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Evaluating Medicaid Managed Care through a Public-Private Partnership

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Abstract

This paper describes how a public-private partnership paved the way for an evaluation of Medicaid managed care with previously inaccessible data. Also included are (1) a brief description of Wisconsin’s Medicaid expansion program, (2) research questions and reflections on implications generated by key informant interviews, (3) some answers to these questions and their policy implications gleaned from a Medicaid enrollee survey, and (4) an assessment of the benefits and policy implications of this partnership. The partnership developed in Wisconsin is relevant for other states with large rural populations who will be facing both welfare reform and managed care.

Evaluating Medicaid Managed Care through a Public-Private Partnership

OVERVIEW

Concerns over the ability of states to deliver cost-efficient health care to Medicaid populations became accentuated in the mid-1980s as health care costs strained states' budgets. By the mid-1980s some states began experimenting with managed care for Medicaid children and their families as a way to control costs and to improve continuity of care; Wisconsin was one of those states. Though enrollment in Medicaid managed care in the early years was fairly slow, it has grown in the last several years, from 9.5 percent of the national Medicaid population in 1991 to almost 48 percent in 1997.[1]

In 1996 Wisconsin began an expansion of managed care beyond its original five, mostly urban demonstration counties to almost all areas of the state, including some of its most rural counties. In 1996, 147,218, or 31.8 percent,[2] of Wisconsin Medicaid recipients were enrolled in managed care. With the expansion, that number increased to 205,523, or 48.6 percent, by 1997.[3] This transition may have been relatively easier to implement in Wisconsin, where the penetration rate for non-Medicaid managed care in rural areas, 17 percent, is almost at the national average of 19 percent.[4] This type of major social policy shift needs evaluation from a variety of perspectives—federal, state, and private. And this evaluation needs to be timely and relevant.

A groundbreaking evaluation of the early demonstration programs encouraged states to pursue this option further.[5] Since then, many evaluations of the Medicaid managed care programs throughout the states have focused on outcomes, access to care, and satisfaction.[6] However, since this transition to rural areas of states is relatively new, we are only beginning to have evaluations of states' experiences with managed care for their rural Medicaid populations.[7,8,9] Further, most of these studies report data in the aggregate because individual claims data have been "lost" in the managed care systems (MCOs). None of these studies link consumer perception about health, health care needs, or satisfaction data with actual utilization. Evaluation of Wisconsin's Medicaid managed care demonstration programs, which began in the mid-1980s, has been minimal, is outdated,[10,11] only reports on data in the aggregate, or is not totally relevant to the current expansion, particularly for the rural counties.[12,13] Further evaluation of this expansion has not yet been planned.

This paper describes how a public-private partnership paved the way for an evaluation of Medicaid managed care using a series of analyses with previously inaccessible individual-level encounter data, linking these to data from a consumer survey. Also included are (1) a brief description of Wisconsin's Medicaid expansion program that led to the need for new research, (2) research questions and reflections on implications generated by key informant interviews, (3) some answers to these questions and their policy implications gleaned from a Medicaid enrollee survey conducted as part of this public-private partnership, and (4) an assessment of the benefits and the policy implications of this partnership. We believe it is worth paying attention to how independent research might continue in an era when most individual patient-based data are lost in MCOs. It is also important to acknowledge the utility of a partnership that is allowing an individual managed care organization to rethink its institutional policies—and perhaps the state as a whole to reevaluate its legislative priorities—on serving the Medicaid population. The fact that the partnership was developed in Wisconsin, a state that is in the forefront of welfare reform and of the transition of its rural Medicaid population into managed care, makes it particularly relevant for other states beginning their own transitions.

