



PROJECT MUSE®

The Poor and Managed Care in the Oregon Experience

Howard M. Leichter

Journal of Health Politics, Policy and Law, Volume 24, Number 5,
October 1999, pp. 1173-1184 (Article)

Published by Duke University Press



➔ For additional information about this article

<https://muse.jhu.edu/article/15413>

The Poor and Managed Care in the Oregon Experience

Howard M. Leichter
Linfield College

To paraphrase Tolstoy, everyone is unhappy with Medicaid managed care in his or her own way: physicians fret about providing care to a population who lives fluid and often unstable lives, who consume more of their clinical time and other resources than their commercial patients, and for whose care they are underreimbursed by health plans; Medicaid clients complain about various barriers to timely and appropriate care, and the fact that primary care practitioners do not have the expertise to deal with their often complex and chronic health problems; the health plans bemoan the discontinuities in the care and behavior of the Medicaid population, which undermines the very concept of managed care; and safety net clinics and providers, who have long served the poorest of the poor in America, see managed care as a threat to their very existence as the Medicaid population is mainstreamed.

These concerns feed into and on the general animosity toward managed care in the United States today, and are a reaction which is both reflected in and fueled by popular culture and academic commentary. The media have reported, for example, that audiences across the country responded audibly, enthusiastically, and sympathetically to the lambasting of HMOs by the Helen Hunt character (a working, single mother) in the movie *As Good As It Gets* (“Fucking HMO bastards, pieces of shit”).

The research reported here is part of a larger study of dependent health care coverage funded by the Milbank Memorial Fund of New York. The author wishes to thank the fund for its generous support. Thanks also is extended to Hersh Crawford, Bob DiPrete, Ellen Pinney, Judy Mohr-Peterson, and Elizabeth Byers. The views expressed here are solely those of the author.

Journal of Health Politics, Policy and Law, Vol. 24, No. 5, October 1999. Copyright © 1999 by Duke University Press.

Although academics have been somewhat more reserved in their assaults on managed care, the message has been basically the same. The author of a recent article on the threat posed by Medicaid managed care asked plaintively: "What should people of conscience and of action do in the face of this new reality?" (Kotelchuck 1994: 322; see also Grogan 1997). One would think that we were dealing with Serb atrocities in Kosovo, rather than a health delivery operating system!

As an antidote to managed care bashing, I report here on one apparently modest, albeit mixed, success in a small corner of the managed care battlefield: Oregon's mandatory Medicaid managed care program. Although not everyone in Oregon agrees that the state's managed program is an unalloyed success, survey data suggest a high level of satisfaction with the system among Medicaid recipients. This success seems even more extraordinary given the fact that Oregon has integrated its aged, blind, disabled, and mentally ill populations into its Medicaid managed care, a population that critics believe is the most likely to suffer from the inflexibilities of fully capitated health care systems.

Although this article, and the case study upon which it is based, hardly constitute a paean to managed care, Oregon's experience is instructive for what it suggests about how both public and private sector managed care programs can reduce, if not eliminate, many consumer concerns. The need for such instruction will continue to grow as the portion of Medicaid clients enrolled in managed care grows. As of 1997, 48 percent of all Medicaid clients nationally were enrolled in some form of managed care. This percentage is certain to increase, in part, as a result of the federal Balanced Budget Act of 1997 which dropped the requirement that states must obtain a U.S. Health Care Financing Administration (HCFA) waiver before mandating managed care enrollment in state Medicaid programs (Deal and Shiono 1998: 96).

Following a brief review of Oregon's Medicaid program, I will highlight areas of concern related to the application of managed care to the Medicaid population: Are the health care needs and lifestyles of the poor insurmountable barriers to the effective use of managed care? Can managed care effectively serve those with special and complex health care needs, such as the aged, blind, and disabled? I will then present survey data that indicate a relatively high level of satisfaction with managed care among all segments of Oregon's Medicaid population. Finally, I will examine some of the steps Oregon has taken to reduce the problems that the Medicaid population faces in the highly complex world of managed care.

