SUMMARY

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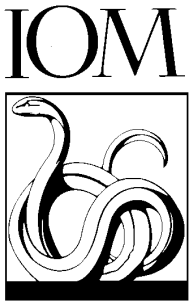
Intact but Endangered



INSTITUTE OF MEDICINE

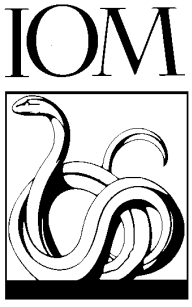
SUMMARY

America's Health Care Safety Net

Intact but Endangered

Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers

Marion Ein Lewin and Stuart Altman, *Editors*



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Support for this project was provided by the Health Resources and Services Administration (Contract No. 240-97-0030). The views presented in this report are those of the Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers and are not necessarily those of the funding agency.

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The report was reviewed by individuals chosen for their diverse perspectives and technical expertise in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments to assist the authors and the Institute of Medicine in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The content of the review comments and the draft manuscript remain confidential to protect the integrity of the deliberative process. The committee wishes to thank the following individuals for their participation in the report review process:

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While the individuals listed above provided many constructive comments and suggestions, responsibility for the final content of the report rests solely with the authoring committee and the Institute of Medicine.

Preface

At a time of unprecedented prosperity and budget surpluses it seems almost out of style to focus on groups in our nation who fall outside the economic and medical mainstreams. These people include not only this country's 44 million uninsured individuals but also an almost equal number of low-income underinsured individuals. Vulnerable populations extend as well to poor and disadvantaged individuals living in inner cities and isolated rural communities, minority and immigrant families, people with special health care needs, and low-income groups who face a variety of other financial and nonfinancial barriers to stable health care coverage.

To address at least the basic health care needs of these impoverished and disadvantaged populations, America has long relied on an institutional safety net system, a patchwork of hospitals, clinics, financing, and programs that vary dramatically across the country. The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources, and public policies. Despite their precarious and unstable infrastructure, these providers have proven to be resilient, resourceful, and adept at gaining support through the political process. Today, however, a more competitive health care marketplace and other forces of change are posing new and unprecedented challenges to the long-term sustainability of safety net systems and hold the potential of having a serious negative impact on populations that most depend on them for their care.

Our committee was asked to examine the impact of Medicaid managed care and other changes in health care coverage on the future integrity and viability of safety net providers, particularly core safety net providers such as community health centers, public hospitals, and local health departments. To carry out its charge, the committee reviewed the evidence from the peer-reviewed literature, held a 2-day public hearing, and elicited a broad array of expert testimony. The committee also conducted a number of regional meetings and commissioned several papers to provide further analyses on topics of special relevance to the study charge. In the course of our work, we were impressed by a

number of excellent ongoing studies and surveys under way to determine how safety net providers and vulnerable populations are faring in the new environment. Much of this work is being sponsored by major health care foundations. At the same time, the committee was struck by the dearth of reliable and consistent data that can be used to accurately assess, measure, or compare the changing status of safety net systems across the country. Compounding the difficulty of accurate measurement is the ongoing evolution of Medicaid managed care and the turbulent health care environment.

These limitations notwithstanding, the committee came away from its deliberations convinced that today's changing health care marketplace is placing core safety net providers in many communities at risk of not being able to continue their mission of caring for a growing number of uninsured at a time when other national, federal, state, and local initiatives to expand coverage are still on the drawing board, in a fledgling state, or falling short of their promise. The growth of Medicaid managed care enrollment, the retrenchment or elimination of key direct and indirect subsidies that providers have relied upon to help finance uncompensated care, and growing demand for charity care are making it more difficult for many safety net providers to survive. Moreover, in many communities these adverse forces are affecting safety net providers all at once, placing already fragile underpinnings in even greater danger of falling apart.

In the absence of agreement on broader health care reform and with growing demand for charity care, the committee came to feel strongly that our nation's core safety net provider system needs to be sustained and protected. At the same time, the committee realized the importance of encouraging safety net providers to actively embrace the positive aspects of current change, including incentives to develop more integrated and accountable delivery systems and a greater emphasis on performance and customer service. Together with the committee's findings and recommendations, this report includes a synthesis of what the committee heard and learned over its 18 months of deliberations. We hope that our work will contribute in some small way to the dialogue on broadening the reach of access to health care for all Americans.

Stuart Altman, Ph.D.
Chair
Committee on the Changing Market,
Managed Care, and the Future
Viability of Safety Net Providers
March 2000

Acknowledgments

This volume has benefited from the encouragement, time, and expertise of many people. Efforts to accurately capture and document the status of America's health care safety net amidst the shifting sands of a tumultuous health care marketplace depended in important ways on generous help from a range of experts and knowledgeable colleagues. Although it is not possible to mention by name all of those who contributed to this study, the committee wants to express special appreciation to a number of groups and individuals for their valuable help.

Particular thanks is extended to the major sponsor of the study, the U.S. Department of Health and Human Services', Health Resources and Services Administration and its administrator, Claude Earl Fox, M.D., M.P.H., for their support, patience, and thoughtful attention. We are especially indebted to Rhoda Abrams and Alex Ross for their enormous help. Before Alex came on board, Jennifer Friedenholtz contributed to the planning of the committee's public hearing. Marilyn Gaston, Michael Millman, and Jennifer Townsend provided valuable early guidance and input. Special words of thanks go to Bonnie Lefkowitz for her unstinting generosity in helping the committee identify and analyze needed data. The contributions of Richard Bohrer, Wayne Meyers, and Robert Politzer were also greatly appreciated.

