

Health Care and the Underserved: America's Poor and Managed Care

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INTRODUCTION

Bringing Managed Care to the Medicaid Population

by David Granger and Audrey Young, M.D.

In the 1990s, two major trends have marked health care for the underserved: rising enrollment in the Medicaid entitlement program, and exponential growth in government health-care spending. A third trend—the expansion of managed care systems—is emerging.

With the election of the 1994 Congress, a “New Federalism” took hold. New Federalism’s tenets included devolution of power to the states and budget reduction. These themes held for health care and propelled managed care into the spotlight.

The introduction of managed care into Medicaid was seen as an opportunity to drastically reduce government health-care costs. Prior to 1997, states had to obtain federal waivers before experimenting with Medicaid

Managed Care Organizations (MCOs) finance and deliver medical care with these features:

- Contracts with physicians and hospitals to provide comprehensive health services to MCO enrollees
- Capitation or monthly budgets which shift some financial risk to physicians
- Utilization review to minimize patient and physician use of services
- Quality controls to improve clinical services or measured health outcomes
- Financial incentives for patients to use contracted providers and facilities

managed-care systems. The Balanced Budget Amendment (BBA) of 1997 eliminated this requirement altogether and opened the floodgates for Medicaid managed care.

Managed care holds great potential to benefit Medicaid clients. Increased access, continuity of care and quality of care measurements are all promises of the new system. Managed care can provide these benefits efficiently because of an organizational network and information system capacity.

Delivering health care to the underserved is a different ball game, however, than caring for traditional managed care populations. Inside, Brenda Shim points out that delivering care to the underserved requires unique

system resources. She finds that Medicaid clients must undergo a lengthy, confusing application process and are thrown into an elaborate health-care system without navigation skills. Then, Staci Dixon examines troublesome issues in the development of America’s first Medicaid managed-care outfit, TennCare, in Tennessee. Lawrence Siegel shows, alternately, how Rhode Island has been able to improve access and health outcomes through its Medicaid managed-care program, RIte Care. He finds, however, that even in a well-run system, thousands eligible for care remain unenrolled and are effectively barred from access.

As access is established, questions arise about managed care’s inexperience in managing populations with high rates of chronic disease and disability. Brian Kit explains how managed care concerns apply in particular to HIV-positive patients, and how a few managed-care organizations (MCOs) have developed effective systems to treat HIV and AIDS.

As more and more Medicaid patients are converted to managed-care systems, the existing “safety net” which furnishes care for America’s underserved—Medicaid patients, the uninsured and the underinsured, or about 25 percent of the U.S. population—is in jeopardy. David Granger examines why funding for safety-net institutions is threatened, and discusses how Medicaid managed-care systems place the safety net in serious danger.

Finally, Ellie Grossman provides one solution by explaining how an MCO can work with a safety net institution to deliver quality care for the underserved. ◆

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The Quick and Dirty on MEDICAID

- Beneficiaries are low-income children, parents of children receiving benefits, or the elderly requiring long term care, the blind and the disabled.
- The elderly, blind and disabled are about 30 percent of the Medicaid pool and consume a disproportionately large share of the Medicaid budget.
- Medicaid patients receive mandatory benefits, including inpatient and outpatient care, and physician, laboratory, radiology, nursing home and home-health services. Optional benefits, provided on a state-by-state basis, include prescription drug, clinic services and prosthetic devices.

Iglehart JC. The American health care system: Managed care. *New England Journal of Medicine* 327: 742-747, 1992. Used by permission.

Access to Care Issues for America's Underserved

by Brenda Shim

Limited access to care is a major difficulty facing America's underserved. Those lacking access are less likely to have a regular source of care, more likely to receive lower quality care, and more likely to die in infancy, in addition to a myriad of other adverse health consequences.¹ Access is defined as the timely use of personal health services to achieve the best possible health outcome.²

A number of barriers restrict Medicaid patients as well as the uninsured and underinsured from accessing health care.

Financial barriers. Lack of insurance is the single largest impediment to health-care access. In surveys conducted in 1994 and 1995, one-third of U.S.

