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How Are Safety-Net Providers Faring Under Medicaid Managed Care?

A case study in Connecticut finds a lack of information about how these critical health care providers are responding to recent policy changes.

by Colleen M. Grogan and Michael K. Gusmano

There are many reasons to believe that state Medicaid managed care reforms will improve the provision of medical services to Medicaid recipients. Nevertheless, there is growing concern that changes in the financing and delivery of Medicaid services may have unintended consequences for safety-net providers’ service delivery and financial viability.1 Because the United States continues to rely on safety-net providers to care for the uninsured and other disadvantaged groups, it is important to understand how policy reforms intended to improve services may affect safety-net providers’ ability to care for those lacking insurance altogether.

Although some information about the performance of safety-net hospitals under Medicaid managed care is available, relatively little information exists about what is happening to community-based safety-net organizations.2 Indeed, in most states good data do not exist on the volume of care that these organizations provide.3 This UpDate helps to fill that gap by presenting findings from our survey of community-based safety-net organizations in one state—Connecticut.

Background And Data

Connecticut began implementation of a mandatory Medicaid managed care program (Connecticut Access) for the state’s Aid to Families with Dependent Children (AFDC) recipients in August 1995. The state contracted with eleven managed care organizations (MCOs). In an effort to determine whether financial and service-related changes in safety-net providers are the result of the implementation of Medicaid managed care, our survey asked two basic questions: (1) How many safety-net providers are participating in Connecticut Access? (2) How are these providers paid by MCOs, and have their reimbursement rates changed under Medicaid managed care?

Working definition. Connecticut cities and towns have relied heavily on the voluntary or traditional nonprofit sector to provide many of the services that normally are delivered by the public sector and are considered “public health.” Therefore, our working definition of Connecticut’s medical safety net was based on the following criteria: (1) The provider’s services and role are essential to the well-being of the community or state, so its presence and activity is mandated or authorized by state public health laws, municipal charter, or local public health ordinances. (2) The provider is funded largely by public monies (federal, state, or local) to carry out certain public health functions or meet the health needs of certain underserved or at-risk populations.

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populations. (3) The focus of service is population based, not just client based. Based on these criteria, we surveyed the following types of providers: community health centers, school-based health centers, child guidance clinics, municipal/local health clinics, non-profit Visiting Nurse Associations, family planning clinics, and public dental clinics.

Survey procedures and response rates.
The questionnaire was first mailed to a population of 236 safety-net providers in October 1996. By March 1997 a total of 110 surveys were returned, for a response rate of 47 percent. This response rate varied by organizational type, from 33 percent of family planning clinics to 80 percent of community health centers.

Data limitations. The information obtained from the survey about changes in Medicaid reimbursement rates and administration time devoted to billing/payment since the implementation of Connecticut Access is based solely on providers' reports. There is no way, short of auditing financial and operational data from these organizations, to verify their accuracy. Therefore, our findings might be biased by safety-net providers' perceptions of the Medicaid managed care program and should be interpreted with this limitation in mind.

In addition, our survey was mailed a little more than a year after the start of the Medicaid managed care program and less than a year for some organizations, since they did not begin participation until well into 1996. These providers' experiences may have changed since the survey was conducted, and the results should be interpreted in light of the broader evolution of Medicaid managed care.

Finally, the findings are not necessarily generalizable to other states whose rules regarding safety-net provider participation in Medicaid managed care might differ from those in Connecticut.

Survey Findings

Participation. Roughly two-thirds (69 percent) of responding safety-net providers in Connecticut participate in the state's Medicaid managed care program. Although it is significant that 31 percent (thirty-five organizations) are not participating, about half of these organizations never participated in the Medicaid fee-for-service (FFS) program, either. Nonetheless, eighteen organizations reported previous participation in the Medicaid FFS program but no contracts with MCOs. We do not know from our survey whether these organizations have tried to contract with MCOs and have been denied, or whether they simply are not interested in participating.

The majority of respondents began participating in the program almost immediately from its inception: 54 percent had contracts signed when the program began. Of the remaining respondents, 63 percent had signed contracts by the time the program was fully implemented statewide (four months later).

