Health Security Act

(b) Such programs are ones for advanced nurse education, nurse practitioners, nurse midwives, nurse anesthetists, and other training in clinical nurse specialties determined by the Secretary to require advanced education. Programs must meet the conditions defined in sections 821, 822, and 831 of the Public Health Service Act.

Section 3062. Applicability of Part 1 Provisions. (a) The provisions of part 1, , apply to the graduate nurse training program under section 3061 in the same extent and manner as they apply to the graduate physician training programs, except as they are modified in this part. (b) For the purposes of this program, the council is the National Council on Graduate Nurse Education. The council will make allocation of nurse training positions in the same way as the Council on Graduate Medical Education does for physician residencies.

Section 3063. Funding. The amount available for graduate nurse training programs under this part is $200,000,000 annually, provided as direct transfers from the Treasury under sections 3034, and 3104. Under section 4051, payments under Medicare for the costs of approved educational programs other than direct graduate medical education costs are specifically continued for cost reporting periods beginning on or after October 1, 1995.

PART 3 -- RELATED PROGRAMS

Section 3071. Programs of the Secretary of Health and Human Services. (a) Authorizes to be appropriated $400,000,000 for fiscal year 1994 and each year thereafter, for carrying out the programs described in this section, in addition to amounts otherwise authorized to be appropriated for such programs. Requires the Secretary of Health and Human Services to carry out the programs in this section.

(b) Establishes or expands existing programs with respect to training primary care physicians and physician assistants, including programs to train additional numbers of physicians and physician assistants; to retrain mid-career physicians previously certified in a nonprimary care specialty; to expand the supply of physicians with special training to serve in medically underserved areas; to expand service-linked educational networks for training in community settings; to provide training in managed care, practice management, and continuous quality improvement; and to enhance information on primary care workforce issues.

(c) Establishes or expands programs with respect to training of underrepresented minorities and disadvantaged persons, including programs to increase the number of such persons in the health professions through financial assistance, recruitment and retention, enhancing interest at the preprofessional level, and training of additional minority health professions faculty.

(d) Establishes or expands programs with respect to training of nurses, including training additional numbers of nurse practitioners and nurse midwives; baccalaureate nurses

for careers in teaching, community health service and specialized clinical care; nurse clinicians and nurse anesthetists; and, school-based community nurses; also programs to promote research on nursing workforce issues.

(e) Establishes a program to develop and encourage adoption of model practice statutes for advanced practice nurses and physician assistants, and other to support efforts to remove inappropriate barriers to practice by advanced practice nurses and physician assistants.

(f) Establishes or expands programs with respect to training health professionals and administrators in managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.

(g) Authorizes the Secretary to carry out these programs through existing programs in Titles VII and VIII of the Public Health Service Act.

Section 3072. Programs of the Secretary of Labor. (a) Authorizes to be appropriated $200,000,000, for fiscal year 1994 and each year thereafter, for carrying out the programs described in this section, in addition to amounts otherwise authorized to be appropriated for such programs. Requires the Secretary of Labor to carry out the programs in this section.

(b) Establishes programs to provide for skills upgrading and occupational retraining (including retraining health care workers as technicians, nurses, and physician assistants) and for quality and workforce improvement; to assist health care workers in career advancement; to develop health worker job banks; to provide for joint labor-management decision-making on workplace matters; and to facilitate the comprehensive workforce adjustment initiative.

(c) Requires the Secretary of Labor, in carrying out programs under this section, to provide for specific skill requirements, internal career movement opportunities, employment during retraining, evaluation and dissemination.

(d) Requires the Secretary, in carrying out programs under this section, to provide for joint labor-management implementation and administration and discussion and consultation.

Section 3073. National Institute for Health Care Workforce Development. (a) Requires the establishment of the National Institute for Health Care Workforce Development jointly by the Secretary of Health and Human Services and the Secretary of Labor.

(b) Authorizes the Secretary of Labor to carry out section 3073 through the Director of the Institute.

(c) Requires the Director of the Institute to make recommendations regarding health

SUBTITLE E - HEALTH SERVICES FOR MEDICALLY UNDERSERVED POPULATIONS
(H.R. 3600 and S. 1757 p. 578)

PART 1 - COMMUNITY AND MIGRANT HEALTH CENTERS

Section 3401. Authorization of Appropriations. (a) Authorizes funds in addition to other authorized funds for community and migrant health centers.

(b) The additional funds authorized are $100,000,000 per year for each of fiscal years 1995 through 2000.

(c) These funds are in addition to other funds available for the centers.

Section 3402. Use of Funds The additional funds authorized may be used for any purposes authorized under sections 329 or 330 of the Public Health Service Act as well as to establish and maintain the financial reserves that are required under Title I for providers of health services.

PART 2 - INITIATIVES FOR ACCESS TO HEALTH CARE

SUBPART A - PURPOSES; FUNDING

Section 3411. Purposes. The purposes of this program are:

(1) to improve access of medically underserved populations to health services through a program of flexible grants, contracts and loans;

(2) to establish transition to a system in which medically underserved populations have adequate choice of community-oriented providers and health plans;

(3) to promote the development of community practice networks and health plans that integrate public and private health providers in underserved areas;

(4) to support linkages between provider of care to underserved populations and regional and corporate alliance health plans; and

(5) to expand system capacity with additional practice sites and improvements in health-care facilities in need of repair.

(6) to link providers in underserved areas with each other, regional health care institutions and academic health centers.

(7) to support activities enabling underserved populations to gain access to and effectively use the health care system.

Section 3412. Authorizations of Appropriations. For the development of community health plans and networks there are authorized to be appropriated $200 million in fiscal 1995, $500 million in fiscal 1996, $600 million for fiscal 1997, $700 million for fiscal year 1998, $500 million for fiscal year 1999, and $200 million for fiscal year 2000. These

funds are in addition to other funds authorized for this program. Funds under this part are also available for use under section 3692 (school health services).

SUBPART B - DEVELOPMENT OF QUALIFIED COMMUNITY HEALTH PLANS AND PRACTICE NETWORKS

Section 3421. Grants and Contracts for the Development of Plans and Networks.

(a) The Secretary may make grants for developing qualified community health plans and community practice networks. These plans and networks may be, in this title, referred to as community health groups.

(b) To be a qualified community health plan, a health plan must be public or non-profit private entity whose principal purpose is to provide the comprehensive benefit package, in areas with shortages of medical personnel or to populations with a significant number of medically underserved persons; the plan must be a member of one or more health alliances; and two or more of the categories of providers specified in subsection (d) must be represented in the plan.

(c) A qualified community practice network means a consortium of health care providers that is a public or private non-profit entity whose principal purpose is to provide services to underserved populations or in health professions shortage areas, which has an agreement with one or more health plans and whose members are governed by a written agreement. Two or more categories of providers in subsection (d) must be included in the consortium.

(d) The relevant categories of providers described in subsections (b) and (c) are the following:

(1) physicians or other health professionals or health care institutions providing care in a shortage area or to an underserved population;

(2) migrant and community health centers;

(3) entities funded under sections 340 and 340A of the Public Health Service Act (homeless health care providers and health care providers in public housing);

(4) entities furnishing health services under Section 1001 or Title XXIII of the Public Health Service Act (family planning clinics and Ryan White program providers);

(5) entities furnishing services under Title V of the Social Security Act (maternal and child health);

(6) entities that are rural health clinics or federally qualified health centers;

(7) entities providing health services to Indians in urban areas under Title V of the Indian Health Care Improvement Act or outpatient services to Indians through the Indian Self Determination Act; and

(8) state or local public health agencies.

The Secretary also may make grants to a health plan that is not a community health

plan but that seeks to develop a community practice network with the entities described in this subsection.

Section 3422. Preferences in Making Grants. In making grants, the Secretary shall give the preference to those applications in which a maximum number of entities described in section 3421(d) are represented and added weight if a large group also includes private physicians, other health professionals or institutions that provide health services in a health professions shortage area, or provide health services to significant numbers of ilndividuals in medically underserved populations.

Section 3423. Certain Uses of Awards. (a) Awards under section 3421 may be spent for the following purposes:

(1) planning the network or health plan, including entering into contracts;
(2) recruitment and compensation of health and administrative staff;
(3) acquisition and expansion of facilities;
(4) acquisition and development of information systems;
(5) other expenditures recognized by the Secretary.

(b) An award that includes funding for capital costs must obligate the recipient to the United States for the amount of the award, plus interest during the 20 year period beginning on the date of completion, if the applicant ceases to be a qualified health plan or network or is sold or transferred to an entity that is not a community health plan or network.

Section 3424. Accessibility of Services. (a) Community health plans and networks must assure that their services are available to persons seeking care, whether or not they are eligible individuals under title I.

(b) A community health group's providers must be approved as Medicare and Medicaid providers. A group must seek reimbursement for the cost of caring for persons entitled to benefits under Title I, Medicare, Medicaid, any other public assistance programs, or private health insurance plans.

(c) The network or plan must prepare a fee schedule that is consistent with local rates and a corresponding schedule of discounts to be determined by a patient's ability to pay.

(d) The plan or network must maximize the accessibility of its services to residents in its area by eliminating barriers resulting from geographical or demographic characteristics, including limited ability of patients to speak English. A plan or network also must periodically determine the accessibility of its services.

Section 3425. Additional Agreements. (a) Networks and plans must provide enabling services (as defined in section 3461(g)) as part of their funding agreement.

(b) Networks and plans must maintain ongoing systems for patient-oriented,

community-responsive quality control, and for collecting and making public information on costs, health-care and financial performance, and other matters.

(c) The plan or network must agree to maximize its use of existing resources.

Section 3426. Submission of Certain Information. (a) The Secretary may make grants only if applicants submit information on the needs (including the need for enabling services) of the medically underserved population to be served by the applicant.

(b) The applicant must also include a description of how the applicant will design the plan or network, a description of efforts to secure financial and technical assistance, and evidence of significant community involvement in the initiation, development and ongoing operation of the project.

Section 3427. Reports; Audits. Funded plans and networks must provide reports and information as required by the Secretary and must submit to annual audits.

Section 3428. Application for Assistance. Applications must include the agreements and information required in other sections of the subtitle and additional agreements and information that the Secretary deems necessary.

Section 3429. General Provisions. (a) The Secretary may not make more than two grant awards under section 3421 for the same project.

(b) The Secretary may determine the amount to be granted for any project.

SUBPART C - CAPITAL COST OF DEVELOPMENT OF QUALIFIED COMMUNITY HEALTH PLANS AND PRACTICE NETWORKS

Section 3441. Loans and Loan Guarantees Regarding Plans and Practice Networks. (a) The Secretary may make loans to public and private entities for capital costs of developing qualified community health groups, and may also guarantee such loans by Federal and non-Federal lenders.

(b) The Secretary shall use the same preferences in making loans that apply to grants under section 3421.

(c) Funds under this section may be used to finance facilities, major equipment, including information systems, to establish financial reserves and other capital costs that are necessary to the purpose of the section (as determined by the Secretary). Priorities shall be placed on loans to modernize facilities, prevent or eliminate safety hazards, and to repair or replace obsolete facilities.

(d) The principal of the loan or loan guarantee, when added to other assistance under

this section, may cover up to 100 percent of the costs involved.

Section 3442. Certain Requirements. (a) The Secretary may approve loans only if reasonably satisfied that the grantee can repay the loan, and only if the grantee provides assurances that additional funds are available to complete the project for which the loan is made. Also, a loan under section 3441 must be on the terms and conditions that are necessary to protect the financial interests of the United States (as determined by the Secretary).

(b) The Secretary may guarantee loans only if the loan conditions, terms and arrangements for repayment are sufficient to protect the financial interests of the United States. Such guarantees are also subject to further terms as determined by the Secretary.

(c) An applicant for a loan or loan guarantee must agree to use existing resources to the maximum extent feasible.

Section 3443. Defaults; Right of Recovery. (a) The Secretary may take necessary action, including waiver of regulatory conditions, deferral of loan repayments or other actions as needed to prevent a default on a loan or loan guarantee. The Secretary may also foreclose a loan in default, or waive, for good cause, any right of recovery from a borrower who fails to make payments on a loan. A waiver of the right of recovery does not modify the Secretary's obligation to make payments for a loan that has been sold and guaranteed.

(b) A loan becomes due and payable immediately if a facility for which loan funds have been used is sold within 20 years after the federally-financed work on it is completed. The loan becomes due if sale is to an entity not eligible for assistance under the section, or not approved by the Secretary, or if the facility ceases to be a public or nonprofit private entity eligible for assistance. The Secretary may also subordinate or waive the right of recovery and any other Federal interest based on a loan or loan guarantee for capital projects, if such waiver(s) would further the purpose of serving medically underserved populations.

Section 3444. Provisions Regarding Construction or Expansion of Facilities. (a) The Secretary may provide loans or loan guarantees for the construction, conversion expansion or modernization of a facility, only if the applicant describes the facility site, provides plans and specifications which meet the Secretary's requirements, and demonstrates that title is vested in one or more of the applicants.

(b) An applicant for a loan must make the following agreements:

(1) Title to the site will be vested in one or more of the applicants;

(2) Adequate financial support is available for completing and maintaining and operating the facility;

(3) The construction contract complies with the Davis Bacon Act (relating to payment of laborers); and

(4) The facility will be available to persons seeking service there, regardless of their ability to pay.

Section 3445. Application for Assistance. The Secretary may provide assistance only if the applicant files the application in the form and manner prescribed by the Secretary.

Section 3446. Administration of Programs. The loans and loan guarantees for capital projects must be administered from a centralized unit in the Department of Health and Human Services.

SUBPART D - ENABLING SERVICES

Section 3461. Grants for Enabling Services. (a)(1) The Secretary may make grants to qualified community health groups (plans and networks) and to other public and private non-profit groups that provide services in one or more health professional shortage areas or to medically underserved populations and are experienced in providing services to increase the capacity of individuals to use health services. The grants are to be used to provide enabling services.

(b) Enabling services are transportation, community and patient outreach, patient education, translation services, and other services that would increase the capacity of individuals to use the comprehensive benefits to which the Act entitles them.

(c) Grants may be made only if the applicant submits information demonstrating the need for the services, a proposed grant budget and evidence of significant community involvement in the project.

(d) Grant applicants must agree not to charge fees for grant-funded enabling services.

(e) Grant applicants must make maximum use of existing resources.

(f) Applications must be filed in a form and manner prescribed by the Secretary, and include agreements and assurances deemed necessary by the Secretary.

(g) Enabling services are services described in subsection (b), when furnished by an entity described in subsection (a).

PART 3 - NATIONAL HEALTH SERVICE CORPS

Section 3471. Authorization of Appropriations. (a) Funds for carrying out subpart II of part D of title III of the Public Health Service Act, and section 3472 of the Health Security Act, are authorized in the following amounts: $50,000,000 for fiscal year 1995, $100,000,000 for fiscal year 1996, and $200,000,000 for each of fiscal years 1997 through 2000.

(b) The authorizations are in addition to funds otherwise authorized.

(c) Funds may be appropriated under this section at any time before the fiscal year for which they are appropriated.

Section 3472. Allocation for Participation of Nurses in Scholarship and Loan Repayment Programs. Of amounts appropriated under section 3471, the Secretary shall reserve such amounts as may be needed to ensure that of the aggregate number of persons participating in the scholarship program or loan repayment program of the National Health Service Corps (section 338A of the Public Health Service Act), the total proportion of individuals being educated as or serving as nurses increases to 20 percent.

PART 4 - PAYMENTS TO HOSPITALS SERVING VULNERABLE POPULATIONS

Section 3481. Payments to Hospitals. (a) The Secretary shall make payments to eligible hospitals from funds made available under this part. The amounts specified in subsection (b) must be made available to the Secretary on behalf of eligible hospitals, but payment is not guaranteed to the state in which an eligible hospital is located or to any individual receiving services from the hospital.

(b)(1) The total amount of the payments is $800,000,000 for the fiscal year in which the general effective date occurs and for each subsequent year.

(2) For any year prior to the general effective date, the amount specified shall equal the aggregate disproportionate share hospitals (DSH) percentage of the amount otherwise available under this section. The aggregate DSH percentage is equal to the percent of total payments to DSH hospitals in all states represented by the payments to DSH hospitals in participating states.

(c) Hospitals qualifying for payments shall receive them for five years, without regard to the first year in which a hospital receives payment.

(d) Payments shall be made on a quarterly basis.

Section 3482. Identification of Eligible Hospitals. (a) In order to qualify for payments, a hospital must be located in a participating state. However, a qualifying hospital may continue to receive payments even if the state in which it is located is no longer a participating state.

(b) States shall identify for the Secretary those hospitals that meet the qualification criteria.

(c) In order to qualify, a hospital must have a low income percentage caseload (as defined in section 1923(b)(3) of the Social Security Act) during the base year of not less

than 25 percent.

Section 3483. Amount of Payments. (a) Of total amounts available for payment, 75 percent shall be allocated based on the hospital's low income percentage of the allocation for the year.

(b) Twenty-five percent of the total shall be allocated to hospitals for services that are not covered services under the Act. The Secretary shall develop an allocation methodology.

(c) An eligible hospital's low income percentage shall equal the amount of all low income days attributable to the hospital. Low income days equal the total amount of inpatient days multiplied by the hospital's low income utilization rate under section 1923(b)(3).

Section 3484. Base Year. The base year is the year prior to the year of the general effective date of this Act.

SUBTITLE F - MENTAL HEALTH; SUBSTANCE ABUSE
(H.R. 3600 and S.1757 p. 615)

PART 1 - FINANCIAL ASSISTANCE

Section 3501. Authorization of Appropriations. (a) Funds are authorized for the purposes of this subtitle in the following amounts: $100,000,000 in fiscal year 1995; $150,000,000 in fiscal year 1996, and $250,000,000 for each of fiscal years 1997 through 2000.

