
State Perspectives on Health Care Reform: Oregon, Hawaii, Tennessee, and Rhode Island

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The general consensus among States which have had their section 1115 demonstration projects approved is that there is no one best way to implement State health care reform. The Health Care Financing Administration (HCFA), however, wished to discern how States were accomplishing the task of implementing the demonstrations, and solicited responses from State representatives whose section 1115 demonstration waivers had been approved. The resulting article gives an overview of this implementation process from four State perspectives. Written by representatives from Oregon, Hawaii, Tennessee, and Rhode Island, the ideas presented here are indicative of the complex undertaking of State health care reform.

INTRODUCTION

For the States, implementation of health care reform has been a difficult task. Although the section 1115 demonstrations remain the most effective way for States to expand coverage to uninsured populations and streamline the Medicaid process, the actual execution of reform plans by States has, at times, been arduous. Some implementation issues faced by States have been hard to address in that these are pioneer efforts by both the States and the Federal

Government. Knowing how States have overcome identified problems and seeing the lessons learned thereby can provide insight into both the positive and negative aspects of the process of State health reform. This article is intended to give a voice to the States that were asked to share their knowledge and experiences with the State health care reform community.

HCFA's position must, however, be made clear. That position has always been to ensure the health and well-being of its beneficiaries. HCFA's goal is to ensure that the recipients will not experience serious problems in accessing services, and providers will not experience payment delays. What the eventual outcome of State reform efforts will be has yet to be determined. However, the four States whose perspectives are presented here give a good profile of each one's experience.

OREGON HEALTH PLAN AND MEDICAID REFORM

Oregon's Medicaid program underwent a major reform beginning February 1, 1994, with implementation of its section 1115 Medicaid demonstration project under the Oregon Health Plan (OHP). At that time, the program was expanded to cover persons with incomes below the Federal poverty level. To this end, the traditional package of benefits was exchanged for one based on a prioritized list of health services. Most clients began the process of enrolling in managed care, primarily prepaid health plans.

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Beside the effect on new enrollees, these changes had an impact on Medicaid clients who were low-income pregnant women, young children, or Aid to Families with Dependent Children (AFDC) beneficiaries. Beginning in January 1995, the remaining Medicaid clients (aged, disabled, and children in substitute care) were brought under the demonstration, and the prioritized list was expanded to include mental health and chemical dependency services.

After evaluating the last few years of the planning process for the OHP, as well as the limited time of actual program operation, there is now a better perspective of successes and mistakes. There has been much learning and adjusting in the demonstration project. The health care providers and managed care plans have been partners in helping design the program and in making necessary changes. Overall, it was found there was need to be flexible. The demonstration had both expanded Medicaid and required fundamental changes to the basic program, each of which presented opportunities for chaos.

Oregon's Medicaid program changed in a number of ways under the demonstration, including:

- An expansion of eligibility and simplification of its criteria and processes.
- The use of a prioritized list of health services to determine the benefit package.
- The aggressive movement of clients (and providers) into prepaid plans.
- Payments to prepaid plans based on the estimated reasonable cost of providing the covered services to serve as a means to assure access and end cost-shifting due to Medicaid under-reimbursement.

Eligibility

The eligibility criteria and processes were designed to more closely resemble

an insurance program than a social welfare program. A simple 1-month gross income test was required to prove income below the poverty level, no assets test was included, and eligibility was guaranteed for a 6-month period. Information sessions were held throughout the State for people to receive help in applying, and a toll-free telephone number allowed interested people to request information and application packets. No face-to-face interview was required, as applications could be mailed to a central location.

The goal was to simplify eligibility in order to limit barriers that might otherwise keep people from applying. This succeeded beyond our expectations and staffing levels. Although 5,000 telephone inquiries were expected in the first month, we initially received 4,000 per day. Because so many of the resources were needed to staff the telephones, a backlog developed in mailing the application packets. Thousands of them were mailed out at once, which meant that thousands were returned at once. This in turn overwhelmed the eligibility staff. With the help of additional staff and many hours of overtime, the backlog was cleared up within 3 months.

Since then, a number of changes have been made to the process for handling the applications. The current timeline for determining eligibility is now 5 days from the date the application is received in the central office.

The number of new people eligible under the OHP exceeded projections. The initial projection was 52,000 eligible individuals in the OHP after 6 months; the actual number was 88,000. The increase began to level off after 6 months because the initial period of guaranteed eligibility began to expire and not all clients reapplied. Because of the higher-than-expected number of people coming into the plan,

questions were immediately raised concerning the budgetary impact. The budget for the OHP included both the costs of those newly eligible as well as the costs of those Medicaid clients who converted to the OHP. Although the number of new eligibles was higher than expected, the number of those eligible, because they were on AFDC, was lower than expected. The AFDC caseload in Oregon dropped for a number of months, primarily because of an aggressive welfare reform program, although there was some indication that there also may have been some link to the implementation of the OHP. This kept the OHP within the budget.

As implementation of the OHP proceeded, interesting information about the demographics of those newly eligible was discovered. It was originally anticipated that most new eligibles would be single individuals and childless couples, people who would not have previously qualified for Medicaid regardless of how little income they might have. In fact, almost two-thirds of those newly covered under the plan were families with a child in the household. Moreover, most of those families had two parents at home. Of those without children at home, the single largest group was women 51-64 years of age, too young for Medicare but no longer eligible for AFDC. The OHP was clearly a program that provided vital support to low-income families.