The survey findings indicate some variation in participation by organizational type. The majority of community health centers, child guidance clinics, family planning clinics, public dental clinics, and not-for-profit Visiting Nurse Associations (VNAs) that responded to the survey participate in Connecticut Access. However, only two of the thirty local health departments in the state participate.

Furthermore, although the state gave school-based health centers “preferred provider” status—mandating that Medicaid-participating MCOs contract with them—only nineteen of the fifty school-based health centers in the state had secured contracts eighteen months after initial implementation, and only twelve of these nineteen centers reported billing MCOs for Medicaid services.

Contracting issues. Several obstacles have delayed the contracting process. First, many of the school-based health centers lack the information systems necessary to bill MCOs for the services they provide. Second, the centers report, and some MCOs acknowledge, that because MCOs lack knowledge and understanding about the role of school-based health centers in the public health system, MCOs do not feel the need (or recognize a compelling
reason) to contract with them. Finally, MCOs are hesitant to contract with these centers as primary care providers because of limited staffing hours and concerns about inadequate qualifications of some centers’ providers.

The circumstances under which safety-net providers participate in Medicaid managed care vary widely. Community health centers in Connecticut decided to participate in the program by creating their own MCOs: Community Health Network and Health Right. Initially, centers belonging to Community Health Network had an exclusive contract only with their own plan. However, community health centers were sufficiently concerned about decreases in the volume of Medicaid patients that they soon began contracting with other participating MCOs.

Child guidance clinics hold what has been called “benchmark status” in the state’s contracts with MCOs; that is, MCOs must provide services within their network that are similar to those provided by the clinics. This appears to have helped the clinics to secure contracts with MCOs, since all such clinics in the state have signed contracts with multiple MCOs. Family planning clinics enjoy “federal protection,” which allows Medicaid managed care recipients to use the clinics without a referral or specific network conditions.

No legal provisions govern participation in Medicaid managed care for local health departments, not-for-profit VNA’s, or public dental clinics. Despite the lack of legal provisions, our findings suggest that the latter two have successfully secured contracts, although the former have had difficulties.

The vast majority of participating safety-net organizations have signed contracts with multiple MCOs, and all eleven MCOs have contracts with at least some of the safety-net providers. About two-thirds of respondents reported having contracts with Connecticut’s two “default” commercial MCOs (these plans automatically receive members who do not choose a plan). There is no discernable difference in contracting with safety-net providers between commercial and Medicaid-only MCOs. Of the five MCOs with which 60 percent or more safety-net organizations reported having contracts, three are commercial and two are Medicaid-only.

The number of reported contracts with MCOs varies by organizational type. Community health centers reported significantly fewer signed contracts (an average of three). As mentioned, this finding is undoubtedly related to the initial strategy among nine of the community health centers to have an exclusive contract with their own federally qualified health center (FQHC) plan. In contrast, child guidance clinics have significantly more contracts with MCOs—nine, on average. The remaining participating organizations have an average of five MCO contracts each.

■ Reimbursement. The vast majority of safety-net organizations (92 percent) participating in Connecticut Access are paid by FFS reimbursement. Capitation is the next most popular method (28 percent, or twenty-one providers). As with participation in Medicaid managed care, reimbursement varies by type of organization. All of the community health centers primarily receive capitation payments (from the center-owned MCOs); in contrast, all of the child guidance clinics receive FFS reimbursement. Although 65 percent of providers are paid by one reimbursement method, 35 percent (twenty-five organizations) are paid by two methods: capitation from some MCOs but FFS rates from others.

Determining whether safety-net providers are receiving higher or lower reimbursement rates under Medicaid managed care is complicated by the fact that many organizations contract with multiple plans, and their rates could be higher with some and lower with others. Moreover, the rates may be higher for
some services but lower for others. Recognizing this complication, we asked safety-net providers: “For the service you provide most often, how do the rates you are paid by MCOs (on average) compare to the Medicaid fee-for-service rates paid by the state prior to Medicaid managed care?” The majority of safety-net providers reported receiving the same (41 percent) or higher (25 percent) rates.

