

*The Health Care Safety Net in Four
Communities*

Current Policy Issues Affecting Safety Net Providers

by

Jack A. Meyer
Mark W. Legnini
Emily K. Waldman

with assistance from

Elliot K. Wicks
Lindy M. Hinman

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About the Authors

Jack A. Meyer, Ph.D., is the founder and President of ESRI. **Mark W. Legnini, Dr. P. H.**, is Senior Vice President of ESRI. **Emily K. Waldman, M.H.S.**, is a Research Associate at ESRI.

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Current Policy Issues Affecting Safety Net Providers

Introduction

In a nation that does not have universal health coverage for its citizens, safety net providers play a crucial role in providing care to people whose access would otherwise be severely limited by lack of the means to pay for care. One important set of safety net providers is Academic Medical Centers, which, in addition to serving those without health coverage, are an important source of highly specialized medical services. Another set of safety net providers is Community Health Centers, which provide primary care for large numbers of people without health coverage. But in an increasingly competitive hospital marketplace, both Academic Medical Centers (AMCs) and Community Health Centers (CHCs) are beset by a variety of changes that threaten their traditional sources of funding. The purpose of this paper is to discuss the sources of distress for these safety net providers and to give some information about the ways in which they are coping with these new challenges. The paper is based in large part on a study done by the Economic and Social Research Institute, with support from the W.K. Kellogg Foundation, to assess the roles of academic medical centers and explore the ways they are adapting to the new funding and competitive environments. Thus the emphasis will be on AMCs, but because our research provided related information about CHCs, we will also provide information about their efforts, though in less detail.

Our research approach consisted primarily of doing case studies in four communities: Baltimore, Maryland; Boston, Massachusetts; San Francisco, California; and Seattle, Washington. In each community, we spoke with leaders from hospitals and community health centers; representatives of the state Medicaid program; leaders from the organized physician practice community, the managed care industry, and the business community; and commercial third-party payers. We chose this community-based approach in part because local conditions and values historically have had an important influence on the development of AMCs. The local policy context has become increasingly important as responsibility has shifted more toward local government, and as AMCs are less able to rely on federal funding to remain viable. In addition, the

Historical Background of Academic Medical Centers

ability of AMCs to compete successfully with other local hospitals is key to their financial viability in the current marketplace dominated by managed care.

We begin with a discussion of the historical background of AMCs.

Much of the challenge that safety net hospitals face today results from the inherent tensions between their tradition of service to needy patients and their need to remain competitive in today's market. To understand why these hospitals are challenged by the new environment in which they must operate, it is useful to review the history of AMCs.

Many Eastern urban hospitals were founded in the nineteenth century as charitable institutions used exclusively by poor patients who could not afford to see doctors in private practice. Since those hospitals were also the site of medical training, poor patients have historically received care from doctors in training even though the formation of Academic Medical Centers as we know them (a formal relationship between a hospital and medical school) did not occur widely until the twentieth century.

Education had always played a prominent role in the American hospital, but it was not until the twentieth century that a stable relationship between care and learning evolved... The objects of charity who filled a hospital's beds could hardly refuse to cooperate in clinical teaching; it was the principal way in which they could repay society for the gratuitous care they received. . . . The ward was an excellent setting for clinical instruction.¹

Thus, medical education and service to the less fortunate in the community were historically interwoven, and charity care was an integral part of the mission of the early twentieth century academic medical centers. This tradition developed during a period in which there was no health insurance, people paid what they could for care, and physicians, practicing "solo," donated substantial time to care for patients who could not pay the full cost of care. Indeed, as the sociologist Paul Starr wrote in *The Social Transformation of American Medicine*, the presence of a large number of hospitals emerged only in the early part of the twentieth century, as physicians tried to develop institutions that would help them organize, gain more influence, and receive payment for more of their services.²

In a matter of decades, roughly between 1870 and 1910, hospitals moved from the periphery to the center of medical education and medical practice. From refuges mainly for the homeless poor and insane, they evolved into doctors' workshops for all types and classes of patients. From charities, dependent on voluntary

¹Rosenberg, Charles E. *The Care of Strangers*. New York: Basic Books, Inc., Publishers, 1987.

gifts, they developed into market institutions, financed increasingly out of payments from patients. What drove this transformation was not simply the advance of science, important though that was, but the demands and example of an industrializing capitalist society, which brought larger numbers of people into urban centers, detached them from traditions of self-sufficiency, and projected ideals of specialization and technical competence. The same forces that promoted the rise of hospitals also brought about changes in their internal organization. Authority over the conduct of the institution passed from the trustees to the physicians and administrators.³

The next chapter in the development of this country's hospitals covered a period running from the early part of this century until the explosion of medical costs became an important national issue in the 1970s. During much of this period, physicians and hospitals dominated the health care system; insurance companies who paid the bills and employers who paid the insurance companies were largely passive; and indirect payment mechanisms were in place to compensate AMCs adequately for their unusual mix of teaching, research and service, including uncompensated care. The spread of health insurance after World War II enabled more individuals than ever to pay for their own care. In most cases, AMCs charged more for their clinical services than other hospitals, and the extra charges were covered either through higher payments by commercial insurers or Blue Cross and Blue Shield (often referred to as "cost shifting"), or through subsidizing care with growing amounts of research and training funds from the federal government. Medicare and Medicaid converted many uninsured patients to paying patients, and the federal government also funded the construction of new hospitals (through the Hill-Burton Act) and provided direct subsidies for graduate medical education (GME).

