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Medicaid Managed Care Arrangements: Local Health Department and Community and Migrant Health Center Experiences

This is the second in a series of case studies addressing Medicaid managed care. Look for additional case studies in upcoming issues of MEMBERSHIP MONTHLY. For more information, please contact Robin Shillman Rosenblum at NACCHO.

This month's case study addresses Medicaid managed care in Multnomah County, Oregon. The Multnomah County Health Department, which is a 330 grant recipient, or community health center, is a unique example for examining Medicaid managed care. The Health Department developed its own network of providers, and established a plan, CareOregon, to serve Medicaid enrollees in a fully capitated system (Attachment A).

Multnomah County has a total population of 600,000, and includes the city of Portland. The Multnomah County Health Department has a $70 million budget and 800 full-time equivalent staff.

The Health Department has traditionally provided comprehensive primary care, particularly for medically indigent persons. There are currently seven health clinics, all of which are part of the Health Department.

I. Description of Medicaid Managed Care at the State Level

About ten years ago, the state legislature in Oregon directed the state Medicaid agency to begin moving from a fee-for-service system to a capitated system. In response, Multnomah County took some preliminary steps by moving to a partially capitated system (see Attachment A). This has allowed the opportunity to experiment with managing a capitated system for the last ten years. Two years ago, the Oregon State legislature passed the Oregon Health Plan, establishing the framework intended to bring all Medicaid enrollees into a fully capitated managed care system. In order to do this, Oregon has received a Section 1115 Medicaid waiver from the Health Care Financing Administration (see Attachment B).

In three-quarters of the state, there is the capacity to move Medicaid enrollees to a fully capitated system, while one quarter of the state does not have the providers or competition to move to such a system. Multnomah County holds adequate providers and competition

to participate in a fully capitated system. An Oregon state statute requires all health plans to contract with local health departments *only* for communicable disease activities, such as immunizations, TB screening, and STD screening.

There are currently 11 health plans from which Medicaid managed care enrollees may choose in Multnomah County. One of these plans is CareOregon, the plan which was developed by and through a division of the Multnomah County Health Department (see Roman numeral III below).

The state intends to have all Medicaid recipients enrolled in managed care plans by July 1, 1995. Currently, all Aid to Families with Dependent Children recipients are enrolled and "non-categorically eligible" persons (i.e., those persons with incomes less than 100% of poverty who became eligible for Medicaid through the 1115 waiver) are enrolled in managed care plans. Persons in the aged/blind/disabled Medicaid categories are being phased into managed care, and should be enrolled by July 1.

II. Description of Local Health Department/Community Health Center Before Participation in Medicaid Managed Care

Prior to the implementation of Medicaid managed care, the Health Department's seven clinics saw approximately 45,000 primary care clinic clients per year, with about 180,000 encounters (for specific race/ethnicity, and age data on the population served prior to participation in Medicaid managed care, please see Attachment C). Since becoming a community health center 14 years ago, the Health Department has provided comprehensive primary care services, including: dental care, school-based clinics, WIC and other nutrition services, HIV, TB, and STD clinics, many specialized HIV services, and a clinic for incoming refugees. The Health Department has also provided patients with such enabling services as language interpretation (including sign language and TTY) and case management. About 25 percent of all clinical visits involved language interpretation. Neither transportation nor child care has been offered.

The Health Department's main funding sources included the 330 grant monies, county general funds, and Medicaid. Smaller revenue streams included federal family planning and other categorical grants, WIC, and the maternal and child health block grant.

III. Process to Becoming Involved in Managed Care Arrangement

When faced with the decision of how to participate in Medicaid managed care, the Health Department had to decide whether to continue to serve as an acute and chronic medical care provider, or to focus instead on such activities as immunizations, disease control and health promotion, and health education. If they were to discontinue comprehensive primary care provision, they would have also had to give up 330 grant funding. The Health Department determined that if they did not continue to be a primary care provider, too many uninsured people would "fall through the cracks," and would no longer be able to

obtain necessary, quality primary care services. Representatives from Multnomah County spent about two years weighing options and discussing potential roles as a primary care provider, and eventually decided that developing its own health plan would be the best option.

Because Multnomah County had primary care clinics, but no inpatient facility, there was a need to network with an inpatient facility in developing the health plan. The Oregon Health Sciences University, a public health institution whose complex includes the former county hospital, proved to be the best candidate for the network, as it had provided more indigent care than other facilities over the years. When the University agreed to join the network, the health plan, CareOregon, was established.

