

GAO

Report to the Chairman, Committee on
Labor and Human Resources, U.S.
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COMMUNITY HEALTH CENTERS

Challenges in Transitioning to Prepaid Managed Care





United States
General Accounting Office
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**Health, Education, and
Human Services Division**

B-260900

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The Honorable Nancy L. Kassebaum
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Madam Chairman:

The federal Community and Migrant Health Center program supports access to care in medically underserved areas and serves over 7 million people.¹ In fiscal year 1994, the Congress authorized \$663 million for this program to support about 627 grantee health centers. In addition to medical services, these centers provide other services that facilitate health care. These enabling services may include transportation, health education, counseling, or translation services and linkages with other social services.

Community health centers face a changing health care environment. One of the most significant changes affecting these centers has been the move by states to prepaid managed care delivery systems. States are using this type of arrangement to increase access to and control the costs of their Medicaid programs, which are a major source of funding for most health centers. Under prepaid managed care, health care organizations are paid a per capita amount each month to provide for contracted medical services.

In 1989, the Congress mandated that state Medicaid programs reimburse health centers for the cost of services that the centers provide to their beneficiaries. The more recent change from cost-based reimbursement to a monthly per capita amount for health centers participating in prepaid managed care has raised concerns about the ability of these centers to continue to provide their communities with both medical and enabling services.² Mindful of these concerns, we focused on the following questions:

¹Medically underserved areas are designated by the Secretary of Health and Human Services (HHS) based on the ratio of primary care physicians to population, the percentage of the population below the federal poverty level, the percentage of the population 65 years old and older, and an area's infant mortality rate.

²Some health centers are concerned that reimbursement under a discounted fee schedule will affect their ability to provide services to their communities.

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- Have centers in prepaid managed care been able to continue providing the medical and enabling services needed in their communities without threatening their financial position?
 - What lessons can be learned from health center experiences in prepaid managed care?
 - How does the Bureau of Primary Health Care (BPHC) help centers prepare for operating under prepaid managed care systems?

In conducting this work, we performed detailed reviews of 10 health centers in four states—Arizona, Florida, Massachusetts, and Pennsylvania—that have had Medicaid prepaid managed care programs since the mid-1980s.³ (See app. I for descriptive information on the 10 centers.) At each health center, we collected program and financial data for fiscal years 1989 through 1993. We also interviewed health center and state Medicaid program officials. In addition, we visited state Medicaid offices and health centers in Tennessee and Washington to learn about recent changes in their Medicaid programs and the responses of health centers to these changes. We also interviewed BPHC officials with responsibility for providing guidance and overseeing the Community and Migrant Health Center Program. Appendix II contains a more detailed discussion of our methodology. Our work was performed from January 1994 to March 1995 in accordance with generally accepted government auditing standards.

Results in Brief

In response to the changing health care environment, an increasing number of community health centers are participating in Medicaid prepaid managed care arrangements. While centers continue to serve vulnerable populations, prepaid managed care exposes the centers to significant financial risks.

By 1993, almost one-half million community health center patients were covered by prepaid Medicaid managed care arrangements, an increase of 55 percent from 1991. Capitation rates for primary care services provided to patients at the 10 centers we visited ranged from \$12 to \$38 per patient per month. This variation in capitation rates is related to differences in the services covered under health plan contracts at each center.

Despite initial concerns that capitation and other features of managed care would diminish health centers' ability to provide services to vulnerable

³Nine of the centers receive community health center grants and one receives both community and migrant health center grants.

populations, this was not the case at the 10 centers we reviewed. The centers were able to continue to provide such services in part because they receive other revenues to support them. All 10 health centers were serving more patients and had increased the amount spent on maintaining or expanding a variety of enabling services. Seven centers also increased the amount spent on covering the uncompensated care of low-income patients.

While maintaining or expanding their medical and enabling services, all 10 health centers also improved their overall financial positions to some degree. Improvement was related to increases in revenues that were greater than the centers' overall expenses. Revenues came from a variety of funding sources such as Ryan White Comprehensive AIDS Resource Emergency Care Act grants and state grants. Although prepaid managed care revenues are growing as a percentage of total health center revenues, they did not always exceed expenses for prepaid enrollees. In fact, in 1993, three centers reported losses of up to \$124,000 from prepaid managed care. Six centers fared better, reporting excess revenues up to \$100,000 from prepaid managed care.

Even with improved overall financial positions, as indicated by increased year-end fund balances, some health centers may be vulnerable to financial difficulties. None of the 10 centers met BPHC's suggested benchmark of 60 days of cash on hand to cover operating expenses—they ranged from less than 1 day to 31 days. Health centers may be especially vulnerable financially if they have a sizable portion of total revenues from Medicaid prepaid managed care, have capitation rates that do not fully cover the cost of services, have assumed financial responsibility for services other than primary care, or have relied heavily on other federal and state funds to conduct center activities.

While participation in managed care does not currently appear to have diminished centers' ability to fulfill their mission, some of these centers encountered serious difficulties when they initially entered into managed care arrangements. These include low capitation rates; assumption of too much financial risk; and a lack of managed care knowledge, expertise, and information. In the case of an Arizona health center, problems in all these areas led to insolvency and forced the center to cut back on its medical and enabling services.

Consistent with its role of providing policy guidance and technical assistance to health centers, the Department of Health and Human

Services' (HHS) BPHC is encouraging centers to prepare for prepaid managed care and offers training, consultation, and contract-review services to grantees. Some of these services are offered in conjunction with the centers' national association. BPHC also has begun an Integrated Service Network (ISN) Development Initiative to fund centers' efforts to develop delivery networks with other health care providers for managed care operations.

Background

Grants to states to develop community health centers were first authorized by the federal government in the mid-1960s. By the early 1970s, about 100 health centers had been established by the Office of Economic Opportunity (OEO). When OEO was phased out in the early 1970s, the centers supported under this authority were transferred to the Public Health Service (PHS). Since 1989, close to \$3 billion has been awarded in project grants to health centers. Project grants are authorized under Sections 329 and 330 of the Public Health Service Act and are to be used by health centers to provide primary health care and related services to medically underserved communities.

BPHC sets policy and administers the Community and Migrant Health Center program. BPHC is part of the Health Resources and Services Administration (HRSA) under PHS. Ten regional PHS offices assist BPHC with managing the program. The regional offices are primarily responsible for monitoring the use of program funds by grantees.

Health Centers Provide Medical and Enabling Services to Underserved Communities

In 1994, the Community and Migrant Health Center program offered comprehensive primary health care services to about 7.1 million people through 1,615 health care delivery sites in medically underserved areas. Health centers are expected to target their services to those with the greatest risk of going without needed medical care. About 44 percent of health center patients are children under 19 years old and 30 percent are women in their childbearing years. About 60 percent of health center patients live in economically depressed areas and nearly 63 percent have incomes below the federal poverty level.

A central feature of health centers is their governance structure. Local community boards govern health centers and are expected to tailor health center programs to the community they serve. In addition to comprehensive primary care services and case management, centers are

expected to offer enabling services.⁴ These services are determined from assessments of community needs and are intended to help individuals overcome barriers that could prevent them from getting needed services.

Health Centers Receive Funding From Multiple Sources

Health centers are supported by various funding streams. Community health center project grants and Medicaid provide the two largest components of health center revenues, respectively, 35 and 34 percent in 1994. Health centers may also receive other federal, state, and local grants to support their activities.

While health centers are required to offer services to all individuals regardless of their ability to pay, centers must seek reimbursement from those who can pay as well as from third-party payers such as Medicaid, Medicare, and private insurance. Patient fees are set using a sliding fee schedule that is tied to federal poverty levels. Patients with incomes below a certain percentage of the federal poverty level receive free care or may pay some portion—a discounted fee—while those in the highest income levels pay fees that cover the full service charge. The difference between service charges and the sliding fees collected is a measure of the amount of low-income care subsidized by the center.

Recent Changes in Financing and Health Service Delivery Affect Health Centers

Two major developments in recent years have affected the financial status and, therefore, the viability of health centers. The first is the authorization of a cost-based reimbursement system for health centers and the second is centers' participation in prepaid managed care. In the late 1980s, the Congress recognized that neither Medicare nor Medicaid paid the full cost for services provided to program beneficiaries at community health centers. This was due to low reimbursement rates and because some enabling services provided by health centers were not considered as reimbursable benefits by Medicaid. As a result, health centers had fewer financial resources to subsidize care for patients who could not pay and for conducting other program activities. In recognition of this problem, the Congress—as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89)—created a new Medicaid and Medicare cost-based reimbursement system for health centers. Under this system, both programs were required to reimburse health centers for the reasonable cost of medical and enabling services provided to their beneficiaries.

⁴Case management services (including counseling, referral and follow-up services) are designed to assist health center patients in establishing eligibility for and gaining access to federal, state, and local programs that pay or provide for medical, social, educational, or related services.