Oregon's Health Plan: Expanding Access to the Poor through Priority Setting and Managed Care

On 1 February 1994, Oregon opened Medicaid coverage to all of its citizens who were at or below the federal poverty level (FPL), and to pregnant women and young children up to 133 percent FPL. In order to accomplish both the expansion of care to an estimated 120,000 additional new enrollees, *and* contain costs, the state obtained an 1115 Medicaid demonstration project waiver that allowed it to limit the health services that would be offered to Medicaid clients—the so-called rationing or prioritization of services—and to move most of those clients into fully capitated health plans (FCHPs).¹ Oregon had experimented, on a limited basis, with mainstreaming Medicaid clients into capitated private programs as early as 1976, and expanded that effort in the late 1980s (Hanes and Greenlick 1996: 1). About one-third of all of Oregon's Medicaid population, all of whom lived within the Salem and Portland metropolitan areas, was enrolled in some form of managed care prior to the beginning of its 1115 demonstration project. Now, however, the state proposed moving the vast majority of its Medicaid population, about 85 percent, into fully capitated HMO plans.

The transformation of Medicaid from a primarily fee-for-service to primarily managed care delivery system occurred in two phases: phase 1 involved the traditional Medicaid population. However, “The original 1115 HCFA waiver exempted the elderly, the disabled and children in substitute care (Phase II population). One of the reasons these groups were not incorporated in the first wave of implementation of the OHP [Oregon Health Plan] was a concern that managed care would not be able to take into account the different needs of the population, such as access to specialty care and specialized supplies and equipment” (OMAP 1999: 2). The so-called Phase 2 population was enrolled in managed care starting in February 1995. As of 1 January 1999, 87 percent of all Medicaid clients in Oregon were enrolled in FCHPs.

1. As discussed elsewhere in this volume, the term *managed care* covers a variety of health care delivery systems ranging from primary provider organizations (PPOs) to fully capitated plans such as HMOs. In the case of the Oregon Medicaid program, the term is almost always used to refer to fully capitated health plans.

Everyone is Unhappy in His or Her Own Way

The Poor Are Different

Although most in the provider, insurance, and social advocacy communities supported Oregon's plan to expand access to Medicaid for all those at or below FPL, many had serious reservations about serving this population through managed care. To begin with, providers, health plan administrators, and social advocates in Oregon and around the country argue that the poor are different from the nonpoor in their health care needs, in health-related lifestyles, and in ways that make it more difficult to integrate them into a managed care system. From the perspective of health plans and providers, there is particular concern with the fluidity and instability in the lives of the poor as they move in and out of jobs, and change marital, citizenship, and domiciliary status, all of which interferes with both the continuity of patient care and the administration of the health plans. Commenting on the results of a provider focus group study, the Oregon Office for Health Plan Policy and Research (OHPPR) found that physicians and dentists "reported that between 10% and 50% of their Medicaid patients fail to keep appointments, refuse to follow agreed upon treatment plans, or behave in ways that jeopardize their health. In addition, these patients more frequently display disruptive or abusive behavior in the office" (OHPPR 1999b: 43).

This problem is particularly acute in the case of those poor people who lead the least stable and predictable lives, namely, the homeless, runaway youth, migrant workers, and the mentally impaired. Referring to this highly vulnerable group, the Oregon Health Council noted that:

The paperwork requirements to enroll in the OHP and then to show up for scheduled appointments at distant clinics, between eight and five, Monday through Friday, is extraordinarily difficult, if not impossible, for people without a permanent address, no phone, no predictable schedules and no means of transportation. Some OHP eligibles are simply unable to make their way through the enrollment process, while others have a paranoid fear of "the state" or for other reasons will not seek publicly provided medical attention. (Oregon Health Council 1997)

