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From the Immediate Office of the Secretary
Executive Secretariat

To: CHRIS JENNINGS / DAN MENDELSON

Fax#: 456-5557 / 395-5631

Re: _____

Date: 12/9/98

Pages: including this cover sheet 13

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Comments: JOHN PODESTA RECEIVED THE
ORIGINAL YESTERDAY.

U.S. Department of Health and Human Services
Immediate Office of the Secretary- Executive Secretariat

200 Independence Avenue SW
Washington, DC 20201
Fax: 205-8870 or 205-2135



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 8 1998

MEMORANDUM FOR THE WHITE HOUSE CHIEF OF STAFF

At our recent meeting, you asked for additional information both on a concept that we have been working with to strengthen the health care safety-net and on the characteristics of the adult uninsured population. I am attaching two documents that provide the information that you asked for.

As I stated at our meeting, given the budget constraints that we face this year, it seems unlikely that we will be able to make a significant effort toward covering the 43 million uninsured people in this country. However, with a relatively modest investment, we can make important progress toward strengthening and modernizing the safety-net of health care providers who serve poor, uninsured people.

The concept that we are considering would help build the capacity of the safety-net by (1) assisting safety-net providers to develop and expand integrated systems of care; and (2) addressing service gaps within integrated systems to provide access for more uninsured to a continuum of core health care services. Just as the development of coordinated systems of care has been important for improving the breadth and efficiency of services provided to insured people, the development of strong systems of care among safety-net providers is essential to assuring appropriate access to a coordinated array of necessary services for those who are poor and uninsured.

I look forward to discussing this concept with you more fully after you have had a chance to review our documents.

A handwritten signature in cursive script, reading "Donna E. Shalala", is centered below the text.

Donna E. Shalala

CONCEPT PAPER

December 7, 1998

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

PURPOSE

The purpose of a new initiative would be to increase the capacity and effectiveness of the nation's health care safety-net so that more uninsured people receive needed care, the care received is of higher quality, and the uninsured are served by providers who are accountable for their health.

The health care safety-net is composed of institutions, facilities, and individual health professionals, who individually and collectively, provide a significant volume of health care services either without payment or on a reduced fee basis to those who are uninsured. The nation's health care provider safety-net consists of hospitals; primary care facilities; specialized service providers such as family planning clinics, HIV services providers, community mental health centers, and drug and alcohol treatment clinics; and individual practitioners. Who provides care, how the burden is distributed, how providers are configured and funding streams all vary considerably at the State and local levels.

Among the pressures facing safety-net providers are:

- **Increases in the number of uninsured.** In 1997, the number of uninsured in the Nation stood at over 43 million, an increase of 1.7 million over 1996. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for many 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 poverty. This group--for whom health insurance and health services can be unaffordable--often relies on the safety-net for health care.
- **Lack of insurance coverage for addictive and mental disorders.** Among the insured is a large subgroup that is uninsured for treatment of mental and addictive disorders. About two thirds of the adult population with serious mental health and/or substance abuse disorders does not receive adequate services.
- **Uneven distribution of burden of care.** The burden of providing care to the uninsured is not evenly distributed and safety-net providers report seeing growing numbers of uninsured patients, many with difficult to solve health and social problems. For example,

during the 1990's, community health centers reported that the number of uninsured patients they served grew at a rate more than double the national rate of growth of the uninsured population. Hospital uncompensated care has become increasingly concentrated in the public sector and some health departments have reduced or eliminated safety net capacity.

- **Fragmentation of care.** While many safety net providers have begun to collaborate, fragmentation of services remains a problem. For some services, e.g., mental health, substance abuse treatment, and dental care, there are insufficient providers. These problems are complicated by the fact that many users of the safety net have complex health and other needs.
- **Reduced revenues from Medicaid and other payers.** Changes in the health care system, particularly the growing dominance of commercial managed care organizations in all areas of health care delivery (including in Medicaid), pose immense challenges. While managed care has increased efficiency in the delivery of services to insured populations, it often reduces the capacity of providers to care for the uninsured straining existing relationships at the community level because internal cross-subsidies are no longer available.
- **Lack of capacity to compete for managed care contracts.** Safety-net providers often lack the infrastructure and resources to effectively participate in managed care, and may not always be included in the networks developed for Medicaid and other paying patients. For example, they may lack the accounting systems needed to interface with managed care billing systems. This diminishes the access of safety-net providers to Medicaid and other revenues that support services provided to their insured patients, and inhibits the development of the relationships needed to assure comprehensive, high quality care for the uninsured population and their often multiple and complex health care needs.

Just as the development of systems of 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 comprehensive services, integration of safety-net providers and their patients into mainstream health systems, and strong management and efficient delivery of services to those without means. The effort to create stronger networks is enhanced when it is accompanied by the identification of creative ways of garnering new revenues, particularly for ambulatory care. There are a number of good examples where safety-net providers have successfully created these networks which suggest ways to proceed. Some of these model programs are described below.

STRUCTURE

The initiative would be carried out through a 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 for two purposes: (1) to assist safety-net providers to develop and expand integrated systems of care; and (2) within such integrated systems, to address service gaps so that more uninsured have access to a continuum of core health care services. As we proceed in refining this initiative, we will establish criteria to identify priorities, define uses and allocation of funds, and evaluate proposals. We will also consider steps the Department can take to allow better integration of our existing discretionary grant programs to serve these purposes.

The kinds of activities these grants would support could include:

- development or enhancement of networks or other coordinated arrangements to provide more comprehensive care to low income uninsured individuals;
- design and establishment of the infrastructure necessary to participate in networks or other coordinated arrangements, including assistance with the establishment of financial systems, computer systems, and telecommunications systems necessary to appropriately monitor and manage patient needs and to allow safety net providers to compete effectively in the changing market; and
- financing additional core health services and serving additional uninsured people within integrated systems of care.

Potential grantees would be public or private entities which demonstrate a commitment to and experience with provision of care to uninsured people. Eligible entities would submit applications describing the proposed arrangements to be developed and the intended improvements in health care services and care coordination. Grantees would have to demonstrate that new funds would be used to supplement and not substitute for existing resources. A key goal of the program would be the development of model programs and best practices that could serve as examples for other communities, although grants that seek to develop innovative programs to address particular local circumstances also would be considered.

Potential priorities in funding could include projects which:

- Come from areas where there is a high or increasing rate of uninsurance.
- Have assessed community needs and demonstrate serious involvement among key players at the service level including payers, health plans, providers and community leaders.
- Integrate care of indigent and other at-risk individuals with that of other populations assuring access to quality services.

- Focus on delivering an integrated array of services to uninsured and other individuals drawing on strengths of existing safety-net providers, with a strong emphasis on inclusion of mental health and substance abuse services.
- Integrate service delivery with public health and health promotion and disease prevention activities.
- Commit to developing a means of assuring payment for services and sustainability. Potential sources might include redirection of current funding streams such as DSH or General Assistance or other indigent care programs, existing or new state, county or local resources, and foundation funding.
- Establish systems that effectively manage the care of patients with multiple needs across different care settings:
 - Coordinate and link substance abuse services, mental health services, primary care, specialty and hospital care, and key wraparound services.
 - Link outpatient care and tertiary care to prevent admissions for ambulatory sensitive condition admissions/unnecessary emergency room use.
 - Encourage disease management of chronic conditions, for example by coordinating screening programs and population-based public health services with treatment.
 - Conduct outreach, especially to special needs populations to enhance receipt of preventive services and participation in care.
- Develop data systems that enable tracking of patient care, continuity, finances and health outcomes which make available key data to providers throughout the system and facilitate measurement and improvement of quality.
- Screen users for eligibility for Medicaid and other insurance programs and create seamless transitions to and from Medicaid.
- Coordinate with teaching programs for health professionals.

The intent of these grants is to establish patient-focused systems of care to serve low-income uninsured people. Many of these people suffer from multiple health care problems, and require access to a coordinated set of health care services. For many, however, health services are fragmented and in some cases unavailable, with neither a clear locus of responsibility for the care of individual patients nor a viable "system" for providing care. This grant program seeks to create coordinated health systems that are accountable for the populations they serve that will offer their low-income uninsured patients high quality comprehensive care. Such systems also will enable us to better identify service gaps in the current system and to better target resources to fill those gaps.

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.

ATTACHMENT**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 many 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 to 1/4 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.

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S.2374

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for...
(Placed in the Senate)

`SEC. 23. PRIMARY HEALTH SERVICES PROVIDERS.

`(a) ALLOWANCE OF CREDIT- There shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the product of--

 `(1) the number of months during such taxable year--

 ` (A) during which the taxpayer is a qualified primary health services provider, and

 ` (B) which are within the taxpayer's mandatory service period, and

 `(2) \$1,000 (\$500 in the case of a qualified practitioner who is not a physician).

`(b) QUALIFIED PRIMARY HEALTH SERVICES PROVIDER- For purposes of this section, the term 'qualified primary health services provider' means, with respect to any month, any qualified practitioner who--

 `(1) has in effect a certification by the Bureau as a provider of primary health services and such certification is, when issued, for a health professional shortage area in which the qualified practitioner is commencing the providing of primary health services,

 `(2) is providing primary health services full time in the health professional shortage area identified in such certification, and

 `(3) has not received a scholarship under the National Health Service Corps Scholarship Program or any loan repayments under the National Health Service Corps Loan Repayment Program.

For purposes of paragraph (2) and subsection (e)(3), a provider shall be treated as providing services in a health professional shortage area when such area ceases to be such an area if it was such an area when the provider commenced providing services in the area.

`(c) MANDATORY SERVICE PERIOD- For purposes of this section, the term 'mandatory service period' means the period of 60 consecutive calendar months beginning with the first month the taxpayer is a qualified primary health services provider. A taxpayer shall not have more than 1 mandatory service period.

`(d) DEFINITIONS AND SPECIAL RULES- For purposes of this section--

`(1) BUREAU- The term 'Bureau' means the Bureau of Primary Health Care, Health Resources and Services Administration of the United States Public Health Service.

`(2) QUALIFIED PRACTITIONER- The term 'qualified practitioner' means a physician, a physician assistant, a nurse practitioner, or a certified nurse-midwife.

`(3) PHYSICIAN- The term 'physician' has the meaning given to such term by section 1861(r) of the Social Security Act.

`(4) PHYSICIAN ASSISTANT; NURSE PRACTITIONER- The terms 'physician assistant' and 'nurse practitioner' have the meanings given to such terms by section 1861(aa)(5) of the Social Security Act.

`(5) CERTIFIED NURSE-MIDWIFE- The term 'certified nurse-midwife' has the meaning given to such term by section 1861(gg)(2) of the Social Security Act.

`(6) PRIMARY HEALTH SERVICES- The term 'primary health services' has the meaning given such term by section 330(b)(1) of the Public Health Service Act.

`(7) HEALTH PROFESSIONAL SHORTAGE AREA- The term 'health professional shortage area' has the meaning given such term by section 332(a)(1)(A) of the Public Health Service Act.

