Portraits of the Safety Net:
The Market, Policy Environment, and Safety Net Response

Stephen A. Norton
The Urban Institute

Debra J. Lipson
The Alpha Center

Occasional Paper Number 19
This report is part of the Urban Institute’s Assessing the New Federalism project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

The project has received funding from the Annie E. Casey Foundation, the W.K. Kellogg Foundation, the Robert Wood Johnson Foundation, the Henry J. Kaiser Family Foundation, the Ford Foundation, the John D. and Catherine T. MacArthur Foundation, the Charles Stewart Mott Foundation, the David and Lucile Packard Foundation, the Commonwealth Fund, the Stuart Foundation, the Weingart Foundation, the McKnight Foundation, the Fund for New Jersey, and the Rockefeller Foundation. Additional funding is provided by the Joyce Foundation and the Lynde and Harry Bradley Foundation through a subcontract with the University of Wisconsin at Madison.

The nonpartisan Urban Institute publishes studies, reports, and books on timely topics worthy of public consideration. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

The authors would like to thank John Holahan, Joshua Wiener, Steve Zuckerman, and Alan Weil for their valuable comments on earlier drafts.
Assessing the New Federalism

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, job training, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute’s Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.
Contents

Introduction  1
  Highlights of the Report  3

Denver, Colorado  4
  Highlights  4
  Structure of the Local Safety Net  5
  Need/Demand for the Safety Net  5
  Public Policy  6
  Competition and Safety Net Provider Responses  7
  Outlook for the Future  8

Miami and Tampa, Florida  9
  Highlights  9
  Structure of the Local Safety Nets  9
  Need/Demand for the Safety Net  10
  Public Policy  11
  Competition and Safety Net Providers’ Responses  12
  Outlook for the Future  14

Boston, Massachusetts  15
  Highlights  15
  Structure of the Local Safety Net  16
  Need/Demand for the Safety Net  16
  Public Policy  17
  Competition and Safety Net Providers’ Responses  19
  Outlook for the Future  19

Detroit, Michigan  20
  Highlights  20
  Structure of the Local Safety Net  21
  Need/Demand for the Safety Net  22
  Public Policy  23
  Competition and Safety Net Providers’ Responses  24
  Outlook for the Future  25
El Paso and Houston, Texas  25
Highlights  25
Structure of the Local Safety Nets  26
Need/Demand for the Safety Net  27
Public Policy  27
Competition and Safety Net Providers’ Responses  29
Outlook for the Future  30

Milwaukee, Wisconsin  31
Highlights  31
Structure of the Local Safety Net  31
Need/Demand for the Safety Net  32
Public Policy  33
Competition and Safety Net Providers’ Responses  34
Outlook for the Future  35

Bibliography  37
Notes  39
About the Authors  41

Introduction

The health care safety net consists of inpatient and ambulatory health care providers that are legally obligated to provide care for those who cannot afford to pay for it (Lipson and Naierman 1996). It includes public and private nonprofit hospitals (often teaching hospitals), public health departments, and community health clinics (CHCs), including federally qualified health centers (FQHCs)—clinics entitled by federal law to receive cost-based Medicaid reimbursement because they meet certain criteria for community involvement and are dedicated to providing care to all in need. These safety net providers report that they are experiencing stress because of market and policy changes that threaten their ability to continue providing care to the uninsured (Andrulis 1997; Fishman and Bentley 1997; Norton and Lipson 1998).

According to safety net providers, this stress is largely attributable to three factors. The first is the growth of managed care within public and private markets. Safety net providers have suggested that nontraditional Medicaid providers, including for-profit hospitals, have expanded into the Medicaid market as a result of the penetration of managed care and resultant declines in payment rates. This increased competition threatens an important source of revenue that subsidizes care for the uninsured. The second factor is the reduced disproportionate share hospital (DSH) payments for inpatient care and cost-based reimbursement of FQHCs. Safety net providers note that these revenues are essential to their success and often forestall financial disaster. The third factor is the increased demand for uncompensated care. Safety
net providers are legally bound to care for the uninsured, and greater numbers of uninsured patients elevate both the demand for safety net services and the financial burden that the safety net faces.

This report is part of a larger analysis designed to understand how these market changes are affecting safety net providers. The information in this report is derived from site visits in which analysts interviewed representatives of major safety net providers in 17 communities in 13 states during 1996 and 1997, as part of the Urban Institute’s Assessing the New Federalism project. Senior managers at major safety net hospitals, FQHCs, and local health departments as well as other key public officials were interviewed to assess how various market and policy changes were affecting safety net institutions and how these institutions were responding to such changes. A companion report provides a synthesis of the major conclusions (Norton and Lipson 1998).

