

# Medicaid Managed Care Policies Affecting Safety-Net Providers and the People They Served

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## *Volume III: Finance*

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by

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## **EXECUTIVE SUMMARY: STATE MEDICAID MANAGED CARE FINANCING POLICIES RELATED TO SAFETY-NET PROVIDERS**

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Over the last decade, safety-net providers<sup>1</sup> have become major players in the Medicaid managed care marketplace. This report is the third of three in a series that uses findings from a literature review and an all-state survey conducted by the National Academy for State Health Policy (NASHP) in the fall of 2000 to examine Medicaid managed care policies related to safety-net providers and the people they serve. This third report examines state Medicaid managed care policies regarding financing of particular concern to safety-net providers. Medicaid is a significant source of funding for safety-net providers. One of the reasons safety-net providers have chosen to participate in managed care is to preserve that funding stream, which now flows through managed care.

### **The Medicaid Managed Care Market is Rapidly Changing**

- Among the 45 states that had risk programs in 1998, 37 (82 percent) experienced at least one plan entrance or exit between 1998 and 2000; 29 (64 percent) experienced more exits than entrances; and 5 small, rural states (11 percent) stopped contracting with comprehensive managed care organizations (MCOs) entirely.
- Although the majority of states experienced plan turnover, MCO exits effected fewer than 10 percent of Medicaid managed care enrollees, and an average of eight plans participate in each state that continues to contract with comprehensive MCOs.
- Between 1998 and 2000, the number of Medicaid beneficiaries enrolled in risk and/or Primary Care Case Management (PCCM) programs grew by about 6.6 percent.
- Between 1998 and 2000, the number of states that reported contracting with at least one MCO with primarily public (Medicaid, State Children's Health Insurance Program [SCHIP], Medicare) enrollment grew from 24 to 29, while the number contracting with at least one MCO with primarily commercial enrollment declined from 43 to 38.

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<sup>1</sup> These include Federally Qualified Health Centers (FQHCs), public hospitals, family planning clinics, community/migrant/rural health centers, maternal and child health clinics, local/county health departments, mental health centers, school-based clinics, academic medical centers, early intervention/ special education providers, Indian Health Service (IHS) facilities, tribal clinics, and AIDS service organizations.

## **Finance is the Major Barrier to Plan Participation and States Are Taking Steps to Address this Barrier**

- Among the 36 states experiencing plan exits, 26 (72 percent) reported that the MCO left for financial reasons.
- Among the 42 states with risk contracts in 2000, 34 (81 percent) have already taken steps to adjust plan payment so that plans that serve a relatively more expensive population receive more money than those that serve relatively healthier populations. Among these 34 states, 15 (44 percent) prospectively adjust the rate they pay plans by enrollee health status, and 32 (94 percent) retrospectively share financial risk with plans.

## INTRODUCTION

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Safety-net providers<sup>2</sup> are the healthcare providers of last resort for people, regardless of their ability to pay or any special health care needs. Many Medicaid beneficiaries also obtain care from safety-net providers, making Medicaid a major source of revenue for these providers. Therefore, how states structure their Medicaid programs significantly affects safety-net providers' ability to continue to meet their missions of caring for the underserved.

Managed care—the delivery system used by 49 states to serve Medicaid beneficiaries<sup>3</sup>—has evolved over the past decade. In 1990, most Medicaid managed care programs used primarily commercial MCOs to serve mostly women and children. In 2000, although most agencies continue to use commercial MCOs, a growing number are also using specialized MCOs that serve primarily Medicaid beneficiaries and often include safety-net providers. Agencies are also enrolling the full range of Medicaid beneficiaries, including those with complex needs, into managed care. Medicaid agencies have been challenged to be prudent purchasers, protect enrollee access to quality care, and find ways to compensate plans that better adjust for selection bias. Increasingly, they are, among other things, increasing their efforts to obtain stakeholder input, collecting and using performance measures in both risk and PCCM programs, and varying capitation payments based on enrollee health status.

