Federally Qualified Health Centers: Surviving Medicaid Managed Care, But Not Thriving

Sheila D. Hoag, M.A., Stephen A. Norton, M.P.P., and Shruti Rajan, M.P.P.

This article reviews the experiences of federally qualified health centers (FQHCs) in Hawaii, Rhode Island, and Tennessee before and after Medicaid managed care demonstrations began. Adapting to managed care proved challenging, but all FQHCs survived. Overall, FQHCs performed better financially than anticipated, partly because demonstrations expanded coverage to previously uninsured individuals, and because FQHCs in two States formed plans that paid FQHCs more than other plans. Service encounters declined; it is unclear if this is negative, since it may indicate more efficient care delivery. In some cases, supportive State policies aided FQHCs' survival. Continued adaptation is critical for FQHCs' longer term prospects.

INTRODUCTION

Using fully capitated managed care designs, 43 States have transformed all or part of their Medicaid programs from fee-for-service (FFS) to managed care systems. This transformation may introduce structural changes to the health care delivery system, such as increasing the number and types of providers who will accept Medicaid patients (thereby, increasing provider choice for Medicaid recipients), and shifting resources toward ambulatory care settings (versus inpatient or emergency room care). For community providers that traditionally served Medicaid and uninsured patients, such as FQHCs—sometimes called safety net providers—these changes may be unwelcome: They introduce new competition for patients, dictate new ways of conducting business, and are feared to lower payments for Medicaid patients, which might compromise FQHCs' fiscal viability and their mission to provide care to the uninsured (Ku, Wade, and Dodds, 1996; Lipson, 1997).[1]

How have FQHCs fared under Medicaid managed care programs? In this article, we review the early experiences of FQHCs in Hawaii, Rhode Island, and Tennessee, three States with comprehensive section 1115 Medicaid managed care demonstration programs.[2] We focused our research on three questions: (1) What were FQHCs' predemonstration roles, and what were their concerns about Medicaid managed care at the outset of the demonstration programs? (2) What were FQHCs' responses to and experiences operating in the demonstrations? (3) What were the effects of the demonstrations on FQHCs' finances and services provided? While some literature exists on the effects of

Sheila D. Hoag is with Mathematica Policy Research, Inc. Stephen A. Norton is with the New Hampshire Department of Health and Human Services. Shruti Rajan was formerly with The Urban Institute. This study was funded by the Health Care Financing Administration (HCFA) under Contract Number 500-94-0047. The views expressed in this article are those of the authors and do not necessarily reflect the views of Mathematica Policy Research, Inc., the New Hampshire Department of Health and Human Services, the Urban Institute, or HCFA.

[1] The FQHC program was developed to increase Medicaid payments to community or migrant health centers or health care for the homeless programs that receive Federal grants as community or migrant health centers, so that they could care for more Medicaid and uninsured patients and offer them better services. The program reimburses these community providers for the actual costs of care, rather than paying from a predetermined fee schedule.

[2] Section 1115 of the Social Security Act allows States, with HCFA's approval, to modify their State Medicaid programs. Many States use section 1115 demonstrations to ameliorate problems with Medicaid costs and uninsured populations.

Medicaid managed care programs on community-based safety net hospitals (Baxter and Mechanic, 1997; Anderson and Boumbulian, 1997), there is a dearth of literature focusing on the effects of these programs on FQHCs (Grogan and Gusmano, 1999). This article makes a new contribution to the field by being the first to explore indepth the effects on Medicaid managed care on FQHCs' Medicaid revenues and users, overall financial viability, and services offered. We believe this contribution will advance the knowledge base regarding FQHCs and Medicaid managed care, as well as provide important lessons for community-based safety net providers in other States.

METHODS

Case Studies

Through case studies conducted from 1995-1998 for a HCFA-sponsored evaluation, we and our colleagues spoke with more than 50 key informants in these States on these issues (sometimes more than once). These included representatives from 7 FQHCs; 2 non-FQHC community health centers; 11 managed care organizations (MCOs) operating in the demonstration States (including 2 MCOs sponsored by community health centers); all of the State primary care associations; key State staff operating the demonstrations; and HCFA staff responsible for overseeing the demonstrations.

Data Analysis

We also analyzed quantitative revenue, cost, patient volume, and service use data reported by FQHCs in these States to the Bureau of Primary Health Care (BPHC) under the Bureau Common Reporting Requirements (BCRR) system in 1993, the year before Medicaid section 1115 demonstrations were implemented in the three States, and through the Uniform Data System (UDS) in 1996, 2 years after the demonstrations were implemented. These data are submitted annually by FQHCs. Receipt of certain types of grant funds qualifies a health center as an FQHC. Section 329 grantees are migrant health centers, and section 330 grantees are community health centers. Health care for the homeless programs can receive section 340 funding. A given health center may receive section 329, 330, and/or 340 funding. In addition, an FQHC can include several clinics providing services at more than one site. In our analyses, we include only those health centers that receive section 329, 330, or 340 grant funding. Because not every health center receives this funding (there are FQHC "lookalikes" and other centers not federally funded), our findings are characteristic only of FQHCs; comparable data on similar clinics was not available across States.[3] We limited our analysis to those FQHCs operating in both 1993 and 1996.

