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UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

MEDICAID AND THE POLITICS OF STATE HEALTH CARE REFORM

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

SHAD BRENT SATTERTHWAITE
Norman, Oklahoma
1998

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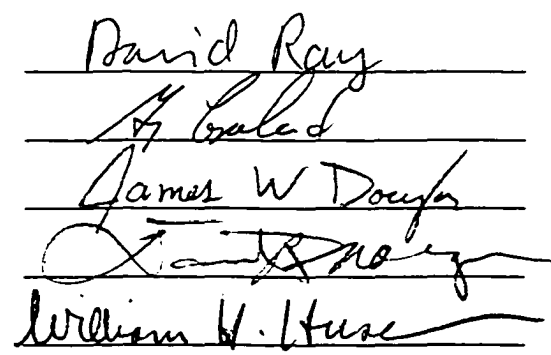
MEDICAID AND THE POLITICS
OF STATE HEALTH CARE REFORM

A Dissertation APPROVED FOR THE
DEPARTMENT OF POLITICAL SCIENCE

BY



Acknowledgments

This dissertation is not only the compilation of my research over the last two years, it is also the result of many hours of support and guidance on behalf of my family, friends, and advisors. I feel it is only appropriate to acknowledge those who contributed so much to this work.

My wife Valerie perhaps shouldered the greatest burden, sacrificing her time and energies to assist me with this project. It was truly a team effort whether she realizes it or not. She responded to countless requests for "dad" when I was occupied at the computer and she seemed to keep the world turning smoothly while I was researching health care policy. Her encouraging words never fell on deaf ears. Without her love and support, I couldn't have completed this project. This dissertation is dedicated to her.

David Ray has been a wonderful mentor and friend. He served as my advisor from the beginning of my graduate program. His 1113 Political Science class has had as much of an impact on my training as any graduate course that I enrolled in. He helped me get started on this dissertation and made sure that I was on track up to the end. His comments and suggestions were always welcome. He is an outstanding teacher in the true sense of the word.

Gary Copeland has also served on my doctoral committee from the beginning. He is one of the most insightful

professors I have had the pleasure to associate with. He taught me that political scientists not only have an obligation to students, but to the community as well. He is an excellent example of someone who tries to make the world a better place through teaching and service.

When I arrived at the University of Oklahoma in 1992, the first person I sought advice from was David Morgan. I found that I never stopped turning to him for advice. No matter how busy he was, it seemed he always had time to talk to me as well as many other graduate students. He has been a great editor, offering me several suggestions for my dissertation.

Jim Douglas was a very inspirational committee member. As someone who was in my shoes not long ago, he always offered words of encouragement. I appreciated his willingness to serve on my committee as well as his friendship.

I am grateful to all of the legislators, staff, and administrators working for the state of Oklahoma. They not only provided me with valuable information, but they made this project enjoyable.

My parents Brent and Dottie Satterthwaite have always supported me in my interests. Throughout my life they provided me with love and encouragement. While it is

impossible to pay them back for all that they have given me, I want them to know that I love and appreciate them.

Finally, one of the biggest daily rewards I have received is to be welcomed, surprised, or tackled by my children Megan, Tanner, and Pace when I came home from school. I am grateful for their patience in prolonging some of our activities while I was studying. I am grateful for my wife who continued to remind them that patience is a virtue whether they understood it or not. My family is my life.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

Medicaid and the Politics of State Health Care Reform

Abstract

This dissertation focuses on state policy innovation among Medicaid programs. Budget constraints and a Republican Congress have led states to become more resourceful in the ways which policies are implemented. Medicaid provides a good example, illustrating how many states have adopted managed care in an effort to reduce costs and broaden health care coverage. I too argue that states draw lessons from other states and that ideas pass through the medium of informal networks within state legislative bodies. I further contend that the adoption of managed care for Medicaid recipients is also influenced by other factors indigenous to a state. These factors create a context favorable to reform. To illustrate, I rely on data derived from a pooled cross-sectional time series analysis using variables such as the number of uninsured, the fiscal health of a state, and the number of years states have had HMOs.

This research draws upon the framework established by Oliver and Paul-Shaheen (1997). They argue that two general types of elements influence health care reform; contextual conditions and dynamic factors. Contextual conditions, described above, provide the opportunity for decision makers to act. Whether decision makers do so or not, depends

largely on the dynamic factors of leadership and information flow. This study closely examines Oklahoma's health care reform efforts in 1992 and 1993. This dissertation points out that while there was certainly an opportunity for reform, key legislators played an important role in getting legislation passed to place Medicaid beneficiaries in a managed care system. The study also examines the group politics involved in the reform process. Generally speaking, Medicaid consumers had the least access. Large interest groups, such as the nursing home association and the medical industry, were better represented than Medicaid beneficiaries. Ironically, those with the most influence, such as physicians and hospitals, fared worse than Medicaid consumers when the new managed care program was implemented in Oklahoma.

Chapter One

In the early 1990s, states began launching efforts to reform their Medicaid programs. These efforts continued despite the Clinton administration's proposal for a comprehensive health care system in 1993. Although the potential passage of the Clinton plan would have had a huge impact on state programs, states proceeded to tackle health care reform at their level.

Many states under heavy political and economic pressure sought to change the way Medicaid is administered. "We just can't wait," remarked Florida Governor Lawton Chiles. That wait, assuming Congress passed the Clinton bill, would have meant perhaps a three to five year implementation period (Lemov 1993). Considering the rising costs of health care and the large numbers of uninsured individuals, states did not have the luxury of waiting for a new federal program and so took the reins on Medicaid reform.

Importance of State Governments

Until recently, states have historically taken a back seat to the federal government in terms of policy innovation. In the 1930s and 1940s, states were obscured by a growing federal government that was responding to the crises of economic depression and war. The federal government continued to take the lead on major policy issues during the prosperous times through the 1960s. In the 1960s

however, states began to respond to public concerns over the economy and social conditions by implementing programs aimed at providing some form of relief for their indigent populations.

Shannon and Kee (1989) argue that the United States entered an era of "competitive federalism" following a trend away from centralized government. They point out that the federal government lost its fiscal advantage as public opinion turned against higher taxes and government spending in the late 1970s. High deficits in the 1980s constrained policy makers who wanted the federal government take a more active role in domestic policy. At the same time, states proved to be incredibly resilient during times of economic hardship and emerged as strong capable governments. Unlike a centralized system of federalism that features a strong federal government, competitive federalism offers a balance between the states and Washington D.C.

Certainly presidents Nixon, Carter, and Reagan emphasized a larger role for state governments. Conant (1989) notes that the states' role in the federal system became more prominent and visible in the 1980s. He lists several reasons for this including Reagan's "new federalism," larger national budget deficits, and new policy initiatives in areas such as education and welfare reform. Conant also points to long term trends that had been

developing throughout the 1970s and 1980s. These trends have contributed to an increase in power for state governments. Over the past three decades the size of state governments has grown. In keeping pace with this growth, states have expanded their capacity to bring in revenue.

Bowman and Kearney (1986) note that other, precipitating factors also appear to have had an impact on state resurgence. They note, for example, that a distrust in government has eroded popular support for many federal programs. A recent Gallup Poll[1] (1995) found public opinion on the side of states for implementing Social Security. The poll asked; "Which do you think is more likely to administer Social Security programs efficiently - the federal government in Washington or the government of your state?" Seventy-four percent of the respondents felt that their state government would administer the programs more efficiently, compared with 20 percent who felt that the federal government would do a better job. Other polls have consistently pointed out that the public feels state and local governments: are more responsive to citizens' needs, have the most honest public officials, and are more efficient than the federal government (Roeder 1994). Roeder (1994, 2) noted that "rather than representing a conservative, backward, invisible, or corrupt level of

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[1] The poll was conducted between March and May 1995.

government, states are now viewed by many as being in the vanguard of governmental reform, innovation, and responsiveness." Bowman and Kearney (1986) also contend that many states have asserted their role in taking the lead on many reforms in public policy.

> The states can no longer be considered the weak links of the federal system. Indeed they have become the new heroes of American federalism, implementing national policies throughout their borders in a responsible and responsive manner, while increasingly assuming an active role in the affairs and problems of their local governments. The resurgence of the states represents a new era in U.S. federalism as power and authority are being attracted from the national and the local governments to the state like bits of metal to a powerful magnet (40).

In efforts to become more efficient, state governments have undergone constitutional and institutional reforms. Conant (1989) points out that between 1965 and 1978, the executive branch in 21 states went through a comprehensive reorganization. Bowman and Kearney (1986) note other factors contributing to the increased role of state governments. These factors include the growth of the intergovernmental lobby and organizations such as the National Council of State Legislators (NCSL) and the National Governors Association (NGA), increased party competition, and "dysfunctions" of federal grants-in-aid.

States have increasingly found themselves in a position to play a more active role in governing. State officials are competent and willing to take innovative approaches to various problems. Shannon and Kee (1989) note:

> Today's state and local governments....are led by more qualified elected officials, with streamlined executive branches, modern financial management systems, and more representative and effective legislative bodies. The innovators of domestic policy of the 1990s are most likely to be found at the state and local level, not in the federal government (15).

These officials have often taken the lead in health care reform efforts.

Facing rising numbers of uninsured, increased Medicaid enrollment, rising health care costs, and limited state budgets, states began turning to managed care as a possible solution. Federal legislation in 1981 made it easier for states to experiment with the administration of Medicaid programs. In the late 1980s, states began to apply for federal waivers to place portions of their Medicaid populations into "experimental" programs using managed care. The Health Care Financing Administration (HCFA) recorded that Medicaid managed care enrollment more than doubled between 1987 and 1992 (GAO 1993). In 1993, the General Accounting Office conducted a study of six states that were experimenting with Medicaid managed care programs. The study found that managed care was generally cost effective when compared to traditional fee-for-service programs. More recently, however, Paul Van de Water, Assistant Director for Budget Analysis at the Congressional Budget Office, noted that any savings achieved from enrolling Medicaid beneficiaries in managed care are not likely to be large in the long run.[2] Most of the managed care programs that have

been implemented have targeted women and children, rather than consumers requiring more expensive medical care, such as the elderly and disabled.

Issue Evolution

Health care and Medicaid reform is an interesting study in issue evolution. Carmines and Stimson (1989) follow the same logic in biological evolution to explain how some issues come to the political forefront and dominate a legislative agenda. Basically, they argue that in a diverse society, such as found in the United States, new issues will continue to arise. However, due to the constraints of legislative institutions, not all of these issues will find room for acceptance, nor will they always be a priority for the electorate. In the competition for attention, some issues will fit well into the current policy environment, while other issues become extinct (Cobb and Elder 1972). Carmines and Stimson note four mechanisms responsible for promoting some issues over others: 1) strategic choice by politicians and parties for leverage in competitive democratic politics, 2) external disruptions, 3) old issues transformed by a new context, and 4) internal contradictions and imbalances within society which generate demands for corrections and change.

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[2] Statement made before the Subcommittee on Health and Environment, Committee on Commerce, House of Representatives, 12 February 1997.

Subsequent chapters point out how health care became an important issue in the early 1990s. It became a central theme in Bill Clinton's presidential campaign in 1992, and it took a high priority on his legislative agenda the following year. In light of the health care policy debate, many states began to focus on their Medicaid programs. They sought ways to trim costs and expand access to those without health insurance. State responses to Medicaid reform vary as do the circumstances surrounding it. Grogan (1997) points out that cost control is a primary goal in most managed care systems. However, many policy makers also hoped that this could translate into broader access to health care.

The goals of adopting a managed care program for Medicaid recipients are not always well defined. These goals may also vary from state to state. Tennessee, for example, was facing a huge budget shortfall in its Medicaid program just prior to its move to managed care. The new managed care system appealed to both sides of the aisle in the legislature since it promised to control costs and improve access. Tennessee is similar to Oklahoma in that it first attempted to pass a provider tax to alleviate fiscal pressures. The tax failed in both states and policy makers had to turn to alternate solutions. Unlike Tennessee, however, Oklahoma began to cut back on available Medicaid

services. Prior to its adoption of managed care, Oklahoma was largely containing Medicaid costs for its AFDC population. Furthermore, Oklahoma did not attempt to expand coverage to a greater number of uninsured as did Tennessee (Ku and Wall 1997). In its first year, Tennessee had expected to enroll 300,000 uninsured and uninsurables in TennCare, its managed care program. The state hoped that eventually, most of its uninsured would be covered in this new system (GAO 1995c).

Getting back to Carmine and Stimson's (1989) framework for issue evolution, they make a distinction between easy and hard issues (1980, 1989). "Easy" issues can be understood by the general public as well as political activists. They require almost no factual knowledge or formal reasoning. An easy issue is understood at the "gut" level. "Hard" issues require more contextual knowledge and are not easily understood by those who pay little attention to politics. Hard issues are clearly the domain of political elites.

Carmines and Stimson note that when race became a partisan issue after 1964, it realigned the parties and their issues in a coherent manner. When combined with partisanship, other issues became easier for those with little political knowledge. They argue that issues cutting

across partisan divisions either bring about a realignment or wither on the vine. Most hard issues simply fade away.

How does the issue of Medicaid reform and managed care in particular fit with the notion of issue evolution? Using Carmines and Stimson's (1989) framework, other scholars (Brandon, Arrington, and Schoeps 1997) argue that mandatory enrollment in HMOs is both a good example of a hard issue and a new issue on the political scene. They point out the complexity of the issue noting that it is not clearly defined in either conservative or liberal terms. As this study points out, the idea of managed care appeals to both political parties. This study also illustrates the complex nature of health care reform and the reliance of legislators on so-called expert colleagues.

Research Problem

This dissertation addresses the question, Why do states adopt managed care programs for their Medicaid populations? Or, put in more general terms, What causes a government to adopt a new program? Using Medicaid as an example, a primary objective of this research is to ascertain factors that lead to policy adoption. The study focuses on Medicaid for several reasons. First of all, it is a federally mandated program that all states participate in. States vary in terms of eligibility requirements, the size of their Medicaid program, and the amount spent per beneficiary. A

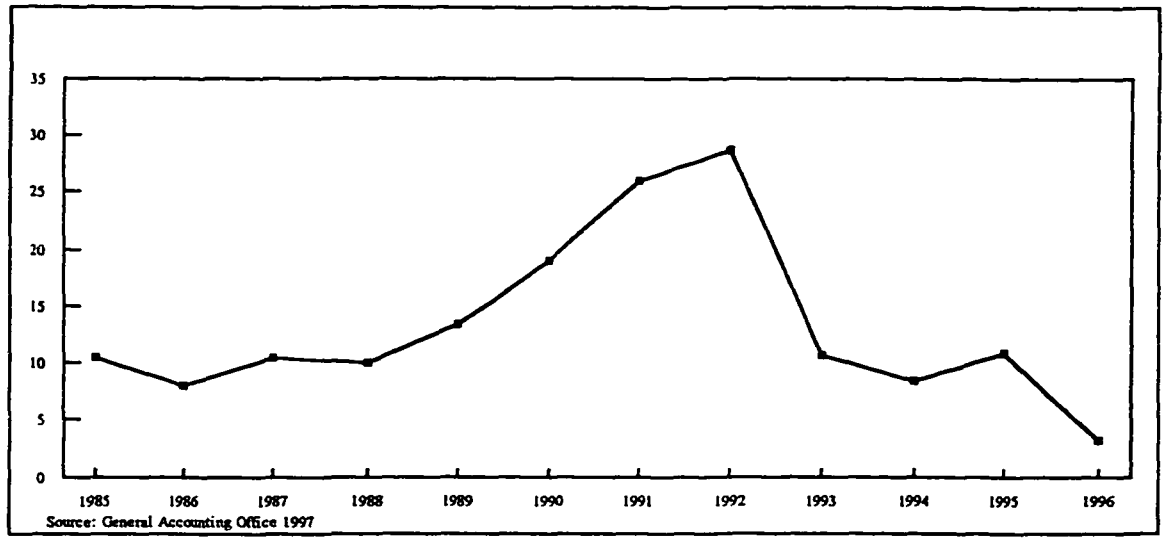
recent study (GAO 1997b) pointed out wide variations in states' Medicaid growth. Whereas one state's 1996 Medicaid expenditures decreased by 16 percent, expenditures in another state increased by 25 percent. As long as they stay within certain federal guidelines, states have a great deal of leeway in implementing the program. Because of this latitude, there is a lot of variation among programs that originated under the same federal law. Consequently, there is ample opportunity for comparison.

Second, Medicaid is a largely untapped resource which could provide clues to possible future health care reform. Sparer (1996) noted that what states have done in regard to Medicaid reform may serve as an indicator as to what health care reforms, if any, may be implemented. There is an abundance of data on Medicaid programs. Health and health care policy statistics are readily available. Most sources break down information by state. In addition, government agencies such as the Health Care Financing Administration (HCFA) publish periodic data detailing health care expenditures. Information and data can also be obtained by interviewing those who played a key role in the adoption of policies. For this study, I conducted several interviews with lawmakers, administrators, representatives from involved health care organizations and policy analysts. Many of those involved in the early stages of the adoption

continue to play a role in its implementation. This information is crucial to understanding the political climate that plays such an important role in health care related policy decisions.

Finally, the topic of Medicaid is relevant. Program costs for Medicaid have fluctuated dramatically over the years. (See figure 1.2) Between 1985 and 1993 federal Medicaid expenditures rose at an average rate of 16 percent a year. The growth in Medicaid spending has recently slowed down. In 1996, Medicaid's growth rate fell to an estimated 3.3 percent. While this is a noticeable and welcome change, sustaining this slower growth rate may be difficult. Medicaid accounts for about 20 percent of all state spending. Changes in Medicaid under the 1996 welfare reform act did little to change the way states administered Medicaid. Under the new welfare law, states would be required to (1) continue to offer Medicaid for one year to those who lost welfare benefits due to increased earnings, and (2) continue to provide Medicaid to those who would have been eligible if the program were still in effect. In an effort to deal with these mandates and trim their costs, states are turning to alternative plans for the administration of Medicaid.

Figure 1.1: Annual Growth Rate of Medicaid Expenditures, 1985-1996



Importance of the Research

The policy process can be defined as "the range of factors which affect governmental policy decisions and the impacts of those decisions on society " (Sabatier 1991). In 1991 Paul Sabatier called for studies that would lead to a better understanding of this process. He contends that the dominant theories in this area have outlived their usefulness primarily because they are not causal. The dominant paradigm of the policy process is the stages heuristic articulated by scholars such as Jones (1970), Anderson (1975), Ripley & Franklin (1987) and Peters (1993). In this model the policy process is divided into succinct stages of agenda setting, formulation and adoption, implementation, and evaluation. While this archetype

provides a useful description of the overall policy process, Sabatier argues that it does not go far enough. He contends that theories of this nature do not take into account factors that drive the process from stage to stage. There is a great deal that takes place at every step of the way. By closely examining each step, we can gain a better understanding of how events, actors, and institutions combine to mold policy decisions.

This research is important because it examines the forces that move the process. By focusing on what causes a government to adopt a new program, in this case managed care in state Medicaid programs, it is hoped that this research will make a useful contribution to theories of policy research. It is also hoped that this study will help bridge a gap between political scientists who tend to focus on institutions and behavior, and policy scholars who pay attention to other areas such as policy communities and information.

Scope and Theory of Study

This study focuses on the first stage of the policy process, i.e., policy formation. Using Medicaid and managed care as an example of innovation in state government, it attempts to point out the variables which contribute to the adoption a new program or policy. The research relies on quantitative data as well as information derived from

surveys and interviews with key players in the legislative process.

Innovation in state government has been defined[3] as a "program or policy which is new to [the state] adopting it" (Walker 1969, 881). Or, as Virginia Gray put it, "a program or policy that is new to one state is labeled an innovation there even though other states may already have adopted it" (Gray 1994, 231). Gray contends that analyzing innovation and the factors that facilitate or retard it is intrinsically valuable. She notes that innovation studies highlight the role of states as "policy laboratories." These laboratories portray the activism in states and serve a valuable role in the federal system. She cites Richard Nathan (1989) who argues that states have often undertaken liberal initiatives when the federal government is controlled by conservatives and later, when it is controlled by liberals, these "tested" policies form the basis for new federal programs. Nathan points out that state initiatives in the 1920s set up a model for many New Deal programs in the 1930s.

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[3] The term "innovation" is misleading as it has traditionally been used by scholars describing the phenomena of policy adoptions across states. Chi (1996) points out that practitioners in the public sector consider innovations to be more of a "pioneering" effort. He argues that by using the definition noted above, every state can be considered an innovator because states borrow ideas from each other. He suggests that other terms such as "adapt" or "borrow" should be used, and that the term innovation be used in the same way as "creation" or "novelty."

To answer the question of why a state adopts a managed care policy, this study argues that the presence of certain conditions creates an environment that is more favorable toward Medicaid reform. These conditions are what Oliver and Paul-Shaheen (1997) refer to as contextual conditions. These conditions create a political opportunity (Berry and Berry 1992) that lawmakers can then capitalize on. Many variables indigenous to a state, such as the percentage of uninsured, policies of neighboring states, a state's financial condition and policy history may constitute an occasion to pass reform legislation. These variables are examined in a pooled time series analysis to see which factors were most prevalent at the time states adopted a managed care policy.

Contextual conditions are useful in determining which states are more likely to pursue health care reform. However, these conditions by themselves do not portray an accurate picture of the policy process. To get a better idea of why states adopt a managed care policy, this study follows a general framework developed by Oliver and Paul-Shaheen (1997). They note that "contextual conditions" provide a background for political reform, but that "dynamic factors" also must be examined. These dynamic factors are often less tangible than the political or economic conditions within a state, but they are none-the-less

valuable. Dynamic factors include the role of legislators and the politics involved in decision making. The second part of the study melds the quantitative analysis with a qualitative process study. In other words, once quantitative indicators of innovation have been analyzed, the study then turns to a detailed analysis of the decision-making process. Here the emphasis is placed on the dynamic factors in the process rather than the context. Using Oklahoma as a case study, the research traces the evolution of Medicaid reform focusing on the role of specialist legislators and the flow of information. The study draws on information from interviews with key individuals to find out the extent which these variables played in the decision making process.

An approach such as this is advocated by Gray (1994), who believes we should explore information networks to find out how information is transmitted. Diffusion studies should perhaps focus on more than just what other states are doing. She feels that surveys of state legislators and staff are needed to find the multiple sources of information used in the decision-making process.

For this research project, I use a similar type of analysis. Through interviews and surveys, I try to identify (1) the primary communication networks linked to the decision-making process, (2) key opinion leaders (policy

entrepreneurs or agenda setters), and (3) the level of influence of key players in the process. To better understand the flow of policy and political information in the legislative process, I conducted interviews with people representing all parties involved in, or affected by the decision to adopt a new policy. These parties include legislators (specialists and nonspecialists), administrators of Medicaid in Oklahoma, committee staff and task force members[4], providers groups, and people in or representing the Medicaid population itself.

Using one state as a case study has its advantages and disadvantages. Advantages include easy access to decision makers and other involved parties, as well as the opportunity to become very familiar with the context and details of the reform process. On the other hand, using only one state as a case study limits the generalizability of the study. However, I feel that generalizability can be sacrificed in favor of a more richly detailed and feasible analysis. Many studies which have examined or followed a single bill through the legislative process (Redman, 1973; Birnbaum and Murray, 1987; Cohen, 1995) have provided valuable insights even though each case was itself unique.

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[4] In 1992, a task force consisting of members of the Oklahoma Legislature and representatives from several health care related fields worked with consultants from KPMG Peat Marwick to develop alternatives to the traditional fee-for-service Medicaid program.

Sparer's 1996 book on health care policy looks at Medicaid programs in New York and California. He notes the vast differences between the two states in the way Medicaid is administered. In truth, no two Medicaid programs are alike. In order to study any Medicaid policy in depth, a caveat limiting inference is always attached. One edited book, attempts to get around this by looking at the experience of Medicaid reform in sixteen states. In essence, it is a compilation of sixteen different studies. While it would be extraordinarily difficult to examine Medicaid programs in all fifty states, single cases can provide valuable insights into the political forces that are at work in health related reform policies. While part of this study may be narrowly focused, I believe that a great deal can be learned about the nature of diffusion which in turn can be applied to future studies.

Contents

The object of this dissertation is to find out why states (Oklahoma in particular) adopt managed care programs for their Medicaid recipients, and more specifically, why a state adopted a particular form of policy. This study will also examine the role of specialist legislators in the policy making process and other factors that contribute to the final policy outcome. In the first chapter, my primary concern is setting up the research question and providing a

brief overview of the research that has been conducted to date on the policy process. In Chapter Two, I will provide an overview of the Medicaid program. Here I want to convey the differences among states and point out the recent trend toward program reinvention.

I introduce a way to study this trend in Chapter Three. I argue that innovation takes place when certain conditions are present. I propose using event history analysis (EHA) to measure the effects of external and internal determinants on policy decisions. These determinants make up the contextual conditions which create an environment favorable for health care reform. This may lend support to Mohr's (1969) argument that organizations are more likely to innovate when they have the motivation for doing so.

Chapter Four examines the history of Oklahoma's health care policy for its indigent and then looks at the events leading up to its decision to adopt a managed care system for its Medicaid program.

In Chapter Five, I provide a more detailed analysis concerning the flow of information in the innovation process and suggest that several dynamic factors such as leadership and the transmission of ideas may play an important roll in the policy making process. Here I refer to the work of Sabatier and Whiteman (1985) who have provided a framework from which information currents can be traced. I also draw

on Kingdon's 1989 study examining sources of information that can be tapped by legislators when it comes time to make a policy decision. To do this, I rely on data obtained by interviews of several key players in the decision making process. I look at the extent to which policy makers draw lessons from other states and the level of influence certain specialists have when it comes to complicated policy issues such as Medicaid reform. The chapter also examines the group politics, or the role of those who were stakeholders in Oklahoma's Medicaid program.

In Chapter Six, I examine some of the consequences of Medicaid reform, not from an implementation perspective, but from a political one. Using data derived from focus group sessions in 1997, the study attempts to determine who, if anyone, either benefited or lost out due to the new managed care program. In Oklahoma's "rush to managed care," there may have been some concerns of involved parties that were overlooked or simply not considered. This chapter tries to assess if the interests of those involved, such as physicians, HMO providers and hospitals were taken into account during the decision making process? And, now in retrospect, were these concerns realized? In other words, who were the winners and losers in the managed care policy?

Chapter Two

Introduction

This chapter provides an overview of Medicaid. Medicaid programs vary from state to state, but all contain the same basic elements as mandated by Congress. Over the years, Congress has increasingly mandated that states alter their programs to include a greater number of eligible beneficiaries. Despite these mandates, states still have a tremendous amount of latitude in determining the nature of their program.

Medicaid grew out of two programs that gave grants to states in order to provide medical care to low income persons. The first program was enacted as an amendment to the Social Security Act of 1950. Before 1950, many welfare payments intended for medical expenses were not earmarked as such, and recipients could use the funds for any purpose. The 1950 Act provided matching federal funds to states for direct payments to medical providers. Ten year later, Congress passed the Kerr-Mills Act, creating the Medical Assistance for the Aged program. The Kerr-Mills program expanded the 1950 laws to include the elderly who were living above federally established cash assistance levels but needed help paying medical bills. It was later expanded to include the indigent disabled. By 1965, 40 states, the District of Columbia, Puerto Rico, the Virgin Islands, and

Guam had implemented Kerr-Mills programs.[1]

In 1965 Congress passed Titles XVIII and XIX of the Social Security Act. Title XVIII created Medicare and Title XIX established Medicaid. Both laws sought to provide medical assistance to two different groups: Medicare for the elderly and Medicaid for the financially and the medically needy. Both programs differed substantially in the way they were to be administered. Rashi Fein (1986) compares the two approaches to two separate social experiments to determine which method of administration is most efficient, effective, and equitable. Medicare was established for the most part as a federal program with some administrative responsibilities *delegated* to carriers and intermediaries, whereas Medicaid programs were in essence *relegated* to the states. While it is relatively easy to determine eligibility for Medicare, eligibility requirements for Medicaid vary from state to state . In truth, Medicaid consists of not one, but 56 separate programs. Participation in Medicaid is voluntary. However, all 50 states plus the District of Columbia, American Somoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands have elected to implement the program. Arizona

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[1] For a detailed history of programs that were forerunners to Medicaid see Congressional Research Service's (1993), *Medicaid Source Book* and Paul Starr's (1982) *The Transformation of American Medicine.*

initially declined to participate, and its program began only in 1982.

Medicaid is a federal and state program that finances health care for about 37 million low income Americans. Medicaid provides health protection for: (1) low-income families and individuals with disabilities; (2) long term care for the elderly and individuals with disabilities; and (3) Medigap coverage that is intended to fill in the gap between Medicare benefits and services that otherwise would not be provided for. In 1995 Medicaid served the following populations:

18.7 million children

7.6 million adults who care for children

4.4 million elderly

5.9 million blind and disabled

This chapter examines the nature of Medicaid in terms of eligibility, the services offered, and the way various programs are administered and financed. The study also points out several reasons why Medicaid costs have risen so drastically over the years. These costs among other things have given states an incentive to restructure their Medicaid programs.

Eligibility

States administer their own programs within broad established guidelines (42 U.S.C. 1396 [a]). All states

must cover certain categories of individuals. States vary greatly in terms of eligibility limits and programs offered (see Table 2.1). The Medicaid statute defines over 50 distinct population groups eligible for coverage. However, these groups can be broken down into 1) AFDC-related groups, 2) Non-AFDC pregnant women and children, 3) Others to include the elderly and disabled, and 4) the medically needy. The following is a brief discussion describing the categorically and medically needy populations.

AFDC[2]-related groups

Aid to Families with Dependent Children (AFDC) is a financial assistance program established under the Social Security Act of 1935. The program provided financial support for children who were living with one parent or a relative. The program was later changed, giving states the option to include children living in two parent families. Before the welfare reform legislation in 1996, states had to provide Medicaid to all of those receiving AFDC assistance. This also included AFDC-related groups such as the "Ribicoff children" whose resources were within AFDC standards but did not meet the definition of "dependent child." States were also required to continue Medicaid coverage for specific

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[2] The Aid to Families with Dependent Children (AFDC) program has been replaced by the Temporary Assistance for Needy Families program with the passage of the Personal Responsibility and Work Opportunity Act of 1996. For this study the terms AFDC and TANF are virtually synonymous.

amounts of time to families who lost AFDC benefits due to employment or increased earnings. Under the 1996 law, states are required to provide Medicaid to those who would have been eligible for AFDC. States also must continue Medicaid coverage to those who lose their welfare benefits for one year.[3]

Table 2.1: Medicaid Eligibility for Families, 1987

State	*Eligibility Limit as a percentage of Three-Person Poverty Line*	*Cover Two-Parent Families?*	*Ribicoff Option?*	*SOBRA for Children & Pregnant Women?*	*Medically Needy Program?*
Alabama	15.6%				
Alaska	79.3		X		
Arizona	53.0		X	X	X
Arkansas	34.1		X	X	X
California	112.5	X	X	X	X
Colorado	55.7				
Connecticut	82.7	X	X	X	X
Delaware	41.0	X		X	
Florida	47.5	X	X	X	X
Georgia	46.3	X	X		X
Hawaii	56.5	X			X
Idaho	40.2				
Illinois	60.6	X	X		X
Indiana	38.1				
Iowa	57.3	X	X		X
Kansas	61.5	X	X		X
Kentucky	35.3	X		X	X
Louisiana	30.8	X			X
Maine	73.8	X	X		X
Maryland	55.2	X	X	X	X
Massachusetts	87.1	X	X	X	X
Michigan	71.4	X	X	X	X
Minnesota	93.8	X	X		X

[3] For a description of how the 1996 welfare bill affected Medicaid see "Provisions of the Welfare Bill." in *CQ Weekly* vol. 54 August 3, 1996. pp. 2192-2193.

Table 2.1: Continued

State	*Eligibility Limit as a percentage of Three-Person Poverty Line*	*Cover Two-Parent Families?*	*Ribicoff Option?*	*SOBRA for Children & Pregnant Women?*	*Medically Needy Program?*
Mississippi	48.7		X	X	X
Missouri	37.3	X	X	X	
Montana	54.0	X	X		X
Nebraska	59.5	X	X		X
Nevada	37.7				
New Hampshire	64.3				X
New Jersey	74.9	X	X	X	X
New Mexico	34.9			X	
New York	81.6	X	X		X
North Carolina	46.3	X	X	X	X
North Dakota	57.6		X		X
Ohio	40.9	X	X		
Oklahoma	62.3	X	X	X	X
Oregon	72.6	X		X	X
Pennsylvania	56.2	X	X	X	X
Rhode Island	83.8	X	X	X	X
South Carolina	51.3	X	X	X	
South Dakota	48.4				
Tennessee	46.7		X	X	X
Texas	35.3		X		X
Utah	97.7		X		X
Vermont	99.2	X	X	X	X
Virginia	47.4				X
Washington	76.1	X		X	X
West Virginia	38.4	X		X	X
Wisconsin	84.8	X	X		X
Wyoming	47.6				

Source: Shapiro and Greenstein 1988

Non-AFDC pregnant women and children

Between 1984 and 1990, Medicaid coverage gradually expanded to include pregnant women and children based on resources rather than those enrolled in AFDC. States are

now required to cover pregnant women and children under age six family incomes below 133 percent of the federal poverty level and children under the age of 19 whose family income is below 100 percent of the poverty level. The Balanced Budget Act of 1997 also expanded medical coverage to children. States have some flexibility in determining eligibility, but it is generally limited to children in families earning up to 200 percent of the poverty level. The new law gives states approximately $20.3 billion to insure children over a five year period. States can use the money to either (1) expand Medicaid coverage to include more children, (2) set up a statewide program designed especially to provide health care to more children, or (3) some combination of both. Some states, such as Oklahoma, have already implemented some type of program.