Access is defined as the timely use of personal health services to achieve the best possible health outcome.

respondents reported financially-based access problems and nearly two-thirds indicated that they delayed care for financial reasons.³ Understandably, those without health insurance were less likely to have a regular source of care.⁴

Medicaid has helped to improve health-care access for the most vulnerable Americans. Of its 36 million beneficiaries in 1996, 46 percent were children living in poverty, 20 percent were adults receiving Temporary Assistance to Needy Families (TANF, formerly AFDC), and 29 percent were elderly, blind or disabled.⁵ An

additional 16 percent of the American population, or 43 million people, remained uninsured in 1995.⁶ This could have been due in part to the rising number of people losing private insurance.⁷

Poor access to health care disproportionately affects those of low socioeconomic status. The 43 million Americans without health insurance are more likely to be poor, less educated, foreign born and hold less than full-time employment than those who have health insurance.⁷ As the cost of medical care continues rising and public-health services are dismantled, health services for the poor will diminish further.

Structural barriers. Studies show that Medicaid eliminates many financial barriers to care.¹ However, structural barriers such as limited physician availability, poor continuity of care and organizational barriers also equate with poor access.

Historically low levels of reimbursement and complexity of the billing process discouraged many physicians from participating in Medicaid. One-third of physicians fully participate in Medicaid, one-third limit the number of Medicaid patients they will see, and the remaining third do not see Medicaid patients at all. The lack of participating private physicians severely limits opportunities for ambulatory care and is especially problematic for the children and pregnant women who make up a large proportion of Medicaid beneficiaries. Because of this limited provider base, Medicaid patients are more likely to use outpatient hospital services, emergency rooms and community health centers than privately insured patients.⁸

The limited number of participating physicians

affects continuity of care for Medicaid patients. Patients often obtain preventive and acute care from different sources due to the limited services offered by their regular provider. In addition, continuity of care is severely hampered by the trend in Medicaid recipients cycling in

Historically low levels of reimbursement and complexity of the billing process discouraged many physicians from participating in Medicaid.

and out of care due to changing eligibility. Fifty percent of Medicaid participants lose their coverage within a year.⁹

The small pool of available providers creates a number of organizational barriers, including long wait times during clinic visits, difficulty making appointments, and having to travel longer distances to receive care.

Personal barriers. Personal barriers to health-care access are often related to lack of knowledge about the medical system and poor levels of education.⁶ Many individuals may not be aware they are eligible for Medicaid, or know the level of insurance for which they are eligible. They may be confused about how to establish care in a managed-care system. Lack of knowledge about preventive care may also impact the frequency and degree of health care sought. Lack of knowledge is exacerbated by a complex Medicaid eligibility process which can change as income, disability status and age change.

The availability of child care and transportation, language difficulties and the inability to miss work have also been cited as barriers to care for impoverished individuals.^{10, 11} Socioeconomic disparities between patients and providers may also present barriers to access.⁹ Poor and minority patients may not feel comfortable receiving care from providers of a completely different socioeconomic background.

Conclusion. While lack of health insurance and financial resources present the largest impediments to health-care access, they are by no means the only difficulties faced by the poor. Difficulties with access and problems of poverty lead to poorer health outcomes, a problem that health insurance alone cannot fix.¹² ♦

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A Brief History of TennCare

by Staci E. Dixon

Governor Ned McWherter (D) declared in April 1993 that Tennessee would be the first state in the nation to withdraw from the traditional Medicaid program. Between 1988 and 1993, the number of Tennessee Medicaid enrollees had grown so quickly that Medicaid expenditures had created a budget crisis for the state government. Despite this rapid growth, nearly 500,000 Tennesseans remained uninsured.

To complicate matters, the state faced a loss of \$494 million in federal Medicaid funding. Without radical change requiring either tax increases or unacceptable reductions in health-care services, the uncontrollable

growth of Medicaid threatened the financial stability of the state.

By the beginning of 1994, Tennessee had obtained a federal Medicaid waiver under Section 1115 of the

Social Security Act and launched an innovative health-care reform plan. The new Medicaid managed care program, known as TennCare, was developed with the dual

objectives of controlling Medicaid spending while extending health insurance coverage to the uninsured and uninsurable residents of Tennessee.

Governor McWherter's TennCare solution would

The median hospital received only 44 cents for each dollar expended on TennCare patients.

bring the existing Medicaid population into capitated managed care networks, mandate enrollment of new eligibles, and broaden Medicaid eligibility to cover most of the state's uninsured. The initial program proposed to enroll 1,775,000 citizens and projected a five-year cumulative cost savings to Tennessee and the federal government of \$7.2 billion.

