Executive Summary

The Oregon Health Plan (OHP) is an innovative effort by the State of Oregon to extend health insurance coverage to uninsured State residents below poverty. The costs of expanded insurance coverage are financed through the use of a prioritized list of health care services (to determine the benefit package), increased enrollment in capitated managed care organizations (MCOs)[1], as well as revenues generated by a cigarette tax earmarked for OHP.

The Oregon Health Plan was implemented in February 1994 under a Section 1115 waiver from the Health Care Financing Administration (HCFA). As a Section 1115 demonstration program, the OHP is being evaluated through a HCFA-funded evaluation contract. The evaluation addresses both the implementation process and program impacts, using qualitative and quantitative approaches.

This report is the First Interim Report produced by the evaluation. This report discusses how the Oregon Health Plan program has evolved since it was implemented in February 1994. The report is based on three site visits conducted in November 1994, October 1995, and June 1996, as well as analysis of secondary data maintained by the State. Data sources include the monthly enrollment and disenrollment reports, audited financial

[1] The *managed care expansion* builds on a previous 1915(b) waiver program in which Aid to Families with Dependent Children (AFDC) Medicaid beneficiaries were mandatorily enrolled in managed care settings in fifteen counties and voluntarily enrolled in two counties. Under OHP, however, enrollment in fully capitated health plans (FCHPs) is mandatory in most counties (and in most ZIP codes in those counties).

statements from managed care plans, and other administrative reports. Additional phone follow-up occurred on an as-needed basis.

Legislative Origins

One of the key components that paved the way for implementation of the demonstration was the "up-front" legislative process that took place before the waiver application was prepared. Senate Bill 27 was enacted in 1989 and provided the foundation for the Oregon Health Plan. The legislation contained four basic premises:

- The State would take responsibility for insuring legal State residents with incomes below the Federal poverty level, without regard to categorical criteria.
- The State would develop a prioritized list of health services (ranked according to clinical effectiveness and social value) and the scope of benefits would be tied explicitly to the budget process. Services above the cut-off line would be funded; those below the line would not be covered.
- The State would set reimbursement levels sufficient to cover costs, to eliminate cost-shifting and to increase provider participation.
- The State would make an overt commitment to managed care where feasible.

The State of Oregon submitted its Section 1115 waiver application to HCFA in August 1991. The waiver application was approved in March 1993 after several revisions of the prioritized list of health services to comply with the Federal Americans with Disabilities Act (ADA). Following a ten-month start-up period, the program began enrolling individuals on February 1, 1994. Phase I of the demonstration included all traditional Medicaid eligibles

other than the aged, blind/disabled, and children in foster care, as well as those who were newly eligible under the poverty-level expansion. Phase II, which began January 1, 1995 brought most of the remaining traditional Medicaid eligibility groups into OHP.

Changes in Program Organization

One of the challenges faced by a State Medicaid agency in implementing a Medicaid managed care program is to transform its organization from a fee-for-service indemnity insurer to managing contracts with capitated managed care organizations (MCOs). The Office of Medical Assistance Programs (OMAP) administers Oregon's Medicaid program, and is responsible for the design and implementation of the demonstration.

Pre-Demonstration Organization. Initial responsibility for planning the demonstration was located within OMAP's Prioritized Health Care Unit, a dedicated staff of five professionals, which had been operational since 1989. Upon approval of the Section 1115 waiver application in March 1993, OMAP created a Managed Health Care Unit to provide a focal point for managed care activities within the agency and to assume the lead role in the demonstration project.

Consolidation and Streamlining. Following the Phase I implementation, OMAP began a series of organizational changes, characterized mainly by streamlining and consolidation of the fee-for-service operations. For example, no longer was it necessary to maintain dual quality assurance units, one for fee-for-service and another for managed care. Similarly, a consolidated Program and Policy Unit was established to assume responsibility

for both fee-for-service and managed care policies and procedures, acknowledging that managed care is now OMAP's primary delivery system.

