AN EVALUATION OF THE IMPACT OF THE SOCIAL SECURITY ACT SECTION 1115 (a) WAIVERS ON FEDERALLY QUALIFIED HEALTH CENTERS

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Executive Summary

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EXECUTIVE SUMMARY

INTRODUCTION

This study was prepared for the Bureau of Primary Health Care, Health Resources and Services Administration by Lewin-VHI to evaluate the impact of the Social Security Act Section 1115(a) waivers on Federally Qualified Health Centers (FQHCs). Two of the initial 1115 states, Oregon and Hawaii are the focus of the study which explores the impacts on FQHCs as the Medicaid population in these states enroll in managed care programs initiated under the 1115 waiver. The changes in state Medicaid programs resulting from the development and implementation of the 1115 waivers (the Oregon Health Plan-OHP and Hawaii Health Quest—QUEST) are expected to have an impact on FQHCs as a consequence of the elimination of earlier provisions established by the Omnibus Reconciliation Act of 1989 and 1990. These provisions made FQHCs a unique set of Medicare and Medicaid providers and provided a defined set of health care services reimbursed based on 100 percent of reasonable costs. The 1115 waivers allow states to eliminate these provisions. In addition, other aspects of the 1115 waiver programs such as changes in eligibility and benefits, restrictions on freedom of choice, and the states' approaches to managed care are also expected to impact on FQHCs as providers. Consequently, FQHCs may find that they need to change their operations in order to serve the Medicaid population and continue to meet their overall mission of addressing the needs of medically underserved populations.

The key areas of questions addressed by the overall study are:

- What characteristics of the state environment and the waiver have had an effect on FQHC participation and the nature of their role? What was the state environment both leading up to the submission of the waiver and during implementation of the waiver?

- To what extent were the FQHCs involved as Medicaid providers in the waiver program and how has the involvement changes from the pre-waiver period?

- What impacts if any have the FQHC providers experienced?

- What impact did the waiver have on health care delivery and services for FQHCs? What is the difference in the services ordinariiy provided by FQHCs and the services provided under the waiver?

- How has FQHC patient access changed to primary, specialty, enabling and health and other related health services provided prior to the waiver changed under the waiver?

- What are the financial impacts? How has the financial position of the FQHC been effected by the waiver? What difference does the shift from cost-based reimbursement

have on participating FQHCs? Is there a revenue loss or shift of Medicaid revenues for those participating?

This report attempts to answer these questions based on data obtained from the states, managed care organizations, and FQHCs and site visits by the study team to four FQHCs, two in each state. A pre-waiver and post-waiver implementation period is compared for each FQHC bases on state specific time periods reflected implementation periods for the waivers. The time periods for Oregon are July to December 1993 and July to December of 1994 and for Hawaii, October to March 1994 and October to March 1995. The findings which follow are limited by four factors: the period of time used for this study which reflects the first year of implementation; the complexity of the health care environment in which FQHCs operate: the limited number of FQHCs included in the study; and data limitations in two critical areas: financial impact and impact on access to care for FQHC patients. More detailed findings and background information are provided in the overall final report and individual case studies of each FQHC.

KEY FEATURES OF THE 1115 WAIVERS HAVE CHANGED MEDICAID FOR FQHCS AND THEIR PATIENTS

Payment method changes from cost-based reimbursement to a combination of prepaid capitation and FFS rates specified in managed care contracts are a major change experienced by the FQHCs in both states. In Hawaii, the state established a fund to address adverse financial impacts on FQHCs, resulting from capitation but only funded it during the first year.

Both states expanded coverage and restricted freedom of choice for beneficiaries. Changes in eligibility varied by state with Oregon's major expansion to include all legal residents below 100% of the Federal Poverty Levels (FLP) and Hawaii increasing eligibility to 300% FPL (with copays above 100%) and combining various prior public categories. Somewhat different approaches were taken to deal with the role of FQHCs with Oregon requiring managed care organizations (MCOs) to document access but not requiring them to contract with FQHCs while in Hawaii, MCOs were required to contract with FQHCs and RHCs unless they could demonstrate capacity and range of services for vulnerable populations without them.

