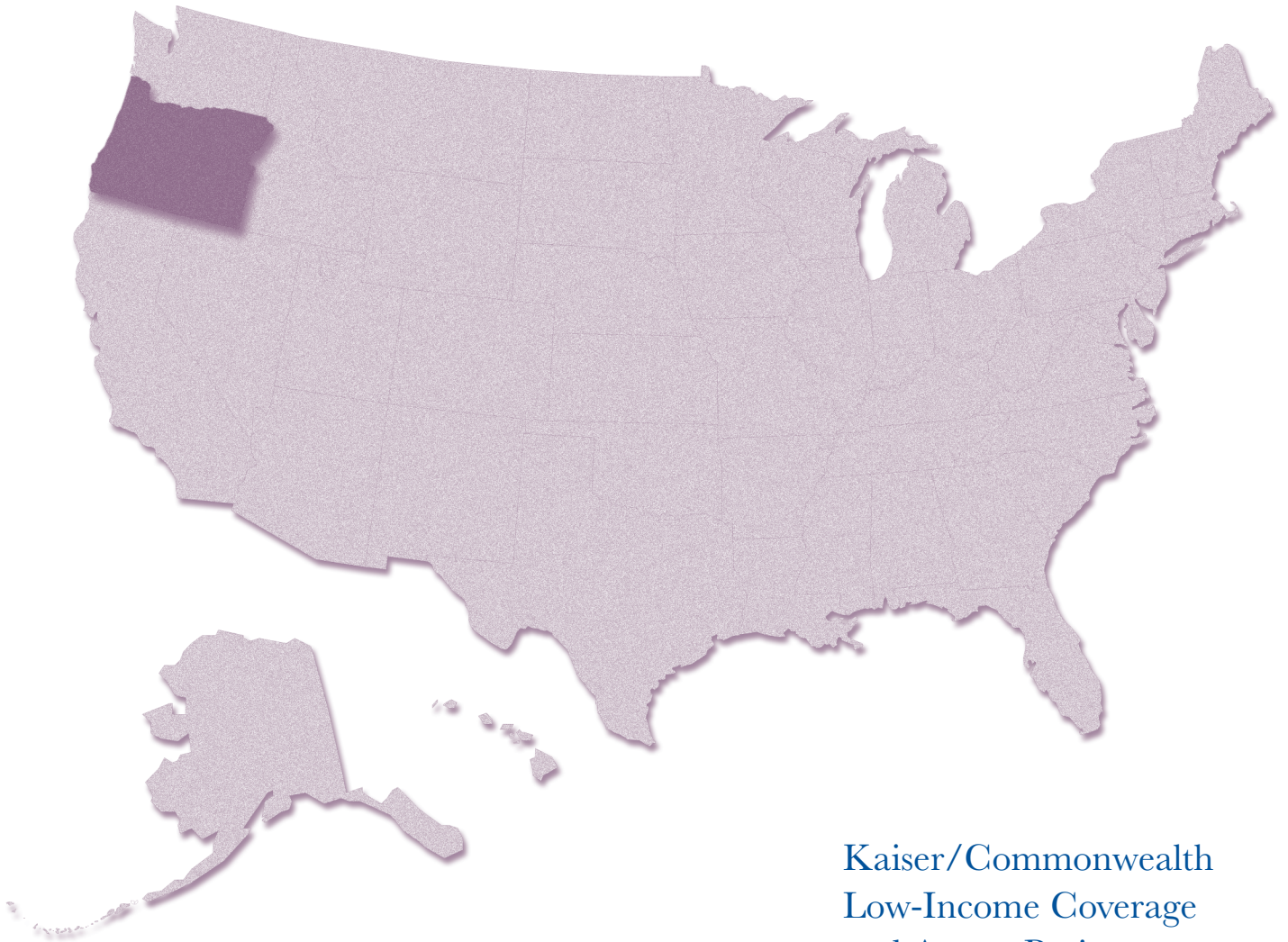
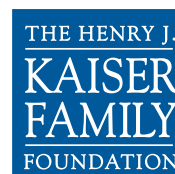


Managed Care for Low-Income Populations with Special Needs: The Oregon Experience



Kaiser/Commonwealth
Low-Income Coverage
and Access Project

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KAISER/COMMONWEALTH LOW-INCOME COVERAGE AND ACCESS PROJECT

The Henry J. Kaiser Family Foundation and The Commonwealth Fund are jointly sponsoring *The Low-Income Coverage and Access Project* to examine how changes in the Medicaid program and the movement toward managed care are affecting health insurance coverage and access to care for the low-income population. This large-scale project, initiated in 1994, has examined the impact of changes in eight states: California, Florida, Maryland, Minnesota, New York, Oregon, Tennessee, and Texas. Information is being collected through case studies, surveys and focus groups to assess changes in health insurance coverage and access to care from the perspectives of numerous key stakeholders — consumers, state officials, managed care plans, and providers.

**MANAGED CARE
FOR LOW-INCOME POPULATIONS
WITH SPECIAL NEEDS:
THE OREGON EXPERIENCE**

May 1999

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EXECUTIVE SUMMARY

The administrator of OADAP at the time deserves much of the credit for getting chemical dependency benefits included in the FCHP capitation rate. His dedication to the vision of integrated services and repeated and forceful defense of the cost offset that could be derived from an increase in timely, appropriate use of chemical dependency services was ultimately persuasive. As with mental health, there were concerns about the ability of health plans to provide appropriate chemical dependency services. Access to methadone services was a particular concern. However, a key distinction between mental health and chemical dependency reportedly was the latter's greater emphasis on a medical orientation and proportionately lesser emphasis on a social service model. This heightened the compatibility of chemical dependency services with the medical model.

1. Structure of Benefits and Payment

Before 1995, Medicaid recipients were eligible for FFS chemical dependency services, but the expansion populations received few services or no treatment at all. With the integration of these benefits into the OHP, chemical dependency services are included on the integrated priority list and available to all OHP eligibles. Benefits covered under the capitation include outpatient, intensive outpatient, and opiate substitution services (methadone treatment).¹ Residential and community detoxification services can be accessed by OHP beneficiaries directly and are paid with "slot funds."² OADAP purchases "beds" (or slots).

BACKGROUND

The Medicaid component of the OHP expands health care coverage to all Oregonians living below the poverty level through savings generated by moving beneficiaries into managed care and by the benefit package design, which employs a "priority list" to define covered care. The program became operational in February 1994 after an extensive planning period prolonged because of delays in federal approval for the Section 1115 waiver on which the OHP was built (Gold, Chu, and Lyons 1995). In 1994, the program's first year, OHP eligibility was limited to those who qualified for Medicaid mainly because of poverty. The state deliberately delayed the introduction of managed care for other populations and for behavioral health services until 1995.

¹Outpatient is defined as two or fewer face-to-face therapeutic contacts per week, and intensive outpatient as three or more face-to-face contacts per week.

²OADAP buys bed slots that are paid for regardless of actual use.

Managed care is now a central feature of the OHP for almost all beneficiaries and services, including behavioral health services. In 1995, the aged, blind, and disabled populations and children in substitute care were all required to enroll in one of the managed care plans offered under the OHP. While those jointly eligible for Medicaid and Medicare were included, they were offered different plan choices to promote a streamlined delivery system and accommodate federal Medicare requirements. Starting in January 1995, chemical dependency benefits were integrated into the general managed care contracts; the movement of mental health benefits into managed care was introduced more slowly to minimize adverse effects on mental health safety net providers. Mental health benefits were carved out to separate mental health organizations (MHOs) beginning with a 20-county demonstration involving 25 percent of OHP eligibles. When, in a state-sponsored evaluation, the demonstration looked successful, the program was authorized statewide, although some county opposition persists. Oregon's MHOs include a variety of entities fully capitated health plans (FCHPs), county plans, and local delivery systems. Roughly 70 percent of OHP enrollees were in county plans as of late December 1997.

While Oregon carved out mental health benefits, it integrated chemical dependency benefits into the general managed care contracts, largely because the relevant parties viewed chemical dependency as consistent with a medical model. In contrast, the mental health system has historically been county-based and has used a social model. Further, mental health safety net providers were more vocal about the risk posed by integrated managed care than were chemical dependency providers.

KEY FINDINGS

1. Most of Oregon's aged, blind, and disabled residents and children with special needs are now in managed care.

By the end of 1997, 67 percent of aged eligibles, 83 percent of blind/disabled individuals, and 72 percent of children in substitute care were enrolled in FCHPs participating in the OHP. Managed care is mandatory for all OHP beneficiaries unless they are granted an individual exemption, are institutionalized, or are designated a medically fragile child. At the time of enrollment, participants choose a FCHP for their physical health needs (including chemical dependency services), a dental care organization (DCO), and a mental health organization (MHO). As a condition of participation, Oregon requires that all OHP plans accept all individuals regardless of their eligibility category.

2. Careful planning and collaboration contributed to a smoother transition.

In expanding managed care in Phase II, Oregon used administrative processes similar to those used in Phase I. However, in Phase II the Office of Medical Assistance Programs (OMAP), which administers the program, had to work closely with more agencies that shared responsibility for enrollment and program design. A collaborative planning process involving these agencies, advocacy organizations, and other stakeholders was thus used to identify administrative refinements to facilitate the transition to managed care. Toward this end, several program enhancements were adopted, including (1) highlighting benefit coverage for comorbidities, which are conditions related to covered conditions that are otherwise uncovered; (2) requiring each managed care plan to hire and train at least one exceptional needs care coordinator (ENCC); and (3) establishing an ombudsman's office to advocate and problem solve for clients. Additionally, a special enrollment effort involving one-to-one choice counseling was developed to facilitate informed choice, a good plan fit, and continuity of care during the transition.

3. Integrating dually eligible persons into managed care was facilitated in Oregon by the structure of managed care participation.

Roughly 50 percent (29,000) of Phase II OHP enrollees are jointly enrolled in Medicare and Medicaid under the OHP. For these individuals Medicare is the primary payer, but the OHP benefit package attends to cost-sharing and expands benefits. Oregon's strategy for enrolling dual eligibles in managed care was to minimize exemptions while facilitating continuity and coordination of care. Dual eligibles have four options: They can (1) choose a prepaid health plan in the OHP that is also a Medicare HMO; (2) choose a prepaid plan for the OHP that is not a Medicare HMO, provided they are not otherwise enrolled in a risk product; (3) receive Medicaid benefits on a fee-for-service basis if they are enrolled in a Medicare HMO that is not part of the OHP; or (4) in rare instances, receive both Medicare and Medicaid on a fee-for-service basis.

Because Oregon is a small state and four large health plans jointly participate in Medicare and the OHP, it was easier for Oregon to encourage managed care enrollment while still avoiding the discontinuities that result when individuals are enrolled in two different managed care plans. Oregon's four joint plans account for 51 percent of OHP enrollment programwide and cover half of all dual eligibles. Most of the remainder are in an OHP plan for Medicaid while covered by traditional Medicare.

4. While Oregon has had some success in enrolling dual eligibles in managed care, substantial administrative barriers remain in coordinating care across Medicare and Medicaid under the OHP.