(b) Of amounts made available, the Secretary shall reserve as much as is deemed appropriate for activities under section 3503. Of the remaining amounts, the Secretary shall reserve 50 percent for activities described in subsection (a) of section 3502 and 50 percent for activities under subsection (b) of section 3502.

(c) The amounts authorized above are in addition to any other funds authorized for the same purposes.

Section 3502. Supplemental Formula Grants for States Regarding Activities Under Part B of Title XIX of the Public Health Service Act. (a) The Secretary shall make mental health grants to states that have submitted applications meeting the requirements of subsection (e). The allotment formula shall be the same one used under section 1918(a)(2) of the Public Health Service Act.

(b) The Secretary shall make grants for substance abuse services to states that have submitted applications. The amounts of the grants are determined by using the formula under section 1933(a)(1)(B)(i) and section 1918(a)(2)(A).

(c)(1) The Secretary shall approve grant uses that are consistent with the mental health and substance abuse activities that are described in this section. The state must agree to spend grant funds in accordance with the Secretary's approved uses.

(2) Approved uses are as follows:

(A) transportation and translation, patient and community outreach, patient education, and such other services as the Secretary deems appropriate for the purpose of increasing the access of individuals to services relating to mental health and substance abuse;

(B) improving the capacity of state and local service systems to coordinate and monitor mental health and substance abuse services, improving information systems, and establishing linkages between mental health and substance abuse services and primary care providers and health plans;

(C) providing incentives to integrate public and private systems for treatment of mental health and substance abuse treatment systems; and

(D) any activity for which a grant may be made under sections 1911 and 1921 of the Public Health Service Act.

(d) As a condition of grant receipt, a state, may not reduce its funding for mental health and substance abuse activities below the level spent in the fiscal year preceding the first year for which the state receives the grant. The Secretary may waive this requirement if the state agrees to spend the funds that would otherwise be subject to the requirement on the developing community based care systems for the eventual integration of the public and private systems for treating mental health or substance abuse (as applicable to the grant).

(e) The state's application must be submitted in a form, time and manner and include agreements and assurances as required by the Secretary.

Section 3503. Capital Costs of Development of Certain Clinics and Centers. (a) The Secretary may make loans and loan guarantees to public and non-profit private entities, for the capital costs of developing non-acute, residential treatment centers and ambulatory clinics.

(b) Priority must be given to loan and loan guarantees for centers and clinics in areas with a health professions shortage or with significant numbers of medically underserved individuals.

(c) Loans and loan guarantees shall be made only in accordance with procedures in subpart C of Part 2 of subtitle E.

PART 2 - AUTHORITIES REGARDING PARTICIPATING STATES

SUBPART A - REPORT

Section 3511. Report on Integration of Mental Health and Substance Abuse Systems.

(a) As a condition of being a participating state, each state must submit, not later than October 1, 1998, a plan to achieve the integration of state and local mental health and substance abuse services with services that are included in the comprehensive benefit plan.

(b) The state's report shall contain the following information:

(1) the number of persons served by state and local mental health and substance abuse systems and the proportion who are eligible persons under title I of the Act;

(2) services furnished to eligible persons, including each type of benefit furnished, the diagnoses for which the benefits are furnished, the amount, duration and scope of coverage of each benefit furnished, applicable limits on benefits, and cost-sharing rules that apply;

(3) the extent to which mental health and substance abuse providers providing services under a state plan participate in alliance health plans and reasons for any lack

of participation by these providers;

(4) the amount of revenues from health plans received by mental health and substance abuse providers that do participate in health plans and that are funded under one or more state program(s);

(5) the amount spent by the state and its political subdivisions in each of the two years before it became a participating state, for items and services covered in the comprehensive benefit package; also, the amount spent on medically necessary care not included in the benefit package, including medical and other health care and related supportive services;

(6) an estimate of the amount the state will need to spend on uncovered benefits and services after mental health and substance abuse services are expanded in the year 2001;

(7) a description of how the state will assure that all eligible individuals served by state-funded mental health and substance abuse programs will be enrolled in a health benefit plan and how mental health and substance abuse services not covered in the benefit package will continue to be furnished;

(8) a description of the conditions under which integration of mental health and substance abuse providers into health plans can be achieved and an identification of changes in provider participation and health plan certification requirements that are needed to achieve integration; and

(9) if integration is not medically appropriate or feasible for one or more groups of individuals treated in state programs, a description of the reasons therefor, and a plan for assuring coordination of care and services covered in the benefit package and the state program for these people.

(c) Reports shall be submitted in a form and manner prescribed by the Secretary.

SUBPART B - PILOT PROGRAM

Section 3521. Pilot Program. (a) The Secretary shall establish a pilot program to demonstrate model methods of integrating mental health and substance abuse services with the mental health and substance abuse services covered in the comprehensive benefit package under title I.

(b) In establishing the pilot program, the Secretary must consider the following factors:

(1) the types of items and services needed by patients in addition to those covered under Title I;

(2) optimal methods of treating persons with long term mental illness and substance abuse conditions;

(3) the capacity of alliance health plans to furnish such treatment;

(4) necessary modifications in coverage and services furnished by health plans; and

(5) the role of publicly funded providers in integrating acute and long-term treatment.

DOLE BILL

330A
State block grant program to create or enhance primary care services provided to low income or medically underserved populations.

Funding Allocation
total funds = State need adjusted population (State FMAP) / national need adjusted population (national FMAP)

need adjusted population = State population (need index)

need index = weighted sum of geographic percentage + poverty percentage + multiple grant percentage : general population percentage of State

geographic percentage = estimated population of State in non-urban areas / total national non urban population

non-urbanized population = 1 - urbanized population of State, expressed as a percentage of total State population

poverty percentage = the estimated number of people in the State below 200% FPL / total number of people below 200% nationally

multiple grant percentage = amount of State funding recieved under 329 330, 340 / total funding recieved under these grants for all States. (ceiling of twice the general population percentage and floor of less than 50% of general population percentage)

FMAP = 1- State matching percentage

State matching percentage = .25 (taxable resource % : need adjusted pop)

taxable resource percentage = total taxable resources of a State / total taxable resources nationally

Purpose
Grants are to be used to deliver primary care services to people without other access to those services in a cost effective, geographically

equitable manner.

321
Grants for technical assistance when establishing health networks and plans in underserved areas.

LOOK AT 152 - 155

331
Loans to health networks, health plans covering individuals in rural, frontier, or underserved areas, or health care providers serving rural, frontier, or underserved areas

Assistance can be used for facility improvement (SEE 155 - 8)

341
Provision of a tax credit for primary health services providers.

The tax credit amount is equal to:

the number of months during the year that the taxpayer is a qualified primary health services provider (1,000) or (500) if the person is not a physician.

Qualified primary health services provider is anyone deemed by BPHC.

The Evolution Of Support For Safety-Net Hospitals

Changes in the medical care marketplace are placing funding for uncompensated care and clinical education provided by safety-net hospitals at risk.

by Linda E. Fishman and James D. Bentley

PROLOGUE: Teaching hospitals hold a special place in America's pluralistic system of health care delivery and financing. They are citadels of medical learning and institutions that care for some of our most vulnerable citizens. But they also are the places where much of the innovation that leads to medical progress is conducted. Because teaching hospitals are complex institutions that perform multiple missions, federal and state governments have woven a complex set of policies that seek to balance public and private interests.

In this paper two veterans of federal health policy making examine the rich history and current status of hospital support for financing uncompensated care and graduate medical education. Linda Fishman, who has a reputation in policy circles as a level-headed realist, is associate vice-president in the Office of Governmental Relations of the Association of American Medical Colleges (AAMC). Fishman holds two degrees from the University of Washington, where she was elected to Phi Beta Kappa. Fishman recently produced a monograph for the AAMC that is essential reading for anyone who wants to understand the complexities of Medicare's financing of graduate medical education. James Bentley, senior vice-president of the American Hospital Association (AHA), has been instrumental in shaping federal policy as it applies to graduate medical education and hospital financing. Bentley directs the AHA's public policy analyses as well as related activities. He holds a doctorate in medical care organization from the University of Michigan. He spent ten years at the AAMC before joining the AHA.

ABSTRACT: The federal government, mostly through the Medicare and Medicaid programs, has created and maintained a set of structural mechanisms to support uncompensated care and clinical education: disproportionate-share hospital payments and direct and indirect graduate medical education payments. This paper provides a history of how these traditional supports have evolved. We note that the need to reduce federal and state spending threatens the level of these payments, while changes in the health care delivery system highlight a range of design and technical inadequacies in the current support mechanisms.

THROUGHOUT THE TWENTIETH CENTURY, the U.S. health care system has supported uncompensated care and graduate medical education (GME) through a complex patchwork of revenue generated by patient care. Hospitals, the sites where most uncompensated care and physician training occur, have traditionally charged privately insured patients more than the cost of their hospital care. More recently, the federal government, through the Medicare and Medicaid programs, has created and maintained a set of structural support mechanisms based on patient care payments to help finance uncompensated care and health professions clinical education, particularly GME. Now the health care system is transforming from one based on a delicate web of confusing cross-subsidies to a system based on price competition in which both private and public purchasers want to pay only for the cost of the services their enrollees receive. Pressure to curb the rate of growth in state and federal health care spending threatens to erode the existing public support mechanisms for uncompensated care and GME.

The question in the current competitive environment is whether, how, and to what extent society will continue to support the additional roles of hospitals that now are funded with patient care revenue. Although other types of health care providers render uncompensated care and participate in health professions education, most of the public structural support mechanisms have been designed specifically as institutional- or hospital-level payments. This paper examines the history and current structure of hospital support for financing uncompensated care, GME, and its related activities. Although the competitive environment does not yet jeopardize the hospital community overall, certain types of hospitals, which form a safety net of care for the poor and/or provide GME and cutting-edge research, are at risk.[1]

A Historical Perspective

■ **Care for the poor.** The evolution of support for uncompensated care and GME closely parallels the development of the hospital. Hospitals in the United States, first built primarily for the poor, were organized as charities under the sponsorship of religious or-

ganizations and wealthy patrons. By the late nineteenth century, hospitals' orientation had changed from charitable institutions to businesses as they began attracting patients from all socioeconomic classes. Today, public, private, and proprietary hospitals all, to varying degrees, serve their communities and provide care to persons who cannot pay.

■ **Clinical education and medical technology centers.** Some hospitals also invest resources in a variety of other medical products. As scientific knowledge exploded in the twentieth century, some hospitals developed close affiliations with medical schools, becoming centers of advanced medical technology and providing the settings for clinical education with organized teams of attending physicians, residents, and students. In these institutions, commonly known as "teaching hospitals," education and research are conducted simultaneously with clinical hospital practice.

■ **Financing: private and public.** As hospitals evolved from charitable institutions to complex business enterprises, their reliance on patient care revenue increased. In 1922 patient care revenue accounted for 65.2 percent on average of the total revenue of general hospitals.[2] In 1994, after the growth of private insurance and introduction of Medicare and Medicaid, 94 percent of hospital revenue on average was derived from services to patients.[3]

Payments from private payers indirectly assist hospitals in meeting the costs of uncompensated care and GME-related activity. To large and varying degrees, hospitals "cost shift," or obtain revenues in excess of costs from one payer of service to offset shortfalls in other categories.

Hospitals also rely on a set of publicly funded structural support mechanisms (Exhibit 1). Some federally appropriated funds, accessible under Titles VII and VIII of the Public Health Service Act, support a variety of clinical education programs. Other appropriated funds are available to hospitals to support certain at-risk populations, such as patients with acquired immunodeficiency syndrome (AIDS), migrant workers, and the homeless, but the bulk of public support is embedded in the Medicare and Medicaid programs. Medicare makes special payments to hospitals, called disproportionate-share hospital (DSH) payments, direct graduate medical education (DGME) payments, and indirect medical education (IME) payments, to maintain access to care for its beneficiaries and to support GME and its related costs. The Medicaid program, financed through a federal/state partnership, also makes DSH payments to hospitals to ensure access to care and, in many states, supports GME and its related costs.

These public support mechanisms are in jeopardy for two rea-

EXHIBIT 1
Public Structural Supports For The Health Care Safety Net

Type of support	FY 1996 amount (billions of dollars)[a]	Purpose	Mechanism
Medicare			
Direct graduate medical education payments[b]	$2.4	Direct costs of graduate medical education	Number of full-time-equivalent residents
Indirect medical education payments	4.3	Differences in patient care costs/access	Intern- and resident-to-bed ratio
Disproportionate-share hospital payments	4.3	Differences in patient care costs/access	Supplemental Security Income and Medicaid inpatient days
Medicaid			
Disproportionate-share hospital payments	19.0	Assistance to hospitals for services to low-income and Medicaid patients	Varies
Clinical education payments	1.0+	Direct costs of graduate medical education and/or indirect patient care costs related to teaching	Varies
Federally appropriated funds[c]	2.0	Varies	Appropriations/grants

SOURCE: Department of Health and Human Services.
NOTE: Medicare and Medicaid funding estimates are for fee-for-service spending and exclude amounts embedded in managed care rates where applicable.
[a] Medicare funding estimates from the Congressional Budget Office, January 1997 baseline. Medicaid disproportionate-share hospital estimate is for 1995; see J. Holahan and D. Liska, "Where Is Medicaid Spending Headed?" (Washington: The Urban Institute for The Kaiser Commission on the Future of Medicaid, December 1996). Medicaid estimate for clinical education spending is for 1995; see D. Plumb and T. Henderson, *Medicaid Funding of Graduate Medical Education: A Survey of the States* (Washington: The Intergovernmental Health Policy Project at The George Washington University, October 1995). Federally appropriated funding levels from the Health Resources and Services Administration overview in the proposed U.S. federal budget for FY 1998.
[b] Includes payments for nursing and allied health training programs.
[c] Includes those programs in Titles VII and VIII of the Public Health Service Act, Ryan White funds, consolidated health centers, National Health Service Corps, *rural health programs, and a few other programs.*

sons. First, federal and state governments are seeking large targets to help them meet increasing budgetary constraints, and these special payments are substantial. Second, the structural support payments are based on fee-for-service payment systems and inpatient use of hospital services. Managed care uses different payment methods, reduces hospital use, and moves care to lower-cost and ambulatory settings. This dynamic distorts and weakens the methodologies for calculating these hospital payments.

Uncompensated Care

■ **Amount.** Hospitals and physicians traditionally have cared for patients regardless of their ability to pay. In this paper, *uncompensated care* is charity care and bad-debt expense. To a limited extent, all types of providers provide some uncompensated care, but data on total uncompensated care costs generally are available only from hospitals. Hospitals provided about $16.8 billion in uncompensated care in 1994, 19 percent of which was offset by government subsidies.[4]

■ **Current financing.** Hospitals finance uncompensated care through a variety of revenue sources. They may receive funds from federal, state, or local grant programs for specific services or special populations; philanthropies; gifts or their own charitable activities; and earnings from the fiscal year. Public municipal or state-owned hospitals receive state or local government appropriations, as do some private institutions. The federal government, through the Medicare and Medicaid programs, has implicitly supported uncompensated care by targeting additional funds toward certain types of hospitals that serve large numbers of poor persons. These payments include two separate and distinct DSH adjustments: one under the Medicare prospective payment system (PPS), and another under the Medicaid program. Some policymakers also believe that the current level of the Medicare IME adjustment is justified by the uncompensated care losses incurred by teaching hospitals.

■ **Medicare DSH adjustment.** In April 1986, with passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272), Congress mandated an explicit payment adjustment in the PPS for hospitals that serve large numbers of low-income patients. It required no new money. Funding was obtained by lowering the basic rate paid to hospitals and decreasing the level of the IME adjustment in recognition that teaching hospitals would receive a large proportion of DSH payments.

The original rationale for the DSH adjustment was to compensate hospitals for the higher operating costs they incurred in treating disproportionately large numbers of low-income patients. Several studies, conducted by the Health Care Financing Administration (HCFA) and the American Hospital Association (AHA), had demonstrated a relationship between higher Medicare costs and the percentage of a hospital's patients covered by Medicare or Medicaid.[5] A 1984 study by the Congressional Budget Office (CBO), based on 1981 data, showed that certain groups of hospitals, particularly those with relatively large shares of Medicaid patients, more than 100 beds, and large-city locations, would do worse, on average, under the new Medicare PPS than would other hospitals, because of

their higher costs.[6] By 1990 another CBO analysis of more recent (1987) data showed that except for urban hospitals with more than 100 beds and the highest levels of service to the low-income poor, the higher cost differences associated with serving the poor had disappeared, and there was little justification for a DSH adjustment based on differences in costs.[7]

However, the CBO noted another rationale for the DSH adjustment. Congress had become increasingly concerned that certain hospitals were at risk of closing as a result of treating large numbers of poor patients and began to view the DSH payment as a mechanism for mitigating hospitals' financial distress. Under this rationale, DSH payments were justified because they aided hospitals in maintaining access to care for low-income Medicare beneficiaries and other patients. Today, most policymakers acknowledge that the DSH adjustment is more a mechanism for channeling payments to hospitals that serve a high proportion of poor patients than it is a means of compensating hospitals for differences in operating costs.

