Chapter 4

Implications for Health Care Providers

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Chapter 4
Implications for Health Care Providers

INTRODUCTION

Implementation of Oregon's proposed Medicaid demonstration would affect providers of health care organizationally, financially, and clinically. Any impact of the proposed demonstration on providers of care is likely to have a resultant impact on Medicaid beneficiaries' access to care-either primary access or access to specific services. (Implications for beneficiary access to care are discussed further in chapter 5.)

Of the many changes proposed under the demonstration, four are likely to have pronounced effects on providers:

- Enrollment expansion,
- Restructuring of the delivery system,
- Changes in methods and rates of provider reimbursement, and
- Implementation of the prioritized list of health services as the Medicaid benefit package.[1]

Not all of these changes would be fully in place at program startup. Enrollment expansions are expected to occur over a period of approximately 3 years (see ch. 5). Delivery system and reimbursement reforms are expected to be completed within the first 2 years. The prioritized list, however, would be in place from the very beginning. The ultimate impact of the demonstration on providers would depend on the combined effect of all of these changes and would probably vary greatly among individual providers.

This chapter provides a framework for predicting provider response to the demonstration by examining the *possible* effects of proposed changes for different types of providers in the State. First, it provides an overview of Oregon health care providers and the current Medicaid delivery system. Next, it summarizes the proposed delivery system and payment changes under the demonstration and speculates about their possible implications for different types of providers. Finally, the chapter discusses provider issues related to the implementation of the prioritized list as a benefit package. It also discusses the level of data collection efforts and other administrative tasks that providers (and the Office of Medical Assistance Programs (OMAP))[2] would need to take on in order to enable an evaluation of the demonstration.

It is important to note that, at the time this report was written, many aspects of Oregon's implementation process had yet to be developed. The goal of this chapter is first to describe the proposed changes in detail, and then to point out issues of potential concern for providers based on the Office of Technology Assessment's (OTA) understanding of the development of Oregon's plan to date. Some of these concerns appear to be relatively simple ones to address, and some are already under consideration by OMAP; others seem less tractable.

CURRENT STATUS OF PROVIDERS IN OREGON

To understand how the proposed demonstration might affect health care providers in Oregon, it is helpful to examine their current involvement in Medicaid as well as the broader climate in which they function. This section describes the supply and distribution of providers in Oregon and, where possible, their financial characteristics and participation in Medicaid. It then describes how health care is delivered and paid for under Oregon's current Medicaid program.

Provider Supply, Distribution, and Financial Characteristics

Hospitals

There are 66 short-term general community hospitals in Oregon.[3] Of these, 30 are in Oregon's 8 metropolitan counties. Of the 36 hospitals in nonmetropolitan areas of the State, 24 have fewer than 50 beds (155). Table 4-1 shows the distribution of hospitals by county and size.

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1 Another change that would affect providers is the State's proposed waiver of liability for not providing to Medicaid patients those medically necessary services that fall below the cutoff point on the prioritized list. This provision is discussed in ch. 7.

2 OMAP is the agency within the Oregon State Department of Human Resources that is responsible for administering the Medicaid program.

3 Data presented in this section are for short-term general community hospitals only.

Table 4-I-Number and Size of Oregon Short-Term General Hospitals[a] by Geographic Area, Current (1991) Medicaid Delivery System Status, and Anticipated Delivery System Status Under the Proposed Demonstration

Current delivery system in county group	Proposed delivery system in county group	Number of counties	Total hospitals	Number of staffed beds		
				6 to 49	50 to 199	200 to 499
PHP[b] enrollment currently mandatory for AFDC recipients	FCHP to be primary mode of delivery for all demonstration eligibles at program startup	9 (7 metro, 2 nonmetro)	30	7	15	8
PHP enrollment currently optional for AFDC recipients	PCO or FCHP to be primary mode of delivery for all demonstration eligibles at program startup	1 (metro)	3	1	1	1
Currently under FFS system	PCOs to be primary mode of delivery for all demonsration eligibles by year three of demonstration	19 (all nonmetro)	28	19	9	0
Currently under FFS system	Case-managed FFS mandatory for all demonstration eligibles at program startup	5 (all nonmetro)	5	5	0	0
Entire State		34	66	32	25	9

NOTE: AFDC = Aid to Families with Dependent Children; FCHP = fully capitated health plan; FFS = fee-for-service; PCO = physician care organization (PCOs are capitated for physician and selected other outpatient services, but not for inpatient care); PHP = prepaid health plan.

[a] Includes all short-term general hospitals in Oregon except military and VA hospitals.

[b] In 1991, there were 15 partially capitated and one fully capitated prepaid health plans serving Medicaid clients in a 10-county area in Oregon.

SOURCES: Oregon Association of Hospitals, Salem, OR, unpublished data on the distribution and financial characteristics of Oregon hospitals, provided to the Office of Technology Assessment in 1991; Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application,* submitted to the Health Care Financing Administration, Aug. 16, 1991.

Available data suggest that the viability of a number of hospitals in the State is tenuous. For example:

- The average occupancy rate for community hospitals in Oregon is significantly lower than the U.S. average (56.8 vs. 66.8 percent in 1990) (6).
- One metropolitan county and 8 of the 25 nonmetropolitan counties had average hospital occupancy rates below 30 percent (162).
- Although net operating margins[4] of Oregon hospitals generally improved between 1987 and 1990, certain classes of hospitals (e.g., hospitals of 6 to 24 beds, government hospitals) on average reported negative operating margins in 1990 (table 4-2). Operating margins of type A and type B rural hospitals have improved over the last 4 years, perhaps due to the implementation of Federal and State policies that exempt them from prospective payment for inpatient services and percent-of-cost limits for outpatient services. Operating margins of type C rural hospitals, which do not benefit from reimbursement protections, have declined.
- In 1990, 23 of the State's hospitals reported negative operating margins, with 9 hospitals reporting margins worse than –10 percent (155). All but 7 of these 23 hospitals were in nonmetropolitan counties.

Although all hospitals serve at least some Medicaid patients, certain hospitals serve more than others and, hence, are more dependent on Medicaid revenues than their counterparts. For example, in 1990:

- The total number of Medicaid inpatient discharges in Oregon was 38,513.[6] Of these, 26,115 (67 percent) were from Oregon's 10 Medicaid disproportionate share hospitals (162).
- Medicaid represented 11.6 percent of total inpatient discharges and 10.2 percent of total inpatient days in Oregon hospitals. Types of hospitals with a greater than average proportion of Medicaid inpatient discharges and days were Medicaid

[4] See glossary for definition of net operating margins.

[5] Refers to classifications developed by the State of Oregon for Medicaid reimbursement exemptions and other resource allocation purposes. Type A hospitals were exempt from prospective payment for inpatient services for all years represented in table 4-2. Type B hospitals were exempt from prospective payment for inpatient services beginning in 1989. Both type A and type B rural hospitals are reimbursed at 100 percent of costs for inpatient services (based on individual hospitals' Medicare cost reports). Type C rural hospitals are not eligible for these reimbursement protections (161a).

[6] Discharges with Medicaid listed as primary source of pay. Excludes discharges from the two Kaiser Permanente hospitals.

Table 4-2—Net Operating Margins of Oregon Short-Term General Hospitals,[a] 1987 and 1990

Hospital category	Number of hospitals, 199@	Net operating margin 1987	1990
All hospitals	66	2.56%	2.58%.
Metropolitan .,	28	2.63	2.41
Nonmetropolitan.	38	2.63	3.04
Rural class A[c]	9	-1.68	1.25
Rural class B	19	-3.11	-0.10
Rural class C	13	4.95	2.87
Nonrural hospitals	25	2.98	2.79
Number of staffed beds			
6 to 24	8	-16.87	-13.20
25 to 49	24	0.42	2.10
50 to 99	10	5.80	4.94
100 to 199.,....	15	2.92	3.51
200 to 299...,..	1	3.49	1,69
300 to 399.....	4	-1.49	-3.52
400 to 499.....	4	6.68	7.64
Ownership			
Private, for profit.	(8)	-0.43	2.32
Nongovernment, not-for-profit	(39)	5.20%	4.26
Government, State or local	(19)	-11,10	-6.60
Medicaid disproportionate share (DSH) status			
DSH	(10)	NA	-3.66
All other hospitals.	(56)	NA	4.20

NOTE: NA = not available.
[a] Includes all short-term general hospitals in Oregon except military and Veterans Administration hospitals.
[b] This column reflects the 1990 totals for each grouping. Numbers forpnoryears were slightly different.
[c] See text (footnote 5)foradefinition of Oregon rural hospital classifications.

SOURCE: PreparedbytheOregonAssociation ofHospitals, Salem,OR,usingdata from the 1990 American Hospital Association Annual Survey of Hospitals and 1990 audited financial statements from Oregon hospitals.

disproportionate share hospitals (22.9 and 22.0 percent of discharges and days, respectively), government hospitals (18.2 and 18.6 percent), type C rural hospitals (16.7 and 11.5 percent), and type B rural hospitals (13.6 and 12.0 percent) (162).

- Medicaid represented 11.9 percent of total inpatient charges for all hospitals. Types of hospitals significantly exceeding this average included hospitals of 200 to 400 beds (where Medicaid represented about 15 percent of charges), State or local government hospitals (16.2 percent), and Medicaid disproportionate share hospitals (22.9 percent). Hospitals below the average included rural hospitals (6.9 percent for class A), hospitals that were not a part of a multihospital system (8. 1 percent), and hospitals that did not have Medicaid disproportionate share status (7.0 percent) (162).

The distribution of outpatient visits by source of pay appears to differ from that of inpatient visits. Small rural hospitals and Medicaid disproportionate share hospitals had a greater proportion of outpatient visits than inpatient discharges attributed to Medicaid (10.9 vs. 6.9 percent for rural class A, 15.0 vs. 13.9 percent for disproportionate share), while the reverse was true for all other hospitals (162). The higher use of outpatient services by Medicaid patients in rural hospitals could be due to the limited availability of office-based health care services in these areas, although no empirical data exist to support this theory. The differences noted could also be due in part to inconsistencies in how individual hospitals report outpatient visits.

Primary Care Clinics

Primary care clinics in Oregon include federally qualified health centers (FQHCs),[7] federally certified rural health clinics (RHCs), county health

[7] FQHCS are clinics funded under sections 329, 330, and/or 340 of the Public Health Service Act, or other public clinics that serve similar clients, as designated by the Secretary of the Department of Health and Human Services (Public Law 101-239, Public Law 101-508). They include community health centers (section 330), migrant health centers (section 329), and health centers for the homeless (section 340).

Table 4-3-Location, 1990 Patient Population Characteristics, and Proposed Status Under the Demonstration of Oregon's Federally Qualified Health Centers (FQHCs)[a]

Clinic name	Total unduplicated users, 1989	PHS[a] grant source	County/ metro status[b]/ No. of clinic sites	Percent of users with no health insurance	Minority status		Age distribution		Percent of users below 100 percent of FPL[c]	Percent of users who have Medicaid coverage	PCO/FCHP status[d] Now	Under demonstration
Clinica del Carino	2,182	329 and 330	Hood River Nonmetro 1	71%	Hispanic Black Other nonwhite	70.0?/' 0.3% 0.8%	0-19 20-64 65+	44.0% 54.0% 2.0%	70%	14%	None	PCOs by start of year 3
Clinica del Vane	3,794	329	Jackson Metro 1	91	Hispanic Black Other nonwhite	70.0 0.5 0.5	0-19 20-64 65+	41.5 57.0 1.5	70	NA	PCO optional	FCHPs mandatory by startup
Hermiston Community Clinic	3,312	329	Umatilla Nonmetro 1	60	Hispanic Black Other nonwhite	38.0 0.5 NA	0-19 20-64 65+	51.0 46.0 3.0	60	16	None	PCOs by start of year 3
Milton-Freewater Clinic	(New clinic in 1990)	329	Umatilla Nonmetro 1	30	Hispanic Black Other nonwhite	NA NA NA	0-19 20-64 65+	NA NA NA	NA	15	None	PCOs by start of year 3
Multnomah Co. Health Department	38,332	330 and 340	Multnomah Metro 14a	82	Hispanic Black Other nonwhite	3.8 16.3 12.6	0-19 20%1 65+	57.0 41.0 2.0	79	21 in a PCO, 1.8 not	PCOs mandatory	FCHPs mandatory by startup
Salud Medical Clinic	8,075	329 and 330	Marion Metro 1	71	Hispanic Black Other nonwhite	60.3 NA 1.0	0-19 2044 65+	48.0 51.0 1.0	74	11	PCOs mandatory	FCHPs mandatory by startup
SORHN	2,827	330	Klamath Nonmetro 2	39	Hispanic Black Other nonwhite	1.0 1.0 24.0	0-19 20-64 65+	40.0 47.0 13.0	77	29	None	PCOs by startup
Valley Family Health Care Inc./ Nyssa	NA	329	Malheur Nonmetro 2		Hispanic Black Other nonwhite	NA NA NA	0-19 20-64 65+	NA NA NA	NA	NA	None	PCOs by start of year 3
Virginia Garcia Clinic	8,494	329	Washington Metro 1	87	Hispanic Black Other nonwhite	88.5 0.1 0.2	0-19 20-64 65+	46.0 53.0 1.0	92	8	PCOs mandatory	FCHPs mandatory by startup
West Salem Clinic	6,891	330 and 340	Marion Metro 1	26	Hispanic Black Other nonwhite	15.0 2.0 3.0	0-19 20-64 65+	23.0 53.0 24.0	68	35	PCOs mandatory	FCHPs mandatory by startup
Clackamas Co. Health Department	(New clinic in 1991)	"Look-alike"	Clackamas Metro 2	74	Hispanic Black Other nonwhite	10.0 0.8 1.1	0-19 20-64 65+	59.0 41.0 0.0	63	22	PCOs mandatory	FCHPs mandatory by startup

NOTE: NA = not available.

a FQHCs are clinics funded under sections 329 (migrant health centers), 330 (community health centers), and/or 340 (health care for the homeless) of the Public Health Service Act (see text). Other public clinics can also qualify under a "look-alike" provision if they provide similar services.

b Refers t. metropolitan or nonmetropolitan status (Bureau of Census definition) of county in which clinic is located.

c FPL = Federal poverty level.

d Denotes proposed service delivery mode i, that county under the demonstration. PCO = physician care organization (a partially capitated plan); FCHP = fully cavitated health plan. Currently, prepaid plan enrollment is mandatory for Aid to Families with Dependent Children (AFDC) eligibles in a 9-county area and is optional in a tenth county. As of March 1991, four FQHCs (Multnomah County Health Department, Clackamas County Health Department, Virginia Garcia Clinic, and Clinica del Vane) were participating as PCOs and an additional two (Salud and West Salem clinics) were participating as subcontractors to a PCO. Under the demonstration, enrollment in prepaid delivery systems would apply to all eligibility groups (see text). FCHPS would be the required mode of service delivery in nine (urban or urban-adjacent) counties. Other counties are targeted for PCO contract negotiations, although Oregon has not stated in which counties PCOs will be mandatory. The dates in the far right-hand column reflect the time at which OMAP had anticipated PCO and FCHP contracts to be finalized in that county. The original anticipated date for program startup was July 1,1992. Contract negotiations have since been delayed on a month-to-month basis pending approval of the waiver by the U.S. Health Care Financing Administration (see text).
e The Multnomah County Health Department is composed of seven COmmUnity clinic sites and seven school-based sites.
f Clackamas County Health Department was designated as an FQHC in October 1991.

SOURCES: Oregon Primary Care Association, unpubiisheddata derived from Bureau of Common Reporting Requirements reports filed by federally funded clinics and reports from individual clinics, prepared for the Office of Technology Assessment August 1991; Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application*, submitted to the Health Care Financing Administration Aug. 16,1991 ; T. Troxel, Director, Public Health Division, Clackamas County Department of Human Services, Portland, OR, personal communication, Mar. 16, 1992.

