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IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS

January 15, 1999

Overview: The Clinton Administration has taken a number of important steps since1993 to expand coverage and respond to rapid changes in the U.S. health care system. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed both making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. Many providers of free or low-cost health care services currently do not have the resources or technical capacity necessary to coordinate their efforts with other providers. This initiative, funded at $1 billion over 5 years, will help fill that gap. The bulk of the funding would provide federal grants to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services to create networks that strengthen comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into a "seamless" system of care for low-income working families.

A key emphasis in the early years of the program will be assisting communities and providers in the development of the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured, reaching approximately 100 communities over five years. Although need will vary by community, the focus will be on expanding access to primary health care and ensuring that it is coordinated with other health care needs, including mental health and substance abuse services.

Millions of Americans still lack health insurance. In 1997, the number of Americans without health insurance stood at over 43 million. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for about half of the approximately 11 million uninsured children, roughly 32 million adults between the ages of 19 and 64 remain uninsured. Among these uninsured adults, about 17 million have incomes below 200 percent of the poverty level. Many of them receive their care at community health clinics and local hospitals.

Many of these Americans suffer from multiple health problems and require access to a coordinated set of health care services. Yet data show that these needs are not being met. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. They were only about half as likely to receive a routine check-up as insured adults. Among those who

did have a regular source of care, uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Yet, health care providers that help uninsured Americans face many pressures. These providers consist of institutions, facilities, and individual health professionals that provide a significant volume of health care services, either without payment or on a reduced fee basis, to those who are uninsured. They face a number of challenges, such as increases in the number of uninsured workers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

The Clinton Administration proposes strengthening health services for uninsured workers. To respond to these needs, the President's FY 2000 budget will propose a competitive grant program that would provide $1 billion over five years to strengthen public and private entities in 100 communities, increasing the availability of comprehensive, coordinated health care for uninsured workers. The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Those who provide health care to the uninsured will get help to create the infrastructure they need to provide quality care. A key emphasis in the early years of the program will be assisting communities and providers to develop the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. This support will improve the ability of providers to track patient care needs and receipt of service over time; permit more clients to be served; and strengthen the financial standing of providers by enhancing their ability to compete for business from Medicaid and commercial managed care organizations. Once a coordinated system has been established within a community, uninsured workers will gain entry into a coordinated health care system that meets their individual needs.

Once health services are coordinated in a community, gaps in service can be identified and filled. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the emphasis will be on expanding access to primary health care and insuring coordination with other health care needs, including mental health and substance abuse services.

There is a history of bipartisan support for coordinating health care for uninsured workers. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Support for coordinating community health services has been bipartisan,

and the Administration looks forward to building that kind of consensus around this new initiative.

The Clinton Administration builds on a strong record of extending health care services to more Americans. Since 1993, HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. In 1996, the President signed the Kassebaum-Kennedy act, which ensured that Americans could take their health care with them when they changed jobs. In 1997, under the Balanced Budget Act, the Administration successfully supported the Children's Health Insurance Program (CHIP). Since then, 49 states and territories have had their CHIP plan approved by the U.S. Department of Health and Human Services.

Sunset Park is a model program for coordinating access to care for the uninsured in urban areas. Sunset Park is a large community health center providing services to over 82,000 residents of Southwest Brooklyn, New York every year. Sunset Park is a multi-site system, operating as a managed care network, that offers primary care facilities, a school health program, and a mental health center which includes mental health and substance abuse treatment along with HIV/AIDS services and primary care. The network offers a full array of ancillary and diagnostic services, rehabilitation and early intervention programs, WIC nutrition programs, social services, comprehensive health promotion/disease prevention activities, and HIV counseling and testing.

The Family Health Center in Marshfield is a model program for coordinating access to care for the uninsured in rural areas. Family Health Center of Marshfield, Inc. (FHC) serves eleven counties in rural north central Wisconsin. FHC offers an insurance-like package of benefits that encompass preventive, primary and secondary physician care, and prescription drugs. FHC also works with local rural hospitals to provide outpatient and emergency room services. FHC has a large grassroots referral network which includes existing and past members, clergy, providers, social service agencies, and may other private and public agencies. FHC has leveraged significant resources to assist Marshfield Clinic in the development of an immunization registry and is now seeking to link population-based registry outreach efforts with health benefits counseling in order to help identify children eligible but not enrolled in Medicaid.

IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS
Questions & Answers
1/15/99 6:01 PM

Q1: What are you announcing? Is this new?

A1: The President's FY 2000 budget will propose a $1 billion federal grant program to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services create networks that foster comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into more a "seamless" system of care for low-income working families.

The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Q2: What does this proposal mean for uninsured people?

A2: The uninsured, low-income worker who relies on these health services will receive higher quality and more coordinated care. For instance, if an uninsured person began experiencing chest pains, she might seek care at a public hospital. Depending on her condition, she may stay at the hospital for treatment or may be referred though a system of coordinated care, to another hospital, community health clinic, or academic health center that could better treat her and provide follow-up care.

Coordinated care will also help uninsured workers get better preventative care. Without a system of coordinated care, many without health insurance wait until they are extremely sick to seek medical care. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. When they get health care services, the uninsured often rely heavily on expensive emergency rooms where there is little or no follow-up. Coordinated care will increase referrals for annual check-ups and other preventive services so that people can learn how to control health conditions before they end up sick in the emergency room.

Q3: What is the goal of this proposal?

A3: We want uninsured, low-income workers to have a place to go for preventive care and treatment. Better coordinated care will help ensure that the uninsured will know how to access all of the services available to them in their communities. We also want to build up the health care infrastructure so that providers have the technology necessary to do business with the government and private health care organizations. Finally, we support this initiative because it has the potential to

save money. When a patient is given options other than the emergency room for non-emergency care, costs go down and more uninsured get the services they need.

Q4: Doesn't this simply add a new bureaucracy to the many federal, state, and local, programs that deliver health care to the uninsured?

A4: No. We intend to make grants to community health clinics, public hospitals, academic health centers, and other public and private providers for developing infrastructure and providing services. We are taking this approach precisely because each community has different needs and different service delivery systems. Whatever the needs and types of providers in a community, uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. We plan to fund innovative proposals that support a community's own efforts to enhance services to the uninsured.

A number of communities have already developed successful models that coordinate care and expand services. These models will serve as examples for other communities working to improve cooperation among its providers.

Q5: Are you saying that this proposal is a substitute for extending health insurance to uninsured workers?

A5: No. This new program will complement, not supplant, existing vital programs that support providers of free or low cost health care services. Those programs fund needed services for the uninsured, but they are focused at specific problems or populations. This new program attempts to coordinate their efforts to ensure that patients are served within a more coordinated setting. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. Our proposal also strengthens the providers served by these existing programs by enabling them to be more efficient and competitive in a changing health care environment.

It is also intended to compliment our on going efforts to expand the number of people with health insurance. We continue to support proposals that will extend health insurance to more Americans. By permitting those ages 55 to 65 buy into Medicare, enabling purchasing cooperatives to help people who have been denied insurance, and allowing the working disabled to keep their medical benefits, we will extend insurance to more Americans. This new initiative supports those who are not insured, but is not a substitute for health insurance.

Q6: Who will actually benefit from this program? How many?

A6: This program is directed at uninsured working Americans with income just above the poverty level. Over five years, we plan to fund projects in at least one

hundred communities. Those projects will eventually reach millions of low-income, uninsured workers.

Q7: Aren't you just trying to find a way to implement the massive Clinton health reform program---one element at a time?

A7: No--but we are trying to give more Americans better health care. Since 1993, we have taken some important steps to increase health insurance coverage. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This program recognizes that despite these efforts, there are still millions of uninsured adults who receive health care from locally funded health care providers. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. It supports existing, vital programs in coordinating efforts to ensure that patients are served in a more coordinated setting. It also strengthens providers served by existing programs by enabling them to be more efficient and competitive in a changing health care environment.

Q8: What makes you think you can follow through on such a massive commitment at a time when resources are limited? (Postponing implementation of the BBA, addressing the Y2K problem, administrative changes)

A8: We are committing ourselves to making funds available because this is a vital need for our health care system. Support for the nation's providers of health care access to the uninsured represents a good investment in the future of the health of the American people. These needs are real, and many of them are being met in less efficient settings because of the lack of coordination of vital services. Episodic, crisis oriented care, the kind of care that many uninsured people are forced to seek -- if they can get care at all -- represents a major drain on our health resources. We cannot afford to neglect the health needs of the uninsured.

In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks" for linking rural health services. While our proposal is similar, it would actually help even more people. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Members of Congress from both parties agree that coordinating care for the uninsured is important and we cannot ignore this need because of other challenges we face.

Q9: How much will this cost? Why are you requesting so little in the first year?

A9: We are proposing an investment of $1 billion over 5 years, with FY 2000 funding of $25 million. We recognize that communities need time to plan for effective use of these funds and that some communities will be more prepared to begin than others. Funding at this level will be sufficient to begin to support capital and infrastructure improvements.

Q10: The fact that uninsured people can not get comprehensive care is not a new phenomenon. Why have you waited so long to address this issue?

A10: We haven't. This Administration has a strong record of helping America's uninsured, low income workers over the last six years. HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. The President signed the Kennedy-Kassebaum bill, which ensured that Americans could take their health care with them when they changed jobs. Under the Balanced Budget Act, the Administration successfully worked to pass the Children's Health Insurance Program (CHIP). Since then, 48 states and territories have had their CHIP plan approved by the Department of Health and Human Services.

Last year we won $100 million from Congress for the Community Health Center program where over 40 percent of patients are uninsured. Similarly, we gained major increases in the Ryan White programs, which also serve many uninsured, low income workers. Last year Ryan White funding reached a record $1.4 billion.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. The coordination of services supported by our proposal will help uninsured workers receive more efficient and higher quality care and move toward a more "seamless" system of care for low-income working families.

Q11: As health services in a community begin sharing information on their uninsured patients, don't they begin to impede on a patient's right to have his or her records kept private?

A11: Increasingly, health care information will be shared and we are concerned about protecting the confidentiality of all health information, including that patient information that would reside in data systems funded through this initiative. HHS will continue to work with Congress to enact federal privacy protections. But many cities and states are already moving toward coordinated record keeping in an effort to improve care.

Q12: Do you really think you are going to get this or any of these big-ticket budget items from a Congress that has impeached and is considering the removal of the President?

A12: We think Congress will be interested in a proposal that helps 32 million uninsured workers. The President is working on behalf of the American people to present proposals that address real problems. There is strong popular support for the FY 2000 initiatives that have been announced so far. Our FY 2000 budget addresses such important problems as support for caregivers, food safety and improving health care access for the uninsured. Our budget is a strong blueprint for addressing the challenges that our country faces and we are confident that Congress will step up to the plate and work with us.

Q13: With only a percentage of uninsured taking advantage of the CHIP program, does it make sense to keep throwing money at a group that has not taken advantage of current programs?

A13: Of course it does. The CHIP program is geared exclusively to children. It is a new program and in some states is just getting off the ground. While some states initially proposed modest programs, many of them are now returning to us with more ambitious plans that will cover many more children. Already, states have submitted plans to us that, when implemented, will provide insurance to 2.8 million children. Many states are only now beginning their outreach campaigns.

But there are 32 million uninsured adults, 17 million of them are below 200 percent of the federal poverty level, who aren't eligible for CHIP. This proposal is aimed at them.

Q14: How much does the federal government spend on health services and programs for the uninsured?

A14: There's no easy answer to this question. Medicare and Medicaid disproportionate share payments are partially used to support care for this population. On the discretionary side, over 40 percent of Community Health Center program (funded for FY 1999 at $925 million) users are uninsured. Other programs providing support for services many of which are received by uninsured people include the Ryan White programs ($1.4 billion in FY 1999), the Maternal and Child Health Block grant ($700 million in FY 1999) and the Substance Abuse and Mental Health Performance Partnership grants ($1.6 billion and $289 million respectively in FY 1999). However, funds from these programs are used for other purposes besides services and some of those who benefit from program activities may have Medicaid or some other form of insurance.

Q15: Is this similar to previous Congressional proposals?

A15: Yes. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks." These systems that would have linked rural hospitals and rural health care providers to other hospitals, so that patient care could be coordinated as they traveled between different facilities with different resources. The history of coordinating community services for the uninsured has been bipartisan, and we look forward to building that kind of consensus around our new initiative.

[Background: Senator Dole sponsored a bill (S2374) supporting grants for community-based networks in 1994 as part of his legislative response to the Health Security Act of 1993. Our 1993 health care reform legislation included a similar provision. As you know, both bills were no longer under consideration by the Fall of 1994.]

Q16: Who applies for the money – the locality or a consortium of providers?

A16: Either would potentially be eligible. We see local governments, consortia of providers, or individual providers on behalf of a group, such as a teaching hospital, all as possible grantees. The creative models that we have looked at, like the Marshfield Family Health Center or the Wishard Plan in Indianapolis, take many forms. Ultimately, grants would be awarded to those governments or providers who show the greatest capacity to build community-based networks and expand and improve services for low-income uninsured.

Q17: Is this just a reaction to the fact that the Medicare Commission is talking about phasing out DSH?

A17: No. This new program is not intended as a substitute for DSH. DSH payments reimburse hospitals for some of the costs they incur in treating the uninsured. There is also federal support for providers like Community Health Centers and Ryan White programs. But our program is different. It does not focus on a single type of provider. It is intended to help the array of providers who serve low-income uninsured people work together so that the care they provide is not episodic, but coordinated and comprehensive, and is delivered effectively and efficiently.