As a community health center and an active member of the Oregon Primary Care Association, the Health Department met with members of the Association about its plan to develop a fully capitated health system. Originally, CareOregon planned to only include community health centers in Multnomah and surrounding Clackamas and Washington Counties. However, many of the other community health centers, most of which are located in rural areas, eventually wanted to participate in managed care. Passage of the Oregon Health Plan and approval of the 1115 waiver were not expected to greatly affect rural community health centers in the early phases. However, Blue Cross/Blue Shield gave incentives for rural physician associations to develop and contract exclusively with its plan. The community health centers then felt they needed to become involved in managed care, or they would risk losing Medicaid funds. This in turn would jeopardize their ability to serve not only Medicaid clients, but the working poor who have no coverage. Therefore, the community health centers requested, and Multnomah County agreed, to bring them into the network.

A legal question arose as to whether Multnomah County could administer a plan that went outside of county boundaries. The state attorney general's office said that this was not permissible. However, Multnomah County attorneys argued that there was no law precluding Multnomah from acting in a proprietary manner in other jurisdictions, and the County prevailed. CareOregon has been in existence as a fully capitated health plan since February 1994.

IV. Description of Local Health Department/Community Health Center as a Participant in Medicaid Managed Care

Currently, the Multnomah County clinics provide the same comprehensive primary care services as before the implementation of Medicaid managed care. Regarding specialty care, CareOregon has a network of contracts with specialists, so that primary care providers may refer patients requiring specialty care to the appropriate physicians.

Of the 20,000 enrollees in CareOregon, about 10,000 are patients in the Multnomah County primary care clinics. Each patient averages about 4 visits per year. For current race/ethnicity, and age information on the population served at the Multnomah County

clinics, please see Attachment D.

The enabling services currently available are identical to those offered prior to the implementation of CareOregon (see Attachment C). There has been no change in funding sources.

V. Experienced or Predicted Impact of Medicaid Managed Care Arrangements on the Medicaid Population

Health Department representatives say access to care and quality of care have not changed with the advent of CareOregon. Patient access to care continues to be good, with the network of clinics in Multnomah and the surrounding counties. Adequacy of care, which was of high quality before CareOregon began, continues to be good. Standards for the Medicaid population which were measured before managed care and after include ensuring that urgent appointments be filled within 24 hours and preventive appointments be filled within 2 weeks.

One reason Multnomah is able to maintain quality care is that it had been involved with managed care on a partially capitated basis for a long time, so the system has not changed significantly under a fully capitated plan.

Regarding public health implications under managed care, as stated earlier, it is required by state law that managed care plans contract with local health departments for communicable disease activities, because they are recognized outside of the public health community as core public health activities. However, under this law, each local heath department has to do its own contracting with each plan individually, making the logistics of contracting problematic. Further, the skills necessary for negotiating reasonable contracts and systems of billing with health care plans are new to some local health departments. The Multnomah County Health Department currently has contracts with some health plans, and will be focusing on developing contracts with additional plans in the near future.

In addition, the move to a fully capitated system may affect some traditional, direct service roles of local health departments, such as providing specialty clinics in prenatal care and family planning. This is because under universal coverage, managed care plans will provide *all* such health care needs for their enrollees.

Managed care has initiated some health care delivery system changes in the private sector. Hospitals are now looking to provide primary care clinics, specialists are becoming primary care physicians, and care has become focused on outpatient services, not inpatient care.

VI. Conclusion

The most tangible lesson learned through establishing CareOregon was that local health departments and community health centers must assess their capacities and the needs in the

communities they serve when considering the roles they should play. In this case, it made the most sense for the local health department to be a primary care provider, as the County had played a significant role in providing primary care to indigent persons for many years. In other cases, if there are sufficient numbers of providers who have experience working with vulnerable populations, that may not be the best role for a local health department.

One goal in operating CareOregon is to impact the way other commercial health plans conduct business, by leading through example. CareOregon aims to show that investing "up front," through prevention and other activities to promote the health of low-income populations, may be economically viable. This follows the philosophy of local health departments and community health centers, and putting it into practice may serve as a challenge to other plans to operate in the same manner. CareOregon also aims to help establish the measures to which they and other plans must be held accountable, and to ensure that data and outcomes analysis become requirements of operating a health plan. As a "player" in the Oregon managed care environment, they are appropriately positioned to have input into this process.

Similarly, one strong recommendation from the Multnomah County Health Department is for community health centers and local health departments to be certain to be involved in some way with implementing managed care in their areas. Regardless of whether these agencies are fully informed about the managed care climate at the very beginning of such discussions, they must do everything possible to ensure that they are included in the process, including taking necessary risks.

Although the Health Department was the creator of CareOregon and is a very active participant, there is some belief that an ideal role for local health departments in managed care is to provide leadership in monitoring public health indicators and work with health plans to improve public health.

Finally, CareOregon has said that if the broad public health community is going to survive in tight economic times, providers and other groups with similar interests (i.e., local health departments, community health centers, and academic medical centers providing care to the indigent) must work together and overcome differences. As CareOregon was being developed, such entities worked together, knowing that the survival of each depended on that of the others. CareOregon recommends that public health entities take the time to explicitly outline their common goals and missions. Agencies may find more in common than they expect. As these entities begin their work together in a managed care environment, they may look to the outline as a guide if working relationships appear to need improvements or changes.