There are some cautions about using these data, the greatest of which relates to the change in the BPHC data collection process between 1993 and 1996. One caution relates to reconciliation payments the States made to the FQHCs for Medicaid services provided in prior years. Under FFS Medicaid, FQHCs were reimbursed based on their actual costs, so States periodically provided lump-sum payments to make up the difference between initial payments and the actual, audited costs of services. Such adjustments can be made years after the services were delivered, and they may still be showing up in the 1996 data, distorting the estimate of Medicaid payments made for services

[3] We caution that FQHCs may have had different experiences under the Medicaid managed care demonstrations than other types of centers.

delivered in 1996. We checked with representatives at the primary care associations in these States on this issue, who reported that few retroactive payments would have been made as late as 1996, and that these would have accounted only for a small percentage (less than 5 percent) of their 1996 Medicaid revenues.[4] In 1996, BPHC implemented a new data collection system, UDS, because of limitations in the BCRR data, particularly with respect to counts of low-income and/or uninsured people using FQHCs and the identification of new revenue associated with managed care. With the switch to the UDS, two data elements appear problematic. First, data on users by payer source, previously collected through grant applications, are now collected through the UDS; the two sources are not comparable over time on this element. To offset this problem, the BPHC provided us with (and we used) an edited 1993 grant application file, which adjusted the data on uninsured and Medicaid users in 1993 to account for errors.[5] We believe the edited file is comparable to 1996 data, but the shift in the method of collecting this information may introduce a bias in the estimates of the number of uninsured and Medicaid FQHC users between 1993 and 1996. Based on our review, however, we think it is unlikely to affect the direction of the change.[6] We also found that 1996 service use data are not comparable to the 1993 data on several elements (such as number of encounters per user). Therefore, we based our analysis of service use data on a comparison of 1993 and 1995 services.

BACKGROUND

All three States in this study received section 1115 Medicaid demonstration waivers from HCFA to implement mandatory, statewide managed care programs. In addition, all three expanded to cover new groups previously ineligible for Medicaid. Of all the new elements introduced with these demonstrations, the expansion of coverage to uninsured populations was probably the only one that safety net providers viewed as having the potential to have a positive impact on them, since it meant that more of their patients would have insurance coverage. Table 1 provides an overview of the program designs in these States, including initial expansion enrollment and subsequent program changes through early 1998.

Despite the potential positive effects of expansion to previously uninsured groups, FQHCs expected and feared that most elements of the demonstrations would have a negative impact. These providers were apprehensive about demonstration impacts on payment rates and financial viability, business practices, and declines in enrollment as a result of competition from nontraditional Medicaid providers.

[4] Since retroactive payments represent a small amount of revenues in the post-demonstration period and, in some respects, reflect a steady State (that is, FQHCs in these three States received retroactive payments in both periods under review), we left these revenues in the data. We were concerned that there might be some measurement problems as a result, but we found that the revenue trends were reasonable and were not strongly affected by the reconciliation payments.

[5] MDS Associates and Stickgold and Associates (1997) suggested that State-based estimates of changes between BCRR and UDS might be unreliable because of problems in the 1993 grant application data, including: (1) grantees do not always report data for the same time period (calendar year versus fiscal year reporting differences); (2) there are descrepancies between grant application and BCCR data on the number of users by insurance status; and (3) in any given year, grant application data have not been available for all grantees.

[6] After reviewing an earlier draft of this report, representatives from Rhode Island's Community Health Centers' Enterprise, Inc. organization suggested that the BCRR and UDS data submitted by their FQHCs to the BPHC might be inaccurate for the time periods in question. Enterprise sent some data to us for the same periods in question and it is inconsistent with the BCRR/UDS data. We did not use their data because it would result in inconsistencies in sources across States (meaning there could be important differences in definitions that would make the data non-comparable across States), and, more importantly, an Enterprise representative agreed that even using this new data source, the conclusions would not change for the FQHCs in Rhode Island (Contey, 1999).

Table 1

Key Features of the Four Demonstration Programs and Evolution of Policies, by State: 1994 Through January, 1998

State	Program Name and Implementation Date	Key Design Elements at Implementation	Anticipated Size of Expansion Population[1]	Expansion Size After First Year	Subsequent Policy Changes
Hawaii	QUEST 8/1/94	Eligibility expansion to uninsured up to 300 percent of the FPL. Mandatory managed care design using MCOs for AFDC, poverty-related, and expansion beneficiaries; MCOs cover medical, acute behavioral, and dental care.	5,000	[2]40,000	April 1996—asset test imposed. August 1996—those with incomes above 100 percent of FPL had to pay full premiums and new reduced-benefit programs, QUEST-Net and QUEST-P, were introduced for those whose assets are too high for QUEST or who lose eligibility for Medicaid. January 1998—expansion group restricted to those under 100 percent of FPL.
Rhode Island	RIte Care 8/1/94	Eligibility expansion to pregnant women and children up to age 6 under 250 percent of FPL. Mandatory managed care design for AFDC, poverty-related, and expansion beneficiaries; MCOs cover medical, acute behavioral, and dental care; extended family planning program for postpartum women.	[3]10,000	[4]1,030	In 1996—the State extended child coverage to children up to age 8 to 250 percent of FPL. May 1997—the State extended coverage to children up to age 18 under 250 percent of FPL.
Tennessee	TennCare 1/1/94	Eligibility expansion to uninsured and uninsurable, with subsidies up to 400 percent of FPL. Mandatory managed care design for all Medicaid-eligibles (except QMB-onlys and SLMBs); MCOs cover medical, acute behavioral, and dental care.[5]	400,000	414,408	December 1994—enrollment to uninsured group closed. July 1996—carve-out of behavioral health care to managed BHOs. January 1997—all MCOs had to be HMOs. April and May 1997—reopened to uninsured children and dislocated workers, respectively. January 1998—opened to 18-year-olds and uninsured children under 200 percent of FPL with no access to affordable insurance.