Others

States are required to cover those receiving Supplemental Security Income (SSI) and those who have lost SSI for a period of time. SSI was a federal program adopted in 1972. It provides federal financial assistance to adults who are blind, disabled, or who otherwise have difficulty caring for themselves. Many states supplement SSI with their own programs. States also have to provide limited coverage for "qualified Medicare beneficiaries" (QMBs), defined as those aged and disabled persons who are receiving

Medicare and have incomes below 100 percent of the poverty level. States may further provide Medicaid to those in nursing facilities or institutions.

The Medically Needy

States have the option to extend Medicaid to the "medically needy." These are persons not eligible for Medicaid because their incomes exceed the maximum standard. Medically needy persons are allowed to "spend down" by incurring medical expenses to offset excess income. Approximately 40 states participated in a medically needy program. States that offer a medically needy program must include children under 18 and pregnant women who except for income and resources would qualify as categorically needy.

Medicaid does not provide medical assistance to all poor persons. While Medicaid generally targets individuals with low incomes, not all the poor are covered and not all who are covered are poor. Health coverage is only available to those who meet the criteria established by federal and state governments. Many states have programs in addition to Medicaid to assist the indigent, but federal funds are not provided to these "state only" programs.

Services

Medicaid services can be categorized as (1) services which states are required to administer, (2) services that are optional to administer but still may be partly funded by

the federal government, and (3) services provided at 100 percent state expense. State Medicaid programs cover a minimum set of health services prescribed by federal law. In order for states to receive federal funding, Title XIX of the Social Security Act requires that the following basic services must be offered to Medicaid recipients:

1. Inpatient hospital services
2. Outpatient hospital services
3. Physician services
4. Medical and surgical dental services
5. Nursing facility (NF) services for individuals aged 21 or older
6. Home health care for persons eligible for nursing facility services
7. Family planning services and supplies
8. Rural health clinic services and any other ambulatory services offered by a rural health clinic
9. Laboratory and x-ray services
10. Pediatric and family nurse practitioner services
11. Federaly-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the state plan
12. Nurse-midwife services
13. Early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age 21

In addition to these medical services, states may provide services such as drugs, eyeglasses and inpatient psychiatric care. These optional services and coverage to optional populations account for over 50 percent of Medicaid benefit payments.[4] Because states have so much discretion

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[4] For a detailed description of how the 1996 welfare bill affected Medicaid see Health Care Financing Administration. 1995. *Medicaid: An Overview*. September. Baltimore, MD. p. iii.

over which options to provide and which population groups to extend benefits to, no two Medicaid programs are alike. The following table illustrates the diversity of optional services provided for among states.

Table 2.2: Optional Medicaid Services and Number of States Offering Each Service, 1995

Service	States offering services to categorically needy only	States offering services to both categorically medically needy	Access to include health services to the uninsured
Podiatrists' services	11	29	6
Optometrists' services	14	30	6
Chiropractors' services	5	21	2
Psychologists' services	6	18	3
Medical social workers' services	1	5	1
Nurse anesthetists' services	8	13	2
Private duty nursing	7	18	3
Clinic services	15	35	5
Dental services	12	31	6
Physical therapy	11	29	4
Occupational therapy	7	24	4
Speech, hearing and language disorder	11	26	4
Prescribed drugs	16	34	6
Dentures	8	26	5
Prosthetic devices	15	32	6
Eyeglasses	13	30	-
Diagnostic services	8	23	4
Screening services	7	23	3
Preventive services	7	21	4
Rehabilitative services	15	31	6
Services for age 65 and older in mental institutions:			
A. Inpatient hospital services	13	22	5
B. SNF services	10	17	4
C. ICF/MR services	22	23	6
Inpatient psychiatric services	11	24	6
Christian science nurses	1	2	1
Christian science sanitoria	2	8	3
SNF for under age 21	14	27	6
Emergency hospital services	13	24	5
Personal care services	9	19	3
Transportation services	14	34	6
Case management services	16	26	5
Hospice services	11	23	4
Respiratory care services	2	10	4
TB related service	2	6	4

Source: The 1996 Greenbook

Administration and Financing

Medicaid is administered at the state level. The Health Care Financing Administration (HCFA), part of the U.S. Department of Health and Human Services (DHHS), is the federal agency responsible for oversight. Most states have a similar agency, such as a health or welfare agency, charged to implement the Medicaid program. Within broad federal guidelines, states are allowed to (1) establish criteria for eligibility, (2) determine the services covered, and (3) administer their own programs and determine provider reimbursement policy. Table 2.2 illustrates the roles played by the federal and state governments in the administration and funding of Medicaid.

Table 2.3: The Federal and State Partnership in the Medicaid Program

Federal Roles	State Roles
Establish Mandatory Eligibles and Services	Set Specific Policy on Coverage of Optional Eligibles and Services
Establish Broad Guidelines for Optional Eligibles and Services	Determine Eligibility of Medicaid Patients
Approve State Plan Amendments for Eligibility, Coverage, and Payment Methods	Determine Provider Qualifications and Enroll Providers
Authorize Program Waivers	Set Provider Payment Methods and Levels
Authorize Demonstrations	Process and Pay Medical Claims
Compile National Statistics on the Program	Communicate With Beneficiaries
Award Grant Moneys to the States	Develop Contracts With Managed Care Plans and Monitor Them
Perform Financial and Program Oversight	Oversee Quality of Care in Facilities Funded by Medicaid

Table 2.3: Continued

Federal Funding	State Funding
Medical Services - FMAP Share	Medical Services - State Share
Claims Processing System Development - 90%	System Development - 10%
Claims Processing System Operation - 75%	System Operation - 25%
Skilled Medical Professional Employees - 75%	Skilled Medical Professionals - 25%
Most Other Administrative Costs - 50%	Other Administrative Costs - 50%

Source: Health Care Financing Review

Costs for administering Medicaid are shared by the states and the federal government. The federal portion of the payment is known as the Federal Medicaid Assistance Percentage (FMAP). Current law requires the federal government to finance a minimum of 50 percent and up to a maximum of 83 percent of the total health care costs.[5] The FMAP is determined on the basis of per capita income and is adjusted on an annual basis.

States are directly responsible for reimbursing health care providers. For the most part, states have general discretion in determining the methods and rates for services. There are, however, three exceptions under which states are required to abide by certain federal guidelines in the reimbursement of providers: (1) for institutional services, payments may not exceed amounts that would be paid under Medicare payment rates; (2) for disproportionate share

[5] One exception to this is the Indian Health Service Facilities which receive 100 percent of federal funds for health services.

hospitals, rates are not bound by the Medicare upper limit; and (3) for hospice care services, rates cannot be lower than Medicare rates. States use several methods to determine fee-for-service payments to institutions and physicians. For institutions, payments can be based on the costs incurred, or they can be determined in advance. Payments to physicians can be broken down into two methods: fee schedules and reasonable charge methods. With fee schedules, states specify a maximum payment for each service. Under the fee schedule method of reimbursement, states use the prevailing or customary charge in the area for comparable services.

Differences Among States

States have a great deal of discretion concerning those who are eligible for Medicaid, the type of services offered to Medicaid recipients, and the way in which health care providers are reimbursed for their services. With this much latitude, it is little wonder that state programs vary as they do. For example, Nevada provides Medical services for 410 of every 1000 people below the federal poverty level. Rhode Island on the other hand, serves 1770 per 1000. State spending varies as well, ranging from an average of $2,436 per person in Mississippi to $7,276 per person in New York[6].

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[6] Arizona and Tennessee have lower figures due to the unique nature of their Medicaid programs and are considered an aberration in this case.

Diversity can be seen in the per capita expenditures of Medicaid enrollees and the number of those enrolled per 1000 living at or below the federal poverty level (fpl)[7] as shown in table 2.4.

Table 2.4: Medicaid Expenditures and Enrollees per 1000 federal poverty line (fpl), Fiscal Year 1995

State	*Federal Match Rate (1995)*	*Spending per recipient (1995)*	*Enrollment per 1000 fpl (1994)*
Alabama	70.45	2,698	660
Alaska	50	3,698	980
Arizona	66.40	441	700
Arkansas	73.75	3,893	770
California	50	2,097	920
Colorado	53.10	3,619	700
Connecticut	50	5,588	1030
Delaware	50	4,128	700
Florida	56.28	2,768	750
Georgia	62.23	2,681	720
Hawaii	50	4,983	780
Idaho	70.14	3,129	540
Illinois	50	3,608	740
Indiana	63.03	3,359	770
Iowa	62.62	3,406	880
Kansas	58.90	3,250	820
Kentucky	69.58	3,035	790
Louisiana	72.65	3,449	680
Maine	63.30	4,965	980
Maryland	50	4,873	660
Massachusetts	50	5,460	1114
Michigan	56.84	2,918	890
Minnesota	54.27	5,386	710
Mississippi	78.58	2,436	760
Missouri	59.85	2,932	680
Montana	70.81	3,300	530
Nebraska	60.40	3,609	910

[7] Some of these results will be overstated since several states have set eligibility requirements to receive Medicaid benefits above the federal poverty level.

Table 2.4: Continued

State	*Federal Match Rate (1995)*	*Spending per recipient (1995)*	*Enrollment per 1000 fpl (1994)*
Nevada	50	3,322	410
New Hampshire	50	4,880	740
New Jersey	50	4,828	890
New Mexico	73.31	2,491	640
New York	50	7,276	920
North Carolina	64.71	2,928	730
North Dakota	68.73	4,839	750
Ohio	60.69	3,644	1060
Oklahoma	70.05	2,680	610
Oregon	62.36	2,937	880
Pennsylvania	54.27	3,766	840
Rhode Island	55.49	4,973	1770
South Carolina	70.71	2,902	630
South Dakota	68.06	4,120	610
Tennessee	66.52	check	920
Texas	63.31	2,562	640
Utah	73.48	2,895	810
Vermont	60.82	3,210	1310
Virginia	50	2,690	860
Washington	51.97	2,285	1010
West Virginia	74.60	3,009	760
Wisconsin	59.81	4,118	810
Wyoming	62.87	3,328	880

Source: Health Care Financing Administration

Medicaid's Growing Share of the Federal and State Budgets

Medicaid grew at a rapid pace between the early 1980s and 1990s. In 1981, Medicaid primarily served welfare recipients at a cost of $28 billion (constant dollars). By 1996 it had grown into a $152 billion program that enrolled

about 37 million people with different health insurance needs (See figures 2.1 and 2.2)

Figure 2.1: Growth in Medicaid Expenditures, 1981-1996.

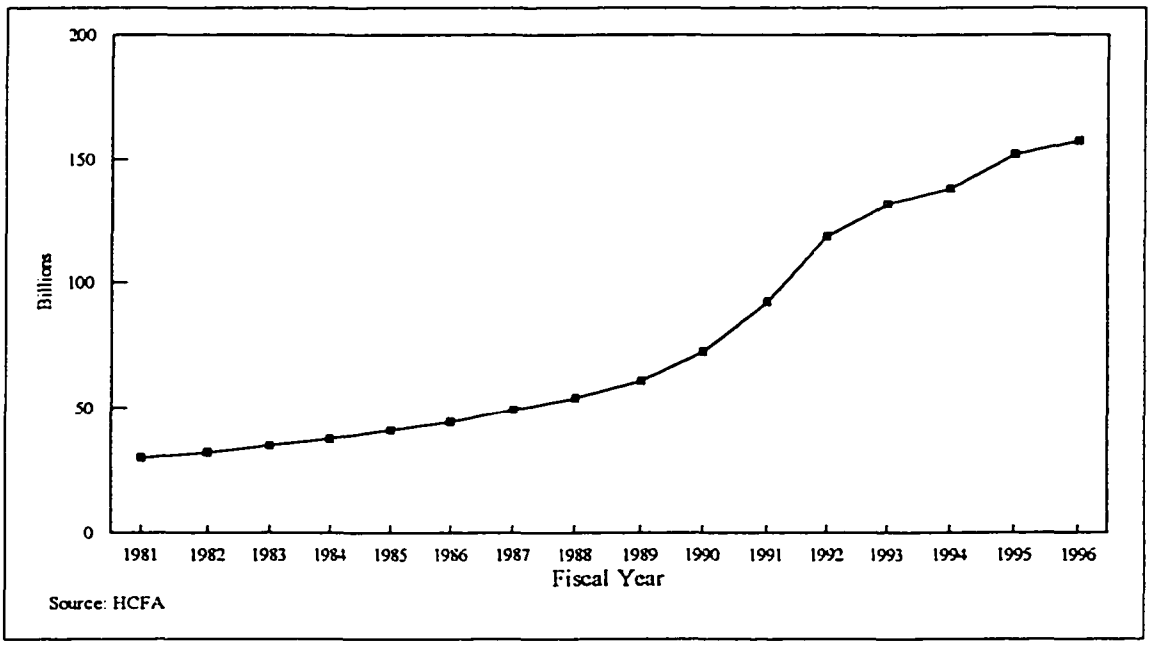
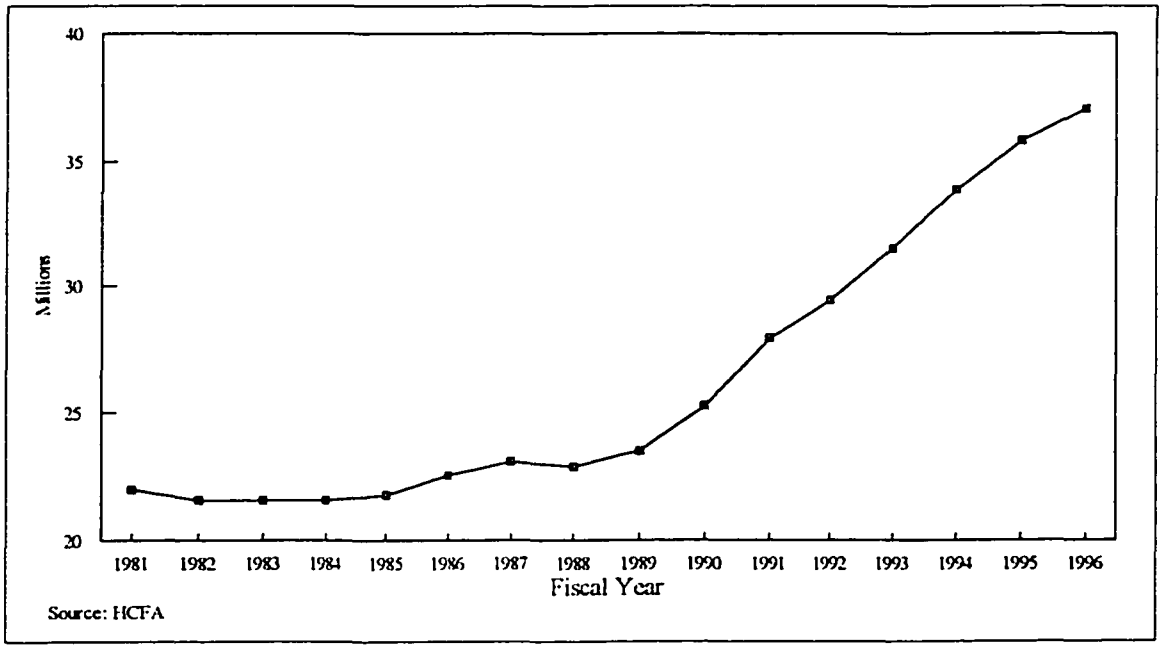


Figure 2.2: Growth in Medicaid Enrollees, 1981-1996.



Medicaid has been one of the fastest growing items in states budgets and it currently accounts for 5 percent of total federal spending. In 1995, states paid $66 billion or 43 percent of all Medicaid costs while the federal government paid $86 billion or 57 percent of the program costs.

The growth in Medicaid spending since the early 1980s is interesting in light of the Omnibus Budget Reconciliation Act (OBRA) of 1981. OBRA 81 enacted a three year reduction in federal matching percentages for states that exceed growth targets. It also reduced eligibility for welfare benefits and gave states with medically needy programs more authority to limit coverage. OBRA 81 also established section 1915(b) and 1915(c) (freedom of choice and community based services) waiver programs, which gave states additional flexibility in determining reimbursement methods. Indeed, these actions appear to have had some effect. Between 1979 and 1981, Medicaid spending averaged 17 percent a year. In 1982 it dropped to 7 percent.[8] This decrease in spending was short lived, however, as Medicaid costs began to escalate. Ironically, the drop in Medicaid spending between 1979 and 1981, may have contributed to the rise of

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[8] Not all of this drop can be attributable to these programs. Much of it can be explained by the drop in inflation. One study found that Medicaid spending is sensitive to economic conditions. See Government Accounting Office, *Medicaid: Restructuring Leaves Many Questions*. April 1995.

ideas on how to expand the program. The late 1980s and early 1990s witnessed the most accelerated growth in Medicaid spending. Expenditures increased by 13 percent in 1989, 19 percent in 1990, 27 percent in 1991, and 29 percent in 1992. Even considering the inflation, this rate of growth seems staggering. It should be noted here that the growth in Medicaid has slowed down substantially, from a rate of 29 percent in 1992 to 10.7 percent in 1993. This rate continued to decline averaging about 9 percent for the next two years and a very low estimated growth rate of 3.3 percent in 1996 (GAO 1997b).

Several studies have attempted to explain this rapid growth in Medicaid spending during the late 1980s and early 1990s (Weissert 1992; Coughlin et al. 1994; GAO 1995a). While scholars differ on many points, four explanations generally emerge: (1) the increase in Medicaid enrollment; (2) medical price inflation; (3) higher provider reimbursements; and (4) special financing programs. The following is an overview of each.

Increased Enrollment

Despite early efforts to trim Medicaid spending, Congress passed a series of laws throughout the 1980s that expanded coverage beyond the traditional welfare categories. Beginning in 1984 Congress passed the following:

Deficit Reduction Act of 1984 (DEFRA). Expanded eligibility to first time pregnant women and children up to age five.

It also required states to provide coverage to two-parent families whose principal earner was unemployed.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Required states to cover all remaining pregnant women that met AFDC standards.

Omnibus Budget Reconciliation Act of 1987 (OBRA 87). Allowed states to provide Medicaid coverage to pregnant women and infants with family incomes up to 185 percent of the poverty level. It also extended coverage to children up to age seven, or age eight at the state's option, for those who met financial eligibility standards.

Medicare Catastrophic Coverage Act of 1988 (MCCA). Required states to phase in coverage of pregnant women and infants under age one with incomes under 100 percent poverty level.

Omnibus Budget Reconciliation Act of 1989 (OBRA 89). Required states to extend coverage to pregnant women and children up to age six that had incomes under 133 percent of the poverty level.

Omnibus Budget Reconciliation Act of 1990 (OBRA). Required states to cover all children under the age of 19 with family incomes under 100 percent of the poverty level.

No new expansions occurred after 1990. In fact, the 1993 Deficit Reduction Program, while not limiting or scaling back eligibility, sought to limit some services.[9] Despite the concern, Medicaid enrollment continued to increase. Between 1988 and 1992, approximately 7.5 million more people were added to the Medicaid program. Pregnant

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[9] The 1993 bill did the following: repealed a mandate that required states to provide personal care services for Medicaid beneficiaries outside of the home; stated that organ transplants for illegal aliens did not constitute an emergency procedure; required a delay in granting eligibility to Medicaid patients in nursing homes who disposed of assets for less than fair market value 36 months before the day of application; tightened conditions under which states designate disproportionate share hospitals (DSHs); and established Medicaid fraud control units. See *Congressional Quarterly Weekly Review,* September 18, 1993 pp. 2491-2494.

women and children accounted for most of the new beneficiaries. While they account for nearly 70 percent of the growth, estimates show that this group is responsible for only 9.3 percent of the increase in Medicaid expenditures. The blind, disabled, and elderly make up approximately 19 percent of the increased enrollment, yet Medicaid expenditures for this group account for 20 percent of the total spending increase (Coughlin et al., 1994). By 1995, the blind, disabled and elderly people made up less than 30 percent of the total Medicaid population but that group accounted for more than 60 percent of the total expenditures.

Medical Price Inflation

An report published by the Urban Institute (1994) cites inflation as a factor contributing to Medicaid cost increases. According to the report, inflation made up 26 percent or $16 billion in price increases between 1988 and 1992. In patient hospital care and nursing home care were among the biggest culprits. In patient spending grew from $11.5 billion in 1987 to 17.4 billion in 1990, an increase of 51.8 percent.

Some scholars (Drake 1994 and Blank 1997) note that part of the reason for such high costs is due largely to the practice of American physicians and their increased use of high technology medicine. Technology has recently been

developed in areas ranging from magnetic resonance imaging to genetic repair and organ transplants. It seems that even though only a small portion of the population will ever take advantage of this technology, society wants to have the benefits which these advances in medicine offer.

Reagan (1992) points out that a great deal of expensive diagnostic and therapeutic equipment is now in use in "nonhospital settings," such as physician offices and other clinics. In order to pay for this equipment, costs are passed on to the consumer, or the person being treated. Doctors like to use the technology, and it is reassuring to patients.

Higher Provider Reimbursements

Under most Medicaid programs one of two basic payment methodologies are used: retrospective and prospective. A *retrospective system* determines payment amounts after services are rendered. Reimbursement is based on actual costs and may be limited to "reasonable" costs as defined by the state. In a *prospective system,* payments are determined in advance and are usually a flat rate regardless of whether actual costs are more or less.

Before 1980, state Medicaid programs used the same reimbursement methods found in Medicare. This meant that states used a "retrospective reasonable cost system." Attached to the Omnibus Reconciliation Act of 1980 was an

amendment adopting a less restrictive standard for Medicaid reimbursements to nursing homes. Rather than being cost related, the Boren Amendment, as it became known, required that nursing home reimbursement be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities (42 U.S.C. 1996a [13] [A])." In response, several states developed reimbursement systems which paid a flat rate regardless of the actual costs. Reimbursement systems varied across states, with most states opting for the prospective payment method.[10] This discretion over reimbursement was extended further when Congress applied the Boren Amendment to hospitals in 1981. While the amendment gave states increased flexibility in reimbursement, it also established a benchmark by which payment systems were to be measured.

The language contained in the Boren Amendment set off a string of court cases challenging many state reimbursement systems. In the mid-1980s, the courts upheld state policy decisions. In *Nebraska Health Care Association v. Dunning* (575 F. Supp. 176 [D Neb. 1983]), the court stated that "Congress intended that states set their own reimbursement rates without stifling and expensive oversight." Courts upheld reimbursement policy in other decisions.[11] In the

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[10] See Congressional Research Service's *Medicaid Source Book* (p. 335) for results of a survey conducted by the National Governors' Association in 1989 concerning reimbursement methods used by the states.

late 1980s and early 1990s court opinion began to change. For example, in *Temple University v. White* (729 F. Supp. 1093 1990, affirmed CA.s, 90-1112, 1991), a court ordered Pennsylvania to comply with requirements for extra payments to disproportionate share hospitals (DSHs). In two cases, *Amisub PSL Inc. v. Colorado* (879 F. 2d 789 [10th Cir., 1989) and *Multicare Medical Center v. State of Washington* (W.D. Wa. C88-4212, 1991), courts held that across-the-board cuts in hospital rates did not meet the "reasonable and adequate" standard specified by law. The Supreme Court put its mark on court challenges to the Boren Amendment in *Wilder V. Virginia Hospital Association* (496 U.S. 498 [1990]) by stating that health care facilities had a right to seek judicial review of the reasonableness and adequacy of Medicaid rates. Other court cases followed.[12] Many states raised reimbursement rates to settle cases. In other cases, rate increases were ordered by the courts. States no longer looked to cutting reimbursement rates as a way to save

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[11] See *Mississippi Hospital Association v. Heckler,* 701 F. 2d 511 (11th Cir. 1983); *Colorado Health Care v. Colorado Department of Social Services,* 842 F. 2d 1158 (10th Cir. 1988); *Wisconsin Hospital Association v. Reivitz,* 733 F. 2d 1226 (7th Cir. 1984); and *Carbon Hill Health Care v. Beasley,* 528 F. Supp. 421 (M.D. Ala. 1981).

[12] For example, see *Pinacle Nursing Home v. Axelrod,* 719 F. Supp. 1173, 1990; *Health Care Association of Michigan v. Babcock,* W.D. Mi, K 89-50063 CA 1990. By July 1991 litigation of Boren amendment cases was pending in 12 states, while hospitals in 10 states were considering filing suit. See *Medicaid Source Book,* p. 309.

costs. The Boren amendment was eventually repealed as part of the 1997 budget compromise.

Special Financing Programs

In the mid-1980s, states began tapping into a funding gold mine of sorts in the way of creative financing. It began in 1985 when the Health Care Financing Administration (HCFA) established a regulation which allowed the use of private donations to the state for Medicaid expenditures. A loophole in the regulation let donations finance a portion or all of the state's share of Medicaid services. This new regulation could apply if two conditions were met:

- -the funds had to be transferred to the Medicaid agency and be under its administrative control; and
- -the funds could not revert to the donor unless the donor was a nonprofit organization, and the Medicaid agency decided on its own to use the donor's facility.[13]

West Virginia and Tennessee were the first states to develop a program in which hospitals helped finance the state's portion of Medicaid expenses through donations. The program worked something like this: A disproportionate share hospital (DSH) charges the state $100 for a service which actually costs $60 (perhaps less). Assuming the state had a federal matching rate or FMAP of 60 percent, the state's share of the bill would be $40. The federal government pays $60 for the service and the provider or DSH "donates" an

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[13] See *Medicaid Source Book,* for a detailed review of this policy.

additional $40 to the state, leaving the state with a net cost of $0. Many states began to adopt similar donation programs.

Table 2.5: Hypothetical Donation Scheme

Charged hospital rate	$100
Actual hospital rate	60
Total Medicaid payment	100
Federal share	60
State share	40
Hospital donation to the state	40
Net cost to the state	0

In 1988 HCFA was preparing to issue new rules that would limit donations. Congress through the passage of the Technical and Miscellaneous Revenue Act of 1988, postponed the issuing of these rules until May 1, 1989. This deadline was later extended by OBRA 89 and OBRA 90.

With rising Medicaid costs and a great deal of debate, Congress passed the Voluntary Contribution and Provider-Specific Tax Amendments of 1991. This act virtually put an end to the creative financing schemes developed by states. The new law (1) defined acceptable taxing authorities, (2) defined a bona fide donation, (3) set a cap on revenues from provider-specific taxes and donations, and (4) limited disproportionate share payments. In general, the Voluntary Contribution and Provider-Specific

Tax Amendments of 1991 prohibited the use of federal funds to match revenues obtained through provider donations.

According to a GAO report, this creative financing was "the most important cost driver in 1991 and 1992," representing nearly $1 of every $7 spent on Medicaid (GAO 1995a, p. 33). DSH payments grew from around $1 billion in 1990 to $17 billion in 1992. An Urban Institute study (1994) figures that these payments account for nearly 28 percent of Medicaid's spending increases from 1988 and 1992.

The Drive Toward Program Reinvention

States have historically been active in health care policy innovations. Some scholars (Nathan 1989; Silver 1991) note that many federal social programs have been tested in the states before they were adopted at the federal level. Weissert and Weissert (1996) point out 39 major health care policy innovations among various states between 1965 and 1995. These policies range from state mandated employer sponsored insurance to medical savings accounts. Some states have passed broad sweeping changes, while others have taken a more incremental approach. In the early 1990s, some states like Oregon and Tennessee sought to achieve near universal access to health insurance in part by expanding Medicaid coverage. Other states like Hawaii and Massachusetts approached universal coverage through employer mandates. Hawaii has been the most successful, covering

approximately 98 percent of its citizens. The attempt in Massachusetts, on the other hand, did not work. The Massachusetts plan called for a 12 percent surtax on businesses that did not provide insurance for their employees. This tax would go toward health care insurance to the uninsured provided by the state. The bill was signed by Michael Dukakis, but was later repealed out of fear that it would hurt the state's ailing economy.

One of the more controversial reforms was Tennessee's TennCare program. TennCare replaced the state's fee-for-service Medicaid program with a capitated managed care system. TennCare's objectives were to provide health care to more uninsured individuals and control costs. While these objectives were largely met, concern was raised over the quality of care provided. Managed care organizations (MCOs) complained that they were receiving inadequate funds to support their participation in TennCare. Many physicians who were not satisfied with the program declined to participate, thereby limiting availability. Several Medicaid beneficiaries themselves indicated on a survey that the care they received through TennCare was worse than that through Medicaid (GAO 1995c).

Rising costs, a general dissatisfaction with government, and a recession led to a desire for change in the way government did business in the early 1990s. Bill

Clinton campaigned largely on the theme of change and a new vision. Shortly after his inauguration, President Clinton established the National Performance Review and placed Vice-president Gore in charge. "We intend to redesign, to reinvent, to reinvigorate the entire national government," Clinton remarked as he announced the creation of this new task force (EOP Report 1993). A major feature of this reinvention would be the empowerment of state and local governments. Clinton, the first sitting governor to be elected since Franklin Roosevelt, had always felt that states could be used as experimental laboratories for various programs.

That state and local governments would develop fresh ideas is nothing new. In their book, *Reinventing Government* (1992), Osborne and Gaebler offer several examples of innovation by state and local governments. Their book was used as a blueprint of sorts for Gore's commission on reinventing government. These events depicted by Osborne and Gaebler reflect a general trend among government and business leaders.

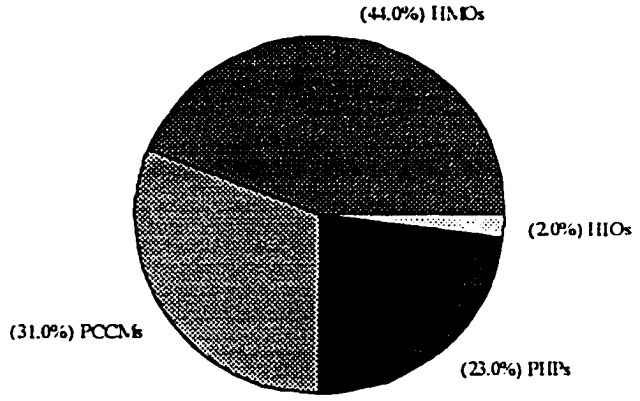
With the issue of health care and Medicaid, many states began experimenting with ways to cut costs and improve access. Perhaps the most popular innovation at the state level was the managed care concept. States use several different types of managed care models. They can place

Medicaid enrollees in risk or non-risk based managed care systems. Under a riskbased system, the state contracts for a full range of Medicaid services. This is often referred to as a capitated model, which bases the capitation payment on the anticipated average, per person, health care cost of a Medicaid population.

There are three types of risk based contractors and one that is non-risk based that will be highlighted here: health maintenance organizations (HMOs), prepaid health plans (PHPs), health insurance organizations (HIOs), and primary care case management (PCCM). Figure 2.3 illustrates the extent to which these are used. HMOs offer an array of services on a risk basis. Enrollees belonging to this system are restricted to using providers authorized by the HMO. All HMOs involved in Medicaid are subject to federal standards and regulations. PHPs are similar to HMOs but offer services based on a "partial capitation" model or, in other words, they only offer a partial array of covered Medicaid services. HIOs finance beneficiary providers and are at risk if costs exceed the state's payment. This type of system is primarily suited for those who use long term medical care such as the elderly and disabled. Primary care case management (PCCM) is a non-risk based system wherein Medicaid beneficiaries are assigned to a primary care case manager. This manager, often a physician, is responsible

for overseeing the health of these patients. The provider is paid by the state on a per-service basis rather than a capitated rate.

Figure 2.3: Types of Managed Care Used by Medicaid (1994)



Source: HCFA

In order to move Medicaid populations into managed care on a large scale, states need to receive approval from HCFA in the form of a waiver. In the early 1990s, states began seeking approval for broader changes to their Medicaid programs under a section 1115 waiver. The authority for the waiver is contained in section 1115(a) of the Social Security Act (U.S.C. 1315[a]), and it waives statutory requirements for Medicaid and other related programs for

demonstration projects. These waivers are granted for a 5 year renewable period. In granting a waiver, HCFA requires the state to prove that its program or demonstration will be budget neutral--that is, federal expenditures should not exceed costs that are projected for the existing Medicaid program. In short, these 1115 waivers gave states flexibility to "reinvent" their Medicaid programs to some degree in an effort to make them more efficient.

There are two general reasons why many states began seeking to reform their Medicaid programs: economic and political.

Economic

Medicaid has been referred to as the PAC-Man of state budgets (Weissert 1992). In the late 1980s and early 1990s, Medicaid grew at a rapid pace, averaging 16 percent a year between 1985 and 1993. In 1993 Medicaid consumed 46 percent of all spending for means-tested programs. This figure was three times than the amount spent on the Food Stamp program. It was this rapid growth that made state officials so nervous.

