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THE EFFECT OF MEDICAID MANAGED CARE ON RURAL PUBLIC HEALTH DEPARTMENTS

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Directors of twenty rural health departments were interviewed to determine how rural health departments and the populations they serve have been affected by the implementation of Medicaid managed care. Where Medicaid managed care was implemented, rural Medicaid beneficiaries who were previously served by health departments are receiving more of their care from the private sector. There have been substantial changes in the quantity of well-child services provided in rural health departments, causing many to lose revenue in recent years.

OVERVIEW

Medicaid managed care programs are now operating in over half of all rural counties. The implementation of Medicaid managed care poses a particular financial risk to public health departments that have provided direct patient care. To determine how rural health departments have responded to and been affected by the implementation of Medicaid managed care, interviews with county public health department directors were conducted at twenty rural health departments in five states (Georgia, Missouri, North Carolina, Oregon, and Wisconsin). Three of the states enrolled Medicaid recipients into fully capitated managed care organizations, and two enrolled their rural populations in Primary Care Case Management programs.

How health departments responded to and were affected by Medicaid managed care appeared to be influenced by the individual organization's flexibility, the ability to react to the environment and a willingness to change organizational structure. State policies which allowed patients to more easily access the services of health departments, either through "carve-outs" or "direct-access provisions" helped some health departments retain more of their Medicaid patients, and consequently, funding.

The degree to which the health department director was proactive appeared to be important. Some directors anticipated the effect of the move to managed care, and planned strategically to insure the organization's continued control over the types and volumes of services provided. Others shifted their focus to population-based services and secured the funding necessary to provide these services. Health departments whose directors were more reactive seemed much more vulnerable to change. Often the directors of these health departments were constrained in their ability to act effectively because of factors beyond their control such as a poor economy or lack of local decision-making authority.

CHANGES IN PATIENT CARE SERVICES

In the 90s, there have been substantial changes in the quantity of well-child services, such as immunizations, well-child screenings and Early and Periodic Screening Diagnosis and Treatment (EPSDT) services provided in rural health departments. Thirteen of the twenty departments reported a decrease in the number of well-child services provided, and four health departments, all in states with fully capitated Medicaid managed care programs, had discontinued these services altogether. The drop in well-child service provision was attributed to: 1) state requirements that referral from a Primary Care Provider was necessary in order for the health department to receive reimbursement; 2) the increased competition for Medicaid children from private providers; and 3) loss of state funds to pay for these services, particularly for the uninsured.

Only four of the health departments studied were actually primary care providers in Medicaid managed care plans. Among those who were not, carve-outs and direct access provisions played an important role in how the health department responded to change.

Many chose to increase the provision of services that were carved out so as to increase revenue. This strategy was not always successful; in some places health department administrators believed that the private sector physicians were encouraging their patients to receive all their services in the private sector.

FINANCIAL STATUS OF RURAL HEALTH DEPARTMENTS

Fourteen of the twenty rural health departments lost Medicaid revenue in recent years, usually due to decreases in EPSDT revenue. These losses could be quite substantial: One health department had EPDST revenue that was almost $200,000 less in Fiscal Year 1999 compared with Fiscal Year 1994. The financial effects of Medicaid revenue losses vary according to the organization's ability to generate revenue from other sources, such as increases in state or local revenue, non-Medicaid family planning fees, programs such as WIC and hospice, charges to paying clients, contracting out staff to other organizations, and grants from private corporations and foundations.

Although none of the studied health departments appeared to be in danger of closing, and some of them were doing quite well, what had changed was their income security. EPSDT fees had provided a reliable source of funds in the past, but now many health departments do not know what will happen to their budgets from year to year. There was an evident level of stress associated with the uncertainty of where future revenue was going to come from and what would happen when reserves ran out. In addition, many rural health departments that historically based their financial security on Medicaid well-child fees may now be more vulnerable to changes in political will, county economy and shifts in state priorities and funding.

Among the health departments that were experiencing or expected to experience financial pressure from the decrease in the personal care service provision, directors responded in several ways. All the directors were committed to their staff, and tried to find ways to avoid eliminating staff positions. In the seven health departments that have lost staff, directors tried to naturally downsize by not filling vacant positions when staff left, but layoffs occurred in four organizations. A strategy used to maintain staffing levels was to cross-train staff to provide other types of services, but these services are not generally revenue producing, so often other sources of revenue needed to be found to support staffing levels.

In some areas Medicaid managed care programs are still relatively new, so it may be too early to assess their full impact. Many of the health departments set aside extra revenue to carry over into subsequent years. A number of the organizations were still using carry-over funds to maintain staffing levels, and a number of directors voiced concern as to how they will support staff at current levels when all carry-over funds are depleted.

IMPACT ON THE MEDICAID POPULATION

With the exception of the few counties where health departments chose to respond to market changes by increasing primary care services, a greater proportion of the Medicaid population in study jurisdictions now have medical homes in the private sector. Although this trend was often attributed to the implementation of Medicaid managed care, in at least two instances the willingness of the private sector to accept Medicaid pre-dates managed care, and was the result of enhanced Medicaid reimbursements.

Many of the health department directors are not convinced that the care their former clients are receiving in the private sector is adequate. Concern was expressed that children were not receiving as thorough EPSDT screens in the private sector as they had when the health departments were providing these services, and that certain screening tests historically provided in the health department and mandated by federal policy (such as lead screening) were not being performed. In addition, the health directors stated that the private practices, unlike the health departments, often lack the infrastructure necessary to provide tracking and follow-up. Several respondents felt that the states were not auditing physician practices as stringently or regularly as they audited the health departments in order to assure that EPSDT requirements were being met.

Children enrolled in Medicaid may benefit from having a medical home, and they and their parents may feel less stigmatized if they are able to access a private provider rather than receiving services at the public health department. However, the move to the private sector has not decreased the fragmentation of the health care system. The concept of a medical home works well for individuals whose health concerns are completely addressed by personal care services. For many poor rural populations, public health functions represent an important facet of comprehensive health services. While coordination between public health departments and private providers, and financial support for public health functions would be desirable, there appeared to be little or no incentive under Medicaid managed care for public-private partnerships to be forged to provide comprehensive outreach, prevention and services to vulnerable populations, particularly children.

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