

# Discussion Papers

## Medicaid Managed Care: State Flexibility in Action

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02-06

March  
2002



Assessing  
the New  
Federalism

*An Urban Institute  
Program to Assess  
Changing Social  
Policies*

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The project has received funding from The Annie E. Casey Foundation, the W.K. Kellogg Foundation, The Robert Wood Johnson Foundation, The Henry J. Kaiser Family Foundation, The Ford Foundation, The John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, The David and Lucile Packard Foundation, The McKnight Foundation, The Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, The Fund for New Jersey, The Lynde and Harry Bradley Foundation, the Joyce Foundation, and The Rockefeller Foundation.

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Publisher: The Urban Institute, 2100 M Street, N.W., Washington, D.C. 20037

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# Abstract

The rapid expansion of managed care in state Medicaid programs over the past decade presents a unique opportunity to examine how broadly based programmatic innovation was promoted, shaped, and constrained by the evolving state-federal relationship in the 1990s. Managed care experiences of the past decade have reinvigorated the debate over whether Medicaid is a national program built around a federal-state partnership, or essentially a state-based program with federally imposed conditions to be met to garner matching funds. In this chapter we examine how managed care implementation and growth has been a revealing experience for students of federalism. We explore why and how most state Medicaid agencies came to see managed care models as a valued innovation and how their aims for them have changed over time. The regulatory context within which innovation has been undertaken is explored, focusing on whether states have in fact had the necessary flexibility to proceed. Whether all states acted responsibly and federal agencies exercised due discretion while nurturing creativity is assessed, particularly given that the program strategy is a market-based one with the risks and uncertainties that implies. Next we appraise the extent and degree to which states have succeeded in transforming their Medicaid programs through these initiatives and examine empirical evidence of program effects. Finally, because the managed care intervention itself has proven to be so controversial in its own right, we offer some thoughts on how generalizable this particular experience may be to other innovations. We conclude with several important lessons to be gleaned from this illuminating era of experimentation.

The past decade of dramatic growth in Medicaid managed care reveals much about how states and federal officials have found a measure of accommodation and collaboration through the waiver granting process. Though subject to contentiousness owing to both specific issues and the general political climate, states have been able to exploit the opportunities that waivers give them to launch innovative initiatives and to introduce and refine creative programs and practices. While states on balance have experimented responsibly with new models of payment and delivery, the impacts of these arrangements have been uneven and will require more time to fully appraise them. It also appears that these developments have led to more variation in Medicaid programs, both by design and necessity. Advocates of expanded state flexibility contend that it is in permitting and promoting variation that program improvement is made both possible and likely.



# Medicaid Managed Care: State Flexibility in Action

## **Introduction**

The rapid expansion of managed care models in state Medicaid programs over the past decade presents a unique opportunity to examine how broadly-based programmatic innovation was promoted, shaped, and constrained by the evolving state-federal relationship in the 1990s. These initiatives involved nearly all states, displaying their characteristic diversity in motives, methods, and achievements. In most cases states had to petition federal officials for explicit permission to deviate from Medicaid requirements to launch managed care models. Dramatic growth quickly immersed state agencies in new, complex administrative responsibilities due to the nature of managed care purchasing. Expansion exposed states and their beneficiaries to the vicissitudes of a turbulent health care market place and the attendant uncertainties market instability has brought to all purchasers during the period. And perhaps not surprisingly, the managed care era has been marked by highly visible successes and failures that have engaged the attention of policymakers, advocates, and the general public.

Managed care experiences of the past decade have reinvigorated the debate over whether Medicaid is a national program built around a federal-state partnership, or essentially a state-based program with federally imposed conditions to be met to garner matching funds. Notwithstanding this debate, at the heart of efforts to pursue new payment and delivery arrangements has been a desire to make Medicaid a better program. It is not possible to disregard this goal as one attempts to reflect on the broader policy question of federalism. In fact, defining the dimensions on which managed care may have improved Medicaid itself is directly pertinent to the federalism issue since state and federal agencies may not be in complete congruence on the criteria or their rank order of importance. Positive and negative impacts on beneficiaries are

important to both parties, but the significance of cost savings, administrative burden, and reduced program uniformity may be seen differently from federal and state vantage points.

In this chapter we examine how managed care implementation and growth has been a revealing experience for students of federalism. We explore why and how most state Medicaid agencies came to see managed care models as a valued innovation and how their aims for them have changed over time. The regulatory context within which innovation has been undertaken is explored, focusing on whether states have in fact had the necessary flexibility to proceed.

Whether all states acted responsibly and federal agencies exercised due discretion while nurturing creativity is assessed, particularly given that the program strategy is a market-based one with the risks and uncertainties that implies. Next we appraise the extent and degree to which states have succeeded in transforming their Medicaid programs through these initiatives and examine empirical evidence of program effects. Finally, because the managed care intervention itself has proven to be so controversial in its own right, we offer some thoughts on how generalizable this particular experience may be to other innovations. We conclude with several important lessons to be gleaned from this illuminating era of experimentation.

### **Origins of Managed Care Innovation in Medicaid**

The antecedents of the 1990s era of managed care experimentation can be traced back a decade earlier. The early innovators among states petitioned for permission to introduce mandatory enrollment in prepaid health plans, an idea that had been seriously discredited by experiences in California in the 1970s when contracting with health plans encountered numerous problems including fraud, marketing abuses, and financial failure (Chavin and Treseder 1977). Most notable among the pioneers was Arizona which became the last state to implement a Medicaid program when it launched the Arizona Health Care Cost Containment System in 1982, built entirely around prepaid health plans (McCall 1985). Other states followed suit devising



demonstration programs in single or multiple counties that included features of the emergent concept of “managed care” (Freund et al. 1988) including:

- California, where the state Medi-Cal agency contracted on a full risk basis with quasi-governmental authorities in Santa Barbara and Monterey to develop county-based managed care programs;
- Missouri, where the Medicaid agency contracted with four prepaid health plans created to serve beneficiaries in the Kansas City area;
- Minnesota, where a portion of Medicaid beneficiaries in the greater Twin Cities area were randomly assigned to enroll in existing and new HMOs;
- New York, where a mandatory HMO enrollment program was implemented in Monroe County (Rochester); and
- New Jersey, which implemented a partially capitated voluntary managed care program in selected counties.

This first generation of programs had the principal aims of improving access to care as well as aspirations to make future program costs more predictable. In the early 1980s, there was virtually no evidence from commercial managed care to support a belief that substantial cost savings were to be expected in Medicaid, though setting or negotiating capitation rates to prepaid plans intuitively suggested some measure of control over future growth rates. But obtaining a contractually assured medical home for beneficiaries was widely espoused by pioneering states (Freund and Hurley 1987). Other states quickly climbed aboard this bandwagon in the mid 1980s, including some that decided that contracting with prepaid health plans was not the only way to achieve the virtues of care coordination and guaranteed access. Utah and Michigan were among the first states to develop what was indeed an innovative model called primary care case management (PCCM), an early version of what became more conventionally known as “gatekeeping” (Freund 1984).

It was not until the late 1980s, when fragmentary evidence began to accumulate cost savings might be realized in these programs, that cost control began to compete with access improvement as a motivator for states (Freund et al. 1988). Then during the period of steeply escalating Medicaid expenditures of the next few years, many more states turned to managed care first with hesitancy and then enthusiasm, informed or misinformed claims of savings

potential (Hurley, Freund, and Paul 1993). The desire of some states to parlay presumed savings into financing for eligibility expansion propelled even more dramatic managed care growth. By the mid-1990s access and costs savings objectives were joined by rising expectations that managed care models could improve vendor accountability and yield improvement in clinical quality and satisfaction with medical care for beneficiaries (Somers and Davidson 1998). Medicaid managed care models seemed to have taken on near panacea-like status (Hurley 1998a).

Table 1 captures the pace of growth in the 1990s as Medicaid managed care increased by about nine-fold in the decade, leveling off at approximately 55 percent of all beneficiaries (National Academy for State Health Policy 2001). During that period the number of states with managed care programs grew from 29 to 49 as nearly every Medicaid agency offered some kind of managed care in at least part of the state. Since the concentration of enrollment is among low-income women and children, managed care models are now the dominant form of care for this group of Medicaid beneficiaries, just as they are for the commercial populations across the nation. Enrollment has lagged among aged and disabled beneficiaries. States quickly adopted managed care models, particularly as Medicaid expenditures rose sharply and the search for antidotes became more intense by the mid-1990s.

Essentially, states offered two main managed care models: 1) enrollment in fully capitated HMOs or prepaid health plans, and 2) PCCM programs that retain fee-for-service payments and relied on the coordinating and authorizing roles of the primary care physician to manage care. Enrollment has grown in both types of programs (table 2) throughout the decade, but the fully-capitated model dominated by 2000 with nearly 70 percent of all beneficiaries in managed care arrangements enrolled with HMOs or prepaid health plans (Center for Medicare and Medicaid Services 2001). Most states mandate enrollment for eligible populations, though voluntary programs have persisted for several special need sub-populations who present

particular challenges for both state agencies and managed care plans. These populations themselves are discussed below because they reveal one of the ragged edges of state-federal relations in the managed care experience.

