Managed Care and Farmworkers: *Oil and Water?*

by David Cavenaugh, Migrant Health Program Consultant

This is the first of several Streamline articles that will review managed care as it applies to the operations of migrant health clinics. This installment will review the basic concepts of managed care, with special emphasis on data needs. Subsequent articles will discuss in more detail the impact of managed care on patients, on internal center operations, and on a clinic's planning and marketing strategies in light of the external environment expected for the foreseeable future.

"'The statistics are in for your first quarter," Kelly said in a somber tone. 'And they are not good."

David looked back and forth between the two men, feeling increasingly anxious.

"Your productivity is not satisfactory," Kelly continued. "You are in the lowest percentile in the whole CMV organization according to the number of patient visits per hour. Obviously you are spending entirely too much time with each patient. To make matters worse, you are in the highest percentile in ordering lab test per patient from the CMV lab. As far as ordering consults from outside the CMV community, you're entirely off the graph."

"And that's not all" Kelly said. "Too many of your patients have been seen in the emergency room rather than in your office."

"That's understandable," David said. "I'm fully booked out for two weeks plus. When someone calls with an obviously acute problem needing immediate attention, I send them to the ER."

"Wrong!" Kelly snapped. "You don't send patients to the ER. You see them in your office provided they're not about to croak."

"But such disruptions throw my schedule into a turmoil," David said. "If I take time out to deal with emergencies, I can't see my scheduled patients."

"Then so be it," Kelly said. "Or make the so-called emergency patients wait until you've seen the people with appointments. It's your call, but whatever you decide, don't use the ER."

"Then what's the ER for?" David asked.

"Don't try to be a wiseass with me, Dr. Wilson," Kelly said.

Robin Cook, Fatal Cure
Berkley Books, New York. 1993

The above fictional account paints an ominous picture of managed care, as agents of parent corporations come to control internal operations in a health care setting.

The Revolution in Health Care

In a model of care that has gone from 25% to 80% of all care in the US in nine short years, outside organizations now monitor all aspects of the delivery of medical and health care and are quick to intervene. The traditional fee-for-service method is no longer permitted. The historical autonomy of the provider has been compromised in the name of cost efficiency. Access is limited to a network of contracted providers, over which the "Managed Care Organization" (MCO) has contractual controls. Rates are set on the average costs of care to large populations, and profit is assured when costs can be held below rates.

In the Medicaid world, the same thing is happening, although for a different reason: the rise in costs of Medicaid care are crippling state budgets, which unlike the federal budget are not allowed to run a deficit. Thus, states are eager for the promised relief that contracting Medicaid out to managed care companies is expected to bring.

Terminology

It is not our desire to underestimate anyone's knowledge of this phenomenon, but to acquaint *Streamline* readers with the implications of managed care for their centers from the ground up. Many clinicians have not been able to attend conference sessions on managed care. Those who do often find the content to be at an advanced level, so a primer/refresher seems in order. We begin with the terminology of managed care.

Capitation

Perhaps more reminiscent of a term describing guillotine use, this term expresses the unit-cost nature of managed care contracts. The term refers to the fact that aggregate costs of care are expressed as a rate per individual — or per head. Actually, the size of the populations covered by managed care contracts is expressed in terms of 5,000 "lives" or 200,000 "bodies" — hardly implying a sensitive provider/patient interface.

Member vs. User

Health centers presently report costs per user and encounter. In these reports, *user* refers to a patient of the center coming for care at least once during the program year, and an *encounter* is roughly equivalent to a medical visit. *Member*, on the other hand, refers to an enrollee of a given health plan, assigned to the center but who may never appear for care.

Target rates under managed care are calculated only in the aggregate for an entire contract population — usually expressed in "rate per thousand" terms, for particular health variables like diabetes, low birth weight, prenatal care — not in relation to health status of actual patients seen in a given year. However, *costs* are kept down by ***minimizing services per member, including reduced use of the clinic.***

Thus, patients who don't use services (presumably because they're being kept healthy) increase clinic revenues. This is very different from the operation of fee-for-service health care, under which revenues are tied directly to services rendered — the greater the use — which is almost to say the sicker the patient — the greater the billable revenues.

Rate setting

Under managed care, rates are determined by calculating expected costs for health care of a large population, reduced through incorporation of assumptions about ability to improve overall health status through adequate access and appropriate utilization, and then divided by the size of the population. This rate is usually expressed in terms of payment "Per Member Per Month." Contracts are negotiated around these rates, and around the services to be provided for a given payment. The rate is inclusive of all components of the category of care (for example, primary care) to be provided — providers, lab, x-ray and pharmacy, and administration costs.

A vitally important corollary to accepting a contract at a given rate is being able to determine if the clinic's costs *are* in fact above or below that rate. Given that Medicaid is now the source of about 40% of Migrant and Community Health Center revenues, a lot is on the line if the clinic ***does not*** meet its target rates. Failure to do so can come from three sources: data that show costs are actually higher, data that show costs are in line ***but the data are wrong because the information system is flawed***, and data that are incomplete and incapable of showing whether the targets are being met or not. Centers just getting into managed care are far more at risk for losing money on managed care due to the second and third reasons.