The second major development has been the move by states to managed care delivery systems for their Medicaid programs to address rising costs and access problems. Managed care in Medicaid is not a single health care delivery plan but a continuum of models that share a common approach. At one end of the continuum are prepaid or capitated models that pay health organizations a per capita amount each month to provide or arrange for all covered services. At the other end are primary care case management (PCCM) models, which are similar to traditional fee-for-service arrangements except that providers receive a per capita management fee to coordinate a patient's care in addition to reimbursement for the services they provide. Both systems require that beneficiaries access care through a primary care provider. Between June 1993 and June 1994, the total number of Medicaid beneficiaries in managed care programs across the country increased 57 percent, from almost 5 million to nearly 8 million, with most of the growth occurring in fully capitated managed care programs.

Health centers may not be as assured that capitated reimbursement will cover their costs as they are under traditional Medicaid fee-for-service systems. This becomes a concern when health centers lose their cost-based reimbursement under Medicaid prepaid managed care programs. Health plans that contract with centers reimburse them on the basis of a negotiated per capita rate for a set of services. This capitation rate must be sufficient to cover the cost of the contracted services for all Medicaid health plan members enrolled at the health center. Incorrect assumptions about the cost of individual services or the frequency with which they are used may result in an inadequate capitation rate. If the rate is too low, it can lead to financial losses for the centers.

States establishing managed care programs that require beneficiaries to enroll in a Medicaid health plan must obtain one of two types of waivers from the Health Care Financing Administration (HCFA). Section 1115 of the Social Security Act offers authority to waive a broad range of Medicaid requirements. Eight states have approved statewide 1115 waivers, and 12 others have waiver proposals pending with HCFA. A second type of waiver is allowed by section 1915(b) of the Social Security Act. These waivers allow states to carry out competitive programs by waiving specific program requirements, such as a beneficiary's choice of provider. Currently, 37 states and the District of Columbia have 1915(b) waivers and 4 other states have pending waivers.

The loss of cost-based reimbursement is a major concern for health centers entering into prepaid capitated agreements. These health centers are concerned that (1) the per capita monthly rate may not adequately cover the costs of providing services to the most vulnerable populations and (2) the lack of reimbursement by health plans for some medical, enabling, or other health services may hinder their ability to continue to provide them.⁵

Health Centers Participating in Managed Care Continue to Provide Medical and Enabling Services to Their Communities

Changes in the health care delivery environment are impacting community health centers as more and more health centers participate in prepaid managed care arrangements. In our review of 10 health centers, we found that prepaid reimbursement for services provided to Medicaid patients did not diminish the centers' ability to provide access to care for their patients. In fact, health centers have improved their overall financial positions to some degree while maintaining or expanding medical and enabling services. This is due to revenue increases from a variety of sources, such as federal funding other than health center grants. Earnings from prepaid managed care were modest and did not contribute significantly to the support of enabling services and subsidized care. Some center officials, however, credited the predictability of monthly capitation payments as assisting them in financial planning. Using another measure to determine financial vulnerability—cash balances—all 10 centers had limited cash balances. For centers with more than 15 percent of their total revenue from prepaid managed care, low cash balances could be a problem if they encounter significant unexpected expenses resulting from inadequate capitation rates or assumption of risk for nonprimary care services.

Increasing Participation in Prepaid Managed Care

In response to the changing health care environment, the number of health centers accepting capitated payments for their Medicaid patients grew from 92 health centers, with 280,000 prepaid patients in 1991, to 115 centers with nearly 435,000 prepaid patients in 1993.⁶ Health centers often feel pressure to enter into managed care arrangements when states implement such programs on a mandatory or voluntary basis statewide. Five of the 10 health centers we visited operate in areas where Medicaid

⁵Because of concerns that the loss of cost-based reimbursement will lead to service cutbacks and health center closures, the National Association of Community Health Centers has filed suit to stop implementation of four approved section 1115 waivers as well as the approval of additional waivers.

⁶While 1994 figures are not yet available, the BPHC believes they will likely show accelerating growth in health center participation in prepaid managed care as more states implement mandatory Medicaid managed care systems.

beneficiaries are mandated to participate in prepaid managed care plans under Medicaid waivers. Increasingly, health centers also choose to participate in areas with voluntary programs. Whether mandatory or not, health center participation is driven by the growing importance of the Medicaid program to health center revenues. In 1993, Medicaid revenues accounted for 17 percent to over 50 percent of health center revenues at the centers we visited. In addition, between 1989 and 1993, 6 of the 10 health centers experienced an increase in the ratio of Medicaid revenues to total revenues. At the same time, 9 health centers experienced a decrease in the amount that federal community health center project grants represented of total revenues.^{7,8} (See fig. 1.)

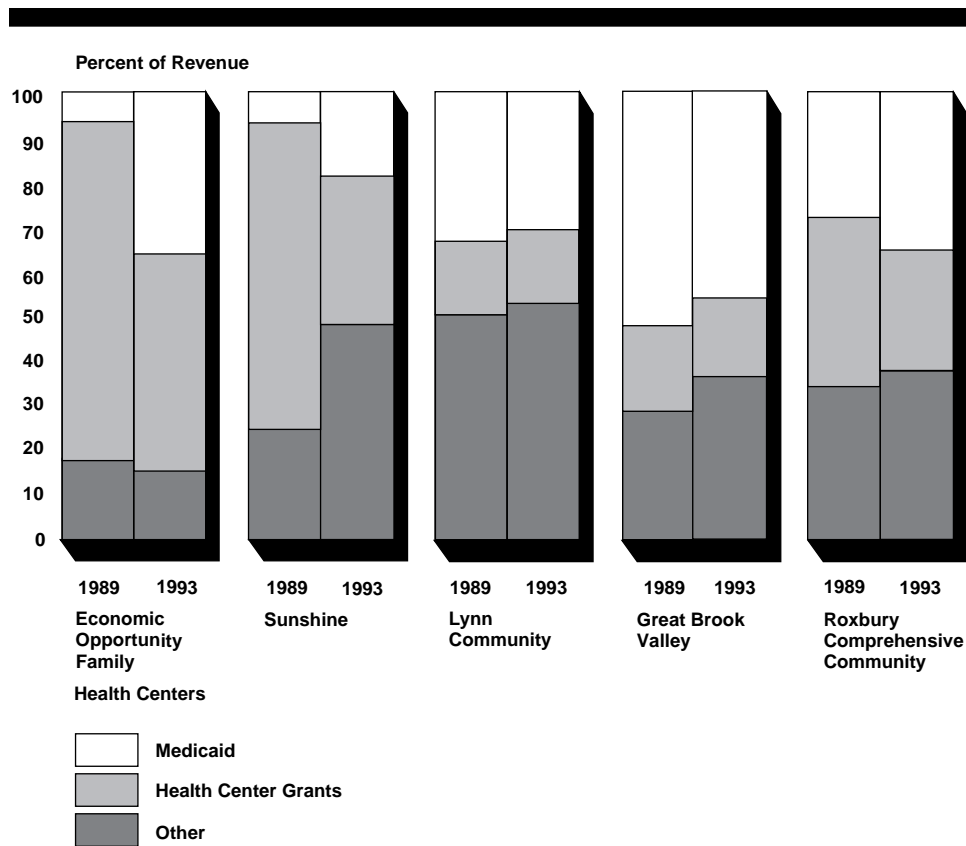
⁷Some of these health centers have also increased the percentage of their revenues from other income sources, such as state and local grants or other federal grants.

⁸Except for Sunshine Health Center and Lynn Community Health Center, which received, respectively, 22 and 17 percent of their revenues in 1993 from other federal grants, contracts, or both, the remaining health centers received less than 7 percent of their revenues directly from other federal grants.

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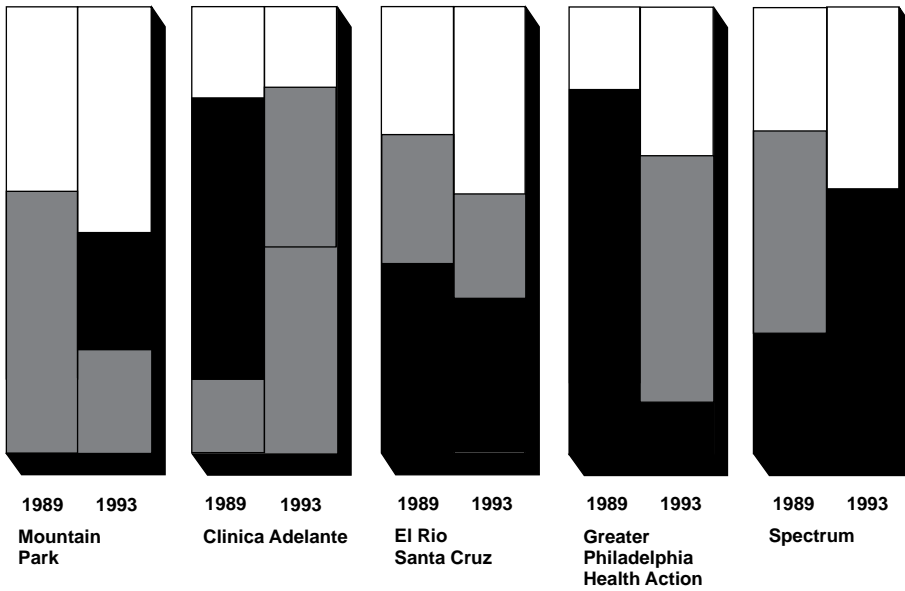
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Figure 1: Percentage of Health Center Receipts, by Source