The evolution of Medicaid managed care programs has an impact on the functioning of safety-net providers and therefore on the people they serve. State policies have a strong influence on the ability of safety-net providers to obtain and maintain contracts as providers within larger managed care entities or contract directly with Medicaid agencies as managed care organizations. This report uses data collected from a literature review and a survey of all 50 states and the District of Columbia to examine Medicaid agencies' policies in financing issues that affect safety-net providers. Policies examined include efforts to prevent MCO withdrawals and provide for continuity of care, use risk-adjustment, and include school-based health centers. It is the third of a series of three reports. The other two reports examine Medicaid agencies' policies and efforts in the areas of:

- *Monitoring and quality*—including the use of satisfaction surveys, efforts to gather input from safety-net related entities and consumers in developing managed care programs, strategies to ensure the coordination of behavioral and physical health care, and efforts to work with other state agencies to coordinate services for enrollees with special needs; and

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<sup>2</sup> *Safety-net providers* may include: Federally Qualified Health Centers (FQHCs), public hospitals, family planning clinics, community/migrant/rural health centers, maternal and child health clinics, local/county health departments, mental health centers, school-based clinics, academic medical centers, early intervention/special education providers, Indian Health Service (IHS) facilities, tribal clinics, and AIDS service organizations.

<sup>3</sup> As of June 2000, this includes both risk-based and PCCM programs.

- *Eligibility and access*—including policies regarding inclusion of safety-net providers, use of FQHCs for outreach and enrollment, populations excluded or exempted from managed care, access of managed care enrollees with special needs to appropriate providers, and the use of outreach workers to assist in accessing medical care.

## METHODOLOGY

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### Survey

Over the past decade, NASHP has conducted five surveys of state Medicaid managed care programs. The information presented in this report is drawn from these five surveys, conducted in 1990, 1994, 1996, 1998, and 2000. All 50 states and the District of Columbia responded to the five surveys.<sup>4</sup> Each survey provides a snapshot of program policies as of June 30 of the survey year and was developed with extensive input from state officials.

In developing the 2000 survey, a focus group composed primarily of state officials reviewed the 1998 survey and suggested revisions to capture topics of new interest. A group of state officials then reviewed the draft 2000 survey, and further modifications were made based on the additional input. The revised draft was then piloted by four states in June 2000, resulting in further refinements. Finally, a focus group consisting primarily of state officials met in March 2000 to review the draft findings of the survey and to identify significant trends.

Every effort has been made to ensure that this data accurately reflects Medicaid managed care program policies. NASHP staff reviewed each survey for completeness and consistency with other sources of information, including previous surveys. All potential discrepancies were discussed with individual Medicaid agencies, and appropriate modifications were made to better reflect managed care program policies and to assure consistency in reporting.

All information reported is related to the two major types of managed care models: risk and PCCM.

- In a *risk program*, a Medicaid agency contracts with an entity or individual (the contractor) to provide or arrange for the provision of an agreed upon set of services in exchange for a set fee per person enrolled per month; the prepaid fee does not vary month-to-month based on services used by the individual enrollee. In other words, in risk-based managed care, the contractor assumes some level of financial risk for providing care to enrollees. There are two types of contractors that participate in risk programs:

***Managed Care Organizations (MCOs)*** are entities that contract to provide a comprehensive set of benefits. Comprehensive is defined as inpatient hospitalization and at least one of the following services: (1) outpatient hospital and rural health clinic; (2) other laboratory and x-ray; (3) skilled nursing facility; (4) physician; or (5) home health. Contracts that exclude inpatient

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<sup>4</sup> To simplify the discussion, this analysis uses the term *state* to refer to the 50 states and the District of Columbia.

hospitalization but include three or more of the five groups of services are also considered comprehensive.<sup>5</sup>

***Prepaid Health Plans (PHPs)*** are risk contractors that cover a less than comprehensive set of services, such as behavioral health services only.

- A *PCCM* program assigns responsibility for the care of a Medicaid beneficiary to a specific primary care provider who receives payment on a fee-for-service basis and who (typically) receives a small additional fee per enrollee per month to compensate for case management functions.<sup>6</sup> *PCCM* providers do not generally assume any financial risk for providing care other than services within their scope of practice that they deliver directly to enrollees.

## Literature Review

In addition to the survey, a literature review was conducted on managed care, health insurance status, the financial stability of safety-net providers, and the impact of managed care on safety-net providers. The findings of this review have been integrated throughout the paper, as appropriate.