The Medicare Commission is charged with developing long-range proposals for Medicare financing and service delivery. We look forward to their proposals, but reserve the right to take steps now to improve and expand health care access for the uninsured.

Q18: How would this really be an incentive for providers to get over their natural disinclination to work together, since it isn't very much money?

A18: There are tremendous incentives to coordinate care in a community, not just for the patient's benefit, but also for the provider's bottom line. We want to build up the health care infrastructure so providers have the technology necessary to do business with the government and private health care organizations. We also support this initiative because it has the potential to save money. When a patient is given options other than the emergency room for non-emergency care, costs go down. We think providers understand that if they do not keep current business practices and ensure efficient care giving through network referrals, they'll be out of business. We want to strengthen the health care infrastructure so that uninsured workers don't just have a place to go now, but in the future as well. We believe that $1 billion will make a real difference in the 100 communities that receive these funds.

Date: 12.30

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Subject: PHI - Safety net draft

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DRAFT 12-29-98

INITIATIVE TO STRENGTHEN THE HEALTH CARE SAFETY-NET FOR UNINSURED AND OTHER AT-RISK INDIVIDUALS

This new initiative will increase the capacity and effectiveness of the nation's health care safety-net in ways that increase the number of uninsured people receiving needed health care and improve the quality of care that is received. Over the first five years of this program, substantial capital and infrastructure support can be provided to 100 communities and millions of additional primary care and mental health/substance abuse services can be provided to hundreds of thousands of uninsured people.

The initiative also will be strongly supported by the public health community and those providers serving low-income uninsured people. The need to strengthen safety-net providers and to improve the efficiency of health care delivery to the poor are widely seen as crucial health care investments by public health professionals and advocates for the poor. A number of communities have developed successful models of integration that have effectively coordinated care and expanded service delivery. This initiative would build upon those successful models. Several of the models are described in Attachment 1.

Finally, the initiative is consistent with other important Administration goals. Promoting coordinated care at the local level allows communities to better focus their efforts on meeting important public health goals contained in Healthy People 2010 and our Race and Health Initiative. Expanding primary care and mental health/substance abuse services also can help fill health care gaps for working people moving from welfare to work.

STRUCTURE

The initiative would be carried out through a competitive grant program that would provide funds to public and private entities to enhance the ability of safety-net providers to provide comprehensive, coordinated health care to a greater number of uninsured people. Funds would be available:

- To assist communities and safety-net providers to develop and expand integrated systems that will coordinate delivery of care to the uninsured, and
- To provide additional health care services which address service gaps within integrated systems so that a greater number of uninsured people have access to a continuum of core health care services.

A key emphasis in the early years of the program will be assisting communities and safety-net providers to obtain and develop the infrastructure necessary to participate in networks or other

coordinated care arrangements. Funds would be available for development of the financial, information and telecommunications systems needed to appropriately monitor and manage patient needs. This capital support will improve the efficiency and effectiveness of service delivery within the safety-net, permitting more clients to be served with existing resources and strengthening the financial standing of the safety-net providers by enhancing their ability to compete for business from Medicaid and commercial managed care arrangements.

The initiative also will target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, a focus will be on expanding access to primary health care and assuring that it is coordinated with other health care needs, including mental health/substance abuse service needs.

Grants would be available to public or private entities. An important goal of the program is to encourage local public officials to work closely with providers of care to better coordinate service delivery and establish accountability within the system for assuring adequate patient care. Applicants will be expected to demonstrate how clients will be provided with a continuum of core health care services, with an emphasis given to applicants that can assure linkage of primary, specialty and tertiary care. Applicants also will be required to document existing funding and resources and to demonstrate that new funds would be used to supplement and not substitute for existing resources. Particularly when grants fund direct health care services, applicants will be required to show how the new grant funds will be integrated with existing funding to expand service capacity and the number of people served. Grant funds will be reduced to the extent that existing steams of revenue are reduced by state or local government.

EXPECTED IMPACTS OF INITIATIVE

Estimating the precise impact of this initiative is difficult because the mix of capital items and health services that will be funded will vary depending on needs of specific communities. Assuming a $500 million dollar commitment over five years ($50 million in FY 2000, increasing to $150 million in FY 2004), the initiative could provide the following level of direct service:[1]

- Substantial capital infrastructure investments in over 100 communities.
- Nearly 3 million primary care visits to a cumulative total of 700,000 uninsured people.
- Over 1 million inpatient and outpatient mental health or substance abuse treatments to a cumulative total of more than 28,000 uninsured people.

[1] Assumes that approximately 25 percent of funds are used for capital infrastructure, roughly 50 percent of the funds are used to expand primary care services, and the remaining funds are used to expand mental health/substance abuse services.

These estimates do not assume that all of the service funding occurs in the 100 communities -- there may be existing coordinated settings that do not need additional funds for infrastructure but that do have significant gaps in service. The opposite also may be true – some communities may need help integrating their service delivery but may not need significant assistance in meeting service demands.

In addition to these direct impacts, the initiative by improving the efficiency and effectiveness of service delivery to uninsured patients will produce savings that can be used to expand the number of clients served. One community that has moved to integrate its indigent care services estimated a 5 percent savings in clinical services and a 20 percent savings in inpatient services.[2] If other communities can achieve comparable savings, hundreds of thousands of additional uninsured people could be served due to the efficiencies produced under this initiative.

CONCLUSION

Just as the development of managed care has been important for improving the breadth and efficiency of services provided to insured people, the development of stronger, better coordinated systems of care among safety-net providers is essential for assuring appropriate access to core health care services for those without means.

This initiative is important now because the safety-net is facing significant challenges, including increases in the number of uninsured people, reduced Medicaid revenues because of the advent of Medicaid managed care, and a growing need for mental health and substance abuse services. It is essential that we find ways not only to support the providers and institutions that serve the uninsured, but that we also improve the quantity and quality of services that they are able to provide.

A number of communities have developed successful models of integration that have effectively coordinated care and expanded service delivery. We have attached descriptions of model programs. They demonstrate how coordinated systems of care can work to address the needs of low income uninsured individuals. While these programs vary in their breadth, focus and financing, they all serve as potential models for other communities seeking to provide coordinated care to uninsured and other low income individuals. These are the types of programs that this initiative would seek to encourage.

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[2] Discussions with officials in Milwaukee County.

ATTACHMENT 1

MODELS OF COORDINATED CARE FOR SAFETY-NET PROVIDERS

Sunset Park

Sunset Park is a large Federally-funded community health center. Over the past 30 years, it has provided more than 500,000 ambulatory care visits and an array of community based services annually to over 82,000 medical and dental users in the underserved, culturally-diverse, urban neighborhood of Southwest Brooklyn, NY.

Sunset Park is a multi-site system, operating as a managed care network. It consists of seven full-time primary care delivery sites and twelve part-time sites, a multi-site School Health Program, and a Mental Health Center which co-locates mental health and alcohol/substance abuse treatment with HIV/AIDS services and primary care. Comprehensive dental care is offered at three sites. Complementing the system, the network offers a full array of ancillary and diagnostic services, rehabilitation and early intervention programs, four WIC nutrition programs, social services, comprehensive health promotion/disease prevention activities, HIV counseling and testing and a range of enabling services.

The network partners with providers and community-based institutions to provide access to a full range of primary and speciality health care services. Its major partners are the Sunset Park Family Health Center, Lutheran Medical Center, Sunset Terrace Family Health Center and Americorps volunteers. Sunset Park Family Health Center, the hub of the network, is located at Lutheran Medical Center (LMC) to provide a full range of speciality and support services, including 14 dental operatories. LMC is also a Designated AIDS Center, offering inpatient treatment to children and adults living with HIV, complementing the outpatient care and case management provided through the Sunset Terrace Family Health Center. The Sunset Terrace Family Health Center is also a model of integrated behavioral health programs and primary care - its Center for Behavioral Health links Sunset Terrace's ambulatory care services to a 26-bed inpatient psychiatric unit and 19-bed chemical dependence unit. Its Mental Health Center works with eight school districts to provide treatment on site to children at risk for school failure as a result of psychological or behavioral problems. Sunset Park has also been able to support patient advocates through Americorps volunteers.

East Side Health Care Coalition

The East Side Health Care Coalition in East St. Louis, IL, oversees an integrated, community-based health care system that provides preventive, primary, and acute health care services, outreach and health education. It is comprised of the lead organization, Southern Illinois

Healthcare Foundation (SIHF), a federally qualified health center, the East Side Health District, the local health department and local public hospital, Touchette Regional Hospital. The coalition has linkages with hospitals, state and local government agencies, community-based organizations, schools, and health professions programs.

The organizations within the coalition share staff and co-locate services to assure easy access to a continuum of care. Physicians from SIHF are assigned to two of the participating coalition organizations and have hospital staff privileges at both Touchette Regional Hospital and St. Mary's Hospital. In addition, the Coalition has opened two community health centers located within WIC offices and two after hours walk-in services at one of the health centers and within the Touchette Regional Hospital. A "one-stop-shopping" approach incorporates comprehensive primary health care and local health department services at all sites.

SIHF provides primary medical care to AIDS consortium, and women's health services through a family planning team from the health department. SIHF and Southern Illinois University at Edwardsville. In conjunction with the health department, SIHF operates a school-based clinic at East St. Louis Senior High School. To eliminate duplication of dental services, all of the restorative dental services are provided by the dental school, the dental sealant programs in area schools are operated by the health department, and preventive dental screenings are performed at the health centers. The health centers serve as training sites for students, interns and residents from area health professions schools. In addition, the Coalition has created several hundred jobs for community residents.

Mental Health and Drug and Alcohol System Integration in King County, Washington

In 1993, King County, Washington, was awarded an ACCESS Demonstration Grant by the Center for Mental Health Services (SAMHSA) to provide outreach and integrated services to homeless people with severe mental illness and to integrate the multiple systems of care that serve this population. As part of the public planning process, King County developed a strategic plan for the integration of mental health and substance abuse services targeting chronically ill populations, including but not limited to the homeless, and for whom more traditional service systems often fail. A major initiative of the plan was the establishment of a Crisis Triage Pilot Project at the county hospital, Harborview Medical Center, that provides assistance to any individual experiencing a behavioral health crisis, regardless of whether it is related to mental illness, substance abuse or developmental disability. People released from the Triage unit may also receive an array of "backdoor" services. Funding for the Triage Unit and the additional services is provided jointly by the mental health fund balance, mental health and substance abuse treatment systems, as well as by the hospital and City of Seattle.

In April of 1995, King County implemented a Prepaid Health Plan based on its 1915(b) waiver from HCFA. In this managed care model, the County retained management of the mental health system and holds the bulk of the risk associated with the plan. Changing their charging structure from fee-for-service to case-rated system generated their significant savings, which they chose to

rechannel into the mental health fund to provide services to those who would fall beneath the safety-net. Many of these individuals may be technically eligible for Medicaid, but are not covered because of barriers caused by their illness or functional status.

Based on the success of the ACCESS demonstration project, the County has committed to providing more than $1 million to continue providing outreach and services to homeless persons with mental illness after the ACCESS demonstration project concludes in June 1999. The County will also expand availability of services beyond the two demonstration project catchment areas to the entire County.

Future innovations will include merging the Division of Mental Health with the Division of Substance Abuse and the establishment of mental health courts, which will enable the County to provide mental health and substance abuse treatment to certain misdemeanor offenders as an alternative to incarceration.

Boston Health Net and Network Health of Cambridge/Somerville
Lincoln County (WA) Public Health Coalition

Hospitals in these communities have taken on some usual functions of public health departments to better coordinate care and integrate inpatient, public health, and health plan functions. The Boston Health Net and Network Health of Cambridge are separate programs that have developed in response to similar environmental factors. Both organizations include a large public hospital with close ties to neighborhood health centers. Both also receive substantial funding for low-income uninsured patients through the Massachusetts free care pool. The programs were developed in anticipation that the Commonwealth of Massachusetts would expand Medicaid eligibility and move toward managed care enrollment. Health Net and Network Health saw this as an opportunity to prepare providers for a managed care environment. At the same time, they hoped to strengthen patient allegiance so patients would stay with network providers as they became eligible for Medicaid. Both programs give enrollees a membership card and assign them to a primary care physician. Hospital and clinic services are financed through the state's free care pool. Most physicians affiliated with Health Net or Network Health hospitals and clinics are salaried and do not bill eligible patients.

In Cambridge, two small city hospitals (Cambridge and Somerville) merged. The CEO of the new organization also serves as Cambridge health commissioner. The new organization is the base of a health plan for covering Medicaid patients. It has negotiated a preferential Medicaid reimbursement rate as well as some funding for uncompensated care. The financing combines Medicaid funds, the State uninsured pool and local match. The network draws on two local service networks that use community providers. The Health Department and service networks are jointly funding an institute to focus on evaluation of existing services and ways to improve care delivery. In Lincoln County two hospitals are coordinating in a similar framework in a rural setting.

Family Health Center of Marshfield, Inc.

Family health Center of Marshfield, Inc. (FHC) serves all or parts of eleven counties in rural north central Wisconsin. Its prepaid integrative approach is relatively unique among rural community health centers. In partnership with Marshfield Clinic, a 501(c)(3) multi-specialty regional medical care system and local rural hospitals, FHC offers an insurance-like package of benefits that encompass preventive, primary and secondary physician care, along with preventive and restorative dental care for children, preventive dental care for adults, and prescription drugs. FHC also works with local rural hospitals to provide outpatient and emergency room services. The goal is to integrate low-income uninsured and under-insured residents into a system of care.

