Money, Mission, and Medicine: An Innovative Managed Care Partnership between the Community Health Centers of Maryland and Johns Hopkins University

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Across the nation, states are placing their faith in managed care as the solution to the rising health care costs associated with the Medicaid program. Historical providers of care to the vulnerable and uninsured are competing in this new price-sensitive market while struggling to remain faithful to their missions. In Maryland, a unique partnership between an academic health center (Johns Hopkins HealthCare) and a coalition of community health centers has emerged as a model that promises to preserve the financial and philosophical goals of historical providers. Key words: academic health center, community health center, managed care, Medicaid

IN THE PAST FIVE years, Medicaid has experienced steady and significant change. Driven by increased costs and concerns about the quality of patient care, and with no resolution of the debate over national health care coverage in sight, states began transforming this insurance for the nation’s poor and disabled themselves. The vehicle for this change has been managed care, a system that tries to manage the cost, quality, and access to health care. Consequently, the national percentage of Medicaid patients enrolled in managed care plans has dramatically increased, more than doubling between 1992 and 1994 (Families USA Foundation, 1995). And, in 1997, the number of enrolled beneficiaries reached 15.3 million, or 48% of the Medicaid population (Health Care Financing Administration [HCFA], 1997).

As a result of states’ efforts to reform Medicaid, historical providers of care for this population—most notably, federally qualified health centers, public and teaching hospitals, and city and county health departments—have implemented changes in their own organizations. The extent of the organizational change varies from state to state and has in general reflected the extent to which the Medicaid environment has been altered. In any case, the trend toward managed care is evident.
care is leaping forward. As of 1997, 33 states had enrolled over 50% of their Medicaid recipients into managed care plans and only 5 states had less than 10% of beneficiaries participating in managed care (HCFA, 1997). The implication is clear: historical providers of care for the Medicaid population must prepare for the introduction of managed care into their market and its eventual expansion.

This article examines the recent changes in the Maryland Medicaid program and the impact of these changes on historical Medicaid and safety net providers by describing an innovative model developed by Johns Hopkins HealthCare (JHHC), the organization designed to create the managed care integrated delivery system at the Johns Hopkins Medical Institution, and the Maryland Community Health System (MCHS), an organization representing eight federally funded neighborhood community health centers. In a unique partnership, JHHC and MCHS have created a Medicaid–contracting managed care organization (MCO), Priority Partners. This model has national relevance as an example of a partnership that effectively capitalizes on the strengths of each partner while compensating for relative weaknesses, thus making each entity more viable in turbulent times.

STUDY METHODS

This study was based on (1) the review of literature relevant to Medicaid managed care and the Maryland Medicaid reform process; (2) the review of the organizational documentation of JHHC, MCHS, and Priority Partners; and (3) structured interviews with representatives from Johns Hopkins and member community health centers (CHCs). Interviews were conducted with the Johns Hopkins personnel who have been most involved in the development of Priority Partners and the implementation of the Maryland Medicaid managed care program HealthChoice. Also interviewed were the chief administrative officer of MCHS and the executive directors of a wide variety of CHCs, including urban centers, rural centers, centers serving special populations, centers with low previous involvement with managed care, and centers with moderate to high levels of prior managed care experience.

The framework for the study was based on organizational change theory. We examined the adaptation process that historical providers of care for the Maryland Medicaid population have undergone in an effort to realign themselves with the shifting environment. Special emphasis was placed on the resource dependency model of organizational change, which hypothesizes that organizations respond to pressures in their external environment by securing the resources needed for survival (Zakus, 1998). This model was consistent with the JHHC-MCHS response to Medicaid managed care, because it describes organizations as striving for equilibrium with their environment through the continuous exchange of materials, data, and energy. The resource dependency model maintains that organizations are incapable of internally producing all of the resources or functions necessary to maintain this equilibrium and therefore must enter into relationships with other elements in the environment that can supply the missing components. Proponents of this model postulate that “when the organization is dependent upon resources for its survival that are scarce or over which it has little control, it must either act upon the environment to secure them or die” (Zakus, 1998).

One strategy utilized by effective organizations in an effort to secure necessary resources is merger or integration. Inherent in integrative management are shifts in responsibilities and power, new relationships and expectations, new sources of information and measurement, and a new vision for the organization (Charns & Tewksbury, 1993). Implementing changes within organizations such as JHHC and MCHS is a complex task that involves physical, cultural, and emotional aspects. The changes present a challenge to the traditional way of doing things. New systems, skills, procedures, and structure replace
the “tried and true,” and their advent is often met with frustration, fear, and resistance.

The case study method allowed for a timely and detailed description of the adaptation process of historical providers involved in Priority Partners. Information was gathered and reported from a wide range of perspectives. All material presented has been related by multiple sources and, whenever possible, examined for consistency with written documentation. However, inherent limitations of this case study include the subjectivity of the information and the lack of empirical data to evaluate the effectiveness of implemented strategies. Moreover, as programs and relationships are still in an evolutionary stage, specific features of the process may have changed since the time the study was conducted. Any errors or omissions should be attributed to the methodological approach and not to any of the parties studied.

