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# Perils of Pioneering: Monitoring Medicaid Managed Care

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*This article reviews Federal and State oversight of section 1115 Medicaid managed care demonstrations in Hawaii, Oklahoma, Rhode Island, and Tennessee from 1994 to 1998. Under Medicaid managed care, the Federal Government and States have had to shift their focus and resources into oversight functions that barely existed in fee-for-service (FFS) Medicaid. We find that managed care monitoring was slow to begin and not always adequate in these demonstrations. While State and Federal monitoring have improved over time, monitoring is not yet at the point of ensuring access and quality.*

Several States have used section 1115 demonstrations to introduce statewide, mandatory Medicaid managed care. When HCFA approves section 1115 demonstrations, it requires States to monitor managed care plans on a variety of measures and to report findings to HCFA. HCFA also monitors the demonstrations to ensure that the financial incentives resulting from capitated payment do not result in inappropriate underservice to the vulnerable Medicaid population (Health Care Financing Administration, 1995).

This article reviews the evolution and the adequacy of Federal and State monitoring of four section 1115 demonstrations between 1994 and 1998: (1) QUEST, in Hawaii; (2) SoonerCare, in Oklahoma; (3) RItE Care in Rhode Island; and (4) TennCare, in Tennessee (Wooldridge and

Hoag, 1999). Our close observation of these four States in a larger evaluation offered an opportunity for assessing monitoring and for drawing valuable lessons for other States. In this review, we seek to answer the following questions:

- Through what structures and processes does the Federal Government monitor the States?
- Through what structures and processes do the States monitor the managed care plans?
- Is monitoring adequate?

We assess State monitoring in five domains: (1) financial, (2) encounter data, (3) quality assurance and quality improvement, (4) access and provider networks, and (5) grievance systems.

We define adequacy to mean that the monitoring agency sets performance standards, checks that the monitored entity meets the standards, provides regular feedback, and develops data and studies to review outcomes. Adequate monitoring also implies timely implementation of monitoring, allocation of sufficient resources to monitoring, consistently applied processes and standards, and improvements over time. Managed care offers a greater potential for improving quality and access to care than does FFS care because managed care monitoring goes beyond any that occurs under FFS.

We review the structure of Federal and State monitoring and analyze how States monitored finances, encounter data, quality assurance and quality improvement, access and provider networks, and grievance procedures between 1994 and 1998. Next, we discuss Federal monitoring

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efforts, and finish by discussing lessons learned from the State and Federal monitoring efforts.

## **DATA**

Findings are based on data describing the structures and processes the States and HCFA use in monitoring, collected from documents and interviews with key people in each State and the Federal Government. We interviewed State officials, staff of managed care plans, providers, legislators, and advocacy organizations during site visits in 1995, 1996, and 1998, as part of case studies conducted for a HCFA-funded evaluation. We also drew on ongoing discussions with HCFA staff.<sup>1</sup>

## **BACKGROUND**

The four demonstrations covered 1.7 million Medicaid enrollees as of July 1999. Key features of these demonstrations such as start date, eligibility groups included, types of participating plans and enrollment are shown in Table 1.

## **STRUCTURE OF FEDERAL AND STATE MONITORING**

When it approves a section 1115 demonstration, HCFA documents which Medicaid statutes are waived and issues "Special Terms and Conditions" (henceforth called "terms") that set the standards it expects the States to meet to secure Federal financial participation. The terms cover a broad range of areas but are not uniform across the States. Terms differed for various reasons, often because States requested different waivers or were implementing different types of programs.

<sup>1</sup>The same interview protocols, focusing on each of the monitoring areas, were used across States, and the same types of respondents were interviewed in each State. We also drew on monitoring reports prepared by the States and their contractors.

States are authorized to monitor managed care plans through State laws and contracts with the plans, which must conform with Federal law and regulations and demonstration terms (Rosenbaum et al., 1997). Several different departments share responsibility for plan oversight including those responsible for Medicaid, public health, and insurance (Horvath and Snow, 1996). Some departments monitor contractually-specified performance standards and some regulatory standards specified under law. Figure 1 summarizes how Federal and State laws and regulations, contracts with managed care plans, and self-regulation interact to promote access, quality, and financial stability.

As expected when implementing such a large new venture, it took the States time to develop mature oversight structures. Moreover, initial contract performance standards, reporting requirements, and sanctions varied widely in specificity and consistency with Federal terms. All four States modified their initial plan contracts to improve plan performance standards and to comply with Federal requirements.

## **STATE MONITORING PROCESSES**

The agencies operating the demonstrations play a key role in monitoring in all five domains we reviewed.<sup>2</sup> Other State agencies also have overlapping responsibilities for monitoring. For example, State insurance agencies monitor health plan finances for regulatory reasons unrelated to the demonstrations. States also use their external quality review organizations (EQROs) to monitor plans, as HCFA requires.<sup>3</sup> Our review indicates which agencies are responsible for monitoring each domain.

<sup>2</sup>In Rhode Island, many of the responsibilities of the demonstration agency are contracted out to Birch and Davis Health Management Corporation, whose staff essentially act as State staff.

Table 1

Key Features of the Four Demonstration Programs

State	Program Name and Implementation Date	Key Design Elements at Implementation	Number and Type of Managed Care Plans as of 1999 <sup>1</sup>	Demonstration Enrollment as of July 1999
Hawaii	QUEST—8/1/94	Eligibility expansion to uninsured up to 300 percent of the FPL. Mandatory managed care design using MCOs for AFDC, poverty-related, and expansion beneficiaries; MCOs cover medical, acute behavioral, and dental care.	6 Total; 5 Commercial 1 Medicaid Dominant Plan	118,112
Oklahoma	SoonerCare—4/1/96 <sup>2</sup>	No expansion initially. Mandatory managed care design for AFDC and poverty-related beneficiaries; MCOs in urban areas covering medical, dental, and behavioral; PCCM used in rural areas.	4 Total; 2 Commercial, 2 Medicaid Dominant Plans	201,737
Rhode Island	Rite Care—8/1/94	Eligibility expansion to pregnant women and children up to age 6 under 250 percent of FPL. Mandatory managed care design for AFDC, poverty-related and expansion beneficiaries; MCOs cover medical, acute behavioral, and dental care; extended family planning program for postpartum women.	4 Total; 3 Commercial, 1 Medicaid Dominant Plan	87,717
Tennessee	TennCare—1/1/94	Eligibility expansion to uninsured and uninsurable, with subsidies up to 400 percent of FPL. Mandatory managed care design for all Medicaid-eligibles (except QMBs and SLMBs); MCOs cover medical, acute behavioral, and dental care. <sup>3</sup>	9 Total; 5 Commercial, 4 Medicaid Dominant Plans	1,284,264

<sup>1</sup> Commercial plans serve mostly non-Medicaid members in that State, while Medicaid-dominant plans are those with only or mostly Medicaid members in that State.