On January 1, 1994, 800,000 Medicaid beneficiaries were moved into 10 managed care networks. In addition, 400,000 uninsured or uninsurable residents enrolled in TennCare. This meant that 95 percent of the residents of Tennessee enjoyed some form of health care, as close as any state had yet come to establishing universal coverage. Manage-care organizations (MCOs) were hired on a capitated basis to deliver broad, preventive, inpatient and outpatient services. Responsible for all covered services except long-term care, the package was slightly more generous under TennCare than under the former Medicaid program.

Because of the short lead time between the announcement and implementation of TennCare, however, information systems and administrative procedures were not in place to handle this patient volume. Backlogs in processing applications and failure of the state to bill for and collect premiums and payments resulted in significant loss of revenue. By the end of the first year, the program had incurred a \$99 million budget deficit. Nevertheless, the state claims that in the first 18 months, TennCare saved an estimated \$1.6 billion in state and federal spending based on the expected growth rate in conventional Medicaid expenditures.

TennCare was opposed by critical interest groups, including the Tennessee Hospital Association (THA) and the Tennessee Medical Association (TMA). Objections included development of the plan without public debate or input from health-care providers and insurers. Concerned about increasing enrollment without adequate funding, TMA also worried about loss of income and autonomy for providers. In a move that outraged physicians, Blue Cross required physicians to accept TennCare patients if they wished to participate in the more lucrative Tennessee Provider Network (TPN), the preferred-provider program that covered one-fifth of the state population. This so-called "cram-down rule" caused half of Blue Cross's 7,000 physicians to withdraw from the network, creating chaos and leaving few physicians to absorb a large number of new patients. But due to TPN's large market share, most doctors returned to Blue Cross by the end of 1994.

Following TennCare implementation, MCOs and hospitals reported major financial problems. Payment levels were at least 25 percent less than the costs of providing care. The median hospital received only 44 cents from MCOs for each dollar expended on TennCare patients. Hospitals had to either raise charges to other carriers or reduce overall expenses. In addition, the state suspended graduate medical education (GME) and Medicare disproportionate share (DSH) payments, which traditionally have aided hospitals treating a high proportion of the underserved. Although payments were later restored, alterations in the funding mechanism contained serious implications for hospital budgets. Some hospitals planned to curtail clinical services, reduce graduate medical educational programs, and lay off significant percentages of their workforce.

As a result of financial troubles and questions about adequate funding for the future, the state closed enrollment for the uninsured on January 1, 1995. To qualify for TennCare now, one must be Medicaid-eligible, uninsurable or rolling off the Medicaid program. Enrollment has been re-opened to uninsured children.

It is too soon to say whether TennCare will sink or swim. Many are watching the developments with interest, however. An accessible, affordable, high quality health-care system for all in Tennessee holds potential benefits for many states. ♦

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Managed Medicaid Care in Rhode Island: Eligibility and Access

by Lawrence Siegel

In 1994, Rhode Island received a waiver from the Health Care Financing Administration (HCFA) to convert Medicaid to a managed-care system with mandatory enrollment that would also expand the eligible population. RIte Care, created in 1994 as a joint effort between the Department of Human Services and the Department of Health, is Rhode Island's managed Medicaid care program. Goals included improving access and quality of care for Medicaid families, uninsured pregnant women and children, while controlling the growth rate of Medicaid expenditures. Services would emphasize primary and preventive care; address language, cultural and transportation barriers to health care; and provide outreach and education. As of December 31, 1998, 74,853 persons were enrolled. Although RIte Care has been effective in improving the health of Rhode Island's poor, enrolling all eligible individuals continues to be a challenge.

Eligibility. The eligibility criteria for the program have broadened greatly since the plan's original drafting. Additional eligible individuals now include the uninsured

Under RIte Care, the number of primary care providers treating Medicaid families has jumped from 350 to more than 800.

or underinsured among TANF families (Temporary Assistance to Needy Families, formerly AFDC), pregnant women with income up to 350 percent of federal poverty level (FPL), and children 18 years of age or under in households with income up to 250 percent of FPL. In addition, an extended family-planning benefit provides 24 months of post-partum family planning and gynecologic services for women who do not qualify for full RIte Care benefits after delivery.