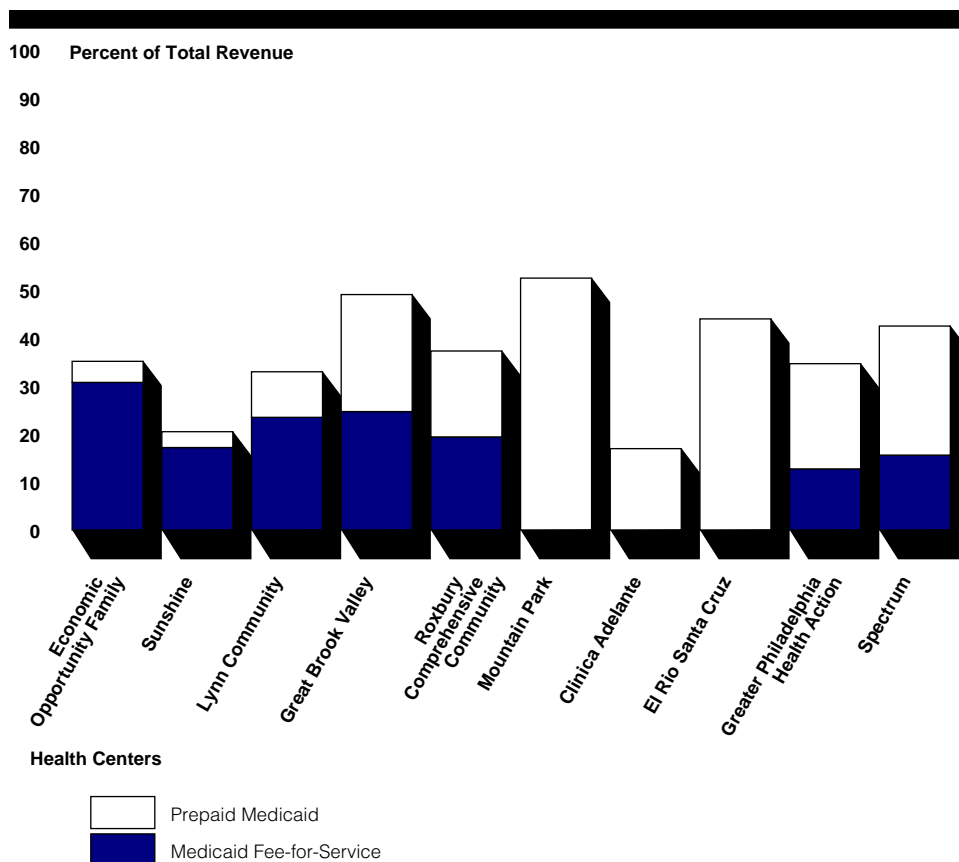
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The degree to which health centers were involved in prepaid managed care varied considerably among the 10 health centers. In 1993, prepaid managed care accounted for as little as 3 percent and as much as 52 percent of the total health center revenues (see fig. 2). Differences also existed in the percentage that prepaid managed care revenues represented of total Medicaid revenues, ranging from about 12 to 100 percent of total Medicaid revenues among the 10 centers.

Figure 2: Medicaid Fee-For-Service and Prepaid Managed Care Receipts



Typically, health centers participate in prepaid managed care through health plans serving Medicaid beneficiaries. The health centers contract with one or more health plans to provide a subset of health plan services. Reimbursement for primary care services at the 10 health centers we reviewed was paid as a monthly capitated rate.⁹ The capitation rates for primary care services ranged from \$12 per member per month at one health center to \$38 per member per month at another. Rates varied in large part because of the different services covered under health plan contracts. For example, a center receiving a higher rate may provide additional services, such as X rays and immunizations. If a center with a

⁹While health centers can be reimbursed on either a capitated or fee-for-service basis, the most common arrangement between health centers and health plans is a capitated payment for primary care services only. Other arrangements exist; for example, one Medicaid health plan pays its primary care providers, including health centers, on a discounted fee-for-service basis.

lower rate provides these services to plan enrollees, it could receive additional reimbursement on a fee-for-service basis. Some centers also told us that they had received a higher rate because they had negotiated for one with the health plan.

In addition to agreeing to provide primary care services, four health centers have assumed financial responsibility for referrals, hospitalization, or both in return for a higher capitation rate.¹⁰ In such arrangements, the managed care plan withholds a portion of the health center's primary care capitation payment to cover referral or hospitalization costs that are higher than expected. In some cases, if the funds withheld are insufficient to cover the losses, the amount withheld in the future from health center capitation payments can be increased.

Health Centers Are Currently Able to Provide Services to the Underserved

Despite the concern that capitation would make it difficult for health centers to maintain their service levels, we found that the 10 centers continue to offer many services targeted to the needs of their communities and that they have maintained the intensity and frequency of the services provided. In addition to medical care, many of the health centers offer transportation and translation services as well as health education, acquired immunodeficiency syndrome (AIDS) case management, and early intervention services for children of substance abusers. These enabling services are very important in reducing the barriers to health care as well as helping to address problems that can lead to the need for further medical care. In addition, these services are available to all health center patients including those whose benefit package may not cover the cost of these services. (See fig. 3 for a list of the enabling services provided at each health center.)

¹⁰Of these four, one health center shares this financial responsibility with the managed care plan.

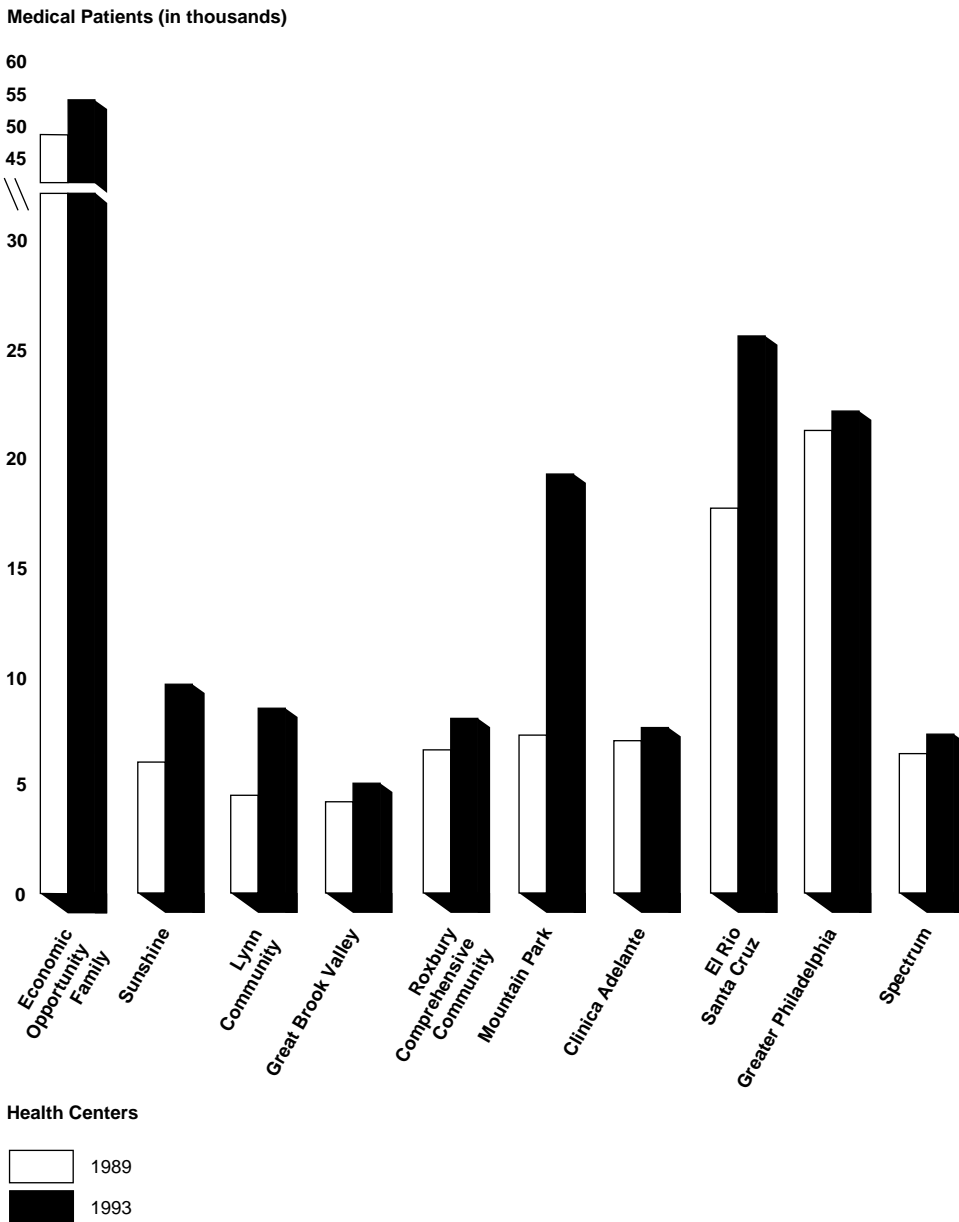
Figure 3: Health Center Programs and Services

