanisms that state Medicaid agencies utilize.

Interest group strength can be measured in different ways. Morehouse (1981) was among the first scholars to estimate the role of interest groups in the states by using a categorical measure based on perceived strengths and concentrations of business interests. Her work was subsequently used by Gray and her colleagues to examine groupings or guilds of interests. Importantly, few works have examined specific relationships between interest group populations and policy outcomes. This study is unique since I collect data on interest group populations specific to Medicaid and attempt to find a relationship between them and the observed variation in contracting choices that Medicaid agencies make.

1.9 The Role and Capacity of the Bureaucracy

The role of the bureaucracy and important early works of Wilson (1887) and Goodnow (1900) cast the bureaucracy and bureaucrats as irrelevant actors in the policy process. Scholarship evolved to consider the bureaucracy as an important player in the policymaking process and essential to a functioning democracy and thus an essential component of policy adoption and implementation (Truman, 1955; Dahl, 1956). More recently, other researchers (Moe, 1989; Meier, 1993; Hill, 1992, 1993; Anderson, 1997) have found additional evidence of the increasing importance of the bureaucracy in the policy process. All of these works assist in the formulation of hypotheses about variation in state Medicaid contracting mechanisms in this study.
Equally as important for understanding the role of the bureaucracy in state government is identifying from whence bureaucracies derive their power. Meier (1993) finds that there are five distinct areas of power: policy environment, public support, the bureau’s special knowledge, cohesion of bureau personnel, and bureau leadership. These sources of power are important in the context of state Medicaid agencies, especially since they are among the largest organs of state government, in terms of both staff numbers and programmatic dollars. In short, in order to understand bureaucracies, it is necessary to assess the role and importance of these five areas to the development and implementation of public policy. In this study, staffing levels and expertise are important factors that I seek to isolate related to the policy choices state Medicaid agencies make.

The capacity of the bureaucracy to implement policy choices are also important aspects of this study. Several scholars have found that the growing capacity of state government agencies is a function of both institutional characteristics and personal attributes. State agencies are increasingly being asked to do more because they are more capable (Bowman and Kearney, 1988; Bowling and Wright, 1998). In particular, state Medicaid agencies have a great deal of programmatic flexibility in determining eligibility standards, reimbursement rates for providers, contracting mechanisms (including managed care risk arrangements), and the range of health care services that are covered (Kousser, 2002). All of these complex processes require staff expertise and management to meet the demands of a vulnerable population (Schneider, 1997). The capacity of state agencies to manage complex programs with a large beneficiary population are important
factors, and I suggest that states with higher levels of capacity make different Medicaid contracting choices versus states with lower levels of capacity.

1.9.1 The Bureaucracy and State Administrative Agencies

State administrative agencies are understudied compared to state elected leaders. Research relevant to this study demonstrates that the expertise of bureaucrats is an important factor in explaining state Medicaid contracting choices. Further, this research also shows that agency administrators work in a complex system that forces them to interact with elected officials such as governors and state lawmakers. (Abney and Lauth, 1986). Technical expertise of state agency personnel was also found to be an important source of power, contributing to their largely unseen role in shaping policy decisions (Elling, 1996; 1999).

State agencies play an equally important role in implementation. Various scholars suggest that in our federalist system of government, the national government relies heavily on the states to carry out national policy, with Medicaid being the largest federal-state program. In addition, almost all public policy is passed through state agencies by principals in state capitals (Ripley and Franklin 1987; Bowling and Wright, 1998). Importantly, several works (Pressman and Wildavsky, 1973; Nakamura and Smallwood, 1980) describe the important role that bureaucracy plays in implementation; which is important to this study and to Medicaid specifically.

Bureaucracies are often described as specialized institutions that are primarily focused on a single policy area. This specialization gives bureaucrats power over other political actors, such as state lawmakers, who must deal with multiple policy areas at one
time (Ripley, 1988). Expertise and specialization grant bureaucrats an important role in the policy process and also foster long-term relationships with interest groups and lawmakers (Kingdon, 1995). The role of bureaucratic expertise and specialization in state agencies is of importance, and this study examines the effect of these factors in explaining Medicaid contracting variation.

1.10 Explaining State Policy Variation—Other Factors

In addition to interest groups and the bureaucracy, other factors that affect policy choice at the state level include: institutional differences, such as the strength of the governor (Beyle, 1968, 2008) and professionalism of state legislatures (Squire, 1992, 2007); socioeconomic and demographic differences among states (Dye, 1979; Nice, 1994); and political culture of the state (Elazar, 1984). By attempting to identify these factors in addition to those that reflect the importance of interest groups, I pursue multiple avenues of inquiry into the variation in state-specific policy choices regarding Medicaid contracting.

1.11 Questions and Approach

Medicaid currently serves 49 million people; with another 16 million projected to be added by 2014 (HHS, 2010). The central question this study seeks to answer is: Why do states make the contracting choices that they do for their Medicaid programs? As a follow-up to that question, what explains the variation in contracting types and scope that states utilize to deliver those services? The answers to these core questions further
suggest that contracting choices made by the states have an effect on the individuals who are served by Medicaid.

This study was also undertaken to discover the factors in states’ choices surrounding privatization and the resultant policy outputs that are a result of many and diverse factors. Specifically, I examine the role of two different stakeholders in the creation of Medicaid policy and implementation of health care contracting – interest groups and the bureaucracy – and I examine how politics and political control relate to health care decision-making at the state level.

1.12 Methods

States constitute an ideal population for a study of policy variation, specifically with respect to Medicaid. My study looks at the contracting methods used by state Medicaid agencies to deliver health care benefits to eligible beneficiaries. In order to fully understand the variation in policy choices, I examine policy choices over a ten-year period along with a range of explanatory variables in light of the previously posed research questions. This study uses a two-fold approach, both quantitative and qualitative, to examine the factors associated with state Medicaid contracting policy choices. The quantitative modeling examines the relationship between political, demographic, and market-related control variables and Medicaid contracting choices over time. These explanatory variables specifically focus on the relationship between bureaucratic capacity and the effect of specific interest group populations on the choices states make regarding outsourcing Medicaid services.
I conducted qualitative research in four states (California, Indiana, North Carolina, and West Virginia) that varies in their methods of delivering contracted Medicaid services, political environments, interest group populations, and market characteristics. In each state, I interviewed senior Medicaid officials, representative interest groups, and state lawmakers. A total of 23 interviews were conducted from May 2009 to September 2009 and were transcribed for analysis by the qualitative software package NVivo. The interview process was conducted using a semi-structured format (see Appendix A); with all subjects being asked the same set of questions to allow for comparative research. The results of the qualitative interview analysis are fully described in Chapter 2.

The principal analytical method I use is a pooled, cross-sectional time series analysis (Sayrs, 1989). By using a set of cross-sections over time, the inquiry produces more robust results than using a cross-section at one particular point in time. In addition, this method is capable of analyzing multiple units (states) at multiple points in time (years) (Stimson, 1985). The use of a pooled cross-section of data over time presents several challenges that may violate regression assumptions. However, these violations, such as uncorrelated error terms and heteroscedasticity, can be dealt with through corrections in the panel data error terms (Beck and Katz, 1996). The statistical program STATA was used to analyze the cross-sections over time and to correct for regression assumption violations (Hamilton, 2006). The quantitative models are fully described in Chapter 3.
1.13 Expected Findings

The variation in contracting mechanisms that states have used to deliver Medicaid benefits is likely based on numerous factors. In explicating the factors that affect the provision of Medicaid services, this study will contribute to the understanding of bureaucratic capacity and the importance that specific concentrations of interest groups play in the policy process. I expect that the specific measure of bureaucratic capacity will yield interesting results about the relationship between states with a capable bureaucracy and Medicaid contracting schemes. Further, I will demonstrate that specific populations of vested interest groups play a role in establishing how contracts are monitored, awarded, and implemented over time and that there is a substantive empirical relationship between Medicaid revenue and specific business interests. The results of both the specified models and the semi-structured interviews are expected to show that interests play an important role in shaping policy outcomes and outputs. The examination of politics of private interests in public health care will demonstrate the vast complexity of state interest group environments and the links to private health insurance markets that the literature on state Medicaid policy does not adequately address. As market forces play an important role in explaining reasons for specific policy outputs (Randall and Johnson, 2008), such as Medicaid privatization efforts, they are expected to show a significant relationship to Medicaid contracting variation.

Data gathered from the semi-structured interviews in targeted states are expected to generate results that will not only confirm the quantitative analysis, but also help interpret the quantitative data. Interviews with state officials, line agency staff, and
organized interests are expected to give an added dimension to both policy evolution and the core rationale for how private interests shape policy outcomes to their benefit. Also important in the interview process is gleaning new information about the role of political contributions to key state lawmakers, the role of political action committees or the sitting governor responsible for setting agency policy, and the interwoven nature of those contributions from lobbyists hired by business interests that would benefit from policy outcomes.

1.14 Organization of Dissertation

In this first chapter, I have described the research questions addressed in the study and have laid out the arguments about the importance of both bureaucratic capacity and the role of interest groups in explaining variation in Medicaid contracting policy choices. A wide array of factors also helps explain variation in the Medicaid contracting mechanisms that states have utilized over time.

In Chapters 2 and 3, I present relevant research and theories that assist in explaining the factors associated with policy choices generally. The literature reviewed in these chapters is tied to the research questions posed in the first chapter and lays out the case that many factors help explain state policy choices. I also examine relevant literature about state policy choices, including interest groups, political control, and institutional factors such as the role of the bureaucracy in state policy making, as well as economic and demographic measures. The literature reviewed is also tied to the questions posed in Chapter 1 about the factors that explain variation in Medicaid contracting.
In Chapter 2, I report on the qualitative interviews with relevant policymakers in four states (CA, IN, NC and WV). Analysis of these data indicate the states have a diverse set of contracting schemes, interest groups, and political and market variables. Importantly, the interviews shed light on the complex dynamics among institutional players in the Medicaid bureaucracy and how interests, state lawmakers and the bureaucracy view the policy process. Collectively, the interviews provide important data about my theory that Medicaid bureaucratic capacity is important in explaining contracting choices and the importance of vested interests in structuring choices that are made by the bureaucracy. Analysis of these data indicate the states have a diverse set of interest groups, and political and market variables that influence the contracting choices that states make.

Chapter 3 is based on original data collection in which I examine the factors associated with specific contracting choices and develop a bureaucratic capacity measure (BCM) that examines the effect of the bureaucracy on Medicaid contracting over time. In addition, I assess the relationship between contracting choices and a range of political, interest group, demographic, and market characteristics in the states. Importantly, I find that bureaucratic capacity is a factor that helps to explain Medicaid contracting choices as well as the strength of interest groups in state capitals.

Chapter 4 concludes the project with a restatement of the primary findings from the quantitative modeling and qualitative interview process, addresses the implications of the findings, and outlines the direction of future research.
CHAPTER 2

Qualitative Interviews in Selected States

2.1 Introduction

The narrative of how and why state Medicaid programs make decisions to contract out services for their beneficiary population can be told from the perspective of those directly involved in the process and through their viewpoint about how and why a state has made decisions about Medicaid services. Interviewing Medicaid officials, vested interests, and lawmakers can assist in unraveling the complex policy dynamic and can also inform the specification of quantitative modeling. The interviews contained in this chapter go beyond the variables of interest outlined in Chapter 1 and provide a nuanced understanding of why the policy choices were made in the respective state Medicaid systems and thus assist in the development of the quantitative models contained in Chapter 3.

Past scholarship has shown that a variety of state actors are important to the decisions made by Medicaid agencies. The enormity of the fiscal impact of state Medicaid spending suggests that many actors are involved in the policy process (Schneider, 1997; Kousser, 2002; Duggan, 2004; Smith and Moore, 2008). The states selected for interviews (IN, WV, NC, and CA) represent a diverse mix of political, policy, and market environments that are vital in answering the research questions in this study. These four states were selected over other states because of the variation in interest
group environments, bureaucratic capacity of the Medicaid agency, political composition of state officials, and health insurance markets. Further, the interviews also assist in understanding the quantitative models contained in Chapter 3 of this study. The story that unfolds from the interview process speaks volumes about the nature of not only Medicaid contracting in the states, but also the intersection of policy and organized interests.

2.2 Relevant Literature and Past Research

The use of private organizations for Medicaid services is best defined as a choice between directly reimbursing providers (hospitals, physicians, and ancillary providers) and contracting for the services by providers through licensed managed care organizations (MCOs, which include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), or Insurers). The choice between reimbursing providers directly or contracting out the services to MCOs is a result of policy choices that state officials make to improve efficiency, reduce costs, and provide quality care to Medicaid beneficiaries (Smith and Lipsky, 1993; Duggan, 2004).

States can choose to directly provide health care to beneficiaries through state-owned public hospitals, contract directly with providers, contract with not-for-profit organizations, and contract with for-profit managed care organizations. The policy choices that state Medicaid officials make can be classified in terms of efficiency, effectiveness, and the savings that accrue to the state from contracting out service delivery (Duggan, 2004; Halverson et al., 1998).

Johnston and Romzek (1999) find that the accountability of private contractors in the Kansas Medicaid program played an important role in the process of privatization.
They also find that organized interests in a niche reimbursement area play a vital role in establishing contract eligibility and rates. Additionally, Johnston and Romzek (1999) find that state officials were motivated by the potential cost savings and efficiency from a new private contracting arrangement. Further, Bovbjerg, Held, and Pauly (1987) find that state contracting with private organizations creates a more efficient mechanism for service delivery and thus saves the state money. State officials believe that contracting out services to private firms may result in programmatic savings, but as Duggan (2004) finds in his analysis of California Medicaid, that outcome is not always the case. The above works suggest that privatization may or may not result in increased efficiency and accountability and is thus an important question I pose in the selected state interviews which will assist in better understanding the perceptions by the policy actors.

Interest group environments play a role in understanding the types of privatization schemes states use. Gold (1997) finds that the states of Tennessee and Oregon made policy choices for their respective Medicaid programs with a similar goal of generating savings. Both states petitioned the federal government and were granted a Section 1115 waiver that allows a state to experiment and modify the existing program requirements under federal law. The goals of both state Medicaid programs were to increase efficiency and expand coverage options within the targeted Medicaid populations (Gold, 1997, 633). Each state utilized the same Section 1115 waiver process but had different outcomes. In Tennessee, the state struggled to implement the program known as TennCare. Stakeholders were excluded from the process and expressed public disdain for how state officials had communicated program requirements and goals (Gold, 1997, 652). In
contrast, Oregon officials included all of the stakeholders directly involved with Medicaid contracting and the state in establishing the program under the Section 1115 waiver. Observations by participants in the Oregon demonstration program routinely gave the state, and those they contracted with, praise for the program; while Tennessee stakeholders gave poor performance and evaluation reviews to the state and accompanying private contractors (Gold, 1997, 643). The case study by Gold (1997) finds that the involvement of relevant stakeholders is a key determinant in how state Medicaid contracting functions.

2.3 Methods

The research in this chapter focuses on the themes of why and how states make policy choices in their Medicaid programs and in describing the complex dynamics among the central policy players in each state. In each interview conducted, there were key questions about role of the bureaucracy, interests, politics, and markets that I theorized were factors that helped to explain the contracting regimens that states chose. As the relevant literature has suggested (i.e., Gold, 1997; Duggan, 2004; Smith and Moore, 2008), the policy and political processes associated with Medicaid programs were among the largest and most complex tasks in which state policymakers and vested interests were involved. The interviews provided specific examples about how and why a state made its contracting choices for Medicaid. Additionally, the interviews helped to explain why differences were observed in the scope and size of contracting choices.

The following questions summarize the range of inquiry during each of the interviews conducted in four states:
What is the role of the bureaucracy in the contracting process?

How involved are interest groups in the policy process?

Are politics and partisanship important in understanding contracting choices?

Are private insurance markets important to the contracting process and policy choices?

These general themes are reflected in the Institutional Review Board (IRB) approved questions contained in Appendix A and were asked of each interviewee in the respective states. In each interview, the semi-structured nature of the questions allowed me to probe further into areas of interest surrounding the general themes. The interview format allowed for a rich, descriptive interview protocol, which is evidenced by the range of responses around the main themes of explaining policy choices highlighted in this chapter.

2.4 Selection of the State Case Studies and Participants

Interviews were conducted in four states and a semi-structured interview was used in targeted states based on those characteristics that differ in these states, namely demographic, political, policy, economic and interest group environments. The variation in the four states selected was based on data collected on the dependent variable (percentage of state Medicaid enrollees in commercial, for-profit managed care plans) and general measures of bureaucratic capacity. The states represent high and low use of commercial managed care arrangements in their Medicaid programs and high and low bureaucratic capacity.
The typology is expressed in a matrix in Figure 2-1. In addition, there is variation (high and low) in HMO market penetration in each state, extent of legislative professionalism, interest group populations, and per capita Medicaid spending. The quantitative models contained in Chapter 3 also use the same variables to help explain why we observe variation in Medicaid contracting.

A good example demonstrating the type of relationship that this study uncovers is seen in the contrasting data in the states of California and West Virginia. California has a rich tradition of managed care innovation as evidenced by the first iteration of health maintenance organizations founded by Henry J. Kaiser and the state’s early use of commercial managed care in California’s Medicaid program (Smith and Moore, 2008, 333-336). California has a very high market penetration of commercial, for-profit managed care organizations (51%) and a very active interest group population associated with the industry (Kaiser, 2009). Unsurprisingly, California also has one of the highest percentages (41%) of Medicaid beneficiaries enrolled in for-profit managed care organizations (Kaiser, 2009). In contrast, the state of West Virginia has a low managed care market penetration (15%), yet a very high percentage (45%) of Medicaid beneficiaries enrolled in commercial, for-profit managed care arrangements (Kaiser, 2009). Given the contrast in these two states, the question arises as to why one sees this reliance by state Medicaid officials on commercial entities to provide Medicaid services.

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8 Percentage figures for Medicaid commercial managed care use and state managed care penetration rates are all from 2007 data obtained from Kaiser (2009).
as opposed to directly contracting with providers. Both the empirical modeling and qualitative case study of the four states assist in answering the questions raised herein.

**Figure 2-1**

**Matrix of Selected States with High and Low Bureaucratic Capacity and Commercial Managed Care Arrangements**

<table>
<thead>
<tr>
<th></th>
<th>HIGH Commercial Managed Care</th>
<th>LOW Commercial Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIGH Bureaucratic Capacity</strong></td>
<td>California</td>
<td>North Carolina</td>
</tr>
<tr>
<td><strong>LOW Bureaucratic Capacity</strong></td>
<td>West Virginia</td>
<td>Indiana</td>
</tr>
</tbody>
</table>

The selected interview subjects included current and former senior state Medicaid officials with direct contract oversight and procurement responsibilities, key lawmakers or staff with oversight and appropriations authority over Medicaid, trade associations specifically dedicated to monitoring and lobbying for Medicaid funding, and a media representative having reporting experience related to Medicaid contracting and funding issues. A total of five interviews were obtained in each state. The persons interviewed included state lawmakers or senior staff with direct jurisdiction over Medicaid funding, current and former state Medicaid officials with direct responsibility for service delivery contracting, interest groups that include representatives of state hospital associations, labor union representatives, patient advocacy groups and managed care organizations that have a contract with the state agency. Each interviewee was selected based on their relevance to the policy process and knowledge of policy and political history.
The interview selection process in each state is based upon a finite universe of possible interview subjects. There are key policy officials (past and present) who have authority over contract choices with the state Medicaid program, which represents a selective group of potential subjects. State Medicaid officials with authority over contracting choices and contract implementation were selected because of their direct involvement in the policy process. State lawmakers and senior staff were selected because the rules of legislative bodies in each state gives their committees jurisdiction over Medicaid spending and implementation. State hospital association representatives were selected because of not only subject matter expertise related to Medicaid reimbursement policy, but also because hospitals are the largest beneficiary of Medicaid spending. Representatives of either health plans (HMOs or licensed MCOs) in each state were interviewed because they received contracts from the Medicaid agency and were thus prime beneficiaries of state spending. Attention was also given to make certain differing political perspectives were gathered both substantively and ideologically and thus avoid potential response basis. All interview subjects were given the assurance of anonymity in their responses and are reflected in the consent form contained in Appendix B.