In this report we provide richer site-specific detail for eight communities in six states: Boston, Massachusetts; Denver, Colorado; Detroit, Michigan; El Paso and

<table>
<thead>
<tr>
<th>Table 1</th>
<th>State- and Community-Level Data on Selected Assessing the New Federalism Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>Colorado</td>
<td>Denver</td>
</tr>
<tr>
<td>Florida</td>
<td>Miami</td>
</tr>
<tr>
<td></td>
<td>Tampa</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Boston</td>
</tr>
<tr>
<td>Michigan</td>
<td>Detroit</td>
</tr>
<tr>
<td>Texas</td>
<td>El Paso</td>
</tr>
<tr>
<td></td>
<td>Houston</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Milwaukee</td>
</tr>
<tr>
<td>U.S. Total</td>
<td>NA</td>
</tr>
</tbody>
</table>

b. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute’s TRIM2 microsimulation model. Excludes those in families with active military members. “Low-Income” defined as those with incomes less than 200 percent of the federal poverty level (FPL).
c. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute’s TRIM2 microsimulation model. Excludes those in families with active military members. “Poverty Population” defined as those with incomes less than 100 percent of the FPL.
d. HCFA, 1996.
f. The proportion of the population with private insurance that are HMO enrollees. InterStudy, 1996.
g. Computed based on 1995 AHA data. Based on the county within which the ANF community resides.
h. Site visits revealed that HCFA data from which this information was drawn significantly overestimated the amount of DSH expenditures in 1995. See text for details.
Houston, Texas; Miami and Tampa, Florida; and Milwaukee, Wisconsin. As the data in table 1 indicate, there is significant variation among these communities, in market characteristics, such as managed care penetration in both the private and public markets, and in policy environments, such as the state’s commitment to providing care for low-income, uninsured residents and DSH payments to inpatient providers. Boston, for example, is in a state where generous public coverage programs and a very large state charity care and bad debt pool protect safety net providers against financial strain. Milwaukee is in a state with low rates of uninsurance and a long history of Medicaid managed care. Detroit is in a state with relatively few uninsured residents and low levels of managed care in the commercial market. Denver, El Paso, Houston, Miami, and Tampa, on the other hand, are in states with limited public coverage programs, many uninsured residents, and relatively small DSH programs compared with the level of uninsurance.

In this paper we first provide a summary of the major factors affecting the safety net in each of the selected sites, with a brief discussion of the implication of state and market characteristics on care for the uninsured. Next, we provide a brief overview for each community, with information on the structure of the safety net, demand for safety net services, public policy affecting the safety net system including policy regarding Medicaid managed care and local financial participation in the safety net, and changes in competition and safety net provider responses. Each section ends with a discussion of the future outlook for the safety net system in the community.

Highlights of the Report

These eight communities illustrate the striking differences in community circumstances under which safety net providers operate, as well as the differences in how safety net providers and state and local governments are responding to these changes. Perhaps the most striking finding is that safety net providers in all sites were attempting, with varying success, to reorganize operations to compete effectively in the new health care market. Of great concern, however, was how these changes affected the ability of safety net providers to continue providing historic levels of care to the uninsured.

The community safety nets that were under the least stress were in Boston, Detroit, and Milwaukee. In Boston, the safety net has not yet been threatened by for-profit competition and has adapted well to managed care penetration in both the Medicaid and private markets. Boston also benefits from strong public support of the safety net through a large, long-standing bad debt and charity care pool.

In Detroit, the health care market has benefited from the prevalence of indemnity products, a low for-profit presence, and low penetration of Medicaid managed care. However, the state is planning a rapid shift into Medicaid capitation, and if this shift does not reap the expected savings, budget pressures may cause the state to lower its Medicaid eligibility standards and curtail other public coverage of the uninsured.

In Milwaukee, the rate of uninsurance is low, the for-profit presence is limited, and there is a generous county program for the uninsured. But the main safety net hospital has closed, and observers are concerned that the county’s support for its
public insurance program will wane. Currently, this program is relatively generous, but if local support shrinks, so will state funds.

The other sites are more affected by market changes and the local policy environment. In Denver, eligibility for the state Medicaid program is limited, resulting in high demand for safety net services. This demand has been kept in check by six years of unprecedented economic growth and very high levels of employer-sponsored coverage. In addition, safety net providers have maintained their dominance during the transition to Medicaid managed care. But this dominance is vulnerable given the state’s limited commitment to caring for the uninsured and the likelihood that economic prosperity will not last forever.

The Miami and Tampa safety nets are both threatened by high market penetration of commercial managed care and high for-profit market shares. In addition, Miami and Tampa have a limited Medicaid program and a low percentage of poor and near-poor residents with private insurance. The safety net providers have tried to reposition themselves to survive in the increasingly competitive market, but with only limited success. Because both sites rely heavily on local funds, and because the state’s commitment to serving the uninsured is limited, the ability of these providers to keep up with future demand for uncompensated care is in question.

