

“Follow the Money”: Advancing Cultural Competency in the Medicaid Managed Care Environment

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So, cultural competency is a good idea. In fact, a great idea. So also with linguistic competency.

So, why aren't they happening generally or universally? It must be somebody's fault. Let us find that person and have a serious talk, right?

The need for these competencies is not a new topic. These competencies have been written about in detail and depth for 30 years in the disciplines of medicine (Harwood), nursing (Leininger), mental health (Cross and Mason), and social work (Pinderhughes). Some of the best work has been done 30 years ago, in big books.

And we are still writing books on this subject. Look, I wrote one myself, hot off the press in the year 2000. 392 pages closely reasoned pages. My sponsor, the Center for Health Care Strategies, was kind enough to call it the bible of organizational cultural competence in health care. And I didn't come close to exhausting the topic.

We continue to write better, longer, more detailed laundry-lists of things that policymakers, HMOs, medical educators, and providers are to do. These appear like a la carte menus, where organizations can choose some items and not others, engage in partial implementation of such services as interpretation, pursue mechanical, checklist compliance rather than organic solutions to the challenge, delegate away the challenge to the lowest-level staff, and avoid the real task of integrated cultural change.

Conferences like this are held. Trainings are conducted. Laws are passed. Regulations are promulgated. Standards are adopted. Contracts are amended.

And we continue to debate and refine the definition of cultural competence, when any one of a dozen would suffice to make profound changes. And we continue to spawn assessment tools, when any one of a dozen would suffice. Too often, we critique each other or some “they” out there that simply refuses to become culturally competent. We become overheated, angry, polemical, and romantic in our discourse, trying to find some way to convince others of the rightness of our views, as if progress rested uniquely on our powers of persuasion.

We seem totally perplexed by the obdurate nature of our health care institutions. With all these years and efforts and money incentives and legal disincentives and powerful, evocative advocacy, why isn't it happening? With literally millions of lives at stake – ethnic minorities, linguistic minorities, racial minorities, immigrants, refugees, poor people, and uninsured – where is the tangible, universal progress?

What we are trying to do is take law, policy, and some money and shove it into a huge black box – health care plans, HMOs, and safety-net providers – and expect that cultural and linguistic competency come out the other end.

We deal with black boxes every day, don't we? I approach a vending machine, insert a dollar, and, most of the time, out comes a Mountain Dew. Dollar in, Mountain Dew out. Do I really know what is going on inside of that vending machine? Not a chance.

I can guess, but I am probably wrong, because I don't know how it works. I just keep on putting in dollars and out comes my Mountain Dew.

We seem to be doing the same with the health insurance and care delivery black box. We don't know how it works either, but we keep writing laws, passing regulations, adopting policies and standards, and writing contracts. But cultural and linguistic competency do not come out the other end. But we keep doing it, our dollars disappearing rapidly.

And now, we are encountering vending machines that are rejecting our dollar. Increasing numbers of insurance companies and provider organizations, looking at their growing risk and declining income, threats to their very survival, are saying they want neither the money nor the patients. It costs more to produce my Mountain Dew than the dollar I am putting in the black box.

My premise is that we have all focused too much on the ideal and now it is time to get real, to look reality in the face, to see whether understanding what is really going on inside that black box might give us the tools to really make progress.

I am not sure that it will, but I am fairly sure that continuing what we have been doing is going to be fruitless in making the system better for the persons we are all concerned about.

The Cross Cultural Health Care Program, where I work, regularly provides training institutes for health care professionals interested in being either evolutionary or revolutionary change agents for their organizations. They work in government, in health care plans, and in provider organizations.

In the two hours I can spend with them, I used to talk about some of the internal institutional things they can address – mission statements, management commitment, staff recruitment, training, and on and on. Challenges, tasks, and goals. I don't do that as much anymore.

Now I ask them whether they know, really know, how their organizations work, their local “big picture,” their very own black box. And, most of the time, they do not. I ask them about such things as:

- their changing mix of patients – Medicare, Medicaid, uninsured, commercial product lines
- the reimbursement rates attached to each,
- the mix of income sources for the organization,
- the health of each of these sources,
- the constraints placed on them by contract and in competition in their marketplace,
- the balance between increasing costs of care and reimbursement rates
- the amount of short-term and long-term risk they bear,
- the increase in their performance and reporting requirements,
- their ability to recruit, hire, and retain good staff (including bilingual and community staff),
- their ability to recruit and retain a specialist network,
- their ability to innovate and cost shift
- the prospects of surviving in the marketplace without being acquired by or merged with someone else
- the degree to which basic organizational decisions are based on productivity and efficiency measures rather than quality of service, and
- the degree to which they have truly implemented managed care or only capitated service.

What I generally find is that many workers, including high-level managers, are unaware of these hardware aspects of organizational life. Most of us, in truth, who produce a product or deliver a service want to avoid these matters. That is what executive directors and chief operating officers are for.

Workers and managers, as change agents, tend to focus their efforts on the software aspects of the organization – beliefs, values, attitudes, purposes, politics, sentiments, sensitivity to minorities, a form of therapeutic anthropology. Often they assume that administrators and managers are simply ignorant of or indifferent to the special issues posed to and by minority patients and that, if only their attention were captured, progress in cultural and linguistic competency can be readily made.