Mechanics of the DSH adjustment. A qualifying hospital receives a DSH payment for each Medicare patient it treats under the PPS. The DSH payment is calculated as a percentage add-on to the basic diagnosis-related group (DRG) payment. Different DSH formulas are used, depending on where the hospital is located, how many beds it has, and its status as a rural referral center or sole community provider. The value of the hospital's DSH "index" determines the hospital's eligibility for a DSH payment and the size of the payment. The index, whose definition has not changed since the original legislation, is the sum of two ratios: the proportion of all Medicare days that are attributable to beneficiaries of Supplemental Security Income (SSI), a means-tested cash benefit program for aged and disabled people, and the proportion of all patient days for which Medicaid is the primary payer.[8]

Medicare DSH expenditures. Since its enactment in 1986, the DSH payment has been modified in every budget reconciliation act except OBRA 1993 (P.L. 103-66). Originally intended to sunset, the adjustment was made a permanent part of the PPS in 1990. Each bill added more money to the adjustment but not always to every category of hospital. Legislation passed in 1990 (P.L. 101-508) added the most money to the adjustment, almost $1 billion, through formula modifications. Medicare DSH spending has increased almost fourfold, from about $1 billion in 1989 to more than $4 billion in 1996, and has grown faster than overall inpatient hospital payments.[9] The CBO estimates that Medicare DSH payments will total $4.5 billion in fiscal year (FY) 1997, increasing to $4.8 billion in FY 1998.[10]

As DSH spending has increased, so has the number of hospitals

receiving DSH payments. In FY 1991, the Prospective Payment Assessment Commission (ProPAC), which monitors the PPS for Congress, estimated that 1,558 hospitals, or 28 percent of all PPS hospitals, received DSH payments.[11] By FY 1996, ProPAC found that 1,957 hospitals, or 38 percent of all PPS hospitals, were receiving DSH payments.[12]

Although almost 2,000 hospitals receive this adjustment, Medicare DSH payments are highly concentrated. Ninety-three percent of total DSH payments go to large hospitals in urban areas, and teaching hospitals receive about 65 percent of all DSH payments. Finally, because Medicaid eligibility and coverage vary widely across states, Medicare DSH payments are distributed unevenly across geographic areas: The Middle Atlantic, South Atlantic, and Pacific regions account for 60 percent of all DSH payments but only 46 percent of Medicare discharges.[13]

■ **Medicaid DSH payments.** The Medicaid DSH payment is based on the assumption that certain hospitals, in addition to providing care to Medicaid enrollees, also serve indigent persons who are not eligible for Medicaid and maintain many public health and social services for all area residents. Legislators recognized that these hospitals could not shift the cost of uncompensated care to the relatively few privately insured patients they serve. Congress took action so that access to care could be maintained. OBRA 1981 (P.L. 97-35) required states to "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs" when setting inpatient hospital payment rates.[14]

At first, states were slow to establish DSH payment adjustments, but in the late 1980s the federal government stimulated the creation of state DSH programs through legislation and regulation. In 1987 budget reconciliation legislation (P.L. 100-203), Congress established minimum criteria for designating and paying DSH hospitals and required states to designate every hospital that met those criteria as a DSH hospital. States could be more generous in their designation criteria or in their payment levels. This led to great variation across states and even among hospital types within states, as many states went beyond the minimum criteria.

In the late 1980s and early 1990s, Medicaid DSH payments exploded. States became very creative in increasing their Medicaid funding via provider-specific taxes, intergovernmental transfers, and donations from hospitals as part of the state share of Medicaid spending. These strategies increased federal payments to states with little impact on state general revenue funds. For example, providers, usually hospitals, would pay a tax or donate funds to the state. The state would then use these funds to make Medicaid pay-

ments and receive a matching payment from the federal government. The federal government objected to this because it believed that the mechanisms increased the federal contribution inappropriately.

In December 1991 Congress passed legislation, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234), as a compromise between the federal government and the states. It restricted the types of provider taxes that states could use and banned the use of provider donations. The law also placed caps on DSH payments, limiting them to 12 percent of program expenditures at both the national and state levels. States whose DSH payments were more than 12 percent of state spending, so-called high-DSH states, were frozen at 1993 levels until the rest of their Medicaid expenditures grew so that DSH payments were 12 percent or less of Medicaid spending. States where DSH spending was below 12 percent were allowed to grow at the same rate as the rest of the Medicaid program. In 1993 Congress, responding to information that some hospitals were receiving excess DSH funds and that some states were diverting federal matching funds for purposes other than health care, placed further restrictions on particularly large Medicaid DSH payments to certain hospitals.

■ **Current rules for Medicaid DSH payments.** The 1991 and 1993 legislative provisions for Medicaid DSH payments remain in effect. Federal matching payments for state Medicaid spending that is financed with revenues from provider taxes continue to be capped, and the 12 percent limit is still applied. States use a variety of methods to make DSH payments, but all are tied in some way to service for Medicaid enrollees and low-income persons.

■ **Medicaid DSH expenditures.** Between 1988 and 1992 Medicaid expenditures grew on average 22.4 percent annually, while DSH spending grew a whopping 149.9 percent annually, from $400 million in 1988 to $17.5 billion in 1992.[15] Legislative changes to the DSH program in 1991 and 1993 moderated the growth of DSH payments and overall program spending. Between 1992 and 1995 Medicaid DSH spending grew only 2.7 percent per year, increasing to $19 billion by 1995, considerably slower than the overall growth of the Medicaid program, which had dropped by then to 9.5 percent per year.[16] As a result, whereas in 1992 DSH payments were 14.6 percent of all Medicaid spending, in 1995 DSH payments had dropped to about 12 percent of total Medicaid spending.

■ **Other federal government support.** The federal government provides support for special populations through certain programs in the Health Resources and Services Administration (HRSA). Without the availability of federal funds for programs such as the Ryan White AIDS program, migrant health centers, and health care

for the homeless, hospitals would have to fund such activities with other revenues obtained through cross-subsidization. These federally appropriated funds, about $2 billion in FY 1996, are available to the health care system through grants and appropriations.[17]

■ **Nonfederal government support.** Another important source of support for uncompensated care is state and local government appropriations. State, county, or city tax dollars may be the primary source of funds for certain types of hospitals, such as public general hospitals. Data on appropriations are difficult to collect at the national level, but among members of the Council of Teaching Hospitals and Health Systems (COTH), twenty-three public municipal teaching hospitals reported receiving $1.7 billion in state, county, and city support for indigent care and general operations in FY 1995.[18] Another thirty-eight state-owned public teaching hospitals received $700 million from state and county appropriations for indigent care, general operations, and medical education purposes.

Clinical Education

Medical education in the twentieth century has been intertwined with care for the poor, particularly in public hospitals where medical education programs have provided a workforce for care of indigent patients. Until the 1960s residents gained their primary clinical experience in public hospitals and on the charity wards of voluntary hospitals. In the mid-1960s and 1970s enactment of the Medicare and Medicaid programs sharply reduced the number of indigent patients, and GME changed, expanding training to other clinical settings. However, since the clinical component of medical education involves students and residents in the direct diagnosis and treatment of patients, and the poor have represented a substantial portion of patients cared for in educational settings, many view support for GME as support for uncompensated care in underserved communities.

■ **The cost of clinical education.** Teaching hospitals, which sponsor GME programs, incur significant direct and indirect costs in operating physician training programs. The direct costs consist of stipends and fringe benefits for residents, salaries and fringe benefits for supervising faculty, costs directly associated with supporting the GME program (such as the clerical personnel working exclusively in the GME administrative office), and allocated institutional overhead costs (such as maintenance, cafeteria, and depreciation).

Indirect costs are those incurred in providing an appropriate environment for clinical education. They include the higher patient care costs that accompany an academic infrastructure because teaching institutions tend to treat a much higher proportion of severely ill patients who require intensive resources. Teaching hospi-

tals also maintain a broader scope of highly specialized services and stand-by capacity, often on an around-the-clock, regional basis. Higher patient care costs also may result when a teaching program is located, for example, in the central core of a large urban area—where labor, land, and operating costs may be higher than in the suburbs. Finally, indirect costs include the reduced productivity of the hospital staff because they are educating residents and the processing of additional diagnostic tests or ancillary services that residents may order during their clinical learning experience.

Current support for clinical education. Support for clinical education comes from many sources, but most of it comes from hospital patient service revenue, such as payments from individuals; third-party payers, such as commercial insurance companies; government-financed programs, such as Medicare and Medicaid; and state and local appropriations. Fees from faculty physician practices, foundation grants, grants from the National Institutes of Health, and other diverse nonhospital sources, in addition to the Departments of Veterans Affairs (VA) and Defense, also support GME. The VA is the largest single provider of physician training sites in the United States today and funds about 9 percent of all residency positions each year at about 130 VA medical centers.

Because the Medicare program makes two explicit payments to teaching hospitals for their direct and indirect costs, many persons mistakenly believe that Medicare is the only payer of GME-related costs. Other purchasers of health services also participate in GME financing. Medicaid makes payments through a variety of explicit and implicit mechanisms. Private insurance companies contribute implicitly to direct and indirect GME costs by paying higher prices than these companies would pay to nonteaching hospitals.

Medicare DGME payments. Medicare DGME payments compensate teaching hospitals for the costs that are directly related to the graduate training of physicians, dentists, and podiatrists.[19] Medicare does not pay the costs of clinical undergraduate medical education, although it occurs in teaching hospitals, usually alongside and intertwined with residency training. In establishing Medicare in 1965, Congress recognized the need to support residency training programs to meet the nation's need for fully trained health care professionals and acknowledged that educational activities heighten the quality of care in hospitals.[20]

■ **Mechanics of the DGME payment.** From 1965 until 1985 Medicare paid its share of each hospital's historical DGME costs. Reimbursement was open-ended: If a hospital increased its costs, Medicare paid its share of the costs incurred. However, COBRA 1985 dramatically changed the DGME payment methodology in

April 1986 by uncoupling the link between costs and payments. Today, Medicare pays a portion of a hospital-specific per resident amount, which is updated annually by an inflation factor. These total per resident amounts vary widely, and in the FY 1984 or FY 1985 period on which the per resident amounts are based, they ranged from $20,000 to more than $100,000. Medicare pays a percentage of the per resident amount based on its share of total inpatient days in each hospital. In recent years the per resident amount has been adjusted to pay a higher rate for primary care residents.

The COBRA legislation also limited the number of years for which Medicare would fully support its share of residency training, and in August 1993 Congress made additional changes. Today, after the period required for a resident's initial board certification in a specialty, Medicare pays only 50 percent of its share of the per resident amount. The program imposes no limit on the number of residents it supports, either at an individual hospital or in the national aggregate, as long as the residents are enrolled in an approved training program. Hospitals may receive payments for residents who are graduates of U.S. medical, osteopathic, dental, and podiatric schools and for trainees who have graduated from foreign medical schools.

■ **Medicare DGME expenditures.** According to CBO estimates, the Medicare DGME payment totaled about $2.4 billion in FY 1996.[21] Included in this estimate are about $300–$350 million in payments to hospitals for a portion of the direct costs of hospital-based nursing and allied health professions education.

■ **The Medicare IME adjustment.** The IME adjustment, part of the Medicare PPS, compensates teaching hospitals for their higher Medicare inpatient operating costs relative to nonteaching hospitals. The roots of the IME adjustment lie in the limits placed on routine hospital costs in the 1970s. Even though Medicare initially reimbursed all Medicare-allowable hospital costs, the federal government soon imposed limits on acceptable costs. Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) authorized the secretary of health, education, and welfare to set payment limits on routine inpatient hospital costs. The cost limits, intended to reduce the variation in hospital costs acceptable to Medicare and the method of setting them, evolved between 1974, when the regulations were first published, and 1979. As the cost limits became more stringent, federal policymakers and the teaching hospital community expressed concern that teaching hospitals were being disproportionately harmed because the limits did not initially recognize the costs associated with operating an educational program. Eventually, teaching hospitals were permitted to remove their DGME costs before determining whether their costs were below the limits.

The concept of indirect costs was recognized in 1980.[22] Government researchers, in studying the relationship between hospital costs and teaching status, found that even after removing DGME costs, teaching hospitals more often reached or exceeded their cost limits than nonteaching hospitals did. Researchers noted that a hospital's intern- and resident-to-bed (IRB) ratio was related to an increase in hospital costs. As a result, the Medicare routine-cost limits for teaching hospitals were increased to incorporate a differential based on the IRB ratio in each hospital. In 1982 the adjustment for teaching hospital costs was included in the extension of the routine-cost limits to cover total hospital operating costs.

In December 1982, when the secretary of health and human services proposed a new Medicare payment system for hospitals, the resident-to-bed adjustment to the routine-cost limits was converted to a PPS payment, the IME adjustment, to adjust for the higher costs of teaching hospitals.[23] The secretary's estimate indicated that Medicare operating costs per case increased approximately 5.79 percent with each 10 percent increase in the number of residents per bed. However, two months after the secretary's report, the CBO presented an impact analysis showing that the proposed DRG-based payment system would have adversely affected 71 percent of teaching hospitals if the IME adjustment were set at the 5.79 percent level. The administration then suggested that the estimate be doubled to 11.59 percent for each 10 percent increase in the IRB. Congress supported this modification, and the IME adjustment was incorporated into the prospective payment legislation.[24]

As more information became available, the IME adjustment was recalculated and lowered. The original adjustment of 11.59 percent was reduced to 8.7 percent in 1986 when better data became available. However, the 8.7 percent adjustment factor was reduced by 0.6 percentage point to finance part of the DSH adjustment, resulting in an IME adjustment factor of 8.1 percent during the time that the DSH adjustment would be in effect. The 8.1 percent IME adjustment recognized that teaching hospitals would receive a large share of DSH payments. The current 7.7 percent IME adjustment, enacted in OBRA 1987 (P.L. 100-203), took effect 1 October 1988.

■ **Mechanics of the IME adjustment.** For every Medicare case paid under the PPS, a teaching hospital receives an additional payment. A teaching hospital's IME payment is determined by inserting its IRB into a formula that is written in statute. In FY 1996 a hospital with five residents for every 100 beds (IRB = 0.05) received a 3.77 percent add-on payment for each PPS case. A hospital with fifty residents for every 100 beds (IRB = 0.50) received a 33.73 percent add-on to its basic DRG payment.

plans, the program pays 95 percent of an "up-front" monthly per capita (capitation) amount (the adjusted average per capita cost [AAPCC]) directly to the health plan. The plan's capitation payment includes what Medicare traditionally spends on DSH, DGME, and IME payments under the fee-for-service payment system.

The managed care plan then contracts with hospitals and physicians to provide services. However, instead of using Medicare fee-for-service payment methods, the risk plan negotiates with providers, including hospitals. The rates that the plan negotiates with the hospital do not necessarily include the DSH, DGME, or IME payments that would be made to the hospital if the beneficiary remained in the fee-for-service system. Alternatively, the risk plan may direct patients away from the teaching or DSH hospital to a lower-cost site of care because the plan receives the same capitation rate regardless of the provider with whom it has a contract. In either case, under a risk contract, the teaching/DSH hospital would not receive the DSH, DGME, or IME payment. These earmarked funds may be used by the risk plan for purposes other than those intended by Congress. Some policymakers and advocacy groups have proposed separating the payments from the calculation of the managed care rates and paying them directly to a teaching or DSH hospital when the facility serves a Medicare risk-plan patient.

Medicaid managed care programs pose the same problem. In general, states set managed care rates using fee-for-service historical claims data. Unless removed before calculating the health maintenance organization (HMO) rate, hospital payments for DSH and GME-related costs are included in the capitated rates the state pays to managed care plans, which are not required to distribute the funds to hospitals. A few states (New York and Michigan, for example) have created mechanisms for "carving out" the GME-related dollars from managed care rates.

■ **Problems with current support mechanisms.** The transformation of the health care delivery system highlights a range of design and technical inadequacies with the current government-funded support structures for uncompensated care and GME. These mechanisms base the level of funding on measures of Medicare or Medicaid inpatient hospital use. As states move Medicaid recipients into managed care plans, the identification of these persons for purposes of calculating both types of DSH payments under fee-for-service becomes more difficult. Because these payments use inpatient days or discharges to distribute funds, managed care's emphasis on reducing inpatient utilization eventually will result in diminished public support for uncompensated care and GME. Finally, these payments are targeted only to hospitals when the delivery system is shifting to

"Managed care's emphasis on reducing inpatient utilization eventually will result in diminished support for uncompensated care and GME."

ambulatory sites of care and nonhospital providers.

To some degree, all support mechanisms use proxies rather than direct measures. Medicaid activity represents service to the poor. The number of residents in the IME's resident-to-bed ratio serves as a surrogate for differences in inpatient operating costs. Because they use proxies, the payments may not be targeted to the appropriate institutions. In addition, the purpose of the payments may be commingled, such as IME payments ensuring access to medical care.

■ **Evolution of the competitive market.** The transition to a competitive health care market has additional implications for municipal hospitals that traditionally have served the poor. As the market constrains prices for all hospitals, Medicaid rates become more attractive to other hospitals. Public hospitals that have relied on Medicaid patients as sources of revenue must now compete with private hospitals for these same patients. Municipal hospitals may be unable to compete because they offer fewer amenities or have more unattractive facilities or locations than their competitors have. Under Medicaid managed care, former patients may seek or be directed to other providers, leaving municipal hospitals with an even less desirable patient mix. In response to the fragile situation of these hospitals, local governments are making decisions to sell tax-supported hospitals or further reduce their support.

Another sign of increased competition is the relatively recent proliferation of niche providers, such as ambulatory surgical centers or cancer management companies. Niche providers siphon off the more profitable lines of traditional hospital services, leaving to hospitals the responsibility of providing costly, often unprofitable, services to very sick populations.

The competitive market also exposes the need to identify the institutional costs related to clinical research and the provision of community services, both of which traditionally have been funded with patient care revenue. As with medical education, there are added patient care costs and lost efficiencies because of the kind of environment needed to conduct clinical research. Hospitals now finance some research through contributions to medical schools, which may support the conduct of unsponsored clinical research.