FHC has a large grassroots referral network which includes existing and past members, clergy, providers, social service agencies, and may other private and public agencies. Its intake process seeks to place patients in public or private programs best able to meet all needs. FHC has on-site Medicaid outstationing . Members have access to a toll-free phone line for patient education information and another toll-free number provides a nurse helpline 24 hours a day.

The integration with Marshfield Clinic has helped to increase the awareness of achieving Healthy People 2000 goals. FHC has leveraged significant resources to assist Marshfield Clinic in the development of an immunization registry that has achieved 100 percent participation by all public and private immunization providers in a growing number of north central Wisconsin counties. It is now seeking to link population-based registry outreach efforts with health benefits counseling in order to help identify children eligible but not enrolled in Medicaid. FHC has not just linked primary and preventive care to specialty and hospital services for disadvantaged populations, it has also helped to orient the resources of a large multi-specialty group practice to population-based public health services.

Hillsborough County/Tampa

The Hillsborough County Health Plan, in Florida, was established in February 1992 in response to rapidly rising indigent care costs that were straining the public health care delivery system, including Tampa General Hospital, the county's largest indigent care provider. Hillsborough County Health Plan established an enrollment process for eligible county residents and a bidding process to select provider networks, dividing the county into four zones. Contracts were established with four networks to provide hospital, specialty physician, and primary care services. The networks, in turn, gave preference to safety-net ambulatory care providers already in contact with the target population. The county which originally had made an annual appropriation of about $25 million for indigent care (most of which was paid to Tampa General) authorized a ½ cent sales tax to finance the Hillsborough County Health Plan. Over time, surplus funds developed from the delivery efficiencies achieved and the sales tax was reduced to1/4 cent. The county also ended its direct appropriation. Hillsborough County Health Plan representatives note that while enrollment nearly doubled from 15,000 in 1991, to about 28,000 today, average

premium costs have fallen by more than 50 percent. This reduction is attributed to movement of patients from emergency room to private care settings while unnecessary hospital admissions and length of stay have been reduced.

Indianapolis/Wishard

Established by the Health and Hospitals Corporation of Marion County, Indiana, Wishard Advantage encompasses the 470 bed Wishard Hospital, an academic health center, and a number of outpatient health clinics, and has an affiliation with a large primary care physician group. Wishard Advantage is open to persons with income below 200 percent of the federal poverty level and currently has 10,000 enrollees. All enrollees receive a membership card and are assigned to a primary health care provider. Physician services are provided through an agreement with the Indiana School of Medicine. Wishard Advantage provides services to members who use network providers but does not pay for care outside the network. Approximately 25% of the corporation's budget comes from a local property tax assessment; some of these funds are now used to support services on behalf of Wishard Advantage members.

		2000	2001	2002	2003	2004	00-04
Total Program		50,000,000	75,000,000	100,000,000	125,000,000	150,000,000	500,000,000
Total percent		100%	100%	100%	100%	100%	
Structure							
Percent of grant		80.0%	40.0%	25.0%	20.0%	10.0%	
Structure $$		40,000,000	30,000,000	25,000,000	25,000,000	15,000,000	135,000,000
Average Am't	1,250,000						
		32	24	20	20	12	108
Primary Care							
Percent of Grant		12.5%	40.0%	50.0%	55.0%	65.0%	
$$ Primary Care		6,250,000	30,000,000	50,000,000	68,750,000	97,500,000	252,500,000
People							
Cost per person	350						
		17,857	85,714	142,857	196,429	276,571	721,429
Services							
Cost per service	87.5						
		71,429	342,857	571,429	785,714	1,114,286	2,885,714
Mental Health/Substance Abuse							
Percent of Grant		7.5%	20.0%	25.0%	25.0%	25.0%	
$$ MH/SA		3,750,000	15,000,000	25,000,000	31,250,000	37,500,000	112,500,000
People							
Average cost per person	4000						
		938	3,750	6,250	7,813	9,375	28,125

Services							
Average cost per service							
Inpatient	300	3,125	12,500	20,833	26,042	31,250	93,750
Outpatient	75	37,500	150,000	250,000	312,500	375,000	1,125,000

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Portraits of the Safety Net: The Market, Policy Environment, and Safety Net Response

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The Urban Institute

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Occasional Paper Number 19

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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Facsimile Cover Sheet

TO: Deborah Adler

FROM: Christian Stenrud

DATE: 1/15/09

RECEIVER FAX: 456-5557

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NOTE: Health care access for uninsured workers paper attached

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IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS
January 15, 1999

Overview: The Clinton Administration has taken a number of important steps since1993 to expand coverage and respond to rapid changes in the U.S. health care system. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed both making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. Many providers of free or low-cost health care services currently do not have the resources or technical capacity necessary to coordinate their efforts with other providers. This initiative, funded at $1 billion over 5 years, will help fill that gap. The bulk of the funding would provide federal grants to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services to create networks that strengthen comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into a "seamless" system of care for low-income working families.

A key emphasis in the early years of the program will be assisting communities and providers in the development of the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured, reaching approximately 100 communities over five years. Although need will vary by community, the focus will be on expanding access to primary health care and ensuring that it is coordinated with other health care needs, including mental health and substance abuse services.

Millions of Americans still lack health insurance. In 1997, the number of Americans without health insurance stood at over 43 million. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for about half of the approximately 11 million uninsured children, roughly 32 million adults between the ages of 19 and 64 remain uninsured. Among these uninsured adults, about 17 million have incomes below 200 percent of the poverty level. Many of them receive their care at community health clinics and local hospitals.

Many of these Americans suffer from multiple health problems and require access to a coordinated set of health care services. Yet data show that these needs are not being met. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. They were only about half as likely to receive a routine check-up as insured adults. Among those who

did have a regular source of care, uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Yet, health care providers that help uninsured Americans face many pressures. These providers consist of institutions, facilities, and individual health professionals that provide a significant volume of health care services, either without payment or on a reduced fee basis, to those who are uninsured. They face a number of challenges, such as increases in the number of uninsured workers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

The Clinton Administration proposes strengthening health services for uninsured workers. To respond to these needs, the President's FY 2000 budget will propose a competitive grant program that would provide $1 billion over five years to strengthen public and private entities in 100 communities, increasing the availability of comprehensive, coordinated health care for uninsured workers. The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Those who provide health care to the uninsured will get help to create the infrastructure they need to provide quality care. A key emphasis in the early years of the program will be assisting communities and providers to develop the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. This support will improve the ability of providers to track patient care needs and receipt of service over time; permit more clients to be served; and strengthen the financial standing of providers by enhancing their ability to compete for business from Medicaid and commercial managed care organizations. Once a coordinated system has been established within a community, uninsured workers will gain entry into a coordinated health care system that meets their individual needs.

Once health services are coordinated in a community, gaps in service can be identified and filled. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the emphasis will be on expanding access to primary health care and insuring coordination with other health care needs, including mental health and substance abuse services.

There is a history of bipartisan support for coordinating health care for uninsured workers. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Support for coordinating community health services has been bipartisan,

and the Administration looks forward to building that kind of consensus around this new initiative.

The Clinton Administration builds on a strong record of extending health care services to more Americans. Since 1993, HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. In 1996, the President signed the Kassebaum-Kennedy act, which ensured that Americans could take their health care with them when they changed jobs. In 1997, under the Balanced Budget Act, the Administration successfully supported the Children's Health Insurance Program (CHIP). Since then, 49 states and territories have had their CHIP plan approved by the U.S. Department of Health and Human Services.

Sunset Park is a model program for coordinating access to care for the uninsured in urban areas. Sunset Park is a large community health center providing services to over 82,000 residents of Southwest Brooklyn, New York every year. Sunset Park is a multi-site system, operating as a managed care network, that offers primary care facilities, a school health program, and a mental health center which includes mental health and substance abuse treatment along with HIV/AIDS services and primary care. The network offers a full array of ancillary and diagnostic services, rehabilitation and early intervention programs, WIC nutrition programs, social services, comprehensive health promotion/disease prevention activities, and HIV counseling and testing.

The Family Health Center in Marshfield is a model program for coordinating access to care for the uninsured in rural areas. Family Health Center of Marshfield, Inc. (FHC) serves eleven counties in rural north central Wisconsin. FHC offers an insurance-like package of benefits that encompass preventive, primary and secondary physician care, and prescription drugs. FHC also works with local rural hospitals to provide outpatient and emergency room services. FHC has a large grassroots referral network which includes existing and past members, clergy, providers, social service agencies, and may other private and public agencies. FHC has leveraged significant resources to assist Marshfield Clinic in the development of an immunization registry and is now seeking to link population-based registry outreach efforts with health benefits counseling in order to help identify children eligible but not enrolled in Medicaid.

IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS
Questions & Answers
1/15/99 6:01 PM

Q1: What are you announcing? Is this new?

A1: The President's FY 2000 budget will propose a $1 billion federal grant program to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services create networks that foster comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into more a "seamless" system of care for low-income working families.

The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Q2: What does this proposal mean for uninsured people?

A2: The uninsured, low-income worker who relies on these health services will receive higher quality and more coordinated care. For instance, if an uninsured person began experiencing chest pains, she might seek care at a public hospital. Depending on her condition, she may stay at the hospital for treatment or may be referred though a system of coordinated care, to another hospital, community health clinic, or academic health center that could better treat her and provide follow-up care.

Coordinated care will also help uninsured workers get better preventative care. Without a system of coordinated care, many without health insurance wait until they are extremely sick to seek medical care. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. When they get health care services, the uninsured often rely heavily on expensive emergency rooms where there is little or no follow-up. Coordinated care will increase referrals for annual check-ups and other preventive services so that people can learn how to control health conditions before they end up sick in the emergency room.

Q3: What is the goal of this proposal?

A3: We want uninsured, low-income workers to have a place to go for preventive care and treatment. Better coordinated care will help ensure that the uninsured will know how to access all of the services available to them in their communities. We also want to build up the health care infrastructure so that providers have the technology necessary to do business with the government and private health care organizations. Finally, we support this initiative because it has the potential to

save money. When a patient is given options other than the emergency room for non-emergency care, costs go down and more uninsured get the services they need.

Q4: Doesn't this simply add a new bureaucracy to the many federal, state, and local, programs that deliver health care to the uninsured?

A4: No. We intend to make grants to community health clinics, public hospitals, academic health centers, and other public and private providers for developing infrastructure and providing services. We are taking this approach precisely because each community has different needs and different service delivery systems. Whatever the needs and types of providers in a community, uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. We plan to fund innovative proposals that support a community's own efforts to enhance services to the uninsured.

A number of communities have already developed successful models that coordinate care and expand services. These models will serve as examples for other communities working to improve cooperation among its providers.

Q5: Are you saying that this proposal is a substitute for extending health insurance to uninsured workers?

A5: No. This new program will complement, not supplant, existing vital programs that support providers of free or low cost health care services. Those programs fund needed services for the uninsured, but they are focused at specific problems or populations. This new program attempts to coordinate their efforts to ensure that patients are served within a more coordinated setting. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. Our proposal also strengthens the providers served by these existing programs by enabling them to be more efficient and competitive in a changing health care environment.

It is also intended to compliment our on going efforts to expand the number of people with health insurance. We continue to support proposals that will extend health insurance to more Americans. By permitting those ages 55 to 65 buy into Medicare, enabling purchasing cooperatives to help people who have been denied insurance, and allowing the working disabled to keep their medical benefits, we will extend insurance to more Americans. This new initiative supports those who are not insured, but is not a substitute for health insurance.

Q6: Who will actually benefit from this program? How many?

A6: This program is directed at uninsured working Americans with income just above the poverty level. Over five years, we plan to fund projects in at least one

hundred communities. Those projects will eventually reach millions of low-income, uninsured workers.

Q7: Aren't you just trying to find a way to implement the massive Clinton health reform program—one element at a time?

A7: No--but we are trying to give more Americans better health care. Since 1993, we have taken some important steps to increase health insurance coverage. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This program recognizes that despite these efforts, there are still millions of uninsured adults who receive health care from locally funded health care providers. Uninsured workers should feel that they can gain entry into a system and do not have to postpone care or piece together the services they need. It supports existing, vital programs in coordinating efforts to ensure that patients are served in a more coordinated setting. It also strengthens providers served by existing programs by enabling them to be more efficient and competitive in a changing health care environment.

Q8: What makes you think you can follow through on such a massive commitment at a time when resources are limited? (Postponing implementation of the BBA, addressing the Y2K problem, administrative changes)

A8: We are committing ourselves to making funds available because this is a vital need for our health care system. Support for the nation's providers of health care access to the uninsured represents a good investment in the future of the health of the American people. These needs are real, and many of them are being met in less efficient settings because of the lack of coordination of vital services. Episodic, crisis oriented care, the kind of care that many uninsured people are forced to seek -- if they can get care at all -- represents a major drain on our health resources. We cannot afford to neglect the health needs of the uninsured.

In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks" for linking rural health services. While our proposal is similar, it would actually help even more people. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. Members of Congress from both parties agree that coordinating care for the uninsured is important and we cannot ignore this need because of other challenges we face.

Q9: How much will this cost? Why are you requesting so little in the first year?

A9: We are proposing an investment of $1 billion over 5 years, with FY 2000 funding of $25 million. We recognize that communities need time to plan for effective use of these funds and that some communities will be more prepared to begin than others. Funding at this level will be sufficient to begin to support capital and infrastructure improvements.

Q10: The fact that uninsured people can not get comprehensive care is not a new phenomenon. Why have you waited so long to address this issue?