[1]The expansion population are those people newly eligible for coverage because of the demonstration (that is, they were not eligible under the old Medicaid program rules).

[2]Estimated size of expansion.

[3]Number subsequently reduced.

[4]Of this number, 316 were pregnant women and 714 were children under age 6. An additional 741 postpartum women were enrolled in the extended family-planning program.

[5]In the first 3 years of TennCare, MCOs could be HMOs or preferred provider organizations.

NOTES: FPL is Federal poverty level. MCO is managed care organization. AFDC is Aid to Families with Dependent Children. BHO is behavioral health organization. QMB is qualified Medicare beneficiary. SLMB is specified low income Medicare beneficiary. HMO is health maintenance organization.

SOURCES: Wooldridge et al., 1996; Ku and Hoag, 1998; and State of Hawaii, 1997.

Table 2

Federally Qualified Health Center (FQHC) User Profile, by State: 1993

State	Total FQHC Users	FQHC Users as a Percentage of the Population	FQHC Users as a Percentage of the Medicaid Population	Uninsured and Medicaid FQHC Users as a Percentage of Total FQHC Users
Total United States	5,995,460	2.3	15.4	90
Hawaii	19,671	1.7	15.6	77
Rhode Island	52,253	5.3	41.9	93
Tennessee	157,017	3.1	15	72

SOURCES: (U.S. Bureau of the Census, 1998); Urban Institute tabulations of 1993 BCRR data and HCFA-2082 data.

FINDINGS

Predemonstration Roles

FQHCs were important providers to the Medicaid and uninsured populations in all the States prior to the demonstration programs, but among these three States, FQHCs in Rhode Island seemed to play the most critical safety net role. Rhode Island made very low provider payments in its FFS Medicaid program (around $18 per routine visit, among the lowest in the Nation at the time) and, thus, had very low private physician participation in Medicaid, making FQHCs essential to service delivery in the Medicaid program there (Wooldridge et al., 1996). Tabulations from BPHC and U.S. Census data indicate that Rhode Island had a much higher proportion of FQHC users, as a percentage of its State population and as a percentage of its State Medicaid population, than the other States in this analysis (or the Nation). As Table 2 indicates, 5.3 percent of Rhode Island's population used FQHCs in 1993, compared with 3.1 percent in Tennessee, 1.7 percent in Hawaii, and 2.3 percent in the Nation. Rhode Island also had the highest proportion of FQHC users who were Medicaid recipients or who were uninsured—only 7 percent of FQHC users in the State were not uninsured or Medicaid recipients, compared with 23 percent in Hawaii and 28 percent in Tennessee.

Concerns about Medicaid Managed Care

Prior to implementation, FQHCs in these three States shared the concerns of other safety-net providers—financial effects from lower payment rates, maintaining their patient base, and impacts on business practices—but their focus was primarily on the payment issue. This was because since 1989, Federal legislation required that FQHCs receive cost-based Medicaid (and Medicare) reimbursement, which was implemented to ensure that Medicaid paid its share of costs (there was concern that FQHCs were diverting Federal grants intended to pay for uninsured users to subsidize underpaid Medicaid services).[7] Cost-based reimbursement also was intended to support services to the uninsured and to enable the centers to improve access and available services for Medicaid recipients (Ku, Wade, and Dodds, 1996). Under a section 1115 demonstration, however, a State may request a waiver of this mandate, and each of these States was granted such a waiver.[8] Thus, participating MCOs could reimburse FQHCs in whatever way they chose, and FQHCs anticipated that

[7] For example, in 1989, it was estimated that the average Medicaid reimbursement was $40 at FQHCs, but the actual average cost of care was $75 (MDS Associates and Actuarial Research Corporation, 1995).

[8] The viability of community health centers has been an issue in every State that has received approval for a section 1115 demonstration. In fact, the National Association of Community Health Centers unsuccessfully sued the Federal Government, seeking a repeal of the waiver of cost-based reimbursement (Rajan et al., 1994).

rates would be far below the actual costs of care. Unlike private providers that might be able to shift the costs of care for Medicaid or uninsured patients to other payers, or simply refuse to serve Medicaid or uninsured users, FQHCs serve mostly Medicaid or uninsured patients, leaving them few places to shift uncompensated costs. Although it might require difficult changes, FQHCs would have to increase operational efficiency to address the gap between payments and costs, just as other providers must do if they want to remain in business.

FQHCs' concerns about maintaining their patient base were twofold. First, they feared the financial effects that would ensue from patient losses. FQHCs also believed that private practice physicians might not be suitable for patients traditionally served by health centers, many of whom needed enabling services, such as social service case management, health education, or translation services (which usually are not available at private practices), just as much as they needed medical services. Moreover, they were concerned that these enabling services would not be covered by MCOs.