Finally, hospitals provide community services, ranging from poison control to Meals-on-Wheels programs. These services are now financed from patient care revenues, gifts, grants, and retained earn-

ings and may be the first types of programs that hospitals reduce or eliminate when confronted with financial difficulty.

Conclusion

In the changing medical care marketplace, if government is unwilling to support the uncompensated care, clinical education, research, and community service missions of hospitals, private payers will feel comfortable avoiding these costs. No one opposes hospitals' providing these services, but few see a responsibility to pay a price differential to support them. In this environment government policies set a benchmark for appropriate behavior and provide critical revenues. Federal and state initiatives to control health care costs, balance budgets, or extend trust funds place payments for uncompensated care and clinical education at risk.

The missions of uncompensated care and GME will not be preserved simply by increasing hospital efficiency. New and modified structures to finance uncompensated care and clinical education must be developed to preserve these functions. Action today can preserve the critical strengths of the U.S. health care system for tomorrow. Support structures for these missions are easy to destroy but costly and devilishly difficult to rebuild.

The views expressed in this paper are those of the authors and do not necessarily represent those of their respective associations. The authors acknowledge Richard M. Knapp and several reviewers for their constructive comments. A portion of this paper was presented at The Robert Wood Johnson/Health Affairs/Alpha Center conference, "What Is Happening to the Safety Net?," 9 January 1997, in Washington, D.C.

NOTES

1. See L.E. Fishman, "What Types of Hospitals Form the Safety Net?" in this volume of *Health Affairs* for a general description of safety-net hospitals.
2. Public appropriations, endowment income, donations, and other sources constituted the remainder. See P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 161.
3. Personal communication from Lloyd Wackerling of the Trend Analysis Group at the American Hospital Association (AHA), using data from the AHA's Annual Survey of Hospitals, 1994.
4. Prospective Payment Assessment Commission, *Medicare and the American Health Care System, Report to the Congress* (Washington: ProPAC, June 1996), 48.
5. Congressional Budget Office, *Medicare's Disproportionate Share Adjustment for Hospitals* (Washington: CBO, May 1990).
6. Nancy M. Gordon, assistant director for human resources and community development, Congressional Budget Office, testimony before the Senate Finance Subcommittee, 29 July 1985.
7. CBO, *Medicare's Disproportionate Share Adjustment for Hospitals*, xiv.
8. The inpatient days attributable to Medicaid managed care enrollees may be counted for Medicare DSH payment purposes. For a more complete discussion, see "Interpretation of Medicaid Days in Medicare DSH Adjustment Cal-

culation," HCFA Ruling no. 97-2 (27 February 1997).
9. ProPAC, *Report and Recommendations to the Congress* (Washington: ProPAC, 1 March 1997), 30.
10. Congressional Budget Office, January 1997 baseline estimates.
11. ProPAC, *Medicare and the American Health Care System, Report to the Congress* (Washington: ProPAC, June 1991), 43.
12. ProPAC, *Medicare and the American Health Care System* (June 1996), 62.
13. Ibid., 63–64.
14. See ProPAC, *Analysis of Medicaid Disproportionate Share Payment Adjustments*, Congressional Report C-94-01 (Washington: ProPAC, 1 January 1994); and L. Ku and T. Coughlin, "Medicaid Disproportionate Share and Other Special Financing Programs," *Health Care Financing Review* (Spring 1995): 27–54.
15. J. Holahan and D. Liska, *Where Is Medicaid Spending Headed?* (Washington: The Urban Institute for The Kaiser Commission on the Future of Medicaid, December 1996).
16. Ibid., 2, Table 1.
17. Derived from the FY 1998 federal budget overview, which reports actual 1996 spending.
18. Association of American Medical Colleges, *COTH Survey of Hospitals' Financial and General Operating Data, 1995* (Washington: AAMC, Autumn 1996).
19. See L.E. Fishman, *Medicare Payments with an Education Label: Fundamentals and the Future* (Washington: Association of American Medical Colleges, 1996). Medicare also recognizes the direct costs incurred by hospital-based nurse education and allied health professions training programs.
20. *Senate Report* 404, Pt. 1, 89th Cong., 1st sess. 36 (1965); and *House Report* 213, 89th Cong., 1st sess. 32 (1965).
21. *Federal Register* (30 August 1996): 46206–46207.
22. K. Davis et al., *Health Care Cost Containment* (Baltimore: The Johns Hopkins University Press, 1990), 16–21.
23. Secretary of the Department of Health and Human Services, *Hospital Prospective Payment for Medicare: A Report to Congress* (Washington: U.S. Government Printing Office, December 1982), 48–49.
24. J.R. Lave, *The Medicare Adjustment for the Indirect Costs of Medical Education: Historical Development and Current Status* (Washington: Association of American Medical Colleges, January 1985).
25. ProPAC, *Medicare and the American Health Care System* (June 1996), 62–63.
26. Ibid., 62.
27. D. Plumb and T. Henderson, *Medicaid Funding of Graduate Medical Education: A Survey of the States* (Washington: The Intergovernmental Health Policy Project at The George Washington University, October 1995).
28. AAMC, *COTH Survey of Hospitals' Financial and General Operating Data, 1995.*
29. *1997 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, House Document 105-73 (April 1997).
30. ProPAC reported at its January 1997 meeting that in 1995–1996, major teaching hospitals' aggregate PPS inpatient margin was 18.6 percent, compared with 3.7 percent for nonteaching hospitals. Major teaching hospitals continue to have the lowest total margins of any hospital group, however, at 3.7 percent, compared with 6.5 percent for nonteaching hospitals in 1995–1996.

A Changing Picture Of Uncompensated Care

Hospitals, physicians, and community health centers all provide charity care. To ignore any one of the groups could distort notions about changes in access to care for the uninsured.

BY PETER J. CUNNINGHAM AND HA T. TU

CHANGES IN THE HEALTH CARE system are causing renewed concern about access to care for uninsured persons. This paper reviews trends in the amount of resources that providers are devoting to care of the medically indigent, as indicated by uncompensated care costs. The results of this study show that the amount of services provided to the medically indigent has indeed changed over the past ten to fifteen years, although the direction of the change is not consistent across types of providers. Hospital uncompensated care costs, which rose rather substantially during the early 1980s, have been relatively stagnant during the 1990s, while provision of uncompensated care by physicians and community health centers has increased. In addition, hospital uncompensated care costs have become more concentrated among public hospitals and other hospitals that provide a disproportionately high level of uncompensated care. These findings may have important implications for access to care among the uninsured.

UNCOMPENSATED CARE TRENDS

There are identifiable groups of safety-net providers—such as public hospitals, some private nonprofit hospitals, and community health centers—that serve a disproportionately high number of the medically indigent. However, focusing only on these providers is problematic, both because they usually serve other patients and because a substantial amount of charity and uncompensated care is dispensed by providers that serve the general population. Also, while hospitals have traditionally been considered the providers of last resort for the medically indigent, ignoring trends in physician uncompensated care may result in false conclusions about changes in access. Thus, this study examines trends in uncompensated care for all hospitals as well as physicians and community health centers.[1]

■ HOSPITALS. Hospitals subsidize care to the medically indigent through both direct funding from public sources—tax revenue, uncompensated care pools, and Medicare and Medicaid disproportionate-share adjustments—and private philanthropy, as well as indirectly by shifting the costs of uncompensated care onto other payers.

Despite increases in the number of uninsured persons, there have not been increases in the relative amount of uncompensated care provided by hospitals during the first part of the 1990s, either in terms of inflation-adjusted costs or as a percentage of total costs (Exhibit 1).[2] However, it appears that uncompensated care costs became somewhat more concentrated among fewer hospitals. The percentage of hospitals that provided high levels of uncompensated care (10 percent or more of total costs) decreased between 1990 and 1994, al-

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though this smaller group incurred a larger proportion of total hospital uncompensated care costs (from 36.5 percent in 1990 to 38.2 percent in 1994). Public hospitals also incurred a larger burden of uncompensated care in 1994 than in 1990, as indicated by increases in both the percentage of total costs devoted to uncompensated care (from 11.8 percent in 1990 to 12.8 percent in 1994) and the proportion of all hospital uncompensated care costs incurred by public hospitals (from 33.4 percent in 1990 to 36.8 percent in 1994).

While these changes are fairly modest in magnitude, they represent a reversal of the trends of the previous decade. Between 1980 and 1990, the relative costs of uncompensated care for all community hospitals increased by about 20 percent, with much of the increase occurring in the first half of the 1980s. Moreover, uncompensated care costs became less concentrated during the 1980s. Substantial increases in the number and percentage of hospitals that provided a large amount of uncompensated care were accompanied by equally substantial decreases in the number of hospitals that provided relatively little uncompensated care. Also in contrast to the 1990s, private hospitals incurred the largest increase in uncompensated care costs during the 1980s, in terms of both the relative amount provided and the proportion of total uncompensated care costs.

Why have the trends in the amount and distribution of uncompensated care that occurred in the first half of the 1980s started to reverse in the 1990s, despite the fact that the "demand" for uncompensated care has continued to increase? Perhaps the most plausible explanation is that market pressures faced by hospitals have constrained their ability and willingness to provide uncompensated care in recent years. The ability to shift costs has been more limited in the 1990s compared with the 1980s, partly because of increasing competition and involvement with managed care plans, which many consider to be more vigorous in controlling costs.[3] More than two-thirds of private hospitals now have at least one health maintenance organization (HMO) contract, compared with about 55 percent in 1990.[4] To compound the problem, government subsidies now cover a smaller share of hospital uncompensated care costs, down from 27.8 percent in 1980 to 19.3 percent in 1994 (Exhibit 1).

If private hospitals become increasingly limited in their ability and willingness to provide uncompensated care, it will be difficult for public hospitals to make up the difference. Medicaid expansions and sizable increases in Medicaid disproportionate-share funding may have helped to fuel the small increase in uncompensated care provided by public hospitals during the 1990s, but continued reliance on this source of revenue is not likely because of smaller increases in the number of Medicaid beneficiaries and new limitations on disproportionate-share payments.

In addition, if private hospitals simultaneously reduce their uncompensated care burdens and attract more Medicaid managed care patients, then public hospitals will be compelled to absorb even larger numbers of uninsured patients while at the same time losing a vital source of revenue. This could seriously harm public hospitals' role as providers of last resort. Not only do public hospitals provide more than twice as much uncompensated care as private hospitals provide on average, but research has shown that the total amount of uncompensated care provided in a community tends to be greater in communities with a public hospital than in those without.[5]

■ **PRIVATE PHYSICIANS.** Although most physicians receive no explicit subsidy to provide services to the uninsured, data from the American Medical Association's (AMA's) Socioeconomic Monitoring System (SMS) survey indicate that the amount of charity and uncompensated care provided by physicians is on the the rise.[6] Nearly 68 percent of physicians in 1994 provided some charity care (that is, care that was provided free of charge or at a reduced fee because of the financial need of the patient) (Exhibit 2).[7] This represents an increase from 1990 (63.8 percent) and 1988 (62.0 percent). For physicians who provided charity care, the average amount of time

EXHIBIT 1
Trends In Hospital Provision Of Uncompensated Care, 1980–1994

Trends	Year 1980	1985	1990	1994
Total costs of uncompensated care (billions of dollars)[a]				
All hospitals	$13.8	$15.7	$16.7	$16.8
Public hospitals	6.0	5.5	5.6	6.2
Private hospitals	7.8	10.2	10.9	10.6
Uncompensated care costs as percent of total costs				
All hospitals	5.1%	5.7%	5.9%	6.1%
Public hospitals	11.2	11.4	11.8	12.8
Private hospitals	3.6	4.5	4.7	4.7
Percent distribution of hospitals, by level of uncompensated care costs incurred[b]				
0–2% of total costs	31.1	19.1	20.6	21.6
3–5%	48.8	48.4	45.3	45.2
6–9%	14.8	23.4	24.4	24.7
10% or more	5.3	9.0	9.6	8.5
Percent distribution of hospitals with "high" uncompensated care costs, by ownership[c]				
Public	68.4	59.7	54.9	56.1
Private	31.6	40.3	45.1	43.9
Percent distribution of total uncompensated care costs, by level of uncompensated care costs incurred[b]				
0–2% of total costs	9.3	5.4	5.0	5.4
3–5%	34.1	35.4	31.9	31.3
6–9%	19.3	22.9	26.5	25.1
10% or more	37.2	36.4	36.5	38.2
Percent of total uncompensated care costs incurred by public hospitals	43.1	35.1	33.4	36.8
Percent of uncompensated care costs covered by government subsidies				
All hospitals	27.8	19.8	21.0	19.3

SOURCE: American Hospital Association annual surveys.
NOTES: Estimates are for all U.S. registered community hospitals.
[a] Results for 1980–1990 were adjusted for inflation to reflect 1994 dollars, based on the Consumer Price Index for hospital services.
[b] Uncompensated care costs were measured as a percentage of total costs for each hospital.
[c] A hospital is classified as incurring high uncompensated costs if these costs equal or exceed 10 percent of its total costs.

they spent providing that care also increased between 1990 and 1994. Total uncompensated care costs (including bad debt) in 1994 were estimated at $21 billion, an increase of about 65 percent from 1990 after inflation.

The increase in physician uncompensated care was a combination of increases in both charity care provision and bad debt. While increases in the number of uninsured may have contributed to the greater amount of charity care provided, increases in bad-debt costs may have resulted from greater numbers of underinsured patients.[8] More vigorous efforts to control uncompensated care costs on the part of hospitals as well as the general shift of health care resources from hospital-based

EXHIBIT 2
Uncompensated Care Provided By Physicians, 1988–1994

	Year		
	1988	1990	1994
Percent of physicians providing charity care	62.0%	63.8%	67.7%
Time spent providing free and reduced-fee care[a]			
Hours per week that physicians provide charity care	6.6	6.5	7.2
Charity care hours as percent of total hours worked	11.0%	10.6%	12.4%
Uncompensated care costs (billions of dollars)[b]	–[c]	$12.76	$21.14

SOURCE: D.W. Emmons, "Uncompensated Physician Care," in *Socioeconomic Characteristics of Medical Practice, 1995* (Chicago: American Medical Association, Center for Health Policy Research, 1995).
[a] Based on physicians who provided charity care.
[b] Results for 1990 were adjusted by the authors for inflation to reflect 1994 dollars based on the Consumer Price Index for physician services.
[c] Not available.

inpatient care to office-based outpatient care may also be fueling the increased demand for physician uncompensated care.

Nevertheless, the substantial increase in physician uncompensated care is somewhat unexpected, since physicians are subject to the same financial pressures that are making it difficult for hospitals to provide charity care. It is possible that the potential effects of some of these pressures either have been exaggerated or have yet to have a meaningful impact on physicians. For example, the proportion of physician practice revenue derived from managed care contracts increased only from 28 percent in 1990 to 34 percent in 1994, which suggests that the level of managed care involvement among physicians was not yet high enough during that time to have a significant impact on charity care provision.[9]

■ COMMUNITY HEALTH CENTERS. Community health centers receive grants from the federal government and other sources to provide comprehensive primary health care services to persons living in medically underserved areas. According to data from the Bureau of Primary Health Care, the number of community health center sites, patients served at those sites, and primary care physicians practicing at those sites increased substantially during the 1990s (Exhibit 3). Community health center capacity and revenue expanded during the 1990s, in large part because of a substantial increase in revenue from Medicaid. Medicaid accounted for one-third of all community health center revenue in 1995, up from 20.3 percent in 1990. The influx of Medicaid revenue is the result of both expanded eligibility and legislation that mandated cost reimbursement for Medicaid patients at federally qualified health centers.

Expansion of community health center capacity has permitted an increase in the number of uninsured patients treated at community health centers—from about 2.2 million in 1990 to almost three million in 1995. The estimated cost of providing services to the uninsured was more than $1 billion in 1995, a 55 percent increase from 1990 even after taking inflation into account.[10] However, it is important to note that even though uninsured patients comprise 40 to 45 percent of community health centers' patients and total costs, community health centers actually serve only a small percentage of the total uninsured population (6.5 percent). The aggregate costs for community health centers of providing services to the uninsured are much smaller than the aggregate costs of services provided to the uninsured by physicians and hospitals. The relatively small number of uninsured persons served by community health centers is probably attributable to the fact that such

centers are not located in all U.S. communities. In addition, many uninsured persons, most of whom have incomes above the poverty line, do not live in the medically underserved areas targeted by community health centers.

Although increased Medicaid revenue has probably benefited community health centers' Medicaid and uninsured patients, increasing reliance on Medicaid as a major source of revenue carries some risks, especially given the shift to managed care. Low capitation rates for Medicaid managed care patients may result in greater financial strains for community health centers, whereas high rates could result in greater competition from private health plans and other providers for this vital source of revenue. In contrast to public hospitals, however, community health centers may be in a better position to survive by entering into various types of arrangements with health plans and providers, which are attracted to community health centers because of their primary care emphasis and expertise and large Medicaid patient base.[11]

■ DISTRIBUTION OF UNCOMPENSATED CARE COSTS. The trends in Exhibits 1, 2, and 3 imply that there has been a shift of uncompensated care resources from hospital to nonhospital sources, although direct comparisons

EXHIBIT 3
Trends in Community Health Centers, 1990–1995

Trends	Year 1990	1993	1995
Number of community health center sites	1,396	1,574	1,647
Number of patients served (thousands)	5,887	6,866	7,787
Primary care physicians			
Total number of primary care physicians serving at community health centers	2,450	3,000	3,450
Average number of primary care physicians per 10,000 medical care users	4.80	5.03	5.14
Community health center revenues			
Total revenues (millions of dollars)	$1,631	$2,158	$2,396
Percent of revenue by source			
Federal grants	40.3%	31.7%	28.4%
State, local, and other sources	15.9	16.7	16.7
Medicaid	20.3	31.9	33.4
Medicare	6.0	5.2	6.5
Other third party	8.8	7.7	8.3
Patient fees	8.8	6.7	6.7
Uninsured patients at community health centers			
Number of uninsured patients (thousands)	2,240	2,770	2,985
Percent of all community health center patients	38.0%	39.0%	39.0%
Percent of uninsured persons who use community health centers	5.4	5.6	6.5
Cost of care for uninsured persons			
For all services (millions of dollars)[a]	$680	$943	$1,054
Percent of total costs	41.8%	44.5%	44.0%

SOURCE: U.S. Department of Health and Human Services, Public Health Service, Bureau of Primary Health Care, unpublished data.