Throughout the 1990s state Medicaid agencies discovered that they face a particularly thorny set of problems and constraints as they adopted and adapted managed care models that private purchasers have not had to confront (Hurley and Wallin 1998; Coughlin et al. 1999). First among these problems is that Medicaid had already achieved savings through its administered pricing such as fee-schedules that were already below market rates for many services and thus not amenable to further discounting. But many other problems arose because Medicaid agencies are encumbered by a variety of additional roles beyond just being an effective purchaser for their sponsored lives. They provide targeted support for safety net providers and Medicaid revenues are often of critical importance to some of the most financially vulnerable providers. Medicaid makes major contributions to medical education. Medicaid agencies also function as the pass-through entity to draw down federal matching funds to support state facilities for institutionalized populations and other programs managed by sister state agencies. These and other functions impede the ability of states to aggressively contract for care, promote new models of financing and delivery, and even extract substantial cost savings. Many Medicaid agencies quickly realized that their maneuverability in using a managed care strategy was limited or had to be implemented cautiously. In other states, Medicaid officials were reminded of confounding responsibilities by providers, advocacy groups, sister agencies, and, in some cases, by federal officials.

Notwithstanding these constraints, the extent to which states have used managed care to redesign their Medicaid programs is both impressive and uneven. The most comprehensive redesigns are reflected in those states that have essentially converted Medicaid into a prepaid-managed-care-everywhere model with nearly border to border enrollment for most eligible

populations such as Arizona, Tennessee, Oregon, Rhode Island, and Hawaii. In effect, this wall-to-wall approach has adopted prepaid managed care and its associated design and operational requirements as the mainstream Medicaid program. At the other end of the spectrum are states that have implemented relatively modest primary care case management programs primarily for low-income women and children in the state, such as Georgia, or also included chronically ill and disabled beneficiaries such as North Carolina and Arkansas. These states continue to rely on a traditional Medicaid administrative structure, but appear to, over time, add additional operational functions and programmatic enhancements such as case and disease management components. In the middle range, are a large number of states that employ mixed models of managed care and varied combinations of eligible populations typically with prepaid health plan arrangements in urban areas and PCCM programs in rural areas such as Pennsylvania, New York, and Virginia; or with prepaid enrollment for low-income women and children but principally PCCM for populations with special needs such as Massachusetts. In these states, it is necessary to maintain many features of the traditional Medicaid program while assuming the additional functions of operating prepaid managed care systems. Adding to this structural diversity is the dynamic nature of the managed care market that has compelled states to adapt their strategies to changing market conditions.

### **Federalism and Experimentation—Waivers as a Framework for Innovating**

The story of Medicaid managed care has been a saga of waivers sought and largely granted (Freund and Hurley 1987; Holahan et al. 1995). The waiver process epitomizes the state-federal relationship in Medicaid because it is the vehicle that states use to seek relaxation of federal Medicaid rules and regulations to allow them to undertake experimentation and still qualify for matching funds. In principle states could, and a few did, allow beneficiaries to enroll voluntarily in HMOs without waivers. But to pursue managed care strategies aggressively states had to request permission to abridge program features that included freedom of choice,

statewideness of programs, uniformity in selected policies such as provider payment, or strictures on release of personal beneficiary information to non-state agency personnel, and others. In return, states had to abide by certain conditions imposed through the waivers, most notably beneficiary protection and budget neutrality, meaning innovation was not expected to cost the federal government more than the traditional Medicaid program would have cost otherwise.

The waiver process has come to exemplify the debate previewed earlier over whether Medicaid is fundamentally a state or a national program, and how federal officials should exercise control and influence over the activities of the states. There are two broad types of waivers that have been employed for Medicaid managed care purposes (Freund and Hurley 1987): one type is sometimes characterized as *research and demonstration waivers* (or Section 1115) and the other *programmatic waivers* (Section 1915b), often characterized as “freedom of choice” waivers though they typically waive regulations beyond just freedom of choice. In both cases, waivers represent use of regulatory authority vested in the Health Care Financing Administration (hereinafter referred to as the Centers for Medicare and Medicaid Services or CMS). The authority allows states to introduce changes to operate their Medicaid program in a fashion that would not be otherwise permissible, i.e. would not qualify for federal matching funds in the absence of a waiver. Stated simply, they permit purposeful variation or deviations from program uniformity in the pursuit of state-specific goals.

The differences between the waiver types are significant in principle, if not always in practice. Research and demonstration waivers were originally conceived to create and test new models of financing and delivery that would be subjected to rigorous review and evaluation (Freund and Hurley 1987). Arizona is and remains the classic research and demonstration waiver program, now nearly 20 years old. An 1115 waiver allowed that state to experiment with a distinct approach to Medicaid, relying exclusively on prepaid health plans, after going more than 15 years without a Medicaid program. These types of waivers extend to states very broad

flexibility, but in return the states are expected to comply with detailed reporting and oversight requirements to facilitate the research and evaluation component that is to generate new knowledge that could benefit other states and the Medicaid program in general. The early Section 1115 waivers implemented in the 1980s in Arizona, California, Missouri, Minnesota, New York, and New Jersey largely complied with these expectations and yielded considerable research evidence (Freund et al. 1988).

Section 1915b waivers had more narrow and targeted aims to grant states the opportunity to devise program models and arrangements that they had reason to believe would enhance their own individual Medicaid program (Freund and Hurley 1987). Expectations and requirements for these waivers were normally more modest, though many states have been able to engineer major transformations of their existing Medicaid program to managed care arrangements with these waivers. Evaluation and assessment demands were proportionately more limited, and focused on state-specific experience in terms of cost and access indicators. Like the 1115 waivers, the underlying assumption was that guided flexibility allows states to introduce program variations that would yield gains for beneficiaries and states. These gains would at a minimum offset loss of intra- or inter-state uniformity and, in some cases, potential risk associated with such changes as restriction on freedom of choice.

In the early 1990s the 1115 waiver authority was seized upon by several states, beginning with Oregon, Tennessee, and Hawaii, as the instrument through which more extensive state Medicaid and health reform, e.g. coverage expansions, was pursued (Holahan et al. 1995). Aggressive expansion in use of these waivers reflected confluence of several forces: a loss of faith in the likelihood of federal reform, a sense in many states that dramatic steps were necessary to control costs and/or expand coverage, and a renewal of states rights sentiments that was also finding voice in promotion of block grants for Medicaid. For some states a waiver was an interim strategy to be used while they awaited the block grants that they hoped would

reconfigure the state-federal relationship around health care coverage for low-income and disabled persons. Block grants were expected to allocate to states a fixed amount of dollars, based on past expenditures, accompanied by a minimum set of federal rules and guidance that states would have to follow. Federal officials seemed hesitant to “throw open the door” initially, but a changing policy environment led to softening of resistance and by 1997, more than 15 of this new wave of 1115 waivers were granted (Iglehart 1999). While some semblance of their research and demonstrations features was maintained by CMS’s support of several evaluations, waiver programs increasingly became highly idiosyncratic models of reform and programmatic innovations cobbled together by individual states, that in nearly all cases included a managed care delivery component.

### **The Federal–State “Cold War” over Medicaid Waiver Policy**

Federal posture toward waivers has gone through several phases, reflecting policy priorities, program interests and concerns, and political considerations. Throughout the past two decades simmering tensions between the federal government and states have sometimes flared up into open warfare. In the early 1980s states were encouraged by federal officials to pursue experimentation and program innovations particularly as waiver authority was liberalized in The Omnibus Budget Reconciliation Act (OBRA) of 1981 with the addition of Section 1915b of the Social Security Act (Freund and Hurley 1987). Though support for expansion of managed care leveled off by the late 1980s, renewed cost pressures on Medicaid programs triggered by OBRA 1989 eligibility expansions intensified the search for new cost containment mechanisms (Kaiser Family Foundation 1993). This coincided with the beginning surge in Medicaid managed care enrollment in the 1990s as detailed in Table 1 and reveals the degree of faith—despite very scant evidence to support this—that these models could produce and sustain large savings (Hurley 1998). CMS officials initially displayed sympathy toward financial duress in state Medicaid programs. They were typically supportive and facilitative of state efforts to initiate expanded

managed care models, particularly for AFDC women and children, despite some of these programs being singled out for harsh criticism such as in Philadelphia and Chicago (General Accounting Office, 1987 and 1990).

This supportive posture continued well into the 1990s under a new presidential administration, particularly once national reform efforts came to naught and the mantle of reform returned to or was devolved to the states. Congressional pressure also began to build for more sweeping reforms like block grants for Medicaid that would virtually render waiver granting authority moot. However, the controversial rationing features of the Oregon waiver were a lightning rod for concerns about granting states excessive discretion in Medicaid reform, and its review and ultimate approval was protracted and spanned two administrations (General Accounting Office 1992; Brown et al. 2001). On the other hand, Tennessee's approval was swift and cleared the way for several other states to both rapidly expand Medicaid managed care, and presumptively reinvest expected managed care savings to expand coverage to previously uninsured persons (Conover and Davies 2000). An indication of the depth of federal support for greatly increased state flexibility was that such support did not flag measurably when Tennessee's program encountered serious difficulties.

While enrollment growth continued, by the mid-1990s increased activism among consumer advocates mounted, particularly though not exclusively for persons with special needs, and challenges to the suitability of conventional managed care arrangements for some Medicaid-eligible populations grew. These groups launched challenges on both state and federal fronts as they attempted to influence state decisions about the nature of program models and the pace of implementation, and also tried to influence the waiver granting or renewal process (Bazelon Center for Mental Health Law 2001). In response to vocal concerns, federal officials required waiver petitioning states to conduct public hearings, an indication of some softening in largely unqualified support for state expansion of managed care. Some states saw this as a change of



direction for CMS. The federal government's waiver-granting authority now garnered criticism as an alleged impediment to innovation and a source of frustration for proponents of devolution of more control to states. The multi-year review process for New York's waiver request for mandatory managed care reveals a number of these sentiments and tensions (Coughlin et al. 2001).