But all of this has changed dramatically over the past two decades. The unrestricted fee-for-service, cost-based reimbursement system that hospitals enjoyed has largely vanished. HMO enrollment has soared, and investor-owned companies have increased their influence in the hospital industry but especially among managed care plans. Even nonprofit organizations have had to become more "bottom-line" oriented and business-like in order to survive financially. Reacting to what is widely believed to be an over-built hospital industry and an over-supply of physicians, the federal government has begun to scale back subsidies for GME, and made other funding reductions related to indigent care (discussed in detail below).

While this revolution was occurring in the health care market, a social and demographic transformation was occurring across the country. America's cities have undergone enormous change over the past four

²Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, Inc., Publishers, 1982.

³Ibid, p. 146.

decades. Since about 1960, large numbers of middle and upper-income families have abandoned cities for suburbs, eroding the urban tax base and leaving many neighborhoods without a viable economy and with a high concentration of low-income households. *These are often the neighborhoods in which AMCs are located, some having been built there in the early part of this century or before.*

Thus, recent changes in the health care market have undercut the ability of AMCs to be fully paid for providing teaching and training and for seeing large numbers of indigent patients; at the same time, socioeconomic changes have eroded their local base of insured patients. AMCs are often unable to pay for teaching and research by charging higher prices, because private purchasers are wary of paying “extra” for care, and competing hospitals in the community will under-bid them for managed care contracts. Today’s community hospitals sometimes offer a range of services that is almost identical to that in an AMC, in part because their medical staffs are made up of the specialists that AMCs have been training in ever-increasing numbers. As a surplus of these specialists has developed over the past few decades, community hospitals have established or expanded their own specialty services to allow these community physicians, often who trained at the local AMC, to attract patients away from their alma mater and to the community hospitals where they now practice.

These long-range trends have profoundly affected the financial base for AMCs, but other more recent changes have exacerbated the problem. We discuss these after giving some background about the role of CHCs.

Relationship Between CHCs and AMCs

Community health centers (CHCs) can have a significant influence on the effectiveness and, in some cases, the financial viability of safety net hospitals. Originally, neighborhood health centers (later CHCs) were directly linked to a medical school or teaching hospital. When the Office of Economic Opportunity (OEO) first established neighborhood health centers in the 1960s, each was affiliated with a medical school or teaching hospital to ensure high-quality care, enhance ability to recruit both physicians and other clinical and administrative staff, and provide administrative support services. In return, neighborhood health centers relieved AMCs of the burden of caring for uninsured patients in their emergency rooms and clinics, and also reduced unreimbursed hospital admissions for this population by improving access to primary care and preventive services. CHCs also provided sites for graduate medical education, further linking community-based settings and AMCs.

Today, the educational links between CHCs and AMCs are growing. Shortages of primary care providers in medically underserved areas have prompted AMCs and CHCs alike to train residents at CHCs in the hope that they will continue as primary care providers in community based settings. Although there is no single government program to fund training at CHCs, a variety of government funds can be used for this

purpose. The availability of private and public funds (through federal GME programs, for example) facilitates training linkages between CHCs and AMCs. There has also been substantial growth in the number of nurses, undergraduate medical students, dentists and other health professionals in CHC training programs. One estimate indicates that well over 60 percent of CHCs nationwide are involved in the training of health professionals. In 1993, the total number of medical students and residents who received training in CHCs was 1,598 (up from 826 in 1992) and the total number of other health professional students trained in CHCs was 2,345 (up from 661 in 1992).⁴

Forces Affecting Safety Net Providers

Changing federal, state, and local policies are having a large impact on how safety net institutions evolve in the market. Most have the effect of reducing the amount of “cushion” that there is in the local safety net. Some of the recent changes that have reduced the financial flexibility of AMCs (and CHCs) include the following:

- “devolution” of responsibility for social programs from the federal government to the state;
- welfare reform;
- changes in employer-based coverage;
- Medicaid managed care;
- the tension between “mission and margin” in an increasingly competitive and commercial health care industry.

We discuss these changes below.

New Federalism or “Devolution”

A major debate in U.S. health and social policy over the past several years involves which level of government should fund and administer social programs for low-income populations. The current trend, referred to as “New Federalism” or “devolution,” reflects a gradual shifting of responsibility for social programs from the federal government to state and local governments. (In this context “federalism” refers to a system where the federal government provides either partial or full funding for certain functions but with a minimum of controls over the way states use the funds to fulfill those functions.) The federal Balanced Budget Act (BBA) of 1997 was a significant step in devolution. It gave the states more responsibility and flexibility in running their Medicaid programs, as well as new federal funds for devising programs for uninsured children (called the State Children’s Health Insurance Plan or SCHIP). While advocates of New Federalism argue that programs like Medicaid and SCHIP are more appropriately run by states and localities with a better understanding of local context, critics contend that some states may not meet the needs of low-income populations and call for national standards.

