Office for Oregon Health
Policy and Research

Health Care Delivery Systems in Oregon

A Report to the Oregon Health Council
by its Access Subcommittee

August 2000

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Introduction

In early 2000, the Oregon Health Council directed its Access Subcommittee to study the problems facing health care delivery systems in Oregon, with a focus on the Oregon Health Plan (OHP). In carrying out this assignment, the Access Subcommittee heard presentations on a sample of representative health care delivery systems in communities around the state (see the Notes section at the end of this report for a list of these delivery systems). Based on those presentations and on more general information, this report explores the characteristics of health care delivery systems in Oregon from the late 1980s through 2000, and presents conclusions about how these characteristics help to determine the emerging strengths and weaknesses of health care delivery in Oregon.

Although the primary focus of this report is on the Oregon Health Plan delivery system, its conclusions generally apply to the overall health care delivery system, as well. Put briefly, both the OHP and the overall health care delivery system in Oregon are undergoing fundamental changes in governance and structure in response to pressures from:

a) Changes in health insurance funding, provider and facility payment levels, and distribution of risk;
b) Increases in the cost of technologies, including diagnostics and prescription drugs;
c) Increasing diversity of patient populations; and
d) Changes in available physician and hospital capacity.

Background

The enabling legislation (passed in 1989) for the OHP Medicaid demonstration project called for a reliance on managed care, wherever feasible, to ensure access and constrain costs. Prior to the OHP, Oregon had a long history of managed care in the commercial sector (Kaiser Permanente dates to WWII) and several years of experience with Medicare and Medicaid managed care. Oregon's Medicaid managed care system was based on Physician Care Organizations (PCOs), a partial-capitation model that could be organized and administered locally, and that was viable with as few as 500 enrollees. Under the PCO model, physicians were paid through capitation while hospital services and prescription drugs were paid directly by the state on the usual fee-for-service basis with a risk-sharing arrangement between the state and the PCOs. In general, PCOs were directly accountable for a portion of covered medical benefits in contrast with HMOs which are directly accountable for all covered medical benefits. With the implementation of the OHP in 1994, PCOs were phased out in favor of HMO-style fully capitated health plans (FCHPs). The OHP Medicaid demonstration waiver granted by the federal government also removed the requirement that Medicaid clients have unrestricted access to federally qualified health centers (FQHCs) in service areas where FCHP capacity was sufficient to enroll all OHP recipients. Clinics in these "mandatory" service areas were paid according to rates negotiated with FCHPs for FCHP enrollees rather than according to cost-based payment levels, as previously.

Encouraged by the thousands of new enrollees coming into the OHP and by the state's explicit reliance on the FCHP model, health plans such as HMO Oregon (Regence) and Good Health Plan (Providence) expanded rapidly into new service areas. In many cases, Medicaid expansion by these HMOs was followed by commercial market expansion. At the height of this expansion in 1996/97, only three counties were without a Medicaid FCHP, and all PCOs had been phased out.

By 1998, however, it had become clear that the large "mainstream" health plans could not sustain indefinitely their expansions into areas outside Multnomah, Washington, and Clackamas counties. During the same period, smaller FCHPs designed specifically for the OHP were being created in service areas where the larger health plans were withdrawing. By 2000, these new FCHPs had supplanted the original FCHPs in several communities both within and outside the Willamette Valley. In some communities, however, the Medicaid managed care presence has shrunk to a single FCHP or has disappeared entirely. In short, the OHP delivery system is experiencing a shift away from mainstream managed care organizations exporting their services to Medicaid populations in new territories, and toward the development of "home-grown" managed care organizations serving the Medicaid population in communities outside the Tri-County Area. Even in the Tri-County Area, the participation of mainstream managed care organizations in the OHP is by no means assured.

In the spring of 2000, the Oregon Health Council directed its Access Subcommittee to examine these changes in the OHP delivery system. As a result, several Subcommittee meetings were held from March through August of 2000. Presentations were made on the characteristics of delivery systems - and communities without effective delivery systems - throughout the state.

