
Innovations in Section 1115 Demonstrations

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This article discusses how States have taken advantage of the flexibility afforded under Section 1115 research and demonstration authority. It describes how States have used Section 1115 authority to develop innovations in outreach and enrollment, eligibility requirements, access, benefits, quality assurance, payment, safety net providers, and special needs populations. It concludes by discussing the future challenges that all the players in Medicaid demonstration projects are facing.

INTRODUCTION

There has been tremendous growth in Medicaid managed care over the last decade. Fourteen percent of Medicaid beneficiaries were enrolled in managed care in 1993. More than 50 percent of Medicaid beneficiaries were enrolled in plans by 1998. (Health Care Financing Administration, 1999) As of June 30, 1999, approximately 17.7 million Medicaid beneficiaries (out of a total of 31.9 million Medicaid beneficiaries) were enrolled in managed care plans on a mandatory or voluntary basis (Health Care Financing Administration, 1999). The managed care plan types being utilized include health insuring organizations, prepaid health plans, primary care case management (PCCM) systems, comprehensive managed care organizations (MCOs) and comprehensive Medicaid-only organizations. Prior to the 1990s, only

a few States were delivering Medicaid benefits through a managed care model. Today, at the start of the new millennium, most States have implemented some type of managed care model to improve access to care for its existing Medicaid population to better manage health care costs. States that expanded Medicaid eligibility to new populations through their 1115 demonstrations are also enrolling these populations into managed care.

This article will focus on States with section 1115 or research and demonstration authority (described later). Many of these States have taken advantage of the flexibility afforded under section 1115 demonstrations to develop innovations in outreach and enrollment, eligibility requirements, access, benefits, quality assurance, payment, safety net providers, and special needs populations. Also, there is a discussion of future challenges for section 1115 demonstrations as changes in the health care market, managed care industry and Medicaid population converge to create a vastly different health care environment.

Waiver Authorities

States may utilize two different types of waivers to increase their flexibility in providing high-quality, efficient health care services through the Medicaid program. Both section 1915 program waivers and section 1115 research and demonstration waivers provide States with the ability to be exempt from certain Medicaid requirements in the Social Security Act (subsequently referred to as the Act).

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Section 1915 Program Waivers

Section 1915(b) of the Act permits certain provisions of section 1902 to be waived—often referred to as Freedom of Choice waivers. These waivers are granted for a 2-year period and can be continued indefinitely through the renewal process. States most frequently request waivers of the following provisions of section 1902 for these reasons:

- Freedom of Choice 1902(a) (23)—allows restriction of a beneficiary’s freedom of provider choice and requires enrollment in a managed care system.
- Statewideness 1902(a) (1)—permits variation in the health care delivery system in different areas of the State and allows managed care to be implemented in some counties and not in others.
- Comparability of Services 1902(a) (10)—allows different benefits, eligibility methods or standards to be provided to one group of beneficiaries and not another and thereby allows States to mandate managed care for some eligibility groups and not for others.

Section 1115 Research and Demonstration Authority

Section 1115, known as research and demonstration authority, has been used by States to enact a broad variety of initiatives. Section 1115 provides greater flexibility than section 1915(b) waivers and is intended to allow States to demonstrate new methods of delivering health care services. Section 1115 demonstrations may waive all of the provisions of the Act that 1915(b) waiver authority provides (e.g., freedom of choice, statewideness, and comparability of services). In addition, section 1115 authority is used to implement a variety of other Medicaid reforms. For example, it is used to expand Medicaid eligibility or pro-

vide additional services, to permit premiums and copayments for expansion populations and relief from the requirement to reimburse federally qualified health centers (FQHCs) at the payment levels identified in the Balanced Budget Act of 1997. This demonstration authority is granted for a 5-year period and can be continued for up to 3 years thereafter through the renewal process. Although the Balanced Budget Act allows States to implement mandatory Medicaid managed care without waivers through the 1932(a) State plan amendment process, the ongoing 1115 waivers continue to play an important role in demonstrating various options for Medicaid reform.

The waiver process also allows States to waive a range of provisions in Medicaid law in order to demonstrate the successes or failures of various activities. Many States have utilized 1115 demonstrations to expand Medicaid eligibility, contain Medicaid expenditures, and experiment with managed care delivery systems. HCFA has worked extensively with States to develop mutually agreeable terms for these demonstrations, providing technical assistance to States through the waiver development, approval, and monitoring process.