⁴Bureau of Primary Health Care, Public Health Services, Health Resources & Services Administration, U.S. Department of Health and Human Services, “Service-Education Linkages in 1993,” unpublished internal document.

In addition to providing states with greater autonomy and new funding for children's health, the BBA also decreased the amount of money the federal government provides for graduate medical education (GME) and disproportionate share hospital (DSH) payments (the payments the federal government provides to match state money that is used to support hospitals that provide a disproportionate amount of uncompensated care). From the states' perspective, the New Federalism in BBA produces a trade-off: they lose money through DSH cuts but gain a new degree of independence in administering programs and some new funding earmarked for children. But from the perspective of AMCs with large indigent care loads and heavy teaching responsibilities, BBA is generally viewed negatively because the effects of decreases in GME and DSH funding are direct and immediate while the benefits of SCHIP to these providers may be indirect and slow to develop.

Welfare reform

States have been reforming their welfare programs for more than a decade, and these initiatives were augmented by the federal Personal Responsibility and Work Opportunity Act of 1996. This welfare reform law sets time limits on the receipt of cash assistance and requires states to move an increasing proportion of welfare recipients into jobs. Welfare reform also breaks the automatic link between eligibility for cash assistance and eligibility for Medicaid. Even though people who are no longer eligible for cash assistance may still be eligible for Medicaid, this "de-linking" is leading to a decline in the number of people receiving Medicaid coverage, which will adversely affect AMCs by increasing their indigent care load.

Currently, welfare diversion programs and lump-sum payments—designed to keep people from going on cash assistance—are leading many lower-income people away from Medicaid at the "front-end" of their experience with the public safety net. Diversion programs use job search assistance and other techniques to keep people from enrolling in the Temporary Assistance for Needy Families (TANF) cash assistance program. In the near future, an increasing number of people will exhaust their cash assistance benefits, and many of these people will lose health coverage at the "back-end" of their public support. They will often either take jobs without health coverage or disappear from both the public and private health care systems. These trends will aggravate the already existing health care problems in low-income communities and likely increase the amount of uncompensated care provided by AMCs.

Erosion of employer-sponsored coverage

The number of working families without health insurance continues to grow year-by-year, driven in part by the large number of employers who offer no health coverage and the rising incidence of "turn-downs" of coverage by workers who cannot afford their share of the premium. In 1997, an estimated 34.8 million workers were employed by a firm that offered no health insurance coverage, and 14.1 million of these workers were uninsured. Another 10.1 million workers were ineligible

for their employers' health benefits, and 3.7 million of these workers were uninsured. Finally, another 11.4 million workers declined their employers' offers of health coverage, and 2.5 million of these had no coverage.⁵ In total, 20.3 million workers were without health coverage in 1997.

The growth in the number of workers who decline their companies' offers of health coverage is especially troubling. Between 1987 and 1996, the proportion of workers who declined employer-subsidized health coverage rose from 11.7 percent to 19.9 percent.⁶ The high proportion of "turn-downs" is undoubtedly partly due to the financial burden employees must bear to acquire coverage. In 1998, the average worker covered by employer-sponsored health insurance contributed \$141 a month. Workers in firms with fewer than 200 employees contributed an average of \$194 a month, or more than \$2,300 a year.⁷ These trends, taken together, contribute to the substantial number of American workers who remain outside the employer-based health coverage system. Many of these workers lack coverage from any source—making them non-paying patients when they need the services of safety net providers such as AMCs.

The changing mix of jobs, with a greater reliance on part-time, temporary, and contract workers, exacerbates this problem. Without health care benefits from their employers, these workers will be forced to rely on government programs and charitable organizations for health coverage and other social support. The resources of these organizations are often already stretched to the limit in dealing with the homeless population, ongoing threats to public health (HIV/AIDS, STDs), substance abuse, violence, and other social challenges that persist even in our strong economy.

Medicaid Managed Care

Medicaid managed care enrollment expanded rapidly during the 1990s. In 1991, only 9.5 percent of the Medicaid population were enrolled in managed care; by 1998, 54 percent were enrolled.⁸ As of June 1998, the rate of Medicaid managed care penetration in our four study sites was approximately 46 percent in California, 67 percent in Maryland, 63 percent in Massachusetts, and 91 percent in Washington State.⁹ The majority of Medicaid recipients who are enrolled in managed care are non-disabled adults and children who are relatively young and healthy. But

⁵Thorpe, Kenneth E., and Curtis S. Florence, "Why are Workers Uninsured?" *Datawatch, Health Affairs*, Vol. 16, No. 6, March/April 1999.

⁶Cooper, Philip F., and Barbara Steinberg Schone, "More Offers, Fewer Takers For Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Vol. 16, No. 6, March/April 1999.

⁷The Kaiser Family Foundation, *Health Benefits of Small Employers in 1998*, Feb. 1999.

⁸Health Care Finance Administration, website (<http://www.hcfa.gov/medicaid/mcsten98.htm>).