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<sup>5</sup> 42 CFR 434.21(b)

<sup>6</sup> The 1990, 1994, 1996, and 1998 surveys defined primary care case management (*PCCM*) programs to include only those programs in which the provider is not capitated. The Balanced Budget Act of 1997 (*BBA*), however, established a definition of *PCCM* that allows capitation in *PCCM* programs. The 2000 survey was updated to reflect this new definition.

## FINANCING ISSUES

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Basic payment issues for safety-net providers participating in Medicaid managed care systems are addressed in the first volume in this series, which deals with eligibility and access. This volume deals with other financing issues, including:

- State Medicaid agencies' efforts to prevent MCO withdrawals and to provide for continuity of care when withdrawals occur;
- Use of risk-adjustment; and
- Policies regarding the inclusion and reimbursement of school-based health centers.

### **Medicaid Efforts to Prevent MCO Withdrawals/Provide for Continuity of Care**

#### **Policy issue**

MCO interest in the Medicaid market is declining in some areas of the country. One study found that in 1998, about one commercial MCO entered the Medicaid market for every six MCOs that exited; in 1997, the ratio was closer to one entering for every two exiting.<sup>7</sup> NASHP's 2000 survey found:

- For the first time since 1990, the number of agencies using comprehensive MCOs decreased between 1998 and 2000.
- Twenty-six states (58 percent) reported that MCOs left the program, but no MCO joined the program.
- In at least five states (Florida, Maryland, Missouri, Texas, and Wisconsin), MCOs continued to participate in the program but reduced the number of service areas they covered.
- Forty-nine percent of the states with risk programs in 1998 (22 states) reported in the 2000 survey that they were concerned about continued MCO participation in their managed care programs.

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<sup>7</sup> Sue Felt-Lisk, *The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation* (Washington, DC: Mathematica Policy Research Inc., 1999).

Most states reported more than one reason for MCO withdrawal. Medicaid agencies reported that MCOs most often exited the managed care program for:

- *Financial reasons*—Of the 36 agencies experiencing MCO exits, 26 agencies (72 percent) reported that the MCOs left for financial reasons. Nineteen agencies reported that MCOs saw finance as a major barrier to their continued participation. Barriers cited included rates (or MCOs' perception of rates) that were inadequate,<sup>8</sup> the financial viability of MCOs, and healthcare cost inflation.
- *Administrative burden or plan unwillingness to meet Medicaid requirements*—Seven agencies (or 19 percent of the agencies experiencing withdrawals) reported that MCOs left because of administrative burden/Medicaid requirements imposed by state and federal rules, and seven (27 percent) reported them as barriers to continued participation.
- *Other concerns*—Three states reported concerns about MCO network adequacy or provider acceptance of managed care. Two reported concerns about MCOs' understanding of special needs populations or their ability to meet those needs. Eight states reported a variety of other reasons, such as enrollee turnover, managed care unfriendly state, and the Medicaid benefit package.

It is important to note that if enough MCOs continue to participate in Medicaid managed care to keep the market competitive and provide beneficiaries with an adequate choice of plans, then MCO exits are not necessarily harmful. Despite turnover, the number of MCOs participating in managed care remains fairly high. An average of eight MCOs participate in each state that contracts with them (down from 8.3 in 1998).

Moreover, although the majority of Medicaid agencies experienced MCO turnover, MCO exits effected a minority of Medicaid enrollees. About 1.5 million Medicaid beneficiaries were members of exiting MCOs. This represents about 8.3 percent of those enrolled in managed care in 2000 and 4.5 percent of all Medicaid beneficiaries. MCOs serving a smaller number of Medicaid beneficiaries are more likely to leave the Medicaid market than MCOs with larger Medicaid enrollments.

## State responses

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<sup>8</sup> Insufficient rates may be related to a Federal requirement that states pay no more under managed care than they would to serve an actuarially equivalent population under fee-for-service (this fee-for-service equivalent cost is often referred to as the upper payment limit or UPL). Since Medicaid fee-for-service payments are often reported to be lower than commercial payments, the UPL may impose a ceiling on Medicaid capitation rates below the cost of serving enrollees.