The passage of the Balanced Budget Act of 1997 was expected to alter the perception of waivers as barriers by enabling states to undertake mandatory managed care programs as a "state plan amendment." This would mean states would not have to request a federal waiver, as long as the programs complied with new regulations called for in the Act. But hopes among states for a more liberal policy faded when it became apparent that the new requirements, when ultimately translated into proposed regulations, raised the bar on what states had to do in order to launch managed care programs without a waiver (Berjona et al. 2000). New requirements on beneficiary information and notification, health plan reporting, and quality improvement initiatives were introduced. Moreover, certain groups were granted special protection in the BBA, namely disabled persons with both Medicare and Medicaid coverage (dually eligible), native Americans, and children with special health care needs and states were required to continue to request waivers if their managed care programs aimed to cover these individuals. Controversy surrounded these proposed new regulations for more than two years as both states and their health plan contractors contended they were burdensome, overly prescriptive, and would contribute to health plan withdrawals. The Bush administration deferred their implementation and proposed an alternative set of regulations, though a number of the original BBA provisions have effectively been implemented through CMS directives to states (Berjona et al. 2000). In sum, however, the BBA that was expected to liberate states from some of the obstacles to managed care innovation failed to do so in the eyes of most states and many in Congress.

## **Beneficiary Protection: By Whom and From Whom?**

One interpretation of the waiver process is that it positions the federal Medicaid agency to have to review and authorize significant deviations from traditional Medicaid policies and practices that are proposed by the states *in the interest of ensuring that beneficiary well-being is not jeopardized*. Concern about adverse beneficiary impacts arose from both around the restriction on choice associated with most managed care models, as well as the potential for the incentives of prepayment to adversely affect access to and quality of care. The latter concerns were particularly extensive because of Medicaid's low payment rates . But federal oversight of beneficiary protection also carries with it the implication that states might put beneficiaries in jeopardy if left to their own devices, or for that matter, leaving beneficiaries in traditional Medicaid arrangements is invariably less threatening than new models of financing and delivery. Not surprisingly states have found this insinuation insulting and unjustified. Many state officials contend a monolithic, inflexible approach to Medicaid (as they argue has been displayed by some at CMS and in Congress) is a far greater threat to beneficiary well-being, since it suppresses innovation and states are inhibited from being able to adapt to changing market conditions and opportunities. Moreover, some states believe, and point to credible evidence from their own or other states' programs (see below), that managed care arrangements have made Medicaid better in such ways as guaranteeing access to primary care, increasing vendor accountability, and reducing costs or gaining more value for current expenditures.

The importance of these contrasting positions cannot be overstated, as they have consistently been at the root of tensions surrounding Medicaid managed care and devolving authority to states to mount and manage these initiatives. Moreover, other parties that have been opposed to managed care models or their extension to certain populations have played upon this federal-state friction. Some have contended that rather than acting as responsible experimenters states may jeopardize beneficiary well-being by pursuing short-term cost containment goals.

States counter that this view distorts their motives and fails to acknowledge that managed care models can allow them to improve their Medicaid programs rather than perpetuating a Medicaid program beset by many problems. They argue that federal preoccupation with program uniformity prevents states from engaging in creative, customized solutions to their own particular problems.

A further argument advanced by states is that they are fully capable of dealing with state and local-level interests and pressures as they design programs without the intrusion of remote federal bureaucrats. They point to instances like California where the state agency responsible for managed care planning in the early 1990s unleashed an enormous level of interest among safety net providers and local officials who opposed the states plan to rely principally in private health plans for expansion (Draper and Gold 2000). The ensuing debate led to a major program redesign and the subsequent introduction of the so-called “Two-Plan Model” in a dozen major counties that gives an explicit role for safety net providers in indigenously developed health plans. This accommodation defused opposition and has led to what is now seen as a particularly successful innovation (Draper and Gold 2000; McCall et al. 2000).

Another realm where contentiousness about appropriate roles has played out has been around the inclusion of persons with chronic illnesses and disability in Medicaid managed care programs. While the number of states that include these persons in managed care arrangements has increased steadily over time, their participation has typically been limited and often left on a voluntary basis (Regenstein and Anthony 1998). Since nearly 70 percent of Medicaid expenditures are made for this segment of the Medicaid population, this has sharply curtailed the ability of managed care strategies to affect overall Medicaid expenditures. But the hesitancy reflects genuine concern about how well conventional managed care models can be adapted to persons with serious and complex health problems. It also is indicative of deep-seated suspicions toward managed care among many persons with chronic disease or disability, their advocates,

and their service providers emanating from a fear that they may be ill-served or under-served (Battaglia 1993; Tanenbaum and Hurley 1995). State's track records have been uneven in this regard. Some, like Tennessee, have moved quickly to include these populations on a mandatory basis (Conover and Davies 2000), while others like Minnesota and Wisconsin have moved far more slowly despite having mature programs in place for low-income women and children.

In most cases, the federal government has not played an active role in intervening but has left these decisions to be handled at the state level, until or unless problems erupt that result in protests being registered about waiver granting or renewal. Such was the case in a recent incident with New Mexico's behavioral health managed care experience (Bazelon Center for Mental Health Law 2001) where several advocacy organizations voiced concerns about program deficiencies that threatened and delayed waiver renewal for a time. The reticence of the federal government has received some criticism from those who believe a more vigilant role is justified. For example, a number of states implemented prepaid managed care programs for these high cost beneficiaries without attention to whether capitation rates were suitably adjusted or refined. In light of the great variation in expected cost that have been documented for some sub-populations one might contend waivers ought not to be granted to programs until a credible risk-adjustment scheme is in place (Hurley and Draper 1998). Despite this, some states have been granted waivers and implemented programs successfully without these adjustments or have chosen to add them at a later date as their relationships with their managed care contractors evolved or data capacity improved.

The waiver granting process has been considerably complicated in recent years because of the breadth and ambition of the reform efforts encompassed by them. Most of the 1115 waivers have incorporated several diverse features beyond simply implementing managed care including eligibility expansions, modifications in payment strategies, and various program design and management issues (Holahan et al 1995). These multiple, concurrent changes make it

difficult to disentangle both the role and expected contribution of managed care to these endeavors and also present serious challenges to understanding the degree to which states are compliant with the budget neutrality expectations on which waivers have been granted. Not surprisingly, this complexity has caused states to employ considerable ingenuity and artfulness to assert that their waiver programs have adhered to budget neutral expectations and that Medicaid beneficiary access to and quality of medical care has not be degraded.

### **States as Laboratories for Innovation: An Operational Appraisal**

State-level innovators have varied in the motivations, consideration, and sophistication with which they have designed, developed, and implemented managed care programs. First generation programs were venturesome and not always successful, as evidenced by failure of 1115 demonstration programs in the 1980s in California with a bankruptcy of the Monterey demonstration and in New Jersey with an inability to sustain pilot programs. Later innovators were able to draw upon both the successes and failures of their predecessors, offering a glimpse into the degree to which states have engaged in collateral or cross-state learning. Moreover, some states have actually made major programmatic redesigns like California with its multiple model approach and Florida with a dual emphasis on HMOs and PCCM. Other states shifted sequentially from one phase to another such as when they have replaced primary care case management programs with fully capitated arrangements, as in Maryland and Michigan. In addition, the number of states that offer multiple models based on within-state (typically rural v. urban) market variation like Texas, Virginia, and New York reveals an ability to refine strategies and adapt them to local conditions, a necessary accommodation for a market-based initiative like managed care.

Experimentation has been opportunistic at least in part because of the evolving nature of managed care models and plans, and the shifting belief and recognition of what they may contribute. Many states offered primary care case management programs as a transitional model

from traditional fee-for-service until prepaid managed care became more broadly available and plans became more willing to venture into the risky Medicaid market. Likewise, in the late 1990s as plans, especially predominantly commercial plans, withdrew from participation, states had to reconsider how crucial maintaining prepaid arrangements was to them when determining their tactical responses (Felt-Lisk 1998; McCue et al. 1999). For some states, such as New York, increased payment rates and expanded reliance on safety net provider-sponsored health plans have been the answer (Coughlin et al. 2001). For others like New Jersey, Maryland, and Washington contracting with fewer plans, and typically those that serve only the Medicaid population, was an effective response (Hurley and McCue 2000). Still others have reverted back to relying solely on primary care case management programs such as Georgia, and Vermont (National Academy for State Health Policy 2001). Proponents of maximum state flexibility point to this homeostatic response as proof that program managers are capable of adjusting to market signals and undertaking responsible program modification.

Among the most revealing aspects of the Medicaid managed care experience is the extent to which state Medicaid agencies have had to transform themselves to take on several new roles and activities in their capacity as prudent, value-based purchasers of managed care services (Fossett et al. 2000). Given their history of being passive, bill-paying organizations expected *not to alter care delivery*, it is not surprising that Medicaid agencies lacked the manpower, expertise, and infrastructure to engage in the design, procurement, rate setting, negotiation and bidding, contract execution and monitoring activities required in launching managed care strategies. Adding to the political context within which they have had to do these things, one cannot help but be impressed with how much success a number of states have had with so few resources with which to work. In part they have done much of this with contractors, rather than internal personnel, in light of the severe constraints on both the numbers of personnel and the skill sets they can attract. Table 3 provides a picture of just how much of this activity is being contracted

out, which states again point out is indicative of their resourcefulness in taking on new responsibilities (National Academy for State Health Policy 2001).