`(e) RECAPTURE OF CREDIT-

`(1) IN GENERAL- If there is a recapture event during any taxable year, then--

`(A) no credit shall be allowed under subsection (a) for such taxable year and any succeeding taxable year, and

`(B) the tax of the taxpayer under this chapter for such taxable year shall be increased by an amount equal to the product of--

`(i) the applicable percentage, and

`(ii) the aggregate unrecaptured credits allowed to such taxpayer under this section for all prior taxable years.

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S.2374

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for...
(Placed in the Senate)

SEC. 421. CREDIT FOR COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

(a) IN GENERAL- Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by inserting after section 23 the following new section:

`SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

`(a) ALLOWANCE OF CREDIT-

`(1) IN GENERAL- In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

`(2) APPLICABLE PERCENTAGE- For purposes of paragraph (1), the term `applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each \$5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds \$45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting `\$2,500' for `\$5,000' and `\$22,500' for `\$45,000'.

`(b) LIMITATION- The amount of personal assistance expenses for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of--

`(1) \$15,000, or

`(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year.

In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

`(c) ELIGIBLE INDIVIDUAL- For purposes of this section, the term `eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any

substantial gainful employment activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

`(d) OTHER DEFINITIONS- For purposes of this section--

`(1) PERSONAL ASSISTANCE EXPENSES- The term `personal assistance expenses' means expenses for--

`(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

`(B) homemaker/chore services incidental to the provision of such personal assistance services,

`(C) communication services,

`(D) work-related support services,

`(E) coordination of services described in this paragraph,

`(F) technology and devices necessary to assist an individual in carrying out the activities of daily living or gainful employment activities, including assessment of the need for particular technology and devices and training of family members, and

`(G) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213) of such individual.

`(2) ACTIVITIES OF DAILY LIVING- The term `activities of daily living' means eating, toileting, transferring, bathing, and dressing.

`(e) SPECIAL RULES-

`(1) PAYMENTS TO RELATED PERSONS- No credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b)) to the taxpayer.

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S.2374

To improve the United States private health care delivery system and Federal health care programs, to control health care costs, to guarantee access to health insurance coverage for...
(Placed in the Senate)

`SEC. 24. COST OF PERSONAL ASSISTANCE SERVICES REQUIRED BY EMPLOYED INDIVIDUALS.

`(a) ALLOWANCE OF CREDIT-

`(1) IN GENERAL- In the case of an eligible individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year an amount equal to the applicable percentage of the personal assistance expenses paid or incurred by the taxpayer during such taxable year.

`(2) APPLICABLE PERCENTAGE- For purposes of paragraph (1), the term 'applicable percentage' means 50 percent reduced (but not below zero) by 10 percentage points for each \$5,000 by which the modified adjusted gross income (as defined in section 59B(d)(2)) of the taxpayer for the taxable year exceeds \$45,000. In the case of a married individual filing a separate return, the preceding sentence shall be applied by substituting '\$2,500' for '\$5,000' and '\$22,500' for '\$45,000'.

`(b) LIMITATION- The amount of personal assistance expenses for the benefit of an individual which may be taken into account under subsection (a) for the taxable year shall not exceed the lesser of--

`(1) \$15,000, or

`(2) such individual's earned income (as defined in section 32(c)(2)) for the taxable year.

In the case of a joint return, the amount under the preceding sentence shall be determined separately for each spouse.

`(c) ELIGIBLE INDIVIDUAL- For purposes of this section, the term 'eligible individual' means any individual (other than a nonresident alien) who, by reason of any medically determinable physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, is unable to engage in any substantial gainful employment activity without personal assistance services appropriate to carry out activities of daily living. An individual shall not be treated as an eligible individual unless such individual furnishes such proof thereof (in such form and manner, and at such times) as the Secretary may require.

`(d) OTHER DEFINITIONS- For purposes of this section--

`(1) PERSONAL ASSISTANCE EXPENSES- The term `personal assistance expenses' means expenses for--

`(A) personal assistance services appropriate to carry out activities of daily living in or outside the home,

`(B) homemaker/chore services incidental to the provision of such personal assistance services,

`(C) communication services,

`(D) work-related support services,

`(E) coordination of services described in this paragraph,

`(F) technology and devices necessary to assist an individual in carrying out the activities of daily living or gainful employment activities, including assessment of the need for particular technology and devices and training of family members, and

`(G) modifications to the principal place of abode of the individual to the extent the expenses for such modifications would (but for subsection (e)(2)) be expenses for medical care (as defined by section 213) of such individual.

`(2) ACTIVITIES OF DAILY LIVING- The term `activities of daily living' means eating, toileting, transferring, bathing, and dressing.

`(e) SPECIAL RULES-

`(1) PAYMENTS TO RELATED PERSONS- No credit shall be allowed under this section for any amount paid by the taxpayer to any person who is related (within the meaning of section 267 or 707(b)) to the taxpayer.

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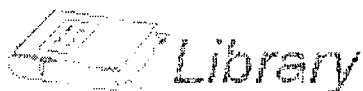
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Supplement
Advances, Issue 1, 1996

The Safety Net: What's Happening to Health Care of Last Resort?

by Julie Rovner

The health care **safety net** is a concept so central to the American way of life that most of us take it for granted. We know that whatever our age, income or insurance status may be, in a real health emergency someone will be there to serve us. In America no one is allowed to die for want of needed medical care. Or are they?

In fact, there is no such thing as an official "**safety net**" for health care. Technically, the **safety net** consists of those health providers who have a legal obligation, under federal, state or local law, to provide free or reduced-fee care to those who could not otherwise afford it, says Sara Rosenbaum, JD, director of George Washington University's Center for Health Policy Research and a professor in the School of Medicine. Rosenbaum is currently working on a Foundation project to develop policy options to ensure health insurance coverage for all children. Federally funded community and migrant health centers are considered **safety-net** providers, as are many public hospitals.

But what most consider the **safety net** includes a much broader array of health care resources. Medicaid, the joint state-federal program that provides health insurance coverage to more than 37 million low-income women, children, elderly and disabled individuals, is a key element of the **safety net**, at least for those who meet its convoluted eligibility requirements. Privately funded entities are an important piece of the **safety net**, too, including free clinics as well as private doctors who treat patients in their offices for free or for nominal fees. And the **safety net** is not just about income, it's also about access to health care in rural and inner-city areas where doctors and hospitals are few and far between.

Only two years ago, the country seemed poised to guarantee health care to every American. Yet today the **safety net** itself is threatened as never before. Both in Washington, D.C., and in state capitals across the country, legislators are in deficit-cutting and budget-balancing modes, and health care, with its dizzying inflation rates over the past two decades, is at the top of their list for reductions. Indeed, the US Congress passed a bill last November that would repeal the 30-year-old entitlement to Medicaid for most low-income people who currently qualify. The bill, vetoed by President Clinton, would have replaced the existing Medicaid with a program of block grants to the states and sharply curtailed the federal government's responsibility to help pay for health care of the poor.

"In the last two years there's been a fairly rude about-face," says Richard Zall, a New York City attorney who represents **safety-net** health providers. Zall is currently working on a Foundation-funded project analyzing options to help remake the **safety net**. "Instead of moving toward greater coverage, now we're moving in the other direction."

But government cutbacks are only part of the threat to the **safety net**. The health care marketplace is remaking itself without government interference, and the new competitive atmosphere is leaving at a considerable disadvantage those hospitals, clinics and other entities that serve large numbers of poor people and people with special health needs. As states seek to save money on their Medicaid programs by requiring beneficiaries to join private managed care plans, **safety-net** providers are increasingly finding themselves robbed of the only part of their patient base that provided a stable source of financing. "The problem for these providers is that, by definition almost, they are not competitive," says Rosenbaum.

What Is the Safety Net?

What we think of as the health care **safety net** is actually a loosely knit network of doctors, hospitals and clinics, both public and private, that provides services to the poor, the uninsured and those with special needs.

In urban areas particularly, the **safety-net** function has fallen to the large public hospitals. These hospitals, notes Larry Gage, president of the National Association of Public Hospitals, "already serve as a 'national health system' by default in most of our nation's urban areas," and provide significantly more than just inpatient care. Between 1980 and 1990, urban public hospitals accounted for only slightly more than 7% of all hospitals, but provided 19% of all emergency room visits and 18% of outpatient visits, nearly half of which were provided to patients who were uninsured and whose care was not otherwise funded through public sources.

The other major source of outpatient care for those who fall into the health care **safety net** are the nation's 550 community and migrant health centers, which provide a vast array of health and social services and collectively serve an estimated 9 million people each year, nearly all of them low-income, and more than a third of them uninsured.

Why Do We Need a Safety Net?

The health care **safety net** is needed for a very simple reason, 39.7 million Americans were without health insurance on any given day in 1994. Assuming current downward trends in employer-provided insurance and changes to the Medicaid program that would prevent expansions in eligibility beyond current levels, that number could rise to 66.8 million by 2002, according to researchers at the Foundation-supported Council on the Economic Impact of Health System Change. Repeated studies have demonstrated that those who lack insurance are more likely to be in poor health, more likely to delay seeking medical care, and less likely to receive appropriate health services than those who have insurance.

And while most analysts agree that even the poor and uninsured should have access to "mainstream" medical care, the fact is, says Rosenbaum, **safety-net** providers are specialists at what they do. "There is a special body of knowledge, whether it's clinical knowledge or legal knowledge or whatever, that goes into doing a first-rate job for patients whose needs are complicated by their poverty," she says. Indeed, most community health centers and public hospitals provide a wide range of medical and other services, including translators, social services, home visits, patient education programs and case management.

Who Pays for Safety-Net Care?

While some of the funding for the care given by **safety-net** providers comes from private insurers and patients themselves, most comes from the government, a combination of federal, state and local tax monies, and virtually all of government is in a cutting rather than a spending mode these days. "Government downsizing is the mantra both at the federal level and in most of the states," says Patricia Riley, MS, director of the National Academy of State Health Policy. Riley has worked on a number of Foundation-funded projects, including serving on the technical advisory committee of the Information for State Health Policy program.

Medicaid is by far the program most associated with the health care **safety net**. The joint federal-state program for the poor covered 37 million individuals in 1995 at a total estimated cost of \$158 billion; \$89 billion of that federal, the remaining \$69 billion from the states. Most of Medicaid spending goes to reimburse providers for services delivered to individuals. But the federal government, through Medicaid, also provides special funding to hospitals that serve a "disproportionate share" of low-income patients; in 1992, these payments totaled more than \$17 billion. Medicare also has its own, separate disproportionate share program for **safety-net** hospitals.

There are other sources of federal funding for **safety-net** health care. Medicare, the federal program for the elderly and disabled, also helps support **safety-net** providers, again, both through direct payments for services rendered and through supplemental payments it makes to support the training of doctors and other health professionals.