Five states continue to use managed care but have changed models, no longer contracting with comprehensive MCOs. Georgia, Mississippi, Montana, and Vermont now rely solely on PCCM programs. Alabama also relies on a PCCM program but continues to contract with PHPs to deliver maternity care. Twenty-five states reported 38 efforts to address barriers to MCO participation. Many states used multiple strategies.

### *Strategies related to financial issues*

Medicaid agency responses to market changes are most evident in the data on policies related to plan payment.

- In order to accommodate selection bias,<sup>9</sup> 34 states (81 percent) either adjust the capitation rate for health status (more details below) or share risk with MCOs. Agencies are becoming more likely to use the prospective method of adjusting for selection bias (adjust the capitation payment by health status) rather than the retrospective method (risk-sharing). MCOs may prefer the prospective method because, that way, they are reimbursed for serving enrollees with above-average costs before they provide the services instead of up to a year afterwards, as may happen in risk-sharing. The increase in the number and percentage of agencies that vary the capitation rate by enrollee health status is particularly noticeable—it more than tripled between 1996 and 2000.
- Although most agencies still reported using rate setting as a method to determine capitation payment amounts, 72 percent of the agencies with risk programs now use negotiation or competitive bidding in addition to, or instead of, rate setting.
- Fifteen states (60 percent of those reporting efforts) stated that they had either increased rates, restructured rates, were attempting to increase rates, or were making attempts to reduce financial risk in ways other than increasing rates (e.g., pregnancy “kick” payments, removing pharmacy from the MCO benefit, increasing the size of the risk pool).
- Three states (12 percent) reported efforts related to increasing enrollment, such as revising marketing guidelines.

### *Contracting with MCOs that serve primarily public enrollees*

The number of states reporting the participation of at least one MCO with primarily public (Medicaid, SCHIP, and Medicare) enrollment grew between 1998 and 2000, even as the number of states reporting the participation of at least one MCO with primarily commercial enrollment declined. Most

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<sup>9</sup> Selection bias refers to the situation in which a plan enrolls a population that is not representative, in terms of cost, of the population that could enroll. The average cost of serving the actual enrollees may be either more or less costly than serving the average person who is eligible to enroll—both situations are referred to as selection bias.

Medicaid agencies that contract with MCOs contract with at least one that is owned or sponsored by a safety-net provider. The growth in state use of MCOs with primarily public enrollment continues a strong trend that began in 1990. This trend may be due to two causes:

- First, the trend may indicate a growing specialization in the Medicaid market—some MCOs may attract a primarily public enrollment because they have learned to meet the needs of Medicaid enrollees better than MCOs that attract a primarily commercial enrollment.
- This trend is also partially explainable by the strong participation of safety-net providers in Medicaid managed care. The most frequently reported owners/sponsors were public hospitals and FQHCs/health centers.

#### *Strategies related to administrative issues*

Six states (24 percent) reported efforts related to meeting program requirements (e.g., offer technical assistance to MCOs, reduce contract requirements, and provide potential bidders with more time, during the bid process, to identify and reduce duplicative reporting). Two states (8 percent) reported developing means of recognizing good MCO performance or encouraging them to serve more beneficiaries.

#### *Strategies related to multiple issues*

Six states (24 percent) reported working with the MCOs, either through regular meetings or by soliciting input on Requests for Proposals (RFPs),<sup>10</sup> to identify specific issues and work to resolve them. Several of these reported making (unspecified) changes in the contract as the result of these efforts. One state reported helping MCOs recruit providers.

#### *Strategies to strengthen PCCM programs*

Medicaid agencies increased their efforts to ensure access and quality in PCCM programs between 1998 and 2000.<sup>11</sup> Thirteen Medicaid agencies (25 percent) reported operating disease management programs at the agency level for Medicaid beneficiaries who are in the fee-for-service or PCCM delivery system.

#### *Strategies to preserve continuity of care*

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<sup>10</sup> A Request for Proposals (RFP) is the document Medicaid agencies use to solicit bids from potential contractors and identify many of their expectations of successful contractors.

<sup>11</sup> For more details on these efforts, see Joanne Rawlings-Sekunda, Deb Curtis, and Neva Kaye, *Emerging Practices in Medicaid Primary Care Case Management Programs* (Portland, ME: National Academy for State Health Policy, 2001).