In 1993 Medicaid was consuming roughly one-quarter of Tennessee's entire budget, and it looked like things would only get worse. Facing a predicted cost increase of nearly $700 million that year, Governor Ned McWherter addressed the state legislature. "No issue is more urgent," he declared,

"and without a solution, the entire state government in Tennessee remains in Jeopardy" (Brown 1996). He requested permission from lawmakers to design an alternative plan for administering Medicaid. Governor McWherter's request was granted and by January 1994, "TennCare," a managed health care program, was established.

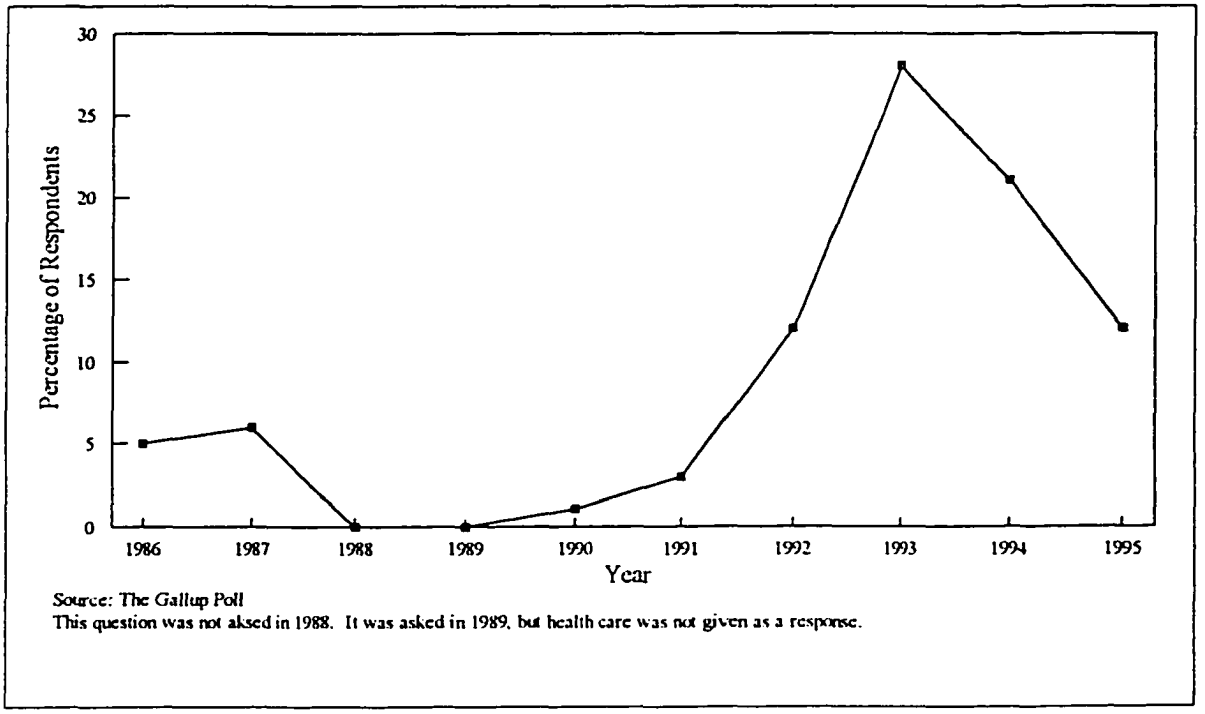
Economic reasons clearly contribute to the need for program reform. As Medicaid expenditures were increasing, states were struggling with their own budgeting problems. The recession in the late 1980s and early 1990s only made matters worse. In fiscal year 1994, Medicaid consumed an average of 19.4 percent of state budgets.

Political

Political conditions can also provide an explanation for the drive for reinvention among state Medicaid programs. Opinion polls conducted by Gallup show that beginning in the early 1990s, health care became a major concern for many Americans (See Figure 2.4). In response to the question "what do you think is the most important problem facing this country today?," 11 percent of the respondents in 1990 said health care. Health care ranked 11th behind other problems with drugs being the most important. Three years later in 1993 health care surpassed crime as being the most important problem in the eyes of 28 percent of those surveyed. While it fell behind crime as the most important issue in 1994 and

1995, it still accounted for a large percentage of responses. In the early 1990s, random surveys asking questions such as, "do you think there is a health care crisis in the United States?," revealed that a majority of Americans felt that there was such a crisis.

Figure 2.4: Survey Results Identifying Health Care as the Most Important Problem



This concern over health care is also illustrated by the 1991 Senate race in Pennsylvania. Following a freak aircraft accident that claimed the life of Senator John Heinz, Governor Bob Casey had a chance to appoint the first Democratic Senator from Pennsylvania in 30 years. After several likely contenders declined, including Lee Iacocca,

he settled on Harris Wofford, his secretary of labor and industry. Republicans gleefully welcomed the appointment figuring Wofford would be an easy target in the fall election. Even the media dismissed his potential as evidenced by a portion of an article in the *New York Times*.

> He (Wofford) has a stunning resume, but relatively few people know his name. He is a suburbanite from the Philadelphia area, a disadvantage when running for a seat usually held by a Pittsburgher. He is closely associated with Gov. Robert P. Casey, whose popularity has plummeted since he proposed raising taxes on businesses and on gasoline and cigarettes this year. And Mr. Wofford, who calls himself a progressive Democrat, carries the heavy political baggage of being a Kennedy liberal in a rather conservative state.
>
> And as if all that were not enough, Mr. Wofford's Republican challenger may be Dick Thornburgh, the United States Attorney General and a former two-term Pennsylvania Governor (Hinds 1991a).

When Thornburgh officially announced his candidacy in August of 1991, he was the odds-on favorite with polls giving him anywhere between a 25 to 40 percent lead. While Thornburgh was running on his reputation as a popular governor, Wofford ran an offensive campaign and stuck to a single issue. That issue, one that Wofford encountered time and time again as secretary of labor and industry, was health care. In one of his campaign ads he remarked, "if criminals have a right to a lawyer, working Americans have a right to a doctor."

Wofford's message had resonance. A statewide Pennsylvania survey conducted during the campaign indicated

that 94 percent felt that "making sure that everyone is able to receive adequate health care," was an important factor in their voting decision (Hinds 1991b). In the last month before the election Wofford climbed in the polls by nearly a percentage point a day and ended up defeating Thornburgh with 56 percent of the vote. In a speech following the election, Wofford echoed President Kennedy saying, "let the word go forth from this place on the Delaware to our nation's capital on the banks of the Potomac. We want national health insurance!" (Hinds 1991c)

The health care issue was addressed by President Bush who said that he would have a health care plan that he could take to the American people before the 1992 election. The issue was also picked up by Democratic presidential hopefuls Bob Kerrey and, later, Bill Clinton. After the November election, Clinton made health care reform a major priority and put his wife in charge of a group responsible for drafting legislation.

Although national health reform failed in 1994, many still held out hope for reform at the state level. Sparer (1996) argues that the only consensus arrived at during the 1993 debate was that authority for implementation of any health reform package would be delegated to the states. As reasons for this consensus, he cites the significant role that states already play in health policy and the aversion

to centralized government in the United States. During the 1995 budget talks, Clinton sought help from a bipartisan group of governors over the issue of Medicaid. Their task was to develop a program that would accomplish three objectives: (1) give states more flexibility to design their Medicaid programs, (2) insure adequate coverage for low-income people, and (3) save money.[14] Many parts of their proposal ended up in the welfare overhaul passed by Congress in August of 1996.

Conclusion

In summary, Medicaid programs vary a great deal across states. Some states provide more Medicaid services than others and spend more per beneficiary. Eligibility also varies. Since Medicaid is a part federal and part state sponsored program, the federal government can set certain standards that have to be met by all states. Federal mandates increasing enrollment in the 1980s led to more Medicaid expenditures. Combined with medical price inflation and higher provider reimbursements Medicaid costs began to soar. Many states began looking for alternate ways to finance their share of the program. This led to creative

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[14] The GOP Congress wanted to control costs and give states more flexibility, and Clinton wanted to ensure access to health care. While he supported state flexibility as governor, as president he felt that he should stand behind the federal government's 30 year commitment to health care. See Fraley, Colette. "Governors Looking for the Key to Open Way for Medicaid." *Congressional Quarterly Weekly Report.* December 16, 1995. pp. 3813-3814.

financing schemes involving disproportionate share hospitals. When congress placed restrictions on this type of financing, several states began to consider reforming their Medicaid programs.

Many state officials feel that states can do a better job managing and serving their Medicaid populations if they were given the leeway to control the system. Kevin Piper, Wisconsin's Medicaid director remarked, "When Congress says, 'We can't run the program, we don't want to, and we can't afford to,' go to the can-do sorts--governors. States are the only parties that have the capability, the expertise and the track record to run Medicaid" (Fraley 1995). Most states agree that as long as there is some equity across states, or that their state is getting its fair share, they would like to have some flexibility in the way their Medicaid programs are managed.

Chapter Three

States have been increasingly encouraging Medicaid recipients to enroll in managed care. Since 1991, 24 states have applied for comprehensive health care reform demonstration waivers. These section 1115 waivers permit states to mandate enrollment in managed care plans. In return, states agree to expand Medicaid coverage and accept federal spending limits.

This change in the way Medicaid programs are administered is a good example of innovation among states. Innovation has been defined as "an idea, practices or object that is perceived as new to [the state] or unit of adoption" (Rogers 1983, 135). By this definition, each adopting state is an innovator, not simply the first state adopting a managed care policy. In one of the earliest studies on innovation by state governments, Walker (1969) sought to answer two major questions: "1) why do some states act as pioneers by adopting new programs more readily than others, and once innovations have been adopted by a few pioneers, 2) how do these new forms of service or regulation spread among the American states?" This research addresses the same questions concerning managed care among states.

Nice (1994) suggests that innovations occur in the context of one of three broad components. These include the problem environment, available resources, and orientation

toward government activity. The *problem environment* refers to the need to address or correct deficiencies that a state may be experiencing. Severe problems, that may constitute a crisis, will force lawmakers to pay attention to an issue. The assassination of James Garfield led to the passage of the Pendleton Act in 1883. The oil embargo in the early 1970s led to the adoption of several energy saving programs. Problems may also encourage interest groups to put more pressure on decision makers. Some problems may not be quite as severe and may only require a simple adjustment or slight policy change. Nice points out that satisfactory performance encourages the continuation of the status quo. *Available resources* allow states to be more innovative since they have more funding for experimentation and start up costs. Slack resources, or resources that are not needed for the ongoing operations of government, can serve as an important force for innovation. They may lead to innovation to avoid the embarrassment of having any money left over. States that are barely making ends meet, will avoid spending funds on a new program that potentially may fail. Since wealthier states have an easier time raising revenue, they are more likely to have more slack resources, and thus be more innovative. *Orientation toward government activity* includes not only the views of the public but the disposition of government institutions toward change. In

states where people are skeptical of change, decision makers are more likely to take an incremental approach, making minor changes to current policy. Ideology may affect prospects for innovation. Whereas liberals may encourage innovation and greater government participation, the more conservative states may favor stability over change and reforms that favor the market. This study concerning managed care in state Medicaid programs draws on factors similar to those proposed by Nice.

Scholars (Berry and Berry, 1990; Gray, 1994) point to two types of explanations that have been helpful in explaining why some states adopt policies before others. *Internal determinants* are factors within the state and may include political, economic, and social characteristics. *External determinants* are influences that come from outside the state, and may include regional diffusion, federal incentives, and professional associations.

Internal Determinants

Most of the models used to test internal determinants involve a cross-sectional analysis where the political, economic, or social characteristics serve as the independent variables. The dependent variable has been either the year in which a policy was adopted, or whether a state has adopted the policy by a specific date or not. A drawback to

these cross-sectional analyses is that the causal variables are not always measured immediately before the event or the year in which a state adopted a particular policy. As a result, it becomes difficult to gauge the effect of political, economic, and social forces in operation at the time of adoption.

A great deal has been written about the effects of internal influences on state policy adoption. Economic factors have consistently been important across studies of innovation. Walker (1969) finds that larger wealthier states seemed to be more innovative than poorer states since they could dedicate more resources for developing new programs. Gray (1973) also obtains similar results. Berry and Berry's (1990) findings suggest that economic factors have an impact on the adoption of a particular policy. They argue that a state's fiscal health is an important factor in determining whether a state will adopt a lottery. For example, if a state's expenditures exceed its revenue, decision makers may consider a lottery to make up for any budgetary shortfalls.

Social and political characteristics of a state also affect a state's ability to innovate. Morgan and Meier (1980) point out that religion has an impact on support for moral issues, such as gambling and liquor laws that come up on referenda. In areas of Oklahoma that were predominantly

Catholic for example, citizens were more likely to favor gambling than other fundamentalists or Protestants. In his seminal 1966 study, Daniel Elazar suggested that states can be defined by their political culture. Miller (1991) concludes that a state's political culture, as categorized by Elazar, influences state expenditures in several different policy areas. Sigelman and Smith (1980) note that affluent states with moralistic political cultures and highly professionalized legislatures were more likely to adopt consumer protection laws. Chi and Grady (1990) find that the professionalism of bureaucrats had an impact on innovation in state governments. Professionals possessing advanced degrees and who are active in their profession tend to more innovative. They note that many of these bureaucrats belong to interstate organizations, and they are informed of new policies introduced in other states.

Nice (1994) suggests that public opinion also may affect a state's innovative behavior. In addition to public attitudes, the inclination of political parties and a state's experience with policy change may further contribute to the orientations of the state concerning government and change. Research on the relationship between public opinion and policy indicates that the collective decisions of government institutions closely mirrors public preferences (Jacobs and Shapiro 1994). Skocpol (1994) notes that public

opinion is often influenced by preexisting government institutions and programs. Both public opinion and previous policy decisions contribute to a specific orientation regarding change and innovation. Some states may simply be more predisposed to innovate than others. Most studies indicate that of the economic, political, and social variables, economic factors consistently seem to be the most important.[1]

External Determinants

Outside influences may also have an effect on state policy decisions. States often find themselves competing with other states to attract businesses and promote economic development. This competition allows citizens to compare tax burdens among the states and move or threaten to move (Dye 1990). Peterson, Rom and Scheve (1996) note that states can pursue two options. States can provide "high quality" places for business with a skilled work force, educational institutions, and cultural amenities. States can also adopt "low cost" strategies with a low tax burden and cheap labor.

States can also be influenced by policies of the federal government. Welch and Thompson (1980) argue that policy diffusion from the federal government to the states is more likely to occur when states are offered direct

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[1] See Gray (1994) for an extended discussion of economic, social, and political factors as internal variables.

incentives of fiscal aid. Even with the incentives, Welch and Thompson point out that the diffusion of most policies takes place over long periods of time. They also note that because the federal government is involved in so many policy areas, many interstate organizations have emerged to deal with matters of policy. These organizations provide networks that facilitate policy diffusion.

Other outside factors may include professional associations or interest groups. Organizations with specific agendas may often focus on state governments as well as Congress in an effort to promote legislation affecting their interests. Unlike businesses looking for a favorable business environment, these groups are more interested in implementing standard policies across states.

Regional diffusion has been one of the most popular external determinants. Diffusion theory has been used in general comparative studies examining a myriad of policies involving several countries (Collier and Messick 1975; Bennett 1991; Rose 1993; Coleman 1994). Also referred to as policy convergence or lesson drawing (Rose 1989, 1993), diffusion theory holds that a state or country is influenced by the actions of its neighbors. Since Walker's 1969 study of policy diffusion across states, several scholars have tested for regional diffusion. Many, like Walker, have used factor analysis to find states having similar orders of

policy adoption and then checked to see if these clusters come from the same region. Another approach involves models examining the relationship between states that have adopted a certain policy and neighboring states adopting similar programs (e.g., Lutz 1986; Filer, Moak, and Uze 1988). Both strategies have come under some criticism by those who contend that the results are too descriptive and ignore the explanation of the diffusion process (Berry and Berry 1990; Gray 1994).

Combined Models

Many scholars have tested internal and external determinant models separately. Berry and Berry (1990) have proposed a model that considers a state's internal factors and external pressures simultaneously. They examine lottery adoptions across states and argue that the actions of a neighboring state have a greater impact when a state's internal characteristics are favorable for innovation. They find that a lottery is likely to be adopted when a state is in poor fiscal health, during an election year, if per capita income is high, when a lower percentage of the states adhere to fundamentalist religions, when party control is split and if neighboring states have a lottery in place. They base their model on Mohr's 1969 analysis of innovation in organizations. Mohr hypothesizes that "innovation is

directly related to the motivation to innovate, inversely related to the strength of obstacles to innovation, and directly related to the availability of resources for overcoming such obstacles" (p. 114). Berry and Berry contend that certain internal characteristics, such as fiscal stress, heighten the motivation of a state to adopt a lottery. They also argue that as more surrounding states adopt a lottery, the motivation for a legislature to adopt one is increased. Their finding that states are influenced by the policies of their neighbors is consistent with other scholars (Eisinger 1988; Dye 1990; Peterson, Rom, and Scheve 1996).

Event history analysis (EHA) has been used to measure the effects of determinants both internal and external on state policy formation. Similarly, this study will use EHA to examine a state's adoption of managed care for its Medicaid recipients. The primary goal of EHA is to explain a qualitative change or "event" at a particular time. An important concept here is the *risk set*. In this case, the risk set consists of states that are "at risk" of adopting managed care. The risk set diminishes as more states adopt this policy. The event to be explained is referred to as the *hazard rate*. The term hazard is frequently used in biostatistics where the typical explanatory variable is death. The hazard rate can be defined as the probability

$P_{i,t}$ that a state will adopt a managed care policy during a particular time *t*, given that the individual is "at risk" at that time. In EHA the observed dependent variable is dichotomous: measured by a one for each adoption and zero otherwise. Probit is an ideal technique for use with EHA due to the dichotomous nature of the dependent variable.

There are some advantages to EHA. It has the capability to simultaneously measure internal and external determinants on policy-making. Since both types are included, it can more readily safeguard against mistaking spurious relationships of diffusion with states sharing similar internal characteristics. It measures the current status of internal characteristics as opposed to measuring characteristics several years before the policy was adopted.

This study offers six explanations derived from the literature which may account for the adoption of managed care in state Medicaid programs. One is economic and considers a state's *financial need* to reform and a state's *capacity* to reform. Another explanation focuses on the *general health* of the state. Here, the emphasis is placed on the *physical health needs* of citizens. The other four explanations are primary political. *Previous policy* looks at the impact existing policies have on new legislation. *Party control* points to which party controls the legislature and whether it is divided. *Regional diffusion* implies that

states look to other states for policy direction. Finally, *federal contribution* suggests that a state is more likely to innovate if it relies more on the federal government for financing (Welch and Thompson 1980).

Explanations of State Medicaid Innovation

Economic Explanations

Nice (1994) argues that innovation frequently occurs in a problem environment. In this environment, states deal with issues that cause stress. These issues may include program failure, poor financial conditions, and other needs that call for a response from law makers. Scholars (Zaltman, Duncan, and Holbek 1973; Polsby 1984) have noted that crises create opportunity for innovation. A problem environment may not necessarily consist of a crisis, but problems often lead to a major change in policy. Problems encourage law makers to look for new and better ways of doing things. Hansen (1983) and Berry and Berry (1990) point out that states are more likely to be innovative in tax policy when they are in poor fiscal health. Similarly, I would argue that states are more apt to innovate when they are in greater financial need. If money can be saved through changes in Medicaid, states are more likely to adopt a new program.

If fiscal stress is a factor for innovation on one side of the coin, then fiscal surplus or the ability to generate revenue is on the other side. Both factors are seemingly contradictory, yet both can lead states to innovate. Some authors (Walker 1969; Gray 1973) contend that larger wealthier states are more likely to adopt new innovations. Here it is important to note that the wealth of a state is not synonymous with the fiscal condition of a state. Wealthier states, however, have a greater capacity to deal with fiscal stress because of their ability to generate new revenue through taxation. A common indicator of fiscal capacity is per capita income.[2] Nice (1994) argues that states with greater fiscal capacity are more likely to produce "slack resources." These resources are not allocated for specific purposes and can be used for start up costs of new programs. One report, for example, claimed that the start up costs for implementing a managed care program for Medicaid recipients in Oklahoma would be approximately $2 million for over a two year period.[3]

Health Needs

Research has shown that policy--makers generally pay attention to the needs of their constituents (Miller and

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[2] For a discussion and debate concerning various measures of fiscal capacity, see Reeves (1986).

[3] In 1992 the Oklahoma State Legislature passed legislation providing the establishment of a task force to evaluate options for the state's Medicaid program. See Peat Marwick (1993) for a detailed analysis.

Stokes 1963). Where a need exists, lawmakers respond by proposing or passing legislation to address that need. Lawrence Jacobs (1993) argues in his book *The Health of Nations: Public Opinion and the Making of American and British Health Policy,* that politicians paid attention to public opinion during the Medicare debates in the 1960s. Polls indicated that a large percentage of Americans were concerned about health care. As a result, Congress resisted pressure from opponents such as the American Medical Association, and established Medicare and Medicaid in 1965. Theda Skocpol (1994) makes a similar argument, suggesting that public concern with health care led to the election Harris Wofford to the Senate. It also persuaded Bill Clinton to place health care reform at the top of the national agenda during his first term in office. Likewise, I would argue that state policy--makers pay attention to the health needs of a state. High infant mortality rates and a large percentage of uninsured, for example, may lead to a new policy addressing these problems.

Previous Policy

There is ample support for theories suggesting that previous policy or policy legacy plays an important role in policy adoption. Fleischmann and Nice (1988) contend that states with a history of regulating campaign finances are more likely to limit PAC contributions. Cowart (1969)

argues that states were more likely to participate in funded anti-poverty programs in the 1960s if they had been involved in welfare-related activities previously. Skocpol and Weir (1985) suggest that state structures and policy legacy played a key role in the types of economic policies adopted by Sweden, Britain, and the United States during the Great Depression of the 1930s. In this study, it would seem that states that have had more experience with managed care would seem more likely to consider managed care as an option in Medicaid reform.

Party Control

The literature on political control of government and policy adoption is rather mixed. Studies imply that states in which the governorship and the legislature are controlled by the same party are more likely to adopt a tax than states with divided control over each institution. Kiewiet and McCubbins (1985) indicate that Democrats are more generous with congressional appropriations than Republicans when they control the legislature. Brown (1995) also finds that party control has a significant impact on a state's welfare effort. Specifically, he finds that Democratic party control has a strong effect in states classified as "New Deal cleavage" states.[4] Other scholars (Mayhew 1991;

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[4] Brown examines the dominant social group partisan cleavage in each state. He develops three classifications; 1) the southern party cleavage, 2) the New Deal party cleavage, and 3) the post-New Deal cleavage. His results

Fiorina 1996) make a case for effective legislation under divided government. Mayhew (1991) conducted a comprehensive study examining the post-World War II federal record. He found that unified governments were no more likely to produce "significant" policies than governments under divided control.

Regional Diffusion

Diffusion, simply defined, is "the process by which an innovation is communicated through certain channels over time among members of a social system" (Rogers 1983, p. 5). Walker (1969) argues that decision makers often struggle to choose among complex policy options. As a way to "satisfice" (Simon 1957) or choose among competing alternatives, states often look to neighbors to simplify the decision-making process. Public officials confronted with a problem take cues from other states that have already addressed the same issue (Sharkansky 1970; Light 1978; Freeman 1985). Others (Dye 1990; Peterson and Rom 1990; Peterson, Rom and Scheve 1996) suggest that states are in competition with each other. As states spend more on economic development, they are pressured to spend less in other areas, particularly welfare. Smaller welfare programs are less salient and give greater flexibility to the states

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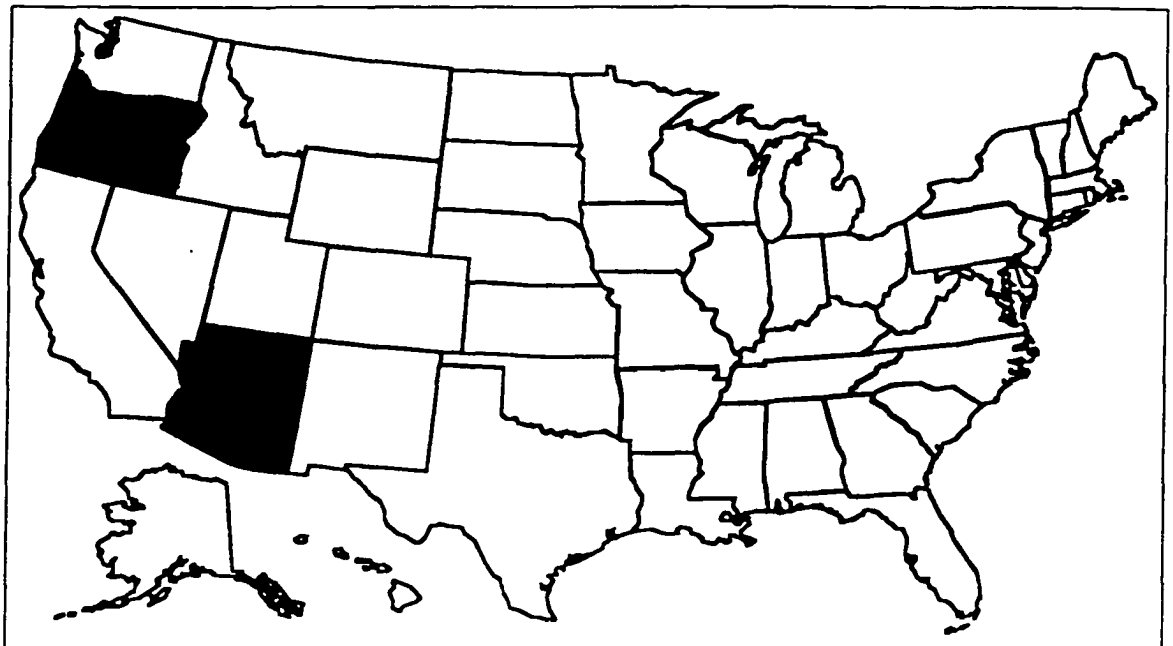
show that the coalition bases of parties differ across states. These differences may provide a better picture for analysis than a simple comparison of parties.

in establishing welfare policies. States can lure businesses by reducing taxes and limiting regulations. Other states, wanting to remain competitive in attracting businesses, will also try and lower their cost environment. Just like a price war, the offer goes to the lowest bidder. The authors note that prices may even reach a point that the costs to promote business may outweigh other benefits. States, feeling the pressure to keep up with other states, thus engage in a "race to the bottom," each trying to enhance its economic environment. In either case, policy emulation or competition, studies suggest that states are influenced by neighboring states.

The maps shown in figures 1-4 illustrate the number of states that have applied for a comprehensive health care reform demonstration or section 1115 waiver. Arizona applied for and was awarded the waiver in 1982. While Arizona is not included in the empirical analysis, it is represented graphically. The maps provide preliminary evidence for diffusion or spatial clustering.

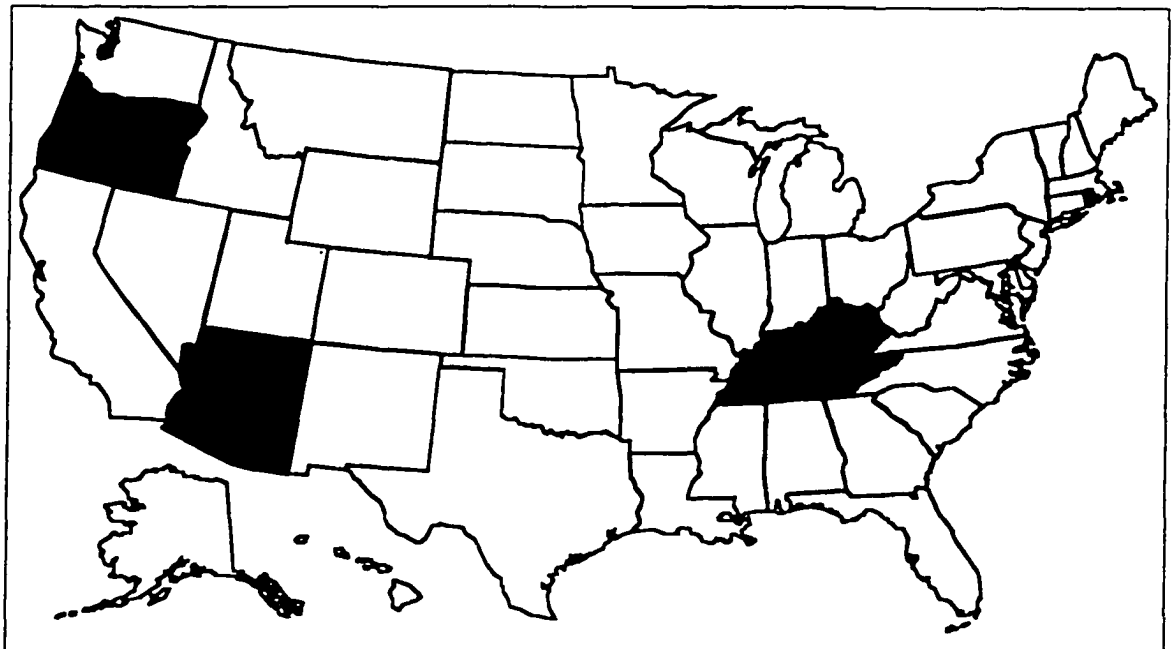
By 1993, five states, Arizona, Oregon, Kentucky, Tennessee and Rhode Island either had or applied for a comprehensive health care reform waiver. Figures 3 and 4 illustrate the "clustering" of states adopting managed care around several of these early adopters.

Figure 3.1: States with or Applying for 1115 Waivers in 1991



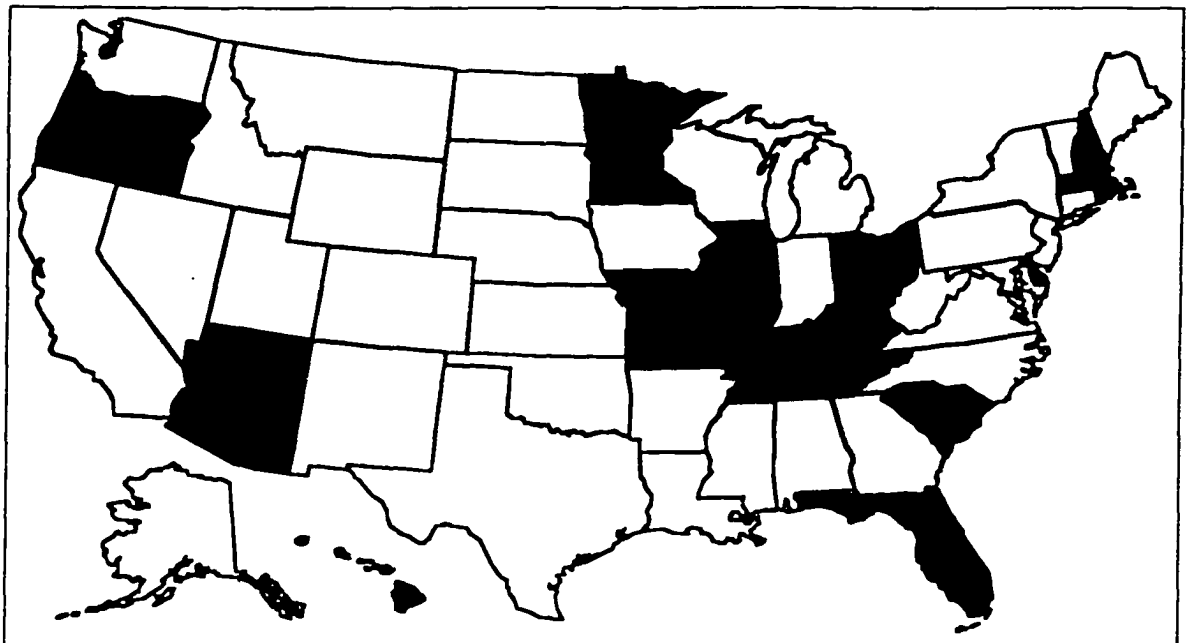
Source: Health Care Financing Administration

Figure 3.2: States with or Applying for 1115 Waivers in 1993



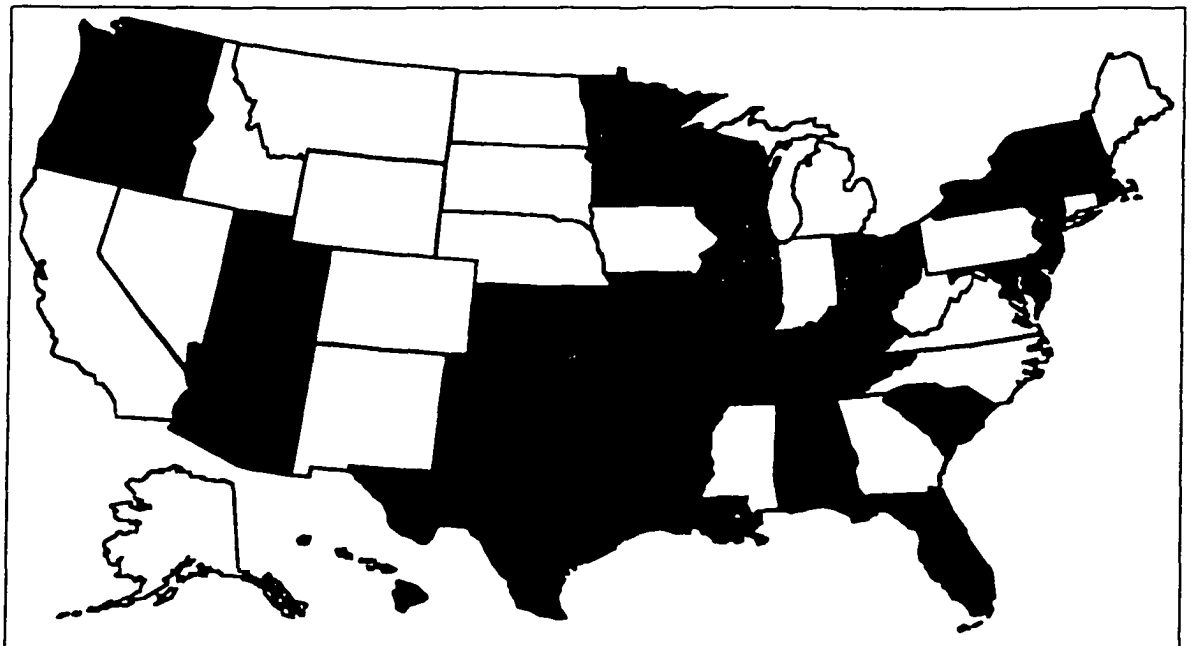
Source: Health Care Financing Administration

Figure 3.3: States with or Applying for 1115 Waivers in 1994



Source: Health Care Financing Administration

Figure 3.4: States with or Applying for 1115 Waivers in 1998



Source: Health Care Financing Administration

Federal Contribution

Regional diffusion and *federal contribution* are the only explanatory variables that represent external pressure to innovate. The financing of Medicaid is shared by both federal and state governments. The federal share of Medicaid is based on the federal medical assistance percentage (FMAP) and is determined by a state's per capita income. In 1995, Arkansas, Mississippi, West Virginia, and Utah had the highest federal match percentages. The FMAP ranges from 50 percent to a maximum of 83 percent of Medicaid costs. Although this variable is external, it may reflect, to a large degree, the wealth of a state. One GAO (1995a, 22) report on Medicaid noted:

> In spite of the formula's sliding match rate, federal spending per Medicaid beneficiary tends to be highest in states with high per capita incomes. Because high-income states tend to offer relatively generous benefits, the absolute amount of federal spending per beneficiary is high, even though the match rate is only 50 percent. For example, New York--a high-income state with a 50-percent match--receives $3,600 per beneficiary in federal aid, while Mississippi--a low-income state with approximately an 80-percent match-- receives $1,900 per beneficiary in federal aid.

