Effects Of Health System Changes On Safety-Net Providers
by Debra J. Lipson and Naomi Naierman

Abstract: Growing competition in health care markets and Medicaid managed care, combined with cuts in government funds that subsidize care to the uninsured, are challenging the viability of the safety net. In response to these pressures, “safety-net” providers in fifteen communities are integrating vertically and horizontally, contracting with or forming managed care plans, and seeking to attract paying patients. Such strategies appear to be successful for community-based primary care clinics, but other providers—including hospitals that cannot quickly develop primary care capacity, most local health departments, and providers that fail to attract Medicaid patients—are more vulnerable to health system changes. While the safety net may be intact now, access to care among the uninsured is more at risk in communities without state programs or local taxes that subsidize such care.

Changes have occurred in recent years that challenge the ability of “safety-net” providers to serve uninsured Americans. These changes include the emergence of a more competitive health care system; the growth of Medicaid managed care, which in some cases has reduced safety net providers’ revenues; and cuts in the federal, state, and local funds that have subsidized free or low-cost care in the past. At the same time, steady growth in the size of the uninsured population has increased the demand for free or subsidized care. More people were uninsured each year from 1990 to 1993, with a small decline in 1994. Although these changes are occurring across the country, the extent and pace of change vary across communities.

This paper examines how health system changes are affecting the safety net in the fifteen communities that were part of The Robert Wood Johnson Foundation’s (RWJF’s) Community Snapshots study, part of RWJF’s larger Health Tracking initiative. The Community Snapshots study was designed to capture the process of health system change in fifteen localities across the country, with particular emphasis on how change affects the people who live and work in these communities. Here we identify the underlying determinants of demand on the safety net and explain how they differ by community. We discuss how changes in local health care markets and in federal, state, and local public policy challenge the ability of safety-net providers to serve the uninsured and examine differences in these changes across communities. We then describe the range of responses by different types of safety-net providers to the changes and assess how well these strategies are working in the short term. We conclude with a preliminary assessment of how the changing health care system is affecting access to care by uninsured and underserved persons and identify key indicators that should be monitored in the future to determine such effects more precisely.

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Definition Of And Concerns About The Safety Net

Health care safety net usually refers to health care providers that are legally obligated to provide care to persons who cannot afford it. Such providers typically include public and teaching hospitals, federally funded community health centers, and city or county health departments. Safety-net providers also include nonprofit hospitals that provide uncompensated care as part of their community-benefit obligation, and private physicians, clinics, and other organizations that offer care at no charge or at a discount.

In addition, the term safety net often refers to the public and private funding streams that subsidize free or reduced-price care provided by safety-net providers. Medicaid is the primary source of health care financing for low-income persons who otherwise would be uninsured. Medicaid disproportionate-share hospital (DSH) funds compensate hospitals for care provided to uninsured patients. Other safety-net financing sources include federal and state grants, local tax dollars, and higher charges to payers that cross-subsidize free care (cost shifting).

We chose to focus on public hospitals, community health centers, and local health departments for this examination of the safety net for three reasons. First, they rely heavily on Medicaid revenues and other public funds to subsidize care for the uninsured. In 1991 Medicaid constituted about 38 percent of gross revenues and 46 percent of net revenues for public hospitals, compared with 12-13 percent for all US. hospitals. About 34 percent of federally qualified community health centers’ total revenues were derived from Medicaid. Hospitals with the highest share of low-income patients (Medicaid and uninsured) are more likely to receive Medicaid DSH funds or distributions from state uncompensated care pools. These funds, combined with other federal and state grants and support from local tax dollars, allow safety-net providers to serve as providers of last resort. Because of these providers’ greater dependence on such funds, changes in Medicaid policy or governmental subsidies that affect the flow of money to them were assumed to have a greater, or at least a more visible, impact on their ability to serve the uninsured.

Second, they serve proportionately more uninsured persons relative to other providers. Public hospitals reported that 30 percent of all discharges and 47 percent of outpatient visits were attributable to “self-pay” or “other” categories that consist largely of uninsured persons. These averages are, respectively, three and four times the corresponding figures for all hospitals nationwide (10 percent of all discharges and 12 percent of outpatient visits). About half of all community health center patients are uninsured; by contrast, private physicians estimate that they contribute 5 percent of their incomes to care for the uninsured.
Third, they provide specialized or essential services not generally offered by other providers in their communities. Although local health departments generally are not major providers of primary or acute care to the uninsured throughout the country, 10 percent of local health departments in a national survey reported that they are the sole provider of care for the medically indigent in their communities, the majority of which were rural. Local health departments often are the only providers of communitywide disease prevention services, including detection and treatment of sexually transmitted and other communicable diseases, family planning services, immunization and school health programs, and environmental safety.