Gatekeeping

This central concept of managing care refers to the limitation of the patient's

access to certain sources of care, selected by the insurer under arrangements that reduce and monitor costs. This requirement of managed care is why state Medicaid programs must seek a "waiver" from the federal government to convert their programs to managed care: Medicaid protections otherwise include the right of the patient to go anywhere of her choosing for medical treatment.

Gatekeeping also permits control of utilization. Restricting the patient's entry point into the health care system permits replacing higher-cost patient or provider preferences (for specialty referrals or tests) with cost-controlled alternatives — the MCO's own subcontractors.

"Managing care" has as its overall goal the maintenance of health by theoretically providing early intervention via primary care to avoid high-cost inappropriate utilization of secondary or tertiary facilities, and to keep conditions from developing unnecessarily. In practice, this logic is not evident to many of the providers affected, and certainly not to the patients who experience confusion about suddenly restricted access, new and less preferable sources of care, and denials of requested services (sometimes including emergency care).

Adverse Selection

This refers to the likelihood that high-cost, poor health status patients will gravitate toward a clinic that reaches out to them, as health centers always have. Therefore, a center's average costs per member per month (PMPM) are almost guaranteed to be higher than the average cost for the larger population on which the rates are set. Adverse selection **must** be factored into the rates a migrant and/or community health clinic negotiates, or substantial losses can be expected.

Risk

When a clinic contracts for a menu of services, it agrees to provide all members with that care regardless of the cost. A migrant/community health clinic may cover primary care only; or primary and emergency care; or primary, specialty care and emergency.

The broader the scope of services, the more an organization can increase revenues by keeping costs down. However, a given organization may not have the ability to control the costs of another organization, so agreeing to a rate that makes assumptions about economies elsewhere may tie the clinic to a money-losing proposition. Successfully managing risk means that the center must accurately determine the needs, the costs, and be able to negotiate an adequate contract.

Centers Are Swept up in the Changes

Community and migrant health centers have traditionally operated independently of private medical care facilities for the most part because the client populations did not overlap. Now, however, for the vendors who win the state Medicaid managed care contracts, client populations will overlap. Centers must rapidly expand efforts both INTERNALLY and EXTERNALLY to provide this contracted care.

Internally, a clinic must produce data that demonstrate to vendors the efficiency of its operations in new, more quantitative terms. Externally, to ensure its own survival, a clinic must link into the new managed care networks.

How Will this Affect Farmworkers?

Managed care has the potential to create enormous new gaps in health care through which the majority of farmworkers, including women and children, will fall. Migrating workers are not often covered by Medicaid. Many are adult males, not usually covered in states that tie Medicaid to Aid to Families with Dependent Children (AFDC); few carry documentation complete enough to assure prompt eligibility determination; and — upstream at least — migrants are in-state too briefly to apply for and obtain eligibility.

Migrant Health Needs Community Health Centers

The fiscal fate of the whole clinic organization, which determines the stability of the farmworker program, will now depend to a substantial extent on its ability to enter into managed care contracts which are fair and adequately cover costs: Centers being pushed to "sign here or you are out of Medicaid" may find in as little as a year that they have accepted payment rates far too low to cover costs.

The clinic director's ability to know what the rate would have to be to cover true costs depends on a partnership of the clinical and administrative staffs to identify what is needed to derive and present those facts. Farmworkers are traditionally more costly to serve due to their isolation and greater health risk. Even if the migrant program generally is still grant-supported, many centers receiving both community health and migrant health funds in effect subsidize their migrant program from other funds.

At present, little data are collected on farmworkers *per se* at Migrant Health centers. According to the author of a recent report on migrant health center data collection, health centers collect very little specific data, e.g. related to diagnoses, outcomes, or utilization patterns, on farmworker users. The only way to assure that the migrant program is appropriately supported is to assist in internal efforts to *identify and track the true costs of services* for all programs.

External and Internal Implications

Compared to the past, state Medicaid managed care programs may actually offer farmworkers more access to care, as more providers take Medicaid. In communities with migrant centers, clients may be drawn away from the clinic, either by the perception of higher quality care or by assignment. This may not last, as patients see the relatively weaker cultural and ancillary support commitments in other facilities, but it does require clinics to compete for their patients, as a business, rather than continuing to operate as a last-resort resource for a segment of the population ignored by the market.

While administrators are at work on these external negotiations, including marketing and advocacy, providers may be able to focus on developing some of the internal planning that will become necessary all too rapidly .

The Engine that Drives Managed Care: Data

For a community clinic, managed care requires **much** more DATA than the organization may be accustomed to routinely collecting. While desirable before, internal operations now *must* be fine-tuned for maximum efficiency. Current and desired performance in a host of measures will be assessed quantitatively. At present, providers may periodically review information such as total encounters per month by service and total lab tests per month. They may wish they could monitor indices such as lab costs per month per provider and annual visits/capacity per specialty. Under managed care, not only will these and other data be needed, but *another organization* will review the clinic's data outputs on utilization management, quality assurance, and management information.