The committee also is greatly indebted to Medi-Cal Policy Institute in Oakland, California, and The Commonwealth Fund of New York for sponsoring regional meetings in California and New York, respectively, that helped the committee gain a firsthand understanding of the diversity of safety net organizations across the country. Valerie Lewis, Crystal Hayling, Brian Biles, and David Sandman deserve special praise for their help in developing these important meetings.

The committee wants to give special thanks to the dedicated and hardworking staff at the Institute of Medicine. We are particularly fortunate that Marion Ein Lewin agreed to take on the responsibilities of study director for the project. Marion brought to this effort a knowledge of the issues surrounding safety net providers and the individuals whose research activities and experience was most important for our evaluation. Above all, Marion's tireless energy, enthusiasm and commitment to excellence pushed the committee to produce what we believe is a first rate report. Judith Krauss, the 1998–1999 Institute of Medicine/American Academy of Nursing/American

Nurse Foundation's Senior Nurse Scholar, contributed in major ways not only to the content of the report but also to many of the other lofty and mundane tasks that this kind of effort involves. Kari McFarlan deserves major commendation for her masterful and proficient handling of communications with the committee, organizing the literature database, and carrying out a myriad of other critical administrative tasks with great professional aplomb. Justine Lang deserves thanks for her administrative help in the early stages of this report and organizing the committee's first site visit to Tampa, Florida. Project assistant Michael Conroy was also helpful to the committee's work.

We thank Michael Hayes not only for his careful and professional editing but also for his interest in the project and thoughtful ongoing support. The committee also appreciated Richard Sorian's editing help from the perspective of his communications and health policy expertise. The committee owes countless thanks to Heather Binder, who "adopted" the study in its final months of gestation. Heather meticulously incorporated all of the edits and checked and double-checked all of the references, charts, and figures. Her proficient and careful review of the draft was a major contribution to the quality of the final product. Claudia Carl and Mike Edington provided assistance during the report review and preparation stages.

The committee wishes to express heartfelt appreciation to the authors of the commissioned papers. The well-researched and highly informative background papers enhanced the committee's understanding of the many dimensions of this complex issue. Alexandra Shields not only authored one of the commissioned papers but also contributed significantly to the research and writing of the report. Marlene Niefled deserves thanks for her research assistance to Alexandra.

The committee extends special thanks to all of the people who contributed to the substance, learning, and enjoyment of our site visits. The committee is especially thankful to Bob Master, Jim Hooley, Jim Bernstein, Bill Remmes, Jane McCaleb, Patricia Bean, and Commissioner Thomas Scott for their help in planning and organizing these activities.

The committee greatly appreciates the help and contributions of Christine Burch, Joel Cantor, Peter Cunningham, Lynn Fagnani, Marilyn Falik, Darrel Gaskin, Brad Gray, Dan Hawkins, John Holohan, Robert Hurley, Lucy Johns, Ronda Kotelchuck, Leighton Ku, Debbie Lewis-Idema, Jack Needleman, Stephen Norton, Magda Peck, and Sara Rosenbaum. These respected experts were never too busy to answer our calls, respond to our inquiries, and give generously of their time and knowledge. Thanks go as well to Joe Anderson, Amy Bernstein, Maura Bluestone, Dennis Braddock, Thomas Chapman, Lisa Tremento Chimento, Anne Dievler, Susanne Felt-Lisk, Irene Frazier, Marsha Gold, Eric Holzberg, Pat Jerominski, Larry Lewin, Jack Meyer, John Murphy, George Schieber, Helen Smits, David Sundwall, Carolyn Taplin, Pat Taylor, and Andrew Wallace for their thoughtful and informed perspectives.

Finally, the committee would like to thank the chair, Stuart Altman, for his intellectual leadership and for his strong commitment to the purposes of this project. He, in turn, wishes to thank the excellent and hardworking committee members whose dedication and perseverance to this effort far exceeded any reasonable expectations.

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Summary

Rising numbers of uninsured Americans, an increasingly price-driven health care marketplace, and rapid growth in enrollment of Medicaid beneficiaries in managed care plans may have critical implications for the future viability of America's health care safety net that serves a large portion of low-income and uninsured Americans. Of particular concern is the future of "core" safety net providers, institutions and physicians with a high level of demonstrated commitment to caring for uninsured and underserved patients. A failure to support and maintain these core providers could cause the entire safety net to collapse.

Despite the nation's vast riches and enormous resources, certain populations (referred to as "vulnerable populations" throughout this report) continue to fall outside the medical and economic mainstream and have little or no access to stable health care coverage. These populations include the 44 million Americans who are uninsured, low-income underinsured individuals, Medicaid beneficiaries, and patients with special health care needs who rely on safety net providers for their care. A large number of individuals who make up these groups are of minority and immigrant status and live in geographically or economically disadvantaged communities. The relationship between health insurance and access to health care and medical outcomes has been well documented (American College of Physicians-American Society of Internal Medicine, 2000; Davis and Schoen, 1977). Uninsured individuals are less likely to have a regular source of care, are more likely to report delay seeking care, and are more likely to report that they have not received needed care. Uninsured Americans may be up to three times more likely than privately insured individuals to experience adverse health outcomes and four times as likely as insured patients to require both avoidable hospitalizations and emergency hospital care (American College of Physicians-American Society of Internal Medicine, 2000).