Although traditional safety-net providers are sounding the alarm about changes that they believe will undermine their viability, there has not yet been a systematic, objective effort to document these effects on the people they serve. The Community Snapshots study affords one of the first glimpses of how the safety net is holding up to the vicissitudes of public financing, market competition, and systems integration.

### Demands On the Safety Net

The number and proportion of persons who are uninsured (or underinsured) are primary determinants of the demand on the safety net in each community. Communities with greater proportions of poor persons, young families, blacks, and Hispanics typically have higher-than-average rates of uninsurance. Safety-net providers in communities with large groups of noncitizens (Miami, Houston, Orange County, and San Diego), who are far less likely to have insurance coverage, also face greater demands.

Because data on uninsurance rates at the community or regional level are unavailable or not comparable, state-level data on the uninsured from the Current Population Survey (CPS) provide the best proxy for uninsurance rates for each of the Snapshot communities, assuming that the cities are representative of their states (Exhibit 1).

The factors that underlie the uninsurance rate and the corresponding level of uncompensated care vary by community. States that have more generous Medicaid eligibility standards help to reduce the uncompensated care burden in communities by raising overall rates of insurance coverage. States with health insurance programs that are targeted to low-income persons who are not eligible for Medicaid also can help to lift overall rates of insurance coverage and reduce the burden on other funding sources to finance uncompensated care; we return to this point later. The structure of the local economy also can influence the rate of insured persons. Communities that are dominated by large businesses and certain industries, such as transportation, communications, government, and manufacturing, are
Exhibit 1
Uninsurance Rates In States With A Robert Wood Johnson Foundation Community Snapshot Site, 1992-1994

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>New Mexico (Albuquerque)</td>
<td>23.0%</td>
<td>26.1%</td>
<td>26.4%</td>
</tr>
<tr>
<td>Massachusetts (Boston)</td>
<td>12.6</td>
<td>14.1</td>
<td>14.3</td>
</tr>
<tr>
<td>South Carolina (Columbia)</td>
<td>20.9</td>
<td>19.9</td>
<td>15.9</td>
</tr>
<tr>
<td>Massachusetts (Minneapolis/St. Paul and Fargo/west central MN)</td>
<td>10.0</td>
<td>12.7</td>
<td>10.6</td>
</tr>
<tr>
<td>Texas (Houston)</td>
<td>26.4</td>
<td>25.1</td>
<td>26.6</td>
</tr>
<tr>
<td>Florida (north central and south Florida)</td>
<td>24.5</td>
<td>24.1</td>
<td>20.8</td>
</tr>
<tr>
<td>California (Orange County and San Diego)</td>
<td>23.0</td>
<td>22.7</td>
<td>23.7</td>
</tr>
<tr>
<td>Oregon (Portland, OR/Vancouver, WA)</td>
<td>15.9</td>
<td>17.2</td>
<td>14.8</td>
</tr>
<tr>
<td>Missouri (St. Louis)</td>
<td>16.6</td>
<td>14.2</td>
<td>14.3</td>
</tr>
<tr>
<td>Delaware (Wilmington)</td>
<td>13.6</td>
<td>15.6</td>
<td>15.6</td>
</tr>
</tbody>
</table>


Note: The Snapshot project site in each state is shown in parentheses. Minnesota, Florida, and California contain two sites each.

likely to have higher rates of private insurance, while local recessions contribute to lower rates of coverage.

Communities that have greater proportions of non-English-speaking people or that are geographically isolated from major urban centers are more likely to rely on safety-net providers, regardless of the uninsurance rate. For example, in rural communities, such as those surrounding Fargo/west central Minnesota, north central Florida, and Des Moines, access to care is limited because few providers practice in rural communities and transportation can be difficult. There also may be language and cultural barriers to care, particularly among migrant farm workers. In these communities, community and migrant health clinics sometimes are the only provider available to persons with special needs. In large cities members of minority groups often have limited access to care; safety-net providers often fill the gap left by mainstream providers.