MCO exits from a managed care program have great potential to disrupt enrollee care.<sup>12</sup> States have taken steps to minimize the disruption. As Table 2 indicates, among the 36 states in which at least one MCO exited the managed care program between 1998 and 2000 most were re-enrolled with another managed care provider. Also, most states used two (13 states or 36 percent) or three (13 states or 36 percent) strategies to preserve continuity of care. Eight states used one method, Michigan used all four, and Tennessee did not report using any method. There was no clear pattern among the “other” strategies reported by 14 states. “Retain primary care provider through enrollment in PCCM program” and “client notification” were each reported by two states. The following methods reported as “other” illustrate the variety of methods states have developed to preserve continuity of care during MCO transitions: recruiting current providers into new MCOs, requiring the use of high risk transition teams, requiring the new MCO to allow enrollees to retain their previous provider for a period of time, and not enforcing enrollee lock-in provisions in the new MCO for the first 60 days.

**Table 2 Strategies to preserve continuity of care when MCOs/PHPs exit the program**

Strategy	2000	
Re-enroll with another managed care provider that has the enrollee’s PCP in the network	25	69%
Marketing efforts to inform of the change	24	67%
Allow for a period of fee-for-service during the transition	14	39%
Other	14	39%
# States where MCOs exited the program	36	100%

## Medicaid Use of Risk-Adjustment

### Policy issue

The absence of adequate risk-adjustment tools may be forcing many safety-net providers serving as Medicaid contracted MCOs or network providers to assume substantial financial risk without sufficient reserves or other protections against insolvency.<sup>13</sup> One way to ensure that MCOs receive appropriate

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<sup>12</sup> Although it must be noted that, given that providers in many states belong to multiple MCOs, an MCO’s exit does not necessarily mean that all of its enrollees need to change providers.

<sup>13</sup> Institute of Medicine. Marion Ein Lewin and Stuart Altman, editors. *America’s Health Care Safety Net: Intact but Endangered* (Washington, DC: National Academy Press, 2000).

payment for serving people with disabilities or chronic illnesses is to prospectively vary the rates paid by health status of enrollees.

The idea behind Medicaid agencies varying the rate they pay to MCOs by health status is to accommodate selection bias.<sup>14</sup> However, an MCO's subcontracted providers may also experience selection bias. If the MCO pays its subcontracted providers on a fee-for-service basis for delivering care to enrollees, it is likely that those who care for enrollees with more complex and expensive care are likely to be paid more than others. However, there has been some concern that in situations in which the MCO capitates subcontracted providers, the rates MCOs pay to those providers also compensate for selection bias.

## State responses

The greatest change between the 1998 and 2000 surveys is the increase in the use of health status as a factor in capitation payment. Despite the drop in the number of states with risk programs (from 45 to 42), the number of states using health status as a payment factor increased from 13 states (29 percent of states with risk programs) in 1998 to 15 (36 percent) in 2000.<sup>15</sup> This comes on top of a 225 percent increase from four states in 1996 to 13 states in 1998. Medicaid programs have been the leaders in the implementation of health-based payment, being much more active than private employers and, in some cases, the Medicare program.<sup>16</sup>

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<sup>14</sup> Selection bias is when a plan enrolls a population that is not representative, in terms of cost, of the population that could enroll. The average cost of serving the actual enrollees may be either more or less costly than serving the average person who is eligible to enroll—both situations are selection bias.

<sup>15</sup> It should be noted that not all of these states use the comprehensive health status adjustment for all managed care enrollees. Some, such as Michigan, limit their use of comprehensive health status adjustments to a specific program. Others, such as Oregon and Utah, limit their use to specific populations, such as the aged.

<sup>16</sup> Richard Kronick, et al., *The Chronic Illness and Disability Payment System: Health-Based Payment for SSI and TANF Medicaid Beneficiaries*. Draft submitted to Health Care Financing Review 1999 July.