The safety nets in Houston and El Paso are potentially the most vulnerable of all the sites described here. With an extremely high percentage of for-profit providers in the market, safety net providers are already losing Medicaid market share and seem ill-prepared to stem the tide, let alone reverse it. The high share of immigrants, particularly in El Paso, makes the situation more ominous. As federal welfare reform and associated legislation reduces the eligibility of certain immigrant groups for benefits, there will be greater pressure on hospitals and emergency rooms for uncompensated care. Moreover, the safety nets in both sites are highly dependent on local funds, support for which seems to be diminishing, and the state’s limited commitment to serving the uninsured is unlikely to yield compensatory support as local support shrinks.

---

**Denver, Colorado**

**Highlights**

The safety net system in Denver faces high demand for services and competitive pressures resulting from the movement toward managed care in both the commercial and Medicaid markets. While safety net providers indicate that they face significant financial pressure, most have not reduced services for the uninsured, in large part because of the strategies safety net providers have developed and implemented to counter the market forces that threaten them.

The most important strategy has been the safety net’s concerted efforts to position itself in an increasingly competitive health care market. First, the largest safety net provider, Denver Health and Hospitals (DHH), has transformed itself into a vertically integrated organization culminating in reorganization in January 1996. Concerned that the constraints of the city’s administrative and personnel structures were hampering DHH’s ability to respond quickly to changes in the health care mar-
ket, the hospital’s board requested and received administrative independence from the city. Second, a coalition of safety net providers developed Colorado Access, a managed care organization that served more than 50 percent of the state’s Medicaid HMO enrollees in 1997. The presence of the safety net–based Medicaid managed care organization has ensured that safety net providers are able to maintain their Medicaid patient base.

**Structure of the Local Safety Net**

The main source of care for the medically indigent in the Denver metropolitan (Metro) area is DHH, a system of 10 FQHCs linked to the Denver Health Medical Center (DHMC). DHH clinics provide ambulatory care in the Metro area. They also provide immunizations, screening, and other public health functions typically performed by local health departments. DHMC, which accounted for 48 percent of the uncompensated care charges in the Metro area in 1995, is also the site of Denver’s consolidated trauma services (Colorado Hospital Association 1996). Other important safety net hospitals in the Metro area are University Hospital (UH)—accounting for 27 percent of uncompensated care in the Metro area in 1995, serving the indigent of the Denver suburbs and the rest of the state, and functioning as the specialty referral center for the DHMC clinics—and Children’s Hospital (CH), which delivers relatively small amounts of charity care overall but provides children’s specialty care for both DHMC and UH.

In recent years there has been a shift in the distribution of uncompensated care in the Metro area, with DHH’s total declining slightly (from $73.4 million to $72.4 million between 1992 and 1995) and UH’s more than doubling (from $18.4 million to $41.5 million over the same period). Institutional changes implemented at DHH may explain some of these changes. Because DHH has both extensive primary and tertiary care capabilities, as well as extensive flexibility, it may have become more proficient at managing care for the indigent. This reduction may also reflect DHH’s increased efforts to collect payments. The growth in UH’s levels of charity care may be because UH serves the suburbs, where respondents indicated there was significant population growth.

A network of nonprofit community clinics also provides primary care and referrals for the medically indigent population in the Metro area. The largest of these are Clínica Campesina, Salud Family Health Centers, and the Metropolitan Denver Provider Network. In addition, Colorado has a state-subsidized medical services program for the indigent: the Colorado Indigent Care Program (CICP). This program, funded out of DSH payments and state general revenues, provides partial payment to providers to cover the cost of care for low-income U.S. citizens and legal aliens who are Colorado residents or migrant farm workers, are uninsured, and are not eligible for Medicaid.

**Need/Demand for the Safety Net**

The state maintains a relatively limited Medicaid program, and as a result demand for safety net services is high. Although the uninsurance rate in Colorado was slightly lower than the U.S. average in 1995 (14.1 percent compared with 15.1 percent),
the percentage of the population who had incomes below 200 percent of the federal poverty level and who were uninsured was higher in Colorado (27.2 percent) than in the nation (24.7 percent), which tracks more closely with the population of major cities (see table 1). While no reliable information regarding uninsurance rates in the Metro area is available, the fact that the low-income population in Colorado are uninsured at a higher rate than the U.S. generally may indicate that demand for safety net services is higher in Denver than in the state as a whole.3

The evidence regarding recent changes in the number of uninsured is mixed. Local respondents indicated that the number of uninsured in Colorado, and Denver more specifically, may be rising because of changes in the local economy. While Denver’s economy is currently strong, respondents indicated that many of the newly created jobs are in the small business sector or are part-time jobs, which typically do not offer health insurance benefits. Data on CICP indicate that the uninsured population is rising, with CICP users increasing by 40 percent between 1994 and 1996.