Considering the uninsurance rate, state Medicaid eligibility levels, local economic and employment benefit trends, and unique population characteristics together, the Community Snapshot sites can be classified as placing high or low demand on the safety net. Communities such as Houston, Albuquerque, south Florida, and San Diego would be considered high demand, whereas Des Moines, Minneapolis/St. Paul, and Fargo/west central Minnesota would be considered low demand. Although one might expect safety-net providers in high-demand communities to be under
greater stress generally, it appears that the pressures they experience are more closely related to changes in the local health care market and to state or local public policies.

**Market And Public Policy Changes**

The trend toward more competition for paying patients, the transition of Medicaid patients into managed care, and the dwindling of public subsidies are evident nationwide. However, the extent to which each occurs and thus the amount of pressure each places on safety-net providers differ across the fifteen communities.

**Market competition and Medicaid managed care.** There is virtually no competition among providers to serve uninsured patients. However, the transition of Medicaid recipients into managed care plans has produced a dramatic surge in competition for Medicaid enrollees among health plans and providers. This has important implications for safety-net providers because it makes their participation in their state Medicaid managed care program(s) more critical. Their level of participation and the payment rates they negotiate can mean either a gain or a loss of Medicaid patients and revenues, which in turn affects their ability to subsidize care for the uninsured. Site visits to the Snapshot communities indicated that the impact of Medicaid managed care on safety-net providers depends on the proportion of the Medicaid population enrolled in managed care plans, the type of program adopted by each state, and the need for plans and providers to compete for Medicaid patients.¹²

Nationally, the proportion of the Medicaid population receiving care through some type of managed care program nearly doubled, from 12 percent of all beneficiaries in 1992 to 23 percent in 1994.¹³ By the middle of 1995 that figure was expected to rise to nearly 33 percent. However, this proportion varies widely. Medicaid managed care enrollment in the Snapshot communities was estimated to range from less than 5 percent to more than 85 percent of all Medicaid recipients (Exhibit 2).

Seven of the fifteen Snapshot communities had Medicaid managed care enrollment rates that exceeded the national average of 23 percent at the time of the site visits. In these communities competition for Medicaid patients was much higher than in areas with low Medicaid managed care enrollment. In six other communities (Indianapolis, Fargo/west central Minnesota, Orange County, San Diego, Wilmington, and St. Louis) managed care enrollment was estimated to be lower than the national average but was expected to grow rapidly in the next six to twelve months. Safety-net providers in these communities are beginning to feel more pressure. For example, community health centers in Wilmington expressed concern
### Exhibit 2
Medicaid Managed Care Enrollment In Robert Wood Johnson Foundation Community Snapshot Sites, 1995

<table>
<thead>
<tr>
<th>Community</th>
<th>Percent of all Medicaid beneficiaries enrolled in managed care plans</th>
<th>Mandatory or voluntary managed care enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuquerque, NM</td>
<td>30% in primary care case management program</td>
<td>Voluntary</td>
</tr>
<tr>
<td>Boston, MA</td>
<td>60% in both primary care case management and HMO programs</td>
<td>Mandatory for AFDC recipients in one or the other program</td>
</tr>
<tr>
<td>Columbia, SC</td>
<td>None</td>
<td>Voluntary HMO program to begin January 1996</td>
</tr>
<tr>
<td>Des Moines, IA</td>
<td>36% in primary care case management program</td>
<td>Mandatory for AFDC recipients</td>
</tr>
<tr>
<td>Fargo, ND/west central MN</td>
<td>5% or less</td>
<td>Voluntary, but mandatory scheduled for fall 1995 in selected Minnesota counties</td>
</tr>
<tr>
<td>Houston, TX</td>
<td>Not available</td>
<td>Voluntary primary care case management program in Charles County</td>
</tr>
<tr>
<td>Indianapolis, IN</td>
<td>Not available</td>
<td>Mandatory, as of January 1995</td>
</tr>
<tr>
<td>Minneapolis/St. Paul, MN</td>
<td>60-75% in Hennepin and Ramsey Counties</td>
<td>Mandatory for AFDC and non-dual eligibles in Hennepin and Ramsey Counties</td>
</tr>
<tr>
<td>North central FL</td>
<td>30% (mostly in HMOs)</td>
<td>Voluntary, except for primary care case management program in selected counties</td>
</tr>
<tr>
<td>Orange County, CA</td>
<td>15% in primary care case management program</td>
<td>Voluntary, but mandatory HMO enrollment effective October 1995</td>
</tr>
<tr>
<td>Portland, OR/Vancouver, WA</td>
<td>85% in fully capitated HMOs and partially capitated PCOs</td>
<td>Mandatory for AFDC and SSI recipients in Oregon</td>
</tr>
<tr>
<td>St. Louis, MO</td>
<td>Not available</td>
<td>Voluntary, but mandatory HMO enrollment effective September 1995</td>
</tr>
<tr>
<td>San Diego, CA</td>
<td>15%</td>
<td>Voluntary, but mandatory HMO enrollment effective in 1996</td>
</tr>
<tr>
<td>South FL</td>
<td>30%, mostly in HMOs, some in primary care case management program in Broward County</td>
<td>Voluntary, except for primary care case management programs in selected counties</td>
</tr>
<tr>
<td>Wilmington, DE</td>
<td>Not available</td>
<td>Voluntary, but mandatory HMO enrollment effective January 1996</td>
</tr>
</tbody>
</table>