Finally, FQHCs often had weak existing business and administrative functions, in large part because the bulk of their business (Medicaid, Medicare, or the uninsured) did not require strong business skills. For example, under FFS Medicaid, FQHCs' incentive was to maximize their Federal grant; centers did not need to know how to bill multiple systems, nor did they worry about data capture, coding, or encounter measurement. Under managed care, FQHCs feared more paperwork and the effects of dealing with multiple payers with multiple rules.

Reported Experiences Under the Demonstrations

In Hawaii and Rhode Island, health centers formed their own managed care plans.[9] This move guaranteed the inclusion of FQHCs as providers, assuming that their plans could contract successfully with the States. They also hoped that as health plans, they might be able to provide input into the emerging Medicaid managed care program (especially regarding payment rates for plans). In Tennessee, FQHCs, after some consideration, did not form an MCO; like other providers, they hoped to contract with one or more of the demonstration MCOs. In Hawaii, Rhode Island, and Tennessee, the inclusion of FQHCs in MCO networks was encouraged but not mandated by the States.

Across States, we heard three broad themes expressed by primary care associations after implementation: (1) although able to secure MCO contracts, FQHCs often found the contracts problematic; (2) FQHCs had financial problems under the demonstrations; and (3) the demonstrations required difficult business/operational changes. In addition, Hawaii and Tennessee FQHCs found that the eligibility expansions initially helped FQHCs.

Managed Care Contracting

FQHCs in all States were able to secure contracts. Nevertheless, the ability of centers to negotiate those contracts was limited, due to their inexperience with managed care, and many ended up with rates far below previous Medicaid rates. In

[9] In both Rhode Island and Hawaii, the FQHC-based MCOs included both FQHCs and non-federally funded health centers among their member-owners.

some States, FQHCs contracted with every MCO that offered a contract, rather than selectively contracting with those offering the most favorable terms.

Some MCOs negotiated capitated risk arrangements with FQHCs, usually just for primary care services, while other MCOs paid FQHCs FFS.[10] We heard conflicting reports about FQHCs' abilities to operate their businesses under capitated arrangements. FQHCs, whether paid capitation or FFS, consistently expressed concern about managing administrative costs.

Financial Experiences

Primary care associations reported that, overall, FQHCs were doing worse financially under the demonstrations than they had under FFS Medicaid, even though they received substantial financial assistance (such as supplemental payments) from the States beyond their payments from MCOs. For example, in an attempt to ease the loss of cost-based reimbursement, Hawaii and Rhode Island gave FQHCs supplemental payments. Hawaii gave the centers $2 million in the first year of the program, while Rhode Island gave centers a monthly supplement for each member who selected a center as a primary care site. In Rhode Island, the supplement was $10 per member/per month, initially (with a cap of $2.2 million), although it was raised to $15 per member/per month, in 1996 (with a cap of $3.3 million). Tennessee did not target FQHCs for financial assistance, although in the first 2 years, some FQHCs received supplemental assistance from Tennessee's Primary Care Assistance Fund, a fund that assisted any primary care provider serving a large proportion of TennCare enrollees. Although the fund was discontinued after 2 years, during that time the centers received an estimated $1 million from this fund.[11]

Some of the financial problems reported by the primary care association in Tennessee were linked to low payment rates from the MCOs or poor risk-sharing agreements with those MCOs. In Rhode Island, where FQHCs' reported financial troubles were substantial, other factors contributed as well: there was lower than expected demonstration enrollment in the FQHC-sponsored MCO, and greater uncompensated care expenses due to growth in the State's uninsured population.[12] Also, in the first year, Rhode Island health centers primarily contracted only with their own health plan, leaving them with few other sources of earnings; in contrast, most FQHCs in Hawaii also contracted with two other participating health plans. (In the second year, some centers in Rhode Island had contracts with other MCOs.)

Business Operations Also Affected

Centers reported that their resources were diverted from service delivery to administration—new staff had to be hired just to deal with the paperwork. FQHCs, like other providers, reported that each MCO had different procedures and forms,

[10] According to Wooldridge et al., 1996, AlohaCare, the FQHC-sponsored plan in Hawaii, paid a capitated rate for primary care. Other health plans in Hawaii paid capitation or FFS, although we are unsure of their direct arrangements with FQHCs. In Tennessee, the primary care association reported that FQHCs were capitated by several MCOs for primary care services, but some MCOs still paid FFS, sometimes with a gatekeeper fee added. FQHCs in Rhode Island were in capitated arrangements for primary care services in their contract with Neighborhood Health Plan of Rhode Island (NHP-RI), the health center-sponsored plan.

[11] During the period when demonstration enrollment was still building up, Tennessee chose to make the balance of the program budget available through pool payments for various purposes. The primary care pool payments were designed to be transitional until the program reached full enrollment.

[12] The RIte Care demonstration started before the FQHC-sponsored MCO in Rhode Island was licensed by the State (Wooldridge et al., 1996). FQHCs alleged that this put them at a significant disadvantage with regard to RIte Care enrollment, even though beneficiaries wanting to enroll in the FQHC-sponsored MCO were allowed to remain in FFS Medicaid until the FQHC MCO was licensed.