Although the legislature had agreed with the objective of simplifying eligibility, once implementation began, concerns quickly surfaced about the possibility of "undeserving" people qualifying under the program. Anecdotes were presented of people coming to Oregon from another State to gain coverage, people "gaming" their income, and people with substantial resources qualifying. HCFA allowed Oregon flexibility in using a quality control

program to provide management information rather than to focus on identifying errors. The quality control staff, therefore, initiated studies to allow a clearer picture of those enrolling in the OHP. Staff looked at such issues as assets, residency, college students, and third-party resources. Plans were made to use the information gathered to determine the need to make changes in the basic eligibility criteria. For example, the information contradicted the notion that the OHP has caused people to move to Oregon to gain health care coverage.

Benefit Package

The use of a prioritized list of health services to determine the benefit package presented new challenges as well as national controversy. The list was developed by the Oregon Health Services Commission, a governor-appointed group of physicians and consumers. After reviewing the list, the Oregon legislature determined how far down the list of health services to fund. Those funded services then defined the benefit package. The list was based on combinations of conditions and treatments (i.e., treatments may be covered or not covered depending on the condition for which they are used). This required providers to use full diagnosis codes and become familiar with the list's intricacies. Agency nurses staffed a hotline to answer questions from providers' offices about placement of services on the list, as well as to determine specific situations which required an exception based on a patient's comorbidities.

Providers were surprisingly patient in learning to use the list. This was probably due to the high degree of physician acceptance of the underlying concept and involvement by physicians in the development of the list. Claims denials due to the decrease in incomplete coding dropped.

Medical directors of the prepaid plans met regularly to discuss: (1) use of the list, (2) increasing the consistency across plans, and (3) Medicaid fee-for-service (FFS) interpretation of the list.

As with any new program, there were a number of "technical corrections" to the list since implementation. The Medicaid office worked closely with the Oregon Health Services Commission to determine where "missing" combinations should fall. Since implementation, only one significant change has occurred, based on input from physicians. Surgery for uncomplicated hernias for children under 18 years of age was carved out of a non-covered line and moved to a higher place on the list. The Commission was charged with completely reviewing the list at least every 2 years to reflect the latest information on effectiveness and costs.

The concept of the list was relatively non-controversial with Oregon itself. In fact, because the list of covered items included a number of services not covered under traditional Medicaid, such as dental care and general preventive care for adults, advocates for those Medicaid clients initially excluded from the OHP lobbied to be included.

Managed Care

Prepaid health plans provided services under the Oregon Medicaid program for a number of years before the OHP, primarily through partial capitation for physician, lab, and X-ray services. Two-thirds of the AFDC population were included in prepaid plans prior to the OHP implementation. During the past 2 years, managed-care plans in Oregon worked aggressively to gear up for the OHP. Oregon traditionally had heavy managed-care penetration in the private sector. Additionally, under the OHP, the Medicaid program planned to use

payment incentives for providers to participate in prepaid plans. By the time the OHP was ready for implementation, contracts were initiated with 20 different plans to provide coverage in almost all areas of the State, even in frontier and remote areas. For those few areas without prepaid plans, a primary-care case management program was developed. The results were dramatic. Prior to OHP, 85,000 Medicaid clients were covered by prepaid plans. Within 6 months, more than 200,000 were enrolled. Therefore, there is sufficient capacity to mandate managed-care enrollment in all areas of the State.

Although the increase in managed-care enrollment was somewhat rapid, the involvement of the plans in program planning helped to ease the expected level of confusion. Misunderstandings about managed-care were primarily found among provider types who had not been involved in managed care or in areas which did not previously have private-sector penetration. Although there was a good deal of information sent to providers and clients, it may not have been read. Clients received managed-care handbooks and charts comparing the plans as part of their application packets. They could have attended informational sessions where additional information about their managed-care choices was available.

The major capacity problem was with access to dental care. Pent-up demands, dentists' distrust of managed care, insufficient capitation rates, and client expectations contributed to dentists' unwillingness to participate. To address these problems, the capitation rates were raised, standards relating to care were clarified, and additional informational materials were sent to clients. Inroads into the problems are beginning to be seen, but constant vigilance will be necessary.

Lessons Learned

Lessons were learned from both mistakes and successes, and the following pointers were noted after several months of operation.

- Major demonstrations cannot be planned and implemented in "spare time." Additional resources in the form of staff, systems, and contract funds will be necessary to successfully plan and undertake major program changes.
- HCFA can be an ally, not an adversary. Our relationship with HCFA throughout the long ordeal of waiver approval and subsequent implementation has been an open one. It would be preferable that HCFA staff hear about problems from those of us in the State rather than from the newspapers. Although HCFA clearly had an oversight role, the central and regional office staffs tried to help us become successful. HCFA suggested additional waivers which might have helped. HCFA was also open to allowing us to adjust as we progressed. States need to understand that HCFA, as well as the States themselves, will need data to prove what works and what does not work.
- Do not scrimp on time to plan, yet recognize that there will never be enough time. Not all the questions or issues can be anticipated, so at some point, you need to "just do it" and begin implementation.
- Upfront involvement from all parties is critical to success. This includes providers, prepaid plans, advocacy groups, and other State agencies. Although this may take time and patience, it can reduce the anguish later. Their involvement can result in better program planning. If they are on your side, they can help prevent, defuse, and solve problems.
- Greater concessions from prepaid plans may be negotiated during the design and

implementation phases than would otherwise be anticipated.