The questions used in the recorded and transcribed interviews are consistent with the guidelines used by Yin (2009) and focus on the key independent variables in the empirical modeling. In addition, the selection of the four states follows the methods used by Kousser (2005) in which he selected six states with difference in key research
variables (term limits) and variations among control variables (political composition and legislative professionalism). I take a similar approach as shown in the Figure 2-1 matrix. Particular attention in the interviews is paid to the respondent’s perceptions of interest group activity, the capacity of the state bureaucracy to implement privatization schemes, the political environment, economic factors such as private health insurance markets and the spending associated with the state’s Medicaid program.

A list of standardized questions was used to probe beyond the collected and modeled data sets contained in Chapter 3 to find out why variations exist in different states and the specific privatization and contracting methods that are employed in each state. The qualitative content analysis software program NVivo was utilized to examine the transcribed interviews with the relevant policy players in each of the four states.

2.5 Data Collection Procedures

A total of 23 interviews were conducted from May to August of 2009 in the states of California, Indiana, West Virginia, and North Carolina. The interviewees include current and past state Medicaid officials with direct contracting policy making authority and with trade groups, including state hospital association officials with an interest in Medicaid contracting and health insurers and their registered legislative agents. State lawmakers and staff with legislative jurisdiction over Medicaid contracting and

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9 Please see Appendix A for the list of questions utilized in the semi-structured interviews. IRB approval was obtained for use of human subjects on May 7, 2009.

10 NVivo (version 8) was used in this analysis. See: http://www.qsrinternational.com.
appropriations were also included in each state. In addition, public advocacy group representatives, including representatives from relevant labor unions, were interviewed in the states where they were actively engaged in the policy discussions related to Medicaid contracting and spending decisions. In order to facilitate direct comparisons, both between states and among similar policy actors in the states, 5 interviews in each state were analyzed; providing a total of 20 transcribed interviews.\textsuperscript{11}

The interviews were all recorded with the consent of the participants under the condition of anonymity.\textsuperscript{12} Each interview lasted approximately 30 to 45 minutes; including question follow-up and dialogue concerning policy and political issues specific to each state. The transcribed interviews were entered into the NVivo qualitative data analysis software. The primary codes used to categorize the interview responses were defined according to the principal themes of the role of interests, the capacity of the bureaucracy, politics and the impact of the private health insurance market. The questions used in the semi-structured interviews contained in Appendix A became the basis for the coded responses used with NVivo. Frequencies of the responses were tabulated and arranged based on states and categories of Medicaid officials, interest groups, and state lawmakers and their staffs.

Response coding was based upon the four central themes posed by the questions in each state interview. The questions served as the basis for a two-stage approach that

\begin{itemize}
  \item[11] The three interviews that were not used in the analysis were duplicative of other policy actors or in the case of one interview, incomplete.
  \item[12] The consent form, as approved by the Kent State Institutional Review Board, is contained in Appendix B.
\end{itemize}
ultimately refined the codes to the four categories used. The coding included responses that indicated the importance of bureaucratic capacity, the significance and role that interest groups play in the policy process, the importance of politics and partisanship in contracting decisions and importance of health insurance markets related to Medicaid contracting choices. Utilizing any content analysis software poses certain questions of validity since there are a potentially infinite number of coding schemes that could be used. Given this fact, I decided to use a simple coding scheme that was based upon the four main areas of research focus that includes general questions about the role of bureaucratic capacity, interest groups, politics and markets.

The coding method used was defined by observed data and trends in the states, theorized relationships of state Medicaid contracting choices and also from the pattern of responses contained in the semi-structured questions. Various researchers using NVivo specifically take this approach that utilizes both a deductive and inductive approach to arrive at coding categories and to gather response and text variation (Coy and Woehlre, 1996; Crowley, 2002; Maney, et. al., 2005). While the coding may appear arbitrary, it does provide a basis by which to garner response variation since all interview subjects were asked the same set of questions contained in Appendix A. Equally as important, the transcribed interviews also allow direct quotes of interview subjects to place each theme in the proper context based upon direct interviewee responses. The coding scheme, when
taken together provide a systemic method of analyzing the response variation in the states and across categories of policy players.\textsuperscript{13}

\subsection*{2.6 Findings}

The interviews served to illuminate the ‘black box’ nature of state policy-making that quantitative models may not be able to discern. Each state selected has a unique set of policy and political attributes, as evidenced in the range of responses and policy histories associated with the contracting mechanisms used. The diversity of the delivery mechanisms and the politics associated with contracting are evident in the data that were used in constructing the matrix in Table 1. In order to place the response variation in its proper context, it is important to review each state’s policy history and the contracting mechanisms employed.

Policy and political history are important aspects of why each state chooses a particular contracting mechanism to deliver Medicaid services. Each state has a distinct policy path that ultimately results in the contracting choices that are made. These choices are the result of political, economic, and institutional constraints that evolve over time. The empirical models presented in Chapter 3 account for variation over time and are used to supplement the findings from this chapter. The interview findings presented in this chapter also account for time by providing an historical policy context for each of the four states. What follows below are the relevant Medicaid policy choices made in each

\textsuperscript{13} The coding method described can also be found in Coy and Woehrle (1996) and in Maney, Woehrle and Coy (2005). Also see Crowley et.al. (2002) for a discussion of the pitfalls of over coding using NVivo.
state and are arranged by the central themes that describe the interest group, bureaucratic, political and private market environment in each state.

2.6.1 Policy Overview and History of the Case Study States

Indiana’s Medicaid program, like most state programs, went through dramatic changes in the last decade as a result of contracting choices made by state officials and program benefit changes. The Office of Medicaid Policy and Planning (OMPP) within Indiana Family and Social Services Administration (IFSSA) administers the Indiana Health Coverage Programs; including the health plan programs. The OMPP is responsible for all program policies and coordination with other state and federal agencies. As with most states, Indiana’s Medicaid agency has a variety of contracting arrangements to deliver services to its population. Indiana’s program has a majority of the state’s Medicaid beneficiaries in managed care arrangements (71.4% in 2007) (Kaiser, 2009) and no beneficiaries enrolled in commercial, for-profit managed care arrangements since the state only permits Medicaid-only managed care plans.

Relevant to the questions pertaining to private insurance market attributes, Indiana’s commercial managed care market is diverse and has close to the national average of 17% of the state’s private insured enrolled in commercial managed care. The Medicaid population and Medicaid spending per capita also are typical of states in the Midwest, the latter of which is highly correlated with overall state spending per capita (Kaiser, 2009). The state’s political environment can also be categorized as stable, with Republicans consistently dominating the governor’s office and both houses of the General Assembly since 1997. The legislature is a part-time body, with no term limits in
place. In addition, there is limited staffing associated with the Medicaid agency and contracting staff as calculated by the Bureaucratic Capacity Measure (BCM) in Chapter 3. The state also has a relatively strong executive as defined by various measures of gubernatorial strength (Beyle, 2008). All of these factors are relevant when discerning the policy choices the state has made with respect to Medicaid contracting.

Identifying and understanding the structure of the bureaucracy is one important aspect of this study. Another focus of this study, which is necessary to understand the policy process, is highlighting the processes by which contracted organizations are paid and managed. The Indiana Office of Medicaid Policy and Planning (OMPP) pays contracted, not-for-profit managed care organizations a capitated monthly premium for each Indiana Medicaid enrollee in the MCO's plan. The capitated premium covers the services provided by the MCO program and the costs incurred by Medicaid enrollees in the MCO plan. The MCO assumes financial risk for services rendered to members in its plan. MCOs are lawful entities authorized to operate a prepaid health care delivery plan (as an HMO) that arrange, administer, and pay for the delivery of health care services to members as designated by the OMPP.

Indiana Medicaid also has a unique program. The Healthy Indiana Plan (HIP) offers a more affordable health care choice than would be available in the private market.

\[^{14}\text{The largest for-profit managed care organization, Anthem Blue Cross and Blue Shield, provides MCO services through a Medicaid-only subsidiary. Under Indiana law, commercial plans cannot directly contract with the state and must be separately organized as Medicaid-only plans.}\]
to thousands of otherwise uninsured individuals throughout Indiana. HIP supplies health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose income is up to 200 percent of the federal poverty level (FPL) and who are not otherwise eligible for Medicaid. Unlike many other government sponsored programs, parents and childless adults can participate. Eligible participants must be uninsured for at least six months and cannot have access to employer-sponsored health insurance. Participants are required to make monthly contributions toward coverage (State of Indiana, 2009). The HIP program is a new initiative of Governor Mitch Daniels and is unique among the states because of its eligibility and contracting attributes.\(^\text{15}\)

West Virginia’s Medicaid program went through a major redesign in 2005 at the direction of Governor Joe Manchin, III. The state used its high federal match formulary of 69% to expand Medicaid spending and eligibility standards used since 1997. Remarkably, 47% of the state’s population is enrolled in Medicaid, Medicare, Veteran’s Administration, and other government health care programs. The total share of Medicaid spending in the state in 2007 was the largest single spending item in the state’s budget. Important to the questions posed in the interview process and the rationale for why this state was selected, West Virginia had 46% of its Medicaid population enrolled in

\(^{15}\) The Healthy Indiana Program is approved by the Centers for Medicare and Medicaid Services under the Indiana’s Medicaid plan amendments. As of 2009, 8% of the state’s Medicaid population is enrolled in the program, which also included Health Savings Accounts as a means of allowing beneficiaries to transition to private coverage after they are no longer eligible for Medicaid (State of Indiana, 2009).
commercial for-profit managed care organizations, yet only 15% of the private insurance market was enrolled in managed care organizations (Kaiser, 2009).16

This fact is worth noting since the choices made by the state of West Virginia were not representative of the characteristics of the private health insurance market. A disproportionate share of the Medicaid population in West Virginia was enrolled in MCOs versus the rest of the state’s population. This fact gives rise to why this occurs and why the great divergence in MCO use in the states’ Medicaid program in relationship the private insurance market in the state. Duggan (2004) has suggested in his study of the California Medi-Cal program that state specific private insurance markets were an important aspect of explaining Medicaid contracting and thus a focus of the interviews to help explain what factors contribute to the disproportionate share of Medicaid recipients being enrolled in MCOs.

The West Virginia Bureau for Medical Services (BMS), Office of Medicaid Managed Care, initiated a risk-based managed care program for certain groups of Medicaid recipients in September 1996.17 Under this program, the Bureau has contracts with three HMOs for the provision of medically necessary services currently provided by the state, with the exception, most notably, of behavioral health, pharmacy, long-term care, and non-emergency medical transportation services. The Mountain Health Choices

16 See Table 2.2

17 Risk-based contracting in the context of the WV example involves a capitated, per member, per month payment to the contracting entity to provide specific service or care as outlined.
Plan has a Member Responsibility Agreement that gives access to services not provided in traditional Medicaid benefits. By visiting their medical home for check-ups and working with their healthcare providers to set goals for health improvement, members qualify for an enhanced benefit package, which lets members participate in weight management, physical activity, and other educational opportunities for health improvement (State of West Virginia, 2009).

West Virginia’s political environment is also of interest, since the Democratic Party has dominated both houses of the legislature and the governor’s office since 1997. Historically, West Virginia has had a low number of state agency staff per capita associated with the state Medicaid agency. In addition, there is only one staff member dedicated to implementation and oversight of the state’s commercial managed care entities that have a contract with the Medicaid program. The state also has a strong executive branch as measured by gubernatorial strength (Beyle, 2008). The interest group community in Charleston is described as active and important, and I collected data identifying Medicaid related organizations and legislative agents in the state capital. Also of importance is the fact that the state has a part-time legislature with limited staff support and no term limits for state lawmakers.

North Carolina’s Medicaid program and other state political and market attributes contrast with those of Indiana and West Virginia. North Carolina’s Medicaid agency made a policy decision to not contract with any traditional managed care arrangements,

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18 Information obtained by the author from interviews in Charleston, WV conducted in May, 2009.
either for-profit or not-for-profit. In 1986, North Carolina began offering managed care to Medicaid recipients eligible for enrollment by contracting with Kaiser Permanente, an HMO. This option was available only in Mecklenburg, Durham, and Wake counties. In 1996, the state contracted with five HMOs to serve Mecklenburg County in a program called Health Care Connection. The Health Care Connection program was extended into four other counties; however, because of an insufficient population base in these counties, the HMOs withdrew participation in all but Mecklenburg County. On December 1, 2002, South Care became the only HMO serving Mecklenburg County, and that contract ended effective August 1, 2006. North Carolina no longer contracts with any HMO to serve the Medicaid population. As a result, health providers directly contract with the state to deliver services to the Medicaid population. Contracting arrangements include fee-for-service arrangements and risk-sharing or capitated payments to provider groups, including hospitals and groups of physicians. The 2007 data from CMS indicate that less than 1% of the state’s Medicaid population was enrolled in the last remaining commercial plan (Kaiser, 2009).

The Center for Medicaid/Medicare Services (CMS) approved a 1915(b) waiver in April 1991 for North Carolina to implement a primary care case management program, Carolina ACCESS. The North Carolina Department of Health and Human Services (DHHS) initiated Carolina ACCESS as a pilot in five counties. The program was co-sponsored by the Division of Medical Assistance and the Office of Rural Health and Community Care. The purpose was to create a system of coordinated health care for Medicaid recipients. The program was designed to offer a medical home with a primary
care provider (PCP) to coordinate patient care by providing and/or authorizing services. Carolina ACCESS pays providers fee for services and pays the recipient’s PCP a management fee for coordinating patient care. The management fee is based on per member/per month (PM/PM), in contrast to the risk contracts executed with managed care organizations (State of North Carolina, 2009).

In 1998, the North Carolina Division of Medical Assistance and the Office of Rural Health and Community Care collaborated to enhance the basic Carolina ACCESS program and launched a new approach to providing health care for Medicaid recipients. The newly renamed Community Care of North Carolina/Carolina ACCESS (CCNC/CA) works directly with community providers who have contracted with the state to be a Carolina ACCESS PCP. The program builds private and public partnerships in which community providers plan cooperatively to meet patient needs. The responsibility for managing the care of the enrolled population falls to the community network. Performance and improvement are the responsibility of those who actually deliver the care. Medical providers are paid a fee for their services, and PCPs participating in a network are paid a management fee on a per member per month (PM/PM) basis. The network in which the provider is enrolled also receives a management fee based on the number of Medicaid recipients enrolled within the network. All funds are kept locally and are recycled into the community for patient care (State of North Carolina, 2009).

19 Commercial for-profit and not-for-profit managed care organizations typically are not granted ‘management fees’ but are usually paid on a per member per month basis to deliver all health care service (Kaiser, 2009; CMS, 2009).
Unlike Indiana and West Virginia, North Carolina has a full time legislature and higher bureaucratic capacity. In addition, the governor is classified by most measures as ‘weak’ as evidenced by the lower-than-average score for gubernatorial strength. The state also has a lower-than-average managed care penetration rate of 12% (Kaiser, 2009). Per capita state spending and per capita Medicaid spending are also above national averages. Finally, various measures also find an active interest group community associated with Medicaid.

California is in many ways unique compared to the other states examined. These differences are evidenced by the political composition of the state, an active and highly professionalized legislature, and an interest group environment that rivals only the thousands of lobbying and trade groups that inhabit K Street in Washington, DC. California’s Assembly has term limits and one of the most professionalized legislatures, as measured by Squire’s Index of Legislative Professionalism (Squire, 1992; 2007). In addition, there is a large and highly professionalized Medicaid bureaucracy as shown by the Bureaucratic Capacity Measures and high staffing numbers, with over 60 individuals directly associated with the state Medicaid Medi-Cal managed care contracting offices.

The contracting mechanisms that are being utilized in California are the result of a series of legislative and agency changes that resulted in three major types of Medi-Cal managed care plans currently offered: County Organized Health Systems, a Two-Plan County Model, and Geographic Managed Care. As a result of the contracting choices, California has one of the highest percentages (41% in 2007) of commercial managed care
organizations. In addition, California has an above-average 42% of the state’s private insurance marketplace enrolled in HMO managed care arrangements (Kaiser, 2009).

County Organized Health Systems (COHS) are health-insuring organizations operated by an independent governing board appointed by the county’s Board of Supervisors. All Medi-Cal beneficiaries residing within COHS counties are required to enroll. This enrollment also includes individuals who are Medicare/Medi-Cal dual eligible. Importantly, there is no Medi-Cal fee-for-service delivery system in these counties. Five COHS plans operate in eight counties (CA DHHS, 2009).

Under the Two-Plan Model, the Department of Health Services contracts with one locally developed health care service plan known as the Local Initiative and one commercial plan selected through a competitive procurement process. Generally, enrollment is mandatory for families and children. The non-mandatory eligible groups (mostly seniors and persons with disabilities) access services through Medi-Cal’s fee-for-service delivery system or can choose to enroll in a health plan. Individuals who are Medicare/Medi-Cal dual eligible are excluded from enrollment. The Two-Plan Model of Medi-Cal managed care is available in twelve counties (CA DHHS, 2009).

In the Geographic Managed Care (GMC) plan, the Department of Health Services contracts with multiple health plans in the county. In contrast to the competitive procurement for the commercial plans in the Two-Plan Model, contracts for GMC are secured via a non-competitive application process in which any plan meeting specified state requirements/standards is permitted to negotiate a contract with the state. Medi-Cal beneficiaries in GMC counties choose from multiple commercial managed care plans.
Sacramento and San Diego counties are the only two GMC counties in California, and enrollment is mandatory for families and children. The non-mandatory eligible groups access services through the Medi-Cal fee-for-service system. Individuals who are Medicare/Medi-Cal dual eligible are excluded from enrollment (State of California, 2009).

Table 2.1 below provides a summary of the relevant percentage of Medicaid enrollees in for-profit MCOs and the percentage of Medicaid beneficiaries enrolled in all forms of managed care arrangements, as outlined in Chapter 1.

Table 2.1. Selected States Percent of Medicaid Population Enrolled by type of Managed Care Arrangement (2007)

<table>
<thead>
<tr>
<th>State</th>
<th>For-Profit MCOs</th>
<th>All Types of MCOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>41%</td>
<td>52%</td>
</tr>
<tr>
<td>Indiana</td>
<td>0%</td>
<td>72%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1%</td>
<td>67%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>46%</td>
<td>46%</td>
</tr>
</tbody>
</table>

Note: Source, Kaiser Family Foundation (2009)

2.6.2 The Role of Interests

In each of the states, interest groups are central to both its policy history and the reasons behind Medicaid contracting choices. The states selected also have a diverse interest group environment with a vested interest in Medicaid contracting policy. Appendix A lists questions that are designed to elicit responses about how interests are involved in the policy process. In each state, interviews are conducted with representatives of the state hospital association (which is the largest beneficiary of Medicaid funding), as well as health plan lobbyists, labor unions, and advocacy groups.
The interests in each state demonstrate how organizations and even individuals help shape the policy process.