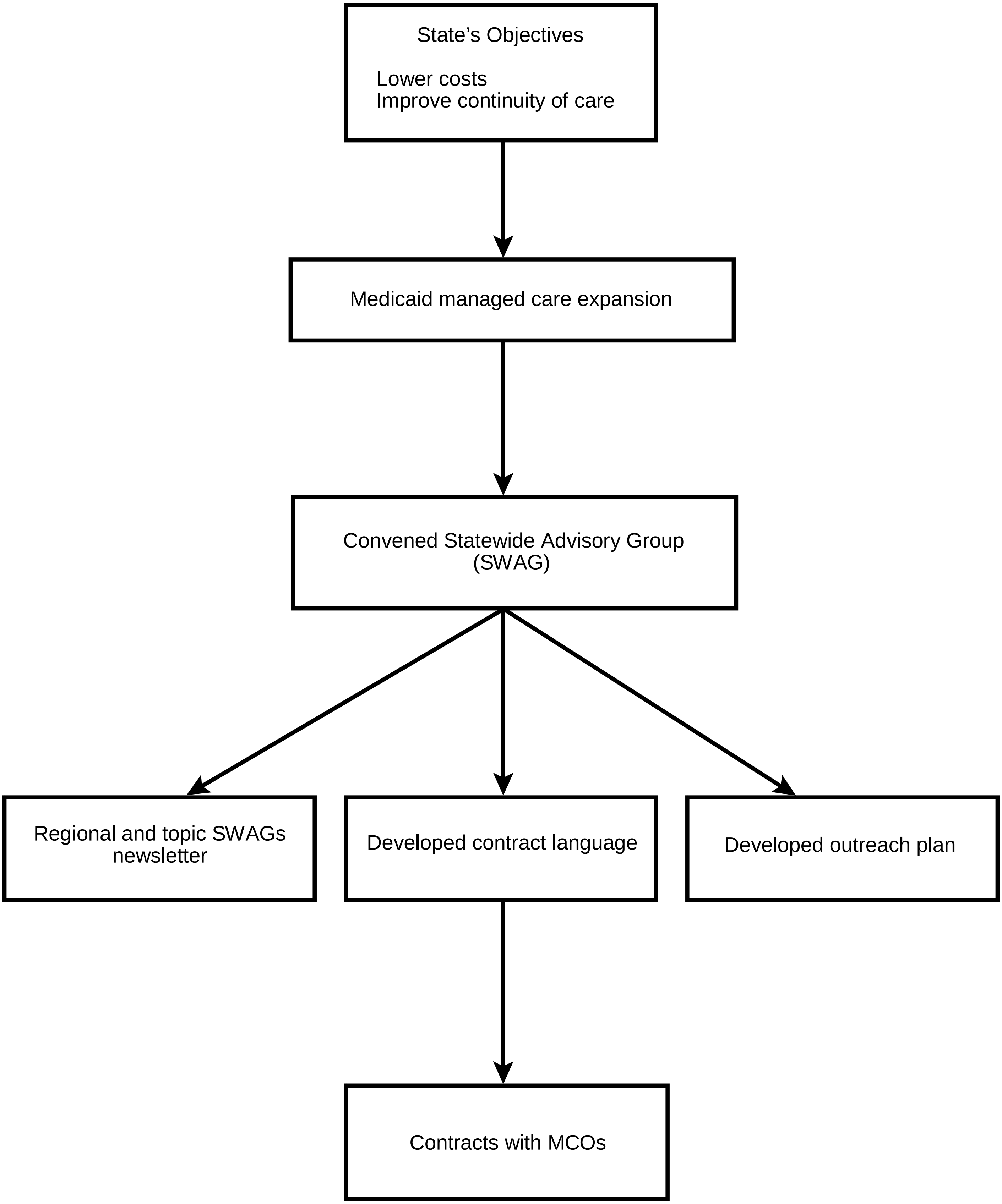
Wisconsin's Medicaid Expansion Program

The federal government has been supporting states in their attempts to try out new market arrangements through waivers of federal requirements.[14] The 1915(b) waiver allowed Wisconsin to develop a program that requires mandatory enrollment into an HMO (hereafter referred to as MCO to acknowledge the broad range of organizational configurations possible) for those service areas in which (1) there are two or more MCOs with sufficient slots for the MCO-eligible population (current AFDC eligibles) or (2) there is one MCO and a Primary Provider Program whose combined slots are sufficient for the MCO-eligible population. If a recipient fails to choose an MCO during a required enrollment period, the Department of Health and Family Services (DHFS) will make the assignment; all assignments have a lock-in period of 6 months. Although there are a number of possible exemptions from this assignment requirement (including those who may have a family member enrolled in Medicaid through SSI), most enrollees were, and new eligibles are, assigned. The plan expanded mandatory enrollment in managed care for the (then) AFDC Medicaid population to some or all parts of all but four counties in Wisconsin. The state contracted with an average of three MCOs per county, though the range is two to eight, and 12 counties have six or more. In a state with such a large rural population, this expansion was a significant commitment to using a different delivery system for at-risk families and children.