- Spend time with your local media providing background information on your plan prior to implementation. Problems with your old system were not especially newsworthy, yet any problem with the new system might be. If your local reporters have a fairly broad understanding of the basics of your program, they may approach their stories more fairly.
- As you implement your program, recognize that all issues have some level of importance to someone. Assess the critical nature of the problem, then show the interest groups the timetables and processes through which you will try to address them. If the end result is that you make no change, explain why, and be sure others they may contact, such as legislators, also understand why.
- Be prepared to prioritize and turn down requests to evaluate or research various aspects of your program. Staff and systems resources needed to support outside researchers can be overwhelming.
- Give yourself time before making another set of major changes. Staff, plans, and providers need time to recover and stabilize.
- Remember that this is a demonstration; not everything will be perfect. If you have your major interest groups in this with you, the ability to make mid-course corrections is greater.
- Above all else, hire highly competent, energized staff who have good negotiating skills and lots of patience!

HAWAII QUEST: IN PURSUIT OF KEEPING HAWAII HEALTHY

On August 1, 1994, Hawaii took a giant step forward in health care with the implementation of the State's section 1115

waiver program: Hawaii QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients). QUEST combined three separate State programs—AFDC, the State Health Insurance Program (SHIP), and the General Assistance (GA) program—into a single managed-care program administered by the Hawaii Department of Human Services (DHS). Five medical plans and two dental plans contracted with the State to provide coverage under QUEST. Approximately 105,000 individuals already enrolled in AFDC, SHIP, and GA were transferred to QUEST on August 1, the same date the program was opened to new applicants. As of January 1995, more than 15,000 new applications had been received.

In the months leading up to QUEST's implementation, extensive preparatory work was necessary in many different areas. New procedures and systems were developed, various issues were addressed, and the resources of the participating health plans were scrutinized, all to help ensure QUEST's stability and viability. Some of these processes were unique to Hawaii, specifically Hawaii's actions in systems adaptation and development, assurance of an adequate provider network, review of the health plans' financial solvency, development of a quality assurance system, and addressing the issue of loss of cost-based reimbursement by the Federally Qualified Health Centers (FQHCs).

To effectively and efficiently administer the QUEST program, the DHS awarded a contract for the design, development, implementation, and operation of the QUEST Information System (QIS). The QIS will be a fully integrated system which will support the administration of the demonstration project and replace the

current Medicaid Management Information System (MMIS). The major functional areas of the QIS include:

- Eligibility determination for QUEST and other State medical assistance programs.
- Enrolling and tracking clients in the QUEST health and dental plans.
- Administering the billing and collection of the recipients' share of their monthly premium.
- Monitoring the utilization and quality of services provided to QUEST clients by health and dental plans.
- Processing FFS claims for Medicaid clients not enrolled in QUEST.
- Generating reports for program management and HCFA.

Although the QIS is expected to be operational in 1996, an interim system was developed to administer the QUEST program. This system has the basic function of the QIS and was developed using existing systems as well as systems developed specifically for the interim period. The interim system is comprised of five major processing components, which follow.

Eligibility and Enrollment Subsystem. These functions are performed on the State's mainframe-based Hawaii Automated Welfare Information System (HAWI). HAWI was modified to determine eligibility for QUEST clients and enroll eligible clients into participating health and dental plans. Enrollment information is provided to plans on a daily and monthly basis.

Premium Share Subsystem. This subsystem is a PC LAN-based accounts receivable and billing subsystem that captures and tracks the billing and collection of QUEST clients' share of premiums owed to the State. It is updated monthly with information from HAWI.

Capitation Payment (Payment to Plan) Subsystem. This PC LAN-based payable

system generates and reconciles monthly capitation amounts due to QUEST plans based on plan enrollment. It is updated daily and monthly with information from HAWI.

Encounter Processing and Provider Subsystem. The interim encounter data system is being developed on a client-server system, using the processing power and storage capacity of a dedicated file server to process and store encounter, eligibility, and provider data. The primary function of this subsystem is to accept, edit, validate, and store encounter data submitted by QUEST health and dental plans. Plans are required to submit service data in a standard format for:

- Physician and outpatient provider services.
- Inpatient services.
- Drug services.
- Dental services.
- Behavioral health services.
- Miscellaneous services.
- Early and periodic screening, diagnosis, and treatment (EPSDT) services.

The requirements of the following functional areas were factors in the development and design of the interim encounter system:

- Demonstration and program evaluation.
- Quality assurance monitoring.
- Health care research.
- Federal reporting.
- QUEST program management.

QUEST Interim Reporting System (QIRS). This system will be designed, developed, and operated by the QIS contractor. It will provide program management reports from data residing on all interim subsystems.

Prior to QUEST's implementation, the State required that the participating medical and dental plans establish and demonstrate adequate provider networks. They were asked to provide to the State a listing

of their provider networks in the various geographic areas they would be serving. Initially, plans were simply required to submit the names of specific providers who had been offered contracts and/or had signed letters of intent. As the program implementation date neared, plans were required to submit names of providers with whom they had executed signed contracts. They were required to submit provider lists at least twice before program initiation. Each time, the lists were reviewed by geographic area to ensure that there were reasonable numbers of primary-care providers in each area of service.

After implementation, assigned plan liaisons randomly reviewed plan contracts to determine whether or not the plans actually had signed contracts with those providers listed on their rosters. In addition, HCFA staff was provided with complete rosters of participating providers for each plan. HCFA then initiated random verification calls to again ensure that those providers claimed by the plans were in fact participating.