Financing Rhode Island contracts with commercial health plans via capitated, per-member per-month payments. Clients choose one health plan and one primary care provider. Participating managed care organizations (MCOs) include Harvard Pilgrim Health Care, BlueCHiP, Neighborhood Health Plan of Rhode Island and United HealthCare of New England, with the last two enrolling more than 80 percent of the clients.¹ Harvard Pilgrim and BlueCHiP are both closed to new members. There are concerns that MCOs may be losing money, and there are questions about MCO commitment to continue serving Medicaid clients.

Benefits. The managed care packages are necessarily more complete than their regular commercial counterparts, representing federal Medicaid requirements and the greater challenges in providing care to the poor. The primary care physician must provide a medical home, continuity of care, availability 24 hours a day, 7 days per week, and referral to specialists as needed. Several

specific benefits include primary, preventive, medical, surgical and mental health care; prescription drugs; certain non-prescription drugs; transportation; and interpreters. Access standards include immediate emergency care, urgent care within 24 hours and routine care within 30 days.²

Access. RIte care has increased access to primary care. The number of primary care providers treating Medicaid families has jumped from 350 to more than 800. Primary care physician visits for the average Medicaid recipient increased from 2 to 5 per year under the program, with emergency room visits and hospital use decreasing by one third.

RIte Care has improved health outcomes for mothers, increasing the number of women waiting 18 months between births and decreasing the number of women who smoked during pregnancy. First trimester prenatal care increased from 76 percent in 1993 to 82 percent in 1995. "Adequate" prenatal care increased from 44 percent in 1993 to 69 percent in 1996.

Infant health outcomes have also improved. The number of low-birth-weight infants born to Medicaid-enrolled mothers decreased from 9 percent in 1993 to 8 percent in 1996. The infant mortality rate dropped to 5.5 deaths per thousand in 1996, the lowest it has ever been in Rhode Island.

Eligibility is not access. Major problems with RIte Care include client difficulty in using a managed care system, administrative barriers in the referral process, MCOs' financial losses, and the remaining thousands of eligible but unenrolled individuals.

RIte Care has suffered from enrollment problems since inception in 1994. Most prominently, one in 10 Rhode Island children, or 20,500 children, were uninsured in 1996, with three-quarters living in families that are qualified for RIte Care coverage.⁷

Primary care physician visits for the average Medicaid recipient increased from two to five per year.

A number of factors may explain why eligible individuals remain unenrolled. Clients were previously required to go to the welfare office to apply, which could be associated with stigma or shame. The process of signing up was unexpectedly long and many recipients could not stay for a meeting on how to choose an HMO. Additionally, language barriers might have prevented program enrollment.⁴

Solutions. Recent steps to enroll remaining eligible persons include program publicity, a streamlined mail-in application, and a community-based outreach "go-gettumm" model.

Community based outreach includes a Family Resource Counselor Program, which provides advisors to community health centers and hospitals to increase enrollment in public programs, including RItE Care. The Parents' Consultant Program has also reached out to families to understand their needs and connect them to Medicaid if appropriate.³

Recently, the state has chosen more aggressive approaches. On January 8, 1999, the Department of Human Services announced the availability of RItE Care funds for organizations interested in hiring up to two full-time outreach workers, with 80 percent of the salary provided by the state plus a per-person enrolled incentive.

The future. Rhode Island has developed an effective Medicaid managed care program, with higher primary care provider use, excellent member satisfaction rates and convincing health outcome data. However, along the way, the state has realized that eligibility does not mean enrollment. Moreover, as Rhode Island blazes a trail towards universal coverage, she must also ask, does enrollment equal access? ♦

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Serving HIV and AIDS Clients in Managed Care Systems

by Brian Kit

Medicaid insures both poor Americans and the uninsured with chronic conditions such as AIDS.¹ For HIV-positive individuals, HIV may be just one more problem in daily struggles with family, housing, employment, finances and discrimination. Frequently, substance abuse and violence are prominent. As a result, non-medical services can be as crucial to a patient's health as

Plans that paid higher predetermined premiums for persons with AIDS were more likely to ensure that these customers had access to the services that they need.

medical care.² Important non-medical services include legal advocacy, housing, education and entitlement assistance, counseling, vocational rehabilitation, childhood development assistance, home health care, drug dependency treatment, and long-term and hospice care.

As Medicaid patients are shifted to managed-care systems, concerns arise about the quality of HIV care that MCOs can provide.