Table 3

Percent Changes in Selected Measures at Federally Qualified Health Centers (FQHCs), by State: 1993-1996

Selected Measure	United States (*n*=504)	Hawaii (*n*=2)	Rhode Island (*n*=4)	Tennessee (*n*=16)
Medicaid Revenues				
Total Medicaid Revenues	22.5	103.5	30.9	59.6
Medicaid Revenues per Medicaid User[1]	49.8	87.5	124.1	19.3
Medicaid Revenues as a Percentage of Total Revenues	1.3	4	7.1	10.5
Users[1]				
Total FQHC Users	11.9	24.5	-2.4	1.5
Total Medicaid FQHC Users	-18.2	8.5	-41.6	21.3
Medicaid FQHC Users as a Percentage of Total FQHC Users	-12.2	-7.5	-22.9	5.9
Uninsured FQHC Users	22.5	117.9	36.7	-5.8
Uninsured FQHC Users as a Percentage of Total FQHC Users	4.2	13.5	14.4	-2.7
Total Revenues, Costs, and Profit Margins				
Total FQHC Revenues	18.0	86.0	6.0	9.1
Total FQHC Costs	24.0	88.9	2.5	22.3
Profit Margins	-4.9	-1.6	3.2	-11.8
Service Encounters and Enabling Services[2]				
Total Service Encounters Per Medical User[3]	0.9	-13.2	-2.4	-7.4
Enabling Service Encounters Per Medical User	9.8	-41.4	-5.5	-22.5

[1] Information for Medicaid users in 1993 is from grant application data; 1996 data are from the Uniform Data System reports.

[2] Enabling services include services such as case management, health education, and other social services. The comparison years for these measures are 1993 and 1995.

[3] This information is for all medical users; a breakout by user type (uninsured, Medicaid, etc.) was not available.

NOTES: All dollar figures are expressed in 1996 terms; 1993 data were inflated using the Medical Consumer Price Index.

SOURCE: Urban Institute calculations of 1993 and 1995 Bureau Common Reporting Requirements data and 1996 Uniform Data System data.

which further complicated centers' ability to cope with paperwork requirements. Centers also discovered that information was a key component of operating under managed care, and some purchased new data systems.

The Rhode Island Health Center Association also reported that its health centers did not understand how to operate under managed care. In the first 18 months of the demonstration, Rhode Island centers encountered problems adapting their administrative practices to managed care, as well as problems managing utilization. (The health centers' MCO, NHP-RI, was struggling itself with the demands of starting an MCO and was not able to help the centers in this area.) For example, some centers were sending patients needing primary care after hours to the emergency room (the historical utilization pattern of Medicaid recipients and FQHC providers), rather than adding after-hours primary care services or trying to schedule these services for a time when the center was open. This type of behavior led to high emergency room and high inpatient hospital use by enrollees and, in turn, high costs for their health plan.

Effects of Eligibility Expansions

The primary care associations in Hawaii and Tennessee concurred that, initially, the large expansion of program eligibility helped centers; more of their patients now had insurance.[13] However, unanticipated policy changes after the first year hurt FQHCs. In Hawaii, the eligibility rules were altered in 1996 and again in 1997, which reportedly caused a large number of individuals (about 20,000) to be disqualified for the program.

[13] The expansion of coverage increased the number of program eligibles in Hawaii by 33 percent between August 1994 and December 1996, while in Tennessee, program eligibles grew 44 percent between January 1994 and December 1996 (State of Hawaii, 1997; State of Tennessee, 1997). Rhode Island's expansion was much smaller than either Hawaii or Tennessee; although the State initially anticipated 10,000 would enroll, only 2,996 had enrolled as of December 31, 1996 (State of Rhode Island 1997).

As a result, Hawaii's primary care association claimed that FQHCs were seeing an increasing number of uninsured patients by 1996. Tennessee FQHCs witnessed a similar closing of eligibility to the uninsured in December 1994 (in 1997, enrollment reopened for uninsured children and dislocated workers).[14] In addition, as the result of an eligibility reverification process, Tennessee disenrolled roughly 40,000 uninsured expansion group members in 1996. From the perspective of the primary care association, the State was reneging on its expansion commitment to the uninsured and thus forcing the problem back on the health centers—but without paying for it.[15,16]

Data Analysis of FQHC Experiences

Here we review post-demonstration changes in: Medicaid revenues and FQHC users, FQHCs' overall financial status, and the level and intensity of services provided.

Changes in Medicaid Revenues and Users

Medicaid revenues increased from 1993 to 1996 for FQHCs in our study States; in fact, their Medicaid revenues increased more than the national average (Table 3). Even in Rhode Island, where FQHCs lost Medicaid users, Medicaid revenues rose by almost 31 percent between 1993 and 1996. For Hawaii FQHCs, Medicaid revenues increased nearly 104 percent in this period, while for Tennessee, FQHCs revenues increased nearly 60 percent.

On a per-user basis, payment rates for Medicaid services increased in each State after the demonstrations were implemented. Between 1993 and 1996, Medicaid revenues per Medicaid user increased 87.5 percent in Hawaii, 19.3 percent in Tennessee, and 124.1 percent for Rhode Island FQHCs—more than twice the national average. At least for this type of primary care provider, Rhode Island seems to have realized its goal of increasing provider payment levels under the demonstration.[17] Most (82 percent) of the revenue increase was due to Rhode Island's supplemental payments to health centers: if the annual per user value of the State's supplement to FQHCs in 1996 ($150) is subtracted from 1996 Medicaid revenues per Medicaid user, the increase in Medicaid revenues per Medicaid user would be 42 percent for this period.