NOTE: Includes community and migrant health centers covered under Sections 329 and 330 of the Public Health Service Act.

[a] Estimated as the sum of costs of medical services to uninsured persons, plus the costs of enabling services, minus patient fees. Results for 1990 and 1993 were adjusted for inflation to reflect 1995 dollars based on the Consumer Price Index for physician services.

in the relative magnitude of hospital, physician, and community health center uncompensated care costs are problematic because of different data collection and computational methods. Charity care and bad-debt expenses in the American Hospital Association (AHA) annual survey are obtained directly from hospital financial records.[12] Physician uncompensated care is calculated by the AMA by multiplying hours of charity care by the value of physicians' time (that is, mean gross earnings) and adding bad-debt expenses. All three components of the physician uncompensated care measure are based on respondents' estimates, which are subject to recall error. Estimates of the amount of care that community health centers provide to uninsured patients involved multiplying the number of uninsured patients by the average cost per patient plus the costs of enabling services.

These methodological differences make it difficult to conclude that physicians actually provided more uncompensated care than hospitals provided in 1994 ($21 billion for physicians versus $16.8 billion for hospitals). However, community health centers clearly have a much smaller share of the uncompensated care market than either physicians or hospitals have. Nevertheless, because these methods are at least consistent over time, it is plausible that the almost zero growth in hospital uncompensated care costs during the first part of the 1990s and the large increases in physician uncompensated care costs and community health center costs strongly suggest that there has been a shift in uncompensated care costs from hospitals to nonhospital sources.

■ IMPLICATIONS FOR ACCESS. While the amount of uncompensated care provided has important implications for access to care for the uninsured, it is a relatively poor measure with which to assess changes in access. First, it is unclear whether trends in uncompensated care reflect changes in demand (for example, the number of uninsured persons) or changes in supply (for example, as a result of competition and providers' financial circumstances). In addition, uncompensated care measures do not reflect the relatively high percentage of uninsured persons who report unmet health needs, nor do they indicate appropriateness of care setting and whether care was received in a timely and cost-effective manner.[13] Direct measures of access to care are required to draw more firm conclusions about trends in access to care for the uninsured.

While physician uncompensated care increased substantially between 1990 and 1994, physician use by the uninsured remained essentially unchanged during this period (about three visits a year on average per person), and the gap in physician use between uninsured and privately insured persons widened slightly (Exhibit 4). Furthermore, the percentage of uninsured persons who lacked a usual source of care, a traditional measure of access that facilitates entry into the system, increased from 27.7 percent in 1977 to 35.9 percent in 1993 (with 7 percent of the increase taking place between 1977 and 1987), which indicates that nonemergency access to primary care among uninsured persons is deteriorating. The percentage of privately insured persons without a usual source of care decreased between 1987 and 1993, thereby greatly increasing the disparity between uninsured and privately insured persons, which may reflect increases in the percentage of privately insured persons who were in HMOs and other managed care plans that require enrollees to have a primary care provider.[14]

Inferences about access based on hospital uncompensated care measures are even more problematic. First, hospital utilization for all groups has declined substantially over the past fifteen years as a result of cost control measures by payers as well as innovations in care delivery that allow more procedures to be done in ambulatory settings. Thus, changes in the consumption of hospital services, as indicated by hospital uncompensated care, rates of discharges, or lengths-of-stay, tell us very little about changes in access to hospital care.

Second, hospitalizations are increasingly viewed as reflective of poor outcomes of care for certain conditions that are considered treatable in ambulatory care settings. Pre-

EXHIBIT 4
Estimates Of Access To Care And Service Use By The Uninsured And Privately Insured, By Measure And Year

Measure and year	Estimate for uninsured persons	Estimate for privately insured persons
Average number of annual physician visits per person[a]		
1986	3.1	4.2
1990	3.2	4.4
1994	3.0	4.6
Percent of persons without a usual source of care[b]		
1977	27.7%	15.3%
1987	34.6	18.5
1993	35.9	11.3
Hospital discharges per 1,000 persons[a]		
1986	63.3	75.5
1990	58.3	64.1
1994	47.7	56.6
Percent of hospital discharges for ACS conditions[c]		
1985	6.8%	5.3%
1990	10.1	6.6
1994	12.7	7.6

SOURCES: National Health Interview Survey; National Medical Expenditure Survey; and National Hospital Discharge Survey.
NOTES: All estimates are for persons under age sixty-five. All estimates are age-adjusted, using as the base the age distribution of the privately insured population in the most recent year (1993 for the usual source of care measure; 1994 for all other measures). ACS is ambulatory care–sensitive.
[a] Based on the National Health Interview Survey.
[b] Based on the National Medical Expenditure Survey (1977, 1987) and the National Health Interview Survey (1993).
[c] Based on the National Hospital Discharge Survey. ACS conditions were defined similarly to those used in J.S. Weissman, C. Gatsonis, and A.M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* (4 November 1992): 2388–2394. Conditions include ruptured appendix, asthma, cellulitis, congestive heart failure, diabetes, gangrene, immunizable conditions, malignant hypertension, pneumonia, pyelonephritis, and chronic obstructive pulmonary disease. Uninsured is defined as discharges that were classified as self-pay or no charge.

vious research has found that rates of hospitalizations for ambulatory care–sensitive (ACS) conditions are higher among the uninsured than the privately insured, which researchers interpret as indicating less access to primary care for uninsured persons.[15] Furthermore, this disparity has grown worse over the past ten years. The percentage of hospital discharges for ACS conditions among uninsured persons almost doubled between 1985 and 1994, and discharges for these conditions were 1.67 times higher for uninsured persons than for privately insured persons in 1994, compared with 1.29 times higher in 1985 (Exhibit 4).[16] With the increasing emphasis on providing timely treatment in the least costly settings, it will be difficult to determine whether increases in hospital uncompensated care costs reflect increased access to hospital services or decreased access to office-based primary care for uninsured persons.

CONCLUSION

Policymakers are concerned about potential reductions in the provision of uncompensated care because these reductions could result in a serious deterioriation in access to care for the uninsured. While much of this concern is focused on the traditional safety-net providers—public hospitals and community health

centers—there is perhaps an even greater threat from the pressures on mainstream providers—private hospitals and physicians—to limit their uncompensated care services. While mainstream providers currently provide most of the uncompensated care, they receive few government subsidies to finance this care, and, unlike public hospitals and community health centers, many do not have an explicit mission to serve the uninsured. Given the substantial challenges that traditional safety-net providers face just to survive in the near future, they will have difficulty absorbing an even greater burden of uncompensated care.

Data required to understand these changes and their effect on access to care for the uninsured are limited. Previous research has focused on hospital uncompensated care, in part because these data are more extensive than are data on uncompensated care by other providers. However, this focus ignores the sizable amount of charity care provided by physicians and other nonhospital providers. In addition, changing delivery patterns are probably resulting in a shift of uncompensated care resources from inpatient to outpatient services. The shift from high-cost hospital-based services to lower-cost outpatient facilities increases the importance of examining changes in the distribution of uncompensated care costs across different providers. This will be difficult, if not impossible, for most communities, however, because of the lack of data on uncompensated care from private physicians and other providers and problems of comparability of data sources when they exist.

Finally, more direct measurement of access through population surveys and other methods is necessary to fully understand the impact that system changes are having on care for the uninsured. Access is not just a question of adequate resources but also includes the process of getting care (for example, the proximity of providers, the convenience of office hours, and getting the necessary care and treatment once inside the system) and the appropriate level and type of care. Measures of uncompensated care tell us very little about these more complex phenomena.

The Center for Studying Health System Change is supported in full by The Robert Wood Johnson Foundation. The authors gratefully acknowledge the support and assistance of the individuals and organizations that provided data for this study: Joe Martin and Lloyd Wackerling, American Hospital Association; Bonnie Lefkowitz, Bureau of Primary Health Care; Joel Cohen, Agency for Health Care Policy and Research; Ann Hardy, Peggy Barker, and Susan Jack, National Center for Health Statistics (NCHS) (National Health Interview Survey); and Robert Pokras, Maria Owings, and Elaine Wood, NCHS (National Hospital Discharge Survey). The authors also acknowledge Linda Kohn of the Center for Studying Health System Change (CSHSC) for valuable contributions to the conceptualization of this study; Mary Harrington of Mathematica Policy Research, Inc., Jack Ashby of the Prospective Payment Assessment Commission, and David Emmons of the American Medical Association for helpful comments on some specific findings; Paul Ginsburg, Joy Grossman, Mark Legnini, and Jim Reschovsky from CSHSC and Jane Stein from The Stein Group for their review of earlier drafts and many helpful comments; Jeremy Pickreign from CSHSC and Ase Sewall and Beny Wu from Social and Scientific Systems for programming support; and Ruth Griffin from CSHSC for assistance with the preparation of tables.

NOTES

1. Local public health departments and clinics that do not receive federal grant funds (but are considered federally qualified health centers for Medicaid reimbursement) also provide a disproportionately large amount of indigent care. However, they are excluded from this analysis primarily because of lack of national data. Although conclusions about trends in the capacity of the safety net must consider these omissions, it is likely that they treat only a small portion of the care provided to uninsured patients. Federally assisted health centers account for more than 80 percent of all patients of federally qualified health centers (estimated by comparing data on all federally qualified health centers, compiled by the National Association of Community Health Centers, with data on federally assisted community health centers from the Bureau of Primary Health Care). Also, approximately 70 percent of local health departments do not provide primary care services. National Association of County and City Health

Officials and Centers for Disease Control and Prevention, 1992–1993 *National Profile of Local Health Departments* (Washington: NACCHO, 1995).

2. Hospital uncompensated care costs are defined as the sum of charity care and bad debt. Uncompensated care net of government subsidies is a more appropriate measure when assessing the financial burden of uncompensated care on hospitals.
3. J. Mann et al., "Uncompensated Care: Hospitals' Responses to Fiscal Pressures," *Health Affairs* (Spring 1995): 263–270.
4. Prospective Payment Assessment Commission, *Medicare and the American Health Care System: Report to the Congress* (Washington: ProPAC, 1996), 34.
5. K. Thorpe and C. Brecher, "Improved Access to Care for the Uninsured Poor in Large Cities: Do Public Hospitals Make a Difference?" *Journal of Health Politics, Policy and Law* (Summer 1987): 313–324.
6. It is important to note that the method for determining charity and uncompensated care costs for physicians is considerably different than it is for hospitals. The former relies largely on physicians' recall of the number of hours they spent in the previous week providing care for free or at a reduced charge and is subject to reporting error. The extent of this error is unknown. By contrast, hospital uncompensated care costs are derived directly from hospital financial records.
7. The estimates of physician charity and uncompensated care in Exhibit 2 were computed by researchers at the American Medical Association. See D.W. Emmons, "Uncompensated Physician Care," in *Socioeconomic Characteristics of Medical Practice, 1995* (Chicago: AMA, Center for Health Policy Research, 1995).
8. P.F. Short and J.S. Banthin, "New Estimates of the Underinsured Younger than 65 Years," *Journal of the American Medical Association* 274, no. 16 (1995): 1302–1306.
9. D.W. Emmons and C.J. Simon, "Managed Care: Participation, Revenues, and Risk," in *Socioeconomic Characteristics of Medical Practice, 1995.*
10. Since community health centers receive federal grants, few services are truly uncompensated. The estimates cited serve as a proxy for uncompensated care costs and refer to services that are not generally reimbursable through third parties but are subsidized through federal grants and other funding sources.
11. D.J. Lipson and N. Naierman, "Effects of Health System Change on Safety-Net Providers," *Health Affairs* (Summer 1996): 33–48.
12. Financial data are missing for some hospitals in the AHA survey. For example, uncompensated care data were missing for about 18 percent of hospitals in the 1994 AHA survey and were imputed by AHA researchers.
13. M.L. Berk, C.L. Schur, and J.C. Cantor, "Ability to Obtain Health Care: Recent Estimates from the Robert Wood Johnson Foundation National Access to Care Survey," *Health Affairs* (Fall 1995): 139–146; and K. Donelan et al., "Whatever Happened to the Health Insurance Crisis in the United States?" *Journal of the American Medical Association* 276, no. 16 (1996): 1346–1350.
14. In this analysis, persons who identified a hospital emergency room as their usual source of care were classified as not having a usual source of care. The differences in usual source of care mentioned in the text were statistically significant at the .05 level. Some caution should be used with these findings, since the estimates for different years are based on different surveys. The National Health Interview Survey (NHIS) was used for the 1993 estimates, while the National Medical Expenditure Survey (NMES) was used for 1977 and 1987. Usual source of care was not available in earlier versions of the NHIS, and the most recent NMES is not yet available. Although there are some differences, the surveys use similar wording for the usual-source-of-care question, mode of interview (in-person), use of proxy responses, length of interview (and placement of the question in a special supplement toward the end of the interview), and design of population weights. There were some differences in the way that insurance status was ascertained, although attempts were made to minimize these differences.
15. J.S. Weissman, C. Gatsonis, and A.M. Epstein, "Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland," *Journal of the American Medical Association* (4 November 1992): 2388–2394.
16. The differences mentioned in the text are statistically significant at the .05 level. It is important to note that the percentage of hospital discharges for ACS conditions increased for all persons during this period, regardless of insurance status. Thus, caution should be used in interpreting these findings, since it is likely that factors unrelated to access are affecting changes in hospital use patterns. Nevertheless, the fact that the rate of increase for uninsured persons was more than double that of privately insured persons suggests that the use of inpatient services for ACS conditions relative to more general changes in hospital utilization patterns is increasing.

Lessons From Arizona's Medicaid Managed Care Program

With thirteen years of experience, Arizona's Medicaid managed care program offers valuable insight into the potential and pitfalls of this form of safety-net system.

BY NELDA MCCALL

WITH INCREASED PRESSURE ON public programs to decrease costs while maintaining a safety net of service use for beneficiaries, many state Medicaid programs are looking to managed care as an important component of an improved and more cost-effective delivery system. This paper examines the lessons learned from evaluations of the first statewide managed Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS).[1] The paper focuses on two questions: (1) Does the experience in Arizona justify expansion of Medicaid managed care to other states? (2) What lessons learned in Arizona should other states consider as they move into Medicaid managed care?

THE AHCCCS PROGRAM

The AHCCCS program began in October 1982 as an alternative to traditional Medicaid. Before AHCCCS, Arizona was the only state not participating in Medicaid. The original AHCCCS program did not cover nursing home care. In 1989 the Arizona Long-Term Care System (ALTCS) was incorporated into AHCCCS. ALTCS provides a full range of acute home-based and community-based services and nursing home services to Medicaid eligibles who are at risk of institutionalization.

The AHCCCS program provides managed care services through acute care plans and long-term care contractors capitated by the state. Covered services for Medicare beneficiaries are paid for on a fee-for-service basis by Medicare. Providers are required to bill Medicare first for such services.[2] The state provides the overall direction for the program with responsibilities for eligibility and enrollment; selecting, paying, and regulating capitated providers; monitoring the quality and appropriateness of care; and maintaining an information system to support program operations. In addition, Arizona provides reinsurance for inpatient services and coverage for catastrophic services. In the past, AHCCCS has also acted as the plan or contractor in counties for which it was unable to find a qualified organization at an acceptable capitation rate.

Plans and contractors engage in a broad range of service delivery, internal monitoring, and data-sharing activities. Besides providing case-managed covered services, they must manage a provider network, distribute a member handbook, and collect third-party

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and patient liabilities. They must also maintain systems for quality management, financial management, grievance and appeals, and data management. The data management system must support timely submission of data to AHCCCS.

AHCCCS covered about 463,000 beneficiaries in the acute part of the program and 23,000 beneficiaries in ALTCS in March 1997. Most acute care beneficiaries were served through one of the fourteen health plans selected through a competitive bidding process. The state releases a request for proposals that lists participation requirements and evaluation criteria. Acute care beneficiaries choose from among the health plans available in their county. All of the counties have more than one health plan.

The long-term care program serves those who are financially eligible (up to 300 percent of Supplemental Security Income eligibility) and determined by state assessors, using a preadmission screening instrument, to be at risk of institutionalization. Beneficiaries include the elderly and physically disabled and the mentally retarded/developmentally disabled. Five counties and two private entities serve as contractors for the elderly and physically disabled. There is only one contractor per county. The Arizona Department of Economic Security is the contractor for the mentally retarded/developmentally disabled.[3] Contractors provide case management and make placement decisions.[4] They are capitated at a negotiated rate using a methodology that provides economic incentives to care for beneficiaries at home rather than in nursing homes.

Does Arizona's Experience Justify Expansion Of Medicaid Managed Care?

The successes and failures of the longest-running statewide Medicaid managed care program serving all eligibility groups should be considered by other states in their decisions about whether and how to implement Medicaid managed care. This section summarizes the evaluation of several aspects of the Arizona program: cost of the program, use of health care services by program beneficiaries, and access to and quality of services received under AHCCCS.[5]

■ COST. The cost analyses for the acute care AHCCCS program compared the actual per capita costs by eligibility group with an estimate of the per capita costs of a traditional Medicaid program in Arizona.[6] Comparison states were those with reliable and complete data that were similar to Arizona in their Medicaid requirements. For fiscal year (FY) 1983 through FY 1993, savings of $197 million were estimated, an average savings per year of approximately 11 percent of medical service costs and 7 percent of total costs (medical service costs plus administrative costs). The average annual increase in cost for the AHCCCS acute care program (9.1 percent) was also smaller than the annual increase for the traditional program (10.3 percent).