In addition to Medicare and Medicaid, the federal government helps pay for the **safety net** through a series of programs that are part of the Public Health Service Act, community and migrant health centers, family planning, maternal and child health block grants, and special programs to prevent and treat AIDS, tuberculosis and sexually transmitted diseases, and to screen women for breast and cervical cancer (see sidebar, **Safety-Net Providers: Who Are They?**).

In past years, important providers of **safety-net** care were hospitals that received construction or other improvement funding from the federal government through the Hill-Burton Act. Originally passed in 1946, when hospital facilities were in short supply in many areas of the country, Hill-Burton required hospitals, in exchange for the federal aid, to provide a set percentage of free or reduced-price care for 20 years to patients who otherwise could not afford care. While no Hill-Burton funds have been appropriated since fiscal 1974, more than 20 years ago, some facilities still have remaining Hill-Burton obligations, either because the construction projects were not finished until the late 1970s or early 1980s (the point at which the 20 years began running), or because they failed to provide the required level of free care and their obligation was extended by the federal government. A few facilities have ongoing Hill-Burton requirements that will continue as long as the facility remains open.

Medicaid represents the largest source of funding for **safety-net** providers from state governments. Indeed, Medicaid is the largest line item in most state budgets, accounting for \$1 of every \$5 states spend. In recent years, Medicaid costs have been rising at double-digit rates, which has helped spur the current backlash against continued federal "mandates" for coverage. Many governors have told the US Congress that if it will take away the federal requirements and red tape, they can run a more efficient Medicaid program even with the proposed federal funding reductions.

Like the federal government, states fund **safety-net** services other than Medicaid. Most states sponsor "bad debt" and charity care pools to help reimburse providers for care provided to the uninsured; they help fund medical schools; they administer the federal National Health Service Corps, which sends health providers to

medically underserved areas; and they operate their own public health programs.

Local governments also play an important role in funding the health care **safety net**. In 1992, counties spent nearly \$85 billion on health care, representing approximately 17% of their budgets.

Of that amount, nearly 40% went to support public hospitals, 5% helped finance the state share of Medicaid spending and 5% went to support local health departments. The remainder paid for health coverage for county workers and retirees. In 30 states, counties are legally responsible for care for the uninsured, according to Thomas Joseph, deputy legislative director of the National Association of Counties. Yet most counties are limited in their ability to raise taxes by state laws or constitutions.

But in the end, it's the **safety-net** providers themselves who are left with the bill for care of those without insurance who cannot afford to pay for their own care.

According to the Congressional Budget Office, hospitals and physicians in 1995 provided an estimated \$28 billion in uncompensated care, up from \$20 billion in 1991. And according to the American Hospital Association, uncompensated and charity care provided by hospitals grew from \$4 billion in 1980 to \$15.9 billion in 1993.

At the same time, however, marketplace pressures have made it more difficult for hospitals to make up these losses. Traditionally, hospitals have paid for uncompensated care by charging paying patients more (through their insurance companies), a practice cost-shifting. But with increasing market competition in the health care sector, insurance companies are not only less and less willing to pay inflated prices for hospital care, they are demanding deep discounts. "The combination of the market push and the fact that insurers are now much more price-sensitive means it's harder to cross-subsidize," says RWJF President Steven A. Schroeder, MD.

What Other Problems Do Safety-Net Providers Face?

A key problem for **safety-net** providers is gaining access to the managed care networks that are rapidly becoming the insurers of choice for those with private or public coverage. "In a world in which your ability to discount your fee determines whether or not you can get into networks, these providers, by definition, can offer very little in the way of discounts," says Rosenbaum. Most analysts agree that the United States has far more hospital beds than needed and could do well with fewer hospitals. But the loss of **safety-net** institutions in particular could have the perverse effect of taking beds from places where they are most needed. "Even people who are insured but have been dependent on institutions in locations that are financially threatened may find it harder to get care," says Schroeder. The loss of **safety-net** providers could also harm more than just the uninsured and those with low incomes. Large public hospitals are often the only source in a region for trauma care, burn units, neonatal intensive care units and other specialized services that are necessary but tend to be money-losers.

And it's not just health care that could be threatened by the loss of **safety-net** providers, in many places they are critical components of the economic base of rural and inner-city areas. "These hospitals are mainstay employers in their communities," says Rosenbaum. "It boggles my mind to think of what losing this economic base would mean for these communities."

Prospects for the Future

The health care revolution now taking place could actually help some of those who currently rely on the health care **safety net**. "As the market gets tighter, the fact that you do have a guaranteed payment for Medicaid patients becomes much more attractive at the margin in a system with excess capacity," says Schroeder. "There's going to be more competition for Medicaid patients and you could spell out a scenario where the Medicaid population might get better care."

At the same time, says Schroeder, providers used to a "captive patient population" may find themselves having to improve service or else face extinction. "So if you're a patient, you may find that the clerks answer the phone better, that it's easier to get an appointment, that the nurses' aides are more pleasant," he adds.

Another potential benefit of the current reexamination of the **safety net** is that various elements may work together more efficiently and effectively. In many areas, for example, public hospitals and community health centers are joining together to provide "integrated service delivery networks" aimed at delivering care that is not only more cost-effective, but more medically appropriate. In New York City, where there are too many hospitals but not enough access to primary care services, the RWJF-funded Primary Care Development Project is using private money and tax-exempt bonds to help develop health care centers in underserved areas.

But there is a real danger that despite the best intentions and overcoming long-standing antipathies, the money simply won't be enough to serve all of those who need care. "**Safety-net** providers don't have the same resources or access to technology and capital that mainstream providers do," says Zall. "At some point, aggregate dollars are required if you want to provide basic services."

Even more ominous is that it could be years before the effects of a disappearing **safety net** become obvious. "There are a lot of different determinants of health status, and medical care's only one," says Schroeder. "When there is a gradual erosion of medical care to the uninsured, it takes a while before this starts showing up in terms of higher infant mortality rates, greater rates of measles and other indicators. We're going to have to watch very carefully the impact of all these changes, because there is a scary possibility that people could be hurt."



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Chronic Care in America: The Health System That Isn't

Carol Levine, a middle-class, middle-aged, urban woman is coping with a daily challenge she never anticipated but one that millions of others share. She is caring for -- and paying for the care of -- a husband who suffered severe brain damage and paralysis seven years ago in an auto accident.

She marvels at her husband's survival -- but despairs that the health care system that took extraordinary care to save his life seems indifferent to his ongoing existence as a totally dependent individual and to her responsibilities as a caregiver.

"It is ironic that in the hospital everybody has a title and a job description," says Levine. "God forbid you should give the patient an aspirin, because only the nurses are allowed to give medications. But the day you go home you are supposed to be able to provide or pay out of pocket for all the care, all the time, with no backup and precious little support."

Levine has excellent private health insurance through her job. That insurance pays for doctor bills and would pay for hospitalization for an acute illness. Her husband also qualified for Medicare benefits after two years of disability. Nonetheless, neither policy pays for the basic long-term home care her husband needs for survival.

What drives people crazy is the irrationality of the "system," Levine says. She is unable to get insurance reimbursement for essential services like feeding, bathing, transferring her husband from bed to wheelchair, prevention of bedsores and the like. These services, and the disposable supplies they require, are paid for in institutions but not at home. She explains: "You learn that insurers have a different language from the one ordinary people use. These services 'are not medically necessary.' They come under the dreaded rubric of 'custodial care.' But should my husband need an injection, that requires skilled nursing and would be covered."

The Levines' experience is not unique. Chronic care in America is unplanned and unformulated -- and not working for the millions of citizens with chronic conditions, many of which are disabling.

Additionally, a number of trends -- an aging population, a growing demand for chronic care services and increasing cost pressures -- are making it harder to meet the needs of patients, families and providers.

What it's going to take, say many experts, is a redesign of the system, with a focus on financing first.

A Growing Population with Chronic Conditions

Chronic conditions include such illnesses as AIDS, diabetes and heart disease; impairments such as blindness and retardation; developmental disabilities such as cerebral palsy; and injury-related impairments such as spinal cord injuries.

Their prevalence and impact is "staggering," says Dorothy Rice, ScD (Hon.), professor emeritus, School of Nursing, University of California, San Francisco. Research by Rice and her team at the university, recently published in *The Journal of the American Medical Association* (November 13, 1996; Vol. 276, No. 18) and detailed in a new Robert Wood Johnson Foundation publication: *Chronic Care in America: A 21st Century Challenge*, found that almost 100 million people have one or more chronic conditions.

While it is true that the elderly are more likely to have a chronic condition, they only represent about one-quarter of all people who live with chronic conditions. Of the 41 million people in 1995 who had conditions that caused limitations and disabilities, fewer than one-third were elderly. And of the 9 million people with disabilities requiring personal care or home management assistance, more than 40% are under age 65.

Demand for chronic care is growing. In 1987, 22 million Americans were identified as having chronic conditions that caused a major limitation of their activity. By 1993, that number had increased by more than 20% to 27 million. By 2020, it is projected that 134 million people will have chronic conditions, and 39 million will have a limitation in major activity.

Cost Pressure

Chronic care already consumes the largest share of US health care expenditures. In 1990, \$425 billion in direct medical costs -- nearly 70% of the nation's expenditures on personal care -- went for people with chronic conditions. Rice's team further calculated that indirect costs, reflecting lost productivity, were an additional \$234 billion. "We haven't taken into account all the indirect costs," Rice says. "We couldn't estimate the lost productivity for caregivers who are unable to work. This is an indirect cost and an important one."

Of the \$425 billion in direct medical costs for chronic care, \$272 billion went for hospital care and physician services that reinforced the system's emphasis on acute incidents. "The challenge we have got to recognize is that our financing of medical care is structured for dealing with acute care problems," Rice says. "We have to change that to think in terms of people with chronic diseases."

An Opportunity for Change

Experts predict a great deal of change will occur in chronic care delivery, largely as the result of managed care arrangements coming to dominate delivery systems.

One of the biggest pushes toward managed care is coming from the states. "They have come to believe that it is a way of containing costs for their Medicaid programs," says Stephen A. Somers, PhD, national program director of RWJF's Strengthening the **Safety Net**: The Medicaid Managed Care Program. "Some states believe that they will be able to provide better care, with more continuity."

But most states have little experience in designing managed care for people with special, chronic needs, Somers says. "People with mental illnesses, physical disabilities, elderly who need long-term care -- this is breaking new ground for the

most part."

Somers' program is intended to help states that have already chosen to adopt the managed care approach to design systems that can more effectively meet the needs of these people. This includes providing information required to consider whether to "carve out" special needs populations and design plans specifically for them, to set capitation rates and do risk adjustments, and to educate consumers about managed care arrangements. "Where managed care is mandated for all of these populations," Somers says, "we want to try to make it work as well as possible for those who now must depend on it."

Integrating Acute and Long-Term Care Services

As the new systems of care are being developed, "the biggest challenge is to develop systems that meet social as well as medical needs," says F. Marc LaForce, MD, national program director of RWJF's Building Health Systems for People with Chronic Illnesses.