A10: We haven't. This Administration has a strong record of helping America's uninsured, low income workers over the last six years. HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. The President signed the Kennedy-Kassebaum bill, which ensured that Americans could take their health care with them when they changed jobs. Under the Balanced Budget Act, the Administration successfully worked to pass the Children's Health Insurance Program (CHIP). Since then, 48 states and territories have had their CHIP plan approved by the Department of Health and Human Services.

Last year we won $100 million from Congress for the Community Health Center program where over 40 percent of patients are uninsured. Similarly, we gained major increases in the Ryan White programs, which also serve many uninsured, low income workers. Last year Ryan White funding reached a record $1.4 billion.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. The coordination of services supported by our proposal will help uninsured workers receive more efficient and higher quality care and move toward a more "seamless" system of care for low-income working families.

Q11: As health services in a community begin sharing information on their uninsured patients, don't they begin to impede on a patient's right to have his or her records kept private?

A11: Increasingly, health care information will be shared and we are concerned about protecting the confidentiality of all health information, including that patient information that would reside in data systems funded through this initiative. HHS will continue to work with Congress to enact federal privacy protections. But many cities and states are already moving toward coordinated record keeping in an effort to improve care.

Q12: Do you really think you are going to get this or any of these big-ticket budget items from a Congress that has impeached and is considering the removal of the President?

A12: We think Congress will be interested in a proposal that helps 32 million uninsured workers. The President is working on behalf of the American people to present proposals that address real problems. There is strong popular support for the FY 2000 initiatives that have been announced so far. Our FY 2000 budget addresses such important problems as support for caregivers, food safety and improving health care access for the uninsured. Our budget is a strong blueprint for addressing the challenges that our country faces and we are confident that Congress will step up to the plate and work with us.

Q13: With only a percentage of uninsured taking advantage of the CHIP program, does it make sense to keep throwing money at a group that has not taken advantage of current programs?

A13: Of course it does. The CHIP program is geared exclusively to children. It is a new program and in some states is just getting off the ground. While some states initially proposed modest programs, many of them are now returning to us with more ambitious plans that will cover many more children. Already, states have submitted plans to us that, when implemented, will provide insurance to 2.8 million children. Many states are only now beginning their outreach campaigns.

But there are 32 million uninsured adults, 17 million of them are below 200 percent of the federal poverty level, who aren't eligible for CHIP. This proposal is aimed at them.

Q14: How much does the federal government spend on health services and programs for the uninsured?

A14: There's no easy answer to this question. Medicare and Medicaid disproportionate share payments are partially used to support care for this population. On the discretionary side, over 40 percent of Community Health Center program (funded for FY 1999 at $925 million) users are uninsured. Other programs providing support for services many of which are received by uninsured people include the Ryan White programs ($1.4 billion in FY 1999), the Maternal and Child Health Block grant ($700 million in FY 1999) and the Substance Abuse and Mental Health Performance Partnership grants ($1.6 billion and $289 million respectively in FY 1999). However, funds from these programs are used for other purposes besides services and some of those who benefit from program activities may have Medicaid or some other form of insurance.

Q15: Is this similar to previous Congressional proposals?

A15: Yes. In the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. In the last Congress, a bipartisan bill was supported by the Blue Dog Democrats and House Republicans that would have created "telehealth networks." These systems that would have linked rural hospitals and rural health care providers to other hospitals, so that patient care could be coordinated as they traveled between different facilities with different resources. The history of coordinating community services for the uninsured has been bipartisan, and we look forward to building that kind of consensus around our new initiative.

[Background: Senator Dole sponsored a bill (S2374) supporting grants for community-based networks in 1994 as part of his legislative response to the Health Security Act of 1993. Our 1993 health care reform legislation included a similar provision. As you know, both bills were no longer under consideration by the Fall of 1994.]

Q16: Who applies for the money – the locality or a consortium of providers?

A16: Either would potentially be eligible. We see local governments, consortia of providers, or individual providers on behalf of a group, such as a teaching hospital, all as possible grantees. The creative models that we have looked at, like the Marshfield Family Health Center or the Wishard Plan in Indianapolis, take many forms. Ultimately, grants would be awarded to those governments or providers who show the greatest capacity to build community-based networks and expand and improve services for low-income uninsured.

Q17: Is this just a reaction to the fact that the Medicare Commission is talking about phasing out DSH?

A17: No. This new program is not intended as a substitute for DSH. DSH payments reimburse hospitals for some of the costs they incur in treating the uninsured. There is also federal support for providers like Community Health Centers and Ryan White programs. But our program is different. It does not focus on a single type of provider. It is intended to help the array of providers who serve low-income uninsured people work together so that the care they provide is not episodic, but coordinated and comprehensive, and is delivered effectively and efficiently.

The Medicare Commission is charged with developing long-range proposals for Medicare financing and service delivery. We look forward to their proposals, but reserve the right to take steps now to improve and expand health care access for the uninsured.

Q18: How would this really be an incentive for providers to get over their natural disinclination to work together, since it isn't very much money?

A18: There are tremendous incentives to coordinate care in a community, not just for the patient's benefit, but also for the provider's bottom line. We want to build up the health care infrastructure so providers have the technology necessary to do business with the government and private health care organizations. We also support this initiative because it has the potential to save money. When a patient is given options other than the emergency room for non-emergency care, costs go down. We think providers understand that if they do not keep current business practices and ensure efficient care giving through network referrals, they'll be out of business. We want to strengthen the health care infrastructure so that uninsured workers don't just have a place to go now, but in the future as well. We believe that $1 billion will make a real difference in the 100 communities that receive these funds.

Public Policy, Market Forces, and the Viability of Safety Net Providers

by
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The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

Note: This report is also available in the PDF format, which many users find more convenient when printing.

Contents

Introduction

Several recent articles have warned of growing threats to community providers whose mission[1] is to provide care to the low-income uninsured—the safety net (Fishman and Bentley 1997; Andrulis 1997). These and other reports suggest that an array of changes—increasing managed care; competition among providers; diminished federal, state, and local funding for safety net providers; and rising demand for free care—are making it harder for safety net providers to provide care to the uninsured. Safety net providers indicate that they are experiencing stress as a result of market and policy changes and that these changes threaten their ability to continue providing care to the

uninsured. But few safety net providers have closed, nor do the major safety net providers report reductions in their capacity to care for the uninsured.

How is it that safety net providers, and community safety net systems as a whole, have been able to maintain their commitment to the uninsured with such significant changes in the market and policy environment? As part of the Urban Institute's Assessing the New Federalism (ANF) project, site visits were conducted in 17 communities in 13 states[2] during 1996 and 1997, assessing the vulnerability of the safety net to market and public policy changes. Senior managers at major safety net hospitals, federally qualified health centers (FQHCs), and local health departments, as well as other key public officials, were interviewed to assess how various market and policy changes were affecting safety net institutions and how they responded to such changes. Other ANF analyses will use provider-level financial data to evaluate the provision of unsponsored care. An analysis of National Survey of American Families (NSAF) data will assess the utilization of health care services by the low-income uninsured.

The purpose of this analysis was to document the nature and magnitude of stress facing safety net providers, how providers are adapting to stress, factors that mitigate that stress, and how the situation varies across communities. The analysis was designed to show which safety net systems in the study states were more vulnerable than others and to explain how the safety net has maintained its commitment to the low-income uninsured despite changes in the marketplace.

What explains the safety net's ability to maintain its commitment so far? There are three reasons for this success. First, all of the various changes that exert pressure on the safety net have not arisen in any one market with a great deal of severity at the same time. Safety net providers can survive a highly competitive market, or sudden reductions in Medicaid patient care revenues, or even large decreases in state and local subsidies. But it is rare that all of these conditions occur simultaneously in any one community. Second, safety net providers and systems have been adept at responding to changing market and policy circumstances. Third, federal and state support in some cases ensures that the safety net remains viable. And in cases where federal and state support are not sufficient to meet the need, local communities have been able and willing to financially support the safety net.

Safety net systems may be holding on for now, but this analysis suggests that certain circumstances leave safety net institutions vulnerable. Ultimately, the safety net is never fully supported, as the institutions are not fully compensated for care to the uninsured. Thus, no matter how high or low the level of pressure they experience, these institutions will be under some stress. In states and communities where the need for safety net services is very high, competition is intense, and state and federal funding is low relative to need, safety net providers are more vulnerable. In this situation, safety net systems often must rely on local funds, which can be a fragile base for financial support.

This report first provides a general description of the safety net systems in the study states. It then discusses the nature of the stresses facing safety net providers and the factors that mitigate that stress. The report then offers an explanation for why safety net systems have, so far, been able to maintain their commitment to the low-income uninsured in spite of the increasing pressure on the systems. The report concludes that as competition increases or the number of uninsured persons rises, federal, state, and local public policies will need to play an increasingly important role in ensuring access to health care for the uninsured.

Overview of ANF and the Safety Nets in the 16 Communities

The 13 study states were selected to ensure significant variation in geographic, fiscal, political, and population characteristics. States were chosen so that the sample would reflect the variation in child well-being, fiscal capacity, and public spending on Medicaid and Aid to Families with Dependent Children (AFDC) across the United States. Local sites within the study states were selected to ensure that site visits were conducted in areas with large pockets of low-income individuals, in line with the focus of the study. Table 1 lists each of the study states and the local sites selected for intensive case study. In three large states—California, Florida, and Texas—more than one site was selected to reflect the relatively large populations and diversity.

In every community visited, there were a significant number of ambulatory and inpatient providers that serve the low-income population, both Medicaid-eligible and uninsured. Together, these institutions—including public and nonprofit hospitals, FQHCs,[3] and local health departments—formed the safety net. Inpatient institutions are often at the center of these systems of care, providing almost $17 billion in uncompensated care in 1994, compared with approximately $1 billion in community health centers (Cunningham and Tu 1997). Other articles provide more background on which institutions, which funding streams, and which populations comprise the safety net in most communities (Fishman 1997; Baxter and Mechanic 1997).

Reflecting the diversity in the states and local communities in which they reside, the safety nets varied based on ownership. The 16 community safety nets can be divided into three groups: those in which most inpatient uncompensated care is provided by state, county, or other publicly owned systems (Los Angeles, Alameda County, Denver, Miami, El Paso, Houston, Minneapolis, and Jackson, Mississippi); those where inpatient uncompensated care is more evenly split between public and private, nonprofit systems or providers (e.g., Birmingham, New York City, Tampa, Seattle, and San Diego); and those in which inpatient uncompensated care is provided only by private, nonprofit providers (e.g., Detroit, and Milwaukee and Boston as a result of recent changes).

With regard to primary care for the uninsured, local health departments, hospital-based outpatient clinics, and FQHCs serve as major providers within the safety net. Although hospitals have traditionally focused on acute care services, the penetration of managed care and the need to maintain patient loads have provided hospitals with incentives to increase their presence in the community. While public health agencies have traditionally provided personal health care services, many states in recent years have shifted their priorities to emphasize population-oriented measures (Wall 1998). Nonetheless, personal health care services currently consume the largest share of the average local health department's staffing and funds. While it was impossible to accurately measure the relative importance of these different providers within the safety net, FQHCs likely are the primary ambulatory care provider in each of the communities.

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While the acute and emergency care components of safety nets may be separated from the primary care component of care for the uninsured, there is another, sometimes more subtle, division of care for the uninsured that exists in many communities. Often, one group of hospitals or community health centers provides care to children, adolescents, or pregnant women, while another group provides care to groups who have more difficult-to-treat problems or are hard to reach, such as homeless people, substance abusers, and people with HIV/AIDS. Because these patients require a great deal of social services to address the health care problems they present, their care is both more complicated and expensive. While there is some overlap in institutions that serve the two groups, it is often a public hospital, local health department, or community-based organization that tries to serve these vulnerable, hard-to-reach populations on anything other than an emergency or inpatient basis. This distinction between "average" and "special needs or hard-to-serve" groups sometimes applies to the Medicaid population, with private institutions preferring to serve AFDC/Medicaid clientele, leaving public institutions to serve Medicaid patients who are disabled, persons with AIDS, homeless individuals, and substance abusers.

Determinants of Safety Net Viability

Local respondents identified four market and policy environment characteristics that affect their ability to continue providing care to low-income populations. These characteristics are (1) the level of demand for their services,

(2) Medicaid managed care penetration, (3) competition in the private market, and (4) explicit subsidies for the uninsured from federal, state, and local sources. The second and third factors affect the level of surplus revenues used to subsidize care for the uninsured. Virtually all safety net providers indicated that these four factors had a significant impact on their ability to carry out their missions.

This section describes how each of these market and policy characteristics affects, or could affect, the stress faced by safety net providers. We attempt to provide a quantitative measure of each of these characteristics. The goal is to indicate the magnitude of the stress experienced by the safety net systems in each community and how this varies by community. Quantitative information at the community level was used where available. In cases where community-level data were not available, state-level data were used.

For each community and each policy and market characteristic, this section also attempts to provide a composite measure of the level of strain faced by safety net systems. In developing these measures, an attempt was made to rank communities relative to a national average. Categories were largely limited to "high" and "low," although in some cases finer classifications were developed. We do not have quantitative information that relates these factors to hospital financial indicators or their provision of care to the uninsured; thus, these composite measures of pressure should not be interpreted as quantitatively precise, but rather as one approach toward identifying the potential magnitude of the stress faced by safety net providers.

Demand for Safety Net Services

With a few exceptions (most noticeably in Minnesota), local safety net providers perceived, and characterized, the demand for their services as extraordinarily high and growing. A variety of factors determine the level of demand for safety net services. The first is the structure of the employer and private insurance market and the resultant coverage of the low-income population. The second is the eligibility standards in the state's Medicaid program and the availability of subsidized insurance programs for the low-income uninsured, which together measure the state's commitment to the low-income uninsured (Rajan 1998). Finally, the demand for safety net services tends to be higher in those areas with a large population of individuals with special health care needs, including those individuals with AIDS and the homeless (Baxter and Mechanic 1997). Table 2 describes these factors in each of the 12 states.