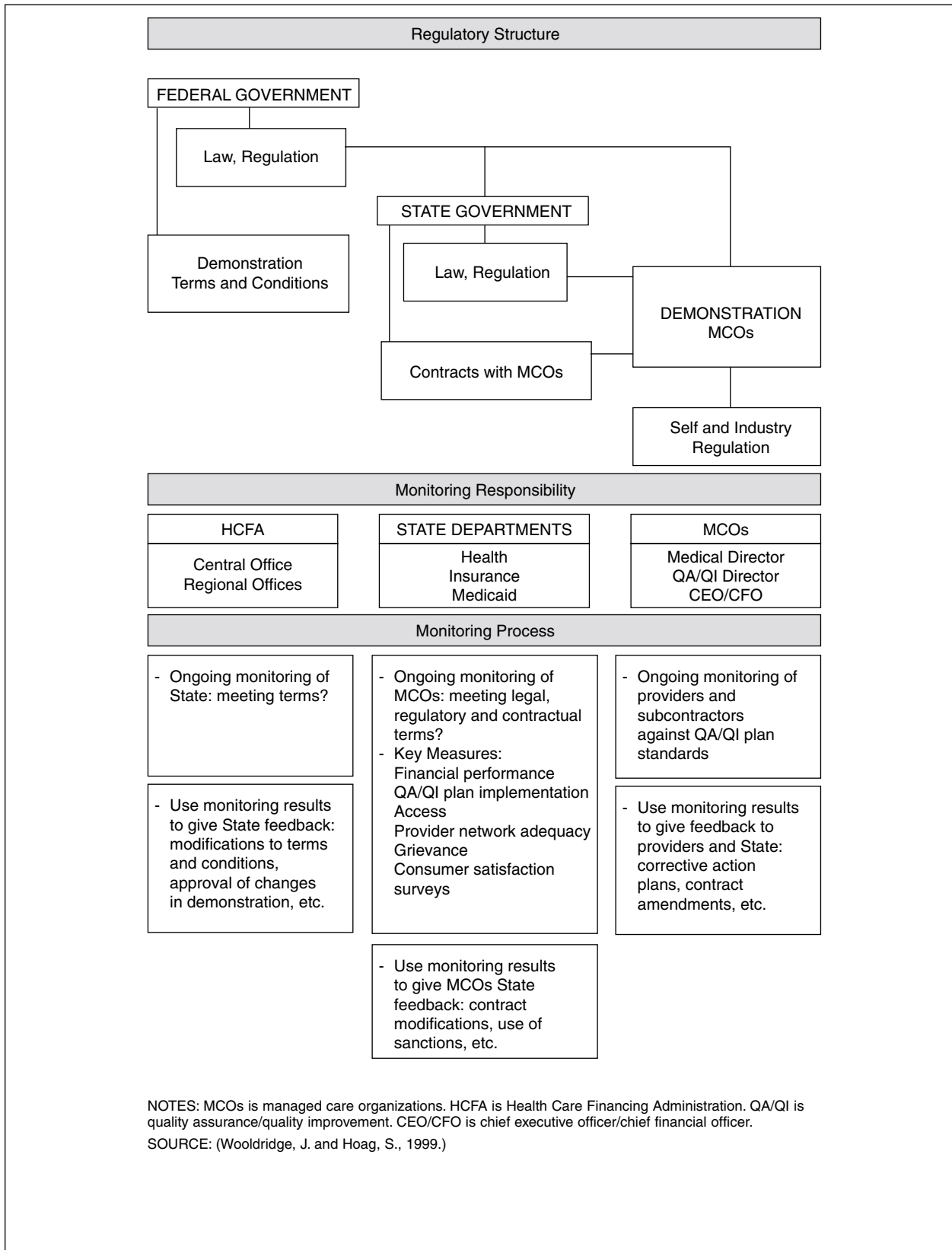
<sup>2</sup> Under a 1915(b) waiver, Oklahoma implemented HMOs in urban areas in July 1995.

<sup>3</sup> In the first 3 years of TennCare, MCOs could be health maintenance organizations or preferred provider organizations.

NOTES: FPL is Federal poverty level. MCO is managed care organization. AFDC is Aid to Families with Dependent Children. PCCM is primary care case management. QMB is qualified Medicare beneficiary. SLMB is specified low income Medicare beneficiary.

SOURCES: (Woodridge et al., 1996; Ku and Wall, 1997; Ku and Hoag, 1998; State of Hawaii 1997; Ku et al., 2000.)

**Figure 1**  
**Framework for Monitoring**



States use various approaches to monitor plan performance, including regular reviews of documents and data, onsite reviews of processes, and audits or special studies. They provide written feedback to plans and may require corrective action plans.

### **Monitoring Finances**

States set standards intended to ensure that plans have the financial strength to accept the risk inherent to capitation, and that they have provisions for continuity in case of insolvency. Financial monitoring is intended to ensure plan stability and adequate financial reserves through reviews of plans' compliance with the standards.

All the States set financial standards for plans in the licensure regulations. These States also enhance the regulatory standards by including terms in their plan contracts:

- Rhode Island includes financial performance standards.
- Hawaii, Oklahoma, and Rhode Island require performance bonds.
- Tennessee requires plans to submit quarterly and annual TennCare-only income statements.

Table 2 summarizes who monitors plan finances and their monitoring methods.

The States have taken actions ranging from establishing informal requirements to mandating the correction of deficient plan financial performance. Sometimes, the demonstration agencies have required the plans to increase deposits to address solvency or other financial concerns. However, these States have not used the ultimate sanction of withdrawing licensure.

<sup>3</sup> States must contract with an entity that is external to and independent of the State and the plans it contracts with to perform an annual review of the quality of services furnished by plans (Office of the Assistant Secretary for Planning and Evaluation, 1999).

Hawaii's procedures are the least formal of the four States. For example, as shown in Table 2, Hawaii does not conduct onsite plan reviews, does not audit plans, and does not provide plans with feedback. When demonstration agency staff are concerned about a plan's financial footing, the plan is required to submit financial reports monthly, rather than quarterly. (Two of the plans have been reporting monthly since QUEST began.) Oklahoma can, and has, required formal corrective actions (in 1997, one plan had to correct deficiencies through a formal corrective action plan). Rhode Island required all four plans to negotiate written corrective action plans after its 1996 reviews showed that none of its plans met all the financial benchmarks, and that two did not meet other financial management requirements. It reviewed the plans 6 months later to assess compliance. Tennessee has the most formal financial monitoring process among the four States. It is the only one that audits plans, and it has taken the most formal actions to correct financial performance problems. Due to problems of program underfunding, some plans in Tennessee have had severe financial problems, and one was taken over temporarily by the State. However, the issue of underfunding is distinct from the adequacy of financial monitoring processes, which is the subject of this section.