The ALTCS cost analyses compared the number of users, cost per month, and total cost for ALTCS with estimates of what a traditional Medicaid program in Arizona would have cost for the first five years of the program, 1989 through 1993. Estimates for the traditional program were made for comparison states using the Medicaid Statistical Information System. ALTCS costs, including medical and administrative costs, were on average 16 percent per year lower than the costs of a traditional Medicaid program in Arizona. When considering medical services alone, the ALTCS savings were 18 percent per year. Total cost savings were almost $290 million, and these savings increased substantially over time (0.2 percent in 1989, 8 percent in 1990, 15 percent in 1991, and 21 percent in 1992 and 1993). The average annual cost increases for ALTCS were lower than the increases for a traditional program, 4.0 percent per year versus an estimated 9.6 percent per year.

■ USE OF SERVICES. Examination of the long-term care and acute care programs found that beneficiaries in these programs used less institutional care than Medicaid beneficiaries in New Mexico used and more or about the same amount of ambulatory care.

The analysis for the acute care program was based on Medicaid claims and encounters for a 5 percent randomly selected sample of AHCCCS and New Mexico Medicaid beneficiaries for FYs 1991 and 1992. For the long-term care program, ALTCS claims data and encounters data for all eligible beneficiaries receiving chronic long-term care services in New Mexico were linked with Medicare claims to give a full picture of all medical care service use for January 1991 through September 1992. Services in both states were categorized using the same methods.[7]

Beneficiaries of Aid to Families with Dependent Children (AFDC) in the acute care programs in Arizona and New Mexico had about five evaluation and management visits (that is, office, home, nursing home, specialty, consultations, and therapies) per person-year, but the number of hospital days per thousand person-years was 40 percent lower in Arizona (590 days versus 976 days). Evaluation and management visits for ALTCS elderly and physically disabled eligibles resulted in more visits (thirteen versus nine), but the number of hospital days per thousand person-years was 22 percent lower than in the traditional program in New Mexico (3,692 versus 4,731).

■ QUALITY AND ACCESS. Several quality and access studies of the AHCCCS and ALTCS programs, which used New Mexico Medicaid beneficiaries as the control group, revealed mixed results. An access and satisfaction survey conducted in 1985 indicated better access to routine and urgent care in AHCCCS than in the New Mexico program and high satisfaction scores for services. Primary prevention, preventive care use, and use of medical care for particular symptoms were similar in the two states. A review of Medicaid records of AFDC children and pregnant women in 1985–1987 indicated earlier, more frequent, and more complete health care for children in Arizona. Maternity care and pregnancy outcomes were similar in the two states, but Arizona had later initiation of pregnancy care and fewer prenatal visits.

With respect to the ALTCS program, a review of nursing home records in 1991 and 1992 revealed that Arizona's elderly and disabled beneficiaries were more likely than New Mexico's elderly and disabled to have pressure sores, fever, or a catheter inserted and less likely to be offered an influenza vaccine. The incidence of falls and fractures and the use of psychotropic drugs were similar in the two states. In response to these findings, ALTCS initiated steps to include monitoring of the problem areas in their ongoing quality assurance activities.

Analyses of new admissions of elderly and physically disabled beneficiaries into the long-term care program found a much more coordinated system of care in Arizona, which permitted transitions from nursing home to home care and vice versa. Evaluation of the cost-effectiveness of home care provided under ALTCS indicated that attempts to limit spending on long-term care by diverting clients to home care settings have been successful. This is in stark contrast to previous evaluations of home and community-based care programs that have found home care to be a complement to institutional care, not a substitute.[8]

The analyses of the two programs' outcomes indicated that the program was providing better access to good-quality care at a lower cost. However, some of the analyses showed the program to be doing worse than a traditional Medicaid program, suggesting the need for close monitoring of quality-of-care and access issues. Studies performed over the course of the two evaluations highlighted areas in which AHCCCS procedures and methods could be improved and demonstrated the importance of having an ongoing analysis capacity within the administration of a managed care program.

Lessons From Arizona?

Besides looking at program outcomes, the analyses also examined the implementation and operation of the major features of the AHCCCS program. States implementing managed care may want to consider the following five recommendations in designing and implementing their programs.

■ SELECT LEADERS WHO HAVE THE REQUIRED SKILLS. When designing and implementing new managed care programs, leadership is needed in three key positions that do not always exist in traditional Medicaid programs: a chief information officer who knows how to collect and analyze data and use it for policy development; a chief financial officer who has experience in the financial management of managed care organizations and who can lead the monitoring of plan operations; and a chief medical officer who has experience leading activities in assuring and monitoring the quality of care in the delivery of Medicaid services. AHCCCS did not have persons with these kinds of skills in place at the beginning of the program, and many of its implementation problems can be traced to this lack of leadership. In the three areas outlined, the leaders must be in senior positions in the organization and have sufficient stature to conduct discussions and negotiations with other state organizations and with health plan chief executive officers. In addition, these leaders must have the vision to formulate a specific plan of operation and select and manage appropriate staff.

■ CONSIDER DESIGN OPTIONS FOR THE PROGRAM'S OPERATIONS. The design of the following operational areas is particularly important to the AHCCCS program and should be carefully considered in any new program.

Eligibility determination and enrollment. AHCCCS acute care implementation analyses suggest that carefully thinking through the process of enrollment and how it interacts with the process of eligibility determination can help to avoid unnecessary fee-for-service liabilities. If beneficiaries select from multiple plans, the plans' marketing materials, media advertising, and solicitation methods should be reviewed and approved. In Arizona's ALTCS program, the state performs the functional/medical assessment for eligibility using a preadmission screening instrument and therefore controls entry into the system.

Responsibilities of the capitated entities and the state. Central to the workings of the AHCCCS program is the relationship between the state and the health plans and contractors. Responsibilities of the contracting entities in AHCCCS include a specifically defined broad range of service delivery, internal monitoring, third-party liability identification and collection, and data-sharing activities. The state also has defined responsibilities that are consistent with its primary responsibility for overall program direction. Clear definition of authorities and responsibilities is critical to program success.

Rules for participation and selection. Participation and selection criteria also need to be clearly defined. Participation in AHCCCS is restricted to organizations that meet specific network requirements; have internal controls for quality, financial, and grievance monitoring; and have systems in place to produce the data that are required under the program. Selection of winning bidders follows a defined structure that emphasizes the provider network in selection but also considers the capitation rate bid, the ability of the contractor to meet the program's requirements, and the qualifications of the organization. Having bidders who do not win contracts is important to keeping the marketplace competitive.

Method of setting capitation payment. The way capitation rates have been set has evolved over time in the AHCCCS and ALTCS programs. Specific marketplace considerations should be taken into account in developing an appropriate strategy for each solicitation. In the beginning of a new program, the active involvement of the state may be necessary to help safety-net providers and other potential bidders get organized to participate. In addition, the state may need to assume some of the risk of the cost of delivering services by retroactively adjusting certain components of the capitation payment.

Meeting the information needs of the program. Perhaps most important in managed care is having a management information system that emphasizes not only the operation of hardware and software but also the quality of the input data. Both the state and the participating plans in AHCCCS have demonstrated

that credible data on eligibility, enrollment, networks, cost, use of services, and, for long-term care beneficiaries, medical and functional assessments can be captured and play an important role in managing the program. Organizations that cannot provide data on plan operations and on the use and cost of services should be excluded from participation because without such data they cannot be a cost-effective partner for the state.

■ ADDRESS THE STATE'S MANAGEMENT RESPONSIBILITIES. Many of the early problems in implementing the AHCCCS program were related to not having effective systems in place to deal with the state's management responsibilities. Not having financial management structures in place resulted in Arizona's not being able to detect impending plan bankruptcies until they were imminent. In the early program years, quality assurance activities, utilization and access monitoring, and program planning functions had no leadership and few operating mechanisms. Early attention to performance in these areas is critical to a well-functioning program, which can avert quality and access problems.

Financial management. Contracting entities must be monitored for financial solvency. If plan failures occur, the stability of the program is threatened. Monitoring the plans can help to identify problems before they become critical or provide early warnings to help a state make arrangements for a plan's orderly phaseout. The state's ability to secure competitive rates also depends on the availability of accurate data on costs.

Quality assurance. Quality assurance activities require early and concerted energy. Important areas include activities to detect underuse of services, review of treatment patterns by diagnosis, monitoring of selected procedures, detection of fraud and abuse, and profiling of plans and physicians for quality and appropriateness.

Utilization and access monitoring. Analysis of the use of medical services is a critical component in understanding how a medical care program is performing. In a capitated program, it is of special importance to ensure that beneficiaries are receiving appropriate treatment by analyzing which services are provided and by monitoring the adequacy of access to ambulatory care.

Planning. Future planning requires systems that can estimate costs of program modifications and future program costs, identify areas that promote long-run cost containment, and research areas for general study.

Coordination with other states. States should participate in developing structures and processes that support national standardization of data collection, sharing of technical knowledge, evaluating what works and what does not, and sharing ideas through collaborative forums.

"Integral to the success of a state's managed care program is the involvement of the governor, key legislators, and their staffs."

■ FOSTER WORKING RELATIONSHIPS WITH THE GOVERNOR, KEY LEGISLATORS, AND THE MEDIA. Integral to the success of a state's managed care program is the involvement of the governor, key legislators, and their staffs. In Arizona both the legislature and the governor were supportive of the program during its early years. This support was unwavering despite substantial problems in the program's administration during its first eighteen months. Fostering strong relationships with the legislature and governor is even more critical today. In an era of concern about state spending, strong marketing will be necessary to convince policymakers to allocate sufficient resources for infrastructure development. Without this development, a state runs a serious risk of problems with access, quality of care, and plan viability.

Program staff should include a press spokesperson who briefs the media regularly about what the state is trying to accomplish and who serves as a contact person for spe-

cific problems or concerns. AHCCCS had daily negative press coverage in its first year, which was exacerbated by the lack of staff to represent AHCCCS's positions to the press. In the early implementation stages of any new program, there are likely to be problems. These problems have less potential to explode if members of the media are familiar with the program and its aims and have a specific person to contact when they have questions.

■ SUPPORT THE DEVELOPMENT OF NATIONAL REPORTING STANDARDS. Reporting formats should include detailed definitions for each element to be included in encounter data, financial reports, quality assessment instruments, satisfaction surveys, and grievance reports. These standards for data collection will not only help the state to attract qualified contracting entities and thereby support market competitiveness, but they also have wide societal uses. Data sets that are integrated across several states can be used to determine disease incidence, document treatment trends, develop knowledge on the success of treatments, and provide a database for general research inquiry. Such a database will make it possible to improve health care for all Americans, not just those eligible for Medicaid.

This paper was prepared in part with funds from The Henry J. Kaiser Family Foundation. It is based on work funded under Health Care Financing Administration (HCFA) Contract nos. 500-83-0027 and 500-89-0067. The analysis and conclusions are solely those of the author and do not express any official opinion or endorsement by the Kaiser Family Foundation or HCFA. The author thanks the many persons who contributed to the two HCFA evaluations of the Arizona Health Care Cost Containment System Demonstration: her coauthors of the AHCCCS evaluation reports: Donald Balaban, Ellen Jones Bauer, Michael Crane, Suzanne Pollack Driver, Susan Haber, Jodi Korb, Stanley Moore, Lynn Paringer, Gordon Trapnell, Pamela Turner, Alice Wade, William Weissert, John Wilkin, and C. William Wrightson; Sidney Trieger, Paul Lichtenstein, William England, Ronald Lambert, James Hadley, Joan Peterson, and Henry Tyson of HCFA; Mabel Chen and Linda Redman, the director and deputy director of the AHCCCS program at the conclusion of the evaluations; and present and former AHCCCS staff members. The author also acknowledges Diane Rowland and Alina Salganicoff from the Kaiser Family Foundation, Stephen Somers from the Center for Health Care Strategies, Inc., and Jodi Korb of Laguna Research Associates for their comments on an earlier version of this paper.

NOTES

1. This paper is based on results from two six-year Health Care Financing Administration (HCFA) evaluations of AHCCCS. Detail on the methodologies, findings, and policy conclusions are available in HCFA evaluation reports, discussion papers, articles submitted for publication, and published articles. A complete list of these documents is available from the author on request, at Laguna Research Associates, Suite 1190, 455 Market Street, San Francisco, California 94105.
2. Arizona has attempted to get a waiver from HCFA to integrate Medicare and Medicaid financing but has been unsuccessful.
3. Two of the counties and the Arizona Department of Economic Security are mandated contractors. Three counties became contractors through legislatively mandated county right of first refusal in effect until July 1995. The two private entities were selected through a competitive bidding process.
4. The ALTCS program as a whole has a HCFA-imposed cap on the percentage of elderly and physically disabled beneficiaries that can be served in home care. Originally set at 10 percent of beneficiaries, it was slowly raised as the program's use of home care was demonstrated to be cost-effective. The rate was 40 percent in fiscal year 1995.
5. The analyses described were limited by the availability of data and especially by the lack of baseline information on Arizona's experiences before the program was implemented.
6. The per capita costs of the traditional Medicaid program in Arizona were calculated from HCFA Reports 2082s and 64s.
7. The methods used were based on The Urban Institute Type of Service Classification System, adapted by Laguna Research Associates for Medicaid beneficiaries.
8. The risk of institutionalization was developed with data from the Institutional Population Component of the 1987 National Medical Expenditure Survey.

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PERSPECTIVE

Beyond The Safety Net In Dallas

Structural solutions are needed for the structural problems of the safety net.

by Ron J. Anderson and Paul J. Boumbulian

PARKLAND MEMORIAL HOSPITAL is one of this nation's largest, most active institutions making up the health care safety net. It has served the residents of Dallas County (Texas) for more than a hundred years.

Just ten years ago, Parkland was a large, centrally located hospital, which, while recognized for its volume of service, excellence in patient care, and high-quality postgraduate medical training programs, was not known for its amenities or for having a patient-centered environment. Over the course of the past decade, Parkland has transformed itself. It is now an integrated health care system. It has created centers of excellence that make available to the entire community the latest knowledge in such areas as arrhythmia management, cerebral vascular disease, epilepsy, and gastrointestinal treatment. It also has developed its own health maintenance organization (HMO). In addition, it has gone through extensive reengineering. These efforts have produced a decline in the average length-of-stay from seven days in 1986 to fewer than five days in 1995; a reduction in emergency department visits from more than 160,000 visits in 1987 to 122,495 visits in 1995; and a reduction in average "dwell" time in the outpatient clinic, including all diagnostic studies and pharmacy services, from 7.5 hours to 2.5 hours.

Parkland decentralized by developing a nationally recognized primary care delivery system based on a community-oriented primary care (COPC) model, which aims to improve care for both individuals and communities. The COPC network now includes eight community health centers, nine youth and family centers, five school-based clinics, and two mobile clinics. Parkland has learned over the past ten years that to truly improve health, it must address the social and economic determinants of disease such as lifestyle, education, and employment opportunities. This means working with school districts, housing authorities, police and fire departments, churches and synagogues, and employers. These efforts have begun to bear fruit. In 1995 a study was completed that compared COPC patients to non-COPC area residents. COPC patients were two times less likely to be admitted through the emergency department, had shorter hospital stays (3.4 days versus 5.3 days, on average), and had 50 percent lower charges.[1]

Solving Structural Problems

To pay for the decentralized system of community care and its educational and research missions, Parkland has had to diversify its revenue streams and cross-subsidize. Fifteen years ago, 66 percent of Parkland's funding came from local property taxes. Today only 33 percent of its funds come from that source. This shift was accomplished primarily by means of an increased Medicaid entitlement in Texas and through Medicare and commercial payments for services provided through Parkland's centers of excellence. As Parkland has worked toward providing relief to local taxpayers while expanding community services and maintaining its missions, it has become more vulnerable in several ways.

■ **Maintaining market share.** First, even though Parkland prevents many unnecessary

Ron Anderson, a physician, is president and chief executive officer of Parkland Memorial Hospital in Dallas, Texas. Paul Boumbulian is senior vice-president of Parkland.

hospital admissions, it does not "save money," because beds that would be empty in a closed HMO system are filled at Parkland with unmanaged, uninsured, high-cost patients who fell out of the market basket.

Second, as traditional commercial insurance has dwindled and managed care has reduced the margins on other patients, the Medicaid market (especially uncomplicated obstetrical cases) has become more appealing to other hospitals with excess capacity. Competition for these patients has resulted in a loss of approximately 2,000 deliveries per year at Parkland.

Through the efforts of the medical school faculty, Parkland has a low cesarean-section rate (18 percent), whereas some of the recent entrants into the Medicaid market have rates more than twice as high. Parkland and the medical school also have achieved an infant mortality rate for African Americans that is essentially equal to the rate for whites (nationally it is two and one-half times higher). However, this breakthrough has not been acknowledged by the local market, where other institutions trade on amenities rather than outcomes. Women and their newborns who are served by other institutions are routinely transferred to the Parkland system after Medicaid is discontinued or if complications arise.

Third, Parkland always will be subject to adverse selection by virtue of its mandate: Any patient can enter the system by being sick or injured any day of the year.