In the absence of universal comprehensive coverage, the health care safety net has served as the default system for caring for many of the nation's uninsured and vulnerable populations. Until the nation addresses the underlying problems that make the health care safety net system necessary, it is essential that national, state, and local policy makers protect and perhaps enhance the ability of these institutions and providers to carry out their missions. In many communities these

providers uniquely offer care that addresses the clinical and social needs of vulnerable patients who remain outside the economic and medical mainstream. Failure to support these essential providers could have a devastating impact not only on the populations who depend on them for care but also on other providers that rely on the safety net to care for patients whom they are unable or unwilling to serve.

To gain a better understanding of the potential impact of the current transformations in health care delivery, financing, and public policies on safety net providers, the U.S. Department of Health and Human Services' Health Resources and Services Administration asked the Institute of Medicine (IOM) to appoint a committee that would

> examine the impact of Medicaid managed care and other changes in health care coverage on the future integrity and viability of safety net providers operating primarily in ambulatory and primary care settings.

A committee of 14 experts was selected to conduct the study. The committee was carefully formulated to reflect a balance of expertise particularly relevant to its charge. The committee met five times between December 1997 and February 1999, and its deliberations and fact-finding activities included expert hearings and testimony, commissioned papers and data analyses, structured interviews, and site visits. These activities are described in greater detail in Chapter 1 of this report.

Although the committee understood that the study's sponsor was particularly interested in the ambulatory and primary care providers that fall under its funding authority, the committee and sponsor recognized that an accurate assessment of the role and future viability of these providers would have to encompass other major inpatient and community-based ambulatory care providers with demonstrated commitment to serving the poor and uninsured.

In carrying out its charge, the committee was asked to focus on the current challenges facing historical providers of care to the poor and uninsured in terms of their future financial viability and survival. In discussing its mandate, the committee was fully aware that this particular focus and perspective necessarily would exclude a broader exploration of alternative frameworks for providing the nation's poor and uninsured access to health care. In an environment of choice and competition, certain subgroups of traditionally safety net-dependent patients may have new and perhaps better care options. Some analysts argue that the future viability of safety net providers should be of concern only to the extent that these providers specifically and measurably improve access to quality health care for individuals in need of their services. Additionally, although traditional safety net providers serve a disproportionate number of poor and uninsured patients, in the aggregate they provide only a portion of the uncompensated care provided in most communities (Cunningham and Tu, 1997; Lefkowitz and Todd, 1999). This perspective could argue for a more global assessment of safety net services and their relative adequacy in a given community. Still others argue that policy and program efforts directed to poor and uninsured populations primarily should be targeted at broadening access to affordable insurance rather than subsidizing a designated class of providers.

Although the committee sees some merit in all of these perspectives, its charge was to assess the health care safety net system as it exists today and to focus its deliberations on these major providers of care to poor and uninsured populations. In addition, over the course of its deliberation the committee read and heard convincing evidence that even within the context of insurance reform segments of America's most disadvantaged populations will continue to rely on traditional safety net providers for their health care services, not only because these may be the only

providers available and accessible but also because many of these providers are uniquely organized and oriented to the special needs of low-income and uninsured populations.

Although no commonly accepted definition of the safety net exists, for the purposes of this study, the IOM committee defines the "health care safety net" as follows:

> Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.

In most communities there is a subset of the safety net that the committee describes as "core safety net providers:"

> These providers have two distinguishing characteristics: (1) either by legal mandate or explicitly adopted mission they maintain an "open door," offering access to services for patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

Core safety net providers typically include public hospital systems; federal, state, and locally supported community health centers (CHCs) or clinics (of which federally qualified health centers [FQHCs] are an important subset); and local health departments. In most communities several smaller special service providers (e.g. family planning clinics, school-based health programs, and Ryan White AIDS programs) also are considered a part of the core safety net. In some communities teaching and community hospitals, private physicians, and ambulatory care sites with demonstrated commitment to serving the poor and uninsured fulfill the role of core safety net providers.

The nation's health care safety net is not comprehensive, nor is it well integrated (Baxter and Mechanic, 1997). Rather, it is a patchwork of institutions, financing, and programs that vary dramatically across the country as a result of a broad range of economic, political, and structural factors. These factors include the strength and configuration of the local economy, the numbers and concentration of poor and uninsured individuals, the structure of the local tax base, the depth and breadth of a state's Medicaid eligibility and benefits, and the community's historic commitment to care for the uninsured and other vulnerable populations.

Although it is difficult to generalize about the overall state of the nation's health care safety net given its local nature and attributes, in carrying out its charge the committee is particularly concerned about the state of the core safety net and its ability to continue to provide needed access to this nation's most disadvantaged and underserved populations. In many underserved inner-city and rural communities, core safety net providers may be the only available source of primary health care services for the vulnerable populations residing in these areas.

Rising numbers of uninsured patients, coupled with changes in Medicaid policies and cutbacks in public and other subsidies, are beginning to place America's health care safety net in a state of serious jeopardy. The loss of safety net providers could harm not only the uninsured and people with low incomes but also the community at large. For example, in many regions, large public teaching hospitals are often the only source of trauma care, burn units, and other specialized services that are vital but that tend to be unprofitable.

THE THREAT TO CORE SAFETY NET PROVIDERS

Core safety net providers serve a disproportionate share of low-income and uninsured patients. In 1997, public hospitals provided 28 percent of services to uninsured patients, and an ad-

ditional 33 percent were to Medicaid patients (National Association of Public Hospitals and Health Systems, 1999). Similarly, more than 40 percent of patients who receive care from FQHCs are uninsured, whereas an additional 30 to 40 percent are Medicaid beneficiaries (Bureau of Primary Health Care, 1998).