OMAP's process of streamlining runs contrary to the original prediction of a permanently expanded staff. After the initial staff expansion prior to the Phase I implementation in February 1994, OMAP has since conducted a gradual downsizing of its staff. In addition to addressing budget constraints, the decrease in staff is viewed by OMAP as an indication of a maturing program whereby much of the administrative support previously necessary for implementation has now become superfluous in an operational program. Two areas of steady growth, however, have been in the hiring of Prepaid Health Plan (PHP) Coordinators to facilitate OMAP's interaction with PHPs and Primary Care Case Managers (PCCMs), as well as Site Review Coordinators to expand OMAP's capacity for monitoring PHPs.[2]

Creation of New Administrative Entities. The State has faced challenges in coordinating the multi-faceted Oregon Health Plan and insuring its continued survival within the changing political context. Besides the Medicaid demonstration, the Oregon Health Plan involves private sector initiatives, including small market insurance reform, a high risk pool, and a voluntary tax credit program. State officials felt that these efforts were not being coordinated effectively with each other, and they were concerned that no one person was responsible for overseeing all of the public and private sector initiatives for the

[2] Prepaid health plans included both fully-capitated health plans (FCHPs) such as HMOs, as well as physician care organizations (PCOs) which were partially capitated. By November 1996, however, there no longer were any PCOs in OHP; they either had converted to FCHPs, or dropped out altogether.

working poor. Thus, the Office of the Health Plan Administrator (OHPA) was created to coordinate OHP's various public and private sector components.[3]

Another important organizational development was the creation of the Federal Policy Coordinator position within the Governor's office (September 1995). At the time, Congress was actively debating the future of the Medicaid program, and the fate of Section 1115 demonstration programs was in jeopardy. The Federal Policy Coordinator position was created to represent the State's concerns during the debate.

Eligibility and Enrollment

OHP expanded Medicaid eligibility to legal State residents below the poverty level, without regard to categorical eligibility criteria. One of the key challenges during the first year of the Oregon Health Plan was in processing applications for the newly-eligible population. Response to the program exceeded all expectations and required program adaptations to accommodate the demand.

Program Modifications. In response to budget pressures, OMAP initiated discussions with HCFA concerning the modification of eligibility criteria to exclude certain

[3] In December 1995, the OHPA merged with the Department of Human Resources (DHR) Office of Health Policy. In 1997, the office was renamed the Office for OHP Health Policy and Research. The name change occurred due to confusion over the role of OMAP versus OHPA vis-a-vis the administration of OHP.

persons who were believed to be less vulnerable. With HCFA's approval, OMAP instituted three changes to the original Phase I eligibility rules beginning on October 1, 1995:

- Income is measured as the average of the most recent three months' income instead of the previous month's income alone. The Medicaid program traditionally used only the income for the preceding month, because beneficiaries were recertified monthly. However, since the expansion population is recertified every six months, persons who qualified on the basis of one month of unusually low income could remain eligible for months during which they might not otherwise have been eligible. The three-month average is designed to minimize this possibility.[4]

- Persons with $5,000 or more in liquid assets, excluding house and car, are now ineligible for OHP.

- Full-time college students are now ineligible for OHP unless they are pregnant or in a JOBS program.[5]

Although these changes introduced eligibility restrictions that were not originally intended, the fundamental 100 percent FPL criterion is still in place.

Effective December 1, 1995, OMAP began charging premiums to expansion eligibles, including single adults, childless couples, and new families. For a single-person family, premiums ranged from $6.00 per month below 50 percent of FPL to $20.00 per month for those 86 to 100 percent of FPL. For a family of four, the monthly payment ranged from $7.50 (below 50 percent of FPL) to $28.00 (86 to 100 percent of FPL). The State maintains continuous eligibility for the six-month certification period if enrollees are not

[4] In part, this change was brought about in response to a highly-publicized case in which a millionaire qualified for the Oregon Health Plan and then held a press conference criticizing the program.

[5] However, beginning January 1, 1998, eligibility for some full-time college students will be reinstated.

current in their premium payments; however, beneficiaries are denied recertification if they are not up-to-date when they reapply unless they have a "hardship exception."[6]

Another recent modification to the eligibility process was the requirement that OHP eligibles choose a health plan before they are actually enrolled in OHP. Previously, they were enrolled in OHP on a fee-for-service basis until they had chosen a health plan; however, to minimize the fee-for-service liability, as well as to maximize managed care enrollment, OHP eligibles are now required to choose a health plan before they are enrolled.