Consequently, we may find that states receiving less federal funding are more likely to adopt managed care for their Medicaid programs.

Empirical Analysis

The hypotheses stemming from the various explanations of innovation have as a dependent variable the probability

that a state will adopt managed care. Although the probability is not directly observable, the dependent variable is measured by a dichotomous indicator. It consists of a series of zeros beginning in 1991 followed by a one in the year of adoption. A state not adopting managed care shows no variation and has zeros for each year between 1991 and 1996.

The first task in EHA is to establish a risk set. For this analysis, the risk set consists of the continental states with the exception of Arizona. Arizona is considered an outlier in this study since its first and only Medicaid program was administered through a managed care system.[5] Oregon was the first state that sought comprehensive change to an existing Medicaid program. Since Oregon applied for a 1115 waiver in 1991, the observations cover the period 1991-1995. Once a state adopts managed care, it is no longer at risk of adopting.

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[5] Although Medicaid was enacted in the mid-1960s, Arizona did not participate until 1982. Health care responsibilities were handled at the county level. As health care costs began to escalate, the counties were less capable to meet their needs. In 1982, the legislature approved the Arizona Health Care Cost Containment System (AHCCCS), a managed care operation that placed the medically needy and medically indigent with health care providers on a prepaid basis.

The following model is a pooled time series using probit analysis:

$$ADOPT_{i,t} = b_0 + b_1 FEDERAL_{i,t} + b_2 HEALTH_{i,t} + b_3 CAPITA_{i,t} + b_4 FISCAL_{i,t-1} + b_5 PARTY1_{i,t} + b_6 PARTY2_{i,t} + b_7 HMO_{i,t} + b_8 NEIGHBORS_{i,t} + b_9 WAIVER_{i,t} + b_{10} UNINSURED_{i,t} + b_{11} INCOME_{i,t} + b_{12} TAXi,t$$

where the dependent variable $ADOPTi,t$ is the probability that a state i will adopt managed care in year t. $ADOPTi,t$ is measured with a dummy variable equaling one if a state adopts the program in year t, and zero otherwise.

In the equation, eight independent variables measure a state's internal characteristics and two, *FEDERAL* and *NEIGHBORS*, reflect external influences.

Economic Indicators

FISCAL is the fiscal health of a state in the previous year. To control for size, it is measured as the ratio of total state revenue minus total state spending to total state spending (Berry and Berry 1990). It is lagged since many legislative sessions beginning in January base policy decisions on the budget of the previous year. *CAPITA* is the Medicaid health cost per capita. It is the combined total amount of both federal and state spending for each Medicaid recipient. *INCOME* is the state per capita income in constant dollars. This variable intends to measure a state's fiscal

capacity. There are other variables that can be used as economic indicators such as the Gross State Product and the ACIR's fiscal capacity measure. While these variables were considered, recent data covering the last few years were not available. As a result, they were not included in this analysis.

Health Indicators

HEALTH measures the general health of a state's population. One possible indicator of health is infant mortality (Copeland and Meier 1987). It is measured as the number of infant deaths per 1,000 live births. *UNINSURED* is the percentage of those with no health insurance in each state.

Policy History Indicators

HMO measures a state's policy history concerning HMOs. It is measured by the number of years in which HMOs have existed in a state. HMOs have been in most states ranging from 0 to 65 years with an average length of about 17 years. *WAIVER* indicates whether a state has already been granted a 1915 trial waiver to explore limited managed care options. The 1915 waiver waives certain federal requirements and allows states do things such as requiring that services be obtained from specific providers, contracting with HMOs, and implementing a primary care case management system. This is

a dichotomous variable with a 1 indicating the adoption of some 1915 waiver and zero otherwise.

Indicators of Party Control

PARTY-1 is a dichotomous variable that indicates whether a single party controls both the executive and legislative institutions in the state. One indicates a unified government and zero a split or divided government. *PARTY-2* is a variable based on Brown's 1995 study of party coalitions and measures the strength of the Democratic party in each state. The measure is scored with; a '4' if both houses of the legislature and the governorship are controlled by Democrats, a '3' if the Democrats control either one house of the legislature and the governorship or both houses of the legislature, a '2' if the Democrats control only the governorship or one house in the legislature, and a '1' if Republicans control both institutions.

Indicators of Regional Diffusion

NEIGHBORS represents the number of neighboring states that have adopted managed care for their Medicaid populations. It is measured as the number of bordering states that have applied for a 1115 waiver. This number increases as more neighboring states adopt managed care.

Obviously, not every state shares a border with a state that has adopted a managed care policy.

Indicators of Federal Influence

FEDERAL is the percentage of the federal contribution to a state's Medicaid program. This percentage varies from 50 to 83 percent.

The results of the model are presented in Table 3.1.

Table 3.1: Probit Results for Event History Analysis Model of Managed Care Adoption

Independent Variables	Maximum Likelihood Estimate	t-ratio	*p*
FEDERAL	.04270	1.7006	.05
HEALTH	.00773.	.13177	-
CAPITA	-.00004	-.37836	-
FISCAL	-.69538	-.70787	-
PARTY1	-.08197	-.47731	-
PARTY2	.03058	-.33420	-
INCOME	.00013	1.70724	.05
HMO	.16450	2.37239	.01
NEIGHBORS	.14274	1.77203	.05
WAIVER	-.09122	-.52348	-
UNINSURED	.00289	.12736	-
TAX	-.00014	-.60386	-
Intercept	-7.84705	-2.96967	.0005
Number of cases	217		
Degrees of freedom	204		
Pseudo R squared*	.68		

Note: All significance tests are one-tailed except for that of the intercept, which is two-tailed.

*See Aldrich and Nelson (1984, 57-59) for a description of this measure.

The results from the model support regional diffusion of managed care. The positive and statistically significant coefficient (at the .05 level) for NEIGHBORS suggests that as more neighboring states adopt managed care, the more likely a state is to adopt a similar policy.

There is also strong support for internal determinants in the model. For example, several states share borders with those that have managed care, yet have not adopted the same policy. This is the case with states such as Arkansas, Mississippi, and West Virginia. While these states border three or more managed care states, internal characteristics may play a more persuasive role. INCOME is another variable that has a positive and statistically significant coefficient (at the .05 level). This is consistent with previous findings which suggest that wealthier states are more likely to be innovative. If this is indeed the case, the probability that poorer states like Arkansas, Mississippi, and West Virginia will adopt managed care is lower.

The level of federal contribution to state Medicaid programs also seems to be an important factor in the adoption of managed care. Currently the federal government funds 50 to 78 percent of a state's Medicaid program. The variable FEDERAL has a positive and significant coefficient; however, it is difficult to interpret since states with a

smaller percentage of federal money often receive more actual dollars.

The variable receiving the strongest support in the model is HMO, an indicator of previous policy legacy concerning managed care in states. The coefficient is positive and has a high statistical significance. This factor suggests that states with a long history and experience with HMOs are especially likely to enroll Medicaid recipients in managed care.

Policy legacy was also measured by whether or not states applied for a 1915 trial waiver to conduct limited managed care operations within their Medicaid population. Interestingly, the coefficient for WAIVER, while statistically significant, was negative. Rather than reflecting a state's previous policy, a more likely explanation is that the 1915 waivers provided enough leeway to successfully implement a limited managed care program. These programs were perhaps sufficient enough to address the needs of the states which applied for the waivers.

Variables designed to measure problem environment factors received little support. The coefficient for FISCAL, a measure of a state's fiscal health, was negative but not significant. Interestingly, the need for better, more accessible health care does not appear to play a major role in a state's decision to adopt managed care. The

variables HEALTH, measured by infant mortality, and UNINSURED, measured by the percentage of those without health insurance, do not produce statistically significant results.

Using the coefficients or maximum likelihood estimates (MLEs) in table 1, one can calculate the probability that a state with given characteristics will adopt managed care as a Medicaid program. The results in table 2 are derived by holding all of the non-significant variables at a constant mean or central value.[6] Hypothetical conditions are then set up using the statistically significant variables; *FEDERAL, INCOME, HMO,* and *WAIVER.* The probabilities can then be used to compare the relative strength of the effect of each independent variable on the dependent variable.

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[6] The two dichotomous values, *WAIVER* and *PARTY-1,* are kept at their minimum value or zero. Calculations were made with their maximum value and the change in results was slight.

Table 3.2: Probability of Managed Care Adoption under Various Scenarios

Hypothetical Adoption Conditions	Federal	Income	HMO	Neighbors	Probability
Federal impact	50	19802.32	19.16	2	.052
with other variables	61.76	19802.32	19.16	2	.084
held at their mean	80.18	19802.32	19.16	2	.167
Impact of income	61.76	13218.00	19.16	2	.037
with other variables	61.76	19802.32	19.16	2	.084
held at their mean	61.76	30303.00	19.16	2	.264
Impact of HMO	61.76	19802.32	0	2	.062
with other variables	61.76	19802.32	19.16	2	.084
held at their mean	61.76	19802.32	66	2	.264
Impact of Neighbors	61.76	19802.32	19.16	0	.067
with other variables	61.76	19802.32	19.16	1	.073
held at their mean	61.76	19802.32	19.16	2	.084
	61.76	19802.32	19.16	3	.095
	61.76	19802.32	19.16	4	.108
	61.76	19802.32	19.16	5	.123
	61.76	19802.32	19.16	6	.140

Table 3.2: (continued)

Hypothetical Adoption Conditions	Federal	Income	HMO	Neighbors	Probability
Impact of Neighbors on high income states	61.76	30303.00	19.16	0	.212
	61.76	30303.00	19.16	1	.237
	61.76	30303.00	19.16	2	.264
	61.76	30303.00	19.16	3	.293
	61.76	30303.00	19.16	4	.323
	61.76	30303.00	19.16	5	.355
	61.76	30303.00	19.16	6	.389
Impact of Neighbors on states with a long policy history of HMOs	61.76	19802.32	66	0	.129
	61.76	19802.32	66	1	.146
	61.76	19802.32	66	2	.165
	61.76	19802.32	66	3	.186
	61.76	19802.32	66	4	.208
	61.76	19802.32	66	5	.233
	61.76	19802.32	66	6	.260
Impact of Neighbors on high income states with a long history of HMOs	61.76	30303.00	66	0	.368
	61.76	30303.00	66	1	.402
	61.76	30303.00	66	2	.437
	61.76	30303.00	66	3	.472
	61.76	30303.00	66	4	.508
	61.76	30303.00	66	5	.544
	61.76	30303.00	66	6	.579

The probabilities indicate that an increase in any of the four variables leads to a greater chance of managed care adoption. A state receiving the minimum percentage of federal support for Medicaid has a .115 (=.167-.052) less chance of adoption than a state receiving a greater percentage of federal aid. The impact is even greater for

wealthy states compared with poor states and states with more experience with HMOs compared to those with less.

When a state has more than one significant characteristic, the chances for managed care policy are enhanced. For example, a wealthy state has a .111 (=.323-.212) greater probability of adoption if it has four neighboring states with managed care than if it had no such neighbors.

It appears that while diffusion may take place, it is more likely to occur under certain conditions. As illustrated in table 2, the predicted likelihood of managed care adoption in a wealthy state with two neighboring states that have a managed care system is .264. That probability increases by .173 (from .264 to .437) when a wealthy state also has had prior experience with HMOs. In short, the results support earlier research which suggests that wealthy states are more likely to innovate. It also illustrates the impact which a state's previous policy has on adoption of a new policy. When taken together, variables affecting policy adoption are magnified.

Conclusion

The results of this analysis are consistent with the findings of other scholars who argue that internal and external factors influence policy decision makers. The

results support the use of a unified model to measure the effects of both internal and external variables. It appears that innovation can and does occur under the three broad categories or components of Nice's (1994) innovation model. Economic, political and perhaps social characteristics contributed to the adoption of managed care in state Medicaid programs. Event history analysis is a good empirical tool which considers all of these factors simultaneously, and can be useful in many types of comparative studies.

This study lends a great deal of support to the literature on policy diffusion. It suggests that diffusion may occur more readily when certain characteristics or contextual conditions within a state are prevalent. What the analysis does not do, however, is point out the linkages where diffusion can take place. While empirical results may indicate that the diffusion of policy occurs, the study falls short in determining or establishing how policies spread throughout the states. What is needed, then, is a follow up study which looks specifically at dynamic factors to determine why state policy-makers decided to adopt a managed care policy and the particular form of the policy adopted. These issues are taken up in Chapters Four and Five.

Chapter Four

Oklahoma Demographics and Health Care Policy History

This chapter examines the experience of one state in its effort to reform its Medicaid program. It examines the conditions precipitating reform and it focuses on other dynamic factors such as the role of policymakers and interest groups. Through legislation passed in 1993, Oklahoma started on a course which led to a managed care system for Medicaid recipients. While all states have their own unique characteristics, Oklahoma is similar to other states in the challenges it faces. Federal mandates in the 1980s and early 1990s required Oklahoma and other states to expand their Medicaid programs. The number of Medicaid recipients increased by over 18 percent from the previous year in 1992 (Oklahoma Health Care Authority).

Oklahoma has a population of roughly 3,317,000. It is a fairly large state with two major metropolitan regions and large rural areas. This becomes an important point later on in the decision making process, when different managed care ideas are being explored. Oklahoma's demographic characteristics differ somewhat compared to those of the United States as a whole.

Table 4.1: National/State Demographic Comparison

Race	National %	Oklahoma %
White	72.5	83.0
Black	12.7	7.6
Indian	.9	7.8
Asian	3.8	1.2
Hispanic	11.1	3.4

Source: U.S. Census Bureau

Oklahoma is not necessarily a good match for the EHA model presented in Chapter Three, yet it was one of the states that adopted a managed care system for its Medicaid program. In terms of the four significant variables in the model; federal contribution, per capita income, the number of years HMOs have been operational, and neighboring states that have adopted a similar policy, Oklahoma is above the national average on only 2 of the 4 variables.

Table 4.2: National/State EHA Variable Comparison

Variable	National Average	Oklahoma
Federal Contribution	61.03	70.05
Per Capita Income	34,911	27,700
HMOs (years operational)	22	14
Neighboring States	2	3

Source: Health Care Financing Administration, Census Bureau, and author's compilation

These variables serve as a gauge for a state's economic and political conditions, factors which are important in creating the right political opportunity or climate from which new ideas or policies might emerge. These conditions

are no doubt important and may lend some insight into why a certain policy, in this case managed care, was adopted. Many of these variables and others came into play during the debates and decision making which ultimately placed Medicaid patients into a managed care program. This chapter will outline the health care reform process in Oklahoma from its beginning to its most recent state (February 1998) and focus more on the "dynamic factors" rather than the "contextual conditions" analyzed in Chapter Three.

The history of Oklahoma's health care policy dates back to the contributions of Senator Kerr's involvement in the Kerr-Mills Act of 1960. Internally, there were several efforts to establish community health cooperatives in rural areas, and provide health care to the economically disadvantaged.

Oklahoma was again involved in health care policy at the national level in the 1970s. In the early 1970s, Congress enacted PL 92-603 which contained a general provision concerning Medicaid payments. In short, section 249 of the law required states to reimburse nursing homes with a "rate reasonably related to the cost." While the meaning of a "cost related" rate was ambiguous, Loyd Rader, the influential director of Oklahoma's Department of Human Services, feared financial repercussions to the state and his department in particular. In 1975, Rader approached

Oklahoma Senator Henry Bellmon and asked him to propose legislation that would repeal section 249. Bellmon sponsored the legislation but it was narrowly defeated. David Boren was elected to the Senate in 1978. Not long after the election, Rader contacted Boren about sponsoring the same legislation. Boren's legislation repealing section 249 set off a storm of controversy by aging advocacy groups who felt that section 249 was necessary in order to maintain a high quality of care. As a compromise solution, Boren drafted language (later known as the Boren Amendment) which said that nursing home reimbursement be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities (42 USC section 1396a)." Both sides left the table thinking they each got what they wanted. The advocacy groups and nursing home industry got the assurance that states would pay a rate to meet the quality of care, and the states got the flexibility to devise plans for reimbursement. In the end, the issue was thrown into the federal courts to decide who was right.[1]

In 1985, the Legislature passed the Oklahoma Indigent Care Act. The law established a voluntary check off contribution on tax returns that was earmarked for health clinics that provided charitable health care. The

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[1] Mike Fogarty, interview by author, Oklahoma City, Ok., 3 December 1997.

initiative did not generate as much revenue as anticipated, but it was another step in promoting health care for the needy.

Two years later, the Legislature created the Oklahoma Council on Health Care Delivery. The Council was to make recommendations to provide health care for the employed uninsured, the medically uninsurable, and it was to explore alternative health care delivery systems for the state's Medicaid population. Many of the Council's recommendations were introduced as bills in the state legislature up through the early 1990s. In 1991, The Universal Health Care Act of Oklahoma was proposed. The bill set up a board that would develop a plan creating a single payer system in Oklahoma. While the bill was defeated by 13 votes on the House floor, it illustrates the Legislature's concern for health care at the time.

During the 1992 presidential campaign, health care became a major issue. As noted in chapter 2, polling data show that Americans became increasingly concerned about their health care. This concern was also prevalent in Oklahoma. While approximately fifteen percent of the nation's population had no health insurance, Oklahoma had a higher rate, with nineteen percent uninsured. A state wide survey taken in 1992 reported that nearly everyone (90 percent) either strongly agreed or somewhat agreed with the

statement; "We should make major changes in the way we finance health care." Ninety-six percent of the respondents felt that the health care system should be changed. While there was a great deal of support for change, only ten percent felt that health care costs should be held down by decreasing services (Commission on Oklahoma Health Care, 1992).

The Commission on Oklahoma Health Care

Oklahoma's governor, David Walters, also wanted to capitalize on the political opportunity that the climate provided. On February 5, 1992, he established the Commission on Oklahoma Health Care and named long time friend and college room mate Garth Splinter as its chairman. Splinter had a Harvard MBA and graduated from the University of Oklahoma College of Medicine. At the time of his appointment he was an assistant professor in the Department of Family Medicine at the University of Oklahoma and was serving as the governor's primary advisor on health policy. The Commission was organizationally placed under Health and Human Services Cabinet Secretary Benjamin Demps, but it was to maintain a high degree of autonomy in its actions. Support for the Commission came from the Governor's Office and other organizations to include The Department of Human Services, The Department of Mental Health and Substance

Abuse Services, The Oklahoma State Department of Health, and the University of Oklahoma Health Sciences Center.

Walters charged the commission to come up with "bold new initiatives" that would reform the state's health care delivery system. The Commission began with several goals in mind, including that of making sure every Oklahoma citizen had access to high quality, cost effective health care. To help support the project financially, the state applied for a grant from the Robert Wood Johnson Foundation. The foundation announced in August 1992, that Oklahoma was one of 12 states to receive a grant for the amount of $854,595. This money was used to staff the Commission for a two year period between 1993 and 1994. The panel met eleven times throughout the year and sponsored fourteen town meetings across the state.

The Commission released its first report November 5, 1992 outlining several recommendations. Reform within the health insurance industry was seen as essential. The Commission recommended a system of health care financing that was a market based approach, where negotiation and regulation could be used to control costs and assure access. The report stressed education and prevention measures that would promote healthy behavior and diminish health risks. It also recommended changes in the law concerning health related tort reform. The panel suggested that physicians

who follow state approved guidelines be immune from malpractice liability. The report called for the creation of a formal organization that would be primarily responsible for carrying out any health care related reforms. For the most part, the recommendations of the commission were broadly based and did not address Medicaid specifically.

Governor Walters was very receptive to the plan calling it "creative and comprehensive." He said, "I suspect what we will do is submit some detailed reforms and perhaps get the Legislature to state some intent in regard to the following year and proceed with the additional work" (Greiner 1992).

Legislation was passed in 1992 to provide funding for the Commission so that it could recommend specific models for reform. The commission released its second report in 1993. This report contained many of the same recommendations as the earlier report. Undoubtedly aware of Clinton's national health care proposal, the commission adopted a few more recommendations that would have tied into, perhaps even complemented the Health Security Act of 1993. The following recommendations were submitted by the Commission's Subcommittee on Health Insurance Reform:

1. Coordinate state legislation with expected federal reforms.

2. Move forward with state legislative initiatives which will complement expected federal reforms.

3. Encourage purchase of cost effective health plans.

4. Consider development of accountable health plans.

5. Study Clinton Administration proposal when announced and make specific recommendations to Oklahoma Legislature (Commission on Oklahoma Health Care 1993, appendix 6).

Although federal reform was anticipated, the Commission also felt that Oklahoma had to act quickly and perhaps independently. The Commission called for universal coverage, but there was disagreement on the funding scheme. The report further noted;

> It is possible that a guaranteed package of health benefits may be mandated through national reform. However, if that does not occur, or if state modifications are allowed, the Commission recognizes that Oklahoma may need to consider whether, or to what extent, a package of benefits should be required for the citizens of the state by insurance carriers or health care delivery systems doing business within the state (Commission on Oklahoma Health Care 1993, 7).

The commission also recommended that a uniform benefits package be made available to all Oklahomans in addition to cost containment of health care through managed care and capitation. The primary focus of the Commission's recommendations was directed toward a universal health care system. Again, the recommendations were geared toward a much broader population, mostly the uninsured and underinsured, rather than Oklahoma's Medicaid recipients.

Budgetary Problems for DHS

In 1992, Oklahoma's Department of Human Services (DHS) was facing a $75 million budget shortfall, largely due to increased Medicaid expenditures. At a DHS board meeting in

February of that year, Governor David Walters suggested that a provider tax might be a long term solution for DHS funding problems. The tax would be levied against doctors, nursing homes, hospitals and others who provide health care for those enrolled in Medicaid and would be earmarked for the state's Medicaid program.

Walters announced an agreement with legislative leaders concerning the provider tax in late April. The bill presented to the legislature called for:

> a 1.8 percent fee on net operating receipts of hospitals;
>
> an assessment of $1.32 per patient per day on nursing homes;
>
> a 10 percent assessment on gross receipts from intermediate-care facilities for the mentally retarded;
>
> a fee on total prescriptions dispersed by pharmacies;
>
> and a 4 percent fee on gross receipts from community health centers (English and Greiner 1992a).

The proposed tax, House Bill 2139, would have raised an estimated $90 million in revenue and when coupled with federal matching funds at approximately 70 percent would have brought in another $210 million. A study released in May by DHS showed that the majority of 130 Oklahoma hospitals would get additional revenue. Hospitals which treated a good number of Medicaid patients stood to gain the most, while 21 hospitals would incur losses. Due to the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments passed by Congress in 1991, the state had to

impose a broad based provider tax as opposed to a provider-specific tax assessed on hospitals or disproportionate share hospitals (DSH) that treat large numbers of Medicaid patients.

House Bill 2139 came up for a legislative vote on May 15, 1992, and passed by a wide margin, 61-37 in the House and 31-13 in the Senate. The bill would have more than likely became law if it were not for the passage of State Question 640 two months earlier.

State Question 640

Oklahoma voters had two questions before them in March 1992; who to select as party nominees for public office and a tax issue on the ballot as SQ 640. If a majority of voters voted 'yes' on State Question 640, then future state tax increases would either have to pass by 75 percent or more in each house of the legislature, or they would have to be approved by a direct popular vote. One study found that in the past 27 years prior to SQ 640, 25 tax increases had been approved by the legislature, and that only 7 of them were carried with majorities of 75 percent or more (English 1992).

Most legislators were opposed to the proposal. Many felt that as legislators, they would have a better understanding of the consequences of a tax increase. Others feared that the passage of SQ 640 would hamper the

legislature's ability to act in times of emergency. State Senator Cal Hobson noted that "it [the initiative] would tie the hands of legislators to respond in emergencies and difficult financial times. Tax proposals submitted to a vote of the people would go on the ballot during a general election, which is held in even numbered years (Greiner, Hinton, and English 1992)."

Proponents argued that a 'yes' vote on SQ 640 would bring more accountability to government. The *Daily Oklahoman* was one of those endorsing the proposal. A series of editorials appeared in the newspaper, some occupying spots on the front page. A front page editorial appearing two days before the election contained the following:

> So desperate are legislators to keep their license to tax, they have resorted to one of the most untruthful campaigns in Oklahoma political history...The truth is, legislative big-spenders are scared to death. They'll stop at nothing to keep the system intact that allows them to increase your taxes at every whim. The money to circulate the lies is coming from big businesses that receive favored tax treatment and from state employees and teachers who want to keep pressure on the legislature for higher taxes and higher pay (Lies, Lies, Lies 1992).

Opponents admitted that these editorials were effective. They also felt that their efforts to convince voters to vote against the proposal were not successful in providing adequate information about the issue to voters. A poll conducted at the end of February confirmed that voters did not feel well informed about the issue. The poll found that

while 49.7 percent felt they had enough information on SQ 640, 50.6 percent said they did not. Proponents prevailed and the proposal was passed with 56 percent of the vote.

A major consequence of SQ 640 was that House Bill 2139 now had to be placed on the ballot for a popular vote. So the tax portion of House Bill 2139 became State Question 647. This posed two major problems for those supporting the measure; 1) the question would not come up for a vote until November, prolonging DHS's funding crisis for another six months, and 2) opponents had an additional six months to campaign against the measure.

State Question 647

Proponents of State Question 647 argued that the health care provider tax was a good deal for Oklahoma since it would bring in $2.33 in federal money for every $1 raised in state. They also felt that the tax was necessary in order to maintain the existing level of Medicaid services. Without the tax, many programs, especially nursing home services, faced major cut backs.

Opponents said that the passage of SQ 647 would equal an increase in the cost of health care, to include hospital visits, nursing home care, and prescription drugs. They also noted that some hospitals, those not treating large numbers of Medicaid patients, would lose money. They argued

that the budget shortfall in DHS could be made up through recognizing and cutting back on unnecessary expenses.

Supporters waged an aggressive campaign spending nearly $500,000 on television and newspaper spots. The question had the support of the governor and the leadership in the legislature.

Table 4.3: Proponents and Opponents of State Question 647

Proponents	Opponents
Oklahoma Hospital Association	Oklahoma Tax Payers Union
Oklahoma Nursing Home Association	No New Taxes
Yes 647	Oklahomans for Integrity in Government
	Citizens Opposed to Outrageous Government
Total Spent $491,745	**Total Spent $28,300**

Source: The Daily Oklahoman (October 28, 1992)

While supporters of the bill spent more on advertising, they were less successful educating or convincing the public. One member of the Council on Aging, an organization that sponsored a forum on SQ 467, said "Nobody seems to know anything about this except people who work in hospitals and they're for it" (McReynolds 1992).

Opponents were much more successful in framing the issue in a way that said a "no" vote on SQ 647 would force a mismanaged agency, DHS, to make the necessary changes to

become more efficient and that a "yes" vote would allow a bloated agency to continue wasting valuable tax dollars.

In a 18 October 1992 article in the *Sunday Oklahoman*, Walters said that "if the public votes down the provider fee, I'm going to interpret that as they're wanting to limit the funding of DHS and they want us to make the cuts, and that's the direction I'm going to take."

In the end, SQ 647 was rejected by 61 percent of the vote. In other measures taken up at the same time, almost the same percentage of voters, 62 percent, voted for a bingo tax, and 55 percent favored a capital bond issue to raise money for higher education.

Without the passage of SQ 647, the governing board of DHS proposed several cuts including the reduction from three to one of free prescription drugs for the needy, a 10 percent decrease in benefits going to AFDC recipients and perhaps the most drastic measure, reducing Medicaid eligibility for nursing home fees. Previously, a Medicaid recipient in Oklahoma could earn up to $1,266 and still qualify for nursing home subsidies. Under the new DHS proposal, that figure was lowered to $633 a month. This would have meant the eviction of about 4,200 Oklahoma nursing home residents. The cuts were heavily protested and some lawmakers called for an emergency legislative session (Hinton, 1992?). In the end, the State Contingency Review

Board, made up of Governor Walters, Senate President Pro Tempore Bob Cullison, and House Speaker Glen Johnson approved a measure which transferred $6.8 million from the Oklahoma Medical Center to the Department of Human Services.

The short term problem was temporarily avoided, but a long term solution was needed in order to insure adequate health care for Medicaid patients.

Interim Task Force

While the tax portion of HB 2139 was put to a vote of the citizens and defeated, another portion of the bill, created an interim task force to study options for the State's Medicaid and welfare programs. Unlike the Commission on Oklahoma Health Care, this panel had a much narrower focus and was to make specific recommendations. While it was also to examine welfare reform, it was evident by the make up of the task force that the central issue would be Medicaid. The task force was to be made up of members representing several interests in health related issues. Among those was Dr. Garth Splinter, chair of the Commission on Oklahoma Health Care. He saw his role primarily as a coordinator between the two panels. An equal portion of members (4) were appointed by the governor, Senate, and House of Representatives. In addition to the twelve appointees, the Chair of the House Human Services Committee, Chair of the Senate Human Resources Committee,

and the Cabinet Secretary of Health and Human Services were to serve as ex officio members on the task force. See appendix 2 for a complete listing of task force members.

A minor controversy surrounding the appointment of task force members ensued shortly after the task force was assembled. The contention began when Reginald Barnes, a member of the Commission for Human Services charged that the make up of the task force was slanted toward the nursing home industry. "We have had this type of pressure from this particular group for as long as I can remember. Nursing home owners make up the largest group of contributors to Governor David Walters' campaign, and the lobby has given heavily to legislators as well." He also pointed out that two other members represented hospital and physician interests. "This means the three largest Medicaid provider groups - doctors, hospitals and nursing homes - control a majority of the task force" (Greene, 1992). While Barnes' claims may have raised some eyebrows, they did little to influence the make up of the task force or its performance.

The legislation provided $300,000 for the funding of a consultant group to assist the task force in its study. The Legislative Service Bureau sent two Requests for Proposal (RFP), one to examine options for Medicaid reform and the other for welfare reform, to several firms in Oklahoma and

other states. The proposal concerning Medicaid required five services or tasks.

1. Develop a plan for the transition of Medicaid from a fee-for-services system to a managed care delivery system.

2. Review the current state Medicaid plan and recommend options for cost reductions and waivers.

3. Identify and discuss non-traditional medical services that have been successfully implemented in other states and provide cost-benefit projections for adopting such alternatives.

4. Develop cost containment policies and establish an evaluation to provide long-term policy direction for the Medicaid program.

5. Provide ongoing technical assistance in implementing any future reforms.

Selection for the successful contractor was based on four criteria on a 100 point scale. Ten (10) points were awarded for the best references given by other agencies or providers. Thirty-two (32) points were given based the ability of the bidder to meet all of the specifications in the RFP. Twenty-five (25) points were awarded based on the prior experience and capacity of the bidder in related state initiatives. Finally, the cost effectiveness and reasonableness of the bidder's proposed budget accounted for thirty-three (33) points. The project was to begin on August 17, 1992 and a final report had to be submitted by December 31, 1992.