BACKGROUND

States are implementing managed care systems in their Medicaid programs for the same reason that CHCs and academic health centers (AHCs) are participating in Medicaid managed care programs—financial stability. States are turning to managed care in the hope of reducing the rising cost associated with the Medicaid program. And CHCs and AHCs are reconfiguring themselves to better fit this new environment in an effort to retain the Medicaid revenue that has become crucial to their operations.

The role of the states in the managed care revolution

As a result of the expansion of federal eligibility guidelines and the effects of a national recession, the Medicaid program has grown significantly in the past decade. In 1987, 23.1 million individuals received health coverage through the Medicaid program, at a cost to federal and state governments of $47.7 billion. By 1995, 36.3 million people were receiving Medicaid, and the cost had risen to an annual total of $151.8 billion (HCFA, 1996). Although the federal government’s share of these costs ranges from 50% to 83% (depending on the state), the burden of health care expenditures on the states remains high. In Maryland, Medicaid enrollment had risen to 444,673 by 1995, an increase of approximately 37% over the enrollment in the late 1980s. The result of the growth in beneficiaries, coupled with increasing costs associated with providing health care, was a doubling of expenditures in the Maryland Medicaid program between 1989 and 1994 (Bureau of Primary Health Care [BPHC], 1998; Oliver, 1998). In an attempt to intervene in this crisis, the Maryland government turned to the vehicle that states are widely using to reform their Medicaid programs, the 1115 research and demonstration waiver.

Under Section 1115, the secretary of health and human services has the authority to waive certain requirements of the Social Security Act programs, including Medicaid, permitting states to pilot innovative techniques that will further the achievement of program goals. This authority was not exercised to any meaningful extent until the early 1990s, when rising program costs and failed national health care reform ignited the spark of state-level efforts and made “1115 waiver” a common term in the health care community.

In the early 1990s, Maryland officials began flirting with the idea of managed care. After a 1992 analysis of the Maryland Medicaid program revealed that over 50% of spending was attributable to only 5% of total beneficiaries, the Maryland Department of Health and Mental Hygiene (MDMH) began exploring methods that would reduce costs and improve outcomes related to the treatment of high-risk Medicaid patients. In 1994, the state received funding from the Robert Woods Johnson Foundation to develop a pilot project, which resulted in the submission to HCFA of an 1115 waiver proposal for a “High-Cost User Initiative” designed to create enhanced case management and integrated care management systems for patients suffering from chronic or multiple ailments. Although
the waiver was ultimately approved by HCFA, a change in Maryland’s political leadership after the 1994 elections resulted in a shift in health care policy, and plans for large-scale implementation of the High-Cost User Initiative were halted prior to the approval (Oliver, 1998).

Under the governorship of Parris Glendening and the leadership of the new secretary of health and mental hygiene, Martin Wasserman, Maryland began moving toward comprehensive utilization of managed care principles. Maryland officials were aware that problems had plagued the introduction of Medicaid managed care in other states, including “implementation delays; marketing abuses; enrollment problems; underservice; inadequate choice of providers; problems gaining access to specialty care; inadequate grievance procedures when care is denied; and lack of state standards for access and quality of care” (Families USA Foundation, 1997). Moreover, state governments have routinely experienced political crises during Medicaid reform by failing to adequately secure the support of the public, consumer advocates, local government officials, and representatives of the health care industry. In an effort to sidestep these problems, the Maryland process strove for inclusion, offering frequent opportunity for comments and recommendations from a wide spectrum of sources during waiver development. On October 30, 1996, just six months after receiving the request, HCFA notified MDHMH that its 1115 waiver had been approved, authorizing the implementation of a statewide health reform initiative. The Maryland research and demonstration project, HealthChoice, began enrolling Medicaid patients in managed care plans on June 2, 1997, and will operate under the authority of this waiver until five years from that date (see box entitled Summary of the Maryland HealthChoice Program).

Community health centers and MCHS

CHCs were designed and have consistently been viewed as a necessary partner to the Medicaid program. Policy makers have long

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<th>Summary of the Maryland HealthChoice Program</th>
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<td><strong>Waived provisions</strong></td>
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<td>• Under managed care, Medicaid enrollees are allowed to receive services that may not be available to enrollees participating in other plans or beneficiaries not enrolled in managed care.</td>
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<td>• Medicaid patients are now restricted in their choice of provider to that which they have chosen or been assigned.</td>
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<td>• Patients are “locked into” a plan for one year in a specified managed care plan, with only one opportunity to change without cause.</td>
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<td><strong>Eligibility</strong></td>
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<td>• Program targets 80% of Medicaid beneficiaries.</td>
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<td>• Of those targeted, a small group (1%) diagnosed with “rare and expensive conditions” will be served through a new case management initiative.</td>
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<td>• Excluded groups are dual eligibles, short-term eligibles in a “spend down” status, institutionalized persons, children in other waiver programs, and patients enrolled in a waiver program for senior assisted housing residents.</td>
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<td><strong>Components of significance to historical providers</strong></td>
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<td>• Mandatory FQHC services (transportation, outreach, translation, access requirements and case management) are preserved.</td>
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<td>• FQHCs are no longer reimbursed on the basis of “reasonable costs.”</td>
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<td>• Waiver includes a mandate that providers who have historically served Medicaid recipients must be included in the demonstration program.</td>
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<td>• FQHCs must be listed by the state in enrollment information.</td>
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<td>• FQHCs must be reimbursed using the Johns Hopkins Ambulatory Care Group system (with adjustments for risk) or on a cost-related basis.</td>
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understood that the existence of public health insurance does not, by itself, bring about access to and utilization of care. Therefore, CHCs have been mandated to do more than simply provide care; these programs were offering a medical home to minority and low-income populations long before the term became popular.