LaForce says that in many states, people with chronic conditions often "manage very poorly until an acute event intervenes. The opportunity to use funds to provide home-based services is not available. The tragedy is that in a lot of states, there just isn't very much Medicaid money put into those services."

Restructuring the financing has to come first, he says, adding, "Innovative service arrangements just won't work if we haven't solved the financing piece."

According to LaForce, risk-based reimbursement is what is needed. This scheme recognizes that the higher-need patient who is chronically ill will consume more health care resources than the average patient, and so it provides a correspondingly higher reimbursement rate. The higher rate is necessary to fully integrate social services with medical services.

"The second step, once financing is there, is an educational process based on information derived from demonstrations," LaForce says.

Integration and Team Work

Because many patients with chronic conditions have multiple and complex needs, many experts see the team approach as critical in the future vision of chronic care. "There is a distinction between a service delivery model that tries to coordinate services better and a true team-based approach," says Thomas E. Hamilton of the Wisconsin Department of Health and Social Services.

The Department is a grantee under RWJF's Building Health Systems for People with Chronic Illnesses Program. It is developing two managed care models that will integrate acute and long-term care services through community-based organizations. One model serves the elderly and the other is for people with physical disabilities.

"In a fee-for-service model, each provider is only responsible for their original line of care," he says. As in fee-for-service, patients in the Wisconsin models have their choice of physician. The community-based organizations put together a care-giving team. That group then works with the patient's physician to develop a comprehensive plan.

"Part of the development of the comprehensive care plan is to meet with the

participant -- in their home, if possible -- to identify their strengths, their disabilities, their lifestyle preferences and the capabilities of their informal support network," Hamilton says.

To emphasize their level of involvement in their own care, patients in the Wisconsin models are known as participants. "We try to make all activities support individual preferences," he says.

In one case, a younger participant with a spinal cord injury had difficulty breathing and needed a bronchodilator to make it easier for her to breathe. The medication was being mixed with saline and delivered through an inhaler. But her home health aide was not qualified to handle the medications and the cost of a nurse to do the work was prohibitive. The participant was on the verge of being put on a respirator or placed in a nursing home.

"All the actors came together and they didn't focus on the services, they focused on the outcomes that the participant wanted to achieve -- to not be on a ventilator and to not be in a nursing home," Hamilton said. The solution was to switch the medication to a pill form that could be more easily administered.

"In the fee-for-service system, each service provider was acting independently," Hamilton says. "Everybody had their own narrowly defined set of responsibilities, but nobody had responsibility for the whole person."

But even if states move toward more integration through better financing schemes, there won't be enough money to pay for chronic care for all those who need it. "As a nation, we are woefully unprepared for the implications of the baby boom generation's pending retirement," says Hunter McKay, deputy director of RWJF's Program to Promote Long-Term Care Insurance for the Elderly. "The public sector will be woefully inadequate."

As an example, McKay points out that the over-65 population of New Hampshire will triple in the next 15 to 20 years, while the state's total population will stay the same.

"It is highly unlikely that public funds will see an equal increase," he says. "There will be an inevitable shift from public sector to private sector financing."

Most people don't realize that state programs do not cover people for catastrophic long-term care expenditures unless they become indigent, McKay says. Long-term care insurance is available in most states -- and the products have improved dramatically over the past few years -- but sales have been slow.

"The distribution system for these products has got to change," he says. "The policies are currently sold one-on-one in three or four different trips to someone's home. That's an extremely expensive way to sell a policy. You ought to be able to get a policy through your workplace."

The growing demand for chronic care is a sleeping giant that may well force structural changes on the American health care system. With demand increasing for certain kinds of services, and frustration increasing as more and more middle-aged Americans find themselves faced with the puzzle of caregiving, public awareness of the limitations of the current system will escalate. At some point, under this pressure, public and private financing mechanisms are likely to begin changing. If support is maintained for diverse and promising experiments of better models for caring, at some point in the future the acute care system may be better able to adapt to the needs of people with chronic conditions.

For the foreseeable future, however, the Levines and millions of others -- young and old, middle class and poverty- stricken alike -- will continue to make do, and patch together their home care, transportation, social support and other needs on a catch-as-catch-can basis.

-- Ellen Freudenheim with Paul Tarini

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What Types Of Hospitals Form The Safety Net?

Despite public financial support, safety-net hospitals are in a worse financial position than other hospitals are.

by Linda E. Fishman

ABSTRACT: This analysis describes hospitals that provide large amounts of uncompensated care and hospitals with sizable teaching programs, using data from the American Hospital Association. Despite current public financial support mechanisms, safety-net hospitals have a lower average total margin and a greater percentage with negative total margins than other groups of hospitals. For graduate medical education, however, the current public financial supports have assisted teaching hospitals with the largest training programs in maintaining their financial viability, although teaching hospitals' average total margins remain below those of nonteaching hospitals.

MANY TYPES OF PROVIDERS and organizations constitute the broad health care safety net that supports the delivery of health care services to a variety of vulnerable populations. However, health services researchers, analysts, and policymakers have focused their attention primarily on the role of the nation's hospitals in forming a safety net of care for those who cannot pay for it and in providing services that may be viewed as public goods, such as medical education, unique or specialized patient care services, and community programs.

Many hospitals claim to be part of the safety net. Every year hospitals provide uncompensated care worth billions of dollars, maintain the facilities for educating thousands of physicians and other health professionals, provide the environment for hundreds of scientific and biomedical discoveries, and improve the lives of millions of persons through community services. However, there is substantial variation in the concentration and dispersion of responsibility for indigent care and graduate medical education (GME).

As the delivery system transforms into a competitive, price-sensitive structure and constraints are placed on public spending, policymakers are concerned about how well the safety net is holding up and what types of hospitals might fall through holes in the fabric. This analysis identifies and describes the characteristics of hospitals that consti-

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tute a safety net for uncompensated care. Another analysis depicts hospitals that maintain substantial commitments to physician training. Public policymakers at the national, state, and local levels may wish to consider these characteristics in formulating strategies for supporting these institutions' missions as they cope with changes in public financing and market transformation.

Data And Methods

With access to limited 1994 data from the American Hospital Association's (AHA's) Annual Survey of Hospitals, 5,229 nonfederal, short-term general hospitals, referred to hereafter as community hospitals, were arranged into deciles according to the ratio of each hospital's uncompensated care costs to its operating expense percentage to determine the distribution of uncompensated care.¹ Uncompensated care costs were defined as charity care charges (reduced by each hospital's overall ratio of costs to charges) and bad-debt expense. Three aggregate financial measures were calculated for the 523 hospitals in each decile: the extent to which each of the ten groups relied on patient care revenue, the average total margin, and the percentage of hospitals within each decile that reported a negative total margin.² Patient care revenue in this analysis excluded tax appropriations and other operating revenue not generated from health care services. To determine the types of hospitals that rendered the most uncompensated care, the characteristics of the 523 hospitals in the decile with the highest uncompensated care percentage were compared with those of the remaining 4,706 hospitals on urban/rural location, region, ownership, and patient/payer mix. This approach has been used effectively in several analyses by the Prospective Payment Assessment Commission (ProPAC).³

The same steps were repeated for a GME analysis of 1,010 hospitals that reported having one or more residents on the AHA survey. Using the average number of residents as the measure of involvement in GME, individual decile groups of 101 teaching hospitals were constructed.⁴ Because provision of uncompensated care and involvement in GME often are closely linked, the hospitals that appeared in the highest-concentration deciles for both uncompensated care and GME were analyzed to determine their characteristics.

Safety-Net Hospitals

Uncompensated care is highly concentrated among a certain group of institutions. The 523 hospitals in the decile with the most uncompensated care carried burdens that were almost twice as heavy as those in the next lowest decile (with an average ratio of 15 percent versus 8 percent, respectively) (Exhibit 1). The top decile

EXHIBIT 1**Distribution Of Uncompensated Care Provided By Hospitals, 1994**

Decile (from highest to lowest)	Average percent of total operating expenses that is uncompensated care	Average percent of patient care revenue	Average total margin	Percent with negative total margin
1	15%	89%	1%	34%
2	8	94	3	29
3	6	93	4	26
4	5	96	5	19
5	5	95	3	25
6	4	95	4	21
7	4	95	5	17
8	3	94	5	16
9	2	95	4	17
10	1	90	4	20

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

NOTE: N = 5,229 hospitals.

relied somewhat less on patient care revenue than other deciles did, had a substantially lower average total margin, and had a more significant percentage of hospitals with negative total margins than the other nine deciles had. In examining the characteristics of the highest-distribution decile compared with those of the other nine deciles, a profile of the safety-net hospitals for uncompensated care emerged.

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Location. Uncompensated care is not strictly an urban problem. Small rural hospitals are important in the fabric of the safety net. Although more than half of the safety-net hospitals were located in urban areas or Metropolitan Statistical Areas (MSAs), hospitals with fewer than fifty beds in rural areas were disproportionately represented (22 percent) in the highest decile compared with only 16 percent in the other nine deciles (Exhibit 2). While the analysis did not permit separating MSAs into inner-city and suburban com-

EXHIBIT 2**Uncompensated Care Safety-Net Hospitals: Urban/Rural Location**

Location	Percent in highest decile (n = 523)	Percent in all other deciles (n = 4,706)
MSA	55%	58%
Rural (fewer than 50 beds)	22	16
Rural (50-99 beds)	13	13
Rural (more than 99 beds)	10	13
Total	100	100

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

NOTE: MSA is Metropolitan Statistical Area.

ponents, hospitals in the 100 largest cities comprised 21 percent of the top decile but only 18 percent of all of the other deciles.

Region. Uncompensated care is concentrated in southern states with relatively restrictive Medicaid programs and many tax-supported small public hospitals. Almost 60 percent of hospitals in the top decile were located in the South Central region of the country stretching from Kentucky to Texas and Oklahoma. The South Atlantic states, from Delaware and Maryland along the Eastern Seaboard down to Florida, also were overrepresented in the top decile, whereas hospitals in the Great Lakes, Western Plains, and Pacific states were notably underrepresented (Exhibit 3).

Ownership. Public hospitals are important components of the safety net, but many private not-for-profit hospitals also provide substantial amounts of uncompensated care. Slightly more than half of all hospitals in the top decile were owned by nonfederal government entities, including state, county, city, or hospital district authorities. State-owned hospitals are primarily teaching hospitals that are under common ownership with a public university. A substantial percentage of private hospitals, which includes church-sponsored and private hospitals that probably receive little funding from state and local governments, maintains a relatively heavy uncompensated care burden (Exhibit 4).

EXHIBIT 3**Uncompensated Care Safety-Net Hospitals: Region**

Region	Percent in highest decile (n = 523)	Percent in all other deciles (n = 4,706)
New England ^a	2%	5%
Mid-Atlantic ^b	9	11
South Atlantic ^c	11	8
Southeast ^d	27	14
Great Lakes ^e	5	16
Western Plains ^f	3	15
Middle South ^g	32	12
Mountain ^h	5	6
Pacific ⁱ	6	13
Total	100	100

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

^a New England includes ME, NH, VT, MA, RI, and CT.

