Medicaid Managed Care And Community Providers: New Partnerships

Can the “arranged marriage” of managed care plans with traditional community-based providers improve care for the poor?

by Debra J. Lipson

PROLOGUE: Partnerships between organizations are often compared to marriages—some are based on necessity, some on convenience, some on synergy, and others on arrangements made by third parties. Harvard professor Rosabeth Moss Kanter describes five stages in the development of organizational alliances: engagement, selection or courtship, setting up housekeeping, learning to collaborate, and changing within. The ability of organizations to progress through these stages depends on the dynamics between them and around them. But ultimately, the endurance of an organizational partnership, just as some would say of marriage, depends on the continued mutual benefit of the alliance to each of the participants.

This paper by Debra Lipson explores the “arranged marriage” of community-based health care providers and managed care plans. Although these two entities make strange bedfellows, they have courted each other for the opportunity to draw on each other’s strengths in an increasingly competitive marketplace. As they come together to negotiate contracts for serving Medicaid patients, will they learn to collaborate or find a way to fulfill their missions and financial objectives independently? Here Lipson looks at what is at stake and at the prospects for their success.

Until June of this year, Lipson was associate director of the Alpha Center, a nonprofit health policy research organization in Washington, D.C. In honor of her own commitment to marriage, she has since moved with her husband to Geneva, Switzerland, where she will complete studies in progress and seek new alliances with international health organizations.
ABSTRACT: Growing enrollment in managed care plans among Medicaid recipients represents a new market for these plans but presents challenges to those providers that traditionally have served this population. To continue serving Medicaid patients, community-based providers must develop contracts or other types of partnerships with Medicaid-contracting health plans. This paper reviews the challenges to such collaboration and discusses the practical issues that plans and community-based providers must resolve to develop productive working relationships. Keys to successful collaboration are identified. Ways in which federal and state governments can help the collaborative process are suggested.

By June 1996, 13.3 million Medicaid recipients were enrolled in some form of managed care, 40 percent of all Medicaid eligibles and nearly twice the proportion two years earlier.¹ The growth curve will surge upward again in 1997 as large states such as California, Illinois, and New York attempt to enroll large numbers of Medicaid recipients into managed care plans or expand Medicaid managed care programs into additional counties. States began their enrollment in managed care with women and children who qualify for Medicaid, and they are turning their attention to elderly and disabled recipients, who have been largely exempt from mandatory managed care enrollment policies.

The growth of Medicaid managed care has spawned new interest on the part of private managed care plans in serving the Medicaid population. In some cases, plans that have contracted with Medicaid for many years are expanding their capacity to serve additional patients. However, as more states jump on the Medicaid managed care bandwagon, plans without prior experience in serving Medicaid patients and brand-new plans are diving into the Medicaid market as never before. Thirty-eight percent of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) surveyed by the Group Health Association of America (now the American Association of Health Plans) in 1995 participated in Medicaid at the end of 1994; another 11 percent began serving Medicaid patients in 1995, and another 12 percent intended to do so in 1996.² This trend is good news for Medicaid officials, who had trouble recruiting enough plans and providers to serve Medicaid patients.

However, there are a number of concerns about the rapid entry of so many new plans into Medicaid managed care. For example, plans new to the Medicaid market sometimes have underestimated the amount of enabling services, such as case management, language translation, and outreach, needed to serve the Medicaid population. The entry of such plans into the Medicaid market also raises concerns about how community-based providers that previously had large Medicaid caseloads will fare under these new arrangements.
Traditional community-based providers are the organizations that historically have provided much of the primary and preventive care delivered to Medicaid recipients and the uninsured. These providers include approximately 635 community and migrant health centers with 1,647 sites; more than 3,000 rural health clinics; nearly 3,000 city and county health departments; and a multitude of maternal and child health clinics, specialty clinics for children with special health care needs, school-based clinics, family planning clinics, and acquired immunodeficiency syndrome (AIDS) care providers (operating under the Ryan White Comprehensive AIDS Research and Education [CARE] Act). Although each community has a different mix of such providers, some or all of them form the primary and preventive “safety net” for the poor and uninsured. Approximately 43 percent of patients in federally qualified community and migrant health centers are covered by Medicaid, Medicare, or other public insurance, and an equal proportion are uninsured. To survive, the centers rely heavily on federal, state, or local government grants and to a lesser extent on private donations.