Although none of these States has had a plan close as a result of financial problems, some of the diverse approaches to monitoring are inadequate, and most States lie near the least rigorous end of a continuum of financial oversight methods. Hawaii's process, which relies only on offsite review, seems inadequate to ensure that plans can fulfill their financial obligations and, therefore, may not ensure financial stability. Oklahoma works co-operatively

**Table 2**  
**Financial Monitoring, by State**

Activity	Hawaii	Oklahoma	Rhode Island	Tennessee
Regulatory-Related Monitoring				
Which regulatory agency monitors plan finances?	Division of Insurance	Department of Health	Department of Business Regulation	Department of Commerce and Insurance and State Comptroller of the Treasury's Audit Division <sup>1</sup>
Offsite reviews of quarterly and annual financial statements by the regulatory agency?	Yes	Yes	Yes	Yes
Demonstration-Related Monitoring				
Who monitors finances for the demonstration?	Demonstration Agency <sup>1</sup>	Demonstration Agency <sup>1</sup>	Demonstration Agency <sup>1</sup>	Department of Commerce and Insurance and State Comptroller of the Treasury's Audit Division <sup>1</sup>
Additional standards required in contracts?	Yes; performance bond required	Yes; performance bond required	Yes; performance bond required; State sets benchmarks on profitability, liquidity, capital structure, and expense analysis based on total business; quarterly reviews	Yes; plans must submit quarterly and annual TennCare-only statements
Line of business monitored for demonstration?	Demonstration only	Demonstration and total business	Total business	Demonstration and total business
Offsite reviews for demonstration?	Yes; uses own formats	Yes; uses the NAIC format reports	Yes; uses the NAIC format reports	Yes; uses adapted NAIC format showing Medicaid and total business
Onsite reviews conducted?	No	Yes; every 6 months	Yes; at least annually since 1996	Yes; at least annually since 1995
Audits conducted?	No	No	No	Yes
Feedback to plans?	No	Ongoing informal feedback	Yes	Yes

<sup>1</sup> The demonstration agencies are: the Med-QUEST Division in Hawaii; the Oklahoma Health Care Authority in Oklahoma; the Center for Child and Family Health in Rhode Island; and the TennCare Bureau in Tennessee.

NOTE: NAIC is National Association of Insurance Commissioners.

SOURCE: (Wooldridge, J., and Hoag, S., 1999.)

with the plans and provides timely informal feedback, while holding them to State standards. Rhode Island has chosen to prop up its weakest and least compliant plan with additional State funds and support, rather than lose it. Tennessee, a strong enforcer, has continually strengthened the structure and process of its financial monitoring. Tennessee also appears willing to lose a plan that cannot meet its performance standards. It took the States time to develop

and fully implement these processes, and the adequacy of their financial monitoring has improved over time.

### Monitoring Encounter Data

Under managed care, States have to change their data role from processing claims data to acquiring, validating, and using encounter data for monitoring. HCFA's terms required that the States

**Table 3**  
**Encounter Data Monitoring**

Activity	Hawaii	Oklahoma	Rhode Island	Tennessee
Who monitors encounter data?	Demonstration Agency	Demonstration Agency and EQRO	Demonstration Agency	Demonstration Agency and EQRO
Encounter data plan prepared?	Yes	Yes	Yes	Yes
Received technical assistance from HCFA for encounter data system development?	Yes	Yes	No	No
When were regular review and feedback implemented?	1995 then stopped from 1996 to 1998	1996	1997	1994
Encounter data validated against medical records?	Planned	Partial validation done in 1998	Planned	Occasionally <sup>1</sup>
Does State use encounter data to report on quality?	No	No	No	Yes
Can encounter data be used for evaluation? <sup>2</sup>	No	No	Maybe <sup>3</sup>	Yes; 1996

<sup>1</sup> The State validates encounter data against medical records extracted in the course of its outcome studies.

<sup>2</sup> Hawaii and Oklahoma have not yet approved their own data. We have conducted face validity checks of TennCare encounters for 1995 and 1996 and plan to use the 1996 data.

<sup>3</sup> Rhode Island has stated that its encounter data are reasonably adequate, but we have not reviewed them to assess their suitability for evaluation purposes (as we have in Tennessee, the other State where data have become available).

NOTES: EQRO is External Quality Review Organization. HCFA is Health Care Financing Administration.

SOURCE: (Wooldridge, J., and Hoag, S., 1999.)

develop plans to implement and monitor encounter data collection and collect encounter data for use in monitoring and demonstration evaluations. The States included the same requirements in the plan contracts: plans had to collect and submit encounter data regularly. In some States, plans that did not do so were subject to financial penalties (such as payment withholds). Table 3 summarizes some of the steps the States took to monitor encounter data.

States focused initially on resolving problems the plans had in submitting encounter data. In the worst cases, States placed staff at the plans to help overcome problems or had the EQRO work closely with the plan. Only later did States implement regular encounter data review with feedback and corrective action plans. Moreover, the States scaled back and delayed ambitious initial plans for validating encounter data.

The approaches and timing of State actions to improve the quality of encounter data varied widely. Some delays were due to insufficient resources being applied to this activity, some to lack of knowledge about how to establish functioning encounter data systems (such as how to set up the system or what elements needed to be included). Tennessee began providing feedback to the plans early in the demonstration and applied sanctions when plans failed to meet contractual standards. It also sent technical assistance staff to help some plans overcome serious difficulties with provider payment related to encounter data processing problems. Rhode Island deferred review and feedback until plans began submitting data regularly.

The adequacy of State encounter data collection and monitoring can be measured by whether a State:

- Implemented its monitoring plans and collects and reviews data regularly.

- Validates its data.
- Uses the data to conduct outcome studies.
- Provides the data in a format that can be used in HCFA's evaluation.

Only Tennessee meets all four of these adequacy measures. It was the first State to develop a full data review process and is the only one that uses encounter data in its quality monitoring program and that publishes reports using the data. In an independent face validation of Tennessee's encounter data for 1995 and 1996, we determined that the 1996 data appear to be usable for some measures (in particular, for inpatient measures) and for some plans. By the end of 1998, Rhode Island had fulfilled the first two of the four steps and declared that its encounter data were reasonably accurate. Oklahoma regularly reviewed plan data, but had not determined that they had reached a sufficiently high standard for use in monitoring quality. Hawaii had only recently begun to review its encounter data regularly.

It is of considerable concern for monitoring quality and for evaluations of Medicaid managed care that, 5 years into their demonstrations (3 years, in the case of Oklahoma), Tennessee is the only State that had produced usable data early enough for us to assess their adequacy and analyze them.