In Indiana, interest groups were not perceived to be active in the policy making process, but specific interests were easily able to persuade state officials about the validity of their policy preferences. This outcome was anticipated, as evidenced by comments from both state lawmakers and Medicaid agency staff. Their responses about interest group involvement were tepid at best; with an almost collegial attitude towards the role that interests play in program implementation. Unlike other states, respondents in Indiana generally viewed the role that interest groups played in the policy process as positive. Vested interests were easily able to press their case to lawmakers regarding contract procurement, rate adequacy, and contracting vehicles used by the state. While this observation may appear to contradict my early assertions about active interest groups, I suggest that the collaboration that was apparent in the interviews is a result of one party (Republican) domination in Indiana that fosters a collaborative environment rather than one built on the natural conflicts that exists when there are competing political parties and interests in a state. Further, state contracting officials routinely held meetings with interest groups and contracting organizations to receive feedback, which is documented by the following quotation from a Medicaid official:

> With Care Select, they had an advisory council, they have a--different advocates, and they--different ideas were presented to them, and they were given the opportunity to provide feedback I know that was incorporated; some into the model for that, and, you know, we engage advocates through different committees, we have some committees that focus on issues such as contracting, prenatal strategies, overall, just Medicaid quality strategy, so we bring folks to the table all the time.
Just as the work by Gold (1997) suggests, when collaboration exists between interests and the bureaucracy, the political culture becomes different. The evidence in Indiana suggests that interests are largely inactive because of lack of commercial market penetration and a part-time legislative body that cedes to the will of a strong executive branch. Indiana has a low percentage of Medicaid enrollees in managed care plans and that fact coupled with a smaller commercial market provide a limited incentive and role for commercial interests seeking Medicaid contracts. This observation is noteworthy since for-profit commercial health plans are absent in the contracting choices made by state Medicaid officials and their lack of activity with policymakers is a possible reason why the collaboration exists.

In West Virginia, state policy decisions, by all accounts, appear to have political overtones tied to key vested interests and lobbyists. One anecdote about a possible expansion of the use of commercial managed care interests to serve the Children’s Health Insurance Program (CHIP) is of particular note and demonstrates the power of the interest group community in Charleston:

I don’t know anything directly, but I know what kind of state West Virginia is, and everything is political, and everything is done through connections. And I can share an anecdote with you, I may have already shared that on the phone -- you know, the managed care industry is trying to get the Children’s Health Insurance Program to go. And I know that they have been pressing this through the governor’s office through their connections with the governor’s office. And the Children’s Health Insurance Program, they’ve done their own studies. They don’t think it’s cost effective, and their Board of Directors is very close to going with managed care. I mean, they were really hostile about it. So, you know the managed care industry, their main lobbyist is a guy named [Name Omitted]. He works through the governor’s office, and I guess the latest thing was like, okay, CHIP won’t play with us, we’ll just get--we’ll just put CHIP into Medicaid. The current Medicaid director--but she has given
me the indication that she doesn’t think it’s cost effective. Think it’s West Virginia, but yet she has to do it. It’s very political.

The respondents all seem to universally acknowledge that lobbyists, law firms, and organized trade associations have a major say in policy outcomes and shape their preferences through the governor and his staff. As the above quote demonstrates, West Virginia has been dominated by one political party (Democrat) and control of all organs of state government and this helps explain why interests are able to concentrate efforts on rent seeking activity, including the routine hiring of former state Medicaid officials.

Organized interests clearly play an important role in policy formulation, implementation, and oversight of the California Medicaid program as well. Each group of policy players in the state emphasized the importance of organized interests and how they influenced the program. As evidence, state Medicaid officials were always mindful of how their actions were perceived by state lawmakers and committees of jurisdiction. Interest groups paid a great deal of attention to the Assembly. This quotation from a trade association representative captures the importance of organized interests in the state:

I know when I go and talk to folks across the country, they say, “Well, we have a nurses’ association,” like an association for nurses, but no, this is a very powerful, very political, organized labor union that organizes a good number of the nurses across the state, but SEIU\textsuperscript{20} organizes facilities even including many nurses. SEIU has their hands in everything, and they have very powerful lobbyists across the street. We often refer to one of them as the 121\textsuperscript{st} member of the legislature. And we have a very Democratic

\textsuperscript{20} SEIU-Service Employees International Union, the largest state and local government union in California.
legislature, very much backed by a good number of unions, and they are extremely influential. They are influential on hospital rates, on eligibility, on health care reform, the whole provider type of thing that we are working on. That’s probably one of the most influential elements, rate structure - everything.

Respondents universally indicated that the highly charged political atmosphere played an important role in how the program was shaped and specifically how the three-tiered hybrid model of contracting came about.

It should be noted that North Carolina interviewees sparingly mentioned the role that interest groups play in the contracting process, principally because the state abandoned the use of all forms of managed care use. The NVivo analysis of responses contained in Table 2.2 related to interest group influence demonstrate this fact in North Carolina with relatively few comments or discussion about the influence of interests in the policy process. In short, interests spend time, money, and resources attempting to influence the Medicaid bureaucracy because they see the returns to their clients and policy choices that benefit them.

2.6.3 Bureaucracy and the Policy Process

A central question posed by this study is the role of the bureaucracy and its capacity to efficiently implement and oversee state Medicaid contracting choices. Questions regarding adequate staff numbers and state Medicaid agency structures and power were asked of all interviewees, as represented in Appendix A. The responses that are highlighted in this section suggest a complex dynamic between political influences
and vested interests, which combine to help shape bureaucratic capacity and the development of policy process over time.

The role of the bureaucracy and its capacity to efficiently and effectively manage the program was generally acknowledged by the interviewees as being a positive thing in Indiana. Many of the key policy actors, including interests and lawmakers, stated that they thought the Medicaid agency did an adequate job of making certain that the state was receiving value for the contracts they have and that beneficiaries, by and large, were efficiently receiving the type of care they required. Again, a common refrain from the interests and lawmakers charged with oversight was the lack of resources, specifically personnel and state Medicaid appropriations.

Perhaps of greater interest were the perceived roles and oversight authority of state lawmakers in the administration of Indiana’s Medicaid agency. The interviews brought out issues and frustrations about the lack of information that was forthcoming from Medicaid staff and senior officials, in particular. In states where there is a strong executive and weak legislative branch, there is particular tension between institutions and a strong relationship between principals (Governors) and the bureaucracy. When the dynamic of a strong executive is in place, the bureaucracy can and does do the bidding of the principal. The following quotation best sums up the lack of cooperation and how the bureaucracy can dominate the policy process, even when Republicans have control of the governor’s office and both houses of the Assembly in Indianapolis:

Joint Committee on Medicaid Oversight that was put in place specifically to monitor everything Medicaid did, because we had a Medicaid director who was ruthless…… I mean, the governor had told them to essentially be ruthless in how they were administering Medicaid, and this isn’t just
MCO, but he enjoyed doing that. And so we had just literally hundreds and hundreds and hundreds of complaints from advocates of patients and providers, and so we put in a committee that does nothing but monitor Medicaid and that committee.

The Medicaid agency in West Virginia has seen its staffing levels decrease as a result of policy choices made by current and previous administrations. Advocacy groups, state lawmakers, and their staffs have expressed frustration in obtaining information from the agency about program contracting and performance. One telling comment in response to a question about the perceived efficiency and effectiveness of the agency sums up the assessment of their expertise:

Absolutely not! Not only would I say they are significantly understaffed with a number of open positions, I would say, secondarily, they have not developed the information systems and reporting capabilities to fully understand what is happening with that managed care population or whether they are truly making or losing money as a state in that process. In other words, are they saying anything relative to the fee-for-service process, and again, I am not sure that the expertise is there, in part because, as I said earlier, we had very little experience with managed care. The state did not hire any managed care experts, it just staffed that part of the agency when they started down this road. The initial rates--they contracted with Lewin to crank out some of the initial rates in their waiver process, but subsequent to that, they haven’t brought any expertise in-house to assist them in that process.

The responses from differing perspectives indicate that West Virginia has limited staffing resources, is heavily reliant on outside interests to assess and develop policy, and puts lawmakers in the position of engaging in meaningful oversight with limited resources. This quote above supports the theoretical expectations outlined earlier where I suggest that low levels of bureaucratic capacity are associated with an increased reliance
on contracting choices that favor for-profit commercial managed care plans. The empirical models advanced in Chapter 3 also test this theoretical construct.

North Carolina’s Medicaid program has had higher staffing numbers and expertise in contrast to other states and was acknowledged by lawmakers, interests, and advocates with an interest in the program. The quotation that follows is reflective of the policy process that eventually caused state officials, in conjunction with organized interests, to abandon the use of commercial managed care organizations. This observation is surprising since policy players in other states did not readily acknowledge the importance and expertise of the bureaucracy. Further, they did not acknowledge how commercial interests could adequately serve the needs of the Medicaid population. One possible explanation for the lack of interest by the private insurance market is North Carolina’s relatively low managed care penetration rate (9%) (Kaiser, 2009) that is coupled with a high percentage of the population residing in rural areas, thus impeding the developing of networks of health care providers. In short, commercial interests did deem the state’s Medicaid system worth the trouble to expand their private market insurance products because of the rural nature of the state and inability to establish provider networks.

Politics and control of committees of jurisdiction in the Assembly also do not seem to be an important factor related to Medicaid policy and contracting choices in North Carolina. One lawmaker, while expressing natural frustration with the executive, gave the agency high marks for implementation and efficient operation. The response below refers to the LMEs, or Limited Management Entities, which are authorized to
perform case and care management in specific geographic areas of the state of North Carolina:

Their LME has done an outstanding job of selecting a fairly limited number of providers in different areas, streaming them very well, staying on top of their contracts, and keeping the control on costs, as well as insuring that there’s quality service being provided. So the LME model can work very well depending on who’s running it and the types of practices that they’re using. And one of the things that we’re at least attempting to do in North Carolina, I don’t know how well we’re doing it, is trying to replicate where the model has worked as it should work and, if we really want it to work, replicating that in other areas of the state where the management and the armies are weaker.

The expertise of Medicaid staff is clearly understood, but not always appreciated by lawmakers, as evidenced by comments from other policy players in North Carolina.

The California Medicaid bureaucracy has a wide range of personnel dedicated to implementation and oversight of the contracting mechanisms used. The legislature is involved in the oversight of the agency as evidenced by the following response:

It is tough because the department, along with many other departments and programs, has taken some serious reductions over the last couple of years because of the budget. You know, for example, when we had the proposal for expanding managed care geographically, we also received resources associated with that, so there is recognition that any time you expand your operations, that we have the opportunity to say that this is going to have a workload impact. And we make our requests for resources, and although the legislature didn’t grant everything that we had requested, we still got a healthy chunk of resources.

California’s Medi-Cal system has a great deal of staff expertise to deal with the complex nature of the program and the multiple types of contracting entities to serve a diverse population. Legislative leaders and staff, while leery of
bureaucratic power, readily acknowledge the need to provide resources to allow the agency to fulfill their mission under California and federal law.

2.6.4 Institutional Factors and Politics

Focusing on the role of political principals in the policy process assists with answering the questions raised in this study. The interview questions allowed respondents to discuss the role that state lawmakers and the governor play in the contracting scheme in each state. The responses demonstrate variation in the role that lawmakers and their staff play in the process and how partisan power and the strength of the governor are important policy determinants.

The story of Indiana’s Medicaid program and evolution in a post-TANF environment is one largely of budget constraints. Respondents always came back to the central question of budgetary resources. However, the state has engaged in unique contracting methods to deal with the limited resources that seem to plague all the states.

One quotation from a former Medicaid official put the state’s dilemma and challenges in perspective:

The Governor [Mitch Daniels] said Medicaid growth was at 10% a year. He said, “Medicaid growth needed to be at 5%, 5%, 5%, 5%! What about 5% didn’t you understand the first time?” I said, “5%, okay! Medicaid growth is going to be 5%.” And I did it.

The political process and tight fiscal resources were echoed by lawmakers and interest groups. The top-down budget numbers in many ways necessitated policy choices to which the policy actors were forced to respond. One possible explanation about the significant role that the governor and his appointees played in the process is the fact the
powers of the governor are termed as ‘strong’ (Beyle, 2008). In addition, Indiana’s legislature is part-time, thus giving great advantage in the policy process to the executive. The above quote demonstrates this fact since the governor dictated budgetary targets and lawmakers perceived themselves as powerless to challenge the authority of the executive in this regard.

The concerns about top-line expenditure growth was a theme universally echoed by political principals (lawmakers and appointees of the governor) in all states surveyed, especially since Medicaid spending (state and federal share) is now the largest appropriation and spending item states must deal with in a budget cycle. In the following chapters, the importance of budgetary variables are explored in the quantitative models to further examine if these constraints are a significant factor in explaining the variation in state Medicaid contracting choices.

Throughout successive Democratic administrations in West Virginia, the governor and his staff were intimately involved in the contracting process. Former Medicaid officials, lawmakers and their staffs, and a range of interests all readily acknowledged the importance of the governor in policy implementation—much more so than in any of the other states selected. This statement best sums up the process:

I think that, and again this is my perspective, there were certainly special interest groups that came in. We often were called to meet with them in governor’s office. They would come and do presentations. In my mind, Medicaid is all about relationships, whether that be with your beneficiary--your Medicaid members, whether that be with your vendors, whether that be with your providers. And it was a trust relationship. So sometimes when special--when the vendors or the interest groups came in and they brought the people, from my perspective again, the ‘suits’ as we call them, from New York or their corporate headquarters, it didn’t impress me as a Medicaid Director because they didn’t always understand the nuances of
the West Virginia--what our needs were. So in some ways, it was to the detriment.

The above quote gives further evidence of the role of interests in influencing the policy process and how principals (the governor) can play a role in facilitating the demands of vested interests. Additionally, the interviews in the states (most notably Indiana and West Virginia) show the importance of the executive and how they can and do influence the policy choice in a state. In Chapter 3, the relevancy of the governor will be examined using measures of gubernatorial strength over time and if this measure has any relationship to Medicaid contracting choices, as the interviews in West Virginia have shown.

Respondents in California universally indicated that the highly charged political atmosphere played an important role in how the program was shaped and specifically how the three-tiered hybrid model of contracting came about. In short, interests spent time, money and resources attempting to influence the Medicaid bureaucracy because they saw the returns to their clients and in the policy choices that benefited them. Equally important is the fact that the legislature appears to drive policy choices, as evidenced by this response to the involvement of health plans with the Assembly committees of jurisdiction:

The legislature certainly--when some of these health plans that are their constituents would come to them and raise these concerns, the legislature certainly--followed up with us, and this did come up in some budget hearings. Although what I will say is that, in general, the legislature wasn’t really pounding us to increase rates overall. I think it was always raised in the context of what a wonderful plan this one is, particularly the locally-based plans and health department: are you paying them enough?
It’s really tough for them. There wasn’t as much sympathy, I think, for commercial plans because of that perception, you know, big evil empire making tons of money, telling everyone no, which I think is a misperception, I know is a misperception, but it means that they don’t have as much sympathy as the locally-based health plans. So, that certainly came up.

The role of governors and state lawmakers varied in each state, largely as a result of the power, both real and perceived, that each governor (principal) has under state law and constitutional powers that direct affects each state governor’s ability to manage and dictate policy choices of state Medicaid agencies. In North Carolina, the role of state lawmakers was somewhat limited as was the direct involvement of the governor and his staff, leaving many of the decisions to the bureaucracy. The ‘strength’ of the governor or state lawmakers appears to be a factor worth highlighting, rather than the role of partisanship in a state, given the diverse political composition and culture of each of the four states. I suggest that as result of these observations that an important determinant of the Medicaid contracting choices is the relative strength of the executive and how that power is used in conjunction with other principals in the legislative branch. These aforementioned political and institutional variables are utilized in the quantitative models in Chapter 3 and compliment the qualitative interviews.

2.6.5 The Role of Private Markets

State insurance markets vary widely based upon numerous factors, including the percentage of enrollees in managed care arrangements. Managed care plan penetration in a state is a function of the availability of qualified health care providers (hospitals, physicians, and ancillary service providers) in a state or geographic location (Kaiser,
When state Medicaid systems began to use managed care arrangements in the 1970s and 1980s, the composition of the managed care networks was an important consideration that state officials used in selecting organizations to deliver and coordinate care (Smith and Moore, 2008). As a result of the reliance on these networks of providers, the role of private insurance market participants becomes an important consideration of state Medicaid systems. Hence, I elicit responses from the policy participants in each state about their observations and perceptions of the role that private insurance entities play in the development and implementation of Medicaid contracting.

North Carolina’s Medicaid program is the most interesting contrast among the four states since the state made a decision to eliminate all commercial carriers as a delivery mechanism for Medicaid. Instead, they adopted a hybrid model that relies directly on primary care physicians to deliver and manage care for beneficiaries. A former state Medicaid official best described the policy path on which the state embarked:

We had not expanded our PCCM to Mecklenburg County, and the County Department of Social Services director was very interested in pursuing a different sort of model for Mecklenburg. And so he, along with the county commissioners from Mecklenburg County, approached the Department about doing the MCO model. The state had always had kind of a voluntary MCO option in some limited counties with Kaiser, I think for probably ten years, but it was a very minimal enrollment, it was a very low enrollment and--for Mecklenburg was, so the DSS really is the one who kind of took the initiative to approach the state about partnering with the department to bring the MCO model there. That continued to expand and, I think, that day-to-day we had probably six or seven MCOs that the state is contracting with there in Mecklenburg County, and that was over a period of, I think, close to eight to ten years that we had the MCO model there. And then in 2005 is when the decision was made for an effective
date, if I am not mistaken, the effective date for the termination of the last HMO in Mecklenburg was somewhere around August 2006, but the decision was made in 2005, and the decision was pretty much that the enrollment was very low and there was just too much of an administrative cost.

The Medicaid agency itself realizes the challenges that are faced as a result of the mix of rural and urban citizens in North Carolina. In order to serve the diverse population of beneficiaries, the agency has constructed contracting mechanisms around existing programs to serve those needs. Notably, the rationale for dropping commercial coverage has not been as a result of political influence, but rather has been a result of the lack of available and willing insurance entities that caused a reassessment of the use of commercial managed care plans. While provider groups were certainly influential in initially persuading state Medicaid officials to adopt their physician-centric contracting model, it appears from the response from state Medicaid officials that the decision was rooted in promoting efficient delivery of services. The decision by the state is best described by the following interview response:

That decision was actually influenced by market conditions in the HMOs. In North Carolina, there was a big influx of HMOs in the early 90s, both in the commercial market and in the mid-90s when we introduced the product and HMOs for the Medicaid population. And as HMOs matured in North Carolina, the big fish started eating the little fish, and at some point HMOs realized the profits were not in the Medicaid market, thus it was their decision to stop participating. In addition, our PCCM product was very mature, was mature even at the time we began all them HMOs. Thus outside of Mecklenburg County, which was the first county in which we offered HMOs, they could not gain market share in other areas, so that along with their own profit margins, the HMOs decided to stop participating.
Managed care penetration rates are lower in North Carolina than in the other states surveyed, which is of interest since both Indiana and West Virginia have a similar rural demographic profile. In short, managed care never matured in NC as it did in other states, even in the urban centers of the state. North Carolina’s policy process is an interesting contrast to the other states in that market forces, not the role of interests or politics, nor the lack of bureaucratic expertise, caused the shift in contracting policy. Insurance carriers in North Carolina assessed the situation and concluded they could operate managed care networks in a profitable manner and made a choice to neither develop Medicaid as a line of business. The policy players in North Carolina recognized this fact in the quotes above and therefore provide us with an explanation why North Carolina made the choice to eliminate managed care as a contracting option for Medicaid.