Health center grantees have always had to monitor and report on revenues, staffing, and costs. These reports — even the new Uniform Data System — are basically accountability reports on the use of federal grant funds, and are not designed to provide the kind of data useful in corporate planning. As businesses, clinics should know the cost of their products if they are to set prices appropriately. They need information analysis tools that calculate **performance indices**, as well as analytic time and effort to review and interpret the results regularly.

In addition, data are needed on enrollments, provider assignments, utilization, quality, referrals, outcomes, training, and staffing, as well as on reimbursements and coordination of benefits. To even begin col-

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lecting data on many of these indicators, clinics must improve information system(s) in use at the center — both hardware/software, and data collection tracking procedures in use.

To assist in developing managed care systems, a template has been developed for employers to use in selecting managed care plans. State Medicaid offices are going to use this template to select plans with which to contract. The template is called HEDIS: The Health Plan Employer Data and Information Set. The HEDIS is now taken as the standard tool for assessing managed care plans, and centers are advised to become acquainted with the final release of the Medicaid HEDIS, just out this year.

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Implementation of managed care varies greatly from one state to the next. This variability presents mobile farmworkers with a whole new series of barricades to eligibility as they move north each year. As this series continues, please assist us in drawing from your experiences to share with others. Call, write or e-mail MCN (mcn@onr.com) with your observations on service reductions, internal data needs and efforts to meet them, patient education, network development — any aspect of the managed care revolution that you find salient as you work in this time of upheaval in health care.

For questions about the article, or your training needs, contact the author at (202) 363-0814 or by e-mail at dave.cavenaugh@access.gov on the HHS Access bulletin board.

David Cavenaugh is a Washington-based consultant to migrant and community health centers on the transition to managed care, especially for rural and migrant centers. On the staff of the National Association of Community Health Centers for over ten years, primarily as its Migrant Program Specialist, he is now working directly with centers and through Bureau training and monitoring activities to aid them in the networking, data system and internal analysis changes which managed care requires.

CALENDAR

Latino Culture and its Impact on the Provision of Health Care
Reading, Pennsylvania
April 17, 1996
Information: MCN
(512) 327-2017

National Primary Care Conference
Orlando, Florida
April 17-20, 1996
Information: Nurse Practitioner Associates for Continuing Education
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Annual Healthier Communities Summit
San Francisco, California
April 20-23, 1996
Information: Healthcare Forum
(415) 356-4300

Closing the Gap: Progressive Strategies for Improving Health in Communities of Color
Chicago, Illinois
April 24-26, 1996
Information: U.S. Dept. of Health and Human Services, Office of Minority Health
(312) 419-7084

14th Annual National Conference on Health Education and Health Promotion
Washington, D.C.
April 25-28, 1996
Information: New York State Health Dept.
(518) 474-5370

Clinical Care Option for HIV
Scottsdale, Arizona
May 2-5, 1996
Information: Clinicale Care Options for HIV
(818) 752-9396

AFOP Spring Conference
Washington, D.C.
May 2 & 3, 1996
Information: Association of Farmworkers Opportunity Programs
(703) 528-4141

Annual Migrant Health and Clinical Issues Conference
Stouffer Hotel, Nashville, TN
May 4-6, 1996
Information: MCN and NACHC
(512) 327-2017; (202) 659-8008

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Acknowledgment: The Streamline is funded by the Health Resources and Services Administration, Bureau of Primary Health Care, Migrant Health Program. The views and opinions expressed do not necessarily represent the official position or policy of the U.S. Department of Health and Human Services. Subscription Information and submission of articles should be directed to the Migrant Clinicians Network, P.O. Box 164285, Austin, Texas 78716, (512) 327-2017, (512) 327-0719.

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May / June 96

Managed Care and Farmworkers: Oil and Water?

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Part II: Proving the Case

This is the second in a series of Streamline *articles that review managed care as it applies to the operations of migrant health clinics. This installment restates the primary importance to migrant health programs of understanding managed care; describes in more detail the evaluation tool expected to be used widely in Medicaid managed care; and offers information on resources for further information. Subsequent articles will discuss in more detail the impact of managed care on patients and internal center operations.*

I. Importance of Understanding Managed Care

States are now deciding whether to include Migrant and Community Health Centers in state Medicaid Managed Care plans. These decisions are based largely on quantitative provider performance data. To recap some of the main points from our first article:

