



Assessing the Early Impacts of OHP2: FQHC Case Study

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HIFA Waiver and OHP2

HIFA provides federal authorization for states to waive provisions of their Medicaid state plan for the purpose of expanding access to Medicaid coverage

- HIFA requires that states expand eligibility while permitting differential benefit packages to non-mandatory populations
- HIFA requires that states promote public-private partnerships in insurance products developed under their waiver

OHP2: Medicaid redesign

Eligibility Group	Original OHP	OHP2
Mandatory Groups: Aged, Blind, Disabled, AFDC/TANF	Full benefit package, no co-pays, FPL set at AFDC needs standard	No change in benefits, no co-pays, now known as <i>OHP Plus</i>
Low-income pregnant women and children up to 19 yrs	Full benefit package, no co-pays, eligibility set at 170% of FPL	No change in benefits, no co-pays, eligibility set at 185% of FPL, now <i>OHP Plus</i>
Optional (Expansion) Groups: Low-income parents and childless adults	Full benefit package, no co-pays, eligibility set at 100% of FPL	Leaner benefits, comparable to commercial benefit package for working adults, co-pays for most services, now known as <i>OHP Standard</i> , capped appropriation
Family Health Insurance Assistance Plan (FHIAP)	Eligibility set at 170% of FPL, commercial equivalent benefit package, co-pays, 100% state-funded, capped appropriation	Eligibility set at 185% of FPL, commercial equivalent benefit package, co-pays, 60/40 federal match, capped appropriation



OHP Standard a leaner benefit package with cost-sharing ...

Co-payments for *Standard* enrollees include:

Outpatient office visits (\$5), ED (\$50), prescription drugs (\$2/\$3)

Benefits not included in *OHP Standard*:

Durable medical equipment

Reduced dental

Vision and eyeglasses

Non-emergency medical transportation



OHP2: February 2003 Implementation


Legislature dealing with revenue shortfalls, budgetary demands, high unemployment, escalating medical care cost inflation

✦ *OHP Plus* and *OHP Standard* implemented against a backdrop of confusion regarding eligibility and coverage levels due to on-going legislative budget deliberations:

OHP Standard income threshold set at 100% of FPL

OHP Standard group loses MH/CD and all dental benefits

Elimination of prescription drug coverage (mid-March-June)



OHREC agrees to study short-term impacts of OHP2 implementation

Focus on Safety Net Providers --

- ✂ Lowe study of OHSU ED utilization
- ✂ OHPI study of safety net clinics (FQHCs)



Portland Area FQHC Case Study

- ✦ Clinic administrators' key informant interviews (n=6) conducted in June 2003
- ✦ Patient interviews (n=320) conducted in August 2003



Key Informant Interviews

- * Administrative and fiscal adaptations
in response to OHP2
 - * Issues related to quality and
continuity of care
 - * Diminished access to primary care



Key Informant Finding #1: Lack of and/or inconsistent information

- ✦ There was widespread confusion reported among providers and patients regarding eligibility, benefits, and cost-sharing obligations when OHP2 was implemented in February 2003
- ✦ Clinic administrators shared this sense of confusion and were in an anticipatory mode regarding further cuts to be made by the legislature in June 2003




Key Informant Finding #2: Unmet demand for MH/CD services stresses PCPs

- ✦ The loss of mental health and chemical dependency benefits for the *OHP Standard* population was reported to have created a demand for these services that could not be met by primary care providers (PCPs)



Signs of the MH/CD problem...

- ✦ In Washington County five safety net clinic sites were sharing one social worker
- ✦ All FQHC informants reported not having the capacity to absorb the increased demand for mental health services brought on by the loss of Medicaid eligibility or coverage by the large number of individuals with significant mental health/chemical dependency problems who visit their clinics



Key Informant Finding #3: Loss of pharmacy coverage strains clinic resources

- ✦ With the imposition of co-payments for office visits and prescription drugs, coupled with the loss of Medicaid eligibility for many patients in need of prescription drugs, Portland area FQHCs reported aggressive efforts to assure continued access to the drugs needed by their patients
- ✦ Pharmacy assistance programs are time and resource intensive, thus clinics experienced a significant increase in administrative costs as they sought out alternatives to secure needed pharmaceuticals for their patients



As noted by one clinic administrator...

“All the pharmaceutical assistance programs are pretty time-intensive, so we’ve actually got to make an investment in order to make them work. They’re not something you can do in your spare time. They take a great deal of time, and so we have put some personnel dollars in the next budget year to assign someone to help clients access pharmaceutical assistance programs.”



Key Informant Finding #5: Communication gaps regarding coverage, benefits, co-pay responsibilities

- ✚ Patients not scheduling follow-up visits because of the \$5 office visit co-pay
- ✚ Patients not getting prescriptions filled or not taking the proper dosage because of drug costs
- ✚ Higher rates of no-shows from patients that can't afford the co-pays



As noted by one clinic administrator...

"I've actually heard physicians talk about patients coming in and having to sit them down, especially if it's somebody who's been dropped off of OHP, and making the decision with the patient about which medications are the most important. Patients are saying 'I can't afford all of this' so their physicians are put in the position of saying, 'Well, you really can't get off of this one, this one I prefer you don't get off. But if you have to choose between the two, this is the most important.' This is not optimal, that's for sure. Providers are having to go in and help figure this out with their patients. Some people are taking a pill every other day or they're cutting their pills in half. Patients are making all kinds of adaptations."