⁹Ibid.

as of 1998, 36 states had enrolled an estimated 1.6 million Medicaid beneficiaries with disabilities in managed care arrangements.¹⁰

While the hope is that Medicaid managed care will benefit Medicaid recipients by providing them with a “medical home” and better coordinated care, this trend toward managed care has a significant impact on safety net providers who have traditionally cared for the Medicaid population. Often, when Medicaid recipients are given a choice of providers and plans, they will leave public providers or formerly public institutions still serving large numbers of indigent patients and go to private facilities. This creates hardships for traditional safety net institutions on two levels. First, they lose Medicaid revenues, which often account for a large portion of their patient revenues. Second, disproportionate share hospital (DSH) payments are often calculated based on the numbers of Medicaid patients served as well as uncompensated care provided, so that a hospital may lose some DSH money if it loses Medicaid patients. Therefore, the persistent movement of Medicaid toward managed care adversely affects the security of the safety net and the ability of safety net institutions to survive. In California, for example, over half of the DSH money going to California hospitals now goes to private community hospitals because of their Medicaid volumes, which has meant that the county and University of California hospitals, which provide the bulk of the uncompensated care in the state, have lost DSH money.

*Tensions between
“mission and margin”*

All of the changes just described are putting increasing financial pressure on AMCs and other safety net providers that have traditionally provided subsidized care for needy people. The financial resources to pay for such care have to come from somewhere, but the traditional sources are drying up. Safety net providers are thus being forced to consider the trade-offs between their traditional mission of serving the poor and the necessity to avoid losses. In addition, like all medical providers, they are under increasing pressure to be business-like in their operations, to be accountable, fiscally responsible, and to seek greater efficiencies. While this more business-like approach is clearly not inconsistent with providing charity care or other forms of not-fully-compensated services, there is a clear tension between being “profitable” and providing care that is not fully compensated. People with the mind-set that leads to them success with one goal may not find it easy to accommodate the other goal.

¹⁰Regenstein, Marsha, and Christy Schroer, *Medicaid Managed Care for Persons with Disabilities: State Profiles*, Economic and Social Research Institute, December 1998.

**State Policy
Toward
Funding
Indigent
Care**

The ability of AMCs and other safety net hospitals to cope with rapidly changing conditions and reductions in revenue is profoundly influenced by the generosity of states in funding health care for lower-income households. If the various subsidy programs cover a high proportion of low-income people and finance a high proportion of their medical costs, AMCs and other safety net providers will have less uncompensated care and less need to look for ways to make up shortfalls that would otherwise occur as a result of the changes just described.

The most important form of funding for low-income people in any state is, of course, the Medicaid program, and states differ widely with respect to both the proportion of poor people covered (determined by eligibility standards) and the level of funding per beneficiary (determined by how comprehensive the coverage). For example, in 1995, Medicaid expenditures per beneficiary, as a percent of the U.S. average, varied as follows for our study states: California, 71 percent; Maryland, 147 percent; Massachusetts, 182 percent; and Washington, 93 percent.¹¹

Other forms of direct subsidy to low-income people are also very important, and these have to be considered along with Medicaid in assessing how well a state does in financing care for low-income people and in easing the financing challenges for safety net providers. For example, the Washington State Health Care Authority (HCA) manages the Basic Health Plan, a program that offers state-subsidized health insurance to persons with incomes below 200 percent of the federal poverty level who would not otherwise have coverage. Without this program, some of these people would incur expenses at safety net institutions that would not be fully compensated.

Also important are state programs to reimburse hospitals for care they provide to low-income patients and for which they would otherwise be uncompensated. The systems vary in design; some states have indigent care pools, while at least one state has a hospital rate regulation system that pays for indigent care. Our four study sites fall along a continuum regarding the extent to which their states intervene with hospital financing policies that affect safety net hospitals. Maryland is at one end of the spectrum with a system of rate regulation for hospital payment and an uncompensated care pool. The rate regulation system sets hospital rates based on several factors including uncompensated care levels. If a hospital provides a level of uncompensated care that exceeds the amount accounted for in their rates, the hospital is eligible to receive money from the pool. Massachusetts is next on the continuum with an uncompensated care pool but no hospital rate-setting system. (Massachusetts, like New York, had an all-payer rate setting system for hospitals but dismantled it.) Washington does not have an uncompensated care pool but does have several supplemental payment programs to fi-

¹¹ Liska, David, et al., *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*, third edition, A Report of the Kaiser Commission on the Future of Medicaid, The Kaiser Family Foundation, Nov. 1997, Table 20.

nance indigent care. In addition, the Washington Basic Health Plan and Medicaid program use “public policy adjusters” when determining per-case hospital payments rates to pay hospitals more depending on their provision of indigent care and their medical education costs. California has created a number of programs with purposes similar to DSH payments. These programs supplement funding for safety net hospitals that, for example, commit to maintaining an emergency room in an urban area.