### **Monitoring Quality of Care**

The primary goal of quality-of-care monitoring is ensuring that beneficiaries receive appropriate care and that quality of care is improving, given that plans' financial incentives may undercut quality and access. The Federal terms required each State to conduct external audits to monitor the plans' performance. All have contracted with an EQRO to conduct special studies; some have used the EQRO for addi-

tional activities (which are described in this and later sections). HCFA's terms require the States to develop internal and external audits and outcome studies to monitor plans' quality assurance and quality improvement activities (Health Care Financing Administration, 1993). The terms also require States to include in their plan contracts requirements for internal quality assurance programs, as established by Federal law (42 CFR 434).

All four States require participating plans to operate quality assurance programs and specify what these programs should include (primarily, written descriptions of the program's goals, scope, standards, and activities to be conducted). The States also incorporated in their plan contracts standards for the plans' quality assurance programs. Every State mandated that plans report some type of outcome, although the specific elements varied. Finally, Rhode Island also imposes an external quality standard, under which all State-licensed HMOs must be certified by the National Committee for Quality Assurance (NCQA) or must have applied for NCQA certification within 2 years of startup. Table 4 summarizes State monitoring processes and their timing.

States initially provided technical assistance to plans to establish adequate quality assurance programs. They then began to take the following steps: review whether quality assurance programs were being implemented; provide feedback and quality improvement recommendations; and require corrective action plans.

The States introduced clinical appropriateness monitoring after they had begun monitoring the plans' quality assurance programs. Over time, States have become more sophisticated about this type of monitoring. They now require the plans to conduct studies focused on various clinical areas and targeted populations, and to



**Table 4**  
**Quality Assurance Program Monitoring, by State**

Activity	Hawaii	Oklahoma	Rhode Island	Tennessee
Who monitors quality assurance programs?	Demonstration Agency	EQRO	Demonstration Agency	EQRO
When did onsite quality assurance program reviews begin?	First year	First year for urban program; second year for rural program	Third year	First year
Is written feedback provided to plans?	Yes	Yes	Yes	Yes
Are corrective action plans required?	Yes	Yes	Yes; negotiated	Yes
Are plans required to conduct population studies?	Yes <sup>1</sup>	Yes	Yes	Yes
Have State outcome studies been conducted? By State or EQRO?	Yes; EQRO	Yes; EQRO	Yes; EQRO and others	Yes; EQRO and others
When did the State outcome studies begin?	Third year	First year for urban program; second year for rural program	Second year	Second year

<sup>1</sup> Hawaii requires "focused" studies but does not mandate that they be population studies. For example, some plans submitted reports that documented the process of generating Medicaid HEDIS data.

NOTES: EQRO is External Quality Review Organization. HEDIS is Health Plan Employer Data and Information Set.

SOURCE: (Wooldridge, J., and Hoag, S., 1999.)

develop clinically appropriate practice guidelines. Moreover, the States themselves began conducting their own special studies.

All four States require plans to submit corrective action plans when their quality assurance programs are out of compliance with State standards. Oklahoma, Rhode Island, and Tennessee documented the comprehensiveness of both their quality assurance program reviews and their feedback to the plans. The feedback was thorough, focused, and had as its goal future quality improvement.

The States have conducted studies to assess outcomes for given populations across plans. Each State recognized that focused studies based on medical record reviews, encounter data, and other data sources are important for assessing clinically appropriate care provision, as these studies can identify important delivery or quality problems (for example, underservice or inappropriate service). (If medical record reviews uncovered problems, the

penalties could be quite severe. For example, Tennessee's contracts provide for suspension if medical records indicate quality problems [State of Tennessee, 1995].) For example, Hawaii's study of Early and Periodic Screening, Diagnosis, and Treatment services uncovered a need to improve lead risk/lead levels, dental screens/fluoride assessments, developmental/behavioral assessments, tuberculosis skin tests, and vision assessment (FMH, Inc., 1997). Oklahoma's EQRO studied birth outcomes and found that plans improved rates of prenatal care in the first trimester between 1995 and 1996, but that females still were not receiving the number of visits recommended by the American College of Obstetricians and Gynecologists (State of Oklahoma, 1997). Oklahoma's study counted only visits paid for by a SoonerCare plan; thus, the smaller-than-recommended number of visits may be a result of females receiving visits prior to their SoonerCare eligibility, as those visits were not counted in the study.

By late 1997, the States were actively monitoring quality assurance programs, requiring plans to conduct focused studies, conducting their own focused studies, providing feedback, and requiring actions to correct identified deficiencies. However, they were slow to initiate these activities. Delays were due to a focus on startup activities, lack of resources, staff turnover, and problems with encounter data. Initially, some contracts did not require plans to conduct their own studies. Rhode Island delayed onsite quality assurance program review until 1996. Hawaii and Rhode Island waited until 2 years into their demonstrations to select EQRO contractors to conduct focused studies, even though it was a Federal requirement to have an external auditor. Although Tennessee selected its EQRO in the first year, the EQRO initially provided technical assistance to help the plans develop adequate quality assurance programs. As a result of these delays, State-sponsored monitoring studies did not take place until at least 2, and sometimes 3, years into the demonstrations (except in Oklahoma). Moreover, only Tennessee has published monitoring studies based on encounter data. Because we believe that States should be publicly accountable for the quality of care delivered under the demonstrations, we consider that States should publish these studies, rather than use them only internally.

### **Monitoring Access and Provider Networks**

One concern that HCFA and the States have about implementing Medicaid managed care programs is how access to providers (and choice of providers) will be affected. Thus, States establish and monitor access performance and provider network standards. Here, we review State

monitoring standards for access (such as appointment waiting times and travel times) and primary care networks.

The Federal terms for Oklahoma and Tennessee require them to comply with standards for appointment waiting times and travel times set by HCFA. In addition, all the States require the plans to meet State-specified access standards for appointment waiting times and travel times. The plans, in turn, are to incorporate these and other access standards into their quality assurance programs and to monitor themselves against these standards.

Because of the importance of the provider network to adequate access, the Federal terms set provider network standards. The States, in turn, included provider network standards in their plan contracts. Rhode Island and Oklahoma incorporated the strictest standards, which specified provider-to-population ratios for both primary care and other practitioners. Rhode Island also specified mandatory mainstreaming.<sup>4</sup> Oklahoma specified that providers could not intentionally segregate Medicaid patients from other patients they serve. Network adequacy standards in Tennessee and Hawaii were less specific. Table 5 summarizes the methods that the States used to monitor access and primary care provider networks.

States were actively monitoring access by the second demonstration year. Hawaii set Health Plan Employer Data and Information Set (HEDIS) access performance standards for its plans and undertook its first onsite performance review in spring 1995.<sup>5</sup> By that fall (1 year after startup), it prepared a report on plan performance based on plan reports to the State.