Over the years, Medicaid (and to a lesser extent Medicare) has become the financial underpinning of the safety net. Historically, Medicaid has provided the majority of insured patients for most safety net providers and has subsidized a substantial portion of care for the uninsured through such programs as disproportionate share hospital (DSH) payments and cost-based reimbursement for FQHCs. State and local government grants also represent an important but variable source of revenues for most safety net providers.

A major cause for concern is the committee's finding that Medicaid as well as other revenues and subsidies that in the past have helped support care for uninsured and other vulnerable populations are becoming more restricted at the same time that the demand on the safety net is rising. The pressures on the safety net in many communities are the result of both intended and unintended consequences of the new health care marketplace and recently adopted public policies. Although the full impact of these dynamics still is still unfolding, the committee has identified several troubling trends.

- **The number of uninsured people is growing.**
  More than 44 million people, or 18 percent of the total nonelderly population, lack health care coverage, an increase of 11 million over the past decade. New studies forecast that, absent major reform, the ranks of the uninsured will continue to grow substantially over the foreseeable future (Custer, 1999). Rising insurance costs relative to family income, the impact of welfare reform, and other factors have contributed to these trends. As a result, both public hospitals and CHCs are seeing an increased number of uninsured patients.

- **The direct and indirect subsidies that have helped finance uncompensated care are eroding.**
  The Balanced Budget Act of 1997 (BBA) reduced some of the major direct public subsidies that have helped finance health care for indigent populations, including significant cuts in Medicaid DSH payments and the phaseout over 5 years of cost-based reimbursement for FQHCs. The recently passed Balanced Budget Refinement Act of 1999 places a 2-year moratorium on the scheduled repeal and extends the phaseout from 2003 to 2005. The 1999 Act also calls for a study to determine how CHCs should be paid in subsequent years (National Association of Community Health Centers, 1999). The committee also read and heard evidence that in a number of states, state and local funds are also are being cut or frozen, despite growing needs (Holahan et al., 1998; Norton and Lipson, 1998). With the decline and planned phaseout of federal subsidies, local revenues become increasingly important to the future viability of safety net providers.

  In some communities a substantial proportion of care for the uninsured is delivered by private physicians and institutions that do not fall within the committee's definition of core safety net providers (Cunningham et al., 1999; Mann et al., 1997). Although these patients may represent only a small part of these providers' total practice or business, in aggregate these providers deliver a significant amount of charity care. Historically, these providers have been able to cover most of their uncompensated care costs by shifting the costs to other payers. Recent data indicate that physicians who derive a major share of their practice revenues

from managed care are less willing or able to provide charity care (Bindman et al., 1998; Cunningham et al, 1999). This is placing even more pressure on an already strained safety net system.

- **The rapid growth of Medicaid managed care is having many adverse effects.**

  A number of core safety net providers operating in mandatory Medicaid managed care environments are experiencing a decline in Medicaid revenues because of a reduction in the absolute numbers of Medicaid beneficiaries, the diversion of some Medicaid beneficiaries to other providers, and lower payments by Medicaid managed care plans (Lefkowitz and Todd, 1999). Competition for market share and downward pressure on prices by private payers have made Medicaid patients relatively more desirable to providers that in the past have not been willing to serve this population, shifting some Medicaid patients away from traditional providers. The committee heard extensive evidence that these factors are challenging the continuing ability of some safety net providers to balance the need to maintain a financial margin and pursue their mission of providing care to the uninsured.

  In the past, safety net providers have served two major groups of poor patients: the uninsured and those on Medicaid. Over the years these two groups have become inexorably linked both because of the transient nature of Medicaid eligibility and because other providers could not or would not serve them. Although they were not originally intended to subsidize care for the uninsured, Medicaid revenues have helped core safety net providers defray some of the overhead and infrastructure costs, freeing limited grant funds and other revenues to be directed more to supporting care for the uninsured.

  Under the traditional Medicaid program, beneficiaries were responsible for finding a willing provider to care for them. In many communities, Medicaid-participating providers were few and far between and safety net providers were the only source of care for the poor. Today, many states are offering Medicaid beneficiaries the opportunity to enroll in private managed care plans with the promise of more choice of providers and facilities. Enhanced choice of quality providers is desirable as a matter of equity and can create incentives for all providers to improve their performance. At the same time, however, the shift of Medicaid patients away from safety net providers combined with the growing number of uninsured people may have the effect of destabilizing an already fragile safety net.

  The categorical and episodic nature of Medicaid eligibility means that individuals tend to cycle on and off insurance, often with long spells of no insurance. Under the traditional Medicaid program, low-income individuals and families who lost Medicaid coverage would continue to see safety net providers without much interruption. Private managed care organizations have no legal responsibility or mission to continue to support the care of patients when they become uninsured. The committee is concerned that these new trends not only undermine the financial viability of core safety net providers but also impair the continuity of care for these patients.