The breadth and scope of section 1115 authority has resulted in a wide range of projects. HCFA has awarded several contracts to independent evaluators to observe the impact of the large-scale changes in Medicaid programs around the country as they have impacted Medicaid beneficiaries, providers, and the larger health care environment. The evaluators have analyzed various features of the demonstrations, including customer satisfaction, service utilization, and systems modifications. The information gained from these evaluations has been useful and continues to provide HCFA with future direction on the opportunities and challenges of 1115

demonstrations. In addition to formal evaluations, HCFA monitors the demonstrations from both the central office and through regional office staff located at 10 sites across the country.

Innovations in 1115 Demonstrations

One of the key features in section 1115 demonstrations is that they are innovative projects. The demonstrations give States an opportunity to test new and creative ideas that could positively impact the Medicaid program. What follows is a selective list of noteworthy examples of innovative approaches developed by 1115 States.

Outreach and Enrollment

States have utilized section 1115 demonstrations to increase Medicaid enrollment by expanding eligibility for State-sponsored health insurance. Additionally, States have been encouraging eligible individuals to apply for Medicaid benefits.

Massachusetts has conducted extensive outreach activities to diverse populations that may be eligible for their 1115 demonstration. Promotional materials have been widely distributed at various locations from food pantries to summer camps in addition to flyers distributed at every licensed day care center, and public and parochial school throughout the State. More than 50 small grants were awarded to community-based organizations throughout Massachusetts to conduct outreach and provide assistance in completing the MassHealth application. These activities, in addition to a variety of other outreach efforts, resulted in more than 231,000 new enrollments in MassHealth (Massachusetts, 2000).

Another State that has harnessed community based organizations to increase enrollment is Delaware. The State has uti-

lized grass roots organizations, including homeless advocates and a group known as Parents of Children with Special Needs, to provide outreach and enrollment to special populations. As Delaware prepared to implement its demonstration, State staff personally contacted all of the Medicaid beneficiaries with disabilities who were scheduled to be enrolled in the program. In many instances, the Medicaid Director actually went to the home of the individual with a disability to explain the program. Delaware also conducts targeted outreach to the prison population. The State determined that persons leaving prison would be likely to be eligible for the 1115 demonstration and chose to conduct education and outreach to the incarcerated population about the Medicaid benefits that would be available to them upon release.

As a result of their increased need for early intervention, high-risk pregnant women are often targeted for outreach and preventive activities in Medicaid managed care plans. For example, the "Baby Arizona" component of Arizona's 1115 demonstration encourages pregnant women to enroll in Medicaid in order to receive appropriate prenatal care. The project conducts outreach through partnerships with community-based organizations, churches, and neighborhood associations, as well as through informational materials at health fairs, community events, concerts, and shopping malls. Baby Arizona also trains physicians and their staffs in the Medicaid eligibility process. Preliminary research suggests that females who enrolled in Medicaid through the Baby Arizona Project were more likely to receive prenatal care in the first trimester of pregnancy and less likely to have infants who require neonatal intensive care services (Arizona, 1999).

Expanded Eligibility

Medicaid eligibility criteria vary from State to State, but the maximum and minimum eligibility criteria are mandated by Federal statute. Section 1115 demonstration authority is the only way that States can expand eligibility for the Medicaid program beyond what is authorized under law. About one-half of approved section 1115 demonstrations have expanded eligibility in various ways. Rhode Island, Tennessee, and Hawaii have cumulatively expanded eligibility to more than 500,000 individuals through 1115 demonstrations (Health Care Financing Administration, 2000).

For example, Rhode Island has gradually expanded eligibility for its 1115 demonstration. Initially, the State expanded coverage to pregnant women and children under age 6 with incomes under 250 percent of the Federal poverty level (FPL). Two years after implementation, Rhode Island expanded eligibility to children under age 8 whose existing income levels fell below 250 percent of the FPL. The following year, the State increased the age requirement to children under 18 with income below 250 percent of the FPL.