Concern: Predetermined premiums. Managed-care financing strategies create strong concerns for HIV-positive individuals. Predetermined premiums or capitated payments for services limit the amount of care that can be provided. HIV and AIDS care is costly, and expenses are often underestimated by states and managed-care organizations (MCOs).³ HIV advocates worry that MCOs cannot

meet profit margins while maintaining the health of HIV clients. Similarly, MCOs' desire to control service utilization provokes anxiety.

A Department of Human Services study showed that the plans that paid HIV or AIDS rates—higher predetermined premiums for persons with AIDS—were more likely to ensure that HIV and AIDS consumers had access to the services that they need.⁴ Nevertheless, inadequate reimbursement levels are perceived to exist in almost one-third of jurisdictions.⁵ Providing MCOs with capitation rates that are adequate for HIV and AIDS care is essential.

Concern: Adequate provision of services. MCOs' history of caring for healthier-than-average patients means not all services required for HIV-positive individuals may be available within the network.⁶ In addition, some worry that low-income consumers will not have the knowledge to request services that are available, either through their

Ninety percent of HIV-positive children depend on Medicaid for health insurance.

MCO or through other providers.

Concern: Cultural competency. For accuracy of diagnosis and treatment adherence, it is important that MCOs recognize cultural values and incorporate cultural competency into treatment of underserved populations.

Concern: Geographic sensitivity. Rural primary

care physicians require up-to-date access to information on diagnosis and treatment of HIV and AIDS.

Concern: Provider knowledge. MCOs must ensure that HIV specialists are available to treat the range of diseases found in HIV and AIDS. Providers must be competent in psychosocial aspects of care.

Concern: Continuity of care. The shifting managed-care market could result in Medicaid programs breaking contracts with doctors who have established relationships with HIV patients.

Solutions. Integrated delivery systems (IDS) are networks of public and private organizations that provide a coordinated continuum of services to a defined population. Service providers and institutions are held accountable for assuring access, providing quality services and achieving health outcomes.

Certainly, managed care's prevention and health-promotion strategy can improve quality of life and quality of health for HIV-positive patients, while reducing high-cost care such as long hospital stays.⁷ Several model MCOs are accomplishing these aims:

- Community Medical Alliance, Boston, MA. Each patient is assigned a nurse practitioner and physician. The nurse practitioner acts as the front-line care coordinator, working with patients in their homes and linking patients to support services. The nurse practitioner and physician together have wide latitude in medical decision making.
- The Health Plan of San Mateo, San Mateo, CA. Most enrollees receive care from the Edison Clinic, which provides a full range of HIV medical and ancillary

care using Medicaid and Ryan White Funding. Members can seek HIV specialty care within the provider network without a referral.

- Positive HealthCare, AIDS Health Care Foundation, Los Angeles, CA. Individuals select a staff primary care provider. Registered nurses act as case managers and help patients gain access to medical and mental health care, nutrition, advocacy and education services, and referrals to community resources.

Whether successes can be replicated in large scale remains to be seen. ♦

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What Will Happen to the Safety Net?

by David Granger

Public hospitals, academic medical centers, federally qualified community health centers (FQHCs), and local public health departments have traditionally provided the majority of health care for the underinsured and uninsured. Approximately half of the patients seen by these "safety net" institutions do not have health insurance.^{1,2} The advent of Medicaid managed care challenges health services for the uninsured by threatening safety net funding sources. Managed care organizations (MCOs) compete for the same Medicaid patient base as safety net providers who depend on Medicaid revenues to cross-subsidize care for those who lack insurance. Medicaid patients consume 45 percent of inpatient care in public hospitals, are 38 percent of the patient base in FQHCs, and provide a significant source of revenue for these institutions.^{3,4,5} As safety net providers scramble to orient themselves toward the market to retain these paying patients, the question is whether they can survive the competition and still maintain their core mission to serve the uninsured.

Funding for services for the uninsured have been very creative. Public hospitals primarily fund health services for the uninsured by four mechanisms: 1) local subsidies; 2) Medicaid Disproportionate Share (DSH) hospital payments; 3) Medicare DSH payments; 4) cross-subsidies from Medicaid and other paying patients. FQHCs primarily fund services for the uninsured by federal grants and Medicaid cross-subsidies.^{3,5}

Cross-subsidizing is very important for public hospitals and FQHCs because of the large number of uninsured patients these institutions see. Cross-subsidizing allows providers to cost-shift Medicaid revenue into services for those who lack insurance. In the past, this patchwork of funding kept the safety net afloat. However, if too many Medicaid patients in the safety net are siphoned away by Medicaid managed care, safety net providers will lose resources to fund care for the uninsured.

