An LAO Report

Medi-Cal Managed Care Has Not Had an Adverse Effect on Rural Health Care Clinics

Background

❖ **Legislative Concerns.** This report is in response to the *Supplemental Report of the 1997-98 Budget Act*, which directs our office to examine the impact of the Medi-Cal managed care program on rural and farmworker health clinics. This directive reflects concerns that Medi-Cal managed care could adversely affect the financial viability of some clinics in rural parts of the state and reduce or eliminate their ability to provide health care to the uninsured.

❖ **Methodology.** We concentrated our review on five nonprofit corporations operating 76 community health clinics in Fresno, Kern, San Joaquin, and Riverside Counties. These corporations operate in counties with large rural areas and where Medi-Cal managed care recently was expanded. These corporations also receive state funding under the Rural Health Services Development (RHSD) and Seasonal Agricultural and Migratory Worker (SAMW) grant programs. Thus, the clinics that we reviewed consist primarily of rural health clinics.

Our findings are based on data provided by the Department of Health Services (DHS), discussions with clinic directors in each of the counties reviewed, and discussions with employees of the health plans operating in these counties.

LAO Findings

❖ **Clinics Viable At Present.** Currently, these rural health clinics generally remain financially viable and continue to be able to treat uninsured patients. Although this finding is contrary to some conventional wisdom, it is not surprising. This is because existing law guarantees these clinics (1) participation in Medi-Cal managed care plans under the same terms and conditions as similar providers that affiliate with the plans and (2) continuation of cost-based reimbursement for Medi-Cal services provided under managed care.

❖ **Future Uncertainties.** It is too early to assess the *long-term* impact of Medi-Cal managed care on these clinics. Competition for patients by commercial and other types of managed care providers could erode the clinics' patient base over time. Furthermore, the continued financial viability of some clinics could be threatened, given that Congress recently acted to phase out the federal requirement for cost-based reimbursement of clinics by October 2003.

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BACKGROUND

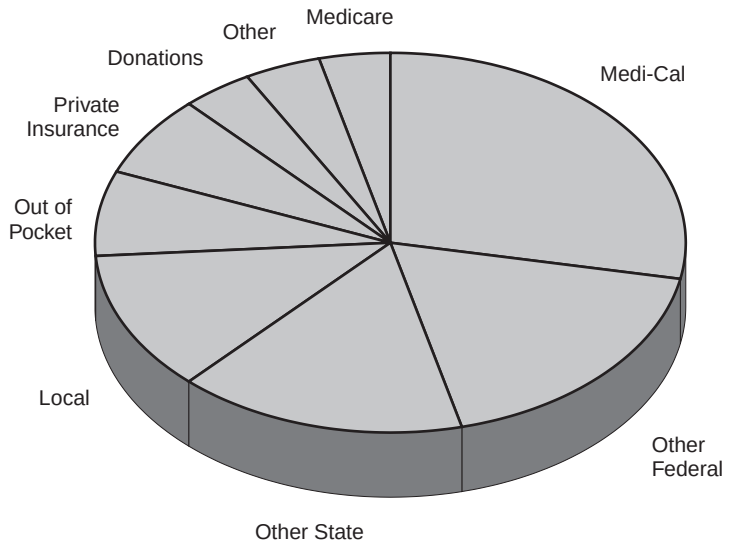
What Are Community Health Clinics? Community health centers and clinics are not-for-profit outpatient health facilities that provide general medical, primary, and preventive health care services. These clinics include Federally Qualified Health Centers (FQHCs), rural health centers (RHCs), free clinics, and migrant farm worker clinics. As part of the health care safety net, these clinics are an important source of health care for low-income individuals, including the uninsured. Clinics generally are required by federal law to treat individuals regardless of their ability to pay. Statewide, there are more than 600 community clinics.

How Are They Funded? Community clinics (including rural clinics) have multiple sources of funding, including public insurance (primarily Medi-Cal), a variety of federal, state, and local public health programs, out-of-pocket patient payments, private insurance, and private donations. In 1996, community clinics statewide received approximately $750 million in revenue from all sources. Figure 1 shows these total revenues by funding source.

