The governor of Oregon on Medicaid managed care

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The Governor Of Oregon
On Medicaid Managed Care

On the front lines of Medicaid reform, Oregon’s chief executive shares his own lessons, including:
Do not let the perfect be the enemy of the good.

BY JOHN A. KITZHABER

EDITOR’S NOTE: Health Affairs commissioned this series of reports from the field in response to the analysis by Marsha Gold, Michael Sparer; and Karyen Chu of Medicaid managed care in five states, which immediately precedes this section.

In their paper on lessons learned by states in initiating Medicaid managed care, Marsha Gold, Michael Sparer, and Karyen Chu provide a list of ingredients that are important to the successful implementation of managed care programs for low-income populations. Having authored Oregon’s initial health care reform bill and watched over its implementation, I agree that there is much that states can learn from one another. Managed care is a critical part of any health system reform. Clear leadership, policy direction, and involvement by all of the various stakeholders are essential to a smooth implementation. Willingness by all parties to acknowledge at the outset that they may not “get it right” the first time will leave the necessary room and political support for making adjustments to improve programs.

MEDICAID MANAGED CARE IN OREGON

More than 80 percent of Oregon’s Medicaid population is now enrolled in prepaid health plans. This includes not only persons who traditionally are enrolled in Medicaid managed care, such as those receiving Aid to Families with Dependent Children (AFDC), but also persons who are eligible for Supplemental Security Income (SSI) and those who are considered “newly eligible” because of Oregon’s waiver to expand coverage to most Oregonians with incomes below the poverty level. This level of managed care enrollment occurred much more rapidly than anticipated. I believe that it reflects a true commitment to managed care shown by many players and a willingness to allow the new system to build on the strengths of the existing system.

LESSONS FROM THE FIELD

To the lessons listed by Gold and colleagues, I add my own, primarily seen from a policy-making role, first as Oregon’s State Senate president and now as Oregon’s governor.

Be Clear About the Policy Goals Of Your Managed Care Program. Oregon’s managed care initiative was part of a broader health care reform plan. We did not approach managed care merely as a way to save money. The legislature engaged in a lengthy policy discussion that centered on making people healthier and holding the legislature accountable for paying the reasonable costs for its chosen benefit package. This meant that the goals of increasing access to health care for more Oregonians, assuring continuous and high-quality care (with an emphasis on prevention), and setting capitation rates to cover costs in a well-managed...
health care environment also were key components of our plan.

These policies then were able to guide the administrative decisions around eligibility and enrollment processes (including six months of guaranteed eligibility), quality standards, and capitation rate methodologies. In addition, because Oregon was expanding the number of persons to be covered by Medicaid by almost 50 percent, it was important for the contracting process to be as inclusive as possible, allowing for the development of new plans and expanded provider participation. Oregon chose not to award contracts initially based on a competitive bidding process, but rather established capitation rates and then set standards against which plans submitted applications.

- **INVOLVE ALL STAKEHOLDERS THROUGHOUT THE PLANNING PROCESS.** Oregon’s medical provider associations, along with business, labor, and consumer groups, all were part of crafting Oregon’s health care reform legislation. They understood how critical managed care was to the entire program. The Medicaid agency then involved them in the planning processes, which were designed to result in a successful program for all: Medicaid clients, the state budget, and the providers and plans themselves. The existing Medicaid population was phased in to mandatory managed care based on category of eligibility. The AFDC population, children and pregnant women, and newly eligible persons were included first, beginning 1 February 1994, and the SSI population was brought in a year later. Although, as I look back, it would have been helpful to have had more time to stabilize the first phase, this phased approach allowed for specific planning around the needs of the elderly and disabled. The prepaid health plans and various advocacy organizations worked together to develop standards and training that would help the health plans to better serve these populations with special needs.

- **BUILD ON EXISTING SYSTEMS.** Oregon’s Medicaid program began its involvement in managed care in the mid-1980s contracting with one health maintenance organization (HMO). At the same time, it encouraged the formation of partially capitated plans, called physician care organizations (PCOs), which were established to serve the Medicaid population. PCOs received capitation payments for physician, lab, and x-ray services and shared in savings resulting from reduced use of hospital services.

The legislative language for Oregon’s health care reform program built upon those systems. The statute (S.B. 27, in 1989) listed the clear preference for delivering services through fully capitated systems. Where those were unavailable, partially capitated systems were to be used, and a case-managed, fee-for-service system could be used where prepaid plans were unavailable.

The Medicaid agency assumed that fully capitated plans would be available in only the more populated areas of the state at first. In fact, because of plans’ interest and involvement and providers’ experience under the previous system, fully capitated plans were available in almost all areas of the state from the program’s start. Now, two years into the program, the few PCOs that initially were part of the program have become fully capitated plans, have merged with such plans, or will do so shortly. All but two of the thirty-six counties in the state now have fully capitated plans available, with sufficient capacity to mandate enrollment.

- **BE WILLING TO LEARN AND TO MAKE ADJUSTMENTS.** From the beginning of the planning process, all parties acknowledged that they would need to be flexible and be willing to make changes to improve the program along the way. As various technical and programmatic issues-problems with eligibility, the enrollment process, and determining the responsibilities of different service plans-have been identified, they have been analyzed, prioritized, and addressed. For example, sending out accurate and current information on physician membership to prepaid health plans proved to be too costly to be maintained weekly. Instead, interested parties (persons interested in specific health
plans, or potential consumers) now must call in to a toll-free telephone line to obtain such information. Although such adjustments have not eliminated negative publicity or legislative intervention, they have kept them to a minimum.

**DO NOT LET THE PERFECT BE THE ENEMY OF THE GOOD.** When Oregon first put forward its reform plan, it received national criticism for its use of a “priority list” of health services. Critics ignored the expansion of health coverage to an additional 120,000 Oregonians living in poverty and focused instead on the elimination of services to persons already covered by Medicaid.

In advocating for and planning new ways of doing business, analysts and observers should make the comparison not to the perfect system, but to the system already in place. For instance, critics of Medicaid managed care often decry the loss of “freedom of choice,” while ignoring the fact that many, if not most, Medicaid clients in a fee-for-service system find themselves going from provider to provider, trying to find one willing to accept Medicaid clients. In a managed care system, although some “choice” is lost, prepaid health plans have a contractual obligation to assure access to necessary care. In addition, these plans are held to standards of quality, something that was largely absent from the fee-for-service system.

**THE DISTANCE TRAVELED**

By most counts, Oregon’s Medicaid reform has been very successful. It has not been without problems, but these have been manageable. This has required the involvement and commitment of a variety of players, especially the medical care provider community. In the end, not only has this expansion of managed care benefited Medicaid patients, it also has led to changes in the overall health care system that will benefit other Oregonians. In some geographic areas, prepaid health plans that initially were designed to serve Medicaid clients now are expanding to serve other populations. Although, as mentioned by Gold and colleagues, managed care in itself will not solve provider shortages in the short term, we have seen instances in which prepaid health plans have helped to finance the recruitment of physicians into certain rural areas and in which the expansion of coverage may have contributed to providers’ willingness to move to such areas. Lastly, we hope that the changes that plans and providers are making to accommodate Medicaid special-needs populations will be helpful to similar populations who are outside the Medicaid system.

I am proud of the work we have done in Oregon. That pride is shared by many other Oregonians who have worked hard to make this a successful program.