The development of this Medicaid managed care expansion took place through a carefully conceived process (see Figure 1). The state began with its objectives, clearly the most important of which was to control costs of the program through expanding the number of enrollees in managed care. One of the aspects making the state's environment ripe for a successful transition to managed care was the existence of a Statewide Advisory Group (SWAG), consisting of a broad range of industry and consumer representatives. Throughout the design, implementation, and refinement of the expansion, the state has sought advice from the SWAG. The SWAG gave rise to regional and subject-related "baby" SWAGs. Through these SWAGs and a bimonthly newsletter, *Forward*, the state seeks continual input and keeps interested parties up to date with contractual changes and new demonstration programs.

The 1996–97 contract between the selected MCOs and the state[15] reflected this broad representation and was indicative of a comprehensive and serious attempt to assure quality through standardization of process and administrative guidelines. The contract requires a variety of quality control features for the MCOs such as quality improvement programs and ongoing monitoring and evaluation. Though not required, the contract includes a strong recommendation for the MCO "to actively pursue accreditation by the National Committee for Quality Improvement or the Joint

FIGURE 1
Development of Wisconsin's Medicaid Managed Care Expansion Program



Commission on Accreditation of Healthcare Organizations."[16] There is also an external quality reviewer under contract with the DHFS.

The managed care model in Wisconsin, as for 62 percent of 403 plans providing Medicaid managed care nationwide,[17] is mostly a full-risk plan whereby a health plan is paid a fixed monthly fee per enrollee and is at full financial risk for the delivery of a comprehensive range of services (minimal exceptions). Priority areas have been established that indicate a strong focus on issues particularly relevant for the high-risk Medicaid population. These include "(1) prenatal services; (2) identification of adequate treatment for high-risk pregnancies, including those involving substance abuse; (3) immunizations; (4) pediatric lead screening; (5) evaluating the need for specialty services; (6) availability of comprehensive, ongoing nutrition education, counseling, and assessments; (7) preventive dental care; (8) diabetic care; (9) children with special health care needs; (10) outpatient management of asthma; (11) the provision of family planning services; and (12) early postpartum discharge of mothers and infants."[18] Also required are such features as anticipatory guidance for use of services.

Also indicative of the state's commitment to the success of this expansion was the careful development of an outreach plan. Wisconsin's outreach plan is reported as being the furthest along in restructuring its educational and enrollment strategies, according to a recent General Accounting Office (GAO) report.[19] The plan targets not only professionals who may come in contact with potential eligibles, but also eligibles themselves through newsletters, colorful brochures, and other educational avenues. The state also contracted with an outreach firm to sign up each eligible recipient and family with a managed care organization and to help in the selection of a primary care provider (if the MCO allows individual choice rather than assignment). This whole transition process began at the end of August 1996.