<sup>4</sup> Mainstreaming is the requirement that providers in the plan's network see all patients.

<sup>5</sup> HEDIS is a set of standardized performance measures developed by NCQA (1998).

**Table 5**  
**Access and Primary Care Provider Network Monitoring, by State**

Activity	Hawaii	Oklahoma	Rhode Island	Tennessee
Who monitors access and provider networks?	Demonstration agency	Demonstration agency	Demonstration agency and separate State regulatory agency—Division of Health Services Regulation	Demonstration agency
What methods do they use to monitor access?	Reviews plan reports	Reviews satisfaction survey results. Will review plan reports in future	Reviews plan reports Special study	Reviews plan reports Reviews satisfaction survey results (at program level); uses ZIP-Code-based program to travel times
Is access monitored at plan or program level?	Plan level	Both	Both	Both
What actions have States taken?	None	None	Fines (by regulatory agency); contract modifications and corrective action plans (by demonstration agency)	None
What methods are used to monitor provider networks?	Reviews of regular reports; monthly checks of provider-to-population ratios	Uses GeoAccess™ software to assess plans' monthly network reports <sup>1</sup> . In PCCM program, GeoAccess™ used quarterly to assess network, and demonstration agency checks whether providers accept new patients.	Regular checks of provider-to-population ratios	Uses GeoAccess™ software to assess plans' monthly network reports
What are the primary care provider-to-population ratio standards?	None specified in the contracts	Urban program: 1:1,750 members; Rural (PCCM) program: 1:2,500 members <sup>2</sup> (ratio to be prorated according to the amount of time provider is available to that plan)	1:1,500 members; 1:1,000 for PCP teams and sites (medical residents)	1:2,500 members
Does demonstration agency require plans to include other patients in provider-to-population ratios?	No	Yes	No	No
Does demonstration agency check whether providers accept new patients?	Yes	No	Yes	Checked once, in special survey
Does demonstration agency conduct additional audits and/or surveys?	No	Checks at plan site visits	Checks at plan site visits	Conducted once, in special survey

<sup>1</sup> GeoAccess™ is a computer software program that can compare and assess the geographic adequacy of the provider network (for example, whether or not there is a provider located within 30 miles of an enrollee's home).

<sup>2</sup> In addition, in both urban and rural programs, up to 875 members for each nurse practitioner, physician assistant, or medical resident affiliated with the PCP is allowed; if the physician assistant or nurse practitioner has a separate PCP contract, these standards do not apply.

NOTES: PCCM is primary care case management. PCP is primary care provider.

SOURCE: (Wooldridge, J., and Hoag, S., 1999.)

These reports showed that the plans were monitoring their performance against both State and plan access standards, and that they had made changes to improve access to care and access to member services. Hawaii set a same-day requirement for seeing patients with emergency and urgent care needs and a 3-week requirement for non-urgent care. Plans reported setting and meeting the State emergency standards. Some plans reported a lower performance standard for urgent care—up to 48 hours, instead of within 24 hours, but reported that the majority of patients were seen within 24 hours. One plan set a 6-week standard for seeing non-urgent cases, compared with the State's 3-week standard, and reported that 25 percent of its patients were seen more than 1 month after they had tried to make an appointment. HCFA reported that communication between Hawaii and the plans appeared to be good, but that the State was not spending enough time reviewing plan compliance with the contract (Health Care Financing Administration, 1997). Hawaii is the only one of these four States that has not required a plan to take corrective action on its provider networks.

Oklahoma reported in its second annual report to HCFA that it monitors access in both the capitated and partially-capitated programs (State of Oklahoma, Oklahoma Health Care Authority, 1997). However, that report focused on how the State monitors plan networks, rather than on access to the networks. Oklahoma also monitors access through analysis of member incident and complaint reports (Pasternik-Ikard, 1999). Oklahoma's 1997 survey found that 65 percent of those surveyed in urban areas believed appointment wait times were too long, an increase from 23 percent during the previous year (State of Oklahoma, 1997). Because it was disturbed

by these survey results, the State planned to monitor plans' compliance against contract-specified timeframes in 1998.

Within 14 months of startup, Rhode Island had embarked on a study of access and network composition (Birch and Davis Health Management Corporation, 1996a). It identified such deficiencies as non-compliance of plan performance standards with State standards. As a result, it modified the plan contracts in 1996 and drew up a detailed plan for monitoring plan performance in all areas, including access (Birch and Davis Health Management Corporation, 1996b). In both 1996 and 1997, it again reviewed deficient plans and negotiated corrective action plans (covering a variety of areas, not just access) with all of them.

Rhode Island is the only State among these four to have two agencies monitoring access and provider networks. Rhode Island's regulatory agency, the Division of Health Services Regulation, cited a plan for access violations in 1996. The agency also received numerous complaints about access problems in another plan, including problems with the plan's physician capacity and provision of mental health care; lack of documentation about complaints, denials, and appeals; and inadequate infrastructure. The agency's investigation culminated in a consent decree with the plan, although representatives from the State regulatory agency indicated that the plan took 18 months to comply with identified deficiencies. The Division of Health Regulation believes that this delay compromised its standing with other plans in the State; its apparent failure to hold this plan to the State's standards may prevent the other plans from taking the Division seriously. This issue caused friction between the Division of Health Services Regulation and the Rite Care demonstration agency.

Tennessee appears to use the plans' routine reports as its only source for routine reviewing of wait time measures and does no independent verification. (Although TennCare uses its annual member satisfaction survey to review the adequacy of wait times to appointments and wait times in the office, the resulting data are at the program level, not the plan level.) Finally, Tennessee has applied financial sanctions to plans that have not conformed to its primary care provider network standards.

The States' standards for monitoring access and provider networks vary greatly, as do their monitoring methods. In some States, access monitoring does not include assessments of whether plans meet the patient travel and wait time standards (to appointments and in the office); for example, Oklahoma relies on its satisfaction survey results, rather than assessing the plans on these standards. Thus, although the Federal Government set standards for wait times and travel standards, it is unclear whether the demonstrations are in compliance.

Provider network standards are relatively weak in most of the States and thus, do not rule out access problems even when plans meet the standards. We share the concerns of the U.S. General Accounting Office about the States' approaches to monitoring network provider-to-population ratios (U.S. General Accounting Office, 1997). Providers usually see many out-of-plan patients, but Oklahoma is the only State to take this factor into account by including those patients in the provider-to-population ratio. Thus, except in Oklahoma, States' measured provider availability overstates actual availability.