In truth most states have struggled mightily with many of these new roles and responsibilities, particularly as they discovered just how different a managed care strategy was from business as usual (Fossett et al. 2000). The more dependent states have been on prepaid managed care contracting, the greater the demands to develop the requisite expertise and infrastructure to administer a transformed Medicaid program. A particularly notable area of under-development was in contracts between Medicaid agencies and health plans. The massive study of these contracts undertaken by Rosenbaum and colleagues (Rosenbaum et al. 1997) revealed just how primitive and underdeveloped these documents were in most states. Contracting officers had developed them largely by literally cutting and pasting together versions of contracts developed by earlier innovative states like Wisconsin (Hurley 1998). Rather than viewing this as an indictment of contracting, many states and advocates came to see the Rosenbaum study as an opportunity to create far more explicit and demanding agreements. Such agreements could extract better performance from health plans and allow states to intensify efforts to improve systematic performance monitoring and quality improvement (Landon et al. 1998).

Rate setting was another area where states floundered, in part, because of their lack of experience and sophistication, low fee-for-service bases to work from, and because of severe data problems that made development of credible and sound rates inherently problematic for many years. For some states it took a number of years to refine their rates to avoid systematically overpaying plans because of selection dynamics associated with voluntary enrollment or offering of multiple models of managed care side-by-side. More generally, rate adequacy was a serious bone of contention with plans for which states had almost no sound benchmarking data until the Urban Institute study in 1999 (Holahan et al. 1999). Alternative methods to devise rates

including pure or modified competitive bidding or rate negotiation have produced uneven and sometimes disruptive experiences across states and within states over time, suggesting that no single best way of producing fair rates has yet been established. Despite the controversy rate issues have generated, rate adequacy was rarely an issue raised in the waiver review process, much to the consternation of many health plans and providers.

Cross-state learning about problem identification and response occurred more successfully in some other areas. The enormous problems Tennessee encountered in 1994 when they implemented TennCare just 45 days after their waiver was granted persuaded other states that this strategy of bulldozing over opposition before it could become entrenched was both ill-advised and likely to result in many years of remedial relationship repair (Hurley 1998). The problems experienced in Florida with health plan marketing abuses was highly influential in states turning to enrollment brokers, which as noted below, has been one of Medicaid managed care's most unique innovations (Kenesson 1997). Several states encountered serious difficulties in program designs of behavioral health services and especially for the chronically mentally ill (Mechanic 1998), and consequently have become much more cautious about both program strategies and the potentially adverse impact on existing providers of services to these populations (Savelle et al. 2000). In general terms, states have also learned from successful programs like Wisconsin and Massachusetts that devising methods to increase stakeholder involvement in program design, development, and implementation can build coalitions and effectively defuse opposition (Perkins et al. 1996).

Beyond these general strategic and tactical successes, there have been some distinct areas of real innovation by states in Medicaid managed care, particularly when contrasted with their private sector counterparts and the Medicare program. Because of the high concentration of special need populations eligible for Medicaid, states including Massachusetts, Wisconsin, and Ohio have been on the forefront of devising program models and arrangements that can promote



care management features without undermining existing relationships and specialized expertise for the providers who serve these populations. They have designed unique partnerships and collaborations to mesh the resources of providers and care management organizations with the interests of persons with chronic conditions and disabilities, including persons with HIV/AIDS, severe physical and developmental disabilities, and severe and persistent mental illness (Master 1998; Pandey et al 2000). In prepaid programs, development of risk-adjustment methodologies emerged as a crucial feature to engage plans and to nurture constructive long-term relationships (Kronick and Dreyfus 1997). Medicaid agencies have devoted considerable attention to these issues as indicated in Table 4. Several states like Colorado, Washington, and Maryland have been on the front lines of testing the suitability and effectiveness of these schemes. By using either newly developed methods or new data sources, they are in advance of most private and Medicare purchasers (Weiner et al. 1998; Tollen 1998, Payne et al. 2000).

Second, nearly two-thirds of Medicaid programs employ enrollment brokers to facilitate beneficiary selection of health plans or physicians or assign those who fail to exercise a choice (Kenesson 1997). This broker model was essentially invented in response to marketing abuses in a number of states and the resultant desire of states to impose more structure and objectivity on the plan selection process. For other states, brokers play a more basic role of simply augmenting existing state staff and bringing to bear expertise, customer service resources, and infrastructure to enable programs to be built quickly or changes made expeditiously. In some states, brokers have been instrumental in ensuring smooth transitions in the face of plan withdrawals (Tucker 2001).

Third, the primary care case management model, with nearly two decades of use in Medicaid, remains one of the few managed care models that has proven to be feasible and sustainable in rural areas (Felt-Lisk et al. 1999). Despite their relatively low aspirations and limited enhancements in most states, these programs have delivered stable medical homes and

provided bolstering of rural health care providers whose patients might otherwise be required to enroll in urban-based HMOs. In some cases, states have made successful investments in ramping up these programs to models that begin to approximate a number of the desired features of more comprehensive and integrated delivery systems (Smith et al. 2000). A few states such as Arizona and Tennessee have attempted to push prepaid medical care to everywhere in the state and in so doing became a market shaper rather than market taker. Others have concluded that the mixed model strategy affords them the opportunity to conform Medicaid with the prevailing financing and delivery systems in local markets, just as most private purchasers have chosen to do as well.

Taking a more global perspective, some states have used a managed care strategy as a central feature of transforming their Medicaid program on a grander scale and in the process achieving substantial, well-documented changes. Arizona used its waiver-supported prepaid health plan strategy to launch what has been characterized as the first managed care-based state Medicaid program (McCall 1997). Rhode Island is another state that employed 1115 waiver authority to devise an HMO-based managed care program that now covers a substantial portion of the state's population and has been widely cited for its positive impacts on participants (Griffin et al. 1999). TennCare's massive expansion of nearly 50 percent additional covered lives, was built on a platform of statewide prepaid plan enrollment (Conover and Davies 2000).

Conversely, there are states whose managed care strategies have fared more poorly either, because of design or management difficulties or because of market and managed care sector forces beyond the ability of Medicaid to control. Ohio, West Virginia, and Connecticut are states that have been seriously hampered by health plan instability and withdrawals and corresponding dislocations for member (National Academy for State Health Policy 2001). TennCare's widely publicized problems could also include it in this category as problems with achieving a solid financing foundation have persisted throughout the life of the program. There are also examples of states that have struggled with a variety of problems that threatened their

viability and policymaker support, but which have successfully responded to these challenges by modifying rates and requirements (Pennsylvania) stepping back from requiring fully capitated programs in all parts of the state (Oregon); or permitting PCCM programs to compete directly with HMOs to ensure that alternative models remain available (Florida and Texas). Some observers would also again add Tennessee to this cluster of states given its adroitness in maintaining its program despite the swirl of criticism that has surrounded TennCare.

Assessment of the relative success and failure of mounting massive managed care initiatives certainly requires a careful look at the empirical evidence, as done in the following section. But, state performance as experimenters also needs to be contrasted with that of other purchasers that have proceeded down this same path. Large private purchasers have encountered many of these same challenges with comparable ups and downs, commensurate with the turbulent market within which all purchasers have had to navigate in the past decade. However, private buyers are far less constrained by the added roles and responsibilities that beset Medicaid agencies. Private purchasers also are expected to be less paternalistic or protective than public agencies. In addition, Medicaid agencies have far less maneuverability in designing managed care products and promotion of informed consumer choice than private purchasers, because they are unable to use substantial cost sharing to influence beneficiary behavior.

Compared to Medicare's foray into managed care, a number of Medicaid agencies have fared better as measured by enrollment growth and market stability (Felt-Lisk 2001; Gold 2001). Certainly, Medicaid's ability to mandate enrollment in managed care makes a major difference. But the monolithic design of Medicare, the centralization and relative inflexibility of its administration, and the constraints on its ability to engage in experimentation, all distinguish it from Medicaid in areas highly pertinent to managed care strategies. Supporters of expanding state flexibility contend these differences allow states to engage in more innovation and adaptation to market changes. It is this elasticity in response that has allowed states like New

York to make major Medicaid rate adjustments to reinvigorate its program ,or California to devise three distinct program models to customize a general managed care strategy to substantially different local market delivery system configurations. On the other hand, there have been states such as Ohio, Georgia, and Kentucky where prepaid managed care efforts have encountered difficulties fully equal to those of Medicare.

### **States as Laboratories for Innovation: An Evidence-Based Appraisal**

The evolution of the Medicaid program through the adoption and expansion on managed care has proceeded steadily over the past two decades. This has required administrative changes in many states, new approaches to purchasing health care through plans as opposed to providers, and fundamental shifts in the role played by the federal government as overseer of Medicaid. This enthusiastic march of one state after another into the managed care arena and the willingness of the federal government to grant waivers grew out of the broadly-held consensus that fee-for-service payments led to excessive utilization and added to program costs. However, most of the assumptions about the *likely* cost savings or access improvements associated with managed care in any particular state were rarely based on solid research findings. The notion that research evidence from early-states shaped the design of Medicaid managed care programs in later-states is hard to establish explicitly. However, a large body of research has emerged that assesses how managed care has transformed Medicaid through impacts on program costs and beneficiary access and use—the two areas that states have identified as their primary motivation for choosing this policy direction.