Unfortunately, this is one area in which the state's Medicaid administrative rules exacerbate rather than alleviate these problems. Oregon requires that Medicaid eligibles must requalify every six months. What often happens is that recipients frequently fail to file their reeligibility

forms. Although state officials assert that this represents only about 10 percent of the Medicaid population, it is large enough to cause administrative headaches for both physicians and health plans. According to an official of HMO Oregon, a nonprofit managed care plan, "People [who have not been certified as reeligible] will have cards with our name on them. We're going to have bloody fights. Doctors are going to try and balance bill, and people will still be using services. . . . It's going to be a nightmare. We have enough trouble getting doctors to see people" (*Oregon Health Forum* 1994a: 4).

Phase II: The Aged, Blind, Disabled, and Mentally Ill

In February 1995, Oregon's Medicaid-eligible aged, blind, and disabled population was brought into the managed care system. No other state has attempted to mainstream these populations into managed care programs on such a scale. And, indeed, there was a high "level of nervousness" among "residential care providers, managed care plans, consumer advocates and numerous state agencies" (*Oregon Health Forum* 1994b: 2). In the focus group referred to above, providers expressed their concerns about treating the Phase 2 population in a managed care setting. "Some have other conditions (mental disorder, substance abuse, developmentally disabled, cognitive impairments) and social circumstances (homeless, domestic violence) that make them difficult to serve, and consume more resources than persons without these conditions or circumstances. These behaviors and characteristics increase the cost of treating this group of Medicaid patients when compared to commercial patients" (OHPPR 1999b: 43).

While the managed care health plans and providers were concerned about the high costs associated with covering the Phase 2 population, consumer advocates worried about the ability of this diverse population to navigate the managed care system and access the services it needed. In addition, they questioned the ability of gatekeeper, or primary care, physicians to handle the special health and social needs of this particularly vulnerable population. One study of Oregon Medicaid clients reported that participants "believe that what works well for healthy individuals in a managed care environment does not necessarily work well for persons with special needs" (OHPPR 1999a: 76). Both the consumers and providers of health care, then, were concerned about the applicability of managed care to the Medicaid population.

Measuring the Effects of Managed Care

As part of the federal waiver creating the Oregon Health Plan, the state is required to periodically monitor and evaluate the effectiveness of the Medicaid program. Thus far the state has conducted four “client satisfaction” surveys, two each for the Phase 1 and Phase 2 populations. In each case, the state conducted a baseline, pre-OHP survey, and then a post-OHP survey. It should be noted here that although respondents were not directly asked to evaluate managed care per se, the first survey occurred when the vast majority were in fee-for-service plans, while the second survey occurred when 85 percent or so were in managed care. In addition, respondents were asked to evaluate their own health plans in the post-OHP survey.

Table 1 reports the results for the Phase 1 population. As the data indicates, in each of the areas surveyed, respondents report improvements in the satisfaction with the care they are receiving, their access to that care, and their overall health status. Reviewing the results of the 1994 and 1996 survey, the OHPPR concluded that, “this comparison suggests that the managed care delivery system is meeting Medicaid clients’ health care needs at least as well as, and in many instances better than, the previous fee-for-service delivery system” (OHPPR 1999b: 69).

Because of the special and complex health care and social service needs of the aged, blind, and disabled (i.e., Phase 2) population, the Office of Medical Assistance Programs (OMAP) decided to monitor, separately, the impact of managed care on the Phase 2 population. In 1995 OMAP conducted a baseline client survey in which respondents were asked to assess the quality of, and access to, the health care they had been receiving. A follow-up, post-managed care survey was conducted in 1997–1998. Comparisons between the two surveys are a bit problematic because the wording of some questions was different. Thus, for example, in 1995, respondents were asked to rate their overall access to medical care as “poor, fair, good, very good or excellent,” while in 1997–1998 they were asked to rate access as “very hard, hard, neither easy or hard, easy, very easy.” Although the differences in wording might offend purists in survey research analysis, I am interested only in general trends and, therefore, ignore the wording differences. I have standardized the categories—negative, neutral/mildly positive, positive—for purposes of general comparison.