- A clinic must produce data that demonstrate to Managed Care Organizations (MCOs) the efficiency of its operations. The ability to know true costs depends on a ***partnership of the clinical and administrative staffs*** to identify what is needed to derive and present those facts. The fiscal fate of the whole clinic organization, which determines the stability of the farmworker program, now depends to a substantial extent on its ability to calculate these costs accurately, for historical and prospective periods, and to enter only into realistic managed care contracts.
- Targeted rates under managed care are calculated only in the aggregate for an entire contract population, usually several hundred thousand, not in relation to health status of actual patients seen in a given year and/or at a given type of clinic. Community and Migrant Health Centers have traditionally delivered care to medically underserved populations. Due to their isolation and greater health risk, farmworkers are clearly more costly to serve. Specific data — diagnoses, outcomes, utilization — specific to farmworker users, is vitally needed. Adverse selection (the likelihood that these higher-cost-to-serve patients will choose to come to a clinic) ***must*** be factored into the rates a migrant and/or community health clinic negotiates, or substantial losses can be expected.
- While few migrants receive Medicaid, it is now the source of about 40% of Migrant and Community Health Center revenues. The migrant program generally is still grant-supported. But, many centers receiving both Community Health and Migrant Health funds in effect have come to subsidize their level-funded grant-based migrant program from other, increasing fund sources. To assure that the migrant program is appropriately supported in the future, internal efforts to identify and track the true costs of services for all programs is required. Thus, the rates set for the Medicaid-eligible patient population can be adjusted to incorporate the continued needs of the migrant program.

II. HEDIS: The Standard for Assessment of Plans Under Medicaid Managed Care

Even though they are non-profit corporations, clinics are businesses and as such should know the costs of their products to set prices appropriately. Clinics need tools for informational analysis that calculate ***performance indices***, and analytic time and effort to review and interpret the results regularly. Clinics must improve information system(s) in use at the center — hardware/software, and data collection tracking procedures. Data are needed on enrollments, provider assignments, utilization, quality, referrals, outcomes, training, and staffing as well as on reimbursements and coordination of benefits.

The National Committee for Quality Assurance has developed a template called ***HEDIS: The Health Plan Employer Data and Information Set*** for employers to use in selecting managed care plans. State Medicaid offices are going to use it to select plans with which to contract. With a very few selected measures as examples, its categories include:

- ***Membership*** — Member months by age, gender and payor
- ***Utilization*** — Maternity, pharmacy, frequency of visits by Medicaid member type
- ***Quality*** — Immunizations, screenings, low birth weight (but compliance with standards is difficult to assure given a mobile population)
- ***Access & Member Satisfaction*** — Outcomes measures, ancillary services
- ***General Plan Management*** — Board certification risk management, new member education, waiting time
- ***Finance*** — Trends, indicators

Although versions of the HEDIS have been available for several years for the general health industry, the version developed specifically for Medicaid was just released this year. Centers are advised to become acquainted with it through CHC program training sessions or their state Medicaid agency.

III. Levels of Impact: Patient, Center, Network, State

Internal cost analysis is a necessary component of a managed care strategy. Prospects for a clinic's migrant program are clearly tied to the organization's overall plan and rate setting calculations. However, program survival also depends on larger inter-organizational factors: formation of networks, (too large a topic to be covered here), and state regulations on Medicaid managed care contracting with existing Medicaid providers. Vendors winning state contracts may or may not subcontract with Community and Migrant Health Centers, particularly if not required to do so by the state. To avoid this risk, several state associations of health centers are assisting their members in forming HMOs so that they can contract with the state directly.

Washington's state association has already done this, and via its spinoff MCO, is serving farmworkers eligible for Medicaid at or below negotiated managed care cost rates. The North Carolina state association has just finished surveying centers to determine data management needs and current tracking on various operations indicators (see also discussion of HEDIS, below).

Colorado's statewide Health Center HMO began operations in December of 1995. One large Migrant Health center has 3,000 of its patients already converted to Medicaid managed care, and foresees this growing to 6,000. Overall in the state, the HMO has already registered 42,000 patients into its Medicaid managed care operations in only four months.

Texas' state plan is moving ahead very rapidly. First announcements of the state's intention to convert Medicaid to managed care were made only last September. Contracts have already been awarded for the first two metropolitan areas not even five months later. Medicaid in the Rio Grande Valley, with its three large Migrant Health centers and major home base population of migrant farmworkers, converts to managed care in early 1997. Although Texas Health Centers had formed an HMO and bid directly with the state for contracts, it was not selected in either competition to date. Centers in those areas can nevertheless solicit subcontracts directly from the chosen vendors.

California centers are very concerned about their ability to retain reimbursement for full and reasonable costs from Medicaid as the state implements over a 24-month period a plan for converting Medicaid in 12 counties to either locally- or state-administered managed care. Presently, only counties choosing local control are required to contract with centers in accordance with the full cost arrangements already in place. Centers in counties opting for state administration stand to lose this revenue, and thus the ability to compete for increased Medicaid patient enrollments. The state association predicts the demise of a significant number of these clinics if this state provision is not rectified — including some with migrant health programs.