Eligibility Trends. The Phase I OHP population swelled from 197,800 in March 1994 to 329,000 in October 1995 (a 66 percent increase), and then gradually declined to just over 268,000 in August 1997 (an 18 percent reduction). During this timeframe, the number of current eligibles actually has fallen, and thus, the entire growth in OHP enrollment is attributable to the expansion population. OMAP staff attribute the decrease in current eligibles to an extremely aggressive JOBS program for the AFDC population, which resulted in reduced categorical eligibility, and the shift of some categorically eligible persons to expansion eligibility. This trend may reflect the joint effect of welfare reform and health care reform in decreasing the AFDC rolls in the State.

The OHP expansion population -- comprised of single adults, childless couples, and new families -- grew from 10,700 eligibles in March 1994 (the second month of the program) to nearly 100,000 by December 1994. This growth exceeded all projections for initial

[6] Hardship exceptions were required by HCFA as a way to provide continuing coverage to persons who are unable to pay the premium. To qualify for a premium waiver, beneficiaries must submit either a written application to the State or explain their circumstances to an AFS worker. The criteria under which a beneficiary may be excluded from paying a monthly premium include: zero income level, victim of domestic violence, victim of crime causing loss of money or income, victim of natural disaster, death of a household member, loss of housing, or homelessness.

program enrollment. The number of expansion eligibles continued to grow, peaking at 134,000 in October 1995, when new eligibility criteria were introduced, including an assets test, income averaging over three months, and elimination of full-time students. Further reductions in the number of expansion eligibles took place following May 1996, when up-to-date premiums were required as a precondition to recertification.

Managed Care Enrollment. The rate of enrollment in a fully or partially capitated health plan grew steadily from 75 percent in July 1994 to 82 percent in December 1996, and leveled off at this rate through July 1997. Enrollment with a primary care case manager (PCCM) accounted for a small additional share (2.4 percent in July 1997), indicating that few formal exemptions from prepaid health plan enrollment have been granted. The share remaining in fee-for-service has declined over time, from 24 percent in July 1994 to 16 percent in July 1997, due in part to more aggressive efforts to enroll eligibles in managed care coupled with greater managed care capacity.

Health Plan Disenrollment Rates. Several health plans are experiencing more rapid disenrollment than they had expected. The disenrollment rate due to loss of eligibility has fluctuated between a low of 4.1 percent in July 1994 (before the six-month recertifications began) to a high of 8.8 percent in December 1995 when the State began charging premiums to expansion eligibles. The disenrollment rate, for all reasons combined, has reached over 10 percent in many months, indicating that one in every ten managed care enrollee left their health plan in a given month. Health plans are concerned about the administrative expenses they incur from turnover, and the potential for adverse selection.

The health plans attribute this higher-than-expected disenrollment to: (1) the instability generated by monthly recertification of categorically-eligible beneficiaries; and (2) the failure of large numbers of newly-eligible beneficiaries to reapply at the scheduled six-month recertification. They believe that some beneficiaries fail to apply for recertification if they are not ill at the time they are scheduled for recertification and then reapply when they next need health care. Although the health plans believe that this rate is high, OMAP staff believe that it is consistent with turnover in AFDC eligibility.

Managed Care Plan Contracts and Financial Status

Managed Care Capacity Prior to OHP. Oregon's Medicaid managed care experience dates back to 1985 under a 1915(b) freedom of choice waiver. At the time of the Section 1115 waiver application (August 1991), the State contracted with 16 health plans, which served 65,320 Medicaid eligibles, representing about 55 percent of the AFDC population. The State and health plans credit their extensive experience with managed care for the smooth transition to OHP. A core group of health plans already had experience with the Medicaid population and existing reimbursement arrangements with hospitals and physicians.

The State used the interval between the Phase I waiver submission and waiver approval to build the delivery system. The State issued an RFA for prepaid health plans in November 1991, requesting letters of intent from prospective health plans interested in participating in the Oregon Health Plan. The State left the RFA open until the waiver was

approved (March 1993). State officials were struck by the profound changes in capacity brought about by the RFA, and provider interest in gaining a share of the Medicaid market. Moreover, new health plans were created just for OHP. The State undertook a review of each plan's policies and procedures, with the aid of a multidisciplinary review panel comprised of experts in public health, managed care, health policy, and medicine. During this interval, the State provided a considerable amount of technical assistance to plans.

Diffusion of Medicaid Managed Care. OHP continues to give impetus to the development of managed care throughout the State. Through a combination of service area expansions, new plan developments, and partially- to fully-capitated health plan (FCHP) conversions, just two counties (Gilliam and Tillamook) remain without an FCHP. OMAP continues to require mandatory PCCM enrollment in Gilliam and Tillamook counties, but is no longer attempting to promote capitated managed care plans in the two counties due to a lack of capacity.

