

*Management Insights is a weekly column about the most important issues in public management. This forum, moderated by Stephen Goldsmith, brings together the country's pre-eminent thinkers in the field to offer their insights and expertise on how to improve government responsiveness and efficiency.*

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## Management Insights

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Neither bad policies well executed, nor great policies poorly executed produce much public benefit.

In this week's column, Bill Eggers, who has studied innovators and managers at all levels of government, makes the obvious, but often ignored, point: policy innovation requires management acumen to accomplish success. Bill helps us focus on what states need to do to produce quality data and build a management system capable of critical improvements.

—Stephen Goldsmith



February 15, 2006

### **Medicaid Management Makeover**

By [William D. Eggers](#)

It's hard to say much that's original about Medicaid reform nowadays. Hundreds of articles, news programs, and think-tank reports have described in excruciating detail the problems with this federal-state program that will cost U.S. taxpayers more than \$5 trillion over the next 10 years. There's also no shortage of experts offering up all manner of policy prescriptions to "fix" the problem.

I'm going to dive in anyway. Why? Because in all the high-flying rhetoric, one point seems consistently overlooked: management matters. The manner in which Medicaid is administered—how cost savings are identified and realized, how state resources are deployed, how policies are implemented and enforced, and how critical day-to-day decisions affect health and financial outcomes—significantly affects its performance. Transforming how Medicaid is managed may not be as sexy as making new policy proposals, but we won't solve the problem without it.

We learned this lesson with AFDC, which was the last time we tried to remake a gargantuan federal-state social program. States with the most success getting people into jobs—such as Wisconsin where the welfare rolls plummeted 91 percent—did enact bold policy changes. But they also fundamentally changed the way they *managed* the program.

Prior to the 1996 welfare reform law, government monopolized the delivery of assistance. Trained clerks applied clear rules to determine who qualified for a check, and their performance was measured in error rates. After the reform legislation, states knit together networks of community, faith-based, private, and government partners to deliver services. They granted more flexibility. They established rigorous performance criteria. They upgraded their IT systems to stamp out fraud.

When the dust settled, it was clear that the rule-driven bureaucratic silos that used to run AFDC couldn't fulfill the new policy goals operating the old way. The same holds true today for Medicaid.

Sustained cost containment in Medicaid requires states to actively and aggressively manage their programs. But most states don't do much of this. They tend instead to be reactive—forecasting numbers of eligibles and costs, then loosely tracking the program's progress and asking legislatures for more money when the rolls increase. Meanwhile, costs go up and up and up.

Three management reforms would vastly improve this situation.

1. State policymakers should start by asking this fundamental question: What should we be doing—and not doing—in our Medicaid programs? Here's the hard truth: most Medicaid programs have an identity crisis. Some are primarily claims processors, while others are policy setters, contract managers, or financial stewards. Many are a confusing combination of all these roles. State leaders need to get off the fence and actively decide what they want their Medicaid program to be. This kind of soul-searching process took place with welfare reform when states asked whether AFDC would continue to be a check distribution system or become a program to move recipients to self-sufficiency.

Florida is one example of a state that has created a new vision for its program by moving from claims processor to more of a policy and quality oversight role. Governor Jeb Bush's new Medicaid initiative, Empowered Care, would allow health care networks to develop their own health care plans to compete for Medicaid patients. The state's role would be to counsel beneficiaries about which program best matches their individual health care needs and monitor the performance of Medicaid providers.

2. States also need to reexamine their operating models—something mostly taken for granted today. What functions should be done in-house? Which are better performed by partnering with others? Texas, for example, outsources most of its Medicaid operations, including claims processing, IT, provider and client relations, third-party liability and recovery, drug program management, and (soon) even eligibility determination. The Texas model isn't suitable for every state, but that shouldn't stop others from asking the make-or-buy question.

3. Most states lack the sophisticated, easily accessible financial information necessary to proactively manage Medicaid. Programs the size of Fortune 500 companies often lack the ability to produce the most basic budget and budget-to-actual reports. Without such data, they can't even begin to answer real questions such as: "If my state has 25 percent more nursing home beds than it can use, what incentives could I put in place to encourage the nursing home industry to reduce the overall number of beds and still provide adequate care?" Medicaid is simply too expansive—and expensive—to be run on hunches. States need to get serious about implementing financial systems that make intelligent decision making possible.

Informed management and cost control based on sophisticated analysis of real data are beyond the capabilities of Medicaid as it currently exists. To be successful, state programs need to be run with the same financial and managerial discipline used in any modern insurance or health care company. Until this is deeply understood, the Medicaid crisis will persist.