GRANTWATCH REPORT

America's Health Care Safety Net: Revisiting The 2000 IOM Report

States and communities must protect their most vulnerable citizens from adverse changes to the health care safety net.

by Marion E. Lewin and Raymond J. Baxter

ABSTRACT: The committee that wrote the 2000 Institute of Medicine report on the health care safety net reconvened in 2006 to reflect on the safety net from the perspective of rising numbers of uninsured and underinsured people, the aftermath of Hurricane Katrina, high immigration levels, and new fiscal and policy pressures on care for vulnerable populations. Safety-net providers now participate in Medicaid managed care but find it difficult to meet growing needs for specialty services, particularly mental health care and affordable prescription drugs. How current state reforms and coverage expansions will affect care for the poor and uninsured is a critical issue. [*Health Affairs* 26, no. 5 (2007): 1490–1494; 10.1377/hlthaff.26.5.1490]

AT THE URGING of health care experts and policymakers, members of the committee that authored the Institute of Medicine's (IOM's) 2000 report, *America's Health Care Safety Net: Intact but Endangered*, reconvened in Washington in late 2006 to deliberate on the safety net's current ability to meet the needs of the poor and uninsured.[1] Rising numbers of uninsured and underinsured people, the catastrophic aftermath of Hurricane Katrina, new fiscal and policy pressures on health care for the most vulnerable U.S. populations, and a reenergized debate on health care reform in key states and among 2008 presidential hopefuls provided important reasons to reflect on the new environment. Along with most of the members of the IOM committee, some forty invited experts attended this productive symposium. A number of them were asked to update the group on the four major themes that shaped the report's findings and recommendations: (1) the financial condition and viability of safety-net providers; (2) the evolution of Medicaid managed care and its impact on safety-net providers and the populations they serve; (3) the challenge for safety-net providers to operate and succeed in an increasingly competitive, technologically sophisticated, and performance-oriented environment; and (4) the federal government's capacity to monitor the changing structure, status, and effectiveness of the safety net. For this paper, where relevant and appropriate, information presented at the symposium has been updated to reflect more recent findings. The IOM received funding to write and disseminate a summary of the meeting in the hope of

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informing ongoing debate on health care reform—specifically, the discussion on the future of health care for the poor and uninsured.

Financial Condition And Viability

A key catalyst for the symposium was reports that the financial status of many safety-net providers had continued to deteriorate since publication of the IOM study. Although state coffers are recovering from one of the worst budget crises in recent history, Medicaid and other programs financing health care for the poor and uninsured continue to be constrained. Also, both states and the federal government are seeking innovative ways to curb Medicaid spending and reshape the program, with an emphasis on benefit-package flexibility, cost sharing, and broadening of consumer choice by giving enrollees risk-adjusted premiums to encourage enrollment in private health plans. Since Medicaid funding is the lifeblood for many safety-net providers, these proposed changes are adding uncertainty to their fiscal outlook and their confidence in being able to sustain their mission.

Although public hospitals are "surviving," in aggregate they remain in precarious financial condition. Some large public hospital systems, such as Denver Health and Boston City, are thriving, but, according to recent reports, almost half of the public hospitals surveyed reported negative operating margins in 2004.[2] Similarly, expansion grants for community health centers (CHCs), launched by the Bush administration in 2002, have tended to benefit larger, financially stronger CHCs rather than smaller struggling ones.[3] Over the past few years, a growing disparity has emerged between the top-tier, successful, and economically viable safety-net providers and the larger group of smaller, less successful ones.

Since the IOM meeting, the U.S. Census Bureau in March 2007 reported a revised figure of 44.8 million uninsured people for 2005. This continues a generally upward trend that began in 2000, primarily because of the erosion of employer-sponsored coverage.[4] The number of low-income underinsured people rose as well, reaching 17.1 million people (under age sixty-five) in 2003.[5] With sixty-two million uninsured and underinsured Americans, safety-net providers are finding it more difficult to meet their patients' growing needs for affordable prescription drugs, mental health care, dental care, and other specialty services. Increased access to primary care over the past few years has both shown the gaps in other services and identified needs for follow-up treatment and diagnostics.