CHCs have become inextricably linked with the Medicaid program over the past decade, largely because of two significant changes in the late eighties. First, Medicaid coverage for pregnant women and children, a large percentage of the health center patient population, was greatly expanded. Second, the Medicare and Medicaid federally qualified health center (FQHC) program was established. The FQHC program provided for (1) additional coverage of “FQHC services” such as transportation, outreach, case management, and translation and (2) mandatory reimbursement for all FQHC and ambulatory care services provided by health centers consistent with a “reasonable cost–based” payment methodology. These changes allowed CHCs to increase capacity not only for the Medicaid and Medicare populations but also for the ever increasing number of the nation’s uninsured. They also created a substantial connection between the financial health of these centers and the Medicaid program. According to the U.S. General Accounting Office (GAO, 1995), CHCs cite grants and Medicaid as their largest sources of revenue, 35% and 34% respectively. The increased dependency of health centers on Medicaid dollars has made participation in Medicaid managed care essential for most CHCs.

In Maryland, revenue from Medicaid made up 45.8% of Community and Migrant Health Center revenues (BPHC, 1998). By the end of 1995, 25% of Maryland Medicaid recipients were enrolled in a managed care plan (Maryland Department of Health and Mental Hygiene, 1997). And the dilemma for CHCs in Maryland had become similar to that experienced earlier by centers in states such as Tennessee, Arizona, Massachusetts, Oregon, and Hawaii: health centers that fail to establish arrangements within managed care could lose some or all of their Medicaid patients and revenue, resulting in catastrophic consequences.

Although it is clear that health centers need to participate in any Medicaid managed care program, such participation is largely uncharted territory and does not come without challenge and risk. A 1995 study by the U.S. General Accounting Office on the challenges facing CHCs as they transition to prepaid managed care warned that they are at risk for financial vulnerability if they (1) depend on Medicaid prepaid managed care for a large percentage of their revenues, (2) negotiate unsatisfactory capitation rates, or (3) assume risk outside of primary care (GAO, 1995). In addition, most CHCs face these challenges handicapped by a lack of managed care expertise and insufficient capital. In spite of these formidable obstacles, CHCs remain a vital component of the Medicaid delivery system and are creating, across the country, new models that promise to preserve their missions.

Increasingly, health centers are being recognized as assets, as well as potential partners, in successful ventures into Medicaid managed care. There are many factors that contribute to the attractiveness of CHCs. First, CHCs are the primary care providers for a significant number of Medicaid patients. In 1996, 2,400 health center service sites delivered care to 9 million people, including 3.5 million Medicaid recipients and 1 million Medicare beneficiaries (National Association of Community Health Centers [NACHC], 1996). The member health centers of MCHS served over 71,000 Medicaid patients in 1996, representing approximately 15% of the entire Medicaid population in the state, and in rural areas they provided care for up to 20% of the total Medicaid population (Managed Care Solutions, 1996). Second, CHCs are located in Medicaid-dense geographic areas, have strong community support; and possess considerable expertise in treating the Medicaid population. Federally funded CHCs are mandated by law to locate in inner-city and rural communities that have been designated as “medically underserved.” It is these areas whose residents constitute the majority of
the Medicaid recipients. CHCs are more than just physically present in these communities—they were designed to be community driven and are governed by volunteer community boards whose membership has 51% consumer representation (BPHC, 1994). Finally, health centers have long practiced care that includes the provision of the FQHC services preserved in most 1115 waivers, such as health education, case management, and outreach.

Although there have been several models employed by CHCs for participation in managed care, development of an integrated service network (ISN) has been the preferred approach, because it joins CHC resources together and creates a strong geographic and patient base. The combined assets make CHCs more competitive and strengthen their negotiating position. Moreover, the ISN has served as a vehicle through which health centers may continue to control their own destiny and protect their collective mission. As of 1996, 147 ISNs existed in various stages of development, and 66% of all health centers were scheduled to participate (Henderson & Markus, 1996).

The origin of MCHS was similar to that of many other ISNs composed of community health centers, and its primary funding for development came from the Integrated Service Network Development Initiative of the Bureau of Primary Health Care. Membership included a subset of the members of the Mid-Atlantic Association of Community Health Centers (MACHC) as well as the Primary Care Association (PCA) for the region, a health care for the homeless program, and several FQHC “look-alike” centers.