Tennessee dramatically expanded Medicaid eligibility when TennCare was implemented, providing health insurance for both the uninsured (persons who are not eligible, either directly or as a dependent, for an employer-sponsored or government-sponsored health plan) and the uninsurable (persons with an existing or prior existing health conditions that causes them to be uninsurable). Uninsurable persons are eligible for TennCare once they provide correspondence from an insurance company indicating that they have been denied health insurance based on their medical condition. Uninsurable persons

are eligible without regard to their income, however they are required to contribute to the costs of their care, with the amount of the cost sharing based on income. Tennessee expanded coverage to all of the uninsured State residents and they provide a subsidy for residents with incomes below 400 percent of the FPL (they have since had to scale back on this expansion due to budgetary concerns). These persons can apply for TennCare in a Medicaid office or at the local health department.

Hawaii's 1115 demonstration initially included a significant simplification in the eligibility process. The assessment of eligibility was modified to rely solely on gross income below 300 percent of the FPL. As the demonstration was scaled back as the result of budget constraints and overwhelming enrollment, income disregards for children and pregnant women were reinstated and the income limit for eligibility was reduced to 100 percent of the FPL for adults, 133 percent for children and 185 percent for pregnant women. Hawaii's Medicaid expansion program, QuestNet, has maintained eligibility at 300 percent of the FPL with significant cost sharing for adults and reduced cost sharing for children.

Some States have added family planning waivers to their pre-existing section 1115 demonstrations. These waivers extend Medicaid eligibility to post-partum women so that unintended pregnancies can be prevented and intended pregnancies can receive adequate prenatal care. Rhode Island, Arizona, New York, and Missouri all offer family planning services to females who were previously eligible for Medicaid due to pregnancy and who have lost Medicaid eligibility 60 days after they gave birth. Eligibility for family planning services usually covers 2 years of care.

Removal of Asset Tests; Eligibility Simplification

While some States have implemented their Medicaid expansions through raising the income level for eligibility, other States have chosen to focus on other areas of the eligibility process to encourage Medicaid enrollment. Two alternative methods for eligibility expansions are simplifying the eligibility process and removing the asset tests traditionally required for Medicaid enrollment.

As part of Massachusetts' 1115 demonstration, Medicaid eligibility was simplified in order to increase timely enrollment in MassHealth. The State restructured its eligibility system to utilize one income level for the family rather than distinct income levels based on the age of children in the family and to require less documentation for enrollment (e.g., a birth certificate is no longer required). Additionally, the asset test was eliminated and the Medicaid application itself was simplified and translated into multiple languages.

Arkansas' 1115 demonstration, ARKids First, is a health insurance program for children who are uninsured yet do not qualify for Medicaid due to their family's income. The benefit package for these children is not as comprehensive as traditional Medicaid and does require copayments and premiums. Children from families with income up to 200 percent of the FPL are eligible for ARKids First. A critical objective of this demonstration is to reduce barriers to insurance for children. Towards this objective, Arkansas requires only mail-in applications and recertifications for children and their families to achieve and sustain eligibility for this program. In addition to the increased income limit of 200 percent of the FPL, ARKids First does not require an asset test.

Access

In rural areas, access to physicians can be challenging due to limited provider participation in Medicaid and significant geographic distances between participating providers. Medicaid providers under fee-for-service (FFS) have historically had difficulty identifying specialty providers who serve Medicaid beneficiaries in rural areas. States have tried to mediate this dilemma by providing directories of FFS Medicaid providers for rural and, in some cases, urban areas; however, these directories can become increasingly irrelevant if they are not regularly updated. This type of problem can be perpetuated when a State Medicaid agency transitions from FFS to Medicaid managed care.

Oklahoma addressed this problem with Rural Partnerships. MCOs in the urban areas of Oklahoma City, Tulsa, and Lawton serve as referral centers for the surrounding rural communities, offering the MCOs the potential to affiliate with the rural providers and enhance access to specialists for providers practicing in rural areas. To qualify as a Rural Partner, the MCO must agree to expand into the rural area and enroll at least 500 rural beneficiaries or a number equal to 10 percent of the MCO's urban enrollment (whichever is greater).