As Figure 1 illustrates, Medi-Cal (jointly funded by the state and the federal government) is the largest source of revenues, representing 28 percent of total clinic revenues. Other federal funding includes the Community Health Center and Migrant Health grant programs. Other state funding includes grants from programs such as the SAMW program, the RHSD program, and the Expanded Access to Primary Care program. In addition, other state funding includes various public health programs, including the Child Health and Disability Prevention program, the Adolescent Family Life Program, Cal Learn, and AIDS education and prevention programs. Some clinics also receive county funds through contracts to assist the counties in meeting their statutory requirement to provide health care to the medically indigent.

Figure 1

1996 Clinic Revenue By Source



Source: Office of Statewide Health Planning and Development, 1996 Annual Report of Primary Care Clinics

Cost-Based Payment to FQHCs and RHCs. Clinics may be designated as an FQHC or RHC by the federal government if they agree to treat anyone regardless of ability to pay, are located in a medically underserved area, are governed by a community board, and meet various other specific requirements. There are about 250 FQHCs and RHCs statewide, comprising almost half of the total number of community clinics in California. Community health clinics that are designated as FQHCs and RHCs are paid for services provided to Medi-Cal recipients using a cost-based reimbursement method, pursuant to federal and state law. This recognizes that clinics must depend on Medi-Cal as one of their primary revenue sources, unlike many other providers who have privately insured patients that cover most of their costs.

Cost-based reimbursement can to result in revenues that exceed the clinics actual costs for treating Medi-Cal patients, thereby allowing the clinics to subsidize the care of indigents who have no insurance and do not qualify for Medi-Cal. Under cost-based reimbursement, Medi-Cal pays its proportionate share of total clinic costs based on Medi-Cal patients' share of total clinic visits. For example, if Medi-Cal patients account for 75 percent of a clinic's visits, then Medi-Cal pays a per-visit rate calculated to total 75 percent of overall clinic costs. Medi-Cal's share of clinic costs, however, is likely to be less than Medi-Cal's share of patients' visits at many clinics, so that a portion of the Medi-Cal payment in effect subsidizes indigent care. This is particularly likely for clinics that have frequent Medi-Cal patient visits for low-cost services, such as routine prenatal and well-baby checkups or for common childhood diseases (whereas uninsured indigent patients are more likely to seek care only when they have a significant health problem).

Cost-based Medi-Cal payments also can help finance indigent care because the costs paid by Medi-Cal are not reduced by any grants or donations that help cover overall clinic costs. Medi-Cal, for example, pays its proportionate share of the full cost of clinic buildings and equipment, even if some of these costs were covered by grants or donations.

What Is Medi-Cal Managed Care and Does It Threaten Rural and Other Community Clinics? Under the two-plan model of Medi-Cal managed care, the state contracts with two types of health care plans—a quasi-governmental "local initiative" that includes many safety-net providers and a commercial plan—in each of 12 counties with relatively large Medi-Cal caseloads. In these counties, most low-income families and children in Medi-Cal (including welfare recipients in the California Work Opportunity and Responsibility to Kids [CalWORKs] program) must receive care through one of these plans. These plans contract with health care providers, including private health maintenance organizations (HMOs), county hospitals and clinics, and community health centers and clinics to provide health care to these Medi-Cal patients. All of the clinics we examined are located in Medi-Cal two-plan model counties.

Some clinics have expressed concerns that, in two ways, managed care potentially threatens their

ability to continue to treat indigent patients, or even to survive. First, managed care could reduce the clinics' Medi-Cal patient "market share" and, thus, their ability to generate revenue. This is because managed care expands the access of Medi-Cal patients to "mainstream" medical providers (such as commercial HMOs), in addition to providers such as the clinics, which have traditionally treated low-income people. Second, managed care plans generally seek to reduce costs and encourage the most efficient provision of care, so they normally would not offer clinics contracts that include cost-based reimbursement. The continued viability of rural clinics is of particular concern because they serve localities in which there may be few or no other providers of indigent health care.