Participating plans were also reviewed and are continually monitored to ensure their financial solvency. In order to review the plan's financial viability, the State developed a number of procedural and functional guidelines and policies. A Financial Reporting Guide was created for the medical and dental plans, which also applies to QUEST's separate behavioral health managed-care plan. The Guide details the reporting requirements, the timing of reports, and the sanctions for non-compliance.

Although QUEST's requests for proposal (RFPs) required quarterly financial reporting by the plans, they also provided the State the right to require monthly reporting if it deemed this necessary. During the negotiation process, it was agreed with two participating plans that they must submit

monthly financial reports. To date, both have submitted as required. The first-quarter financial reports for the rest of the plans were submitted on November 15, 1994. The State will use these monthly and quarterly financial submissions to evaluate the ongoing financial viability of the plans. Specifically, the State will identify baseline ratios which must be met and warning indicators which will be observed. The financial information will be used to compute ratios and identify any potential problems. If problems are noted, the Finance Office and the Health Coverage Management Branch shall determine the additional requirements which should be imposed on the plan, e.g., changing reporting from quarterly to monthly, increasing bonding requirements, and limiting enrollment.

QUEST also requires that a plan's Quality Assurance Program (QAP) be consistent with and incorporate the required components as specified in the *Standards for Internal Quality Assurance Programs of HMOs, HIOs and PHPs Contracting with Medicaid* (U.S. Department of Health and Human Services, 1993). Health plans will also be monitored through Performance Measures which were derived from the National Committee for Quality Assurance's (NCQA) *Health Plan Employer Data and Information Set, Version 2.0* (1993). Each health plan's QAP was reviewed in the onsite review of bidders in the RFP process, and written policies and procedures were reviewed and rewritten, following specific guidelines (American Public Welfare Association, 1993). For monitoring purposes, each medical and dental plan has been assigned to a specific staff person in Med-QUEST Division's Medical Standards Branch, Compliance Section.

Monitoring visits will be keyed to the quarterly and annual reports required of the health plan's QAP activities, as well as

to the annual audit conducted by the contracted external reviewer. Any problems identified by the technical assistance review, the annual external independent review, or the analysis of reports will result in a review by the State. The nature of the findings will determine the type of review to be conducted:

- (1) An uncomplicated problem involving a single element will require a review of the case and the key element only;
- (2) Multiple problems involving one or two elements will likely require a review of a sample of cases and a review of the QAP process; and
- (3) Multiple problems involving multiple critical elements will require a full contractual review.

With the implementation of Hawaii QUEST, one controversial issue has been the loss of the cost-based reimbursement by the FQHCs. Although all of the FQHCs have contracts with one or more health plans, the FQHCs feel that the negotiated capitation with each health plan does not provide them with the level of revenue which they enjoyed under the previous cost-based reimbursement. Typically, the FQHCs have been extremely vocal regarding their displeasure with the impact of QUEST on their budgets. They have lobbied the legislature, the Hawaii Congressional delegation, and the Governor to seek relief from their plight.

The State set aside \$1 million of general funds to be used as "voucher payment" to the community health centers for providing care to those who were uninsured and fall outside any public assistance or other third-party coverage. The DHS and the Hawaii State Primary Care Association (HSPCA) have discussed the possibility of using the \$1 million as the general fund match to provide the centers with a

percentage adjustment of the anticipated deficit. This offer appears to appeal to the majority of the centers. The DHS has made it very clear that, unless members of the HSPCA agree to the adjustment, the offer will not be viable.

Clearly, there are some centers which are suffering a greater deficit than others, and the DHS is committed to an adjustment which is fair and equitable. The HSPCA has contracted with an independent accounting firm to calculate the budget for each center and will be working with the State staff on agreement of numbers. Since the discussion of the possible adjustment, the FQHCs have been more supportive of QUEST and less critical of the program.

New challenges continue to arise as QUEST operations continue. The development and implementation of the QIS, plans to eventually fold in the currently excluded aged, blind, and disabled (ABD) populations, the 1995 legislative session which began in January—all are certain to bring a continued scrutiny of QUEST. However, as the areas detailed herein have been addressed and challenges met, so will future issues and concerns be resolved in pursuit of keeping Hawaii healthy.

TENNCARE: ENROLEE PROTECTIONS IN A MEDICAID MANAGED-CARE PROGRAM

In June 1993, Tennessee submitted to HCFA a request for a Medicaid waiver under section 1115 of the Social Security Act. The waiver was granted in November 1993, and implemented less than 2 months later. Under the waiver, all 800,000 of the State's Medicaid beneficiaries have been assigned to managed-care organizations. The waiver also authorized coverage of individuals who are uninsured or uninsurable,

and by year's end, approximately 400,000 such individuals had enrolled. Altogether, more than 1.2 million enrollees receive capitated managed care through the waiver program, which is called TennCare. As other States and Congress contemplate rapid expansion of mandatory managed care for Medicaid beneficiaries, TennCare's experience may be instructive. Lessons from TennCare are especially relevant for States with little prior managed-care experience.

Quantitative measures of TennCare's performance are not yet available, and it is premature to draw definitive lessons. However, the TennCare experience already sheds light on those problems which similar Medicaid managed-care initiatives are likely to encounter, and suggests at least some possible approaches to addressing those problems.

A central concern in any transition to managed care is the protection of enrollees and the quality of their care. Several TennCare features were designed to address that concern.