In Alabama's 1115 demonstration, the Bay Access Health Plan, HCFA's terms and conditions required the sole participating Medicaid managed care plan to contract with all historic Medicaid providers in the geographic area served by the demonstration. This was done as an acknowledgment of the critical role that traditional Medicaid providers perform in serving the Medicaid population. All of the area FQHCs contracted with the participating Medicaid managed care plan for the duration of the demonstration. Alabama's demonstration

is no longer operating but this provision was seen as a significant innovation in terms of access.

In order to ensure that an MCO provider network is providing sufficient coverage of provider services whether it is primary, specialty, hospital, or ancillary services, most States rely on geographic mapping software programs to ensure coverage. Geographic mapping identifies the capacity of the provider network to serve the geographic coverage area. This is especially important for rural areas and urban communities that may have been previously underserved by the provider network and may require additional efforts to recruit participating providers.

While many States utilize geographic mapping to ensure adequate access to care, a comprehensive assessment of health care access may involve a more thorough analysis of physician capacity. New York State's capacity analysis for their 1115 demonstration includes a series of steps involving managed care plan data and the State's examination of that information. The process began with each managed care plan submitting provider network information for each geographic area in which the plan sought a Medicaid managed care contract. The State combined all of the managed care plan data into one data base to obtain borough (for New York City) or county capacity estimates of unduplicated primary care physicians and obstetricians/gynecologists to determine the physician to provider ratio in each county or borough. New York further analyzed each Medicaid managed care plan's network to assess specialist capacity as well as accessibility, training/certification, mainstreaming, and cultural competency of plan providers.

Expanded Benefits

While many 1115 demonstrations have expanded eligibility or improved access to health care, two demonstrations have provided an enhanced benefit package to participating Medicaid beneficiaries.

Rhode Island has developed a unique benefit expansion to combat lead poisoning in the Medicaid population. Within Rhode Island's 1115 demonstration, window replacement is a benefit that is provided on an out-of-plan basis if a housing inspection determines that it would effectively reduce the child's future exposure to lead. The State has recognized lead poisoning as one of the most critical health problems affecting young children. It is estimated that approximately 700 children are lead-poisoned in Rhode Island each year. Window replacement is an extremely effective lead reduction strategy since most lead found in older homes is located in window casings. Prompt replacement of the window is an aggressive strategy that can be implemented to prevent further lead poisoning.

Vermont's 1115 demonstration, known as the Vermont Health Access Plan (VHAP), has expanded eligibility to persons who are dually eligible for Medicare and Medicaid in order to meet a common need for this lower income elderly population: low cost access to prescription drugs. Dually eligible persons with incomes up to 175 percent of the FPL are eligible for a Medicaid pharmacy-only supplemental benefit. This benefit provides dually eligible individuals with a \$1 copayment on prescriptions under \$30 and a \$2 copayment on prescriptions of \$30 or more. This program currently serves more than 10,000 people.

Quality Measurement Tools

Medicaid managed care has promoted high quality health care services for Medicaid beneficiaries through the collection and analysis of utilization and encounter data. Section 1115 demonstrations have provided States with an opportunity to monitor the quality of health care services delivered to beneficiaries and utilize these data, in collaboration with health plans, to improve the quality of care.

Arizona was the first State to be granted an 1115 demonstration in 1982. Arizona has invested significant resources in the development of data systems to monitor the health care Medicaid beneficiaries receive in managed care. Arizona's encounter data system is a critical component of their program management. The State analyzes plan-level encounter data to evaluate the quality of care in Medicaid managed care plans. This information is used as a component of the scoring process for awarding Medicaid managed care contracts.

Massachusetts develops quality improvement activities for its Medicaid managed care plans in negotiation with participating plans and conducts performance reviews semi-annually to assess plan progress towards the specified goals. Previous quality improvement goals have included care of persons with disabilities, well childcare visits, and access to behavioral health services. Massachusetts collects Health Plan Employer Data and Information Set (HEDIS) statistics as one method of assessing the quality of care provided in MassHealth. A subset of HEDIS information is collected from both the managed care plans and PCCM providers on an annual rotating basis. For 1998, the required HEDIS measures were childhood immunizations, adolescent immunizations, breast and cervical cancer

screening, and eye exams for persons with disabilities. Participating Medicaid managed care plans have demonstrated higher HEDIS rates on these preventive services than national averages for commercial managed care plans.