Furthermore, only in Hawaii and Rhode Island do the provider-to-population ratios take into account whether providers accept new patients. Oklahoma and Tennessee do not monitor the proportion of network

providers that accept new patients. Tennessee recognized this problem and undertook two network studies to monitor providers' acceptance of new patients. However, it does not conduct this monitoring on an ongoing basis, as Hawaii and Rhode Island do.

Although numeric network standards are designed to protect access adequacy, they do not take into account quality changes that can result from providers leaving the network. There is considerable potential for care disruption when providers leave a plan. Some States have limited the ability of plans to drop providers to protect continuity of care.<sup>6</sup>

## Monitoring Grievances

Managed care plans operate under financial incentives that might cause them to limit, deny, or delay members' care. Therefore, the States require that the plans establish formal procedures members can use to complain, grieve, or appeal a decision about care or coverage (Raymond, 1995). The intent of these procedures, collectively referred to as the "grievance system," is to protect members against harm and to hold the plans accountable for their actions. Each of the four States has a different formal definition of the elements of the grievance process. A "complaint" usually refers to the lowest level of member dissatisfaction, often expressed through a telephone call to the plan (by either a member or his or her provider). A "grievance" is a formal written complaint that once sent, requires review within a certain period, with provisions for expedited reviews if the member's physician believes a decision is urgently needed (again, filed by a member or his or her provider). An "appeal" is a member's last chance to have another

<sup>6</sup> Tennessee recently modified its plan contracts to limit the plans' ability to drop network providers.

**Table 6**  
**Grievance System Monitoring, by State**

Monitoring Process	Hawaii	Oklahoma	Rhode Island	Tennessee
Who monitors plans?	Demonstration agency	Demonstration agency	Demonstration agency	Agency outside demonstration agency (since 1997)
State reviews plan grievance logs and quarterly reports?	Yes	Yes	Yes	Yes
State monitors plans' grievance systems, including onsite review?	Planned	Yes	Yes (Since 1996)	Yes
State sanctions for missing grievance-response deadlines?	No	No	No	Yes

SOURCE: (Wooldridge, J., and Hoag, S., 1999.)

hearing of the issue by the State, if the grievance has not been decided in the member's favor. Although not formally a part of the grievance process, part of the managed care plans' education efforts must include informing members about their rights to file grievances.

HCFA requires the States to ensure that the plans institute functioning and timely grievance systems, and to send HCFA the plan grievance reports. (Hawaii is the exception, because State reporting was not specified in the initial terms.) The process standard was explicitly specified only in Oklahoma's terms. The States set comparable standards for plans. Grievance standards typically limit the time plans have to review and resolve a complaint or grievance; they also specify procedures for resolution. All States require plans to report grievances periodically that they, in turn, report to HCFA.

Tennessee's grievance procedures underwent a major change in 1996, when a Federal district court ruled that the TennCare grievance and appeals process was inadequate. The Federal ruling required the State to adopt a new grievance procedure that gave members greater access and stronger rights, and that strengthened monitoring. As a result, Tennessee is the only State that includes

sanctions for non-compliance in its plan contracts, and the only State in which the demonstration agency does not monitor plans on grievances. It requires plans that do not respond to grievances within the specified time to cover the denied service. Table 6 summarizes grievance-monitoring responsibilities and methods, by State.

Two States have never found their plans' grievance procedures to be deficient and two have taken action in response to deficiencies. Hawaii has neither taken action against a plan based on its reviews of plan grievance reports nor provided feedback to the plans in this area. Oklahoma has never requested that a plan take corrective actions because of grievances (MacCauley, 1998). In contrast, Rhode Island, in its 1996 plan reviews, found all four plans to be deficient in some aspect of the grievance procedures. Deficiencies identified ranged from serious (one plan not implementing the grievance procedures as specified in the State contract) to minor (one plan requiring some minor wording changes in its grievance policies to reflect the State's exact 1996 contract language). Rhode Island required the plans to correct these deficiencies. Tennessee uses its annual EQRO reviews to give plans feedback on their grievance systems. The State "automatically" takes action against

non-compliant plans by requiring them to cover any denied service if they fail to respond to the grievance within the prescribed time.

States did not monitor grievance systems initially, not only because available resources were being devoted to operations when the demonstrations began, but also because they did not recognize the importance of effective grievance systems in offering protection to a vulnerable population that lacked experience with managed care. Over time, they have made it easier for enrollees to complain. Furthermore, most States make the final decision about the validity of a complaint. Except in Hawaii, States are now actively monitoring grievance structures and processes, and giving the plans feedback. Thus, Hawaii's grievance monitoring process is inadequate. HCFA found that some QUEST plans were not reporting complaints or grievances that had been resolved to the member's satisfaction (Health Care Financing Administration, 1997). It also found that the State had not investigated or verified one plan's report of no complaints. HCFA reported that Hawaii does not know whether plans have informed their members about their rights to submit grievances. Rhode Island and Tennessee have established systems that give beneficiaries greater access to the grievance system than HCFA requires.<sup>7</sup> Oklahoma meets the minimum HCFA standard.

Onsite reviews of the plans' grievance systems are necessary to ensure that all the required elements of the grievance system are in place, as is feedback about those processes. Tennessee and Oklahoma have conducted these reviews from the beginning of their demonstrations, while Rhode Island conducted its first onsite reviews of plans' implementation of grievance procedures in 1996.

<sup>7</sup>In the case of Tennessee, the legal action was prompted by the legal aid society which has had an important role in shaping the TennCare program.

## FEDERAL MONITORING OF STATES

HCFA must monitor the demonstrations to verify that the States comply with the terms, and that quality of care and access to care do not diminish under managed care. Although HCFA had considerable experience (primarily at the regional offices) monitoring section 1915(b) Medicaid managed care programs, the scale and number of the new section 1115 demonstrations was unprecedented, and HCFA accordingly had to make changes in its approaches to monitoring. The responsibility for monitoring section 1915(b) demonstrations lay primarily with the regional office staff, following a central office protocol. The monitoring elements included document review, site visits, and ongoing communication with State staff, but there was wide variation in regional office monitoring practices. Major changes for the section 1115 demonstrations were the development of joint central and regional office monitoring teams headed by project officers in the central office and a systematizing of monitoring approaches.

The project officer, who is based in HCFA's central office in Baltimore, leads this team and is a State's chief point of contact at HCFA. However, the appropriate HCFA regional office usually has the primary obligation for overseeing a State's compliance with the terms and conditions, although there is considerable variation across States in how the roles are distributed across central and regional offices. HCFA monitoring begins with an onsite readiness review before implementation. After implementation, HCFA conducts onsite reviews, offsite document reviews, and conference calls with State staff.