**Table 3 Factors in capitation payment: 1994-2000**

Factor	1994		1996		1998		2000	
	Age	17	53%	33	87%	41	91%	37
Sex	16	50%	28	74%	36	80%	33	79%
Geography	23	72%	27	71%	30	67%	30	71%
Eligibility category	8	25%	29	76%	38	84%	34	81%
Institutional/Medicare status	NR		10	26%	13	29%	11	26%
Health status	NR		4	11%	13	29%	15	36%
# States with risk programs	32	100%	38	100%	45	100%	42	100%

Narrowing the analysis to only those agencies that serve those beneficiaries with the most complex needs (SSI or aged eligibility groups) through risk programs finds that 24 of the 26 agencies that serve one or both of these groups in risk programs (92 percent) have a strategy in place to address selection bias.

**Table 4 Risk-adjustment in states that serve the aged and SSI Medicaid populations through comprehensive MCOs**

State	Adjusts capitation by health status	State	Adjusts capitation by health status
Arizona	✓	California	✓
Colorado	✓	Connecticut	
Delaware	✓	District of Columbia	
Florida		Kentucky	
Maryland	✓	Massachusetts	
Michigan	✓	Minnesota	✓
Nebraska		New Jersey	
New Mexico		New York	✓
North Carolina		Oklahoma	✓
Oregon	✓	Pennsylvania	✓
South Carolina		Tennessee	
Texas		Utah	✓
Virginia		Wisconsin	✓

States with risk-adjustment strategies believe that such adjustments encourage MCOs to enroll more people with complex needs and enable them to better serve these members. Risk-adjustment strategies include:

- Comprehensive systems that assign beneficiaries to groups reflecting health status and service utilization, with risk-adjusted rates developed for each cost group;
- Systems that adjust for certain diagnoses, but that are not comprehensive; and
- Systems that adjust for certain items appearing in claims processing systems, such as HIV drugs.<sup>17</sup>

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<sup>17</sup> Joanne Rawlings-Sekunda, *Trends in Serving People with HIV/AIDS Through Medicaid Managed Care* (Portland, ME: National Academy for State Health Policy, 1999).

Of the fifteen states that reported using health status, seven reported using a comprehensive adjustment system, and eight reported using specific payment arrangements for a few specific conditions (e.g., AIDS).<sup>18</sup>

Of the 15 states that health status in risk adjustment, one (Wisconsin) reported requiring MCOs to pass on all or part of the adjustment to providers. This state specified that the requirement applied to poverty level pregnant women.

Difficulties can arise in identifying beneficiaries who qualify for an adjusted rate in order to both calculate and pay the rates appropriately. This can be difficult, as there is frequently no marker on a Medicaid eligibility file identifying those who have special healthcare needs. States work around this in various ways. For example, Medicaid agencies often identify people living with HIV/AIDS through claims data and AIDS registries; others have MCOs submit medical documentation for verification of HIV/AIDS status.<sup>19</sup>

## Medicaid Policies Regarding School-based Health Centers

### Policy issue

School-based health centers increased 29 percent, from 900 during the school year 1995-1996 to 1157 in 1997-1998.<sup>20</sup> The centers are frequently administered by local health departments, community health centers, or hospitals. A recent study found that these centers serve as point-of-entry into the health system for children who lack access to a regular source of care and are often the only provider for uninsured kids; most maintain summer office hours and provide emergency and after-hours care.<sup>21</sup> Studies of school-based health centers have demonstrated greater utilization of primary and preventive

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<sup>18</sup> The seven states using comprehensive systems are Colorado, Delaware, Maryland, Minnesota, Michigan, Oregon, and Utah. The eight states using condition specific adjustments are Arizona, California, Indiana, New York, Oklahoma, Pennsylvania, Utah, and Wisconsin.

<sup>19</sup> Joanne Rawlings-Sekunda and Neva Kaye, *Emerging Practices and Policy in Medicaid Managed Care for People with HIV/AIDS: Case Studies of Six Programs* (Portland, ME: National Academy for State Health Policy, 1998).

<sup>20</sup> Julia Graham Lear, Nancy Eichner, and Jane Koppelman, "The Growth of School-based Health Centers and the Role of State Policies: Results of a National Survey," *Arch Pediatr Adolesc Med* 153(11), (Nov; 1999):1177-80.