Health Centers	Programs and Services													
	WIC Nutrition Program	Transportation	Translation	Health Education	Health Outreach Workers	Substance Abuse Counselors	AIDS Case Management	Violence Prevention	School-Based Services	Homeless Assistance	Outreach Workers	Social Workers	Child Care	HIV Testing and Counseling
Economic Opportunity Family	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Sunshine	■		■	■		■	■	■			■		■	
Lynn Community	■	■	■	■	■		■		■		■		■	
Great Brook Valley		■	■	■	■			■	■		■		■	
Roxbury Comprehensive Community	■	■		■	■	■	■	■			■		■	
Mountain Park			■	■	■		■				■		■	
Clinica Adelante	■	■	■	■	■									
El Rio Santa Cruz Neighborhood	■	■	■	■	■			■	■		■		■	
Greater Philadelphia Health Action	■	■		■	■	■	■	■			■	■	■	
Spectrum				■			■							■

Indicators of a health center’s ability to increase access to the community it serves include growth in the number of patients served and in the amount of funds spent on subsidizing low-income care. All the health centers increased access to medical care. The number of medical patients

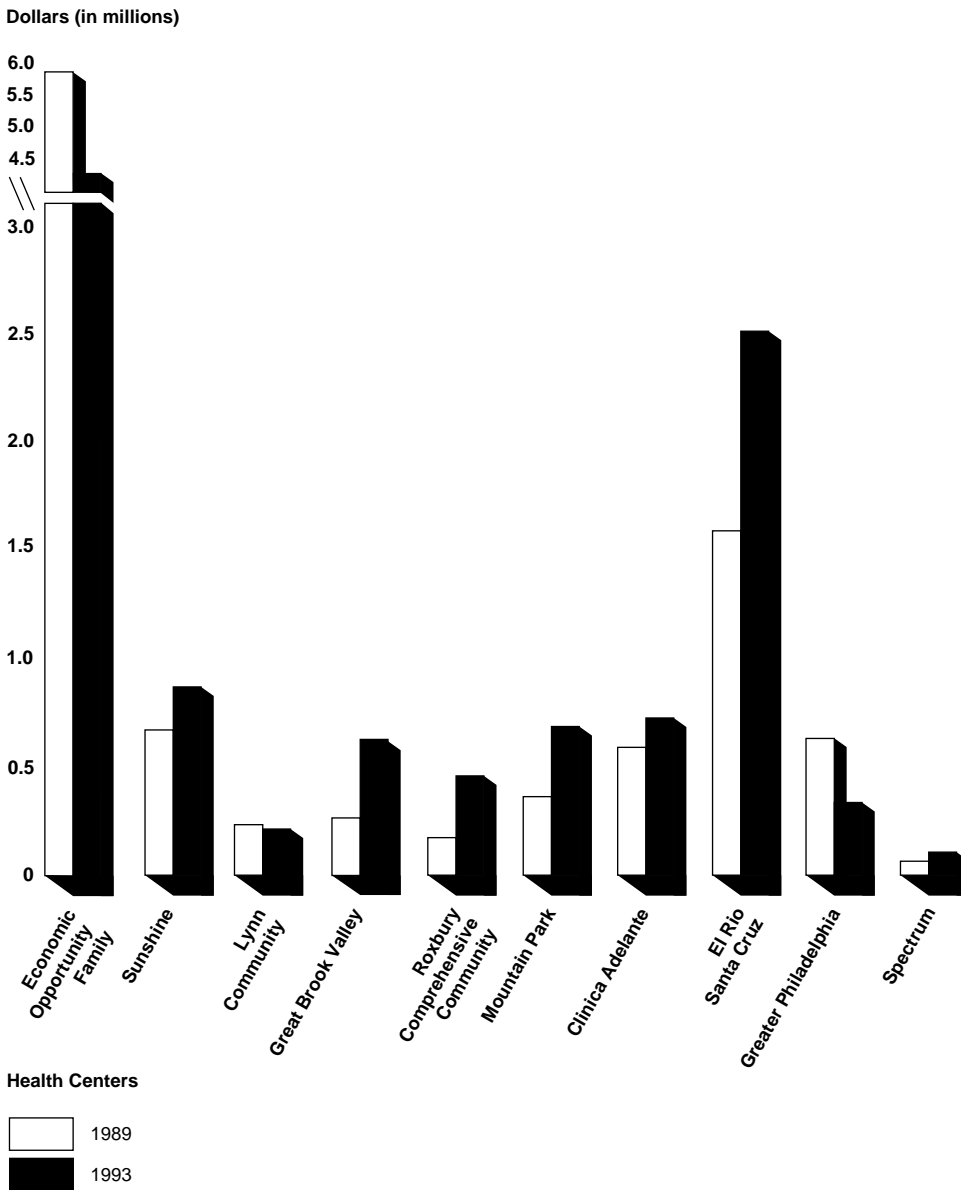
served by the health centers increased from 131,000 to almost 169,000 from 1989 to 1993, with individual center increases ranging from 4 to 164 percent (see fig. 4). In addition, the number of patient visits or encounters increased from 596,063 to 828,848 between 1989 and 1993 at the 10 health centers.

Figure 4: Health Center Medical Patients



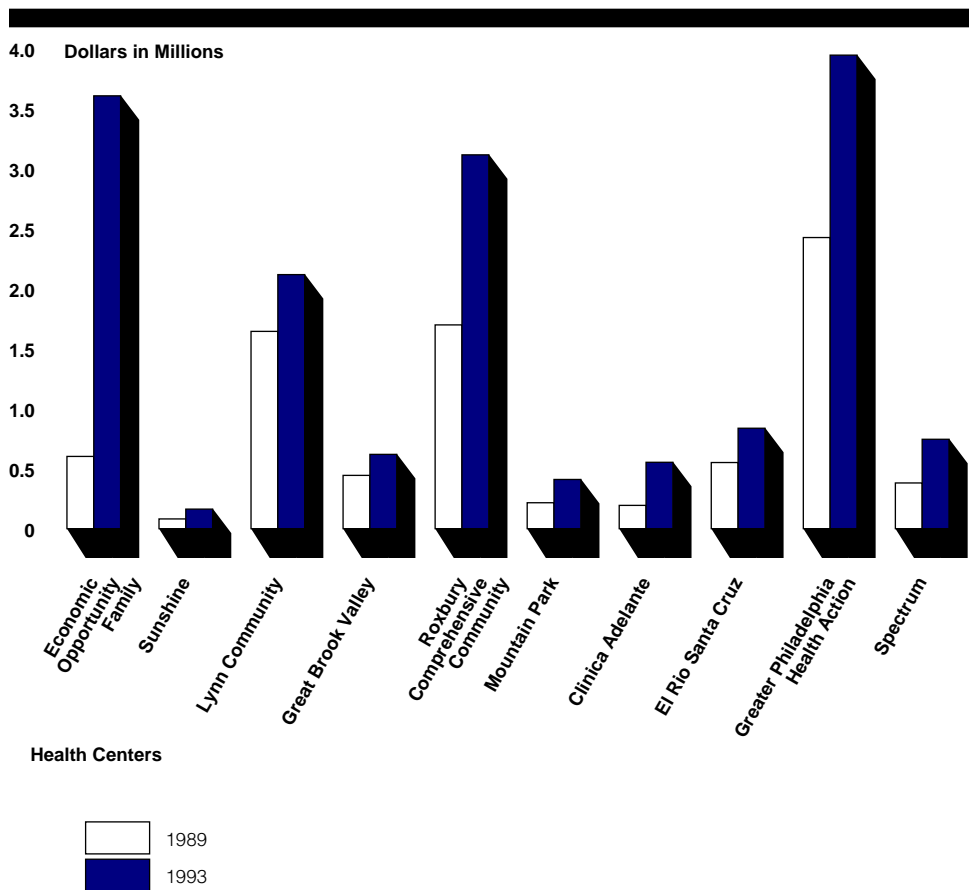
Between 1989 and 1993, 7 of the 10 health centers increased their spending on subsidized low-income care; that is, the amount of spending for free care and the remaining portion of care that uninsured low-income patients are unable to cover (see fig. 5).

Figure 5: Subsidized Care for Low-Income Patients



We examined the growth of spending on enabling services in each health center, another indicator of a health center’s ability to increase access to care. We found that all 10 of the health centers had increased spending on these services between 1989 and 1993 (see fig. 6). Further, health center officials told us that enabling services were expanded or enhanced in response to growing community needs. In addition, officials at all 10 centers reported that the intensity or frequency of services typically provided at the center had not been reduced with prepaid managed care.