^b Mid-Atlantic includes NY, NJ, and PA.

^c South Atlantic includes DE, MD, DC, VA, WV, NC, SC, GA, and FL.

^d Southeast includes KY, TN, AL, and MS.

^e Great Lakes includes OH, IN, IL, MI, and WI.

^f Western Plains includes MN, IA, MO, ND, SD, NE, and KS.

^g Middle South includes AR, LA, OK, and TX.

^h Mountain includes MT, ID, WY, CO, NM, AZ, UT, and NV.

ⁱ Pacific includes WA, OR, CA, AK, and HI.

EXHIBIT 4**Uncompensated Care Safety-Net Hospitals: Ownership**

Ownership	Percent in highest decile (n = 523)	Percent in all other deciles (n = 4,706)
Public municipal, county, or hospital district	50%	22%
State government	4	1
Private	46	77
Total	100	100

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

Payer mix. Service to Medicaid patients accompanies uncompensated care. Although Medicare and Medicaid inpatient days represented about two-thirds of all inpatient days in all deciles, the composition of public payers' inpatient days was quite different. Hospitals with the highest concentration of uncompensated care had more Medicaid inpatient days (31 percent of all days) and fewer Medicare inpatient days (33 percent) than did hospitals in the other nine deciles (19 percent and 46 percent, respectively) (Exhibit 5).

Hospitals Involved In GME

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Graduate education of physicians is concentrated in relatively few of the nation's hospitals. Only about one-fifth, or 1,010, of the 5,229 community hospitals in this analysis had medical residents.⁵ The hospitals with the greatest involvement in GME had an average of 404 residents. Hospitals in the second decile had 143 residents (Exhibit 6). A rough estimate is that these 202 hospitals, taken together, educated more than half (54 percent) of all residents in the country in 1994.⁶ Hospitals that maintain large teaching programs often have additional distinctive characteristics that go hand-in-hand with the presence of GME: highly specialized patient care, such as transplant surgery and regional trauma services, and an environment for clinical research.

EXHIBIT 5**Uncompensated Care Safety-Net Hospitals: Patient Days By Payer**

Payer	Percent in highest decile (n = 523)	Percent in all other deciles (n = 4,706)
Medicare days	33%	46%
Medicaid days	31	19
Other payer ^a	36	35
Total	100	100

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

^a Other payer includes private insurance, welfare payments not covered by Medicaid, self-pay, and other payers.

EXHIBIT 6
Distribution Of Graduate Medical Education Hospitals, 1994

Decile (from highest number of residents to lowest)	Average full-time- equivalent residents	Residents per 100 beds	Average percent patient revenue	Average total margin	Percent with negative margin
1	404	64	88%	3%	22%
2	143	31	88	2	18
3	78	23	91	3	15
4	46	17	91	4	12
5	26	11	93	4	13
6	17	7	93	4	12
7	10	7	93	3	23
8	5	3	94	4	26
9	3	2	94	2	33
10	1	1	94	3	28

SOURCE: American Hospital Association's Annual Survey of Hospitals, 1994.

NOTES: N = 1,010 teaching hospitals. Each decile contains 101 teaching hospitals.

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Teaching hospitals with the most involvement in GME relied less on patient care revenue than did teaching hospitals in the other eight deciles. The average total margins of teaching hospitals were similar across deciles, ranging from 2 percent to 4 percent, and were somewhat below the average for nonteaching hospitals, which was approximately 5 percent in 1994 (data not shown).

When the characteristics of teaching hospitals with the highest distribution of residents were analyzed, several patterns appeared.

Location. The vast majority of teaching hospitals in the top decile were large medical centers located in urban metropolitan areas, often in inner cities. More than 60 percent were in the Northeast, Middle Atlantic, and Great Lakes regions, with a heavy concentration in New York City, where 12 percent of all residents are trained. Many hospitals in the top decile have national reputations for being sites of scientific or medical discoveries.

Ownership. Not surprisingly, more than three-fourths of the teaching hospitals in the top decile have particularly close relationships with medical schools. Typically called "university hospitals" or "academic medical center hospitals," these institutions can be described as being either hospitals under common ownership with a college of medicine at a public or private university or hospitals where the majority of medical school academic department chairs are also the chiefs of service at the hospital.⁷

About half of the hospitals in the top decile were owned by state, county, or municipal governments. State-owned teaching hospitals are under common ownership with medical schools. Municipal and county hospitals frequently are affiliated with medical schools but

are not always as closely tied as is the chair/chief-of-service relationship. Many municipal hospitals with the heaviest involvement in GME are located in New York City. The other half of the hospitals in the most concentrated decile were not-for-profit teaching institutions. A few private, not-for-profit teaching hospitals in the top decile are independent of the chair/chief-of-service relationship but maintain substantial teaching programs.

Double-Duty Hospitals

A small number of hospitals support large uncompensated care burdens while maintaining large teaching programs. Thirty-three of the 101 hospitals heavily involved in GME also were in the top decile for uncompensated care. While there was at least one in every region of the country, sixteen of the thirty-three hospitals (48 percent) were located in the Middle Atlantic and South Atlantic states, and seven (21 percent) were in New York City.

Twenty-eight of the thirty-three hospitals (85 percent) were owned by state, county, or city governments. Twelve hospitals were supported by state governments, and sixteen were supported by county or city governments or local hospital districts. The remaining five hospitals were private, not-for-profit.

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Conclusion

Uncompensated care and GME are highly concentrated among relatively few of the nation's hospitals. Despite public financial support structures for uncompensated care, such as disproportionate-share payments in both the Medicare and Medicaid programs and other support from state and local governments, the 523 hospitals that carried a particularly large uncompensated care burden relative to their operations were in a worse financial position in 1994 than other hospitals were. This raises questions about how well the current support structures are working.

Financial support mechanisms, notably Medicare's direct GME payment and indirect medical education payment and Medicaid's payments supporting GME-related activities, have assisted teaching hospitals by providing reasonable total margins across the continuum of GME involvement. However, the average total margins of all teaching hospitals remain below the total margins of nonteaching hospitals.

As the health care delivery system transforms into a price-driven market for services amid increasing public budget constraints and the general recognition that there is an oversupply of physicians in this country, the policy debate is centered on whether, how, and to what extent society is willing to support the graduate education of

physicians and the concomitant research and specialized service roles of teaching hospitals.

This DataWatch was presented at The Robert Wood Johnson Foundation/Health Affairs/Alpha Center safety-net conference in Washington, D.C., 9 January 1997. The author acknowledges the contribution of Lloyd Wackerling of the Trend Analysis Group at the American Hospital Association, who supplied the summary data, and the helpful comments of James D. Bentley, Richard M. Knapp, David Witter, and two reviewers.

NOTES

1. The AHA classifies data on uncompensated care and other hospital financial measures as confidential. In preparing for a presentation at the January 1997 safety-net conference, James Bentley, senior vice-president of the AHA, and the author had limited access to aggregate confidential data prepared by the AHA's Trend Analysis Group.
2. Community hospitals include nonfederal, short-term general, and other special hospitals that are open to the public. Federal hospitals, long-term care, psychiatric, and chronic disease hospitals were excluded from this analysis.
3. The total margin is the margin attributable to all payers and includes revenue from non-patient care activities, such as investment income.
4. For example, see Prospective Payment Assessment Commission, *The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989*, Technical Report I-91-04 (Washington: ProPAC, October 1991); *The Relationship of Hospital Costs and Payment by Source of Revenue, 1980-1981*, Technical Report I-95-01 (Washington: ProPAC, October 1995); and other related work in ProPAC's annual June reports to Congress.
5. Because the distribution of residents is so heavily skewed, hospitals in deciles six through ten were randomly apportioned to the adjacent deciles.
6. Federal hospitals, which were excluded from this analysis, play an important role in physician education. Both the Department of Veterans Affairs (VA) and the Department of Defense support GME. The VA is the largest single provider of training sites for GME in the United States today and funds about 9 percent of all residency positions each year at about 130 VA medical centers.
7. In 1994, the Association of American Medical Colleges (AAMC), through its GME Tracking Census database, reported 102,168 residents in the United States. The 101 teaching hospitals in the top decile for GME educated 40,804 (101 x 404), or 39.9 percent of all residents. The 101 hospitals in the second-highest decile trained 14,443 residents (101 x 143), or 14.1 percent.
8. The term *academic medical center hospital* often has been used in confusing and imprecise ways. In the AAMC lexicon, all members of the AAMC's Council of Teaching Hospitals and Health Systems (COTH), which constitute almost one-third of all U.S. teaching hospitals but train about three-quarters of all residents, are referred to as "academic medical center hospitals." However, the author uses the definition here to describe what the AAMC labels "integrated academic medical center hospitals" (emphasis added). If a COTH teaching hospital is not "integrated," as defined by the common ownership or the medical school department chair/chief-of-service relationship described in the text, then the COTH institution is called an "independent academic medical center hospital" (emphasis added).

A Profile of Uncompensated Hospital Care

A look at who provides the uncompensated care and the effect market conditions have on it.

by Joyce M. Mann, Glenn A. Mann

ABSTRACT: This DataWatch examines uncompensated hospital care. It shows that uncompensated care has grown by modest growth through 1995. Uncompensated care is established in some regions. Uncompensated care from 1991-1993, a disproportionate share of payments through 1995. The increase in uncompensated care is not to have kept pace with growth. However, the trend data do not show a clear trend.

BECAUSE THE UNCOMPENSATED health care system is a delicate balance of interests, providers to serve the community, particular, serve as providers of legal sanctions against those who do not or urgent conditions. The uncompensated care costs in 1995, which is a testament to hospitals.

Hospitals have been a delicate balance of interests. In this extent, this balance depends on the reimbursement from paying those patients, a practice of these cross-subsidies and care trust funds as part of the through the establishment of some of the costs of care.

Joyce Mann is a resident consultant at the California Institute of Health and Blue Cross Chair in Health Administration and a resident at RAND. Jack Zwanziger (New York) and a consultant

Safety Net

alism and the allocation mechanisms, a safety net is needed in the United States that a segment of the health care and social ends up to the rigors of a care and amount of this by country, dependence, circumstance, and history. Raymond Baxter and his overview, the institutions that constitute a safety net. The transformation of the U.S. and government rewrites the safety net. The shift is placing greater responsibility on the government's shrinking government's role. The shift was reflected in the application to new Medicare and Medicaid. Congress is incorporating the safety net. This volume is largely about the safety net. A commissioned for presentation sponsored by Health Affairs, being critiqued there, external peer review, reissue. (All of the material in the book reviews, Letters, GrantWatch grant and external peer review.) The volume benefited from the support and the guidance of program officer Rosemary for its continuing support. Monthly policy journal, and, editorial freedom.