Given their dependence on Medicaid, it is imperative that community-based providers participate in evolving Medicaid managed care plans and networks. If they do not, they may lose the ability to serve Medicaid patients, which in turn could threaten their ability to serve uninsured patients.

Community-based providers have two major strategies for participating in Medicaid managed care. They can form a managed care plan by themselves or in partnership with others, or they can seek contracts with managed care plans. This paper focuses on the second strategy. First, I explain the issues that have arisen as Medicaid managed care plans seek to develop provider networks that can serve the diverse Medicaid population and negotiate contracts with traditional community-based providers. I then highlight some of the strategies and elements that have proven effective in overcoming barriers to mutually beneficial contracts. I conclude by discussing the policy implications for federal and state governments in their role as purchasers of care for the Medicaid population.

**Challenges And Opportunities For Collaboration**

Why would private managed care plans want to contract with community-based providers of primary and preventive care to Medicaid patients? Primarily because they share the same mission—providing high-quality, easily accessible primary and preventive care services to Medicaid patients. But they differ in how they approach this mission, based on different organizational cultures and strengths. Just as state health departments and Medicaid agen-
cies used to engage in what was once called the “Cold War between the health zealots and the Medicaid infidels,” community-based providers and managed care plans today often view each other with suspicion.

Managed care organizations (MCOs) typically have experience in claims processing, provider relations, utilization review, and financial risk management. As insurers, they are focused on purchasers and enrollees, most of whom have been commercially insured. If nonprofit, they are accountable for financial performance to boards of directors; if for-profit, they are accountable to stockholders. In contrast, community-based providers have experience in providing personal health care services to “vulnerable” persons—those with low incomes, special health care needs, or cultural or language barriers to care—regardless of ability to pay. It is their mission to provide care to the uninsured; in some cases they are obligated to do so. They are accountable to consumer-dominated boards of directors or to governmental bodies if they are publicly sponsored or funded. These different cultures and strengths present both challenges and opportunities for collaboration.

- **Challenges.** The two organizations come to the negotiating table speaking different languages, using the same words to mean different things. For example, to MCOs, “case management” is the responsibility of primary care physicians to coordinate and authorize all of the care needed by patients. But to community-based providers, case management is often the responsibility of social workers, nurses, or community health aides to assess patients’ needs, refer patients to all appropriate services, and advocate on patients’ behalf to assure access to care.

There are also many stereotypes that must be broken down before real collaboration can occur. MCOs may assume that all community-based providers serve high-risk, sicker populations, which would increase the risk of adverse selection for MCOs that have community-based providers in their provider network. There may also be the misconception that most community-based providers are unable to comply with HMOs’ utilization controls and quality assurance processes. Some community-based providers believe that MCOs’ only concern is the bottom line and that MCOs are not committed to providing the full range of services needed to effectively serve vulnerable populations.

- **Opportunities.** Despite these differences, private managed care plans and community-based providers are drawn to each other for a number of reasons, even if it sometimes seems more like an arranged marriage than love at first sight. MCOs find community-based providers attractive because they have experience serving the
Medicaid population, a powerful advantage for any MCO that has not worked with this group of patients before. “Community providers have leverage, if they’re good,” said David O’Brien of the Gateway Health Plan in Pittsburgh. “If a community-based provider functions well and is well-thought-of in a particular community, a plan will need to include that provider in its network if it wants to attract members from that community.” MCOs readily acknowledge that they do not know how to deliver care to a less-educated population, how to help patients get to appointments, and how to communicate the importance of prevention and early treatment. They find that community-based providers are particularly strong in providing enabling services. “The most I’ve learned from anyone about the Medicaid population is from the community-based providers,” said John Monahan of Blue Cross of California. In addition, MCOs find that community-based providers may be among the few, or perhaps the only, providers of primary care services to Medicaid patients in some neighborhoods. One plan turned to community-based providers after it tried to sign up physicians in its commercial plan to serve Medicaid patients but was unable to convince enough physicians to serve the number of such patients expected to enroll. In other communities, community-based providers may be the only source of particular services required by the state Medicaid agency, such as maternity care coordination or human immunodeficiency virus (HIV) counseling. Finally, MCOs may perceive efficiencies in having low-income residents, who frequently go on and off Medicaid, see the same provider regardless of their eligibility.