Synthesizing evidence into a broad overview of Medicaid managed care is challenging, because most studies have focused on single states or small groups of states and have often been limited to specific populations or health outcomes. Over the years, several papers and reports have met this challenge by summarizing extant findings and drawing somewhat generalizable conclusions through a meta-analysis (Hurley et al. 1993; Rowland et al. 1995; Brown et al.

2001). Many of the studies cited in these reports are derived from specific evaluations of the Section 1915(b) and Section 1115 waivers granted to states by the federal government. More recently, studies have attempted to examine nationally representative data to draw broader conclusions about the impact of Medicaid managed care (Garrett et al. 2001; Zuckerman and Brennan 2001). The ongoing series of literature reviews by Miller and Luft looking at managed care in general (private sector, Medicare and Medicaid) has never found strong evidence suggesting that managed care creates problems for patients. Recently, they have suggested that the expansion of managed care means that patients both within and outside of managed care plans are being seen by the same providers and, as a result, patterns of care are converging (Miller and Luft 2001). In this section, we focus on research related to the effects of managed care on Medicaid program costs and beneficiary access and use.

***Program Costs.*** Although all of the 1115 waivers were supposed to cost no more than the state's Medicaid program without the waiver, CMS has not insisted that evaluations of these waivers attempt to confirm whether or not "budget-neutrality" has been achieved. In part, the movement away from a strict budget-neutrality test may have been motivated by the difficulty in making and justifying assumptions related to expected trends in costs.<sup>1</sup> In lieu of a state-specific budget-neutrality analysis, researchers have compared the cost experiences of the states operating under waivers to the national average.

The bottom line is that expectations of between 5 and 10 percent savings on those enrolled in managed care based on early studies (Hurley et al. 1993 and Holahan, et al. 1998) did not materialize and managed care did not translate into dramatically slower growth in program costs per beneficiary. For Hawaii, Oklahoma, Rhode Island and Tennessee – holding price levels constant overall expenditures grew at or near the national average through 1998 (Ormond et al.

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<sup>1</sup> For example, studies of TennCare and other 1115 waivers have concluded that original projections of costs without the waiver do not represent a valid comparison because of changes in medical cost inflation

2001). Findings like these should not have been entirely surprising given that Medicaid programs already had low provider payments (Norton 1995) and, in some instances, had imposed utilization controls (Zuckerman 1987). Maryland was an exception within the Section 1115 waiver states. Real costs per beneficiary did not change between 1996 and 1998 (the first two years of the state's 1115 waiver), while costs rose nationally by about 2.6 percent per year. In addition, despite the extra administrative costs that were expected in order to allow states to run their managed care plans alongside continuing fee-for-service programs, programs size and complexity did not seem to be related to administrative costs changes (Ormond et al. 2001).

***Beneficiary Access and Use.*** The inability to confirm that the savings apparent in the programs that started in the 1980s has also accrued to the major initiatives of the 1990s may have implications for the future of Medicaid managed care. States intent on savings may no longer feel that the effort required to contract with plans and maintain their participation is worthwhile. Without some reasonable expectation of savings, states' enthusiasm about Medicaid managed care may wane. In the end, this major change in the Medicaid program may be only justified on the grounds that it is better for beneficiaries and, as the evidence to be discussed suggests, the results on this point are mixed.

Most of the research on beneficiary impacts has focused on how Medicaid managed care has affected access and use. There have also been some attempts to actually examine health outcomes, quality of care, and patient satisfaction. Although the bulk of the research has focused on the impact of moving from Medicaid fee-for-service to managed care, one recent study has examined the influence of variation in managed care plan characteristics.

One of the first major reviews of Medicaid managed care research was prepared by Hurley et al. (1993). This synthesis examined evidence on 25 programs that varied according to whether they included PCCMs or HMOs, the nature of provider risk-sharing and reliance on

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that occurred independent of the waiver (Conover and Davies 2000; Brown et al. 2000).

voluntary or mandatory enrollment. The evidence suggests that, in this early era, Medicaid managed care was associated with reduced use of emergency rooms, prescription drugs and hospital care relative to the fee-for-service program. There was, however, no broad evidence to suggest that the level of physician use decreased. The authors suggested that physician visits did not decline because of incentives for more visits in the PCCM programs that relied on fee-for-service payment approaches.

Throughout the 1990s the literature on Medicaid managed care continued to grow. The Kaiser Commission on the Future of Medicaid prepared a literature review in 1995 that covered 130 studies (Rowland et al. 1995). That review confirmed the Hurley et al. synthesis showing that Medicaid managed care reduced emergency room use and had no effect on physician visits. However, the Kaiser review also found reduced use of specialists' care, but only minimal changes in preventive care or hospital use. In addition, where satisfaction with Medicaid managed care was high, it appeared to be because beneficiaries were able to enroll without having to change providers.

Findings from Section 1115 waiver programs that started in the mid-1990s did not always confirm the benefits of Medicaid managed care seen in many of the earlier and smaller evaluations (e.g., Coughlin and Long 2000 and Mitchell et al. 1999). As has been pointed out (Gold 1999) however, methods for assessing the effects of moving from fee-for-service Medicaid to managed care are difficult to develop and, as a result, may not be robust. However, beyond methodological issues, there are reasons to have expected that the effects found in the earlier Medicaid managed care programs would differ from those of more recent efforts. First, in the 1980s, Medicaid was implementing managed care in a health care market in which most privately insured and Medicaid individuals were still in fee-for-service. As such, the potential to induce providers to treat Medicaid managed care enrollees differently from patients covered under fee-for-service arrangements and to detect those differences was greater than in the 1990s when

managed care was widely implemented by all payers. Second, by the late 1990s overall savings from managed care leveled off as utilization reductions became more difficult to sustain (Gabel et al. 2001). Third, in the 1990s, Medicaid managed care was often part of a broader reform of the Medicaid program that included eligibility expansions and, as a result, isolating the effects of managed care became more difficult.

The complexities of assessing the impact of the 1990s' 1115 waivers can be illustrated by the experience of Tennessee. The research effort that has gone into studying the TennCare program, one of the most unique 1115 waivers in the country, is perhaps the greatest of all the 1115 waivers. Through creating this program, the state of Tennessee moved all of its current Medicaid population into managed care and used projected savings to expand eligibility to roughly 400,000 uninsured Tennesseans (Conover and Davies 2000). Both the federally funded evaluation of TennCare and a variety of other studies have allowed analysts and policymakers to know a great deal about the effects of this program. However, because TennCare includes an eligibility expansion, measuring the managed care effects on their own is a challenge.

Unfortunately, none of the available studies of TennCare have been able to separate the effects of the managed care component of the program on traditional beneficiaries from its eligibility expansion. In fact, to the extent that *expectations* of savings from Medicaid managed care convinced policymakers to move ahead with the eligibility expansion, the biggest effect of Medicaid managed care under TennCare may be through its effect on the previously uninsured, not on persons who were already Medicaid beneficiaries. For the newly insured, out-of-pocket costs fell, preventive care increased and satisfaction with care improved as a result of gaining coverage under TennCare (Brown et al. 2001).<sup>2</sup>

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<sup>2</sup> However, actual savings under TennCare managed care were not as great as expected and the extent of expansion was slowed when the state was forced to freeze enrollment in 1995; it subsequently opened the program to new enrollment in 1997. Recent budgetary concerns have led to a new round a enrollment freezes and proposals to rollback eligibility or increase beneficiary costs.



In more recent studies of Medicaid managed care based on national data, researchers have applied consistent analytic methods to compare traditional Medicaid to PCCMs and HMOs and to contrast the effects of these approaches across adults and children. Zuckerman and Brennan (2001) and Garrett et al. (2001) both report that, relative to traditional Medicaid, HMOs improve health care utilization for adults or children in comparison to traditional Medicaid.<sup>3</sup> There is also some evidence showing that PCCMs are able to better connect beneficiaries with providers than traditional Medicaid, but these gains in access have limited effects on patterns of use.<sup>4</sup> Although these findings raise questions about the value of the types of PCCMs that were in place by the mid-1990s, we recognize that they are not directly relevant in assessing the enhanced PCCMs that some states (e.g., Massachusetts, Arkansas, and North Carolina) have been turning to recently as a response to difficulties that have arisen in contracting with HMOs.<sup>5</sup> Despite the advantages of the research methods employed in these studies, results are not always consistent with expectations. For example, Zuckerman and Brennan find little evidence to suggest that HMOs reduce hospitalizations, a result often viewed as a given when predicting the effects of private HMOs.

Given the foothold that managed care has within the Medicaid program and difficulty in developing comparisons to beneficiaries' fee-for-service experience, one of the major evaluations tried to examine the effects of differences in plan characteristics. Moreno et al. (2001) argued that this type of information could be more useful to states as they consider which types of plans with which to contract. However, small samples of enrollees in various types of plans produced

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<sup>3</sup> These conclusions are based on data and models that include enrollees in PCCM, HMO, and fee-for-service arrangements. Earlier studies often made such comparisons by linking studies from different states that may have used fundamentally different types of data.

<sup>4</sup> Zuckerman and Brennan (2001) found that, for children, the probability of seeing a physician or other health professional was increased in comparison to traditional Medicaid, but that there was no effect on preventive care. There were no effects related to care provided to adults.