Despite some successes in cross-program administrative coordination, such as the development and implementation of a single enrollment application for managed care, frustrations and challenges remain. One key problem is the disparity in the speed with which applications for the two programs are processed: Medicare applications take longer to process than OHP applications. Consequently, the programs' effective dates for any newly enrolled dual eligible differ, which causes administrative confusion for plans. The confusion resulting from two sets of rules and policies and inconsistencies in administrative procedures detract from Oregon's ability to manage care for this subgroup of Medicaid and Medicare. The state would prefer one application with a single effective date, a single set of benefits, and a consolidated funding stream for dual eligibles.

5. The ENCC program is considered effective, but it does have weaknesses.

Working from within the plan, the ENCC's job is to safeguard vulnerable populations through early identification and resolution of their needs. ENCCs are encouraged to solve their clients' unique needs by thinking outside the box and using community support and social service systems. ENCCs are also expected to work with state agencies, especially the ombudsman and Senior and Disabled Services Division (SDSD), to resolve beneficiary issues. While state and plan officials feel that the ENCC program is meeting its fundamental goals, the program has some weaknesses. The role and responsibilities of the ENCC are vaguely defined and, consequently, ENCCs function differently at different plans. Some plans appear to have ENCCs functioning as both patient advocate and high-cost case manager, which causes conflicts. Also, because advocate and provider knowledge of their role varies, ENCCs are not used as fully as they might be. Coordination among the ENCCs, ombudsman, agencies, and other actors is also less than optimal.

6. Implementing the mental health carve-out in Oregon has been challenging.

As with other OHP components, careful pre-implementation planning was employed in developing the mental health carve-out. This process anticipated potential problems and helped to minimize them. Still, implementing the behavioral health carve-out has been challenging. Because Oregon estimated that county providers could remain viable only if at least 50 percent of OHP eligibles were in the county system, it required contractors to consult with local mental health contractors and made trade-offs that favored these providers.

The nature of the carve-out meant that most MHOs were required to learn to care for patients who differed from their typical caseload: the county-based systems had little or no experience with mild or moderate mental health needs or managed care, and most FCHPs did not have much experience with the seriously and persistently mentally ill. As a result, in a number of interesting partnerships developed between providers within counties and between county providers and plans. The carve-out's structure required that care now be coordinated: (1) between physical and mental health services; (2) for the dually diagnosed (i.e., those with both mental health and chemical dependency needs, since chemical dependency benefits are included in FCHPs); and (3) between covered and uncovered services for those with mental illness. The decision to allow both FCHPs and MHOs to order antipsychotic and antidepressant medication, which the state pays for on a fee-for-service basis, mitigated some of the particularly troublesome coordination issues.

7. Focusing on populations with special needs means that states have to coordinate with a much broader range of agencies and associated provider systems.

In Phase I, OMAP was the lead agency for the OHP as well as the main agency for the Medicaid component of the OHP, although Adult and Family Services (AFS) and, to a lesser extent, SDSO were involved in determining eligibility. With the introduction of Phase II, many more agencies had substantial roles in the OHP. SDSO and Area Agencies on Aging (AAA) determine OHP eligibility for the aged, blind, and disabled population. Supplemental Security Income (SSI) status is determined by the Social Security Administration (SSA). The regional office of the Health Care Financing Administration (HCFA) is responsible for Medicare policy coordination.

Additional agencies became involved in behavioral health issues. The Mental Health and Developmental Disability Services Division (MHDDSD) is responsible for MHO contracting and, with the counties, for the state mental health system, while the Office of Alcohol and Drug Abuse Programs (OADAP) is responsible for licensing and monitoring chemical dependency providers and contributes to the oversight and monitoring of these providers under OMAP. Phase II therefore entailed more agencies becoming involved in administration, which meant that more public sector program related providers and their associated constituencies would be affected by the OHP. In Oregon, this increased complexity was handled relatively well. Other states, however, may experience greater difficulty, especially where conflicts exist and where the history of cross-agency work has been troubled.

8. Although monitoring systems is more complicated for special populations than for others, currently most oversight in Oregon tends not to be focused specifically on these subgroups.

Monitoring and evaluation in Phase II of the OHP, as in Phase I, is the responsibility of OMAP and involves an external quality review organization (EQRO). While OMAP has evaluated the ENCC program, and the EQRO has conducted focused studies on issues such as depression and diabetes, the oversight systems are not structured to specifically assess how individual subgroups added in Phase II are faring. Further, problems remain in obtaining and manipulating encounter data, which is limiting the ability of OMAP to identify subsets of users based on their clinical needs. Monitoring with respect to the dually eligible continues to be done both by OMAP (for the OHP) and HCFA (for Medicare).

There are few ongoing mechanisms for coordination between OMAP and HCFA, but staff in both agencies have made efforts to communicate and meet. While OMAP is ultimately responsible for the OHP and all the prepaid health plans, MHDDSD handles virtually all the oversight and communication for mental health, including contract compliance, monitoring, and evaluation. OADAP worked with OMAP to develop contract standards that apply to chemical dependency and remains responsible for provider licensing and related monitoring.

CONCLUSION

Oregon's experience shows that states can move forward in integrating special-needs populations into managed care, although the challenges are major. Careful planning that incorporates elements tailored to these patients' needs helps to encourage coordination and appropriate care delivery. However, states seeking to expand managed care systems in this way need to recognize that doing so will increase the complexity of state administration and oversight mechanisms.

In expanding beyond the basic medical model for a core welfare population, states will need to include new organizations and service providers; develop coordinated, coherent policy; and create structures that encourage coordination and minimize disincentives. Although Oregon's experience is encouraging, the state's relatively small size, substantial experience with managed care, and established mechanisms for coordination created favorable conditions that may not exist in other states. States need to consider their own situations before deciding how ambitious their initial goals should be, what they should anticipate, and how rapidly they want to move forward.

I. INTRODUCTION AND OBJECTIVES

Until recently, efforts to extend managed care to low-income populations under the Medicaid program have focused largely on the Aid to Families with Dependent Children (AFDC) and related populations: low-income children and pregnant women. This Medicaid population, the most similar to the working population in commercial markets, represented nearly three-fourths of all Medicaid beneficiaries in 1995 but accounted for only 28 percent of the expenditures (Kaiser Commission on the Future of Medicaid 1997). In contrast, the aged and the blind and disabled accounted for only 11 percent and 17 percent, respectively, of Medicaid beneficiaries but accounted for 26 percent and 34 percent of all Medicaid spending.

Continued budgetary pressures are driving states to seek to contain Medicaid costs, which account for a large share of aggregate state spending. While many states are looking to managed care to achieve this goal, though, states also are increasingly aware that savings will be limited unless managed care is extended to aged, blind, and disabled (ABD) beneficiaries and other special populations that account for a large share of program expenses. Beyond the anticipated financial benefits, states also hope that managed care will improve health care delivery for beneficiaries who are ABD or have other special health conditions. These special populations have complex needs and may have the most to gain from the greater care coordination associated with managed care. Conversely, because of their intense or chronic care needs, many of these individuals are also more vulnerable to the potential failures of managed care, including the incentives for underutilization and increased barriers to care such as service authorization and formulary restrictions.

Efforts to expand Medicaid managed care to the aged, blind, and disabled are complicated for a number of reasons. Managed care organizations (MCOs) have not typically had experience serving ABD populations. The eligibles are a complex mix with heterogeneous needs. The involvement of additional state agencies, with varying philosophies regarding care delivery, adds to the complexity of interagency and intra-agency administration and oversight. In early 1997, 25 states were enrolling the aged and/or the disabled into plans with some degree of risk through both voluntary and mandatory programs (Rawlings-Sekunda 1997).

Oregon's experience is of interest because Oregon is one of the few states in the nation with relatively large numbers of supplemental security income (SSI) eligibles enrolled in managed care.³ At year-end 1997, there were 335,000 enrollees in the Oregon Health Plan (OHP), a major state initiative for health care reform authorized under a Section 1115 waiver and implemented in February 1994.⁴ Because of the complexity of the issues associated with employing managed care for ABD Medicaid beneficiaries, Oregon decided to defer employing managed care for 79,000 eligibles in special populations until 1995 (program year two or Phase II).⁵ Because the Phase II populations were already covered by Title XIX, the focus was on transitioning these groups into a managed care model under the new benefit package.⁶ Oregon employed an extensive planning process to develop mechanisms for integrating the Phase II population into the OHP. Oregon also planned to integrate mental health and chemical dependency benefits into managed care as part of Phase II of the OHP implementation. Mental health benefit levels, particularly for adults, were expanded concurrent with these efforts.

Oregon's deliberate decisions to delay the integration of special populations and to phase in behavioral health benefits differ from the strategies of some other states moving to a managed care model. Oregon was also distinct in that its planning process resulted in a number of innovative program elements. Thus, Oregon's experience presents an excellent opportunity to draw lessons that may be useful to other states.

This paper examines Oregon's experience integrating into managed care the aged, blind, and disabled; subgroups of that population that are dually eligible for Medicaid and Medicare; and mental health and chemical dependency services. These efforts present important care coordination and integration issues that will confront all states. The paper first reviews the key features of the Oregon Health Plan and then reviews in turn Oregon's experience with enrolling SSI-eligible individuals in managed care and

³In Oregon, all ABD persons qualify for SSI because there is no program specifically for the medically needy.

⁴A Section 1115 waiver allows states to deviate from a large number of standard Medicaid requirements in order to test new policies deemed meritorious. In return for greater flexibility, states must commit to a policy experiment that can be formally evaluated.

⁵The Phase I population consists of those eligible for Medicaid/OHP mainly for reasons of poverty and not necessarily "categorically" limited. Phase II included the ABD who receive SSI, including the dually eligible subgroup (those qualifying for both Medicaid and Medicare) and children in substitute care.

⁶Title XIX of the Social Security Act authorizes the Medicaid program, which provides medical assistance for certain individuals and families with low income and resources.

with the rollout of managed care for behavioral health services. The paper draws on interviews conducted during a week-long site visit to Oregon in early December 1997, a document review, and the authors' earlier work on the OHP (Gold 1997; Gold, Chu, and Lyons 1995). A more general description and analysis of the OHP is also available (Mittler, Gold, Lyons 1997).

II. KEY FEATURES OF THE OREGON HEALTH PLAN

The Medicaid component of the Oregon Health Plan aims to expand coverage to all Oregonians below the poverty level with savings generated by two sources: the design of the benefit package, which uses a "priority list" to define covered conditions and treatment pairs, and the use of managed care for beneficiaries. In 1987, after the highly publicized death of a child who potentially could have been saved by a transplant, questions of who and what ought to be covered under Oregon's Medicaid program were debated. Equity and access appeared to be the main motivating factors behind development of the OHP, which is based on the flexibility provided by Section 1115 waiver authority.