As the data in Table 2 indicates, the Phase 2 population reports improve-

Table 1 OHP Consumer Satisfaction Survey Results, 1994 and 1996

Measure	1994 (Pre-OHP) (%)	1996 (Post-OHP) (%)
Satisfaction with Access*	70	88
Satisfaction with Care*	77	84
Self-Reported Health Status*	66	76
Health Status**	73	83

Source: Oregon Health Plan 1997: 3–4.

*Good, very good, or excellent.

**Unchanged or better.

ment in the accessibility of information about their health plans (60 percent of the respondents in 1997–1998 compared to only 29 percent in 1995 offered the most positive assessment); respect shown by providers (82 percent in 1997–1998 compared to 59 percent in the most positive category in 1995); and health promotion information (67 percent positive in 1997–1998 compared to 47 percent in 1995). Even in an area where managed care plans are most notorious, specialist referrals, there has been an increase in the most positive assessment, from 45 percent to 55 percent of the Phase 2 population.

Table 2 reveals areas, however, where there has been no improvement: neither in the wellness or illness services provided by their health plans, nor in their overall health status. This latter result, in which only 16 and 17 percent in each year reported their health as “very good/excellent” while 55 and 56 percent self-reported that their health was only fair or poor, should come as no surprise given the chronic health problems of this population.

In general, then, both categories of the Medicaid population see themselves as at least no worse off under managed care than before, and in many instances report considerable improvement in the availability, accessibility, and quality of their health care. None of this is to suggest, however, that the Oregon Medicaid managed care program is working to everyone’s satisfaction, or that it is uniformly working better than the old fee-for-service system. The Phase 2 population survey identified several areas of concern where clients indicated that they were worse, not better, off. In particular, clients reported that it was more difficult now than under fee-for-service to get special (e.g., durable) medical equipment and special therapies (e.g., physical, occupational, and speech therapy)

Table 2 OHP Consumer Satisfaction Survey Results, Phase 2 Population, 1995, 1997–1998

Measure	1995 (Baseline)			1997/98 (Post-OHP)		
	Client Assessment					
	negative or mildly positive (%)	neutral	positive	negative	neutral	positive (%)
Accessibility of information about plan and benefits*	32	39	29	18	23	60
Ease of referrals to specialists*	20	35	45	16	29	55
Respect shown by 11 providers**	30	59	5	13	82	
Information about avoiding illness and staying healthy**	20	33	47	10	23	67
Rate illness and treatment coverage of health plan**	15	39	46	16	35	49
Rate preventive care coverage of health plan**	20	40	40	17	38	45
Rate general level of health**	55	29	16	56	27	17

* In 1995 the response categories were poor/fair [negative]; good [neutral]; very good/excellent [positive]. In 1997–1998 the categories were very hard/hard [negative]; neither hard nor easy [neutral]; easy/very easy [positive].

**Both years used the same poor/fair; good; very good/excellent categories.

Source: OMAP 1999.

(OMAP 1999: 22, 24). In addition, social advocates report that Phase 2 clients are having increased difficulty in getting prescriptions for drugs, and especially pain medication, that they have been taking over the years (Pinney 1999).

The overall impression, however, remains one of a system that is generally working well for those who depend on it for their health care. The important question is why, despite the awful reputation managed care has, does the system seem to be working in Oregon?

Managing Managed Care

Safeguarding Recipients

One explanation rests with an elaborate set of safeguards that the state has developed to minimize client concerns and problems. Mindful of the difficulties and anxieties attending the transition of the Medicaid population to managed care, state officials developed a series of “safeguard” programs to assure the quality of, and access to, the kind of care that the poor, and especially those with extraordinary health problems, require.