The Medicaid situation is poised to become even more distressing. Parkland now has 60 percent of the Medicaid market share in Dallas County. Under the proposed state Medicaid managed care program, Medicaid patients will be distributed among three or four managed care vendors, and although Parkland will inevitably be one of these providers, it would be foolish to assume that it can maintain its current market share. The loss of this revenue will jeopardize the system's ability to provide educational, research, and mandated services, particularly to persons who lack coverage.

■ **Business versus safety-net ethic.** While Parkland has attempted to improve the health status of its patients and the community, others have been busy trying to refine the "sick care" system—learning how to transform clinical services into commodities and patients to "covered lives." Risk selection has become far more profitable than true innovation. We are finding that what is a good commodity may not be what is good for the community's health. It is difficult for the public to understand what is to be gained in preserving safety-net "utility" services such as trauma, burn, and neonatal care and specialized drugs for patients with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), as few citizens have direct contact with these services. Most healthy people never consider their vulnerability to injury or catastrophic illness, much less that of their community to natural and man-made disasters.

■ **Building social capital.** The means for addressing the determinants of health reside not in the efficiencies of the market but in what Robert Putnam termed *social capital*, that is, the bonding that characterizes a strong civil society.[2] Communities with rich networks of nonmarket relationships provide a sense of trust, sharing, and cooperation that increases the efficiency of human relationships. Yet most of the dollars available to affect health status remain in the business of curing.

Some of the public systems that make up the safety net, a few of the not-for-profit institutions, and a very limited number of the for-profit systems have recognized this situation. These foresighted organizations are beginning to establish partnerships with other public or nonprofit institutions to improve health. Current market incentives may lethally harm these institutions and leave inefficient, ineffective, and bureaucratic institutions unharmed. Policymakers should not preserve publicly sponsored health care institutions for the sake of publicly sponsored health care. What should be preserved is a

system of choice by patients. Monolithic palaces of patronage and institutions that treat patients as captives in a disease-oriented sick care system should be reengineered, redirected, and held to high standards of accountability for clinical outcomes, patient satisfaction, and community health status. A civil servant mentality must give way to servant leadership and community partnership.

Summary And Recommendations

The current structural problem, wherein safety-net institutions must operate not only in the marketplace but also under state mandates to provide utility services, must be reconciled through structural change. That means that an all-payer system is required to support medical education and provide for the "stand-ready" costs of services such as trauma, burn, and neonatal intensive care. Reimbursement strategies must acknowledge not only severity of illness but also social severity. The provision of care to large numbers of low-income persons carries a real cost for "wraparound" services that lower barriers to care.

Safety-net institutions should also provide incentives to maintain or create a community health care infrastructure that enhances the health status of the community, particularly in underserved inner-city and rural areas. This could include the development and maintenance of comprehensive primary care networks in underserved communities. Reimbursement methodologies and grant awards should foster collaborative models and not create disruptive competitive behaviors that undermine community partnerships.

Funds need to be made available for outcomes-oriented research. Both safety-net and other providers must be able to show that investments of new dollars or redirected dollars lead to desired results. Safety-net institutions should directly receive direct and indirect payments for medical education and disproportionate-share adjustments for caring for a large volume of low-income persons instead of leaving these payments in the adjusted average per capita cost (AAPCC), which creates a windfall for the managed care organization.

Legislative support also will be required to support safety-net pricing, especially with regard to pharmaceuticals for special populations. We are especially concerned about pharmaceutical support for HIV/AIDS populations because their care is often provided by only a few hospitals in a given area. Pharmaceuticals are part of the safety net but are not always provided at present.

Without these structural changes, we will continue to see the results of failing federal and state policies into the next millennium. Their failure will ultimately come down hard on local governments as unfunded mandates. Communities strapped for revenues to meet challenges of devolution ultimately will be required to reduce services. Unless some fundamental change is made, they will focus only on the "resurrection medicine" of the emergency room and pull back from real innovation and real reform capable of improving the health and productivity of all of our nation's residents. We do have a structural problem that needs a structural solution, but we also need a change in our hearts to better understand that we cannot leave needed reform of the health care delivery system to the invisible hand of the marketplace.

*A version of this paper was presented at The Robert Wood Johnson Foundation/*Health Affairs*/Alpha Center conference, "What Is Happening to the Safety Net?," 9–10 January 1997, in Washington, D.C.*

NOTES

1. Y.M. Coyle and P.J. Boumbulian, *Parkland's COPC Evaluation System* (Unpublished quality management report, 1995).
2. R.D. Putnam, "The Prosperous Community: Social Capital and Public Affairs," *The American Prospect* (Spring 1993): 2; and R.G. Evans and G.L. Stoddard, "Producing Health, Consuming Health Care," *Social Science and Medicine*, 31, no. 12 (1990): 1347–1363.

Medicaid Managed Care And Community Providers: New Partnerships

Can the "arranged marriage" of managed care plans with traditional community-based providers improve care for the poor?

by Debra J. Lipson

PROLOGUE: Partnerships between organizations are often compared to marriages—some are based on necessity, some on convenience, some on synergy, and others on arrangements made by third parties. Harvard professor Rosabeth Moss Kanter describes five stages in the development of organizational alliances: engagement, selection or courtship, setting up housekeeping, learning to collaborate, and changing within. The ability of organizations to progress through these stages depends on the dynamics between them and around them. But ultimately, the endurance of an organizational partnership, just as some would say of marriage, depends on the continued mutual benefit of the alliance to each of the participants.

This paper by Debra Lipson explores the "arranged marriage" of community-based health care providers and managed care plans. Although these two entities make strange bedfellows, they have courted each other for the opportunity to draw on each other's strengths in an increasingly competitive marketplace. As they come together to negotiate contracts for serving Medicaid patients, will they learn to collaborate or find a way to fulfill their missions and financial objectives independently? Here Lipson looks at what is at stake and at the prospects for their success.

Until June of this year, Lipson was associate director of the Alpha Center, a nonprofit health policy research organization in Washington, D.C. In honor of her own commitment to marriage, she has since moved with her husband to Geneva, Switzerland, where she will complete studies in progress and seek new alliances with international health organizations.

ABSTRACT: Growing enrollment in managed care plans among Medicaid recipients represents a new market for these plans but presents challenges to those providers that traditionally have served this population. To continue serving Medicaid patients, community-based providers must develop contracts or other types of partnerships with Medicaid-contracting health plans. This paper reviews the challenges to such collaboration and discusses the practical issues that plans and community-based providers must resolve to develop productive working relationships. Keys to successful collaboration are identified. Ways in which federal and state governments can help the collaborative process are suggested.

BY JUNE 1996, 13.3 MILLION Medicaid recipients were enrolled in some form of managed care, 40 percent of all Medicaid eligibles and nearly twice the proportion two years earlier.[1] The growth curve will surge upward again in 1997 as large states such as California, Illinois, and New York attempt to enroll large numbers of Medicaid recipients into managed care plans or expand Medicaid managed care programs into additional counties. States began their enrollment in managed care with women and children who qualify for Medicaid, and they are turning their attention to elderly and disabled recipients, who have been largely exempt from mandatory managed care enrollment policies.

The growth of Medicaid managed care has spawned new interest on the part of private managed care plans in serving the Medicaid population. In some cases, plans that have contracted with Medicaid for many years are expanding their capacity to serve additional patients. However, as more states jump on the Medicaid managed care bandwagon, plans without prior experience in serving Medicaid patients and brand-new plans are diving into the Medicaid market as never before. Thirty-eight percent of health maintenance organizations (HMOs) and preferred provider organizations (PPOs) surveyed by the Group Health Association of America (now the American Association of Health Plans) in 1995 participated in Medicaid at the end of 1994; another 11 percent began serving Medicaid patients in 1995, and another 12 percent intended to do so in 1996.[2] This trend is good news for Medicaid officials, who had trouble recruiting enough plans and providers to serve Medicaid patients.

However, there are a number of concerns about the rapid entry of so many new plans into Medicaid managed care. For example, plans new to the Medicaid market sometimes have underestimated the amount of enabling services, such as case management, language translation, and outreach, needed to serve the Medicaid population. The entry of such plans into the Medicaid market also raises concerns about how community-based providers that previously had large Medicaid caseloads will fare under these new arrangements.

Traditional community-based providers are the organizations that historically have provided much of the primary and preventive care delivered to Medicaid recipients and the uninsured.[3] These providers include approximately 635 community and migrant health centers with 1,647 sites; more than 3,000 rural health clinics; nearly 3,000 city and county health departments; and a multitude of maternal and child health clinics, specialty clinics for children with special health care needs, school-based clinics, family planning clinics, and acquired immunodeficiency syndrome (AIDS) care providers (operating under the Ryan White Comprehensive AIDS Research and Education [CARE] Act). Although each community has a different mix of such providers, some or all of them form the primary and preventive "safety net" for the poor and uninsured. Approximately 43 percent of patients in federally qualified community and migrant health centers are covered by Medicaid, Medicare, or other public insurance, and an equal proportion are uninsured.[4] To survive, the centers rely heavily on federal, state, or local government grants and to a lesser extent on private donations.

Given their dependence on Medicaid, it is imperative that community-based providers participate in evolving Medicaid managed care plans and networks. If they do not, they may lose the ability to serve Medicaid patients, which in turn could threaten their ability to serve uninsured patients.

Community-based providers have two major strategies for participating in Medicaid managed care. They can form a managed care plan by themselves or in partnership with others, or they can seek contracts with managed care plans. This paper focuses on the second strategy. First, I explain the issues that have arisen as Medicaid managed care plans seek to develop provider networks that can serve the diverse Medicaid population and negotiate contracts with traditional community-based providers. I then highlight some of the strategies and elements that have proven effective in overcoming barriers to mutually beneficial contracts. I conclude by discussing the policy implications for federal and state governments in their role as purchasers of care for the Medicaid population.

Challenges And Opportunities For Collaboration

Why would private managed care plans want to contract with community-based providers of primary and preventive care to Medicaid patients? Primarily because they share the same mission—providing high-quality, easily accessible primary and preventive care services to Medicaid patients. But they differ in how they approach this mission, based on different organizational cultures and strengths.[5] Just as state health departments and Medicaid agen-

cies used to engage in what was once called the "Cold War between the health zealots and the Medicaid infidels," community-based providers and managed care plans today often view each other with suspicion.[6]

Managed care organizations (MCOs) typically have experience in claims processing, provider relations, utilization review, and financial risk management. As insurers, they are focused on purchasers and enrollees, most of whom have been commercially insured. If nonprofit, they are accountable for financial performance to boards of directors; if for-profit, they are accountable to stockholders. In contrast, community-based providers have experience in providing personal health care services to "vulnerable" persons—those with low incomes, special health care needs, or cultural or language barriers to care—regardless of ability to pay. It is their mission to provide care to the uninsured; in some cases they are obligated to do so. They are accountable to consumer-dominated boards of directors or to governmental bodies if they are publicly sponsored or funded. These different cultures and strengths present both challenges and opportunities for collaboration.

■ **Challenges.** The two organizations come to the negotiating table speaking different languages, using the same words to mean different things. For example, to MCOs, "case management" is the responsibility of primary care physicians to coordinate and authorize all of the care needed by patients. But to community-based providers, case management is often the responsibility of social workers, nurses, or community health aides to assess patients' needs, refer patients to all appropriate services, and advocate on patients' behalf to assure access to care.

There are also many stereotypes that must be broken down before real collaboration can occur. MCOs may assume that all community-based providers serve high-risk, sicker populations, which would increase the risk of adverse selection for MCOs that have community-based providers in their provider network. There may also be the misconception that most community-based providers are unable to comply with HMOs' utilization controls and quality assurance processes. Some community-based providers believe that MCOs' only concern is the bottom line and that MCOs are not committed to providing the full range of services needed to effectively serve vulnerable populations.

■ **Opportunities.** Despite these differences, private managed care plans and community-based providers are drawn to each other for a number of reasons, even if it sometimes seems more like an arranged marriage than love at first sight. MCOs find community-based providers attractive because they have experience serving the

Medicaid population, a powerful advantage for any MCO that has not worked with this group of patients before. "Community providers have leverage, if they're good," said David O'Brien of the Gateway Health Plan in Pittsburgh. "If a community-based provider functions well and is well-thought-of in a particular community, a plan will need to include that provider in its network if it wants to attract members from that community." MCOs readily acknowledge that they do not know how to deliver care to a less-educated population, how to help patients get to appointments, and how to communicate the importance of prevention and early treatment. They find that community-based providers are particularly strong in providing enabling services. "The most I've learned from anyone about the Medicaid population is from the community-based providers," said John Monahan of Blue Cross of California. In addition, MCOs find that community-based providers may be among the few, or perhaps the only, providers of primary care services to Medicaid patients in some neighborhoods. One plan turned to community-based providers after it tried to sign up physicians in its commercial plan to serve Medicaid patients but was unable to convince enough physicians to serve the number of such patients expected to enroll. In other communities, community-based providers may be the only source of particular services required by the state Medicaid agency, such as maternity care coordination or human immunodeficiency virus (HIV) counseling. Finally, MCOs may perceive efficiencies in having low-income residents, who frequently go on and off Medicaid, see the same provider regardless of their eligibility.

Community-based providers find that they need to court MCOs for many reasons, as well. As mentioned earlier, contracts with MCOs are essential to continue provider/patient relationships with Medicaid beneficiaries and to retain Medicaid revenues. This is particularly true if community providers cannot or choose not to form their own MCOs. Community-based providers find that being part of an MCO provider network gives them access to information systems, management expertise, and specialty clinical services that might otherwise be unavailable or unaffordable. Finally, the experience of dealing with Medicaid managed care can give community-based providers the tools they need to be more competitive.

Major Contracting Issues

As plans and community-based providers dance closer together, they are just starting to come to grips with the details and issues that go into contracting. Before contracts can be signed, community-based providers and MCOs must decide on (1) the role and authority of the provider in relation to other parts of the delivery system; (2) which

quality and basic operating standards must be met and how compliance will be monitored; and (3) the basis on which payments will be made. Finding common ground on these issues is rarely easy.

■ **Providers' scope of responsibilities.** Depending on what is included in the contract between a state Medicaid agency and managed care plans, Medicaid MCOs need to arrange for a wide array of clinical and supportive services. It is administratively simpler for MCOs to contract with providers that can deliver a comprehensive set of services. But other than community health centers, most community-based providers can only deliver pieces of the package. MCOs that contract with multiple community-based providers must decide whether preauthorization from a primary care physician will be needed for every visit, which services require prior authorization, whether there are certain conditions for which patients need not get authorization from their primary care provider, and whether they will guarantee a minimum number of referrals to the community-based provider. The two parties must also decide how case management will work.

■ **Quality assurance and reporting requirements.** Defining "high-quality" care can be difficult when the two parties are accountable to different accreditation bodies that emphasize different aspects of quality, have different standards, and require reporting of different indicators and measures. Health plans are oriented to National Committee for Quality Assurance (NCQA) standards and Health Plan Employer Data and Information Set (HEDIS) measures, whereas community-based providers are accountable to a variety of government and private organizations and report various data depending on funding sources. For example, community and migrant health centers follow federal rules, local health departments use the Assessment Protocol for Excellence in Public Health system to assess and improve their organizational performance, and Ryan White centers have their own federal requirements.

Individual providers also complain about the conflicting requirements imposed by health plans. Zoila Torres-Feldman, a community health center director in Massachusetts, said, "Each plan has different formularies, different labs, separate utilization review staff, different benefit packages, different hospitalization contracts, different networks of specialists, and different expectations of the levels of provider control."

MCOs sometimes criticize the capacity of community-based providers to meet basic operational expectations, such as submitting utilization and quality data in formats that are consistent with plans' information systems, answering telephone lines in a timely fashion, and making appointments available within required time-

"Payment between plans and community-based providers is one of the most important and difficult issues in contract negotiations."

lines. According to Herb Wheeler of HealthKeepers, Inc., a subsidiary of Trigon Blue Cross Blue Shield, in Richmond, Virginia, "In trying to gain NCQA accreditation, we feel like we're being pulled down if we deal with community health centers." He and other health plan officials say that not all community-based providers' record keeping and quality of care are yet up to NCQA's credentialing standards.

■ **Payment arrangements.** Payment between plans and community-based providers is one of the most important and difficult issues in contract negotiations. Community-based providers typically want fees to cover the costs of providing all care to patients, whereas MCOs want to pay the same amount they pay other providers for the same services. Some MCOs complain that community-based providers do not have adequate information systems to determine unit costs, and some community-based providers say that MCOs do not want to pay adequately for the additional services they provide.

Most plans and community-based providers believe that few such providers are equipped to accept financial risk for the entire spectrum of services patients need. Their data systems are ill-equipped to manage utilization, their financial systems are not sophisticated enough, and sometimes they are legally unable to suffer even short-term financial losses. "Community health centers could survive if they can share in the savings they generate for the health plans," said Torres-Feldman. But if community-based providers are only capitated for primary care, they could lose money.

Strategies For Contracting Collaboration

The growing number of contracts between MCOs and community-based providers indicates that many have overcome the obstacles in order to gain the potential benefits. The examples presented here demonstrate that the secret to success lies in translating contract requirements into practical working relationships.