Tennessee has collected encounter data from all participating Medicaid managed care plans. The State has used these data to conduct studies on infants born with low birth weight, preventive care for diabetes, and pharmacy utilization among other topics. These studies have been primarily used for Tennessee's internal quality management of TennCare. Tennessee has also used its encounter data to develop report cards comparing participating Medicaid managed care plans.

Payment

States found it difficult to contain costs under an FFS environment because of the over-utilization of high-priced services such as the use of the emergency room for primary care services and the mismanagement of health care resources. In addition, States were lacking in the number of Early Periodic Screening, Diagnosis and Treatment (EPSDT) screenings that ensured that children were receiving the required screenings and immunizations for their age group. Managed care provided a solution to this by assigning the responsibility to a medical professional to manage the primary care services of an assigned beneficiary and to refer the beneficiary to specialty care whenever appropriate. States discovered that managed care was helping to control costs and it was also facilitating good health by having members utilize primary care services, (which usually are lower in cost than that of specialty care) and having them utilize specialty care more appropriately. However, for some chronic medical conditions, the

medical costs are higher because of the utilization of specialized care and treatment. As the population with chronic medical conditions increases, so do the costs associated with them. Some States have taken steps to handle costs associated with a specific medical condition or service.

Maryland has developed a sophisticated risk adjustment methodology for rare and expensive diseases, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The State of Maryland has identified a list of conditions and diagnoses that are eligible for the enhanced capitation rate. An additional adjustment is made for the cost of certain drugs, such as protease inhibitors. Once individuals enrolled in Medicaid managed care plans are pre-identified as meeting these criteria, the plan becomes eligible for significantly increased capitation payments.

In Alabama's 1115 demonstration, the State's contract with the managed care plan included incentive payments when the plan performed specified levels of EPSDT visits. The plan was reimbursed for increases in the average number of screenings for beneficiaries up to 2 years of age. The average number of screenings had to increase more than 10 percent over the previous year in order to be eligible for the incentive payment. Likewise, the plan was penalized if the screening rate fell below 90 percent of the number of screenings completed in the base year.

Safety Net Providers

Safety net providers, usually (but not always) synonymous with FQHCs, have a unique relationship with the Medicaid program. FQHCs are organizations such as inner city health centers or a rural health

clinics that have traditionally focused on serving the indigent and medically needy. The section 1115 health reform demonstrations have been a particular challenge for the FQHCs because the demonstrations changed the Medicaid environment from FFS to managed care at an extremely rapid rate and the FQHCs had to adapt quickly to a capitated environment. How the FQHCs adapted varies from State to State, but some of the States incorporated FQHCs into the programs in particularly innovative ways.

In Hawaii's 1115 demonstration, one of the participating health plans, Aloha Care, was formed by area FQHCs. FQHCs receive supplemental wraparound payments in addition to the capitation payments clinics received from Medicaid managed care plans. Like Hawaii, all the Rhode Island FQHCs have formed their own health plan called the Neighborhood Health Plan of Rhode Island. The plan is administered by the Rhode Island Community Health Center Association.

Massachusetts has supported the development of two Medicaid managed care plans comprised of traditional safety net providers based at public hospitals. The State provided technical assistance and support to these plans to enable them to participate in MassHealth, Massachusetts' 1115 demonstration. These plans also provide outreach to assist individuals in applying for MassHealth benefits.

In Tennessee's 1115 demonstration, all TennCare plans are required to contract with FQHCs and traditional safety net providers. While the FQHCs have not always been completely satisfied with their reimbursement from Medicaid managed care plans, the increased reimbursement for previously uninsured persons has been significant for many centers.

Special Needs Populations

The newest area of innovation in 1115 demonstrations is in advancements in the care of people with special health care needs. While some States are integrating these individuals into Medicaid managed care, other States are using 1115 authority to expand health insurance coverage to disabled populations.