Market Shares of Prepaid Health Plans. In December 1994, nearing the end of the first year of OHP, 220,000 OHP eligibles were enrolled in the 20 prepaid health plans. HMO Oregon, the Blue Cross & Blue Shield HMO, had 37 percent of OHP enrollment. The next two largest health plans, CareOregon and Kaiser, had 9 percent each. Another two plans -- ODS Health Plan and SelectCare -- enrolled 5 percent or more. These five largest plans accounted for two-thirds of OHP enrollees in managed care plans. With a cumulative enrollment of just 9 percent, the eight smallest plans enrolled less than 2 percent each. Four of these plans enrolled less than 1 percent.

The level of concentration increased over time, with the top five plans accounting for slightly over 70 percent of the OHP market in December 1995, and nearly 73 percent in July 1996. In December 1995, HMO Oregon alone enrolled 41 percent of OHP members, climbing to nearly 43 percent as of July 1996.

We expected the level of concentration to increase further with the termination of several plan contracts in August and September of 1996 (PacifiCare, PACC, and QualMed). However, this was not found to be the case. HMO Oregon's statewide market share dropped to 33 percent as of July 1997 (from 43 percent a year earlier). A new plan, Central Oregon Independent Health Services (COIHS), grew to 6.7 percent of the OHP enrollment with the expansion of its service area into counties previously served by other plans. Together, the top six plans (each with shares of 5 percent or more) accounted for 66 percent of OHP enrollees. This represents a reduction in the level of concentration over time and reflects the growth of regional health plans. The statewide plans are losing dominance, while local plans are gaining market share.

Financial Performance of Prepaid Health Plans. An analysis was performed of the financial performance of the 20 health plans participating in OHP during calendar year 1994 through the third quarter of 1995. The aggregate OHP premiums paid to these plans amounted to $542 million. HMO Oregon, with $223 million in premiums, accounted for 41 percent of the total. Ten of the 20 plans were profitable, and ten were not. Aggregate net income ranged from a $1.4 million loss for HMO Oregon to a $1.8 million gain for the Medford Clinic. Moreover, the percent net income (or profit margin) ranged from -12

percent for both Coordinated Healthcare Network and QualMed to +45 percent for the Medford Clinic.[7] In total, however, the plans reported that they lost half a million dollars on OHP, for an aggregate average profit margin of -0.1 percent. That is, the quarterly reported financial data imply that the health plans basically broke even on OHP *in the aggregate*. However, all but one of the plans that has terminated its contract with OHP incurred a financial loss. Also of concern is the financial status of the top-five plans, which together enrolled 73 percent of OHP members as of the July 1996. Again, all but one had a financial loss, and the other had only a nominal gain.

The Oregon Health Plan Benefit Package

The Oregon Health Plan benefit package is based on a prioritized list of health services. The priority list consists of paired conditions and treatments ranked hierarchically from most to least medically necessary or appropriate. Covered services are those above a cut-off line that is determined according to the level of resources available to fund the program. Services "below the line" are uncovered, except in cases where there is a comorbid condition that would qualify for coverage.

The priority list was intended to assist the State in rationing the services, not the people, that would be covered by the Medicaid program. The theory was that the State could expand insurance coverage to more low-income uninsured people (who were not otherwise categorically eligible for Medicaid) by eliminating coverage for treatments that were not

[7] Columbia Managed Care (now defunct) reported a profit margin of -26 percent.

proven effective, or for conditions which improved on their own. The list of covered benefits would be reduced when the State faced a budget shortfall, as opposed to restricting eligibility or cutting provider fees.

Provider Responses to the Priority List. The priority list has provided the health plans with a document with which to identify services that are covered under the Oregon Health Plan. The health plans can describe to providers the specific services for which they will be paid. In turn, the providers can use the list to explain to patients which services will and will not be covered by OHP. Most providers have an understanding of what falls below the cut-off line, but how this information is translated into practice differs from plan to plan and from provider to provider.