The design and implementation of the OHP involved extensive planning that began even before the waiver was approved, and a deliberate choice was made to defer integration of particularly vulnerable subgroups and behavioral health benefits into the plan until the second phase. The implementation effort was considered a joint endeavor involving public and private stakeholders and orchestrated by high-caliber state staff. Extensive formal and informal discussions essentially involved, at some level, all stakeholders in Oregon. In addition, Oregon had a well-developed managed care infrastructure that had been built by respected and experienced plans, all of which initially participated in the OHP, although none had extensive experience with special needs populations.

This section reviews the general features of the OHP as it operated in 1994, the end of Phase I, to provide a context for understanding the subsequent adaptations.

A. ELIGIBILITY AND ENROLLMENT

In Phase I, the OHP used a contractor, HealthChoice, to handle most dissemination of information and preliminary screening for eligibility. Information sessions were held throughout the state, and a toll-free information line was set up. Responsibility for determining eligibility varied. Those eligible for cash assistance were enrolled in person. All others, including those eligible for noncash assistance related to Medicaid, applied by mail. During Phase I, SSI eligibles and children in substitute care were excluded from mandatory enrollment in managed care.⁷

B. BENEFIT PACKAGE

The OHP benefit package is based on a ranked priority list of condition/treatment pairs that was developed through a process established by the state legislature and led by the Oregon Health Services Commission (HSC) using such criteria as ability to avert death and cost of care.⁸ The relatively open process and deliberate efforts to insulate the process from political pressure resulted in a credible priority list that was not an issue within the state, although there was some national controversy regarding the development and use of the list. To keep the waiver process moving, the priority list was modified to address federal concerns related to the Americans with Disabilities Act, despite the feeling that these changes violated the state's intention to keep the process of establishing the list free from political interference.

The benefit package consists of those condition/treatment pairs located above a line on the priority list based on funding availability (referred to as "above the line"). Pairs not included in the benefit package are referred to as "below the line." Diagnosis is always covered, and when a condition/treatment pair is covered, all medically appropriate ancillary services are covered (such as durable Medicaid equipment or prescription drugs) unless excluded by the state's general rules. The priority list is reviewed and modified every two years.

In the plan's first year of operation, 565 of 696 treatment pairs were covered. Beyond typical acute care, the basic benefit package included preventive services to promote health and reduce risk of illness, comfort care or hospice treatment for terminal

⁷Children in substitute care refers to children age 18 or younger who are in the legal custody of the state office for Services to Children and Families (SCF) and have been placed outside the parental home. Also, enrollment was not mandatory in counties with inadequate capacity.

⁸Other criteria include public health risk, medical effectiveness, prevention of future costs, and the nature of the service (i.e., high priority given to preventive services, family planning services, and maternity care) (Health Services Commission 1997).

illnesses (regardless of where treatments for the conditions are on the list), ancillary services ranging from prescription drugs to physical therapy (if they are medically appropriate for a covered condition/treatment), and most transplants. The benefit package also included all diagnostic services regardless of the location of the suspected condition on the priority list, alternative services that show equivalent or better effectiveness, and medically appropriate services for comorbid conditions. This benefit package was more comprehensive overall than the previous Medicaid package because it added new benefits for adult Medicaid beneficiaries, including dental care, preventive care, and transplant and hospice services. In the first year, behavioral health benefits continued to be covered under traditional Medicaid. The priority list was not a major issue for health plans or providers in the first year, although differences of opinion were expressed about its value.

C. PLAN PARTICIPATION

In the plan's first year of operation, the state contracted with managed care organizations that were either fully capitated health plans (FCHPs) or partially capitated physician care organizations (PCOs) to provide the basic medical care benefit package, including dental care.⁹ In addition, a primary care case management (PCCM) option was used either alone or as a complement to FCHPs and PCOs in areas of the state judged to have insufficient managed care capacity. Any organizations that met the plan standards relating to such issues as access, quality, and financial solvency were eligible to participate in the OHP as FCHPs or PCOs. Plans were responsible for establishing their own provider networks and were not mandated to contract with any particular providers (e.g., federally qualified health centers or FQHCs).

Twenty health plans participated in the OHP at year-end 1994, including 16 FCHPs, 4 PCOs, and 5 dental care organizations (DCOs). Participating health plans included all 8 commercial HMOs and 12 health plans that served only OHP eligibles. In sum, about 70 percent of those eligible for the OHP were enrolled in FCHPs in late 1994 with five plans dominating the market.

At the outset, payment rates were less controversial in Oregon than in some other states, in large part because of the orientation the state brought to the process. One of the explicit goals of the OHP was to eliminate cost-shifting from the public to the private sector, and rates were actually raised under the OHP relative to traditional Medicaid.

⁹FCHPs either delivered dental care themselves or subcontracted to dental care organizations (DCOs).

Capitation payments were calculated for each of 13 eligibility categories in five geographical regions using historical utilization data and accounting for managed care efficiencies. Plans and providers generally considered the payment rates adequate in the first year. The rates were better than traditional Medicaid rates, although still lower than commercial rates. One exception to this generally favorable financial picture was the FQHCs, which lost cost-based reimbursement under the Section 1115 waiver.

D. STATE ADMINISTRATION AND OVERSIGHT

From the beginning, the Office of Medical Assistance Programs (OMAP) within the Department of Human Resources (DHR) was responsible for the implementation, administration, and oversight of the OHP. OMAP retained essentially all activities except for some enrollment activities (involving other DHR divisions and the contracted enrollment broker) and some quality assurance activities (charged to the external quality review organization or EQRO). To handle its responsibilities in the first year, OMAP reorganized its functions and hired staff with needed expertise. It was clear during the initial site visit, in December 1994, that OMAP staff members were well-respected. This level of respect, in conjunction with a tight administrative structure, contributed to well-coordinated administration and oversight efforts in the first year.

III. MANAGED CARE AND AGED, BLIND, AND DISABLED BENEFICIARIES

Bringing the Phase II population into managed care was controversial when planning for the OHP began. However, Oregon's success in Phase I generated support for extending managed care to additional Medicaid-eligible groups. Implementation of Phase II also was enhanced because Oregon's Phase II planning committee, like the Phase I team, involved a cross-section of stakeholders, including advocates, plans, providers, and state agencies. This collaborative planning process led to a number of features for Phase II — such as the requirement for an exceptional needs care coordinator (ENCC) at each plan, the establishment of a state ombudsman's office, and the development of a process for encouraging continuity of care with managed care enrollment — that were important in gaining support for the program.

In Phase II, as of December 1997 Oregon had enrolled into managed care roughly 60,000 persons who receive old-age assistance (OAA) and aid to the blind and disabled (ABD).¹⁰ By year-end 1997, roughly three-quarters of Phase II eligibles were enrolled in FCHPs (Table 1). This total included “dual eligibles,” those jointly eligible for Medicare and Medicaid. Because processes differed for these individuals, this section discusses first the experience of those eligible only for Medicaid and then how these processes varied for those dually eligible for Medicaid and Medicare. (Fifty percent of the Phase II population enrolled in the OHP are dual eligibles).

¹⁰Not everyone eligible for the OHP enrolls in managed care. Particularly in the Phase II population, exemptions from managed care are allowed. There were a total of 69,000 OAA and ABD and 10,000 children in substitute care, for a total of 79,000 Phase II eligibles as of December 1997. Roughly 60,000 OAA and ABD eligibles and 7,500 children in substitute care were enrolled in at least one MCO at that time.

Table 1

**Phase II Eligibles and Percent Enrolled in
Fully Capitated Health Plans (FCHPS)
December 1997**

	Total Number of Eligibles	Percent in FCHPs
Phase II	79,163	75.9
Old Age Assistance (OAA)	26,638	66.7
Aid to Blind/Aid to Disabled (ABD)	42,022	82.8
Children in Substitute Care	10,503	71.7

Source: Oregon Department of Human Resources, Office of Medical Assistance Programs, *Enrollment and Disenrollment Reports*, December 1997.

A. MEDICAID ABD ELIGIBLES

This subsection describes the integration into the OHP of ABD Medicaid beneficiaries who do not also qualify for Medicare. Many of the initiatives also apply to dual eligibles, but there are some important differences.

1. Eligibility and Enrollment

While Oregon's administrative processes for determining eligibility in Phase II were similar to those employed in Phase I, the nature of the population included in Phase II meant that more agencies were involved. In addition to Adult and Family Services (AFS), which determined eligibility for most of the Phase I populations, the Phase II process involved the Senior and Disabled Services Division (SDSD) and Area Agencies on Aging (AAA).¹¹ SSI status is determined by the Social Security Administration.

Oregon designed a special program for enrolling the ABD that included one-on-one counseling to help beneficiaries choose a good fit for their needs from the OHP managed care options and to ensure continuity of care during the transition period. SDSD and AAA case managers enrolled Phase II beneficiaries during these face-to-face choice counseling sessions, which lasted an average of one-and-a-half to two hours per client. Enrollment counselors were trained by SDSD in all aspects of the process, including the criteria for exempting beneficiaries from managed care and how managed care works, to help Phase II clients make informed decisions. After enrollment, each plan is responsible for educating its OHP enrollees about plan specifics. The state felt that the plans were generally doing a good job with this task.

During choice counseling, caseworkers took steps to ensure continuity of care, which included completing a continuity of care referral form and obtaining prior authorization for out-of-plan referrals. The continuity of care referral form was developed to smooth the transition into managed care by preventing any disruptions in care for the Phase II population. The form is completed by the caseworker at the time of enrollment and sent to plan ENCCs (discussed below). It includes information about the immediate and transitional needs of the client. The use of one-on-one choice counseling and the continuity of care referral form probably reduced the potential number of highly publicized adverse scenarios and helped to place beneficiaries in the most appropriate plans.

¹¹In Phase I, SDSD determined eligibility for the persons receiving general assistance and those ages 60 to 65. The AAAs contract with SDSD to administer Medicaid in some counties. Because of the intertwined system of branch offices, AAA and SDSD are perceived as one system.

Managed care is mandatory for all OHP beneficiaries unless they are granted an individual exemption, are in a state psychiatric or mental retardation and developmentally disabled (MRDD) institution, or are designated medically fragile children.¹² Individuals can receive an exemption from participating in an MCO if there is no fully capitated health plan (FCHP) in their county (two counties have none), are covered by third-party resources, or have special care needs that are not fulfilled by the existing delivery system (such as a specialized provider or facility that is not in the MCO network). At the time of enrollment, all OHP beneficiaries are eligible for acute medical, chemical dependency, mental health, and dental care, and all participating plans must accept all OHP eligibles. At the time of enrollment, all eligibles choose an FCHP for their physical health needs (including chemical dependency services), a DCO for dental care, and an MHO for mental health care.¹³

During the planning phase, some state officials were concerned that a significant number of beneficiaries would be granted exemptions from prepaid health plan enrollment (that is, receive benefits under primary care case management or (PCCM) and fee-for-service or (FFS). The state has been fairly satisfied with its ability to enroll the Phase II population into managed care. SDSA data show that exemptions for ABD clientele grew from roughly 4 percent in May 1996 to 10 percent in September 1997. Most exemptions are granted because of third-party coverage. The state intends to monitor the population receiving exemptions, but it is relatively comfortable with current experience.