Community-based providers find that they need to court MCOs for many reasons, as well. As mentioned earlier, contracts with MCOs are essential to continue provider/patient relationships with Medicaid beneficiaries and to retain Medicaid revenues. This is particularly true if community providers cannot or choose not to form their own MCOs. Community-based providers find that being part of an MCO provider network gives them access to information systems, management expertise, and specialty clinical services that might otherwise be unavailable or unaffordable. Finally, the experience of dealing with Medicaid managed care can give community-based providers the tools they need to be more competitive.

**Major Contracting Issues**

As plans and community-based providers dance closer together, they are just starting to come to grips with the details and issues that go into contracting. Before contracts can be signed, community-based providers and MCOs must decide on (1) the role and authority of the provider in relation to other parts of the delivery system; (2) which
quality and basic operating standards must be met and how compliance will be monitored; and (3) the basis on which payments will be made. Finding common ground on these issues is rarely easy.

Providers’ scope of responsibilities. Depending on what is included in the contract between a state Medicaid agency and managed care plans, Medicaid MCOs need to arrange for a wide array of clinical and supportive services. It is administratively simpler for MCOs to contract with providers that can deliver a comprehensive set of services. But other than community health centers, most community-based providers can only deliver pieces of the package. MCOs that contract with multiple community-based providers must decide whether preauthorization from a primary care physician will be needed for every visit, which services require prior authorization, whether there are certain conditions for which patients need not get authorization from their primary care provider, and whether they will guarantee a minimum number of referrals to the community-based provider. The two parties must also decide how case management will work.

Quality assurance and reporting requirements. Defining “high-quality” care can be difficult when the two parties are accountable to different accreditation bodies that emphasize different aspects of quality, have different standards, and require reporting of different indicators and measures. Health plans are oriented to National Committee for Quality Assurance (NCQA) standards and Health Plan Employer Data and Information Set (HEDIS) measures, whereas community-based providers are accountable to a variety of government and private organizations and report various data depending on funding sources. For example, community and migrant health centers follow federal rules, local health departments use the Assessment Protocol for Excellence in Public Health system to assess and improve their organizational performance, and Ryan White centers have their own federal requirements.

Individual providers also complain about the conflicting requirements imposed by health plans. Zoila Torres-Feldman, a community health center director in Massachusetts, said, “Each plan has different formularies, different labs, separate utilization review staff, different benefit packages, different hospitalization contracts, different networks of specialists, and different expectations of the levels of provider control.”

MCOs sometimes criticize the capacity of community-based providers to meet basic operational expectations, such as submitting utilization and quality data in formats that are consistent with plans’ information systems, answering telephone lines in a timely fashion, and making appointments available within required time-
“Payment between plans and community-based providers is one of the most important and difficult issues in contract negotiations.”

lines. According to Herb Wheeler of HealthKeepers, Inc., a subsidiary of Trigon Blue Cross Blue Shield, in Richmond, Virginia, “In trying to gain NCQA accreditation, we feel like we’re being pulled down if we deal with community health centers.” He and other health plan officials say that not all community-based providers’ record keeping and quality of care are yet up to NCQA’s credentialing standards.

- **Payment arrangements.** Payment between plans and community-based providers is one of the most important and difficult issues in contract negotiations. Community-based providers typically want fees to cover the costs of providing all care to patients, whereas MCOs want to pay the same amount they pay other providers for the same services. Some MCOs complain that community-based providers do not have adequate information systems to determine unit costs, and some community-based providers say that MCOs do not want to pay adequately for the additional services they provide.