The move toward managed care began slowly among the Maryland CHCs. Several initial efforts were made to generate a managed care task force to study the emerging issues, but, in the absence of perceived urgency, these efforts lacked cohesion. In March 1996, dissatisfied with the progress of the efforts and now confronted with a statewide managed care waiver, MCHS began to “evaluate both the readiness of individual health centers for participation in managed care and the options available for the formation of a statewide network to support community-based primary care centers” (Managed Care Solutions, 1996). Several options were considered by the group, including using a member CHC’s existing HMO license for Medicaid-contracting purposes. Ultimately, the decision was made to solicit a partner in the development of a new MCO/HMO, with the goal of maximizing equity and control of the CHCs.

During the partnership review and negotiation process, the number of participating health centers shrank from 15 to 8. In Maryland, two ISNs involving CHCs were operating concurrently, and the initial period of development saw some health centers participating in both ISNs. Ultimately, however, health centers either became aligned with one ISN or decided to develop their own relationships independent of other centers. Maryland health centers tended to affiliate across geographic lines, and the network development activity of the hospitals that dominated the area played a role in these partnerships. One of the area’s most prominent medical institutions, Johns Hopkins, became MCHS’s partner in the development of a new MCO serving Maryland’s Medicaid population.

The development of Johns Hopkins Health Care

Across the country, AHCs have actively pursued participation in Medicaid reform. Like CHCs, many AHCs rely heavily on Medicaid revenues. Since the origination of Medicaid in 1966, AHCs have been major providers of care in this program (Carey & Englehard, 1996; Chessare & Herrick, 1996). Like CHCs, AHCs are at potential risk when a prepaid system for the Medicaid program is initiated in their state. Their unique mission of teaching, research, and provision of highly specialized clinical care places them at a disadvantage in a competitive atmosphere. They “provide care for the sickest patients, invest in biomedical research, educate medical students, and train physicians” (Chessare & Herrick, 1996, p. 216), and they are consequently 30% to 40%
more expensive than other hospitals. Moreover, they have traditionally focused on inpatient care, have given minimal attention given to primary care, and have been staffed by faculty physicians, who spend significantly less time in direct patient care than do community doctors. Many AHC practices are inconsistent with a managed care environment, in which volume and overall spending restrictions are used to lower the per-unit cost of care and the rate of utilization of services, especially expensive specialty and tertiary care services.

In order for AHCs to preserve their role in the health care community, they have had to seek out, through merger or integration, the resources they lack. In mass, AHCs are looking toward vertical integration to expand their primary care base. Any AHC that continues to depend exclusively on referrals from primary care physicians in the community for specialty and tertiary care is at risk. Therefore, AHCs, along with other hospital-based historical Medicaid providers, are reinforcing their existing acute care capacity with more in-house, satellite, and network-based primary care. Hospitals are creating this primary care base by buying primary care clinics and by rapidly building their own facilities.

In addition to marketing vertically integrated services to other health plans, many hospitals are developing their own HMOs. This strategy, like that associated with CHC ISNs, allows hospitals to maximize revenues from skilled patient management, which increases long-term financial viability. Equally important, ownership allows the AHC to control its own destiny rather than compete “at the top of the health care pyramid as a niche contractor for health insurers” (Chessare & Herrick, 1996, p. 216). This route, of developing its own managed care organization, was taken by Johns Hopkins University while the operating environment in Maryland was changing.

In 1994, Johns Hopkins Health System and Johns Hopkins University collaborated to form Johns Hopkins Health Care (JHHC). Johns Hopkins Health System is the parent corporation of Johns Hopkins Hospital and Bayview Medical Center (which some years back was the city-owned hospital). Johns Hopkins University operates the Johns Hopkins School of Medicine and the Clinical Practice Association, a physician group practice composed of the full-time faculty of the medical school.

JHHC was designed as the vehicle through which Johns Hopkins Institution would develop its managed care integrated delivery system. In 1996, JHHC began the Employee Health Plan (EHP), which provides health care programs to employers who “self-fund” their employee benefit plans. EHP, which currently manages over 25,000 people, represented the second Hopkins effort aimed at managed care participation. In earlier years, the institution had formed an HMO for commercially insured and Medicaid patients in the Baltimore area. However, these rights were sold to Prudential and, as a part of the contract, the Johns Hopkins Institution was prohibited from operating a state licensed HMO until the year 2002. Therefore, as Maryland moved in the direction of comprehensive reform, an opportunity was created for JHHC to expand its managed care efforts by participating in Medicaid managed care as a non-HMO MCO.