Table 4-4-insurance Coverage and Income Characteristics of Patients in Oregon Primary Care Clinics, 1990[a]

	Number and percent of clinics who reported[b] that the percentage of their patients having the characteristics listed below was:																				Total number of clinics with valid responses
	o-lo%		11-2070		21-30%		31-40%		41-50%		51-60%		61-7070		71-80%		81-90%		91-100%		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Insurance coverage:																					
Medicaid coverage	17	30.3	16	28.6	14	25.0	3	5.4	3	5.4	0	0.0	1	1.7	2	3.6	0	0.0	0	0.0	56
Medicare coverage	13	43.3	5	16.7	5	16.7	1	3.3	3	10.0	2	6.7	0	0.0	0	0.0	0	0.0	1	3.3	30
Private insurance	20	51.3	3	7.7	6	15.4	4	10.3	4	10.3	2	5.0	0	0.0	0	0.0	0	0.0	0	0.0	39
No health insurance	4	8.1	3	6.1	10	20.4	4	8.1	2	4.1	2	4.1	8	16.3	3	6.1	4	8.2	9	18.5	49
Income characteristic:																					
Have incomes below 100 percent FPL[c]	3	6.5	2	4.4	2	4.4	3	6.5	10	21.7	6	13.0	7	15.2	5	10.9	4	8.7	4	8.7	46
Pay nothing for clinic services	10	25.5	2	5.1	7	18.0	0	0.0	7	18.0	2	5.1	1	2.6	2	5.1	1	2.6	7	18.0	39

a Based on a 1990 survey to which 97 clinics (all nonprofit) responded. These clinics included 49 county clinics, 10 school-based clinics, 11 federally qualified health centers (FQHCs), 2 Indian Health Service clinics, and 25 other types of clinics. Only 43 of the total 97 clinics reported payment/insurance coverage data.
b Clinics were asked t. report what percentage of all their patients in 1990 fit the categories listed on the left-hand side of this table. Percentages of patients do not add to 100 due to overtap between categories of insurance coverage and income characteristics.
c FPL = Federal poverty level.

SOURCE: Oregon Department of Human Resources, Office of Health Policy, Salem, OR, unpublished data from the June 1991 Primary Care Clinics Survey.

departments (CHDs), and other public and private clinics. These clinics have traditionally played a key role in providing basic primary care services to the Medicaid population.

There are 11 FQHCs in Oregon, located in both urban and rural areas (table 4-3), and 17 RHCs.[8] The 11 FQHCs include clinics with community health center, migrant health center, and health care for the homeless funding, as well as one county health department designated under the so-called "look alike" provision (table 4-3).[9] All FQHCs use an income-based sliding-fee scale for their uninsured patients—some patients may pay the full charge, while others pay nothing. To subsidize uncompensated care, these clinics rely on Federal grant dollars and cross-subsidies from patients who do have health insurance, including those with Medicaid coverage.

Data derived from quarterly utilization reports for 1989 and 1990[10] show that, in the 11 FQHCs, anywhere from 26 to 91 percent of patients seen in a given clinic had no health insurance, and from 8 to 35 percent had Medicaid coverage (table 4-3). The proportion of patients below the Federal poverty level (FPL) ranged from 60 to 79 percent (table 4-3). OTA was unable to obtain service capacity, financial, or patient demographic data for RHCs.

Other primary care clinics include Indian Health Service clinics and 35 CHDs. Data for these facilities are scarce. In a 1990 survey of all nonprofit primary care clinics conducted by the Oregon Primary Care Association, a few such clinics reported patient financial and insurance information (table 4-4). Most clinics reporting data claimed that somewhere between 11 and 30 percent of their patients had Medicaid coverage. The majority also reported that the proportion of their patients with incomes below the FPL ranged from 40 to 100 percent (table 4-4). A CHD in Clackamas County reported that one-third of its operating budget came from Medicaid (261).

Table 4-5-Number of Physicians[a] per 100,000 Population: United States and Oregon, Selected Years, 1980-90

Year	Number of physicians per 100,000 residents: United States	Oregon	Percent difference
1980	202	182	–10.0%
1986	227	209	-8.0
1988	231	219	-5.0
1990	240	220	-9.0

a Includes both allopathic (MD) and osteopathic (DO) physicians.

SOURCE: Oregon Health Sciences University, Office of Rural Health, *Physician Resources /nOregon: A Summary Report* (Portland, OR: Oregon Health Sciences University, September 1991), table 1-1.

Professional Providers

Physicians—As of December 31, 1990, there were an estimated 6,241 practicing physicians[11] in Oregon (188). Of these physicians, 84 percent practiced in the 10 Medicaid "managed care" counties (counties where Oregon currently requires most Medicaid beneficiaries to enroll in prepaid health plans—see "Current Medicaid Program," below); the remainder practiced in other areas of the State (189).

Oregon has historically lagged behind the United States in supply of physicians relative to the population. Although the gap lessened somewhat during the 1980s, 1990 data indicate that it may be growing again (table 4-5). In 1990, 117 (47.7 percent) of Oregon's 241 cities and towns had no physician (188). All of these were places of fewer than 5,000 residents (188). Three counties (Gilliam, Wheeler, and Sherman) had no physicians in either 1980 or 1990 (188).

A larger proportion of Oregon physicians are in primary care specialties than in the United States as a whole. For example, Oregon has 40 general or family practitioners per 100,000 residents, compared with 28 per 100,000 for the United States (table 4-6) (188). In Oregon's metropolitan counties (where prepaid plan enrollment is mandatory for all AFDC eligibles under the current Medicaid pro-

[8] RHC certification for purposes of Medicare and Medicaid reimbursement was authorized by the Rural Health Clinics Act of 1972 (Public Law 95-210). These clinics are entitled to reimbursement at 100 percent of reasonable cost for their services from both Medicaid and Medicare if they meet certain requirements (e.g., they must use midlevel practitioners at least 50 percent of the time).

9 Two of the clinics with community health center (section 330) funding also receive grants under section 340 of the Public Health Service Act ("health care for the homeless' ').

10 These reports are required as a condition of obtaining Federal grant dollars. They are collected by regional offices of the Department of Health and Human Services.

11 Includes both allopathic (MD) physicians and osteopathic (DO) physicians.

Table 4-6-Number of Primary Care Physicians[a] per 100,000 Population, by Specialty: United States and Oregon, 1990

Specialty	United States		Oregon	
	Number of physicians	Number per 100,000 residents	Number of physicians	Number per 100,000 residents
General/family practice	69,339	28.0	1,119	40.1
Obstetrics/gynecology	32,278	13.0	346	12.4
Pediatrics	38,231	15.4	315	11.3
Internal medicine	94,674	38.3	918	32.9

a Includes both allopathic (MD) and osteopathic (DO) physicians.

SOURCE: Oregon Health Sciences University, Office of Rural Health, Physician *Resources in Oregon: A Summary Report* (Portland, OR: Oregon Health Sciences University, September 1991).

gram), 41 percent of physicians are in a primary care specialty.[12] In Oregon's nonmetropolitan counties (only two of which are currently under the Medicaid prepaid managed care system), 51 percent were in primary care (189).

Despite the relatively high prevalence of primary care physicians, a recent study by the Oregon Office of Rural Health cited a ''conspicuous [geographic] maldistribution" of physicians in the State (188). A State tax credit of $5,000 offered to physicians who practice in rural shortage areas has reportedly enhanced rural physician retention in recent years (187). Nonetheless, the study notes a declining supply of primary care physicians statewide, and a declining supply of physicians overall in rural areas between 1986 and 1990 (188).

Medicaid Participation-In a recent national study of Medicaid physician participation conducted by the Physician Payment Review Commission, Medicaid officials in Oregon reported problems with physician participation in rural areas and among providers of obstetric services (203). When asked what factors inhibited participation, Medicaid directors from the 51 programs surveyed most frequently cited low fees, malpractice insurance premiums, and complex billing procedures (203).

Empirical data on Medicaid participation are scarce for Oregon physicians as well as for physicians nationally. Medicaid physician participation data typically derive from one of two sources: Medicaid claims databases, or physician surveys. Data based on Medicaid claims may overstate participation because they count physicians who submit only a single claim (203). Physician survey data are problematic because physicians themselves tend to overstate their level of participation (1 17). OTA was able to obtain data from each of these sources for Oregon physicians, as described below:

- Data from OMAP's claims database and State medical licensing board counts of practicing physicians in Oregon indicate that 76.2 percent of all practicing physicians in the State were paid directly by Medicaid for at least one service in 1990.[13] The degree of participation among these physicians can be illustrated further by examining their distribution by annual Medicaid billings (table 4-7). Approximately 40 percent of all participating physicians billed Medicaid for $5,000 or less.
- In a 1988 survey of all physician members of the Oregon Medical Association (OMA) (195),[14] 59.5 percent of responding physicians reported that they accepted all Medicaid patients; 33 percent said they restricted their Medicaid practices; and the remaining 7.5 percent said they did not accept any Medicaid patients (195). The percentage of respondents reporting unlimited Medicaid practice is shown by county in table 4-8. Physicians in rural areas tended to have a higher rate of unrestricted Medicaid practice than their urban counterparts (195). Implementation of prepaid plans for Medicaid enrollees in urban areas probably accounts for much of this difference.

Uncompensated Care—Information on physicians' uncompensated care costs are similarly scarce and problematic. In the same 1988 OMA survey

12 Primary care specialties are defined here as family practice, general practice, general pediatrics, general internal medicine, and obstetrics and gynecology.

13 It was not possible to calculate separate rates by specialty due to duplication problems. Approximately 20 percent of all physicians on file at OMAP listed more than one specialty on their record (252).

14 The response rate was 28.9 percent (1,249 responses).

Table 4-7—Distribution of Physicians Participating[a] in Oregon's Fee-for-Service Medicaid Program, by Annual Medicaid Billings (Fee-for-Service System Only), 1990[b]

	Annual billed charges to Medicaid for services performed and paid							
	$1 to $1,000	$1,001 to $5,000	$5,001 to $10,000	$10,001 to $25,000	$25,001 to $50,000	$50,001 to $75,000	Over $75,000	Total
	Percent of participating physicians							
All physicians (MD and DO)	17.4	20.3	13.7	24.7	15.3	4.6	3.9	100.0
Primary care physicians	18.1	23.4	13.9	22.5	12.5	4.7	5.0	100.0
General/family practice	19.8	22.1	12.9	23.3	13.7	5.5	2.7	100.0
Internal medicine	21.0	26.7	15.5	25.6	8.9	1.9	0.4	100.0
Pediatrics	14.9	23.9	11.8	17.4	16.3	6.5	9.3	100.0
Obstetrics/gynecology[d]	9.6	17.0	14.4	17.5	13.6	7.6	20.3	100.0
All other physicians	16.4	17.4	13.7	27.4	18.0	4.4	2.7	100.0

NOTE: Percentages may not add to exactly 100 due to rounding.

a "Participating physician" is defined here as a physician who performed at least one paid Medicaid service in 1990. Includes physician providers in Washington, Idaho, Nevada, and California who provided services to Oregon Medicaid patients.

b Excludes services not allowed by OMAP. Includes all Medicaid enrollees seen in the fee-for-service system, regardless of voluntary or mandatory enrollment in a prepaid plan. Average number of unduplicated enrollees seen is expected to be less in counties where enrollment in a prepaid plan is mandatory for AFDC enrollees, because physicians in prepaid plans do not bill OMAP directly for most services.

c Primary care includes MDs and DOs who listed one of their specialties as general practice, family practice, internal medicine, pediatrics, obstetrics, gynecology, Obstetrics/gyn&ZOIOgy, or did not list a specialty.

d Includes physicians who listed as one of their specialties gynecology, obstetrics, or obstetrics/gynecology.

e Includes all MDs and DOs who listed a specialty other than, or in addition to, one of the primary care specialties described in footnote c. There is duplication between primary and nonprimary care physicians because approximately 20 percent of physicians on file with OMAP list more than one specialty.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, data on 1990 physician participation in Medicaid, provided to the Office of Technology Assessment Nov. 14, 1991.

Table 4-8-Proportion of Oregon Physicians Reporting an Unlimited Medicaid Practice by County, 1988a

Proposed delivery system status under demonstration[b]/county	Percentage of physicians in area who do not limit their Medicaid practice[c]	Average percentage of practice devoted to Medicaid	Number of surveys sent	Percent responding
Fully capita ted health plans [b]				
Benton	63.5%	8.9%	121	28.994.
Clackamas	55.0	10.0	203	29.6
Lane	55.8	11.5	395	30.4
Linn	58.6	15.1	85	34.1
Marion	52.9	10.8	310	33.5
Multnomah	48.5	10.2	1,835	22,9
Polk	42.9	15.0	22	31.8
Washington	46.7	5.3	251	28.7
Yamhill	76.0	12.7	74	33.8
Physician care organizations (PCOs—partially capitated) [b]				
Baker	33.3	5.0	12	50.0
Clatsop	66.7	18.3	29	29.6
Columbia	80.0	22.3	14	35.7
coos	53.6	13.3	81	34.6
Crook	100.0	17.5	8	50.0
Deschutes	67.4	10.7	133	32.3
Douglas	68.9	11.7	125	36.0
Haney	NA	NA	5	0.0
Hood River	62.5	12.0	19	52.6
Jackson	62.5	10.8	219	29.2
Jefferson	100.0	21.7	5	60.0
Josephine	48.1	16.1	65	41.5
Klamath	59.1	12.9	65	33.8
Lincoln	58.8	26.0	35	48.5
Malheur	54.4	12.5	35	31.4
Sherman	NA	NA	NA	NA
Tillamook	57.1	12.5	14	50.0
Umatilla	60.0	15.0	63	47.6
Union	76.5	12.0	39	43.6
Wasco	62.5	16.1	41	39.0
Case-managed fee-for-service [b]				
Curry	100.0	25.0	10	10.0
Grant	66.7	NA	3	100.0
Lake	100.0	40.0	5	20.0
Morrow	NA	NA	NA	NA
Wallow	66.7	7,5	5	60.0

NOTE: NA = not available.

a Based on a mail survey of all physician members of the Oregon Medical Association. Response rate was 28.9 percent (1,249 total responses).

b Indicates anticipated mode of Medicaid health services delivery by the end of the second year of the demonstration (according to timeline in waiver application). Although the State expects case-managed fee-for-service to be the primary mode of service delivery under the demontration in the five counties indicated, it would execute prepaid contracts in those areas with any willing and qualified providers (175). Under the current Medicaid prograrn, Aidto Families With Dependent Children (AFDC) Medicaid recipients in Clackamas, Benton, Lane, Linn, Marion, Multnomah, Polk, Washington, and Yamhill counties are required to enroll in a prepaid health plan. Prepaid plan enrollment is optional for AFDC recipients in Jackson County. In all other counties, Medicaid pays for services on a fee-for-service basis.

c Percentage of physicians who reported they accepted any Medicaid patient who came to their office.

d Of all physicians reporting unlimited Medicaid practice, the average percentage of their practice they reported was made Up of Medicaid patients.

SOURCE: Oregon Medical Association, Portland, OR, "Bridging The Gap: The Role of Oregon Physicians in Uncompensated Care," 1989.

cited above, 83 percent of responding physicians reported that they sometimes offered care at reduced fees,[15] and 68 percent reported that they waived fees for some patients.[16] Primary care physicians were more likely than specialty physicians to report reduced or waived fees. Based on the results of this survey, OMA estimated total uncollected practice revenues due to free care or reduced fees of physicians in Oregon to be approximately $239 million (195). Because physicians did not *indicate* the insurance status of patients for whom they reduced or waived fees, however, this estimate

15 "R~uA fee" relative to the individual physician's typical charge fOr a given service.

16 For all physicians reporting waived fees, the average number of patients per year for whom they waived fees was 47 (195).

probably greatly overestimates the amount of uncompensated care costs that would be offset by expanded coverage under the proposed demonstration.