  Most plans and community-based providers believe that few such providers are equipped to accept financial risk for the entire spectrum of services patients need. Their data systems are ill-equipped to manage utilization, their financial systems are not sophisticated enough, and sometimes they are legally unable to suffer even short-term financial losses. “Community health centers could survive if they can share in the savings they generate for the health plans,” said Torres-Feldman. But if community-based providers are only capitated for primary care, they could lose money.

**Strategies For Contracting Collaboration**

The growing number of contracts between MCOs and community-based providers indicates that many have overcome the obstacles in order to gain the potential benefits. The examples presented here demonstrate that the secret to success lies in translating contract requirements into practical working relationships.

- **Providers’ scope of responsibility.** In some cases MCOs contract with community-based providers for a limited set of services initially and increase the scope of services included in the contract as the providers’ expertise expands. For example, Blue Cross of California’s HMO initially contracted with a Planned Parenthood clinic for just family planning and obstetrical services but expanded
the contract to include primary care services when the clinic developed the capacity to provide them. When community-based providers can deliver only a specific component of the service package, some plans have authorized the providers to deliver all necessary care without requiring referrals for each visit. In a study of seven school-based clinics, for example, nineteen of twenty-six health plan contracts authorized the clinics “to provide a specific set of services—typically well-child visits and acute, episodic sick care—to the plan’s beneficiaries without preauthorization by the plan.” When community-based providers can deliver only a specific component of the service package, some plans have authorized the providers to deliver all necessary care without requiring referrals for each visit. In a study of seven school-based clinics, for example, nineteen of twenty-six health plan contracts authorized the clinics “to provide a specific set of services—typically well-child visits and acute, episodic sick care—to the plan’s beneficiaries without preauthorization by the plan.”

The Health Start school-based clinics in St. Paul, Minnesota, developed three different models for relating to primary care providers in health plans, depending on each plan’s particular needs.

**Quality assurance and reporting requirements.** NCQA accreditation standards and HEDIS 3.0 measures, which recently incorporated Medicaid HEDIS, are becoming the industry standard. As more Medicaid agencies use them to hold contracting health plans accountable, they have become *de rigueur* for plans and their providers to follow. But how plans meet such standards may differ from one plan to the next. When working with community-based providers, plans often find that they must work closely through joint quality assurance committees, provide data that show providers how their practice patterns compare with those of others, and agree on priorities for improvement. For example, one publicly sponsored health plan (CareOregon) holds monthly quality improvement and utilization committee meetings with community health centers in its network to educate both plan and clinic representatives about meeting quality assurance requirements.

On the other hand, some community-based providers may be able to show other providers in a plan’s network how to meet certain standards. As John Bartkowski, a community health center director in Wisconsin, pointed out, “The health centers bring to the HMOs the ability to meet Early and Periodic Screening, Detection, and Treatment [EPSDT] requirements. We also were able to demonstrate that health centers are much better on certain outcomes [for example, emergency room visits, low-birthweight rates] than other contracted physicians.”

Still, plans sometimes find that community-based providers require technical assistance and funds to meet quality, utilization, or other reporting expectations. One health plan that was created by community health centers allocates half of its annual earnings to community providers to invest in infrastructure; in recent years management information systems have been the priority for these funds. A commercial health plan has provided computer hardware and software to several community-based providers to enable them...
to bill for services and comply with prior-authorization requirements. In addition, MCOs may provide community-based providers with information about their patients’ overall utilization patterns to help manage care more effectively and EPSDT check-up lists to help with follow-up. Trigon provided funds to a group of minority physicians to help them organize into a group, hire administrative staff, and collect data.