The Status Of Local Health Care Safety Nets

Is the health care "safety net" in crisis? A look at care in communities across the country.

by Raymond J. Baxter and Robert E. Mechanic

PROLOGUE: As the United States and other nations have embraced market incentives, questions have emerged regarding the sustainability of health and welfare safety nets both here and abroad. Indeed, the recent election of Lionel Jospin as prime minister in France served as a startling referendum by its citizens to its politicians to take more care in preserving that nation's safety net and to move more slowly toward privatization. The United States, which has a much more market-driven system than its European counterparts, faces perhaps an even more complex task in preserving its safety net. Other industrialized nations coordinate their safety-net efforts at the national level, while the American version is really a compilation of safety nets that vary tremendously across communities.

Raymond Baxter and Robert Mechanic of The Lewin Group, a Fairfax, Virginia-based health care consulting firm, present here a snapshot of health care safety nets across the United States. Baxter, as senior vice-president at The Lewin Group, heads the firm's national public policy practice; he also heads the community monitoring initiative of the Center for Studying Health System Change, which is funded by The Robert Wood Johnson Foundation to track health care in sixty U.S. communities. Baxter has more than twenty years of public health experience, including serving as director of public health for San Francisco and as president of the New York City Health and Hospitals Corporation. He holds a doctorate in public and international affairs from Princeton University. Mechanic is a senior manager at Lewin, where he assists health care providers, government agencies, and community groups with financing, reimbursement, and organizational issues. Recently he published a paper on the impact of managed care on clinical research in *Health Affairs* (Fall 1996). He holds a master of business administration degree in finance from the University of Pennsylvania.

ABSTRACT: This paper examines variations in the composition, concentration, financing, and community context of local health care "safety nets" and the market pressures that they face. It also reviews financing mechanisms that support these systems and strategies being undertaken to retain publicly insured patients. As safety-net providers compete more aggressively, the availability of the public health, behavioral health, and social services they provide may be affected. Communities may have to consider more explicit investments in these "public goods" if competitive markets remove existing cross-subsidies.

THERE IS A LONG-STANDING NOTION in the United States, dating back to the nineteenth century, that we should maintain a health care safety net for persons who are uninsured, difficult to serve, discriminated against, or who cannot get care elsewhere. In recent years, however, the desirability of having a health care safety net has been questioned by some, including both advocates of universal health insurance and partisans of a "market" approach to health care. Discussion has turned from the important gap-filling role of safety-net providers to debate over whether they can "compete" or should receive help to "level the playing field."

In the absence of major federal or state actions to broaden health insurance coverage, there has been growing concern that the emergence of a competitive, price-driven health care market will prove detrimental to the viability of the safety net and the populations it serves. This is a difficult issue to address because of the complex and ambiguous nature of the safety net and its wide variation across communities. Furthermore, the lack of consistent data limits systematic evaluation of the impact of changes in public financing, market competition, and organizational structure on the stability and effectiveness of the safety net.

In light of these problems, researchers are beginning to examine the impact of health system change through qualitative studies of communities that vary in their political, demographic, and market conditions.¹ Our own work over the past eighteen months has taken us into twenty-three communities where the role and future of the safety net were part of the focus of our research and consulting.² Drawing on these experiences, we have attempted to update earlier assessments of the safety net and to identify indicators that help evaluate more systematically how it is being affected by health system change. This "work in progress" addresses four principal questions: (1) What is the safety net, and how does it differ across communities? (2) How do pressures from a changing health care environment affect the safety net in different settings? (3) Is the safety net in crisis? (4) What is needed to stabilize the safety net? We conclude with a discussion of the types of data that could increase our ability to track and understand safety-net developments.

What Is The Safety Net?

The term *health care safety net* describes an extremely broad range of providers, services, and populations. The composition of the safety net and the concentration of responsibility for care of the poor vary greatly across communities. The relative contribution of different sources of financing is also quite different across settings. The mix of safety-net services—both personal health and public health—varies considerably, as do the local community environments in which these safety nets operate. It is important to understand these variations because the composition, concentration, financing, and community context all affect evaluation of the questions “Is the safety net in crisis?” and “What should be done?”

■ **Composition.** For purposes of this paper, we define the safety net in any given community as the institutions, programs, and professionals devoting substantial resources to serving the uninsured or socially disadvantaged. Although any provider can participate in the safety net, urban public hospitals, community health centers, some inner-city teaching hospitals, and local health departments are generally considered to be the core safety-net institutions. These organizations assuredly provide a great share of services to the poor. They also provide the lion's share of the data with which some of the questions we pose can be explored. And they have persistently and effectively publicized their safety-net role to government policy-makers and others. But in fact, the safety net extends to a much wider array of providers, services, and clientele.

The mix of services, though dominated by hospital inpatient and outpatient care, is another source of variation in local safety nets. There also are substantial differences in the breadth of mental health, chemical dependency, and health-related social services. The service mix in a given community is closely related to that community's history and expectations. In some, such as San Francisco, Minneapolis, Boston, and New York, a wide array of population-based and personal care services has traditionally been considered essential. In others, such as Phoenix, Syracuse, and Orange County, California, the provision of basic emergency, clinic, and inpatient care seems to be generally viewed as the safety net.

The populations served by safety-net providers range from the uninsured and Medicaid populations to a broader array of vulnerable populations, including persons with acquired immunodeficiency syndrome (AIDS), substance abusers, the frail elderly, low-income children and pregnant women, the homeless, and the mentally ill.

■ **Concentration.** The concentration of safety-net responsibilities also varies from community to community. In some, such as

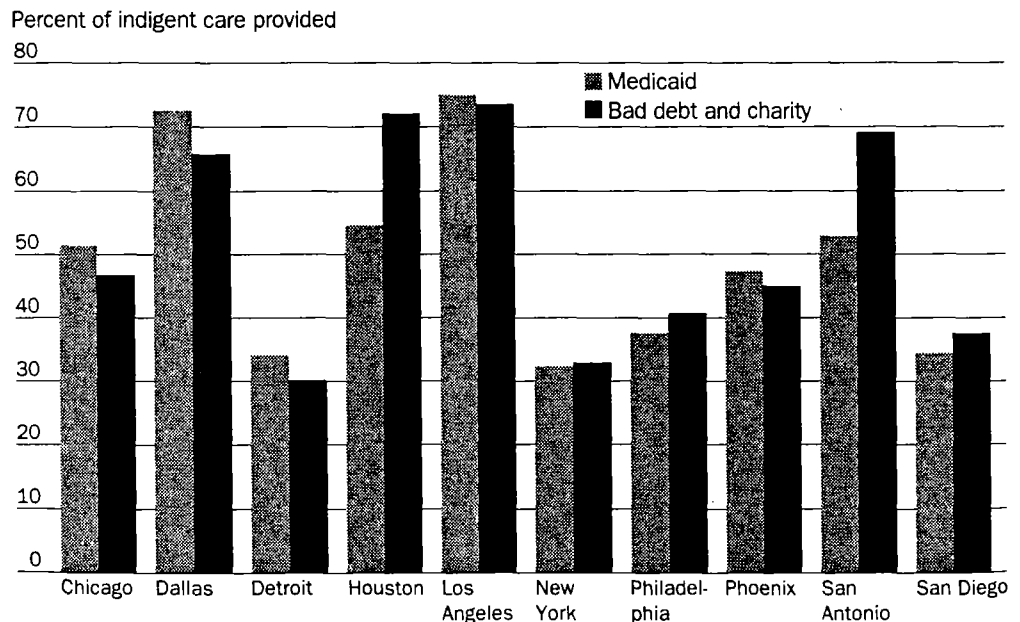
Dallas, a sole public hospital is the core of the local safety net. In others, such as Denver, it is a comprehensive public health and hospital system. Elsewhere, as in Boston, networks of community health centers with private and public mission-driven hospitals exist. In a few places, such as New York and Seattle, many formal and informal organizations share responsibility for safety-net functions, although not necessarily in a systematic way.

One indicator of this is the wide-ranging concentration of hospital indigent care, which varies greatly across large metropolitan areas (Exhibit 1). The top decile of hospitals in 1995 providing the most bad debt and charity care accounted for less than 35 percent of that care in Detroit and New York and more than 65 percent in Dallas, Houston, Los Angeles, and San Antonio. The same 10 percent of hospitals accounted for less than 35 percent of the Medicaid payments in New York, Detroit, and San Diego and more than 70 percent in Los Angeles and Dallas.³

Emergency department use, which also varies greatly, is another indicator of hospitals' safety-net role (Exhibit 2).⁴ The top 10 percent in 1995 provided a concentration of emergency department visits ranging from less than 20 percent in San Antonio to more than 35 percent in Los Angeles and Houston.

■ **Financing.** The mix of resources used to support safety-net

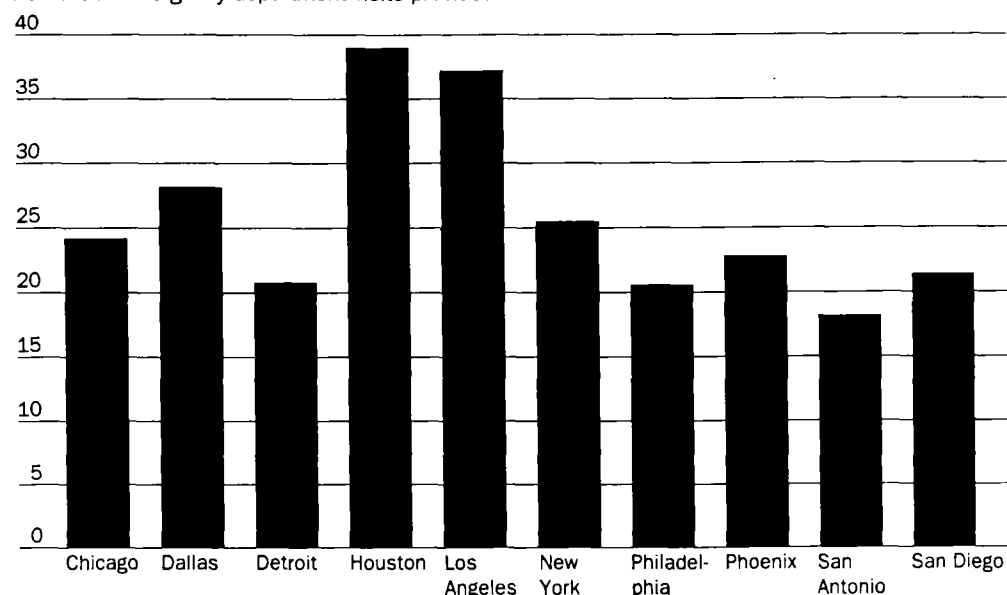
EXHIBIT 1
Concentration Of Hospital Indigent Care Among Top 10% Of Hospitals, 1995



SOURCE: The Lewin Group analysis of 1995 American Hospital Association Annual Survey data.