Participation in the imminent prepaid managed care program was not only desirable but also essential for the Johns Hopkins institution, which received considerable revenue from the treatment of Medicaid patients. In 1995, the Johns Hopkins Institution provided care for tens of thousands of Medicaid patients, including over 12,000 inpatients at Johns Hopkins Hospital and the Bayview Medical Center. By 1996, the number of persons receiving inpatient care through Johns Hopkins facilities represented 25% of all Medicaid discharges in central Maryland (Johns Hopkins Medical Institutions, 1996), and Medicaid was the source of approximately one-fifth of all patient-related reimbursement at Johns Hopkins (Oliver, 1998). In addition to the immediate goal of preserving Medicaid revenue, there were other factors that added to the attractiveness of participation in Medicaid managed care. A primary goal of all AHCs is the development of
As the nation increasingly focuses on the need for more primary care providers, the demand for primary care training sites has risen.

As a result of managed care, more procedures are being performed in less expensive nonacademic, community-based facilities. Consequently, AHCs have been placed in a position of developing new resources for educating students and residents in outpatient ambulatory care settings that “do not compromise the inefficient but essential hands-on training traditionally available in inpatient settings” (Carey & Englehard, 1996, p. 839). Vertical integration that expands access to primary care sites enhances the training resources of the institution. This integration also enhances financial resources by generating referrals for Johns Hopkins’ specialty and tertiary care services. Moreover, a statewide network opens new markets to Johns Hopkins, creating the opportunity to develop geographically. These relationships not only generate new Medicaid revenue but also develop provider networks for other insured patients. Therefore, like MCHS, JHHC decided it would be advantageous to pursue approval from the state for the operation of a Medicaid MCO.

RESULTS

The development of Priority Partners

Although there are many similarities in the missions of CHCs and AHCs, the paths of these two historical provider groups have not crossed in any meaningful way until recent years. Limited collaboration had occurred in the areas of research and training, but the recent forces of external change in health care have driven the two groups to expand and formalize relationships.

The partnership of JHHC and MCHS is a classic example of appropriate utilization of the resource dependency model. The sharing of partner assets provided each partner with elements that were missing in its own organization (see box entitled Key Features of the JHHC and MCHS Partnership Contributions). Thus, the combining of resources was highly beneficial to each party, because the needs of both organizations were met in the formation of Priority Partners. Equally important, representatives from both JHHC and MCHS report that a synergy exists supported by their sharing of the same mission: the continued provision of quality health care to vulnerable populations. Thus, the creation of Priority Partners made sense for the organizations from both a business and an ideological perspective.

Organizational structure

Priority Partners, Inc. was formed in October 1996 for the purpose of operating an authorized non-HMO MCO under the terms of the Maryland Medicaid Managed Care Program. Priority Partners is 50% owned by JHHC and 50% owned...
by MCHS, and each partner appoints one-half of the membership of the MCO’s 16-person board of directors. Although hospitals and CHCs co-exist in other networks, this equity and control split, which places equal value on each partner’s assets, is unique.

JHHC wears two hats in Priority Partners, as a partner and as the management services organization. As the management services organization, JHHC reports to the Priority Partners board of directors and is responsible for functions such as marketing, administrative and management services, and health services. JHHC also assumes risk for enrollees’ care up to the stop-loss limit and submits to the direct jurisdiction of the state for Medicaid program activities. Prior to the incorporation of Priority Partners, JHHC had received a private review agent’s license, Maryland’s certification for the operation of managed care activities, and EHP had been operational for two years. Although it was necessary for JHHC to expand its capacity and create new functions specific to the Medicaid population, the core infrastructure and experienced administrative staff of the management services organization enabled Priority Partners to secure timely approval as a Medicaid MCO.

Provider network development and contracting

At the time of its application to MDHMH for approval as a Medicaid MCO, Priority Partners’ network consisted of 742 primary care providers located at 297 sites and 1,080 providers of specialty care located at 312 sites. In developing its Medicaid network, Priority Partners sought to develop exclusive relationships with CHCs, Johns Hopkins medical providers, Johns Hopkins Medical Services Corporation facilities outside the Prudential area (which is off-limits as a result of the earlier contract), network hospitals, and other health care providers scattered throughout the state. The goal of exclusivity was a difficult one to achieve owing to the fact that, at the time of the waiver, over 82% of providers were under the former voluntary Medicaid managed care program.

Both JHHC and MCHS played important roles in network development. CHCs, particularly those located in rural areas, helped JHHC recruit specialists, primary care physicians (PCPs), and hospitals. The long-standing presence of CHCs in these areas facilitated contract negotiations for Priority Partners. Likewise, many CHC directors reported that the reputation of Johns Hopkins opened doors to specialty and tertiary care in their area in a manner they had not previously experienced.

Priority Partners negotiated agreements that compensate providers in two basic methods: fee-for-service and capitation. Providers may also choose to assume different risk levels for different patient populations. For example, an MCHS health center that primarily serves the HIV/AIDS population assumed a full-risk arrangement for its AIDS-defined Medicaid patients but only limited risk for patients experiencing general primary care needs. This allows the health center to share more completely in the savings generated from its expertise in managing the care of this high-risk group. The savings may then be reinvested in ways that support the mission of the health center.