Patience and willingness to educate community-based providers about administrative practices are also necessary. One plan official expressed frustration with county health departments that have inadequate or nonexistent appointment systems and other community-based providers that cannot meet reporting or performance standards. But the plan is giving these providers time to get up to speed because they are regarded as valuable partners for ensuring access and service capacity. Community-based providers are clearly willing and able to change. One study found that contracts with managed care plans had prompted management improvements at community health centers, such as strengthening twenty-four-hour on-call service, more timely scheduling of appointments, and more active monitoring of utilization and specialty referrals.\(^\text{10}\)

**Payment arrangements.** Flexibility is the key to setting suitable payment arrangements and rates. Many contracts between plans and community-based providers still include fee-for-service payments for each contracted service, based on previous Medicaid fee schedules, fixed global visit rates, or a service-specific rate negotiated by the provider and the plan. However, some plans have developed successful risk contracts with community-based providers. Plan and provider representatives caution that to work well, such arrangements require (1) experience on the part of providers, in managing risk, and (2) substantial numbers of enrollees seeing the provider. As Robert Gomez, head of a community health center in Tucson, Arizona, said, “If you can talk capitation, you’ve broken a lot of the cultural barriers between us and the plans.”

Even when providers do not have prior experience in risk assumption, some form of risk sharing can still be developed. For example, in the first year of St. Paul Health Start’s contracts with MCOs, the plans held back a small portion of the rates paid to other capitated clinics to fund school clinics while both parties collected utilization data to set future rates. Another plan has several shared risk contracts that “carve out capitation for services that CBPs [community-based providers] perform and pay the rest on a fee-for-service basis which we manage ourselves,” according to Dan Bailey of CompCare Health Services, an HMO owned by United Wisconsin Services, Inc., the Blue Cross Blue Shield affiliate in Wisconsin.
Some unusual payment arrangements are found in contracts between plans and community-based providers, which again reflects the special needs of some providers and the willingness of plans to be flexible. For example, Blue Cross of California pays for some services provided by its community-based providers up front to help with cash flow. The cost of intensive outreach such as home visits for preventive services is not usually included in capitation rates, so health plans and community providers sometimes cooperate in seeking additional funding through public or private grants. The Blue Cross Blue Shield plan in Wisconsin developed a risk-sharing agreement with providers on EPSDT to give providers more incentive to help the plan meet its screening goals.

While plans’ payment arrangements with federally qualified health centers are governed to a great extent by federal and state regulations, which I discuss later, health plans and health centers still have some options that form the basis for rate negotiations. For example, the Blue Cross plan in California convinced one center to waive cost-based reimbursement and accept capitation in exchange for the promise of a larger volume of patients. It is not clear whether the non-cost-based payment rates will be adequate in the long run.11

**Keys To Successful Contracting**

This brief review highlights several factors that are critical to successful Medicaid contracting.12

(1) The parties to a contract must learn as much as they can about each other—their language, values, and goals. The differences that exist among MCOs and community-based providers are important when considering the pros and cons of a particular contract. Local market factors also influence the dynamics of contracting.

(2) To meet the needs of Medicaid patients, both parties must be willing to cast aside “business as usual.” Health plans that believe that community-based providers are valuable partners must be willing to trust what has been learned and invest in the services that are needed to make a difference (for example, offering services in multiple languages, respecting the influence of culture on health-seeking behavior, and developing special exceptions for confidential services). Plans may need to stretch usual primary care physician authorization requirements, while community-based providers may need to hire new staff to perform the tasks required by MCOs.

(3) Plans and community-based providers must be willing to meet regularly to work out the details of collaboration. Even when managers agree to referral and authorization procedures, there will always be special cases that require accommodation and compromise. It may be useful to start with something small before embark-
ing on a long-term contract.

(4) Plans and community-based providers must be willing to experiment with different payment arrangements. Because not all community-based providers are alike (some can handle capitated rates, others cannot), and because each state's Medicaid program is different (capitation rates in some states may be meager, some have more sophisticated risk-adjustment mechanisms than others have), MCOs and community-based providers must work together to resolve the array of payment issues that will arise.

(5) Community-based providers have shortcomings in information systems and facilities, but these can be improved. These providers have limited capital budgets to invest in computer systems or facility improvements. Plans must be willing either to invest in community-based providers' infrastructure or help them to find alternative sources of capital. Community-based providers must put a high priority on finding the resources and technical staff to bring their facilities and systems up to speed.

