
Medicaid Managed Care: How Do Community Health Centers Fit?

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Managed care has brought about important changes in how the health care system is financed and services delivered. The authors describe the approaches adopted by community health centers to participate in Medicaid managed care and argue that these providers, commonly referred to as providers of last resort, have a role to play in this system. Many challenges lie ahead for these centers, such as the potential imposition of Medicaid block grants, the increasing number of uninsured persons, and cuts in both Federal grants and State budgets. These various forces may adversely impact health centers, leaving them with more uninsured patients and fewer resources.

INTRODUCTION

Managed care is increasingly being seen as a way to contain costs and simultaneously maintain the quality of care. According to the latest data from the Group Health Association of America (1995), enrollment in health maintenance organizations (HMOs) has grown more than fourfold since 1983, with a dramatic 13-percent jump between 1993 and 1994 alone. One in five Americans is now enrolled in an HMO.

Like employers and other third-party payers, States are turning to HMOs and

other managed care arrangements to control costs in Medicaid programs. The managed care portion of the Medicaid revenue stream is still low, but it is likely to increase in the future, mainly as a result of Medicaid statewide section 1115 research and demonstration and 1915(b) waiver programs, and/or Medicaid block grants. The waiver programs, which authorize States to enroll Medicaid recipients in managed care, represent the most recent strategy adopted by States to shift the emphasis from a fee-for-service to a managed care system. From 1990 to 1994, the number of Medicaid managed care enrollees jumped from 2.3 million to 7.8 million, with enrollment more than doubling between 1992 and 1994. Approximately one-quarter of all Medicaid beneficiaries were enrolled in managed care in 1994 (Hegner, 1995). Some of this increase has been attributed to the implementation of section 1115 waiver programs.

In this article, we describe the approaches adopted by federally funded Community and Migrant Health Centers (C/MHCs) to participate in Medicaid managed care. These providers, who have traditionally played an important role in serving the Medicaid population, have been able to maintain their financial stability as managed care continues to change the environment in which they operate. Retaining their basic mission of serving the underserved and the uninsured, however, may be at risk because of cuts in funding and the growing number of uninsured persons. This number was estimated to range from 40.1 to 41.7 million people in 1993, up from 39.8

This article was prepared with the support of a purchase order agreement with the Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Public Health Service. The authors are with the Intergovernmental Health Policy Project, The George Washington University. The opinions expressed in this article are those of the authors and do not necessarily represent the views of the U.S. Public Health Service, The George Washington University, or the Health Care Financing Administration.

million in 1992 (Employee Benefits Research Institute, 1995). Increasing health care costs and declining employment-based coverage are often seen as factors behind the steady increase in the number of uninsured persons (Employee Benefits Research Institute, 1995). Information on C/MHCs was obtained from interviews conducted by the staff of the Intergovernmental Health Policy Project with State officials, health center administrators, and the Bureau of Primary Health Care of the U.S. Public Health Service.

Mission Versus Margin

Health centers are required to serve Medicaid patients as well as anyone else, regardless of ability to pay. Since their inception about 30 years ago, health centers have played an important role in providing community-based primary care to medically underserved populations, including the uninsured. These populations have tended to use C/MHCs as a final, guaranteed source of continuous care. A major portion of the funding for C/MHC operations comes from two Federal grant programs and the Medicaid and Medicare programs. The remaining portion derives from State and local governments, patient fees that are set on a sliding-scale basis according to income and family size, private insurance, and other contributions (National Rural Health Association, 1995). Overall, grants tend to offset the difference between the actual costs of providing care and the amount collected from third-party payments and fees. These grants usually pay for the care of the uninsured, as well as essential support services (e.g., transportation, translation, outreach, case management), not covered by traditional insurers, that improve the health outcomes of underserved populations. In the current environment of decreasing Federal grant support, health centers have

become more dependent on Medicaid and commercial insurers to provide the necessary revenue to further their mission.

A substantial number of C/MHCs have been involved in managed care for more than 20 years, and recently, many more have taken up the challenge. Of the 644 health center grantees, 157 (about 25 percent) participated in managed care arrangements that served 566,000 enrollees in 1994. The latest available data show a 30-percent increase in managed care enrollment from 1993 to 1994. Approximately 73 percent (or 115) of those involved in managed care have either full or partial capitated payment contracts with Medicaid for a total of 436,000 enrollees (U.S. General Accounting Office, 1995).

Many State policymakers, in designing Medicaid managed care programs, have come to recognize the benefits of including health centers as Medicaid providers. First, C/MHCs play a dominant role as providers of care for more than 8 million of the 43 million people who lack access to primary care, including the Medicaid population and the uninsured. Second, C/MHCs are recognized by many HMOs and Medicaid agencies as cost-effective providers of care for the high-risk vulnerable Medicaid population (Lewin-VHI and MDS Associates, 1994). Third, C/MHCs increase the State's managed care capacity to serve Medicaid patients.