Marketing

In order to better understand the Medicaid market in Maryland, Priority Partners conducted a market analysis in preparation for the submission of its MCO application. As a result of this analysis, which included patient focus groups, Priority Partners developed three main objectives in regard to enrollment: (1) retain 45% of Johns Hopkins’ Medicaid patient base, (2) retain 60% to 70% of MCHS’s Medicaid enrollees, and (3) attract approximately 13,000 new Medicaid enrollees. Two useful strategies were the inclusion of a “value-added benefit package” and the close identification of Priority Partners with the reputation of Johns Hopkins and the CHCs. The value-added benefit package (covered services that exceed Medicaid requirements) includes coverage of additional adult dental benefits, an over-the-counter medication benefit (no charge for certain nonprescription drugs with
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physician prescription), and an adult vision benefit (eye exams every other year and $50 credit toward glasses).

**Enrollment and financial projections**

The Priority Partners business plan included the target of enrolling 33,500 Medicaid patients over a six-month period, approximately 10% of the statewide market. Priority Partners contracted, as did other MCOs, with MDHMH based on a combination of age-sex capitation rates, ambulatory care group capitation rates, and special program capitation rates.

The Maryland waiver application reports that a total of 462,157 persons receive Medicaid in Maryland. Of these, 75,319 were projected to be ineligible for managed care because of certain special statutes, such as dual Medicaid-Medicare eligibility. This left a projected 386,838 eligible Medicaid patients. As of 1996, the Maryland CHCs were the primary providers of care for approximately 14% of these patients.

At the end of the initial enrollment period, Priority Partners exceeded its membership projections and has experienced an average enrollment of 37,000 members. However, as individual providers, the CHCs experienced lower Medicaid enrollment than was anticipated. Although a complete analysis of the causes of this reduction in Medicaid patients and revenues has not yet been conducted, MCHS cites implementation problems (discussed later) as a primary contributing factor.

**HealthChoice: the implementation process**

It was anticipated that the implementation of Medicaid managed care would proceed more smoothly in Maryland than it had in other states. Maryland had gone to great lengths to be inclusive in the development of its 1115 waiver and was praised for its efforts to avoid potential implementation difficulties. And, in fact, the implementation of HealthChoice has experienced less severe complications than in those states pioneering Medicaid managed care. However, the process was not without problems.

Maryland employed an external company as the enrollment broker for HealthChoice to assist eligible Medicaid recipients in selecting a managed care plan as part of the enrollment process. Should an individual fail to choose a plan, brokers would assign him or her to a plan based on a variety of factors associated with continuity of care (patient’s previous provider) and access (zip code, translation needs, etc.). In reality, however, significant flaws in the enrollment process resulted in negative consequences for patients and providers.

It has been hypothesized that one main source of many of the problems was the database and directory of providers used in selection and assignment. Prior to the initiation of enrollment, MCOs were asked to submit their provider lists to the state. However, when this information was electronically merged with the state’s historical database (which in many cases was outdated), the result was an incorrect and incomplete provider directory. One CHC reported that a nurse practitioner that had not been employed with the center for eight years was listed among its providers. The problem was compounded by the fact that some MCO-supplied data indicated that some providers participating in commercial HMO panels were also listed in the Medicaid directory, despite the fact that these physicians were not Medicaid providers. In fact, some CHCs that had commercial contracts with an HMO were listed by the HMO on their Medicaid panel despite the fact that they had rejected a Medicaid contract with that HMO in accordance with their exclusive relationship with Priority Partners.

In a letter to the secretary of MDHMH, MCHS described many of the concerns regarding the enrollment process. In addition to inaccurate provider information, MCHS identified other problems (supported by anecdotal reports of patients and staff), including lack of translation services at the broker level, long telephone waiting times for accessing enrollment information, and inconsistency between patients’ reported choice of MCO and their assignment. MCHS reports that, at the end of the initial phase, Medicaid
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enrollment in member health centers was estimated to be 50% lower than would have been expected based on CHCs’ historic gatekeeper populations (MCHS, personal communication, November 6, 1997).

Although health centers had anticipated a reduction in Medicaid patients and revenues during the enrollment period, few expected a reduction of this magnitude. One CHC reported a 54% decrease in Medicaid revenue at the conclusion of enrollment period. A second health center reported retaining only 60% of the enrollment it had under the former voluntary Medicaid managed care program. As a result of decreased Medicaid revenue during the first six months of the waiver, many CHCs reportedly had to rely on accelerated use of other federal grant funds in order to make up for the financial losses.

Yet, despite the decrease in enrollment and revenue, the number of patients and patient visits remained stable, as confused patients continued to seek care from the health centers, despite being enrolled in other health plans. CHC staffs have devoted significant time to assisting these patients in the enrollment process. All of the centers interviewed reported either hiring new staff or shifting the responsibilities of existing staff in order to cope with the initial chaos associated with the transition to managed care.

Efforts were made to remedy the enrollment problems. Both the state and the brokering agency were responsive to the concerns of the MCOs and the providers. Representatives of MDHMH routinely meet every six to eight weeks with CHC representatives to discuss the status of enrollment and other related topics. Regional staff from HCFA and HRSA (both headquartered in Maryland) have been informed of the meetings and have, on occasion, attended. In response to difficulties associated with auto-assignment, MDHMH demonstrated flexibility in allowing patients to change health plans as long as continuity of care was preserved, and it solicited input and cooperation from the MCOs during this time of transition. The brokering agency also improved its effectiveness by shortening and simplifying the enrollment script after receiving feedback from CHCs and other providers.