The first of these was to require that all fully capitated health plans employ an exceptional needs care coordinator (ENCC) to respond to the “special and complex” needs of the aged, blind, and disabled population. Medicaid clients either self-identify as potential candidates for special care coordination, or are identified at some point during their contact with their health plan or the health care system (e.g., at the time of admission to a hospital, or through requests for particular pharmacy services or durable medical equipment). The task of the care coordinator is to respond to specific problems a client may be experiencing (e.g., refusal of a health plan to fund a particular service) as well as to make certain that the multiple health and social services needed by this population are coordinated (OHPPR 1999c: 4). Although social advocates generally give this service high marks, some point out that the oversight of ENCCs is left to the individual plans and not to OMAP. This, they contend, results in considerable unevenness in quality and effectiveness in coordinating care among the various plans (Byers 1999). In addition, state officials admit that “not every patient who could benefit from the exceptional needs care coordinators is being put in touch with them” (DiPrete 1999).

Another effort to protect the interests of Medicaid population was the creation of an ombudsman office. Although initially intended to serve the Phase 2 population, the ombudsman staff actually deals with problems brought to them by any Medicaid recipient or groups advocating on her behalf, including state legislators, health plans administrators, providers, and social workers. “An ombudsman serves as a patient’s advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on, the care provided by a health care provider” (OHPPR 1999c: 15). Does the ombudsman system work? Evidence from a survey conducted by OMAP suggests that in some important respect it does. In response to the question, “Do you believe that the Ombudsman staff listened

objectively to your client's problem and, when appropriate, advocated for the interests of your client?" 94 percent of those interviewed responded, "Yes, almost always." More important, in response to the question, "When it was appropriate, was the Ombudsman staff successful in advocating for your client's interests?" 82 percent said "yes, almost always," and additional 10 percent said "sometimes" (OHPPR 1999c: 25).

Third, the federal Health Care Financing Administration requires each state Medicaid program to provide a "fair hearings" process for any person whose claim is denied or is unreasonably delayed, or who has had benefits reduced or terminated. Hearings are administered by OMAP, and usually occur within four to six weeks from the date of request, although there is provision for an expedited process in case of a pressing medical condition. Hearings have dealt with such issues as prior authorization denials, denial of payment for either services below the prioritization list cut off or for use of emergency room care, and requests to be exempted from managed care enrollment. The number of requests for hearings has increased over time but remains small relative to the size of the Medicaid population (350,000). In the managed care portion of the Medicaid program there has been an increase of requests for hearings from 215 (1994–1995), to 248 (1995–1996), and 273 (1996–1997), although 60–70 percent of the hearings have been dismissed (OHPPR 1999c: 10).

A fourth safeguard mechanism is a "client hotline" to answer questions by Medicaid eligibles about various administrative issues, such as how to fill out the OHP application form or what to do with a bill they may receive from a provider. In addition, hotline staff redirect callers to others who handle questions or problems that the hotline does not cover. Since its inception in 1996, the hotline has averaged between 5,000 and 6,000 calls per month. (In December 1998 the state merged the hotline and the the Ombudsman Office into the new Client Advocacy office.)

Evaluating Medicaid Managed Care in Oregon

In sum, Oregon, largely on its own initiative, has developed an elaborate set of safeguards to help the Medicaid population navigate the difficult terrain of managed care and to seek redress for perceived grievances with the state Medicaid office or the health plans and providers. Based on the limited empirical data available, it appears that Medicaid clients are

satisfied with the responses they get when they have a grievance. Although there is no direct evidence that the safeguard system contributes to the relatively high marks that both the Phase 1 and 2 populations give to managed care, it is not unreasonable to assume that these channels for accessing information or seeking a redress of grievances play an important role in this positive assessment. Although the usual technical glitches occur—being put on hold for long periods of time, or being directed to the wrong person/office for help—the very fact that these multiple channels exist almost certainly defuses much of the anger that people in the commercial managed care market experience.