Findings from the Site Communities

The structure of the safety net in each community we studied and the role of the AMC in that market are shaped to a large degree by the local political, historical, and economic context. As noted above, state policies relating to Medicaid and state mechanisms for funding indigent care have an important impact on the adequacy of the safety net and the ability of safety net providers (including AMCs) to continue to provide uncompensated care. A safety net institution in Maryland, which has both hospital rate regulation and an uncompensated care pool, operates in a very different environment than an otherwise similar hospital in California.

It is also important to note that the communities studied in this project are in states that are relatively affluent and whose overall effort to assist lower-income families (Medicaid plus state-sponsored initiatives) is near or above average compared to all states.

In each site, there is increasing awareness of the need to control health care costs and growing concern about changes in federal and state policies that will reduce health care funding. The following summaries illustrate the diversity in approaches that communities have followed in striking a balance between the need to maintain the missions of safety net hospitals and the need for those institutions to remain financially viable.

San Francisco, California

The safety net in California is different from that in other study sites because California’s county hospitals, which along with the University of California’s five medical centers provide the bulk of uncompensated care, are funded primarily with state and federal funds, and thus their financial viability is not under county control.¹² But the most important

¹²A number of features of California state laws have effectively removed counties from the role of key decision-makers and major financiers of indigent care. Most recently, California passed a ballot initiative in 1996 (Proposition 218) that forced counties to obtain the approval of two-thirds of voters in order to raise county taxes. This, in conjunction with other past ballot initiatives (e.g., Proposition 13), makes it very difficult, if not impossible politically, to raise taxes locally. Second, California has a decade of experience in sending state revenues to the counties to help fund indigent care, first with a state tobacco tax and since 1991 with sales taxes and vehicle licensing fees. California also has used DSH payments and GME payments to help localities finance indigent care. In these varied ways, the State of California has more or less taken over the financing of indigent hospital care from its counties, although the counties are still responsible for the direct administration and operation of their hospitals. See Meyer, Jack, et al. *The Role of Local Governments in Financing Safety Net Hospitals: Houston, Oakland and Miami*. Urban Institute, 1999.

implication for the safety net in San Francisco is that San Francisco General Hospital (SFGH), even though its physicians are all medical school faculty and residents from the University of California at San Francisco (UCSF), is not part of the newly-merged UCSF Stanford system. Local observers feel that UCSF, because it does not control SFGH in the same way that University of Washington Medical Center controls Harborview in Seattle (that is, employing all staff and managing the hospital), has never fully integrated its clinical, teaching, and research services with those at SFGH. As a result, some observers feel that UCSF could, in the future, begin to shift activities now located at SFGH to other venues if costs are lower, the ability to generate revenue is higher, or the relationship with the County becomes more complicated. This could adversely affect uninsured patients' access to highly specialized services in areas such as pediatrics and trauma care.

A current proposal to provide health care coverage to uninsured residents of San Francisco presents an example of another issue of importance to policy makers dealing with safety net issues. The San Francisco plan would allow the previously uninsured to receive care from the provider of their choice, instead of being limited to, for example, SFGH or other safety net hospitals. There is strong opposition, however, from advocates for traditional safety net providers who fear that, given a choice, uninsured patients will take advantage of the opportunity to go to other hospitals. If that happens, traditional safety net providers will lose both patients and revenues, endangering their very existence. We have seen this issue arise in other communities where innovative programs for the uninsured include a choice of providers not before available to them. Unfortunately, many of these proposed programs are doomed politically unless some way can be found to give vulnerable populations the same choices other populations enjoy, but at the same time not eviscerate the safety net that had served them previously.

Baltimore, Maryland

The State of Maryland has taken a regulatory approach to assure a viable safety net, with two key steps to "level the playing field" for AMCs and other safety net hospitals. First, the all-payer rate regulation system permits a limited "add-on" to charges for major safety net hospitals to reflect their higher costs. Second, the indigent care pool redirects resources from hospitals with relatively little indigent care to those with higher burdens. So an AMC such as the University of Maryland Medical Center (UMMC) gets two sources of relief—rates that are probably above the level that could be sustained in a competitive market for hospital care, and a draw on the pool to cover a substantial part of the remaining shortfall. Both UMMC and Johns Hopkins Hospital are in close proximity to low-income neighborhoods in Baltimore and provide a significant amount of uncompensated care. In addition, the inclusion of reimbursement for charity care, another objective of Maryland's rate-setting system was to get the public sector out of the business of running hospitals. There are no longer any publicly owned acute care hos-

pitals in Maryland, and several respondents believed that it was a benefit for low-income patients to have access to private hospitals rather than having to receive care in a public “charity” institution. Maryland is a relatively wealthy state with an uninsurance rate lower than the national average and a relatively generous Medicaid program that spends more money per Medicaid beneficiary than the U.S. average.

*Boston,
Massachusetts*

In Boston, a combination of relatively weak pressure from purchasers and a mixture of both strategies discussed above—direct state aid to safety net providers and mergers within the provider system—have combined to keep provider systems financially viable. The regulatory relief has been through a generous Medicaid managed care program, as well as a state uncompensated care pool. Massachusetts has had an uncompensated care pool since 1986 that is intended to compensate hospitals that serve the uninsured so that they would not be penalized by that mission. The uncompensated care pool is funded through several mechanisms: (1) a state contribution; (2) an assessment of acute care hospitals based on a hospital’s share of total private sector revenue among all hospitals (excluding Medicare and Medicaid revenue, revenue from other government agencies, free care, and bad debt); and (3) a contribution by private third-party payers, including HMOs, other commercial insurers, self-insured plans, and Blue Cross.