For its part, MCHS was proactive in securing these remedies. The member health centers monitored, documented, and reported difficulties encountered by patients and staff. In its letter to Martin Wasserman, MCHS outlined a plan to further examine issues associated with enrollment in order to further clarify this perplexing and debilitating situation (MCHS, personal communication, November 6, 1997).

GROWING PAINS FOR HISTORICAL PROVIDERS ASSOCIATED WITH MEDICAID MANAGED CARE

As Medicaid reform has descended upon states, many historical providers of care have been forced to change their organizational environments in order to survive. The decision to participate in a prepaid system often served as a catalyst for both overt and subtle alterations to the climate of CHCs, AHCs and other "safety-net" providers. The impact of this new climate affected many facets of these organizations, including their organizational culture, personnel, service delivery, and systems and infrastructure needs.

Change in organizational culture

JHHC may have experienced less change than other organizations entering Medicaid managed care because it had prior experience with a prepaid system. At the time Priority Partners was formed, JHHC had been operating a managed care program for approximately two years. Consequently, administrators were experienced, clinical staff had become acclimated, and infrastructure was developed. However, three factors did require JHHC to undergo considerable adaptation: (1) the large increase in the number of members enrolled, (2) the short development and implementation time frame, and (3) the special requirements of the Medicaid population.

Prior to the participation in Medicaid Managed Care, JHHC covered approximately 25,000
members through EHP. In less than one year, JHHC submitted an MCO application, partnered with MCHS, developed systems and service delivery mechanisms, and enrolled 37,000 new members through Priority Partners. These new members were different from those covered under EHP, in that they included more disabled patients, more children, more individuals in need of enabling services, and a more geographically diverse patient population. As a result, JHHC management had to incorporate new programs, staff, and service delivery models into their organizational culture.

Similarly, the eight CHCs involved in MCHS have undergone fundamental governance, administrative, clinical, and operational changes. In many health centers, a new organizational culture characterized by a more “business-minded” approach has emerged. The adoption of this new approach has been necessary for health centers to compete within the context of managed care and preserve their mission. However, striking a balance between the incorporation of this new approach and the historical identity of CHCs as grass-roots providers of health care to the vulnerable has not been easy.

Volunteer boards of CHCs have been faced with increased time demands and increased participation in education on the new forces within health care. Some CHC board members have expressed anxiety regarding the preservation of mission within this new organizational culture. In many cases, board composition changed as health centers sought to match membership expertise with new demands. The new board members have become valuable internal resources in this time of transition. For example, one health center recently added a software architect to its board in response to increased management-of-information needs.

Changes in personnel

For JHHC, the development of Priority Partners resulted in a larger and more diverse staff. The number of JHHC employees more than doubled during the implementation of Priority Partners. Hiring and training new employees became a consuming task, which is still underway. The new patient population also resulted in a demand for new staff skills, particularly in the area of care coordination. In contrast to the EHP patient population, whose health care needs were more acute, the Medicaid members of Priority Partners mostly have care needs resulting from chronic conditions. Larger numbers of disabled members increased the need for care coordinators with long-term patient management skills. In addition, larger numbers of children increased the need for pediatric expertise, especially in the areas of birth defects, developmental disability, childhood asthma, and cerebral palsy.

MCHS health center personnel have also undergone a transformation. CHCs report that the developments in recent years have taken a toll on senior management. As executive directors have devoted the majority of their time to navigating Medicaid reform, other development and operational tasks have been delegated to their senior administrators. As a result, some CHCs have reported high rates of turnover in these positions. In many cases, the move into Medicare managed care was seen as an opportunity to redefine and expand administrative positions in order to meet new organizational needs. For example, one health center added a new director of development, another recently hired a management information systems director, and many have filled existing positions with individuals who have some background in managed care. Also affected are health center support staff, who have experienced, among other changes, increased demands for data collection, job descriptions changes reflecting the need to include more managed care–enabling services such as transportation, and the burden of assisting patients who are experiencing confusion related to managed care enrollment.

Changes in infrastructure needs and service delivery

The new management functions resulting from the formation of Priority Partners had a big impact on JHHC’s physical plant requirements and operations. The significant increase in staff necessitated the addition of office space, which has
been under constant construction since the initiation of the Priority Partners venture. Moreover, the needs of the Priority Partners membership and the requirements of MDHMH mandated the creation of new operational services. The 1115 waiver that created HealthChoice did not eliminate the federal requirement for FQHC services, which include outreach, transportation, and translation services. These services, seen as essential for the high-risk Medicaid population, are not typically provided by commercial MCOs. Therefore, it was necessary for JHHC to develop these services and incorporate them into its existing service delivery model. And, along with the initiation of new services, JHHC staff was called upon to modify and expand existing components such as utilization management, quality assurance, billing and collections, and member services.