HCFA can modify a State's demonstration terms, as it has done in two of the four States reviewed here. There is little other formal feedback to the States, unless

unusual situations or problems arise. HCFA had the opportunity to annually modify the terms of these demonstrations, or could do this at the waiver renewal time (after the demonstrations were running for 5 years). According to HCFA representatives, HCFA is contemplating dropping the annual renewal process during which the terms could be modified in favor of a more collaborative approach. Furthermore, once demonstrations approved prior to August 1997 are extended beyond the initial 5 years, the Balanced Budget Act of 1997 prohibits HCFA from modifying the terms (*Federal Register*, 1998).

Rather than formal feedback, HCFA provides feedback through more informal channels, such as teleconferences and personal telephone calls. The emphasis on informal communications allows HCFA to convey any concerns to the States quickly. However, some monitoring team members suggested that HCFA could improve its feedback to States by documenting findings more often and sharing them with the States.

HCFA's monitoring processes and oversight procedures have matured, but resource and political constraints and staff turnover have hampered the monitoring process. Early Federal monitoring was focused on operational problems, but as the demonstrations have matured, HCFA has focused on monitoring compliance with the terms and has been particularly attentive to monitoring quality issues. Still, some areas of the Federal monitoring process need improvement. For example, despite substantial informal feedback, there is a dearth of formal feedback on findings; when there is formal feedback, it is often late, making it difficult for the States to take HCFA seriously.

## DISCUSSION

These four States implemented their demonstrations at a period when Medicaid managed care and Medicaid managed care monitoring processes were in their infancy. It took them time to implement the basic demonstrations (especially getting enrollment working smoothly) and, initially, these implementation issues took the time and attention that might have been devoted to monitoring in a more mature Medicaid managed care world. Thus, monitoring in these demonstrations was slow to start and all these demonstrations were operating for months or years before thorough monitoring of managed care plans became routine. Over time, States were able to develop, implement, and strengthen monitoring structures, thus coming mostly into compliance with their Federal terms and conditions for operating the demonstrations. Most of the limitations in monitoring we found were procedural rather than structural. In some States, monitoring has been hampered by a lack of resources. Federal monitoring has similarly suffered from a lack of resources, as well as political pressure. After 4 years of operations, we concluded that monitoring was not adequate to ensure access and quality even though monitoring it is critically important for protecting vulnerable Medicaid populations from harm.

### **Full-Scale Monitoring After a Learning Period**

Monitoring was slow to begin. The States had little experience in monitoring managed care, and although HCFA had monitored numerous section 1915(b) demonstrations, it had not refined its



approach to address the monitoring needs of the comprehensive section 1115 demonstrations. The States initially focused on overcoming their own and the managed care plans' operational problems, which limited the resources available for monitoring and delayed its implementation. Some managed care plans, especially new ones, had no experience monitoring quality assurance and quality improvement. States sometimes provided technical assistance to overcome plan problems and delayed implementing regular monitoring review and feedback until plans had made progress. Finally, the lack at startup of Medicaid-specific tools, such as a Medicaid HEDIS or a Consumer Assessments of Health Plans Survey Medicaid satisfaction survey, slowed implementation of some aspects of monitoring.

### **More Resources to Monitor Managed Care**

Adequate financial resources and well-trained staff are necessary to support monitoring. However, building a staff with appropriate skills and knowledge of managed care has been a challenge for the States. Some reported that they had to work with and re-train staff from their traditional Medicaid programs, who usually lacked monitoring experience.

States devoted inadequate resources to monitor some of the five domains we reviewed. For example, Hawaii lagged in devoting sufficient resources to monitoring plan finances and plan quality assurance processes. A report by HCFA (1997) criticized the State for insufficient quality improvement resources, a situation that worsened in 1998. Except in Tennessee, which has collected and used encounter data for outcome studies, the resources allocated to collecting and reviewing encounter data

were sparse until late in the 5-year demonstration period. Thus, early HCFA review of resources available for implementation does not ensure that States have adequate staff to fulfill all their monitoring commitments.

Although all four States increased their Medicaid administrative expenditures since the demonstrations began, Rhode Island was the only one to do so substantially (Table 7). Both Oklahoma and Rhode Island increased their administrative expenditures modestly as a percentage of total Medicaid expenditures. Oklahoma's expenditures are the highest among the four States. However, Oklahoma's high level of spending was not solely a consequence of managed care, which was not implemented until 1995, as spending historically is high in that State. Rhode Island authorized the biggest absolute (and relative) increase, nearly doubling its administrative budget the year the demonstration was implemented. In Rhode Island, two events contributed to the large administrative increases between 1993 and 1994 and may be distorting the 1993-1996 comparison: (1) Rhode Island established its Management-Medicaid Information System in this period, leading to a significant increase in administrative expenditures between 1993 and 1994; and (2) Rhode Island hired Birch and Davis as a consultant in 1994, which also contributed to the increase seen in this period. Using 1994 as the baseline period, administrative expenditures in Rhode Island decreased by 0.8 percent between 1994 and 1996. Hawaii's and Tennessee's expenses fell as a percentage of total Medicaid expenditures.

We have not assessed the States' administrative budgets sufficiently closely to determine whether current levels are adequate for conducting all the types of monitoring required, as well as other administrative duties (such as operations).

Table 7

**Administrative Expenditures, in Millions of Dollars and as a Percentage of Total Medicaid Expenditures: 1993-1996**

State	1993		1994		1995		1996		Percentage Change 1993-1996
	Expenditures	Percent	Expenditures	Percent	Expenditures	Percent	Expenditures	Percent	
Hawaii	\$18.70	4.30	\$17.00	3.40	\$38.80	5.00	\$24.60	3.80	31.7
Oklahoma	92.00	7.40	92.70	7.80	95.40	7.80	104.70	8.30	13.8
Rhode Island	19.80	2.20	37.20	4.40	36.60	3.50	36.90	4.70	85.9
Tennessee	90.90	3.10	81.40	2.80	129.80	3.70	92.70	2.90	2

NOTES: Hawaii, Rhode Island, and Tennessee implemented Section 1115 demonstrations in 1994. Oklahoma implemented its section 1115 demonstration in 1996.

SOURCE: Urban Institute (1998) analysis of HCFA-64 data. Presented in 1996 dollars.

## **States are Using Performance Standards**

Performance standards play different roles in quality improvement approaches to monitoring than in quality assurance approaches. In the former, the standards are goals toward which the plans must move (and which may be changed after the standards have been met); in the latter, attention focuses on meeting the standards.

Every State's contracts specified performance standards for all five domains reviewed, although the standards varied across States. All four States adopted a similar approach to setting performance standards, choosing to combine some external standards (such as HEDIS or Quality Assurance Reform Initiative) with some newly developed ones.