Identifying those states with extremely high or low demand is relatively straightforward. For example, in Texas and Florida, where public coverage is relatively limited (Rajan 1998), coverage of the low-income population in the private market is low (Liska et al. 1997), and AIDS prevalence rates are high (Brangen et al. 1996), demand is likely greater than in states such as Minnesota and Washington, which are characterized by high levels of coverage of the low-income population in both the public and/or private sectors as well as low AIDS prevalence rates.

Unfortunately, community-level data tracking these factors are unavailable. To provide some measure of the variation in demand in local communities, table 2 presents state uninsured rates among the nonelderly population with incomes less than 200 percent of the federal poverty level. The uninsurance rate of those below 200 percent of poverty reflects the demand for services in the local sites more accurately than state-level estimates, given that these individuals are more likely to use safety net providers and that the poverty population is often concentrated in the cities that were visited. With

the exception of our local sites in Mississippi and some locales in California, the proportion of the population living in poverty in 1990 was significantly higher in all our local site visit areas than in the state generally. The poverty rate was almost three times the state rate in Detroit and Miami and double in Boston and Milwaukee (Bureau of the Census 1991). The final column of table 2 provides an indicator of whether or not demand was high or low. Study states with uninsurance rates above the national average were identified as states, and the communities within them, in which demand can be considered high.

It is worth noting that a very high proportion of the low-income population is uninsured, regardless of the state. Even in states like Minnesota (with a state uninsurance rate of 9.2 percent in 1995), the proportion of the low-income population that is uninsured is almost 20 percent, indicating that safety net providers may face significant levels of demand given the concentration of uninsurance in central cities regardless of the level of uninsurance in the general population. At the same time, communities in some states clearly face higher levels of demand for safety net services than others. The uninsurance rates were higher than the national average in Alabama, California, Colorado, Florida, Mississippi, New York, and Texas. Study communities within these states are also likely to have higher-than-average uninsurance rates as well.[4]

An important caveat to this discussion, however, is that the distribution of demand across providers within a community may vary considerably across these sites. Uncompensated care market share, or the proportion of a community's total uncompensated care burden borne by one hospital or certain types of hospitals, indicates how evenly uncompensated care is spread among providers. Consistent with other work, information on the concentration of uncompensated care from the study sites indicates that publicly owned hospitals tend to bear a much higher uncompensated care market share than private safety net hospitals. For example, in Los Angeles and Oakland, which have public safety net systems (see table 1), the concentration of uncompensated care is much higher than in San Diego, which has a safety net system composed largely of nonprofit private institutions. Although data are incomplete, comments from site visit interviews and information in local documents indicate that several safety net hospitals with very high uncompensated care market shares (e.g., Denver with 47 percent, Boston with 57 percent, and even Oakland with 90 percent) are doing quite well (see table 3).

This suggests that a better measure of safety net hospital vulnerability might be the proportion of uncompensated care in each hospital's total costs or revenues, sometimes referred to as the uncompensated care ratio. A hospital that provides the majority of uncompensated care in a region may have a low uncompensated care ratio because it also has a large share of privately insured patients, allowing it to cross-subsidize its large share of service to the uninsured. Furthermore, even if a hospital has more than half of all uncompensated care in a given region, if the uninsured rate is low, then the burden will be more manageable than in an area that has a much higher uninsured rate. Though data limitations did not permit a complete financial analysis of all safety net hospitals interviewed in this study, safety net hospitals' overall financial condition and market share may be more important than the uncompensated care market share alone.[5]

Medicaid Managed Care

In nearly every community, states have begun to aggressively pursue lower-cost care for the Medicaid population through capitated Medicaid managed care. Safety net providers indicated that this was one of the most significant factors affecting the safety net. In El Paso, Houston, Jackson (Mississippi), and Montgomery (Alabama), safety net providers were starting to respond to the expected implementation of capitated Medicaid managed care. In

Detroit, Boston, Miami, New York City, and all three California communities, substantial increases in capitated Medicaid plan enrollment prompted change by safety net providers. Only providers in Milwaukee seemed relatively unconcerned about capitated Medicaid managed care, probably because it has been mandatory for most AFDC or AFDC-related beneficiaries for over a decade.

Managed care heightens competition among providers over Medicaid patients and revenues, which represents a danger to safety net providers since Medicaid constitutes a major portion of total revenue and can help to cross-subsidize care for the uninsured. Across virtually all locales visited, observers noted that nontraditional Medicaid providers had expanded into the Medicaid market as a result of competitive pressures in the private managed care (and fee-for-service [FFS]) markets. Competition tends to focus on newly eligible pregnant women and children but not on the disabled or children with special health care needs.

Capitation payments—fixed monthly payments that cover the cost of all care covered in the contract—exert more pressure to cut costs on Medicaid-dependent providers than do primary care case management models of managed care. They often receive lower fees from managed care organizations (MCOs), compared with FFS.[6] In addition, special Medicaid payments made to safety net providers—disproportionate share hospital (DSH) payments to hospitals and cost-based reimbursement for FQHCs—may be included in the capitation rate but not passed on to safety net providers by health maintenance organizations (HMOs).[7]

The site visits indicated that capitated managed care's effects on safety net providers differed by community and by type of provider, based on two factors: (1) the proportion and types of the Medicaid population covered by mandatory enrollment policies and (2) state program design features, some of which are specific to safety net providers. In what follows, we provide state-level information on both of the factors that provide an indication of the likely trends in the study communities that were evaluated. Site visits suggested that the extent of Medicaid managed care penetration varied somewhat by community, but reliable and comparable information was not available at the community level.

With regard to the first factor, states' percentages of capitated Medicaid managed care enrollment varied from 0 percent to 54 percent in 1996 (see table 4), with the national average being 24 percent. Interviews with providers and state officials suggest that the higher the proportion of Medicaid patients in capitated plans, the more competition they experienced with other providers. Interviews with providers and state officials suggest that safety net providers in states with more than 20 percent of all Medicaid patients in capitated plans (California, Colorado, Florida, Michigan, Minnesota, New York, Washington, and Wisconsin) were under greater pressure to compete than others (Alabama, Massachusetts, Mississippi, and Texas). While mandatory enrollment policies at present apply primarily to the AFDC population, the pressure on safety net providers is also heightened when Supplemental Security Income (SSI) beneficiaries are mandated to enroll in managed care, as in Colorado, Florida, Massachusetts, and Michigan. Column 2 in table 4 provides an indicator of whether the state mandates capitated enrollment for groups other than the AFDC population.

Reports from providers suggested that not just the proportion but the rate of growth in the proportion of Medicaid enrollees enrolled in capitated plans has a significant impact on the viability of the safety net. Nationally, between 1990 and 1996 the annual rate of increase in the proportion of the Medicaid population enrolled in capitated plans has accelerated (Holahan et al. 1998). This rapid increase in managed care gives safety net providers little time to adapt. In California, for example, providers expressed significant concern over the fact that there was a nearly 30 percent increase in capitated Medicaid enrollment between June 1996 and July 1997.

Regarding the second factor, state Medicaid managed care program characteristics can mitigate the competitive pressure safety net providers face as well.[8] States can help the competitive position of safety net providers by offering incentives for managed care plans to contract with them. Some states award bonus points to bids of managed care plans that contract with specified types of providers, as in California, Michigan, Florida, New York, and Washington. While officials in these states believe that this incentive has worked well, some providers (especially local health departments) may still be left out. And without accompanying policies regarding payment of such providers, being included in MCO networks does not guarantee that patients will be referred by the plan's primary care providers or that they will be paid adequate rates.

Some states choose to give special dispensation to managed care plans formed by safety net providers themselves. The local initiative plans in California, where county-initiated plans are required to contract with safety net providers, are awarded higher capitation rates to reflect their higher cost structure. In California, Michigan, and New York, policies give preferential assignment of patients who do not elect a plan to safety net–sponsored plans. And for safety net providers that do not sponsor their own HMOs, state policy regarding automatic assignment can affect them positively or negatively, depending on the criteria used for making such assignments. In California, beneficiaries who do not select a plan are assigned to the local initiative plan (sponsored by the county and specifically required to contract with safety net providers) until the local initiative plan's level of Medi-Cal DSH funding prior to the two-plan model is reached. When assignments are made on the basis of the lowest-cost plan, as they are in Washington state, safety net provider–sponsored plans may be disadvantaged, as their costs tend to be higher.

Together, the proportion and type of populations enrolled in managed care and the degree to which competitive pressure exerted by such factors is mitigated by these state policies provide an indication of how state capitated

managed care will affect safety net providers. Safety net providers in states with more than 20 percent capitated enrollment and no special policies for safety net providers may experience the greatest pressure. Only two states—Colorado and Wisconsin—fell into this category. Safety net providers in states with less than 20 percent capitated enrollment and some safety net provider protections—such as Texas—or states in which capitated enrollment is nonexistent—such as Alabama and Mississippi—are likely to experience the least pressure. The remainder of the states have more than 20 percent capitated enrollment but enacted some explicit protections for safety net providers.

Commercial Market Competition

Akin to the Medicaid market, purchasers of health care in the private market are also aggressively pursuing lower-cost care through capitated managed care. Safety net providers in every community indicated that the penetration of managed care in the private market has resulted in an increase in price-based competition. They also indicated that there has been a general increase in competition on the basis of nonprice aspects of care, including consumer choice of providers and various nonmedical amenities, such as the choice of private versus nonprivate rooms, and the general upkeep of the physical plant (Miller 1996). Together, these forms of competition threaten safety net providers' private-pay patient base. However, such competitive forces also increase competition for Medicaid patients as the downward pressure on prices associated with penetration of managed care in the private market increases the relative level of reimbursement for Medicaid. As mentioned previously, changes in Medicaid revenues also threaten safety nets, as these revenues have traditionally been used to subsidize the costs of the uninsured.

According to local observers, the factors that contribute most to the level of competition include the penetration of private managed care, the concentration of market share among providers, and the presence of for-profit providers. Table 5 provides measures that track two of these three dimensions of market competition—the penetration of managed care in the metropolitan area within which the community resides and the presence of for-profit inpatient institutions in the county within which the community resides—as well as a summary measure of competition.[9]

While safety net providers indicated that competition was high in all communities, communities did vary in the degree of managed care penetration and the presence of for-profit providers. In nine of the study communities, managed care penetration was higher than the national average. In Miami, Tampa, and Los Angeles, the penetration rate was almost double that of the national average. In California, Florida, and Texas, for-profit competition in the hospital industry was significantly higher than the national average. In the remainder of the states, it was virtually nonexistent.

The final column in table 5 provides an aggregate measure of competition in each community. For providers in Los Angeles, Oakland, San Diego, Miami, and Tampa, in which commercial managed care and for-profit presence were high relative to the national average, competition, and the impact on safety net providers, was likely to be greater. Competition was also likely to have been relatively high in sites with either a high degree of managed care penetration or a significant for-profit presence, such as New York or El Paso. In states such as Michigan and Mississippi, where the penetration of managed care was low and there was not a significant for-profit presence, competition was relatively limited.

Federal and State Financial Support for the Safety Net

Federal and state subsidy programs for both ambulatory and inpatient care providers are used by institutions to cover the difference between Medicaid payment and Medicaid costs and to cover the costs of the uninsured. In addition, these funds can be (or can free up resources to be) used for infrastructure upgrade and the development of ambulatory care capacity, information systems, and managed care capacity, all of which are essential to hospitals attempting to compete in both the private and Medicaid markets. Providers in states with smaller subsidy programs are potentially exposed in ways providers in other states are not, as they must rely more extensively on other revenue sources to meet the demands of their mission and the changing market.

DSH Subsidies for Inpatient Providers

State Medicaid DSH programs are the primary method for states to directly subsidize hospitals. As of 1996, California and New York had very large DSH programs, over $2 billion (see table 6). States such as Minnesota and Wisconsin have very small programs. Table 6 also illustrates that the share of these expenditures designed for the provision of acute medical care is generally smaller, as some states—such as Michigan, New York and Texas—use some DSH funds to fund mental health institutions.

However, aggregate non–mental health DSH expenditures can be a misleading indicator of safety net support, as the need for these resources and program characteristics vary considerably across states. For example, if the state funds its program through a broad-based tax rather than an intergovernmental transfer program, then the costs of the program are spread out over a broader group of institutions and generally more funds are available to the program. In addition, the formula for distributing these dollars—especially the extent to which the state targets hospitals providing the most charity care—has a significant impact on the subsidy.[10] Finally, some states have developed supplemental payment programs, called "DSH-like" payments, that are not included in these data on

DSH expenditures.[11] The characteristics of each state's financial support for inpatient safety net providers are listed in table 6.

These program characteristics can have a significant impact on the extent to which the state actually supports the safety net mission to provide ambulatory and acute care services to low-income populations.[2] Ideally, an analysis of financial support would track the flow of funds to each safety net hospital and in so doing account for all these factors. However, such hospital-specific information is not available. The final column of table 6 provides an indicator of the overall level of financial support, given the state's program characteristics. Non–mental health expenditures per uninsured person relative to the national average is used as the basis for this classification, and the actual level of financial support can increase or decrease based on program characteristics that either increase or decrease the level of support that safety net providers likely receive.