The Legislative Service Bureau sent an RFP to over 50 consulting firms. After the submission deadline, four firms, Coopers and Lybrand, Deloit and Touche, Lewin-ICF, and KPMG Peat Marwick, received serious consideration. Bids for the project ranged from $94,000 to $399,000.

A legislative staff was asked to conduct an initial review of the different proposals and provide a recommendation, based on the criteria in the RFP. Since costs and the number of billing hours by each consulting firm varied, the staff members decided to use the cost per hour, rather than the total price, as a basis to judge cost effectiveness.[2] The group with the least expensive billing hours was Coopers and Lybrand at $96 per hour, followed by KPMG Peat Marwick at $118, Lewin-ICF at $122, and Deloit and Touche at $143. Regarding the ability to meet the specifications outlined in the RFP, the staff recommendation was Lewin-ICF. According to the recommendation, Lewin appeared better suited in most categories to assist the task force in achieving its goals. Lewin was also working on a similar project in New Mexico, and the staff felt that a synergistic effect would result by working with both states and that Oklahoma and New Mexico could benefit and learn from each other in the process. Lewin also had worked in

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[2] Interim Task Force on State Welfare and Medicaid Reform. Tape recording of the 9 September 1992 meeting, Oklahoma City, Ok.

Oregon on the development of its managed care system for Medicaid recipients, and their proposal was based largely on Oregon's partially capitated model.

Alternatively, Peat Marwick based their model primarily on the Arizona plan. Arizona had a fully capitated managed care program. On their proposal, six of the ten members on the consulting team noted experience with the state of Arizona and its plan, the Arizona Health Care Cost Containment System (AHCCCS). One member, David A. Lowenberg, was a former deputy director of AHCCCS.

Tom Walls, a legislative analyst in the Senate presented the proposals and recommendation to the task force at its first meeting on September 9, 1992. A lot of discussion followed, and it was decided that a meeting would be scheduled two days later, where representatives from Lewin and Peat Marwick would make presentations to the task force members who were able to attend. Due to the short notice, a motion was made to authorize Bob Vincent, the task force chairman, to act as the decision maker, with the consultation of members to direct the Legislative Service Bureau as to whom to award the contract.

Walls also discussed the proposals for the welfare portion of the task force. Three proposals were received, and the staff recommended the consulting firm Maximus. A motion was made to accept the staff recommendation. The

motion was seconded and voted on, and Maximus was awarded the contract at a cost of $52,061.

A final negotiating meeting took place on September 11. Task force members heard presentations and questioned representatives from Lewin-ICF and KPMG Peat Marwick. Bob Vincent felt inclined to go with KPMG Peat Marwick. He felt that Peat Marwick had a more practical approach and that their proposal would address more fully the considerations of the task force. Nevertheless, there were a few concerns such as price and the number of hours spent on the project that had to be ironed out. Peat Marwick agreed to a rigid time schedule in order to produce the necessary results by December 31, 1992. The firm also agreed to lower its price by $12,000 bringing the final bid to $155,950.

Vincent then telephoned task force members that were not present at the meeting and informed them of the selection. Since the task force had voted on a motion to grant decision making authority to the chair, there was little disagreement. On September 25, Vincent sent a letter to Governor David Walters outlining the agreement and reporting on the progress made to date by the task force. Governor Walters received the letter the same day *The Daily Oklahoman* printed the announcement detailing the agreement between the task force and the two consulting firms.

Walters, apparently surprised by the decision, sent a letter dated October 2, 1992 to Vincent expressing his concern. In part the letter read:

> One of the goals in my administration is to reduce the hundreds of thousands of dollars that are spent annually on outside consulting contracts. To my knowledge, there have been very few because I have discouraged them frequently....While Medicaid reform is a very complicated topic, I would imagine, that we would have enough horse power internally to check what other states are doing. What has been successful for us, is to check with the National Governor's Association and the National Legislative Councils in order to glean the good ideas and to incorporate them within our own indigenous needs. I am always skeptical about an outside consultant's ability to make that happen any better. Of course, we will get thick and attractive reports that will tell us a lot of things we already know. If it is not late, I think we should look very carefully at the work plans and attempt to at least reduce these contracts.

Walters was not so much concerned with the choice of Peat Marwick, as he was with the idea that a consulting group was even needed in the first place. His letter is instructive for two reasons. First of all, the legislation which he signed creating the task force, allocated $300,000 for outside consultants. The governor should have known about this allocation when the bill was signed several months earlier. It may serve as an indication of the governor's priorities concerning the source of health care reform proposals. While this task force was largely a "legislative task force," The Commission on Oklahoma Health Care established earlier by the governor was also considering health care reform. As noted earlier, this commission

worked and was supported from the governors office, and the commission's chair, Dr. Garth Splinter also served as the governor's principal health care advisor. When asked which panel was the most important in terms of his policy goals, the Interim Task Force on Medicaid Reform or the Commission on Oklahoma Health Care, Governor David Walters responded; "The Commission was of our creation and I believe resulted in broader recommendations."[3]

Second, the letter is quite specific in suggesting that ideas from other states should be considered. Obviously, in the past, Oklahoma used laws in other states as a basis to solve its own problems. Governor Walters notes the National Governor's Association and national legislative councils, such as the National Council of State Legislatures, as vehicles from which to obtain information about other states. The letter provides evidence that supports diffusion theory, where state officials often look to other states to see how they addressed similar problems. Walters said that looking at other states was "in vogue" at the time, and that he and his staff looked at what other states were doing. Specifically, he visited Tennessee and Hawaii.[4]

Bob Vincent wrote a letter back two weeks later, noting that KPMG Peat Marwick and Maximus were contracted at a

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[3] David Walters, written interview by the author, Oklahoma City, Ok., 23 February 1998.

[4] Ibid.

price well below the $300,000 allotted by the state legislature. He defended the hiring of the outside consultants;

> Engaging these consultants for Medicaid and Welfare reform is mentioned directly in House Bill 2139, along with 15 fairly specific charges to the Task Force which left members with little choice except whether to take our responsibilities seriously or simply meet and provide the necessary "puff" to advance the provider tax. The members expect to make detailed Oklahoma relevant recommendations complete with fiscal impact analysis and time frames for implementation.

He gave a brief overview of the work that had been scheduled for completion and noted that he would forward the results to the governor.

The committee had little time to work with. Their first scheduled meeting was September 9, 1992, and they had less than three months to complete their study and submit a formal report of their findings in order to make the December 31 deadline. There was also another deadline that affected the task force. The provider tax was going to come up for a vote on November 3. Those on the task force felt that the passage of the provider tax would be timely and help out significantly with costs associated with any start up programs that would be recommended. At the September 23 meeting, Peat Marwick presented managed care as an alternative delivery system for Medicaid. Senator Bernest Cain indicated that it would perhaps be beneficial to release a possible statement concerning an initial recommendation of the task force.[5] Jerry Rothlein mentioned

that the Tulsa Chamber of Commerce was very interested in the committee's work and that the Chamber would not likely support the provider tax if nothing came from the task force before the election. Garth Splinter wrote a statement that he thought could be distributed. A motion was passed unanimously to release the following:

> The Interim Task Force recommends the adoption of a Managed Care approach in the Medicaid program that would lead to appropriate controls of health care services utilization and promotion of the health status of Medicaid recipients.

In an interview with *The Daily Oklahoman* on October 30, Bob Vincent noted that "the passage of the tax would certainly give us a jump start on implementing a managed care plan."

A managed care subcommittee was selected to work directly with Peat Marwick. The subcommittee was made up of four members from the task force; Gerard Rothlein of the Children's Medical Center, State Senator Bernest Cain, Boyd Talley, an aging advocate, and Barbara Gardner, Vice President of Metropolitan Life Insurance Company. The subcommittee held four half-day sessions with Peat Marwick consultants. The subcommittee and the task force focused their efforts on the following questions.

> What are the managed models which other states have implemented and how feasible is it that they could be employed successfully in Oklahoma?

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[5] Interim Task Force on State Welfare and Medicaid Reform. Minutes of the 23 September 1992 meeting, Oklahoma City, Ok.

Which program models are most compatible with the environment in Oklahoma and the State's objectives for the program?

Which population groups should be included in the program and when?

How will the program affect access and quality of care?

What is a reasonable implementation timeline?

What are the costs associated with program start-up?

What level of savings (short and long term) are reasonable to expect?

How receptive is Oklahoma's provider community likely to be?

How can provider participation be encouraged?[6]

The subcommittee met with members of the Peat Marwick consulting team and considered four models of managed care; (1) urban hospital-sponsored prepaid plan, (2) urban physician-sponsored prepaid plan, (3) primary care case management (PCCM), and (4) rural hospital/physician sponsored plan. They also discussed two "special population" models; long term care patients, and mental health patients.

Recommendations

The key characteristics of the recommended managed care program included a five year, phased in implementation plan that would eventually replace the state's fee-for-service Medicaid system. The plan called for phasing in different populations according to the following time line.

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[6] Interim Task Force on State Welfare and Medicaid Reform. 1993. February. Oklahoma City, Ok.

Year	Population
1	50% of AFDC recipients and medically needy
2	The remaining 50% of the above groups
3	Aged, Blind and Disabled
5	Institutionalized populations (long term care) and the seriously and persistently mentally ill (SPMI)

Another key component was the formation of a partnership between the state and health care providers. Contracts for service would be competitive and based on full and partial capitation. These contractors would be offered multi-year contracts in order to emphasize the long-term nature of the partnership and have a better opportunity to realize financial gains associated with efforts to promote health and prevention.

To assure quality, the task force recommended a number of quality management requirements administered through HCFA and the state agency responsible for the administration of Medicaid. The plan called for active state oversight and the implementation of several internal quality management programs. An independent, external review which would be conducted on an annual basis was also recommended.

In terms of program structure, the task force recommended different approaches to serving Medicaid

populations in urban and rural areas. In urban areas, Medicaid would be based on fully capitated health plans using commercial HMOs and newly developed provider sponsored prepaid plans. In the rural areas of the state, partially capitated primary care case management models (PCCM) would be used. Also in these rural areas, it was suggested that the state provide technical assistance to participating physicians aiding them in establishing some of these programs. In both urban and rural areas, Medicaid recipients would be offered a choice of prepaid health plans or PCCM programs. Recipients who failed to choose a plan would automatically be assigned to one as well as a health care provider in their geographic region.[7]

As for long term care patients, the report recommended; 1) the establishment of alternative home and community based long term institutional care facilities, 2) the screening of individuals wishing to enter a nursing facility based on a uniform guidelines, 3) setting up an automated system to manage the screening process, 4) defining operational requirements for long term care contractors, and 5) the establishment of capitation rates that would encourage the use of less expensive alternatives to long term care. The report noted that in order to implement these changes, as well as other changes in the first phase of the managed care

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[7] Ibid.

program, the state would have to apply for a waiver with HCFA.[8]

The report discussed three possible models for the state's mental health program. The first model would place all mentally ill patients in prepaid health plans. Under this plan, HMOs assume responsibility for the patients' health and mental health. The second model would separate mental health services and health services. In this case, mental health providers would be responsible only for individuals mental health needs regardless of the severity. The third model distinguishes patients with serious mental health illness from those without serious illness but may still have mental health needs. Under this system, those without serious problems would receive treatment as is the case in the first model. A department or agency specializing in mental health would be responsible for the mental health and health of those with serious mental illness.

Perhaps the biggest change recommended by the task force was the creation of a completely new organization to implement this managed care system. The report stated:

> It is a monumental undertaking to transform a Medicaid fee-for-service operation into a managed care, capitation model....Some states make the erroneous assumption initially that one can retrofit a managed care system onto the existing fee-for-service structure with only minor modifications. What these states have learned is that minor modifications fail to provide the

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[8] Ibid.

> member service, fiscal management and contract monitoring capabilities required of a government sponsored model.
>
> A Medicaid managed care agency does not see its role as controlling detailed processes and regulating every provider action. Instead, it is an insurer and manager of a health care system developing risk sharing partnerships with provider groups and organizations (Interim Task Force Final Report 1993).

Such an agency would need to be established within the state's Department of Human Services or perhaps be removed from it completely. The agency would initially hire 18 employees and include operations teams in the Oklahoma City and Tulsa metro areas as well as in rural regions throughout the state. The creation of an independent agency to carry out reforms is a recommendation that both the Commission on Oklahoma Health Care and the Task Force on Medicaid Reform had in common.

To implement the recommendations, Peat Marwick proposed a developmental time line. They recommended a two year period following the passage of legislation and appropriation of funds to gear up for implementation. This time would be used for the hiring of key staff, the application for necessary waivers, the selection of and negotiations with contractors, and the development of the managed care system. The first operational year following this two year period would then be the first year to enroll adults and children receiving AFDC benefits.

In a cost/benefit analysis of the proposed managed care program, Peat Marwick ran the following models:

Model	Annual Rate of Inflation	Percent Growth in Number of Eligibles
1	10%	0%
2	10%	5%
3	15%	2%

Each model showed an increase in spending for the first two years of the new program. Costs were projected to be approximately $2 million. The third year illustrated a significant savings over the fee-for-service system that was currently in place. Peat Marwick estimated a cumulative savings for each model by the year 2000 ranging from $526,208,492 to $1,100,556,600.

The final report of the Interim Task Force was submitted in February 1993. The report had two components, reflecting the original intent of the task force. One component focused on welfare reform and was formed in consultation with Maximus. The component focusing on Medicaid received the most attention. It became clear that the Legislature was going to take up the issue of Medicaid and managed care during the 1993 session. Although the contract with Peat Marwick ended 31 December 1992, the state negotiated another contract with KPMG Peat Marwick for consulting during the legislative session. The contract

amount was for $30,000. In a December 21 memo to Bob Cullison, then President Pro Tempore of the Senate, legislative analyst Brian Maddy recommended the contract noting:

> The Medicaid and Welfare Reform Task Force has recommended that the state begin to move toward a Medicaid delivery system of managed care. As this will require a significant change in direction from the current fee-for-service system the state must invest in the appropriate staff and technical assistance that will provide for a smooth and efficient transition....I believe that it would be beneficial for the legislature to contract with Peat Marwick, the consultants working with the Medicaid Task Force, to provide ongoing technical assistance.

Meanwhile, the task force recommendations were drawn up in legislative form by Senator Bernest Cain, an *ex officio* member of the panel, and submitted as Senate Bill 76.

In January 1993, legislators including Senators Cain, Hendrick, and Monson, and Representatives Seikel and Thomas, and members of the task force went to Arizona to examine its managed care system first hand. They were impressed with the delivery system and felt that a good deal of it could be incorporated into Oklahoma's Medicaid program. They felt that the recommendations of the task force were adequate.[9] There was practically no opposition to Senate Bill 76. It passed by a wide majority in both the House and Senate.

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[9] Bernest Cain and Mark Seikel, interviews by author, Oklahoma City, Ok., 9 October 1997 and 28 January 1998 respectively.

Oklahoma's State/Federal Connection

On 15 November 1992, twelve days after the election, Oklahoma Governor David Walters had a telephone conversation with President-elect Bill Clinton. In the course of the conversation, Clinton asked Walters to suggest specific executive orders that would help relieve the Medicaid funding crisis in several states. Arkansas was also facing a severe budget shortfall in its Medicaid program. When Clinton left the office of governor, he left a problem that had lawmakers considering a tax increase. Like Oklahoma and other states, Arkansas was facing a Medicaid funding crisis. Arkansas had a health care provider tax similar to the one Oklahomans rejected in the November election. The Arkansas Legislature was contemplating either raising this tax or looking at making cuts in its Medicaid program. This no doubt was a problem that several governors were facing and Clinton experienced this first hand.

Two days after Governor Walters' telephone conversation, he sent a letter to President-elect Clinton outlining eleven executive orders that would have allowed states to act more quickly in solving the Medicaid funding crisis. The letter, dated 17 November 1992, suggested ways that could help states obtain federal waivers more efficiently. He focused primarily on 1115(a) and 1915(b) waivers and suggested several steps be taken such as;

speeding up the approval process, removing time limits on waivers, allowing states to use other states' experience with waivers, and allowing states to deviate from the 95% fee-for-service equivalency in establishing managed care programs.

Governor Walters continued to establish a connection with the Clinton team on health care. He felt that any reforms in Oklahoma needed to be integrated with any national health care plan that might have been proposed.[10] He first made sure that Hillary Rodham-Clinton's task force on health care had a representative from Oklahoma. Through Governor Walters' efforts, Leigh Brown, a staff member on the Commission on Oklahoma Health Care was appointed to serve on the task force. Calvin Anthony, a pharmacist and a representative in the Oklahoma Legislature also became involved in the national health care reform process. As Oklahoma neared its own reforms, both Walters and Anthony were assured by Clinton that any proposed reforms in Oklahoma would be able to be incorporated with Clinton's national health care proposal.[11]

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[10] Garth Splinter, interview by author, Oklahoma City, Ok., 26 January 1998.

[11] Garth Splinter interview, 26 January 1998 and Calvin Anthony, interview by author, Alexandria Va., 29 January 1998.

Oklahoma Health Care Authority

In 1992, two reform processes were going on simultaneously. The Interim Task Force on State Welfare and Medicaid Reform was considering the adoption of a managed care delivery system for Medicaid patients. The Commission on Oklahoma Health Care was exploring options for universal health care coverage. While the recommendations of both panels led to different objectives, there was one item on which both agreed. Both panels recommended the creation of an independent agency that would be responsible for carrying out health care reforms.

In context, this went well with the mood of the legislature at the time. The interim task force was very direct in stating that "a business as usual" mind set was not going to be conducive to a reform of this magnitude. It recommended moving the Medicaid program out of the state's Department of Human Services (DHS), and placing it under the control of this newly created agency. Just prior to this, the Legislature had been dismantling DHS and had begun moving programs, such as hospital administration, and juvenile crime and rehabilitation, into other agencies or creating agencies to support them. Under the direction of Loyd Rader, the Department of Human Services assumed control of a broad range of programs in the 1970s. It was felt that DHS had simply become to big to manage anything effectively

(McReynolds 1992). The recommendation to move the Medicaid program out of DHS fell on welcome ears.[12]

Representative Angela Monson sponsored HB 1573, the bill creating the new agency that would administer Medicaid. The new agency would be known as the Oklahoma Health Care Authority. In its earliest version, the Health Care Authority was intended to be a sort of policy think tank to consider health care policy. As the legislative session wore on, and the task force's recommendations were adopted, the Health Care Authority became the agency that would soon be responsible for Medicaid and its new delivery system of managed care. The law, O.S. 63-5009, formally established the Health Care Authority on 1 July 1993. On January 1, 1995, it was to assume responsibility for Medicaid. The director of the new agency would be Garth Splinter, Governor Walters' primary policy advisor on health care and chairman of the Commission on Oklahoma Health Care.

Conclusion

This chapter summarizes the context for Medicaid reform in Oklahoma. It illustrates the problem environment (Nice 1994) that the legislature and the governor had to deal with. While health care was an important issue in 1992 and 1993, the two branches approached it in different ways. The legislature sought to reform Medicaid, while the governor

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[12] Tommy Thomas, interview by author, Oklahoma City, Ok., 3 December 1997.

pursued universal health care coverage. The interim task force had a very definite goal in mind and it made very specific recommendations. The Commission on Oklahoma Health Care was not as narrowly focused, and the panel's recommendations were very broad and general. The creation of a separate agency that would be responsible for all health care policy was one point that both panels agreed upon. Subsequently, the Oklahoma Health Care Authority was established. It took over the administration of Medicaid and it provided a platform for future health care reform.

The managed care option was not the first attempt to address the Medicaid funding crisis. Oklahoma, like other states, tried to pass a health care provider tax. Because of a ballot initiative passed just prior to the vote in the legislature, the provider tax was subject to a state wide vote. The tax was rejected and DHS was forced to make cuts in Medicaid services. The adoption of such a tax may have slowed down the reform process by easing the financial burden on the state.

Chapter Five

Contextual Conditions and Dynamic Factors in State Medicaid Reform

Chapter three examined the context from which states reformed their Medicaid programs by adopting a managed care delivery system. While certain conditions may make it easier for reform to occur, there are other factors which need to be examined. These elements are not always easy to quantify, but they are none-the-less important in determining policy outcome. Drawing upon previous models (Heclo 1974; Sabatier 1988; and Oliver 1991) Oliver and Paul-Shaheen (1997) derived a general model to explain state action on health care reform. They look at two sets of factors; "contextual conditions" and "dynamic factors." They essentially argue that while contextual conditions help facilitate reform, the dynamic factors of leadership, ideas, and power are the ultimate determinants of policy outcome. Their model is summarized in Table 5.1.

Their list of contextual conditions roughly parallels the variables in the event history analysis in Chapter three. The EHA model considered; income, the states' fiscal condition, party control of the government, previous policy, health factors, federal contribution, and the policy of neighboring states. Of these variables, four were found to be significant and supported several theories dealing with

innovation. All of these factors may affect a state's political will[1] to enact legislation; however, other factors within the policy making body are equally, if not more important determinants of the final policy.

Table 5.1 General Factors in a Model of State Health Care Reform

Contextual Conditions	Dynamic Factors
Socioeconomic Factors	*Leadership*
-Levels of income, education, and employment	-Recognition of opportunities for change
-Current performance of the state's economy	-Commitment to challenge the status quo
Political Factors	*Ideas*
-Political culture	-Persuasive definitions of the situation
-Durable patterns of partisanship	-Innovations to exploit opportunities or solve problems
Institutional Factors	*Power*
-Resources, structure, and culture of the health policy community	-Generation of resources to translate ideas into action
	-Prior health care reforms

Source: Oliver and Paul-Shaheen (1997).

This chapter provides an analysis of the contextual and dynamic factors present during Oklahoma's move to managed care for its Medicaid recipients. Chapter four outlined many of the contextual variables that existed when health care reform was being considered between 1991 and 1995. This chapter draws on and adds to the contextual and dynamic

[1] I am indebted to Tom Walls, a legislative analyst in the Oklahoma State Senate, for suggesting this term.

factors listed in Oliver and Paul-Shaheen's model. In analyzing Oklahoma's experience in Medicaid reform, the complexity of the problem, is included as a contextual factor. Dynamic factors include; specialist legislators, group politics and information flow. The chapter examines the complex nature of the problem, the role of specialist legislators, group politics, and the importance of information flow.

Complexity: The Provider Tax (State Question 647)

As options for Medicaid reform were being considered, a health care provider tax (SQ 647) was placed on the ballot for a popular vote. The measure was approved by the legislature 61-37 in the House and 31-13 in the Senate. The tax would have raised an estimated $90 million in revenue and when coupled with federal matching funds at approximately 70 percent would have brought in another $210 million. In short, Oklahoma stood to gain $2.33 for every $1.00 raised in taxes. While the tax passed by a wide margin in the legislature, over 60 percent of the electorate voted against it in November. Polls before the election indicated that the public was against the provider tax, however, it is not clear how informed the public was concerning the issue. Past studies of voting behavior have wrestled with the issue of how well informed the public is. *The American Voter* painted a disappointing picture of

the electorate in terms of knowledge of politics, events, and parties (Campbell et al. 1960). Later research supported this notion, when Converse (1964) using panel studies over a four year period found that the opinions of voters would change over time with no consistent pattern. Miller and Stokes (1963) found that less than half of the electorate could name the representative in their district. In short, early studies suggested that the voting populace was largely uniformed and out of touch with politics

Perhaps one of the earliest scholars to refute this notion was V.O. Key (1966). He stated that "the electorate behaves about as rationally and responsibly as we should expect, given the clarity of the alternatives presented to it and the character of the information available to it" (Key 1966, 7). Robert Lane (1962) also challenged this view by suggesting that researchers were using the wrong instruments, such as party and ideology, to measure sophistication in the electorate. This idea has been elaborated by Luskin (1993) who claims that the decision making process, which voters use, is influenced by other factors and that sophistication depends on, among other things, interest in politics, education, exposure to political information in print media, intelligence, and occupation. David Elkins (1993) has found that voters draw from a common basis on which they make voting decisions.

Using data obtained from open-ended survey questions, he concludes that the public is capable of understanding specific issues that it feels are important.

Others have made a distinction between "hard" and "easy" issues (Carmines and Stimson 1980). According to their study, hard issues will only be important to people with high levels of information, whereas easy issues will be important to most voters regardless of the level of information which they possess. Carmines and Stimson look at examples of both types of issues and how they effected voting in the 1972 presidential election. They use race and desegregation as examples of easy issues, and the Vietnam War as a difficult one. The Vietnam War was seen as a hard issue since the country was so divided about what approach should be taken. Many solutions to the problem cut across party lines, and in fact, the two presidential candidates in 1968 both took similar positions. In 1972 "the confusion was heightened," they write, "by the fact that Democratic presidents had initiated and vigorously prosecuted the war while the Republican incumbent had sharply reduced the number of U.S. troops in Vietnam" (Carmines and Stimson 1980, 81).

Carmines and Stimson view issue voting as a two part process that includes: (1) the assessment of the voter's own preference and (2) the calculation of their relative

positioning of parties and candidates. The second part is what they refer to as the spatial mapping process and that is what distinguishes the hard from the easy issues. Without enough information, the hard issues are more difficult to map out, especially when there exists seeming inconsistencies in parties or candidates. They list three requisites for an easy issue: (1) the issue would be symbolic rather than technical; (2) it would more likely deal with policy ends than means; and (3) it would be an issue long on the political agenda. They claim that during the time research was underway for *The American Voter,* there were no easy issues, and as a result, there was little issue voting.

To borrow Carmines and Stimson's terms, the health care provider tax was both an "easy" and "hard" issue depending on whether you supported the measure or not. Those supporting the tax had to convince the public that the net result of the tax would mean net gains in terms of additional dollars brought into the state. The initiative would have more than doubled the amount of money raised. Making this point, however, did not appear to be so simple. Educating the public on how this was possible required some explanation of the Federal Medical Assistance Percentage (FMAP) in determining the amount of federal money that is contributed to the state's Medicaid program. This was not

done effectively. A review of seventeen newspaper articles before the November election in the *Daily Oklahoman*, found that the term FMAP was never used. This is not to say that there was never a general explanation of the federal matching rate, but there was never a lot of space dedicated to it.

While those favoring the tax struggled to gain support for a relatively "hard issue," opponents took advantage of its more complex nature and were successful in framing the debate as an "easy issue." Opponents of the measure had a much easier time attacking it. Suggesting that the outcome of the tax was too good to be true, a Senator from Shawnee argued, "I wouldn't vote for this bill. It belongs in Ripley's Believe It or Not." A representative from Warr Acres said that the tax sounded "too good to be true." "It's a $300 million tax increase and it's a bad bill because it raises the federal debt." (Hinton and Greiner 1992). The issue then was boiled down to a tax increase.

Interestingly, as was noted in chapter 4, proponents of the bill outspent opponents by a ratio of 17 to 1. Supporters, mostly stakeholders in the Medicaid program, contributed nearly $500,000 to the campaign, while opponents were barely able to raise $30,000. Despite all of the advertising, the perception of a tax increase remained. In an interview, Senator Bernest Cain, a supporter of the bill

suggested that opponents of the bill raised a lot more money to defeat the issue. "Supporters hardly had any money for State Question 647," he noted (Cain 1997). Undoubtedly, Cain's false perception of the campaign stems from the success opponents had in creating concern over another tax.

Oklahoma's Department of Human Services served as the whipping boy during debates on the tax measure. At one forum sponsored by the Areawide Aging Agency in Oklahoma City, those in attendance took their frustrations out on DHS as a mismanaged, bloated government agency. One man commented:

> DHS is not to be trusted. Every time there appears to be a problem with money, they cry wolf. What is the incentive for DHS to do anything at all organizationally when they can just go and ask for the money (McReynolds 1992).

Another women felt that DHS was wasteful with taxpayers' money and proposed an audit of all state agencies and cuts in executives' salaries.

> We're not going to pick up the tab (for waste in government). We're going to say, 'You made the problem. You're going to correct it (McReynolds 1992).

Some felt that had DHS been a better managed agency, they would have been more likely to vote for the tax. Following the defeat of SQ 647, an editorial in the November 8, 1992 edition of *The Sunday Oklahoman* reflected this view.

> Defeat of the proposed health-care provider tax may at last force the bloated Department of Human Services to get on with the task of paring its bureaucracy....Had the agency made the cuts, voters might have been more sympathetic to the needs of welfare clients. Instead, the agency went into its usual poor-mouth act,

> threatening to throw old people out of nursing homes and deny life's necessities to poor children. Hogwash! The time has come for the welfare department to quit wheedling for new bailouts and get on with the task of providing efficient, professional and fiscally responsible services to needy Oklahomans.

What was seemingly lost in the debate was a discussion of how Oklahoma stood to benefit with an increase in federal money. The complicated issue of federal matching funds took a back seat to the easy issues of a tax increase and bureaucracy bashing. Legislators may have had a better understanding of the issue. This may help explain why they voted in favor of the provider tax by such a wide margin.

Specialist Legislators

Oliver and Paul-Shaheen (1997) consider leadership an important "dynamic" factor in bringing to pass health care reform in state legislatures. They argue that "policy entrepreneurs" who develop legislation for reform play a critical role in this process. In reviewing the literature[2] dealing with policy entrepreneurs, Oliver and Paul Sheehan outline several types of entrepreneurs, from elected officials wanting to boost their career ambitions to government aides and analysts wanting to advance policy objectives. They argue that policy entrepreneurs act much the same way as entrepreneurs in the market. They develop policy innovations, attract political investment and market their product.

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[2] Here I rely on a literature review from Oliver and Paul-Shaheen (1997).

In the Oklahoma case, key legislators played an important role in the passage of SB 76, the bill that would move Medicaid patients into a managed care system. In 1993, the Oklahoma Legislature considered over 1400 bills. Many of these bills were rather complex, including SB 76. While health care reform was a major issue, there were other matters that the Legislature took up. Like members of Congress, legislators are busy and do not have time to consider every bill individually. Kingdon (1989) noted that it would be nearly impossible to devote careful study to bills that come up for a vote and still have time for committee work, constituent services, travel, and various sorts of meetings. To account for this, legislators seek shortcuts in gaining information and deciding how to vote.

Several studies (Mathews and Stimson 1975; Uslaner and Weber 1977; Ray 1982 and Kingdon 1989) have sought to identify sources which legislators rely on for information. Kingdon (1989) identified the following as sources of information: fellow lawmakers, party leadership, the congressman's staff, constituents, the executive branch, organized interest groups, and personal reading. Ray (1982) included formal committee reports with those noted above. Both Kingdon and Ray found that fellow legislators served as important cue sources. Ray's research suggests that fellow legislators are consistently considered important, but that

the relative importance of cue sources varies from legislature to legislature.

The studies noted above have sought to examine sources of information in general. Ray's (1982) study illustrates that sources differ among legislatures. While the sources used by Kingdon and Ray are applicable to most situations, the degree to which legislators rely on those sources may not only vary from state to state, but it may also vary depending on the type of legislation being considered.

In order to determine the degree to which legislators in Oklahoma rely on various sources of information, a survey was developed based on preliminary interviews (Appendix 3). It was then sent out to all of the legislators who were in the 43rd Legislature (the Legislature that considered Medicaid reform in 1993), and were currently in office. Oklahoma's Legislature is composed of 48 members in the State Senate and 101 members in the House of Representatives. Of the 149 legislators, 131 were in office in 1993. The response rate was 32 out of 131, or 24 percent.

The survey was sent out with a cover letter explaining the research and briefly detailing the bill concerning managed care. The survey asked legislators to rate the importance of a series of information sources concerning managed care. The scores ranged from "1," or "not at all"

to "7," or "a great deal." The survey found that among all of the sources listed, legislative analysts tended to be relied on more as a source of information than any other source. The results are summarized in Table 5.2. Other legislators ranked second as an important source of information, closely ahead of medical experts and independent analysts.

Table 5.2: Rank Order of Managed Health Care Information Sources

Information Source	Score
Legislative Analysts	5.15
Fellow Legislators	4.78
Medical Experts	4.71
Independent Analysts	4.65
Other Interest Groups	3.34
Personal Staff	3.21
Federal or State Agencies	3.18
Other	0.75

A higher score represents a greater degree of reliance.

Specialist legislators have been defined as "trusted colleagues who are knowledgeable on the particular issue under consideration" (Matthews and Stimson, 1975; Sabatier and Whiteman, 1985; Kingdon, 1989). These specialists are primarily defined by their position, either as a committee chair or as a senior ranking committee member on the committee considering the particular piece of legislation.

There is no doubt that legislators take cues from specialist legislators. They may also turn to them for advice or ask for their opinion on certain issues within their realm of expertise. While the literature generally defines specialist legislators by virtue of their position, this study finds that the definition of a specialist legislator can be refined even further. Former senator Edmund S. Muskie once commented:

> People have all sorts of conspiratorial theories on what constitutes power in the Senate. It has little to do with the size of the state you come from. Or the source of your money. Or committee chairmanships, although that certainly gives you a kind of power. But the real power up there comes from doing your work and knowing what you're talking about. Power is the ability to change someone's mind....The most important thing in the Senate is credibility. *Credibility! That* is power (Davidson and Oleszek 1998).