2. Benefit Package Refinement

Oregon's Phase II expansion employed the same benefit structure used for the Phase I population, but changes were made in the priority list to accommodate special needs associated with Phase II eligibles. The list was specifically reviewed for conditions disproportionately affecting the aged and disabled population, such as treatment of fecal impaction and surgical treatment for spastic diplegia. Five dysfunction lines were added, addressing respiration, eating and elimination, posture and movement, short-term rehabilitation, communication, and reasoning and judgment. Attention to these lines eased the concerns of advocates.

¹²An MRDD institution cares for those with mental retardation and development disabilities.

¹³If a beneficiary chooses an FCHP in his or her county that has a partner MHO (or vice versa), the beneficiary is automatically enrolled in the partner plan. For example, if a beneficiary selects Providence Health Plan as the FCHP and the MHO is also offered in that county, the beneficiary is automatically enrolled in Providence for both. A beneficiary cannot select a different organization if the FCHP or MHO has a partner organization.

Second, in response to concerns about how the priority process would affect the ability of the Phase II populations to receive services and keep needed benefits, the “comorbidity rule” was reemphasized. This rule, adopted but not emphasized during Phase I, extends coverage to include care for unfunded conditions when the conditions are medically related to a funded condition.¹⁴ An example is fungal infections, which are common among diabetics; although fungal infections are located below the line, treatment of this condition is often required in appropriate care for diabetes, which is a covered condition.¹⁵ The comorbidity rule sanctions coverage of this service for diabetics. Because plans are reportedly still pretty flexible in providing below-the-line care, application of this rule has not been a big issue yet. Nonetheless, advocates feel this rule is important because it creates another avenue of redress when beneficiaries believe they are being denied needed care.

3. Plan and Provider Participation

All plans participating in the OHP are required to accept all eligibles, including those newly eligible for managed care in Phase II, as a condition of participation.¹⁶ At year-end 1997, there were 14 participating FCHPs, 12 participating DCOs, and 10 participating MHOs. PCCM and FFS arrangements are still options, although they are discouraged by administrative features; eligibles must receive an exemption to opt out of MCO enrollment, and providers receive higher reimbursement under capitated managed care.

The only significant change for the ABD population with respect to plan contracting was the addition of a requirement that each plan employ at least one ENCC to coordinate services and navigate managed care for the Phase II population from within the plan. Otherwise, modifications to the contract were minimal. In concept, the ENCC safeguards these vulnerable populations through early identification and resolution of their needs. To solve this group’s unique problems, the state wanted ENCCs to think “outside of the box,” which meant including the use of community support and social service systems among the possible options. ENCCs are hired and trained by each FCHP, although the state holds periodic meetings to discuss general issues. The ENCCs are supposed to work with the state agencies, in particular the ombudsman and SDSD, to resolve beneficiary issues.

¹⁴This rule was an original term required by HCFA in order to implement Phase I.

¹⁵The May 1998 revision to the priority list identified foot care as a covered service for people with specific diagnoses, such as diabetes, which are likely to lead to compromised circulation.

¹⁶Two plans could not accept Phase II enrollees: One had its enrollment closed by the state because of quality issues and the other had reached its enrollment limit.

The state and plans feel that overall the ENCC program is meeting its fundamental goal of acting as the Phase II population's advocate, navigator, and coordinator of plan and community services from within the health plan. The recent report of the statewide evaluation of the ENCC program calls it a "success in progress" (OMAP 1998). However, there appear to be some weaknesses in the program. In particular, advocates said the effectiveness of the ENCC program varies across plans, in part because of a vague definition of ENCCs' responsibilities and in part because of the absence of standardized job descriptions and training across plans. Advocates also cited examples that illustrated their concern about ENCCs' timely resolution of issues. In at least some cases, conflicts appears to exist between an ENCC's potential dual roles as patient advocate and high-cost case manager. Also, advocates and providers exhibited varying knowledge of the ENCCs' role. Many providers had not yet begun to use ENCCs' services.

Capitation payments were calculated using historical data for two Phase II non-Medicare ABD eligibility categories, OAA without Medicare and aid to the blind and disabled without Medicare, using the same methodology established for the Phase I rates. Consistent with program philosophy, rates were calculated with concern for actuarial soundness. This calculation led to payments above the fee-for-service equivalent and limited the potential for cost-shifting. Plans and providers generally felt that the rates were adequate.

Although more providers participate in Medicaid since the start-up of the OHP, there are still provider shortages in Oregon that vary by geographic area and physician specialty. Shortages of dental providers have been a particular issue in Phase II because of the high level of need for such services in the Phase II population. Before they got OHP coverage, these beneficiaries had access only to emergency dental care. Moreover, some providers were not comfortable treating the kinds of complex cases presented by Phase II eligibles. These factors created access problems as Phase II was implemented.

Problems with access to dental providers originated in the first year, when capitation calculations underestimated dental care expenses. Oregon subsequently amended the capitation rate, increasing it roughly 40 percent in late 1994. To further facilitate provider participation and reduce administrative complexities, dental care was carved out exclusively to DCOs in 1996. So, while dental care still is problematic, advocates cited the increased access to dental providers and the expanded dental benefits as important advances for Phase II beneficiaries.

4. Oversight and Administration

Integration of the ABD population into the OHP necessitated involving SDSD, a service-oriented agency responsible for virtually all ABD eligibles. SDSD worked closely with OMAP during planning and implementation for the Phase II population. OMAP also created the ombudsman's office to be an advocate for the Phase II populations. In reality, this office addresses any issue forwarded to it regardless of the beneficiary's eligibility category.

The involvement of a number of new agencies and compliance mechanisms made the Phase II implementation inherently more complicated. For example, beneficiaries have a number of options for lodging complaints — ENCC, ombudsman, plan hotline, SDSD, caseworker — but as of the site visit no formalized mechanisms or policies existed to define the relationships or standards for communications across organizations. In Phase I, administration of the program was easier and tighter because essentially the only agency involved was OMAP. The increased number of agencies involved, some with traditionally different operating philosophies (particularly with the integration of behavioral health), complicates administration and oversight. Oregon is still working on smooth inter- and intra-agency administration, but all agencies involved are striving to build relationships and define the avenues of communication and their respective roles.

Despite these challenges, transitioning the Phase II population into managed care seemed to go relatively smoothly overall, although specific supporting data or evidence is scarce. OHP credits the success of the Phase II transition in large part to the efforts of a cross-agency task force, which included representatives from OMAP, other agencies, and various advocacy organizations, that met and developed criteria on specific aspects of the Phase II transition. Since implementation of Phase II, plans and advocacy groups note that their participation and input is still sought — for example, in developing contract standards and rules — but they feel less like partners in the decision-making process. As an operating program, Phase II has proven more difficult and administratively challenging, with some inconsistency in resolving beneficiary issues across agencies and variability in the focus and scope of the ENCC role.

Monitoring and evaluation of Phase II are part of OMAP's established oversight of the OHP. The EQRO has conducted some focused studies that are particularly relevant to the Phase II population (namely, on depression and diabetes), and OMAP has just completed an evaluation of the ENCC program. Otherwise, monitoring and evaluation for Phase II beneficiaries are largely indistinguishable from those for any other OHP

population, and no specific efforts have been made to identify how particular subgroups included in Phase II are faring.¹⁷ The most daunting problem actually is obtaining and manipulating useful encounter data for monitoring and analysis. This problem affects the evaluation of the entire OHP and inhibits the ability of the state to define and assess issues.

B. THE SPECIAL CIRCUMSTANCE OF THOSE DUALY ELIGIBLE FOR MEDICAID AND MEDICARE

Dual eligibles are individuals who qualify for both Medicaid and Medicare.¹⁸ Nearly all of the aged and roughly a third of the younger disabled Medicaid beneficiaries also have Medicare coverage (Mollica 1997). In Oregon, roughly 50 percent (29,000) of the Phase II enrollees as of December 1997 were dual eligibles.

The dual eligible population is diverse, typically costly, and vulnerable. Aside from a number of small-scale demonstrations, there is little experience with an integrated managed care approach for dual eligibles (Feder 1997). Efforts to integrate them into managed care are complicated by increased administrative complexity, including the need to coordinate program enrollment, benefits, payment, and oversight between Medicare and Medicaid. Although Medicare is the primary payer, the states want to have a hand in controlling expenditures. The payment structure can create a number of incentives to shift costs between programs. Also, tension arises in defining the delivery system: how to accommodate the rights of Medicare beneficiaries to the choice and access afforded by that program in the delivery system available to Medicaid recipients. Oregon's design for the dual eligibles attempted to address many of these issues.

Oregon's approach to the integration of dual eligibles into managed care was designed to minimize exemptions, facilitate continuity and coordination of care, and establish reasonable payment. The program promotes structural simplicity by, for example, eliminating the option for dual eligibles to be enrolled in two separate prepaid health plans, and continues to pursue streamlined answers. The program structure and implementation experience are discussed below.

¹⁷The relatively small number of individuals in such subgroups, and their dispersion across plans, is another constraint on such analysis, particularly in a state with as small a population as Oregon.

¹⁸For ease of discussion, the term "dual eligibles" in this paper refers to the population fully eligible for both Medicare and Medicaid.

1. Eligibility, Enrollment, and Benefit Integration Across Programs

The eligibility determination process for the OHP is the same for dual eligibles as for other OHP populations; Medicare eligibility is determined by SSA. To simplify the process, with Health Care Financing Administration (HCFA) approval, Oregon developed a single application that is used for enrollment in the OHP and the Medicare HMO. However, the processing times differ for the two programs, and as a result the effective date for enrollment in the OHP precedes the effective date for enrollment in the Medicare HMO by approximately two months.¹⁹ The differing effective dates create administrative confusion for the plans about what benefits are covered, what rules apply, and which program is financially responsible.

The enrollment process for dual eligibles is different from the process for other OHP populations. Dual eligibles are educated about their plan options through one-on-one choice counseling, like other Phase II populations. However, because the OHP is structured to simplify plan coordination across Medicare and Medicaid, they have more specific options. The following four options are available to dual eligibles:

1. Choosing a prepaid health plan in the OHP that is also a Medicare HMO. Four plans are both Medicare and Medicaid HMOs. When dual eligibles select this option, they are automatically enrolled in that one organization for both Medicaid and Medicare services. Both programs pay the plan on a capitated basis consistent with their managed care program structure.²⁰
2. Choosing a prepaid plan under the OHP that is not a Medicare HMO. (Those already enrolled in a Medicare risk product cannot choose this option.) In this situation, Medicare services continue to be paid on an FFS basis.
3. If a dual eligible has third-party insurance, choosing to remain enrolled in a private Medicare HMO or to enroll in one of the Medicare HMOs not in the OHP. In this situation, Medicaid benefits are paid on an FFS basis.

¹⁹The state is working on a waiver to allow these beneficiaries to be retroactively enrolled in Medicaid.

²⁰These four options are not available to all dual eligibles because plan availability varies by county.

