

and disproportionate share hospitals in their service area warrants further evaluation.

Alert 7: Changing the Medicaid Program Through Demonstration Waivers

Many state Medicaid programs are using research and demonstration waiver authority to replace traditional fee-for-service payment systems with capitated, managed care arrangements. Some states are using savings from enrolling the Medicaid population in managed care to cover additional individuals. These state initiatives have the potential to slow spending growth per enrollee and enhance continuity of care. However, oversight of enrollment, service patterns, and quality of care is necessary to protect the Medicaid population from unscrupulous plans and providers.

- Demonstration programs that enroll all of a state's Medicaid recipients in managed care plans represent a significant change for this vulnerable population. Capitated payment systems contain strong incentives to control the volume of services furnished. Converting Medicaid from a fee-for-service to a capitated, managed care system, therefore, can slow the rise in spending per enrollee. Capitated payment methods may also improve quality by promoting continuity of care, increasing the availability of primary care providers, and encouraging the appropriate use of other needed services. These programs, however, limit recipients' choice of providers and may alter covered benefits.
- Currently, eight states have statewide Medicaid research and demonstration projects authorized under section 1115 of the Social Security Act. Nine other states have waiver applications that are pending authorization. Section 1115 projects allow states to receive Federal Medicaid matching funds for the existing Medicaid population and others who become eligible under the terms of the demonstration. Because the projects are authorized under demonstration authority, some of the Medicaid program regulations are waived. States may alter provider reimbursement requirements, such as disproportionate share payments to hospitals and cost reimbursement for federally qualified health

centers. Further, voluntary disenrollment and certain plan participation conditions may be waived. This is in contrast to the freedom of choice waivers authorized under section 1915(b), which allow states to enroll selected recipients in managed care programs for limited periods. Consequently, the 1115 projects are altering the eligibility, benefit, service delivery, and regulatory oversight of the Medicaid program in states with waivers.

- State demonstration projects using managed care approaches for Medicaid enrollees may expand the availability of Medicaid coverage to otherwise uninsured groups and improve the continuity of care for those who are already enrolled. These projects, however, must be carefully evaluated for any adverse effects on these vulnerable populations, including the impact of how restricting provider choice and changing benefit design would affect quality of care.
- The effects of these changes on providers that have traditionally cared for these populations should also be monitored. Many participating states are redistributing disproportionate share payments through capitated rates for recipients. Consequently, hospitals that historically have served many poor patients may lose these extra payments. Managed care plans also may reduce their payments to these hospitals or choose other providers. Using savings from enrolling recipients in managed care to expand coverage for the uninsured, however, may provide additional revenue to these hospitals. The effects of changes in revenue on the ability of this important group of hospitals to care for Medicaid enrollees and the remaining uninsured population must be assessed. The impact of Medicaid waivers on access to care for individuals who have traditionally relied on rural health clinics, federally qualified health centers, and other providers that serve vulnerable populations should also continue to be examined.

Alert 8: Protecting Vulnerable Populations' Access to Services

In response to the increasingly competitive environment in which they operate, health plans, hospitals, and other providers are developing comprehensive, integrated financing and deliv-