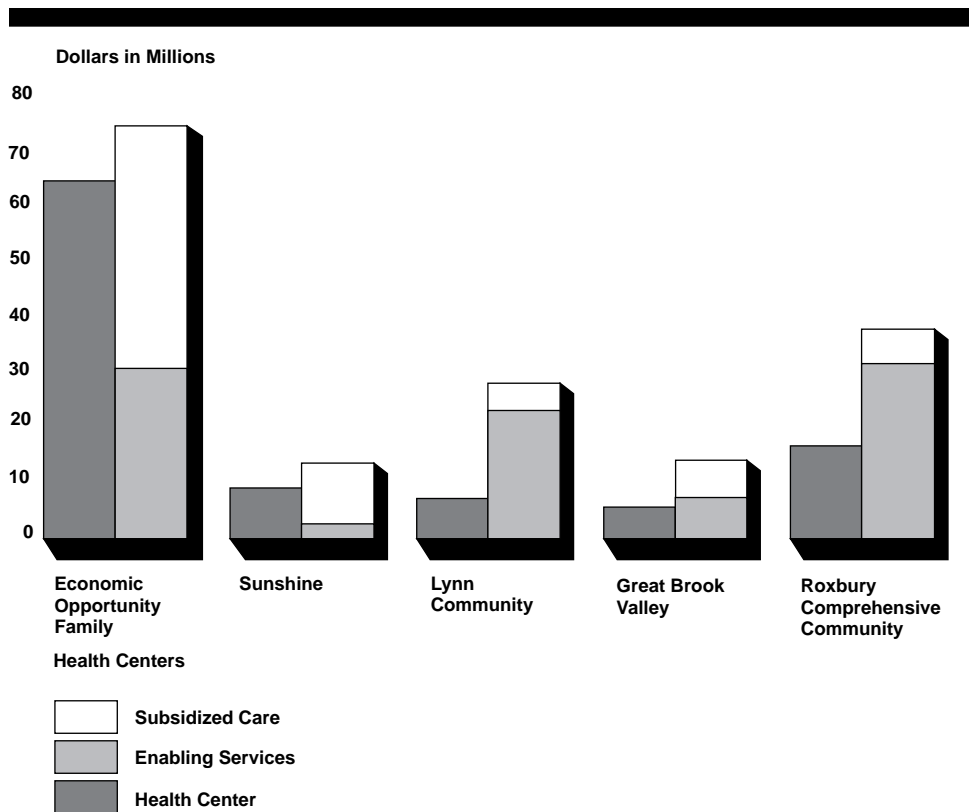
Figure 6: Spending on Enabling Services

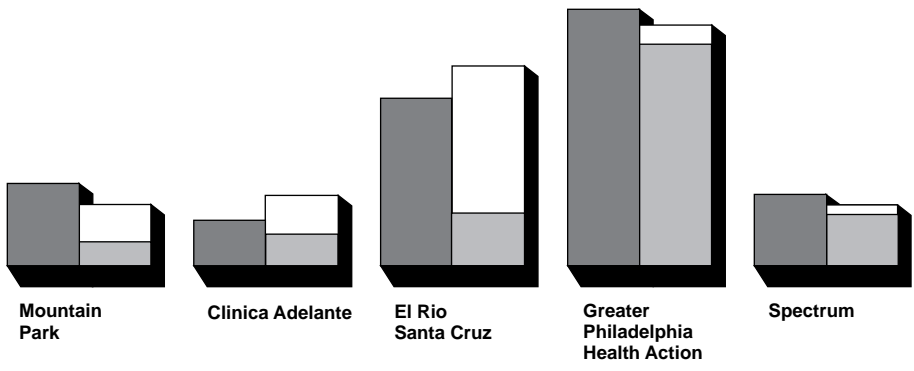


While the amount of spending on enabling services and subsidized low-income care generally increased among all health centers, these amounts varied considerably from center to center as did the distribution

of spending between enabling services and subsidized care of low-income patients. In most cases the sum of spending on enabling services and subsidized care exceeded revenues received from the Community and Migrant Health Center program grant (see fig. 7).

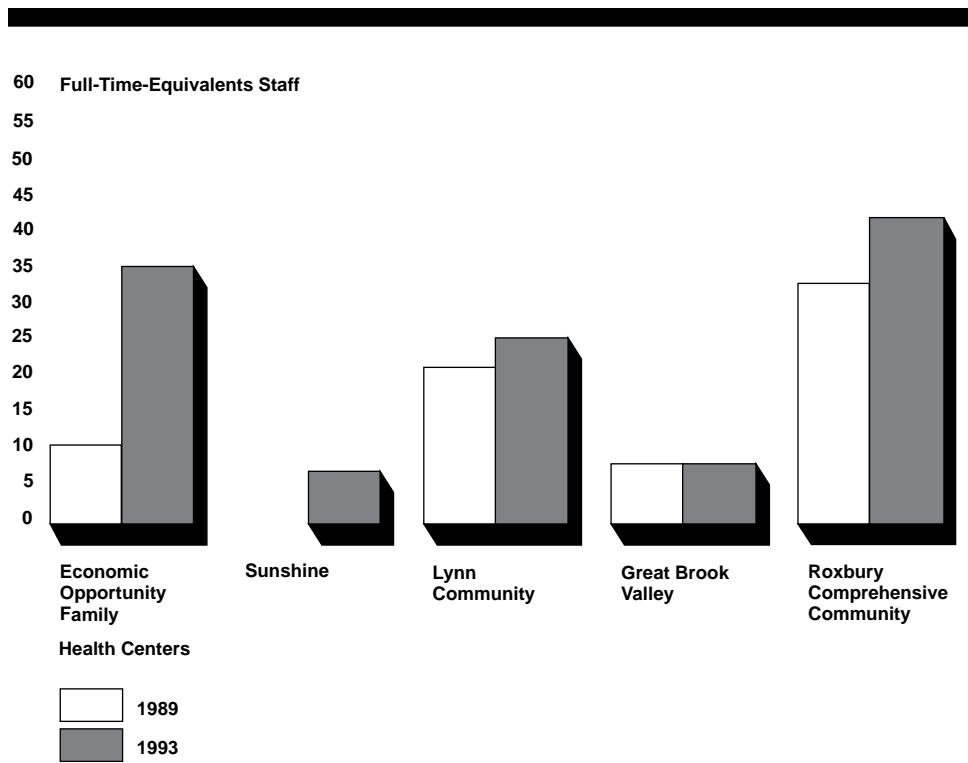
Figure 7: Revenue From Health Center Grants and Spending on Enabling Services and Subsidized Care

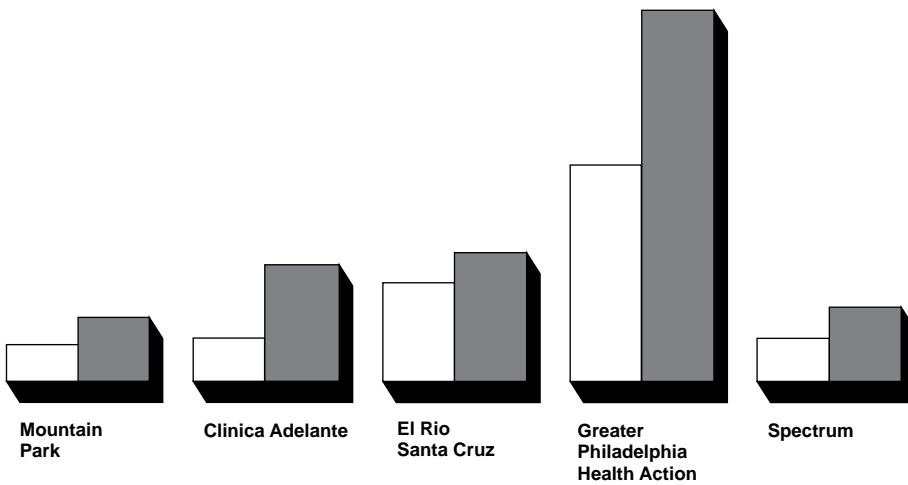




With more spending on enabling services, 9 of the 10 health centers increased the number of full-time-equivalent staff involved in providing services other than medical or dental. These included health education, social services, and case management. Staff providing these services included drivers for transportation services, outreach workers, dietary technicians, and home health aides (see fig. 8).

Figure 8: Nonclinical Full-Time-Equivalent Staff





Center officials told us that community needs largely influenced patterns of spending on enabling services and to subsidize low-income care. For example, the health centers that we visited in densely populated areas spent more money on enabling services, which include social case workers, than the other centers. The health centers in less populated areas tended to subsidize low-income care to a greater extent. Officials also reported that changing local community conditions—such as an increase in drug abuse or AIDS—could affect the combination of enabling services and subsidized care.

Health Centers Have Improved Their Financial Positions While Maintaining Services

While maintaining or expanding their medical and enabling services, all the health centers that we studied reported improved financial positions, as indicated by increases in their year-end fund balances; that is, the excess between a center’s assets and liabilities.¹¹ One contributing factor is an increase in total revenues. Among the 10 health centers, increases in total revenues ranged from 35 percent to 142 percent between 1989 and

¹¹Fund balance information was taken from health center financial statements. These statements may be stand-alone for primary care services or consolidated with other operations of the community health center. Health center assets may include property, plant, equipment, inventory, and receivables, all of which may not be easily convertible to cash.