In the final analysis, however, the overall positive assessment of the Medicaid managed care program may be, for many, the result of a “halo effect” that accompanied the inclusion of new eligibles and new benefits between 1994 and 1996. “New eligibles included those eligible for Medicaid based upon income and previously without health care coverage and the new benefits covered included, most notably, dental services” (OHPPR 1999b: 70). Tens of thousands of Oregonians were added to the ranks of the insured between 1994 and 1996, and those who previously had Medicaid now had access to dental care, which was not available under the fee-for-service system, as well as more predictable primary and preventive care. For these folks, how care is delivered is almost certainly less important than the fact that it is delivered at all. In addition, a case can be made that managed care itself, as a delivery or health care organizing system, facilitates rather than inhibits the successful delivery of health care to the Medicaid population. Prior to managed care, sophisticated patients could put together the providers and care they needed, and, in effect, manage their own care. For the average Medicaid patient, however, it is probably more, rather than less likely, that they are getting the care that they need, when they need it, then they did under fee-for-service. And, for those who have lived most of their lives without any health coverage at all, the point is not how that care is delivered but that it is there when they or their families need it. Despite what you may see in the movies, the poor may be adjusting to managed care better than the more pampered middle class.

References

- Byers, Elizabeth (Project Equality coordinator). 1999. Interview by author. Salem, OR, 3 April.
- Crawford, Herschel (director of Office of Medical Assistance Programs). 1999. Interview by author. Salem, OR, 2 April.
- Deal, Lisa W., and Patricia H. Shiono. 1998. Medicaid Managed Care and Children: An Overview. *Future of Children* 8(summer/fall):93–103.
- DiPrete, Robert (director of Oregon Health Council). 1999. Interview by author. Salem, OR, 1 April.
- Grogan, Colleen M. 1997. The Medicaid Managed Care Policy Consensus for Welfare Recipients: A Reflection of Traditional Welfare Concerns. *Journal of Health Politics, Policy and Law* 22(3):815–838.
- Hanes, Pamela, and Merwyn Greenlick. 1996. *Oregon Consumer Scorecard Project: Final Report*. Portland, OR: Oregon Consumer Scorecard Consortium, 30 September.
- Kotelchuck, Ronda. 1994. The Threat and Promise of Medicaid Managed Care: A Mixed Review. In *Beyond Crisis: Confronting Health Care in the United States*, ed. Nancy F. McKenzie. New York: Meridian.
- Office for Health Plan Policy and Research (OHPPR). 1999a. *Analysis of Oregon Health Care Safety Net Services*. Salem, OR: Oregon Department of Administrative Services, February.
- . 1999b. *Assessment of the Oregon Health Plan Medicaid Demonstration*. Salem, OR: Oregon Department of Administrative Services, February.
- . 1999c. *Analysis of Safeguard Programs of the Oregon Health Plan Medicaid Demonstration*. Salem, OR: Oregon Department of Administrative Services, July.
- Office of Medical Assistance Programs (OMAP). 1999. *Adult Phase II: 1995 Baseline and 1997/98 Report*. Salem, OR: Oregon Health Plan Medicaid Demonstration Project, January.
- Oregon Health Council. 1997. Short Term Recommendations for Maintaining Safety Net Providers. *Oregon Health Council Minutes* (May):1–4.
- Oregon Health Forum*. 1994a. Managed Competition Escalates in Central and Eastern Oregon. September:1–12.
- . 1994b. Fear of High Costs, Over-Regulation Surfaces as Phase II Draws Near. November:1–12.
- Oregon Health Plan. 1997. Progress Report. Salem, OR: Oregon Department of Administrative Services, January.
- Pinney, Ellen (director of Oregon Health Action Coalition). 1999. Interview by author. Salem, OR, 2 April.