Many health centers view the section 1115 and 1915(b) waiver programs as an opportunity to be involved in managed care. They have taken a positive and active stance toward managed care, understanding that the restructuring of their operations for managed care is necessary for them to compete for Medicaid patients. The main purpose of participating in managed care is to ensure that their patients can continue to be served by their traditional provider. One C/MHC executive director

explained what health centers face. "Under Medicaid managed care, a nationally deep-pocketed insurance company can come in and essentially siphon off 40, 50, 60 percent of an established patient base just on the basis of having been granted the State contract" (*Primary Care Weekly*, 1995). Although C/MHCs may lose patients to competitors in the bidding process with the State, they also see patients leave because of their decision to join an HMO or another primary-care provider, thinking, perhaps mistakenly, that they can obtain better care from these providers.

Even as they adapt to the managed care environment, health centers have raised concerns about section 1115 waiver programs and two aspects in particular. These programs waive the 1989 Federally Qualified Health Center (FQHC) reforms requiring Medicaid to reimburse health centers on a cost basis and to include FQHC services as a mandatory benefit. This means that States are allowed to cut reimbursement levels and deny health centers the right to participate in the program. Managed care contracts can, at State option, supersede cost-based reimbursement. Although not mandated, many States supplement prepaid rates that are too low to recover costs. Also, waiver programs require managed care organizations (MCOs) to contract with FQHCs unless the MCOs can demonstrate that they have adequate capacity without the latter.

The section 1115 waiver programs were originally designed to obtain savings from enrolling Medicaid patients in managed care and to invest these savings in efforts to expand access for low-income uninsured persons who are not eligible for Medicaid. But in view of a more conservative fiscal environment, States are now focusing on the first step only, leaving the expansion for a later date. This shift in emphasis in the implementation of section 1115 waiver

programs, along with funding cuts, means that C/MHCs may:

- Face an increase in the number of Medicaid patients, particularly high-risk patients, who are rejected by private physicians because of low reimbursement levels.
- Become increasingly financially vulnerable as a result of inadequate capitation rates, as States are pressured to cut costs.
- Face increasing numbers of uninsured persons because of cuts in eligibility.
- Face a loss of Medicaid patients as competition for these patients increases.

Additionally, Medicaid block grants, as currently discussed by Congress, can be expected to further compound these problems. If enacted, block grants (which would limit the growth in program spending to 4 percent with some adjustments across States) are likely to negatively impact the dollar amounts and the eligibility levels of the program. As a result, health centers may be forced to serve more uninsured (non-Medicaid-eligible) people with fewer resources.

Managed Care Models

C/MHCs' experience with managed care has been varied, but their most common arrangement with health plans involves receiving capitated payments for providing limited primary care services and selected specialty services over which they have direct control (Lewin-VHI and MDS Associates, 1994). There are four basic models of health-center participation in managed care:

- C/MHCs contract directly with the State as primary-care case managers and receive cost-based reimbursement as well as a case-management fee.

- C/MHCs subcontract with HMOs as primary-care providers. Under this model, C/MHCs bear some risk that is generally limited to primary care. They are paid either on a capitated, fee-for-service, or discounted fee-for-service basis.
- C/MHCs contract directly with the State and are at full risk for providing the full range of services to Medicaid recipients, including primary, specialty, and hospital care. C/MHCs are paid a capitated rate to provide these services. This model is only used by a small number of health centers and is not expected to increase.
- C/MHCs create a new entity, an Integrated Service Network (ISN), which in turn contracts back with them and other providers for either the full range of services or a limited number of services. The network contracts for primary care with C/MHCs and with specialists and hospitals for other services. ISNs are often subject to HMO regulation.

Although all these models have been used by health centers to serve Medicaid patients enrolled in managed care programs, the second and fourth approaches have gained some momentum in the recent past. The ISN model seems to be the preferred approach to ensure health centers' participation in section 1115 and 1915(b) Medicaid waiver programs. There is little evidence to suggest that one model would be more effective for C/MHC participation in managed care than another. Health centers are still experimenting with various models, and ISNs have gained acceptance among them.

There are 147 ISNs in various stages of development, with 429 (66 percent) of all health centers scheduled to participate in them. Seven fully operational ISNs, with 71 health centers taking part, are located in Hawaii, Massachusetts, New York (with

two ISNs), Oregon, Rhode Island, and Washington. These networks serve a minimum of 165,000 enrollees—approximately one-third of all prepaid enrollees served by health centers.