Specialist legislators can be seen as either; (1) true specialists, or (2) specialists by default. In the Oklahoma Legislature there were only a handful of "true specialists" on health care policy when a managed care delivery system was approved for Medicaid patients. To distinguish between "true specialists" and "specialists by default," I asked legislators, legislative staff, and those in the medical profession who they considered to be experts in health care policy. Nine names came up the most frequently. I was particularly struck by the response of two legislators, Senator Monson and former House member, Calvin Anthony, when

I asked this question. Senator Monson replied "nobody" (Monson 1997). Representative Anthony said,

> There really wasn't anyone with the background when I left. Angela Monson went over to the Senate, and this made it hard for me to leave (Anothony 1998).

Both Senator Monson and Representative Anthony had extensive backgrounds in health care. Senator Monson was the Executive Director for the Oklahoma Health Care Project prior to her election to the legislature. As a representative in the House and later as a senator, she was a member of the National Academy for State Health Policy and served as vice-chair on the Health Committee for the National Conference of State Legislators. Representative Anthony was a pharmacist and owned his own pharmacy. He was the director of the Stillwater Medical Center and president of the Oklahoma Pharmaceutical Association. He also served as chairman for the National Association of Retail Druggists. He met with President Clinton and provided input for the National Health Security Act.

True specialists can be distinguished by their background in health care policy or for that matter any other complicated policy area such as tax law or banking. They can perhaps also be distinguished somewhat by the ratio of bills in their given policy area to the total number of bills which they sponsor. Senator Monson said, "If you look at the bills I sponsor, 85 percent of them are health care related." To identify the true specialists in health care

policy, this study looked at the nine most frequently mentioned members of the legislature as experts on the subject, and the bills they sponsored over a four year period. The bills cover two legislative session between 1993 and 1996. The number of health care related bills is compared to the total number of bills sponsored or co-sponsored by each legislator. The results are summarized in Table 5.3.

Table 5.3 Specialist Legislators 1993-1996

Legislator	1993 health/total	%	1994 health/total	%	1995 health/total	%	1996 health/total	%	cumulative health/total	%
Anthony	1/1	100%	2/3	66%	7/10	70%	12/17	71%	22/31	71%
Boyd	1/3	33%	6/15	40%	1/7	14%	2/5	33%	10/30	33%
Cain	4/12	33%	10/19	52%	8/21	38%	7/22	32%	29/74	39%
Deutschendorf	NA		NA		0/1	0%	1/2	50%	1/3	33%
Hendrick	7/35	20%	5/37	13%	6/38	16%	5/30	17%	23/140	16%
Monson	3/7	42%	11/15	73%	20/35	57%	23/46	50%	57/103	55%
Robinson	3/12	25%	6/13	46%	10/22	45%	10/22	45%	26/69	42%
Seikel	3/14	21%	3/15	20%	4/22	18%	5/24	21%	15/65	23%
Thomas	3/5	60%	2/7	28%	6/7	85%	3/4	75%	14/23	60%

Arbitrarily, one can say that a true specialist will sponsor health care policy related bills more than 50 percent of the time. Using that rule of thumb, only three legislators would qualify as "true specialists;" Calvin Anthony, Angela Monson, and Tommy Thomas. One can also look at the volume of bills sponsored. Representative Thomas sponsored a total of 23 bills compared to Anthony's 31 and Monson's 103. That measure alone however, isn't sufficient. Out of the three, Monson and Anthony fit the description of a true specialist, both with backgrounds in health care.

Thomas and the other six make up a second category of specialist legislators that I refer to as "specialists by default." This type of specialist is categorized as such because of the legislative positions they occupy. Most of the time these are leadership seats on specific committees. This is not to say that a true specialist can not be a committee chair or ranking committee member, but a true specialist is defined by more than a position.

Take Representative Tommy Thomas for example. Representative Thomas was elected to the Legislature in 1988. He felt most qualified and wanted to focus on three primary areas; corrections, agriculture, and transportation (Thomas 1997). He had a degree from Oklahoma State University in Agriculture Education, and he has been in the real estate and insurance business. Near the end of his

first term, Dan Mentzer, chair of the House Human Services Committee passed away, and Representative Thomas was chosen in his second term to succeed him on the committee. The following year, Larry Gish, chair of the Human Services Appropriations and Budget Subcommittee died. Again, the majority party leadership selected Thomas to fill in the vacancy. Within a year, Thomas found himself chairing two of the most influential committees dealing with Medicaid. Along with his counterpart in the Senate, he served on the Interim Task Force on State Welfare and Medicaid Reform as an *ex officio* member in 1992.

Representative Thomas was considered by many to be an "expert" in health care policy. However, as he noted in an interview, he did not feel qualified when he was appointed to serve as chair over the two committees which handled Medicaid. "That's not the path I would have chosen, but it put me in a position where I was quickly looked at by the leadership," he said (Thomas 1997). Thomas wanted to focus on other areas, but happened to get into health care policy "by default."

Thomas's counterpart in the Senate was Bernest Cain. Like Thomas, Cain did not have a background in health care. He was elected to the legislature in 1979 and became involved with Medicaid more for ideological reasons. His primary concern was the needs of low income people. While

he is frequently mentioned by his peers as an expert on health policy, he hinted at his inexperience; "I'm not as knowledgeable as people think I am" (Cain 1997). Because he chaired the Human Resources Committee in the Senate, he was also appointed to serve as an *ex officio* member of the Interim Task Force on State Welfare and Medicaid Reform.

Legislators take cues from specialists on health care. However, party also is an important factor in making decisions. Members of the Republican party, for example, are more likely to look to a Republican expert on health care when voting. One representative said that in some instances, she would "rather turn to interest groups for information rather than consult someone in the other party" (Greenwood 1998). Of the nine most frequently mentioned experts on health care, only one is a Republican. Other specialists are aware of this, and as a matter of strategy, will try to get him on board, knowing that his vote will translate into votes from other Republicans (Monson 1997).

On the issue of managed care, specialists in the Oklahoma Legislature may support it for different reasons. There have been no studies to indicate whether managed care is more of a Democratic than a Republican issue. Referring to managed care, Senate analyst Tom Walls noted that it seemed like a bipartisan issue; "Republicans like it for its fiscal restraint and I know some Democrats who don't like it

because they worry that the services will be bad" (Walls 1997). At an early task force meeting on Medicaid reform, Democrat Senator Cain made it clear from his standpoint that the objective of the task force was to find a way to control costs so as not to cut back on services or eligibility. The idea that conservatives like managed care due to its cost savings and liberals like it because they see it as a way to improve access or the services, may explain why party control did not turn out to be a significant variable in the event history analysis outlined in Chapter three. If managed care were a bipartisan issue, then it should not matter whether or not Democrats controlled the legislature and/or the executive branch.

The survey also asked legislators to rank the importance of three factors that influenced their vote on converting Medicaid to a managed care system; the need to insure more people, the need to save money, and the need to raise health standards. The survey used a seven point scale ranging from "1," being "not at all important" and "7," being "extremely important." The results are summarized in Table 5.4 below.

Table 5.4: Factors Influencing Legislators Votes for Medicaid Managed Care

Factor	Level of Importance
The need to save money	5.40
The need to insure more people	5.09
The need to raise health standards	4.96

The results show that in Oklahoma, legislators considered the need to save money to be a slightly more important factor than the need to insure more people or raise state health standards. A few respondents noted other reasons for their vote on managed care such as; to encourage private insurance, to provide greater access to health care in rural areas, and who would shoulder the cost burden.

In the end, Senate Bill 76 passed easily through the legislature. The vote was 44-1 in the Senate and 92-5 in the House. As Representative Mark Seikel remarked, "It was a slam dunk deal." Part of the reason for the bill's success could have been its appeal to both sides of the isle. Another reason it was perhaps adopted with little change was its complex nature. The complexity meant that the opinions of specialists in health care policy would carry a great deal of weight. Referring to the Medicaid reform bill Seikel (1998) commented; "There were not even five people out there who understood what was going on, and

those of us who did still were not sure. We didn't know if it would work or not."

This study already noted that Kingdon (1989) identified "fellow legislators" as a possible cue source. Ray (1982) went a step further and distinguished "committee reports" as a subcategory of "fellow legislators." Ray felt that this distinction was necessary based on cases he encountered in his study. He quoted one legislator as saying; "Well, I hate to admit it, but I find myself relying on committee reports more and more, and on legislators less and less."

The plan to move Oklahoma's Medicaid population into managed care was drawn up by the Interim Task Force on State Welfare and Medicaid Reform. The Task Force's report served as a basis for SB 76. As noted in the last chapter, the report was developed with a lot of input from consultants at Peat Marwick. This report was also considered by many legislators when deciding how to vote for the bill. It may be one reason why "independent analysts" ranked nearly as high on the survey concerning information sources as "fellow legislators" and "medical experts." While the report of the task force may not have been a committee report in the technical sense, it was the only report on managed care and Medicaid. The report can be considered as an information source stemming from fellow legislators who served on the task force.

In hindsight, it is probable that whatever recommendations the task force proposed, as long as they were within reason, would have been adopted. The independent consultant team of Peat Marwick then, had a great deal of input into a policy decision. The task force based its recommendations largely on the Arizona model. It is difficult to speculate what the outcome may have been if another consultant group received the contract. Had Bob Vincent, the task force chair, and others on the task force chosen to adopt the recommendations of the legislative analysts assigned to work with the committee, then Lewin-ICF would have been awarded the contract. If that had happened, Oklahoma could have ended up with a system of managed care more closely resembling Oregon's model than Arizona's. It is clear that Peat Marwick drew upon Arizona's experience without considering many events in other states such as Tennessee.

It appears that one reason why Peat Marwick ended up the successful bidder, was the consultants' ability to draw parallels between Arizona and Oklahoma. This appealed to many members of the task force as well as legislators. They noted that both states were relatively large, each having two major metropolitan centers with scattered rural areas. Demographically, the populations were also similar. Each state had a university hospital that served as a safety net,

treating large numbers of Medicaid patients. The hospital in Tuscon was free standing, and Oklahoma considered following a similar path.

In the end, many legislators felt that the Arizona experience provided a useful model. They were impressed by the relatively low inflation of health care costs within the Medicaid program. They also considered the level of Medicaid consumer satisfaction, which was high in relationship to other states. And they thought that since the system had been around for over ten years, that most of the bugs had been worked out.

Group Politics

Whether it was realized or not, the political battle over managed care and Medicaid was not fought in the chambers of the legislature. The bulk of the input had already been entered and was manifest by the recommendations of the task force. A good time for input from stakeholders then, may have been during the task force meetings in the fall of 1992. Unlike the legislature however, it was difficult to tell when and where the task force meetings were being held. While the meetings were open to the public, it was hard to determine when they met without a meeting schedule. The make up of the task force and its proceedings give a pretty clear indication of the group politics involved. Most of the members on the task force

represented health care providers. What follows is an examination of the involvement o stakeholders in Medicaid, primarily the consumers and the providers.

Medicaid Consumers

A 1996 report by the National Health Law Program noted that Medicaid recipients have traditionally taken a back seat in the development and implementation of state Medicaid programs. There are several reasons for this and they can generally be divided into systemic and political causes.

Systemic Reasons. Many Medicaid recipients are very mobile and they are often hard for state health care agencies to track. In addition, Medicaid for many is an off-again-on-again proposition (National Committee for Quality Assurance 1995). Recipients may find work with basic health care benefits and return to Medicaid when employment is lost or if medical needs require it. This lack of continuity coupled with a lack of resources, to include any type of a trade association, makes it difficult for consumers to obtain information or protect their interests. Therefore, consumers rely on government agencies and health care providers to ensure the quality of health care that they receive.

Some researchers (Perkins et al. 1996) have found that the contractual nature of Medicaid restricts consumer involvement. According to the authors, the government

enters into the Medicaid contract for recipients. These recipients have virtually no role in negotiating the contract, yet the terms are binding for their future health care needs. In many cases, the government, not the recipient, selects the health care plan and thus takes away the market place incentive to ensure consumer protections. Their study also pointed out that in general, individual Medicaid beneficiaries often: do not know that they are enrolled in a risk-based managed care program; do not know what managed care is or how to use their managed care plan; do not know the scope of the benefits package or the process for obtaining services inside and outside of the plan; do not know how to resolve problems within the plan; and do not know how to register suggestions and complaints with the plan or state Medicaid purchaser.

Political Reasons. There are basically two groups who have a claim on Medicaid spending; recipients and providers. Within these groups are subgroups that differ in terms of resources and political visibility. Recipients include the elderly, people with disabilities, children in low income families, and adults that qualified or would have qualified for AFDC benefits. Providers include hospitals, physicians, and nursing homes.

Kronebusch (1997) argues that among Medicaid recipients, the elderly enjoy a political advantage in terms

of participation, political recognition, group image, and history. The elderly have the highest voting rate of all age groups. In contrast to low income families, they are stable and relatively settled. Walker (1991) notes that federal policy facilitated the creation of aging advocacy groups. Increased income, much of it due to Social Security, gave seniors the means to join such organizations as the American Association for Retired Persons. This capacity to organize gives the elderly increased political visibility. Since the elderly are not clearly identified with a particular party, both Democrats and Republicans appeal to them. The elderly also benefit from the altruism of their children and others who hope to be elderly someday.

In contrast, those who qualify for AFDC generally have lower levels of education and income, and are far less likely to vote or participate in other forms of politics (Wolfinger and Rosenstone 1980; Verba and Nie 1972). Kronebusch (1997) suggests that their status as "welfare recipients" carries a social stigma and acts as a barrier to the establishment of effective political organizations. This same argument was made by Schlozman and Verba (1979) regarding the unemployed. Their inability to organize contributes to a lower level of political visibility. While the elderly are associated with popular programs, those

receiving welfare benefits are generally associated with politically unpopular programs.

Children and the disabled fall somewhere in between the elderly and poor adults in terms of political advantage. Children represent an appealing group since programs designed for them are seen as an investment in the future and have a potential "payback" for society. However, all children are not eligible for Medicaid unless they come from low income families. People with disabilities have become increasingly active politically, yet the disabilities themselves may prevent them from fully participating. Those with disabilities are not tied to a particular political party. Watson (1992) points out that many of the sponsors, both Democratic and Republican, of the 1990 Americans with Disabilities Act either had a disability or had a close relative who did. This relationship is perhaps the biggest advantage for disabled advocates.

Cook and Barrett (1992) provide some insight into the way the public and policy makers view Medicaid recipient groups. They conducted surveys which asked respondents to prioritize groups in terms of the allocation of resources. As a group, the elderly received the highest scores. The results are summarized in Table 5.5. The same study found that the public prefers children to be among the first group included in an expansion of catastrophic health

insurance, followed by the elderly and then adults. These results suggest that the elderly have a major political advantage when it comes to Medicaid policy making.

Table 5.5 Public Rankings of Groups for Financial Assistance

Group	Mean Ranking Score
Disabled elderly	1.84
Poor elderly	2.86
Poor children	3.11
Disabled adults	3.41
Poor adults	
Poor female household heads	4.15
Poor unemployed men	5.52

Source: Cook and Barrett 1992, 72. Lower scores represent a higher priority rank.

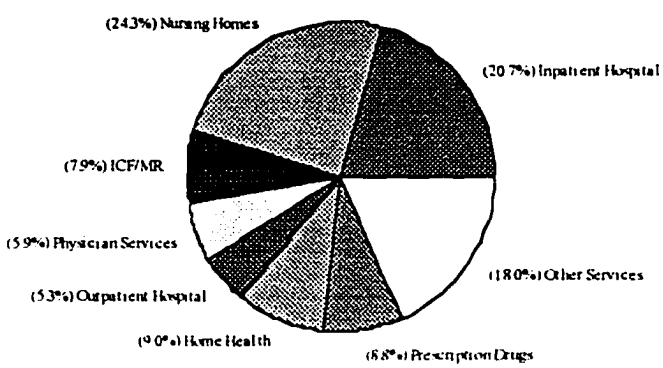
Health Care Providers

Medicaid providers have a political advantage over recipients. They are generally wealthier, better educated, and are more likely to vote and contribute to their professional organizations. Health care providers belong to several different associations representing the various types of work in the medical field. They are well organized, resourced, and are very influential in the policy making process. In addition, they provide a service that is very much sought after. Policy makers need the cooperation

of health care providers for the implementation of any Medicaid program (Kronebusch 1997).

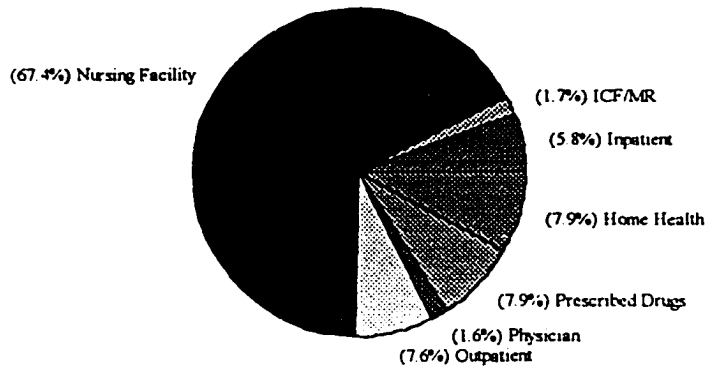
The stakes in Medicaid services also vary. By breaking down the overall Medicaid expenditures, nursing homes and hospitals have a high incentive to be politically active, whereas physicians have relatively somewhat less at stake. See figures 5.1 and 5.2.

Figure 5.1: Medicaid Payments by Type of Service

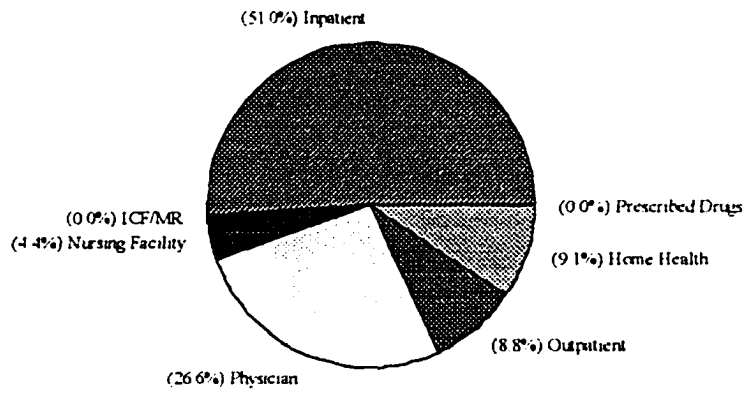


Source: Health Care Financing Review: Medicare and Medicaid Statistical Supplement (1996).

Figure 5.2: Comparison of Medicaid and Medicare Payments for the Aged



Medicaid Payments for the Aged: $33.6 Billion



Medicare Payments for the Aged: $128.1 Billion

Source: Health Care Financing Review: Medicare and Medicaid Statistical Supplement (1996).

In terms of political participation in the decision making process, the Oklahoma experience is consistent with the literature. However, while stakeholders were represented, the process was not adversarial. Issues were discussed and compromises were reached. As one task force member said, "Everyone wins in a plan like this" (Oklahoma Legislative Reporter, 1992).

As was discussed somewhat in Chapter four, the make up of the task force reflected those affected by Medicaid, with the exception of consumers who were poor or those with disabilities. On the 15 member panel, three members represented nursing home interests, hospitals, physicians and pharmacists each had a representative, and there were two aging advocates. Those who were the most politically active or politically visible were granted more access in the decision making process. Not surprisingly, the nursing home industry, a big stake holder in Medicaid had the best representation. Although this was pointed out by an official in the Department of Human Services, there were no changes made. According to some, the nursing home lobby is one of the most powerful lobbies in Oklahoma (Cain 1997). They contribute heavily to campaigns and they have several registered lobbyists. The interests of other health care providers, such as hospitals and physicians, were also represented.

The health care community took a more active political role in general during this time. For example. between 1992 and 1993, the Commission on Oklahoma Health Care conducted a series of town meetings to discuss possible health care reform options. Attendees were asked to fill out a survey so that the commission could better assess the health care needs of Oklahomans. In all, 409 adults filled out the questionnaire in 1992 and 405 the following year. The survey included personal information such as education level and profession. In 1992, 42 percent of the respondents were health care professionals and 6 percent noted that their spouse's occupation was health care related. In 1993, the percentage of health care professionals responding to the survey climbed to 49 percent and nearly 10 percent of those surveyed had a spouse in the same profession (Commission on Oklahoma Health Care 1992, 1993).

The law creating the task force specified that consumer interests should be represented, but it did not go as far as stating which interests these would be. The consumer delegates as it turned out were Boyd Talley and Vivian Smith, both aging advocates. No one represented poor families or the disabled.

As the task force business got underway, two attorneys, Travis Smith and Steve Novick from Legal Aid of Western Oklahoma contacted members of the task force. They became

concerned about the potential major changes in Medicaid and wanted to make sure that it would not adversely affect the poor. According to Smith, lobbying the legislature or a task force was rare[3], but in this case they felt that it would have an impact on so many of their clients. They were primarily concerned about the quality of care and were asking that a set of consumer protections be included in the law. Smith (1997) felt that their attempts were largely in vain. "The train had left the station," he said, "and it wasn't going to be stopped."

Tom Walls, a staff member of the committee, met with Smith and Novick. He pointed out the positive things of managed care and tried to sell them on its merits including more access and better service. Walls (1997) felt that the task force was looking out for consumers and that managed care would be an improvement over the current system. Smith remained skeptical but felt that any further efforts on his part would be useless.

Smith and Novick became involved as consumer advocates, not consumers. This is an important distinction. They would not be able to lobby on the behalf of consumers under current law. There is no indication that consumers were ever directly involved in the political process. The 1992

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[3] A law passed by the 104th Congress prohibited an organization receiving federal funds from lobbying a legislative institution.

and 1993 surveys conducted by the Commission on Oklahoma Health Care provide perhaps the best evidence in helping to determine the consumers' level of political involvement. In 1992 roughly 2 percent of those attending town meetings noted that they were covered by Medicaid. By contrast, 22 percent claimed that they were covered by Medicare. This comparison is useful in highlighting the differences in involvement between the elderly and the poor.

Although research suggests that stake holders become involved for political reasons, there is another possible explanation in the Oklahoma case. The explanation doesn't necessarily contradict group political theory, but in this case it can perhaps be a complement to it. Those interviewed on the task force felt that they were selected to serve on the panel, not because of who they represented, but because of their expertise in the given area. In other words, they saw their job primarily as providers of information, rather than defenders of their industry. Expertise in the health care delivery system is another political advantage health care providers enjoy. Medicaid recipients generally do not have the ability to contribute in the same way.

The Oklahoma case suggests that larger, organized groups with high levels of political recognition do indeed have more political leverage than smaller groups with little

if any resources. Senator Ben Robinson (1997) frequently noted that "Medicaid money doesn't go to the recipients, it goes to the doctors." The primary mechanism for developing the new managed care program was the interim task force, and it was largely dominated by health care providers. Health care providers have an advantage over health care consumers and among health care consumers the elderly have an advantage over disabled or poor Medicaid recipients.

Information Flow

Sabatier and Whiteman (1985) developed two and three-staged models of legislative decision making and they tested them in the California Legislature. Citing studies which found that legislators rely heavily on cues from "specialist" legislators,[4] they set up a framework to trace the flow of information. They make a distinction between "political information" and "policy information." For them, "political information" concerned the positions of other political actors and the impact of the legislation on reelection prospects. "Policy information" on the other hand referred to the actual content of the legislation and its possible impact on society.

In their two-stage model depicted in Figure 5.3, policy information flows from agencies and interest groups to specialist legislators and their nonspecialist colleagues.

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[4] Here I rely on a literature summary given by Sabatier and Whiteman (1985).

External actors such as constituents, and private individuals can also be a source of both policy and political information, while parties primarily are a source of political information.

Figure 5.3: Two-Stage Model of Information Flow

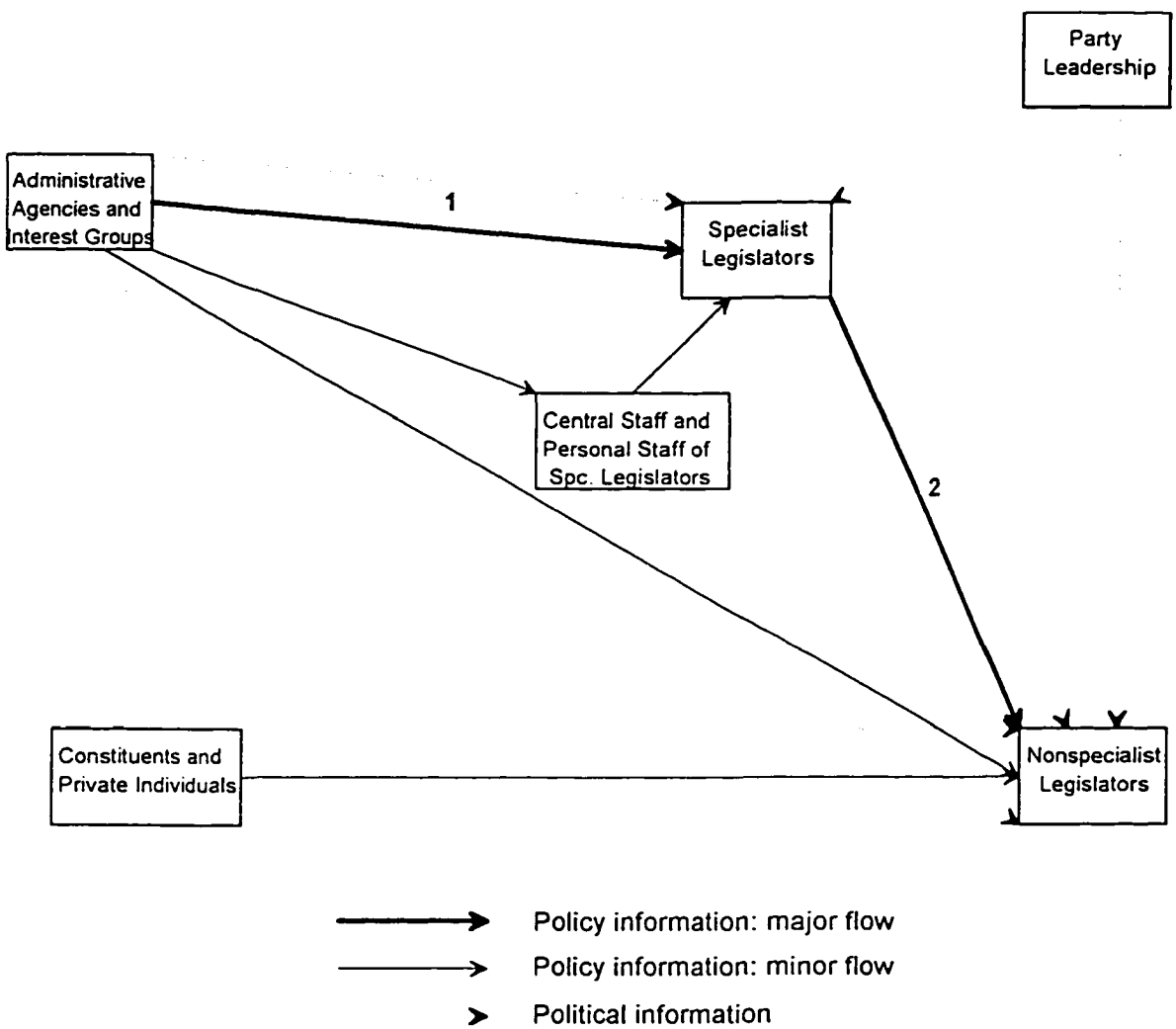
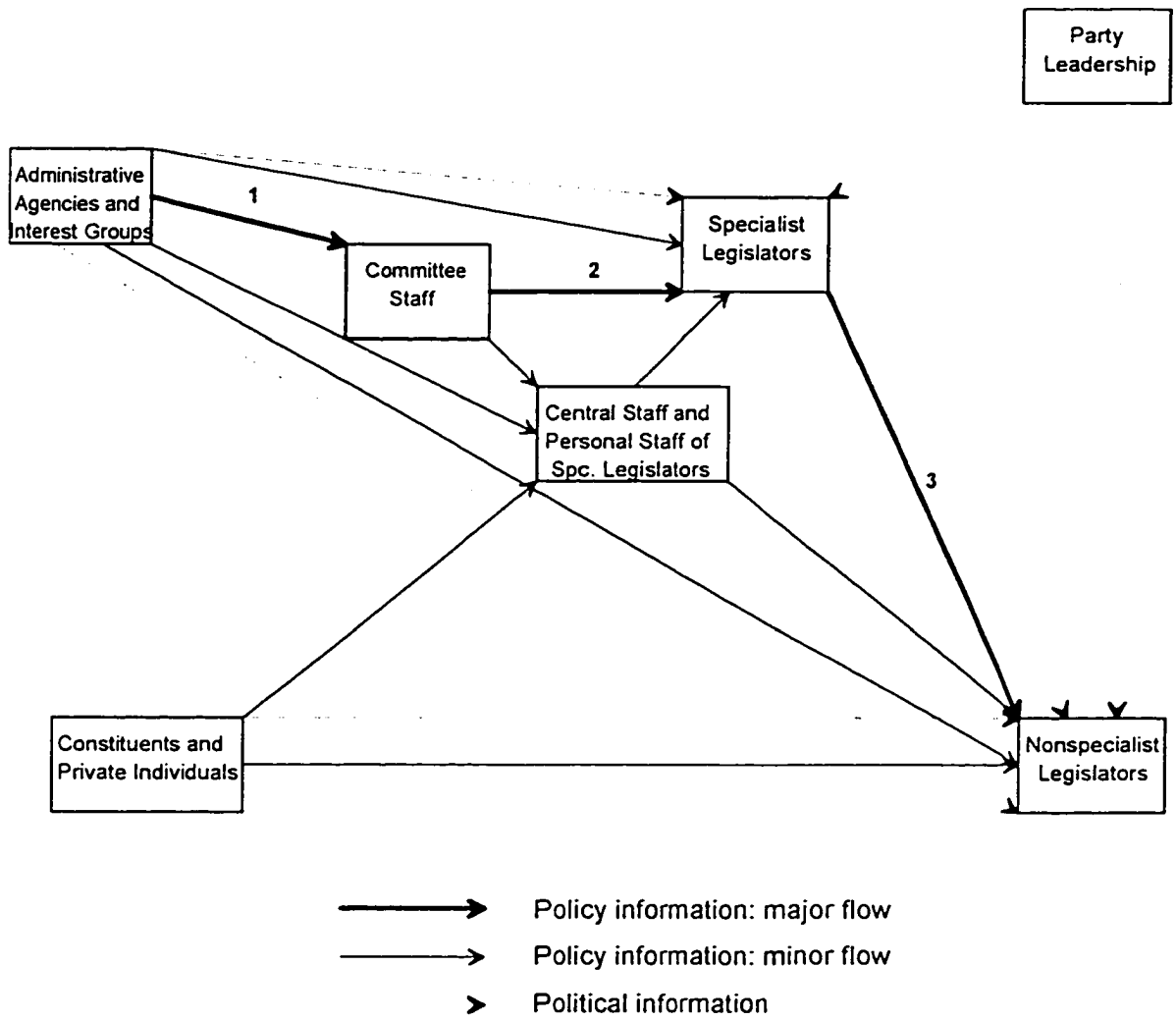


Figure 5.4: Three-Stage Model of Information Flow



Sabatier and Whiteman's three-stage model, depicted in Figure 5.4, is a little more elaborate and is designed primarily for legislatures with "well-developed staff systems." In the two-stage model, information flows from

the "environment" directly to the specialist legislator. The three-stage model adds a third step, with information flowing from the environment to committee staff, next to specialist legislators, and then on to their nonspecialist colleagues. They applied a three-stage model to California, arguing that it was better suited to states with large legislative staffs.

Based on an analysis by Morgan et al. (1991), I would contend that the two-stage model is more appropriate for Oklahoma. In their analysis, the authors claim that the Oklahoma Legislature's 27th place ranking among states in its ability to acquire, assimilate and handle information is primarily due to the size and resources of the legislative staff. Members of the Oklahoma Legislature have no personal staff except for someone to handle the clerical duties in each legislator's office. Each house has in excess of 100 staff members, most of whom are policy or fiscal analysts. These analysts generally focus on a primary field of policy, such as education, transportation, health, etc. The Legislative Service Bureau is an organization within the legislature and is responsible for the production of proposed legislation. It serves as a clearinghouse for research reports and information. Any requests for proposals (RFPs), such as the one drawn up seeking

consultants on managed care, are produced by the Legislative Service Bureau.

While Sabatier and Whiteman's model is largely correct in a general sense, it could be adapted for specific cases. While their two-stage model is more appropriate for Oklahoma, there are some other things to consider in this study. In particular, the original source of information for managed care and Medicaid and the role of political information.

The original source of information for managed care was ultimately another state, Arizona. The specialist legislators on health care policy however, did not go directly to the state for information. The information came through the intermediary of the Peat Marwick consulting team. In this case, administrative agencies or interest groups (with the exception of representatives on the task force) had little to do with providing information to specialist legislators.

In their study, Sabatier and Whiteman are careful to note that one should be cautious when generalizing from their data. They too found instances where information roots could be traced to other states or consulting firms on some bills. This may suggests that the nature of the bill has a lot to do with where legislators or staff turn to for information.