Many more states are converting Medicaid to managed care, taking away patient choice of provider and locking Medicaid recipients into one plan. As migrants move with the seasons across the country, they are already encounter-

ing these strictures. Georgia migrant health sites, for example, are not even being presented with MCO plan cards by migrant from Florida, as out-of-state provider reimbursement arrangements are even more convoluted under MCO-based Medicaid managed care than they were previously.

IV. Resources for Further Information

The Bureau of Primary Health Care (BPHC) has developed one- and two-day training curricula on aspects of managed care: contracting, networking, MIS considerations, Board issues, and more. These are presented at the quarterly or annual meetings of state primary care associations.

Training conferences, such as those offered by the National Association of Community Health Centers (NACHC), also include sessions on many aspects of managed care, for clinicians as well as administrators. The 1996 Annual Migrant Health and Migrant Clinical Issues Conference held in May in Nashville, Tennessee, had several such sessions. Contact NACHC at (202) 659-8008 for more information about upcoming conferences.

BPHC in 1995 released two self-assessment tools for centers to prepare for managed care: one on external issues, a "Market Area" self-assessment tool; the other on internal operations, such as clinic management, MIS, and quality assurance. These can be obtained from the National Primary Care Clearinghouse at (703) 821-8955, ext. 248.

Conclusion

This article has touched on several internal and external aspects of the impact of managed care in migrant health. Please assist us in drawing from your experiences to share with others. Call, write or e-mail to MCN (mcn@onr.com) your observations on any aspect of managed care operations of interest in your clinic, network or state. Such input will enable us to present a spectrum of specific impact on migrant health in future installments. For questions about this article, the series, or your training needs, please contact the author at (202) 363-0814, or by e-mail to: dave.cavenaugh@access.gov on the HHS Access bulletin board. MCN can be reached at P.O. Box 164285, Austin, Texas 78716; 512/327-2017 (voice), or 512/327-0719 (fax).

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Primary Eye Care *continued from page 1*

Migrant Health Outreach.

More than 50 mushroom harvesters, ages 17 through 39, were screened during the first two weeks of the primary eye care project. Approximately half of those screened were referred to the Pennsylvania School of Optometry. Referrals are given for people with suspected refractive errors and/or eye problems including scratched corneas, conjunctivitis, and pterygium.

Data collected during the eye care screening becomes part of the client's permanent medical record. Relevant information about the client's overall health status, gathered during the eye care screening, is conveyed to the optometrists working with the project to assist them in properly assessing the client. Pertinent information would include conditions such as diabetes, high blood pressure, cholesterol, tuberculosis, and sexually transmitted diseases.

Education on the prevention of eye injuries was provided during the eye care screenings. It is also reinforced during pesticide training for the farmworkers.

Most of the farmworkers in the pilot project were not available for screening until the end of the day or early evening due to harvesting schedules. Poor lighting conditions in the work camps forced the screenings outside into the sunlight — and the cold — whenever possible, since the Focomoter™ is easiest to use in even lighting.

It takes approximately 15 minutes to screen each worker, including the intake interview. But for the farmworkers, the majority of whom had never had an eye exam, the long wait for their turn was no problem. They were vocal in their gratitude for the opportunity to have their eyes checked, and eager to help in the process.

The screening quickly became a camp event. The men took turns holding the eye chart, teaching and assisting each other to use the Focomoter™, and prompting each other's memories when histories were being taken.

Although the mushrooms are grown in the dark, many of the men pick fruit or prune trees during slow times in the mushroom industry. It became evident early on that the sunglasses, intended as an inducement to the eye screening project, would actually play an important role in preventive care. None of the farmworkers screened wore sunglasses outdoors, not even when their work required them to look skyward most of the day. UV damage, ranging from serious retinal injury to near continually red eyes, are a fact of life for many of these men.

We anticipate being able to screen more than 400 workers over the next few months. This is just the beginning. With our new skills, low-cost tools and the opportunity to sell glasses to supplement our resources, we can both sustain and expand these efforts.

Building on the successful start we have had with this project, many participating organizations in Migrant Health Outreach have agreed to expand into counties beyond Berks County. We are excited about the prospect of bringing this project to more people.

Implementing Primary Eye Care for Migrant Farmworkers *continued from page 1*

when a more serious problem presents, can be referred to an ophthalmic professional.

Education

Education about the prevention of eye problems goes hand-in-hand with screening activities. The most effective education occurs one-on-one as a person is going through the screening process. However, printed or visual preventive messages left in the community or available at the clinic can also be very effective. Primary eye care education messages should stress injury prevention, UV protection, hygiene, and nutrition.

Referrals for prescriptions or treatment

Screening efforts are only useful if there is the ability to refer individuals with problems to an ophthalmic professional. A few health centers may have an ophthalmic professional on staff. But, most health centers will have to rely on referrals to outside sources. Communities that are reasonably close to a School of Optometry can sometimes arrange for services through these institutions. Other communities must rely on the local ophthalmic community to provide low-cost or free services to the farmworker population.