The nature of changes in benefit packages vary between the two states. In Oregon, use of a priority list adds some new and restricts some old benefits, including major new coverage for dental services, emphasis on prevention and primary care, coverage for all diagnostic services, and changing benefits based on priority level funded. In Hawaii, the benefit package represents an expansion of services for some of the previously covered populations. In both states the range of enabling services to include in benefit packages was the subject of considerable discussion, with very limited direct services being explicitly included.

FQHC INVOLVEMENT IN WAIVER DEVELOPMENT AND IMPLEMENTATION VARIED IN THE Two STATES

In Oregon, the waiver process up to final approval by the Health Care Financing Administration was a highly open and participatory process contrasted to the process in Hawaii where the application was submitted within a very short timeframe and outside involvement focused on implementation after waiver approval. The involvement of the FQHCs and their Primary Care Associations were reflective of this general difference.

In both states, managed care plans were established by the FQHCs in conjunction with other provider groups to assure active participation by FQHCs and a more "center-friendly" approach to managed care. CareOregon was established by Multnomah and Clackamas County Health Departments. Oregon Health Sciences Center, the University Medical Group, and the Oregon Primary Care Association. It has developed as an organization within the Multnomah County Health Department, operating in eleven counties with major enrollment in Portland area and an 8.6 percent marketshare. AlohaCare is a MCO formed by the FQHCs and other members of the Hawaii Primary Care Association and organized as a separate entity operated by an outside contractor locally staffed by former FQHC staff.

FQHCs in both states are actively participating in OHP and QUEST. both as providers within CareOregon and AlohaCare as well as with other plans. In Oregon, FQHCs are contracting with 8 of the 16 MCOs in OHP, generally only with a single plan. In Hawaii, the FQHCs all have multiple contracts. Enrollment in Hawaii FQHCs reflects approximately 17 percent of QUEST enrollees. Similar data were not available for Oregon.

ADMINISTRATION AND MANAGEMENT OF THE FQHCs HAS BEEN AFFECTED BY THEIR PARTICIPATION IN 1115 WAIVERS

There are considerable differences among the centers in this study in terms of their size, the populations they serve, services provided. and their prior managed care experience. All of these differences have influenced the extent to which FQHCs needed to make changes in their administrative and management structures and procedures. In some cases, changes were in process due to other issues (primarily financial difficulties) at the centers and could not be attributed to either OHP or QUEST participation. Among the reported changes related to waiver implementation were:

- Increased requirements for 24 hour coverage at the Centers
- Increased paperwork and additional administrative staff associated with participation in managed care plans
- Increased needs for management information and systems were identified
- Staffing and other organizational changes required to address various FQHCs responsibilities under managed care

BOTH OHP AND QUEST HAVE INFLUENCED CHANGES IN THE DELIVERY SYSTEM AND IN SERVICES

Several factors appear to effect FQHC changes including increased competitiveness in the health care markets in which the centers are located, changes and restrictions in the delivery networks created for each plan, and the FQHC's "readiness" for managed care. Services provided are partly influenced by the nature of the benefit packages in the two states and the extent to which they have changed the previous Medicaid scope of services. Differences between the experiences in Hawaii and Oregon were identified as well as across all the four centers.

- All centers report expanded availability of providers for the Medicaid population
- Oregon FQHCs have experienced changes in their actual or potential delivery system
- Participation in the waivers has emphasized the importance of the role of primary care providers
- Different impacts on the clinical aspects of managed care reflect pre-waiver systems and operations
- Changes in benefits and eligibility have increased demand for dental and enabling services

THE 1115 WAIVER PROGRAMS ARE VIEWED BY THE FQHCS AS INCREASING ACCESS

Increased access is reported in both states as a result of the implementation of the 1115 waivers. This is attributed to eligibility and benefit changes as well as to increased provider participation. While there are very little data available to accurately measure access changes, a variety of changes were reported by FQHC administrative and clinical staff.