Equally, many advocates focus most of their attention on the provider-patient encounter and styles of communication, when this is not reality, because

- Physicians are decreasingly free agents in their organizations; their behaviors are determined by powerful incentives, disincentives, and constraints
- Service is provided discontinuously, commonly in emergency, urgent care, and walk-in clinics
- Much service is provided by teams, not individual providers

I think that this is a naïve and romantic view of organizational life. Operating as if these enormous forces do not really exist may be a useful coping device, but a blinkered existence often poses mortal risks. We need to understand the foregrounds and backgrounds, the parts and the wholes, in the real world in which for-profit and non-for-profit decision-makers work.

I think that many administrators and managers are or would be interested in cultural and linguistic competency, if for no other reason than ultimate competitive advantage and/or improving quality of care and service. But I also think that, to the degree that these competencies come with a cost and many organizations are operating at a loss in service to the insured and uninsured poor, these competencies are 20th or 40th or 50th on the priority list of these decision-makers.

So, I suggest to these trainees that what they must first do is to study their own organizations, interview senior administrators to construct an operating sense of their organizations, before attempting to tinker with them. Otherwise, all they will experience is indifference, lip service, and ultimately, anger and personal loss.

And I am suggesting that we, who are part of a national dialogue on this important, need to do the same. We need to get real, look at the real external forces operating on these organizations, shaping their purposes, rewarding, threatening, and punishing them, constraining their ranges of freedom, dictating their behaviors and self-representation.

I can't determine whether this kind of realism will result in pessimism and demoralization or something else. But it would be nice to stop sending even more people to run head-long and head-first at concrete walls, without at least some warning.

These real forces are hard-edged and tough conditions. They are not subject to personal or organizational re-interpretation. While they may go away, due to the economics and politics of health care, the organizations cannot wish them away.

Inside of those conditions, organizations try to find their own way, their own course, their own small short-term strategy, based on their own sense of mission and values. They drag their feet on compliance with new requirements, they project false realities, they pretend to do more than they can do, they do more than they are paid to do, they work beyond their own capacity, and they try to maintain both momentum and balance. They use categorical grants to underwrite the basic public health and supportive services really needed by their patients and communities. I am amazed to find such basic roles as breast and cervical cancer screening supported by competitive grantsmanship rather than by core funding.

Not easy.

When I interviewed inside of safety-net health care organizations, administrators and managers described themselves using circus terms – they talked about constantly being in a balancing act, a high wire act. Failure to keep their balance would result in their

organization's demise or loss of access or quality of service to increasing numbers of the poor who present a wide array of linked social, physical, and emotional problems. In fact, they are juggling the three basic elements of health care delivery – access, quality, and cost.

Stop me if you have heard this before, but there is a truism that, among these three elements, you can have any two.

ACCESS + QUALITY = UNACCEPTABLY HIGH COSTS

ACCESS + ACCEPTABLE COSTS = REDUCED QUALITY

QUALITY AND ACCEPTABLE COSTS = REDUCED ACCESS

However, drop any one of these elements and it is no longer a juggling act, but a true high wire act. Your organization dies.

While I agree that a high wire act is an appropriate description of plan and provider organization managers, adding the workers and patients to the mix produces a different metaphor – a pressure cooker. They are all inside a pressure cooker and external forces keep adding heat and pressure.

Inside the pressure cooker, people are working harder and harder, re-engineering like crazy, cost-cutting, inventing, trying to survive, racing into the future, hoping to avoid being crippled or wiped by the next increase in external pressure, and becoming frustrated and overloaded. They start attacking each other, ignoring the fact that their problem has been created and is being maintained by forces far beyond their control.

Important studies of the plight of these important organizations, while pointing out how much more they have to do to survive in an increasingly hostile environment, also point out how little control they have to shape their own lives.

Certainly, it is correct for workers to focus on the needy patients in front of them. The patients certainly do have problems. But they are not the problem.

The problems are social, economic, political, institutional, professional, conceptual, and cultural. By cultural, I mean the culture of the contemporary health care industry and professions.

This culture needs to be understood at least as much if not more than the cultures of the patients seeking appropriate services.

In the time available to us today, I cannot even list all of the forces operating on the safety-net part of the industry. I suggest to you that, individually, collectively, and interactively, these forces are blindly conspiring against all of our efforts to make the health care industry more responsive to its tens of millions of constituents who need

access to care and better care. I am not in a position to say if these governmental and business forces are good or bad. They are, however, like forces of nature. You don't ask whether waves breaking on the shore are good or bad. They simply *are*. It is their impacts that concern me.

I say "blindly" because the forces at work are not, seemingly at least, part of a grand plan, but are non-integrated decisions taking place at very different places in the external environment.

Among some of the factors at work are: (needs re-ordering)

A newly-dominant corporate health-care delivery system that fits neither a socialist model, a public utility model, nor any capitalist model anyone has ever seen. The consumer knows or controls neither the purchaser nor provider of the care upon which he or she depends. The definition of "good" has shifted away from quality and toward cost efficiency.