This report is the result of that process, and it is organized into the following sections:

- Access as a primary objective and concern, with particular emphasis on physician and hospital care
- Provider payments as a determinant of access
- Risk management and the effects of provider risk sharing on provider payments
- Market changes and delivery system diversity
- Benefits, eligibility, and population characteristics of Medicaid enrollees as compared with commercial enrollees and the problem of integrating diversity of health care needs into the delivery system
- Governance as a determinant of delivery system stability
- How the above factors can work together in combination to determine success or failure in the delivery system

This report ends with a section identifying key conclusions and recommending next steps, including further work by the Access Subcommittee on recommending priorities for modifying the OHP delivery system to increase effectiveness and stability.

Access

In the Board Room of Network Management, Inc. (a Seattle PPO) there used to hang a sign that said "Access, Quality, Price – Pick Any Two". In Oregon and elsewhere, the promise of managed care has been to guarantee timely access to appropriate care, assure quality, and contain costs. The OHP was designed and approved with the promise that it would, through contracts with managed care organizations, realize these objectives beyond what could reasonably be expected through an "open card" or even through a PCO. Such an emphasis was placed on access that eligibility was expanded and payments restructured. That is, the OHP made an additional 120,000 Oregonians eligible for Medicaid by expanding eligibility to all below federal poverty level, and required that payments be sufficient to cover the cost of care so that there would not be barriers to access (or cost shifting to other purchasers of care).

Oregon Medicaid experience in the 1980s included convincing evidence that many recipients had either no personal physician or a number of personal physicians who were unaware that they were treating the same patient. Impoverished and uninsured Oregonians who did not qualify for Medicaid often used (and were sometimes encouraged to use) the emergency room for outpatient care, and even primary care. In short, access was uneven and fragmented both for those with Medicaid and for those who were simply poor and uninsured. The OHP has had some success (through more than one managed care model) in solving these access problems arising from the fragmentation of care under an "open card".

The 1980s also held Medicaid problems still all too familiar in 2000: persistent provider complaints about inadequate payment levels and unacceptable financial risk, and crises in access to basic services (notably prenatal care) for Medicaid recipients in more than one delivery service area (a problem today in Curry and Lincoln counties, for example). If this second, persistent set of problems cannot be addressed, then access to care will be increasingly jeopardized.

Payment Types and Levels

PCOs had previously demonstrated that even partial-capitation arrangements could substantially increase access to primary care - including prenatal services – and coordination of care. Since the 1970s, federal requirements for HMOs had identified specific standards for testing adequacy of access, and similar requirements were included in the OHP contracts with FCHPs. With managed care as the basis for assuring access, the OHP designed a variance in payment levels between FCHP premium rates and fee-for-service (FFS) payments: FCHP premiums would reflect the cost of care while FFS payments levels remained at their previous (and lower) levels. It was presumed that this payment differential would provide an effective incentive for FCHPs and providers to expand managed care to new geographic areas. The strategy worked, and two years after OHP implementation, all but three Oregon counties had FCHP enrollment available. To provide some management of care in service areas without adequate FCHP capacity, Oregon developed a primary care case manager (PCCM) program. PCCMs are paid fee-for-service for patient care provided, but also receive a case management fee that was originally set at $3 per member per month (pmpm) and increased in 1999 to $6 (pmpm). Concern was voiced that the increase to $6 pmpm and the recent increase in fee-for-service payments may have the unintended consequence of destabilizing FCHPs in some rural areas.

Regarding physician payments, much of the discussion centers on the relative value unit (RVU) equivalent for payments in the commercial, OHP FCHP, and PCCM sectors. In general, the perception is that commercial is the highest, next are Medicare rates. OHP FCHP rates are perceived as being lower than Medicare rates and also lower than costs, but higher than Medicaid fee-for-service rates and payments by the uninsured. The recent increase in the PCCM monthly case management payment has made participation in that program more financially attractive in rural areas and for OHP populations with relatively low utilization rates. This PCCM increase may also have raised the effective payment rate to primary care clinicians to the level of OHP FCHP payments. Commercial HMO and OHP FCHP physician payment comparisons are complicated by the fact that the net payment to the physician is often dependent on risk-sharing arrangements that may include a withhold against physician performance in meeting utilization targets.

Hospital payments under the OHP are subject to a state law requiring that rural and semi-rural hospitals receive facility-specific cost-based Medicaid payments. This means that hospital payment levels vary significantly from community to community and are often not subject to negotiation with FCHPs. Cost-based payments to rural and semi-rural hospitals tend to act as a limit on the portion of total premium available for physician payments.