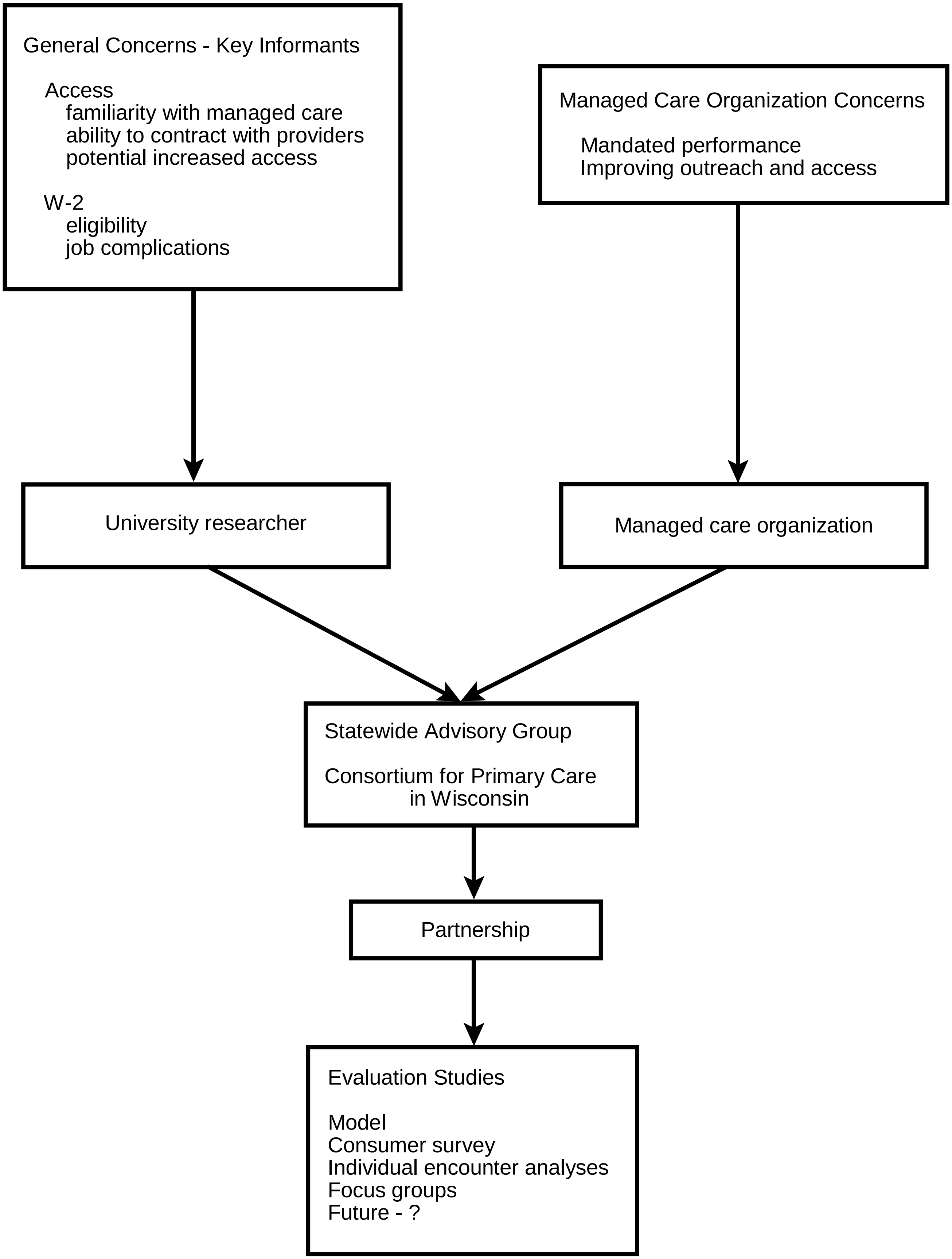
Figure 2 depicts the partnership that was developed for an ongoing comprehensive evaluation of managed care for this Medicaid population. The idea for a partnership began as a reaction by an academic researcher to a series of questions that were surfacing as the expansion was put into the field. As a first step in determining the most appropriate questions for an evaluation, this researcher conducted interviews with several key informants from important public and private agencies in the state. The overriding concern they reported was the possible impact of the expansion on health care access for the Medicaid population, particularly for those in rural areas. In its most general terms, how would the Medicaid population in rural areas fare when even most of the general population in rural areas was unfamiliar with the concept of managed care? Further, would the contracted managed care organizations be able to secure providers within a reasonable driving distance? The state mandated a maximum limit of 20 miles to a primary care provider but no mile limit for other types of care.

The final point related to general access was whether the MCOs would be able to provide mental and dental services. Providers of mental and dental services are known to be scarce in rural areas. Difficulties are compounded by the presence of mental and dental health care providers who are unwilling to accept Medicaid reimbursement. As it turned out, most MCOs did not include dental services as part of their contracts with the state. The ones that did were from the Milwaukee area, the most urbanized part of the state. Medicaid enrollees from the rest of the state still use the former fee-for-service system to access dentists. Despite the concern about access to dental and mental health services, all of the informants were excited about the potential increased access to primary care that MCOs could provide if they were successful in contracting with physicians, nurse practitioners, and physician assistants willing to treat Medicaid enrollees.