In the 11 States with section 1115 waivers approved between 1993 and August 1995,¹ all C/MHCs are participating in networks and/or are contracting with HMOs to provide services to Medicaid patients. Most networks target the Medicaid Aid to Families with Dependent Children (AFDC) population and some of the uninsured for whom coverage is expanded under the waiver proposals. Often the networks form as horizontal alliances to provide primary care, including at least one C/MHC as well as other primary-care providers. Networks sometimes expand to become vertically integrated by adding other types of providers. These networks also tend to develop in a defined service area and then expand to offer services on a statewide basis.

Two Illustrations

Two examples of successful networks are ones developed in response to section 1115 waiver programs in Rhode Island and Oregon. In both cases, health centers formed an HMO that they owned and controlled (as opposed to contracting with an existing HMO). In the view of these centers, a network HMO was the best way to ensure their independence and to be more effective providers of care. However, experience suggests that the centers have to work with other providers to be able to offer all necessary services (e.g., inpatient

¹Since 1993, States have turned to section 1115 waiver programs in increasing numbers. Arizona was the first State to obtain a section 1115 waiver in 1982. From 1993 to August 1995, 11 more States obtained Federal approval of their section 1115 waiver applications: Hawaii, Kentucky, Oregon, Rhode Island, and Tennessee in 1993, Florida in 1994, and Delaware, Massachusetts, Minnesota, Ohio, and Vermont in 1995. However, only Hawaii, Oregon, Tennessee, and Rhode Island have started to implement their programs.

care) and spread the risk of delivering these services.

Neighborhood Health Plan of Rhode Island

The most notable reform in access in Rhode Island is associated with the State's Rite Care program. This fully capitated managed care program, developed under a section 1115 Medicaid waiver approved in 1993 and implemented in 1994, covers all AFDC recipients, children 7 years of age or under, and pregnant women with incomes below 250 percent of the poverty level. Rite Care currently covers 58,000 Medicaid recipients, plus 1,000 poor, uninsured pregnant women and children 7 years of age or under who were not previously eligible for the program.

The waiver eliminates the mandatory aspect of FQHCs' services for traditional beneficiaries and persons eligible for Rite Care but still allows health centers to continue as providers of covered services, albeit no longer under a cost-based reimbursement system. The State is providing an actuarially determined transition payment for the difference between capitation and cost for the entire demonstration period. In addition, Rhode Island requires health plans to include C/MHCs unless the plans can demonstrate comparable access without such arrangements.

Operational since December 1994, Neighborhood Health Plan of Rhode Island in Providence is a State-licensed, horizontally integrated network that includes four C/MHCs, one rural health clinic, five look-alike centers² and four free-standing clinics. The network has adopted a for-profit HMO approach. The 14 health centers assume risk for primary-care services only. The network targets the AFDC population, the medically needy, and some of the underinsured, including certain children and pregnant women. The centers

deliver primary-care services, and the network contracts with seven community hospitals and five academic medical centers to provide specialty care and ancillary and inpatient services on a statewide basis. Capitation applies to C/MHCs, which are at risk for the provision of primary-care services, and risk pools are in place for specialty, ancillary, and inpatient services.

Under the plan, Neighborhood Health Plan of Rhode Island projects that its membership for the first year will reach 26,000, and 30,000 for the second year—more than one-third of the 75,000 people Rite Care plans to enroll. It is one of five managed care plans that serve Rite Care enrollees.

Like any other plan involved in Rite Care, health centers have had to adapt to new constraints, such as a long licensing and slow State-enrollment process. During that process, Neighborhood Health Plan lost about 5,000 Medicaid patients to other plans (Demkovich, 1995). The plan also reported a negative impact on their finances and the impression that they were burdened by a larger caseload of people with no health insurance. According to the executive director of the Rhode Island Health Center Association, total payment in the first year was estimated to be 20-25 percent short of what the centers used to receive. Nevertheless, health centers remain hopeful that through effective management they will be able to realize some savings by the third year of the program (Henderson, 1994; 1995).

Care Oregon

The State of Oregon received a section 1115 waiver from the Federal Government to restructure its Medicaid program in

²Look-alike centers are health centers meeting eligibility requirements for but not actually receiving section 329 (migrant health centers), 330 (community health centers), and 340 (health care for the homeless) grants of the Public Health Services Act.

1993. Started in 1994, the Oregon Health Plan expanded eligibility for Medicaid, enrolling everyone with income below 100 percent of the poverty level, while reducing the scope of covered services under Medicaid. As of May 1995, participation in Medicaid managed care under the plan had reached 70 percent of those enrolled in the first phase of the plan that started in 1994. Forty-one percent (20 percent higher than projected) of the aged, blind, and disabled enrolled in the second phase of the plan that started in 1995.