■ **Providers' scope of responsibility.** In some cases MCOs contract with community-based providers for a limited set of services initially and increase the scope of services included in the contract as the providers' expertise expands. For example, Blue Cross of California's HMO initially contracted with a Planned Parenthood clinic for just family planning and obstetrical services but expanded

the contract to include primary care services when the clinic developed the capacity to provide them. When community-based providers can deliver only a specific component of the service package, some plans have authorized the providers to deliver all necessary care without requiring referrals for each visit. In a study of seven school-based clinics, for example, nineteen of twenty-six health plan contracts authorized the clinics "to provide a specific set of services—typically well-child visits and acute, episodic sick care—to the plan's beneficiaries without preauthorization by the plan."[7] The Health Start school-based clinics in St. Paul, Minnesota, developed three different models for relating to primary care providers in health plans, depending on each plan's particular needs.[8]

■ **Quality assurance and reporting requirements.** NCQA accreditation standards and HEDIS 3.0 measures, which recently incorporated Medicaid HEDIS, are becoming the industry standard. As more Medicaid agencies use them to hold contracting health plans accountable, they have become *de rigueur* for plans and their providers to follow. But how plans meet such standards may differ from one plan to the next. When working with community-based providers, plans often find that they must work closely through joint quality assurance committees, provide data that show providers how their practice patterns compare with those of others, and agree on priorities for improvement. For example, one publicly sponsored health plan (CareOregon) holds monthly quality improvement and utilization committee meetings with community health centers in its network to educate both plan and clinic representatives about meeting quality assurance requirements.[9]

On the other hand, some community-based providers may be able to show other providers in a plan's network how to meet certain standards. As John Bartkowski, a community health center director in Wisconsin, pointed out, "The health centers bring to the HMOs the ability to meet Early and Periodic Screening, Detection, and Treatment [EPSDT] requirements. We also were able to demonstrate that health centers are much better on certain outcomes [for example, emergency room visits, low-birthweight rates] than other contracted physicians."

Still, plans sometimes find that community-based providers require technical assistance and funds to meet quality, utilization, or other reporting expectations. One health plan that was created by community health centers allocates half of its annual earnings to community providers to invest in infrastructure; in recent years management information systems have been the priority for these funds. A commercial health plan has provided computer hardware and software to several community-based providers to enable them

to bill for services and comply with prior-authorization requirements. In addition, MCOs may provide community-based providers with information about their patients' overall utilization patterns to help manage care more effectively and EPSDT check-up lists to help with follow-up. Trigon provided funds to a group of minority physicians to help them organize into a group, hire administrative staff, and collect data.

Patience and willingness to educate community-based providers about administrative practices are also necessary. One plan official expressed frustration with county health departments that have inadequate or nonexistent appointment systems and other community-based providers that cannot meet reporting or performance standards. But the plan is giving these providers time to get up to speed because they are regarded as valuable partners for ensuring access and service capacity. Community-based providers are clearly willing and able to change. One study found that contracts with managed care plans had prompted management improvements at community health centers, such as strengthening twenty-four-hour on-call service, more timely scheduling of appointments, and more active monitoring of utilization and specialty referrals.[10]

■ **Payment arrangements.** Flexibility is the key to setting suitable payment arrangements and rates. Many contracts between plans and community-based providers still include fee-for-service payments for each contracted service, based on previous Medicaid fee schedules, fixed global visit rates, or a service-specific rate negotiated by the provider and the plan. However, some plans have developed successful risk contracts with community-based providers. Plan and provider representatives caution that to work well, such arrangements require (1) experience on the part of providers, in managing risk, and (2) substantial numbers of enrollees seeing the provider. As Robert Gomez, head of a community health center in Tucson, Arizona, said, "If you can talk capitation, you've broken a lot of the cultural barriers between us and the plans."

Even when providers do not have prior experience in risk assumption, some form of risk sharing can still be developed. For example, in the first year of St. Paul Health Start's contracts with MCOs, the plans held back a small portion of the rates paid to other capitated clinics to fund school clinics while both parties collected utilization data to set future rates. Another plan has several shared risk contracts that "carve out capitation for services that CBPs [community-based providers] perform and pay the rest on a fee-for-service basis which we manage ourselves," according to Dan Bailey of Compcare Health Services, an HMO owned by United Wisconsin Services, Inc., the Blue Cross Blue Shield affiliate in Wisconsin.

Some unusual payment arrangements are found in contracts between plans and community-based providers, which again reflects the special needs of some providers and the willingness of plans to be flexible. For example, Blue Cross of California pays for some services provided by its community-based providers up front to help with cash flow. The cost of intensive outreach such as home visits for preventive services is not usually included in capitation rates, so health plans and community providers sometimes cooperate in seeking additional funding through public or private grants. The Blue Cross Blue Shield plan in Wisconsin developed a risk-sharing agreement with providers on EPSDT to give providers more incentive to help the plan meet its screening goals.

While plans' payment arrangements with federally qualified health centers are governed to a great extent by federal and state regulations, which I discuss later, health plans and health centers still have some options that form the basis for rate negotiations. For example, the Blue Cross plan in California convinced one center to waive cost-based reimbursement and accept capitation in exchange for the promise of a larger volume of patients. It is not clear whether the non-cost-based payment rates will be adequate in the long run.[11]

Keys To Successful Contracting

This brief review highlights several factors that are critical to successful Medicaid contracting.[12]

(1) The parties to a contract must learn as much as they can about each other—their language, values, and goals. The differences that exist among MCOs and community-based providers are important when considering the pros and cons of a particular contract. Local market factors also influence the dynamics of contracting.

(2) To meet the needs of Medicaid patients, both parties must be willing to cast aside "business as usual." Health plans that believe that community-based providers are valuable partners must be willing to trust what has been learned and invest in the services that are needed to make a difference (for example, offering services in multiple languages, respecting the influence of culture on health-seeking behavior, and developing special exceptions for confidential services). Plans may need to stretch usual primary care physician authorization requirements, while community-based providers may need to hire new staff to perform the tasks required by MCOs.

(3) Plans and community-based providers must be willing to meet regularly to work out the details of collaboration. Even when managers agree to referral and authorization procedures, there will always be special cases that require accommodation and compromise. It may be useful to start with something small before embark-

ing on a long-term contract.

(4) Plans and community-based providers must be willing to experiment with different payment arrangements. Because not all community-based providers are alike (some can handle capitated rates, others cannot), and because each state's Medicaid program is different (capitation rates in some states may be meager, some have more sophisticated risk-adjustment mechanisms than others have), MCOs and community-based providers must work together to resolve the array of payment issues that will arise.

(5) Community-based providers have shortcomings in information systems and facilities, but these can be improved. These providers have limited capital budgets to invest in computer systems or facility improvements. Plans must be willing either to invest in community-based providers' infrastructure or help them to find alternative sources of capital. Community-based providers must put a high priority on finding the resources and technical staff to bring their facilities and systems up to speed.

(6) Continuous quality improvement requires partnerships. Community-based providers that deliver high-quality services and have a good reputation in their community should have little difficulty contracting with Medicaid MCOs. Those that do not continuously improve quality may not belong in Medicaid managed care. To improve quality, plans, providers, consumers, and state agencies must join together to collect and analyze data, conduct patient satisfaction surveys, stress the importance of EPSDT screenings, and improve risk-adjustment methods.

Policy Context

Contracts between Medicaid managed care plans and community-based providers do not occur in a vacuum. They are greatly affected by federal and state Medicaid laws and policies and by the specific language in the contracts between state Medicaid agencies and managed care plans. Thus, the relationships that evolve between Medicaid managed care plans and community-based providers will in part reflect the federal and state policies that govern them.

■ **Federal policy.** Most of the formal policies related to community-based providers' relationships with MCOs emanate from the Health Care Financing Administration (HCFA) through its administration of state Medicaid waivers. Several other Department of Health and Human Services (HHS) agencies are involved in providing technical assistance.

State waivers of federal Medicaid regulations. Federal Medicaid law (Sections 1115 and 1915(b) of the Social Security Act) grants HCFA the authority to grant waivers to states that wish to be exempt from

certain rules.[13] States with 1915(b) waivers must assure cost-based reimbursement to federally qualified health centers participating in managed care when they affirmatively assert their right to it. But because states requesting Section 1115 waivers can ask to waive health center payment rules, many centers have been forced to accept less than they formerly received. Even so, many of the states with Section 1115 waivers still make some provisions that help federally qualified health centers to participate in or get adequate payment from Medicaid managed care plans.

In approving a state's Medicaid waiver program, HCFA may impose special terms and conditions with which the state must comply. Most often, these terms and conditions relate to rules that MCOs must follow in reimbursing community-based providers and to assuring access to services provided by community-based providers. For example, HCFA's special terms and conditions often include a requirement that MCOs contract with community-based providers to assure that MCOs have adequate capacity to serve Medicaid patients. If MCOs have adequate capacity to serve vulnerable populations without contracting with federally qualified health centers, MCOs are relieved of this requirement. If health centers develop their own Medicaid managed care plan, other MCOs in the same service area are also exempt from this condition. In most states HCFA also requires states to adjust rates for patient case-mix.

Technical assistance and training for community-based providers and MCOs. HHS agencies—including the Bureau of Primary Health Care, the Maternal and Child Health Bureau, the Centers for Disease Control and Prevention, and the Agency for Health Care Policy and Research—conduct comprehensive training and technical assistance programs to help community-based providers to participate in or relate to Medicaid managed care programs. These agencies also provide information and training to MCOs on developing delivery systems for Medicaid patients.

■ **State policies.** Within the context of federal policies and guidelines, states have adopted a range of approaches to ensure a role for community-based providers in Medicaid managed care plans. Some states have designed systems to assure that community-based providers are given the chance to develop their own plans. For example, California formulated a managed care model "designed in large part to protect safety-net institutions."[14] Medicaid recipients in twelve densely populated counties will choose between two different plans—a commercial plan and a Local Initiative plan that is developed by county governments and safety-net and traditional Medi-Cal (California Medicaid) providers, along with community representatives. "Unlike the commercial plans, Local Initiatives are

required to contract with safety-net and traditional providers."[15] Rates paid to the Local Initiative plans are higher to reflect cost-based payments made to federally qualified health centers.

However, most states have not gone this far. Instead, they are using one or more of the following more limited strategies to encourage partnerships between community-based providers and MCOs.

(1) Contract requirements. Some states explicitly require that Medicaid managed care plans contract with particular community-based providers. For example, Oregon mandates that Medicaid managed care plans contract with county health departments and other publicly funded programs to provide immunizations, as well as screening for sexually transmitted and other communicable diseases. Exceptions are allowed when community providers are not available.[16] Minnesota's Medicaid program requires that at least one MCO in a given service area include a community clinic in its network.

(2) Preference points for collaboration. Arizona, California, and Massachusetts, among other states, add points to plans' bids if they include community providers in their networks.[17] For example, Massachusetts specifies in its request for proposals that plans must attempt to establish linkages, though not necessarily contracts, with school-based clinics and encourages coordination with public health clinics to serve persons with HIV infection.

(3) Preferential assignment to plans that include community providers. In some states Medicaid MCOs that include community-based providers are assigned patients who do not voluntarily choose a plan. For instance, in California, the Orange County CalOPTIMA (Orange Prevention and Treatment Integrated Medical Assistance) program has made the plan organized by Children's Hospital of Orange County and the University of California-Irvine the default for persons who fail to select a plan.[18]

(4) Setting quality or access standards to encourage collaboration. Certain performance standards in a state's contracts with health plans can increase the likelihood that plans will contract with community-based providers. For example, Minnesota requires health plans to submit annual "action plans" that specify how they will deliver services, provider capacity, quality improvement plans, and policies and procedures for serving high-risk or special-needs populations. This serves as an incentive for plans to work with community-based providers that can provide care to special-needs groups.

(5) "Transitional" payments and other enhanced reimbursement to community-based providers. To help federally qualified health centers or other essential community providers to develop the systems and economies of scale needed to assure cost-effectiveness while continuing to deliver health care to all persons regardless of their ability

to pay, many states have developed transitional payments to federally qualified health centers. For example, Rhode Island pays an extra $10 per member per month to the center's HMO for each Medicaid recipient enrolled. And in Hawaii and Vermont, federally qualified health centers in Medicaid managed care plans are entitled to a "wraparound" payment to settle the difference between capitation and cost. In addition, some states provide enhanced capitation rates to plans that contract with federally qualified health centers to compensate for a more costly patient case-mix. Minnesota adjusts for a more costly case-mix in some safety net–sponsored plans.[19]

Next Steps

Federal and state policymakers often find themselves caught between the plans, which argue that strict governmental requirements to contract with community-based providers or pay them certain rates hurt the plans' ability to provide cost-effective care, and community-based providers, which assert that the government must protect them from competition that could threaten their financial viability. In an effort to find middle ground, HCFA and most state Medicaid agencies have tried to ensure, at a minimum, that community-based providers are given a chance to participate in Medicaid managed care plans, even if they cannot guarantee their ultimate success. After all, federal and state governments have invested in community-based providers through grants, loans, and other support for several decades. If community-based providers are forced to close as a result of competitive forces, and private managed care plans decide to abandon the Medicaid market because it is not sufficiently profitable (as some already have done), governments will have to rebuild the entire care infrastructure for the poor. But if community-based providers, which have always formed the safety net, are given a greater chance of survival, they might constitute an important "fallback."

■ **Policies to improve provider competitiveness.** If this remains the preferred policy choice, there are avenues in addition to those already mentioned that might make community-based providers more competitive. For example, subsidies for care of the uninsured and funds for capital investments (data systems and facility improvements) might make it easier for community-based providers to accept discounted fees from managed care plans. Risk-adjusted rates to plans might make it more likely that they would contract with community-based providers that serve sicker groups of people. For these to occur, MCOs might have to join with providers in the political process.

The question remains whether such policies are needed temporarily

or on a permanent basis. For example, some argue that it goes against the economic interests of MCOs to contract with community-based organizations that are not directly controlled by the MCO. Robert Reischauer of The Brookings Institution stated, "A managed care entity that wants to operate efficiently [would want] . . . to exercise complete control over the provision of services either directly or by subcontracting that control through a risk-based contract to some other provider." Based on this possibility, as MCOs gain more experience in serving the Medicaid population, they may find it more efficient to operate a van service to bring Medicaid members to risk-assuming providers, rather than contract with neighborhood-based providers that are seeking higher payments to support their social mission.

Community-based providers may find that as they become better at managing care and financial risk under capitation, they will be better able to form their own managed care plans. Hospitals and physician groups are now forming integrated delivery systems and provider-sponsored networks that are trying to compete directly with MCOs; some community-based providers are emulating this strategy. If they are successful at managing risk and winning contracts with Medicaid or other purchasers, they might be able to channel the savings or profits into services for the uninsured.

There are those who believe that contracts between Medicaid MCOs and community-based providers will last because they benefit both parties and result in higher-quality service and better outcomes for Medicaid recipients. Others caution that no matter what works best economically or from a health care delivery perspective, politics will remain influential. "On the state level, which plans get Medicaid contracts has to do with politics. In communities, which providers are chosen to get plan contracts has to do with politics," said JoAnne Fischer of the Maternity Care Coalition in Philadelphia.

■ **The value of collaboration.** Before plan/community provider contracts can develop into long-term relationships, more "dating" must begin. One way to encourage such pairing might be to provide evidence of the value of such collaborations. There are few, if any, studies showing that collaborations have improved care to vulnerable populations or resulted in more cost-effective care. What have community-based providers done that has helped MCOs to meet the special needs of Medicaid clients? How have the resources and expertise of MCOs improved the care of Medicaid enrollees?

Solid, objective studies that answer these questions would do much to move the collaboration agenda. Indeed, evidence of the cost-effectiveness of individual community-based providers or particular outreach or educational methods could be the strongest sell-

ing point of all. MCOs might not need any prodding to contract with community-based providers if such proof were readily available. On the other hand, evidence of Medicaid managed care plans' ability to improve access to care, which is also in short supply, might convince community-based providers of the value of collaboration with private plans.[20]

■ **Opportunities for discussion.** As important as research and public policy are to encouraging collaboration, it may be just as important to provide opportunities for representatives of private Medicaid managed care plans and community-based providers to discuss openly the differences that divide the groups and to sort out mutually acceptable roles, responsibilities, and mechanisms to ensure accountability for the care of vulnerable populations. Further meetings, held at the community level, may go a long way in moving these "arranged marriages" toward true compatibility.

EVEN WITH SUCH STEPS, Medicaid managed care plans might still come to the conclusion that they can serve the Medicaid population without the help of community-based providers. If that is the case, and federal or state policymakers still believe that partnerships between the two sets of organizations are important, financial incentives or regulatory requirements may be needed to ensure that such arrangements are established.

This paper was adapted from an issue brief prepared for a meeting sponsored by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services and the National Institute for Health Care Management (NIHCM). The meeting, held 15 November 1996 in Washington, D.C., brought together representatives of private Medicaid managed care plans and community-based providers to discuss the issues that promote or hinder contracts between them and to explore how collaboration can improve care for vulnerable populations. Any quotes in this paper that are not footnoted are drawn from the transcript of that meeting. The author appreciates the support of the NIHCM and HRSA for this paper and extends particular thanks to Kathleen Eyre, Jeanne Ireland, Michael Sparer, Ed Neuschler, and Julia Tillman for their review and comments.

NOTES

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11. Bureau of Primary Health Care, HRSA, "Impact of Changes in the Nation's Health Care System on Safety Net Providers: The Case of Health Centers" (Memorandum from Marilyn Gaston, associate administrator, Bureau of Primary Health Care, HRSA, July 1996). According to the bureau's review of 150 contracts between health plans and federally qualified health centers, an estimated 50 percent do not offer reasonable reimbursement rates (page 18).
12. Some of these lessons appear in the paper by Orbovich, "Collaborative Strategies," 15, and were raised by participants in the meeting sponsored by HRSA and AAHP, "Collaborative Strategies," 1–2 April 1996, in Washington, D.C.
13. Under Section 1915(b), states can ask to waive provider "freedom-of-choice" rules to mandate enrollment of Medicaid beneficiaries into managed care arrangements. Under Section 1115, states can ask to waive many rules to conduct research and demonstration projects that advance the objectives of the Medicaid program. Typically, Section 1115 waivers have been granted to allow states to implement mandatory managed care plans on a statewide basis and use the savings to extend eligibility to additional groups of low-income persons.
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