  Although managed care has been shown to improve access to primary care in some communities, Medicaid managed care appears to have major differences from commercial managed care. Compared with privately insured persons, Medicaid beneficiaries tend to be far more vulnerable, their needs more diverse, and their experience with and capacity for exercising choice more limited. They may also lack the resources to go “out of plan” if they are dissatisfied with their care. In addition, nonmedical services of special importance to vulnerable populations (e.g., enabling services such as translation services, transportation to clinic

visits, and the provision of child care services, and outreach) may not be part of a managed care contract or amenable to a managed care infrastructure. Procedures that facilitate ease of beneficiary enrollment and the exercise of choice, together with adequate oversight of plan performance, take on special importance for this population. Unfortunately, many of these efforts are in a fledgling stage and vary widely from state to state.

During the course of its deliberations, the committee was struck by the complexity and variations of local safety net systems, their various dynamics and financial circumstances, and the lack of sufficient and comparable data that can be used to reach with confidence empirical conclusions in certain areas in this period of ongoing evolution. These observations were reinforced by a number of articles, evaluations, and research papers that highlighted the promise and problems of Medicaid managed care in a more competitive, performance-based environment. In most cases, these studies concluded that the promise has not yet been fully realized and that the problems, although worrisome, have not yet reached crisis proportions.

In summary, the committee finds that core safety net providers in most communities are experiencing the adverse effects of many forces. The safety net has historically functioned in a precarious environment, surviving through many shifts in the economy, in policy, and in funding. Today, however, the convergence of new and powerful dynamics—the growth of mandated Medicaid managed care, the retrenchment or elimination of key direct and indirect subsidies that help finance charity care, and the growth in the number of uninsured Americans—is beginning to place unprecedented strain on the health care safety net in parts of the country. These dynamics and their potential impact on access to care for the nation's uninsured and most disadvantaged populations call for more concerted public policy attention and concrete action. In light of these considerations, the committee offers the following findings and recommendations (described in greater detail in Chapter 7 of this report):

FINDINGS

Finding 1. The shift to Medicaid managed care can have adverse effects on core safety net providers and the uninsured and other vulnerable populations who rely on them for their care. These dynamics demand greater attention and scrutiny by policy leaders and administrative agencies at the federal, state, and local levels.

The growth in price competition and the reduced payments made by private payers has made Medicaid a more attractive payer in many communities. Providers that previously shunned this market because of low reimbursement rates are now competing for Medicaid patients, especially with the introduction of managed care. The committee heard evidence that in some communities these developments have had the positive effect of offering beneficiaries a broader network of providers from which to choose. Enhanced choice of quality providers is desirable as a matter of equity and fairness and can create needed incentives for all providers to improve their performance and be more responsive to patients.

The committee is concerned, however, that programs that promote choice are not always implemented in a manner that adequately

- considers the impact on the ability of core safety net providers to sustain their missions to provide care for indigent populations

- ensures that patients are adequately informed about their choices and that those choices are facilitated
- ensures that patients who require complex coordinated care are supported by the necessary enabling services, and
- ensures that continuity of care is not seriously disrupted as patients cycle on and off Medicaid and plans enter and exit the Medicaid managed care market.

Given the special characteristics of the Medicaid population, the committee heard and read testimony suggesting that expanded choice could hold unintended risks for beneficiaries and those who provide care for indigent populations. For example:

- The categorical and episodic nature of Medicaid eligibility means that individuals tend to cycle off and on coverage, often with long spells without insurance. Most managed care organizations and their providers, especially those new to the Medicaid market, often have no formal responsibility or mission to take care of patients when they become uninsured. These new dynamics can impair continuity of care for patients who may have switched from a provider who will serve them whether or not they have Medicaid coverage to a provider who can only serve them when they are receiving Medicaid benefits. The dynamics can also undermine the stability of a community's safety net if core safety net providers lose their Medicaid patient base and other safety net providers find it difficult to shift the costs for additional uninsured patients in a increasingly competitive environment.
- Although Medicaid was not originally intended to support care for the uninsured population, over the years Medicaid revenues have come to provide a critical "silent subsidy" that helps core safety net providers pay for fixed infrastructure costs, freeing limited grant funds and other revenues to pay for care for uninsured patients. Thus, care for Medicaid and uninsured patients became become inexorably linked, creating an interdependency in the absence of more explicit state or federal subsidies and policies regarding care for the uninsured population. The increasing separation of care for Medicaid beneficiaries and care for the growing number of uninsured individuals may have the effect of destabilizing the safety net in many communities.
- A number of states have been successful in encouraging commercial and other plans to enter the Medicaid market by creating a hospitable market environment and offering attractive premium rates. Recently, however, a number of major commercial plans have exited all or major parts of the market because of the complexities of serving Medicaid patients, the inability to make a profit, and administrative requirements that they perceive to be burdensome. These developments have spurred the growth of Medicaid-only plans, which are organized in many cases by local safety net providers. Thus, safety net providers are once again providing care for their traditional patient populations, but often with fewer overall resources, more administrative requirements, and an increased demand for uncompensated care.

Finding 2. Managed care principles offer significant potential for improved health care for Medicaid patients, but implementation problems can undermine this potential.

The literature holds convincing evidence on the potential of managed care principles to improve the quality and efficiency of care for most patients and accountability to patients. When properly implemented, managed care can (1) promote comprehensive, integrated care with an emphasis on primary care, prevention, and population health; (2) offer greater incentives for effi-

cient and appropriate care; and (3) provide a greater accountability for performance on the part of providers.

In addition, the growth of competition and choice in an environment of Medicaid managed care has produced new and powerful incentives for safety net providers to raise the bar in areas of operating efficiency, administrative and information systems, customer service, and general accountability to patients and payers. Safety net providers operating in a managed care environment may be able to offer vulnerable populations additional benefits in the important enabling, social, and outreach services that many of these patients require.