<sup>5</sup> Enhanced PCCMs are programs in which state Medicaid agencies try to actively manage their provider networks using care management, incentives, and oversight similar to those employed by private health plans.

statistically insignificant results that were not generally consistent for adults and children. With this caution in mind, the results may ease some concerns about poor care being delivered in plans that provided financial incentives to potentially skimp on care or that serve a predominantly Medicaid clientele. But, the study seems to suggest a need for uneasiness about plans that use safety net providers as primary care gatekeepers. Holding constant a range of demographic, economic and health status indicators, beneficiaries in these plans reported worse satisfaction with and access to health care. To the extent that states are becoming more dependent on plans organized around safety net providers (Coughlin et al. 2001), the evidence of poor service delivery detected by Moreno et al. (2001) may warrant careful monitoring of these plans.

***Vulnerable Populations.*** In 1995, Rowland and her colleagues pointed out that most of the studies of the effects of Medicaid managed care were based on low-income families and did not cover the elderly or disabled beneficiaries. In fact, by the time the Kaiser Family Foundation review was prepared, literature was already developing that pointed to the potential problems that could arise when trying to bring these groups into managed care (e.g., Fox et al. 1993; and Newacheck et al. 1994). These studies noted that states were already excluding these vulnerable populations from managed care enrollment or paying for extra services that might be required outside of the basic managed care contracts. As a result, Medicaid has not yet demonstrated the ability to manage care to improve access and quality or control costs for elderly and disabled beneficiaries. Since these are the groups with the greatest service needs and the highest costs, this is an important missed opportunity. But states have generally been hesitant to mandate enrollment for these groups because of concerns among beneficiaries and their families over potentially withheld services and the difficulties associated with risk-adjusting payments to appropriate levels.

Under TennCare, however, SSI beneficiaries were required to enroll in managed care, although behavioral health care was delivered through separate plans. Evidence shows that the

SSI population was less satisfied with their care than the non-SSI population and that people with mental illness reported low levels of service use and high levels of unmet need under TennCare (Hill and Wooldridge 2001). This suggests that earlier concerns about the adverse effects of Medicaid managed care on these groups may have been warranted, and that states need to be cautious and attentive to problems as they attempt to enroll these groups in managed care.

***The Overall Role of the Evidence.*** Although studies related to disabled populations may have slowed the expansion of Medicaid managed care to these groups, the general evaluation evidence does not seem to have influenced the policy process a great deal. For example, states that combined Medicaid managed care with eligibility expansions in the 1990s (e.g., Tennessee, Oregon and Hawaii) had no credible research roadmap based on the managed care programs from the 1980s to guide their policy design. The conflicting evidence for non-disabled beneficiaries derived from different states, different time periods, different data sources and different methodological approaches make it nearly impossible to draw definitive conclusions about how Medicaid managed care will work in any particular state. These inconclusive results may have given both state and federal decisionmakers the opportunity to use or to ignore the research findings as policies were designed and implemented. Instead states seem to be inclined to monitor broad indicators of program performance (e.g., auto-enrollment rates, plan participation and provider availability) as the frontline approach to identifying immediate problems.

The role of research appears as a part of a secondary “quality assurance” process intended to identify egregious problems not otherwise detected. To the extent that strong evidence of these types of problems are not uncovered, the federal government renews waivers and states continue to rely on Medicaid managed care. Year-to-year decisions are more likely to be driven by political considerations and market conditions rather than by research evidence that tends to take longer to develop. In fact, it may be that the recognition that research evidence

plays a small role in federal policy decisions made some states reluctant to invest in the potentially-costly encounter data that many researchers believe is necessary to compare Medicaid managed care relative to fee-for-service Medicaid. However, after over two decades of research on Medicaid managed care programs, there is little definitive evidence that harm is being done to beneficiaries and this should assuage most concerns about the limited role that empirical evidence has played in policy development.

### **Summing Up: A Balanced Scorecard on an Age of Innovation**

While the past decade of intensified interest in federalism and devolution has been an especially active one for Medicaid managed care initiatives, the age of innovation in this realm is now really two decades old. Consequently, it is possible not only to weigh considerable evidence but also to have a lengthy period over which to observe the durability of state efforts to use waivers effectively to “remake Medicaid” (Somers and Davidson 1998). Evidence and observations permit the following conclusions to be drawn.

*1. States have been able to navigate successfully the waiver process and several have been able to introduce genuine innovations to enhance the operations and effectiveness of their Medicaid programs.* In part the cumbersome nature of the process is purposeful as a protracted, interactive review that can provoke deliberateness and attention to operational detail and potentially unintended consequences. The interrogatories posed by and conditions forthcoming from CMS have in many instances strengthened programs or forced better planning and preparation, thereby increasing the likelihood of success. The small number of waiver renewal denials is particularly telling about the reluctance of federal officials to interfere with programs that are already underway. Knowing that has probably also provoked more searching reviews on initial submission. Operationally, CMS has been vulnerable to legitimate criticism about the timeliness of its actions in no small part because of its limited resources to respond to the volume of waiver requests submitted in recent years. However, the complaints raised by many state officials and

some members of Congress are to be expected, given inherently conflicting viewpoints about the philosophical underpinnings of Medicaid, which are likely to remain irreconcilable.

*2. States have, in most instances, proven themselves to be responsible, though at times overly ambitious innovators.* The success of several states in the 1990s to broaden Medicaid coverage and more recently implement SCHIP expansions has successfully challenged the assertion that cost control is the only interest of state policymakers. In addition, as managed care became the mainstream delivery system for most persons with private coverage the aspersions cast on states that pursued managed care initiatives as “peddling the poor to the lowest bidder” have largely receded. States generally have won over critics who doubted their motives for undertaking managed care or questioned their capacity to select and contract with credible and creditable managed care vendors. It is not that states have been uniformly successful in their endeavors, they certainly have not; but they have displayed impressive resilience and resourcefulness when they have encountered obstacles. Nearly every state that implemented mandatory managed care programs have stayed the course, though a few have been unable to achieve or sustain their preferred models. Many states, however, have chosen to step back from excessively ambitious timetables or curtailed extension of their programs to populations for whom the time was not right for managed care enrollment, sometimes in response to federal pressure and in other cases to avoid engendered local resistance . On balance these efforts have revealed the responsible innovation states have contended is their aim and forte. Conversely, this model of permitting, but not requiring, adoption of innovations like managed care means that little change may occur within some state Medicaid programs that lack the interest and/or resources to pursue new initiatives.

*3. Medicaid’s experience as a purchaser of managed care services has been an uneven one.* The new and difficult roles associated with managed care purchasing and the confounding additional responsibilities with which Medicaid is saddled impose dual handicaps on state efforts to make

Medicaid a better program through managed care. As shown by the empirical evidence, experience to date with managed care programs has been decidedly mixed across states, models, populations, and performance indicators. Of course, the same would also be true for the fee-for-service experience of states and their beneficiaries. States have generally succeeded in moving their programs to a point of operational stability making prospects for improved outcomes more plausible, as indicated in some of the mature programs. In addition, the durability and relative stability of most Medicaid managed care programs can be contrasted with the parallel instability and impermanence of Medicare managed care (Felt-Lisk et al. 2001; Gold 2001). Medicaid programs generally have reacted quickly and successfully to developments that jeopardize program viability, and by many accounts, a number are shifting toward more long-term contracting relationships with their remaining managed care contractors. States are also generally achieving cost neutrality or generating small savings while the Medicare HMO program has been demonstrated to cost more than fee-for-service because of favorable selection among beneficiaries who participate.

*4. Medicaid managed care experience demonstrates that states have displayed elements of “learning organizations” by showing discrimination in drawing on the experience of sister states.* Given unfamiliarity with managed care in the early years of innovation, it is hardly surprising that many first generation programs made some ill-considered attempts to imitate what was done in other states. Limited availability of timely research and evaluation evidence made it difficult to determine what was working and what was not, leaving states to operate at times with limited information. This state of affairs changed quite substantially in the 1990s as experience broadened, exchange among states improved, and more and better evidence began to be disseminated. The aforementioned examples of innovations with enrollment brokers, rate setting, and risk adjustment are illustrations of areas where states have become more operationally astute in part by going to school on what has and has not worked in other states. Currently, states are

rightly leery of adopting managed care approaches that are not consonant with local market conditions and provider sentiment. This seems to reveal how well they—and their health plan contractors—have learned that local delivery systems are much more resistant to change than once thought. The fact that almost all rural Medicaid managed care is built on primary care case management programs speaks clearly to this.

*5. Managed care innovation is an especially challenging enterprise for states because of its instability and the turmoil it has provoked and experienced in health care markets.* The meteoric rise of managed care models between the mid-1980s and 1990s created powerful pressures on state Medicaid programs to conform their payment and delivery systems with private sector developments. Though initially lagging private markets, states quickly caught up in the late 1990s, just as the managed care backlash was building and health plans lost traction in their own efforts to contain health care costs. Moreover, many plans have seen their membership demand and then migrate to less restrictive products, and a number have introduced practices and payment methods that they hope their network providers will find less odious. These developments are daunting to Medicaid programs that cannot rely on products that have substantial cost-sharing features, cannot afford sustained double digit premium increases, and expect to continue to rely on tight provider networks to control costs. However, most states clearly do not want to return to unmanaged fee-for-service for their beneficiaries, even if many providers find this desirable. Consequently, the future plans, models, and methods of Medicaid managed care may need to be a new generation of more clearly customized arrangements if the managed-care-as-we-know-it market drifts away from what Medicaid can and wants to purchase.