A second related set of issues concerned the interaction between this transition to managed care and the almost simultaneous implementation of Wisconsin Works (W-2), Wisconsin’s welfare reform

FIGURE 2

Development of a Partnership for Comprehensive Evaluation of Medicaid Managed Care



program. With continued eligibility a critical aspect of health care access for this population, the concern raised was the impact of welfare reform on perceived and assigned eligibility for Medicaid. Federal reports show a drop from 463,142 to 422,870 Wisconsin Medicaid eligibles between 1996[20] and 1997,[21] a reduction of almost 41,000 individuals, or 9 percent. Recent data indicate a loss of almost 54,000 children from Wisconsin's Medicaid rolls since 1994.[22]

Theoretically, we should have seen only minor changes in the number of Medicaid eligibles. For one, eligibility criteria remained the same as they were in July 1996, regardless of work status. Second, one would expect the state's exemplary efforts at outreach, detailed above, to pay off more strongly. And third, anecdotal evidence suggests that some MCOs in the demonstration counties were being particularly attentive to advising enrollees, especially new moms, to keep their recertification appointments.

However, two complications arose. One was the state's decision to separate the eligibility determination process of these two programs–W-2 and Medicaid; the process is detailed in another GAO report.[23] Even in the presence of an exemplary Medicaid outreach program, this decision likely contributes to the loss of eligibles. A second complication of W-2, one that has both pluses and minuses, has to do with working moms in general. It is anticipated that some moms will be in jobs paying salaries high enough to disqualify the family from Medicaid. As these women become part of the working poor, they will lose Medicaid eligibility. If families are unable to obtain any health insurance, as is the case with other working poor, most will consider this a negative outcome. Regular exposure to an environment outside of the home, however, might have a positive influence on families' attitudes and knowledge about health care, at the same time that it adds a whole new level of complication to these families' lives—the need to juggle work and family responsibilities.

A third line of issues was raised about how to protect the consumer rights of Medicaid enrollees. If one believes the media hype, choice appears to be the paramount consumer right related to health care. One might speculate on whether Medicaid "consumers" under the traditional fee-for-service system had such rights. Perhaps enrollees were able to "vote with their feet" if they were unsatisfied with care, yet the lack of willing Medicaid providers would lessen that prospect. Enrollees in Medicaid managed care in Wisconsin do have some choice. Mandatory enrollment with an MCO is only required if the enrollee has a choice between at least two competing plans. Though enrollees are locked into the plan for 6 months, this is a better deal than most employer-based choice programs allow. Choice between physicians in the panel is usually possible, though perhaps more limited in rural areas where providers are generally less available.

What about other rights, for example to a particular type of care? In this case the Medicaid contract clearly outlines what is covered, and in many cases this is more comprehensive than many private plans offer. Still, one does wonder, in an era when legislative remedies to ensure patients' rights are being proposed, if Medicaid consumers would be similarly protected. For example, what types of complaints, and filed by whom, would be sufficient for the state to reassess its MCO contracts?

All of the above were raised as issues that might warrant further attention in a comprehensive evaluation of the Medicaid managed care expansion plan.

How Are We Going to Know the Answers?

In attempting to determine how to find the answers to some of these concerns, the first response may be to revisit how we know what we already know. In the past, the Medicaid population has been monitored quite closely by independent (usually academic) researchers, by states, and by the federal government. These evaluations have often used individual patient claims data and have yielded much worthwhile information about the utilization patterns and health care needs of this at-risk population. However, as states make the transition to managed care, the type of outcome evaluation is usually dependent on aggregated data.

Wisconsin's annual reports track the performance of each contracted MCO using aggregated data.[24] These reports include comparative rates between the MCOs and the fee-for-service system in the state's 12 aforementioned priority areas. Most of this is information about access to preventive services and preventable hospitalizations. Since fee-for-service is now an option in only a few select ZIP codes in the state, we expect future reports to be mostly a comparison between the MCOs. The state is also doing routine medical chart reviews for quality control purposes.[25]

Why a Partnership?

Several problems point to the need for some other type of evaluation beyond what the state conducts. First, aggregate data that the state makes available in table form are not suitable for sophisticated techniques such as multivariate analysis or for tracking of health outcomes based on individual consumer/patient health care needs. Do families with more members have different problems with accessing care? What about those with family members who are in ill health? Second, the state has yet to present a consumer perspective on accessing care, using care, and satisfaction with care, even though consumer satisfaction surveys are required by the state. Third, although apparently planned by the state, a full evaluation of managed care and its impact on the health and health care access of the Medicaid population has not been implemented. And finally, even if such an evaluation were implemented, all major social policy changes need independent evaluations.