Under the waiver, the mandatory aspect of the clinics' services is eliminated for traditional beneficiaries and persons eligible for the demonstration. However, FQHCs are allowed to continue as providers of covered services. The cost-based payment was eliminated for traditional beneficiaries and persons eligible for the demonstration enrolled in prepaid plans but was retained for the primary-care case-management portion of the program. Additionally, Oregon requires managed care organizations to include C/MHCs and public health clinics for immunization services and the treatment of sexually transmitted and communicable diseases, all of which are paid on a fee-for-service basis.

Care Oregon in Portland is a State-licensed, vertically integrated service network that includes nine C/MHCs and the Oregon Health Sciences University. The network is a fully capitated health plan, administered by the Department of Health. C/MHCs assume risk for primary-care services only and the Oregon Health Sciences University for hospital care services only. The plan targets the AFDC population, persons receiving Medicaid Supplemental Security Income, the medically needy, and Medicaid patients with incomes below 100 percent of the poverty level, and provides comprehensive services, including primary

care, specialty care, ancillary services, and inpatient services, on a statewide basis.

Under the plan, Care Oregon provides services to 9 percent of the total Medicaid managed care enrollment. It is one of the five major health plans in the State that serve the section 1115 waiver population. At the end of the first phase, several centers that participate in Care Oregon reported almost no change in the number of uninsured persons they saw, even though the plan had expected that number to drop. The plan also reported an average decrease of 20 percent in revenue (Gold, Chu, and Lyons, 1995).

Challenges

Neighborhood Health Plan of Rhode Island and Care Oregon demonstrate both the success of health centers in becoming an important partner under section 1115 waiver programs and the implementation problems of such programs. The waiver programs present many challenges; specifically, how can C/MHCs:

- Reconcile participating in managed care while retaining their mission to serve all regardless of ability to pay? How can they guarantee the continuation of the availability of services to the underserved, particularly the uninsured, with a decrease in overall revenues from managed care?
- Ensure a smooth transition from a cost-based to a capitated payment system? How can they ensure that rates are reasonable and the level of financial risk appropriate?
- Make sure that they are explicitly included as essential providers of care for Medicaid patients?
- Set up an ISN that ensures appropriate medical management, monitors their financial position under each managed care agreement, and maintains an infor-

mation system to support all these clinical and financial management activities?

The Bureau of Primary Health Care has undertaken a number of strategies to help health centers meet these various challenges and strengthen their position in the managed care market. The Bureau has implemented a Managed Care Assistance Program, based on a partnership with HMO executives, that provides health centers with the skills necessary to participate in managed care and change the structure of their delivery system. In addition, the Bureau has provided funding to networks through the Integrated Service Network Development Initiative.

CONCLUSION

Although it is still too early to gauge the success of C/MHCs in managed care, most health centers that have participated have sustained themselves financially, at least in the short term. Retaining their mission, however, remains at risk because they face a growing number of uninsured persons, State budget cuts, Federal grant reductions, and potential block grants.

Both the Rhode Island and Oregon examples show how increasingly difficult it may become to maintain (for the uninsured) access to providers that have historically served the poor under section 1115 waiver programs. ISNs in both States have observed decreased revenues and a steady or growing number of uninsured. This situation may worsen if these States experience further budget cuts and if proposed block grants (in the form of spending caps) are implemented. Under block grants, States would have trouble maintaining their current level of services. Enrolling Medicaid beneficiaries in managed care is likely to continue and may bring in additional savings, but managed

care is unlikely to be enough. Tighter utilization controls, decreased payment rates, fewer covered services, and reduced eligibility levels will all be options considered by States to achieve the necessary savings.

If they are to thrive in the coming difficult years, health centers must search for alternatives to support their basic mission. Analysts have suggested several options:

- Increasing Federal grant funding.
- Instituting partnerships between C/MHCs, managed care organizations, and other providers (e.g., hospitals) to develop community-based plans.
- Reforming the individual health insurance market to facilitate the purchase of health insurance, combined with the establishment of a reinsurance pool, to spread the cost of providing such insurance.
- Creating health insurance programs for low-income workers who are unable to afford health insurance.
- Changing the financing and delivery of care in a comprehensive fashion.

These options are likely to provide C/MHCs the significant opportunities they need to participate effectively in a managed care environment.

ACKNOWLEDGMENTS

The authors wish to acknowledge the contributions of the following persons who provided critical comments in their review of initial drafts of this article: Corinne Axelrod, Project Officer; Lynn Spector; and Rhoda Abrams; all of whom are officials of the Bureau of Primary Health Care.

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