The complexity of a particular policy may dictate to what extent consulting firms will be used. Most bills do not require outside analysts to make recommendations, and this may help explain why Sabatier and Whiteman found fewer instances where consulting firms were considered as a primary source of information. As noted in Chapter four, Governor Walters did not want to involve outside consultants, believing that Medicaid reform could be handled internally. Legislative leaders, however, felt that outside expertise would be required and allocated funds for that purpose. Referring to the need of consultants in this case, Representative Tommy Thomas commented:

> We don't often hire consultants, but this was a big change. We were swimming in new waters and mistakes could have been costly. We were dealing with a big Medicaid budget. It was important to have additional expertise. Other times we do our homework and just try to work it out (Thomas 1997).

In Chapter three, the number of neighboring states adopting a managed care system for their Medicaid program was considered an external factor in trying to predict whether a state would apply for an 1115 waiver. It is interesting to note that at the time Oklahoma applied, three bordering states were either applying for a waiver or had already received one. Yet Oklahoma did not look to Kansas, Missouri, or Texas as a model from which to develop its own policy. Instead, it based its system largely on that of Arizona.

Conclusion

This study suggests that while diffusion of policy takes place, it may not always come from neighboring states. Even though, neighboring states turned out to be a significant variable in predicting policy adoption. It may be that the number of neighboring states adopting a certain policy contributes to an environment more conducive to a policy's adoption. In other words, it creates a "keeping up with the Jones's" effect. When it comes to substantive policy decision making legislators will turn to a state that is similar to their own.

Although Sabatier and Whiteman's research indicates that legislators and staff look less to the Council of State Governments or contacts in other states as sources of information, this research finds support for policy diffusion theory. Analysts interviewed in the Oklahoma Legislature say they find organizations such as the National Council of State Legislatures and the Southern Legislative Conference useful sources of information. Legislative analysts attend at least one conference a year and many are involved serving in various positions of these organizations at the national level. In the area of health care policy, the Health Care Financing Administration sponsors seminars and invites state officials to participate. The Academy for State Health Policy also sponsors periodic conferences.

When it comes to drafting policy legislation, many say that there is no need to reinvent the wheel. Analysts look at what other states are doing and get ideas from them or umbrella associations that compile state innovations. "This job is 90 percent plagiarism," said Paul McElvany (1997). McElvany is the director of the Legislative Service Bureau, the organization which produces legislation. He often refers to the publication, *Suggested State Legislation* and sees it as sort of a "recipe" for a bill. McElvany pointed out that on some issues, the policies of neighboring states are more likely to be similar. For example, analysts generally try to be in line with bordering states when it comes to tax law.

Oklahoma's experience in Medicaid reform also indicates that "political information" did not play a significant role in developing a managed care delivery system. The bill was passed by an overwhelming majority, and there was little, if any, opposition. As the discussion concerning specialist legislators illustrated, legislators are more likely to trust in a specialist that is a member of their own political party. In the case of managed care, all specialists were on board. The concept of managed care is also embraced by both Democrats and Republicans alike. A bill that receives bipartisan support is less likely to draw fire from party leaders on either side.

Medicaid reform is a complex process. Complexity was a disadvantage to those who supported a provider tax. It was beneficial for those who supported SB 76, the bill placing Medicaid recipients in a managed care system. Because of its complex nature, specialists in the legislature had a great deal of influence and they were all for it. Those affected by changes in the Medicaid program had varying degrees of input, depending on whether one was a consumer or a provider. Due to the complicated disposition of Medicaid reform, outside consultants were relied on to help the task force come up with recommendations for reform. These consultants also had some influence. In the end the task force adopted many of the provisions in the Peat Marwick report. Oklahoma based its new managed care program on the Arizona model, and the Peat Marwick consultants provided a vehicle for policy diffusion.

Chapter Six

This dissertation has sought to determine why states adopt managed care as an alternative to the traditional fee-for-service Medicaid program. In doing so, two different approaches were used. Chapter 3 was based on a national survey that examined a set of conditions prevalent when states applied for demonstration waivers. Chapters 4 and 5 provided an in depth study focused on one state's experience with Medicaid reform. These two approaches shed light on the subject of health care reform across states, and they complement each other in terms of the depth of the research project.

In the end, Medicaid reform is a product of a host of variables. Using the framework provided by Oliver and Paul-Shaheen (1997), these variables can roughly be categorized as contextual and dynamic. The authors note that it is important to consider all of the diverse and complex factors rather than broader, more superficial characteristics of state policy environments in explaining any pattern of policy innovation. Reform is more likely to happen when a state's contextual conditions are ripe for political opportunity. These favorable conditions then allow dynamic factors, such as leadership or information flow to play an important role.

States as Laboratories

The notion that states could serve as laboratories of democracy received its clearest and most notable formulation when in a dissenting court opinion, Justice Louis Brandeis argued; "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country" (New State Ice Company v. Liebmann, 285 U.S. 262 [1932]). This dissertation has pointed out the extent to which states borrow ideas from states that have already developed health care policies. In particular, Oklahoma based its managed care system for Medicaid patients on Arizona's health care program for the indigent. Many legislators, such as Senators Cain and Robinson, felt that Arizona's system had been tried and proven. While it was understood that Oklahoma's new system would undoubtedly have a few bugs to work out, a great deal could be learned from a state that had several years experience with a capitated health care program.

Some scholars (Sparer and Brown 1996; Leichter 1997) argue that the metaphor of states acting as a laboratory is overused. Sparer and Brown (1996) point to four images of states as laboratories: (1) "state officials and policy analysts working together to test theoretical policy

hypotheses;" (2) states learning from one another; (3) federal officials adopting programs that have been implemented in a state; and (4) "social scientists studying state initiatives, evaluating programs, and suggesting improvements." Sparer (1997) argues that, in reality these images do not reflect what actually occurs. He contends that federal officials rarely adopt programs that have been implemented in other states and that few social scientists actually compare and contrast various state initiatives. Moreover, he argues that when diffusion of innovations occurs, there is a great deal of variance between programs. He claims that states "learn relatively little from each other; what they learn is filtered to accommodate local needs and institutions, and the federal government only occasionally builds on state initiatives" (Sparer 1996).

Others (Nathan 1989; Rose 1993) have a different take on states serving as policy laboratories. Nathan (1989) argues that the federal government has indeed looked to states as innovators. He maintains that several New Deal programs initiated in the 1930s originated from state programs adopted years earlier. In his 1993 book, *Lesson Drawing in Public Policy,* Richard Rose points out the value of learning from other states. He notes that states can benefit from the experiences of other states, even if they do not adopt an identical policy. He writes;

"Lesson-drawing is not about the uniform spread of programs throughout a nation; it is about finding programs that can transfer."

Legislative analysts interviewed in this study agree that a great deal can be learned from other states.[1] When the legislature considers a new policy, quite often these analysts begin by looking at bordering states. If those states do not have a policy that would work well in Oklahoma, then they may go elsewhere looking for a state that shares similar characteristics, and has adopted a similar program. Arizona was viewed as such a state. Not only did Arizona have a history of managed care, it was geographically and demographically similar to Oklahoma.

Arizona was obviously not the only state that had implemented some type of managed care program. Governor Walters visited Hawaii and Tennessee. In fact, he never personally went to Arizona to examine its program. As pointed out in Chapter 4, Walters was against hiring an outside consulting firm. He felt that analysts could look at other states and borrow ideas that could be adapted to fit Oklahoma's situation. While the Medicaid reform initiative began during Walter's administration, he played a relatively small role in its development. Unlike Tennessee, Rhode Island, and Hawaii, where the governor began the

[1] Paul McElvany, interview by author, Oklahoma City, Ok., 9 October 1997.

reform process, Oklahoma's Legislature served as the primary force in shaping health care reform (Ku and Wall 1997).

Contingency

In the 1946 film, *It's a Wonderful Life,* George Bailey gets the opportunity to see what his town would have been like had he never existed. He learns that the condition of his town and many of the people living there was contingent on his earlier actions. Like George Bailey's life, Oklahoma's new managed care program for Medicaid recipients was also contingent upon many variables.

Individual legislators who play a key role in legislation may owe their positions to a strange twist of events. Representative Tommy Thomas is now the House Majority Leader. His position now is largely the result of the attention he received as the chairman of the Human Services and Human Services Budget Committees. While he said that he would have chosen a different path in his legislative career, he was noticed by the leadership when he became very involved in these committees. At the time, many important issues were surfacing, and his committees played a key role in several types of reform. As was noted in Chapter 5, Thomas's background is better suited to other areas, such as agriculture or insurance. His position on the committees came because two legislators, Don Mentzer and

Larry Gish, both passed away and created an opening that needed to be filled.

It is difficult to speculate as to the fate of Medicaid reform had the provider tax been approved by voters in November 1992. The provider tax may not have been a permanent cure for the funding crisis at DHS, but it would have softened the fiscal burden on the state. Some analysts such as Claudia Durrill in the House and Tom Walls in the Senate believe that Medicaid reform would have been carried out regardless of whether the tax passed. "The state would have gone to a managed care system eventually," Durrill said.[2] Walls felt the same way but added; "The defeat of State Question 647 gave us the political will to adopt a managed care system."[3]

It is interesting to note that Oklahoma was largely containing Medicaid expenditures for its AFDC population even before it adopted a managed care system. An improved economy would have meant less pressure on AFDC-related spending and more revenue generated through the state's tax system. A recent report released from the General Accounting Office (1997b) noted a marked decline in national Medicaid expenditures for 1996. A number of states in the report attributed the low growth rates to a generally

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[2] Claudia Durrill, interview by author, Oklahoma City, Ok., 9 October 1997.

[3] Tom Walls, interview by author, Oklahoma City, Ok., 21 October 1997.

improved economy. Had Oklahoma delayed its decision to adopt a managed care initiative, perhaps the "political will" to reform Medicaid would have evaporated.

The provider tax would have gone into effect had it not been for State Question 640 calling for tax increases to be approved by voters. The Legislature had voted for the tax by a wide margin in May 1992. However, due to the passage of SQ 640, the provider tax went before voters at the ballot box. State Question 640 was a significant measure that makes innovation more difficult. As was suggested in Chapter 3, many new programs require large start-up costs. Without the ability to increase revenue, funds for these programs have to be diverted from other areas, or projects may have to be scrapped entirely.

The nature of Oklahoma's managed care policy was also contingent upon the interim task force's decision to hire KPMG Peat Marwick consultants instead of those from Lewin-ICF. Had the task force chairman, Bob Vincent, accepted the staff recommendation and contracted with Lewin, Oklahoma's program may have been more akin to that of Oregon. Oliver and Paul-Shaheen (1997) use the analogy of a marketplace for legislatures where policy ideas are developed, promoted, and ultimately sold to other legislators. While they focus primarily on legislators as "policy entrepreneurs," in like manner, representatives from

consulting firms also try and market their product. Consultants promote themselves through proposals and presentations. In this case, Peat Marwick won the contract over Lewin even though their costs were similar. The deciding factor was presentation. Peat Marwick did a better job convincing task force members that they were better suited to assist Oklahoma in developing recommendations for Medicaid reform. It is interesting to note that the Peat Marwick consultants who worked with the task force eventually broke away from Peat Marwick and formed their own consulting firm, Pacific Health Policy. When it came time to begin implementing the recommendations of the task force, the state contracted with Pacific Health Policy rather than Peat Marwick for assistance. This illustrates the importance of individual players. It is analogous to people who purchase insurance because of the sales representative rather than the company. The representative may change companies several times, but often maintains the same clientele.

The path eventually leading to managed care for Oklahoma's Medicaid program resembles a flow chart used in computer programming. A change at any of the decision points along the way could have resulted in a different product. A different task force chair may have preferred another consulting firm. Had the provider tax been

approved, Oklahoma may not have adopted such sweeping reform measures. The provider tax would have passed had it not been for SQ 640.

Winners and Losers

In the final analysis, it is too early to determine if there were any clear winners or losers in Oklahoma's Medicaid reform package. It was initially touted as a program that would be beneficial for all of those involved. Task force member Gerard Rothlein said, "We're suggesting a system in which providers would benefit by emphasizing prevention and primary care and be financially at-risk if they incur unnecessary costs." Vivian Smith, a task force member serving as a consumer advocate, said that the proposal "creates an atmosphere that fosters innovative, less-costly and more appropriate types of care for people who are otherwise institutionalized; everyone wins in a plan like this" (Oklahoma Legislative Reporter 1992). Did the groups involved in the process get what they wanted? Did everyone win?

Oklahoma began to enroll its Medicaid patients in a managed care program in August 1995. The state started the new system in the metropolitan areas, where HMOs were operational and readily available. *SoonerCare Plus* was the new health care program for those living in urban areas. In 1996, *SoonerCare Choice* was implemented for Medicaid

beneficiaries living in rural areas. Since there were few HMOs located in areas outside of Oklahoma City, Tulsa, and Lawton, SoonerCare Choice relied on primary care physicians (PCPs) rather than HMOs. Table 6.1 illustrates the rate of enrollment for SoonerCare Plus and SoonerCare Choice between 1995 and early 1997. Original legislation called for the enrollment of the aged, blind, and disabled (ABD) beneficiaries by the third year of the program (1997) and the mentally ill to be enrolled by the fifth year (1999). However, recent legislation extended the start date for the ABD population to July 1, 1999. Since the AFDC/TANF[4] recipients are the only ones involved to date, this study cannot assess the satisfaction of all the stakeholders, such as the nursing home industry and other institutions.

[4] TANF is the Temporary Assistance for Needy Families program. This replaced the AFDC program with the passage of the Personal Responsibility and Work Opportunity Act of 1996. For simplicity, the two terms are synonymous in this study.

Table 6.1: Managed Care Enrollment Levels in Oklahoma : Urban HMOs and Rural PCPs

Month	Urban HMOs: Sooner Care Plus	Rural PCP/CM: Sooner Care Choice	Total
YEAR 1			
August 1995	1,361		1,361
September 1995	6,190		6,190
October 1995	18,646		18,646
November 1995	28,106		28,106
December 1995	34,590		34,590
January 1996	49,808		49,808
February 1996	53,624		53,624
March 1996	67,457		67,457
April 1996	66,095	3,274	69,369
May 1996	65,739	3,052	68,791
June 1996	64,631	3,206	67,837
YEAR 2			
July 1996	77,872	3,784	81,656
August 1996	74,725	3,585	78,310
September 1996	73,327	3,733	77,060
October 1996	73,226	51,907	125,133
November 1996	76,396	54,260	130,656
December 1996	78,058	47,521	125,579
January 1997	78,224	40,490	118,714

Source: Urban Institute 1997

The following is a brief assessment of the stakeholders involved in the new managed care program. This is not an evaluation of the final policy, but rather, a short sketch examining the satisfaction levels of those involved.

Health Maintenance Organizations - Undecided

The state contracted with five HMOs to service its Medicaid population in urban areas: Heartland, Foundation Health, BlueLincs, Community Care, and Prime Advantage. BlueLincs and Community Care were commercial HMOs formed in the early 1990s. The others were new plans. Heartland and Prime Advantage were created specifically to participate in SoonerCare. Both were developed by physicians associated with hospitals that had traditionally been Medicaid providers. Heartland is owned by the University of Oklahoma Health Sciences Center. Technically, the Board of Regents serves as the Board of Directors. This move was encouraged by the legislature to help protect its revenue. The Oklahoma Health Care Authority has given "extra" autoassignment cases to Heartland to keep revenue as consistent as possible with prior levels of Medicaid funding. Prime Advantage is owned by the Comanche County Hospital Authority. Comanche County Memorial Hospital in Lawton has also served as a safety net hospital.

Four of these HMOs are based in Oklahoma and one, Foundation Health, is headquartered in California. It enrolls a large number of Medicaid patients and receives a large number of auto assignments due to its low capitation rates. Foundation's involvement with Oklahoma's Medicaid program is something that legislators like Gary Bastin did

not want to see: "Why should we hire a for-profit institution out of state when we should be concerned with keeping money in the state?"[5] Foundation's move in Oklahoma, however, illustrates the potential for HMOs under a new managed care system. Between 1994 and 1996 five HMOs entered the Oklahoma market (Perry 1997). Not all of these, however, were awarded Medicaid contracts.

At first many of these new HMOs were eager to spread into counties bordering the metropolitan areas and increase the number of enrolled patients. It would seem that HMOs are big winners under the new Medicaid system. However, as more HMOs entered the market, increased competition led to lower rates. HMOs began reporting losses in 1995. In 1994, HMOs reported earnings of $21.8 million which fell to a negative $17.8 million in 1996. Rick Rinehart, an administrator for Community Care, said that start-up costs are a primary reason for losses. He noted that it typically takes six to seven years for a new HMO to be profitable (Perry 1997). While new HMOs have sprung up in Oklahoma, it is perhaps too early to tell whether they are winners or not. At this point, there is an increased market potential for HMOs, but to date few of the new HMOs have realized profits.

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[5] Gary Bastin, interview by author, Oklahoma City, Ok., 13 November 1997.

Physicians - Losers

In an effort assess the implementation of SoonerCare, The Urban Institute conducted a study funded in part by The Health Care Financing Administration (HCFA). Part of its research involved meeting with participating physicians and soliciting their input. On 18 March 1997, researchers assembled a physician focus group in Oklahoma City to discuss the SoonerCare program.

The feedback received from physicians during this meeting reflected widespread dissatisfaction with the program. Most of the complaints could be summarized as follows:

> Patient eligibility for SoonerCare or enrollment status in a particular plan is sometimes unclear or incorrect, resulting in the physician's services not being reimbursed.
>
> Payments are low and often delayed.
>
> The administrative burden associated with referrals, authorization for services, patient eligibility, and billing is unsatisfactory (Ku and Wall 1997).

While most physicians said their practice did not change by type of insurance coverage, they noted that there are incentives to do less under a capitated program. When asked to compare the new SoonerCare program with the old fee-for-service program, physicians were clear to point out their preference for the former Medicaid program. One physician speculated that because so many are 'disgusted'

with SoonerCare, managed care would eventually be 'rolled back' to be replaced with the former system. Most felt that the traditional Medicaid system was better in terms of payments and administrative interaction. One physician stated: "SoonerCare and capitation in general, I think, is a losing game for most of us" (Ku and Wall 1997).

Consumers in Urban Areas - Winners

One report (GAO 1997a) pointed to the difficulties assessing how well managed care matches the needs of beneficiaries. It states that benchmarks derived from providers and patients in the fee-for-service sector may not be appropriate for a managed care plan. Nevertheless, researchers examining Oklahoma's new health care delivery system attempted to solicit some response from Medicaid patients. They also conducted a focus group with consumers in the SoonerCare Plus and SoonerCare Choice programs. They found that compared to other states (Hawaii, Rhode Island, and Tennessee) where they had conducted a similar study, those with chronic illness were generally more satisfied with the care they received in Oklahoma. Most of the consumers in this group had prior experience with Medicaid fee-for-service and had been enrolled in SoonerCare for at least six months. Most of the participants said they were "very satisfied" with the program. The following summarizes their reactions:

> Participants reported that they were very satisfied with their health plan. Most had selected their own plan and none, including those who were assigned to a plan, had switched to another.
>
> Most were satisfied with their primary care physician and found him or her accessible.
>
> Many participants were pleased with the plans' Nurse Line and frequently took advantage of the readily accessible health advice (Ku and Wall 1997).

While they may not have brought it up in the focus group, consumers actually had access to better quality health care than under the old system. Due to Medicaid cuts in 1992, a lot of services were taken away, such as dental coverage for adults. Hospital days were reduced from 20 to 15, physician's visits were scaled back from four to two a month, and podiatrist and psychologist services were reduced. Senator Angela Monson continues to get several calls from constituents and others that want to enroll in SoonerCare. Under the old system, Medicaid patients were restricted to three prescriptions a month. With SoonerCare, patients can be given an unlimited number of prescriptions. Other benefits include longer hospital stays and access to more specialists. Senator Monson tells about a constituent who needed an ear, nose, and throat specialist. Under the fee-for-service plan, a specialist of that nature was not available. SoonerCare however, was able to refer the constituent to a specialist that was able to treat him.[6]

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[6] Angela Monson, interview by author, Oklahoma City, Ok.

The primary complaint that most consumers had was the lack of information and education about SoonerCare. Many felt that they were simply turned over to a new health care organization without any direction. Their caseworkers were either not very well informed themselves, or their explanations were brief and cursory. Some also wished that the state covered dental or vision care for adults.

Consumers in Rural Areas - Losers

While their urban counterparts expressed approval of the new system, those enrolled in the SoonerCare Choice program were largely unhappy with the new arrangement. Like those in the urban areas, many consumers felt that they received inadequate information or education on SoonerCare. Many were unhappy with the limited choice of providers, and a few switched their primary care physicians. They missed what they described as a more "patient-friendly" attitude of the nurses in the health department. Overall, most preferred the former fee-for-service Medicaid system.

Judging from the preliminary feedback about SoonerCare, consumers in urban areas fared better than those in rural areas. While the increased services available under the SoonerCare program suggest that consumers are better off, it is interesting to note that Medicaid eligibility was not expanded initially. In fact, Oklahoma was the only state

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15 October 1997.

adopting a managed care program that did not expand eligibility.[7] So while consumers in the program could take advantage of more services, many potential consumers lost out on Medicaid benefits. Recent legislation (Senate Bill 639), however, has expanded eligibility for children and low income families.[8]

Others

Safety net providers. Some safety net providers such as local health departments and clinics stand to lose a significant amount of Medicaid revenue because they no longer receive cost-based reimbursement. Many of these clinics in the past were able to assign overhead costs to their Medicaid reimbursement rate. Several local health departments have historically played an important role in providing some limited health services to the Medicaid population. Under SoonerCare, some of these services, such as immunizations, have to be given by the patient's primary care physician. Many of these small organizations lose out on Medicaid funding which was available under the old fee-for-service program.

Hospitals. It is difficult to determine how hospitals fared with the state's new managed care system. Under the new SoonerCare Plus program, hospitals and HMOs have a

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[7] Claudia Durrill interview.

[8] Mike Fogarty, interview by author, Oklahoma City, Ok., 3 December 1997.

complex relationship. A goal of managed care is to cut back on the use of inpatient hospital services. Some hospitals such as University and St. Anthony also own or co-own HMOs. Table 6.2 illustrates HMO affiliations with several hospitals in the Oklahoma City area. St. Anthony co-owns Community Care, yet the hospital also participated as a subcontractor for BlueLincs. This situation makes it difficult to assess the overall impact of managed care on hospitals, since hospital losses could be offset by HMO gains. Researchers for the Urban Institute found that of the four hospitals they examined in Oklahoma City, three have lost Medicaid-related revenue (Ku and Walls 1997).

State legislators, such as Mark Seikel, anticipated some of the consequences for safety net hospitals under a new system of managed care. For example, University Hospital received approximately $26 million a year in Medicaid funds to care for indigent patients. Under the SoonerCare program, the hospital stood to loose a major portion of its funding. University officials began looking for a solution to the mounting financial troubles and sought a partnership with a nongovernment entity. Partnership talks between the hospitals and Columbia began in November 1995.

In February 1998, University and Children's Hospitals merged with Columbia/HCA Healthcare Corporation, the

nation's largest for-profit hospital company. Technically, the hospitals are leased to Columbia for a 50 year term. Under the agreement, Columbia agreed to provide a minimum of 120 percent of the current funding for indigent health care. Columbia also owns Presbyterian Hospital, located just blocks from University and Children's Hospitals. Together, the three hospitals have become the Medical Center Hospitals. Presbyterian also handles some indigent care, although not as much as University. Columbia agreed not to reduce Presbyterian's charity level.

Researchers (Ku and Walls 1997) noted that like physicians, hospitals complained about administrative delays and a loss in payments. They also noted some tension resulting from emergency room use. For example, if a patient went to a hospital's ER and did not receive authorization from the appropriate PCP or HMO, the hospital still had to provide some diagnosis, but received no payment. Many physicians also feel that they are obligated by federal law to treat patients that show up in an ER seeking treatment.[9]

[9] John Coffey, interview by author, Oklahoma City, Ok., 20 May 1997.

Table 6.2: Oklahoma City Acute Care Hospitals and Their HMO Affiliations

Hospital	BlueLincs	Community Care	Foundation	Heartland
University/Children's	X	X*	X	X
Columbia Presbyterian	X		X*	X
Baptist			X*	
Hillcrest	X	X	X	
Southwest			X	X
Deaconess			X	X
St. Anthony	X	X		
Mercy		X		

* These hospitals will terminate their contracts with these HMOs in 1998.

Source: The Urban Institute

The State

SoonerCare produced a modest savings in urban areas, but the state had to increase payments in rural areas to strengthen the system. Since Oklahoma was already containing costs, due to cutbacks in Medicaid services that were offered, it is perhaps too early assess the full financial impact of the new program. A GAO report (1997b) pointed to the low growth rate in Medicaid spending in

recent years. The average growth rate in the United State fell from a high of 28.6 percent in 1992 to 3.3 percent in 1996. While this rate is low, there is a great deal of variation among states. For example, Louisiana's Medicaid spending decrease by 16 percent in 1996, whereas Indiana's Medicaid expenditures increased by nearly 25 percent (GAO 1997b). States that have reformed their Medicaid programs attribute their slow growth rate to the implementation of a managed care system.

The 1997 GAO report notes that between 1995 and 1996, Medicaid expenditures decreased "substantially" for ten states. Twenty states, including Oklahoma, saw a "moderate" decrease in Medicaid spending. One could speculate that Oklahoma could have realized an even greater decrease had the state not been forced to cut back on services following the defeat of the provider tax in 1992. By keeping all of the services provided under the fee-for-service system, Oklahoma's Medicaid expenditures would have remained at a higher level than after the cut backs. If managed care had been introduced at a time when spending was high, the savings resulting from a managed care program may have been greater.

In assessing which groups involved in Medicaid benefited and which did not, it should be understood that the SoonerCare program is quite new and that any assessment

at this stage is only preliminary. It is clear that the move to managed care from a traditional fee-for-service system was a major policy change. Obviously, a lot of adjustments had to be made. Chapter 5 examines the dynamics of group politics and suggests that health care providers have more input in decision-making processes regarding health care reform. At the same time, consumers or those enrolled in Medicaid have very little input. That seemed to be the case when the Oklahoma Legislature was considering managed care for its Medicaid program. Interestingly, it appears that consumers, at least the ones in the metropolitan areas, benefited most from the change, yet they had the least input. Health care providers, on the other hand, have more political clout and were more involved in Medicaid reform discussions. However, most physicians seem to be unhappy with the new system. Since SoonerCare has not yet been expanded to include the aged, blind, or disabled, it is too early to tell how this group will fare under the managed care program. Nor, is it possible to determine the extent to which providers that care for this population, such as nursing home operators, will benefit.

Why States Adopt Managed Care Programs

As of February 1998, twenty-seven[10] states have applied for a 1115 waiver to conduct comprehensive health care

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[10] Kansas applied for a waiver in 1995 and withdrew its proposal in 1997.

reform demonstrations involving managed care. Seventeen of these states have actually implemented a managed care program. Most of these waivers were applied for between 1993 and 1995. Since that time, fewer states have been applying. The Health Care Financing Administration reports that only two states, Arkansas and New Jersey, applied in 1997, and one state, Wisconsin, applied in 1998. Most states have instituted at least some form of managed care for their Medicaid populations. Many of these programs however, have a more narrow focus and only effect small groups of people. Why some states adopt a comprehensive managed care system for their Medicaid programs and others do not depends on several factors. These factors can be grouped roughly as either contextual or dyanamic.

Contextual Conditions

Chapter 4 provided a brief overview of Oklahoma's experience with Medicaid reform. In doing so, it pointed out the prevailing conditions of the time, notably the budget shortfall of DHS, and the defeat of the provider tax, an attempted measure to correct the problem. David Nice (1994) refers to this as the "problem environment." Nice comments:

> A crisis, a deteriorating situation, or a vague perception that current performance is not satisfactory can spur decision makers into searching for new approaches, assessing their merits, and adopting those innovations that offer some prospect for improving the situation (33).

Oklahoma was not alone in its experience with fiscal shortages. Medicaid spending increases in the early 1990s affected most states (GAO 1995a), yet each state responded differently.

Chapter 3 examined several factors that theoretically could contribute to Medicaid reform. While several of these are plausible, the analysis showed that only four variables were likely to have a significant impact: federal contribution, a state's history of HMOs, a state's wealth, measured by per capita income, and the number of neighboring states adopting a similar program. As chapter 4 pointed out, Oklahoma rated above the national average on two of these variables.

Three neighboring states had applied for a waiver to conduct Medicaid reform projects. While Kansas, Missouri, and Texas were all considering health care reform, Oklahoma looked to Arizona, a state beyond its borders for guidance. During early discussions of the task force, Texas in particular was brought up. What the task force wanted to know about Texas, however, was not what it was doing in the area of Medicaid reform, but which consulting firm Texas used to help with the project (Interim Task Force 1992). This study supports claims made by scholars (Walker 1969; Gray 1973, 1994; Berry and Berry 1990) that the diffusion of innovations from other states takes place. There is one

difference, however, that should be noted. Most of these studies use the variable of neighboring states to determine the extent of diffusion. This study does not refute this claim. A case can be made for states adopting policies similar to their neighbors, including Oklahoma. What is interesting in the Oklahoma case, however, is that in considering Medicaid reform, Oklahoma based its policy largely on Arizona's model. It appears that while the policies of neighboring states may contribute to the political climate and help create a condition were reform is more likely to occur, states do not necessarily replicate their policies. States may look to other states not because they are in close proximity, but because they share similar characteristics.

Dynamic Factors

Oliver and Paul-Shaheen (1997) claim that while contextual conditions contribute to policy innovation, dynamic factors also play an important role. Ultimately, ideas, leadership, and the ability to get legislation passed make health care reform a reality.

The issue of Medicaid reform and managed care is a complex one. This study has pointed out how one state dealt with this problem by relying on specialist legislators and a task force. Outside expertise was brought in with a consulting firm hired to assist the task force in developing

recommendations. Ray (1982) and Kingdon (1989) illustrate the degree to which fellow legislators are relied on when it comes to decision making and voting. Ray considers formal committee reports as another source stemming from legislators. This research considers the task force report to be on par with formal committee reports and supports claims made by Ray and Kingdon.

Drawing on Sabatier and Whiteman's (1995) work, this research used their two-staged model of information flow to examine how legislators become informed on the complex issue of health care reform. In Oklahoma's case, policy information basically flowed from Arizona, through the intermediaries of the consulting firm to the task force (which involved specialist legislators) and on to other legislators. Political information, as defined by Sabatier and Whitman, was not so relevant in this case since it seemed to cut across party lines. Its complex nature kept it from being too salient of an issue, and therefore, contributed to less political involvement on part of the public.

The Road from Here

As Michael Sparer (1996) has pointed out, Medicaid is an untapped source that can offer tremendous insight on health care related reform efforts. While this study has

examined many factors that contribute to health care reform, there is still room for continued research.

The Urban Institute (1997) noted that Medicaid reform in Oklahoma was largely driven by the legislature. In other states, the governor, such as Ned McWherter in Tennessee, acted as the catalyst for reform efforts. Oklahoma's Governor, David Walters, was active in health care reform, but not necessarily Medicaid. One possible explanation as to why he was not as involved in developing a managed care system, could be that his health care priorities were different. He focused more effort on the development of a plan that would provide universal health care coverage for Oklahoma. Perhaps, he figured that universal health care coverage, while larger in scope and more complex, would have incorporated health care for Medicaid recipients. Future studies may want to include the role of governors as a dynamic factor in states that have sought Medicaid reform.

This study examines the diffusion of policy as shaped by both a contextual condition and by dynamic variables. While there have been several studies examining diffusion at the decision making level, fewer studies have looked at diffusion at the implementation stage. Quite often agency heads will often communicate with their counterparts in other states. For example, Mike Fogarty, Oklahoma's Medicaid Director, often compares notes with other states to

see how they are going about implementing new policies.[11] Fogarty belongs to the National Association of State Medicaid Directors. The organization meets biennially, and provides seminars and round tables on a host of topics. Just as governors and legislators have national organizations they belong to, administrators can also take advantage of similar networks. Further research may look at the extent to which states borrow from other states when health care reforms are being implemented.

As states establish managed care networks to provide for their Medicaid patients, it would be interesting to see if Medicare beneficiaries will start to be incorporated into the same system. There are many differences between Medicare and Medicaid. In terms of group politics, it would seem that Medicare consumers would be a much more active voice those receiving Medicaid benefits. However, as illustrated in the Oklahoma case, consumer advocates on the task force examining Medicaid reform were actually representative of the elderly, and nursing homes were perhaps disproportionately represented. What these managed care networks do, however, is establish a policy history with HMOs. Oklahoma first wanted to enroll the AFDC/TANF population and gain experience in managed care before

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[11] Mike Fogarty interview.

including other groups such as the elderly and disabled. Perhaps Medicare will follow a similar path.

Finally, it would be useful to examine the correlation between states considered to be innovative in the area of health care reform[12] and states with high percentages of specialist legislators on health care. It seems reasonable that state legislatures with several health care policy experts would be more likely to innovate than those without. This study provides a possible framework for distinguishing such specialists.

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[12] For a ranking of innovative states in health care see Carter and LaPlant (1997).