Key Informant Finding #6: Increased administrative burden of co-pays

- ✦ *Standard* patients are confused, not scheduling and/or not showing up because of co-pays for each visit
- ✦ Clinics are responsible for collecting co-pays or 'turning in' their patients to OMAP for not paying
- ✦ Co-payments are a direct cost-shift to providers
- ✦ Many private physicians not seeing *Standard* patients because of increased administrative burden associated with co-pays



To summarize...

- ✦ Significant confusion reigned for several months post-OHP2 implementation because of the uncertainties around the state budget
- ✦ Lack of reliable information available to providers and consumers most likely exacerbated any negative impacts from the policy changes that were enacted
- ✦ Attention to patient and provider education are critical in any systems/policy change initiatives and particularly during times of fiscal uncertainty when the challenge can become an opportunity for increased accountability and innovation



2003 FQHC Patient Survey

The Face of FQHC Patients....

Demographic Profile of FQHC Patients in Sample

Demographic Characteristic	Total Sample	Insured Patients	Uninsured Patients	2002 OHP/CAHPS
Children (0-18 yrs)	24%	82%	18%	N/A
Adults	76%	70%	30%	N/A
Female	60%	70%	30%	67%
Marital Status:				
Married	32%	35%	56%	N/A
Single	24%	35%	22%	N/A
Ethnicity:				
Hispanic	42%	30%	70%	N/A
Race:				
White	52%	62%	26%	90%
Health Status				
Adults:				
Fair/Poor	55%	N/A	N/A	45%




Observations about the FQHC patients interviewed...

- ✦ The FQHC patients interviewed are a more diverse population than the general OHP population, particularly from a racial and ethnic perspective
- ✦ As a group, the respondents at the FQHC clinics were significantly less likely to be White relative to OHP enrollees; in much more dramatic proportions if they were uninsured (25% versus 52% and 90% respectively)
- ✦ The uninsured patients in the FQHC sample were employed at twice the rate of those who were insured
- ✦ There was an eight-fold difference in the proportion of African-Americans in the FQHC sample relative to the OHP population
- ✦ The children in the FQHC sample were three times more likely to have a parent or guardian report their health status as 'fair'

Peeling back the onion: Impact of clinic location

Demographic Profile of Respondents by Clinic Location

CLINIC	Virginia Garcia	North County	Westside	Mid-County
Children (ages 0-18)	24%	16%	9%	34%
Adults (ages 19+)	76%	84%	91%	66%
Gender				
%Female	63%	68%	48%	76%
Marital Status:				
Married/Partner	58%	48%	25%	61%
Single	21%	29%	40%	22%
Employment Status:				
Employed	31%	23%	16.5%	31%
Unemployed	69%	77%	83.5%	69%
Ethnicity:				
Hispanic	73%	37%	24%	29%
Non Hispanic	27%	63%	76%	71%
Race:				
White	22%	60%	68%	62%
African American	2%	14%	20%	10%
Reason for Visit:				
Follow-up Appt	51%	63%	61%	31%
Preventive Care	23%	19%	12%	36%
Urgent Care	17%	8%	22%	9%
Non-urgent care	9%	10%	5%	24%
Insurance status:				
Insured	44%	84%	84%	89%
Uninsured	56%	16%	16%	11%



Site variations in patient profiles: Why is this important?

- ✦ To view the 'safety net' as a homogenous entity is to miss the differential impacts of policy change as they affect distinct population groups
- ✦ The adult patient respondents at Virginia Garcia Clinic and Mid-County were more likely to be employed; while the adults at Virginia Garcia were disproportionately more likely to be uninsured relative to the other three clinics (56% versus 16%, 16% and 11% respectively)
- ✦ The respondents at Westside Clinic were virtually all adults with a significantly higher proportion of men relative to the other three clinics and they also had the highest percentage of unemployed adults



What picture does the FQHC survey data paint?

Adults in the FQHC sample report an exceptionally high burden of illness:


- ✚ 49% reported having symptoms lasting in excess of 6 months
- ✚ 56% reported a physical or mental condition expected to last at least 12 months
- ✚ 54% were at the clinic for a follow-up visit
- ✚ 18% had had an overnight stay in a hospital during the past 6 months
- ✚ 58% reported currently taking at least one prescription medication
- ✚ 80% had seen a doctor more than twice in the past 6 months
- ✚ 45% reported their health status as 'fair' or 'poor'
- ✚ 32% reported a worsening of their health from last year



Does the safety net represent the 'canary in the mine'?

ORIGINAL RATIONALE FOR STUDYING SAFETY NET CLINICS...

"Safety net clinics have historically seen a disproportionate share of the uninsured in Oregon and elsewhere. Since the implementation of OHP in 1994, the safety net has also seen a growing number and percentage of Medicaid patients throughout the state. As a result, we might expect that the early system shocks resulting from eligibility and cost-sharing changes in Medicaid, will be most acutely felt by health care providers in this sector of local health care markets."



Why monitoring the 'health' of the safety net is an important public policy function

- ✦ Any changes in eligibility and benefits in Medicaid will surely send a significant wave of change through the safety system as it seeks to absorb the 'shock'
- ✦ The safety net system exists to serve the un- and underinsured and as such has striven to maintain access in the face of current and future Medicaid cuts
- ✦ As financing options for basic coverage continue to be debated, the safety net represents a model of coordinated, comprehensive care delivery worthy of study and replication, particularly for the marginalized populations they have historically served