In contrast to North Carolina, the other states surveyed use managed care plans to varying degrees, but there is evidence that suggest a reason why: managed care penetration rates. Indiana, West Virginia and California all have higher managed care penetration rates than North Carolina (Kaiser, 2009). In each of these states, there exist well-developed and mature managed care networks that service the private employer market. Further, as various scholars such as Kettl (1993), Gormley (1989) and Savas (1987) have found in examining why government chooses to use private entities to provide public services, a market must usually exist to be used by government. I further suggest that the existence of markets and their size contribute to a greater use of managed care in state Medicaid systems. Thus, managed penetration rates in the states are an important variable that I theorize helps to explain the variation in managed care use by
state Medicaid programs. This theory is tested in the various quantitative models presented in the next chapter by using managed care penetration rates in each state and examining if there is a significant and positive relationship between Medicaid contracting choices and managed care use in a state in the private health insurance market.

2.7 Cross Case Analysis of the States

The descriptions and quotations from the transcribed interviews depict how the capacity of the bureaucracy can help shape policy outcomes and implementation of Medicaid contracting mechanisms. Equally as important, the narrative also confirms that interest groups play a vital role in some states and not in others. In addition, it is also evident that politics, control of legislative bodies, and committees of jurisdiction can play important roles in shaping policy. Markets are similarly necessary for assessing how and why contracting programs have evolved. As the interviews presented here have shown, the formulation and implementation of Medicaid contracting is a complex dynamic in which several variables help explain each state’s current Medicaid contracting arrangement.

The interview responses highlighted above demonstrate some of the variation across the states and important influences on state Medicaid programs. The transcribed interviews also supply comparative and contrasting data for investigating the questions posed by this research. Table 2.2 represents the mean frequency of responses related to the key issues of bureaucratic capacity, interest group influences, political influences, and the importance of markets to the respondents. Coding for the nodes associated with the responses are derived from the questions contained in Appendix A.
Table 2.2. Cross Case Analysis by State Using NVivo Mean Frequency of Key Themes

<table>
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<tr>
<th>Variable Code</th>
<th>Indiana</th>
<th>West Virginia</th>
<th>North Carolina</th>
<th>California</th>
</tr>
</thead>
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<td>5.2</td>
<td>0.6</td>
<td>11.4*</td>
</tr>
<tr>
<td>Bureau. Capacity</td>
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<td>11.4*</td>
<td>3.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Politics’ Influence</td>
<td>1.4</td>
<td>8.6</td>
<td>2.6</td>
<td>13.8*</td>
</tr>
<tr>
<td>Market’s Impact</td>
<td>2.2</td>
<td>2.6</td>
<td>5.2*</td>
<td>3.6</td>
</tr>
</tbody>
</table>

*Note:* Coding of nodes using NVivo was derived from the IRB-approved questionnaire in Appendix A. Greatest value for each code is placed in bold and is expressed as a mean of responses. * Indicates a significant t-test value (95% Confidence Interval) within the response variable code. Appendix E contains the raw response codes for each interview in each state.

Utilizing the NVivo software, 20 separately transcribed interviews were analyzed using coded response categories derived from the list of standardized questions. The interviews were balanced in each state (5) and by policy actors from the bureaucracy, interests and state lawmakers. This allows for a robust comparison by having not only differing perspectives, but also sustainably policy players from each state that were all subjected to the same IRB approved interview protocol. As a result three interviews were discarded since they were incomplete or duplicative of other interviews in a state.

The frequencies in Table 2.2 represent mean sums of all paragraphs containing an instance of the code in each category. As an example, on average, all interviewees in California mention the importance of the role of the bureaucracy on average 11.4 times in their transcribed comments. The mean frequencies demonstrate the importance or relevance of each key theme and provide quantitative measures relevant to the qualitative process. Also, Appendix E contains the raw values of the coded responses for each interview in each state.
Table 2.2 shows that there is significant variation in respondents’ perception of the importance of bureaucratic capacity. West Virginia respondents clearly suggested that staff numbers in the Medicaid agency were not adequate, contrary to the responses from the other states. As an example, respondents in West Virginia were almost three times more likely to mention that the capacity and capability of the bureaucracy was a concern versus respondents in California. Unsurprisingly, California interviewees emphasized the role of interest groups in the policy process and indicated they were an important factor in explaining the contracting decisions made by state Medicaid officials and lawmakers. In addition, political influences were also coded more frequently among the policy actors in California. Finally, North Carolina respondents focused on the impacts of markets more than interviewees in other states, as evidenced by the fact that the state no longer uses commercial managed care organizations to deliver Medicaid services.

2.8 Conclusions and Discussion

The results of the analysis of the interviews offer a contrasting narrative of policy implementation and choices made by the states selected over time. The transcribed interviews and accompanying descriptive data show that a clear pattern has emerged in these states. Each state had a unique political, bureaucratic, interest group, and market environment. The interviews and analysis make an important contribution to state policy literature because the findings show that a variety of new factors such as the interaction between the capacity of the bureaucracy and interest group strength can assist in explaining policy choice.
Bureaucratic capacity was found to be relevant in several of the states. West Virginia’s low staffing levels in the Medicaid agency had an effect on policy, as evidenced by the reliance on private interests to assist in policy formulation and an increased reliance on those same interests to implement Medicaid policy through commercial managed care entities. In contrast, states with higher capacity used several contracting mechanisms to deliver services. North Carolina and California developed contracting models specific to markets and geographic areas for their respective Medicaid populations. While the capacity of an agency to fulfill its statutory duties is not the only factor in explaining policy outcomes, the evidence suggests that it is important in the context of a host of other factors.

Interests also play an important part in the contracting process, but this fact must also be placed in the larger context of their interaction with established institutional structures. As an example, California has a highly professionalized Medicaid agency staff and a highly professionalized legislature which forces interests to adapt to institutional capabilities. Interests dedicate significant resources to influencing and being politically responsive to lawmakers as a result of the developed expertise of the agency. They utilize a wide range of resources to achieve their influence, seek favorable policy preferences, such as hiring an army of lobbyists and creating a healthy Political Action Committee, and force the agency to respond to their needs. The dynamic nature of interaction between these forces is an important factor in explaining the interactions of organized interests with Medicaid contracting.
The findings presented here strongly suggest that the capabilities of the bureaucracy have a much larger effect on policymaking than previously thought. These findings also confirm the importance of interest groups in the policy process and interaction between vested interests with the bureaucracy. Importantly, the interviews also show the relevancy and importance of private health insurance markets and their relationship to Medicaid contracting decisions. The finding also collectively assists in the development of the quantitative models and the specification of the variables used in Chapter 3.
CHAPTER 3

A Political Model of Medicaid Contracting and Privatization Influences in the States

3.1 Introduction

States are increasingly relying upon managed care arrangements to serve the needs of an ever-expanding Medicaid population. As a result of the passage of the Patient Protection and Affordable Care Act of 2010 (PPACA), the trend is expected to accelerate (Kaiser, 2011). States now utilize many types of managed care arrangements that include for-profit, not-for-profit and hybrid managed care to serve the Medicaid population. As a result of the numerous options, there exists a diverse set of policy choices states make in contracting out Medicaid. As outlined in previous chapters, scholarship related to Medicaid and to state policy formulation and implementation has left several unanswered questions about why we have observed variation in the type of contracting choices made by states for Medicaid programs. As Medicaid contracting mechanisms have matured in a post-TANF environment, patterns have emerged in state contracting choices and the means that they have employed to deliver services to Medicaid beneficiaries. Questions about how and why states utilize certain types of contracting arrangements take on even more significance as a result of PPACA implementation; since by 2014 it is estimated that there will be an additional 16 million Medicaid enrollees or a nearly 40 percent increase in the Medicaid population (HHS, 2010; Kaiser, 2011).
In this chapter, evidence is presented about numerous political, market, and bureaucratic influences that help explain variation in state Medicaid contracting policy choices. These influences include specific interest group populations associated with Medicaid, the capacity of state Medicaid bureaucracy, the political composition of states, state spending and state health insurance markets. The importance of understanding the factors that influence Medicaid contracting decisions has taken on added significance in a post-PPACA implementation environment as states are now making decisions about how to deliver health care services to a whole new cadre of beneficiaries. In addition, Medicaid has become the single largest expenditure in state budgets and is expected to outpace spending on all other state programs after 2014 (NGA, 2010). The models and descriptive statistics contained in this chapter provide empirical evidence that help to explain state Medicaid contracting choices.

Examining the role of key policymakers in the states is essential to understanding the choices these actors make regarding Medicaid contracting. The choices that governors and state lawmakers (principals) and the bureaucracy (agents) make over time should yield policy preferences. Structural choice theory suggests that the actors will engage in rational decision making and thus one preference should emerge as a result. Moe (1984, 1989) argues that policy outcomes are a result of the interplay between these rational interests and the structure of bureaucratic agencies. Moe (1995) further argues that interests gain influence in a particular policy domain (i.e., Medicaid) and are able to pressure political principals to structure the bureaucracy (agents) to benefit the interest’s policy choices.
In the case of Medicaid contracting, one would expect to see one type of arrangement emerge that promotes a rational blend of cost containment, control of utilization of health care services, and efficient management. However, as the chart contained in Figure 3-1 shows, there is no convergence towards a dominant policy preference collectively by the states. Rather, there are many different options in use by states over time; with no one contracting mechanism dominating state Medicaid policy choices. Moe (1995) finds that political uncertainty and compromise do not always allow interests to structure the bureaucracy to achieve policy preferences that benefit their interests. A key question posited by this study is to explain what factors help to explain the choices that state Medicaid agencies are making over time and what role and importance political principals and agents play in making Medicaid contracting choices.

Figure 3-1

[Graph showing percent of Medicaid managed care enrollment from 1997 to 2007 for different types of Medicaid managed care: Commercial MCO, Medicaid-only MCO, PCCM, PIHP, PAHP. Source: Author created chart from Kaiser Family Foundation (2009) and CMS (2009).]
Since one would expect to see a contracting policy preference emerge among state Medicaid agencies, a key question is what explains the trends observed in Figure 3-1? Clearly, there are many factors at work in explaining the contracting mechanisms employed. I theorize that the roles of the principals and agents are perhaps being influenced by other forces and motivations suggesting a complex dynamic. Lane and Kivisto (2008) suggest in their examination of higher education bureaucracies that the role of bureaucratic structures and vested interests could be used to explain the complex dynamic in a policy process. Lane and Kivisto (2008) further argue that the role of the bureaucracy and the influence of outside interests assist in explaining policy implementation and administration. Hence, factors such as the role of the bureaucracy in policymaking, interest groups, politics, and institutional attributes become relevant when attempting to understand the dynamics of Medicaid policy choices because Lane and Kvisto (2008) found these factors to be important in studying education spending. The analogy is worth noting since education spending is a significant budget item. We would expect these factors to also be important for explaining Medicaid since it is also one of the most significant state budget items. The models that follow in this chapter show the importance of interest groups and the capacity of the bureaucracy in explaining Medicaid contracting choice variation.

3.2 Medicaid Managed Care Contracting Measurement

In order to discern what factors help to explain the specific Medicaid contracting policy choices made by states over time, it is useful to describe the contracting choices made by states in the last decade. While the phrase ‘contracting out’ may be familiar to
many, how states contract Medicaid may not be clear because of the multiple ways that are available. The graph in Figure 3-1 demonstrates the types of Medicaid managed care that the states use. These contracting choices typically revolve around the types of managed care arrangements and the use of for-profit health plans and not-for-profit plans (Smith & Moore, 2008; Kaiser, 2010).

States not only vary by utilizing a wide variety of contracting mechanisms, but also vary by the type and percentage of the contracting services employed (Kaiser, 2011). In particular, some states use for-profit commercial health plans more than other contracting mechanisms. Table 3-1 shows the percentage of each state’s Medicaid population that is served by all forms of managed care arrangements. States can also use different types of managed care arrangements beyond commercial for-profit firms, including nonprofit Medicaid-only managed care and a variety of hybrid arrangements as outlined in Chapter 1.

Table 3.2 shows the percentage of for-profit managed care arrangements used by states in 2007. The two tables presented below, while appearing to be similar, in fact are quite distinct; each show the variation in the use of managed care by both type and use of for-profit managed care arrangements. For-profit arrangements are of particular interest since a principal rationale by state Medicaid systems is that these types of arrangements promote efficiency and assist in controlling health care utilization (Duggan, 2004; Smith and Moore, 2008). Given that for-profit MCOs are expected to yield efficiency and cost savings, why is there variation among state Medicaid agencies in their use of for-profit contracting? That question is the main focus of this study.
<table>
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Table 3.2. Medicaid Commercial For-profit Managed Care Organization (MCO) Contracting Percentage (2007)

<table>
<thead>
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<th>State</th>
<th>Percentage</th>
<th>State</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
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<td>Missouri</td>
<td>12</td>
<td>Wyoming</td>
<td>0</td>
</tr>
</tbody>
</table>


While the types of contracting arrangements may appear to be nuanced, they are different in their financial and operational attributes (Kaiser, 2010). States have created specific Medicaid-only nonprofit health plans and only allow those entities to serve beneficiaries; as contrasted with states that allow commercial for-profit firms to deliver Medicaid benefits. Obviously, for-profit firms have a different motive than non-profit firms, and, thus, this difference is an important construct of the two distinct dependent variables used in the models contained herein. The distinctions in the use of managed
care arrangement are worth exploring as states are increasingly turning to managed care to serve the Medicaid population. In a recent *Health Affairs* publication, Iglehart (2011) suggests that the use of managed care by state Medicaid systems is likely to increase as a result of PPACA. As a result of this trend, I suggest that understating the influences associated with the policy choice and variation of each Medicaid contracting type has taken on added importance as states begin to implement one of the central policy initiatives of PPACA and thus the potential impact these policy choices will have on an estimated 16 million new Medicaid beneficiaries.

### 3.3 Interest Groups and Medicaid: Theory and measurement

The role of business interest groups in the state policy process can be seen in many forms of influence. Business interests clearly have the financial motive to shape and participate in state Medicaid programs. Various scholars demonstrate that business interests in the states are the most numerous and the most powerful in state capitals. Importantly, once they are motivated, they mobilize and shape policy to their benefit (Lindblom, 1977; Morehouse, 1981; Hrebenar, 1993; Klarner, 1999). Because of this connection, I theorize that the role of interests play a specific and tangible role in explaining the contracting choices made by state Medicaid programs.

However, other scholars suggest that business interests seeking favorable policy outcomes from government are but one of a number of vested groups competing for the attention of elected and appointed officials (Wilson, 1982; Vogel, 1987; Herber, 1988). Additionally, they argue that business interests give policy makers valuable information, expertise and insight that assist in shaping policy. So, given the divergent views between
a business-dominated interest group model and a more pluralistic collaboration model, which one is relevant to understanding how and if private business interests shape state Medicaid privatization choices in the states? I argue that the answer to this question lies in the examination of specific interest group communities and how those communities are related to Medicaid contracting variation in the states.

This study extends the basic categorical variables used by Morehouse (1981) in her study of state interest groups by suggesting that when specific concentrations of interests are present, policy outputs vary depending upon the state policy choice. Morehouse (1981, 107-112) uses a categorical range of 1 (weak), 2 (moderate) to 3 (strong) to express the relative strength of interest group environments in a state. Her measure was based upon a general assessment of the effectiveness of business groups in a state with those deemed to be more influential in pressing policy preferences. In addition, while providing a useful typology, the measurements were based generally on the business groups (i.e., state Farm Bureaus and manufacturing concerns) and do not translate well to understanding the complex dynamic of state specific health care lobbies that have changed dramatically in the last three decades. While Morehouse (1981) establishes a theoretical frame around the issue of interest group strength, the range of the categorical variable can, arguably, be of limited utility in answering questions specific to policy areas such as state Medicaid programs.

Building on the work by Morehouse (1981), Gray and Lowery (1996) find there is a great deal of variation and diversity in state interest group systems. Their research suggests that there are specific ecologies or groupings of interest communities that help
to explain influence over state policy choices. This scholarship argues that interest groups function within systems of influence and use analogies from biological science to describe a system that operates in a distinct environment and groups together in pursuit of common goals (Gray and Lowery, 1996; 1999). Gray and Lowery (1999) also suggest that state interest groups should be examined in specific time and place and that interests in concentrated numbers can and will sway the actions of elected and appointed officials. This study extends this theory by examining specific concentrations of vested Medicaid interests over a specific time series, thus operationalizing the suggested examination by Gray and Lowery (1999, 2001).

Equally as important, other scholars suggest that large numbers of business groups have an undue influence on policy outcomes (Schattschneider, 1960; Scholzman and Tierney, 1986). Miller (2008) also finds that a strong link exists between federalism and state-based pluralism in her study of state crime policy. Given that Medicaid is a federal-state program, Miller’s (2008) work suggests a similar pluralistic system is at work with state Medicaid systems. Related scholarship from Barrilleaux and Miller (1988) finds that having a diverse interest group system in a state influences policymaking related to Medicaid decisions. More recently, Klarner, Mao, and Buchanan (2007) find that business interest group power is positively related to the state generosity of benefits under TANF, a program that is closely associated with Medicaid. The above works demonstrate that business interests exert influence over specific policy outcomes and are, thus, relevant to the questions posed in this study.
Extending previous scholarship, Gray, Lowery, and Godwin (2004) measure groupings or guilds of interest group communities that could potentially explain the variation in Medicaid contracting. Guilds are generally defined as similar organizations or firms dedicated to similar tasks, such as delivery of pharmacy benefits, as is the case in research conducted by Gray, Lowery, and Godwin (2004). Specially, they find that concentrations of state health lobby guilds lead to increased spending on state Medicaid pharmacy benefits. One trait in particular that Gray, Lowery, and Godwin (2004) suggest as an important factor in policy outcomes is the specific density or concentration of interest groups\textsuperscript{21}.

This study uses their concept of interest group density to test the hypothesis that states with large and specific concentrations of health plan lobbyists will be more likely to utilize private, for-profit organizations to deliver Medicaid benefits. As an extension of this body of literature, Randall and Johnson (2008) find that when there are specific concentrations of interests around specific concentrations of market forces, states utilize higher levels of commercial, for-profit managed care arrangements to serve the Medicaid population.

Various researchers have found that interest groups have a powerful impact on establishing state policy outcomes and spending priorities. The actual make-up, strength, and diversity of the interest group “ecology” in a state in part explains what expenditure

\textsuperscript{21} The concept of interest group density was initially described in Gray and Lowery (2001) and shows how interest group guilds differ in the states based upon broad classifications of registered lobbyists.
areas the state favors and what policies it enacts (Gray and Lowery, 1999; Heinz et al., 1993; Jacoby and Schneider, 2001; Nice, 1984; Tandberg, 2006, 2009). Other scholarship confirms the importance that interest groups have on state spending priorities and their impact on policy preferences (Nice, 1984; Heinz, et al., 1993). Recent literature stresses that interest groups are most successful when there are relatively few of them within the state, when the groups are concentrated in particular substantive policy venue, and when the active interests possess economic power (Browne, 1990; Cigler, 1991; Gray and Lowery, 2001). The scholarship on state interest groups clearly makes an important observation that when vested interests wish to sway policy choices they clearly can and do.