4. In rare cases, receiving both Medicare and Medicaid benefits under an FFS arrangement.

Dual eligibles receive the full Medicare benefit package and the same OHP benefit package as all other OHP populations (acute medical, chemical dependency, mental health, and dental care). Medicare is the primary payer, covering most primary and acute care. Medicaid is the principal payer for long-term care, dental care, and prescription drugs. Home- and community-based waiver services and institutional care in state facilities are delivered on an FFS basis.

While the priority list feature of the OHP applies for benefits *not* jointly covered by Medicare and the OHP (Medicare coverage supersedes Medicaid's for the others), some plans and providers said that they do not aggressively regulate whether care delivered falls above or below the line.²¹ Up to this time, the capitation rate has supported this behavior. Some plans and providers noted that dual eligibles were emerging as the most costly OHP population and the hardest to manage, although most plans said that reimbursement has been adequate. At the same time, plans and providers said they do not yet feel that they are really managing care for the dual eligibles. The extent to which plans and providers *can* manage care for this group is not clear. Some providers were concerned that the lack of experience in accepting risk for this population will threaten their practices. This is particularly problematic for the OHP plans that have no counterpart Medicare plan because Medicare services continue to be paid on an FFS basis and the plan has less control over service use.

2. Effect on Plan Enrollment and Rates

There are six Medicare HMOs in Oregon, and five risk and two cost contracts, which together offer ten products and cover 180,000 lives (HCFA 1997). Originally, all of the Medicare HMOs participated in the OHP. Now, four of the six Medicare HMOs participate (Regence HMO Oregon, Providence Health Plan, Kaiser Permanente, and SelectCare). These four plans are a subset of the OHP's 14 participating, fully at-risk FCHPs, and they account for 51 percent of total OHP enrollment program-wide and half of all dual eligibles enrolled in FCHPs.

Of all the dual eligibles enrolled in Medicaid managed care (29,000), roughly half are enrolled in a counterpart Medicaid/Medicare Plan (option one) and half in a

²¹In Oregon, Medicaid does not pay for coinsurance below the line.

Medicaid-only plan with Medicare FFS (option two). Most of the 10 percent of dual eligibles who are exempted from participating in a Medicaid managed care plan are enrolled in a Medicare HMO that is not in the OHP (option three). A negligible number of dual eligibles receive their care under both programs from the FFS sector (option four). Under the current structure, no dual eligible can be enrolled in two prepaid health plans.

There are three capitation rates specific to dual eligibles: OAA with Medicare Parts A and B, OAA with Medicare Part B only, and ABD with Medicare.²² Originally, Oregon did not separate Medicare Parts A and B from Part B only. However, it became clear that some plans were experiencing a disproportionate enrollment of beneficiaries with Part B only, so the capitation was broken out. As with all of its populations, Oregon made a distinct effort to create reasonable reimbursement for dual eligibles. While a number of plans and providers mentioned the relatively high expense of dual eligibles, none indicated that the current capitation rate was inadequate.

The structure of the OHP for dual eligibles appears to be working as planned to simplify and facilitate care coordination across plans. Four of six Medicare HMOs participate in the OHP. When an OHP beneficiary is enrolled in one organization for both Medicaid and Medicare, delivery of most services is relatively uncomplicated, and incentives for cost-shifting between the two programs (with the exception of residual FFS services such as long-term care) is minimized. The plans receive dual capitation — the standard capitation from Medicare and a coordinated capitation from Medicaid — which is fairly close to a single funding stream. These plans can effectively coordinate care between Medicaid and Medicare, reducing service fragmentation and eliminating the incentives to shift costs. Nevertheless, coverage involving an FFS wraparound of either program necessarily makes it harder to align incentives, as shifting care to the other program becomes more desirable.

Plans in which dual eligibles continue to receive FFS Medicare benefits have less ability to coordinate care and control use. However, under waiver authority, Oregon does not pay copayments for dual eligibles who receive care outside of their Medicaid HMO or for any services falling below the line because they fall outside the Medicaid

²²Not all dual eligibles automatically qualify for Medicare Parts A and B. For example, an individual may not have accumulated enough work history to automatically qualify for Part A. However, these individuals can purchase Part A.

benefit package.²³ This has effectively eliminated out-of-network use, affording plans the opportunity to deliver coordinated care.

3. Oversight, Monitoring, and Administration

The state does not perform any special or distinct oversight for the dual eligibles beyond what is designed to monitor the Phase II population in general (see Section A3). Monitoring the Medicare program is the responsibility of HCFA. The state and the regional HCFA offices (Region 10) have made a number of joint on-site visits to share information and are involved in other ongoing efforts to work collaboratively. However, this collaboration had demanded special effort that was unnecessary before the OHP existed.

While there are some examples of successful administrative coordination between the Medicaid and Medicare programs (such as the development and implementation of a single enrollment application), state officials seem generally frustrated by their lack of success in persuading HCFA to simplify its processes. One particularly thorny issue is the longer time lag between application and enrollment in Medicare managed care than for Medicaid managed care. This difference complicates coordination of benefits and creates general confusion. HMO plans and providers cited administrative coordination, such as that needed for two distinct effective dates, as the major obstacle to delivering and coordinating care for these beneficiaries. In fact, the dominant issue raised during the site visit regarding the dual eligibles was the administrative difficulties created by the two programs. It appeared that, until some of these issues are resolved, plans and providers will not be able to focus on actually managing care.²⁴ Ultimately, the state would like to see one application, one effective date, one set of benefits, and one funding source for dual eligibles.

IV. EXPANSION OF BEHAVIORAL HEALTH AND INTEGRATION INTO MANAGED CARE

From the inception of the OHP, Oregon planned to deliver an expanded set of behavioral health benefits to the OHP population under managed care. This plan was

²³Oregon is one of three states (also Arizona and Minnesota) that is exempted from paying copayments for out-of-plan care. HCFA has stated that it will no longer approve requests to withhold copayments for service use outside of a dual eligible's Medicaid HMO.

²⁴The state is working on a waiver to allow for retroactive enrollment in Medicaid.

consistent with the state's overall goals of minimizing the number of services delivered on an FFS basis and fully integrating health care delivery to OHP beneficiaries (i.e., having one organization responsible for delivering both physical health and behavioral health services that are paid for under one capitation rate to that organization). The initial design called for maintaining behavioral health benefits on an FFS basis for the first year and integrating them into managed care beginning in 1995. However, the complexity of this process resulted in both design changes and some implementation delays.

Oregon's approach to integrating behavioral health benefits separated chemical dependency treatment from mental health benefits. The state chose to integrate chemical dependency services with its acute medical benefit package delivered by FCHPs and to carve out mental health benefits to MHOs).²⁵ This approach differs from the approach of some other states that combine chemical dependency and mental health benefits into one behavioral health services package that is carved out and provided by a separate behavioral health organization (BHO).

The decision to carve out mental health benefits to MHOs was influenced greatly by political considerations related to the various public and private mental health providers involved in care delivery, by local government politics, and by concerns that managed care would destabilize the safety net and traditional delivery system. Because Oregon treats the delivery of chemical dependency treatment and mental health benefits separately, despite an integrated priority list and benefit package, they are discussed separately here.

A. MENTAL HEALTH

Underlying program decisions about the design and delivery of mental health benefits is the state's philosophy that the OHP should (1) help create parity between physical and mental health benefits, (2) encourage sufficient provider and professional capacity to deliver care, (3) focus on early intervention and lower costs, and (4) protect safety net and traditional providers. In addition, the state wants agencies, plans, and providers to embrace the recovery model, which assumes that all individuals can

²⁵Carve-out refers to an arrangement in which some benefits (e.g., mental health) are removed from coverage provided by an insurance plan (e.g., an FCHP) but are provided either on an FFS basis as part of the traditional Medicaid program or through a contract with a separate set of providers (e.g., an MHO). Carve-out also may refer to a population subgroup for whom separate health care arrangements are made.

improve their quality of life and level of functioning. This is a change for providers who subscribe to models focusing on maintenance therapy or crisis intervention.

Protection of the traditional delivery system was an explosive issue at the center of the integration debate. Mental health providers were vocal in their concerns that access to care would ultimately be jeopardized by the movement of mental health into managed care. Community providers believed that they would become victims of adverse selection as private plans skimmed the least serious cases. Counties feared that private plans would develop their own behavioral health programs, drive traditional providers out of the market, and leave the market when it became unprofitable, resulting in a dismantled delivery system for low-income Oregonians. The more general concerns, particularly among legislators, were about the ability of managed care to deliver access to quality mental health care and the budget implications of an expanded mental health benefit package. Because of the controversy associated with these issues, Oregon decided to pursue a demonstration before proceeding with the statewide implementation of managed care for mental health benefits.

1. Initial Demonstration Design and Experience

In 1993, the state legislature mandated a demonstration to test rates and delivery of mental health benefits by MCOs in the public sector. The demonstration involved 25 percent of OHP eligibles in 20 counties. The residual 75 percent of eligibles continued to receive mental health benefits under the pre-OHP Medicaid model delivered on an FFS basis.

Under the demonstration, the Mental Health and Developmental Disability Services Division (MHDDSD) selected 10 contractors: four FCHPs (HMO Oregon, PacificCare, Oregon Dental Services, and Quality Health Alliance), four county-operated organizations (Benton, Clackamas, Coos, and Josephine counties), one nonprofit public benefit alliance representing CMHCs in 15 counties, and a carve-out nonprofit MHO operated by the Providence Health System. Oregon Dental Services withdrew from the demonstration before contracting was completed, leaving only one MHO in Coos County.

During the demonstration period, some changes occurred in the roster of participating plans, which reflected some plans' inexperience with managing mental health as well as some broader corporate decisions about involvement in Medicaid managed care or behavioral health. Late in the first year of the demonstration (October 1995), for example, HMO Oregon decided not to renew its contract for mental health

services. MHDDSD contracted with Ceres, a partnership of mental health providers in Washington County, to serve these OHP enrollees. PacifiCare withdrew from the demonstration (and the OHP) as part of its national withdrawal from Medicaid contracting in October 1996. PacifiCare's partner, Benton County, assumed responsibility for administering the mental health benefits for its enrollees. Fortunately, continuity was maintained by contracting with these alternate organizations.

According to state officials, the state-sponsored evaluation of the demonstration showed an increase in the number of persons served, a decrease of six weeks in the average wait time from referral to first appointment date, a decrease in the number of acute inpatient hospital days, consistent or improved client satisfaction, and overall cost savings.²⁶ This success spurred the 1997 state legislature to approve statewide expansion of mental health managed care and expanded mental health benefits beginning July 1997. It is too early to say if the demonstration results will be realized across the state.

Most of the county-based opposition to managed care's penetration into mental health has folded in the face of the inevitable, although a couple of counties are suing the state to grant them more leverage because of concerns about county delivery system viability under managed care. The state had hoped to achieve statewide MHO coverage by October 1997, but contracting and administrative complexities postponed this milestone until the end of 1997.