Other Professional Providers--Other providers eligible for direct fee-for-service (FFS) reimbursement under Oregon Medicaid include nurse practitioners, optometrists, chiropractors, naturopaths, physical therapists, occupational therapists, and speech-language pathologists.[17] Data on the supply of selected providers in Oregon follow:

- In 1990, there were an estimated 792 nurse practitioners (including nurse midwives) licensed in Oregon (163). Of these, 100 (12.6 percent) resided out-of-State; 601 (75 percent) resided in the 10 'managed care' counties (see below); and the remaining 91 (11.4 percent) resided in other Oregon counties (163).[18] Approximately 80 percent of NPs in Oregon have the authority to prescribe at least some medications (198).
- In 1990, there were 457 optometrists, 358 (73 percent) of whom are in the 10 managed care counties, with the remaining 27 percent in other areas of the State (196).
- As of 1988, there were 1,827 professionally active dentists[19] in the State, 1,466 (80 percent) of whom practiced in the 10 managed care counties (5).
- As of July 1991, there were approximately 850 chiropractors in the State (158). Their rural/urban distribution was not available, but 382 (44 percent) had addresses in either Portland, Salem, or Eugene (158).

Current Medicaid Program

The Oregon Medicaid program currently operates through three delivery systems. The first is the traditional FFS system. The other two are variations within Oregon Medicaid's ongoing prepaid health plan (PHP) system: one, a fully capitated[20] plan (the Kaiser Permanente-Northwest Region health maintenance organization (HMO)); the other, a system of partially capitated plans.

Fee-for-Service Health Care

The FFS system serves individuals in all Medicaid eligibility categories in 26 of Oregon's 36 counties as well as non-AFDC[21] (and 15 to 20 percent of AFDC) enrollees in the 10 counties where prepaid plans have been implemented for AFDC eligibles (see below). AFDC eligibles enrolled in partially capitated prepaid plans in these 10 counties also receive many services through the FFS system.

In the FFS system, OMAP controls utilization through prior authorization for selected services (e.g., physical, occupational, and speech-language therapy services; home health services; selected diagnostic and treatment codes) and through other limits (e.g., an 18-day annual limit on inpatient hospitalization for adults). Case management is covered for prenatal and maternity care services.

All services are paid according to OMAP's established methods of payment, which are summarized for some key facilities in table 4-9. FFS physicians are paid according to a fee schedule. A recent comparative analysis of State Medicaid physician payment rates showed that, for a bundle of 18 services,[22] Oregon's payment was equal to the average for all States in 1989 and represented 75 percent of the Medicare allowed charge for the same services in the previous year (203).

FQHCs are exempt from fee schedule reimbursement for primary care services rendered to Medicaid patients. Instead, they receive facility-specific cost-based reimbursement on a per-encounter basis in accordance with provisions of the Omnibus Budget

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17 Physician assistants are reimbursed under the supervising physician's provider number.

18 Data on distribution of NPs by practice location or setting were not available.

19 Includes both full-time and part-time dentists.

20 "Capitated plan" refers t. a provider that receives periodic (in this case monthly) payment in advance to cover all or certain types of health care services it provides to an individual patient (i.e., per capita payment). The provider assumes financial risk for patients whose actual costs exceed the payment amount.

21 Aid to Families with Dependent Children.

22 Fees for 18 services were grouped into 9 service types: office visits, hospital visits, emergency room visits, consultations, x-ray services, electrocardiograms, psychiatric services, obstetrical services, and surgical and other procedures. Fees for total obstetrical care (vaginal and caesarean section deliveries) were excluded from this analysis because many States could not report fees for these services. Fees for each service type were combined in proportion to their Medicaid utilization to create a "typical" Medicaid fee for each State (203).

Table 4-9-Oregon Medicaid Reimbursement Methods for Selected Services in the Fee-for-Service Delivery System, 1991

Type of service	Reimbursement method
Physician services	Fee schedule (fees frozen for 1991-93 biennium)
Hospital inpatient	Prospective, DRG-based rate for most hospitals; certain rural hospitals exempt from prospective payment and reimbursed at 100 percent of costs[a,b]; certain specialty hospitals also exempt from prospective payment and reimbursed according to special contracts with OMAP; Medicaid disproportionate share hospitals receive 5 to 25 percent DRG rate increases depending on their Medicaid caseload
Hospital outpatient	Percent of cost[a] (59 percent for the 1991-93 biennium); certain rural hospitals exempt from percent of cost limits and reimbursed at 100 percent of Cost[a,b]
Rural health clinic services[c]	Per visit, 100 percent of costs[b]
Federally qualified health centers[d]	Per visit, 100 percent of costs[a]
Durable medical equipment	Fee schedule
Home health services	Per-visit fee schedule
Physical, occupational, and speech therapy	Fee schedule

ABBREVIATIONS: DRG = diagnosis-related group; OMAP = Office of Medical Assistance Programs.
a Costs determined from Medicare cost reports.
b Type A rural hospitals reimbursed at 100 percent of costs for inpatient and outpatient services (excluding lab and x-ray); type B rural hospitals reimbursed at 100 percent of cost for inpatient services only (excluding lab and x-ray).
c Rural health clinics as federally certified for purposes of Medicare and Medicaid reimbursement (42 CFR 440.20(b)).
d Federally qualified health centers include federally funded community health centers, migrant health centers, health centers for the homeless, and "took-alike' " clinics (see table 4-3). Public Law 101-239 and Public Law 101-508 mandate 100 percent facility-specific cost-based reimbursement for services provided in these clinics (see text).

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, provider services reimbursement guides and updates, provided to the Office of Technology Assessment in 1991.

Reconciliation Act of 1989 (OBRA-89).[23] OMAP has implemented these reimbursement provisions for FQHCs in the FFS system. For the two FQHCs that serve as subcontractors in the prepaid system, OMAP intends to reconcile any differences between actual reimbursement from the prepaid provider and reimbursement allowable under OBRA-89 at the close of the State fiscal year (213,259,306).[24]

currently, the vast majority of Oregon's 66 short-term general acute-care hospitals are reimbursed directly by OMAP for all covered services rendered to Medicaid patients. Exceptions are the two hospitals owned by Kaiser Foundation Hospitals, which are paid by the Kaiser Permanente HMO for services rendered to Medicaid eligibles enrolled in that HMO; and several other hospitals that are paid negotiated rates by physician care organizations (PCOs) for certain outpatient services rendered to PCO enrollees. Of the hospitals reimbursed directly by OMAP, 32[25] are reimbursed on a prospective, diagnosis-related-group (DRG)-based system for inpatient services and on a percent-of-cost[26] basis for outpatient services (2 13). Institutions exempt from prospective reimbursement for hospital inpatient and percent-of-cost limits for hospital outpatient services include:

- Specialty hospitals, which are reimbursed according to the terms of unique contracts with OMAP; and
- Rural hospitals (defined essentially as hospitals of fewer than 50 beds that are located more than 10 miles from a town of more than 10,000 residents), which are reimbursed as follows:

  Type A rural hospitals—100 percent of cost for all inpatient and outpatient services[27] and

23 OBRA-89 (Public Law 101-239) requires State Medicaid programs to pay 100 percent of reasonable cost for services provided by FQHCs and RHCs-a provision meant to protect the financial viability of these ''safety net' primary care providers. Facility-specific per-encounter reimbursement rates are based on average costs for all patients seen at each facility in a given year.

24 The two clinics have already received interim reconciliation from OMAP; final reconciliation for the fiit year in which FQHC reimbursement protections were in effect in Oregon (State fiscal year 1991) had not yet occurred at the time this report was written.

25 Excludes the two hospitals owned by Kaiser Foundation Hospitals. These hospitals receive reimbursement directly from OMAP (at regular FFS rates) for services rendered to patients not enrolled in the Kaiser Permanence HMO.

26 Cost based on hospitals' Medicare cost reports.

27 Excludes laboratory and x-ray services, which are reimbursed according to a fee schedule.

Table 4-10-Current Status of Physician Care Organization (PCO) Involvement in Providing and Managing Services for Medicaid Clients, 1990

Service	Number of PCOs that are capitated for service	PCOs required to case manage fee-for-service delivery	OMAP or OMPRO[a] prior approval required
Physician	All		—
Laboratory	All		—
Radiology	All	—	—
Hospital outpatient	None	Yes	—
Hospital inpatient	None	Yes	—
Prescription drugs	1	Yes[b]	—
Dental[c]	4	No	—
Chiropractor	4	Yes	—
Podiatrist	All	—	—
Nurse practitioner/nurse-midwife	All	—	—
physical therapy	1	No	—
Speech, language, and occupational therapy	None	No	Yes
Optometrist	None	No	—
Home health	None	No	Yes
Durable medical equipment/oxygen	None	No	Yes

a OMAP = Office of Medical Assistance programs; OMPRO = Oregon Medical Peer Review Organization.
b The primary care physician must write or authorize all prescriptions. There is a built-in financial incentive to control utilization of prescription drugs. Excessive utilization of prescription drugs causes a decrease in the pool of money available for an individual plan's savings incentive payment (see text).
c Four PCOs are capitated for dental services. In addition, roughly 10,000 to 15,000 Medicaid beneficiaries are enrolled in "dental care organizations." The Kaiser Permanente-Northwest Region HMO is not capitated for dental services.

SOURCE: L. Read, Director, Prioritized Health Care Systems, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, personal communication, July 10, 1991.

Type B rural hospitals—100 percent of cost for all inpatient services and most outpatient services.[28]

For hospitals qualifying for Medicaid disproportionate share (DSH) payments by virtue of Medicaid utilization criteria, DRG rates are increased depending on the hospital's share of Medicaid patients relative to the State average for all hospitals (144).[29] There were 10 such qualifying hospitals in Oregon in 1990 (see table 4-2) (155).[30] Total Medicaid DSH payments to hospitals in Oregon (State share only) increased by 67 percent between fiscal years (FY) 1989 and 1990 and by an additional 131 percent between FY 1990 and FY 1991 (144).[31]

American Hospital Association data show that the 1989 Medicaid hospital payment-to-cost ratio[32] was lower in Oregon than in any other State except Illinois (59 percent in Oregon compared with a national average ratio of 78 percent) (207). Medicaid outpatient hospital services reimbursement rates have decreased significantly in recent years-horn 75 percent of costs in the 1987-89 biennium to 65 percent in 1989-91, and finally to 59 percent in the current biennium (223). In a recent out-of-court settlement of a Boren Amendment lawsuit brought against the State by the Oregon Association of Hospitals, OMAP agreed to pay $64 million over the 1991-93 biennium to compensate for previous underpayment (156,157) (see ch. 2).

Prepaid Plans

In December 1984, Oregon received a Federal regulatory waiver under section 1915(b) of the Social Security Act to implement a managed care

28 Excludes laboratory and x-ray services (reimbursed on a fee schedule) and outpatient services provided to general assistance clients (reimbursed at 59 percent of cost).

29 For hospitals with utilization between 1 and 2 standard deviations of the mean, the DRG rate increases 5 percent; fOr hospitals 2 to 3 standard deviations above the mean, 10 percent; for hospitals greater than 3 standard deviations above, 25 percent (144).

30 Hospitals can also qualify for DSH status based on their low-income utilization rates (144). In 1990, no Oregon hospitals were designated as DSH under these rules (213).

31 FY 1989 act@ FY 1990 estimated, FY 1991 projected.

32 Includes payment and cost for both inpatient and outpatient services. Data obtained from the American Hospital Association's 1989 Annual Survey of Hospitals. Medicaid costs estimated by multiplying hospitals' reported Medicaid charges by each hospital's overall cost-to-charge ratio (203).

33 See ch. 5 for a description of the various Medicaid eligibility categories.

system for its AFDC[33] Medicaid enrollees.[34] Enrollment in prepaid plans in Oregon has since increased to the current level of some 68,000 AFDC Medicaid enrollees[35] (approximately 54 percent of the total AFDC enrollment and approximately 31 percent of total Medicaid enrollment[36] in 1991), making it second only to Arizona in the proportion of its Medicaid population enrolled in PHPs (252). These PHPs include one fully capitated HMO and 15 PCOs in which selected outpatient services, but not inpatient services, are capitated. At present, enrollment of AFDC clients in a PHP is mandatory in nine counties (seven of which are in metropolitan statistical areas) and optional in a tenth county. All non-AFDC eligibles and all eligibles residing outside this 10-county area receive services on an unrestricted FFS basis.

Even in areas where enrollment in a PHP is required, some AFDC eligibles are still in the FFS system. At any given time, roughly 20 percent of the AFDC eligibles in the nine mandatory managed care counties receive health care on an FFS basis (40,212). These eligibles include:

- Individuals who have other sources of insurance coverage and are exempt from mandated enrollment in a PHP;
- Pregnant women who become Medicaid-eligible in their third trimester and who elect to continue receiving FFS services through delivery;
- New AFDC eligibles, who may take up to 2 months to become enrolled in a PCO or an HMO after becoming eligible;
- Individuals who elect to disenroll from their previous plan and have not yet been enrolled in another plan;[37] and
- Individuals who exceed their PHP's stop-loss limit in any given year (see below) (40).

Fully Capitated Plans—A single HMO-Kaiser Permanence, Northwest Region-serves approximately 11,60038 AFDC eligibles under the current program. Kaiser Permanence is prepaid on a capitated basis for all acute health care services except dental services. The cavitation rate is currently set at 100 percent of FFS equivalent costs.[39]

Partially Capitated Plans—As of October 1991, there were 15 PCOs serving approximately 56,400 AFDC eligibles in the 10-county area (252). PCOs are prepaid on a capitated basis for a basic package of services that includes physician services (including podiatry, osteopathic, nurse practitioner, and physician assistant services), laboratory, radiology, and EPSDT[40] services. Between 1985 and 1989, OMAP reported savings of $7.5 million relative to expected FFS payments for PCO enrollees (41).[41]

The PCOs are made up of anywhere from 4 to 280 primary care physicians (305). Some are experienced managed care providers (e.g., Capitol Health Care, a well-established independent practice association (IPA) that also has private fully capitated business), others are primary care clinics (four FQHCs currently participate as PCOs—see table 4-3), and still others are loose associations of primary care physicians who are organizationally bound merely by virtue of their contract with OMAP (245). The annual contract stipulates a maximum Medicaid caseload per PCO, based on the number of primary care physicians available. Risk is managed through a stop-loss mechanism whereby enrollees whose health care costs exceed an established threshold in a given year leave the PCO and receive the remainder of their services through the FFS system.

PCOs have the option of receiving capitated payment and assuming risk for services other than

34 Oregon has since obtained an extended waiver that permits it to expand mandatory enrollment in prepaid plain to other categories of eligibles. To date, however, Oregon has only enrolled AFDC eligibles in the prepaid system.

35 Enrollment as of October 1991. Includes 11,580 Medicaid eligibles enrolled in the Kaiser Perman ente HMO on a full-risk basis. Medicaid enrollment in Kaiser Permanence is authorized by Federal statute and hence is not officially part of Oregon's current 1915(b) waiver program.

36 Total enrollment includes elderly, blind, disabled, general assistance, medically needy, etc.

37 In the current system, AFDC eligibles in mandatory managed care counties Cm choose between at least two prepaid health plans.

38 Enrollment as of October 1991 (252).

39 Capitation rates for both partially and fully capitated plans are based on expected FFS costs of an actuarially equivalent client population, projected using utilization data for AFDC Medicaid enrollees in the FFS system (41). There is no separate administrative allowance for prepaid plans in the current system.

40 Early and periodic screening, diagnosis, and treatment services fOr children.

41 Savings were attributed primaril y to reduction of unnecessary inpatient services by PCOs, but also to reduction of unnecessary outpatient and prescription drug services (41,177).

those in the basic package, but few of them have done so to date. Currently, four PCOs are capitated for chiropractic services, four for dental services, one for physical therapy services, and one for pharmaceutical services (table 4-10) (213,252). In addition, all PCOs are required to act as gatekeepers to preapprove all nonemergency inpatient and outpatient hospital services.[42] To provide an incentive for decreased hospital inpatient and outpatient and prescription drug services utilization, OMAP shares savings relative to FFS equivalent costs[43] 50/50 with the PCOs. Utilization of certain other services is controlled by OMAP directly through prior authorization (e.g., physical, occupational, and speech-language therapy; home health services-see table 4-9).

A forthcoming U.S. General Accounting Office (GAO) study will focus more closely on the role of prepaid managed care delivery systems in the current Oregon Medicaid program. Even if the waiver is not granted, OMAP has indicated that it intends to expand its current PCO program, adding more plans and increasing enrollment (177).