Provision of glasses

Once a prescription has been provided by an ophthalmic professional, trained MHC or outreach staff can dispense glasses to fit to an individual. MCN has a link with Morrison International, a company whose mission is to provide corrective eyewear of a high optical quality at a low price. Morrison International sells an eye glass collection called Instant Eyeglasses™, which are designed to fit an individual's prescription and be dispensed in only a few minutes. The glasses are sold at a very low cost, and the profits can be put back into the primary eye care project.

In addition, sunglasses can be provided either free of charge or for a small fee. The sunglasses can be used as an incentive to bring people in while also serving to prevent UV damage, a serious problem among farmworkers.

The Next Step

MCN is available to assist MHCs and outreach teams that wish to implement some or all of these elements of a primary eye care project. The services we are able to provide include the following:

- A Primary Eye Care Manual for Working with Farmworker Populations
- Training assistance for your staff
- Assistance with acquiring vision screening tools
- Assistance with developing a starter kit, including glasses and educational materials
- Sample protocols
- Possible ophthalmic professional contacts in your area

If you would like further information about primary eye care programs, please contact Jillian Hopewell at MCN, (512)327-2017.

July/Aug 96

Managed Care and Farmworkers:

Oil and Water?

By David Cavenaugh, Migrant Health Program Consultant

Part III: Confused Patients, Troubled Staff

This is the third in a series of Streamline articles that review managed care as it applies to the operations of migrant health clinics. This installment reviews the impact of managed care on patients and internal center operations.

Managed care poses serious fiscal threats to health centers. Such serious fiscal threats demand that health center management develop the capacity to quantitatively monitor operations and costs as well as to competently predict risk under contracts at various capitation rates. While these changes seem disruptive, they are still not as fundamental as the changes that managed care poses from the patient's view, where the very right to access health care — even for those *with* health coverage — seems now in jeopardy..

Managing to Reduce Care

The new wave of organization in health care, managed care, has in reality more to do with *limiting* care rather than augmenting access. The move to limit care resulted from the previous inability of insurers to constrain patient access has led, in the opinion of the industry, to excessive and improper use of specialists. This combined with a rise in "defensive medicine," ordering of tests and treatments in excess of what is medically indicated, dramatically increased costs to insurers.

Negotiating the Labyrinth

One of the greatest challenges in developing a new managed care system is protecting the patient's ability to obtain appropriate and continuous care. A system will be insufficient if it lacks incorporation of patient input, knowledge, perceptions, and actual utilization patterns. Unfortunately there are numerous examples of systems that do not adequately protect patients. In one eastern state which implemented managed care, health center patients were aggressively approached in their homes to sign up, and were routinely being told the migrant health center was a part of the plan when it was not. Another center lost 200 home base farmworker patients on Medicaid per month during the transition to managed care, and then endured a lengthy time of insult added to injury when the patients came anyway, not understanding that the center could not seek reimbursement from the state. Worse, the new plan continues to refer former health center patients back to the health center for routine preventive care such as immunizations, without compensation, when it has the requirement for immunization coverage in its state contract. A heath center staffer attending a banquet given by a large managed care plan was concerned by the opulence of the occasion, startled by the hard-driving slide/sound presentation on the plan's sales accomplishments, and saddened to realize that it trumpeted the annual profits — in the millions — but mentioned not *one word about health or the patients*. "It could have been about manufacturing cars or TVs," she said.

Without accompanying ongoing patient education (not just enrollment hype) appropriate to the education and health utilization patterns of patients, a new health system can leave the goal of actual maintenance or improvement of health care in great jeopardy.

In state after state, the advent of Medicaid managed care has been disruptively confusing to patients, and has severely and sometimes fatally blocked their access to needed care. Medicaid has thrown the operations of the primary care gatekeepers into chaos as they try to meet this major and, unfortunately, too-often unanticipated need, while still attempting to make almost emergency-level adjustments to their own operations in order to operate under the new rules, and continue daily caregiving.

A clinic in Oregon that served farmworkers and others, reported having to assign the nursing staff half-time to telephone duty for weeks after the plan began there. Most frequently the nursing staff told concerned patients that they had signed up with (or been assigned to) other providers, sometimes thirty to fifty miles distant, and should no longer come to the Health Center routinely. Many came anyway despite the Center's inability to secure Medicaid reimbursement for their care.

In a review in April of one eastern state's implementation of Medicaid managed care, the *Washington Post* noted an all-too-recurrent pattern;

> *"People had been promised free diapers, even chicken dinners to sign up. Sales people... often falsely promised that patients could stay with their longtime doctors. It wasn't just the marketing abuses. Participants were confused over which physicians and hospitals they could use, and there was widespread concern that the sickest people might receive inadequate care."* "Managed Care for the Poor Tough to Manage, Virginia Finds", *Washington Post*, April 29, 1996

The American Association of Health Plans sent over 100 physicians to the Halls of Congress last month to improve the image of managed care. "There's this perception out there that all these plans want to do is reduce costs, but we think they also enhance the quality of care," one physician was quoted as saying. A reporter comments that the managed care industry is "increasingly under attack in state legislatures for curtailing access to medical care," noting that over 400 bills to restrict HMO operations have been introduced in 40 states this year alone. While this association points to polls citing improved patient satisfaction, the author notes that

KEEP US INFORMED

Implementation of managed care varies greatly from one state to the next. This variability presents mobile farmworkers with a whole new series of barricades to eligibility as they move north each year. The best way for us to help one another as we struggle with the changes managed care brings is to share information. Please assist us in this effort by filling out the following information and sending it to: MCN, PO Box 164285, Austin, TX 78716 or you may also e-mail David Cavenaugh at dave.cavenaugh@access.gov.