Experts' reports at the 2006 IOM meeting underscored a growing crisis regarding availability of mental health services. Medicaid and state budget pressures have produced critical service gaps for low-income adults with mental illnesses, resulting in a severe shortage of key outpatient providers, especially psychiatrists.[6] Many safety-net providers have noted changes in their local markets—with hospitals and ambulatory care providers scaling down or completely closing their psychiatric services, further concentrating the burden of caring for seriously mentally ill, uninsured patients on safety-net providers.

Representatives from safety-net constituencies reported on other new forces that threaten their financial viability and ability to adequately serve their clientele. Although immigration into the United States has decreased since peaking in 1999 and 2000, immigration levels remain high.[7] A growing proportion of immigrants lack health insurance, and more newly arrived immigrants are undocumented.[8] Although low-income noncitizen adults have little access to Medicaid coverage, uninsured noncitizens, particularly, rely less on emergency departments (EDs) for their care and more on clinics and health centers.[9]

Since the 2000 IOM report, a host of new regulations spanning disaster preparedness, health information technology (IT), language access, and translation services have been added to the requirements of safety-net hospitals without any additional resources to cover compliance costs. Diane Rowland, executive vice president of the Henry J. Kaiser Family Foundation, expressed concern at the IOM meeting that new Medicaid flexibility granted to states under the Deficit Reduction Act

(DRA) of 2005 is posing a serious financial threat to safety-net providers, as grant programs and other payments that traditionally have helped these providers subsidize care for the uninsured are now being redirected to restructure state Medicaid programs.

The 2000 IOM report emphasized the critical interrelationship of providers and institutions that serve the uninsured and vulnerable in any particular community. Although traditional safety-net providers represent the central core of this responsibility, their limited funding and finite capacity make them reliant on some other providers in the community to assume part of the burden of care. In recent years these interdependent relationships have become frayed as a growing number of community hospitals have closed or downsized their EDs or moved out of the central city. In addition, physicians have been increasingly less willing to treat uninsured patients, a trend already apparent when the IOM report was written.[10] All of these dynamics add to the rising pressures on the safety net.

Medicaid Managed Care

A major finding reported at the 2006 meeting was evidence of positive developments in Medicaid managed care. At the time of the IOM study, Medicaid managed care was still at a fledgling stage, and the committee expressed serious concern about its potential adverse effects on safety-net providers' revenues as well as on their patients. States then were implementing Medicaid managed care primarily to control costs and to give enrollees more choices regarding where they receive care. Initially, commercial plans rushed into the Medicaid managed care business, most without extensive experience in organizing care for this more complex, high-need population. Many of these new entities soon exited the market, citing inadequate premium rates, unstable enrollment, and cumbersome regulatory requirements. Even before the IOM report was completed, the committee noted a shift away from efforts to "mainstream" Medicaid recipients and a move to Medicaid-only plans, organized in many parts of the country by traditional safety-net providers. The panel urged careful monitoring of the evolving Medicaid managed care market, particularly the adequacy of payment rates and the ability of core safety-net providers to continue serving their uninsured patients.

In many parts of the country, Medicaid managed care has become a stable enterprise, creating medical homes for enrollees and improved budget predictability for Medicaid. More than 60 percent of the Medicaid population is now in managed care arrangements, up from 50 percent when the IOM report was released.[11] Federally qualified health centers and other core safety-net providers have become increasingly involved in the Medicaid managed care market. States and the federal government realize the critical role of these providers and continue to be protective and subsidize their operations through disproportionate-share hospital (DSH) payments and cost-based reimbursement.

As they have matured, Medicaid managed care plans have broadened the populations they serve to include those with chronic conditions, disabilities, and other complex health care needs. In response to new federal requirements and new competition, plans have had to become more sophisticated in doing case management and in monitoring and improving patient care.[12]

Safety-net health plans have survived better than originally anticipated in the world of Medicaid managed care, but serious threats and challenges remain. The scope and quality of the Medicaid managed care market continue to be uneven; some states are developing exemplary programs, while others lag behind. Eliminating racial and ethnic health disparities persists as a critical but unmet objective. By virtue of the diversity of the populations served by Medicaid, safety-net providers are uniquely positioned to be leaders in this area.