Utilization Data Collection in PHPs--One of the incentives for providers to serve Medicaid patients through PHPs is reduction of the paperwork and other ''red tape' associated with FFS Medicaid (17,143). However, this often comes at the expense of collecting detailed, consistent utilization data, which is useful for program evaluation. A few State Medicaid PHP demonstrations (e.g., Tennessee, Arizona) have tried "shadow billing"[44] in order to better evaluate differences in utilization and access between FFS and PHP enrollee groups. Oregon chose not to do so in the current system in order to maintain the incentive of reduced billing and data collection requirements (212). Until October 1990, in fact, PHPs in Oregon were not providing any systematic utilization data to the State. Since October 1990, PCOs have been required to submit quarterly reports to OMAP detailing utilization for selected services (166). Services identified are groups of procedure codes that reflect different services types of interest+. g., EPSDT and physician office services (166). The first data were not reported until the end of the first quarter of 1991, and data reported for the third quarter of 1991, although obtained from all PCO providers, were still incomplete and inconsistent as of December 1991 (310).[45]

Information on the utilization of noncapitated (i.e., FFS) services by PHP enrollees is available through OMAP's claims database. For noncapitated services, OMAP provides plans with monthly reports of utilization by their enrollee population by type of service (166,213). Such reports help OMAP and the PHPs confirm that all referral services were preapproved by the primary care physician.

Dental Services

Although most Medicaid enrollees receive dental services on an unrestricted FFS basis,[46] a growing number receive them through one of two types of managed care arrangements: PCOs that are capitated for dental services, or special 'dental care organizations" (DCOs) that provide services on a prepaid, capitated basis. As of February 1992, 28,479 clients were enrolled in three DCOs and four PCOs that cover dental services (213). OMAP is in the process of expanding DCO enrollment (252).

HEALTH CARE DELIVERY UNDER THE DEMONSTRATION

The State of Oregon projects that, in year 1 of the demonstration, an additional 46,800 people would be covered by Medicaid-a 31 percent increase over projected enrollment in the existing Medicaid pro-

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42 Originally, PCOs also case-managed physical, speech-language, and occupational therapy services, but prior authorization by OMAP is now required for these services (see table 4-9).

43 Savings are calculated by comparing utilization of these services by PCO enrollees with utilization by an actuarially equivalent group of FFS Medicaid enrollees.

44 ''Shadow billing'' is a practice in which prepaid providers are required to submit ''dummy' claims that provide data as detailed as those required on FFS claims forms (e.g., patient characteristics, date of service, diagnoses, specific procedures performed, provider identification).

45 Although &U from the last quarter of 1991 are expected t. improve (310), the broad categories represented would not be sufficient to serve as a baseline for detailed measurement of the impact of service prioritization under the demonstration (see ch. 8).

46 Under the current Medicaid program in Oregon, most dental care for adults is not covered. The proposed demonstration would expand coverage for dental care to the entire Medicaid population.

gram for that year (177).[47] By the final year, an additional 120,000 people are expected to be covered beyond projected enrollment for that year without the demonstration (42, 177).[48]

To accommodate the expanded number of Medicaid eligibles and to control the costs of providing their care, Oregon would expand its prepaid managed care system significantly. The proposed expansions would not merely entail increased enrollment in existing plans; rather, they would entail a complete restructuring of the current system and the creation of a number of entirely new fully capitated plans to provide services to a Medicaid population nearly twice as large as that currently served. The proposed expansions include:

- Converting some existing PCOs to fully capitated plans,
- Expanding enrollment in existing prepaid plans and contracting with new fully capitated plans[49] to serve the expanded Medicaid population,
- Developing new PCOs in some rural areas, and
- Implementing a case-managed FFS system in rural areas where prepaid care arrangements are not feasible.

OMAP would require that all prepaid plans have adequate referral mechanisms and subcontractual arrangements to provide the full range of services covered under the benefit package (174).

Providers in the Proposed System

The levels of risk and other characteristics of providers in the proposed system, as described in the waiver application, would be as follows (177,212):

1. Fully capitated health plans (FCHPs)[50]

   FCHPs would provide and pay for all inpatient, outpatient, and ancillary services (with the exception of select optional services[51]) either directly or through subcontractors. The State would pay hospital claims on behalf of any FCHP that is permitted such an option in its contract.[52] FCHPs would be the required mode of delivery in the 9-county area currently served by PCOs and one HMO.

   A. Full-risk contract-Provider is at full risk for individual patient losses. Only federally qualified HMOs would be allowed to participate at this level of risk.

   B. Buffered-risk contract—Provider purchases insurance against high-loss patients either directly from the State or from a private insurer. A provider could choose among the following three levels of stop-loss insurance.

   1. High--Annual $10,000 deductible, 5 percent plan-paid coinsurance, and a cap of $100,000 on stop-loss eligible expenses. In other words, the plan is liable for 100 percent of per-enrollee costs up to $10,000; for 5 percent of costs between $10,000 and $100,000; and for none of the costs in excess of $100,000.
   2. *Medium—Annual $15,000* deductible, 10 percent coinsurance, and a $100,000 cap.
   3. Low--Annual $30,000 deductible, 20 percent coinsurance, and a $100,000 cap.

Other risk protections for FCHPs would include: reduced liability for persons who are hospitalized at the time of their enrollment;[53] a fixed additional

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47 Percent increase based on enrollment projections for State FY 1993. The original target date for program startup was July 1, 1992 (the beginning of State FY 1993). Because OMAP had not obtained waiver approval from the Health Care Financing Administration (HCFA) by the end of January 1992 as expected, it has announced that it will delay program startup on a month-to-month basis pending approval (e.g., if approved at the end of February 1992, startup would have been Aug. 1, 1992) (256).

48 The 120,000 projection does not assume implementation of the employer mandate (see chs. 1 and 5). If the employer mandate is fully implemented, projected Medicaid enrollment for the final year would be 96,400.

49 Some prospective fully capitated plans already have commercial HMO business; others may have no experience as full-risk providers (212).

50 Here and elsewhere in this chapter, fully capitated plans under the proposed system are referred to as FCHPs rather than HMOs. While Kaiser Permanence, the only current Medicaid prepaid provider capitated for the full range of services, is a federally qualified HMO, some fully capitated providers under the new system would probably not be.

51 Optional services for FCHP cavitation include dental, maternity case management, abortion, family planning, certain contraceptive and psychiatric prescription drugs, and patient transportation (175).

52 This option would be made available to smaller FCHPs and FCHPs located in noncompetitive hospital markets. These plans' capitation rates would be adjusted to reflect prevailing Medicaid hospital payment rates (DRG- or cost-based, depending on the hospital) and OMAP would bill the plan for the cost of claims paid (177).

53 This protection would not apply to newborns whose mothers were enrolled on the day of birth (177).

payment for each maternity case occurring above a specified average limit; and adjustment of cavitation rates by eligibility cohort (see below).

2. Physician care organizations

   PCOs would be paid on a per capita basis for all outpatient physician, laboratory, x-ray, and preventive services. Additional services such as prescription drugs, physical therapy, and dental care could be either included or excluded from the PCO cavitation rate. Hospital inpatient and outpatient services[54] would be preauthorized by the PCO but would be billed to and paid by OMAP at prevailing Medicaid FFS rates. PCOs would be the preferred mode of delivery in all non-FCHP counties where there is critical mass for enrollment.

   A. *First level of risk: fewer than 500 enrollees—These* PCOs would not be paid a cavitation rate, but would instead be reimbursed at prevailing FFS Medicaid rates for PCO services. They would still be fully responsible for managing care of enrollees according to PCO contract provisions and would still receive 40 percent of any estimated savings for hospital inpatient, hospital outpatient, and prescription drug services relative to an actuarially determined FFS target. This "no risk' approach is designed to protect new, small plans as they enter the system. OMAP does not anticipate that many PCOs would remain at this level of risk for long,

   B. *Second level of risk: 500 to 999 enrollees or 1,000 or more enrollees and less than 12 months' experience as a contractor—These* PCOs would be paid on a per capita basis for PCO services and would retain 50 percent of any estimated savings for hospital inpatient, hospital outpatient, and prescription drug services.

   C. *Third level of risk: 1,000 or more enrollees* ***and at least 12 months' experience as a contractor—These*** PCOs would be paid on a per capita basis for PCO services and would retain 60 percent of any estimated savings for hospital inpatient, hospital outpatient, and prescription drug services. They would also beat partial risk for the noncapitated services they case manage-the State would withhold a payment penalty, limited to the lesser of half of the excessive cost or 10 percent of the PCO's cavitation rate, if the cost of noncapitated services used by their enrollees is higher than actuarially targeted.

3. Case-managed fee-for-service

   Physicians and other providers would be paid on an FFS basis at prevailing Medicaid rates for all covered services. Case-managed FFS would be the mode of service delivery in those rural counties that lack a sufficient enrollee population to make the PCO model feasible, and for patients in other counties who don't enroll in PHPs. A designated primary care case manager (PCCM) would preauthorize any nonemergency care provided by other individuals or institutions. PCCMs would be paid a small flat per capita fee ($3 per enrollee per month) for the administrative costs of management. Most PCCMs would be primary care physicians, although nurse practitioners and physician assistants would also be allowed to participate. PCCMs would be required to:

   - Provide routine primary care services;
   - Deliver emergency medical treatment or refer the patient to another appropriate source of care when the PCCM is unavailable;
   - Conduct emergency admission review within 24 hours of receiving notice that a patient has undergone an emergency hospitalization, to confirm appropriateness and initiate discharge planning;
   - Develop an adequate referral network to ensure access to the full spectrum of covered services, refer patients to appropriate specialists, and preapprove all referral care;
   - If possible, admit and discharge hospital patients or oversee their admission and discharge by a specialist;
   - Maintain a central medical record for each enrollee; and
   - Participate in program-wide oversight, monitoring, and quality assurance activities as directed by OMAP (177).

For catastrophic-cost patients, OMAP itself would offer supplemental case-management services (e.g., designate central managers for patients in special

[54] Excluding professional components of hospital outpatient services.

categories, such as those with AIDS[55]). The agency would also provide oversight of PCCMs and preauthorize certain elective procedures.

The explicit goal of the State of Oregon is to encourage provider participation in prepaid managed care wherever possible (177,212). The spectrum of risk arrangements proposed for PHPs reflects this goal and provides a strategy for gradual conversion to prepaid health care for the entire State. Groups of FFS physicians are encouraged to form PCOs and, if their enrollment is below 500, can continue to receive FFS reimbursement for the first 12 months as they build their patient base and become more familiar with the system. After that, they can proceed to assume higher levels of risk under partial cavitation or become full-risk plans if they so desire. Ultimately, OMAP hopes to extend prepaid health care to even the most rural areas of the State (212).

Although not described in the waiver application, the current dental managed care system would also be expanded under the demonstration, with PCOs and FCHPs being given the option of cavitation for dental services. Enrollees in plans not capitated for dental services would receive their dental care on an FFS basis or through an expanded DCO system (212).

Distribution of Enrollees by Delivery System

In a *nine-county* area containing seven of Oregon's eight metropolitan counties, OMAP intends to enter solely into fully capitated contractual arrangements (table 4-11) at one of the varying levels of risk described above. Selected other counties are targeted for PCO contract negotiations, and enrollees in the remaining counties would choose or be assigned to PCCMs. Although OMAP expects that certain counties will not have sufficient caseloads to make prepaid arrangements feasible, it intends to execute prepaid contracts with any qualified, willing providers in these counties (175).

Table 4-12 illustrates the magnitude of proposed delivery system changes. According to State sources, the over 56,000 Medicaid beneficiaries currently enrolled in PCOs would automatically be transferred to FCHPs at program startup (212). Non-AFDC current eligibles and new eligibles would be enrolled in FCHPs, PCOs, or with PCCMs, depending on their geographic location and other characteristics. By program steady state, 54.8 percent of all beneficiaries are projected to be enrolled in FCHPs; another 17.4 percent in partial-risk PCOs; and the remainder (27.8 percent) in case-managed FFS (table 4-12) (40). Implementation of the case-managed FFS system, which would affect mostly the rural areas of the State, is expected to take considerably longer than the enrollment of clients into PHPs (40). OMAP estimates that all enrollees not in a prepaid plan would be enrolled with a PCCM by the 10th month of the demonstration (212).

The frost-year cost estimates assume that some eligibles in case-managed FFS areas will receive noncase-managed FFS care for the first nine months of the demonstration (40). overall, cost estimates assume that delivery systems in each county will be operational roughly by the target dates shown in table 4-11.[56]

Cavitation Rate Calculation

OMAP released preliminary cavitation rates to prospective prepaid providers on November 26, 1991 as part of an official request for application (RFA) (175). The proposed rates were revised on February 7, 1992, to correct for errors in expected length of eligibility and utilization patterns of the demonstration's eligible population (176).[57] The rates, developed by OMAP in conjunction with the actuarial firm Coopers & Lybrand, reflect the anticipated cost of providing all covered services (i.e., diagnostic services and all services in condition-treatment (CT) pairs 1 through 587) during the startup year of the demonstration within a prepaid managed care setting. While cavitation rates for prepaid providers in Oregon's current Medicaid program are based on Medicaid FFS equivalent costs, the new rates are based on a detailed actuarial

[55] Acquired immunodeficiency syndrome.

[56] The original date for program startup was July 1, 1992. OMAP intends to delay implementation of the prepaid system on a month-to-month basis pending final approval (e.g., startup date would have been Aug. 1, 1992 if waiver had been approved by the end of February 1992) (256).

[57] The corrections resulted in a substantial increase in the estimated rates for poverty level medical (PLM) women and a slight decrease in the rates for PLM children (175, 176).

Table 4-1 l-Current and Proposed Oregon Medicaid Delivery System by County

County	Delivery system	
	1991	Proposed under demonstration
Metropolitan counties[b]		
Clackamas	PHP[c] mandatory (AFDC only)	FCHPs by startup
Lane	PHP mandatory (AFDC only)	FCHPs by startup
Marion	PHP mandatory (AFDC only)	FCHPs by startup
Multnomah	PHP mandatory (AFDC only)	FCHPs by startup
Polk	PHP mandatory (AFDC only)	FCHPs by startup
Washington	PHP mandatory (AFDC only)	FCHPs by startup
Yamhill	PHP mandatory (AFDC only)	FCHPs by startup
Nonmetropolitan counties[b]		
Baker	FFS	PCOs by start of year 3
Benson	PHP mandatory (AFDC only)	FCHPs by startup
Clatsop	FFS	PCOs by start of year 2
Columbia	FFS	PCOs by start of year 2
coos	FFS	PCOs by middle of year 2
Crook	FFS	PCOs by startup
Curry	FFS	Case-managed FFS by startup[e]
Deschutes	FFS	PCOs by startup
Douglas	FFS	PCOs by start of year 2
Gilliam	FFS	Case-managed FFS by startup[e]
Grant	FFS	Case-managed FFS by startup[e]
Harney	FFS	PCOs by startup
Hood River	FFS	PCOs by start of year 3
Jackson	PHP optional (AFDC only)	FCHPs or PCOs by startup[d]
Jefferson	FFS	PCOs by startup
Josephine	FFS	PCOs by startup
Klamath	FFS	PCOs by startup
Lake	FFS	Case-managed FFS by startup[e]
Lincoln	FFS	PCOs by start of year 2
Lien	PHP mandatory(AFDC only)	FCHPs by startup
Malheur	FFS	PCOs by start of year 3
Morrow	FFS	Case-managed FFS by startup[e]
Sherman	FFS	PCOs by start of year 3
Tillamook	FFS	PCOs by startup
Umatilla	FFS	PCOs by start of year 3
Union	FFS	PCOs by startup
Wallowa	FFS	Case-managed FFS by startup[e]
Wasco	FFS	PCOs by start of year 3
Wheeler	FFS	Case-managed FFS by startup[e]

ABBREVIATIONS: AFDC. Aid to Families With Dependent Children; FCHP = fully capitated health plan; FFS = fee-for-service; OMAP. Office of Medical Assistance Programs; PCO - physician care organization (partially capitated health plan); PHP - prepaid health plan.

a The dates in the far right-hand column reflect the time at which OMAP had anticipated PCO and FCHP contracts to be finalized in that county. The original anticipated date for program startup was July 1, 1992. Contract negotiations have since been delayed on a month-to-month basis pending approval of the waiver by the U.S. Health Care Financing Administration (see text).

b Metropolitan and nonmetropolitan areas as defined by the U.S. Bureau of the Census.

c In the current Medicaid managed care system, AFDC recipients are required to enroll in 1 of 15 PCOs or in the Kaiser Permanence HMO.

d The request for application sent t. providers Nov. 26, 1991 indicates that both PCO and FCHP contracts would be negotiated in Jackson County.

e Although OMAP expects case-managed FFS to be the primary mode of service delivery under the demonstration in these counties, it has indicated it would execute prepaid contracts with any willing and qualified providers.