Within the State, there is virtually unanimous praise for the list. In fact, the list of covered services is quite extensive, and represents an expansion of benefits received under the traditional Medicaid program (e.g., preventive care for adults, dental care for adults, hospice care, and transplants for adults), while few services of consequence are being denied. Some providers have decided to continue to practice medicine as they always have in the past, not distinguishing an OHP patient from a patient with private insurance. If care is provided for which no reimbursement is provided, then the provider simply is not paid for services rendered. An example of this behavior involves the surgical management of adults with symptomatic hernias. Although not covered by the current priority list, young working men with symptomatic hernias often cannot work when their job involves lifting. Some provider groups have decided to fix the hernia even though they won't be paid. In Roseburg,

the hospitals have had a "hernia day" on a weekend, where the surgeons donated their time and the hospital donated its operating room.

Other approaches to providing care may involve a creative use of the priority list. For example, tonsillectomy and adenoidectomy fall below the cut-off line on the priority list. However, there is a guideline specifying that tonsillectomy and adenoidectomy will be approved when the enlarged tissue is associated with obstructive sleep apnea related to upper airway obstruction. The frequency of obstructive sleep apnea among children and adolescents is believed to be increasing as a result of this coding phenomenon.

The impact of the priority list on provider practice patterns is an empirical question. Our provider surveys will assess the impact of the priority list on provider practice patterns. In addition, we hope to undertake claims/encounter data analysis to assess patterns of care before and after OHP implementation.

The Role and Future of the Priority List in the OHP Demonstration. The priority list is central to the OHP demonstration because it is intended to provide a mechanism for the State to allocate resources within a given budget constraint. The State has found that the priority list is a difficult way to manage a fiscal crisis. HCFA must approve all line changes before they can be implemented by the State. While awaiting HCFA approval of line changes, the State has had to look for other means of controlling costs. The State feels this is counter to the original intent of the demonstration.

A salient question is: How much higher can the line be raised, and still be considered a "basic benefit package"? HCFA denied the State's recent request to raise the line to line

573, approving a movement only to line 578. Whether this limits all future line movements remains to be seen.

In the meantime, some stakeholders would prefer that the State allow health plans to impose limits on the number, frequency, or annual costs of diagnostic services, physical therapy encounters, and/or mental health services, similar to those in commercial benefit packages. The problem with this approach, however, is that if OHP benefit limits begin to resemble commercial benefit packages, there is no longer a safety net for those with more intense and complex medical needs.

The Oregon Health Plan has faced budget shortfalls virtually every year, requiring interim requests for changes in the cut-off line, changes in the eligibility criteria, reductions of health plan and FFS payment rates, and other policies designed to reduce OMAP spending. To date, the Oregon Health Plan has shown that the priority list alone is not enough to manage budget shortfalls. Moreover, it remains to be seen whether further line movements will be possible while still preserving a basic benefit package.

Employer and Private Health Insurance Issues

The Oregon Health Plan was implemented in the context of a broad statewide health insurance reform effort in Oregon. The Medicaid demonstration constitutes the Federally-funded part of this broader effort. Although the employer mandate and the small business insurance programs are separate from the Medicaid demonstration, they are important to its success. The waiver cost estimate for the Medicaid program assumed that Medicaid

beneficiaries who are employed would shift to employer coverage by February 1997. Under the assumption of Federal budget neutrality, the program may not be able to meet projected expenses with the demise of the employer mandate, unless the State contributes additional State revenues or reduces program costs. Options included:

- Imposing additional taxes,
- Shifting existing State revenue from other uses,
- Lowering capitation rates from reasonable cost to some lower proportion of cost,
- Introducing copayments and/or deductibles,
- Introducing premiums,
- Raising the line on the priority list,
- Excluding selected groups of persons from coverage.

The last three options on the list were implemented in FY 1996. In November 1996, approval of Ballot Measure 44 authorized a tax on tobacco products to support expansions of the Oregon Health Plan. Three expansions are planned for 1998 using these funds. The first two expand Medicaid eligibility to: (1) reinstate approximately 1,700 full-time college students who are eligible for Pell grants (college students were made ineligible in FY 1996 because of budget limitations) and (2) cover 1,800 additional pregnant women and 25,000 children through age 11 under the Poverty Level Medical (PLM) program. The third expansion involves the private insurance market. The Family Health Insurance Assistance Program (FHIAP) will subsidize private insurance premiums for group or individual coverage for approximately 20,000 adults and children, easing the potential budget problem caused by the loss of the employer mandate.