Despite this potential, however, the committee collected substantial evidence that raises the following concerns:

- The health plans and providers that serve Medicaid beneficiaries may have conflicting incentives that can diminish the potential value of managed care. For example, since poor patients tend to go on and off Medicaid, some health plans may see little advantage in investing in preventive care or other services to improve the long-term health of their Medicaid members.
- To remain viable a number of community-based providers are creating joint ventures with large hospitals or academic health center-owned systems. For example, many safety net providers do not have sufficient capital to invest in the management information systems and other capital improvements necessary to succeed in managed care. Although affiliations with a hospital or an academic health center may hold significant advantages., these uneven partnerships, if not properly structured, could affect the long-term ability of community-based safety net providers to maintain their past commitments to the uninsured population.
- Inadequate capitation rates in many states and the absence of adequate risk-adjustment tools may be forcing many safety net providers to assume substantial financial risk without sufficient reserves or other protections against insolvency.

The transition of state Medicaid programs from bill payer to prudent purchaser requires the development of specific new skills by program administrators, including skills in contracting, premium rate setting, quality and financial oversight, patient education, and enrollment protocols. The committee finds that in many states the implementation of managed care has been attempted with insufficient preparation and staffing. Although some states have moved to managed care to improve access and quality of care, in recent years, a priority objective for most states appears to be program cost savings.

The committee finds it difficult to gauge the success of the states' Medicaid managed care initiatives. Results have been inconsistent and vary widely from state to state. The committee found that better methods are needed to both capture and disseminate the lessons that have been learned and the problems that need to be avoided, as well as to help diminish inappropriate and potentially harmful interstate variations in the provision of safety net services.

Finding 3. The financial viability of core safety net providers is even more at risk today than in the past because of the combined effects of three major dynamics: (1) the rising number of uninsured individuals; (2) the full impact of mandated Medicaid managed care in a more competitive health care marketplace; and (3) the erosion and uncertainty of major direct and indirect subsidies that have helped support safety net functions.

Safety net providers have always operated in a precarious financial environment and over the years have learned to survive in both good and bad economic times. The committee believes that, absent new policies, the increasing demand for care for indigent populations, the diminishing resources to support such care, and the mounting access barriers faced by uninsured people will endanger the fragile patchwork of providers and institutions that serve this nation's most vulnerable groups.

Finding 4. The patchwork organization and the patchwork funding of the safety net vary widely from community to community, and the availability of care for the uninsured and other vulnerable populations increasingly depends on where they live.

Although federal Medicare, Medicaid, and other policies (such as cost-based reimbursement for FQHCs) have a critical impact on the financial viability of the safety net system, the strength and viability of a community's safety net system are highly dependent on state and local support, state Medicaid policies, the structure of the local health care marketplace, and the economic health of the community. With the devolution of responsibilities from the federal government to state and local governments, care for vulnerable populations is increasingly determined by local economic, political, and social factors. These trends are resulting in ever widening state and community variations in care for vulnerable populations and the adequacy of the health care safety net.

The committee found substantial evidence that states with the greatest demands for safety net services often have the weakest economic, political, and social infrastructures to effectively respond to local needs.

Although policies of devolution have contributed to innovative programs and policies directed to care for vulnerable populations, they have also made it more difficult to collect adequate and comparable data to track and monitor the changing status of state and local safety net organizations and how program and policy changes are affecting care for vulnerable populations.

Finding 5. The committee found that most safety net providers have thus far been able to adapt to the changing environment. Even for these providers, however, the stresses of these changes have made it increasingly difficult for them to maintain their missions while protecting their financial margins. In addition, the full consequences of changing market forces, increases in the number of uninsured, and reduced levels of reimbursement have not yet been felt by these providers in some communities. The committee further observed that the current capacity for monitoring the status of safety net providers is inadequate for providing timely and systematic evidence about the effects of these forces.

Although the committee heard frequent testimony and studied a number of reports about the negative consequences of the various changes in the environment of safety net providers, it was continuously frustrated by its inability to find a single source where such information was collected and analyzed. It was also evident that the information that was available took many years to assemble and that important data was often missing or only describing the situation in a few communities.

In some parts of the country, all of the major forces of change, including growth in the numbers of uninsured individuals, high rates of penetration of mandated Medicaid managed care, strong market competition, and the full impact of the BBA of 1997, have not yet converged,

making it possible for many core safety net providers to maintain their missions to provide care for the uninsured population. The committee believes, however, that in the current policy and political environment, these forces will continue to have increasingly adverse effects.

Safety net providers are placing major emphases on gaining contracts with managed care organizations, developing partnerships and networks to gain leverage and to benefit from economies of scale, diversifying funding streams, improving clinical and administrative protocols, and improving customer-oriented services.

- Virtually all safety net providers have come to realize that they must participate in Medicaid managed care, but little is known about what adaptive strategies appear to be the most successful.
- Although on the whole the safety net has remained intact, many of these organizations are becoming increasingly fragile given the growing number of uninsured individuals and cutbacks in grants and revenues. New studies show that managed care cost pressures are forcing other providers to retrench on the provision of care for vulnerable populations, placing an even greater burden on the core safety net.
- State and local policies and programs that support care for vulnerable populations have proved to be critically important to the ability of community safety net systems to remain viable while maintaining their missions to provide care for the uninsured population.
- At this stage of Medicaid managed care and restructuring of the U.S. health care system, few reliable and consistent data exist to determine clearly how beneficiaries are faring in the new environment.