SOURCES: L. Read, Director, Prioritized Health Care Systems, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, personal communications, July 10 and Dec. 3, 1991; Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, The Oregon *Medicaid* Demonstration *Waiver Application,* submitted to the Health Care Financing Administration Aug. 16, 1991; Oregon Department of Human Resources, Office of Medical Assistance Programs, *Oregon Health Plan: Prepaid Health Plan Request for Applicafions,* (Salem, OR: OMAP, Nov. 26, 1991); L. Read, Director, Prioritized Health Care Systems, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, letter to E.J. Power, Office of Technology Assessment, Mar. 4, 1992.

analysis of both private and Medicaid claims, adjusted to exclude costs of services below line 587.[58] Although language in OMAP's waiver application suggested that rates would be negotiated with prepaid providers, *rate setting* is a more accurate description of the process outlined in the November RFA. The document indicates that inclusion or exclusion of some of the "basic' services may be negotiated, but the service-specific rates calculated by Coopers& Lybrand are *not* negotiable (175).

[58] See ch. 6 for a detailed description of the data and methods used to calculate service-specific costs under the demonstration.

Table 4-12—Distribution of Oregon Medicaid Enrollment by Eligibility Category[a] and Health Care Delivery System: 1993 Without Demonstration, 1993 Demonstration Startup,[b] and 1993 Demonstration Steady State

Eligibility category	Delivery system[c] FCHP	PCO	CMFFS-Man	FFS-Man	CMFFS	FFS	Total
			Percent of enrollees in system				
Average fiscal year 1993 without demonstration [b]							
AFDC	6.17	38.56	0.00	0.00	0.00	36.69	81.42
General assistance	0.00	0.00	0.00	0.00	0.00	1.76	1.76
PLM adults	0.00	0.00	0,00	0.00	0.00	3.98	3.98
PLM children	0.00	0.00	0.00	0.00	0.00	12.84	12,84
New categorical eligibles	NA	NA	NA	NA	NA	NA	NA
New noncategorical eligibles	N A	NA	NA	NA	NA	NA	NA
Total	6.17	38.56	0.00	0.00	0.00	55.27	100,00
Average fiscal year 1993 at demonstration startup [b]							
AFDC	34.48	10.37	5.79	2.59	6.20	2.97	62.40
General assistance	0.89	0.19	0.67	0.08	0.18	0.08	2.10
PLM adults	0.96	0.51	0.70	0.11	0.36	0.16	2.80
PLM children	2.79	1.47	2.03	0.31	1,03	0.47	8.10
New categorical eligibles	2.91	0.93	0.68	0.00	0.78	0.00	5.30
New noncategorical eligibles	10.60	3.38	2.47	0,00	2.86	0.00	19.30
Total	52.63	16.85	12.33	3.09	11.41	3.69	100.00
Average fiscal year 1993 at demonstration steady state [b]							
AFDC	26.30	8.21	6.09	0.00	7.00	0.00	47.60
General assistance	0.98	0.21	0.21	0.00	0.20	0.00	1.60
PLM adults	1.05	0.40	0.26	0.00	0.39	0.00	2,10
PLM children	3.11	1.18	0.76	0.00	1.15	0.00	6.20
New categorical eligibles	4.89	1.56	1.14	0.00	1.32	0.00	8.90
New noncategorical eligibles	18.45	5.88	4.29	0.00	4.97	0.00	33.60
Total	54.78	17.44	12.75	0.00	15.03	0.00	100.00

ABBREVIATIONS: NA - not applicable; FCHP - fully capitated health plan; PCO = partially capitated health plan; CMFFS = case-managed fee-for-service (i.e., individuals enrolled with a primary care case manager (PCCM) who manages their fee-for-service care); CMFFS-Man - individuals in areas of the State where enrollment in a prepaid plan is mandatory who receive their care on a CMFFS basis; FFS-Man = individuals receiving services on an unrestricted fee-for-service basis in areas of the State where enrollment in a prepaid health plan is mandatory; FFS = individuals receiving services on an unrestricted fee-for-service basis in areas of the State where enrollment with a PCCM is mandatory; AFDC = Aid to Families with Dependent Children; PLM = poverty level medical.

a Eligibility categories in this table correspond to standard Medicaid eligibility categories and not to the categories used by Oregon Office of Medical Assistance Programs to calculate cavitation rates under the proposed demonstration.

b Dates reflect original anticipated program startup date of July 1, 1992. Program startup has been delayed on a month-to-month basis pending Health Care Financing Administration approval of the waiver (see text). Fiscal year 1993 startup and steady-state enrollment estimates differ due to assumptions regarding the pace of uptake of eligibles into the various delivery systems. Oregon assumes steady state would be achieved by the end of the 9th month of the demonstration.

c Enrollment distribution by delivery system was calculated by Coopers & Lybrand based on information provided by the Oregon Office of Medical Assistance Programs.

SOURCE: Coopers & Lybrand, *Oregon Medicaid Basic Health Services Program: Calculation of Per Capita Costs Report* (San Francisco, CA: Coopers & Lybrand, May 1, 1991), exhibits 24-A, 24-B; Coopers & Lybrand, San Francisco, CA, unpublished data provided to Office of Technology Assessment, September 1991.

There are a total of 40 separate basic cavitation rate estimates under the plan—a partial and full cavitation rate for each of four eligibility groups in each of five geographic regions, as follows:

Eligibility groups:

1. All Medicaid enrollees eligible under the demonstration with incomes below 100 percent of the Federal poverty level (FPL) except for general assistance enrollees.
2. Poverty level medical (PLM) adults with incomes between 100 and 133 percent FPL.
3. PLM children under age 6 with incomes between 100 and 133 percent FPL.
4. General assistance enrollees.

Geographic regions:

1. Portland tri-county area (Clackamas, Multnomah, and Washington Counties).
2. Linn, Benton, Marion, Polk, and Yamhill Counties.
3. Lane County.
4. Jackson, Josephine, and Douglas Counties.
5. All other counties.

Each cavitation rate is broken down into specific categories of mandatory (i.e., must be capitated) and optional (plans have the option of receiving capitated payment) services. Table 4-13 illustrates this breakdown for eligibility group 1 in region 1. Prospective providers can use tables such as this to

Table 4-13-Breakdown of Preliminary Cavitation Rates for Providers in the Oregon Medicaid Demonstration in State Fiscal Year 1993: Rates for Clackamas, Multnomah, and Washington Counties for All Demonstration Eligibles Under 100 Percent of the Federal Poverty Level Except General Assistance[a]

Fully capitated health plan covered services		Physician care organization covered services	
Physician		***Basic services***	
Basic	$23.13	**Physician**	
Therapeutic abortion[b]	0.75	Basic	$23.13
Maternity	8.81	Maternity	8.81
Somatic psychiatry	0.14	Subtotal	31.94
Family planning[b c]	1.12		
Subtotal	33.95	**Outpatient**	
Outpatient		Professional	1.33
Basic	11.80	Maternity	0.29
Maternity	0.29	Lab and x-ray	3.52
Somatic psychiatry	0.07	Subtotal	5,14
Subtotal	12.16		
Prescription drug		Total of mandatory services	37.08
Basic	6.05	Administrative fee[g]	4.00
Family planning[b c]	0.33	Total with administration fee	41.08
Psychiatric[b]	0.18		
Subtotal	6.56	Maternity/newborn withhold[f]	-2.30
Inpatient		***Optional services***	
Basic	28.54		
Family planning[b c]	0.01	Dental[b]	14,64
Nursing facility	0.00	Maternity management	0,19
Hospice	0.01	Outpatient somatic psychiatry[b]	0,07
Maternity	14.02	Outpatient--facility[b]	6.94
Subtotal	42.58	Physical/occupational therapy[b]	0.26
		Physician therapeutic abortion[b]	0.75
Dental[b]	14.64	Physician family planning[bc]	1,12
Maternity management	0.19	physician somatic psychiatry[b]	0.14
Vision	0.88	Prescription drugs--basic[b]	6.05
Home health service	0.25	Prescription drugs--family planning[b c]	0.33
Physical/occupational therapy	0.26	Prescription drugs--psychiatric[b]	0.18
Transportation (ambulance)	0.69	Transportation (ambulance)[b]	0,69
Transportation (other)[b]	0.52	Transportation (other)[b]	0.52
Miscellaneous medical[b]	0.73	Vision[b]	0.88
Total service cost[d]	113.41		
Administrative cost[e]	7.24		
Total with administration cost	120.65		
Maternity/newborn withhold[f]	-8.84		

a Rates shown reflect adjustments forfunding through line 587 of the prioritized list and for anticipated managed care savings.
b Indicates optional services, subject to negotiation regarding inclusionin contract.
c Reflects 6.8 percent reduction for universal client access to family planning services.
d Total based on the assumption that ail services are included in the capitation contract.
e A 6 percent administrative cost allowance for all capitated services is included for fully capitated health plans.
f To be withheld from the total capitation rate and applied toward a fund to support prepaid plans With a disproportionately high share of maternity/newborn cases.
g Administrative cost for physician care organiztions is set at a flat fee of $4 per enrollee permonth.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, *Oregon Health Plan: Prepaid Health Plan Request for Applications Additional Information* (Salem,OR:OMAP, Feb. 7,1992).

estimate the rates they would receive under the demonstration. Final rates would be different, however, because these estimates do not reflect certain applicable premium deductions (e.g., high-risk maternity and newborn care, stop-loss insurance).

In the current prepaid system in Oregon, capitation rates are set annually and are fixed for the duration of a PHP's contract (78). This would change under the demonstration in order to allow greater expenditure control by OMAP in the event of any changes in the benefit package during a contract cycle. Under the demonstration, cavitation rates would be subject to change at any time during the contract cycle, either as the result of technical

amendments to the list, legislative amendment of the benefit package, or other unspecified amendments to the prepaid contracts (174). PHPs would be entitled to a minimum of 30 to 60 days' notice[59] before the new rates went into effect, and they would be allowed to terminate their contracts on 30 days' notice on the condition that they facilitate full transfer of all their enrollees to alternative providers (173, 174). However, the model PCO/FCHP contract states that financial loss would *not* be considered sufficient cause for termination of contract (174),

IMPLICATIONS OF DEMONSTRATION CHANGES FOR PROVIDERS

Delivery System Changes

Implementation of prepaid managed care systems generally involves changes in the distribution of enrollees among existing providers; limitation of enrollees' freedom of choice among practitioners; changes in provider payment and participation; and shifts in incentives to over- or underprovide services. In Medicaid to date, mandatory enrollment of eligibles in prepaid and managed care delivery systems has been allowed only under waiver authority due to concerns about possible negative effects some of these changes might have on quality and accessibility of Medicaid services. Oregon has operated one of the largest prepaid Medicaid programs in the country for the last 7 years in and around its metropolitan areas.

Because the demonstration's predicted costs and effects depend heavily on the assumption that most enrollees will be in prepaid managed care, the capacity of this system to accommodate an estimated 120,000 new eligibles is critical. preliminary results of a study being conducted by GAO indicate that the current managed care system in Oregon appears to have avoided many of the pitfalls of similar systems in other States (238). However, GAO has recommended that the proposed demonstration not begin until Oregon has more fully developed the expanded managed care infrastructure (e.g., until it has executed provider contracts sufficient to cover projected new enrollees) (238).

Timeline and Plans for Delivery System

Development of the delivery system would be a gradual process. As of November 1991, OMAP had entered into preliminary negotiations with prepaid providers (252). PHP contract negotiations for the entirety of the proposed prepaid system, however, are not anticipated to be complete until the end of the second year of the demonstration (table 4- 11) (177). The original deadline date for contract applications was February 7, 1992, but this has been changed to 2 weeks after approval by the Health Care Financing Administration (HCFA) of the State's request for waivers (213). Awards of the first round of contracts, originally scheduled to occur between May 18 and June 15, 1992, have been delayed on a month-to-month basis pending HCFA approval (256).

OMAP requested that all providers interested in participating submit a nonbinding letter of intent to participate by February 7, 1992 (256). Based on letters of intent received as of February 12, 1992, OMAP estimated a capacity to serve 190,000 enrollees through prepaid plans at program startup (212). Actual capacity cannot be predicted until OMAP has reviewed the full applications, accounted for any duplicate counts of primary care physicians (e.g., physicians associated with more than one plan), and negotiated contracts. As of March 17, 1992, OMAP had not yet received any applications (212). However, many providers who have expressed interest in participating reportedly have their referral and subcontract mechanisms in place or are well on their way to establishing them (212).

Underestimation of enrollment increases could impede OMAP's ability to enroll the anticipated proportion of eligibles in PHPs, unless additional capacity (i.e., more prepaid providers) could be developed. The State assumes that the geographic distribution of new eligibles would be the same as the geographic distribution of current eligibles, with the demonstration leading toa31 percent increase in enrollment in each county during the first year compared with the expected enrollment without the demonstration (182). OMAP officials claim that development of additional capacity in the nine-county area where prepaid plans have already enrolled the majority of AFDC patients-and where

[59] Thirty days if changes are due to technical amendments; 60 if they are due to legislative changes in the benefit package (174).

[60] This estimate is based on plans' indication of the number of primary care physicians that they would have available to serve Medicaid enrollees, using a ratio of one primary care physician per 1,200 enrollees or fraction thereof (175,212).

the bulk of the newly eligible population would reside-would be less problematic than in some of the outlying areas where delivery has been strictly FFS to date (212).

Distribution of PHP Enrollees by Eligibility Category

PHPs that attract a greater proportion of high-cost patients would be at a financial disadvantage compared with those that attracted lower cost patients, a phenomenon known as "adverse selection." To help protect PHPs from adverse selection, OMAP would:

- Develop a separate cavitation rate for each of four eligibility "categories," to reflect average differences in cost between patients in each category (see above) (175);
- Require each PHP to accept any enrollee that selects it, regardless of eligibility category (175);
- Adjust cavitation rates for certain "predictable" events (e.g., pregnancy) (175); and
- Provide stop-loss insurance for other cost-outlier patients (e.g., in the event of costly catastrophic conditions that cause costs per patient to exceed a predetermined threshold) (177).

At least in the early stages of the demonstration, the inability of providers to predict the distribution of their enrollees by eligibility category may affect PHPs' ability to budget and subcontract for specific services, which could in turn have an effect on beneficiary access and quality of services provided. The issue of distribution of enrollees across eligibility groups is not unique to Oregon. However, because existing prepaid providers' experience is limited to AFDC enrollees under the current benefit package, and because proposed cavitation rates are calculated for nontraditional eligibility categories, the level of uncertainty for new prepaid providers in Oregon is likely to be greater than it would be under a more traditional Medicaid managed care demonstration. To assist providers in anticipating the distribution of their own enrollment, OMAP has sent prospective providers lists of anticipated eligibles by rate category and geographic location (212).

Reimbursement Changes

A major selling point of the demonstration to providers in the State has been the promise of enhanced reimbursement (177). There is little question that aggregate Medicaid payments to health care providers in Oregon would increase under the proposed demonstration, but whether individual providers would see a net increase in Medicaid revenue after costs is unclear. In both the prepaid and FFS parts of the proposed system, providers are expected to experience costly increases in administrative responsibilities. They may also be providing more services, or services to more people. Most providers in the managed FFS system would not receive payment rate increases, although expanded eligibility may reduce some of the existing uncompensated care burden.