As a specific example applicable to Medicaid, higher education within the states has been legitimately considered to be a type of interest group (Thomas and Hrebenar, 2004). In fact, Thomas and Hrebenar (2004) find that state higher education lobbying is acquiring greater influence within the states. Most universities, acting as a type of interest group, have either an in-house lobbyist or an outside contract lobbyist, and all public institutions engage in some form of lobbying (Tandberg, 2006). Many large public universities have an office of government affairs that lobbies at the state and federal level. At the state level, one of its primary purposes is to lobby for more state funding and to work strategically in the institution’s interest (Tandberg, 2006). Even if the institution does not have an office or individual responsible for lobbying, as is the case for some smaller institutions, presidents frequently assume that role, as do others within the institution, including students. Tandberg (2009) developed a fiscal policy framework for
understanding state appropriations for higher education, and I argue that this research can be used as an extension to understanding the interest group environment associated with Medicaid. Just like higher education lobbying, there exists a diverse and large interest group population associated with Medicaid, and, thus, Tandberg’s findings are extended to this research.

3.3.1 Interest Group measurement and Medicaid

The measurement of specific concentrations of interest groups is achieved through examining the number of legislative agents employed by firms and organizations directly interested in Medicaid policy outcomes. This measure includes hospitals, physician groups, health plans (insurers) and advocacy groups. All 50 states were surveyed to include specific counts of lobbyists employed by firms and organizations over the 1997 to 2007 time period.

I measure interest groups by counting the number of legislative agents registered to advocate on behalf of clients or organizations with a specific interest in Medicaid. My measure improves on the work by other scholars (i.e., Morehouse, 1981; Gray and Lowery, 1996, 1999, 2001; Gray and colleagues, 2004) by examining specific concentrations and counts of interests who are specifically interested and vested in the outcome of Medicaid policy choices. Due to the fact that Medicaid is a large program, an array of health care providers and insurers have a vested interest in program spending and reimbursement rates, which are implemented through different contracting mechanisms (Smith and Moore, 2008). The data for the range of health care interests associated with
Medicaid were obtained from a variety of sources, including the Center for Public Integrity, which maintains a state database of registered legislative agents, as well as individual state websites that have lobbyist registration arranged by categories. In addition, individual state level data were collected by phone in those states where data were available from public sources.

Benz and colleagues (2008) supplied data from the 1996 to 2006 election cycles that track health care Political Action Committee (PAC) expenditures in the states, which were used as a measure of political spending by interests associated with state Medicaid spending. This measure was coded as a categorical variable with states that have a high political giving as 4, states with moderately high PAC spending as 3, and states in the middle to low range of political giving coded as 2 and states in the lowest range coded as 1.²² In this study, I expect to find a significant and positive relationship between Medicaid types of contracting, including for-profit managed care and all forms of managed care, and the interest group populations associated with the Medicaid program. In addition, I expect to find a significant and positive relationship between political giving and the contracting choices that states make. Finally, I expect to show a positive relationship between

²² The data supplied from Benz had missing values and years. The ordinal measure is a best fit based upon the data supplied and, thus, a general representation of political contributions by interests associated with the Medicaid program. The coding of the created categorical value was based upon supplied data and extrapolated for the years 1997-2007. As an example, when only 1998 and 2004 data were available, 1998 coded data was used for years 1998-2003 and 2004 data was used for 2004-2007. In addition, the health related PAC contributions were standardized to reflect contributions per lawmaker in each state. Appendix E contains the distribution of values among the states and the cut-off values used for categorical variables, including the mean and median statistics used to justify the categorical variable designations.
relationship between concentrations of interest groups, higher relative levels of political giving and increased use of for-profit Medicaid managed care organizations.

3.4 The Role of the Bureaucracy: Theory and Measurement

The role of the bureaucracy in the policy process has become more important to the study of policymaking. Recent scholars have argued that administrative agencies in both formal and informal policymaking are relevant, in contrast to early works by Wilson (1887) and Goodnow (1900) that viewed the bureaucracy as a neutral and even subservient player in the affairs of government. More recent works by Moe (1989), Anderson (1997), Meier (1993), and Hill (1992) have portrayed the bureaucracy as active participants in the policy process and as an important component in a pluralist democracy. In order to understand the role of the bureaucracy in the policy process, it is useful to examine the role and sources of bureaucratic power and how this role relates to state Medicaid bureaucracies.

Various studies suggest that the issue of state administrative capacity has become vital for a variety of reasons including the devolution of policymaking responsibility to the states and increased state authority (Elling, 1999; Bowling and Wright, 1998). For all of the reasons stated above, bureaucratic capacity in state Medicaid agencies and the relationship between bureaucratic capacity and state contracting choices is considered here. The size of state governments and, hence, the bureaucracy, has also increased in recent decades; in many cases doubling and even tripling in both size and scope (Elling, 1999; US Census Bureau, 2009). Even with many states facing fiscal pressures in recent years, the size of state administrative agencies, including Medicaid bureaucracies,
continue to grow as a result of the new authority and responsibility given by the federal
government. Thus, due to this growth, the capacity of state governments to implement,
innovate and administer complex programs has taken on added significance.

The functional specialization that occurs in a bureaucracy is especially conducive
to policy implementation (Rose, 1993). Agency heads are likely to be much more
interested in the activities of their counterparts in neighboring states than in the activities
of other functional areas within their own state (Sharkansky, 1970). This relationship is
partly based on physical proximity but is also related to an attitude on the part of these
administrators. Thus, those working close by are likely to have similar problems and
circumstances. State agencies become an important part of policy communities that
actively and regularly exchange information about policy ideas (Klase, 2005). This policy
specialization is one of the major components of bureaucratic power in the policymaking
process (Meier, 1993). The acquisition of bureaucratic power is one of the reasons the
bureaucracy can be an active policymaking actor.

Bureaucratic capacity is generally defined as the resources, staffing, expertise,
and power that a bureaucratic agency possesses to implement public policy directives
(Bowman and Kearney, 1988; Huber and McCarthy, 2004). Meier (1993) suggests that
there are five distinct primary sources of bureaucratic power, including personnel and the
special knowledge that the employees in an agency possess. The role of agency staffing
is a measurable and easily quantifiable attribute of the capacity of the bureaucracy. The
other attributes that Meier (1993) suggests as sources of power (perceptions of power,
public support, expertise and leadership) are not easily quantifiable and thus addressed in
the interviews in Chapter 2. In this chapter, I quantify the capacity of the bureaucracy using standardized personnel data from all 50 states from 1997 to 2007.

3.4.1 State Agencies and Resource Availability

Much of the implementation of public programs, such as Medicaid, is performed by state administrative agencies. These agencies control a large portion of public funds either through direct appropriation from state legislatures or as the recipient of federal grants. In some cases, the state agencies directly deliver program activities, and in others, they allocate monies to local agencies to do so. State agencies also generally set out specific program guidelines including rules and performance standards and provide oversight. This point is especially the case in the current era of devolution when many federal programs give broad latitude to state agencies to determine program implementation strategies. Thus, the administrative capacity of a particular state agency should be related to its ability to implement public policy and programs. Moreover, those states that have high levels of administrative capacity should be more capable of developing and implementing programs that are new to their state.

Bureaucratic capacity is the capability of the bureaucracy to perform the tasks required by law (Bowman and Kearney, 1988). However, the notion of bureaucratic capacity extends beyond the basic functions prescribed by statute to include factors such as expertise, educational capability of the agency staff, and overall staffing levels. Huber and McCarthy (2004) extend the definition of bureaucratic capacity by giving us a typology of low versus high. When ‘low’ bureaucratic capacity exists, the political state
tends to diminish the incentives for bureaucrats to comply with legislative edicts, and thus they become even more inefficient. Bureaucracies that have low capacity or expertise are not only inefficient, but they are also harder for elected officials to control because general competence among the staff decreases and thus implementation of policies becomes more difficult (Huber and McCarthy, 2004, 481).

Various works suggest that successful implementation and program administration is specifically tied to agency staffing numbers and staff expertise (Morris and Travis, 2003; Mead, 2004; Hall, 2007). In an example with direct application to this study, Mead (2004) finds that state welfare agencies are more likely to have a successful implementation of the state TANF program if the agency is adequately staffed, possessed significant expertise, and coordinated their activity with key state lawmakers and other relevant state executive agencies. These works suggest that staffing numbers, expertise, and professionalism are key attributes that define bureaucratic capacity in state agencies. Thus, the number of agency staff and their professional expertise are important implementation factors that this study uses in defining bureaucratic capacity in state Medicaid agencies.

Numerous studies have attempted to develop various measures of state administrative capacity (Barrilleaux, Feiock and Crew, 1992; Bowman and Kearney, 1988; Grady, 1999; Sigelman, 1976). For the most part, these studies use readily available proxy measures such as percentage of employees under a merit system, educational level of employees, etc. Recent studies have developed more direct measures of administrative capacity such as the Government Performance Project (2008) and work
by Brudney and colleagues (1999). The Government Performance Project (2008) rates all 50 states on five specific measures: capital management, financial management, human resources, information technology, and managing for results. The measure assigns ‘grades’ to the states based upon the five measures that are arguably subjective. Given its components, this measure focuses on management aspects of state agencies and is compiled on a comparative basis: one state in comparison to other states. Brudney and colleagues (1999) used survey data to determine if 11 particular government reinvention techniques had been implemented in various state agencies (Klase, 2005).

These measures are, however, somewhat problematic. Unlike various measures of legislative professionalism these two measures of administrative capacity have a low correlation, which brings into question whether the measures are tapping the same latent variable (Brudney et al., 1999, Klase, 2005). For this study, a new measure of capability is used to measure administrative capacity. It is expected that as bureaucratic capacity increases, agencies will rely less on the expertise and contracting capability of private interests to service Medicaid beneficiaries. The bureaucratic capacity measure, which is fully described below, is standardized across a range of quantifiable components including overall agency staffing levels and specific staffing levels associated with Medicaid contracting offices.

### 3.4.2 Measurement of Bureaucratic Capacity

The measurement of bureaucratic capacity is constructed using employment within state Medicaid agencies and staffing levels in state Medicaid contracting offices.
As indicated in Appendix C, information on the staffing for Medicaid contracting offices was collected from a variety of sources and reflects expertise, staff directly responsible for program contract implementation, and overall state staffing within state Medicaid agencies. Due to data limitations, the number of contracting staff within state Medicaid agencies was collected in two-year increments that reflect the majority of states’ appropriation and budgeting cycles. As an example, in California, there are over 60 staff members responsible for contracting oversight and procurement for the 23 health plans under contract with the state agency. In contrast to other measures of state agency capability (i.e., Government Performance Project), the measure constructed for this study is specific to Medicaid agencies and standardized to reflect the attributes associated with implementing Medicaid based upon the populations served and hence unique.

Consistent with the definitions of bureaucratic capacity used by Bowman and Kearney (1988) and Huber and McCarthy (2004), staffing levels in state Medicaid agencies is used as my measure of bureaucratic capacity that reflects the capability and quantifiable expertise associated with implementing and administering the program. State and agency specific staffing levels over time were gathered from the U.S. Census Bureau, National Governors Association and the State Medicaid Officers Association based in Washington, DC. The state personnel data were used to construct a measure of

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23 Data collection for specific staffing arrangements was obtained from individual state websites, the National Governors Association, and the State Medicaid Officers Association based in Washington, DC. In addition, calls to individual states and Medicaid agencies were made from May 2009 to August 2009 to gather data not available from the aforementioned associations.
bureaucratic capacity measure or BCM. The staffing levels are standardized based upon the relationship between a state’s overall population and Medicaid population. In addition, other measures related to the expertise of the bureaucracy were also collected that included specific numbers of Medicaid agency staff dedicated to all forms of managed care contracting.

The Bureaucratic Capacity Measure is constructed using Medicaid state agency staffing levels and the population of Medicaid beneficiaries served in a given year. This ratio is standardized against the mean value for the year. As an example, California has a BCM value of 175.8, which finds that the state is 75.8% higher than the average state for 2007. Values below 100 indicate that the state is less than the average for a given year. As a test of validity of the measure, a correlation of the BCM and all variables used in the model was performed (Appendix E). The data provide confirmation of the measure since state spending per capita is highly correlated with the BCM (.43). Meier (1993) suggests that staffing levels and hence state spending are indicative of highly capable state bureaucracies.

While the term ‘bureaucratic capacity’ can be widely construed and defined by attributes such as political power, staffing expertise and autonomy, and perceptions of power and authority, many of these metrics are not quantifiable. Various scholars (Bowman and Kearney, 1988; Meier, 1993; Huber and McCarthy, 2004; Kelleher and Yackee, 2010) find bureaucratic capacity as difficult to measure because of the many subjective and perceptions associated with the exercise of political power. As a recent example, Kelleher and Yackee (2010) assign categorical values (grades) in their
modeling of a scale of overall influence of organized interests on state agency decision making. I argue that a quantifiable measure such as standardized staffing levels in relationship to the population served is a better measure suited to robust statistical analysis.

Various measurements have attempted to use quantitative models to test the performance, capability and capacity of state agencies (Brundey, et. al., 1999; Government Performance Project, 2008; Kelleher and Yackee, 2010). More recent measures utilize a categorical measure of state agency capacity and more importantly do not address specific agencies or relate agency function to the population served (Government Performance Project, 2008; Kelleher and Yackee, 2010). The Government Performance Project (2008) acknowledges the limitations of their grading scheme (A-F) and is an assessment of quality and the perceptions of policy players in the states, including state lawmakers, state-level managers, and opinion leaders. In addition, the survey grades are not specific to any state agency department. This study provides a quantifiable variable that standardizes a measure of staffing which also varies as a result of changes in population being served. Finally, most of the measures of bureaucratic capacity suggested by Meier (1993) are subjective and perceptive in nature and hence the BCM provided herein is measureable in a more precise manner than a grading scale and thus best suited to statistical modeling techniques.

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24 As a test of the Bureaucratic Capacity Measure validity, a correlation between the BCM and Government Performance Project grading scale was conducted and showed that the BCM positively correlated with this measure at .5192 and is statistically significant.
As Table 3.3 shows, higher values are associated with higher levels of bureaucratic capacity and expertise to implement Medicaid contracting programs. I expect to find a negative relationship between higher bureaucratic capacity levels and amount of privatization in the states as expressed by higher percentages of contracting out and the use of commercial, for-profit managed care arrangements. Thus, I expect to find more bureaucratic capacity yields to less reliance on contracting out and specifically less use of for-profit managed care arrangements. Table 3.3 shows 2007 values of the BCM for all 50 states.
Table 3.3. Bureaucratic Capacity Measure, Standardized Values, as a Percentage Relationship to state Medicaid Agency Employment and total Medicaid Population (2007)

<table>
<thead>
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<th>State</th>
<th>Percentage</th>
<th>State</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
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<td>New York</td>
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<td>Texas</td>
<td>58.8</td>
</tr>
<tr>
<td>Maine</td>
<td>97.1</td>
<td>Utah</td>
<td>97.5</td>
</tr>
<tr>
<td>Maryland</td>
<td>54.5</td>
<td>Vermont</td>
<td>122.3</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>80.2</td>
<td>Virginia</td>
<td>58.4</td>
</tr>
<tr>
<td>Michigan</td>
<td>45.9</td>
<td>Washington</td>
<td>158.9</td>
</tr>
<tr>
<td>Minnesota</td>
<td>73.2</td>
<td>West Virginia</td>
<td>92.4</td>
</tr>
<tr>
<td>Mississippi</td>
<td>87.7</td>
<td>Wisconsin</td>
<td>52.2</td>
</tr>
<tr>
<td>Missouri</td>
<td>49.5</td>
<td>Wyoming</td>
<td>231.3</td>
</tr>
</tbody>
</table>

*Note: Source, US Census Bureau, State Government Employment and Kaiser Family Foundation, Centers for Medicare and Medicaid Services (CMS) for state Medicaid population data.*

Data were restricted to a 1997 to 2007 time-frame because a major policy shift occurred in the states with the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, which significantly modified the
nature of welfare programs in the states, including Medicaid. This new Act transformed Medicaid from being a federal entitlement program to awarding block grants to states. It further limited families to five years on the rolls and stiffened work requirements, among other changes. At the same time, it gave states unprecedented authority to determine their welfare policy. States had always controlled benefit levels, but now they could also set many details of eligibility, institute work incentives, and force other requirements on the recipients (Johnson, et al. 2004; Mead, 2004). Johnson and colleagues (2004) find that state administrative capacity changed as a result of the increased authority and responsibility given to the states and importantly find a great deal of variation in the implementation of TANF. This shift in state authority and responsibility in 1997 is why I chose to begin the data analysis at this point in time.

Various works suggest that with the introduction of TANF, states began to experiment with means of controlling costs and attempts to reduce the number of beneficiaries (Schneider, 1997; Smith and Moore, 2008). Somewhat contrary to the policy direction associated with the welfare reform provisions associated with TANF, states expanded Medicaid eligibility with programs such as the State Children’s Health Insurance Program. These collective policy shifts provide additional rationale for using a 1997 to 2007 time period because these shifts in responsibility from the federal government to the states forced the states to innovate.

25 It is important to note that in 1996 many states rushed to submit welfare waiver requests before the passage of PRWORA, which eliminated the AFDC program and replaced it with the Temporary Assistance to Needy Families (TANF) program (Greenberg, 1996).
3.5 Politics and Institutional Factors

The composition and control of state political institutions such as the governor and state legislatures are an important factor in explaining state policy choices (Beyle, 1996; Squire, 1992; Squire and Hamm, 2005). Governors have been found to exert influence on state spending and policy choices as a result of the powers and authority they have under state constitutions and can often serve as a check on legislative spending priorities (Bails and Tieslau, 2000). Equally as important, political control of state institutions has also been found to contribute to the understanding of state policy choice and is utilized in the models that follow (Barrilleaux and Berkman 2003; Plotnick and Winters 1985). The dual role of politics and institutions is considered in the context of how they assist in explaining state Medicaid variation and contracting choices.

The role of the governor in state policy making has been found to greatly vary based upon the power given to them by state constitutions and how that power is exercised across policy types. Numerous scholars have found that the governor is a significant policy player in explaining state policy choices (Barrilleaux and Berkman, 2003; Beyle, 1996). Governors vary in the amount of institutional power they have over the political and policy processes of their states, including the budgetary process (Beyle, 1996). As an example, Barrilleaux and Berkman (2003) developed a budget powers index in order to measure the relative power of the governor over the state budgetary process versus the legislature. Given the powers associated with state governors and their role in making budgetary decisions, the relative strength of the governor’s powers is an important variable to use in explaining Medicaid policy choices. I use Beyle’s (1996,
2008) index of gubernatorial strength in the models as a variable since this index provides a composite score based upon numerous factors including gubernatorial powers related to spending, appointment of state officials, and powers granted to governors under their state constitutions.