**Source:** Alpha Center.

**Notes:** Information reflects status at the time of the site visits (April-August 1995). HMO is health maintenance organization. AFDC is Aid to Families with Dependent Children. SSI is Supplemental Security Income. PCO is physician care organization.
about the move to capitation under Medicaid, fearing the substantial loss of Medicaid revenues and thus their declining ability to subsidize care for the uninsured. In the two remaining communities (Columbia and Houston) Medicaid managed care enrollment was virtually zero. As a result, safety-net providers in those communities were much less concerned about competition for Medicaid patients.

Even when Medicaid managed care enrollment rates are high, the pressure on safety-net providers to participate in such programs may be reduced because of the type of managed care program that is implemented. For example, exclusion of elderly and disabled Medicaid beneficiaries from managed care programs makes it easier for safety-net providers to continue to serve those Medicaid patients at prevailing Medicaid rates. Moreover, when the managed care program is solely a primary care case management program, as in Iowa, or primarily such a program, as in Boston, community-based safety-net providers usually are able to serve as Medicaid-participating providers and continue to receive fee-for-service Medicaid payments without having to form or contract with managed care plans.

Medicaid managed care pressures also can be ameliorated through state policies that help safety-net providers to retain Medicaid patients or revenues under managed care programs. At least four states with Snapshot communities (Massachusetts, Oregon, Florida, and Minnesota) have policies that facilitate safety-net providers’ participation in Medicaid managed care programs, either as contractors with the state or as subcontractors to managed care plans. For example, the Massachusetts Medicaid agency makes it clear that contracts between managed care plans and community-based providers are viewed favorably for purposes of state contract review. In some cases, local governments are trying to help safety-net providers. The Orange County CalOPTIMA (Orange Prevention and Treatment Integrated Medical Assistance) program (the county Medicaid managed care program) is attempting to help its traditional safety-net providers (Children’s Hospital and University of California, Irvine) by excluding them from the enrollment cap that applies to all other contracting plans.

Competition for Medicaid managed care enrollees appears to confer some advantage to safety-net providers with strong links to the Medicaid population or those that are able to provide primary care services in communities where primary care physicians are in short supply. Both factors have contributed to the attractiveness of community health centers in Boston, Albuquerque, and San Diego, as partners for health plans and hospitals trying to capture the Medicaid managed care market. The more ample supply of primary care physicians in Miami, however, has posed greater challenges to community health centers’ and local health departments’ attempts to participate in privately sponsored Medicaid managed care.
care plans, which can more easily contract with private physicians. As a result, safety-net providers in south Florida have lost Medicaid and Medicare patients to private health maintenance organizations (HMOs), proprietary clinics, and home health agencies.

**Government subsidies to safety-net providers.** Although safety-net providers rely on a combination of federal, state, and local government funds to subsidize the care they provide to low-income and uninsured persons, the availability of these funds varies by state and community. For example, DSH payments, which support care provided by hospitals to low-income persons, range from just $27 per uninsured person in New Mexico and $53 in Indiana to $835 in Massachusetts and $1,046 in Missouri.¹⁴ Local tax dollars in several Snapshot communities provide large annual subsidies to safety-net hospitals (for example, $180 million to Dade and Broward County public hospitals in south Florida, and $42 million to Wishard Hospital in Indianapolis), while hospitals in other communities (such as Columbia and Wilmington) get little or no local tax support.