1993. Three of the centers saw revenue increases of over 100 percent during this period.

Improvement in fund balances results when increases in revenues from a variety of sources are greater than a center's expenses. Five centers had increases in grants from other federal and state sources. For example, one health center received \$556,000 from a Ryan White AIDS grant in 1993.¹² All health centers, however, had increases in their Medicaid revenue between 1989 and 1993. Increases ranged from 12 percent at one center to over 1,000 percent at another.¹³ Medicaid prepaid managed care income also contributed modestly to fund balance increases.

Prepaid Managed Care Revenues Support Medical Services but Play a Small Role in Supporting Other Services

Prepaid managed care earnings were modest at best and played a small role in supporting enabling services and subsidized care. In 1993, three centers reported losses of up to \$124,000 from prepaid managed care. Other funds offset these losses. During the same year, six centers reported excess prepaid managed care revenues of up to \$100,000 after paying the cost of care for medical services and administrative expenses. One center reported no excess revenues from prepaid managed care.

Officials at nine of the health centers told us that returns from managed care had not contributed significantly to center support of enabling services and subsidized care. At the tenth center, however, the director told us that growth in managed care revenues had allowed the center to increase its spending on subsidized care. Between 1989 and 1993, the center's health center grant funding remained level, while the amount of spending on subsidized care grew from nearly \$1.6 to \$2.5 million revenues from prepaid managed care contributed to the spending on subsidized care. At the same time, the director noted that the federal health center grant was indispensable to the center's maintaining a steady level of funding for enabling services and subsidized care. Officials from three health centers told us that the predictability of monthly capitation reimbursements allowed them to better manage center finances.

¹²The Ryan White Comprehensive AIDS Resource Emergency Act of 1990 (P.L. 101-381) was enacted to improve the quality and availability of services for individuals and families with the human immunodeficiency virus (HIV).

¹³The 1,000-percent increase at the one center was due to a combination of factors. Not only did the center see a growth in its Medicaid population, it also began to receive a higher rate of reimbursement for Medicaid patients as cost-based reimbursement was implemented.

Despite Increases in Fund Balances Some Centers Are Vulnerable to Unexpected Losses

Although all the health centers have increased their year-end fund balances, some may be vulnerable to financial difficulties. While all 10 health centers had year-end fund balance increases, none of the centers had cash on hand to cover more than 60 days of operating expenses.¹⁴ Cash on hand ranged from fewer than 1 day of operating expenses at 2 centers to 31 days' worth at another. Three centers only had available cash to cover fewer than 10 days of operating expenses.¹⁵

Cash reserves are important because they represent liquid assets that can be used to pay for contractual obligations and unexpected expenses. Funds for unexpected expenses are especially critical for health centers with more than 15 percent of total revenues from prepaid managed care arrangements and those that have accepted financial responsibility for services other than primary care.¹⁶ For example, when centers take on risk for medical care and hospitalization but more patients than expected require costly treatment or extended hospitalization, losses could be substantial. We found that seven centers received more than 15 percent of their total revenue from prepaid managed care. The four centers that have assumed financial responsibility for specialty referrals, hospitalization, or both all had cash reserves of 31 or fewer days of operating expenses, thereby making them vulnerable to financial difficulties.

Centers can also be financially vulnerable when capitation rates do not fully cover the cost of the care they provide. Centers are faced with either depleting their reserves or cutting back services. Several health center directors told us that their capitated reimbursements are adequate to cover the costs of medical services and some believed that their capitation rate roughly equaled what they would receive from cost-based

¹⁴In 1992, the Congress amended sections 329 and 330 of the Public Health Service Act to allow health centers to establish cash reserves. These reserves would be available to the grantees to cover unexpected expenses, some of which could result from prepaid services. In June of 1994, BPHC issued guidance to health centers on how to implement the 1992 amendments. However, BPHC did not specify an amount of cash reserves that centers are required to maintain because centers differ in the amount of revenue derived from prepaid managed care and in financial risk assumed by centers for nonprimary care services. BPHC believes that a cash reserve equivalent to normal expenses for 60 to 90 days would be reasonable for centers assuming financial risk for primary care services. In addition, BPHC believes that a much larger reserve would be required of centers assuming financial risk for specialty and hospital services.

¹⁵Because our review of health centers was conducted for the period of 1989 through 1993, and the BPHC guidance for establishing cash reserves was issued in mid-1994, none of the centers had established such reserves. We compared the centers' cash and investments that would be used to establish a reserve. BPHC anticipates that these reserves will be established over a period of time starting with the 1995 grant period.

¹⁶This is a BPHC-suggested benchmark.

reimbursement. In most cases, however, center directors could not provide us with data to substantiate their position.

Lessons Learned From Health Center Experience With Prepaid Managed Care

While the health centers we visited are now providing medical and enabling services to their communities, some initially faced several problems that are likely to confront other health centers as states expand Medicaid managed care. First, health centers must determine whether not participating in managed care arrangements will affect the number of patients served or revenues needed for financial viability. Centers that do participate may face financial problems if reimbursement is inadequate and they accept too much financial risk or lack managed care skills.

Health Centers That Do Not Participate in Prepaid Managed Care Risk Losing Patients

Directors of most of the health centers we visited felt compelled to enter into agreements with Medicaid managed care plans to maintain their Medicaid patient population and revenues. The Medicaid population is an important component of the medically underserved population that health centers are intended to serve. Health centers that do not have agreements with Medicaid health plans can lose some or all of their Medicaid patients and revenues, jeopardizing their continued operation. Because Medicaid revenue is a large and growing part of most health centers' funding, losing this funding could be catastrophic.

In 1994, a health center in Washington state experienced severe financial difficulties when its relationship with the only local Medicaid health plan was discontinued.¹⁷ The structure of the health plan, which limits membership to individual physicians, made it impossible for the health center to contract directly with the plan. Rather, one physician employed by the center contracted with the plan. When this physician resigned from the center, its relationship with the plan ended. The center's other physicians were not acceptable to the health plan because of concerns about the physicians' admitting privileges at the local hospital and their ability to guarantee 24-hour coverage or because the physicians were not willing to contract with the plan.¹⁸ Because all Medicaid beneficiaries in the health center's service area were enrolled in this health plan, the center lost 1,000 Medicaid patients when they were assigned to other health plan providers. As a result, the center abruptly lost one-third of its

¹⁷Although we visited this center, we did not select it for detailed study because of its short tenure as a federally funded community health center.

¹⁸Physicians joining this plan must accept financial responsibility for ensuring continued care of plan members if the health plan becomes insolvent.

patients and 17 percent of its revenue over a 7-month period. The center's director told us that without this revenue the center was not viable and eventually would have to close. The center reestablished its relations with this health plan when the physician returned and Medicaid patients are being reassigned.

Also in 1994, health centers in another state, Tennessee, faced the loss of Medicaid revenues if they did not participate in the TennCare program. As a result, all the health centers in Tennessee participate in the TennCare program despite their loss of cost-based reimbursement.¹⁹ Health centers had no choice but to contract with the TennCare health plans, according to the director of the Tennessee Primary Care Association, an association of community health centers in Tennessee. Health centers felt compelled to participate because the Medicaid population is an important part of the health centers' target population. In addition, without the Medicaid revenue, health centers would not be able to continue to offer the range of services they typically provide. Some center officials believed that centers would have closed without this revenue.

Health Centers That Do Participate May Incur Financial Risks

While the 10 health centers we studied expanded their support for enabling services between 1989 and 1993, the early experience of 3 of these centers with managed care was problematic. Each reported initial depletion of financial resources, and in one case a cutback in services occurred as well as a reorganization due to bankruptcy. Early center problems stemmed from

- inadequate capitation rates paid to health centers;
- assignment of more financial risk to health centers than they were capable of managing; and
- a lack of managed care knowledge, expertise, and systems.

Low primary care capitation rates and assignment of financial risk for referral services contributed to financial difficulties at two Philadelphia health centers in 1987 and 1988, according to health center and BPHC officials. Because the capitation rate did not fully cover the centers' operating costs, the centers were forced to deplete their cash balances to continue providing services. Both centers reported that they could not negotiate higher rates or avoid accepting too much financial risk in part because the Medicaid beneficiaries were all assigned to one health

¹⁹The National Association of Community Health Centers has sued the Secretary of HHS to invalidate the section 1115 statewide waiver granted to Tennessee to implement a statewide Medicaid managed care program.

maintenance organization. This left the health centers in a poor position to negotiate a higher capitation rate or different risk arrangements. Since that time, competing health plans have been added to the Medicaid managed care program. In addition, the health centers are more knowledgeable about managed care arrangements. They no longer accept risk for services that they do not provide and have negotiated more acceptable rates. After one of the Philadelphia centers gained experience in tracking managed care operations, it developed data in 1991 showing that the utilization patterns of its health plan enrollees justified a higher capitation rate.