- Increased access to dental services is reported in both states as a result of benefit changes although somewhat mitigated by limited provider supply in parts of Oregon
- Increased access to primary care as a result of expanded eligibility and benefits
- Mixed experiences with specialty services related in part to availability of specialty providers and the nature of the MCO provider networks in which the FQHCs participate
- Restricted networks of hospitals and specialists for one FQHC appears to limit availability of obstetric and pediatric services influencing selection of the FQHC as a provider

THERE HAVE BEEN A VARIETY OF POSITIVE AND NEGATIVE FINANCIAL IMPACTS ON THE CENTERS

To fully address the financial impacts on FQHCs, the analysis involves four major components that address different but related questions including:

- Budget analysis provides information about budget changes between the pre and post waiver study periods
- An analysis of managed care contracts identifies the capitation and risk sharing arrangements which impact FQHC financial performance
- An analysis of FQHC patient populations, patient volume, and services identifies changes in these areas which impact FQHC costs and reimbursements
- A rate adequacy/cost analysis examines the adequacy of payments for FQHC costs under the new Medicaid reimbursement system

The full financial analysis required a wide range of data that no individual FQHC had available. Therefore the findings which follow are limited by each center's specific data set. It should also be noted that the pre-waiver financial health of each center also varied and can therefore be expected to influence the impacts of the waiver.

- **The Adequacy of Capitation Rates Varied for Each of the Four FQHCs**

In Oregon, both FQHCs effective payment rates for medical visits did not cover their costs. Rate adequacy ranged was 43 to 53 percent of costs for one center and 63 percent for the other. Mixed results were found in Hawaii, where for one center rate adequacy was 62 to 76 percent for medical visits and for the other, between 5 and 9 percent above costs for its contracts. For that center, which was the only one where analysis of rate adequacy for dental services could be determined, the dental rates were 64 and 106 percent above costs.

- **Centers Could Not Specifically Identify Patient "Conversions" to Medicaid**

FQHCs did not track their pre-waiver population to determine whether existing FQHC patients who previously were not eligible for Medicaid were now enrolled. However, the FQHCs data do show that the centers experienced changes in payer mix that suggest some conversions have occurred. For example, there were major increases in Medicaid volume and visits for the two smaller centers and in a third center, the decrease in the percent of uninsured patients appears to be related to an increase in Medicaid patients.

- **FQHCs Continue to Provide Services Not Included in Capitation and Continue to Provide Services to Non-enrollees**

FQHCs indicate that they have continued to see patients who present at their centers, even when they are enrolled with other providers. Since a primary purpose of FQHCs is to meet the needs of the underserved, it is philosophically difficult for centers to turn people away. However, as more of the FQHCs revenues are derived from capitation, FQHCs are beginning to reexamine how they address such issues. We found that centers have developed protocols to work with other providers to send patients to the provider with whom they are enrolled and to develop some arrangements for reimbursement when that is not appropriate.

In addition, FQHCs may continue to provide services to enrollees that are not included in the capitation that they receive. Prior cross-subsidies are being eliminated making it difficult to absorb these costs as a fixed payment becomes the basis for reimbursement, Finally to the extent, that enrollees at FQHCs are high utilizers, the capitations negotiated across providers may not be adequate. Our study found that where data were available, centers reported high utilization by enrollees. For example, in Oregon, over 70 percent of the enrollees in the centers were actually using center services and in Hawaii, some increases in visits per Medicaid eligibles were noted. Appropriate utilization will depend upon provider and patient education and effective monitoring.

WHAT ARE THE IMPLICATIONS FOR FQHCS IN THE FUTURE?

Our findings in Oregon and Hawaii suggest that the impacts of capitation may vary from center to center and are effected by differences in the state's waiver program provisions as well as specific characteristics of the centers. Our analysis of rate adequacy suggests that at least for one of the four centers, the rates do appear to cover the costs of services while at the others, rates appear not to be adequate. While there are still other issues that are of concern to the centers, this issue of costs and adequacy of rates will continue to be of paramount concern for the survival of the FQHCs. Given the many factors that can change as implementation of the 1115 programs continue, currently observed impacts can change what the study found for the first year of implementation.

Actual impacts over time may be expected to vary due to changes in the waiver programs eligible populations and benefits. New populations such as persons with disabilities are often phased in during the second year of the waivers and pose a different set of issues for service providers such as FQHCs. In addition, the increased experience by the state, MCOs, and FQHCs with managing care for the Medicaid population should also have a variety of impacts. However, it is clear that FQHCs need better data and information systems to appropriately manage care both clinically and financially. In addition, issues related to the FQHC mission and philosophy to serve the underserved will need to be addressed at the appropriate levels to assure FQHCs can continue to address this mission.