Providers in Oregon are likely to experience changes in their gross Medicaid revenues due to increases in and redistribution of the eligible population. It can be assumed that, under the proposed demonstration, some providers who currently see Medicaid patients would lose these patients to other providers due to unwillingness or inability to participate as PHPs or subcontractors. This phenomenon is common to any shift from unrestricted FFS to prepaid managed care. At the same time, many providers who currently participate (as well as some who do not) are likely to maintain or increase their Medicaid caseload under the demonstration due to expanded eligibility and redistribution of eligibles between providers. However, increased caseloads would only bring increased net revenues if: 1) they displaced current uncompensated care losses, and/or 2) payment rates under the demonstration were greater on average than current reimbursement rates.

Case-Managed FFS System

Payment rates for specific services in the case-managed FFS system would not increase. Most providers in the case-managed FFS system would continue to be paid according to prevailing Medicaid rates, many of which have been frozen or reduced for the current biennium (see table 4-10).[61] The only reimbursement enhancements in the case-managed

[61] Fees for physicians and certain other categories of providers were frozen for the 1991-93 biennium. OMAP does not intend to change these FFS rates under the demonstration (212). A few categories of providers received CPI (consumer price index) increases in their FFS rates. Hospitals paid on a DRG basis have seen an increase in reimbursement for inpatient care as a result of a recent out-of-court settlement of a lawsuit brought against the State (see ch. 2). Hospital outpatient reimbursement was reduced from 65 to 59 percent of costs for the 1991-93 biennium. Pharmacies will see a cost-of-goods update twice monthly, but the dispensing fee has been frozen. Dentists received increases for certain procedures (212).

FFS system would be: 1) the additional $3 per enrollee per month for primary care case managers, and 2) any additional reimbursement realized as a result of new coverage for services previously provided, or patients previously seen, free of charge. For sole providers in areas with sparse population and many newly insured persons, expanded eligibility may mean *de facto increases in* revenue.

OMAP's decision not to extend reimbursement rate increases to the FFS portion of the delivery system represents a conscious effort to move more providers into the prepaid arena (212). If they succeed in achieving and maintaining a statewide prepaid delivery system, the lack of payment increases for FFS providers would no longer be an issue. However, 25 percent of the Medicaid population is anticipated *to* be under case-managed FFS at program steady state. This 25 percent would be relatively concentrated in the more remote rural counties where OMAP is not aggressively targeting prepaid contracts. Assuming that the demonstration would entail a 31 percent increase in enrollment in each of these counties, lack of reimbursement rate increases could have negative implications for provider participation in FFS and, hence, beneficiary access to care in those areas if providers were not willing to accept additional Medicaid patients at prevailing rates. An official of the Oregon Medical Association recently characterized current FFS reimbursement rates as ''woefully inadequate, ' and suggested that the Oregon demonstration would ''penalize' rural physicians by not extending to them enhanced reimbursements (30). It is not clear how much of an incentive the additional $3 case management fee would be to participation by PCCMs.

Prepaid System

Estimated cavitation rates appear to be roughly comparable to those currently offered to prepaid Medicaid providers (table 4-14). A true comparison is difficult, however, because the rates reflect a demographically dissimilar population, a significantly different benefit package, and a new rate-setting methodology. Current cavitation rates for PCOs, which are based on Medicaid FFS-equivalent costs for a similar population, range from $30.16 to $37.00 per month for AFDC clients.[62] For the most comparable eligibility category under the proposed system (non-general assistance clients with incomes below 100 percent of the FPL), estimated PCO rates for basic services[63] range from $36.59 to $44.42 per month ($32.59 to $40.42 per month if one excludes the $4 administrative allowance)[64] (table 4-14).

Current prepaid contractors who plan to participate under the proposed system can make a rough comparison between current and proposed rates for certain services and patients (e.g., those services and patients for which they have previously received capitated reimbursement). Both new and existing providers, however, are likely to have greater difficulty anticipating the costs of other patients (e.g., general assistance and PLM clients). The extent to which the new rates would represent increases in reimbursement to PHPs would depend on a number of factors, including:

- The extent to which PHPs are able to cut costs by curtailing the provision of noncovered services or through other means,
- The extent to which their current uncompensated care load is displaced by newly covered patients or services,
- The extent to which cavitation rates cover actual costs of patient care, and
- The extent to which new rates adequately compensate for any increased administrative tasks they must assume under the demonstration.

For subcontractors in the prepaid system (e.g., physician specialists, hospitals, providers of ancillary services), higher payment would depend on the ability of these providers to negotiate such rates with prepaid plans. There are no floors or other guidelines for subcontractor rate negotiation.[65] Under the current managed care system in Oregon, hospitals that provide outpatient services to Medicaid patients under subcontract to PCOs have generally been paid at rates equivalent to those they could expect if they were paid directly by OMAP (52). This practice,

62 There is no administrative allowance for prepaid providers under the current system.

63 See table 4-13 for a description of PCO basic services.

64 These figures reflect the withholdance for the maternity care reinsurance pool, but they do not reflect any applicable stop-loss insurance premium deductions.

65 The proposed capitation rates reflect newly calculated ''reasonable cost' for subcontracted services (e.g., hospital services, home health services, pharmacy services); however, OMAP has not established a policy whereby PHPs would be required to reimburse their subcontractors at these levels.

Table 4-14--Capitation Rates for Prepaid Health Providers in Oregon: Current and Proposed Benefit Packages[a]

Monthly capitation rates *as of October 7,* 1991 *(AFDC only)*[a]

***Fully* capitated health *plan (FCHP)--Kaiser Permanence,* Northwest Region:**
$84.16 to $98.54

Physician care organizations (PCOs): [b]
$30.16 to **$37.00**

Proposed monthly capitation rates under the demonstration for State* fiscal year 1993, including administrative *allowance: [c]

	Range[d]	
Eligibility category: [e]	FCHP	PCO
Ail eligibles with incomes under the Federal poverty level (FPL) except general assistance	$109.32 to $129.81	$36.59 to $44.42
Poverty level medical (PLM) adults with income 100 to 133% of FPL	$603.49 to $701.10	$234.87 to $293.40
PLM children (i.e., less than 6 years of age) with income 100 to 133% of FPL	$180.64 to $209.67	$47.16 to $58.78
General assistance	$259.03 to -$287.34	$52.91 to $63.14

ABBREVIATIONS: AFDC-Aidto Families with Dependent Children; FCHP = fully capitated health plan; PCO - physician care organizaton (partially cavitated health plan).
a Although presented side by side in this table, current and proposed cavitation rates are not directly comparable because they were calculated from different data sets and represent significantly different benefit packages. There is no administrative allowance in the current system.
b Rates include basic services only (physician, lab, x-ray, early and periodic screening, diagnosis, and treatment program).
c Cavitation rates as estimated by Coopers & Lybrand using a mixture of private and Medicaid claims databases (see ref. 40). They reflect FCHP covered services (including all optional services) and PCO basic services (see table 4-12) for lines 1 through 567 on the prioritized list of health services. The rates in this table do not reflect applicable premium deductions for: 1) maternity and newborn cases, or 2) stop-loss protection. They do include a 6 percent administrative allowance for FCHP services and a $4 per enrollee administrative allowance for PCO services.
d Represents range among the five different geographic areas for which OMAP has calculated separate cavitation rates (see text).

SOURCES: State of Oregon, Department of Human Resources, Office of Medical Assistance Programs, *Prepaid Health Plan Request for Applications Additional Information* (Salem, OR: OMAP, Feb. 7, 1992); Coopers& Lybrand, *Oregon Medicaid Basic Health Services Program: Calculation of Per Capita Costs* Report(San Francisco, CA: Coopers& Lybrand, May 1, 1991); B.Terhaar, Operations Project Manager, Prioritized Health Care Systems, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, personal communication, Dec. 4, 1991; L. Read, Director, Prioritized Health Care Systems, Office of Medical Assistance Programs, Oregon Department of Human Resources, Salem, OR, letter to E.J. Power, Office of Technology Assessment, Mar. 4, 1992.

however, is negotiated by the plan and the hospital rather than the result of a formal policy decision by OMAP (212).

Another potential issue for PCOs under the demonstration is the ability of OMAP to measure savings for noncapitated services due to PCO case management. Under the proposed plan, PCOs would receive a percentage of any savings achieved through reduced utilization of covered noncapitated hospital outpatient, hospital inpatient, and prescription drug services, measured against predetermined target costs for an actuarially equivalent FFS population (see above) (177). In other States, the ability to perpetuate such incentives in partial cavitation arrangements has been hampered by erosion of the FFS base against which actual utilization is measured (143). This problem might be of particular concern in Oregon, because by the time the demonstration is at steady state, the State intends to have *all* eligibles enrolled in some form of managed care. Also, measurement of total savings must be detailed enough to discount savings from service prioritization. Under the current system, savings are calculated by comparing utilization of broad service categories. OMAP claims that, although difficult, such a comparison is actuarially feasible, and that the primary purpose of such a mechanism-to provide an incentive for prepaid providers to control costs—would still be served (212).

Impact of the Prioritized List

Implementation of the prioritized list of services, by design, is likely to influence the way physicians and other health care practitioners diagnose and treat their Medicaid patients. The impact of the list may differ depending on the delivery system in which the practitioner operates.

To get a better sense of how clinical practice might be affected by the list, OTA had several physicians evaluate the list in light of their own clinical experience. The contractors' findings, presented in more detail in chapter 3, include concerns regarding:

- The clinical appropriateness of ranking certain CT pairs either above or below the line,
- Dissatisfaction with the use of broadly defined service categories in the prioritization process, and
- The inadequacy of the list at valuing the relative effectiveness of specific treatments for certain patient subpopulations.

If physicians serving Medicaid patients under the demonstration share these concerns and feel the list either prevents them from providing appropriate or necessary care or forces them to provide alternative treatments they feel are less appropriate, they may respond by attempting to code claims or encounter data forms for potentially uncovered conditions into alternative CT pairs (see ch. 3). If physicians or other health care providers are unable or unwilling to code conditions into alternative CT pairs, they might either deny treatment or choose to absorb the cost of providing that treatment themselves.

According to the clinical contractor evaluations and OTA's own analyses of list coding, there appear to be many opportunities for alternative coding of below-the-line conditions into covered CT pairs. If alternative coding is more extensive than anticipated in the cost estimates (see ch. 6), savings from prioritization may not be as great as anticipated. Noncovered services range from inexpensive treatments such as elastic bandages and splints for strains and sprains to extremely costly treatments such as liver transplants for alcoholic cirrhosis of the liver (see ch. 3).[66]

List Interpretation and Coding Issues

The ability of providers and OMAP to interpret coding used in the list has implications for program evaluation and costs, provider reimbursement and financial risk, and beneficiary access to specific services.[67] In completing claims and encounter data forms, providers *would not* indicate the CT pair into which they felt it appropriate to classify a patient. Forms would be completed and coded much as they are now, using ICD-9-CM[68] diagnostic and CPT-4[69] procedure codes (212). Based on this information, OMAP would decide whether or not to pay a claim or, in the case of encounter data, would classify encounters as either ''covered' or ''noncovered' services for purposes of program evaluation and determination of stop-loss thresholds or PCO incentive payments (88,212).

Since September 1989, OMAP has been upgrading its claims and data processing capabilities (212). As of the end of January 1992, however, OMAP officials had not yet finalized a strategy for processing FFS claims against the list (212). At that time, they were reportedly considering developing a computer program that would focus primarily on below-the-line CT pairs rather than one that would categorize each paid claim by CT pair (212).

Whether submitting FFS claims or providing OMAP with detailed encounter data, providers would need to have an intimate understanding of list coding. Providers may also need to change the way they code claims in order to more clearly associate specific diagnoses with specific treatments. There are a number of reasons why providers may have difficulty interpreting the list and coding their claims or encounter data accordingly.

First, numerous coding duplications on the list (many of them appropriate, others apparently unintentional) could lead providers to misinterpret the scope of conditions or treatments included in CT pairs, which could in turn influence their decision as to whether or not to treat the patient. The list contains many ICD-9-CM code duplications, with some codes appearing in five or more CT pairs. overall, 291 of 709 CT pairs contain at least one diagnosis code that is repeated in at least one other CT pair.

Second, the distinction between primary and secondary conditions in certain CT pairs is vague and could be misinterpreted by physicians. For example, CT pair 708 reads ''end-stage HIV[70] disease-medical therapy," and lists the full range of medical therapy CPT-4 codes. According to the

66 Cost estimates for the demonstration assume that a small portion of below-the-line services would still be provided, but it is *difficult to assess* whether these estimates are realistic. See ch. 6 for a detailed discussion of how demonstration costs were estimated and how the assumptions may affect providers in the FFS and prepaid delivery systems.

67 For a general discussion of program evaluation issues, see ch. 8.

68 *International* Classification *of Diseases, 9th* Edition, Clinical Modification (316).

69 Current Procedural Terminology (CPT) codes, 4th revision (7a).

70 Human immunodeficiency virus.

Oregon Health Services Commission (HSC), the intent was only to deny treatment for the primary diagnosis (i.e., to deny payment for azidothymidine (AZT) or any other approved drug for the treatment of HIV infection) (1 18). However, physicians might interpret the CT pair to mean treatment for a number of HIV-related conditions that are in fact included in CT pairs above the line.

Third, it remains unclear how OMAP intends to make noncodable distinctions (e.g., treatable vs. nontreatable cancer, end-stage HIV disease) when processing claims. As of late January 1992, both the HSC and officials within OMAP indicated that they were considering leaving these distinctions to the discretion of the physician (77). While such a strategy would increase physicians' autonomy in making these distinctions, it could also decrease OMAP's ability to achieve anticipated cost savings if physicians chose to code these patients liberally into covered CT pairs.

Finally, hospital claims forms typically contain multiple diagnosis and treatment codes. To accurately determine which procedures were performed for which diagnoses-a determination that could ultimately affect coverage--claims forms and encounter data requirements may have to be refined.

Ambiguities such as these suggest that development of extensive and detailed CT pair assignment guidelines is at least as important as correcting specific coding problems on the prioritized list. As of the end of January 1992, OMAP had just begun the process of revising the existing FFS provider guidelines to reflect the new benefit package (77,212). According to the OMAP official responsible for coordinating revision efforts, the strategy will be to focus on services that are not covered and to clarify potential ambiguities with specific examples (77).[71]

Differences by Delivery System

Because they face denial of payment on a claim-by-claim basis, providers in the case-managed FFS system would be most directly affected by implementation of the prioritized list. For providers in the prepaid system, the effect could be dampened by lack of immediate claims oversight. For example, in an "independent practice association' '-type plan that subcontracts with physicians and does not internally monitor covered vs. noncovered services, physicians maybe at greater liberty to treat below-the-line conditions. On the other hand, some PHPs may adopt strict internal policies to deny payment for (or provision of) noncovered services. Whether PHI% promote or resist such policies could depend on a number of factors, including: 1) the extent to which providers believe that cutting below-the-line services can save them money, 2) the extent to which OMAP monitors line-specific utilization of PHP enrollees, and 3) providers' belief that certain noncovered services are indeed medically necessary and should be performed.

Kaiser Permanente-Northwest Region, a large HMO that has indicated an intent to participate under the demonstration, has indicated that, while it might adopt policies to deny services for certain below-the-line conditions (e.g., specific surgical treatments), it might continue to provide others--either out of moral obligation or because certain services (e.g., splints and bandages for sprains supplied during an office visit) would be practically impossible to monitor (100). Other PHPs—especially those that lack the financial resources or will to absorb costs associated with noncovered Medicaid services-might deny below-the-line treatments to a greater extent than larger providers.

Potential variability among providers in adherence to the prioritized list as a benefits package could lead to inequalities in beneficiary access to services for specific conditions. Indeed, some level of inequality in access exists already between FFS and PHP Medicaid patients. Kaiser Permanence claims that it routinely provides hospice and adult preventive services to its current Oregon Medicaid enrollees, even though these are not covered benefits under the current Medicaid program (100). An evaluation of cost savings in Oregon's PHP program between 1985 and 1989 found PHP enrollees' overall utilization of hospital (both inpatient and outpatient) and prescription drug services to be lower than that for an equivalent FFS population (41). To term these differences "inequalities" would be to ignore one of the original goals of the PHP program: to reduce utilization of unnecessary and costly services through managed care. Decreased inpatient utilization in the current PHP system is defined broadly and attributed to better

[71] For example, the medical-surgical provider guidelines might clarify that, although aggressive treatment for terminal cancer is not covered, a surgical procedure to remove a bowel obstruction ina terminal cancer patient or palliative chemotherapy would be covered (if OMAP were to adopt such a policy).

management of care by primary care physicians (41). Broadly defined differences in beneficiaries' utilization of services, however, fail to capture service- and condition-specific differences in access that could result from inconsistencies in adherence to the benefit package.