Even these government subsidies are being reduced. State Medicaid spending on DSH adjustments has declined as a result of 1991 federal law changes that limited overall DSH spending.¹⁵ Because such cuts are occurring more in certain states than in others, they pose a greater threat to the financial standing of safety-net hospitals in a few of the Snapshot communities. Until 1993, for example, St. Louis City and St. Louis County each provided $15-$35 million annually to cover operating losses at the St. Louis Regional Medical Center—subsidies that subsequently were replaced by state and federal Medicaid DSH funds. In 1995 state DSH payments to the hospital were cut by a third, endangering Regional’s survival.

Local revenues, which often spell the difference between financial success and failure for safety-net providers, also are starting to diminish in some communities. For example, San Diego and Orange County subsidize care for the uninsured at the University of California hospitals in their communities. However, local tax dollars in both counties have declined in recent years, which raises questions about these providers’ willingness and financial ability to continue serving indigent populations. Safety-net providers that continue to serve illegal immigrants are especially vulnerable.¹⁶

One bright spot in the recent policy environment has been the development of state programs that subsidize coverage for previously uninsured persons. Three states with Snapshot communities (Oregon, Washington, and Minnesota) have established programs that pay all or part of the cost of coverage for persons with low or moderate incomes who are not eligible for employer-provided or Medicaid coverage. Such programs can relieve safety-net providers from the need to find other funds to subsidize care of the uninsured. Four other states with Snapshot communities (Delaware, Massa-
Massachusetts, Missouri, and Texas) were planning similar programs at the time of the site visits.17

Responses Of SafetyNet Providers

To address these challenges and opportunities, safety-net providers are pursuing a variety of strategies, including vertical and horizontal integration, managed care contracting, and special marketing efforts geared toward patients who pay. Not all types of safety-net providers are equally equipped to undertake such activities. In general, the winners seem to be community-based primary care clinics and any provider that can successfully compete for Medicaid managed care contracts. The losers seem to be those hospitals that cannot readily develop primary care capacity, providers that do not attract Medicaid patients, and most local health departments.

Community health centers. Community health centers are positioned well in the current environment because they can sell primary care services a valuable commodity in today’s health care market. In nearly all of the Snapshot communities, community health centers are actively marketing their capacity to state Medicaid agencies, health plans, and hospitals. In some communities, such as Boston and St. Louis, community health centers are regarded as extremely attractive contractors because of their experience in serving Medicaid enrollees and because of their locations in neighborhoods where many Medicaid recipients live; For example, the Harvard Community Health Plan in Boston is touting its joint venture with twelve community health centers in an aggressive marketing campaign in low-income neighborhoods.

Some community health centers and similar primary care providers are pursuing vertical integration by joining, or developing strategic alliances with, larger hospital-based systems. Community health centers view this strategy as helping them to gain better access to private-pay patients and financial resources, as well as affording them a greater chance to hold on to existing Medicaid patients. Other reasons cited by safety-net providers for joining larger systems include better information systems, quality monitoring, and continuing education programs that were unavailable to them before. For example, in San Diego and Orange County some community health centers have aligned themselves with major health care systems partially to maintain access to Medi-Cal (California Medicaid) managed care enrollees and to gain access to Medicare and commercial enrollees. In Portland/Vancouver both community health centers and county health departments contract with at least one of the five major plans serving Oregon Health Plan enrollees. In Columbia a joint venture with two hospitals has given a community health center a portion of the funds
necessary to build a new clinic. This additional site is expected to expand
the clinic’s niche as the main primary care provider for low-income persons.

In several sites (for example, south Florida, Minneapolis/St. Paul, Bos-
ton, and San Diego) community health centers are choosing instead a
horizontal integration strategy, which involves banding together to negoti-
ate with managed care plans and hospitals from a stronger bargaining
position. Those opting for this strategy are often wary of becoming part of
larger hospital systems. Horizontal integration makes it possible to improve
the efficiency of many functions required of providers in any managed care
system, such as management information systems and utilization control.

In some areas community health centers have formed or are trying to
form their own HMOs or other types of managed care plans, either alone or
in partnership with others. This strategy positions them to assume risk, not
only for primary care services but also for specialty services. In San Diego
fourteen community health centers have formed their own HMO with
primary care capitation. They also are beginning to contract with seven
other HMOs to assume risk for specialty services. In communities with large
Medicaid primary care case management programs (Boston, Des Moines,
and Albuquerque), community health centers have contracted directly
with the state to serve as primary care gatekeepers for individual patients.
Some community health centers in Portland have entered into partially
capitated contracts with the state Medicaid agency, which holds these
providers at risk only for a limited set of outpatient services.