Another factor that has helped Boston hospitals cope with the rise of managed care is the creation of several large provider systems. The hospital market in Boston is composed primarily of several large academic medical center systems, each organized around the teaching hospitals for one of the city’s three medical schools. For example, Boston Medical Center (BMC) was created by the merger of Boston City Hospital (the former municipal hospital) and Boston University Medical Center (a private university teaching hospital), both teaching hospitals for Boston University School of Medicine. One major reason for the merger creating BMC was to strengthen the position of these two hospitals *vis-a-vis* other major provider systems like Partners HealthCare (created by the merger of Brigham Hospital and Women’s Hospital and Massachusetts General Hospital) and CareGroup (created by the merger of Beth Israel Medical Center and Deaconess Medical Center).

An interesting and unique feature of this market’s safety net is the influence of CHCs and their ability to bargain for the resources and attention of these large, prestigious medical centers. Boston’s large and numerous CHCs are seen by its hospitals as key components of their strategy of building primary care networks.

Seattle, Washington

The University of Washington Academic Medical Center (UW AMC) is the only AMC in Seattle, although there are also several large community hospitals. Although Washington does not have an uncompensated care pool or rate regulation, it has a variety of supplemental programs to provide individuals with insurance coverage, such as the Basic

Health Plan (BHP) discussed in an earlier section. In addition, the Health Care Authority, a large state purchaser of health care which manages the BHP, uses “policy adjusters” in calculating hospital reimbursement rates to account for expenses such as teaching and uncompensated care.

In addition to receiving assistance from the state’s supplemental programs, the University of Washington Medical Center (UWMC) has benefited in part from a “horizontal” affiliation with Harborview Medical Center and in part from a “vertical” merger strategy (the affiliation with primary care centers). The University of Washington AMC has included both UWMC and Harborview since 1967 when Harborview hospital was in danger of closing. Since Harborview was an important safety net hospital as well as an important teaching hospital for UWMC, the Legislature authorized King County to contract with UWMC to staff and operate Harborview. This continued affiliation with Harborview has allowed UWMC to expand clinical services, and there is a high degree of clinical integration between Harborview and UWMC. UWMC has also benefited from the relationship because Harborview is regarded very favorably by the state legislature and the general public.

Community Health Centers

The relationship between safety net hospitals (especially AMCs) and community health centers (CHCs) influences the effectiveness of safety net hospitals and in some cases their financial viability. For example, in Boston, CHCs have played a vital role in the safety net since the first clinics were started in the 1960s. Unlike the situation in other states where close links between primary and tertiary care for the indigent often are not well-established, in Boston, the CHCs often are closely aligned with tertiary care centers. In fact, the large, prestigious teaching hospitals in Boston vie with each other to affiliate with CHCs as patient “feeder” systems, to the point of providing capital and other support to CHCs in return for referral agreements and other sorts of affiliations.

Differential development of CHCs across four markets

In Boston, community health centers are significantly more influential in their health care market than CHCs in the other sites studied, primarily for three reasons.

First, there has always been a strong historical commitment in Boston to community health centers. The first CHCs (then called neighborhood health centers) were started by the Department of Preventive Medicine of Tufts University Medical School with grants from the now-defunct federal Office of Economic Opportunity (OEO), which was one of the Johnson Administration’s War on Poverty programs. Through Tufts Medical School, two different health centers were developed: Columbia Point Health Center in urban Boston and the Tufts-Delta Health Center in northern Bolivar County, Mississippi. The success of these centers prompted OEO in 1964 to fund neighborhood health centers across the country. Neighborhood health centers were established primarily to

bring newly-insured Medicaid recipients and the uninsured into the health care system.

The second reason Boston health centers have thrived is the force of individual personalities and the political tenor of the community. Much of the health center movement's early leadership was in Boston. The city had a liberal political and social climate that was conducive to creating a community-based health care system for low-income patients. There was less opposition in Boston from local physicians in private practice than in other parts of the country. Academic medical institutions supported health centers because of the beneficial role the centers would play in helping to relieve the demand placed on AMCs and local private hospitals by uninsured patients.

Finally, there were structural reasons why Boston CHCs fared so well. New England historically has not had strong county government, and indigent health care was not provided through county hospitals. In Boston, the uninsured relied primarily upon Boston City Hospital (BCH) for inpatient care. After the enactment of Medicaid and Medicare in 1964, the city of Boston took advantage of the state's generous cost-based Medicaid reimbursement rates to develop community health centers. With substantial Medicaid revenues, the city government could stretch federal OEO funds provided to CHCs even further; this enabled Boston to create more health centers with the available amount of funding. Some of these centers were affiliated with Boston City Hospital and received substantial operating subsidies from BCH. Some CHCs developed independently of any hospital, drawing their support from Medicaid cost-based reimbursement and direct federal subsidies; some independent centers performed so well on just the institutional reimbursement rate provided by Medicaid that they did not require any federal grants to subsidize operations.