Existing Protections for Clinics. Recognizing the vulnerability of safety-net providers, state and federal law provide protections to community health clinics. Under the two-plan model, for example, state law requires the local initiative plan to contract with all safety-net providers that agree to provide services in accord with the same terms and conditions that the plan requires of any other similar provider that affiliates with the plan. The commercial plans, moreover, are encouraged by the state to contract with safety-net providers. Federal law also requires that FQHCs continue to be available to Medi-Cal patients whether the FQHC is a managed care provider or not. Finally, federal and state law have guaranteed FQHCs and RHCs continued access to cost-based reimbursement for Medi-Cal managed care patients.

LAO FINDINGS

Rural Clinic Participation in Managed Care Is High. Our analysis found that the rural health clinics we reviewed have achieved a high rate of participation in Medi-Cal managed care. Figure 2 shows that most of the clinics in the counties that we reviewed had managed care contracts with participating health plans. In some cases, clinics were offered contracts but chose not to participate. We also examined patient enrollment with the clinics we reviewed as an indication of clinic participation in Medi-Cal managed care. As Figure 3 shows, the market share of these clinics for Medi-Cal managed care enrollees was significant, ranging between 17 percent and 28 percent on a countywide basis (including urban areas). (Data for Riverside County were not available.)

We note that a high percentage of patients choose their primary care provider (PCP), instead of having one assigned to them by the health plan. For example, health plans report that in Fresno and Kern Counties 85 percent and 95 percent of patients, respectively, chose a PCP. This information, when combined with the data showing significant Medi-Cal managed care enrollment at these community health clinics, implies that clinics are successfully competing with other providers.

Specifically, many Medi-Cal managed care enrollees are choosing—rather than being assigned—a clinic as their PCP, instead of selecting "mainstream" providers.

Revenues Generally Stable. A health clinic corporation's share of Medi-Cal managed care patients is only one measure of its ability to compete in a managed care environment. Figure 4 (see page 6) shows Medi-Cal revenue and utilization data for fiscal years 1993 through 1997 for the selected clinic corporations that we reviewed. As the figure illustrates, three of the four clinic corporations for which data are available show slightly increased Medi-Cal revenue between 1996 and 1997, the time when Medi-Cal managed care was implemented in the four counties. Sequoia Health Foundation, the provider with a reduction in Medi-Cal revenue, attributed this reduction to factors other than managed care.

Figure 2

Rural and Community Health Clinic Corporations Participation in Medi-Cal Managed Care

November 1997

	Health Clinics		
		With Managed Care Contracts	
Selected Managed Care Counties	Total	Number	Percent
Fresno	35	31	89%
Kern	23	19	83
Riverside	13	8	62
San Joaquin	5	4	80

Source: Department of Health Services.

Figure 3

Medi-Cal Managed Care Patients Enrolled in Rural and Community Health Clinics in Selected Counties

November 1997

	Medi-Cal Managed Care Patients		
		In Rural and Community Clinics	
Selected Managed Care Counties	Total	Number	Percent
Fresno	114,000	25,050	22%
Kern	80,000	22,000	28
San Joaquin	43,000	7,500	17

Source: Data provided by health plans, Federally Qualified Health Centers, and Rural Health Centers.

Clinics Continue to Provide Indigent Care. Reliable data on the frequency and level of services provided to the medically indigent are not available. However, clinic administrators that we contacted indicated that managed care has not had a detrimental impact on their clinics' care for the uninsured. We looked at the uninsured as a percentage of all patients served by the five health clinic corporations that we reviewed, both before and after implementation of managed care as a possible indication of indigent care activity. Figure 5 (see page 6) shows that the share of