(6) Continuous quality improvement requires partnerships. Community-based providers that deliver high-quality services and have a good reputation in their community should have little difficulty contracting with Medicaid MCOs. Those that do not continuously improve quality may not belong in Medicaid managed care. To improve quality, plans, providers, consumers, and state agencies must join together to collect and analyze data, conduct patient satisfaction surveys, stress the importance of EPSDT screenings, and improve risk-adjustment methods.

Policy Context

Contracts between Medicaid managed care plans and community-based providers do not occur in a vacuum. They are greatly affected by federal and state Medicaid laws and policies and by the specific language in the contracts between state Medicaid agencies and managed care plans. Thus, the relationships that evolve between Medicaid managed care plans and community-based providers will in part reflect the federal and state policies that govern them.

- **Federal policy.** Most of the formal policies related to community-based providers' relationships with MCOs emanate from the Health Care Financing Administration (HCFA) through its administration of state Medicaid waivers. Several other Department of Health and Human Services (HHS) agencies are involved in providing technical assistance.

  *State waivers of federal Medicaid regulations.* Federal Medicaid law (Sections 1115 and 1915(b) of the Social Security Act) grants HCFA the authority to grant waivers to states that wish to be exempt from
certain rules. States with 1915(b) waivers must assure cost-based reimbursement to federally qualified health centers participating in managed care when they affirmatively assert their right to it. But because states requesting Section 1115 waivers can ask to waive health center payment rules, many centers have been forced to accept less than they formerly received. Even so, many of the states with Section 1115 waivers still make some provisions that help federally qualified health centers to participate in or get adequate payment from Medicaid managed care plans.

In approving a state’s Medicaid waiver program, HCFA may impose special terms and conditions with which the state must comply. Most often, these terms and conditions relate to rules that MCOs must follow in reimbursing community-based providers and to assuring access to services provided by community-based providers. For example, HCFA’s special terms and conditions often include a requirement that MCOs contract with community-based providers to assure that MCOs have adequate capacity to serve Medicaid patients. If MCOs have adequate capacity to serve vulnerable populations without contracting with federally qualified health centers, MCOs are relieved of this requirement. If health centers develop their own Medicaid managed care plan, other MCOs in the same service area are also exempt from this condition. In most states HCFA also requires states to adjust rates for patient case-mix.

Technical assistance and training for community-based providers and MCOs. HHS agencies—including the Bureau of Primary Health Care, the Maternal and Child Health Bureau, the Centers for Disease Control and Prevention, and the Agency for Health Care Policy and Research—conduct comprehensive training and technical assistance programs to help community-based providers to participate in or relate to Medicaid managed care programs. These agencies also provide information and training to MCOs on developing delivery systems for Medicaid patients.

State policies. Within the context of federal policies and guidelines, states have adopted a range of approaches to ensure a role for community-based providers in Medicaid managed care plans. Some states have designed systems to assure that community-based providers are given the chance to develop their own plans. For example, California formulated a managed care model “designed in large part to protect safety-net institutions.” Medicaid recipients in twelve densely populated counties will choose between two different plans—a commercial plan and a Local Initiative plan that is developed by county governments and safety-net and traditional Medi-Cal (California Medicaid) providers, along with community representatives. “Unlike the commercial plans, Local Initiatives are
required to contract with safety-net and traditional providers. Rates paid to the Local Initiative plans are higher to reflect cost-based payments made to federally qualified health centers.

However, most states have not gone this far. Instead, they are using one or more of the following more limited strategies to encourage partnerships between community-based providers and MCOs.

*(1) Contract requirements.* Some states explicitly require that Medicaid managed care plans contract with particular community-based providers. For example, Oregon mandates that Medicaid managed care plans contract with county health departments and other publicly funded programs to provide immunizations, as well as screening for sexually transmitted and other communicable diseases. Exceptions are allowed when community providers are not available. Minnesota’s Medicaid program requires that at least one MCO in a given service area include a community clinic in its network.