*6. The iterative and opportunistic nature of state level reform invariably leads to controversy and disputes over methods and pace of change.* A continuing theme that has emerged in the debate between the states and federal agencies and elected officials is that the practical demands of meeting citizens' needs are much more acutely felt at the state and local level. As such, while

states may have interest in the ideological debates in Washington over state and federal rights and roles, they are not permitted the luxury of only debating since they feel impelled to do something. Invariably, this carries with it a certain iterative—i.e. trial and error—dimension to state innovation. It also means that state officials must move opportunistically to seize the moment that provides them with a policy window or a fortuitous alignment of favorable circumstances. Turbulent private health care markets and cyclical state revenues introduce additional uncertainty and undermine better, or at least more deliberate, strategizing. This sense of sensitivity to timing consideration has contributed to legitimate frustration among state officials with the pace of the waiver review and granting process. Expediting reviews and renewals has been one remedy already tried, and additional flexibility, such as the originally intended relaxation of waiver requirements in the BBA, would seem like a reasonable next step. But continued conflict on this front seems inevitable.

*7. State Medicaid program variation has probably been amplified by forays into managed care.*

The shape of Medicaid programs has certainly become more diverse in the years since managed care models were introduced. Not only is this because the structural features and operational requirements of managed care programs differ from traditional fee-for-service arrangements, but also states have subjected themselves to market forces in their managed care strategies in ways that they did not do in their traditional programs. In some respects, this parallels what Medicare managed care has been through as well—i.e. raising equity concerns because some beneficiaries in some locales gain access to services and benefits not available to others not similarly situated. The fact that Medicare managed care enrollment is voluntary while Medicaid managed care enrollment is typically mandatory intensifies these concerns.

In Medicaid, the waivers granted to states explicitly permit departures from program uniformity both across and within states. While variation across states is endemic to the Medicaid program, differential employment of waivers in essence promotes more variation. This



has clearly been the case in the managed care experience. However, seen from a different perspective, *diminished uniformity is in fact a license to some states for program improvement that would not be possible if program homogeneity and standardization could not be relaxed.* A more trenchant argument would be that releasing states from the strictures of uniformity allows them, or at least the venturesome among them, to improve their Medicaid programs beyond what other states are doing to meet minimum requirements. By implication, if improvements can be substantiated then other states will follow suit as their interests and opportunities allow them and some will not and state-to-state variation will grow. But, fundamentally, it is the belief that waivers truly foster an ethos of program improvement that underlies the past two decades of Medicaid managed care expansion.

# Conclusion

The past decade of dramatic growth in Medicaid managed care reveals much about how states and federal officials have found a measure of accommodation and collaboration through the waiver granting process. Though subject to contentiousness owing to both specific issues and the general political climate, states have been able to exploit the opportunities that waivers give them to launch innovative initiatives and to introduce and refine creative programs and practices.

While states on balance have experimented responsibly with new models of payment and delivery, the impacts of these arrangements have been uneven and will require more time to fully appraise them. It also appears that these developments have led to more variation in Medicaid programs, both by design and necessity. Advocates of expanded state flexibility contend that it is in permitting and promoting variation that program improvement is made both possible and likely.

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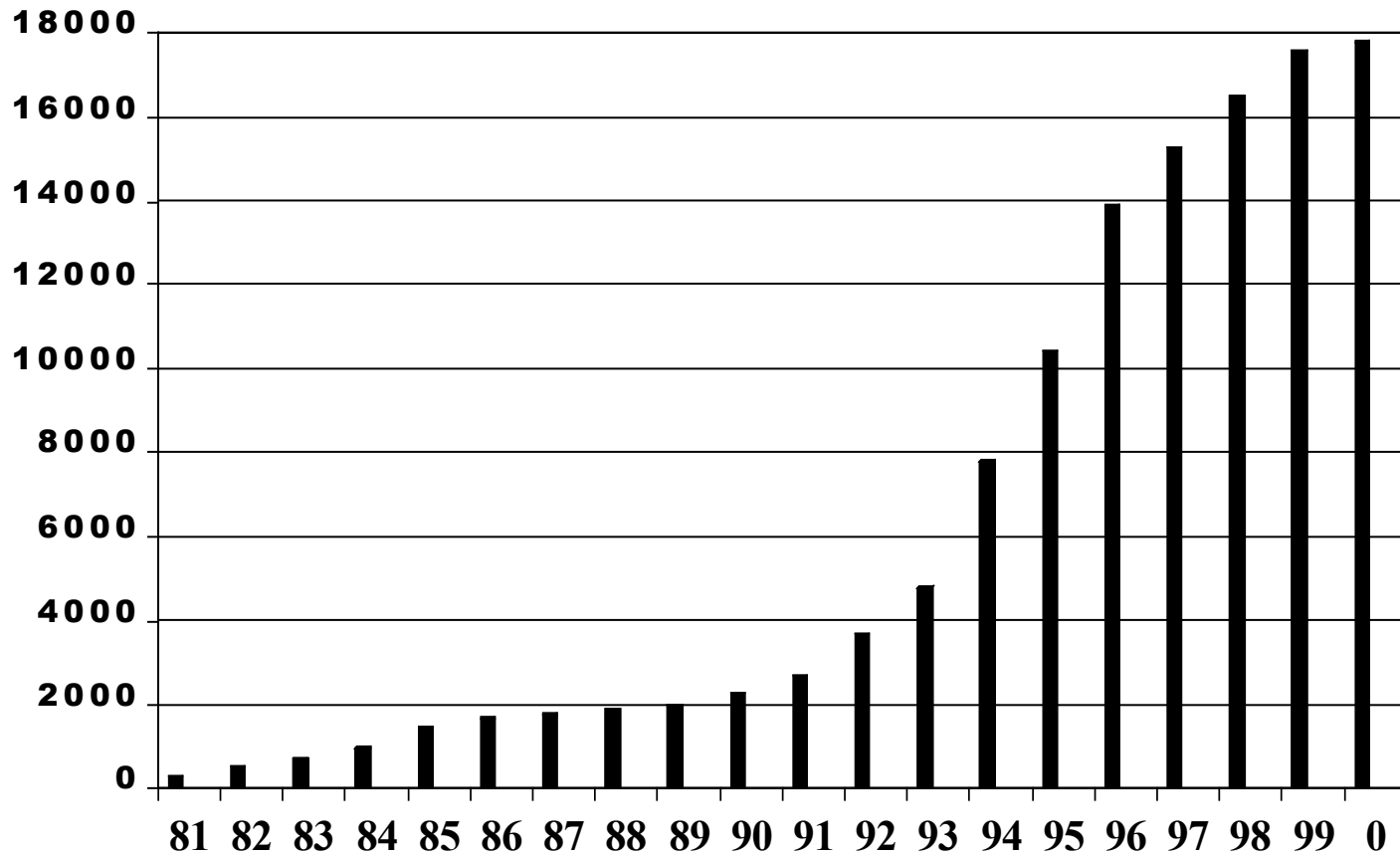
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Table 1

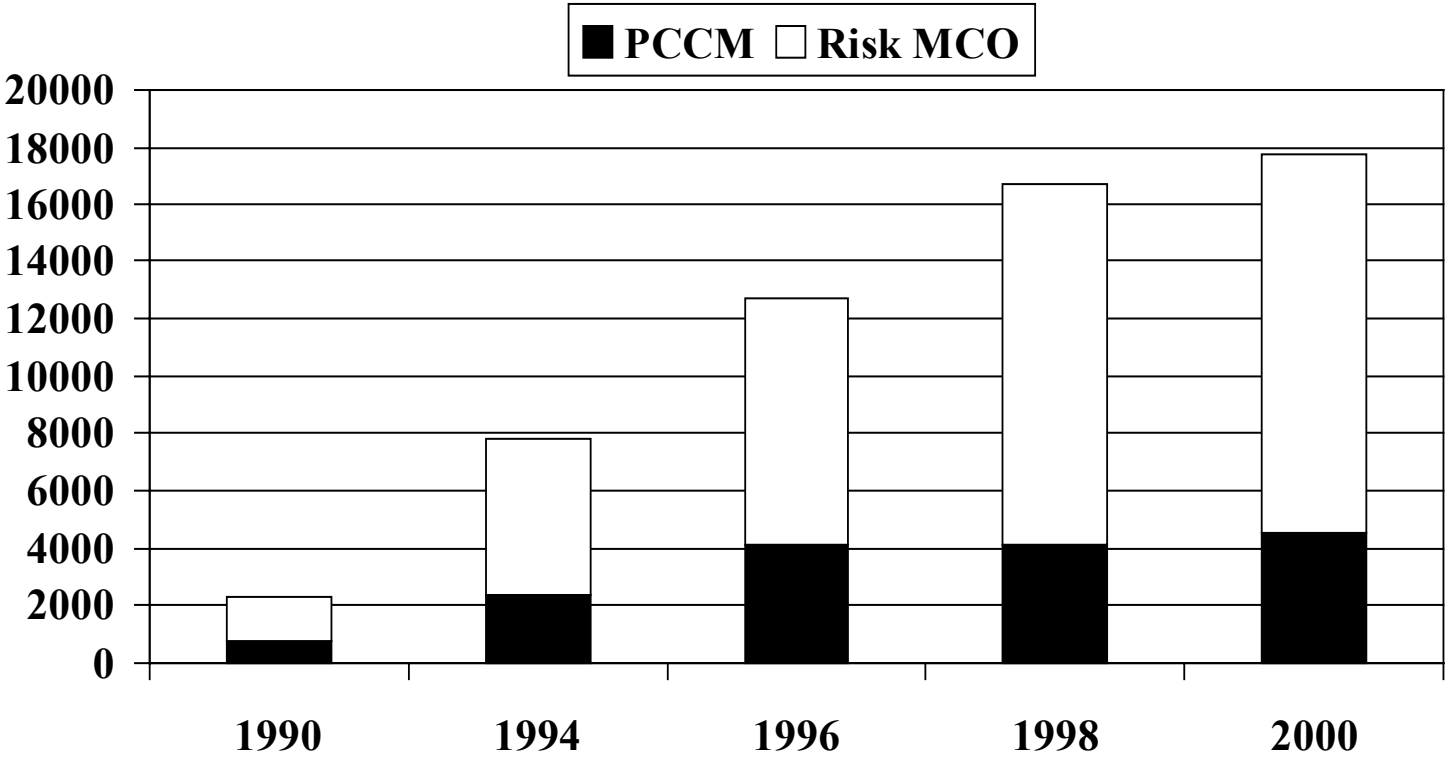
# Medicaid Managed Care Enrollment 1981-2000 (in thousands)