One of the most innovative components of New York's 1115 demonstration is the development of special needs plans (SNPs) to serve people living with HIV and AIDS, persons with serious and persistent mental illness, and children with serious emotional disturbances. These Medicaid-managed care plans, while not yet operational, would begin as voluntary programs in selected areas and develop into one of the options available during mandatory enrollment of these populations. The SNPs are sponsored by community-based organizations, existing Medicaid managed care plans, and traditional providers for these populations. The State pre-identified a range of services and specialist providers that must be included in the HIV/AIDS SNP, ranging from medical case management to alcohol and substance abuse services, durable medical goods to home health and nursing services. Individuals living with mental illness may dually enroll in a Medicaid managed care plan for basic health services and the mental health SNP. The mental health SNP only provides mental health services. Individuals living with both HIV/AIDS and mental illness can enroll in both SNPs simultaneously. The SNPs will be held to the same standards as other Medicaid managed care plans regarding the reporting of encounter data, processing claims, providing member services, etc.

Maryland has a case management program that serves people with rare and expensive special health care needs within

its 1115 demonstration. This program includes people with a range of special needs—from children living with HIV and/or AIDS to ventilator-dependent individuals. The program provides case management, multi-disciplinary care and family support services. While each enrollee is assigned a primary care provider (PCP), preference is given to existing patient-provider relationships and specialists may act as PCPs. The State is considering integrating some individuals with special health care needs into fully capitated Medicaid managed care plans.

Maine has recently received HCFA approval to implement an 1115 demonstration for people living with HIV and/or AIDS. Individuals with income below 300 percent of the FPL and HIV and/or AIDS are eligible to participate in this demonstration. This demonstration is intended to increase access to various therapies (i.e., "cocktail therapy," protease inhibitors) that can significantly delay the onset of disabling illness among HIV+ individuals. The benefit package includes prescription drugs, primary and specialty care, mental health and substance abuse services, and other enabling services.

Future Challenges in 1115 Demonstrations

The growth of Medicaid managed care has paralleled the experience of managed care in the private sector. The significant growth in section 1115 demonstrations that took place in the mid-1990s has slowed. The hopes that Medicaid managed care would provide higher quality, accessible health care, and save money have given way to fluctuating health care markets in which managed care plans merge, file for bankruptcy, or leave the Medicaid market.

The exodus of managed care companies from the Medicaid market was explored in an issue paper written by Mathematica

Policy Research, Inc. for the Kaiser Commission on Medicaid and the Uninsured Mathematica Policy Institute, 1999, which analyzed trends in commercial plan participation in the Medicaid market. The paper documented the following trends:

- Commercial plans continue to play an important role in serving the Medicaid population. In 1997, commercial plans served 64 percent of all Medicaid beneficiaries enrolled in full-risk managed care.
- Commercial plans withdrew from the Medicaid market much more often and entered it less frequently in 1997 and 1998 in comparison with previous years.
- Participation of commercial plans varied by State and type of plan. States with mature managed care programs experienced a more significant decline in plan participation than those with newer managed care programs. Plans affiliated with a national managed care firm or Blue Cross and Blue Shield appeared to be more inclined to withdraw from the Medicaid market.

If the current trend continues, the study suggests, States' ability to offer a choice of commercial plan to Medicaid beneficiaries may be jeopardized. However, this period of plan withdrawal could be an adjustment period followed by stabilization in the Medicaid market. It is difficult to assess the lasting impact of the commercial plan exodus now. It is a phenomenon that requires ongoing observation and analysis.

The programmatic design and intent of new 1115 demonstrations is changing. New proposals are focused on expanding health insurance coverage through models like Maine's HIV 1115 demonstration. The

State Children's Health Insurance Program may soon begin approving 1115 demonstrations to test innovations in the program. States have been submitting a number of smaller 1115 demonstration proposals. For example, there have been a number of proposals to expand eligibility only for family planning services.

Existing State 1115 demonstrations continue to use their demonstration authority as a vehicle to modify their programs through amendments. Many States are utilizing the amendment process as a mechanism to modify the delivery systems that were implemented at the onset of the 1115 demonstration. States continue to explore options for integrating chronically ill and disabled populations into Medicaid managed care.

SUMMARY

The 1115 demonstration process to date has enabled States to innovate in a wide array of areas, from expanded eligibility and efforts to improve access to care to collection of encounter data and development of risk-adjusted capitation rates. This innovation continues in ongoing 1115 demonstrations as well as in new proposals. We can only expect that States will continue to explore diverse methods of providing health care to their beneficiaries through the 1115 waiver process.

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