Public hospitals and FQHCs have responded by entering the health-care market. Institutions have either formed managed care plans of their own or contracted out

services to an existing plan. Some states give extra points to MCOs with safety net providers who bid for Medicaid contracts, but this does not ensure their participation.⁵ Although FQHCs have the advantage of experience with Medicaid populations, they have many severe disadvantages in landing managed-care contracts: lack of managerial expertise, reduced ability to take on risk in capitation, and lack of information systems.⁶

When safety net institutions do win contracts, another problem arises: in many circumstances, the capitated rates are significantly lower than in the fee-for-service era. This leaves safety net providers with barely enough revenue to cover costs, let alone cross-subsidize care for the uninsured. In addition, DSH payments were reduced by the Balanced Budget Amendment of 1997 by \$10.4 billion over the next five years.⁷ These events significantly jeopardize the ability of the safety net to provide access and care to the uninsured.

Some providers have already left the safety net, particularly local public health departments. Local public health departments have found it difficult to continue provision of care for the poor, so some have stopped providing health services and now strictly focus on traditional public health activities.⁸

As the remaining safety net providers struggle to survive, many private for-profit MCOs are leaving the Medicaid market. Aetna U.S. Healthcare, Pacificare and Prudential are among MCOs that have scaled back because they no longer find the Medicaid market profitable.^{9,10} This has damaging implications. If the safety net crumbles and private MCOs leave, who will be left to provide services?

The uncertain future of Medicaid managed care could also aggravate safety net instability. As yet, Medicaid managed care has not saved as much as some had predicted. This is partly because most states only enroll women and children in the managed-care portion of Medicaid, leaving the sicker Supplemental Security Income (SSI) segment of the Medicaid population in the more expensive traditional program. Currently, typical managed care savings is 5-10%¹¹ less than fee-for-service expenditures. In addition, Medicaid managed care has shifted a huge regulatory burden to the states and will likely increase the size of state bureaucracies. To implement Medicaid managed care, states must oversee bidding

for contracts, set capitation rates (by risk adjusting), and monitor marketing, enrollment and quality—all money-consuming tasks.

Medicaid managed care is not a panacea. Although it offers some benefits to enrollees, potential drawbacks are severe: destruction of the health-care safety net and reduced access for those who remain uninsured. A successful Medicaid managed-care system will incorporate safety net providers and make special funding provisions so these providers may continue to serve the uninsured. A Medicaid managed-care system that leaves the safety net behind would surely have devastating consequences. ♦

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A Managed Care Plan and a Community Health Center Work Together

by Ellie Grossman

Neighborhood Health Plan (NHP) is a non-profit Massachusetts-based network-model HMO. One of NHP's primary goals is to address the unique needs of Medicaid patients and other underserved patients. Many NHP provider sites are community health centers (CHCs) or federally-qualified health centers (FQHCs) that have a great deal of experience in caring for the underserved. CHCs were developed to aid the underserved and "are recognized by many HMOs and Medicaid agencies as cost-effective providers of care for the high-risk, vulnerable Medicaid population." In July 1998, 80 percent of NHP's 57,000 enrollees had Medicaid insurance, and most were racial minorities living in areas with few medical resources.

Community health center patients have both medical and non-medical needs. CHCs attempt to meet many of these needs. Many patients are immigrants, so CHCs offer culturally competent care in community-specific languages—e.g., several Chinese languages in Boston's Chinatown. CHC services may include financial counseling, outreach services, social services and case management, family planning and counseling, mental health services and dental services. In addition, some CHCs address very specific medical needs such as HIV, pediatric asthma and substance abuse. Services are offered on a sliding-fee scale, so that all can afford to receive care. CHCs are often run on very tight budgets, with little money to spare for capital or operational improvements.

In efforts to build a membership base and strengthen its provider site, NHP has long worked with CHCs to improve patient care. NHP's strategy to ensure provider quality encompasses several tactics:

- continuing medical education on the special needs of NHP patients;
- experiments which tie capitation rates to quality-of-care measurements; and
- a technical assistance team which consults with CHCs on financial and operational issues.