*Source:* Center for Medicare and Medicaid Services

Table 2

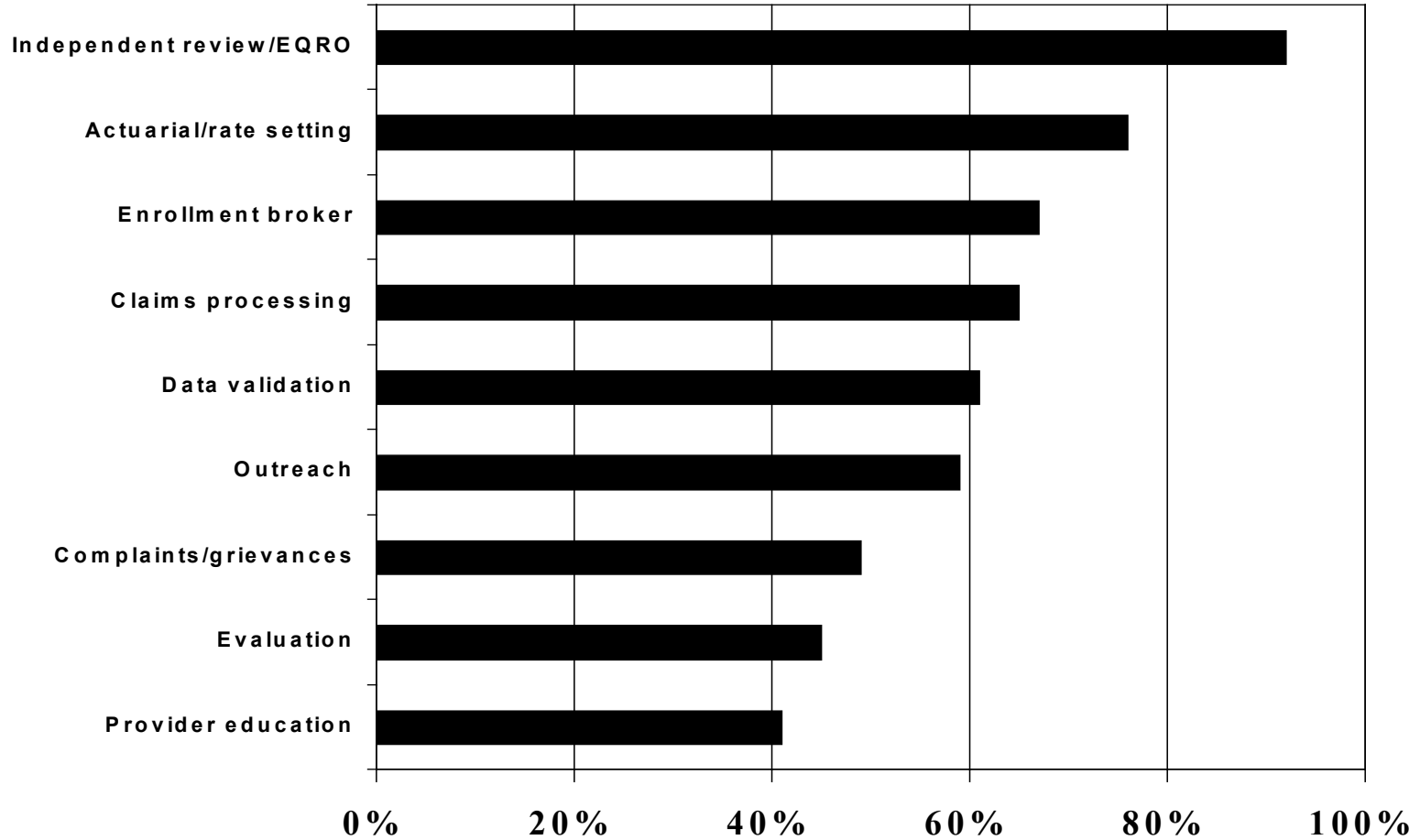
# Enrollment by Model Type, Selected Years (in thousands)



Source: National Academy for State Health Policy, 2001

**Table 3**

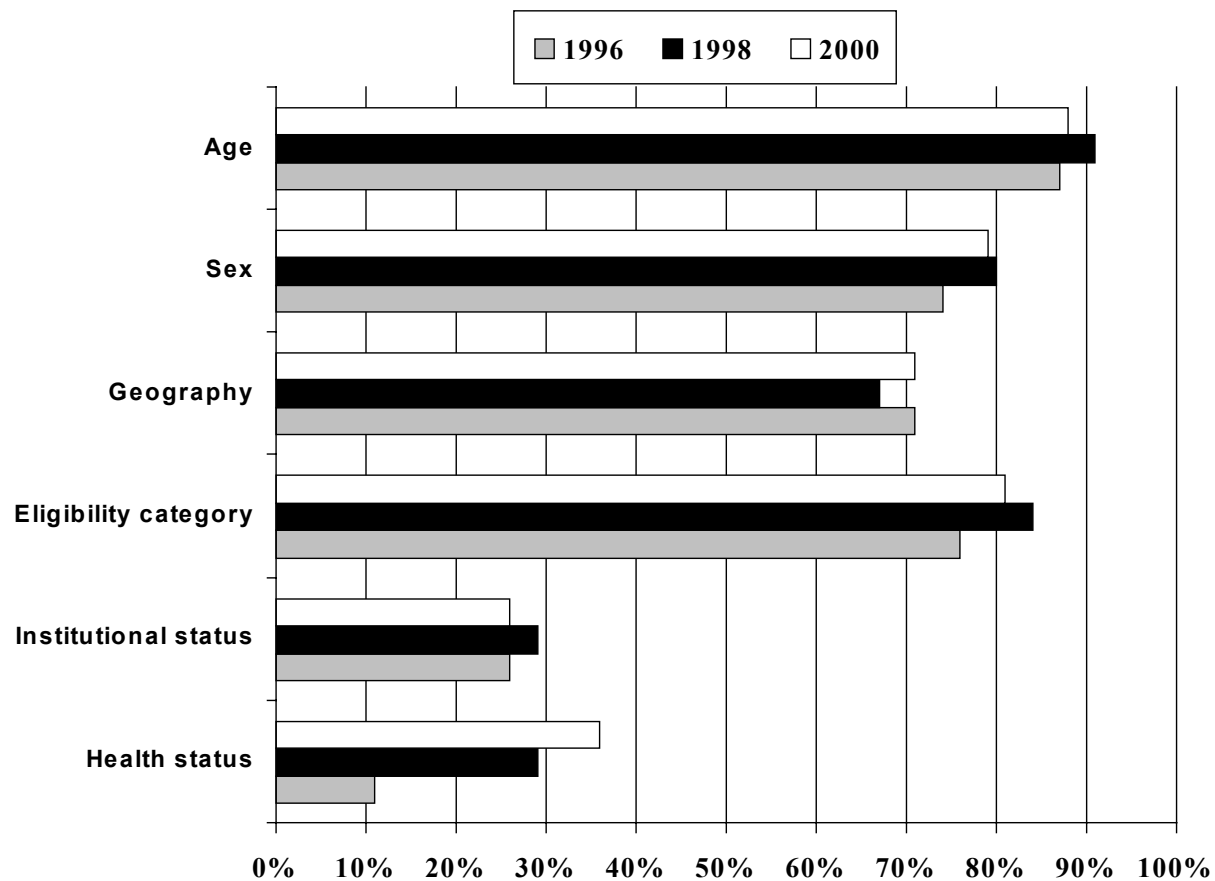
**Selected functions performed fully or  
in part by contractors in 2000**  
(percent of states)



**Source:** National Academy for State Health Policy, 2001

Table 4

# Factors being used in capitation payment ratesetting (Percent of states with capitation programs)



*Source:* National Academy for State Health Policy, 2001

# About the Authors

**Robert E. Hurley, Ph.D.**, is an associate professor in the Department of Health Administration at Virginia Commonwealth University. He has conducted research in managed care for the past fifteen years with a special emphasis on public sector programs. He has published extensively in the area of Medicaid managed care and his research has been supported by a number of public and private funding sources. He is a member of the National Academy for State Health Policy and a fellow of the Association for Health Services Research. Dr. Hurley received his Ph.D. in health policy and administration from the University of North Carolina, Chapel Hill School of Public Health.

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