As the final column in table 6 indicates, California, New York, and Massachusetts are the only study states that provide high levels of financial support to safety net providers. In New York and Massachusetts, despite the fact that a significant portion of federal matching revenues is kept by the state, the size of the programs is sufficient to ensure that a large amount of money is distributed to hospitals. Furthermore, both the funding mechanism, which ensures that the costs of providing care to the low-income population are distributed across all health care institutions, and the targeting of these funds, which ensures that the majority of the money flows to those hospitals with high uncompensated care market shares, guarantee that the subsidies for those safety net hospitals most in need are quite large. Despite slightly lower DSH levels than Massachusetts and New York, and a distribution method that does not target DSH funds specifically to high charity care providers, California has a supplemental payment program that provided approximately $350 million in additional payments to hospitals in 1995.

In Alabama, Colorado,[13] and Michigan, the level of support is lower. In both Alabama and Colorado, the size of the DSH program relative to the need is relatively high and the program is well targeted to charity care providers, yet the proportion given to hospitals is relatively low. As a result, in these states, safety net providers receive a relatively smaller amount of additional revenues beyond the intergovernmental transfers that the state uses to generate federal match. Michigan is an example of a state with a relatively small program but significant DSH-like payments. In 1996, Michigan made more than $600 million in targeted supplemental payments (Coughlin and Liska 1997). In essence, these payments have effectively replaced a large share of its DSH program expenditures.

In the remainder of the study states—Florida, Minnesota, Texas, and Washington—subsidies are very low.[14] Despite a very large program in the aggregate, Texas generates only $301 per uninsured person in non–mental health DSH dollars. While funds have been well targeted at those facilities providing the lion's share of care to the uninsured in the past, because the state allocates these funds on the basis of Medicaid days, and the distribution of Medicaid days has been shifting from safety net to non–safety net providers, subsidies to safety net providers have declined. In Florida, despite the fact that subsidies are well targeted at the largest providers of charity care in the state, the amount of funds available for inpatient providers is very low relative to the national average.

Financial Support for FQHCs

Cost-based reimbursement, federal grants from the Bureau of Primary Health Care (BPHC), and, in some states, special subsidies for ambulatory providers are the primary methods for subsidizing ambulatory services to the uninsured. Since 1989, federal legislation has required that states reimburse FQHCs on a cost basis for services delivered to Medicaid and Medicare enrollees. Evidence suggests that these additional revenues have allowed health centers to expand their provision of care to the uninsured (Ku et al. 1996). In addition to cost-based reimbursement, FQHCs also receive both federal and state grants. In three states—Colorado, Massachusetts, and New York—these state subsidies are distributed through the state's DSH program[15]

Federal grants through the BPHC Section 329 and 330 Migrant and Community Health Center grant program and state subsidies are a significant source of revenues for FQHCs. The BPHC program provided $608 million in funds, and state subsidies totaled $118 million, together accounting for approximately 32 percent of FQHC revenues (unpublished Urban Institute estimates). Although the amount of financial support provided to FQHCs varied from state to state, the variation is not as great as that experienced by inpatient providers, in part because lower levels of federal grants seem to be offset by state subsidies.

Together, federal and state subsidies provide an indication of the level of support for FQHCs. FQHCs in Texas received by far the highest federal and state subsidies in 1995 (see table 7). FQHCs in Alabama, Colorado, Massachusetts, and Washington also received subsidies that were higher than the national average in 1995. FQHCs in the remainder of the states receive subsidies that are lower than the national average, but no individual state was a real outlier. Like inpatient providers, FQHCs in states where subsidies are smaller are potentially exposed to financial stress in ways that FQHCs in other states are not, as they must rely more extensively on other revenue sources to serve the uninsured and respond to the changing market.

Local Support for the Inpatient Safety Net

Cities and counties often have an important role to play in supporting the health care safety net, particularly so in cases where federal and state support is not sufficient relative to the need. Some state laws or constitutions

explicitly assign responsibility to local government entities for care of the indigent, as in Alabama, California, Florida, Michigan, Texas, and Wisconsin. As table 8 illustrates, in all but two sites (Jackson, Mississippi, and Seattle, Washington),[16] county or city governments provide some financial support to safety net hospitals.[17] The amounts vary from $14 million in San Diego to over $200 million in Houston. As information from each receiving institution was unavailable, we could not determine what proportion of total revenue these funds represent in all cases. But several reports from site visits indicate that the funds generally represent between 5 and 10 percent of total budgets, with a few notable exceptions. In Houston and El Paso, local property taxes comprised nearly 38 percent and 16 percent of the public hospitals' revenues in 1995, respectively. Miami's public hospital drew nearly a quarter of its budget from local tax sources.

Regardless of the share of total revenues, local funds were reported to be very important to all safety net providers who received them. In Colorado, for example, local revenues represented just 10 percent but were still regarded as important. But they appeared particularly critical to publicly owned safety net hospitals in states with small DSH programs. In communities in Texas and Florida, states with relatively small DSH programs relative to need, a large part of hospital revenues are obtained through taxes raised by local hospital districts.

For half of the 16 sites, there were no significant changes in local funding in the last three years. In the remaining eight, site visit interviews indicated that all of the significant changes in local funding have been downward. Houston's public hospital saw a 70 percent decline in the absolute amount of funds provided by the local hospital district between 1992 and 1995, a result of significant reductions in local property taxes. Before 1995, it was able to absorb these steep cuts because of growing Medicaid patient loads (due to expanded Medicaid eligibility for pregnant women and children), without the pressure of Medicaid managed care or intense competition from other providers.[18] On the other hand, both Dade and Hillsborough Counties in Florida increased their commitments to financially support indigent care in the early 1990s.

What Determines Safety Net Strength or Vulnerability?

Though safety net providers indicated that changes in the market and policy environment threaten their ability to continue providing care to the low-income uninsured, safety net systems in the study sites appeared to be holding steady. Individual safety net providers may be in severe financial straits, and some have even shut down, but the systems that ensure access to care for the uninsured remain firmly in place. How have they maintained their commitment to providing care to the low-income uninsured? The answers are threefold: (1) very few communities have all factors that exert pressure on the safety net working against them at the same time; (2) the majority of providers within safety nets have responded quickly and effectively to the pressures as they have arisen; and (3) states and local communities have responded quickly and effectively to ensure that the safety net will survive.

Varying Levels of Vulnerability

When taken together, these four factors describing the market and policy environment—demand for safety net services, the effects of growing Medicaid managed care enrollment, the strain faced by competition in the private market, and financial support for safety net providers—can help assess the degree to which the mission of safety net systems in different communities could be undermined. Table 9 presents the summary measures developed in previous sections to assess variability in these factors for the 16 study communities. To some degree, the safety net is never fully supported, as the providers are not fully compensated for care to the uninsured. Thus, no matter where they stand relative to the national average, they still will be under some stress. Rather than giving a quantitatively precise estimate of the strain faced by the safety net, the summary measures are designed to provide some indication of which sites are more and which are less vulnerable.

Of note is the fact that no community has experienced a situation in which all variables potentially affecting their viability are working against them. Nonetheless, safety net systems are more exposed to financial strain in areas where there is very high demand for services and high levels of competition or where Medicaid managed care penetration is high or state support is low. Safety net systems in four study states—California, Colorado, Florida, and Texas—meet these criteria. In table 9, these safety net systems are classified as the "most vulnerable" of the 12 study states.

Among these four states, where federal and state support is low relative to need, local support appears to provide safety net providers with a cushion that either directly compensates uncompensated care costs or has so far protected safety net providers from the worst of the competitive pressures. Safety net systems that rely heavily on local taxes may be more vulnerable if their needs increase substantially. Thus, safety net providers in Florida and Texas, which rely on local resources for their provision of care to the uninsured, may be the most vulnerable, as federal and state financial support for the safety net is lower than in the other states.

Though also facing high demand for safety net services, safety net systems in Alabama, Mississippi, and New York are less vulnerable than the previous set of states and are shown as "somewhat vulnerable" in table 9. In Alabama and Mississippi, demand for services is high, yet competition and the penetration of managed care are average or lower compared with the nation. More important, financial support for the safety net is average or higher. In New York, while demand for safety net services is high, the level of competition is not as high as in the other states, and the state has a very large charity care pool for inpatient providers.

Finally, there are those safety net systems that face relatively low levels of demand for their services and generally low competitive forces, which are classified as "least vulnerable"—Massachusetts, Michigan, Minnesota, Washington, and Wisconsin. In Minnesota, though there is a relatively high level of competition, it is offset by relatively low demand for safety net services. In all five cases, low demand has translated into less pressure on the safety net to find other sources to cross-subsidize care for the uninsured. Public support for the safety net relative to need in these communities is generally average, and with the notable exception of Massachusetts, DSH funding tends to be low.

Saving the Safety Net: Provider Response

Another reason safety net systems have been able to maintain their commitment to the low-income uninsured is that safety net providers have responded to changing circumstances quickly and, at least currently, effectively. In fact, safety net providers' responses to changes in markets differ little from those of their non–safety net counterparts. Virtually all providers are making concerted attempts to develop commercial or Medicaid managed care initiatives; reduce costs and increase efficiency; improve the quality of care or service to patients; better manage care for the uninsured; and lobby for financial support at the federal, state, or local level. Even in communities such as Birmingham, where the need to respond to pressure is lower, safety net providers are taking these steps to ensure that they will not be left out of the changing market.

Development of Managed Care Products

To succeed in managed care, many safety net hospitals are developing stand-alone managed care products, developing networks and affiliations to facilitate managed care contracting, and/or directly contracting with managed care organizations to maintain market share. In Miami, Florida, for example, the major public hospital (Jackson Memorial Hospital) has expanded its primary care patient referral base considerably in the past three years and now owns or is affiliated with six primary care clinics. In addition, it expanded an existing managed care plan and created new managed care products to maintain or even increase its Medicaid and commercial capitated markets.

In Seattle, Washington, the largest provider of charity care services, Harborview Medical Center, joined together with the University of Washington and the University of Washington Medical Center to create CareNet, a health plan to serve the AFDC populations. Harborview had previously attempted to align with Group Health, the largest managed care provider in Washington, but was rejected because it had too many specialists on staff. As a result, it created the University of Washington Physician Network (along with the University of Washington), which includes a host of primary care providers (including seven clinics) and serves as the primary care base for CareNet.

Differentiating the effectiveness of inpatient safety net providers' responses is difficult for all but the best and the worst. In Denver, arguably the most well-prepared safety net, Denver Health and Hospitals (DHH) merged its own Medicaid managed care plan with Colorado Access, a network that consists of the primary safety net providers in the Denver metropolitan area, including University Hospital, Children's Hospital, and DHH, as well as the Colorado Community Managed Care Network, which is composed of most of the community and migrant health centers in the state.

On the other hand, the largest safety net providers in Houston and El Paso appeared ill-prepared to deal with anticipated expansions in Medicaid managed care. In Houston, the Harris County Hospital District (HCHD) has no current managed care contracts and no experience contracting with other plans. Moreover, the state has indicated that it has a strong preference for plans that are not Medicaid-only. This is likely to put HCHD—and other safety net providers attempting to create managed care products to retain or enhance their Medicaid patient base—at a significant disadvantage. Thomasson Hospital in El Paso may be even more disadvantaged; it has no ambulatory care capacity and has relied on Texas Tech for patient referrals. For various reasons, Texas Tech physicians have begun to develop relations with private hospitals and are increasingly referring patients to them rather than to Thomasson.

Since they already provide primary care, most ambulatory care providers are actually sought out by managed care plans. In fact, health center executives in many local communities reported being actively and aggressively pursued by hospitals. However, in part in an attempt to maintain their autonomy, community clinics have pursued two major strategies independent of hospital affiliations to maintain their Medicaid patient base: creating their own independent HMOs and forming networks of clinics to improve their bargaining position with health plans. Community health centers (CHCs) in Florida, Michigan, Massachusetts, and Washington formed their own Medicaid managed care organizations, which have won contracts. CHCs in Birmingham, Miami, Minneapolis, Oakland, and San Diego have formed local networks that perform joint purchasing and management of services and, in some cases, develop common management information and fiscal systems and share medical directorships.

Reducing Costs and Increasing Efficiency

As a result of considerable pressure to reduce prices and become more efficient, hospitals generally have been downsizing and have been implementing mergers and joint ventures to reduce redundancies and to achieve

economies of scale in purchasing, administration, and inpatient care (Duke 1996). The Detroit Medical Center (DMC), for example, was in the process of significant organizational changes in 1996. DMC officials announced that they would close two hospitals (Hutzel and Rehabilitation Institute) and cut 2,500 jobs over the next three years. These cuts, in combination with management changes, were designed to save nearly $250 million and reduce costs by 20 percent over three years. In order to maintain its competitiveness as a contract bidder, Puget Sound Neighborhood Health Centers (PSNHC) implemented a strategy to reengineer medical unit costs through information and staff management.

In addition, providers have affiliated or merged with national or local systems in order to take advantage of volume purchasing and reductions in administrative costs. While safety net institutions seem to be at a comparative disadvantage in the struggle to develop networks, they have been successful at participating in networks if not creating their own. For example, both safety net hospitals in the Boston area acquired or merged with other private, nonprofit hospitals, which will expand their patient base to include more private paying patients. In New York, the market was extraordinarily volatile, demonstrated by 19 mergers or affiliations between 1995 and 1997. However, those serving mostly the uninsured and Medicaid were at more risk of being left out of the flurry of network information, acting as network takers rather than network makers. In Milwaukee, the closure of the public hospital (John Doyne Hospital) was in many respects a merger of two facilities, John Doyne and Froedtert (a nonprofit hospital), which led to sizable efficiencies that helped Froedtert take on its new role as the primary safety net hospital.