The patchwork and categorical nature of funding for the safety net has created barriers to systems building, integration, and more flexible responses to new requirements, all of which are critical for successful adaptation to managed care. Safety net organizations are not well integrated at the regional or local level. There are only a few examples of communities in which core safety net providers have integrated into a more seamless system (e.g., Denver Health and Cambridge Hospital in Massachusetts). In most cases, community health centers, public hospitals, and public health departments do not have common governance, shared physical or information infrastructures, joint staffs, common patient identifiers, or defined integration of services. The historical separation of funding streams as well as the different missions and constituencies of various providers have worked against effective collaboration.

A resurgence of inflation in health care costs, an economic downturn, or further increases in the rolls of the uninsured could further destabilize the safety net and place essential care for America's vulnerable populations at the risk of significant peril. In light of these circumstances, the committee finds a compelling need for a stronger ongoing capacity to monitor the changing status of the safety net.

RECOMMENDATIONS

Recommendation 1. Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve.

In making this recommendation, the committee believes that the following issues need heightened public policy attention:

- failure to take into consideration the impact on safety net providers of changes in Medicaid policy could have a significant negative effect on the ability of these providers to continue their mission to serve the uninsured population, particularly those who move back and forth between being eligible for Medicaid and being uninsured;
- the adequacy and fairness of Medicaid managed care rates;
- the erosion of the Medicaid patient base and the financial stability of core safety net providers that must continue to care for the uninsured population;
- the declining ability or willingness of non-core safety net providers to provide care for the uninsured population; and
- the current instability of the Medicaid managed care market including the rapid entry and exit of plans and the impact of this churning of program beneficiaries.

Recommendation 2. All federal programs and policies targeted to support the safety net and the populations it serves should be reviewed for their effectiveness in meeting the needs of the uninsured.

Major new forces have altered the financing and delivery of health care services, including the move to managed care by both private and public payers, the separation of care for Medicaid patients from care for uninsured individuals, the erosion and retrenchment of direct and indirect subsidies that have helped provide care for those without coverage, and the increasing concentration of care for the uninsured population among fewer providers. These dynamics call for a careful review of programs and policies that were designed to improve access to care for vulnerable populations and support the providers that serve them to make sure that that these programs are still effectively targeted to meet their original objectives. The committee believes that such an analysis is especially important given the growing number of uninsured Americans and the declining ability to meet their health care needs. Federal health care programs that provide direct or indirect support for safety net providers and for services for vulnerable populations should be reviewed and modified to ensure that any funding allocation formula specifies explicit criteria for the delivery of services to the uninsured population as a basis for support. Eligibility for Medicaid and Medicare DSH funds should also be reexamined to include a greater focus on the level and share of services for the uninsured. Although the committee believes strongly that no funds should be diverted from the core safety net, any funds that become available as a result of this reexamination should be distributed in a manner that ensures that providers of both ambulatory and inpatient care are eligible to receive support.

Recommendation 3. The committee recommends that concerted efforts be directed to improving this nation's capacity and ability to monitor the changing structure, capacity, and financial stability of the safety net to meet the health care needs of the uninsured and other vulnerable populations

The committee believes that the fragility of local safety nets has the potential to become a national crisis, and therefore, it calls for stronger federal tracking, direction, and targeted direct support. At this time, no single entity in the federal government has the responsibility for monitoring and tracking the status of America's health care safety net and its ability to meet the needs

of those who rely on its services. Various agencies have responsibility for programs and policies that affect one part of the safety net delivery system (e.g. the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the Health Care Financing Administration, the Head Start program, the Indian Health Service, and the Departments of Veterans Affairs, Defense, Agriculture, and Housing and Urban Development), but no comprehensive, coordinated tracking and reporting capability exists. Although it acknowledges the appropriate roles and responsibilities of the various agencies and the benefits of state and local innovations, the committee believes that such a tracking capability could promote public accountability, as well as a more coordinated approach to data collection, technical assistance, and the application and dissemination of best practices.

A number of organizational settings could be considered for the placement of an enhanced safety net tracking and monitoring activity, including an existing agency, department, or program, or a newly established entity. Although the committee elected not to come to final decision on where such an entity could be placed, it did discuss and identify the major organizational attributes that would be needed to enable a safety net oversight entity to successfully carry out its mission. The committee strongly believes that such an entity should be independent; organized as an ongoing activity with dedicated staff; nonpartisan in its membership; and include a range of expertise required to carry out its charge. Such an oversight body would affect a number of state and local entities and would cut across several federal agencies. In identifying these attributes the committee viewed with favor an organization like the Medical Payment Advisory Commission (MedPAC) with its mandate to report directly to Congress. Alternatively, the oversight body could reside in the executive branch at a Departmental level. As an example of the executive branch model, the committee was impressed with the work and impact of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. However, the Quality Commission had a limited term, consistent with its mandate to produce recommendations for action and implementation by other parts of the federal government and the private sector. The committee's proposed tracking and monitoring activity would require an ongoing term of operation, since its major function would be to assess, monitor, and report on the status of America's health care safety net over time. The committee in its deliberations referred to the monitoring and oversight entity as the Safety Net Organizations and Patient Advisory Commission (SNOPAC).