Figure 4

Medi-Cal Revenue and Patient Visits Selected Health Clinic Corporations

1993 Through 1997
(Dollars in Thousands)

Clinic Corporation	1993	1994	1995	1996	1997
Clinica Sierra Vista					
Revenue	$2,967	$3,306	$3,944	$4,988	$5,595
Patient visits	38,858	40,510	46,360	56,737	63,473
Community Medical Centers					
Revenue	$1,883	$2,200	$2,754	$3,408	$4,215
Patient visits	26,218	30,078	34,146	42,275	53,946
National Health Services					
Revenue	$1,300	$2,080	$3,000	$3,340	$3,390
Patient visits	19,142	24,319	32,457	37,026	36,638
Sequoia Community Health Foundation					
Revenue	$2,300	$3,400	$4,600	$3,400	$3,260
Patient visits	26,426	31,633	42,415	29,571	33,962
United Health Centers of the San Joaquin Valley					
Revenue	$3,845	$3,600	$5,760	$3,500	—[a]
Patient visits	56,122	45,927	70,933	42,969	—[a]

[a] Data not yet available.
Source: Department of Health Services, Medi-Cal audit reports.

Figure 5

Percent of Uninsured Patients Served Before and After Medi-Cal Managed Care

Clinic Corporations	Uninsured as Percent of All Patients Served	
	Pre Managed Care 1996	Post Managed Care 1997
Clinica Sierra Vista	40%	45%
Community Medical Centers	25	25
National Health Services	22	24
Sequoia Community Health Foundation	14	20
United Health Centers of the San Joaquin Valley	20	20

Source: Based on Legislative Analyst's Office survey of clinics.

uninsured treated in these clinics has grown slightly. Given that the clinics' Medi-Cal patient base generally has held steady or grown, this indicates that the clinics have been able to maintain their uninsured caseload as well as their Medi-Cal patient base.

Medi-Cal Managed Care Contributes to Cash Flow Problems. Some clinics indicated that the transition to managed care has increased their cash flow problems. This is the result, they report, of delayed payments from health plans. Prior to managed care, these providers generally were reimbursed by Medi-Cal two weeks after providing services. Under managed care, this reimbursement period has increased to between 60 and 90 days. This is particularly problematic for smaller clinics which do not have reserves to hold them over.

Recent state legislation regarding Medi-Cal man-

aged care may help to address the clinic cash flow problem. Chapter 649, Statutes of 1997 (AB 1337, Shelley), authorizes DHS to establish two pilot projects to test alternative methods of clinic reimbursement with a local initiative and a commercial plan that contract with DHS as Medi-Cal managed care plans.

Potential Loss of Cost-Based Reimbursement Is a Major Concern for Rural and Other Health Clinics. The federal *Balanced Budget Act of 1997* phases out the federal requirement for cost-based reimbursement of FQHCs and RHCs. The federally required reimbursement will decline to 95 percent of costs on October 1, 1999, 90 percent on October 1, 2000, 85 percent on October 1, 2001, and 70 percent on October 1, 2002. No cost-based reimbursement will be required starting October 1, 2003. Clinics are concerned that, without this enhanced reimbursement, they will not be financially viable or that they will have to cut back substantially on uninsured indigent care.

Existing state law—Section 14087.325 of the Welfare and Institutions Code—requires Medi-Cal managed care plans in the counties operating under the two-plan model to contract with FQHC clinics and to pay those clinics at rates equivalent to cost-based reimbursement (unless a clinic agrees to accept different rates). Although this state requirement is imposed "pursuant to" the existing federal requirement for cost-based reimbursement, DHS indicates that the state mandate will remain in place despite the federal phase out of this requirement. Accordingly, clinics that are designated as a FQHC will continue to be entitled to cost-based reimbursement under their contracts with Medi-Cal managed care plans in counties operating under the two-plan model. However, rural health clinics that do not have FQHC status will be subject to the phase out of cost-based reimbursement. Furthermore, the phase out of the federal requirement for cost-based reimbursement will affect all clinics (including FQHC clinics) with respect to services provided to Medi-Cal beneficiaries who are not in managed care or who are in managed care in counties other than the 12 counties in the two-plan model.

Partly in reaction to the potential future loss of cost-based reimbursements, all of the community health clinics we reviewed reported investigating the possibility of merging or affiliating with a managed care organization. Clinics are also forming informal partnerships to explore ways to reduce administrative costs. According to some clinic administrators, these strategies will be essential if community health clinics must operate in a future environment that does not include cost-based reimbursement.

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