As noted earlier, federally qualified health centers (FQHCs) and also Rural Health Clinics were previously entitled to cost-based Medicaid payments but this was waived for the OHP Medicaid demonstration for clients enrolled in managed care. FQHCs still receive facility-specific cost-based Medicaid payments for FFS patients.

Such cost-based payments to rural hospitals and clinics give rise to the question of whether urban communities in Oregon are subsidizing rural communities, and if so to what extent. A second question is whether such subsidies are appropriate. This is a complex issue involving not only access to health care but also the economic viability of rural communities in the event of hospital closure due to inadequate payments.

Risk Management

How a delivery system handles the sharing of risk is a pivotal factor in determining whether that delivery system can weather bad times. The allocation of savings is on the surface easier than the allocation of losses, but in both cases the allocation must be seen as equitable by participating providers or the system will be strained.

Two key issues in risk management are the level of risk and the extent to which risk sharing is aligned so that all participants in the delivery system either win together or lose together. The level of risk should be more than just symbolic but should not be so great that one or two bad years can break a competent provider.

Regarding alignment of risk sharing, even the best scheme is not likely to be equitable under all scenarios. When, for a given year, it turns out that some participants (physicians, hospitals, or others) do much better than others for reasons not attributable to clinical effectiveness, the risk-sharing arrangement can include an agreement that adjustments will be made to “smooth out the bumps” over time. Analysis of these “bumps” should provide a basis for reviewing and adjusting the risk-sharing approach to reflect actual experience.

It is also critical that the basis for performance penalties and rewards be directly related to agreed upon performance targets. This implies that the tracking of physician performance against standards should be reported accurately and clearly and in a timely fashion. Misunderstanding about the relationship between risk withholds and net year-end payments can severely strain relations between a health plan and its physicians. It is worth noting that performance monitoring includes both a basis for allocating savings and losses against performance targets, and a basis for assessing quality of care.

The importance and complexity of provider payments and risk management underscores the fact that provider participation in managed care organizations and in Medicaid is voluntary. In fact, various FCHPs have withdrawn from various OHP service areas over the life of the program, and others may follow.

Market Changes and Delivery System Diversity

Oregon's health care environment is changing along several dimensions. The number and nature of health plans in the state is evolving through mergers, acquisitions, and conversions. (In one notable instance, a not-for-profit health plan converted to for-profit status in 1997, resulting in the endowment of the Northwest Health Foundation.) Insurance premiums and provider payment levels fluctuate from year to year, but not always evenly or predictably. Managed care organizations, physicians, hospitals, and clinics are all subject to complex and changing requirements for collecting and reporting data to various payers and regulators. Specialty referral protocols change over time and vary from one managed care organization to another.

Given this degree of complexity, it is not surprising that mounting pressure on physicians, hospitals, and clinics - and on managed care organizations - has produced casualties. Hospitals and clinics have closed, physician group practices have disbanded, FCHPs have left the OHP, and managed care organizations have withdrawn from Medicare. In the OHP and in the overall delivery system, market forces are disrupting established patterns in both the insurance and patient care functions. While disruption in the OHP may be more evident – and more prominently debated in the legislative process – the various health insurance and care delivery sectors are interconnected through explicit and implicit subsidies. A problem in the OHP often implies a related problem in private coverage and/or in Medicare, with one line of business being called upon to make up for deficits in another.
In response to these challenges, delivery systems have grown increasingly diverse over the last few years. Although the PCOs are gone, a new sort of managed care entity has appeared. This new model can be defined only in general terms since each example reflects the particular requirements of its service area in terms of: population size, density, and racial and ethnic composition; economic health of the community and profile of the workforce; shortage or surplus of physicians and other provider types; physician organization (e.g., IPA) or lack thereof; hospital number and type (A and B, teaching, tax district, etc.); and commercial insurance and Medicare characteristics. Given these complicating factors, the new model generally is:

- Headquartered outside the Portland Metropolitan Area and locally governed in its community or region
- Based on a physician/hospital partnership, probably formalized in the organization's charter
- Not-for-profit
- Primarily, or exclusively, OHP enrollment
- Diverse in the make-up of its participating providers and typically including safety net clinics
- Including substantially all providers in the service area

Benefits, Eligibility, and Population

The patients seen in a given community fall into four general categories with the following rough proportions for Oregon's population as a whole: Medicaid (11%), Medicare (15%), private coverage (63%), and uninsured (11%). These proportions vary greatly, however, from community to community with the result that health care in some communities is much more generously funded than in others. For example, the percent uninsured varies greatly among Oregon's counties, from Columbia at 3% and Washington at 5% to Lincoln at 16% and Coos at 18%. Even among the uninsured, payment levels vary significantly enough that the mix of

Medicare, Medicaid, and private insurance is critical in determining the total resources available for health care in a community.