Improving Quality of Care and Infrastructure

In order to appeal to Medicaid patients, safety net providers must provide the same amenities (or different ones of equal value to patients) as those that the non–safety net providers have developed. One clinic in Colorado, for example, offers continuity of coverage to all family members no matter what their current or future eligibility may be, hoping to gain their loyalty so that they will stay at the clinic rather than seek care at a local for-profit hospital. In Detroit, one clinic was expanding rapidly into a new, modernized building in an effort to transform its image. Similar efforts were being conducted in New York City. Hospitals and health centers in New York were attempting to attract or maintain patients' interest through cosmetic improvements such as reducing the number of beds in hospital rooms, painting facilities, placing artwork on the walls, or improving the external appearance of the institution (Cantor et al. 1998).

Managing Care for the Uninsured

In all study communities, local inpatient safety net providers were developing initiatives to shift more care out of the hospital and the emergency room into ambulatory, community-based sites to improve their ability to manage care for the uninsured. In some cases, these efforts were institutionalized into a managed care "product" for the uninsured. The Los Angeles County Department of Health Services (LACDHS), for example, obtained a special Section 1115 Medicaid waiver that allows it to restructure operations and transform its largely hospital-based medical care system into an integrated system that relies more on primary and outpatient care. As part of the restructuring, Los Angeles County is also developing partnerships with private-sector clinics in order to nearly triple the number of primary care access points for the indigent. In many cases, the 50 or so participating clinics will be getting reimbursed for providing care to the indigent for the first time, albeit at very low rates.

The major safety net institution in Denver—DHH—developed a vertically and horizontally integrated health care delivery system over a 30-year period. The system includes the Denver Health Medical Center, a city-owned hospital, and also operates ambulatory specialty clinics, 10 FQHCs, 10 school-based clinics, a substance abuse detox facility, a local health department, and other important health service units. As a result, DHH can provide care to the uninsured more efficiently. Hillsborough County's (Tampa) Health Care Program, which has linked formerly uninsured patients seeking care in emergency rooms to primary care providers, has reduced emergency room use by program participants by nearly 25 percent and the average length of hospital stays by more than 30 percent. Other sites in which closer linkages between hospitals and community health centers were being developed, or substantially strengthened, at the time of the site visits include Birmingham, Boston/Cambridge, Detroit, San Diego, and Miami.

Lobbying Efforts

Another important strategy for some providers has been lobbying state and federal legislators to maintain support for the safety net mission. In Boston, the two safety net providers—The Cambridge Hospital (TCH) and Boston City Hospital—successfully lobbied the Health Care Financing Administration (HCFA) to support special provisions in MassHealth, the state's Medicaid Section 1115 waiver application, that maintained the level of federal and state funding of their safety net mission. TCH was also successful at ensuring that these supplemental payments would go directly to the hospitals rather than through any managed care organization, as state officials had preferred. Safety net hospitals have also been instrumental in gaining passage of provisions in both state and federal laws that keep DSH payments separate from states' capitation payments to Medicaid HMOs, so that they are paid directly to qualifying hospitals.

Government Efforts to Preserve the Safety Net

The third reason explaining how safety net systems have been able to maintain their mission in the face of increasing pressure is concerted efforts by state and local governments (and, in a few cases, the federal government). In some communities, competitive pressures or increasing numbers of uninsured have converged to create a crisis for safety net systems. For example, in 1995, LACDHS was staring at a projected deficit of $655 million out of its $2.3 billion operating budget, which nearly led to several hospital closures and drastic service reductions. At the end of 1995, Milwaukee's major public hospital closed down. In New York, several hospitals in the Health and Hospitals Corporation were put up for sale. Tampa General Hospital experienced severe budget shortages in the early 1990s and by 1997 had proposed privatization. (Tampa General has since converted to private ownership.)

Yet, in each case, safety net systems (and nearly all of the providers) survived, in large part because of government intervention at some level. In Los Angeles, county officials convinced the federal government to agree to a $364 million bailout, allowing LACDHS to restructure operations on a more gradual basis. Over a five-year demonstration period, the federal government is expected to send over $925 million to Los Angeles County to help stabilize the system's finances, match local funds to serve indigent patients in outpatient settings, and defray costs of the restructuring. In Milwaukee, where the survival strategies of John Doyne Hospital were ineffective, state and local policymakers decided to sustain financial support for a safety net system, despite closing down the major safety net provider. In Tampa, an innovative program developed by the county commissioners to cover the uninsured helped Tampa General Hospital to weather its financial storms.[19] This dramatic, though limited, experience suggests that when push came to shove, federal, state, and local governments were able to preserve the safety net before it collapsed entirely.

There are also less dramatic but still important ways in which local communities have supported their safety net institutions. City or county commissions in Denver and Boston/Cambridge have granted additional authority and flexibility to public providers to operate in an increasingly competitive market. Alameda County developed a new publicly accountable managed care plan that places its public providers in a better position to compete for Medicaid patients. Local officials in four locales (New York City, El Paso, Los Angeles, and Alameda County) have seriously considered selling public hospitals, but community opposition has prevented this from occurring.

Conclusion: The Growing Importance of Public Support

Although an empirical analysis of access to care for the uninsured will have to wait until survey data are available, this qualitative analysis suggests that the safety net systems in these 16 communities, which provide much care to the uninsured, are holding steady despite mounting pressures. In part, the safety net continues to be viable because of fortunate circumstances: In no community studied were the pressures high in all critical areas that affect safety net stability. At the same time, a great deal of credit for success in the face of adversity goes to the quick and effective responses of most safety net providers. Finally, public support has often made the difference between success and failure. In short, the safety nets and the communities within which they reside have adopted various strategies that balance the mission to provide care to the low-income uninsured against the pressures of a competitive marketplace and growing need.

However, there are three important reasons to question the long-term stability of the current balance. First, the approach toward financing the safety net will likely have a significant impact on its future viability. In two states, Florida and Texas, safety net systems facing high demand for services and high competitive forces are very reliant on local resources. In Texas, for example, the state maintains a relatively modest Medicaid program and the DSH program is small relative to the need for those resources; as a result, local areas have been an important source of financial support for the safety net. However, there is reason to believe that local areas will have a difficult time shouldering this burden. In Texas, many local areas are trying to reduce their level of support for care for the indigent. This is in contrast to New York, which balances high levels of demand for safety net services against a comprehensive Medicaid program and very high levels of federal and state subsidies for the safety net. In New York, there is a "safety net for the safety net."

Second, little quantitative information exists regarding the impact of safety net responses to market changes on care to the uninsured. Safety net providers indicated that they have not reduced their commitment to care for the uninsured, but their attempts to reduce costs and eliminate costly services as a result of financial pressures may have reduced comprehensive services to the low-income uninsured. Hoag et al. (1998) found, for example, that FQHCs in states that were implementing mandatory managed care demonstrations through Section 1115 waivers significantly reduced the number of services provided to their patients. The decline in services may indicate less access to services for vulnerable populations or a more appropriate level of service provision.

Third, the pressures that strain the financial base of the safety net are increasing. The implicit cross-subsidy of care for the uninsured is eroding as a result of the federal, state, and private payers' aggressive approach to seeking low-cost care for a defined population that excludes the uninsured. At the same time, the number of uninsured persons continues to increase, because of reductions in employer-sponsored coverage or declines in Medicaid rolls resulting from welfare reform. The coincident reduction in surplus revenues and the growth in the number of low-income uninsured will increase the strain on the safety net considerably. Six years of unprecedented growth in the economy and declining rates of growth in health care costs may end, which would exacerbate the pressures faced by safety net providers.

Where pressures are already intense, this analysis suggests that public support has ensured that a safety net continues to exist, through a variety of direct funding streams and policies that give safety net providers some advantage in the competition for Medicaid patients. In a few extreme cases where failure was imminent, the continuation of a viable safety net was the result of high-profile bailouts by federal, state, or local governments. This pattern suggests that the commitment of government to the safety net will become more critical as competition becomes more intense and the number of uninsured people continues to grow.

But as the uninsured population grows and market competition continues to increase, will federal, state, or local governments maintain or possibly even increase their support in response to growing need? The federal government has recently limited direct support of the safety net through the Balanced Budget Act (BBA) of 1997. The BBA cuts DSH funding, repeals Boren amendment requirements that govern state Medicaid hospital reimbursement, and reduces support for community-based ambulatory safety net providers by phasing out cost-based reimbursement. On the other hand, by enacting the State Children's Health Insurance Program (S-CHIP) last year, the federal government indicated its support for efforts to reduce the ranks of the uninsured. While S-CHIP may reduce the number of individuals seeking care from the safety net, the total impact of these federal changes is uncertain (Ullman et al. 1998). It is possible, however, that funding relative to the need for safety net services will fall, forcing states and local areas to take more responsibility for financing care to the indigent.

Given the variation in state programs, there is likely to be significant variation in state response as well. States that have historically provided support for the safety net are likely to try to adjust their policies to take new pressures into account. For example, California and Massachusetts have implemented programs that either give safety net providers a head start in competing for managed care patients or ensure special payments for safety net hospitals. By contrast, states that have provided less support for safety net providers are unlikely to provide any new support should competition pick up. For instance, in Texas, DSH funds are allocated on the basis of Medicaid utilization patterns, and the state has proved unwilling to change its DSH allocation formula to ensure that payments continue to flow to hospitals serving disproportionate numbers of uninsured persons.

However, there are significant concerns regarding state capacity to provide support. Unlike the federal government, states are subject to constitutional balanced budget requirements that may constrain their ability to support the safety net. The current strong economic climate has benefited both federal and state governments, and state governments in particular are freer to be generous toward the safety net. Should an economic downturn occur, states can only be as generous as their budgets allow. If states were faced with a serious recession, for example, legislatures might cut back on Medicaid eligibility or on state programs for the uninsured, as many states did during the last recession in the early 1990s (Lipson and Gold 1992). This suggests they might also cut back on direct subsidies benefiting safety net providers. There is some evidence that states are currently reducing taxes and fees rather than increasing spending during this period of growth in revenues (National Association of State Budget Officers 1998), even though the number of uninsured persons continues to increase.

If states are limited in the revenues they can raise, local governments may be even more constrained. While nearly all of the 16 communities examined in this study provided some financial support to local safety net providers, local tax bases are fragile. The smaller the unit of government, the more circumscribed it is in raising tax revenues. Safety net systems that rely heavily on local taxes are thus more vulnerable if their needs increase substantially. And communities that raise taxes for indigent care from a city, rather than a county or region, are even more vulnerable, as the tax base they can draw from is even smaller.

Although government policy will need to play an increasingly important role in keeping the safety net viable as competitive pressures or numbers of the uninsured grow, the strategies of the safety net itself will continue to be significant. Governments will not be willing to uphold the safety net if it does not provide care to the uninsured with reasonable efficiency and effectiveness. It remains to be seen whether the very nature of the strategies that safety net providers must adopt, including an emphasis on cutting costs and reducing unprofitable services, will diminish their ability or commitment to serve the uninsured.

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Tables

Table 1. The 12 Study States, Local Sites, and Ownership of Major Safety Net Institutions

State	Site	Ownership of Major Safety Net Inpatient Institutions
Alabama	Birmingham	State and Private, Nonprofit
California	Los Angeles County	
	Oakland County	
	San Diego	State University and Private, Nonprofit
Colorado	Denver	City/County and State University
Florida	Miami County	
	Tampa County	
Massachusetts	Boston	Private, Nonprofit
Michigan	Detroit	Private, Nonprofit
Minnesota	Minneapolis	County
Mississippi	Jackson	State University
New York	New York City	City and Private, Nonprofit
Texas	El Paso	Hospital District
	Houston	Hospital District
Washington	Seattle	County and Private, Nonprofit
Wisconsin	Milwaukee	Private, Nonprofit

Table 2. Demand for Safety Net Services in 12 States

	Factors Affecting Demand for Safety Net Services			Level of Demand for Safety Net Services	
State	Typology of State's Commitment to Low-Income Uninsured[a]	1995 Percent of Poverty Population with Private Coverage[b]	1995 AIDS Prevalence Ratec	1995 Percent of Low-Income Population That Is Uninsured[d]	Demand for Safety Net Services[e]
Alabama	Limited	20.6	15.1	28.5	High
California	Moderate	13.1	35.2	29.1	High
Colorado	Limited	21.5	18	27.2	High
Florida	Limited	14.6	56.9	29.3	High
Massachusetts	Comprehensive	23.1	23.8	22.9	Low
Michigan	Moderate	20.7	12.6	19.4	Low
Minnesota	Comprehensive	24.3	8	19.3	Low
Mississippi	Limited	18.1	16.4	28.2	High
New York	Comprehensive	15.7	68.4	27.3	High
Texas	Limited	12.8	23.9	39.2	High
Washington	Comprehensive	13.2	16.4	24.1	Low
Wisconsin	Moderate	22.1	6.8	19.9	Low
United States		17.3	27.8	24.7	

a. Rajan (1998).
b. Two- year concatenated March CPS files, 1995 and 1996. These files are edited by the Urban Institute TRIM2 microsimulation model. Excludes those in families with active military mem- bers. Poverty population defined as those with incomes less than 100 percent of the federal poverty level.
c. Normandy Brangen, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996.* Washington, DC: American Association of Retired Persons, 1996.
d. Two- year concatenated March CPS files, 1995 and 1996. These files are edited by the Urban Institute TRIM2 microsimulation model. Excludes those in families with active military mem- bers. Low-income population defined as those with incomes less than 200 percent of the FPL. low-income population that is uninsured is above the national average are categorized as high. The remainder are characterized as low.