In addition to these strategies, several community health centers are
trying to survive by reinforcing neighborhood ties and increasing their
attractiveness to patients. In Boston one community health center opened
its facilities for neighborhood meetings; another center is offering services
in six different languages; and yet another center has expanded its scope of
services to include nontraditional care such as acupuncture and massage.
Other marketing strategies undertaken by community health centers in-
clude expanded hours and on-site Medicaid application assistance.

Hospitals. Most safety-net hospitals in the Snapshot communities are
pursuing vertical integration to expand their primary care capacity and sell
their integrated services to health plans. To do so, some hospitals are buying
primary care clinics or building their own facilities as quickly as possible to
develop a continuum of inpatient and outpatient services. For example,
Jackson Memorial Hospital in Miami, the two Broward County Hospital
Districts in south Florida, and Wishard Hospital in Indianapolis all have
bought or assumed responsibility for operating primary care clinics formerly
run by local health departments (and a physician practice, in one case),
The University of New Mexico Hospital System recently bought two
primary care clinics, and the University of California, San Diego, built a
community primary care network through contracts with physicians and now contracts with all of the major HMOs. A proposed hospital merger in Boston includes a network of seven community health centers that could generate referrals worth as much as $20 million. Wishard Hospital in Indianapolis and Shands Hospital in Gainesville, Florida, have developed even broader networks with nursing homes and home health centers, respectively, to expand their service capacity in long-term care.

In some communities safety-net hospitals are forming their own HMOs, either alone or in partnership with others. Jackson Memorial Hospital in Miami, which already had a licensed HMO, recently began to enhance its marketing to Medicaid and commercial patients. Last year it tripled enrollment in the plan, and it is actively seeking a Medicare risk contract. Jackson also entered into an alliance with another managed care plan to offer an HMO product. Regional Medical Center in St. Louis purchased a share in a Medicaid managed care plan to ensure a steady flow of patients who were expected to enroll starting in September 1995.

Local health departments. Of all of the safety-net providers, local health departments are generally at a disadvantage in the competitive marketplace. Their primary care services are often much weaker compared with those of community health centers, and their ability to negotiate with health plans may be hampered by bureaucracy. However, a few local health departments with very strong primary care capacity have decided to enter the competitive fray. The Multnomah County Health Department in Portland, for example, entered a joint venture with the state’s sole academic health center, the Oregon Health Sciences University, to form their own managed care plan, called CareOregon. The plan is one of five that enroll the majority of Medicaid and formerly uninsured persons in the state.

Several local health departments have decided to opt out of the primary care business entirely. For instance, several local health departments in Snapshot sites (south Florida, Minneapolis/St. Paul, Portland/Vancouver, and Indianapolis) are turning over their primary care service delivery functions to community health centers and public hospitals. This permits them to focus on their core public health functions, such as community health assessment, policy development, environmental protection, disease control, and community health promotion.

Results Of Strategies

Survival of safety-net providers. The Snapshot site visits indicated that the strategies discussed above have enabled nearly all safety-net providers to survive in the increasingly competitive market. Admittedly, this assessment is based on two crude indicators: (1) There were no reports
of safety-net providers’ closing down or falling into bankruptcy in the Snapshot communities over the past two years; and (2) the majority of community health centers in the communities have secured a seat at the managed care table. Unfortunately, the design of the study did not permit the collection of more precise data to judge how effective these strategies have been in terms of revenues or profit/loss margins, numbers of Medicaid or uninsured patients served, or other important indicators of impact.

Despite their apparent ability to meet various challenges, however, it was clear that risk-based managed care contracts are hazardous to safety-net providers’ financial standing. While managed care contracts can expand or maintain their base of paying patients, another study has shown that safety-net providers remain financially vulnerable if a large proportion of their revenues comes from Medicaid managed care and/or they accept capitation rates that do not cover their costs. The Snapshot site visits produced further testimony to this finding.

Even when they have negotiated a contract with a managed care plan, safety-net providers are not necessarily used regularly by the plans. For example, the Ramsey County Health Department in Minnesota has signed contracts with managed care plans to serve as a home health care provider. Yet the health department has not received many referrals from the plans and has lost about $40,000 in monthly Medicaid revenues as a result. Community health clinics in south Florida encountered a similar situation; one was forced to develop its own managed care plan, and others, to form a network to strengthen their bargaining position with health plans.