To carry out its mission, the committee recommends that the initial activities of a safety net oversight entity include the following:

- monitor the major safety net funding programs (e.g., Medicaid, the State Children's Health Insurance Program [SCHIP], Title V, FQHCs, and the various government DSH payment plans) to document and analyze the effects of changes in these programs on the safety net and the health of vulnerable populations;
- track the impact of the BBA of 1997 and other forces on the capacity of other key providers in the safety net system to continue their supportive roles in the core safety net system;
- monitor existing data sets to assess the status of the safety net and health outcomes for vulnerable populations;
- wherever possible, link and integrate existing data system to enhance the current ability and to track changes in the status of the safety net and health outcomes for vulnerable populations;

- support the development of new data systems where existing data are insufficient or inadequate;
- establish an early-warning system to identify impending failures of safety net systems and providers;
- provide accurate and timely information to federal, state, and local policy makers on the factors that led to the failure and the projected consequences of such failures;
- help monitor the transition of the population receiving Supplemental Security Income into Medicaid managed care including careful review of the degree to which safety net-based health plans have the capacity (e.g., case management and management information system infrastructure) to provide quality managed care services to this population and the degree to which these plans may be overburdened by adverse selection; and
- identify and disseminate best practices for more effective application of the lessons that have been learned.

Recommendation 4. Given the growing number of uninsured people, the adverse effects of Medicaid managed care on safety net provider revenues, and the absence of concerted public policies directed at increasing the rate of insurance coverage, the committee believes that a new targeted federal initiative should be established to help support core safety net providers that care for a disproportionate number of uninsured and other vulnerable people.

Funding would be in the form of competitive three-year grants. Grants will vary in size, based on the scope of the project. Sources of financing could include funds available from the federal budget surplus and unspent funds from SCHIP and other insurance expansion programs. Although the committee projects such a new initiative may require a minimum of $2.5 billion range over five years, the specific size and scope of this program should be determined by the administration and the U.S. Congress and should be modified based on an assessment of the parameters of the problem by the safety net oversight entity. These assessments should be an ongoing responsibility of the safety net oversight entity.

The following principles should govern the distribution of these funds:

- Because the committee recognizes the challenges of delivering coordinated, seamless care for the poor uninsured and other vulnerable individuals at a time when the number of such people is increasing, the new initiative should concentrate on both the infrastructure for such care and subsidies of the care itself. Multiple models could be funded under this initiative, mirroring the multiple models of safety net arrangements in the various states and local communities. For example, in some areas a large safety net hospital could take the lead and join with other providers, including community-based clinics. A state or local government could stimulate cooperative efforts in other areas, participating with its own service-delivery capacity. In still others, coalitions of ambulatory care providers, such as community health centers allied with local private physicians, could form and undertake the initiative.
- Funds could be used for infrastructure improvements (e.g., for equipment, rehabilitation of unattractive and inefficient buildings, and management information systems) or to help defray costs or support items and activities such as legal and other costs related to establishment of the network (in ways to avoid charges of antitrust and fraud and abuse), improvements in quality of care (e.g., patient tracking systems, reengineering, and programs targeted to high-risk patients), and, where needed, the health care itself.

- Funds would be available to communities that demonstrate the potential capacity to deliver comprehensive services, to track patients and their outcomes as they move through the system, and to provide appropriate outreach and marketing efforts to reach patients with special needs. The allocations would specifically reward initiatives with demonstrated commitment and capacity to improve access and health outcomes for poor uninsured individuals in the community. Continuation of funding would be based upon ongoing satisfactory performance and accountability.
- Eligibility for funding would include a maintenance of effort requirement with documentation that the new funding would supplement and not replace state or local funding already directed to this effort.

During the time the committee was completing its study, the U.S. Department of Health and Human Services (DHHS), as part of its FY 2000 budget request, proposed a five year initiative designed to increase the capacity and effectiveness of the nation's health care safety net providers. To begin this effort, $25 million in the form of grant funding was appropriated under the FY 2000 Appropriations Act. The committee believes this new national program, the Community Access Program, which will provide funding for approximately 20 communities in the coming year, represents a good first step.

Recommendation 5. The committee recommends that technical assistance programs and policies targeted to improving the operations and competitive position of safety net providers be enhanced and better coordinated.

Several federal agencies including the Health Resources and Services Administration, the Health Care Financing Administration, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention currently provide technical assistance to some safety net providers, but these funds are usually targeted exclusively to the programs funded by the respective agencies. The committee strongly believes that technical assistance funds should promote capacity building and the management and operating capabilities of safety net providers seeking to compete in a managed care environment. Technical assistance programs should promote rather than deter the development of partnerships and collaborations that can contribute to these objectives.

The committee believes the following areas require specific attention:

- management of service delivery and implementation of changes, including improvements in management information systems, appointment scheduling systems, patient telephone access, efforts to streamline operations, and reengineering of services so that they are more responsive to patients;
- development of new business skills such as negotiating managed care contracts and developing marketing techniques to maintain and expand the patient base of safety net providers;
- development and collection of reliable data on which to calibrate rates and assign appropriate risks to develop appropriate reimbursement systems; and
- nonmedical factors that affect utilization and health outcomes of low-income and other vulnerable patients using the health care delivery system (e.g., care-seeking behavior, cultural competence, and public health interventions).

CONCLUSIONS

The committee concludes that the safety net system is a distinct delivery system, however imperfect, that addresses the needs of the nation's most vulnerable populations. In the absence of universal insurance coverage and while the new market paradigms are unfolding, it seems likely that the nation will continue to rely on safety net providers to care for its most vulnerable and disadvantaged populations.

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