Although the OHP accounts for approximately 11% of the population statewide at a given point in time, over one million Oregonians have been on the OHP since 1994, and over 500,000 new eligibles have been covered who would not have been eligible for Medicaid without the OHP. Given these numbers, the ongoing impact of the OHP on the health care system in Oregon is substantial. The composition of the OHP population is quite diverse, and includes:

- Families in transition (toward self-reliance, from one job sector to another, and moving into Oregon)
- Early retirees awaiting Social Security and Medicare
- Young and childless adults with acute health care needs
- Chronically ill children and adults, including the disabled
- Impoverished Medicare beneficiaries ("dual eligibles")
- A broad spectrum of racial and ethnic communities (including Latinos, Russians and Eastern Europeans, Southeast Asians, African Americans, and Native Americans/Pacific Islanders)

This degree of diversity places demands on the health care delivery system beyond those of commercial coverage, certainly, but even beyond the demands of Medicare. More than with other types of coverage, some OHP patients have coverage for only six months or one year; some have never been insured before and do not understand what insurance means; some cannot access needed care without interpretation, transportation, and other enabling services. Even outside the OHP, Oregon's population is becoming more diverse, making it reasonable to expect that many problems currently encountered with OHP (and uninsured) patients will increasingly be encountered with commercial and Medicare patients. Conversely, the problems besetting the delivery system in dealing with other patient populations are often exacerbated for the OHP, given the diversity of its population, the complexity of its administrative requirements, and the political nature of its funding.

Mission and Governance

How a delivery system defines its mission and makes decisions is a key factor in its survival, particularly at the community level. Based on presentations to the Access Subcommittee on delivery systems in communities around the state, these key common factors in governance were identified:

- Community-based mission
- Local/regional control versus "remote control"
- Financial management (including risk sharing) in support of mission
- Timely availability of data in useful form
- Collaborative relationships between physicians (organized, as in IPAs) and hospital(s)
- Equitable sharing of savings and losses and of the burden of patient care

Although all of these factors appear to be important, three stood out in the cases presented: 1) mission; 2) locus of control; and 3) equitable distribution. These factors appear to be primary determinants of the level of delivery system satisfaction for physicians, hospitals, and clinics.

Why Do Delivery Systems Succeed or Fail

The presentations to the Access Subcommittee suggest a set of elements that can, when present or missing in various combinations, either make or break the health care delivery system in a community or region. These elements may have a greater or more immediate effect for the OHP than for the more general delivery system, but in many instances what happens with the OHP has been a harbinger for the larger system.

These elements are:

- Mission reflects long-term commitment to meeting the community's health care needs
- Effective physician and hospital leadership
- Diverse partners in the delivery system, including "mainstream" providers, safety net clinics, nurse practitioners, and other specialty clinics/practices
- Collaborative partnerships between physicians (and clinics) and hospitals
- Alignment of incentives through "win/win" risk sharing models based on collaborative distribution of savings and losses (risk management versus risk avoidance)
- Control and predictability of savings and losses and adjustments in distribution methodology to reflect experience over time
- Clear and agreed upon relationships between payment levels and risk sharing
- Timely distribution of accurate information about physician and hospital performance, in a useful form
- Discrete "product lines" with OHP services kept within budget without implicit subsidies from other accounts
- Explicit arrangements for balancing and meeting the needs of the Medicare, OHP, the privately insured, and the uninsured populations, including explicit subsidies (e.g., urban/rural and Type A/B hospitals, cost-based fee-for-service /capitation, Medicaid/Medicare/privately insured/uninsured)
- Recognizing and accounting for uncompensated care throughout the delivery system
- Enough administrative simplicity to produce a tolerable "hassle factor" regarding management of care, submittal and payment of claims, and information management
- Constructive connection between the health care delivery system and the economic development of the community

Although many combinations of these elements are possible, fewer combinations are likely. For example, it is not likely that a delivery system would have collaborative partnerships between physicians, clinics, and hospitals without also having an effective alignment of financial incentives. It is also important that the "hassle factor" be kept at a tolerable level even with increased accountability for performance. Note also that the final element is as much an overarching community goal as it is a determining factor in the success or failure of health care delivery.