Although FQHCs had large gains in Medicaid revenues nationally and in the three States, Medicaid revenues as a percent of total revenues increased only slightly nationally, as well as in Hawaii, Rhode Island, and Tennessee. These figures signal that centers must have increased their total revenues from other sources.

The number of Medicaid users increased in both Hawaii and Tennessee, helping fuel the Medicaid revenue increases experienced by centers in these States. These increases were not surprising, since

[14] The uninsurable expansion group in Tennessee never closed to new enrollment; and enrollment to the uninsured group was always open to people losing their Medicaid eligibility.

[15] Because Tennessee expected its uninsured expansion to substantially reduce charity care in the State, the State set its capitation payments to MCOs 20 percent lower than historical payment levels (Wooldridge et al. 1996). MCOs, in turn, reduced provider payments. However, the uninsured did not go away, as the State had predicted, thus creating a political issue that remains controversial today.

[16] Estimates of Current Population Survey (CPS) data indicate that Tennessee experienced a dramatic decline in the number of uninsured from 1993 to 1994, when TennCare was first implemented; this situation had reversed by 1995; and it worsened in 1996 (Fronstin, 1997 a,b). The increase in the number of uninsured in Tennessee between 1994 and 1995 was statistically significant (at the 90 percent confidence level) (U.S. Bureau of the Census, 2000), which seems to validate Tennessee FQHCs' concerns. In Rhode Island, the number of uninsured in the State increased in both 1994 and 1995, after RIte Care was implemented, although by 1996 the uninsured rate had returned to the 1993 level. In Hawaii, the uninsured rate declined throughout the study period.

[17] At the outset of RIte Care, the State's primary goal was to improve access to primary care; one of the strategies to achieve this was to increase physician payment levels, which under FFS Medicaid had been among the lowest in the Nation (Wooldridge et al. 1996).

both States made significant expansions to cover uninsured people (classifying many more people as "Medicaid" in these States).[18] At the same time, the primary care associations in these States expected to lose patients to their new competitors. In fact, on average, this did not occur, although the patient panels of FQHCs in both States did change. As Table 3 shows, Medicaid users as a percentage of total users declined 7.5 percent in Hawaii but increased 5.9 percent in Tennessee.

The increases in Medicaid revenues in Hawaii and Rhode Island may appear inconsistent with the declines in Medicaid users as a percentage of total FQHC users in these States. However, since both of these States had FQHC-sponsored MCOs, it seems that these FQHC-sponsored plans were paying their owners better rates than FQHCs in the other States were able to negotiate with unaffiliated MCOs. It is likely that FQHC-sponsored MCOs (more so than unaffiliated MCOs) would have recognized the additional costs FQHCs would incur transitioning to managed care (setting up new administrative systems, hiring additional staff, extending operating hours) and structured rates to assist the centers in this transition.

Another possible explanation for the apparent inconsistency between fewer Medicaid users and more Medicaid revenues is that Medicaid users and Medicaid revenues have a different relationship in the post-implementation period when capitation is introduced. In FFS Medicaid, the number of services an FQHC provided determined the Medicaid revenues realized by a center because the center billed by the service. Therefore, the total number of Medicaid users did not determine Medicaid revenues nearly as much as the amount of overall services provided. Under capitated arrangements, the FQHC realizes revenues for each assigned member, whether or not that member receives services. Because the FQHCs in Hawaii and Rhode Island reported that they were mostly capitated, a drop in users while revenues increase may not be an inconsistency as much as a reflection of the different payment systems in the two periods.[19]

The number of uninsured FQHC users increased absolutely and as a percentage of total users in all the States except Tennessee (which is consistent with Tennessee's large program expansion to uninsured residents). The increases in uninsured users in Hawaii and Rhode Island are surprising, given that in this period, CPS data indicate that the number of uninsured people in these States either declined (Hawaii) or remained unchanged (Rhode Island) (although small CPS sample sizes may have created statistical noise rather than real changes in the number of uninsured in these States). This might signal that the increasing movement of the overall health care market toward managed care has limited the willingness of other providers to care for uninsured patients, forcing the uninsured to rely more heavily on FQHCs, although we have no evidence about any trends among private practice providers. The increases in Medicaid revenues under the demonstrations probably helped FQHCs supplement services to the uninsured; if there are decreases in payment rates in the future, however, they may not be able to shift costs from Medicaid.

[18] In contrast, in this same time period, Medicaid caseloads were falling nationally due to State welfare reforms (Ellwood and Ku, 1998).

[19] Not all Medicaid recipients in Hawaii and Rhode Island were in managed care. Hawaii and Rhode Island excluded aged, blind and disabled-related individuals in the Supplemental Security Income (SSI) program; Hawaii also excluded individuals in the Refugee Cash and Medical Assistance programs and those in the Medical Payments for Pensioners program (Wooldridge et al., 1996).

Changes in Overall Financial Viability

Medicaid revenues and users tell only part of the financial story for FQHCs. Examining total revenues and costs helps us see how the centers were affected financially by all payers. Table 3 shows that, in Hawaii, Rhode Island, and Tennessee, total revenues increased, but so did total costs.