Attachment A

RISK-BASED MODELS: PARTIALLY AND FULLY CAPITATED PLANS

In Medicaid managed care risk-based models, providers assume partial or full financial risk for the services they provide. Providers are reimbursed a capitated, predetermined payment per enrollee for some or all of the services provided. The payment is based on the projected costs of treating a patient. If actual treatment cdcosts exceed the prepayment amount, the provider must absorb the cost. Two types of risk-based plans are **partially and full capitated plans.**

In partially capitated plans, the provider receives a predetermined, fixed payment for a limited set of services, including no more than two ambulatory services, while other services are reimbursed on a fee-for-service basis. Therefore, the provider is not at financial risk for all services provided.

Fully capitated plans reimburse a fixed amount for all services provided, placing the provider at full financial risk. The provider absorbs the loss if the provider's expenses exceed the capitated payment. If the provider's expenses are less than the capitated payment, the provider retains the surplus.

Source: "In Brief: Health Policy Studies," National Governors Association, October 21, 1993.

Attachment B

SECTION 1115 RESEARCH AND DEMONSTRATION WAIVERS

States can test new approaches to publicly supported health care by obtaining waivers of Medicaid statutory requirements and limitations from the Secretary of the Department of Health and Human Services.

Two types of Medicaid waivers exist: Section 1915 program waivers and Section 1115 research and demonstration waivers. Section 1115 waivers are sufficiently broad to allow states substantial flexibility to test new ideas of policy merit. In return for greater flexibility, states commit to a policy experiment that can be evaluated.

Section 1115 waivers have been used by states to enact a broad variety of initiatives. For example:

- most state waiver programs extend coverage to poor and near-poor adults;
- state waiver programs require some or all categories of both "demonstration" and "traditional" eligibles to enroll in managed care plans that are either partial or full-risk;
- state waiver programs involved the purchase of managed care enrollment from full-risk managed care plans that do not meet the requirements of the federal statute;
- most state waiver programs eliminate one or more categories of cost-based reimbursement, as well as disproportionate share payments to one or more classes of hospitals; and
- state waiver programs establish per capita annual payment limits for those services included in the plans' capitation rates.

Approved waiver initiatives range from projects that test providing special services to special populations, to projects that test some major restructuring of the Medicaid program and facilitate the state's goal for health care reform. Section 1115 waivers are also used for welfare reform projects.

Sources: "Review Guide for Section 1115 Research and Demonstration Waiver Proposals for State Health Care Reform," Health Care Financing Administration, 9/6/94; and "Medicaid Section 1115 Demonstration Waivers: Approved and Proposed Activities as of February 1995, " Center for Health Policy Research, The George Washington University

II. Description of Local Health Department/Community Health Center Before Participation in Medicaid Managed Care

The following is based on 1993-1994 primary care data.

Population Served

- Age:

Medicaid Clients	
40%	Age 4 and below
20%	Ages 5 to 14
7%	Ages 15 to 19
26%	Ages 20 to 44
6%	Ages 45 to 64
1%	Age 65 and over

Clients with Other Coverage	
19%	Age 4 and below
14%	Ages 5 to 14
6%	Ages 15 to 19
30%	Ages 20 to 44
14%	Ages 45 to 64
17%	Age 65 and over

- Race/Ethnicity:

Medicaid Clients	
58%	Caucasian
16%	African American
13%	Hispanic
10%	Asian/Pacific Islander
1%	Native American
2%	Unknown

Clients with Other Coverage	
70%	Caucasian
12%	African American
9%	Asian/Pacific Islander
7%	Hispanic
1%	Native American
1%	Unknown

*Data on clients with no coverage is not available.

IV. Description of Local Health Department/Community Health Center as a Participant in Medicaid Managed Care

The following is based on 1994-1995 primary care data.

Population Served

- Age:

Medicaid Clients

32%	Age 4 and below
20%	Ages 5 to 14
6%	Ages 15 to 19
30%	Ages 20 to 44
11%	Ages 45-64
1%	Age 65 and over

Clients with Other Coverage

14%	Age 4 and below
12%	Ages 5 to 14
7%	Ages 15 to 19
32%	Ages 20 to 44
17%	Ages 45 to 64
18%	Age 65 and over

- Race/Ethnicity:

Medicaid Clients

55%	Caucasian
16%	Hispanic
15%	African American
11%	Asian/Pacific Islander
1%	Native American
2%	Unknown

Clients with Other Coverage

64%	Caucasian
13%	African American
12%	Asian/Pacific Islander
9%	Hispanic
1%	Native American
1%	Unknown

*Data on clients with no coverage is not available.