The health centers have also incorporated new operational requirements. Most significant is the accommodation of additional reporting requirements that accompany participation in managed care. Although CHCs have needed to submit reports to the federal government and other funding sources in the past, the data requirements associated with monitoring a prepaid system demand a much more sophisticated management information system. As a result, the majority of health centers have reported plans to purchase or recent purchases of new systems. In addition to the initial cost of a management information system, new staff positions often need to be created so that the system is properly implemented and maintained. Also, existing staff, who are already overburdened with other organizational changes, must be trained in the new system. In short, their increased information needs have created additional financial burdens for health centers and heightened staff anxiety.

In accord with resource dependency theory, JHHC and MCHS responded to the changes in the health care environment by securing the resources they needed for survival. Each made a pragmatic decision to enter into a relationship with the other in order to obtain the components that were missing in their own organization.

There are several lessons learned from the Priority Partners experience that have implications for other CHCs and AHCs:

- Critical analysis of organizational strengths and weaknesses aids in both the choice of appropriate partners and in negotiating partnership terms. Because JHHC and MCHS were complementary to one another, the pooling of their resources made Priority Partners a strong and viable competitor in the new Medicaid managed care market in Maryland (see box entitled Resources of JHHC and MCHS).

- It is important for AHCs and CHCs to participate in state planning and development activities. JHHC and MCHS participation in the development of the 1115 waiver contributed to the inclusion of such elements as

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<th>Resources of JHHC and MCHS</th>
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<td><strong>JHHC</strong></td>
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<tr>
<td>- Sufficient financial resources</td>
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<tr>
<td>- Access to high-quality specialty and tertiary care</td>
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<tr>
<td>- Experience in managed care operations</td>
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<tr>
<td>- Expertise in managing the health care needs of the poor and disabled</td>
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<td>- Name recognition</td>
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<tr>
<td><strong>MCHS</strong></td>
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<tr>
<td>- Large and geographically diverse primary care base</td>
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<tr>
<td>- Expertise in the provision of mandatory FQHC services</td>
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<td>- Expertise in managing the health care needs of the poor and disabled</td>
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<td>- Name recognition</td>
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the assurance that historical providers would have at least one Medicaid contract with an HMO in their area. And although the implementation process was problematic, MCHS was proactive in bringing its concerns to the attention of the state. Simply put, had the health centers not acted on their own behalf, what was a bad situation might have become much worse.

- **It is advantageous to secure supplemental resources for a wide variety of entities.** Although JHHC and MCHS have considerable primary, secondary, and tertiary care capacity, Priority Partners sought contracts, many exclusive in nature, with a wide variety of providers and provider groups (e.g., private physicians and independent practice associations).

- **Ownership of an MCO offers positive financial opportunities for AHCs and CHCs in a Medicaid managed care environment.** Ownership of Priority Partners allows MCHS to offset the potential loss of revenue as a primary care provider with revenue earned as an MCO owner. For JHHC, ownership has provided an avenue into managed care that was lost through the agreement with Prudential. It also provides JHHC with an expansion of their managed care capabilities for future potential contracts with Medicare and private insurance. Without this revenue, there would be negative consequences for JHHC, and the results might be catastrophic for CHCs, especially smaller centers and centers that are highly dependent on Medicaid revenue.

- **Ownership of an MCO safeguards the mission of AHCs and CHCs in a Medicaid managed care environment.** JHHC and MCHS need to preserve their respective commitments to graduate medical education and grass-roots provision of health care to the poor and underserved. Ownership, although it does not ensure the integrity of mission, promotes its continuation.

- **AHCs and CHCs will undergo significant organizational change as a result of Medicaid managed care.** Boards of directors, administrative and financial staff, medical personnel, operational staff, facilities and infrastructure, and patients are all impacted by the organizational shifts required in a managed care environment. It is crucial to prepare for the effects of this change, which may include fear, anger, resistance, and anxiety.

The transformation of the Maryland Medicaid program and the participation of historical providers is a “work in progress.” Although the AHC-CHC partnership exemplified by Priority Partners is in many ways novel, the driving forces, concerns, challenges, and risks are familiar to policy makers and analysts. As the process unfolds, it will be useful to continue to observe and describe the rare AHC-CHC alliance that follows the Priority Partners model and to ask questions such as these:

- To what extent will the MCHS member health centers restore their patient base to their pre-HealthChoice level? For patients that opt for other providers, what factors contributed to this decision?

- To what extent and in what manner will MCHS and JHHS governing bodies and personnel continue to change?

- As safety-net providers face increasing financial burdens and decreasing resources, what will be the effect on the ever expanding numbers of uninsured persons and the providers mandated to provide them with care?

- As FQHC services become required components of health care plans and must be provided for through the monthly capitation fees rather than fees for service, what will the impact be on the quality and quantity of enabling and culturally sensitive programs for Medicaid recipients?

- And lastly, to what extent will the JHHC-MCHS model be replicated by other ventures in other states and what successes will they face and what successes will they achieve?
REFERENCES