Higher Beyle index scores are associated with ‘strong’ governors and lower scores are associated with ‘weak’ governors. The index is constructed on a scale of 0 to 5 for each component and a composite score is produced based upon the factors described above. As an example, governors with strong appointment powers would have a score of 4 of 5 for the appointments power component. The range of composite index scores used in the models is from 2.7 to 4.1. Further, I suggest that when we observe ‘strong’ governors there is greater likelihood of state Medicaid agencies contracting out services and specifically utilizing for-profit managed care organizations.

Governors with greater budgetary powers tend to limit funding for major state expenditures and often serve as a check against legislative spending (Bails and Tieslau, 2000; Dearden and Husted, 1993). Governors may also divert funds away from one spending area and toward other policy areas. Hendrick and Garand (1991) found that governors with greater powers were more willing to engage in expenditure tradeoffs between programmatic areas of state budgets. The importance of state spending choices is thus a necessary consideration especially since Medicaid has become the largest appropriation states make in budget cycles and is expected to grow dramatically in the coming decade (Kaiser, 2010). Thus, I include a standardized per capita measure of state Medicaid and education spending since these two items are the largest items state
governors deal with in a budget cycle. I would expect to see a negative relationship
between states that choose to spend more per capita on Medicaid versus education
spending because of the tradeoff concept described above.

Equally as important as institutions of state government, legislative bodies play
relevant roles in the policy process. A useful dynamic in understanding state legislatures
is between the capabilities and professional abilities of state lawmakers and their staffs.
Legislative professionalism is generally defined as the extent to which state legislatures
embody the attributes of the U.S. Congress such as high staffing levels, annual
compensation, and time in session (Squire, 1992). Fiorina (1994) found that Democrat-
controlled legislatures were much more likely to be more professional and other studies
have found that professionalism is associated with greater policy innovation (Squire and
Hamm, 2005; Rosenthal, 1990) and increased spending in general (Squire and Hamm,
2005). Also of interest is if term limit restrictions on state lawmakers affect policy
choices and specifically Medicaid policy choices. Kouser (2005) suggests in his text that
term limits are an important factor and states that have enacted limits tend to spend less
and also cede greater authority to the governor and agencies, such as Medicaid. Thus, I
use a dichotomous variable if term limits are present in a state to determine if they
influence Medicaid contracting choices. This measure is coded a ‘0’ if a state does not
have term limit restrictions and ‘1’ if term limits are present in a state.

Legislative professionalism is used in the models to determine if any relationship
exists between the capabilities of state lawmakers and Medicaid contracting choices.
Squire’s (1992; 2008) measure is used since it accurately reflects the capabilities of state
lawmakers by taking into account legislative staffing, salary, and expertise. The numbers expressed by the measure are a composite index of these factors and reflective of the variation in state lawmaker’s capability.

The Squire index is a composite score that relates state legislative attributes to the Congress. As an example, California has dedicated staff, full time state lawmakers, specialized committee staff and extensive expertise. This results in California having the highest score of .626 meaning that the state is most similar to how the Congress functions (Squire, 2008). The range of values associated with the Squire Index is from .027 to .626. I expect to find that more professional legislatures will place a greater value on the use of contracting out Medicaid services since past studies that have examined state policy choices have found that more professional legislatures tend to appropriate more (Barrilleaux and Berkman, 2003).

Another question posed by this study is whether political control of the governor or legislative bodies helps to explain the observed variation in Medicaid contracting choices. Various studies have shown that a relationship exists between party strength in governmental institutions and the policy choices of the state. For instance, market-oriented policies have been associated with Republicans, and greater spending on education has been associated with Democrats (McLendon et al., 2006). Most recently, McLendon and colleagues (2009) and Tandberg (2009) found that a Democratic governor was positively associated with appropriations per $1,000 personal income. Different spending priorities have been associated with shifts in partisan control of the state legislature (Alt and Lowry, 1994; Garand, 1985).
Political control of state institutions is used in the models with specific emphasis on the party affiliation of the governor’s office, and if this factor helps to explain Medicaid variation and contracting choices. In this study, a dummy variable is constructed with Democratic governors coded as ‘0’ and Republican governors coded as ‘1’. Given past research about how governor party affiliation explains spending preferences, I would expect to find that higher levels of Medicaid managed care contracting and the use of for-profit MCOs would be associated with GOP governors.

Equally important in understating how political control affects state policy choices is whether a state has a competitive political environment. Electoral competition is a measure of how competitive elections are for public office within states. When state contests are highly competitive, political leaders will vie for support by catering to interests that assist them in gathering political support (Barrilleaux and Berkman, 2003; Plotnick and Winters, 1985). Plotnick and Winters (1985). Thus, I use a measure of unified political control in the states to test if one party’s domination of the governor’s office or legislature affects Medicaid contracting choices. A dummy variable is used where lack of unified political control is coded as ‘0’ and unified political control is coded as ‘1’. I expect to find that if a state has unified political control that they are more likely to contract out Medicaid services since one party domination of state institutions would suggest removal of roadblocks toward policy choices associated with vested interests.
3.6 The Role of Private Insurance Markets and Demographics

Private health insurance markets have increasingly played a role in state Medicaid policy and are expected to play an even greater role in the next decade (Iglehart, 2011; Smith and Moore, 2008; Duggan, 2004). The use of private firms to deliver services is not a new concept to government, but has increased since World War II as government has become more complex with the provision of a wider array of benefits and services (Kettl, 1993). As a result, state governments have made the choice to increase their contracting of state Medicaid as beneficiary populations have swelled and the service needs increased (Smith and Moore, 2008). As a central theme of this study, I suggest that private health insurance market characteristics help to explain the policy choices that states have made over time.

In his monograph *Sharing Power*, Donald Kettl (1993) argues that there are multiple reasons and underlying rationales for why governments at all levels privatize services. Kettl presents several case studies from the problem of prairie dogs at the Department of Energy’s Rocky Flats facility to how local governments contract out almost every conceivable service. One general observation he finds is that a strong private market alternative is present before the contracting choice is made. In short, there exists a symbiotic relationship between private firms and government choices to use their service.

Government and private organizations can become dependent upon one another, as Evans (1997) found in his review of market-based health care reform, as institutional structures lead to more privatization when the capabilities of government diminish and
services are outsourced. Evans (1997) raises a question in his work about the role of private firms in health care and if government is capable of oversight and administration of the private contracts associated with health care delivery. Kettl (1993, 157-158) suggests a potential answer to Evans’ (1997) question about the role of institutional structures by giving an analogy to cities with populations over 5,000 that employ only a clerk and an administrator to oversee all private contracts, indicating governments can contract out virtually all services that were once directly provided by the government and government employees. As issues of management capacity and agency expertise diminish, theoretically, state Medicaid programs will become nothing more than the contract administration offices that Kettl (1993) describes.

Further, there is potential for a dramatic increase both in the use of privatization tools for health care services, rehabilitation, and other social services, as well as in the limitations inherent in the management deficiencies in state government (Auger, 1999, 438). Collectively, these works (Kettl, 1993; Evans, 1997 and Auger, 1999) raise questions about the ability of state agencies to effectively administer, oversee and manage the complex programmatic requirements associated with Medicaid and the current drive to add more beneficiaries to the Medicaid rolls (Iglehart, 2011). This study will demonstrate if higher levels of managed care use are associated with diminished bureaucratic capacity and many other factors associated with the role that private markets play in these decisions.

More recently, Duggan’s (2004) case study of California Medicaid privatization over a multiple year time frame examines the use of private, for-profit managed care
arrangements by the state. Contrary to the rationale used by state policymakers (and in academic works), California’s reliance on the state’s managed care entities actually increased Medicaid per capita spending over time (Duggan, 2004, 2570). Duggan’s case study prompts several questions about how the state’s heavy reliance on private firms to manage Medicaid spending resulted in increased costs to the state. While Duggan (2004) does not directly address the causes of spending, he suggests that additional factors such as interest groups, political composition, state spending, managed care market demographics, and the role of the bureaucracy in shaping the contracting process might explain the policy contradiction. This study is partially motivated by Duggan’s work and his suggestion that ‘other factors’ are at play and can explain why states are increasingly relying on private firms to deliver Medicaid services.

The use of private organizations for Medicaid services is best defined as a choice between directly reimbursing providers (hospitals, physicians, and ancillary providers) and contracting the services of providers through licensed managed care organizations (MCOs, which include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or Insurers). The choices that states make between reimbursing providers directly or contracting out the services to MCOs is a result of policy choices that state officials make to improve efficiency, reduce costs, and provide quality care to Medicaid beneficiaries (Smith and Lipsky, 1993; Duggan, 2004).

The privatization of health care services can take a variety of forms; as evidenced by the diversity of contracting arrangements that states have recently employed. Various scholars have outlined the types and forms of state privatization of public health care
programs, and this research is relevant to the reasons behind the variations found in Medicaid programs (Halverson et al., 1998; Duggan, 2004; Smith and Moore, 2008). States can choose to: a) directly provide health care to beneficiaries through state-owned public hospitals; b) contract directly with providers; c) contract with not-for-profit organizations; or d) contract with for-profit managed care organizations. Each of these choices can be classified in terms of their efficiency and cost savings (Duggan, 2004; Halverson et al., 1998).

As a result of the scholarship outlined above, I suggest that composition of state health insurance markets helps to explain the variation in Medicaid contracting choices. I utilize measures suggested by both Kettl (1993) and Duggan (2004) as variables in the models that capture the market and demographic characteristics outlined above. These measures include private market characteristics such as HMO penetration rates in a state over time, private health insurance percentages in each state and unemployment rates.

HMO penetration rates are the percentage of a state’s population enrolled in managed care arrangements and the percentage of the private insurance markets represents the portion of the state’s population that receives health care coverage from a licensed state insurance entity (i.e., not from a government source such as Medicare, Medicaid, or the Veteran’s Administration). The range of values observed for the period 1997 to 2007 are from 0 to 59.5 percent of a state’s population enrolled in licensed HMOs. The private health insurance percentage represents the portion of an entire state population that is covered by private (non-government) sources of health insurance coverage. The range observed from 1997 to 2007 in all states is from a low of 47.9
percent to a high of 75.3 percent. I theorize that states that have higher levels of Medicaid managed care use (all types and for-profit) that there is a positive relationship to HMO penetration rates and private health insurance coverage.

Consistent with past scholarship, I also include measure of state spending, education spending and Medicaid spending per capita. Tandberg (2009) found that there exists a tradeoff between education spending and Medicaid and Kousser (2002) found that discretionary Medicaid spending was negatively associated with education spending in the states. The per capita measures are used in the models to test if there higher levels of managed care are associated with these measures of per capita spending. Unemployment rates have also been found to be related to Medicaid policy choices and spending (Schneider, 1997; Grogan, 1994) and I expect to find that higher levels of managed care use in the state positively associated with higher unemployment levels. Finally, I expect to find a negative relationship between higher use of Medicaid contracting which would be consistent with past research that demonstrates that state policy makers make spending tradeoffs to favor their policy priorities.

Table 3.4 contains the descriptive statistics for the independent variables described above and used in the models presented and specified below.
Table 3.4. Descriptive Statistics for Independent Variables (1997-2007)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range Min</th>
<th>Range Max</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Variables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial Medicaid MCOs*</td>
<td>0</td>
<td>61</td>
<td>14.50</td>
<td>19.21</td>
</tr>
<tr>
<td>All Medicaid MCOs*</td>
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<td>100</td>
<td>69.95</td>
<td>20.33</td>
</tr>
<tr>
<td><strong>Interest Group Measures</strong></td>
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<tr>
<td>Medicaid Interest Group Pop.</td>
<td>2</td>
<td>88</td>
<td>21.00</td>
<td>17.20</td>
</tr>
<tr>
<td>Health PAC Strength</td>
<td>1</td>
<td>4</td>
<td>2.3</td>
<td>.98</td>
</tr>
<tr>
<td><strong>Institutions and Capacity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bureau. Cap Measure (BCM)(t-1)*</td>
<td>10.9</td>
<td>282.5</td>
<td>100.02</td>
<td>49.52</td>
</tr>
<tr>
<td>Gubernatorial Strength</td>
<td>2.7</td>
<td>4.10</td>
<td>3.46</td>
<td>.39</td>
</tr>
<tr>
<td>Squire Legislative Professionalism</td>
<td>.027</td>
<td>.626</td>
<td>.18</td>
<td>.11</td>
</tr>
<tr>
<td>Med. Spending Per Capita**</td>
<td>231.00</td>
<td>2113.00</td>
<td>780.00</td>
<td>289.00</td>
</tr>
<tr>
<td>Edu. Spending Per Capita**</td>
<td>735.00</td>
<td>2052.00</td>
<td>1145.00</td>
<td>242.00</td>
</tr>
<tr>
<td>State Spending Per Capita**</td>
<td>2404.00</td>
<td>11023.00</td>
<td>4045.00</td>
<td>1200</td>
</tr>
<tr>
<td><strong>Political Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Limits</td>
<td>0</td>
<td>1</td>
<td>.24</td>
<td>.42</td>
</tr>
<tr>
<td>Unified Party Control</td>
<td>0</td>
<td>1</td>
<td>.43</td>
<td>.49</td>
</tr>
<tr>
<td>Governor’s Office party</td>
<td>0</td>
<td>1</td>
<td>.52</td>
<td>.50</td>
</tr>
<tr>
<td><strong>Markets and Demographics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Penetration Rates*</td>
<td>0</td>
<td>59.50</td>
<td>19.80</td>
<td>12.96</td>
</tr>
<tr>
<td>Private Insurance Percent*</td>
<td>47.9</td>
<td>75.3</td>
<td>62.8</td>
<td>5.97</td>
</tr>
<tr>
<td>Unemployment*</td>
<td>2.20</td>
<td>7.70</td>
<td>4.86</td>
<td>1.15</td>
</tr>
</tbody>
</table>

*Is a percentage  
**is in dollar amounts

3.7 Model Specification and Methods

The tool I use to analyze the theorized relationship between Medicaid managed care use in the states and the various factors outlined in this chapter is a pooled, cross sectional time series analysis (Sayrs, 1989). By using a set of cross-sections over time, the inquiry can produce more robust results than using a cross-section at one particular
point in time. Panel data have a number of advantages including corrections for heterogeneity in the micro units, alleviating multicollinearity problems, and the examination of issues that are otherwise ignored in standard time-series and cross-sectional data (Stoutenborough and Beverlin, 2008). Panel data are also more robust since the use of time specific data provides additional explanatory power versus using just a single year or cross section. In addition, this method is capable of analyzing multiple units (states) for multiple points in time (years) (Stimson, 1985).

The use of a pooled cross-section of data over time does present several challenges that may violate regression assumptions. Problems encountered with the design can include correlated error terms and heteroscedasticity. Since I want to have errors to be uncorrelated, I will make corrections to model to account for these issues. It is possible to overcome these challenges through corrections in the panel data error terms (Beck and Katz, 1996). The statistical program STATA is used to analyze the cross-sections over time and make adjustments related to the error terms, thus correcting for regression assumption violations (Hamilton, 2006).

The analysis is further complicated by the fact that many of the independent variables have little variation over time; while others remain constant. As an example, political control of statehouses will often be the same for decades, as is the case with the 1997-2007 time periods. This situation leads to a problem with data becoming autocorrelated and heteroskedastic. To alleviate these issues, a linear regression with the assumption of panel-correlated errors is used. The parameters are estimated using a Prais-Winsten regression that assumes the panel data is heteroskedastic and correlated
across panels (STATA, 2007, 330-339). This technique is used to explain the percentage of a state’s Medicaid population enrolled in all forms of managed care contracting (Table 3.1) commercial for-profit managed care (Table 3.2) by Medicaid agencies from 1997-2007.

3.8 Results

The primary goal of this study is to determine what factors help to explain the variation in type and scope of Medicaid contracting policy choices made by the states. I theorize that there are statistically significant relationships between types and variation in Medicaid managed care use and specific relationships between these contracting choices and interest group populations, bureaucratic capacity, political control of institutions and the characteristics of state health insurance markets. My hypotheses also expect to find a positive and significant relationship between concentrations of interest groups and contracting choices; as well as a negative relationship between greater use of Medicaid contracting choices and levels of bureaucratic capacity.

The paneled regression analysis produced interesting and contrary results to my stated hypotheses about the influences associated with state Medicaid contracting choices. The results and subsequent discussion are arranged based on the key areas of this study and include interest groups, bureaucratic and institutional capacity, political control, and private market characteristics. Of particular interest are the variables
associated with measures of Medicaid interest group populations and bureaucratic capacity that shed new light on the nature of Medicaid contracting in the states.\textsuperscript{26}

The results in Tables 3.5 and 3.6 allow me to draw a series of interesting conclusions about the nature of contracting choices that states have made since 1997.\textsuperscript{27}

The results in Table 3.5 clearly show a negative and statistically significant relationship between the bureaucratic capacity measure (BCM) and all forms of Medicaid contracting. The negative relationship between Medicaid contracting staffing as expressed by the BCM is consistent with my hypothesis that states with higher levels of bureaucratic capacity tend to be states that place less reliance on the managed care industry. The findings suggest that as bureaucratic capacity decreases by one percent, we can expect to see a decrease in state reliance on all forms of managed care. As an example, if there a one standard deviation increase (49.3) in my bureaucratic capacity measure, we could expect to see all forms of Medicaid managed care use increase by 2.13 percent.

The results contained in Table 3.5 are also consistent with the formal models advanced by Huber and McCarthy (2004). These models suggest that when bureaucratic capacity is ‘low,’ there is a greater reliance on the presumed expertise and capability of

\textsuperscript{26} The models presented in Tables 3.5 and 3.6 include all 50 states for the time periods indicated. Earlier model iterations included dropped values for some states where data was not available for certain time periods. In the end, no significant difference in the results was observed as a result of dropped state panels or missing data, and thus all 50 states are used in each of the models presented in this chapter.

\textsuperscript{27} Analyses of the 2007 cross-section using both logistic and linear regression techniques was used to test the validity of the paneled data models and confirm the statistically significant relationships contained in Tables 3.5 and 3.6.
private firms to serve the Medicaid populations. Further, this factor is evidence of a symbiotic relationship (as Kettl (1993) suggested) between the state and its outside interests and contracting mechanisms that together make up for the state’s diminished capacity.

Contrary to my expected findings, there is not a significant relationship between the use of for-profit managed care firms and bureaucratic capacity as indicated in Table 3.6. I suggest the evidence for this contradiction lies in the presence of interest groups in the states and not necessarily the capacity of Medicaid bureaucracies. Table 3.6 shows a positive and highly significant relationship between state use of for-profit managed care and concentrations of interests associated with Medicaid appropriations. In addition, there is a positive and significant relationship between Health PAC strength in a state and the use of for-profit firms as shown in Table 3.6.

This finding is consistent with Gray et al. (1996, 2001, and 2004) and their concepts of interest group density and the relationship to policy choices in the states. As interests concentrate their efforts to persuade policymakers, including the governor and the bureaucracy, they are able to overwhelm them to achieve their goals. As state interest group populations increase by a single standard deviation (17.04) we can expect to observe a 4 percent increase in state Medicaid use of commercial managed care plans. In addition, the results in Table 3.6 show that as political giving increases there is corresponding increase use of commercial firms to serve Medicaid beneficiaries. I suggest this is tangible evidence that rent seeking activity and the employment of
lobbyists in state capitals represents real revenue (and results) to for-profit managed organizations that serve the Medicaid population.