Access to Care

The TennCare waiver did not exempt Tennessee from Medicaid's requirement that it afford beneficiaries access to care at least equivalent to that afforded the general population. In fact, the waiver quantified the requirement by specifying that, throughout the State, there must be available at least one primary-care physician accessible to each 2,500 enrollees. Meeting the access requirement has been a difficult challenge for Tennessee's Medicaid program, as it is throughout the country.

Crucial to the State's effort to meet the access requirement was a policy linking TennCare to the State employee insurance plan. State and local government employees represented the largest subgroup of

the Tennessee Preferred Network (TPN), whose 1,000,000 enrollees also included many other private and public employees. TPN, administered by Blue Cross and Blue Shield of Tennessee, is the largest managed-care organization in the State, and attracted the largest enrollment of any of the 12 competing TennCare managed-care organizations (MCOs).

Under the policy linking TennCare and TPN, Blue Cross and Blue Shield required that any provider serving State employees must also treat TennCare patients on a non-discriminatory basis. Without actually merging the State employee plan and its new Medicaid waiver program, Tennessee was thereby able to capitalize on TPN's large market share to pressure providers to serve TennCare enrollees. Although resented by many physicians and highly controversial, this policy is regarded by many beneficiary advocates as the single most important consumer protection in TennCare. Although access remains problematic, this policy has made available to TennCare enrollees the services of many providers who previously refused to see Medicaid patients. Despite provider criticism of the TPN-TennCare link, severing the link would have an immediate adverse impact on access to care for much of the TennCare population.

Beneficiary Education

Movement from traditional FFS coverage to a capitated system of managed care demands major adjustments from any population. Success in making those adjustments depends, to a great extent, on the quality of education and information provided to the program's beneficiaries. This task is especially important—and challenging—for Medicaid programs. In addition to lacking sophistication regarding the use of health care systems, many Medicaid

beneficiaries have limited reading skills, significant cognitive or communicative disabilities, or limited English language proficiency.

Shortly after submitting their waiver application, Tennessee Medicaid officials established a working group to develop educational materials, application forms, and enrollee communications. The group included representatives of the State Medicaid bureau, a public relations firm, and several legal aid and consumer advocacy organizations.

At the urging of the consumer advocates, State officials established two protocols that were to govern all TennCare written materials. First, all materials were to be written, if possible, at a sixth grade level of reading comprehension, and in no event were to exceed an eighth grade level of readability. Also, all materials were to be field-tested before final approval, by having them reviewed and critiqued by individuals who are representative of the target audience.

Experience has taught that such field-testing is as simple as it is essential. People waiting for Medicaid appointments in the local office of the welfare department usually are quite willing to spend a little time reviewing and critiquing draft materials. Their insights were indispensable. For example, the design team spent hundreds of hours drafting multiple revisions of the one-page application form to be used in the enrollment of uninsured or uninsurable individuals. Nonetheless, when residents of a homeless clinic reviewed the form, they immediately identified several important problems that the professional designers had missed. Whenever the working group, which operated under intense time pressures, put into use forms or publications that had been inadequately reviewed by members of the target population, they later had reason to regret the lapse, because of enrollee and staff confusion and corresponding inefficiency.

The effort to inform affected Medicaid beneficiaries of the impending change was aided by extensive news media coverage of the TennCare proposal from the moment it was announced. Media coverage meant that many individuals were at least aware that Medicaid changes were in the offing, even before the State began to inform beneficiaries of the new program.

In October 1993, the State sent all Medicaid households a ballot on which beneficiaries were to show their preference of MCOs. The ballot was accompanied by brochures from those MCOs that served the region of the State in which the household resided. The brochures were confusing and the amount of information provided about the new managed-care plan was sparse. Still, some 60 percent of all Medicaid households completed and returned their ballots. This is an extraordinarily high number of returns for any mass mailing, and attests to the relative success of efforts to design TennCare written communications in an appealing and readable manner.

TennCare officials recognized that, no matter how readable their written materials, any effort to communicate with the target audience would require substantial reliance on the electronic media. They recognized, too, that such media could only deliver a short, simple message, far short of the volume and complexity of information that had to be disseminated regarding TennCare. A paid television and radio campaign urged Medicaid beneficiaries and prospective waiver-eligibles to contact a toll-free telephone hotline for further information about the program. The effectiveness of that message was evidenced by the huge volume of calls received by the hotline during its first weeks of operation.

The hotline was often overwhelmed by the volume of calls and was not always

adequate. However, the use of a centralized telephone operation for this purpose enabled the State to monitor system problems highlighted by the type of calls received. The centralized operation also served to maintain a relatively high degree of consistency in the information disseminated by the program during its initial phases.

Although these aspects of the TennCare outreach effort were successful, others were not. Notably, the State failed to require the MCOs to meet the same standard of readability in their written communications with enrollees. The toll-free hotlines maintained by the MCOs for servicing their enrollee populations were grossly inadequate. There were not nearly enough telephone lines to meet the demand, and MCO staff were often untrained or otherwise ill-equipped to answer the questions or resolve the problems that had prompted the enrollee's calls.

Enrollee handbooks and grievance forms were slow to be developed and distributed to enrollees. Because much of the information in each enrollee handbook was common to all MCOs, it would have been more efficient for the State to have developed that generic information and provided it to all MCOs. The different managed-care plans could have, subject to State review and approval, added information particular to their own network.