2. Current Structure of the Mental Health Managed Care Carve-Out

In Oregon, the county mental health authorities and their contracted providers — namely the community mental health centers (CMHCs) — have been responsible for delivering mental health services for more than 30 years. This system was built to serve clients who were in crisis situations or who had chronic conditions. As required under state law, clients were served based on need in terms of the threat they posed to themselves and the community. Historically, CMHCs have had sufficient funding to complete this mission. As a result, Oregon counties have a lot of experience serving the severely and persistently mentally ill, but less experience dealing with mild or medium mental health needs.

²⁶Expenditures for the demonstration were less than projected largely because of the continued drop in the actual number of eligibles as opposed to the number of eligibles estimated for budgetary purposes.

The counties were extremely concerned that managed care would threaten their ability to provide emergency mental health services (as required by state statute) and coordinate community resources. In response, all the contractors that bid on providing services under the OHP were required to complete a planning process with the local mental health associations in their service areas to ensure that community mental health systems would remain viable. The MHOs' treatment of traditional providers was a consideration in the award process.

The same types of contractors involved in the demonstration — FCHPs, county plans, and local delivery systems — remained involved as mental health managed care was extended statewide. At year-end 1997, 12 MHOs covered the entire state, and two more MHOs began operations in the beginning of 1998. The state and provider advocates concluded that the traditional county network could remain viable if approximately 50 percent of OHP eligibles were in the county system. However, no formal contract specifications were developed to ensure that 50 percent of beneficiaries are with traditional providers. Roughly 70 percent of OHP beneficiaries were in county systems at the time of the site visit. So far, the state feels that it is succeeding in protecting the mental health safety net through the policies governing the carve-out (e.g., the requirement that contractors consult with the local mental health authorities).²⁷

The county-based systems and their providers had little to no experience with mild or moderate mental health needs or managed care. Conversely, most FCHPs had little experience with mental health, and especially the severely and persistently mentally ill population. As a result, a number of partnerships emerged. Some MHOs shared financial responsibility with FCHPs for jointly managed programs. A number of MHOs were subcapitated by FCHPs for the chemical dependency benefit. One county (Benton) entered into a public/private partnership with a FCHP (PacifiCare). In this partnership, the county provided outpatient and rehabilitative services and PacifiCare managed the inpatient benefit.

Most MHOs made a number of changes in order to deliver mental health services to OHP enrollees under managed care. Many MHOs added preventive and educational

²⁷Protecting the safety net has required the state to make tradeoffs. For example, one FCHP (Kaiser) was interested in an MHO that spanned its multicounty service area. Concern about the loss of safety net involvement in the area led the state to decide not to allow the plan to contract for all the desired counties. As a result, the plan withdrew its application entirely, perceiving that a less than systemwide approach was not in its best interest.

services, supportive services, and a number of group therapeutic services. County staff, in particular, were educated about the use of brief therapies and operation under managed care (where cost is a consideration for organizational survival but service design and delivery is more flexible). The state also wanted MHOs to become accustomed to thinking about delivering services under the recovery model (rather than a maintenance care model), which encourages independence and discourages dependence. Finally, many MHOs were inexperienced with managed care and risk. It is still unclear how well some of the MHOs will adapt to these fundamental changes in care delivery and management.

a. Payment Rates

MHOs receive a monthly capitation payment from one of 70 rate cells. The cells are defined by 14 eligibility categories and five geographic regions (e.g., OAA without Medicare in the tri-county area). These rates are determined by estimating per capita utilization and costs of providing the services in the mental health benefit package. The base per capita rate for each eligibility category is adjusted for a number of factors, including differences in severity of illness across categories, inflation, administrative costs, managed care efficiencies, and location in one of five geographical areas. Services not covered under the MHO capitation rate include home and community-based waiver services, which are not funded by the OHP, and pharmacy related to mental health (Table 2).²⁸

Before 1998, the state used only nine eligibility categories. It decided to increase the number of rate cells — for example, breaking out the OAA with Medicare into OAA with Medicare Parts A and B and OAA with Medicare Part B only — to maintain consistency with the FCHP and PCO reimbursement cells. One element that was not accounted for in the capitation rate for dual eligibles was Medicare's 50 percent copayment for most mental health services.²⁹ MHOs will have to subsume this expense. No state or plan officials commented on this issue, but indirect comments from others indicate that the omission is a concern. As the managed care carve-out becomes operational statewide and more dual eligibles are enrolled in MHOs, it could emerge as an access issue.

²⁸Home- and community-based waiver services include case management, homemaker services, home health aid services, personal care services, adult day health habilitation, and respite care. Some additional services, such as transportation, may also be included subject to HCFA approval.

²⁹The Medicare copayment for mental health services (50%) is higher than for other Medicare-covered services (20%).

b. Benefit Package

As defined by the 39 mental health conditions located “above the line”, the mental health benefit package extended to the entire OHP population in 1997 represents a significant expansion over traditional Medicaid, especially for adults. Most mental health conditions are covered, including acute inpatient care, case management, therapy, and urgent and emergent services (Table 3). Under traditional Medicaid, adults had to pose an imminent danger to themselves or others or be seriously and persistently mentally ill to receive any mental health treatment. Now, all persons requesting mental health services included in the benefit package are eligible for these services regardless of the severity of their mental disorder (e.g., mild and moderate symptoms). Children already had access to full mental health benefits as part of early and periodic screening, diagnosis, and treatment coverage.

c. Coordination of Care

Oregon’s experience with managed mental health carve-outs has highlighted three specific coordination issues: (1) coordination of somatic (i.e., physical health) and mental health services; (2) coordination for those dually diagnosed as needing both mental health and chemical dependency treatment services; and (3) coordination with non-OHP services important to subgroups of those with mental illness.

Coordination with Somatic Services. A major challenge facing Oregon is the coordination of benefits across FCHPs and MHOs. Physical health care that overlaps with mental health care is defined by the state as “somatic mental health care” and includes screenings by primary care practitioners (PCPs) for mental disorders, prescribing and monitoring medications for mental disorders, and providing laboratory services and electrocardiograms to monitor the effects of mental health medications. To ensure efficient collaboration between FCHP and MHO practitioners and plans for these crossover services, the state — along with mental health practitioners and the FCHP medical directors — developed the somatic mental health protocols. The protocols allow limited authorization for psychiatric providers to order necessary laboratory studies and medications, although payment for such services remains with the FCHP, and require that psychiatric providers using the protocols send treatment information to the FCHP (and vice versa).

Table 2
Financing of Mental Health Services

OHP-Funded Services	
<i>Covered Under Capitation</i>	<i>Covered Under FFS</i>
Acute inpatient Hospital Psychiatric Care	Medication (Classes 7 and 11)
Assessment and Evaluation	
Case Management	
Consultation	
Daily Structure and Support	
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services	
Medication Management	
Mental Health Services in Supported Housing Settings	
Skills Training	
Therapy (individual, group, and family)	
Urgent and Emergent Services	
Job Opportunity Basic Skills Treatment	
Interpreter Services	
Services Funded by Non-OHP Sources	
Enhanced Care Services in Special Facilities	
Extended Care Management	
Long-Term Hospitalization	
Personal Care in Adult Foster Homes	
Preadmission Screening and Annual Residential Review	
Precommitment	
Psychiatric Security Review Board	
Residential Care Facilities (General Fund-supported and programs including Residential Medical Youth Care and JCAHO Residential Center)	
Supported Employment	
Therapeutic Group Home	
Treatment Foster Care for Children in Custody of SCF	

Source: Mental Health and Developmental Disability Services, Department of Human Resources, Distribution of Mental Health Services, 1997.

Table 3
Covered Mental Health Conditions as of May 1, 1998: Integrated Priority List

Item	Line Number	Diagnoses/Condition
1	88	Rumination disorder of infancy
2	144	Anorexia Nervosa
3	145	Reactive attachment disorder of infancy or early childhood
4	159	Schizophrenic disorders
5	160	Major depression, recurrent
6	161	Bipolar disorders
7	185	Major depression; single episode or mild
8	186	Brief reactive psychosis
9	187	Attention deficit disorders with hyperactivity or undifferentiated
10	241	Acute stress disorder
11	242	Separation anxiety disorder
12	264	Adjustment disorder
13	265	Oppositional defiant disorder
14	266	Tourette's disorder and tic disorders
15	303	Post-traumatic stress syndrome
16	304	Obsessive-compulsive disorders
17	339	Agoraphobia without history of panic disorder
18	338	Panic disorder with and without agoraphobia
19	373	Conduct disorder, mild/moderate: solitary aggressive, group type, undifferentiated
20	374	Overanxious disorder
21	375	Bulimia nervosa
22	376	Anxiety disorder, unspecified; generalized anxiety disorder
23	390	Paranoid (delusional) disorder
24	425	Dysthymia
25	426	Acute delusional mood anxiety, personality, perception and organic mental disorder caused by drugs; intoxication
26	427	Borderline personality disorder
27	428	Identity disorder
28	429	Schizotypal personality disorders
29	434	Conversion disorder, child
30	435	Functional encopresis
31	436	Avoidant disorder of childhood of adolescence; elective mutism
32	437	Psychological factors affective physical conditions (e.g. asthma)
33	465	Eating disorders NOS
34	466	Dissociative disorders: depersonalization; multiple personality; psychogenic fugue; psychogenic amnesia; dissociative NOS
35	467	Chronic organic mental disorders including dementia
36	482	Stereotype/habit disorder and self-abusive behavior due to neurological dysfunction
37	523	Somatization disorder; somatoform pain disorder
38	524	Simple phobia
39	525	Social phobia

Note: Cutoff line was at 578 as of February 1, 1997.

Source: Mental Health and Developmental Disability Services, Oregon Department of Human Resources, *Oregon Health Plan Integrated Mental Health Conditions*, effective May 1, 1998.

The state decided to carve out payment for prescription drugs in therapeutic classes 7 and 11 (antipsychotics and antidepressants) from the capitation rates and pay for them on an FFS basis to simplify coordination and financial responsibility. Initially, these drugs were considered part of the benefits covered by the capitation rate. However, the state felt that care might be compromised under an ambiguous financing structure, so they were carved out. This arrangement allows the state to collect information about utilization and expenditures and decide how pharmacy services should be financed and delivered in the future. A number of other medications, such as anti-epileptics, that are used in both acute medical and mental health settings are not paid for on an FFS basis. The responsibility for payment for these drugs and other crossover services is often a matter of careful negotiation between the MHOs and FCHPs.

How well care is being coordinated across plans and providers, even in demonstration counties, is still unclear. Somatic health protocols and agreements among FCHPs, MHOs, and PCPs regarding laboratory work and treatment are being assimilated, and the remaining kinks are being worked out.

Coordination for the Dually Diagnosed. The bifurcation of chemical dependency treatment and mental health care has most seriously affected those dually diagnosed with chemical dependency and mental health needs. While a number of crossover services are being addressed through the somatic mental health protocols, the care and payment issues of the dually diagnosed have not yet been dealt with satisfactorily. Estimates of the percentage of persons with mental disorders who also misuse drugs and/or alcohol range from 40 to 60 percent (Ross 1997). Jurisdictional authority and financial responsibility for care are not well established. Many MHOs do not have contractual arrangements with chemical dependency treatment providers and, more problematic, some MHOs provide both mental health and chemical dependency treatment services but are not part of the beneficiary's FCHP network. Effective resolution of these issues is currently being discussed by the state, plans, and providers.