Impact of OHP on Providers

Provider Support for OHP. Providers were among the key supporters of the Oregon Health Plan (OHP) during its inception and development.[8] They favored the expansion of Medicaid eligibility to improve financial access among the uninsured (and reduce the level of uncompensated care). Moreover, with the increased fees to minimize cost-shifting, Medicaid reimbursement was viewed more favorably by the private medical community.

Physician concerns centered on the accelerated growth and diffusion of managed care, and the implementation of a prioritized list of benefits. Although managed care was prevalent in Oregon prior to OHP, it was concentrated in the Portland metropolitan area and a few other urban pockets. Under OHP, managed care was destined to spread virtually statewide. Furthermore, implementation of the priority list was a complete "unknown." While in theory, there was widespread support for the prioritization of benefits, physicians were not sure how it would affect their practices in reality.

At the outset, public and community-based providers were less certain about their role in OHP. Long the providers of last resort when private providers closed their doors to indigent patients, it was unclear how Federally-qualified health centers (FQHCs) would fare when they were no longer assured cost-based reimbursement, and when they faced increased competition for patients. The role of public health departments was evolving as well.

[8] In fact, the program's architect (and now Governor), John Kitzhaber, is a physician.

As part of our evaluation, we sought to understand how private and public providers had been affected by the Oregon Health Plan, including the impacts of managed care, the introduction of the priority list, and the expansion of Medicaid eligibility. Our approach was to conduct intensive site visits in three communities in Western Oregon -- Hood River, Roseburg, and Salem. We met with private practice physicians (primary care and specialists), physician office staff, public health department directors, hospital administrators and emergency room staff, and the staff of Federally Qualified Health Centers (FQHCs) and other clinics. All visits took place during October 1995.

The three communities were chosen primarily because of the competitive environment in which OHP was implemented. Physicians in Roseburg, for example, chose to form their own Independent Practice Association (IPA) and contract directly with the State as a prepaid health plan under OHP. Their plan has become a model for other communities that are beginning to form regional IPAs that can contract directly with OHP. Salem faced considerable provider shortages *before* OHP, but consumer advocacy in the community brought about creative solutions to the capacity problem during OHP. Hood River was chosen because it is a relatively rural county, with a substantial seasonal and migrant population. An FQHC serves the migrant, largely Hispanic, population.

Establishment and Evolution of IPAs. In all three communities, physicians are organized in local Independent Practice Associations (IPAs) as a vehicle for increasing negotiating power with managed care organizations. Each of the three IPAs includes almost every physician in the community. The IPAs act as the contracting agent and fiscal

intermediary for members, and in Salem, the IPA is taking on responsibility for almost all quality assurance activities. In Roseburg, the IPA has been so successful in operating its OHP health plan that it is now seeking commercial contracts as well. Roseburg's success has spawned the creation of other regional IPAs, which are seeking OHP and/or commercial contracts. The IPA in Hood River was formed just prior to OHP to contract with health plans. Recently, the IPA discontinued its contract with two statewide plans and entered into an agreement with a new regional plan (begun by an IPA in Central Oregon). Physicians in Hood River and Roseburg felt that the local or regional plans were more responsive to local providers, and offered more cost and utilization data with which to monitor performance.

Common Themes. A number of common themes about the impact of OHP on providers were echoed in the provider interviews. First, as discussed above, the priority list has not had a major impact on physician practice. Physicians have found ways to provide care that they feel is necessary, either by obtaining exemptions from the health plans, or by providing care free of charge (e.g., "hernia days" in Roseburg).

Second, there is a widespread perception that access and capacity has improved, especially for the expansion population. The managed care structure, together with the higher fees that encouraged provider participation, were critical to the success of OHP in improving access to care. Physicians feel that OHP's increased reimbursement rates alone would not have achieved the positive outcomes. In Roseburg, physicians initially sought to limit the number of new OHP patients, but now, will take as many as are available. Physicians praised the improvements but acknowledged that the population which remains

uninsured continues to face barriers to care. Additionally, concerns were raised, especially by the public health departments, that there is not enough focus on preventive care.[9] And as with any managed care program, specialists raised concerns over the adequacy of specialty referrals as well as reimbursement rates for specialty care.