## **State Monitoring—Improvements Must be Maintained**

Over time, the States have implemented and improved monitoring of managed care plans. States have introduced stronger requirements in their plan contracts, hired staff to monitor the plans, and implemented more thorough reviews of plan performance. However, some States are more advanced than others. Furthermore, the States face the ongoing challenge of encouraging the plans to continue to provide quality services, in part by ensuring that plans do not backtrack after meeting a given standard. Staff turnover, both at the plan and the State levels, also caused some periodic discontinuity in monitoring, although as State and plan monitoring procedures improved and became more institutionalized over time, they were easier to transfer to new staff.

## **Feedback and Corrective Actions Vary**

Monitoring is pointless unless it includes feedback and requires improvements in deficient performance. The extent of feedback and corrective action varied. All four States give plans feedback on encounter data, and quality assurance programs. All the States except Hawaii give feedback and require corrective action in the domains of finances, grievances, and access and provider networks. Thus, Hawaii seems to be lacking in an important dimension of monitoring.

## **States Have Different Plan Monitoring Styles**

Some States adopted a partnership approach to monitoring, based on a quality improvement philosophy in which plans were not always held to performance standards, sanctions were rare, but improvement was required and monitored. However, not holding the plans to standards causes equity problems. In contrast, some States adopted a regulatory approach to monitoring, based on a quality assurance philosophy in which sanctions were applied when plans did not meet the standards. A drawback to this approach is that some performance standards may be unreasonable, even if they are useful as goals. Thus, applying sanctions may be more punitive than quality-enhancing.

In reality, the States apply a mix of both the regulatory and partnership approaches to monitoring although some States are closer to one model than the other. Rhode Island embraces the partnership model in which continuous feedback, assistance, and negotiation of issues are the chief monitoring methods and sanctions are rare. Tennessee comes closest to the regulatory

model, in which enforcement is the norm, and penalties are imposed when plans do not meet performance standards. Tennessee does provide assistance and feedback to the plans but negotiates with them less often than does Rhode Island. Oklahoma incorporates elements of both approaches: it negotiates with its plans but also enforces performance standards. Hawaii rarely enforces contract terms and rarely provides feedback and assistance to the plans.

Under the partnership approach, frequent communication limits problems and improves relationships with the plans. Rhode Island, in particular, has a commitment, which includes resources, to use monitoring to improve plan performance. However, this approach can have drawbacks, because States may have to commit substantial resources to supporting weaker plans, and interplan equity may be undermined. For example, Rhode Island has jeopardized its credibility with some plans by working closely with just one plan, Neighborhood Health Plan. Rhode Island gave the plan financial assistance and a risk-sharing deal that no other plan has received; nevertheless, the State's actions clearly communicate that it does not intend that any participating plans should fail.

Benefits of the regulatory approach to monitoring are that plans have strong incentives to comply with State standards, and the States have some assurances that plans will not fail or perform poorly if they follow the rules. Penalties—usually financial ones—are imposed if the standards are not met. Moreover, in a State with many plans (like Tennessee, which originally had more than twice as many plans as did the other States), a regulatory approach may have been the better choice; the partnership approach may be more feasible when there are fewer plans. The disadvantages of the regulatory approach result

from the more distant relationship between the State and plans. There is less communication between the plans and the State and the plans may lack incentives to exceed the minimum standards. Moreover, regulation and sanctions do not always produce improvements. As the number of plans in Tennessee dropped from 12 to 9 between 1994 and 1997, the State adopted more elements of the partnership approach.

### **HCFA's Monitoring**

HCFA faces two contradictory forces in monitoring section 1115 demonstrations. Like all Federal agencies, it must be publicly accountable to taxpayers, yet it is under pressure to be more flexible in its relationships with the States. We find that this situation makes it very difficult for the agency to fulfill its duties. HCFA has legal responsibilities to monitor the demonstrations, and a partnership approach was envisioned. The reality is that HCFA is under political and resource pressures to take a laissez-faire approach, in which the States operate the demonstrations as they see fit, rather than take a true partnership approach. HCFA intervenes when it believes that a major problem is occurring, but a partnership implies a two-way dialogue. Thus, the States must share responsibility for ensuring successful partnering.

HCFA's oversight and monitoring of State managed care demonstrations has evolved. HCFA learned from these demonstrations, and the forthcoming final Balanced Budget Act regulations on Medicaid managed care will provide more specificity for Medicaid managed care monitoring by HCFA (Sachs, 1999). We have seen changes in the terms over time, with greater clarification about what HCFA wants. In the future, HCFA could improve its monitoring and promote partnering with

the States by providing more formal feedback to the States (either by issuing revised terms in a timely way or working collaboratively with States to solve problems of compliance with terms), and spending more time in face-to-face meetings with the States to work through issues. However, as of late 1998, more resources are needed to monitor and to provide constructive feedback to the States.

## CONCLUSIONS

Based on the four States we reviewed, monitoring by HCFA and the States is not yet at the point of ensuring access and quality. Initial State monitoring of plans was clearly inadequate; in response, HCFA and the States have improved the monitoring structure (regulatory and contractual standards), monitoring processes, and resources devoted to monitoring in the five domains examined. Some States have stressed the enforcement of performance standards (a quality assurance approach), others have focused on quality improvement toward standards. To some extent, all four States (and HCFA) implemented elements of both approaches. However, an approach in which frequent communication and feedback is wedded to assurance of standards seems most likely to ensure access and quality. Regardless of the approach taken, and while recognizing that resource and political constraints will be limiting factors, we have shown that HCFA and the States can take many steps to improve their monitoring.

These findings raise two questions about implementing Medicaid managed care monitoring:

- Should these government entities have been more diligent about establishing the right monitoring structures and processes from the inception of the demonstrations?

- How sophisticated should we expect Federal and State monitoring to be, especially relative to the commercial sector?

HCFA and State monitoring of Medicaid managed care in the section 1115 demonstrations took a while to be fully implemented because of both avoidable and unavoidable problems. Avoidable problems are ones that could have been overcome with additional resources (although as a practical matter, resources were necessarily allocated initially to implementing critical demonstration activities, such as enrolling beneficiaries). Lack of experience in these States led to some probably unavoidable delays in full implementation of monitoring, although we would argue that some of the delays were too long. When the demonstrations began, few tools were available for monitoring Medicaid managed care—a signal that monitoring was in its infancy. In the commercial sector, which provides the only standard of comparison, monitoring of managed care plans by private purchasers has been limited to a few large purchasers of care.

In conclusion, we recommend that as States expand their capitated Medicaid managed care programs, they build on the experiences of the States that have pioneered Medicaid managed care monitoring, by identifying what methods are successful in a given social, economic, and political climate, and what level of resources will be required. All States face the challenge of convincing legislators that they need more staff to monitor managed care than they did to run the traditional Medicaid insurance program. We hope that this article, by presenting details of different approaches and methods used in “pioneer” States, will help States to develop effective monitoring in their Medicaid managed care programs.

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