In Boston, we also found that AMCs had contractual arrangements with CHCs to provide subsidies from the medical centers in return for access to CHCs for teaching and patient referral services.

CHCs response to changes in the health care market

Recent decreases in total Medicaid enrollment,¹³ the continued growth in the numbers of uninsured and the increasing shift of Medicaid enrollees into managed care plans all contribute to reducing the ability of CHCs (and other safety net providers) to provide adequate services to the uninsured. Traditionally, CHCs have used grant funds plus revenues from Medicaid and private pay patients to subsidize care for uninsured populations. However, the Balanced Budget Act of 1997 mandated a reduction of Medicaid cost-based reimbursement rates to CHCs

¹³The total Medicaid population began decreasing during 1995 and continued that way through 1998. Kaiser Commission on Medicaid and the Uninsured, "Looking Ahead: Critical Health and Welfare Issues for 1999 and Beyond: The Future of Medicaid," briefing pack for Health and Human Services Chairs Conferences, June 5, 1999, Washington, DC., Figure 14.

designated as Federally Qualified Health Centers (FQHC).¹⁴ (See note below for definition; all subsequent data refer to CHCs that are FQHCs.) Beginning in fiscal year 1998, when reimbursement was based on 95 percent of cost, rates were incrementally decreased; they will decrease to 70 percent of cost by fiscal year 2003.

In addition to cuts in Medicaid reimbursement, CHCs are experiencing a decrease in the proportion of their budgets that comes from federal grant funds. From the mid-1970s to 1980, the typical CHC received at least 60 percent of its revenue from federal grants, and only 10 percent from Medicaid revenues. In 1997, the typical health center grantee received only 30 percent of its revenues from federal grants and 40 percent from Medicaid. While federal grant funds are still important to CHCs, this trend clearly depicts the growing need on the part of CHCs to receive Medicaid and other patient care revenues.

As noted earlier, welfare reforms have reduced Medicaid enrollment, and most states are moving remaining Medicaid patients into managed care plans, which pay lower reimbursement rates to CHCs. This combination presents a problem to CHCs struggling to use decreasing overall revenues to cover increasing numbers of the uninsured. Between 1980 and 1995, the uninsured remained the single largest group of CHC patients, growing by 1.3 million persons over that time period, accounting for 41 percent (3.8 million uninsured patients) of the 9.3 million patients served by health centers.¹⁵ How CHCs will manage to continue the mission of serving the uninsured under tighter financial constraints is the crux of their challenge.¹⁶

Many CHCs have responded to these threats to their traditional sources of revenue by negotiating managed care contracts with Medicaid or private insurers. In 1997, nearly two-thirds of CHCs had managed care contracts. This number was up 16 percent from 1996. Eleven states, including California, Maryland, Massachusetts, and Washington, where our study sites are located, had over 50,000 managed care enrollees receiving care at CHCs. CHCs had contracts with both private and public purchasers: 54 percent had Medicaid managed care contracts, 13 percent had Medicare contracts, 31 percent had contracts with HMOs to serve privately insured people, and 13 percent had similar contracts with other forms of managed care (PPO, POS, etc.).¹⁷

¹⁴Federally Qualified Health Centers (FQHC) is the term used by the Health Care Financing Administration to refer to CHCs with federal Section 330 grants plus institutional, cost-based reimbursement rates. Currently, there are 672 grantees with 3,042 sites. CHCs that do not receive federal Section 330 grants but still receive institutional, cost-based reimbursement rates are called FQHC "look-alikes." There are 129 look-alike grantees, with 224 sites.

¹⁵Hawkins, Dan, and Sara Rosenbaum, "The Challenges Facing Health Centers in a Changing Health Care System," unpublished, January 1997.

¹⁶Ibid.

¹⁷Bureau of Primary Health Care, Public Health Services, Health Resources & Services Administration, U.S. Department of Health and Human Services *Analysis of Managed Care Enrollment in Health Centers: 1997*.

Medicaid managed care contracts are particularly important to CHCs. Among CHCs participating in any kind of managed care, 76 percent of their managed care *enrollment* involved Medicaid managed care. Massachusetts' CHCs experienced a 48 percent increase in Medicaid managed care enrollment from 1996-1997. In Washington and California, CHCs had 5 percent and 35 percent increases, respectively, in Medicaid managed care enrollment. Maryland, on the other hand showed a 29 percent decrease in Medicaid managed care enrollment in CHCs between 1996 and 1997.¹⁸ This decrease has been attributed to Maryland's CHCs' inability to obtain Medicaid managed care contracts, the loss of a major managed care feeder system and CHCs' slowness in responding to market changes. Other respondents have suggested that this decrease could be due to Maryland's Health Choice Medicaid managed care program (implemented in 1997) shifting its enrollees from more expensive FQHCs to less costly "look-alike" CHCs. However, we have found no consensus nor any data to document the reasons for this decrease.¹⁹

There are two sides to an ongoing debate regarding CHCs' involvement with Medicaid managed care. One perspective is that CHCs' increasing reliance on Medicaid managed care has distracted them from their traditional mission to serve the uninsured. Critics contend that CHCs have focussed their competitive efforts on obtaining Medicaid managed care contracts at the expense of providing clinical and support services that are necessary to serve the most vulnerable uninsured population. The opposing perspective, however, asserts that Medicaid expansions since the late 1980s (more people covered for more services and cost-based reimbursement to FQHCs for Medicaid patients), allowed many formerly uninsured patients served by CHCs to become eligible for Medicaid coverage. This perspective suggests that CHCs are serving many of the same patients they have in the past, but because of Medicaid expansion, more of these formerly uninsured patients are now covered under Medicaid or Medicaid managed care.