The question of how these elements can be brought together in the right combination (and in the right sequence) to produce an effective delivery system for a given community is complex, with plenty of room for further study.

Questions to be Answered

Members of the Access Subcommittee have commented that the presentations and subsequent discussions have raised important questions that cannot be resolved without further discussion by the Access Subcommittee, the Oregon Health Council, and others. These questions include:

- Is there greater access to care in 2000 than in 1994? If so, how much of the increase is due to expanded Medicaid eligibility under the OHP? How much to increased employer-sponsored insurance? How much to managed care?
- When exactly does being on Medicaid NOT ensure access to care? Or, continuity of care? Why not?
- What was the effect of phasing out PCOs? Was partial capitation (as opposed to full capitation) a good model in some cases, and should we revive it? If so, under what conditions and with what changes? What will be their level of accountability?
- What is the appropriate role for PCCMs? When are they constructive as an alternative to the unstructured "open card", and when might they undermine more effective models for managing or coordinating care?
- What is the relationship between Medicaid managed care and Medicare managed care? How might they support each other or drag each other down?
- What is the impact of the OHP on access to care for those outside the OHP (particularly, for the uninsured)? How does this affect the safety net?
- Has there been managed care competition in Oregon? Is there now? If so, where and with what effects?
- What populations are not a good fit for the insurance model? Why? What alternative models are there besides "open card" Medicaid? What is the role of the safety net in Oregon's various communities, and how is that role changing?
- Are current approaches to risk adjustment reasonable? Is something more needed to make capitation substantially equitable, and if so, what?
- Do OHP health plans manage care according to the prioritized list? If so, how and with what effect on patients? If not, with what effect on funding? What does the prioritized list mean in the public mind regarding health care in Oregon? Has it helped or hindered access?
- Is employer-sponsored insurance eroding? If so, how much, and is this erosion in who is covered (full-time only, employee only, spouse, dependent children) or in the amount of the employer contribution? What does this erosion mean for Oregon – urban and rural?
- What are the effects of the gatekeeper/case manager and of capitation and risk sharing on access under managed care in Oregon?
- What is the effect of outreach – or lack of outreach – on access to care through the OHP?
- How have reimbursement changes in the private and Medicare markets affected participation levels in the Medicaid Program and access for the uninsured?

Next Steps and Recommendations

The Access Subcommittee makes the following recommendations to the Health Council as the most reasonable steps toward solving the problems in health care delivery in Oregon:

1. That the conclusions and outstanding questions in this report be provided for inclusion in the panel discussion on delivery system issues at the Oregon Health Summit with the expectation of suggestions for further action from that panel.
2. That the Department of Human Services reflect the diversity of challenges facing Oregon's communities by increasing the flexibility of models available for health care delivery systems contracting with the OHP.
3. That the Department of Human Services develop a partial capitation model as an alternative to fee-for-service, to be available when specified conditions are met. Examples of such conditions are:
    A. The partial capitation model would not be available in areas where FCHPs provided sufficient capacity for all OHP enrollees;
    B. The partial capitation model would be available where FCHP capacity was insufficient and OHP enrollees were enrolling in PCCM or "open card" fee-for-service;
    C. The partial capitation model would be made available in a new area only after a waiting period (say, six months) following the closing of enrollment into the FCHP(s) in that area.
    D. The partial capitation model would meet OMAP contract requirements ensuring appropriate accountability.
4. That the Access Subcommittee develop a prioritization of challenges facing Oregon's health care delivery system with a focus on the OHP, and report this prioritization to the Health Council.

NOTES

Presentations to the Access Subcommittee

Organization	Presenter
• Samaritan Health System	Rick Wopat, MD
• Central Oregon Independent health Services	Pat Gibford
• Lane Independent Practice Association	Robert Wheeler, MD
• Mid-Valley Independent Practice Association	Debra Waln
• Coos DOCS	Bill Murray
• Lincoln County	Rick Wopat, MD Jean Cowan
• Regence	Annie Mockabee
• CareOregon	Mary Lou Hennrich
• La Clinica Del Cariño	Tina Castañares, MD

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