In other cases, community health centers that subcontract with managed care plans or contract directly with state Medicaid agencies are not as popular with new plan enrollees as the centers had hoped. CareOregon, the managed care plan formed by the Multnomah County Health Department in Portland, has not been as successful as its competitors have been in marketing to Medicaid enrollees and has lost Medicaid revenue as a result. Throughout Oregon, community health centers have lost an average of 20 percent of their Medicaid revenue because of the loss of Medicaid patients to managed care plans and other providers.

The adequacy of provider reimbursement rates or payment arrangements under managed care is also important to safety-net providers’ financial health. The experience so far among the safety-net providers we interviewed suggests mixed results. Some of those interviewed reported that the rates negotiated between community health centers and managed care plans are close to, or even exceed, the rates paid by the state under cost-based reimbursement. Indeed, because of their lower costs, community health centers appear to be able to make a profit that can be an important source of funding to subsidize uncompensated care. In other
cases, however, the negotiated fee-for-service rates or capitated payments are less than the former Medicaid rates. For example, Miami’s Jackson Memorial Hospital gets paid substantially less by managed care plans for a baby born via normal vaginal delivery than it did under former Medicaid fee-for-service rates.

Access to care for the uninsured. Because the Community Snapshots project did not collect data from individual safety-net providers and the site visits were not designed to interview all safety-net providers in each community, this study did not lend itself to an empirical analysis of changes in access to care for uninsured and underserved persons. However, interviews with key stakeholders, along with other published data or reports, show clear differences among the communities in the direction of change in access to care.

Reports of improved access to care for the uninsured were found in communities where a significant proportion of the uninsured have gained coverage through state programs. In Oregon, Washington, and Minnesota, where coverage has been expanded, nearly 120,000 more people in Oregon, 79,000 in Washington, and 85,000 in Minnesota now have health coverage, and their access to health care reportedly has improved. Newly insured persons covered in the three Snapshot communities (Portland/Vancouver, Minneapolis/St. Paul, and Fargo/west central Minnesota) have gained access to a wider array of private health plans or providers that had not previously served low-income persons. (There were no data on how many participating providers had not previously served these patients.) However, consumer advocates in Portland and the Twin Cities expressed concerns about how well these patients are being served by the private health plans and providers. Translation, transportation, and other enabling services delivered by private plans were reported to be less readily available than they were at publicly supported clinics.

Despite the loss of some Medicaid revenue resulting from the switch to managed care contracts with private plans, most of the community health centers and public hospitals in the Snapshot communities that participated in capitated managed care reported that they were able to maintain the level of care they provide to the uninsured. Generally, this was possible only when these providers obtained additional funds from sources other than Medicaid, including more revenues from private-pay patients or increased funds from state or local governments. Community health centers in Albuquerque, rural north central Florida, and Boston are beginning to attract more private-pay patients. Jackson Memorial Hospital in Miami secured additional funds from a half-cent increase in the local sales tax, which was approved by voters in 1991.

Although state insurance subsidy programs have reduced the burden of
uncompensated care on some safety-net providers, the net effect is not entirely positive. For instance, the Oregon Health Plan added more people to the ranks of the insured, but the loss of DSH funds has reduced hospitals’ ability to subsidize care to those who remain uninsured. According to a recent study on the impact of the Oregon Health Plan on safety-net providers, “the Oregon Health Sciences University has benefited by reductions in unsponsored care [which declined from 11 percent to 9 percent of total charges] but the removal of disproportionate share has limited their capacity to provide such care.”

In the two rural communities access to care also seems to have improved through closer linkages between urban health centers in Gainesville and Fargo and rural health care providers in the surrounding communities. As urban hospitals and physician groups have sought greater market penetration, specialists are more likely to rotate through rural facilities. The emerging field of telemedicine also is showing signs of improving access to care for some rural residents. As rural hospitals realize the new economic realities, some have gradually switched to emphasize primary care and home health care, which are sorely needed in most rural areas.

In a few communities Snapshot interviewees reported “early warning signals” that market or public policy changes are contributing to deterioration in access to care. For example, persons interviewed in Orange County cited eroding public funds for services to undocumented immigrants as the cause of greater access problems and a threat to safety-net providers that continue to serve them. Similarly, consumer advocates in south Florida noted that more Hispanics were being asked about their immigration status and that more of them were being denied care. State cuts in Florida for children’s mental health services, primary care, and care for migrant farm-workers and persons with human immunodeficiency virus (HIV) infection have led to longer waiting times for and fewer services to persons without insurance. Emergency department use among the uninsured reportedly remains high in some areas of Florida because of a lack of other options.