Perhaps the most vocal concern raised by providers was related to the provision of after-hours care. In two of the communities, hospitals had been sanctioned for violation of COBRA "anti-dumping" provisions. Providers in all communities noted a fundamental conflict between COBRA's requirements for *physician* screening of all ER patients and an unwillingness of managed care plans to compensate adequately for the costs of triage. This is perceived as an irreconcilable "catch-22" that has profound financial and liability implications for the hospitals. Hospitals have responded by establishing urgent care centers to which they can triage non-emergent patients. But this is viewed as only a partial solution, because a physician still must screen anyone who presents at the ER prior to triage.

Differential Impact of OHP on Public and Private Providers. An important implication of the community case studies is the differential reaction to OHP between the private providers and public agencies. The difference of opinion focuses on the operational aspects of managed care and its cost implications. The private practice physicians and the local community hospitals strongly favor OHP, seeing it as a way to improve the coordination of care for persons who in the past had few, if any, resources available for health

[9] This is consistent with results of the External Quality Review conducted by OMPRO (1995).

care. Moreover, many physicians reported that reimbursement rates have increased and bad debt has decreased.

In contrast, the community-based providers that we interviewed -- the FQHCs and other clinics -- tended to be wary of managed care under OHP and reported problems working with the health plans. The FQHCs and other clinics reported financial losses due to one or more factors, such as decreased reimbursement rates, adverse selection, loss of patients, and significantly higher administrative expenses because of the lack of standardization in policies and procedures across health plans. These providers apparently encountered losses despite receiving increased payments for individuals who were previously uninsured. Loss of patients may be a consequence of increased accessibility to providers who previously were not participating in Medicaid.

Next Steps. Future site visits will follow-up on the themes identified in these provider case studies, and hopefully the investigation will extend to additional communities (especially in Eastern Oregon). Moreover, the provider survey, which will include over 1,000 physicians and agencies, will obtain quantitative estimates of provider reactions to OHP and how the program has affected their practices. Special attention will be given to the impact of OHP on providers who treat people with disabilities.

Impact of OHP on Consumer Access

The Oregon Health Plan was designed to improve access for traditional Medicaid enrollees by: (1) increasing Medicaid fees as an inducement to provider participation, and (2)

accelerating the growth of private managed care to bring new providers into the program. The OHP eligibility expansions were designed to remove financial barriers to care experienced by the low-income uninsured who were categorically ineligible for Medicaid. Most of our current impressions about the impacts of OHP on access to care are based on anecdotal evidence, through case study interviews and analysis of secondary sources. Empirical information is not yet available for the evaluation.

Findings from State Surveys. The State has conducted two waves of a survey comparing levels of satisfaction before and after OHP was implemented. Not only did satisfaction with the choice of primary care providers increase, but also satisfaction with the ability to get medical care whenever it is needed. Thus, Phase I clients appear to be more satisfied with the shift to managed care and the implementation of the priority list than they were under traditional Medicaid. Similarly, another State survey of newly-enrolled women ages 52-64 found higher rates of physician use, including routine check-ups and mammograms, following enrollment in OHP. This evidence suggests that the expansion of financial access through OHP, and perhaps the emphasis of managed care on preventive care, has resulted in increased rates of preventive care use.

Access to Maternity and Dental Care. We also reviewed anecdotal evidence concerning access to maternity care and access to dental care. The State encountered challenges in meeting the dental care needs of the OHP population, in part because of longstanding shortages of dental providers, but also because of high levels of pent-up demand and a generous benefit package which until recently had few limits. The State has

responded by issuing guidelines for dental care, establishing new dental care plans and new dental clinics, and providing mobile dental services for individuals with special dental needs.

The State also faced unanticipated challenges in the shift of pregnant women to managed care. Due to the OHP application process, women encountered delays in obtaining referrals to prenatal care. Referrals to maternity case management services dropped as a result of lack of health plan and provider familiarity with the services. The State has instituted administrative procedures to expedite the processing of applications for pregnant women. In addition, the State has eliminated the need for a referral to an OB provider (including certified nurse midwives). Both of these mechanisms should ensure more timely initiation of prenatal care. The State also has instituted outreach and education services regarding maternity case management services, to alert both providers and beneficiaries about their availability.

Next Steps. The evaluation will continue to monitor access and satisfaction through such mechanisms as case study interviews, focus groups, telephone surveys, and encounter data analyses. In particular, we will be comparing levels of access and satisfaction among low-income individuals enrolled in OHP versus those who are privately insured or who remain uninsured.