An Arizona health center also suffered financial difficulties once it entered into Arizona's Medicaid managed care program, established in 1982. According to the center's current director, capitation rates were inadequate to cover the costs of serving patients in Arizona's Medically Needy/Medically Indigent eligibility category.²⁰ In the early 1980s, the center had accepted financial risk for all medical services, including referrals and hospitalizations for its enrollees. Further, the center did not have adequate information systems to manage the risk it had assumed or adequate capital to absorb losses. Within 4 years the center became insolvent and reorganized under chapter 11 of the Federal Bankruptcy Code. It was forced to cut back on its medical and enabling services as it reorganized through bankruptcy in 1986 after experiencing large managed care losses. The health center has completed its restructuring and is now a provider for several health plans. In addition, the health center no longer accepts full financial risk for referrals or hospitalizations.

BPHC Provides Assistance to Health Centers Entering Prepaid Managed Care

The explosive growth in Medicaid managed care leaves many community health centers with little choice about participating in these new arrangements. However, health centers entering prepaid arrangements are faced with a series of new activities, each of which they must manage well to succeed. First, they must negotiate a contract that pays an adequate capitation rate and does not expose them to undue risk or otherwise hinder them. They must also perform the medical management functions of a prepaid system. In addition, health centers must monitor their financial positions under each managed care agreement, including any liability for referral and hospital services. They must also develop and maintain the information systems needed to support the above clinical and financial management activities. BPHC has strongly encouraged health centers to consider participating in managed care arrangements, while

²⁰This is an eligibility category specific to Arizona's program. Applicants are allowed to subtract the previous years' medical expenses from the applicants' annual income. In 1992, the qualifying income level after the spend-down was \$3,200 for an individual.

cautioning them of the dangers of accepting risk for services provided by others. Further, BPHC is funding a number of activities to help health centers become providers that can effectively operate in a managed care system.

Recognizing that health centers require both specific and general knowledge of managed care, BPHC cooperates with the National Association of Community Health Centers to provide training and technical assistance to grantees. Several training sessions are available to BPHC grantees. Subjects include managed care basics, negotiating a managed care contract, medical management, and rate setting. In 1994, 48 sessions in 35 states were provided, reaching over 1,500 individuals. Technical assistance consists of intensive one-on-one consultations between managed care experts and health center officials. During 1994, 65 health centers requested and received one-on-one technical consultations.

BPHC has also developed various publications for health centers to use as self-assessment tools. These publications offer guidance on aspects of managed care such as preparing for prepaid health services, negotiating with managed care plans, and assessing the market area and internal operations.

Realizing that health centers lack experience in negotiating contracts with health plans, BPHC offers a contract-review service between centers and health plans.²¹ These contracts are typically reviewed by outside private-sector managed care specialists who provide written advice on specific sections that could be revised more favorably for health centers. In 1994, BPHC reviewed 45 contracts for approximately 30 health centers.

In addition to activities targeted toward individual health centers, BPHC also assists centers in planning and initiating participation in managed care arrangements through the ISN, established in 1994. These one-time awards are to be used by health centers for planning and developing an integrated delivery system with other providers that will ensure access for the medically underserved. Approximately \$6 million was awarded to 29 health centers in 1994.

One of the health centers we visited in Florida is using an ISN award to develop a network of community health centers that can negotiate with

²¹Our review of health center contracts with managed care organizations showed that many left key contractual elements (scope of services, access to accounting information, assignment of members, and the like) unspecified or unclear.

managed care plans. In Washington state, a health center received an ISN award to help establish a statewide Medicaid managed care plan.

Conclusions

As states move to prepaid managed care to control costs and improve access for their Medicaid populations, the number of participating health centers continues to grow. Medicaid prepaid managed care is not incompatible with health centers' mission of providing access to health care for medically underserved populations. However, health centers face substantial risks and challenges as they move into these arrangements. Such arrangements require new knowledge, skills, and information systems. Centers lacking this expertise face an uncertain future and those in a vulnerable financial position are at even greater risk.

Today's debate over possible changes in federal and state health programs—including Medicaid and other health grant programs, important funding streams for health centers, and the lack of available cash at all 10 centers—heightens the concern over the financial vulnerability of centers participating in prepaid managed care. If this funding source continues to grow as a percentage of total health center revenues, centers must face building larger cash reserves while not compromising medical and enabling services to the vulnerable populations that they serve.

Agency Comments

HRSA and BPHC officials reviewed a draft of this report and considered it a balanced presentation of the challenges facing community health centers involved in Medicaid prepaid managed care arrangements. We also incorporated their technical comments as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services and other congressional committees. Copies will be made available to others on request. If you or your staff have any questions about this report, please call me at (202) 512-7119; Rose Marie Martinez, Assistant Director, at (202) 512-7103; or Paul Alcocer at (312) 220-7615. Other contributors to this report include Jean Chase, Nancy Donovan, and Karen Penler.

Sincerely yours,

A handwritten signature in black ink that reads "Mark V. Nadel". The signature is written in a cursive style with a large, sweeping initial "M".

Mark V. Nadel
Associate Director
National and Public Health Issues

Contents

Letter		1
Appendix I		36
Characteristics of	Arizona	36
Community Health	Florida	37
Centers Visited	Pennsylvania	38
	Massachusetts	39
Appendix II		41
Scope and		
Methodology		
Table	Table II.1: Characteristics of Four State Programs	41
Figures	Figure 1: Percentage of Health Center Receipts, by Source	10
	Figure 2: Medicaid Fee-for-Service and Prepaid Managed Care Receipts	12
	Figure 3: Health Center Programs and Services	14
	Figure 4: Health Center Medical Patients	16
	Figure 5: Subsidized Care for Low-Income Patients	18
	Figure 6: Spending on Enabling Services	19
	Figure 7: Revenue from Health Center Grants and Spending on Enabling Services and Subsidized Care	21
	.	22
	.	
	.	
	.	
	Figure 8: Nonclinical Full-Time-Equivalent Staff	23
	.	24

Abbreviations

AIDS	acquired immunodeficiency syndrome
BPHC	Bureau of Primary Health Care
EOFHC	Economic Opportunity Family Health Center
GPHA	Greater Philadelphia Health Action, Inc.
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
ISN	Integrated Service Network
LCHC	Lynn Community Health Center
MPHC	Mountain Park Health Center
OEO	Office of Economic Opportunity
OBRA 89	Omnibus Budget and Reconciliation Act of 1989
PCCM	primary care case management
PHS	Public Health Service
RoxComp	Roxbury Comprehensive Community Health Center

Characteristics of Community Health Centers Visited

The health centers included in our review serve primarily minority communities with serious health problems such as infectious diseases, diabetes, cardiovascular disease, AIDS, and substance abuse. In addition to these problems, many of the communities have infant mortality rates that are higher than the national rate. Health center patients are generally poor with incomes at or below 100 percent of the federal poverty level. At some centers, over 90 percent of patients are at this poverty level. A large percentage of the centers' patients are covered by Medicaid but a significant portion have no health insurance coverage.²² Listed by state, the following health centers were included in our review:

Arizona

Mountain Park Health Center

Founded in 1979, Mountain Park Health Center (MPHC) was formerly known as Memorial Family Health Center and was part of Phoenix Memorial Hospital. In 1987, MPHC became a community-organized primary care center. The center operates in urban South Phoenix, described as the "most multicultural community in Arizona." Seventy-five percent of the center's patients are Hispanic and 18 percent are African American.²³ AIDS and infant mortality are among the health problems in South Phoenix, where the infant mortality rate for African Americans is 17.3 per 1,000 live births. Seventy-eight percent of the center's patients are at or below the poverty level. Sixty-eight percent have Medicaid coverage and 14 percent are uninsured.

Clinica Adelante, Inc.

This center's rural-based service area consists of a main site in Surprise, Arizona, and two other sites; one in Queen Creek and another at Gila Bend. Eighty-eight percent of Clinica Adelante's population is Hispanic. Thirty-nine percent of the center's patients are migrant and seasonal farmworkers. Major health problems in the population covered by the center include a lack of adequate prenatal care, inadequate postpartum visits and newborn checks in the perinatal population; infectious diseases, inadequate nutrition, and dental decay in the pediatric population; and diabetes, hypertension, and cardiovascular disease in the adult population. Twenty-nine percent of the center's patients have Medicaid coverage and

²²Demographic, economic, and insurance data are provided for 1992 in the case of three centers, for 1993 (four centers), and for 1994 (two centers).

²³This racial/ethnic category may include blacks from Haiti, Jamaica, and other countries.

67 percent of them have no insurance coverage at all. Eighty-five percent are at or below the poverty level.

**El Rio Santa Cruz
Neighborhood Health
Center, Inc.**

Established 25 years ago, the El Rio health center consists of a main clinic and seven satellite clinics that provide medical and other services to the medically underserved in Tucson. With the majority of patients residing on the south and west sides of Tucson, the significant geographical barriers to health care access are isolation and the remoteness of these locations as well as poor public transportation. The locations of other health care facilities can be at a considerable distance from where most of the patients reside. In addition, language and cultural differences characterize the patients of the El Rio center. Almost one in seven households in the center's service area routinely uses a language other than English in the home. Other factors exacerbating access to services are proximity to the U.S. border with Mexico, a large undocumented population and a local and transient homeless population.