Table 3. Concentration of Uncompensated Care

State	Site	Concentration of Uncompensated Care*
Alabama	Birmingham	N/A
California	Los Angeles	70–95%[a]
California	Oakland	90%
California	San Diego	38%[b]
Colorado	Denver	47%
Florida	Miami	55%
Florida	Tampa	65%
Massachusetts	Boston	57%
Michigan	Detroit	30%
Minnesota	Minneapolis	NA
Mississippi	Jackson	NA
New York	New York City	32%[b]
Texas	El Paso	66%
Texas	Houston	61%
Washington	Seattle	NA
Wisconsin	Milwaukee	NA[c]

NA = not available.
*Concentration of uncompensated care is calculated as the percentage of total hospital uncompensated care in the hospitals' catchment area provided by safety net hospitals (those providing the most bad-debt and charity care). This is based on most recent figures collected in site visits or on a Lewin Group analysis of 1995 American Hospitals Association data.
a. Baxter and Mechanic (1997) reported 70 percent; site visits indicated that 95 percent of all inpatient care was con-centrated in the safety net.
b. Baxter and Mechanic (1997).
c. Data were unavailable for 1995.

Table 4. Characteristics of Medicaid Managed Care in 12 States

	Percent of Medicaid Enrolled in Capitated Care, June 1996	Other[a] Non-AFDC Mandated Capitation	Special Treatment of HMO Plans Sponsored by Safety Net Providers		Safety Net Pressure[f]
			Yes/No	Type	
Alabama	0	No	NA		Low
California	21	No	Yes	Higher Rates/ Auto-Assignment/Contract Requirements	Medium
Colorado	27	No	No	High	
Florida	26	No	Yes	HMO Licensure/Contract Requirements	Medium
Massachusetts	13[b]	Yes[b]	Yes[g]		Medium[g]
Michigan	25	No	Yes	Auto-Assignment/ Contract Requirements	Medium
Minnesota	33[c]	Yes[c]	Yes	Higher Rates	Medium
Mississippi	0	No	No		Low
New York	23[d]	Yes[d]	Yes	Higher Rates/ Auto-Assignment/Contract Requirements	Medium
Texas	2	No	Yes	Contract Requirements	Low
Washington	54[e]	No[e]	Yes	Contract Requirements	Medium
Wisconsin	30	No	No		High
United States	24				

a. Includes SSI and other non-AFDC groups, excluding income-eligible pregnant women and children.
b. Individuals with severe disabilities or AIDS have the choice of two special HMOs.
c. Aged dual beneficiaries required to enroll in HMO to receive non-Medicare acute care benefits.
d. SSI and medically needy beneficiaries upon federal Section 1115 waiver approval.
e. Proposed for 1999.
f. States in which more than 20 percent of enrollment was capitated and there were no special safety net policies were categorized as states in which managed care penetration was the highest and most likely to significantly affect safety net providers. States in which there was more than 20 percent capitated enrollment and some special safety net policies were categorized as states in whichmanaged care penetration was likely to have an average, or medium, impact. the state is a very aggressive purchaser of health care through its primary care/ case management program. See Holahan et al. (1997).

Table 5. Competition in Study Communities

State	Site	1996 Commercial Managed Care Market Penetration[a]	1995 Percent of Hospitals That Are For-Profit[b]	Safety Net Pressure[c]
Alabama	Birmingham	26.%	0.0	Low
California	Los Angeles	58.9%	42.6	High
California	Oakland	46.9%	15.4	High
California	San Diego	48.5%	16.7	High
Colorado	Denver	41.6%	12.5	Medium
Florida	Miami	72.9%	57.7	High
Florida	Tampa	69.1%	44.4	High
Massachusetts	Boston	54.9%	0.0	Medium
Michigan	Detroit	17.6%	3.8	Low
Minnesota	Minneapolis	38.3%	11.1	Medium
Mississippi	Jackson	0.5%	0.0	Low
New York	New York City	39.%	0.0	Medium
Texas	El Paso	7.9%	66.7	Medium
Texas	Houston	26.0%	64.9	Medium
Washington	Seattle	20.9%	11.1	Low
Wisconsin	Milwaukee	23.4%	6.7	Low
United States		32.2%	14.1	

a. The proportion of the population with private insurance that are HMO enrollees. "The InterStudy Competitive Edge" (1996).
b. Computed based on 1995 AHA data. Based on the county within which the study community resides.
c. States in which commercial managed care penetration and the for-profit inpatient presence were above the national average were classified as states with high levels of competition. States in which either commercial managed care penetration or the for-profit presence was above the national average were classified as having medium levels of competition.

Table 6. Financial Support for Safety Net Providers in 12 States

	1996 Subsidies for Inpatient Providers						
State	1996 Total DSH Expenditures[a]	1996 Non-Mental Health[b]	1996 Non-Mental Health DSH per Uninsured Person[c]	Funding Mechanism[a]	Proportion Given to Hospitals[a]	Targeted at Charity Care Providers	Supplem Payme
Alabama	$417,000,000	$412,413,000	$651	IGT	Low	Yes	No
California	$2,915,000,000	$2,915,000,000	$523	IGT	High	No	Yes
Colorado	$355,000,000	$352,870,000	$753	IGT	Low	Yes	No
Florida	$334,000,000	$184,368,000	$81	IGT	N/A	Yes	No
Massachusetts	$610,000,000	$507,520,000	$764	HRT	Low	Yes	No
Michigan	$438,000,000	$133,152,000	$152	IGT	Low	Yes	Yes
Minnesota	$24,000,000	$21,480,000	$58	GR	High	Yes	No
Mississippi	$183,000,000	$183,000,000	$397	IGT	N/A	N/A	No
New York	$2,917,000,000	$2,491,118,000	$939	HRT	Low	Yes	No
Texas	$1,513,000,000	$1,228,556,000	$301	IGT	N/A	No	No
Washington	$348,000,000	$171,912,000	$285	IGT	N/A	Yes	No
Wisconsin	$12,000,000	$7,800,000	$19	IGT	High	Yes	No

IGT = intergovernmental transfer.
GR = general revenue.
HRT = health- related tax.
a. Coughlin and Liska (1997).
b. Non– mental health DSH expenditures from Coughlin and Liska (1997).
c. Information on uninsured from Liska et al. (1997).
d. States with DSH per uninsured above the national average of $423 were considered, at baseline, high. Program characteristics such as supplemental payments could increase or decrease the level of subsidy to the safety net. See discussion in text.

Table 7. Financial Support for Ambulatory Care Safety Net Providers in 12 States

State	1995 Subsidies for Ambulatory Providers[a] State Grants per User	BPHC Grants per User	Total Federal and State Grants per User	Level of Support by Local, State, and Federal Governments[b]
Alabama	$1	$125	$126	High
California	$25	$69	$94	Low
Colorado	$9	$114	$123	High
Florida	$4	$107	$111	Low
Massachusetts	$77	$56	$133	High
Michigan	$18	$91	$109	Low
Minnesota	$14	$83	$97	Low
Mississippi	$2	$115	$117	Low
New York	$21	$70	$91	Low
Texas	$13	$147	$160	High
Washington	$40	$100	$140	High
Wisconsin	$5	$92	$96	Low
United States	$19	$98	$117	

a. Calculations using Bureau Common Reporting Requirements data, 1995.
b. States in which federal, state, and local support is above the national average are classified as high.

Table 8. Local Funding of the Safety Net in Study Communities

State	Site	Local Support	Local Payments per Low-Income Person in Poverty	Level of Local Support
Alabama	Birmingham	$35,000,000	$542	High
California	Los Angeles	$160,000,000 [a]	$249	High
California	Oakland	NA	NA	NA
California	San Diego	$14,000,000	$52	Low
Colorado	Denver	$21,000,000	$267	High
Florida	Miami	$180,000,000	$1,642	High
Florida	Tampa	$84,000,000	$1,598	High
Massachusetts	Boston	$36,000,000 [b]	$353	High
Michigan	Detroit	$15,000,000	$46	Low
Minnesota	Minneapolis	$18,000,000	$275	High
Mississippi	Jackson	$0	$0	Low
New York	New York City	$60,000,000	$43	Low
Texas	El Paso	$31,200,000	$242	High
Texas	Houston	$205,000,000	$616	High
Washington	Seattle	NA [c]	NA [c]	NA
Wisconsin	Milwaukee	$20,000,000	$148	Low

NA = not available.
a. Baxter and Mechanic (1997) report $224 million in local appropriations in 1995 compared to a reported $160 million in 1996/ 97.
b. Baxter and Mechanic (1997) report $129 million in local appropriations in 1995 compared to a reported $36 million in 1996/ 97.
c. County does not pay for public hospital operating costs but helps defray major construction costs.
d. Low- income individuals defined as the number of individuals with incomes less than 125 percent of the poverty level in 1990 (Bureau of the Census 1991).
e. Sites in which local support per low- income person in poverty in 1990 was above $200 were classified as high-support sites.

Table 9. Factors Threatening Safety Net Systems

State	Site	Demand[a]	Competition[a]	Medicaid Managed Care[a]	Federal and State Support		Local Support
					Inpatient[b]	FQHCs	Inpatient
Most Vulnerable Safety Net Systems							
California	Los Angeles	High	High	Medium	High	Low	High
	Oakland	High	High	Medium	High	Low	NA
	San Diego	High	High	Medium	High	Low	Low
Colorado	Denver	High	Medium	High	Medium	High	High
Florida	Miami	High	High	Medium	Low	Low	High
	Tampa	High	High	Medium	Low	Low	High
Texas	El Paso	High	Medium	Low	Low	High	High
	Houston	High	Medium	Low	Low	High	High
Somewhat Vulnerable Safety Net Systems							
Alabama	Birmingham	High	Low	Low	Medium	High	High
Mississippi	Jackson	High	Low	Low	Medium	Low	Low
New York	New York	High	Medium	Medium	High	Low	Low
Less Vulnerable Safety Net Systems							
Massachusetts	Boston	Low	Medium	Medium	High	High	High
Michigan	Detroit	Low	Low	Medium	Medium	Low	Low
Minnesota	Minneapolis	Low	Medium	Medium	Low	Low	High
Washington	Seattle	Low	Low	Medium	Low	High	NA
Wisconsin	Milwaukee	Low	Low	High	Low	Low	Low

NA = not available.
a. "High" indicates pressure on safety net providers is high relative to other communities based on definitions in previous tables.
b. Includes state DSH programs and charity pools.

Notes

1. The term "safety net providers" usually refers to health care providers that are legally obligated to provide care to persons who cannot afford it (Lipson and Naierman 1996).

2. New Jersey is a study state but is not discussed here.

3. The FQHC and FQHC look-alike classification resulted from federal legislation providing Medicaid cost-based reimbursement to community clinics that met certain criteria regarding community involvement.

4. Whether or not the state maintains a medically needy program is likely a very important determinant of the level of demand that inpatient safety net providers face. Alabama, Colorado, and Mississippi are the only study states that do not have a medically needy program, suggesting that even if the uninsurance rate were low in these states, the demand for uncompensated services could be even higher than in the other states identified as high-demand states.

5. An even better measure is unsponsored care—uncompensated care net of subsidies—as a percentage of total costs. The data to conduct such an analysis, however, are difficult to collect.

6. Safety net providers in states that already experienced low payments under FFS reimbursement are likely to face even greater pressure, as any surplus in reimbursement is likely to be very small. Unfortunately, complete information to evaluate this is not yet available.

7. The 1997 Balanced Budget Act prohibits states from folding DSH payments into HMO rates, but exceptions are

made for states that previously included DSH payments in their rates. The only state among the 12 that includes DSH payments in capitation payments is Minnesota.

8. One option not discussed is for states to maintain cost-based reimbursement for FQHCs. In both Colorado and Wisconsin, FQHCs are reimbursed on the basis of their costs. In Florida, Michigan, and Mississippi, on the other hand, capitation rates to HMOs include FQHC costs. As a result, FQHCs must assert their right to cost-based reimbursement, but if the HMO does not agree to it in the contract, the FQHC's right to bill the state for the difference is subject to various legal interpretations.

9. Information on market share was not available in enough detail to provide an indication of the market share of various providers.

10. As has already been discussed, a related issue is the inclusion of DSH monies in Medicaid capitation rates.

11. These DSH-like payments are reported as a Medicaid service expenditure, not as a DSH expenditure.

12. For a complete discussion of how DSH program factors affect the degree to which hospitals actually receive DSH funds, see Coughlin and Liska (1997).

13. Our site visits revealed that these expenditures from HCFA data include extraordinary payments that were provided to hospitals in Colorado in the early to mid-1990s. As a result, actual expenditures in 1995 were lower. This explains why, despite a subsidy of over $700 per uninsured person, it is considered a medium as opposed to high DSH subsidy state.

14. In both Michigan and California, the state provides DSH-like payments.

15. Unlike the inpatient DSH program, these state funds are not eligible for federal match. Thus, including the outpatient provider subsidies under the penumbra of the state's DSH program likely serves only an administrative purpose.

16. Alameda County provides a sizable amount of direct funding to its hospital system, but the amounts were unavailable from site visit documents.

17. Data on contributions to local health departments were available for just a few sites, so they were not added to the total, so as not to distort the figures.

18. Since 1995, Medicaid payment rates have fallen, competition has increased for FFS patients, and it has lost Medicaid market share to other hospitals. It is unclear how the hospital has fared since then.

19. While the program reduced county costs considerably and initially helped Tampa General, the dedicated indigent care revenues used to cover the uninsured were distributed to a number of institutions, not just Tampa General. This may have contributed to Tampa General's decision to privatize, as funds that were originally dedicated to Tampa General were considerably reduced.

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