Clearly the state has different purposes for its planned evaluations, paramount among which will be monitoring the costs and administration of the managed care contracts. Others might suggest that to enhance utilization of the system and improve health care outcomes for this at-risk population, we need to understand how consumer perceptions about care might be related to the actual use of that care. Such an analysis is possible only with linked data. To gain the consumer perspective, we need to interview those consumers. To track health care outcomes for families and their members, we need access to individual-level encounter data. To link them, we need to access both.

The MCOs could do this type of analysis on their own, and it is likely that most do. However, they are usually checking utilization for capitation rate adequacy and utilization review concerns. In addition, they do not necessarily share what they find. So the MCOs can easily identify this target population and maintain encounter data on their Medicaid enrollees. States certainly can identify this population, both as the source of eligibility determination and payment. Independent researchers, however, are faced with confidentiality rules that do not allow for identification of enrollees. The answer would appear to be developing some state-sanctioned relationship with the MCOs to obtain access to data needed for evaluation.

The lead researcher had a number of opportunities to meet with the various MCOs serving the Medicaid population in the state. One link was at the regularly scheduled SWAG meetings, which representatives from all the MCOs regularly attend. A second link was through a statewide organization called the Consortium for Primary Care in Wisconsin (CPCW), a multiorganizational group comprising those with broad interests in primary care. The CPCW had convened a number of educational conferences. One in particular, called the Workforce Forum, brought together MCOs and educational institutions for purposes of determining the state’s preparedness for meeting the health care of all of its various populations through a trained health care workforce. These two arenas, plus numerous other informal networks, made it easy to meet with the MCOs and to determine their needs and interests in monitoring this population. Information gained through these opportunities clearly showed how concerned the state’s MCOs were about appropriately caring for this new type of enrollee. This was especially true for those MCOs moving into rural areas where most had only minimal, if any, experience with privately insured populations. The MCOs were aware that needs, particularly for outreach, were going to be different, and they were looking for new ideas. The MCOs were also aware that additional information about the target population might be needed to meet state-mandated performance goals.

An arrangement was worked out between one of the state’s MCOs and this researcher. This particular MCO was selected for a variety of reasons. One, it serves a multicounty region of Wisconsin that includes both rural and urban counties. Second, it had among the lower rates of preventive care utilization for this population. And third, it had an eager staff who were looking for answers, particularly toward improving usage of the Medicaid EPSDT screen (preventive health care for children). This researcher entered into negotiations with the MCO through a well-positioned contact. Due to the confidentiality of the Medicaid data, and the contract between the state and the MCO, state approval for this public-private partnership was sought and subsequently granted. The contractual arrangement stated that the researcher would conduct the state's required consumer satisfaction survey for the MCO. Access to individual-level encounter data were allowed as well because of the plan for more sophisticated analyses matching this to the satisfaction data.

RESEARCH PROJECTS AND OBJECTIVES

The first phase of the research was the adaptation of an evaluation model, one that would allow for attention to all of the broad categories of concerns raised by the key informants. The model is based on the PRECEDE model, developed by Green and colleagues,[26] and is described in detail elsewhere.[27] Its basic tenets allow for the identification of the predisposing (demographic and attitudes), enabling (family and MCO support), and reinforcing (health care system experiences) factors likely to have a bearing on utilization of health care. The evaluation is of the assignment to a managed care organization, the intervening factor. The model calls for process, impact, and outcome evaluation and helps determine what kinds of data might be needed to ask what kinds of questions. It is this latter aspect of the model that directed attention to the need for both consumer-related information and individual-level encounter data, and an attempt to link the two.

To date two projects have been designed in response to some of the key informants' concerns and the dictates of the evaluation model. Further study intends to address the full range of key informants' concerns and other issues raised by the evaluation model. The first project, described below, is a consumer survey to determine (1) Medicaid enrollees' attitudes toward health and perceptions of access to and reported use of health care, (2) Medicaid enrollees' evaluation of managed care, and (3) whether there are differences between enrollees from urban and rural counties in access, use, or satisfaction. The second project, still in progress, is an evaluation of individual-level encounter data. This project's objectives are (1) to determine the documented utilization rates, including rates for preventive hospitalizations (e.g., asthma) of Medicaid enrollees, (2) to search for patterns/differences in utilization between enrollees from urban and rural counties, and (3) to use data matched to the family survey to determine the accuracy of Medicaid enrollee utilization self-reports and to understand the health care needs and utilization patterns of Medicaid families.