EXHIBIT 2**Percent Of Emergency Department Visits Provided By Top 10 Percent Of Hospitals, 1995**

Percent of emergency department visits provided

**SOURCE:** The Lewin Group analysis of 1995 American Hospital Association Annual Survey data.

activities is by no means uniform, either. Medicaid and, to a lesser extent, Medicare have been the financial backbone of the safety net in recent years. For example, in 1995, 45 percent of inpatient days in large urban public hospitals were attributable to Medicaid patients and 20 percent to Medicare patients; for outpatient visits, the comparable figures were 34 percent Medicaid and 13 percent Medicare.⁵ Similarly, approximately 38 percent of patients seen in federally qualified community and migrant health centers were covered by Medicaid and 11 percent by Medicare.⁶

In addition to providing the majority of insured patients for many safety-net providers, Medicaid subsidizes a substantial portion of care for the uninsured. According to the National Association of Public Hospitals and Health Systems (NAPH), the three sources of financing in 1995 for the uninsured in its member hospitals were local subsidies (51 percent), Medicaid disproportionate-share hospital (DSH) payments (40 percent), and Medicare DSH payments (9 percent).⁷ Although a similar breakdown is not available for community health centers, 30 percent of their revenue comes from federal grants, and substantial Medicaid cross-subsidies come from mechanisms such as cost-based reimbursement for federally qualified health centers (FQHCs). Other federal sources, such as Medi-

"It is difficult to talk about whether 'the safety net is in crisis,' since there is little consistency across communities."

care's indirect medical education adjustment, have provided substantial revenue for large teaching hospitals with a safety-net role.

Local subsidies have been extremely variable, as have other sources such as state subsidies and grants. But the absolute contribution of indigent care financing sources, and their attendant vulnerability, is not the full story. In addition to differences in the structure of Medicaid and local subsidy mechanisms, the competitiveness of local markets greatly affects the ability to cross-subsidize indigent care and other safety-net functions.

■ **Community context.** Health care safety nets are influenced by local attitudes and politics. Many communities have a strong culture of responsibility for serving the poor, as is evident in cities with long histories of supporting safety-net institutions such as New York and Los Angeles. Others are often less willing to devote substantial public resources to health care for the poor. Community culture is also reflected in and influenced by the presence of organized advocacy groups representing disadvantaged populations. The effectiveness of these groups in mobilizing resources to support safety-net activities and in influencing local politics and the media varies greatly. Finally, some communities have been very successful in influencing federal programs and policies to bring funding into local safety-net programs, which reduces the pressure on state and local resources.

The overwhelming evidence is that safety nets are local. There is no one "safety net" that an observer can point to. The interaction of composition, concentration, financing, and community context defines each local safety net. Thus it is difficult to talk about whether "the safety net is in crisis," since there is little consistency across communities.

To be sure, changes at the national level in Medicare and Medicaid, welfare reform, and health and social service grant funding greatly affect safety nets at the local level. But at least as important are regional and local pressures. Medicaid managed care, for instance, is driven by state policy and regional health care trends; insurance coverage is also a regional economic phenomenon, mediated by state policy. Ultimately, it is local factors, played out in the context of state policies and regional economic trends against the backdrop of federal policy, that determine the nature of local safety nets and their stability or vulnerability.

Are Local Safety Nets In Crisis?

We have attempted to assess the current status of local health care safety nets based on site visits to a range of communities, discussions with experts, and review of available data. It is difficult to make broad generalizations. However, in the course of this research, we have developed a series of questions, which are helpful in assessing community safety nets: (1) What is the level of need for safety-net services? (2) How competitive is the local health care market, and to what degree are private providers competing for patients who traditionally were served by safety-net providers? (3) Do safety-net providers have capabilities that will allow them to compete effectively in the marketplace while maintaining their safety-net mission? (4) To what extent does the community support safety-net providers and services?

Here we present examples from specific communities. We are cautious about drawing strong conclusions about particular communities based on brief site visits and limited data. Nevertheless, as we synthesized observations from twenty-three communities, a number of common themes emerged.

■ **Level of need.** A basic measure of need for safety-net services is the number of persons without health insurance. Other important measures include the percentage of the local population in poverty, the prevalence of certain illnesses, and the rate of underinsurance for services such as mental health care. There is wide variation in the uninsurance rate across major metropolitan areas (Exhibit 3). Factors underlying the uninsurance rate include Medicaid eligibility standards, the existence of publicly subsidized insurance programs targeted to low-income persons, local economic conditions, and unique local population characteristics.⁸

Rates of uninsurance tend to be higher where there are heavy concentrations of small businesses and "underground economy" jobs that do not provide health insurance. The need for safety-net services also tends to be high where there are large immigrant populations who are more likely to be uninsured and to need special services such as translation and assistance in gaining access to health and social services. These populations are most concentrated in New York, New Jersey, Florida, Texas, Arizona, California, and Illinois. Recent federal welfare legislation that limits Medicaid and other welfare benefits available to legal immigrants is likely to increase the need for safety-net services in these states.

■ **Market environment.** One of the most important market trends is increasing competition for publicly insured patients. Safety-net providers are concerned that competitors will "cherry

EXHIBIT 3**Selected Local Market Characteristics Affecting The Safety Net, 1995**

Market	Market characteristic				
	Percent uninsured	Inpatient days per 1,000	Hospital beds per 1,000	HMO penetration	Medicaid HMO penetration
Boston	10.4%	886	3.5	42.1%	11.0%
Dallas	22.1	554	2.8	16.6	0.0
Memphis	14.1	950	3.7	22.4	100.0
Phoenix	15.6	543	2.6	26.3	100.0
Indianapolis	10.8	893	3.7	13.3	3.0
Cleveland	12.1	895	4.0	20.9	53.0
Los Angeles	19.8	594	2.8	39.2	23.3
New York	14.2	1,340	4.5	23.0	13.9
U.S. average	14.5	760	3.3	20.1	— ^a

SOURCES: Lewin Group estimates based on data from the Current Population Survey, American Hospital Association Annual Survey, and InterStudy.

NOTES: Inpatient days include service provided to out-of-area residents in community hospitals only, including long-term care units. Calculations assume 1 percent population growth between 1994 and 1995. HMO is health maintenance organization.

^a Not available.

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**LOCAL
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pick” profitable patients while leaving the uninsured in traditional safety-net settings. Competition is influenced by marketwide provider capacity relative to demand for services. Medicaid managed care adds another dimension by changing the basis of competition from service delivery to coverage. Medicaid patients’ access to safety-net providers may be curtailed unless they are enrolled in managed care plans that include these providers in their networks. The competitive dynamics are also influenced by the degree to which private providers are willing to support the safety-net system. Exhibit 3 presents some indicators of changing local market environments.

In some markets, Medicaid patients are being aggressively courted by private hospitals and clinics for “profitable” services such as maternity services. In Los Angeles, for example, billboards placed near the county’s public hospitals attempt to lure Medicaid recipients into private hospitals for maternity care.⁹ Unfortunately, there are numerous anecdotes but no systematic studies of how many Medicaid recipients have left safety-net providers, for which services, and under what market conditions.

The loss of publicly insured patients threatens the patient volume and revenues of safety-net providers, as well as the availability of special subsidies for indigent care. In Los Angeles, shifting patterns of care have reduced the Medicaid disproportionate-share funding going to the Los Angeles County hospital system from \$387 million in 1991–1992 to \$253 million in 1994–1995, while the amount going to private Los Angeles County hospitals increased from \$98 million

in 1991-1992 to \$230 million in 1994-1995.¹⁰

■ **Marketwide provider capacity.** Excess capacity—measured by high numbers of hospital beds per thousand population, low hospital occupancy, and high physician-to-population ratios—tends to create more aggressive local market competition. Providers that were not interested in Medicaid patients when their waiting rooms were full find them increasingly attractive as patient volume declines. Hospitals with declining occupancy may find that, at the margin, Medicaid patients are profitable, even at rates substantially below average costs.

Markets with excess capacity and low health maintenance organization (HMO) penetration are more susceptible to wrenching future changes than are those that have already experienced substantial restructuring. For example, if inpatient utilization in New York City dropped overnight to the rates observed in Los Angeles, hospital occupancy would fall from its 1995 level of 81 percent to about 36 percent.

■ **Medicaid managed care.** The growth of Medicaid managed care presents both threats and opportunities for safety-net providers. It is a vehicle for private-sector health plans and providers to access the Medicaid funding stream. It also creates pressures for changes in business practices that are threatening to providers that historically have focused on mission. At the same time, it provides opportunities for safety-net providers to attract new Medicaid patients and to serve them more cost-effectively.

Risk-based Medicaid HMO programs, with strong incentives to treat patients in defined provider networks, can have a much bigger impact (positive or negative) on safety-net provider volume and financial status than primary care case management (PCCM) programs, which impose only limited controls on patient choice or service use. Medicaid HMO enrollees can only use safety-net providers in their plan's network. Furthermore, Medicaid HMOs generally are not required to make special disproportionate-share or medical education payments to safety-net providers.

Indianapolis is one market where core safety-net providers appear to have maintained a strong Medicaid presence. While all Indiana Medicaid Aid to Families with Dependent Children (AFDC) recipients are enrolled in "managed care," relatively few are in at-risk HMOs. The first Medicaid HMO in Indianapolis (there are now two) was established by Wishard Hospital (the public hospital) in a joint venture with several other downtown hospitals and affiliated clinics. In contrast, nearly 100 percent of Medicaid recipients in Phoenix are enrolled in capitated health plans through the Arizona Health Care Cost Containment System (AHCCCS). Many of these

plans send few patients to core safety-net providers. In Arizona's most recent 1994 bid cycle, a number of commercial HMOs entered the market, which previously had been dominated by provider-sponsored plans. This has led to substantial deterioration of Medicaid enrollment in the county-sponsored Maricopa Health Plan.¹¹

Some communities have attempted to facilitate participation of safety-net providers in Medicaid managed care through special consideration for plans that contract with safety-net providers in their bid evaluation criteria.¹² Safety-net providers have also been excluded from restrictions that apply to other plans and providers, such as enrollment caps. West Virginia recently implemented a special capitation rate adjustment for Medicaid HMOs depending on the proportion of services provided by publicly supported providers such as health centers, rural hospitals, and local health departments. Although helpful to some, these mechanisms by themselves are not sufficient to level the competitive playing field.

■ **Participation in the safety net.** Many non-safety-net providers support safety-net institutions through caring for underserved patients and providing political and technical support for core safety-net providers. This support is consistent with the missions of many providers, even if they do not serve many uninsured patients. Many also support safety-net providers because they do not want direct responsibility for indigent care and the special service capacity required.

The level and breadth of support are affected by local culture and financing mechanisms. For example, in communities such as Dallas, an understanding that the safety net is concentrated in a core institution (Parkland Memorial Hospital) is often accompanied by strong public and private support. In Dallas, this is indicated by the high proportion of Parkland's operating budget provided by local government sources and by the local provider community's vocal support for its mission.