Laws, such as those requiring access to care, non-discrimination in care, and provision of language interpretation are not self-enforcing. Without tangible carrots and sticks, reimbursements and lawsuits or tax implications, laws are meaningless in an environment where money is the ultimate and ubiquitous and universal bottom-line. Unfunded mandates carry very little weight in an environment where organizations, even HMOs and safety-net providers, are actively dropping or contemplating ditching their Medicare and Medicaid contracts, placing caps on the numbers of Medicaid patients they will accept, dropping services to the uninsured, and so on.

Systematic decline in support to federally qualified health centers

Systematic decline in medical education loan repayment programs

Systematic decline in institutional support for graduate medical education

Systematic decline in the educational role and direct services to the poor of scores of teaching hospitals and academic hospitals

Downward ratcheted reimbursement rates for Medicaid managed care

Increased ratcheted performance, productivity, and reporting requirements for Medicaid managed care; increasing (in absolute terms, in relation to reimbursement rates) administrative and information services costs associated with complex, highly-regulated contracts

Rising costs of specialist network services not accounted for in fixed reimbursement conditions

Increased transfer of risk from insurance companies and specialist providers to primary care provider organizations

The abandonment of Medicaid managed care by insurance companies, HMOs, and other provider organizations that have recognized, early on, the scale of the risks they originally accepted. Short-term Medicaid contracts allow them the regular and routine abandonment of risk. This abandonment directly increases the Medicaid burden on safety-net provider organizations, that are not in a position to accept such large and disproportionate risks.

Increased tendency for health-care organizations to

- adopt “carve out” strategies,
- capping and closing their Medicaid and other public enrollments and participation,
- dropping their Medicaid participation,
- dropping their interpretation services and other ancillary support services to the poor,
- moving from shared or pooled risk to actuarial risk.

The inability of large, complex organizations to rationalize providing “unique” services to only some of their members, those with the highest cost and lowest reimbursement

Providers and provider organizations reverting to a Medicaid fee-for-service model and abandoning global capitation as an income/risk strategy

Decline in the purchasers’ attachment to managed care just as safety-net provider organizations are in the midst of accommodating to it, perpetuating their historical pattern of building to unreliable funding models and sources

Safety-net provider organizations becoming seen as decreasingly attractive for primarily service-motivated physicians and nurses, due to the precedence of productivity over quality

Loss of ability of safety-net providers to maintain their community service mission as the focus of business changes

Decreasing organizational ability to engage in cost-shifting, having money-making product lines underwrite money-losing product lines, due to tougher contracting and increased auditing by third-party payers

Rapid increases in the number of uninsured seeking care from provider organizations

Increased tendency for safety-net providers to 1) merge with, be acquired by, or contract with larger commercial organizations and 2) shift their efforts increasingly to commercial “product lines” as part of implacable marketplace realities, masking the movement away from their primary missions

The development of Relative Value Unit and other productivity measures which do not reflect the increased complexity, time demands, and interpretation costs of providing care to minority populations

Changing incentives to

- Contain costs
- Raise profits
- See more patients
- See fewer patients
- See patients more
- See patients less
- Increase intervals for visits
- Decrease intervals for visits

Major increase in manpower costs and turnover for all provider organizations, but particularly fixed-income safety-net provider organizations, due to a full employment economy

Increased demands to make safety-net provider organizations emulate their commercial counterparts, e.g., panel size, daily productivity, performance incentives and disincentives, scheduling, cost containment methods

Loss of traditional independent providers of minority care

Successful anti-affirmative legislation, reducing the access and numbers of ethnic and racial minorities in health professions schools

The lack of successful integration of managed care into Medicaid; many organizations have implemented “unmanaged care”, taking the capitated risk but operating as walk-in, urgent care medical interveners rather than as maintainers of the health of large patient panels; many patients see no benefit in Medicaid coverage, membership in a plan, and assignment to an overworked PCP, when they can get care anywhere merely by walking in to a care center

The risks inherent in being tied to a single national funding and managed care service model that appears far more permanent than it is likely to be

Financial inability to borrow or otherwise raise sufficient capital to underwrite required infrastructure to support larger, but unprofitable, patient enrollments

Lack of progress in integrating and centralizing common functions across safety-net providers to reduce costs

And doesn't it bother you that, in the midst of the greatest prosperity ever known in this country, the national health care debate in the current election is over Medicare

prescription benefits, not the 40 million people without any health-care insurance. What happens when we have the inevitable recession in employment and economic activity? What happens if significant numbers of safety-net providers drop their traditional missions or disappear just as the recession occurs?

End State:

In the midst of this attempt at realism, I can be hopeful but not necessarily optimistic.

This feels like a contest among current health care delivery models and economics, public policy without attached dollars, and the survival skills and strategies of safety-net providers.

Or it feels like a reversion to earlier times, a two-tiered system of care, one for the prosperous, one for the poor

Like HMOs, we need to examine the possible end or transformation of managed care and its replacement with uncertain and unknown new funding mechanisms

But, ultimately, money is the counterforce to institutional racism, bias, and lack of cultural and linguistic competency.