The Consumer Survey

A brief description of the survey and some results as they relate to the concerns raised by the key informants are presented here; the study methods and results are described in full elsewhere.[28] A telephone survey of 313 randomly selected Medicaid families[29] was conducted in fall 1997. Respondents were enrollees from one of the state's MCOs serving urban and rural counties in Wisconsin, and as such, results are generalizable only to this unique population. Although this population may not differ from those enrolled in other MCOs on basic demographics, and some respondents had had experience with other MCOs, their evaluations of the care they received are specific to this MCO.

One of the key informants' concerns had been about how much rural residents would understand about managed care. The data suggest that the transition to managed care has gone smoothly for most, and even more so for the enrollees from the rural counties. Those in the rural areas report knowing more about managed care than those in the urban counties (19.8 percent of rural residents knew a lot and 35.3 percent knew a little, compared to 8.5 percent of urban residents who knew a lot and 40.2 percent who knew a little about managed care; $X^2 = 8.33$, $p \leq .05$). This difference might indicate the success of outreach efforts to explain managed care to these communities new to the concept. Further, the types of things we might expect to give rural residents more problems did not. Residents of rural areas report less trouble finding transportation (11.9 percent report problem compared to 25.6 percent of urban residents; $X^2 = 10.83$, $p \leq .01$). The findings do raise concerns for how these barriers impact on health care needs for urban Medicaid families.

At the same time, in a multivariate analysis, those living in a rural county were statistically more likely to report negative comments about their families' use of health care (odds ratio = .42, $p \leq .05$). Included in the open-ended verbiage of these negative responses were concerns about distance traveled to specialists, suggesting either a problem with local providers not signing on or the MCO choosing to let enrollees travel farther for specialty care. As reported by these families, access to mental health (behavioral health) providers does appear to be less than desirable. The particular MCO in this study does not offer dental coverage through its managed care contract, so the answer to the question about dental providers cannot come from this population. A more direct answer with information about the location of available specialists will come from a separate analysis.

Of particular interest are two findings perhaps related to the simultaneous implementation of welfare reform and the managed care expansion. The first is the finding that 8 percent of those contacted reported that they were no longer eligible for Medicaid. An unknown percentage of these 25 families might truly be eligible but confused about this because of the separation of the W-2 and Medicaid eligibility determination sites. Earlier data from 1993 suggest that 40 percent of this (AFDC) Medicaid population goes on and off Medicaid in a given year.[30] An alternative explanation, alluded to above, suggests that working family members might find it harder to meet Medicaid eligibility-determination appointments.

Related to this last point, and of further concern, are the large numbers of families reporting difficulty with meeting the health care needs of family members, particularly preventive health care for their children, because of job scheduling; almost 40 percent (n = 122) report such difficulties. This might be due to the increasing number of caregivers who work outside the home, particularly those in this population who are now off welfare and adjusting to juggling work and family responsibilities.

Current attitudes toward preventive health care for children reported by these families are not ideal for optimal care. Only a little more than a third of respondents felt that it was very important for a healthy child to visit a physician (35.8 percent, n = 112); 24 (7.7 percent) believed it was not important at all. Others have encountered this attitude toward preventive health care.[31] Whether attitudinal changes toward the importance of health care will result from more women in the workforce being exposed to others with enlightened attitudes is not yet known. A follow-up survey with these families will help to assess their changing attitudes about health care, particularly toward preventive health care for children. These are findings from families who are still enrolled in Medicaid. It is possible that those not enrolled are even more complacent about preventive care. This complacency could contribute to their decision not to enroll apparently healthy children in Medicaid when the eligibility process, work schedule, and negative attitudes present barriers.

Advantages of a Public-Private Partnership

The most important outcome of this partnership is that it allowed for access to information about a Medicaid population that was not previously available for analysis. In particular, it made possible access to individual-level encounter data and consumer survey data, and the matching of the two. The direct application of the data analysis has three benefits for the MCO and the population it serves. First, this MCO now has a much broader general perspective of its Medicaid-enrolled population than it had had previously. Second, staff are currently implementing institutional policy changes in reaction to a long list of positive and negative consumer comments. For example, this MCO is considering transportation concerns among its urban enrollees and expanding hours in selected clinics. This produces a positive result for both the public and the private sectors—the public because it will receive a better product more appropriately suited to its needs, and the private because it is likely to improve its consumer report card ratings. And third, the MCO is now ready to acknowledge that it can learn from this population of enrollees directly and can have more confidence in independent research; this sets the stage for future collaborative efforts.