For FQHCs in Tennessee and Rhode Island, the increases in total revenues are fueled by the Medicaid revenue increases; in both States, the increases in total revenues are consistent with the increases in Medicaid revenues as a percent of total revenues. Non-Medicaid revenues, although not presented here, fell for FQHCs in Rhode Island but remained about the same for FQHCs in Tennessee. In contrast, Medicaid revenues as a percentage of total revenues for FQHCs in Hawaii increased only slightly (4 percent), while total revenues were up 86 percent. Thus, the large Medicaid revenue increases were not the only source fueling the total revenue increases for FQHCs in Hawaii. In fact, revenue from non-Medicaid sources (including the uninsured, who pay for services on a sliding scale) increased 73 percent between 1993 and 1996 (whereas non-Medicaid FQHC users increased 47 percent during this period).[20]

Although not shown in Table 3, FQHCs in Hawaii were losing money prior to the demonstrations, whereas FQHCs in the other States were profitable (although only the profit margins of FQHCs in Tennessee were above the national FQHC average of 2.2 percent in 1993). Thus, in the year prior to the demonstrations, FQHCs had either no profits or only small profits to cushion them through the transition to Medicaid managed care, when revenues were expected to be uncertain (however, they may have had other reserves to help them in this transition). After the demonstrations were implemented, only FQHCs in Rhode Island enjoyed profits.

The review of profit margins validates Hawaii and Tennessee primary care association reports that centers were losing money after the demonstrations began. Despite huge gains in Medicaid revenues and total revenues in Hawaii and Tennessee, costs outpaced the gains. Primary care associations in these States did complain that the administrative load of managed care was much higher than under FFS Medicaid (including such items as purchasing information systems and hiring administrative staff) and that operational costs were higher under managed care (for example, additional staffing costs to meet MCOs' 24-hour-access requirements, which may have contributed to the expense increases).[21] In Hawaii, the increases in uninsured users (who pay for services on a sliding scale) also affected FQHCs' finances. Without other hard data, we can only speculate as to why costs outpaced revenue increases. It is likely a combination of factors: centers may have been required to provide more services for less money; centers may have begun spending more on marketing to attract new patients; there may have been a change in the patients now coming to FQHCs—that is, centers may have begun seeing sicker patients; or perhaps FQHCs were just unprepared for Medicaid managed care implementation. It also is possible that some FQHCs had capitation arrangements that made them responsible for paying for care received outside the center (such as

[20] In Hawaii, the uninsured accounted for 43 percent of non-Medicaid users in 1993 and 64 percent of non-Medicaid users in 1996; other non-Medicaid users (that is, insured users) in Hawaii decreased commensurately in this period, from 57 to 36 percent. BPHC data indicate that, nationally, users with either private insurance or Medicare increased from 10 to 18 percent of all FQHC users, which suggests a growing source of revenue for health centers.

[21] Of course, the administrative load introduced by managed care is not a problem exclusive to FQHCs or safety net providers, but is a problem for every type of provider.

at a hospital), and that FQHCs had difficulties managing this outside utilization (although the FQHCs we interviewed were capitated only for the primary care services they provided).

Changes in the Number and Types of Services

Prior to the demonstrations, FQHCs expected that new provider competition would decrease the number of services FQHCs provided and that cost constraints would limit the types of services delivered (that is, they expected to be able to provide fewer enabling services). Table 3 presents data on changes in the percentage of medical encounters per user and enabling service encounters per user between 1993 and 1995.[22] Consistent with the theory that the movement toward managed care provides an incentive to reduce the units of service delivered, in all three States, on average, total encounters per user declined between 1993 and 1995, ranging from a 2.4-percent decline in Rhode Island to a 13.2-percent decline in Hawaii. In contrast, FQHC total encounters per user rose very slightly in the rest of the Nation.

Similarly, enabling services per medical user increased in the United States (by 9.8 percent on average), while in our States, enabling service encounters per medical user fell. The declines in enabling services provided in Hawaii and Tennessee were the most dramatic. However, BCRR data from prior years (not presented here) shows that the actual average number of enabling services per user provided before the demonstration was quite low in Tennessee. In every State, the rate of decline in enabling services outpaced the rate of decline in total services.

We cannot say with certainty if the reductions in encounters and enabling services are a good or bad thing: managed care incentives put financial pressure on providers to decrease services, but it is quite possible that services are being provided more efficiently under managed care (e.g., capitation might lead providers to handle some services by telephone instead of through an office visit). This area of research merits further investigation, because the declines in encounters may indicate less access to services for vulnerable populations.

DISCUSSION AND POLICY IMPLICATIONS

The movement of Medicaid from a FFS payment system to a managed care delivery system has affected all areas of the health care market, including safety net providers such as FQHCs. Before the demonstrations were implemented, FQHCs, like many policymakers, were concerned that the shift to managed care would undermine them and thus, jeopardize care for Medicaid beneficiaries and the uninsured. In the three States we reviewed, FQHCs have survived in the short term, similar to the findings of other studies of safety net providers (Felt-Lisk, Harrington, and Aizer, 1997). The majority of their fears about Medicaid managed care were not realized; in fact, the data indicate that many FQHCs did better than expected, although they did not do as well as they wanted to do. Their ability to continue to evolve and to be active players in this market—as they did during the first 3 years of the demonstrations—will be critical for their longer-term prospects.