According to Robert Hurley, associate professor in the Department of Health Administration at Virginia Commonwealth University and a national expert on Medicaid managed care, safety-net plans are seeing renewed competition for their Medicaid patients. Commer-

cial plans are again becoming interested in the Medicaid managed care market; four investor-owned plans reached enrollment of more than a million Medicaid members each in 2006.[13] Also, Hurley said, large multiproduct firms are entering the Medicaid market more aggressively, saying that they have better tools and technology to serve high-cost enrollees.

Adding to this potentially troubling mix are current state reforms and coverage expansions that rely on private plans and more limited benefit packages. While the IOM's 2000 report focused on Medicaid managed care's threat to the future viability of safety-net providers, a more pressing concern these days is how state and federal health insurance expansion initiatives will ultimately affect care for the uninsured and other vulnerable populations. Most of the current health care reform proposals would finance expanded insurance coverage at least in part by redirecting funds now paid to safety-net providers.

Operating In A More Competitive Environment

Staying competitive in today's more demanding environment remains a major hurdle for core safety-net providers, dependent as they are on Medicaid and other public financing. Many safety-net providers are unable to invest in sorely needed capital improvements because of more critical needs for direct patient care. As their physical plants and infrastructure deteriorate, they find it harder to compete with newer and more attractive local facilities for patients. Aging facilities with outmoded services also make it harder to maintain a high-quality, high-morale workforce. CHCs are finding it increasingly difficult to recruit enough health professionals to keep up with 7 percent growth in medical visits, 36 percent growth in dental visits, and 76 percent growth in mental health visits between 1999 and 2004.[14] Many public hospitals and clinics are struggling to hold onto their pharmacists, translators, and IT workers; they are forced to compete with other employers that can offer higher pay and more amenities.

Many of the 2006 meeting's presenters highlighted the contribution of the federal government's Healthy Communities Access Program (HCAP) in helping safety-net providers integrate their services and improve their outreach and IT capabilities. The need for a special program to increase collaboration and develop better systems of care for vulnerable populations was a major recommendation in the 2000 report and contributed to the development of the Community Access Program (CAP) in 2000, the demonstration program on which HCAP was modeled. Regina Benjamin, founder and chief executive officer of the Bayou La Batre Rural Health Clinic, in Alabama, testified about how HCAP contributed greatly to the number of survivors in her community in the aftermath of Hurricane Katrina. Earlier HCAP grants had helped local providers forge critical long-term relationships and expand outreach—capabilities that made a major difference in saving lives and providing emergency services. Under HCAP, more than $400 million was invested to help community-based organizations strengthen health services for the under- and uninsured. The program was defunded in 2006. It remains to be seen how many of the programs launched and supported by HCAP will survive. Safety-net providers with the greatest need may be the least likely to find new money to build on what HCAP nourished.

In spite of these challenges, safety-net providers, with their special expertise in caring for the poor and uninsured, continue to improve their health IT and quality improvement programs, spurred by the requirements of a more demanding health care marketplace. Patricia Gabow, CEO and medical director of the highly regarded Denver Health, reminded the IOM audience that safety-net institutions are built on two pillars: caring for the special needs of the entire population (that is, trauma care and disaster preparedness) and caring for the needs of special populations. Both missions remain critical and must be maintained.

Tracking The Changing Safety Net

The 2000 IOM report found that the federal government lacked any comprehensive, coor-

dinated ability to track and monitor the changing status of America's health care safety net and its success in meeting the needs of our most vulnerable populations. The report underscored the critical need for better, more reliable data in these areas. In response, the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) launched an effort in 2002 to help track and monitor the changing status of safety-net providers. Although this effort was a meaningful undertaking, a limited budget and changing priorities brought the project to a close in 2004.

AHRQ/HRSA surveys confirmed wide variations in the strength, effectiveness, and reach of safety-net organizations across the country, however. The project found little systemic cohesion in how the safety net functions, but rather a patchwork of different providers, resilient and surviving, whose cost structure and impact on the populations they serve were hard to quantify.

The committee noted with regret that no federal entity is yet dedicated to reviewing and assessing the safety net's changing structure and performance. Health care reform and insurance expansion are again front-burner issues for states and the federal government. As part of that laudable goal, states and communities must look at ways to ensure that the poorest and most vulnerable citizens are not left worse off than they were, as a result of these changes. Being able to give decision-makers at all levels better information about how to do that would be both useful and timely.

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NOTES

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