Although the list may have a more direct financial impact on FFS providers, its implementation could also affect providers in the prepaid system, who would be required to submit detailed encounter data in a format similar to FFS claims (175). Understanding the mechanics of the list would also be important for PHPs if they wanted to monitor the extent to which their subcontractors (e.g., hospitals) provide noncovered services. OMAP has no plans to develop specific tools to aid prepaid providers in their internal claims or service management (212). Each prepaid provider would presumably be responsible for interpreting and implementing the list within its own service structure.

Implications of Future Changes in the Benefit Package

If, in the event of future budgetary constraints, the coverage line moved above 587, implications for providers would also be likely to vary by delivery system. In the FFS system, providers would be denied direct payment for specific services. In the prepaid system, the cavitation rates would decrease, with a corresponding decrease in service liability. If PHPs were unwilling and unable to make up for possible rate decreases, either by cutting additional services or through various forms of cross-subsidization, they might opt out of the program.

Providers in the State have expressed reasonable satisfaction to date with the benefit package and proposed cavitation rates at line 587. As in any prepaid health care environment, however, providers may opt out if they feel the rates are too low. It is impossible to predict the threshold (either in terms of the rate or the benefit package) below which providers would no longer be willing or able to participate in the Oregon demonstration.

Data Collection Under the Demonstration: Issues for Providers

Collection of detailed encounter data from PHPs would be critical to evaluation of the effects of service prioritization and managed care expansions on program costs, beneficiary access to care, quality of care provided, and any relevant health outcomes measures.[72] It would also help risk-based providers in their internal financial management by enabling them to track both patient- and service-specific utilization and costs. Documenting patient-specific utilization would enable providers to avail themselves of stop-loss protections offered by the State. Efforts to track service-specific costs would enable providers to develop their own cost-containment strategies.

In late November 1991, OMAP informed potential prepaid providers that they would be required to submit detailed encounter data to OMAP for purposes of utilization monitoring and program evaluation (175). Encounter data would include the "patient's name, Medicaid ID number, treating professional, date of service, diagnosis, services provided, and plan payment amount and would have to be reported-preferably electronically-within 60 days of the date of service (175).

Because the proposed encounter data requirements are essentially the same as information requirements on current FFS claims forms, new prepaid providers who currently see patients in the FFS system would not need to undergo major adjustments to comply with encounter data collection requirements. For some existing prepaid providers, however, significant adjustment would be required. The inability of PHPs in the existing managed care system to submit even the most basic quarterly utilization data for Medicaid enrollees in a consistent manner (310) is not encouraging. Nonetheless, most current prepaid providers have reportedly accepted the need for these requirements and are willing to comply (212). At least one large prepaid provider, however, has requested that OMAP grant it a waiver from the specified encounter data reporting requirements under the demonstration. Kaiser Permanence objects to the requirement because it would entail the development of a new data collection system and the reporting of confidential patient information (19).

PHPs are expected to bear the cost of putting the necessary data collection and utilization review systems in place. The proposed cavitation rates (table 4-14) reflect increased administrative costs associated with data collection and other administra-

[72] See ch. 8 for a general discussion of program evaluation issues.

tive tasks, but OMAP acknowledges that the administrative allowances would probably only be sufficient to cover operational costs (212). OMAP intends to have staff available to provide technical assistance to PHPs to aid them in meeting data collection and other administrative requirements *(177,212).*

OMAP also intends to collect information from primary care case managers and PHPs about what noncovered services they provide to clients (175). How they would accomplish this is unclear. If providers felt that reporting the provision of noncovered services might result in either increases in the benefit package or increases in their payment rates, they might feel an incentive to overreport these services. If, however, providers felt that such reporting might jeopardize their reimbursement in any way (e.g., reduce cavitation rates or PCO incentive payments), they might tend to underreport.

Overall Implications for Provider Participation

To accommodate the almost twofold increase in Medicaid enrollment under the demonstration, provider participation in both the prepaid and FFS systems would have to increase. Although it is impossible to predict with any certainty what provider participation would be like under the demonstration, factors that may influence participation deserve examination. These factors, which are discussed throughout this chapter, are summarized briefly here for the prepaid and case-managed FFS delivery systems.

Prepaid System

Key factors in initial participation by prepaid providers include attractiveness of payment rates, level of commitment to providing care to poor populations, capacity for increased caseloads, providers' perceptions of the appropriateness or feasibility of implementing the prioritized list of services, and the ability of providers to meet the terms of prepaid contracts. Adequate long-term participation would depend on additional factors, including the ability of prepaid providers to: 1) control costs through below-the-line exclusions and effective patient management, *2)* comply with the (not unreasonably) stringent standards of performance set forth by OMAP, and 3) adapt to possible reductions in cavitation rates mid-cycle. Participation of subcontractors would depend on their ability to negotiate acceptable arrangements and rates with prepaid plans.

PCOs in the current system have already established referral and subcontracting arrangements for basic services; however, the vast majority of these PCOs would be required to convert to FCHPs at program startup, entailing development of new subcontractual arrangements for inpatient and other care not currently capitated for PCOs. As noted earlier, OMAP has obtained letters of intent to participate as FCHPs from many of these plans. However, the plans' abilities to shoulder increased risk for patient care over the long term has yet to be tested.

Case-Managed FFS System

In the case-managed FFS system, financial and organizational incentives for provider participation would not differ as greatly from the current system as they would for prepaid providers. Furthermore, the case-managed FFS system would be the primary mode of service delivery only in the most rural parts of the State, where the number of providers—particularly secondary and tertiary care providers—is already limited. Referral patterns, to the extent that they exist at all, are 'fixed' by default and have already been at least informally established. For example, a primary care physician in a sole-hospital area with only a limited number of geographically accessible specialists has few options when it comes to secondary or tertiary care referrals.

Providers in rural areas who have difficulty maintaining adequate caseloads of charge-paying or otherwise insured patients are likely to welcome the opportunity to receive reimbursement for a larger number of low-income patients. Nonetheless, the additional responsibilities required of PCCMs (e.g., 24-hour availability, preauthorization of all care) could act as disincentives to participation if they are perceived as burdensome by providers. The wide geographic dispersion of patients and limited availability of secondary and tertiary care providers may present an additional challenge to PCCMs in establishing adequate referral networks for newly assigned patients. In addition, rural physicians maybe less able than their urban counterparts to take on additional administrative responsibilities because they are less likely to be able to afford support staff to assist them in these functions.

One possible advantage of case-managed over unrestricted FFS health care delivery is that it can increase beneficiary access to care by providing a guaranteed point of contact for patients (17,143), In several other States where case-managed FFS systems have been implemented, increased access (e.g., more specialty care referrals) has also led to increased per patient costs because these systems were not as successful in changing physician practice patterns as those that put physicians at risk (143)$_0$

Experience in other States also indicates that case-managed FFS and PCO systems have not always been successful at recruiting providers in underserved areas (143). A 1987 evaluation of Medicaid case-managed FFS programs in six States found that achieving adequate participation by primary care practitioners was problematic and slow and had the net effect of limiting the States' ability to achieve anticipated case management savings (17). The shortage of health professionals in rural areas is a nationwide problem, however, and not one that the Oregon proposal set out to address.

Understanding the current extent of provider participation in rural areas of Oregon would be helpful in assessing the potential impact of the proposed demonstration in the case-managed FFS delivery system. Unfortunately, little is known about the extent to which providers currently participate in the Medicaid FFS system.[73] An advisory group established by OMAP to guide case-managed FFS implementation met for the frost time in early December (212).

Implementation of the prioritized list may also present problems in case-managed FFS, at least at the outset. OMAP has indicated a commitment to minimizing the "hassle factor" for providers by keeping as many as possible of the burdens of list complexity transparent to providers and by working collaboratively with providers in the case-managed FFS system (212). However, the difficulties inherent in implementing the prioritized list of services in the FFS system may increase the "hassle factor" in claims payment somewhat during the first year or two of the demonstration.

Issues for Selected Providers

Hospitals

Under the proposed demonstration, both the amount and the immediate source of Medicaid reimbursement are likely to change for the majority of hospitals. Perhaps the most pronounced change would be the offset of current uncompensated care costs due to expanded eligibility. Hospital reimbursement would also change due to addition and elimination of services from the benefit package, changes in reimbursement rates, and reductions in inpatient and outpatient services utilization due to the expansion of managed care. The net balance of these changes for hospitals, however, is impossible to predict at this time.

Many hospitals would shift from State-set DRG rates to rates negotiated with prepaid providers. Thirty hospitals[74] would receive most of their payment for inpatient and outpatient care from FCHPs. An additional31 hospitals in the PCO areas would negotiate payment for certain outpatient hospital services rendered to PCO enrollees with the PCOs, but they would continue to receive the prevailing payment rates for inpatient services (either DRG- or cost-based) directly from OMAP.[75]

Hospitals may find it difficult to anticipate the magnitude of expected Medicaid revenues for a number of reasons. First, managed care may reduce hospital utilization. Indeed, the State has projected that, purely as a result of managed care incentives, nonmaternity/newborn-related inpatient hospital costs would decrease by 25 percent for FCHP enrollees, 13 percent for PCO enrollees, and 9 percent for case-managed FFS enrollees (178). These projections are based on its reported experience with the current PHP program and cost studies done by Coopers & Lybrand. In testimony presented before Congress in September 1991, the Congressional Budget Office and GAO questioned the validity of these estimates (237,238).

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73 A comprehensive study of primary care practitioner availability in each of the State's 125 health service areas has recently been completed by the Oregon Office of Health Policy. The results of this study should help determine whether there is sufficient capacity in the system to handle the estimated 120,000 newly eligible Medicaid enrollees.

74 Excludes the two Kaiser Foundation hospitals, which are already under full capitation arrangements with Medicaid for patients enrolled in the Kaiser-Permanente-Northwest Region HMO.

75 According t. OMAP, approximately one-third of outpatient services reimbursement for PCO enrollees is subject to negotiation. The remaining two-thirds are paid on an FFS basis by OMAP (212).

Second, although cavitation rates reflect the "reasonable cost" of hospital inpatient and outpatient services for covered CT pairs, OMAP has not established a floor for FCHPs' hospital reimbursement rates. Hospitals recently succeeded in obtaining increased Medicaid reimbursement from the State as the result of a lawsuit filed under Boren Amendment provisions (156,157) (see ch. 2)-a fact that might put hospitals in a stronger position to guard themselves against inadequate reimbursement from PHPs.

As noted earlier in this chapter, financial data indicate that a significant number of Oregon hospitals--particularly small rural hospitals-are already in financial distress. A number of these hospitals are currently exempt from prospective payment and instead receive facility-specific, cost-based reimbursement (see table 4-9). Under the demonstration, some of these hospitals would lose these statutory protections because, according to State officials, the statutes have been interpreted as applying only when payments are made directly by the State and are not likely to be upheld for hospitals receiving payment from PHPs (52,134). If the demonstration is approved, payments to these rural hospitals should be monitored closely.

For hospitals that continue to be reimbursed on a DRG basis, implementation of the prioritized list poses an additional reimbursement problem because DRGs do not adequately distinguish between covered and noncovered services provided during the course of a single hospital stay. For example, for a patient who receives treatment for several conditions during the same hospital stay (e.g., intravenous AZT for HIV infection and intravenous antibiotics for *pneumocyctis carinii* pneumonia), it may be impossible to determine from the hospital claim form which treatment is being provided for which diagnosis.

Of particular concern is the ability of the payment system to distinguish between diagnosis- and treatment-related inpatient charges. Oregon has stated that, under the demonstration, all Medicaid patients are entitled to a full diagnosis of their condition, even if treatment for that condition is not covered (177). Under the current system, however, diagnostic and treatment charges are bundled into a single diagnosis-related payment. If a treatment for a covered condition is incorrectly attributed to a noncovered condition on the basis of claims coding, payment may be inappropriately denied. There are a number of below-the-line conditions where extensive inpatient diagnostic procedures might be required to confirm the diagnosis (e.g., exploratory surgery or magnetic resonance imaging (MRI) for certain cancers). If hospitals were denied payment for these procedures, the financial consequences could be serious. As of January 1992, Oregon had not yet developed policies to address payment of diagnostic services provided in an inpatient hospital setting where treatment was also provided for a noncovered condition (212).

Publicly Funded Primary Care Providers

Publicly funded primary care clinics (e.g., FQHCs, RHCs, county and local health departments) have played a major role to date in serving Medicaid and uninsured patients in Oregon and throughout the country. Federal, State, and local subsidies have supported them in this role, and payments from Medicaid often represent a substantial proportion of their budgets. If demonstration enrollment increases took place without any changes in the delivery system, most of these providers would probably see increases in their Medicaid revenues due to expanded eligibility. As proposed, however, the demonstration could end up having a negative rather than a positive financial impact on some of these clinics. Like other providers, they would be forced either to assume risk as primary contractors, negotiate with other prepaid plans as subcontractors, or serve an increasingly limited number of Medicaid patients in the FFS system.

A state law passed in 1991[76] would guarantee a limited role for publicly funded clinics under the proposed system by requiring prepaid providers to subcontract with them for point-of-contact services for immunizations, sexually transmitted diseases, and other communicable diseases. Their ability to participate as full-scope primary care providers, however, is less certain. Publicly funded providers are likely to have difficulty meeting requirements for participation as primary contractors for a number of reasons, the foremost of which is that they may be less able than larger providers to assume full or partial risk for patient care due to limited financial resources.

76 Oregon Senate Bill 760, 1991.

Federally Qualified Health Centers and Rural Health Clinics—Implementation of the proposed managed care expansions would have significant implications for FQHCs and RHCs. All 11 FQHCs (table 4-3) and 14 of the 17 RHCs[77] are in areas where OMAP has indicated it would implement prepaid health care delivery (177,197). The 6 FQHCs in areas where FCHPs would be mandatory represent a total of 19 individual clinic sites, serving an estimated 65,586 unduplicated persons (both Medicaid and non-Medicaid) in FY 1989.[78] Four of these FQHCs operate as PCOs in the current managed care system (see table 4-3), but they would have to convert to FCHP status in order to maintain primary contracts under the demonstration. The 5 FQHCs in areas where PCOs would be implemented represent 7 individual clinic sites that served at least 8,321 unduplicated persons in 1989.[79]

OBRA-89 (Public Law 101-239) mandated that FQHCs receive facility-specific cost-based reimbursement from the State for services they provide to Medicaid patients. Each clinic's reimbursement rate is determined by calculating the average cost per patient encounter across all patients over the course of a year. RHCs are entitled to the same type of reimbursement under Public Law 95-210. The Consolidated Omnibus Reconciliation Act of 1990 (OBRA-90)[80] reinforced OBRA-89 reimbursement protections by mandating that FQHCs participating in Medicaid prepaid delivery systems receive the same payment per encounter to which they are entitled when paid directly by the State. OBRA-90 also mandated that, whenever States require Medicaid patients to enroll in prepaid plans, at least one of the plans available in any given area either be an FQHC or subcontract with an FQHC for the provision of primary care services.

Under the proposed demonstration, Oregon is seeking a waiver from cost-based reimbursement provisions for FQHCs and RHCs and from OBRA-90 FQHC guaranteed access provisions (177,257). These waivers would give the State greater latitude in choosing prepaid contractors and would enable OMAP to pay FQHCs and RHCs the same rates that they would pay other providers under the demonstration. If these waivers are granted, the impact on FQHCs and RHCs in prepaid areas would depend on a number of factors, including:

- The ability of the clinics to: 1) assume either full or partial risk for the care of their Medicaid enrollees, or 2) negotiate successfully with FCHPs and PCOs in their service area to act as subcontractors for primary care services;
- The extent to which the clinics currently depend on Medicaid revenues;
- The extent to which current sliding-scale patients in the clinics would be newly eligible under the demonstration;[81] and
- How OMAP's cavitation rates or rates negotiated with FCHPs under subcontract compare with their actual costs.