Given their market-based approach to Medicaid, should States care whether or not safety net providers can endure? We think States should care about what hap-

[22] As mentioned in the introduction, comparable 1996 data were not available (1996 was the year the BPHC switched data systems, and the questions on services changed). The data are presented for all users; they cannot be broken out by Medicaid users versus other users.

pens to the safety net: leaving these providers to survive on their own in the market jeopardizes those who still need these safety net providers—the uninsured, those who are difficult to serve, and those who cannot get care elsewhere (Baxter and Mechanic, 1997). However, getting policy concessions to support safety net providers can be difficult, unless the State wants the providers to succeed or the providers have some political clout in the State.

Among these three States, Hawaii and Rhode Island combined their market-based approach to Medicaid with policies designed to support FQHCs' transition to managed care (such as transitional FQHC payments). In contrast, Tennessee adhered strongly to a hands-off market-based approach, in large part because the State expected to achieve near-universal insurance coverage through its demonstration and thus, anticipated a greatly diminishing need for charity care.[23] The need for charity care, however, did not go away as the State had anticipated (largely because universal coverage was not achieved). FQHCs in Tennessee have adapted under the demonstrations, but the State has generally resisted modifying its policies toward these providers (although in March 1999, the State earmarked $1 million in funding for FQHCs and other community health centers to support care to TennCare enrollees). Nevertheless, the experiences of these providers indicate that State Medicaid programs may need to provide the long-term support not offered these providers by the market, even though the problems of uninsured users and scarce revenues are not solely Medicaid problems.

What types of support can States offer FQHCs? Financial subsidies, whether permanent or temporary, clearly are important, but other types of assistance may also be helpful. States might consider arranging technical assistance for FQHCs on how to manage under managed care, or encourage new business arrangements (such as partnerships of health centers with other providers). Because cost-based reimbursement to FQHCs is largely being eliminated on a national level as a result of the Balanced Budget Act of 1997, a multifaceted approach seems critical to the preservation of FQHCs.

There are some important lessons to be learned from these three States about safety net providers' adjustment to managed care. First, it is challenging for non-profit, mission-oriented providers to shift to more business-oriented, bottom-line-focused organizations, as others have noted (Baxter and Mechanic, 1997). Providers realized that they needed to adapt their business practices to meet the demands of Medicaid managed care, but this did not happen overnight; FQHCs found it took time (sometimes 2 or 3 years) to adapt.

Second, the administrative burden of managed care turned out to be a much bigger problem for FQHCs than they anticipated at the outset—safety net providers planning to participate in similar programs in other States should anticipate this as well.[24] Providers did not grasp the complexity that would be introduced by dealing with more than one payer, thus, requiring many more resources to be directed toward administration. States might help offset this in the future by considering requiring participating MCOs to use standardized procedures and forms, so providers do not have

[23] FQHCs in Tennessee benefited from pool payments in the first 2 demonstration years, but were not targeted by the State to receive assistance because of their safety net status; all high-volume primary care providers were eligible for these funds.

[24] Interestingly, the same thing has been found about the States operating these demonstration programs. Wooldridge et al., /1996 noted that these States underestimated the administrative demands and resources required to operate the demonstrations, at least in the short term.

to report differently to each MCO. Newly formed MCOs in these States also made the administrative problems more complex at the outset—many of these MCOs did not have their operations fully in place, which resulted in payment delays and other complications for all types of providers (although these usually were alleviated by the second demonstration year).

Finally, as with any business venture, when forming an MCO, safety net providers should look before they leap. Some of the FQHCs viewed forming an MCO as a survival strategy at the outset, but in these States, FQHC-sponsored MCOs have had dramatically different experiences. Although Hawaii's health center-sponsored plan appeared profitable from 1994-1996, the Rhode Island plan has had extreme difficulty, surviving only because of major financial and technical assistance from the State. The experiences of plans that have done poorly lead us to conclude that safety net providers wishing to start an MCO need to have numerous pieces (financing, information systems, technical expertise) in place, preferably before operations begin. The States also hold some responsibility for ensuring that these pieces are, in fact, in place; although the States may have looked worse politically had they not approved safety net-sponsored plans to participate, States do the enrollees a disservice if the plans are not ready to operate and to provide high-quality services.

How, or if, market changes have affected Medicaid beneficiaries and the uninsured—in terms of access, satisfaction, and outcomes—remains unknown at this point, but, in general, State-sponsored satisfaction surveys have found high levels of satisfaction with managed care. Later stages of this project will evaluate the programs' impacts, using household survey data and, where feasible, analyses of existing claims and encounter data.

ACKNOWLEDGMENTS

The authors are grateful for the cooperation of those they interviewed and for the help of several reviewers, including Penny Pine, Bonnie Lefkowitz, Rhoda Abrams, Harold Luft, Mary Layne Van Cleave, Christopher Koller, and representatives from the demonstration agencies in the three States. The authors also thank Judith Wooldridge, Leighton Ku, and Marilyn Ellwood, who helped collect data for this article and reviewed an earlier draft.

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Reprint Requests: Sheila D. Hoag, M.A., Mathematica Policy Research, Inc., P.O. Box 2393, Princeton, NJ 08543-2393. E-mail: Shoag@mathematica-mpr.com