Future Prospects And Need For Monitoring

Safety-net providers in the fifteen Snapshot communities have adopted many strategies to meet the challenges or take advantage of support offered to them to continue providing care to the uninsured. Although these strategies appear to have resulted in short-term survival, it remains to be seen whether they will continue to be viable in the long term.

The pressure that results from enrolling all Medicaid patients in managed care has been applied in only a few communities across the country. It is not clear that all safety-net providers will be able to participate in managed care
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programs or to secure adequate payment rates. Not all providers believed that if payments fall short they would be able to replace the losses in Medicaid revenues with other public and private revenues, especially at a time when all levels of government are cutting spending. The future of state subsidies for the uninsured is extremely uncertain; some of the states that plan to expand Medicaid eligibility under Section 1115 waiver programs have already scaled back their plans.

Future efforts to monitor the effects of changes on the safety net should look at how these changes affect safety-net providers as well as their effect on vulnerable populations that depend on them. As publicly subsidized patients are absorbed by mainstream providers, will safety-net providers diminish in number along with their capacity to serve those who remain uninsured? Will the safety net split into a “two-tier” system in which low-income insured patients (that is, Medicaid beneficiaries) have greater access to care while uninsured patients face more restricted access? Will the uninsured, who already have lower rates of health services use compared with the insured population, receive even less care, or will they receive care in different settings than they have in the past? How much will cost shifting decline? The answers to these questions will have much to say about the changing condition of the safety net.

NOTES


2. See P.B. Ginsburg, “The RWJF Community Snapshots Study: Introduction and Overview,” Health Affairs (Summer 1996): 7-20. The fifteen communities are Boston, Massachusetts; Wilmington, Delaware; Columbia, South Carolina; north central Florida; Miami/Ft. Lauderdale, Florida; St. Louis, Missouri; Indianapolis, Indiana; Des Moines, Iowa; Minneapolis/St. Paul, Minnesota; Fargo, North Dakota/west central Minnesota; Houston, Texas; Albuquerque, New Mexico; San Diego, California; Orange County, California; and Portland, Oregon/Vancouver, Washington.


6. NAPH, America’s Urban Health Safety Net.

7. U.S. Department of Health and Human Services, National Center for Health Statistics, National Hospital Discharge Survey, 1993; and National Hospital Ambulatory Medical Care Survey, 1993.
8. Estimates provided by the National Association of Community Health Centers and the Medical Group Management Association.


11. EBRI, Sources of Health Insurance and Characteristics of the Uninsured.

12. Within each community the pressure imposed by Medicaid managed care also may vary according to each safety-net provider’s number of Medicaid Aid to Families with Dependent Children (AFDC) patient days or visits relative to total Medicaid days or visits, since these recipients are most likely to be affected by Medicaid managed care. Because the Snapshot visits did not involve interviews or data collection from all safety-net providers in each community, it is not possible to identify those providers in each site.


15. ProPAC, Analysis of Medicaid Disproportionate Share Payment Adjustments.

16. California voters recently passed Proposition 187, which requires government agencies to verify that only American citizens or legal residents receive the benefits of publicly funded education, social services, and nonemergency medical care. Although the law is technically in effect, it is being challenged in a number of lawsuits. Because of uncertainty about possible violations of the law, some health care providers continue to serve this population but do not report such care.

17. Two states with Community Snapshot sites (Florida and South Carolina) had been planning to expand coverage to low-income uninsured persons but have delayed implementation indefinitely.

18. GAO, Community Health Centers: Challenges in Transitioning to Prepaid Managed Care.


20. Federal Medicaid law has required state Medicaid programs to pay community health centers that are federally qualified health centers payment rates that are based on their actual costs. Many states with approved Section 1115 Medicaid waivers have received federal approval to exempt the state and its contracted managed care plans from this requirement.


22. T. Mark et al., “Medicaid Managed Care Program Access Requirements” (Report prepared for the Prospective Payment Assessment Commission, Project HOPE, Center for Health Affairs, Bethesda, Maryland, 1995).

23. Gold et al., “Managed Care and Low-Income Populations.”