<sup>21</sup> *School-based Health: An Update (Reporting on Creating Access to Care for Children and Youth* (Washington, DC: National Assembly on School-based Health Care, State Health Notes, 9/25/00), 21(333).

healthcare services for low income school-age children in schools with health centers than for children in schools without these facilities:

- In school-based health centers in rural West Virginia, students who had Medicaid or no insurance accounted for 52 percent of enrollees and 63 percent of all visits,<sup>22</sup> showing that these centers have contributed to greater access for youths in rural areas.
- A study in Atlanta, Georgia, showed that children using the school-based health center had significantly lower expenses for ER, inpatient, and nonemergency transportation, and higher EPSDT preventive care expenses.<sup>23</sup>
- A study of two schools in Denver, Colorado—one with a health center and one without—found an increased use of primary medical, dental, and emotional health resources, decreased use of ERs, and higher parental satisfaction with their child’s health care among children at the school with the health center.<sup>24</sup>

## State responses

### *States with risk programs*

In 2000, 19 of the 42 states with risk programs (45 percent) reported that school-based health centers participated in these programs. This shows a steady increase from 1994, when 11 states (34 percent of those with risk programs) identified these centers as participants, through 1996 (with 16 states—42 percent of those with risk programs) and 1998 (with 20 states—44 percent).

In 2000, 25 states (60 percent of those with risk programs) either required MCOs to contract with school-based health centers as network providers or encouraged these affiliations. Specifically:

- four states required MCOs to contract with school-based health centers;
- twenty-two states encouraged them to do so; and
- one state did both.

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<sup>22</sup> Richard D. Crespo and George A. Shaler, “Assessment of School-based Health Centers in a Rural State: the West Virginia Experience,” *J Adolesc. Health* 26(3), (Mar 2000):187-93.

<sup>23</sup> E. Kathleen Adams and Veda Johnson, “An Elementary School-based Health Clinic: Can It Reduce Medicaid Costs?” *Pediatrics* 105(4 Pt 1) (Apr 2000):780-8.

<sup>24</sup> David W. Kaplan, et al., “A Comparison Study of an Elementary School-based Health Center,” *Arch Pediatr Adolesc Med* 153(3) (Mar 1999):235-243.

The 2000 number of 25 states represents an increase of more than 700 percent since 1996, when three states required or encouraged such behavior. States have encouraged MCOs in some of the following ways: awarding extra points during the contractor selection process, requiring that the MCO make a good faith effort to contract, and facilitating meetings between the MCOs and providers. For example, Connecticut both requires and has taken steps to encourage MCOs to include school-based health centers in their networks. A study of school-based health centers' contracting success credits it to the following:

- Ongoing communication between the state health department and the Medicaid agency to address problems in the contracting process; and
- State threats of sanctions on health MCOs and school-based health centers that would not contract with each other.<sup>25</sup>

### *States with PCCM programs*

In PCCM programs, two states allowed school-based health centers (as opposed to individual physicians) to serve as PCCM providers (7 percent of states with PCCM programs). This may be due to Medicaid access rules, which would be difficult for these centers to meet during the summer.

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<sup>25</sup> Jane Koppelman and Julia G. Lear, "Partnering with School-based Health Centers: Connecticut's Medicaid Managed Care Experience," *Managed Medicare & Medicaid* (Jan.1999).

## **SUMMARY OF FINDINGS ON FINANCING ISSUES**

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Medicaid is a significant source of funding for safety-net providers. One of the reasons safety-net providers have chosen to become stakeholders in managed care is to preserve the funding stream that now flows through managed care. As a result, the turmoil in the managed care marketplace that many states are experiencing has severe potential ramifications for safety-net provider. There is no doubt that the market is changing; most states that contract with health plans saw more plan exits than entrances between 1998 and 2000, and five states stopped contracting with comprehensive MCOs entirely. At the same time, the number of states that reported contracting with at least one plan that serves primarily public enrollees (Medicaid, Medicare, and SCHIP—such as safety-net sponsored MCOs) grew. It is yet unclear if the current turmoil is simply a shake-out of those less qualified to serve Medicaid beneficiaries or a failure of the MCO model to effectively manage care, at least for the payment provided by Medicaid.

Medicaid agencies have clearly identified finance as the major cause of plan exits and most agencies reported efforts to address those concerns. For example, 34 states have already taken steps to adjust plan payment so that plans that serve a relatively more expensive population receive more money than those that serve relatively healthier populations. These states either prospectively adjust the rate they pay plans by enrollee health status or retrospectively share financial risk with plans.