If unable to obtain prepaid contracts, FQHCs and RHCs might be able to continue serving Medicaid patients under subcontract to other prepaid providers. OMAP would encourage but not require prepaid providers to subcontract with these entities for services other than immunizations and point-of-contact services for sexually transmitted and other communicable diseases (175). However, participation as subcontractors introduces further uncertainties regarding the adequacy of reimbursement, because the proposed waiver of OBRA-89 and OBRA-90 provisions would relieve OMAP of its current obligation to reconcile differences between subcontractor rates and FQHCs actual costs for services.

In Oregon's current prepaid system, 2 of the 11 FQHCs see patients under subcontract to a PCO. Both are paid according to the PCO's fee schedule for all covered services, and both contend that their average per-encounter reimbursement from the PCO falls well below their FQHC entitled rate (219,259), although OMAP has disputed this claim (213). To comply with Federal law, OMAP intends to reconcile the difference between the amount paid by the

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[77] Four RHCs are in areas slated for FCHP implementation the remaining 10, in areas where OMAP intends to execute prepaid contracts.

[78] Clackamas County Health Department did not report users in 1989 because it was not designated as an FQHC until October 1991 (261).

[79] Two of these five FQHCs did not report users for 1989. Similar data were not available for RHCs.

[80] Public Law 101-508.

[81] FQHCs that receive migrant health center funding may be less likely to benefit from expanded eligibility under the demonstration because many of their patients may not meet the Federal Medicaid residency requirements and thus would not be eligible for coverage (259). See ch. 5 for further discussion of eligibility issues.

PCO and the amount each clinic would have received for its services in the FFS system (212,259).

If unable to participate in the prepaid system, the remaining option for FQHCs and RHCs would be to serve as PCCMs for clients not enrolled in managed care plans (estimated to be 15 to 20 percent of clients in prepaid plan areas and 100 percent of clients in counties with no prepaid plans). In the PCCM system, FQHCs would continue to be reimbursed according to OBRA-89 provisions (257). However, the Oregon Primary Care Association and some of its member clinics have expressed concern that, should HCFA grant Oregon a blanket waiver from cost-based reimbursement provisions, OMAP could exercise this waiver in the case-managed FFS delivery system as well (259,306).

OMAP has suggested that FQHC and RHC reimbursement would be as high if not higher under the demonstration (255). If this is the case, then the only argument for waiving OBRA-89 and OBRA-90 provisions is an administrative one: it would simplify provider payment under the demonstration by removing the need for facility-specific cost estimates and payment reconciliation. However, facility-specific rates would still need to be determined for FFS payment purposes unless a blanket waiver were granted, and reconciliation could be accomplished on an annual or semiannual basis to minimize the administrative burden for OMAP.

The issue of FQHC and RHC reimbursement and participation under the demonstration is critical because, if the demonstration ended, these clinics would need to resume their significant role as safety net providers. For some clinics, loss of patients to other prepaid providers under the demonstration could mean significant losses in Medicaid revenues, which currently account for over 30 percent of the total operating budget at some sites (261). If losses of existing Medicaid patients as well as some currently indigent patients who would become eligible under the demonstration bring the operating volume of these clinics below a viable threshold, their ability to serve the remaining indigent population (e.g., migrants and individuals with incomes over 100 percent FPL but without insurance) could be compromised.

This potential problem could be remedied through year-end reconciliation by OMAP of differences between FQHC rates and PHP rates paid to qualifying clinics, as it is in the current system. Alternatively, OMAP could require PHPs themselves to pay the clinics' actual costs. In addition, OMAP could provide PHPs with stronger incentives or requirements to subcontract with publicly funded facilities.

County and Local Health Departments--County and local health departments have also played a major role in providing certain services (e.g., eligibility screening, immunizations, health screening, maternity case management) to the Medicaid and uninsured population in Oregon (212,252). The ability of these and other publicly funded facilities to participate under the demonstration could be hampered by a number of factors.

First, budgetary retrenchment in the State could lead to hard dollar losses for county health departments (CHDs) and other State-funded facilities in the near future. Under Ballot Measure 5,[82] Oregon's 35 CHDs have seen and will probably continue to see decreases in direct subsidy from the State that could threaten their overall financial viability (259). This could further limit their ability and willingness to assume risk as prepaid providers in the proposed system.

In the case-managed FFS system, CHDs would be allowed to participate as PCCMs and be paid according to OMAP's prevailing FFS rates, provided they had the appropriate staff (i.e., physicians and/or nurse practitioners) to assume case management responsibilities. However, CHDs are typically not staffed or otherwise equipped to provide the full range of core primary care services required of a PCCM.

Several other issues may also present barriers to participation of publicly funded clinics in the proposed demonstration. First, their historical difficulty in recruiting and retaining physicians could limit their ability to maintain a stable primary care physician population, as required in the prepaid contract. For example, many FQHCs are staffed by physicians serving their obligations under the National Health Service Corps scholarship program (273). The attrition rate of these physicians is high, and FQHCs have difficulty competing with the salaries and benefits available in other settings (273).

82 See ch. 2 for a description of Oregon's Ballot Measure 5.

Second, a few clinics have expressed concern that the public-private differential in the State capon tort liability (an overall cap of $200,000 for public agencies[83] and a $500,000 cap on noneconomic damages for all other providers) will discourage private entities from entering into patient care arrangements with them in the prepaid system (259,261). Because of Oregon's joint and several liability[84] statute, providers not protected by the $200,000 overall cap could conceivably be vulnerable to unlimited economic liability for malpractice cases in which they shared responsibility for patient care with a publicly funded provider. It is not at all clear how much of an issue this would be under the proposed demonstration. Multnomah County Health Department, an existing PCO subject to the $200,000 liability cap, has been able to circumvent this problem, and it currently has referral arrangements with several hospitals (both public and private) in its service area (213,259). At the same time, Clackamas County Health Department, an FQHC that would like to participate as a PHP in the proposed system, claims that the sole hospital in its service area refuses to enter into arrangements and is citing liability concerns as the reason (261).

Third, some clinics have expressed concern that, even if able to negotiate prepaid contracts, they may be affected by "adverse selection" in spite of the preventive measures taken by OMAP (259,261). These clinics fear that they may attract a disproportionate number of ''high-risk' patients (e.g., migrant farm workers, homeless patients, drug abusers) *within* a given eligibility category, either because patients find it easier to access services in these settings or because these settings provide services not available elsewhere (e.g., interpreters) (153,259). This potential problem could be closely monitored by both the clinics and OMAP. If stop-loss and other protections proved inadequate, problems could be addressed through rate adjustment.

Finally, clinics are concerned that, once enrolled with a prepaid health plan, patients may still show up at their doors for care, either because they are accustomed to accessing services there, because they feel it is more convenient, or because they have had difficulty obtaining an appointment with a physician in their prepaid plan (259,261). Because publicly funded clinics are required by State and/or Federal law to see all patients regardless of insurance status or ability to pay, they fear they could be forced to see these patients but be unable to demand reimbursement from the patient's prepaid plan for services provided (259,261).[85] Again, it is not clear how much of a problem this would be under the demonstration, but it is an issue that may deserve some monitoring should the program go into effect.

Alternative Providers of Care

In Oregon's FFS Medicaid system, enrollees who prefer nontraditional sources of care have been able to seek medically necessary care from any provider recognized by OMAP. Oregon has been more liberal than most other State Medicaid programs in allowing FFS reimbursement for services of nontraditional providers (see table 4-15). All States are required to reimburse for the services of doctors of osteopathy[86] and for pediatric and family nurse practitioners under Medicaid.[87] Under the proposed demonstration, OMAP would continue direct reimbursement for medical services delivered by these and other alternative providers in the case-managed FFS system as long as those services were preauthorized by the PCCMs. In addition, OMAP would allow nurse practitioners and physician assistants to serve as PCCMs.

Expansion of physician-controlled managed care systems, however, would probably result in reduced opportunities for participation by certain nontraditional providers of care (e.g., chiropractors, naturopaths). This phenomenon is characteristic of managed care systems generally. Some alternative provider

83 Includes county, municipal, and State facilities (including Oregon Health Sciences University), but nOt federally funded clinics specifically. For example, Multnomah County Health Department is an FQHC, but it is subject to the public agency cap by virtue of its county funding status (259).

84 Joint and several liability refers to the ability of a plaintiff to sue one or more parties for a tort and the right of a plaintiff to collect the entire compensation from a single entity.

85 Family planning services are the exception. Under the proposed demonstration, enrollees would have universal access to these services and FQHCs would be paid on an FFS basis for providing them to any Medicaid patient.

86 Doctors of osteopathy (DOs) @cup approximately 5 percent of the total physician population in the United States (273). In general, State licensing boards recognize the DO degree as equivalent to the MD (allopathic) degree.

87 As of July 1, 1990, all States were required to provide direct Medicaid reimbursement for pediatric and family nurse practitioners (Public Law 101-239). Oregon had already exercised its option to do so prior to this time.

Table 4-15-Coverage of Selected Optional Medicaid Services, Oregon vs. Other States, October 1,1989

Type of service	Total number of Medicaid programs that cover service (N = 56)		Oregon	
	Categorically needy only[a]	All Medicaid eligibles	Categorically needy only[a]	All Medicaid eligibles
Podiatrist	12	32	—	Yes
optometrist	16	36	—	Yes
Chiropractor	8	21	—	Yes
Other practitioner	11	30	—	Yes
Private duty nursing	8	20	—	Yes
Dental	13	34	—	Yes
Physical therapy	10	29	—	Yes
Occupational therapy	5	23	—	Yes
Speech/language/hearing	8	28	—	Yes
Case management	6	25	No	No
Respiratory care	3	6	—	Yes
Personal care	7	19	—	Yes

[a] Includes aged, blind, or disabled individuals and families and children who meet financial eligibility requirements for Aid to Farnilies with Dependent Children, Supplemental Security Income, or an optional State supplementary coverage population.
[b] Includes both categorically needy and medically needy eligibles. Medically needy eligibles are aged, blind, or disabled individuals or families and children whose income is above the categorically needy eligibility limits but which, after deduction of expenses incurred for medical services covered under the Medicaid program, falls within limits set by the State Medicaid program, permitting the individuals to become eligible for Medicaid. States are allowed to establish separate coverage restrictions for medically needy eligibles.

SOURCE: U.S. Department of Health and Human services, Health Care Financing Administration, Office of Research and Demonstrations, *Program Statistics: Medicare and Medicaid Data Book, 1990*, HCFA Pub. No. 03314 (Washington, DC: U.S. Government Printing Office, March 1991), table 4-6.

groups have begun to organize themselves in anticipation of the managed care expansions. For example, chiropractors in Oregon have formed an independent practice association and have already entered into subcontracts with one or more of the current prepaid Medicaid providers. 88 They have also approached OMAP to discuss the possibility of becoming a full-fledged PHP (320). Within the prepaid system, however, participation of and access to these and other practitioners (both physicians and nonphysicians) would ultimately depend on the referral policies and staffing preferences of individual PHPs.

SUMMARY OF CONCLUSIONS

Organizational and Financial Implications

Oregon anticipates that 75 percent of beneficiaries under the demonstration would receive care on a prepaid basis, while the remaining 25 percent would receive case-managed FFS care. Although OMAP has a good track record in the development and management of prepaid managed care systems thus far, with approximately 31 percent of all Medicaid patients currently enrolled in prepaid plans, achieving the anticipated level of prepaid plan enrollment and maintaining it for the duration of the demonstration may be difficult. To qualify and remain viable, prepaid providers would have to be able to control costs through below-the-line exclusions and effective patient management, adapt to possible reductions in the benefit package and cavitation rates, and comply with OMAP's stringent standards of performance. Although letters of intent to participate indicate the potential to achieve the anticipated capacity, OMAP had not received any full applications as of March 1992.

Shifting from FFS to prepaid Medicaid would result in redistribution of some patients among providers, with some providers maintaining or increasing their caseloads and others seeing a decrease. If the demonstration were put into place, the effects of this redistribution on the financial viability of critical providers (e.g., publicly funded primary care clinics) should be closely monitored.

To encourage providers' support and participation in the demonstration, Oregon promised them reimbursement increases. Reimbursement increases would be focused on prepaid providers. The extent to which individual providers would see a net increase in payment relative to costs, however, is unclear. Proposed cavitation rates, which are based on estimates of average 'reasonable costs' for covered

88 As noted earlier in this chapter, 4 of the 15 existing PCOs are capitated for chiropractic services.

CT pairs, cannot be compared easily with current rates because they reflect costs of a substantially different benefit package and a demographically dissimilar population.

Furthermore, while expansion of prepaid health care would improve predictability and strengthen control of overall program costs from the State's perspective, providers may have difficulty anticipating their own net Medicaid revenues during the initial years of the demonstration. Careful tracking of utilization and costs from program startup would be essential to long-term provider viability. Providers might require significant technical assistance from OMAP in these efforts.

Subcontractors in the prepaid system would see increases relative to prevailing FFS reimbursement rates only if they were able to negotiate higher rates with prepaid plans; OMAP has not established a floor for subcontractor rates under the demonstration.

Provider participation in the case-managed FFS system, which is expected to serve approximately 25 percent of demonstration eligibles, maybe harder to increase than that in the prepaid system, since payment for individual Medicaid services would remain at prevailing FFS rates. Oregon has indicated current problems with FFS provider participation in rural areas of the State, where most FFS delivery would occur under the demonstration. To help offset additional case management responsibilities, primary care case managers would receive an additional payment of $3 per enrollee per month. How much of an incentive this additional payment might be for participation in rural areas cannot be predicted.

Impact of the Prioritized List

Orienting providers to the list would not be a trivial undertaking. Diagnostic and procedure codes used in the list, although familiar to providers in current practice, are inadequate to make distinctions between many CT pairs. Detailed, extensive guidelines would be required in order for providers to accurately and consistently interpret the list. As of the end of January 1992, OMAP had just begun to develop new provider guidelines, but their level of detail is not known.

Because they face denial of payment on a claim-by-claim basis, providers (both professional and institutional) in the case-managed FFS system would feel the financial impact of the prioritized list more directly and may respond to it behaviorally in a different reamer than their counterparts in the prepaid system. Differences in providers' adherence to the prioritized list could lead to unequal access to specific benefits across as well as within the proposed delivery systems.

Under cavitation, cutting services from the benefit package would mean reducing prepaid reimbursement rates, presumably in proportion to reductions in provider service liability. It is difficult to anticipate the threshold below which prepaid providers would no longer be willing to participate. This threshold would probably vary depending on the financial and other characteristics of individual providers.

Issues for Selected Providers

Publicly funded primary care clinics may find it difficult to participate in the proposed managed care system because they may lack the resources necessary to assume full or partial risk for patient care. Reductions in current Medicaid caseloads could limit the ability of some of these clinics to maintain sufficient operating volume. Closing clinics could in turn endanger access to care for the remaining medically indigent population (e.g., persons with incomes just over the poverty level who cannot qualify for Medicaid). State and Federal Medicaid officials should ensure that these safety net providers remain financially stable throughout the demonstration. Possible strategies for doing so include maintaining the Federal reimbursement and patient freedom of choice protections for rural health clinics and FQHCs and offering stronger guarantees that existing publicly funded providers could participate under the demonstration.

Most hospitals should benefit under the demonstration due to reductions in uncompensated care. However, billing and payment methods for inpatient services would need to be amended to permit distinctions between covered and noncovered services provided during the course of a single hospital stay. Hospitals that would continue to be paid according to the current DRG system under the demonstration (about half of all hospitals in the State) could face denial of payment for a number of diagnostic and other covered services for patients whose principal diagnosis falls below line 587. In

corollary, OMAP could end up paying for below-the-line services to the extent that they are masked by "covered" DRGs. OMAP has indicated that it will address this problem.

The proposed managed care expansions would probably limit opportunities for participation of nontraditional providers of care (e.g., chiropractors and naturopaths) in the Medicaid system. Physician case managers in both the prepaid and FFS systems may be less likely to allow patients to use alternative sources of care than patients might choose for themselves under an unrestricted FFS system.