In other communities such as New York and Boston, there are expectations that a broader range of providers will serve the uninsured, despite the presence of large, public safety-net institutions. This is reinforced by broad-based charity care programs to pay providers that serve the uninsured. In Massachusetts, however, the charity care pool pays higher rates to hospitals with the highest uncompensated care burdens. As a result, Boston's two public hospitals received more than 90 percent of the cost of caring for eligible patients in 1995 compared with an average of about 50 percent for hospitals statewide.¹³

■ **Safety-net provider capabilities.** The future success of safety-net providers is influenced by their operational assets, leadership,

and ability to respond quickly to market change.

Operational assets. Physical plant, staff capabilities, and linkages with other providers are important for safety-net providers to compete effectively. Ownership or strong alliances with outpatient clinics also provide a competitive advantage in attracting Medicaid patients. Contrary to stereotype, many public hospitals and community clinics have attractive physical plants in good locations. For example, through its merger with Boston City Hospital, Boston University Medical Center gained a brand-new hospital building and strong referral relationships with local community health centers.

Leadership. The relative concentration or dispersion of leadership affects the overall strength of the safety net. For example, in Dallas, health care providers, the business community, and elected officials all identify the leadership of Parkland Memorial Hospital as a major factor in its perceived effectiveness. One person, referencing its relatively low per unit costs, referred to Parkland as "good government." Such perceptions have helped Parkland to obtain support from the county Commissioners' Court. In contrast, Los Angeles has a wide range of organizations and individuals that participate actively in the safety net, but conflicting agendas and insufficient communication have contributed to a lack of consensus about how to approach many of that city's health-related problems.

Flexibility. Many safety-net providers face constraints such as Civil Service restrictions on hiring and firing, procurement regulations, and uncertainty about annual budget resources, which limit their ability to respond rapidly to market change. And although today's health care providers are increasingly consolidating to achieve negotiating power and economies of scale, the presence of large public or academic bureaucracies is intimidating to potential partners. Many public and academic institutions are examining their governance structure and implementing changes to create greater flexibility. One of many examples is Denver Health (formerly Denver Health and Hospital Corporation), which recently restructured as an independent public authority to "permit needed flexibility while maintaining a public structure."¹⁴

■ Community support and stability of financing sources.

Support for the safety net can be gauged by community attitudes, the tone of local media reports, the activity and influence of organizations advocating for safety-net populations, and the level of public financial support. One indicator of financial support, the size of the public health care delivery system and level of local funding, varies substantially across communities (Exhibit 4). New York and Los Angeles had the largest public hospital systems in 1995, with budgets two to three times higher on a per resident basis than those of

other large cities. Dallas and Boston had the largest per capita local appropriation for public hospitals. These figures, however, tell only a partial story. Community financial support includes other sources of public funding (for example, charity care pools) and the breadth of local provider participation in the safety net.

The future impact of health system change is affected by the stability of safety-net financing mechanisms. Medicaid DSH payments, which grew from several hundred million dollars in the late 1980s to nearly \$19 billion by the early 1990s, provided a major short-term boost to safety-net providers, but retrenchment occurred with passage of federal legislation in 1991 and 1993 to limit the use of this mechanism. In the interim, some local governments reduced local funding commitments, which are now difficult to revive. Redistributive indigent care financing mechanisms, such as free care pools supported by hospital or insurance assessments, have also come under fire in states such as Massachusetts as the private hospital market has become more competitive. Dedicated revenue sources, such as local hospital tax districts, linked to a broad-based measure, such as local property values, provide more stability. However, developing the political consensus to put dedicated mechanisms in place can be difficult.

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■ **Assessing the viability of local safety nets.** Our general impression from brief examinations of a wide range of communities is that three major elements are needed to sustain strong local safety nets: (1) safety-net providers that are sufficiently competitive and innovative to maintain their traditional base of publicly insured patients; (2) a reasonably stable mix of financing sources; and (3) local markets that are not changing too rapidly for rational restructuring. Many health care executives have noted the need for sufficient time to restructure service capacity, develop information sys-

EXHIBIT 4
Public Hospital System Beds, Budgets, And Local Subsidies, 1995

Market	1994 population	Public system beds	Total revenue (millions)	Local appropriation (millions)	Revenue per resident	Local funding per resident
Boston	3,211	452	\$323	\$129	\$101	\$40
Los Angeles	9,150	2,909	1,796	224	196	24
Phoenix	2,473	474	271	73	110	30
New York	8,584	7,358	3,006	50	350	6
Dallas	2,898	901	397	154	137	53
Memphis	1,056	529	185	25	175	23
Indianapolis	1,462	328	187	43	128	29
Cleveland	2,222	1,000	299	12	135	6

SOURCES: Lewin Group estimates based on data from the National Association of Public Hospitals and Health Systems, the American Hospital Association, and the U.S. Bureau of the Census.

NOTES: Population and bed capacity data are from 1994. Revenue data are from 1995.

tems, and create new linkages among providers. While safety-net providers in slow-moving markets can take advantage of this foresight, there is less time for planning and more opportunity for mistakes for those in the throes of rapid change.

Competitive Strategies

In addition to lobbying to maintain public sources of support, many safety-net providers are working intensively to develop more competitive operations. Specific strategies include improving quality and customer service; increasing efficiency; reducing inpatient capacity and refocusing resources on prevention and primary care; measuring and improving performance; building integrated delivery systems; and developing new partnerships.

Despite notable successes, safety-net providers are not perceived as leading the industry in these areas. Safety-net providers face real barriers to change; however, some view their unique characteristics as the basis for new competitive strategies.

■ **Unique mission and capacities.** Safety-net providers offer a range of nonmedical services such as assistance in gaining entitlements, language translation, transportation, referrals for housing and employment, and day care. These services rarely generate sufficient revenue to cover their cost and are less likely to be provided by non-safety-net programs. However, as private providers expand into Medicaid managed care, some will be unprepared to manage patients who are ethnically and culturally diverse, have above-average health risks, and require a broad range of medical and social services. In this context, safety-net providers that traditionally have served these populations may prove to be effective competitors and attractive partners.

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■ **Financing structure.** Management of safety-net programs is complicated by their predominantly public financing and attendant uncertainties about available resources. Heavy reliance on inpatient-focused subsidies such as Medicaid DSH payments also conflicts with the need to develop more effective outpatient and community-based services. Many believe that Medicaid DSH funding formulas should be changed to more effectively target funds to core safety-net institutions.¹⁵ Some states are now exploring the possibility of using Medicaid DSH funds to support primary care services.¹⁶

Some forward-thinking providers have taken advantage of variable sources of funding as "investment capital." For example, hospitals in Indianapolis and Dallas have used DSH funding to upgrade physical plants and invest in new information technology. Community health centers in Boston have used charity care pool funding to upgrade facilities, and community health centers in Washington

State have "traded in" cost-based FQHC revenues for more favorable capitation rates in their Medicaid managed care plan.

■ **Medical school relationships.** Many safety-net hospitals serve as major teaching sites. Faculty physicians often provide the professional services in these institutions and supervise the residents who deliver a large volume of indigent care. While providing access to state-of-the-art technology, services, and personnel for disadvantaged patients, these relationships also pose difficulties. For example, in most medical schools, educational programs still emphasize subspecialty medical care in inpatient settings. Similarly, many safety-net teaching hospitals have closed medical staffs that do not provide admitting privileges to community physicians who care for their indigent patients outside of the hospital.

However, close links to medical schools provide an opportunity to broaden the appeal of safety-net providers through "centers of excellence." For example, San Francisco General Hospital is a national leader in clinical care and research on AIDS, as is New York's Bellevue Hospital for emergency care and reimplantation. Furthermore, reform of graduate medical education is increasingly being linked to safety-net providers, such as community health centers.¹⁷

■ **Links to government and unions.** Safety-net providers that are part of city or county governments or other public entities, including universities, often have constraints in areas such as personnel, procurement, and contracting. Many are also unionized, which has often been blamed for high labor costs and limited management flexibility. However, government and unions are major purchasers of health care services, and safety-net providers can take advantage of these relationships to increase market share. Systems such as the Boston Medical Center make their health plan available to employees at competitive rates. Having employees as customers has a positive influence on service. Finally, public employees and unions can provide important political support. Collaboration with these groups may help safety-net providers to access public investment capital and other assistance needed to become more competitive.

Outlook For The Future

There are many possible models of how safety-net systems might evolve in the future. At one end of the continuum, safety-net systems can gear up to compete directly with other providers in the medical services marketplace. To be successful, most will have to enhance their technical capabilities in managed care contracting, clinical practice management, performance monitoring, and information technology. This response, however, may not be fully compatible with their charitable and social missions. Safety-net systems that

"The pace of change affecting the safety net is faster than our ability to monitor the stability of safety-net institutions."

adopt this strategy may be motivated to reduce activities such as public health, behavioral health, and social services that do not contribute to their financial stability, which will make them look more like private health care providers. Under this model, other providers might pick up some of the slack for safety-net services (if funding is available); more likely, access to care for the uninsured and underserved will decline.

At the other end of the continuum, safety-net providers may focus on maintaining or expanding their original mission. They will still have to make operational changes to compete effectively. But this approach recognizes that competitive markets will not provide all of the resources necessary to realize the safety-net mission; maintaining a "public goods" role will require a social compact with one's community. As competition removes cross-subsidies from these systems, communities will have to make more explicit investments to maintain an effective safety net.

Making the second concept work requires changes in the historical competition among safety-net providers for resources, attention, and control. Linkages that make sense from a mission and operational perspective can no longer be inhibited by competitive relationships. In developing new partnerships, safety-net providers also will have to think beyond traditional allies. For example, public and academic hospitals must at least be open to asking, "What can I learn from Columbia/HCA?"

■ **Data needs.** The pace of change affecting health care safety nets is faster than our current ability to monitor the stability of safety-net institutions and the welfare of populations that depend on them. Unfortunately, most of the available data, research, and analysis are focused on the hospital setting. As we review the role of public policy in an increasingly competitive health care system, one of the most important public goods is information that will allow more effective tracking of the safety net.

In particular, more comprehensive data are needed about care provided to uninsured patients in non-inpatient settings, including hospital outpatient departments, physicians' offices, community health centers, and other primary care settings. In addition to supporting research, these data could be used to develop indigent care financing mechanisms with incentives for appropriate primary care. There is also a pressing need for better data on mental health, sub-

stance abuse, and senior and family services provided by community-based organizations.

As researchers try to assess whether local safety nets are "in crisis," better data are needed about the financial status of safety-net providers, the volume of care they provide, and the relative importance of different financing sources. Better data on patterns of care for Medicaid managed care patients are critical for understanding whether patients are being served effectively and appropriately under these programs and to quantify the extent to which these programs have shifted patient volume away from traditional safety-net providers. Such data, combined with the types of community tracking activities being sponsored by The Robert Wood Johnson Foundation and others, will help community leaders, policymakers, and providers to better understand and shape future changes in the health care safety net.

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 17. Examples of this are the Health Professions Education Community Partnerships and Community-Based Public Health Initiatives of the W.K. Kellogg Foundation.