Problem Resolution

TennCare officials have adopted a couple of innovative approaches to facilitating the resolution of enrollee problems and grievances. These approaches have relied on contracts with existing consumer advocacy organizations.

Shortly before TennCare was implemented in January 1994, the State contracted with the Tennessee Health Care Campaign, Inc. (THCC), a statewide

advocacy coalition, to provide advocacy services for TennCare enrollees with serious chronic medical conditions. THCC in turn subcontracted with a non-profit crisis call and suicide prevention agency in Nashville. That agency already had experience fielding problem calls, and was structured so that it could quickly add staff and telephone lines to service the new contract. The Advocacy Line's toll-free telephone numbers were disseminated through health agencies across the State to consumers whose chronic conditions made them particularly vulnerable to disruption of care resulting from the change over from Medicaid to TennCare. The Advocacy Line fielded and resolved thousands of such calls during the first quarter of TennCare's existence, functioning as an independent ombudsman to ensure maintenance of care to chronic patients.

The Advocacy Line's existence was not generally publicized during the first 6 months of TennCare's operation, for fear that the Line would be so overloaded with general inquiries that it would be incapable of addressing the special needs of its vulnerable target population. Public and private outreach and publicity continued to promote the State's TennCare Hotline as the number to receive general inquiries, leaving the Advocacy Line free to deal with the special problems of the chronically ill. However, 8 months into TennCare's implementation, and after the volume of general calls had declined and the program had stabilized somewhat, the Advocacy Line mission broadened to serve as an ombudsman for enrollees generally, and not only those with special medical needs. The State is now routinely publicizing the availability of the Advocacy Line's services for resolving problems that cannot be immediately taken care of through the State's own TennCare Hotline. Notices of termination of coverage

or denial of eligibility applications now routinely inform individuals of the availability of the Advocacy Line. Consumer satisfaction with the Advocacy Line has been high, and it has been able to resolve the great majority of enrollee problems without having to advise the enrollee to resort to a formal due process hearing. By diverting enrollees from the formal grievance process, the Advocacy Line has not only served consumers, but materially assisted the State and MCOs as well.

TennCare has recognized that a substantial number of individuals have disabilities that impair their access to the program and the medical services it provides. To accommodate those disabilities, TennCare is negotiating with the Coalition for Tennesseans with Disabilities, a statewide advocacy organization. The Coalition would assist individuals with disabilities in applying for TennCare coverage and resolving problems regarding access to covered services. Individuals receiving assistance from the Coalition are to include those whose submission of incomplete or deficient applications indicates the likely presence of a disability requiring such accommodation. When it is possible to accommodate the individual's needs by telephone, the coalition would refer the case to the Advocacy Line. Cases requiring direct personal contact with the individual would be handled by the Coalition's staff.

Both consumers and State officials believe that advocacy services have been more effective when delivered by independent consumer groups, and would have been possible through an ombudsman staff employed by the State. TennCare has been less successful in its operation of a fair hearing process that satisfies due process and resolves formal enrollee grievances. An initial policy of requiring enrollees to first grieve to MCOs before invoking State

fair hearing procedures has proven controversial. Consumer advocates contend that, in a capitated system such as TennCare, an MCO has an incentive to deny disputed coverage claims for as long as possible, because it is money ahead for as long as the care is withheld. TennCare also failed initially at the important task of establishing an expedited mechanism for processing appeals in instances where there is an urgent need for the disputed care.

Enrollment

In an effort to enroll as many new waiver-eligible individuals as possible, the State made a decision to bypass the traditional Medicaid application and eligibility process. Individuals who are eligible for TennCare as Medicaid enrollees must still apply to the local office of the Tennessee Department of Human Services. However, in order to minimize the "welfare" stigma, those seeking TennCare coverage as an uninsured or uninsurable individual may mail an application directly to the TennCare Bureau. Forms are available by calling the TennCare Hotline, and have been distributed by the State through local Human Services and unemployment insurance offices, and by hundreds of private agencies and health care providers.

The application form for waiver-eligibles consists of a single sheet with questions on one side and instructions for completing the form on the other. The State has contracted with a private insurance company to verify the eligibility of uninsured and uninsurable enrollees. Experience has revealed shortcomings in the application form, which is being revised. However, the idea of using a short, simple application process has been vindicated by the State's success in enrolling large numbers of applicants in a brief period.

The user-friendly application process, combined with the availability of a widely publicized telephone hotline, produced an overwhelming response. Ten months into the new program, the State had enrolled nearly 400,000 waiver-eligibles, thereby increasing total enrollment by 50 percent. This accomplishment was particularly significant, and speaks to the strong desire of uninsured individuals to obtain coverage, in light of the fact that most media coverage of TennCare during its implementation was strongly negative. News reports focused on the confusion and disruptions attending the transition from Medicaid to TennCare, yet a substantial majority of the population of waiver-eligibles nonetheless sought TennCare coverage. Within less than a year, a study conducted for the State concluded that TennCare was covering one in every four Tennesseans, and private or public insurance programs together covered 95 percent of the State's population.