Otherwise, coordination of care for medical needs and mental health care across FCHPs and MHOs seems to be working fairly well. Some policies regarding payment still need to be developed, however. For example, a beneficiary may be admitted under one diagnosis, such as a broken hip, and discharged under another, such as depression. Because no formal policy exists dictating which diagnosis will be used to

determine which plan is financially responsible, confusion persists. The state, plans, and providers are in the process of addressing these care management and fiscal issues.

Coordination with Services Funded by Non-OHP Sources. Some mental health services are funded by non-OHP sources, such as extended care management and long-term psychiatric care, which are managed by the extended care management unit (ECMU). Located within MHDDSD, the ECMU authorizes all admissions to state-operated psychiatric facilities, secure residential treatment facilities, and state-contracted “hold beds” in acute care hospitals. The ECMU is also responsible for coordinating transitions between care settings and from extended care to lower levels of care (e.g., supported-living programs). Admissions to state-operated facilities have not increased since the integration of the Phase II population into the OHP, nor has there been a disproportionate number of admissions by MHOs. Concerns about the incentive for MHOs to cost-shift through long-term care admissions have not been realized.

d. Oversight and Monitoring

OMAP is ultimately responsible for oversight of the OHP and all of the prepaid health plans. However, MHDDSD handles virtually all the oversight and coordination for mental health including contract compliance, monitoring, and evaluation. In fact, MHDDSD’s Office of Mental Health (OMH) was responsible for oversight and evaluation of the demonstration and is responsible for contract procurement, provider education, and monitoring for the statewide expansion. OMH also developed a comprehensive quality management guide and standards for the mental health managed care program and its contractors.

B. CHEMICAL DEPENDENCY

As originally planned, chemical dependency services were integrated with acute medical benefits in January 1995. The Office of Alcohol and Drug Abuse Programs (OADAP) felt that chemical dependency services were underutilized by the OHP population, ultimately resulting in higher expenditures for medical care. OADAP estimated that the need for chemical dependency services in the OHP population (3 to 4%) was double the rate of actual use (1 to 2%). As a result, OADAP expected important cost savings in acute medical services as use of chemical dependency benefits increased.

The administrator of OADAP at the time deserves much of the credit for getting chemical dependency benefits included in the FCHP capitation rate. His dedication to the vision of integrated services and repeated and forceful defense of the cost offset that could be derived from an increase in timely, appropriate use of chemical dependency services was ultimately persuasive. As with mental health, there were concerns about the ability of health plans to provide appropriate chemical dependency services. Access to methadone services was a particular concern. However, a key distinction between mental health and chemical dependency reportedly was the latter's greater emphasis on a medical orientation and proportionately lesser emphasis on a social service model. This heightened the compatibility of chemical dependency services with the medical model.

1. Structure of Benefits and Payment

Before 1995, Medicaid recipients were eligible for FFS chemical dependency services, but the expansion populations received few services or no treatment at all. With the integration of these benefits into the OHP, chemical dependency services are included on the integrated priority list and available to all OHP eligibles. Benefits covered under the capitation include outpatient, intensive outpatient, and opiate substitution services (methadone treatment).³⁰ Residential and community detoxification services can be accessed by OHP beneficiaries directly and are paid with "slot funds."³¹ OADAP purchases "beds" (or slots) on an annual basis from residential and community detoxification providers.³² FCHPs refer members to these services, but clients also can gain access directly. FCHPs are still responsible for medical care while clients are in a residential or community detoxification setting.

Administration of chemical dependency benefits and assumption of risk was phased in over six months beginning in January 1995. Chemical dependency services were paid on an FFS basis through May 1995, and beneficiaries could access these services directly or go through the plan. Beginning in May 1995, FCHP capitation payments included coverage for chemical dependency services. At that time, beneficiaries had to begin complying with plan requirements. Intensive outpatient services remained under the FFS structure until July 1, 1995.

³⁰Outpatient is defined as two or fewer face-to-face therapeutic contacts per week, and intensive outpatient as three or more face-to-face contacts per week.

³¹OADAP buys bed slots that are paid for regardless of actual use.

³²The residential and community detoxification beds are available to persons meeting established income requirements. Most OHP beneficiaries qualify.

There was concern that capitation dollars intended for chemical dependency benefits would be shifted to cover other health services, especially because plans receive one payment from the state. The possibility that plans are using chemical dependency funds for other services has not been substantiated in Oregon, but the potential exists for appropriate referral and use to be undermined by reallocation of these funds to other services.

2. Managed Care Contracting

According to OADAP, there is essentially one chemical dependency delivery system for both public and private clients, which is concentrated in the Portland metropolitan area. Most plans did not have a lot of experience with administering or delivering chemical dependency benefits. OADAP educated plans about chemical dependency services and the potential for savings, but plans were particularly resistant to the use of methadone treatment. They were wary of patient compliance, of methadone's success as a maintenance therapy, and of the quality of available programs. After the chemical dependency benefits were integrated into FCHPs, the number of providers and methadone treatment average length of stay increased by nine weeks (OADAP 1996). In fact, according to OADAP, methadone treatment has proven successful enough that Kaiser Permanente has decided to add this benefit to its commercial offering.

OADAP took a number of steps to safeguard plans, providers, and beneficiaries, smooth the transition, and quell concerns, including the following:

- training providers and PHPs about managed care;
- developing a simplified screening tool for physician use;
- establishing criteria to guide admission, continued stay, and discharge decisions;
- advocating for a sound and adequate capitation; and
- developing contract standards specific to delivery of these benefits.

The 21 contract standards were developed with provider input and are part of the FCHP contract. These standards require contractors to do the following:

- make a reasonable effort to engage members requiring treatment;
- make referrals using the established OADAP approved criteria;
- coordinate referral and follow-up of members to residential treatment and community detoxification centers;

- submit encounter data;
- use the OADAP screening instruments to determine diagnostic status;
- screen 75 percent of all members by October 1998;
- use licensed and approved programs;
- employ knowledgeable gatekeepers;
- refer 50 percent of members to traditional community providers for diagnostic or treatment services;
- inform all members about the availability of chemical dependency services;
- adopt access standards; and
- maintain beneficiary confidentiality.

Oregon felt that requiring referral to traditional community providers in the contracts was essential to ensure quality of care and to protect against major changes in OHP policy or funding. Concerns about a withered delivery system have not materialized; the chemical dependency provider population (alcohol and drug abuse outpatient and methadone services) has grown 10 percent in the two years since integration into the OHP.

3. Care Coordination

In general, it appears that integration into FCHPs has improved coordination of chemical dependency care with medical care, with the exception of the dually diagnosed, because before the OHP there was very little formalized coordination. Philosophies about treatment may vary among organizations and providers (e.g., medical versus social model, maintenance versus recovery model), but OADAP feels that continuing education and experience with these benefits are building awareness and improving decision-making among plans and providers.

Interviewees during the site visit said that coordination issues between FCHPs and FFS programs and services (such as residential care) have not materialized and that there has been no indication that plans are under-referring or over-referring beneficiaries to the FFS programs. The state feels that the screening tool developed for providers has been successful in moving clients into the appropriate level of care. Furthermore, OADAP feels that the criteria guiding levels of care have been instrumental in avoiding long and costly disputes about appropriate care and responsibility for delivery and payment.

The biggest care coordination issue concerns the dually diagnosed. Still to be resolved are issues of coordination between the primary care practitioner and the mental health practitioner and responsibility for authorization and payment of a number of overlapping services. The somatic mental health protocols attempt to clarify some of the issues involving care that is included in the FCHP capitation — namely authorization of laboratory tests and dissemination of care information — but do not really address needs specific to the dually diagnosed. Treatment of the dually diagnosed becomes even more difficult when MHOs do not have contractual arrangements to provide chemical dependency services under the OHP.

Overall, the integration of chemical dependency benefits into managed care appears to have increased access and coordination with primary care. The state reports a 20 percent increase in the total number of clients served from 1995 to 1997. This growth occurred across most subgroups (i.e., adult men and women, minorities, and urban and rural beneficiaries). Even so, the number of OHP beneficiaries using chemical dependency services is below the state's target of 3 to 4 percent.

Analysis by the state shows that the percentage of beneficiaries receiving treatment for chemical dependency is disproportionately distributed across plans. For example, Care Oregon has 1.2 times more enrollees in chemical dependency treatment than the next closest plan and twice as many as the average plan. These selection issues are being considered in the state's current risk adjustment efforts.

4. Oversight and Monitoring

OMAP monitors and evaluates the delivery of chemical dependency benefits as part of its oversight of the FCHPs. OADAP contributes to oversight and monitoring mainly through its mandate to license and monitor all chemical dependency providers that receive public funds. At roughly one and two years after integrating chemical dependency services into managed care, OADAP analyzed indicators of access and use. Except for traditional licensing and monitoring tasks, however, evaluation and analysis by OADAP are sporadic because it lacks explicit funding for those purposes.

V. DISCUSSION AND KEY ISSUES

Oregon's experience shows that states can successfully integrate special populations into managed care. Careful planning that incorporates elements tailored for these special populations is very helpful in encouraging continuity of care and promoting appropriate care. Examples of these elements employed by Oregon include the modification of the priority list to include benefits appropriate for the population, one-on-one choice counseling so that beneficiaries can make educated decisions about enrollment in managed care, the continuity-of-care form to safeguard essential care during the transition into managed care, the ENCC program to address the unique needs of Phase II beneficiaries (along with the ombudsman's office) and protect them from being disadvantaged by managed care, the somatic health protocols for coordinating crossover medical and mental health services, and the chemical dependency screening tool to identify need and facilitate placement in the appropriate level of care. But even with these provisions, meeting the heterogeneous needs of these special populations is a challenge.

Moving to expand managed care to SSI and other special needs populations increases the complexity of state administration and oversight mechanisms. It necessitates involving many different agencies, each of which has a unique perspective and philosophy. And the challenge does not end with successful implementation, because ongoing operational issues will require attention. It is not clear that the collaborative process that was important to Oregon's relative success in implementing its Phase II population remains as strongly in place now to address thorny operations issues. These issues include, for example, how best to coordinate the roles of consumer protection agents and how best to identify weaknesses or operational problems that may need attention, such as the different ways in which ENCCs are being used by health plans.

The Medicare-Medicaid dual eligibles present special challenges. States have to think about how to integrate monitoring and oversight for Medicare and Medicaid if this group is to be included in managed care. The state and HCFA (and its regional offices) are each accustomed to having prevailing authority. Reconciling jurisdictional issues across programs, analogous to interagency coordination, takes forethought and planning because of established roles and philosophical differences as well as contradictory statutes and requirements. Oregon faced an easier task in integrating Medicaid with Medicare than many other states will face because of the advanced role

of Medicare risk products in the market and these plans' participation in the OHP (Thompson and Brown 1998).