The El Rio service area has a higher proportion of Hispanics to the total population, 55 percent versus 23 percent. Twenty-two percent of other center patients are white and 14 percent are American Indian. Seventy-eight percent are at 100 percent or below the poverty level. Forty-one percent of center patients have Medicaid coverage and 38 percent are uninsured.

Florida

**Sunshine Health Center,
Inc.**

Since 1964, Sunshine Health Center, Inc., has provided comprehensive primary medical and dental services to migrant and urban poor residing in Broward County, Florida. The Sunshine Health Center serves a patient population of migrant and seasonal farm workers; emigrants from various countries including Haiti, Jamaica, Puerto Rico, and Nicaragua; and African Americans and whites, most of whom are the poor and the working poor. Thirty-two percent of the center's patients are white, 30 percent are African American, and 20 percent are Hispanic.

Located in a county that leads the United States in the increase in AIDS patients, the center serves a population with high rates of infant mortality and morbidity, sexually transmitted diseases, and chronic disorders such

as hypertension and diabetes. Ninety-three percent of the patients of the center are at or below the poverty level. Thirty-eight percent are Medicaid patients and 58 percent have no insurance.

**Economic Opportunity
Family Health Center**

From its 1967 start in a trailer, the Economic Opportunity Family Health Center (EOFHC) has evolved into its main center, six satellite centers, and affiliated school outreach programs serving the north and northwest areas of Dade County. Dade County has a large and rapidly growing AIDS population, significant substance abuse problems, a large migratory farmworker population, and minority populations with extremely high incidence of tuberculosis, sexually transmitted diseases, and infectious diseases. The population served by EOFHC is 70 percent African American and 20 percent Hispanic. Sixty-six percent of center revenues are generated primarily from the federal government.

Pennsylvania

**Spectrum Health Center,
Inc.**

This center began operations in 1967 to provide family planning and general health services to women. Located in the West Park section of Philadelphia, Pennsylvania, the center serves an area characterized by high infant mortality, low birthweight, teenage pregnancy, and the spread of sexually transmitted diseases including HIV infection. Ninety-nine percent of Spectrum's patients are African American and 90 percent of the center's patients are at or below the poverty level. Seventy-one percent of center patients have Medicaid coverage and 27 percent have no insurance.

**Greater Philadelphia
Health Action, Inc.**

Greater Philadelphia Health Action, Inc. (GPHA) is targeted to provide health care to Philadelphia's medically underserved population. GPHA operates five primary health care centers, a drug and alcohol counseling and treatment program, a child care program, and two comprehensive school-based clinics. Philadelphia's health care problems include an infant mortality rate of 14.2 deaths per 1,000 live births; an 11.7-percent low-birth-weight rate; a high teen birth rate of 49 births per 1,000 females (up from 46 per 1,000 in 1988); increasing rates of substance abuse, especially among women; and increasing rates of HIV/AIDS. The vast majority of patients are African American (73 percent) and have incomes at or below 100 percent of the federal poverty level (88.5 percent).

Seventy-three percent have Medicaid coverage and 22 percent are uninsured.

Massachusetts

Lynn Community Health Center

The Lynn Community Health Center (LCHC) was organized in 1971 as a small storefront mental health center. It has grown into a comprehensive care facility that is the largest provider of outpatient primary care in Lynn, a city characterized by the center's executive director as the most medically underserved area in Massachusetts.

LCHC's programs focus on people with the greatest barriers to care: the poor, minorities, new immigrants, non-English speaking people, teens, and the frail elderly. Sixty percent of the population served by the center do not consider English to be their first language. At present, Spanish and Russian are the most common languages spoken by the center's patients. Over 30 percent of LCHC's staff is bilingual or multilingual and can provide translation services in Spanish, Khmer, Vietnamese, Laotian, and Russian.

Forty-five percent of center patients are white, 35 percent are Hispanic, and 11 percent are African American. Sixty-three percent are at or below the poverty level. Fifty-six percent have Medicaid coverage and 31 percent have no insurance.

Great Brook Valley Health Center, Inc.

This center was founded in 1972 by a group of mothers living in Worcester's largest housing project—the Great Brook Valley and Curtis Apartments. These women founded the center because they and their children lacked access to primary care. The center has grown from providing well-child care services to the residents of public housing projects to a comprehensive health center serving the surrounding neighborhood.

Special populations requiring services include the perinatal population (in Worcester, rates in two areas—infant mortality and low-birth-weight infants—have been above the state average for the past decade) and the Spanish-speaking elderly population who are monolingual. In addition, the HIV/AIDS epidemic is growing in Worcester, particularly among the minority populations and among the estimated 4,000 injection drug users in the city.

In addition, adolescents are exposed to high levels of stress, violence, and depression.

The Hispanic community represents 76 percent of center patients. Ninety-five percent of those using the center are at or below the poverty level. Fifty-five percent are covered by Medicaid and 30 percent have no insurance.

**Roxbury Comprehensive
Community Health Center,
Inc.**

Roxbury Comprehensive Community Health Center (RoxComp), established in 1969 by a mother concerned about the lack of medical services in the Roxbury community, is the largest community health center serving the Roxbury and North Dorchester areas. Health status indicators for these communities are higher than the national average. For example, the infant mortality rate is twice the national average of 10.1 per 1,000 live births. The area served by the center also exceeds the national average in deaths from heart disease, cancer, stroke, pneumonia, influenza, cirrhosis, homicide, suicide, and injuries. Approximately 20 percent of reported AIDS cases in Boston come from this area. Substance abuse among patients 19 years old and younger and among pregnant women is a problem in the area.

Residents served by the center are poor, with 91 percent at or below the poverty level. Eighty-eight percent of center patients are African American. Sixty-two percent have Medicaid coverage and 26 percent have no insurance.

Scope and Methodology

To examine how Medicaid prepaid managed care affected community health centers' ability to continue their mission of providing community-based health care to underserved populations, we first selected a nonrandom judgmental sample of states with a variety of Medicaid managed care situations. The states included Arizona, Florida, Massachusetts, and Pennsylvania, whose prepaid managed care programs included (1) mandatory and voluntary enrollment of beneficiaries, (2) statewide and more geographically limited programs, and (3) capitated Medicaid programs implemented with and without waivers (see table II.1).

Table II.1: Characteristics of Four State Programs

State	Mandatory enrollment	Statewide program	Waiver type
Arizona	Yes	Yes	Section 1115
Florida	No	No	1915(b) ^a
Massachusetts	No	No	1915(b) ^a
Pennsylvania	Yes	No	1915(b)

^aThese waivers are for primary care case management model programs that do not involve capitated payments.

In each state, we then visited selected health centers that had prepaid managed care plans operating in their areas for at least 3 years and gathered at least 5 years' worth of audited financial statements. Program data for the same period were obtained from health center responses to the Bureau of Primary Care's Common Reporting Requirements.²⁴

To determine whether health centers were encountering financial difficulties while engaged in prepaid managed care operations, we compiled data on their financial positions. Specifically, we reviewed data on year-end fund balances, which represent the excess between center assets and their liabilities. In addition, we calculated the number of days of operating expenses that cash balances could support.²⁵

We analyzed program data in several different ways. To determine whether health centers were maintaining access for underserved and vulnerable populations, we compiled data on the number of patients

²⁴We did not independently verify the data contained in these reports.

²⁵Daily operating expenses were calculated by dividing total expenses as reported on annual financial statements by 365 days as defined by generally accepted accounting principles. Cash available included cash and investments such as certificates of deposit reported on annual financial statements. The number of days of operating expenses covered by available cash was determined by dividing cash balances by daily operating expenses.

served and the number of patient encounters—a proxy measure for patient visits. To determine whether health centers were continuing to provide enabling services to their communities, we compiled data on spending for other health and community services, including transportation and translation services. In addition, we reviewed the number of full-time-equivalent staff hired to provide these services. To determine whether health centers were continuing to provide care to indigent and low-income patients, we compiled data on the amount of subsidized care. To determine whether health centers' sources of funds were changing under prepaid managed care, we compared these sources to total receipt of funds.

We also conducted work in two states that have more recently begun capitated Medicaid managed care programs—Tennessee and Washington. Washington is making specific accommodations for health centers as it implements its Healthy Options program and is helping the centers establish their own Medicaid health plan. In contrast, Tennessee has so far not made programmatic changes to accommodate health centers, such as requiring their inclusion as providers.

At all the health centers we visited, we toured the facilities and interviewed administrators. We also interviewed officials of health plans operating in the area, some that contracted with health centers and some that did not; state community health center associations; and state Medicaid officials. We also interviewed BPHC, HRSA, and National Association of Community Health Center officials.

Because we selected our sites judgmentally, our results do not necessarily represent all health centers' experience with prepaid managed care but illustrate the kinds of issues faced by health centers in these systems.

Our work was performed between January 1994 and March 1995 in accordance with generally accepted government auditing standards.

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