It is also important to emphasize that political giving was found to have an equally important affect on the use of commercial for profit Medicaid managed care arrangements. This finding compliments the positive relationship between the hiring of lobbyists and concentrations of vested interest in states. As political giving increases with greater incremental per lawmaker contributions, there is an associated 3.7 percent increase in state use of for-profit managed care. Again, this finding and the results of the qualitative interviews in Chapter 2 confirm the strong effect that vested interests have on the magnitude and choices state Medicaid agencies have made over time.

The ordinal measures of gubernatorial strength were also found to be significant in both models, but in contrary ways. Higher levels of this measure find that governors have greater powers and authority. Just as lower bureaucratic capacity was found to be negatively related to use of managed care in the states, lower levels of gubernatorial strength were found to be positively related to use of managed care organizations in state Medicaid systems, as Table 3.6 demonstrates. However, in Table 3.5 the relationship is reversed since higher levels of gubernatorial strength is positively related to states using higher levels of for-profit managed care organizations. Strong governors have the ability to make decisions more readily than weak governors, as Beyle (1996) suggests, and thus this finding is consistent with the theorized relationships.

State legislatures and their professionalism were not found to be a significant factor related to any type of managed care use by the states as shown in Tables 3.5 and
3.6. This finding was somewhat unexpected since state lawmakers have been found to play significant roles in policy making as Kousser (2005) suggested in his examination of state legislative term limits. However, the presence of term limits in a state was shown in Table 3.6 to be significant and negatively related to the increased use of for-profit managed care firms. This finding suggests that states without legislative term limits were more likely to prefer using for-profit managed care organizations. This finding suggests that states with long-term state lawmakers were more likely to have a ‘cozy’ relationship with vested interests as a result of long standing personal relationships and campaign contributions based upon those relationships.

Conversely, in Table 3.5 there exists a positive relationship existed between the use of managed care generally and the presence of term limits in a state. This suggests that when term limits are present that power is ceded to the bureaucracy, which would also explain the negative relationship between my measure of bureaucratic capacity and use of all forms of Medicaid managed care. As bureaucratic capacity diminishes and arguably legislative capacity in the form of less tenured and seasoned lawmakers, there is a general greater reliance on services that are contracted out by state Medicaid programs.

The state spending variables used in both models contained in Tables 3.5 and 3.6 are significant, but vary in their relationship to the policy choices. The results in Table 3.5 show that there is a statistically significant negative relationship between total per capita state spending and higher use levels of Medicaid managed care, but there is a positive relationship in Table 3.6 between higher levels of state spending per capita and higher levels of Medicaid system use of for-profit managed care organizations. This
finding suggests that states that have a heavy reliance on for-profit managed care organizations tend to spend more generally. I argue that this finding confirms and supports the findings by Duggan (2004) that the California Medicaid program spent more on Medicaid as a result of reliance on managed care. While MCOs are often touted as a policy tool to control Medicaid costs and utilization, the collective research cited argue that heavy reliance on for-profit firms does not achieve the intended policy goals of reducing Medicaid system costs.

Table 3.5 shows there is a statistically significant negative relationship between total per capita state education spending and higher levels of Medicaid managed care use. These findings show that increased use of Medicaid managed care are associated with higher levels of overall Medicaid spending, but this outcome is not the case for aggregate state spending or education spending. These results are consistent with past research by Kousser (2002) and Tandberg (2009) who shows that higher levels of Medicaid pharmacy spending is negatively related to education spending. Collectively, the results in both models confirm the tradeoff between and among spending priorities that state policymakers engage in during appropriation cycles.

The finding suggests that as states make the choice to spend incrementally on education that Medicaid managed care use declines. As an example, if a state spends an additional dollar per capita, there is an associated .053 decrease in overall Medicaid managed care usage. So, if state education spending per capita decreased by $242 (one standard deviation), we could expect to see a 12.8 percent increase in overall Medicaid managed care use. Given the budget realities that states struggle with, the per capita
numbers potentially represent a serious trade-off between choosing to contract out Medicaid services versus additional per pupil funding for secondary and post-secondary education.

Political control of state institutions was found to be of significance in Medicaid systems use of for-profit managed care organizations. Table 3.6 shows that the party affiliation of the governor is significant and related to state use of for-profit firms delivering Medicaid services. This suggests that Democratic governors are more likely to be associated with the use of for-profit managed care plans and Republican governors are associated with an associated 3.6 percent decrease in commercial managed care use. However, political control of the governor’s office was not significant in explaining the use of all types of managed care use in Table 3.5.

State specific health insurance market attributes were found to be a statistically significant factor in explaining the variation in all types of Medicaid managed care use and state use of commercial for-profit managed care organizations. In both models, there exists a positive relationship between higher HMO penetration rates in the private market and Medicaid managed care use. This finding suggests that when there is a private market concentration of vested interests that will seek new markets and expanded opportunities in government. For each percentage change in managed care use there is an associated .44 percent increase in commercial managed care use and a .26 percent associated increase with all forms of Medicaid managed care use. As an example, if a state had a greater than average (one standard deviation) managed care penetration rate, we could expect to see a 5.7% increase in commercial for-profit Medicaid managed care
use and a 3.4% increase in all forms of Medicaid managed care use in a state. This finding is also consistent with the privatization research that finds that private interests view government as another market to expand their sale of goods and services (Kettl, 1993; Gormley, 1989; Savas, 1987).

Unemployment rates were not found to be a significant factor in either model. A probable reason for this fact may be that unemployment levels were relatively low during the 1997-2007 time periods. Schneider (1997) and Smith and Moore (2008) find that higher levels of unemployment are obviously associated with increased Medicaid populations and spending, thus, as levels of unemployment increase, the increased use of managed care arrangements by states increases as well.

The use of private markets to meet public policy goals through privatization is demonstrated by these results and consistent with theories advanced by Kettl (1993) that suggest a symbiotic relationship between private markets and use of those services by government. Also, these results are consistent with previous single cross-sectional models that show a similar relationship between the policy choices and contracting out the services (Randall and Johnson, 2008).
Table 3.5. Prais-Winsten Regression, heteroskedastic panels, corrected standard errors for percent of State Medicaid population enrolled in all types of Managed Care Organizations (1997-2007)

<table>
<thead>
<tr>
<th>Changes in Variable</th>
<th>Coefficient</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interest Group Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid IG Population</td>
<td>-.073</td>
<td>(.054)</td>
</tr>
<tr>
<td>Health PAC Strength</td>
<td>-.092</td>
<td>(.874)</td>
</tr>
<tr>
<td><strong>Institutions and Capacity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bureau. Cap Measure (BCM)(t-1)*</td>
<td>-.043***</td>
<td>(.011)</td>
</tr>
<tr>
<td>Gubernatorial Strength</td>
<td>-6.83***</td>
<td>(1.89)</td>
</tr>
<tr>
<td>Squire Legislative Professionalism</td>
<td>-18.64 **</td>
<td>(7.25)</td>
</tr>
<tr>
<td>Medicaid Spending Per Capita</td>
<td>.0158***</td>
<td>(.0023)</td>
</tr>
<tr>
<td>Education Spending Per Capita</td>
<td>-.0049**</td>
<td>(.0021)</td>
</tr>
<tr>
<td>State Spending Per Capita</td>
<td>-.006***</td>
<td>(.0007)</td>
</tr>
<tr>
<td><strong>Political Control</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Limits</td>
<td>4.44**</td>
<td>(1.77)</td>
</tr>
<tr>
<td>Unified Party Control</td>
<td>-.65</td>
<td>(.51)</td>
</tr>
<tr>
<td>Governor’s Office</td>
<td>2.01</td>
<td>(1.50)</td>
</tr>
<tr>
<td><strong>Market and Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Penetration Rates</td>
<td>.265***</td>
<td>(0.7)</td>
</tr>
<tr>
<td>Percent Private Ins. Coverage</td>
<td>.106</td>
<td>(.07)</td>
</tr>
<tr>
<td>Unemployment</td>
<td>-.277</td>
<td>(.28)</td>
</tr>
<tr>
<td>Constant</td>
<td>108.58***</td>
<td>(8.16)</td>
</tr>
<tr>
<td>Wald X²</td>
<td>234.42***</td>
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</tr>
<tr>
<td>R-Squared</td>
<td>.8549</td>
<td></td>
</tr>
<tr>
<td>Rho</td>
<td>.8968</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Standard error for each coefficient in parentheses
***p<.01, **p<.05, *p<.10
N=50, T=11, Observations=550
Table 3.6. Prais-Winsten Regression, heteroskedastic panels, corrected standard errors for percent of State Medicaid population enrolled in Commercial For-Profit Managed Care Organizations (1997-2007)

<table>
<thead>
<tr>
<th>Changes in Variable</th>
<th>Coefficient</th>
<th>SE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interest Group Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid IG Population</td>
<td>.236***</td>
<td>(.076)</td>
</tr>
<tr>
<td>Health PAC Strength</td>
<td>3.70***</td>
<td>(1.05)</td>
</tr>
<tr>
<td><strong>Institutions and Capacity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bureau. Cap Measure (BCM)(t-1)*</td>
<td>.0048</td>
<td>(.009)</td>
</tr>
<tr>
<td>Gubernatorial Strength</td>
<td>6.17***</td>
<td>(2.06)</td>
</tr>
<tr>
<td>Squire Legislative Professionalism</td>
<td>-.812</td>
<td>(5.10)</td>
</tr>
<tr>
<td>Medicaid Spending Per Capita</td>
<td>-.0023</td>
<td>(.0016)</td>
</tr>
<tr>
<td>Education Spending Per Capita</td>
<td>-.0005</td>
<td>(.0017)</td>
</tr>
<tr>
<td>State Spending Per Capita</td>
<td>.0014 ***</td>
<td>(.0005)</td>
</tr>
<tr>
<td><strong>Political Control</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Term Limits</td>
<td>-10.56***</td>
<td>(1.20)</td>
</tr>
<tr>
<td>Unified Party Control</td>
<td>-.309</td>
<td>(.345)</td>
</tr>
<tr>
<td>Governor’s Office party</td>
<td>-3.61 ***</td>
<td>(1.39)</td>
</tr>
<tr>
<td><strong>Market and Demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HMO Penetration Rates</td>
<td>.440***</td>
<td>(.067)</td>
</tr>
<tr>
<td>Percent Private Ins. Coverage</td>
<td>-.03</td>
<td>(.052)</td>
</tr>
<tr>
<td>Unemployment</td>
<td>.042</td>
<td>(.21)</td>
</tr>
<tr>
<td>Constant</td>
<td>-26.71***</td>
<td>(8.46)</td>
</tr>
<tr>
<td>Wald X²</td>
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<td></td>
</tr>
<tr>
<td>R-squared, overall</td>
<td>.4664</td>
<td></td>
</tr>
<tr>
<td>Rho</td>
<td>.9392</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Standard error for each coefficient in parentheses  
*** p<.01, ** p<.05, *p<.10.  
N=50, T=11, Observations=550

3.9 Discussion and Conclusions

The results contained in this chapter provide empirical evidence to support my theorized relationship between interest group populations, bureaucratic capacity and their
relationship between state Medicaid contracting choices. First, the results confirm that increased use of state Medicaid for-profit commercial firms are a result of specific concentrations of interest groups and generally higher levels of political giving by those same interests. These findings are consistent with past scholarship (Gray and Lowery, 1996, 1999; Lowery et al., 2010) and show that when there is a dense concentration of interest group populations, policy choices are skewed toward those interests. These two findings contribute to the argument that pluralism is alive and functioning very well in state capitals and consistent with the anticipated outcome regarding the importance and dominance of interests in explaining the respective policy choices. But, this outcome is only part of the story.

The results confirm the hypotheses raised in Chapter 1 that bureaucratic capacity matters, and when there is significant expertise, agencies can utilize options beyond privatization tools to manage public programs. This conclusion is based upon the results in Table 3.5 that show that lower levels of bureaucratic capacity help to explain increased state reliance on contracting out Medicaid services to managed care organizations. Importantly, the results empirically support the theoretical models advanced by Huber and McCarthy (2004) that suggest that ‘low’ levels of state administrative capacity lead to increased reliance on private firms. Finally, the lack of a relationship between state use of for-profit firms and bureaucratic capacity also help to support the importance of the pluralistic model and the role that vested commercial interests play in state policy making.
The models provide an empirical basis for understanding the relationship between
the capacity of the bureaucracy and a specific policy choice that contributes to the
understanding of state policymaking. While the dynamic of bureaucratic capacity is an
important finding in understanding state Medicaid programs, the data yield even more
interesting results in what I term the ‘black box’ of how and why state spending choices
are made, who benefits, and why. The results suggest there are multiple factors,
including interest group density and bureaucratic capacity, which are related to the policy
choices that states have made over time, but it is also only part of the story relative to the
role of interests, the bureaucracy, and politics in the Medicaid process. The modeling
provides us with the framework for understanding the dynamics of how states spend their
billions of dollars each year on Medicaid. The rest of the story is more complex and
political than quantitative modeling can demonstrate.
CHAPTER 4

Conclusions

The policy choices that states make to serve the needs of Medicaid enrollees are as widely varied as the states themselves. Medicaid policy and implementation is increasing becoming more relevant to not only policymakers but also to researchers seeking a better understanding of the complex policy dynamic associated with the program. Advancing the knowledge of Medicaid policy has taken on an added significance due to the passage of PPACA and an estimated 16 million new beneficiaries that will added to the program after 2014. Given the inherent problems associated with state-level comparative research and the current accelerated trend toward devolution to the states for health care implementation, the importance of understanding the complexities of state-specific policymaking takes on added importance and relevancy. The growing significance of state government capacity and policy capability, along with state policy research will continue to increase as state institutions and policy actors gain more power, responsibility, and attention.

In the beginning of this dissertation, I sought to explain the variation in contracting choices by states regarding their Medicaid program. I theorized that bureaucratic capacity was an important determinant in explaining the choice, which I supported with empirical evidence. In addition, I supplied evidence that interest group
populations can also account for some of the observed variation in Medicaid contracting choices.

There is a dearth of research related to the capacity of state government agencies in the policy process or how agency capacity affects policy choices. Much of the existing literature related to state agency functions has a public administration and management focus, rather than investigating how agencies contribute to the policymaking process. Importantly, this study offers insight into how the interaction of diverse factors can explain an important policy area, which, in turn, can assist us in broadening our understanding of the policy process. Previous research has not examined the factors associated with Medicaid policy variation, which is especially important considering the fact that Medicaid is the largest single appropriation item that state officials must deal with on a yearly basis. The research presented here gives us insight into the bureaucracy, institutions, interests, and market factors that help to better explaining the dynamics of the state policymaking process.

4.1 Bureaucratic Capacity and Its Importance in the Policy Process

The capacity of state agencies to implement large and complex programs, such as Medicaid, is becoming increasingly important as the number of beneficiaries is expected to dramatically increase and responsibility is shifting from Washington to state capitals. The importance of the relationship between capacity and the policy process is evidenced by the inverse nature of capacity and the policy choices that states make to serve the Medicaid populations. In Chapters 3 and 4 of this study, I offer evidence about the nature of capacity as well as the relationship between the bureaucracy and contracting choices.
Bureaucratic capacity is a measurement of an agency’s ability to professionally, efficiently, and effectively implement a program or service in a cost-effective manner. As the literature suggests, bureaucratic capacity can be measured by staffing levels, professional affiliations, and program-specific staffing within an agency (Bowman and Kearney, 1988; Huber and McCarthy, 2004).

This study finds that when state Medicaid agency staffing numbers are comparatively low, there tends to be a greater reliance on outside vendors to meet program needs. Importantly, the evidence suggests that a lack of capacity creates a void of expertise within an agency; a void that is filled by organized and vested interests that offer services as a delivery option. The relationship between policy choices and the composition of bureaucratic institutions gives us recognition of the temporal nature of policymaking.

The qualitative research contained in Chapter 2 also supports the conclusions of the robust statistical analysis in Chapter 3. Bureaucratic capacity was found to be an essential factor in several of the states. West Virginia’s staffing limitations has had an effect on policy choices since interests play a large role in structuring Medicaid policy in the absence of a robust bureaucratic expertise and capacity. In contrast, states with higher levels of capacity used several contracting mechanisms to deliver services. North Carolina and California developed contracting models specific to markets and geographic areas for their respective Medicaid populations. While the capacity of an agency to fulfill its statutory duties is not the only factor in explaining policy outcomes, the evidence suggests that it is important in the context of the contracting mechanisms presented.
Interests also play a part in the contracting process, but this fact must also be placed in the larger context of their interaction with the established institutional structures. As an example, California has highly professionalized Medicaid agency staff and a highly professionalized legislature which forces interests to adapt to these institutional capabilities. Interests will dedicate significant resources to influencing and being politically responsive to lawmakers as a result of the developed expertise of the agency. They utilize a wide range of resources to achieve their influence to seek favorable policy preferences that range from hiring an army of lobbyists and a healthy Political Action Committee, and the ability to force the agency to respond to their needs and wants. The dynamic nature of interaction between these forces is a useful fact when explaining the interactions of organized interests with Medicaid contracting.

The findings presented here strongly suggest that the capabilities of the bureaucracy have a much larger effect on policymaking than previously thought. While the role of interest group influences on state policy making and implementation are well documented, no studies have examined the interactions of interests and the capacity of the bureaucracy to carry out its duties. The implications about the interactions of interests and state lawmakers with the bureaucracy have larger impact across a range of policy venues.

4.2 Bureaucratic Capacity Measure (BCM)

The development of a Bureaucratic Capacity Measure (BCM) is an important contribution of this research; principally because it allows for a standardized measure of state government capability. As previously discussed, the Government Performance
Project (2008) measures five specific metrics of state government capability: capital management, financial management, human resources, information technology, and managing for results. While these measures are useful in examining the general capabilities of state government, they fall short as an explanatory measure to answer questions about specific state capabilities to implement specific programmatic functions associated with Medicaid programs. As the wide array of literature reviewed suggests, staffing capability and professionalization of the bureaucracy are important factors associated with the implementation of complex programs such as Medicaid.

The constructed BCM gives us insight into the role that bureaucracies play in the policy process and how programs are implemented. The two models explored in Chapter 3 supply useful empirical data about the factors that can help in explaining contracting and policy choices that state Medicaid programs make. Consistent with past scholarship (Huber and McCarthy, 2004), I find that there is a negative relationship between higher values in my BCM and increased use of all types of managed care in the states. This relationship strongly suggests that as states increase their Medicaid agency capacity, there is less of a reliance on managed care organizations and a greater diversity of policy options deployed to serve the Medicaid population. Further, in the absence of a statistically significant relationship between bureaucratic capacity and the use of for-profit managed care organizations, there suggests that other factors such as a strong interest group environment are more important. Both models offer evidence that bureaucratic capacity is necessary factor when attempting to understand the contracting dynamic at work in state Medicaid agencies.
4.3 Interests and Medicaid Contracting Choices

The results also suggest that interest group populations surrounding Medicaid programs are an important factor in explaining the policy choices that states make. Again, consistent with past scholarship (Gray and Lowery, 1996, 1999; Gray, Lowery, and Godwin, 2004; Benz et al., 2009), the results show that when there is a dense concentration of interest group populations, policy choices are skewed toward those interests. In addition, I find that greater political giving in a state by those same interests associated with Medicaid are related to the contracting choices associated with commercial, for-profit managed care organizations. The evidence suggests a direct link between aggregate PAC spending, concentrations of organized interests, and the policy choices that have the potential to directly financially benefit those organized interests. Finally, the results in Table 3.5 indicate that states containing larger concentrations of specific interests have a direct relationship with higher levels of varying forms of managed care; also in addition to for-profit plans.