Oregon's experience also highlights the complexity of moving toward managed care for behavioral health services. Both mental health and chemical dependency needs are met by a variety of programs funded in different ways. Philosophies differ across the involved providers, as does the emphasis on care management. Further, providers differ in their dependence on Medicaid and on the population of their primary focus. For example, providers that concentrate on care for the severely and chronically mental ill tend to be very different from providers that care for those with less severe needs. Similarly, providers' experience caring for those with chemical dependency needs varies across subpopulations, as does familiarity with the different ways chemical dependency conditions can be treated. All of these factors complicate state efforts to identify the most suitable structures on which to base managed care delivery.

Virtually any approach to integrating acute medical care and behavioral health into managed care presents challenges. Building on established managed care providers involved in delivery of acute medical health services has the advantage of encouraging coordination between somatic and behavioral health needs and allows primary care providers to serve persons with mild mental health needs. It also builds on existing managed care experience and infrastructure. Yet such providers may be inexperienced in treating certain conditions or in providing the full range of services needed for a given population.

Using a mainstream model also has potentially adverse implications for safety net services. When forced to compete with other providers for clients and capitation dollars under managed care, a safety net provider is particularly vulnerable if insured clients leave for other providers, taking with them dollars essential to the organization's survival. In Oregon, the traditional providers of mental health care felt they were facing demise without explicit protection. Oregon felt that the safety net would be protected by carving out mental health to managed care, although this accommodation resulted in a structure that accentuates coordination problems across delivery systems.

The decision to allow both physical and mental health providers to prescribe certain psychotropic drugs paid for on an FFS basis was important to minimizing the adverse effects of the carve-out. Oregon also attempted to address the heightened coordination issues and differences in treatment philosophy across plans for care that overlaps with the somatic mental health protocols. Some of the resolutions have seen relative

success, such as some blanket authorizations for laboratory tests, but a number of coordination issues still must be resolved. For example, coordination for the dually diagnosed was not planned for up front, and the OHP is now trying to sort out the consequences.

Another challenge highlighted by carving out mental health benefits to providers whose experience with managed care was mostly limited was the need to teach such providers what managed care and managing risk means. During the site visit, it was not clear how well the mental health providers understood the accountability they have assumed for the full spectrum of mental health services and the financial risks associated with capitation in this model. A purported benefit of moving to managed care, for both acute medical services and mental health, is that it forces safety net providers to examine their delivery systems and operations and make changes to become more competitive. It appeared, although little data exist, that few county providers had modified their delivery systems extensively at this point to accommodate their new obligations under managed care.

In sum, states seeking to expand their managed care systems beyond the basic medical model inherent in service delivery for the AFDC population must recognize that the decision will raise a host of issues and operational challenges. These challenges include working with new organizations and service providers, developing coordinated, coherent policy, and minimizing disincentives. Oregon shows that significant progress toward these goals is possible when explicit efforts are made to identify the unique needs of these special populations and modify or construct program elements to address these needs as proactively as possible. The task is far from simple, however, and its execution requires a concerted effort by a variety of parties. Oregon's relatively small population (3.2 million people), substantial managed care experience, and established mechanisms for coordination undoubtedly shortened the distance that had to be traveled to implement change. States less favorably situated with respect to these factors may want to be more conservative in their initial goals and anticipate the need to address at least as many issues, and probably more.

REFERENCES

Coopers & Lybrand, *Oregon Health Plan Medicaid Demonstration. Analysis of Federal Fiscal Year 1993 & 1999 Average Costs*. Report to the Oregon Department of Human Resources, Office of Medical Assistance Programs. San Francisco: Coopers & Lybrand, September 1996.

Coopers & Lybrand, *Oregon Health Plan Medicaid Demonstration. Analysis of Federal Fiscal Year 1996 & 1997 Average Costs*. Report to the Oregon Department of Human Resources, Office of Medical Assistance Programs. San Francisco: Coopers & Lybrand, February 1995.

“Cuts from Oregon’s Prioritized List Uncontroversial So Far, but Future Budget Constraints Promise to Reignite Public Debate.” *State Health Watch*, July 1996.

Feder, Judith, “Medicare/Medicaid Dual Eligibles: Fiscal and Social Responsibility for Vulnerable Populations.” Washington, DC: The Kaiser Family Foundation, May 1997.

Gold, Marsha, “Markets and Public Programs: Insights from Oregon and Tennessee.” *Journal of Health Politics, Policy and Law*, Vol. 22, No. 2, April 1997.

Gold, Marsha, Karyen Chu, and Barbara Lyons, “Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon.” Washington, DC: The Kaiser Family Foundation, 1995.

Health Care Financing Administration, *Managed Care and Medicare+Choice Reports, Files, and Data; Medicare Managed Care Plans Monthly Summary Report*. [<http://www.hcfa.gov/Medicare/mmcc.htm>]. May 1997.

Health Plan Unit, Mental Health and Developmental Disability Services Division, Oregon Department of Human Resources, *Mental Health Services in the Oregon Health Plan*. Report to the Emergency Board, Salem, OR, 1997.

_____, *Oregon Health Plan Mental Health Services Newsletter* (draft). Salem, OR: DHR, December 1997.

_____, *Somatic Mental Health Services: Integrated Model of Practice for Collaborating Oregon Health Plan Mental Health and Primary Care Providers*. Salem, OR: DHR, August 1997.

_____, *Mental Health Oregon Health Plan 1997–1999 Budget Implementation*. Salem, OR: DHR, September 9, 1996.

Health Systems Research, *The Development of Capitation Rates under Medicaid Managed Care Programs: A Pilot Study*, Vol. II: State Summaries. Washington, DC: The Kaiser Family Foundation, 1997.

Kaiser Commission on the Future of Medicaid, *Medicaid Facts*. Washington, DC: The Kaiser Family Foundation. November 1997.

Liska, David et al., *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990–1995*. Washington, DC: The Kaiser Commission on the Future of Medicaid, 1997.

Memo from Barry S. Kast, “Selection of Contractors for Provision of Managed Mental Health Services Under the Oregon Health Plan,” September 19, 1997.

Memo from Ralph Summers, “Fee-for-Service Billing for Medicaid-funded Mental Health Services Provided Under the Oregon health Plan List of Prioritized Conditions and Treatments.”

Mental Health and Developmental Disability Services Division, Department of Human Resources, *OHP Integrated Mental Health Conditions Effective May 1, 1998*. Salem, OR: DHR, 1998.

_____, Request for Proposals To Provide Managed Mental Health Services Under the Oregon Health Plan. Salem, OR: DHR, January 1997.

_____, *Distribution of Mental Health Services 1997*. Salem, OR: DHR, 1997.

_____, *Mental Health Services in the Oregon Health Plan: Report to the Emergency Board*. Salem, OR: DHR, undated.

Mittler, Jessica, Marsha Gold, and Barbara Lyons, "Managed Care and Low Income Populations in Oregon: 1996–1998 Update," draft report, August 1998.

Mode, Michael, "1998 Medicare Plan Comparison." *The Oregonian*. Dec. 8, 1997, p. E1.

Mollica, Robert, Paul Saucier, Trish Riley, and Maureen Booth, *Protecting Low Income Beneficiaries of Medicare and Medicaid in Managed Care*, Vol. II: Coordination of Benefits, Payment Mechanisms and Quality Management. Portland, ME: National Academy for State Health Policy, August 1997.

Oregon Department of Human Resources, "Percent in Treatment: Ages 12 and up (5/96–5/97) by Plan." Salem, OR: DHR.

_____, *Report to the Statewide Evaluation of the ENCC Program*. Salem, OR: DHR. March 31, 1998.

_____, *Enrollment and Disenrollment Reports*. Salem, OR: DHR. November 1994, January 1995, January 1996, January 1996, December 1997.

_____, *Oregon Health Plan Fully Capitated Health Plan Agreement*. Salem, OR: DHR, Oct. 1, 1997.

_____, *Oregon Health Plan Model Mental Health Organization Agreement*. Salem, OR: DHR, November 1997.

_____, *Overview of The Public Mental Health System in Oregon*. [<http://omhs.mhd.hr.state.or.us/context.htm#Introduction>]. November 1997.

_____, *Progress Report: The Oregon Health Plan Medicaid Reform Demonstration*, Part I: Overview of Key Accomplishments. Salem, OR: DHR, January 1997.

_____, *Progress Report: The Oregon Health Plan Medicaid Reform Demonstration*, Part II: The Health Care Program. Salem, OR: DHR, June 1997.

_____, *Oregon Health Plan Medicaid Demonstration Project Quarterly Reports*, March-June 1996, July-September 1996, October-December 1996, and January-March 1997. Salem, OR: DHR.

_____, Oregon Health Plan Administrative Rules. Salem, OR: DHR, December 1996.

_____, "Second Phase of Oregon Health Plan Set to Start January 1, 1995." Press Release. Salem, OR: DHR, Sept. 29, 1994.

Oregon Health Plan Policy and Research, *Effects of the Oregon Health Plan: A Summary Report*. Salem, OR: OHPPR, April 1997.

Oregon Health Services Commission, *Prioritization of Health Services. A Report the Governor and Legislature*. Salem, OR: Oregon Health Services Commission, 1995 and 1997.

Oregon Office of Drug Alcohol and Drug Abuse Programs, Department of Human Resources, *A Status Report: Chemical Dependency Benefits in the Oregon Health Plan*. Salem, OR: DHR, July 1996.

_____, *Chemical Dependency Services in the Oregon Health Plan*. Salem, OR: DHR, December 1996.

Physician Payment Review Commission, "Managing Health Care for Dually Eligible Beneficiaries." Chapter 19 in *1997 Annual Report to Congress*. Washington, DC: 1997.

Rawlings-Sekunda, Joanne, *Directory of Risk-Based Medicaid Managed Care Programs Enrolling Elderly Persons or Persons with Disabilities* (Update: January 1997). Portland, ME: Center for Vulnerable Populations, 1997.

Ross, Kathryn, *Oregon Health Plan Mental Health Demonstration Project Biennial Report*. Prepared by the Mental Health and Developmental Disability Services Division. Salem, OR: August 1997.

Ross, Kathryn, and Jim MacLeod, *Guide to Quality Assurance and Quality Improvement*. Prepared by the Mental Health and Developmental Disability Services Division. Salem, OR [undated].

Saucier, Paul, and Robert Mollica, *Protecting Low Income Beneficiaries of Medicare and Medicaid in Managed Care*, Vol. I: Contracting Arrangements, Beneficiary Choice, Enrollment and Disenrollment, and Tracking. Portland, ME: National Academy for State Health Policy, August 1997.

Senior and Disabled Services Division, *SDSD Managed Care Enrollment Reports*. Salem, OR: June, July, September 1997.

Thompson, Rachel, and Randall Brown, "Medicare Beneficiaries and HMOs: A Case Study of the Portland Market." Washington, DC: The Kaiser Family Foundation, May 1998.

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