RHODE ISLAND'S ENTRY INTO HEALTH CARE REFORM

In July 1993, Governor Bruce Sundlun delivered Rhode Island's application for a section 1115 demonstration waiver to the DHHS for the development of a statewide managed-care project called RItE Care. RItE Care seeks to increase access to primary and preventive health services for low-income individuals by enrolling them in commercial prepaid health plans and health maintenance organizations (HMOs). On November 1, 1993, Secretary Shalala approved Rhode Island's waiver application, and, after the completion of HCFA's readiness review, the State began enrolling eligible individuals in this new program on August 1, 1994. The RItE Care program intends to enroll 65,000 AFDC and Medical Assistance (MA) recipients, as well as approximately 10,000 previously uninsured

individuals through expansion of MA program eligibility. This newly eligible group consists of pregnant women and children up to 6 years of age with incomes up to 250 percent of the Federal poverty level. RItE Care is not an optional program and, significantly, does not include Medicaid recipients who are aged, blind, or disabled.

RItE Care was developed to address the problems associated with limited access to primary and preventive care for low-income families due to financial, cultural, language, knowledge, and transportation barriers. RItE Care intended to address the lack of access to primary-care services for Rhode Island's low-income population by increasing participation of primary-care physicians in the Medicaid program. Using a fully capitated model, RItE Care HMOs will offer enhanced reimbursement rates to primary-care physicians in order to meet RItE Care's most immediate objective of a medical home—a primary-care physician—for every enrollee. The program's long-term goal is to improve the health status of Rhode Island's low-income population. Specific objectives for meeting this goal include:

- Reducing the frequency of low birth-weight infants.
- Increasing the percentage of pregnant women who receive early and ongoing prenatal care.
- Increasing the intervals between pregnancies.
- Improving childhood immunization rates.
- Increasing the provision of preventive dental care.
- Reducing the frequency of inappropriate or unnecessary hospital admissions.

RItE Care also offers the DHHS an important opportunity to evaluate, on a relatively small scale, a number of potential outcomes associated with using the title XIX program as a vehicle for health care reform.

Program Administration

RItE Care is administered by the newly created Office of Managed Care (OMC). This office resides within the State Medicaid Agency—the Department of Human Services (DHS)—and is operated jointly by DHS and the State Department of Health (DOH). Joint administration by these departments assures that the RItE Care program benefits from the guidance of the public health principles promoting access to quality health services, as well as the more traditional MA program principles of health care coverage, administrative accountability, and efficiency.

DOH is responsible for three major program components: medical management, research and evaluation, and certain member services, including publicity and a statewide consumer information telephone line (Infoline). DHS responsibilities include program administration, contract administration, financial management, eligibility and enrollment, and computer systems management. The State has had limited experience with managed care. To address this, the State has contracted with Birch and Davis Health Management Corporation to provide technical assistance on managed-care issues, as well as to provide assistance with the administration of the RItE Care program. As expected, developing clear lines of communication among the three entities has been an evolving process. However, given the rich experience each entity provides to the administration of the RItE Care program, Rhode Island believes that this is a model structure for other States.

Prepaid Health Plans and HMOs

With four well-established statewide HMOs, Rhode Island ranks fifth among all

States for HMO penetration into the commercial health insurance market (Loprest and Gages, 1993). Fortunately, each of these HMOs is participating in the RIt Care program, thus eliminating the need for the State to establish a Medicaid HMO. The four HMOs have demonstrated more than sufficient practitioner capacity to provide services for this population. However, only one of these HMOs has significant experience with Rhode Island's MA program clients, and RIt Care provides an enhanced benefit package that exceeds the HMOs' traditional levels of primary care. Therefore, the State has devoted significant time and resources to weekly meetings with the HMOs in order to define the special needs of these populations and to outline the HMOs' responsibilities related to providing care to these clients.

Of particular importance to the State is communicating to the HMOs how they can assist the clients in overcoming their non-financial barriers to care, e.g., lack of transportation, and cultural and language barriers. Furthermore, the State must familiarize HMOs with the RIt Care benefit package which requires them to provide all facets of the EPSDT program. In addition, the HMOs must provide certain non-medical health services (e.g., smoking cessation and parenting training), and coordinate with services of other agencies (e.g., Women, Infants and Children [WIC], Head Start, and Early Intervention programs). As the RIt Care program has progressed, the health plans have clearly demonstrated their ability to recognize and address the special needs of the Medicaid population. Biweekly meetings are continuing between program staff and the participating HMOs that have evolved into a forum for discussion of a broader range of program issues including enrollment and eligibility, marketing, data collection, benefit clarifications,

systems issues, and consumer relations. In this regard, Rhode Island benefits from the luxury of its small geographic area, as biweekly meetings with HMO representatives may not be a feasible option in larger States.

Community Health Centers

In addition to the four licensed HMOs mentioned above, a new HMO, Neighborhood Health Plan of Rhode Island (NHPRI), comprised of the State's 14 community health centers (CHCs), was licensed in December 1994, allowing NHPRI to participate in RIt Care. Rhode Island's community health centers have traditionally provided care for approximately 30-35 percent of the RIt Care clients; therefore, it has been a primary goal of the OMC to include them, either as free-standing HMOs, providers within the existing HMO networks, or both. The HMO licensing process for NHPRI has proved to be lengthy and challenging.

During the planning stages of RIt Care, one of the driving forces for the State choosing to file a section 1115 demonstration waiver application (rather than a 1915 program waiver) was that a section 1115 waiver would allow for certain provisions beneficial to federally qualified HMOs to be extended to non-federally qualified HMOs. Of particular importance was ensuring that any new HMO, including NHPRI, would benefit from the provision for a guarantee of 6 months of eligibility for RIt Care enrollees. Additionally, with an 1115 waiver, the 75/25 rule can be waived (it cannot be waived with a 1915 waiver). This rule states that no more than 75 percent of a participating HMO's members can be Medicaid or Medicare beneficiaries. Waiving this rule was sought to allow NHPRI to form an HMO and not be held to

this standard. Also, the State felt that the cost-neutrality requirement of the 1115 waiver was preferable to the cost-effectiveness requirement of the 1915 waiver. The cost-neutrality requirement allowed the State to transfer 100 percent of the FFS funding into the capitation rates, thereby assuring full participation of the State's HMOs and maximizing the clients' choice and access.