The technical assistance team mission is to help CHC streamline services; enhance accounting, financial analysis and business planning capability; and improve the care process—tasks which CHCs often have difficulty with on their own.

One project the technical assistance team embarked on was a patient-flow improvement project at a CHC. This project aimed to improve patient cycle time—the time it takes a patient to go through a primary-care unit, from arrival at the unit to exit—so that patients

flowed more efficiently through the system. This particular CHC had experienced rapid growth in usage in the preceding few years, patients were experiencing long wait times, and providers were chronically running behind schedule. Ensuing operational changes were aimed at decreasing patients' waiting times and increasing patient and staff satisfaction.

The process of identifying and analyzing problems and developing solutions is one example of how an HMO can work with a provider site to improve quality of care. These studies can be difficult for resource-strapped

community health centers to perform on their own. In this model of HMO-CHC cooperation, the CHC learns how to make its operations more efficient and satisfying for its

patients, and the HMO improves the quality of care its members receive. Patients are the main beneficiaries of this exchange, as they will experience shortened wait times, greater access to care, and a provider-HMO health-care team attuned to patients' needs. For Medicaid patients who are often short-changed by the health-care system, this type of project to improve patient care is especially important. With strong partnerships, HMOs may indeed have much to offer to Medicaid members. ♦

CHCs are recognized as cost-effective providers for the vulnerable Medicaid population.

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Editor's Note

by Audrey Young, M.D.

The managed-care industry faces an uncertain future. Some managed-care organizations (MCOs) are purchasing smaller plans or merging to expand patient base. Some face the growth of physician and hospital networks that negotiate for higher provider fees. And all are threatened by federal legislation that, if passed, is certain to raise regulatory barriers and increase operating expenses.

The Medicaid market, already problematic with its low reimbursement level and mandated benefits, is no longer looking like the cash cow it once did.

States, likewise, continue to have difficulty holding down Medicaid expenditures. Although reductions in expenditures occurred initially, the savings may have been both transient and misleading. Doctors, hospitals and MCOs initially accepted Medicaid Managed Care's (MMC) lower reimbursement rates because they wished to protect their market share. As practitioners and institutions found themselves losing money on services for Medicaid patients, however, many questioned the wisdom of continuing MMC contracts. Some have canceled services for this population. States now must scrape up funds to reimburse MCOs at a level that allows provision of services to continue.

Why has Rhode Island succeeded where others fail? There are several potential answers. Rhode Island is a relatively wealthy state with a small, educated population. The state has an efficient, effective health department, and Medicaid expenditures per capita are #2 in the nation. It is likely that the market is appealing for insurers. Competition among contractors may help to boost the quality of services.

It seems uncertain that the Rhode Island model can be replicated in other states, however. Many states simply do not have the revenue needed to plow into Medicaid. Tennessee, for example, struggles with a enormous budget deficit.

And while Rhode Island's improvement in health outcomes is impressive, there are questions about reproducibility in other states. Philosophically, MMC encour-

ages Medicaid clients to establish a medical home, with a primary care provider and access to a network of services and specialists. Yet, many states have not realized these benefits because patients do not understand how to choose a health plan or how to select a primary provider. In fact, many who are eligible for Medicaid insurance aren't even aware of it.

What is most disturbing is watching MCOs dabble in the Medicaid market, lose money and cancel contracts. Medicaid clients on the receiving end are simultaneously enrolled, unenrolled and left uncertain about where to go when sick. In the meantime, safety net institutions like community health centers and county hospitals are faced with a shrinking Medicaid base and reduced reimbursements from MCOs. This means trouble for the uninsured and underinsured who depend upon the safety net for health care. The population caught by the safety net is hardly trivial; 1 in 4 Americans are uninsured, underinsured or on Medicaid.

Ellie Grossman has presented an optimal solution, where a managed-care plan that exists primarily for the underserved works closely with a safety net institution to improve quality of care. Solutions like this require more than the slashing of state Medicaid budgets and contracting of services to low bidders, however. It is not good enough to rely on the idea that managed care assigns clients to medical homes; active steps must be taken by either the state or the plans to ensure that patients know where to go and how to get there.

Those interested in improving health care for the underserved should strive to be effective in public policy-making and managed-care administration, where human concern can raise the level of access to and quality of available health care. ♦

Audrey Young, the editor of this publication, obtained her M.D. degree from the University of Washington School of Medicine. She will begin a residency in primary care internal medicine in July 1999.

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