Again, there appear to be some differences by organizational type: All of the community health centers, child guidance clinics, and local health departments receiving FFS (not capitation) from MCOs reported an increase in rates, whereas the majority of VNAs and family planning agencies receiving FFS payments reported a decrease in rates (Exhibit 1). All of the community health centers that receive capitation payments reported a decrease in rates. This reduction in rates is not surprising, because community health centers were paid cost-based reimbursement under Medicaid FFS and have no guarantees of securing equal payment levels under Medicaid managed care.

**Policy Implications**

Three main findings are worth emphasizing. First, although legal provisions to help assure safety-net providers’ participation in Medicaid managed care may help, they do not guarantee participation. The lack of secured MCO contracts by school-based health centers in Connecticut, where they have arguably the most favored legal status of all of the safety-net providers, illustrates this point.

Second, while Medicaid managed care might suggest the use of capitation, very few respondents reported being paid on a capitated basis. Moreover, while some reported a decrease in rates negotiated with MCOs compared with rates paid by the state under Medicaid FFS, many reported an increase. Yet safety-net providers’ success in securing MCO contracts and negotiating higher rates is not necessarily the prerequisite to long-term organizational viability. For example, child guidance clinics, all of which have contracts with MCOs at higher reimbursement rates than those offered under Connecticut’s FFS Medicaid program, reported concerns that they were losing money because of denied payments for services rendered.

Just as secure contracts and higher reimbursement rates from MCOs do not guarantee financial viability, neither does some safety-net providers’ lack of participation in Medicaid managed care.

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**EXHIBIT 1**

**Rate Changes For Safety-Net Providers Receiving Fee-For-Service Reimbursement From Managed Care Organizations, By Organizational Type, 1997**

<table>
<thead>
<tr>
<th>CHC</th>
<th>BHC</th>
<th>DC</th>
<th>CGC</th>
<th>LHD</th>
<th>VNA</th>
<th>FPC</th>
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**SOURCES:** Authors’ survey of safety-net providers in Connecticut.

**NOTES:** CHC is community health center. BHC is school-based health center. DC is dental clinics. CGC is child guidance clinic. LHD is local health departments. VNA is Visiting Nurse Association. FPC is family planning clinic. N = 64.
aid managed care necessarily mean that they are suffering financially. Nonetheless, lack of participation should indicate to the state that some providers may be experiencing difficulties because of loss in Medicaid revenues.

Finally, this survey revealed how little the state actually knew about what services safety-net organizations provide and the extent to which specific organizations provide services to Medicaid recipients and the uninsured. For example, simply finding out which local and district health departments participated in Medicaid FFS and now in Medicaid managed care proved useful to state policymakers, because Connecticut’s Department of Public Health did not have this information.

The lack of information about safety-net providers, and about where the uninsured get health services more generally, makes it difficult for states to plan or know whether the demise of some safety-net providers is something they should be concerned about. For example, does it matter if local health departments are not involved in Medicaid managed care or do not provide clinical services to the broader community? Without more data the state cannot answer these pressing questions.

It seems likely that Connecticut is not alone in suffering from a dearth of information about the role of safety-net providers in Medicaid and in the health care system generally. Medicaid managed care may have the unintended positive effect of forcing states to take a closer look at their medical safety nets and consider what their role should be.

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NOTES


4. An obvious exclusion from this list is public hospitals, which we excluded based on the complexity of surveying hospitals and because very little attention has been given to the wide range of community-based safety-net organizations that serve Medicaid recipients and the uninsured.

5. Aside from two refusals, we know nothing systematic about the nonrespondents. It appears that some respondents did not initially respond because they were not participating in Connecticut’s Medicaid managed care program and, consequently, thought that the survey was not applicable. Therefore, we could have a larger proportion of Medicaid managed care participants than that which truly exists.

6. Information about school-based health centers contracting comes from a survey conducted jointly by Connecticut’s Departments of Public Health and Social Services. The findings correspond with ours.

7. This information came from responses to survey questions about changes in revenues and services since the implementation of Connecticut’s Medicaid managed care program. Most respondents said that they did not have the data yet to answer this question. Child guidance clinics were the exception.