*(2) Preference points for collaboration.* Arizona, California, and Massachusetts, among other states, add points to plans’ bids if they include community providers in their networks. For example, Massachusetts specifies in its request for proposals that plans must attempt to establish linkages, though not necessarily contracts, with school-based clinics and encourages coordination with public health clinics to serve persons with HIV infection.

*(3) Preferential assignment to plans that include community providers.* In some states Medicaid MCOs that include community-based providers are assigned patients who do not voluntarily choose a plan. For instance, in California, the Orange County CalOPTIMA (Orange Prevention and Treatment Integrated Medical Assistance) program has made the plan organized by Children’s Hospital of Orange County and the University of California-Irvine the default for persons who fail to select a plan.

*(4) Setting quality or access standards to encourage collaboration.* Certain performance standards in a state’s contracts with health plans can increase the likelihood that plans will contract with community-based providers. For example, Minnesota requires health plans to submit annual “action plans” that specify how they will deliver services, provider capacity, quality improvement plans, and policies and procedures for serving high-risk or special-needs populations. This serves as an incentive for plans to work with community-based providers that can provide care to special-needs groups.

*(5) “Transitional” payments and other enhanced reimbursement to community-based providers.* To help federally qualified health centers or other essential community providers to develop the systems and economies of scale needed to assure cost-effectiveness while continuing to deliver health care to all persons regardless of their ability
to pay, many states have developed transitional payments to federally qualified health centers. For example, Rhode Island pays an extra $10 per member per month to the center’s HMO for each Medicaid recipient enrolled. And in Hawaii and Vermont, federally qualified health centers in Medicaid managed care plans are entitled to a “wraparound” payment to settle the difference between capitation and cost. In addition, some states provide enhanced capitation rates to plans that contract with federally qualified health centers to compensate for a more costly patient case-mix. Minnesota adjusts for a more costly case-mix in some safety net-sponsored plans.19

Next Steps

Federal and state policymakers often find themselves caught between the plans, which argue that strict governmental requirements to contract with community-based providers or pay them certain rates hurt the plans’ ability to provide cost-effective care, and community-based providers, which assert that the government must protect them from competition that could threaten their financial viability. In an effort to find middle ground, HCFA and most state Medicaid agencies have tried to ensure, at a minimum, that community-based providers are given a chance to participate in Medicaid managed care plans, even if they cannot guarantee their ultimate success. After all, federal and state governments have invested in community-based providers through grants, loans, and other support for several decades. If community-based providers are forced to close as a result of competitive forces, and private managed care plans decide to abandon the Medicaid market because it is not sufficiently profitable (as some already have done), governments will have to rebuild the entire care infrastructure for the poor. But if community-based providers, which have always formed the safety net, are given a greater chance of survival, they might constitute an important “fallback.”

Policies to improve provider competitiveness. If this remains the preferred policy choice, there are avenues in addition to those already mentioned that might make community-based providers more competitive. For example, subsidies for care of the uninsured and funds for capital investments (data systems and facility improvements) might make it easier for community-based providers to accept discounted fees from managed care plans. Risk-adjusted rates to plans might make it more likely that they would contract with community-based providers that serve sicker groups of people. For these to occur, MCOs might have to join with providers in the political process.

The question remains whether such policies are needed temporarily
or on a permanent basis. For example, some argue that it goes against the economic interests of MCOs to contract with community-based organizations that are not directly controlled by the MCO. Robert Reischauer of The Brookings Institution stated, “A managed care entity that wants to operate efficiently [would want] . . . to exercise complete control over the provision of services either directly or by subcontracting that control through a risk-based contract to some other provider.” Based on this possibility, as MCOs gain more experience in serving the Medicaid population, they may find it more efficient to operate a van service to bring Medicaid members to risk-assuming providers, rather than contract with neighborhood-based providers that are seeking higher payments to support their social mission.