There has been no comprehensive study of the effect of Medicaid managed care on CHCs and their ability to care for the uninsured. CHCs in many communities around the country have begun either to negotiate contracts with existing managed care plans and integrated health systems or to develop their own HMOs and compete with private managed care plans for Medicaid managed care patients. Some states are organizing networks of CHCs into state-operated HMOs. The first two CHC-sponsored HMOs were created in Tennessee in 1985 and in Massachusetts in 1986. By 1994, five states had created CHC network HMOs and three additional states began operations in 1996. Anecdotal evidence suggests that "CHC-sponsored HMOs have retained most of their Medicaid clients and have also negotiated contracts to serve as provider

¹⁸Ibid.

¹⁹Ibid.

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sites for private HMOs.”²⁰ It is clear that if they have not already, CHCs must learn to cope with and adjust to an increasingly competitive health care market while pursuing their traditional mission as safety net providers.

Another provider relationship that is important to the safety net is the relationship between the AMC and the public hospital. In our four study sites, there are different models for this relationship.

- As noted above, in Maryland, one of the stated reasons for instituting hospital reimbursement rate regulation (including an uncompensated care pool) was to *eliminate the need for public hospitals* by adequately paying private hospitals to care for the indigent. There are no longer any public general acute-care hospitals in Maryland, and the principal burden of charity care is spread over more of the urban hospitals than in markets that have a public institution.
- In Seattle, as mentioned earlier, the public hospital, Harborview, is owned by the county but completely staffed and operated by the University of Washington Medical Center (UWMC). For example, Harborview is the focus of clinical neuroscience for UWMC, and any patient, regardless of insurance status, who needs neurosurgery at UWMC will be hospitalized at Harborview. The public hospital in Seattle is therefore not perceived exclusively as the “poor people’s hospital.” This degree of clinical integration and administrative control by the University in essence makes Harborview an integral part of UWMC. Therefore, certain UWMC services and facilities are located only at Harborview, and there is less duplication of services between Harborview and the medical facilities on the UW campus than in other medical school/public hospital arrangements we have seen.
- In contrast to the situation in Seattle, the University of California at San Francisco (UCSF) provides only the physician staff (faculty and residents) for San Francisco General Hospital (SFGH), which continues to be owned and operated by the County of San Francisco. The county employs all the non-physician staff, including executive management. This structure is not conducive to the degree of integration with the University one finds in Seattle.
- In Boston, the former municipal hospital, Boston City Hospital, merged with Boston University Medical Center to form Boston Medical Center (BMC). BMC is faced with the task of integrating a private AMC with a public hospital, and will attempt a degree of integration similar to that found in the UWMC/Harborview model.

²⁰Shauffler, Helen Halpin, and Jessica Wolin, “Community Health Clinics under Managed Competition: Navigating Uncharted Waters,” *Journal of Health Politics, Policy and Law*, Vol. 21, No. 3, Fall 1996.

Summary

A variety of federal, state and local policies, the rapid evolution of the health care market, and socio-demographic changes in urban areas are adding to the burden of AMCs, other hospitals and CHCs that serve as safety net providers. The shift of large numbers of Medicaid patients into managed care has pulled them away from traditional safety net providers as they are given a new medical home in the community. Cutbacks in federal payments to hospitals for GME and indigent care are handicapping AMCs as they try to pursue their historical mission. Welfare reform is beginning to reduce Medicaid caseloads as people lose cash assistance and take jobs without private insurance. Many employers do not offer coverage, particularly among small firms, and a rising number of workers are turning down employer coverage because they cannot afford their share of the premium. Finally, deterioration of inner-city neighborhoods, the loss of good jobs and the erosion of the urban tax base have added to the financial burden of traditional safety net providers that are often located in these communities.

Our four case studies show that AMCs and the state and local governments where they are located have developed a variety of coping strategies to weather these storms. These strategies include indigent care reimbursement pools, the use of rate regulation to maintain safety net hospitals' payment rates above market-based levels, the use of supplemental state funding programs beyond risk pools, and a series of actions by AMCs to adapt to the new market climate. The latter include mergers with other hospital systems to buttress the bargaining clout of AMCs *vis-a-vis* managed care organizations; privatization to free hospital systems from public-sector bureaucracies and regulations; the formation of close relationships with community health centers that can provide a ready source of patient flow; and the development of vertically integrated systems that can compete for business.