NAME _____ HEALTH CENTER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ FAX _____ E-MAIL _____

I would like more information on the following: _____

Problems our health center has encountered with managed care: _____

Solutions: _____

among those interacting with their plans most often — the sickest members — the opposite sentiment exists. "Doctors Offer Prescription for Managed Care's Image", *Washington Post*, April 24, 1996.

Farmworkers, even if eligible for Medicaid and successful in securing coverage, will have an even more difficult time with these changes, particularly in areas lacking Migrant Health Centers. Many plans require "lock-in periods, often of six months or a year, within which patients cannot switch to another plan. In states where plan enrollment is voluntary, those not returning a ballot for selecting a plan within the required time period (possibly because they were out-of-state doing farm work) can be involuntarily assigned to plans. In these cases, as well as those wherein farmworkers are duped deliberately, the odds are greatly increased that the plan with which they have been enrolled is actually inaccessible to them, effectively locking them out of the health care coverage that Medicaid is designed to provide for the poor.

Even if enrolled in a managed care plan, farmworker access to acceptable, appropriate care may be restricted if a Migrant Health Center is not a part of the plan. Migrant Health Centers, in essence, provide specialists in serving this population's needs, and without a MHC in the plan, both the plan and the patient, lose access to its knowledge, sensitivities, and support services.

In homebase areas the number of migrant farmworkers who can obtain Medicaid is much larger than upstream. When Medicaid recipients are asked to select a plan, they may be unable to tell which plan includes the health centers: plans usually do not list member *facilities*, such as health centers, but rather providers by name only, without their staff status at the health center.

Were there a case wherein all of these system barriers did not occur or were overcome, the concept of *gatekeeper*, may place new obstacles in the path of obtaining care — tragic in a population that already underutilizes preventive primary care. This most often occurs when Medicaid populations continue to attempt to utilize the Emergency Room, as they have had to for years as no other providers would see them. Now, while on paper they have a new provider, the plans are confusing, the offices distant, the telephone is answered by monolingual English speakers. The baby is sick tonight, so the family goes to the emergency room — only to be told their "plan" has "refused to pay" and they must shoulder the cost. This, however, is an aspect of plans that is necessary, and can be addressed through early and intense patient education.

Staff Shakeup

Center staff are hit almost as personally as patients by managed care plans. Credentialing requirements will sharply increase, and board eligibility will no longer suffice. Staff must be added to track and analyze data, with no increase in space or capacity. Time spent on educating patients, negotiating with the various provider components of each plan, and multiple plans to provide services to farmworkers through them, is time taken away from the provision and management of patient care. As staff must be kept current and retained as changes sweep through the Center, time is further drawn by a seemingly endless schedule of training and planning meetings. Some providers will be lured away by higher salaries; not a new dilemma for health centers.

Conclusion

All of these internal changes, as was noted in the earlier articles in this series, will most often impact a Center's services to the nonmigratory, resident Medicaid population. However, there is no way for farmworkers to be unaffected by changes, eligible for coverage or not. Once again, therefore, it is necessary for staff serving farmworkers to anticipate the impact of these changes on farmworker patients, as well as the true costs of services to them using the new monitoring activities being put in place in the Center (even though these are for monitoring care of a different group of patients). Moreover, providers should regularly monitor and report on disruptions to care of farmworkers by changes in the facility as it adapts to capitation for others.

Nationwide, reaction to the alienation of patients and disruption of care giving systems brought on by managed care, have been noted by lawmakers, as observed above. Abusive marketing practices can be guarded against when identified. But the profit motive that is now plowing into the long-standing effort to provide some health care to those without it, has enormous and disruptive effects. Vigilance, patient advocacy, and increased reporting of true health needs and care giving performance are called for in order for health centers to survive this era. With effective vigilance and patient advocacy, hopefully systems will fade from view like the one mentioned in Congressional testimony two years ago, in which the managed care provider set up its enrollment offices on the second floor to minimize the number of handicapped who became its members. Your evidence of patients' needs and the negative impact of these changes on an already fragile system are needed to assure protections are put in place in states where programs are still being designed. It seems clear enough that soon everyone will operate Medicaid managed care programs; the time to act is *now*.