Community-based providers may find that as they become better at managing care and financial risk under capitation, they will be better able to form their own managed care plans. Hospitals and physician groups are now forming integrated delivery systems and provider-sponsored networks that are trying to compete directly with MCOs; some community-based providers are emulating this strategy. If they are successful at managing risk and winning contracts with Medicaid or other purchasers, they might be able to channel the savings or profits into services for the uninsured.

There are those who believe that contracts between Medicaid MCOs and community-based providers will last because they benefit both parties and result in higher-quality service and better outcomes for Medicaid recipients. Others caution that no matter what works best economically or from a health care delivery perspective, politics will remain influential. “On the state level, which plans get Medicaid contracts has to do with politics. In communities, which providers are chosen to get plan contracts has to do with politics,” said JoAnne Fischer of the Maternity Care Coalition in Philadelphia.

The value of collaboration. Before plan/community provider contracts can develop into long-term relationships, more “dating” must begin. One way to encourage such pairing might be to provide evidence of the value of such collaborations. There are few, if any, studies showing that collaborations have improved care to vulnerable populations or resulted in more cost-effective care. What have community-based providers done that has helped MCOs to meet the special needs of Medicaid clients? How have the resources and expertise of MCOs improved the care of Medicaid enrollees?

Solid, objective studies that answer these questions would do much to move the collaboration agenda. Indeed, evidence of the cost-effectiveness of individual community-based providers or particular outreach or educational methods could be the strongest sell-
ing point of all. MCOs might not need any prodding to contract with community-based providers if such proof were readily available. On the other hand, evidence of Medicaid managed care plans’ ability to improve access to care, which is also in short supply, might convince community-based providers of the value of collaboration with private plans.

**Opportunities for discussion.** As important as research and public policy are to encouraging collaboration, it may be just as important to provide opportunities for representatives of private Medicaid managed care plans and community-based providers to discuss openly the differences that divide the groups and to sort out mutually acceptable roles, responsibilities, and mechanisms to ensure accountability for the care of vulnerable populations. Further meetings, held at the community level, may go a long way in moving these “arranged marriages” toward true compatibility.

Even with such steps, Medicaid managed care plans might still come to the conclusion that they can serve the Medicaid population without the help of community-based providers. If that is the case, and federal or state policymakers still believe that partnerships between the two sets of organizations are important, financial incentives or regulatory requirements may be needed to ensure that such arrangements are established.

This paper was adapted from an issue brief prepared for a meeting sponsored by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services and the National Institute for Health Care Management (NIHCM). The meeting, held 15 November 1996 in Washington, D.C., brought together representatives of private Medicaid managed care plans and community-based providers to discuss the issues that promote or hinder contracts between them and to explore how collaboration can improve care for vulnerable populations. Any quotes in this paper that are not footnoted are drawn from the transcript of that meeting. The author appreciates the support of the NIHCM and HRSA for this paper and extends particular thanks to Kathleen Eyre, Jeanne Ireland, Michael Sparer, Ed Neuschler, and Julia Tillman for their review and comments.

**NOTES**

3. Other safety-net providers include public and private hospitals, including academic health centers, that serve disproportionate numbers of Medicaid and uninsured patients. This paper focuses on providers that provide only outpatient care.
7. J. Schlitt et al., “School-Based Health Centers and Managed Care: Seven School-Based Health Center Programs Negotiate a Difficult Fit” (Washington: Making the Grade Program, The George Washington University, February 1996).
12. Some of these lessons appear in the paper by Orbovich, “Collaborative Strategies,” 15, and were raised by participants in the meeting sponsored by HRSA and AAHP, “Collaborative Strategies,” 1–2 April 1996, in Washington, D.C.
13. Under Section 1915(b), states can ask to waive provider “freedom-of-choice” rules to mandate enrollment of Medicaid beneficiaries into managed care arrangements. Under Section 1115, states can ask to waive many rules to conduct research and demonstration projects that advance the objectives of the Medicaid program. Typically, Section 1115 waivers have been granted to allow states to implement mandatory managed care plans on a statewide basis and use the savings to extend eligibility to additional groups of low-income persons.
17. Ibid., 3-2.
20. Ibid., 164.