The modeling offers a framework for understanding the dynamics of how states spend their billions of dollars each year on Medicaid. The rest of the story, I argue, is much more complex and political than empirical modeling can demonstrate. Further, I argue that the qualitative interview results not only support the significance of bureaucratic capacity but also are the most significant factor in explaining state specific policy choices. The use of both qualitative and quantitative methods helps to demonstrate the interaction between a policy model that favors pluralism versus a more institutional view of policy making. I suggest that the research findings give rise to
pluralistic institutionalism where vested interests shape institutions to serve their specific needs then reap the rewards of the processes and bureaucracies they help to shape.

4.4 Directions for Future Research

Insight into the nature of the functioning of bureaucracy and its capacity to implement complex programs has been gained through this research. Gaining additional knowledge relating to the factors that help to explain Medicaid contracting choices is significant today as state Medicaid enrollment continues to increase. This fact may take on greater significance in the future as Medicaid rolls increase at a faster pace as a result of the passage of the 2010 health care reform measures, with an estimated 16 million additional Medicaid enrollees (Kaiser, 2010). However, the insight raised by this study also has implications about the dynamic relationships that exist between state bureaucracies, state lawmakers, and the interests that are vested in the programmatic choices that are made.

In order to better understand the dynamic at work in Medicaid policy, it would be useful to examine the specific relationships that exist in the wide range of state legislative committees of jurisdiction that have specific oversight over Medicaid. While both the models and the interviews analyzed in Chapter 2 and 3 contain useful information about the contracting choices made by states, there is still much to be learned about the nature of legislative involvement. The policymaking environment between state bureaucracies and legislative committees is different, as evidenced by the interviews, but there are some similarities. Exploring this difference and the approaches taken by the two principal institutions in state government is a possible avenue of future research.
The creation of the bureaucratic capacity measure (BCM) is an important contribution to literature on state politics and policy and can be expanded upon and potentially applied to other state policy arenas. The BCM could be applied to contracting policy choices beyond Medicaid. State government is filled with an increasing number of contracting and procurement policy choices across a spectrum of government spending. It would be of interest to policy scholars to see if the findings contained in the Medicaid contracting study would hold true in the contracting choices made in state education spending decisions, for example. A key question would be to determine if bureaucratic capacity is related to the contracting choices that state governments make in secondary education.

Also of interest, and not used in the models presented in this research, are the impact, if any, on the health status of Medicaid beneficiaries that are served by commercial managed care interests. Models could include additional health status variables that include levels of obesity, smoking, cardiovascular disease and diabetes. All of these diseases are linked to individual behavior and are of keen interest to managed care plans in reducing medical expenses. As an extension of this research, these variables could be included in models that track health status over time and see if any relationship exists between these measures and Medicaid contracting choices.

Equally important, and as an extension of this study, it would also be of interest to determine if the size, scope, and relative influence of interest group populations play a significant role in the contracting choices made in specific policy venues. As evidenced by past scholarship (Moorehouse, 1981; Gray and Lowery, 1996; Gray et al., 2000,
2002), there is diversity in interest group populations in state capitals, and interest groups are often closely tied to economic interests, which are reflected in the relative and perceived strengths of interest groups. This study supports past scholarship by demonstrating a significant relationship between interest group communities and Medicaid contracting choices.

4.5 Generalizability to Other Policy Areas

A key question that arises as a result of this study is whether the research can be applied to other policy arenas. Because this research examines a specific policy choice (Medicaid contracting), it is possible to apply the same range of variables to examine other broad policy areas and to replicate the findings. As a means of examining other policy venues and choices, the work by Lowi (1964) offers a useful typology. This would include general categories such as regulatory, redistributive, and distributive to determine if state bureaucratic capacity and interest group environments is a relevant factor in explaining policy choices based upon these three categories.

There does exist some degree of commonality across these broad categories, as Anderson (1997) has suggested. As an example, redistributive policies often have similar political and economic attributes and thus could behave in ways similar to the Medicaid contracting choices examined in this study. Thus, one could use the models presented herein to examine the effects of state government policymakers’ choices about the scope, degree, and nature of contracting mechanisms to transfer programmatic authority to outside contractors.
The application of the BCM to other policy areas can be achieved through the construction of a similar index that standardizes the measures of staffing related to the specific programmatic area and a component that includes a measure of staff professionalization. As this study suggests, the use of an index measure can assist in determining if there is a relationship between the capacity of the bureaucracy and the contracting choices. Arguably, redistributive policies (such as Medicaid) may be more likely to show a relationship between contracting choices and bureaucratic capacity due to the nature of the programs involved. However, regulatory and distributive policy areas also have bureaucracies that must implement programs and policies that are subject to the same set of political, economic, and interest group environments and pressures as a redistributive policy such as Medicaid. Given this observation, there is a wide array of policy venues on which a measure of bureaucratic capacity can be used to examine specific state-level policy choices.

4.6 Final Thoughts

The evidence presented in this study indicates that there are many factors that account for variation in Medicaid contracting. The capability of state agencies to implement public policies should be of central concern to elected leaders; especially in the era of continued devolution of programmatic and policy authority to the states from the federal government. Equally as important to capabilities of the bureaucracy is the fact that interest groups are becoming increasingly influential in state capitals. Understanding their role can better assist policymakers in implementing programs that promote both efficiency and effectiveness.
The relevancy of the questions raised by this research has increased as a result of the passage and subsequent implementation of the patient Protection and Affordable Care Act of 2010 and the addition of estimated 16 million new beneficiaries to state Medicaid programs after 2014. Policy scholars and practitioners suggest that managed care organizations will play a vital role with helping states meet the dramatic increase in beneficiary populations (Iglehart, 2011). As a result, states should make certain that they have the bureaucratic capacity to successfully add new enrollees and have the management and information systems to make policy choices not for the benefit of vested interest but for the efficient management of the Medicaid system. Duggan’s (2004) findings of increased use of managed care in the California Medi-Cal system and higher costs should also be noted in the context of the findings of this research. A broad array of policy choices should be considered to deal with the increased population with an emphasis on seeking cost effective contracting options.

The intersection of politics, private markets, and vested interests is often a misunderstood aspect of political science and public policy research. It is my hope that the information presented in this study will help to illuminate the ‘black box’ nature of the range and types of influences that explain public policy choices so that future policymakers and researchers can learn from the evidence put forth. A better understanding of the policy process can contribute to improved public policies for all citizens.
APPENDIX A

Approved Questions for Semi-Structured State Interviews

“The Politics of Privatization and Medicaid”

1. Please describe the process of privatization of state Medicaid services over the last ten years.

2. Is the use of private managed care organizations effective and efficient in your state?

3. Why did the state choose to use or not use private managed care organizations to deliver Medicaid services?

4. Please explain the choices and rationale for using traditional fee-for-service provider contracting versus the use of private, for-profit and not-for-profit managed care arrangements.

5. Please explain how vested interests are involved in the contracting process including bid specification, contract awards, implementation, and rate setting for per capita payments.

6. How do you judge the effectiveness of your Medicaid contracting with private firms?

7. Please describe the attributes of a successful Medicaid contracting program.

8. Is there adequate staffing, expertise, and authority in the Medicaid agency to administer private contracts with managed care organizations?
9. What are your perceptions of the strengths and weaknesses of your Medicaid contracting office?

10. Please explain the role of Medicaid Section 1115 innovation waivers and how private contracting has or has not played a role in the waivers.

11. Please describe how contract adjustments have been dealt with over the last ten years.

12. How have the rate of per-capita payments to managed care organizations process been handled by the Medicaid agency, and what role do legislative leaders and interest groups play in the process?

13. Please describe the process of rate revisions in the recent period of state fiscal constraint.

14. How involved are legislative leaders and staff in the process of Medicaid managed care contracting?

15. How involved are interest groups in the process of Medicaid managed care contracting?
APPENDIX B

Consent Form

Research conducted by David Randall, PhD Candidate, Department of Political Science, Kent State University

Research Topic: The Politics of Privatization and Medicaid

I want to do research on state Medicaid privatization and contracting. The purpose of the research is to better understand the process and variation in state Medicaid contracting and privatization efforts. I would like you take part in this project. If you decide to do this, you will be asked to answer questions about your state’s Medicaid program for a taped interview no longer than 60 minutes.

Your responses and taped interview will be held in confidence and all responses in the research will be anonymous. Your name will not be used in written research associated with the dissertation and any subsequent publication of the results. All consent forms will be held in a locked office in the Political Science Department of Kent State University.

If you participate in this project, all associated research will be made available to you. Taking part in this project is entirely up to you, and no one will hold it against you if you decide not to do it. If you do take part, you may stop at any time.

If you want to know more about this research project, please call me at (330) 270-1809 or via email at drandal1@kent.edu. You may also contact my PhD Dissertation Co-Chair, Dr. Mark Cassell, Department of Political Science, via email (mcassell@kent.edu) or phone at (330) 672-8930. The project has been approved by Kent State University. If you have questions about Kent State University’s rules for research, please call Dr. John West, Vice President of Research, Division of Research and Graduate Studies (Tel. 330.672.2704).

You will get a copy of this consent form.

Sincerely,

David Randall, PhD Candidate, Department of Political Science
B. CONSENT STATEMENT(S)
1. I agree to take part in this project. I know what I will have to do and that I can stop at any
time.

   Signature ___________________________________________ Date _____________________________

Waiver or Alteration of Informed Consent
Informed consent assures that participants understand the nature of the research and can
knowledgeably and voluntarily decide whether or not to participate. The basic elements of informed
consent (e.g., explanation of the study’s purpose, description of foreseeable risks and benefits,
description of the extent to which confidentiality will be maintained, explanation of whom to contact
with questions, statement that participation is voluntary and may be discontinued at any time, etc.)
are outlined in federal guidelines (Title 45, Code of Federal Regulations, Part 46). In rare instances,
the guidelines allow IRBs to approve a consent procedure that does not include, or alters, some of the
elements of informed consent. To request an approval for a waiver or alteration of informed
consent, the investigator must document that the proposed study meets the following criteria:

1. The research involves no more than minimal risk to participants;
2. The waiver or alteration will not adversely affect the rights and welfare of participants;
3. The research could not practically be carried out without the waiver or alteration (e.g.,
   some research on child abuse and neglect or on runaway teens could not be carried out without a
   waiver of parental consent);
4. Whenever appropriate, the participants will be provided with additional pertinent information after
   they have participated in the study.

Waivers cannot be granted because the investigator lacks the resources (e.g., personnel, time, money) needed
to obtain informed consent. In most instances, granting a waiver of informed consent involves full board
review.

Passive Consent
Passive consent is when parents are sent a letter explaining the research and are told that unless they return
the letter the child will be enrolled in the study. This is different from a waiver because parents are notified
about the research through a letter. The Board’s concern with this type of consent is that there is no
guarantee that parents see the letter. Unless justification beyond inconvenience is provided, passive
consent will not be allowed.
APPENDIX C

Variable Definitions and Sources

**Medicaid Commercial Plan Enrollment: 1997 to 2007** - Percentage of Medicaid beneficiaries enrolled in a commercial, for-profit managed care arrangement to provide services. Also coded as a dichotomous variable with ‘1’ as a state using commercial plans and ‘0’ for a state not using a commercial plan. Source: Centers for Medicare and Medicaid Services (CMS) and as compiled by the Kaiser Family Foundation. Source: [http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4.](http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4).

**Medicaid Contracting-All forms: 1997 to 2007** - Percentage of Medicaid beneficiaries enrolled in a contracted arrangement to provide services. Source: Centers for Medicare and Medicaid Services (CMS) and as compiled by the Kaiser Family Foundation. Source: [http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4.](http://www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4).

**Bureaucratic Capacity Measure: 1997 to 2007** - A standardized ratio of state Medicaid agency staff per number of beneficiaries. Source: Original data collection from U.S. Census Bureau, National Governors Association, State Medicaid Officers Association.

**Medicaid Interest Group Population: 1997 to 2007** - Compilation of state-specific lobbyists engaged by commercial Medicaid HMOs. Original data collection from state lobbyist firm profiles, state lobbyist registrations, and the Center for Public Integrity.
based in Washington, DC. Data also supplied by Jennifer Benz, University of North Carolina, from Benz et al. (2008) and Lowery et.al (2010).


Gubernatorial Strength: 1997 to 2007 - Beyle index of institutional strength relative to other actors. Source: SPPQ data sets.

Legislative Professionalism - Squire’s 1996 and 2003 measurement of state legislative staff, salary, and session length compared to Congress. Source: SPPQ and Squire (2008).

Term Limits: 1997 to 2007 - Dummy variable reflecting whether a state has a term limit restriction on state lawmakers. Source: SPPQ data sets.


Unemployment Rate: 1997 to 2007 - Unemployment rate for each state in each year. Source: SPPQ State Data Set.


### Appendix D

**List of Acronyms**

The following are a list of recurring acronyms used in the text:

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCM</td>
<td>Bureaucratic Capacity Measure</td>
</tr>
<tr>
<td>CA DHCS</td>
<td>California Department of Health Care Services</td>
</tr>
<tr>
<td>CCNC/CA</td>
<td>Community Care of North Carolina/Carolina ACCESS</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>GMC</td>
<td>California’s Geographic Managed Care</td>
</tr>
<tr>
<td>HHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>HIO</td>
<td>Health Insuring Organization</td>
</tr>
<tr>
<td>HIP</td>
<td>Healthy Indiana Program</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>IFSSA</td>
<td>Indiana Family and Social Services Administration</td>
</tr>
<tr>
<td>IOMPP</td>
<td>Indiana Office of Medicaid Policy and Planning</td>
</tr>
<tr>
<td>LME</td>
<td>Limited Management Entities (North Carolina)</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MEDI-Cal</td>
<td>California’s Medicaid Program</td>
</tr>
<tr>
<td>OBRA</td>
<td>Omnibus Budget Reconciliation Act of 1981</td>
</tr>
<tr>
<td>PACE</td>
<td>Program for All inclusive Care</td>
</tr>
<tr>
<td>PAHP</td>
<td>Prepaid Ambulatory Health Plan</td>
</tr>
<tr>
<td>PCCM</td>
<td>Primary Care Management Provider</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
</tr>
<tr>
<td>PIHP</td>
<td>Prepaid Inpatient Health Plan</td>
</tr>
<tr>
<td>PM/PM</td>
<td>Per Member Per Month</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act of 2010</td>
</tr>
<tr>
<td>PPO</td>
<td>Preferred Provider Organization</td>
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<tr>
<td>WV BMS</td>
<td>West Virginia Bureau of Medicaid Services</td>
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APPENDIX E

Descriptive Statistics

a. Matrix of Individual Interview responses from NVivo analysis contained in Table 2.2

<table>
<thead>
<tr>
<th></th>
<th>Health Insurer</th>
<th>Medicaid Official</th>
<th>Legislative</th>
<th>Providers</th>
<th>Media/other Advocacy Group</th>
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<td>13</td>
<td>15</td>
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<td>Politics Influence</td>
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<td>14</td>
<td>16</td>
<td>12</td>
<td>15</td>
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<tr>
<td>Market Impact on Contracting Choices</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
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<table>
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<tr>
<th></th>
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<th>Medicaid Official</th>
<th>Legislative</th>
<th>Providers</th>
<th>Media/other Advocacy Group</th>
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</thead>
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<td><strong>Indiana Interview Classification</strong></td>
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### North Carolina Interview Classification

<table>
<thead>
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<th>Media/other Advocacy Group</th>
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<tbody>
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<td></td>
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<td>0</td>
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<td>1</td>
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<tr>
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<td>4</td>
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<td>3</td>
</tr>
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<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
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<tr>
<td>Market Impact on Contracting Choices</td>
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<td>3</td>
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</table>

### West Virginia Interview Classification

<table>
<thead>
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<th>Medicaid Official</th>
<th>Legislative</th>
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<th>Media/other Advocacy Group</th>
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</thead>
<tbody>
<tr>
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<td>5</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Bureaucratic Capacity as a concern</td>
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<td>14</td>
<td>11</td>
<td>10</td>
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<tr>
<td>Politics Influence</td>
<td>6</td>
<td>12</td>
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<td>8</td>
</tr>
<tr>
<td>Market Impact on Contracting Choices</td>
<td>3</td>
<td>2</td>
<td>3</td>
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<td>2</td>
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</table>

*Note: Significant t-test (95% Confidence Interval) results are noted in Table 2.2*
b. Distribution of Categorical Variable measuring state Health Political Action strength. Data supplied from Benz et al. (2010) standardized as contributions from Health related PACs per state lawmaker. Median Value of per state lawmaker contribution is $1719, Mean value is $5217. Categorical values are normally distributed based upon standardized values.

c. Distribution of Categorical Variable measuring state Health Political Action strength. Data supplied from Benz et al. (2010) standardized as contributions from Health related PACs per state lawmaker.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Distribution</th>
<th>Cut-Off Values</th>
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<tbody>
<tr>
<td>1=Low PAC spending</td>
<td>12 States</td>
<td>$43 to $603</td>
</tr>
<tr>
<td>2=Middle PAC spending</td>
<td>13 States</td>
<td>$646 to $1719</td>
</tr>
<tr>
<td>3=Moderately High PAC Spending</td>
<td>13 States</td>
<td>$1724 to $6187</td>
</tr>
<tr>
<td>4=High PAC spending</td>
<td>12 States</td>
<td>$6607 to $48,494</td>
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</table>

*Note:* Median Value $1724, Mean Value $5217.

<table>
<thead>
<tr>
<th>Bureaucratic Capacity</th>
<th>Correlation</th>
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</thead>
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<tr>
<td>Interest Group Measures</td>
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<td>Medicaid Interest Group Pop.</td>
<td>-.135*</td>
</tr>
<tr>
<td>Health PAC Strength</td>
<td>-.117*</td>
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<tr>
<td>Institutions and Capacity</td>
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</tr>
<tr>
<td>Gubernatorial Strength</td>
<td>-.087*</td>
</tr>
<tr>
<td>Squire Legislative Professionalism</td>
<td>-.139*</td>
</tr>
<tr>
<td>Medicaid Spending Per Capita</td>
<td>.117*</td>
</tr>
<tr>
<td>Education Spending Per Capita</td>
<td>.145*</td>
</tr>
<tr>
<td>State Spending Per Capita</td>
<td>.432*</td>
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<tr>
<td>Political Control</td>
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<td>Term Limits</td>
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<td>Unified Party Control</td>
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<tr>
<td>Governor’s Office</td>
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<tr>
<td>Markets and Demographics</td>
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<tr>
<td>HMO Penetration Rates</td>
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<tr>
<td>Percent Private Insurance Coverage</td>
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<tr>
<td>Unemployment</td>
<td>.1787*</td>
</tr>
</tbody>
</table>

*Indicates correlation is statistically significant where t<.05.

Note: *Indicates correlation is statistically significant where t<.05.

e. Construction of Bureaucratic Capacity Measure

\[ BCM = \frac{\text{Total Medicaid Agency Staff}}{\text{Total State Medicaid Population}} \]

An average value per year is calculated. This value is 100%. Each state is expressed in relation to the average for a given year.

Example: California has a value of 175.8 in 2007 (Table 3.3), which means the staffing levels as a portion of the population being served is 75.8% higher than the average state for 2007.
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