Prior to certification of NHPRI, the CHCs received cost-based reimbursement for their Medicaid clients, and they asserted that they could not continue to provide their full range of services under a Medicaid capitated payment system. In response, the State offered a financial transition plan to the CHCs to lessen the impact of their transition from cost-based reimbursement to capitation payments. This plan provides an additional \$10.00 per-member, per-month payment for each RItE Care client who selects a FQHC or rural health clinic as his or her primary-care provider. HCFA has approved Federal matching funds for the transition payments to a level of \$2.1 million annually (representing the State plus Federal total).

NHPRI was not licensed by the State as of August 1, 1994, when enrollment into participating HMOs began. Clearly, the State could not allow clients to enroll in a non-licensed HMO; however, they did not want to exclude the NHPRI from participating at the start of the program. Therefore, between August 1, 1994, and December 1, 1994, when NHPRI became licensed, the State allowed clients to provisionally select the NHPRI and remain in the Medicaid FFS system.

Client Enrollment and Education

In order to minimize disruption to the current care system, OMC is gradually enrolling eligible individuals into RItE

Care. The State projects to enroll approximately 5,000 persons per month during a 15-month period. The original enrollment process planned for the head of each household to meet individually with a non-biased enrollment counselor to learn about managed care and choose his or her health plan. This meeting was intended to take place at the time of the bi-annual recertification of AFDC and MA benefits. However, the individual sessions were problematic. Often, the clients were not able to stay for their counseling session on the day of their recertification, and counselors were unavailable for the high volume of make-up appointments. This created a bottleneck of persons awaiting individual enrollment counseling. Other factors that added to the slow initial program enrollment included: retraining of staff, delays in advertising, verifying the eligibility for newly eligible clients, allowing eligible individuals using the community health centers to remain in the FFS setting, and allowing pregnant women with non-participating prenatal providers to remain in the FFS system.

To increase the volume of enrollees, enrollment counselors now conduct presentations to groups of eligibles rather than individuals; a video presentation has been developed for group enrollment counseling, and a mail-in enrollment system has been developed. The combination of group presentations, videotape, and mailings has been very successful. These methods have been effective in bringing program enrollment up to the program's original projections.

Medicaid Management Information System (MMIS)

DHS, through a contract with Electronic Data Systems Corporation (EDS), implemented a Rhode Island MMIS in December 1993. This system was designed principally

to pay Medicaid claims and to provide reports of services and expenditures. The State decided to adapt the MMIS to serve Rite Care, and OMC and EDS have designed two MMIS Rite Care subsystems. The first subsystem tracks enrollee membership in the health plans, notifies the plans of enrollments and disenrollments, and makes the capitation payments to the plans. The second subsystem establishes an encounter data base with service information received from the plans on clients' episodes of care. The advantages of adapting the MMIS, rather than developing a new and separate system, are that Rite Care can access existing client information on the MMIS, and that reports for both the FFS and managed-care programs can be generated from one source. Reports generated from the encounter data base previously mentioned will be used by OMC to monitor the HMOs' medical care quality assurance and to support the research components of Rite Care.

Community Relations and Education

Although Rite Care will be providing health care coverage for only 7.5 percent of Rhode Island's population, the program affects nearly every component of the State's human service and health care delivery system. Furthermore, Rite Care has gained added attention because it is often viewed as the State's first "health care reform" effort. Therefore, OMC has devoted significant resources to developing methods for disseminating program information to clients, providers, and the community.

A telephone information line, staffed with both English and Spanish-speaking operators, has been established to field client questions and complaints. Each client is also provided with information at enrollment directing them to contact their

DHS field office or their chosen HMO's customer service line for information. A Rite Care Consumer Advisory Committee has been established to obtain the clients' and their advocates' input on policy decisions, and program implementation and operation issues.

In addition, OMC has provided the State's service providers with information regarding general program goals and objectives, and the MMIS contractor has distributed information to the providers regarding specific operational and billing issues. The HMOs have the primary responsibility for informing providers regarding specific client service issues. A public information campaign was conducted primarily to reach the newly eligible population and encourage them to enroll in the program. This effort has utilized a variety of multilingual outreach activities including billboards, bus signs, public service announcements, print media advertisements, and information booths. As well as reaching newly eligible families, the publicity campaign was even more successful in reaching lower income, uninsured families who actually would have been previously eligible for MA, but who had never applied.

Rhode Island's article has focused on the major implementation and operation issues that Rite Care has faced throughout its development and early months of operation to include the licensure of NHPRI. What shows clearly in this description is the tremendous level of cooperation required of all parties involved—the MA clients, the health plans, the service providers, and the State agencies.

CONCLUSION

As this article shows, each State's experience with health care reform is unique to

that State. However, some issues and problems are overarching, and can be used as models, both as good examples and as careful caveats for other States not yet involved in the reform process. HCFA is committed to working with the States in their efforts to transform their health care systems. Regardless of this exceptionally complex process, the Federal-State partnership is vital to the success of this venture.

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