This series has touched on several internal and external aspects of the impact of managed care in migrant health. Please continue to let us know by calling, writing or e-mailing MCN (MCN@onr.com) your observations on particular aspects of managed care operations that are unusually positive or negative that you observe in your work in your clinic, or even at the level of network or state changes of which you become aware. For questions about this article or the series, or your training needs, contact the author at (202) 363-0814 or by e-mail at dave.cavenaugh@access.gov on the HHS Access bulletin board.

David Cavenaugh is a Washington-based consultant to migrant and community health centers on the transition to managed care, especially for rural and migrant centers. He works directly with centers and through Bureau training and monitoring contracts on the networking, data system and internal analysis changes which managed care requires.

NEWS FLASHES

- Rubella outbreak in North Carolina: Carolina immunization program and local health department staff have been working intensely for several weeks in an attempt to halt the progress of a Rubella outbreak among Hispanic workers in several industries in Chatman and Lee Counties. Rubella has spread primarily among workers in these plants. Attack rates are higher among immigrant Hispanic workers than among non-Hispanic co-workers. As a number of these workers move from industry to industry, the Rubella virus has traveled with them, and there has been transmission in their crowded living quarters as well. Several pregnant women have been affected. We are now aware of at least two cases whose infections were acquired in Mexico; infection was brought to North Carolina during the incubation period. We understand that children — but not adults are immunized against Rubella in Mexico. Are any of you aware of Rubella cases occurring among migrant workers or other recent immigrants from Mexico in your state? If so, please contact Hollard G. Phillips of the Southeast Health Unit at (912) 285-6002.

- Current Welfare Reform bill that the President may sign will be more severe than last year's vetoed bill. The current bill proposes saving $23 billion over six years on immigrant restrictions, while the previous vetoed bill proposed to save $22 billion over seven years.

HYPERTENSION

continued from page 1

registered lower rates of hypertension than did their counterparts. Factors to be considered, however, which may account for the differences, include the possibility that the Hispanic population in the study perhaps represents a heartier subpopulation which is inherently physically suited for the rigors of agricultural work. Added to this is the cardiovascular benefit derived from the daily routine of the Hispanic worker. On the other hand, it is probable that the non-Hispanic population in the study represents a less hearty subpopulation which, like other populations in parts of Southeastern US, suffers from higher rates of hypertension than does the average American.[6]

Odds ratios were then calculated, as shown in Figure 3, and indicate, for each category, a favorable advantage for Hispanics. However, when confidence intervals were calculated only these categories listed as "Total" and "Male Total" yielded results which were significant at the 0.05 level using Chi-Square. The categories listed as "Male ages 20-39" and "Male ages 40-59" narrowly miss meeting the criteria for showing statistically significant differences between Case and Control populations.

Thus, when adjusted to for age and sex, rates of hypertension in Hispanics versus non-Hispanics did not vary significantly.

Conclusions

Without evidence showing statistical significance by age-specific groupings, the significant differences shown between the two populations (total male and male total only) apparently reflect a difference in age composition, with a younger population being a healthier one. However, if a disparity truly exists, further investigation is warranted to determine if there are factors (i.e., lifestyles, diet) which might be adopted by non-Hispanic populations.

Figure 3.
Hypertension: Case vs. Controls
Odds Ratios and Confidence Intervals

Population	OR	95 CI
Total (Male and Female)	.55	.32 - .93*
Male Total	.42	.20 - .87*
Male ages 20-39	.36	.12 - 1.02
Male ages 40-59	.34	.10 - 1.03
Female Total	.72	.28 - 1.79
Female ages 20-39	.78	.13 - 4.05
Female ages 40-59	.99	.31 - 3.10

*Significant at the 0.05 level using x^2

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Acknowledgment: *The Streamline* is funded by the Health Resources and Services Administration, Bureau of Primary Health Care, Migrant Health Program. The views and opinions expressed do not necessarily represent the official position or policy of the U.S. Department of Health and Human Services. Subscription Information and submission of articles should be directed to the Migrant Clinicians Network, P.O. Box 164285, Austin, Texas 78716, (512) 327-2017, FAX (512) 327-0719.

[6] Statistical Abstract of the United States 1993; US Department of Commerce, Economics, and Statistics Administration; Bureau of the Census; p. 95.

CALENDAR

Annual Conference for the National Association of Community Health Centers
San Francisco, California
August 23-28, 1996
Information: National Association of Community Health Centers
(202) 659-8519

1996 Multi-Regional Clinicians Conference Community Health Centers 2001: New Partnerships-New Directions
Woodcliff Lake, NJ
September 27 - October 1, 1996
Information: Education/Membership Coordinator at the Clinical Directors Network
(212) 255-3841

9th Annual East Coast Migrant Stream Forum
Tampa, Florida
November 8-10, 1996
Information: Primary Health Care Association
(919) 469-5701

Midwest Farmworker Stream Forum
El Paso, Texas
November 14-17, 1996
Information: National Center for Farmworker Health
(512) 328-7682

Western Migrant Stream Forum
Phoenix, AZ
January 24-26, 1997
Information: Northwest Regional Primary Care Association
(206) 932-2133

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