Appendix 1: Data Sources

The Dependent Variable in the EHA Model

ADOPT: Health Care Financing Administration, Office of Research and Demonstrations. The following states had applied for an 1115 waiver by 1995: Oregon 1991; Kentucky, Hawaii (excluded), Tennessee, and Rhode Island 1993; Florida, Ohio, South Carolina, Massachusetts, New Hampshire, Missouri, Delaware, Minnesota, and Illinois 1994; Louisiana, Oklahoma, Vermont, New York, Kansas, Utah, Alabama, and Texas 1995. Although these states were not included in the empirical analysis, Maryland and Washington applied for an 1115 waiver in 1996.

The Independent Variables in the EHA Model

FEDERAL: *Health Care Financing Review (Medicare and Medicaid Statistical Supplement)*, selected years.
HEALTH: *Statistical Abstract of the United States*, selected years and the National Center for Health Statistics, 1995.
CAPITA: *Health Care Financing Review (Medicare and Medicaid Statistical Supplement)*, selected years and the *Green Book*, selected years.
FISCAL: *Statistical Abstract of the United States*, selected years.
PARTY-1 and PARTY-2: *Statistical Abstract of the United States* (for party control of the legislatures) and *CQ Weekly Report 48:3840*, November 10, 1990 (for party affiliation of governors) for 1991, *The Book of States* for 1992 and 1994, *Governing* February 1993 pp. 36-43 for 1993, *State Legislatures* January 1995 p. 20 for 1995.
INCOME: *Current Population Reports: Money, Income in the United States*, selected years.
HMO: The *National HMO Census 1981*, and state offices for Arkansas, Delaware, Idaho, Mississippi, Montana, Nevada, South Dakota, Vermont, Virginia, and Wyoming.
NEIGHBORS: Information concerning states that applied for 1115 waivers came from the Health Care Financing Administration, Office of Research and Demonstrations.
WAIVER: The states and the dates which they applied for a 1915 waiver were found in the *National Summary of State Medicaid Managed Care Programs*.
UNINSURED: *Statistical Abstract of the United States* and *Current Population Reports*.

Interviews

Legislators

Representative Calvin Anthony (telephone interview)	January 29, 1998, Alexandria, VA
Representative Gary Bastin	November 13, 1997, Oklahoma City, OK
Representative Laura Boyd	May 20, 1997, Oklahoma City, OK
Senator Bernest Cain	October 9, 1997, Oklahoma City, OK
Representative Joan Greenwood	February 23, 1998, Oklahoma City, OK
Senator Howard Hendrick	October 29, 1997, Oklahoma City, OK
Senator Angela Monson	October 15, 1997, Oklahoma City, OK
Senator Ben Robinson	November 18, 1997, Oklahoma City, OK
Representative Mark Seikel	January 28, 1998, Oklahoma City, OK
Representative Tommy Thomas	December 3, 1997, Oklahoma City, OK

Legislative Staff

Shaun Black	October 29, 1997, Oklahoma City, OK
David Blatt	January 26, 1998, Oklahoma City, OK
Claudia Durrill	May 20, 1997, Oklahoma City, OK
	October 9, 1997, Oklahoma City, OK
Connie Johnson	October 14, 1997, Oklahoma City, OK
Paul E. McElvany	October 9, 1997, Oklahoma City, OK
Tom Walls	October 21, 1997, Oklahoma City, OK

Interest Group Representatives

John Coffey	May 20, 1997, Oklahoma City, OK

Consumer Advocates

Travis Smith	October 28, 1997, Oklahoma City, OK
Vivian Smith	November 26, 1997, Oklahoma City, OK

Health Care Authority (HCA)

Mike Fogarty	December 3, 1997, Oklahoma City, OK
Darendia McCauley	November 4, 1997, Oklahoma City, OK
Garth Splinter	October 21, 1997, Oklahoma City, OK January 26, 1998, Oklahoma City, OK

Others

Tuzie Despain	February 28, 1998, Norman, OK
Bob Vincent	November 13, 1997, Oklahoma City, OK
David Walters (written interview)	February 23, 1998, Oklahoma City, OK

Tape Recordings

Approximately 13 hours of tape recorded proceedings were reviewed. The following meetings of the task force were recorded:

Full Task Force	State Insurance Department (Oklahoma City)	September 9, 1992
Managed Care Subcommittee	Oklahoma State University Campus (Stillwater)	October 22, 1992
Full Task Force	Oklahoma State University Campus (Stillwater)	October 22, 1992
Full Task Force	Oklahoma State University Campus (Stillwater)	October 23, 1992

Appendix 2:
Members of the Legislative Interim Task Force

Name	Representing	Appt. Authority
Garth Splinter	State Employee Health	Governor
Wayne Hoffman	Nursing Home Association	Governor
Robert Vincent		Governor
C.S. Lewis	Physician	Governor
John Coffey	Ok Hospital Association	House
Gary Kirk	Pharmicist	House
Boyd Talley	Aging Advocate	House
Jearl Smart	Nursing Homes	House
Vivian Smith	Aging Advocate	Senate
Barbara Gardener	Metropolitan Life	Senate
Gerard Rothlien	Children's Medical Center	Senate
Bruce Thevenot	Nursing Homes	Senate
Bernest Cain	Senator	Ex Officio
Tommy Thomas	Representative	Ex Officio
Benjamin Demps	DHS	Ex Officio
Anne Garcia	House of Representatives staff	
Brian Maddy	Senate staff	
Tom Walls	Senate staff	

Managed Care Subcommittee

Gerard Rothlein, Chair
Bernest Cain
Boyd Talley
Barbara Gardner

Medicaid Subcommittee

Vivian Smith, Chair
Bruce Thevenot
C. S. Lewis, Jr.
Tommy Thomas

Management Subcommittee

John Coffey, Chair
Garth Splinter
Jearl Smart
Benjamin Demps

Welfare Subcommittee

Gary Kirk, Chair
Wayne Hoffman
Robert Vincent

Appendix 3:
Sample Questionnaire for Legislators, Analysts and Other Interested Parties

Name_____ Political Party Affiliation_____

Legislators

1. What do you consider to be your area of expertise?

2. How long have you been involved in this field/area?

3. Do you have interests in other areas? Please specify?

4. Who do you look to as an expert on health care/managed care
   - -in the legislature?
   - -in the medical field?
   - -in a state or federal agency?
   - -as an analyst?

5. Which legislators have you worked with on this and similar projects?

6. How long have you known each?

7. Have you worked with any outside interest groups on this or similar projects?

8. How long have you been acquainted with interest group X?

9. How influential is this group on your decisions in the legislature?

10. When did you first hear about the managed care concept in relation to Medicaid?

11. Where did this information come from?

12. How was it presented (i.e. word of mouth, scheduled presentation, handouts, etc.)?

13. Who else played a key role in getting a managed care program for Medicaid recipients passed in Oklahoma?

14. How important were the following in your decision to vote for/against managed care for Oklahoma's Medicaid population (rank from "not at all important" to "extremely important")?

-the need to insure more people
-the need to save money
-the need to raise health standards
-other (please specify)

15. Who do/did you rely on for information concerning managed care (rank from "not at all" to "a great deal")?
    -personal staff
    -legislative analysts
    -other legislators
    -independent analysts
    -interest groups (specify)
    -federal and state agencies (specify)
    -medical experts (physicians, nurses, hospital administrators etc.)
    -others (please explain)

16. Did the success or failure of managed care programs in other states influence your decision?

17. Were any other consulting firms in addition to Peat Marwick considered in preparing an analysis of managed care?

18. What were the primary reasons for choosing Peat Marwick?

Analysts

Name_____ Political Party Affiliation_____

1. How long have you been involved in this field/area?

2. Do you have interests in other areas? Please specify?

3. Who do you look to as an expert on health care/managed care
    -in the legislature?
    -in the medical field?
    -in a state or federal agency?
    -as an analyst?

4. Which legislators have you worked with on this and similar projects?

5. How long have you known each?

6. Have you worked with any outside interest groups on this or similar projects?

7. How long have you been acquainted with interest group X?

8. When did you first hear about the managed care concept in relation to Medicaid?

9. Where did this information come from?

10. How much attention did you pay to other states that had similar programs?

11. Which states in particular?

12. Were any other consulting firms in addition to Peat Marwick considered in preparing an analysis of managed care (if applicable)?

13. What were the primary reasons for choosing Peat Marwick (if applicable)?

14. What factors were considered in your analysis and how important were each ("not at all" to "extremely important")?

Interest Groups (agencies, physicians, consumer advocates)

Name_____ Political Party Affiliation_____

1. Who do you look to as an expert on health care/managed care
   - -in the legislature?
   - -in the medical field?
   - -in a state or federal agency?
   - -as an analyst?

2. What do you consider to be your area of expertise?

3. How long have you been involved in this field/area?

4. What has been your prior experience with managed care?

5. When did you first hear about the managed care concept in relation to Medicaid?

6. Where did this information come from?

7. What are your major concerns with managed care?

8. Did you inform legislators about these concerns?

9. How receptive were they?

10. How much influence do you or your group have vis a vis the legislature?

11. Which legislators do you work with the best?

12. Did they consult with you about placing Medicaid patients in managed care programs?

APPENDIX 4:
Legislative Survey on Managed Care

1. How important were the following in your decision to vote for/against managed care for Oklahoma's Medicaid population?

   a. The need to insure more people.

   "not at all important" *"extremely important"*

   1 2 3 4 5 6 7

   b. The need to save money.

   1 2 3 4 5 6 7

   c. The need to raise health standards.

   1 2 3 4 5 6 7

   d. Other (please specify)._____

   1 2 3 4 5 6 7

2. Who do/did you rely on for information concerning managed care?

   a. Personal staff.

   "not at all" *"a great deal"*

   1 2 3 4 5 6 7

   b. Legislative analysts.

   1 2 3 4 5 6 7

   c. Other legislators.

   1 2 3 4 5 6 7

   d. Independent analysts.

   1 2 3 4 5 6 7

e. Interest groups (please specify)._____

"not at all" *"a great deal"*

1 2 3 4 5 6 7

f. Federal or state agencies (please specify)._____

1 2 3 4 5 6 7

g. Medical experts (physicians, nurses, hospital administrators etc.).

1 2 3 4 5 6 7

h. Others (please specify)._____

1 2 3 4 5 6 7

3. How often do you get reports concerning the quality of managed health care from the Health Care Authority?

never *seldom* *sometimes* *usually* *always*

4. How important to you are reports such as these?

"not at all important" *"extremely important"*

1 2 3 4 5 6 7

Comments:_____

_____

_____

_____

_____

_____

_____

Thank You

References

Aldrich, John H. and Forrest D. Nelson. 1984. *Linear Probability, Logit, and Probit Models.* Beverly Hills: Sage.

Anderson, James. 1975. *Public Policy-Making.* NY: Praeger.

Arizona Health Care Cost Containment System. 1992. *Arizona's Health Care Program for the Indigent: An Overview.* December. Pheonix, AZ.

Bennett, Colin J. 1991. "Review Article: What is Policy Convergence and What Causes It?" *British Journal of Political Science* 21:215-233.

Berry, Frances Stokes, and William D. Berry. 1990. "State Lottery Adoptions as Policy Innovations: An Event History Analysis." *American Political Science Review* 84:395-415.

_____. 1992. "Tax Innovation in the States: Capitalizing on Political Opportunity." *American Journal of Political Science* 36:715-742.

Birnbaum, Jeffrey H. and Alan S. Murray. 1987. *Showdown at Gucci Gulch: Lawmakers, Lobbyists, and the Unlikely Triumph of Tax Reform.* New York: Random House.

Blank, Robert H. 1997. *The Price of Life: The Future of American Health Care.* New York: Columbia.

Bowman, Ann O'M. and Richard C. Kearney. 1986. *The Resurgence of the States.* Englewood Cliffs, NJ: Prentice Hall.

Brandon, William P., Theodore S. Arrington and Nancy Schoeps. 1997. "Is Mandatory HMO Enrollment for Dependent Populations Acceptable?: Public Opinion and Its Evolution since the Backlash against Managed Care." Paper presented at the 1997 Annual Meeting of the American Political Science Association in Washington DC.

Brown, David "Mixing Medicine and Money," *Washington Post Weekly Edition.* July 15-21, 1996.

Brown, Robert D. 1995. "Party Cleavages and Welfare Effort in the American States." *American Political Science Review* 89:23-33.

Butler, Kenneth and Eric Pentecost. 1993. "Regional Service Sector Convergence." *Regional Studies* 27:623-636.

Campbell, Angus, Philip E. Converse, Warren E. Miller, and Donald E. Stokes. 1960. *The American Voter.* New York: Wiley Press.

Carmines, Edward G. and James A. Stimson. 1980. "The Two Faces of Issue Voting." *American Political Science Review* 74:78-91.

_____. 1989. *Issue Evolution: Race and the Transformation of American Politics.* Princeton University Press.

Chi, Keon S. and Dennis O. Grady. 1990. "Innovators in State Government: Their Organizational and Professional Environment." in *The Book of States: 1990-91.* Lexington, KY: Council of State Governments.

Chi, Keon S. 1996. "Innovations in State Government." in *The Book of States: 1996-97.* Lexington, KY: Counicl of State Governments.

Cobb, Roger and Charles Elder. 1972. *Participation in American Politics.* Baltimore: Johns Hopkins.

Cohen, Richard E. 1995. *Washington at Work: Back Rooms and Clean Air 2d Ed.* Boston: Allyn and Bacon.

Coleman, William D. 1994. "Policy Convergence in Banking: A Comparative Study" *Political Studies* 42:274-292.

Collier, David, and Richard E. Messick. 1975. "Prerequisites Versus Diffusion: Testing Alternative Explanations of Social Security Adoption." *American Political Science Review* 69:1299-1315.

Committee on Ways and Means. 1996. *The 1996 Greenbook.* Washington, D.C.

Commission on Oklahoma Health Care. 1992. *Report to the Governor.* November. Oklahoma City, OK.

Commission on Oklahoma Health Care. 1993. *Report to the Legislature and Governor.* December. Oklahoma City, OK.

Conant, James. 1989. "The Growing Importance of State Government." in *The Handbook of Public Administration* (by James L. Perry and Associates). San Francisco: Jossey-Bass.

Congressional Research Service. 1993. *Medicaid Source Book: Background and Analysis.* Washington, D.C.

Converse, Philip E. 1964. "The Nature of Belief Systems in Mass Politics." In *Ideology and Discontent,* David A. Apter ed. New York: Free Press.

Cook, Fay Lomax, and Edith J. Barrett. 1992. *Support for the American Welfare State: The Views of Congress and the Public.* New York: Columbia University Press.

Copeland, Gary W. and Kenneth J. Meier. 1987. "Gaining Ground: The Impact of Medicaid and WIC on Infant Mortality." *American Politics Quarterly* 15:254-273.

Coughlin, Teresa A., Leighton Ku, and John Holahan. 1994. *Medicaid since 1980: Costs, Coverage, and the Shifting Alliance between the Federal Government and the States.* Washington, D.C.: The Urban Institute.

Courgeau, Daniel and Éva Lelière. 1992. *Event History Analysis in Demography.* New York: Oxford Press.

Cowart, Andrew. 1969. "Anti-Poverty Expenditures in the American States: A Comparative Analysis." *Midwest Journal of Political Science* 13:219-236.

Daniels, Mark R. (ed.) 1997. *Medicaid Reform and the American States: Cases on the Politics of Managed Care.* Westport,CN: Greenwood Publishing Group.

Davidson, Roger H. and Walter J. Oleszek. 1998. *Congress and Its Members.* 5th Ed. Washington, D.C.: Congressional Quarterly Press.

Drake, David F. 1994. *Reforming the Health Care Market: An Interpretive Economic History.* Washington, D.C.: Georgetown University Press.

Dye, Thomas. 1990. *Competitive Federalism: Competition Among Governments.* Lexington, MA: D.C. Health.

Eisinger, Peter K. 1988. *The Rise of the Entrepreneurial State: State and Local Economic Development Policy in the United States.* Madison, WI: University of Wisconsin Press.

Elazar, Daniel J. 1966. *American Federalism: A View from the States.* New York: Harper & Row.

Elikins, David J. 1993. *Manipulation and Consent: How Voters and Leaders Manage Complexity.* Vancouver: University of British Columbia Press.

Filer, John E., Donald L. Moak and Barry Uze. 1988. "Why Some States Adopt Lotteries and Others Don't." *Public Finance Quarterly* 16:259-283.

Fein, Rashi. 1986. *Medical Care, Medical Costs: The Search for a Health Insurance Policy.* Cambridge, MA: Harvard.

Fiorina, Morris. 1996. *Divided Government, 2nd Edition.* Boston, MA: Allyn and Bacon.

Fleischmann, Arnold and David Nice. 1988. "States and PACs: The Legacy of Established Decision Rules." *Political Behavior* 10:349-363.

Freeman, Patricia K. 1985. "Interstate Communication among State Legislators Regarding Energy Policy Innovation." *Publius* 15:99-111.

_____. 1996. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996.* Baltimore,MD

General Accounting Office. 1993. *Medicaid: States Turn to Managed Care to Improve Access and Control Costs.* March. Washington, D.C.

_____. 1995a. *Medicaid: Spending Pressures Drive States Toward Program Reinvention.* April. Washington, D.C.

_____. 1995b. *Medicaid: Restructuring Approaches Leave Many Questions.* April. Washington, D.C.

_____. 1995c. *Medicaid: Tennessee's Program Broadens Coverage but Faces Uncertain Future.* September. Washington, D.C.

_____. 1997a. *Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort.* May. Washington, D.C.

_____. 1997b. *Medicaid: Sustainability of Low 1996 Spending Growth Is Uncertain.* June. Washington, D.C.

Gray, Virginia. 1973. "Innovation in the States: A Diffusion Study." *American Political Science Review* 67:1174-1185.

_____. 1994. "Competition, Emulation, and Policy Innovation," In *New Perspectives on American Politics.* (Lawrence C. Dodd and Calvin Jillson eds.). Boulder, CO: Westview.

Greene, Wayne. 1992. "DHS Official Rips Makeup of Reform Study Panel." *Tulsa World,* October 2, 1992

Greiner, John. "Panel Suggests State Health-Care Reforms." *The Daily Oklahoman.* November 6, 1992.

Grogan, Colleen M. 1997. "The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns." *Journal of Health Politics, Policy and Law* 22:815-838.

Hansen, Susan B. 1983. *The Politics of Taxation: Revenue without Representation.* New York: Prager.

Health Care Financing Administration. 1995. *Medicaid: An Overview.* September. Baltimore, MD.

Heclo, Hugh. 1974. *Modern Social Politics in Britain and Sweden.* New Haven, CT: Yale University Press.

Hinds, Michael deCourcy. 1991a. "Behind-the-Scenes Player Seeks Extended Run as a Pennsylvania Senator." *New York Times,* May 21, 1991.

_____. 1991b. "Pennsylvania Senate Race Tightens." *New York Times,* October 30, 1991.

_____. 1991c. "Wofford Wins Senate Race, Turning Back Thornburgh." *New York Times,* November 6, 1991.

Hinton, Mick and John Greiner. "Health Provider Tax Goes to State Voters." *The Saturday Oklahoman.* May 16, 1992.

Jacobs, Lawrence R. 1993. *The Health of Nations: Public Opinion and the Making of American and British Health Policy.* Ithaca, NY: Cornell University Press.

Jones, Charles. 1970. *An Introduction to the Study of Public Policy.* Belmont, CA: Wadsworth.

Key, V.O.. Jr. 1966. *The Responsible Electorate.* Cambridge, MA: Harvard University Press.

Kiewiet, D. Rederick, and Mathew D. McCubbins. 1985. "Congressional Appropriations and the Electoral Connection." *Journal of Politics* 47:59-82.

Kingdon, John W. 1989. *Congressmen's Voting Decisions.* 3rd ed. Ann Arbor: University of Michigan Press.

Kronebusch, Karl. 1997. "Medicaid and the Politics of Groups: Recipients, Providers, and Policy Making." *Journal of Health Politics, Policy and Law* 22:839-878.

Ku, Leighton, and Susan Wall. 1997. "The Implementation of Oklahoma's Medicaid Reform Program: SoonerCare." *Perspectives on Medicaid Managed Care.* Washington, DC: The Urban Institute.

Lane, Robert E. 1962. *Political Ideology.* New York: Free Press.

Leichter, Howard. 1997. "State Health Policy Analysis: On the Abuse of Metaphor and the Pathology of Variation." *Journal of Health Politics, Policy and Law* 22:897-906.

Lemov, Penelope. 1993. "States and Medicaid: Ahead of the Feds." *Governing* (July) vol. 6, no. 10:27-28.

Light, Alfred R. 1978. "Intergovernmental Sources of Innovation in State Administration." *American Politics Quarterly* 6:147-165.

Luskin, Robert C. 1990. "Explaining Political Sophistication." *Political Behavior* 12:331-361.

Lutz, James M. 1987. "Regional Leadership Patterns in the Diffusion of Public Policies." *American Politics Quarterly* 15: 387-398.

Mathews, Donald, and James A. Stimson. 1975. *Normal Decision-Making in the U.S. House of Representatives.* New York: Wiley.

Mayhew, David R. 1991. *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946-1990* New Haven, CN: Yale.

McReynolds, J.E. "Concil on Aging Declines to Endorse Health Provider Tax." *The Daily Oklahoman.* July 10, 1992.

Miller, David Young. 1991. "The Impact of Political Culture on Patterns of State and Local Government Expenditures." *Publius* 21:83-100.

Miller, Warren E. and Donald E. Stokes. 1963. "Constituency Influence in Congress." *American Political Science Review* 57:45-56.

Mohr, Lawrence B. 1969. "Determinants of Innovation in Organizations." *American Political Science Review* 63:111-126.

Morgan, David R., Robert E. England, and George C. Humphreys. 1991. *Oklahoma Politics and Policies.* Lincoln, NB: University of Nebraska Press.

Morgan, David R. and Kenneth J. Meier. 1980. "Politics and Morality: The Effect of Religion on Referenda Voting." *Social Science Quarterly* 61:144-148.

Nathan, Richard. 1989. "The Role of the States in American Federalism," in *The State of the States,* ed. Carl E. Van Horn, Washington D.C.:CQ Press, 15-32.

National Committee for Quality Assurance. 1993. Medicaid HEDIS

Nice, David C. 1994. *Policy Innovation in State Government.* Ames, IA: Iowa State University.

Oliver, Thomas R. 1991. "Ideas, Entrepreneurship, and the Politics of Health Care Reform. *Stanford Law and Policy Review* 3:160-180.

Oliver, Thomas R. and Pamela Paul-Shaheen. 1997. "Translating Ideas into Actions: Entrepreneurial Leadership in State Health Care Reforms." *Journal of Health Politics, Policy and Law* 22:721-788.

Osborne, David and Ted Gaebler. 1992. *Reinventing Government.* New York: Plume.

Peat Marwick Management Consultants. 1993. *Interim Task Force on State Welfare and Medicaid Reform: Options for Implementing a Managed Care Approach.* February. Oklahoma City, OK.

Perkins, Jane, Kristi Olson and Lourdes Rivera. 1996. *Making the Consumers' Voice Heard in Medicaid Managed Care: Increasing Participation, Protection and Satisfaction.* December. National Health Law Program, Inc.

Perry, John. "HMOs Hit by Falling Earnings." *The Sunday Oklahoman.* November 30, 1997.

Peters, B. Guy. 1993. *American Public Policy: Promise and Performance,* 3rd Ed. Chatham, NJ: Chatham House.

Peterson, Paul E. and Mark C. Rom. 1990. *Welfare Magnets: A New Case for a National Standard.* Washington, D.C.: Brookings.

Peterson, Paul E., Mark C. Rom, and Kenneth F. Scheve., Jr. 1996. "The Race among the States: Welfare Benefits, 1976-1989." Paper presented at the 1996 Annual Meeting of the American Political Science Association, San Francisco, CA.

Polsby, Nelson. 1984. *Political Innovation in America,* New Haven, CN: Yale.

Ray, David. 1982. "The Sources of Voting Cues in Three State Legislatures," *Journal of Politics* 44: 1074-1087.

Redman, Eric. 1973. *The Dance of Legislation.* New York: Simon and Schuster.

Reeves, H. Clyde. 1986. *Measuring Fiscal Capacity.* Boston: Oelgeschlager, Gunn, and Hain.

Report from the Executive Office of the President. 1993. *A Vision of Change for America.* February. Washington, D.C.: GPO.

Report of the National Performance Review. 1993. *Creating a Government that Works Better and Costs Less.* September. Washington, D.C.: GPO.

Ripley, Randall B. and Grace A. Franklin. 1987. *Congress, the Bureaucracy and Public Policy,* 4th Ed. Chicago: Dorsey Press.

Roeder, Phillip W. 1994. *Public Opinion and Policy Leadership in the American States.* Tuscaloosa, AL: University of Alabama Press.

Rogers, Everett M. 1983. *Diffusion and Innovation, 3rd Ed.* New York: Free Press.

Rose, Richard. 1993. *Lesson Drawing in Public Policy: A Guide to Learning Across Time and Space.* Chatham, NJ: Chatham House.

Sabatier, Paul A. 1991. "Toward Better Theories of the Policy Process." *PS: Political Science and Politics.* June: 147-156.

_____. 1988. "An Advocacy Coalition Framework of Policy Change and the Role of Policy-Oriented Learning Therein." *Policy Sciences* 21:129-168.

Sabatier, Paul A. and David Whiteman. 1985. "Legislative Decision Making and Substantive Policy Information: Models of Information Flow." *Legislative Studies Quarterly* 10:395-421.

Shannon, John and James Edwin Kee. 1989. "The Rise of Competitive Federalism." *Public Budgeting and Finance* 9:5-20.

Shapiro, Isaac and Robert Greenstein. 1988. *Holes in the Safety Nets: Poverty Programs and Policies in the States.* Washington DC: Center on Budget and Policy riorities.

Schlozman, Kay Lehman, and Sidney Verba. 1979. *Injury to Insult: Unemployment, Class, and Political Response.* Cambridge: Harvard University Press.

Sharkansky, Ira. 1970. *The Routines of Politics.* New York: Van Nostrand.

Sigelman, Lee and Roland E. Smith. 1980. "Consumer Legislation in the American States: An Attempt at Explanation." *Social Science Quarterly* 61:58-70.

Simon, Herbert. 1957. *Administrative Behavior.* New York: Macmillan.

Silver, George A. 1991. "The Route to a National Health Policy Lies through the States." *Yale Journal of Biology and Medicine.* 64:443-53.

Skocpol, Theda. 1994. "From Social Security to Health Security? Opinion and Rhetoric in U.S. Social Policy Making." *PS: Political Science and Politics.* 27:21-25.

Sparer, Michael S. 1996. *Medicaid and the Limits of State Health Reform.* Philadelphia: Temple University Press

Sparer, Michael S. and Lawrence D. Brown. 1996. "The Limits and Lessons of the Laboratory of Federalism. In *Health Policy, Federalism, and the American States,* Robert E. Rich and William D. White (eds.). Washington DC: Urban Institute Press.

Starr, Paul. 1982. *The Social Transformation of American Medicine.* New York: Basic.

United States Department of Health and Human Services. 1981. *National HMO Census.* June. Rockville, MD.

_____. 1996. *Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1996.* Baltimore, MD.

Uslaner, Eric, and Ronald Weber. 1977. *Patterns of Decision-Making in State Legislatures.* New York: Praeger.

Verba, Sidney, and Norman H. Nie. 1972. *Participation in America.* Chicago: University of Chicago Press.

Walker, Jack L. 1969. "The Diffusion of Innovations among the American States." *American Political Science Review* 63:880-899.

Watson, Sara D. 1992. "A Study in Legislative Strategy: The Passage of the Americans with Disabilities Act of 1990. In *The Americans with Disabilities Act: What it Means for All Americans,* (Lawrence O. Gostin and Henry A. Beyer eds.) Baltimore: Paul H. Brookes Publishing Co.

Weir, Margaret and Theda Skocpol. 1985. "State Structures and the Possibilities for Keynesian Responses to the Great Depression in Sweden, Britain, and the United States." in *Bringing the State Back In* (Peter B. Evans, Dietrich Rueschemeyer, and Theda Skocpol eds.) New York: Cambridge Press.

Weissert, Carol S. 1992. "Medicaid in the 1990s: Trends, Innovations, and the Future of the PAC-Man of the State Budgets." *Publius.* 22:93-109.

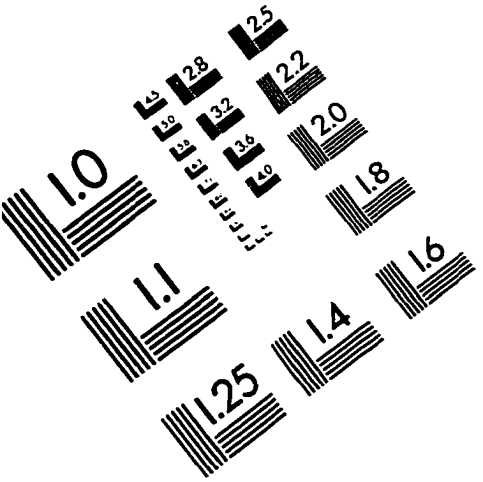
Welch, Susan and Kay Thompson. 1980. "The Impact of Federal Incentives on State." *American Journal of Political Science* 24:715-729.

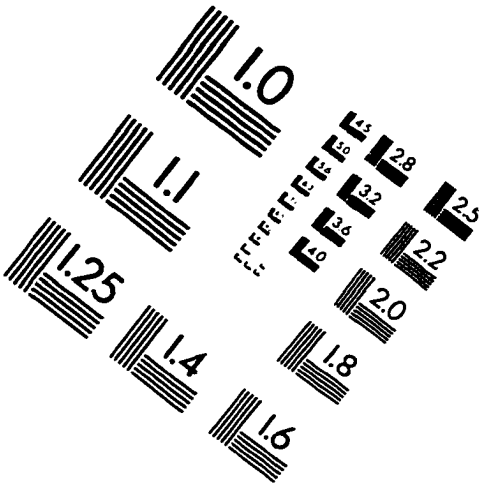
Weissert, Carol S. and William G. Weissert. 1996. *Governing Health: The Politics of Health Policy.* Baltimore: Johns Hopkins.

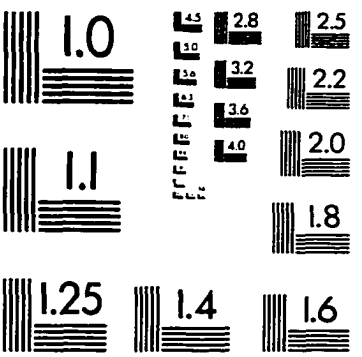
Wolfinger, Raymond E., and Steven J. Rosenstone. 1980. *Who Votes.* New Haven, CT: Yale University Press.

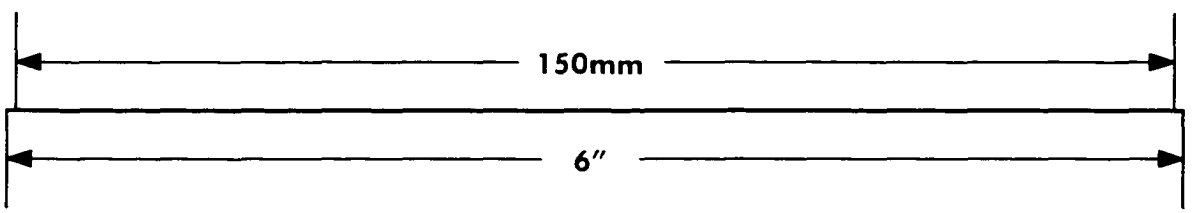
Zaltman, Gerald, Robert Duncan, and Jonny Holbek. 1973. *Innovations in Organizations.* New York: Wiley.

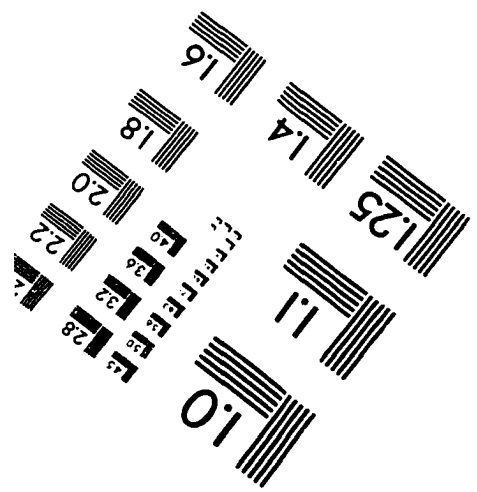
IMAGE EVALUATION TEST TARGET (QA-3)

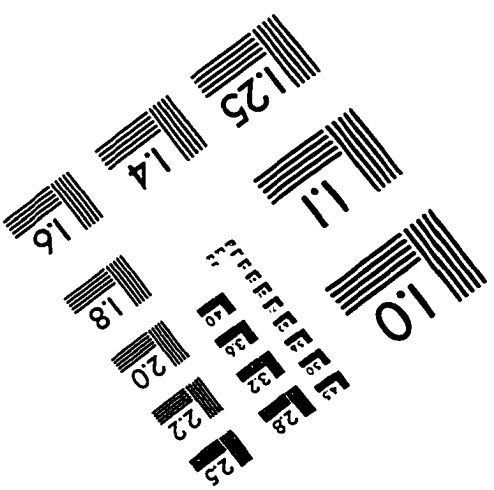












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