This partnership also allows for broader benefits for understanding the health care needs and health care use of this population, as well as the development of appropriate policies. Accessing individual-level data allows for analysis of issues related to health and health care for populations often lost in the aggregate. Part of the concern here is for the rural Medicaid population; smaller units are often excluded from analyses of aggregated data. More important, individual-level data will allow for understanding health care needs, use, and satisfaction within the context of family units.

Another positive outcome is the addition of a consumer perspective that can be compared to the state's annual report findings. In an era when consumer report cards help private-pay consumers make choices, this creates the potential for governmentally insured parties to have access to evaluations from others similarly insured.

This partnership also opens the door for future collaboration and work with this and perhaps other at-risk, and even not-at-risk, populations. Currently planned are focus groups with Medicaid families to help determine further their attitudes and beliefs about the need for health care and their suggestions about improving the care they receive. Because the general private-pay population is no longer tracked by ambulatory care utilization surveys, and because data, when available, are aggregated, this type of partnership would also be useful for those trying to understand the health care utilization of privately insured populations. And finally, the acceptance of this research by the state paves the way for the state to embark upon other such evaluation partnerships with unbiased, independent researchers.

Policy Implications

The research resulting from this partnership exemplifies the good that come of independent researchers working with the private sector. It showcases a workable way to obtain data that can then be used for institutional and legislative policy changes. Understanding and responding to specific consumer concerns is as relevant for the Medicaid population as for private-pay consumers, and perhaps more so when one considers the state interest in the product. The state could begin to require more substantive consumer surveys and also require timely responses by the MCOs to concerns raised by consumers. However, since many consumer concerns probably reflect problems with barriers to care that are system-wide, state initiatives might be the best response. For example, concerns about scheduling and availability are likely to be present for families in other MCOs. Meeting these needs in a variety of ways could be required under the contractual arrangement. Conflicts between job and health care needs might be resolved if the state would create opportunities for closer working relationships between employers and providers. Together they might be able to help newly working family members negotiate job and health care needs of family members. This has implications for how the health care system can help these families participate appropriately in their own care and in their use of the health care system, managed care or not.

The partnership described in this paper has enabled the beginnings of an ongoing series of analyses of individual-level encounter data and consumer perceptions and concerns. The partnership was able to happen partly because of the friendly environment the state had created. Through the SWAG, the state has encouraged a good working relationship between provider groups, advocacy groups, and state representatives. Whether researchers in other states can develop partnerships for access to individual-level data might depend on the presence of such factors. Nevertheless, it is important that other researchers try to gain access to data for this population. As researchers we need to describe more fully what has happened to access for the Medicaid population as they make the transition out of welfare and into new work arrangements, and into managed care. Because states appear unwilling or unable to track individual-level data, it is up to the research community to step forward. We should claim responsibility for making sure that multivariate analysis of individual-level data remains a viable way to understand the health care use and needs of all populations. Part of this commitment may involve convincing the states and the federal government (1) to ensure that data for analysis be made available either through partnerships or other means and (2) to set up funding mechanisms for this to happen.

Endnotes

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[13] K. B. Pipers and P. Bartels, "Medicaid primary care: HMOs or fee-for-service?" *Public Welfare* (Spring 1995): 18–22.

[14] The 1115 waiver allows states to test new methods of administering Medicaid and other Social Security Act programs. Wisconsin’s 1115 waiver was for the five county managed-care demonstration programs. Twelve other states and the District of Columbia have been granted 1115 waivers by the Health Care Financing Administration. The 1915(b) freedom-of-choice waiver of the Social Security Act allows states to require Medicaid beneficiaries to enroll in managed care or to implement managed care in only part of the state or for certain categories of waivers. As of September 1995, 42 states had 1915(b) waivers (D. Rowland and K. Hanson, “Medicaid: Moving to managed care,” *Health Affairs* (1996): 150–152).

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[17] D. Rowland and K. Hanson, “Medicaid: Moving to managed care,” *Health Affairs* (1996): 150–152.

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