Public Policy

Medicaid managed care has a long history in Colorado. The state began operating its Primary Care Physician (PCP) case management program under a Section 1915(b) federal waiver in 1983. As of 1993, half of the state’s Medicaid population was enrolled in managed care of some type, with the majority in the PCP program. Only recently, however, has there been a shift towards capitated care. As of 1996–97, slightly more than one-quarter of Medicaid enrollees were enrolled in capitated plans. Colorado recently established a goal of enrolling 75 percent of its Medicaid enrollees in managed care programs by 2000. However, the enabling legislation is unclear about whether this goal of 75 percent includes only capitated managed care or PCP enrollment as well. Most interviewees believed that the way the state implements its new managed care initiative will determine the future stability of the safety net. If the state encourages non–safety net HMOs to participate in the Medicaid process, the safety net is likely to suffer, because it depends so heavily on Medicaid for revenues and on its current dominance in the Medicaid managed care market.

Another major cause of concern for safety net providers is DSH funding. In 1997, the single most important source of funding for DHH was expected to be CICP and DSH monies, which provided nearly one-third of the organization’s revenues. Although UH and CH are less dependent on DSH and CICP funds than DHH, they still rely heavily on them. Colorado currently receives a federal allotment of $300 million, and the state targets DSH funds toward the major safety net institutions, but the state keeps a significant share of the additional federal matching dollars (about 35 percent in 1996–97) for general use. Colorado has also chosen not to spend up to the DSH state cap for federal matching funds, primarily because legislators are concerned that getting more federal money might stimulate program expansion, which—if DSH payments are reduced in the future—would force the state to either cut back or make up the difference with state funds. An additional reason is the effect DSH funds have on the state’s overall budget, given Colorado’s complex revenue and spending limitations.
While the state does not plan to increase support for indigent care through the DSH program, it has passed a number of initiatives that should help curb the demand for free care and thus reduce the safety net burden. The largest of these is the state’s expansion of the Children’s Basic Health Plan. In February 1998, Colorado received federal approval for the state’s Children’s Health Insurance Program (U.S. Department of Health and Human Services, February 18, 1998). According to state estimates, the expansion aims to cover 40,000 by July 1999 (BNA, May 4, 1998). Other initiatives include a state-only program, which covers current Medicaid clients in specific vulnerable groups who would otherwise be disqualified for Medicaid by the immigrant exclusions of Supplemental Security Income (SSI) and Temporary Assistance for Needy Families (TANF), and a number of small programs (such as a Medicaid buy-in option for former TANF recipients to extend Medicaid coverage indefinitely after they return to work and a pilot Medicaid buy-in program that provides indefinite eligibility for disabled persons returning to work.)

**Competition and Safety Net Provider Responses**

Both the penetration of commercial managed care and the presence of for-profit inpatient institutions have significantly increased the level of competition for privately insured and Medicaid patients. Commercial managed care is well-developed in the Metro area. In 1996, almost 42 percent of the privately insured were enrolled in capitated plans. In 1995, for-profit hospitals represented only 13 percent of the total inpatient institutions in Denver county, slightly less than the national average (table 1). But these for-profit institutions are reportedly aggressive enough to threaten safety net providers’ private-pay and public patient base.

Virtually all safety net providers have attempted to cut costs, either through the reduction of unit costs or the management of care for the uninsured. DHH’s reorganization, for example, was primarily motivated by a need for flexibility in staffing and purchasing decisions. In addition, the integration of the primary care system with the hospital at DHH has helped the administration implement changes in clinical behaviors that increase efficiency. New information systems help coordinate patient care between the clinic and the hospital, allowing DHH not only to track patients but also to monitor and evaluate physician clinical practices and outcomes. Through these changes, DHH is increasing the efficiency and accountability of the institution.

UH implemented a plan to assess how much an investment in primary care for uninsured patients would reduce admissions and associated expenses. Working with Kaiser Permanente, UH instituted CU Care. This is an HMO-type service for uninsured people eligible for CICP. Preliminary results indicate that, for people enrolled in CU Care continuously for six months, hospital admissions and total patient days (and costs) were reduced below the level of the six months preceding CICP. However, the patchwork nature of the eligibility system, whereby the same person is Medicaid eligible one month (receiving services elsewhere) and CICP eligible another month, creates care discontinuities that are a significant barrier to achieving real cost savings.
Safety net providers are also attempting to diversify their revenue sources. DHH has developed special initiatives, including various managed care products designed for the non-Medicaid population, a health care program for prisoners, a substance abuse clinic for the state called SIGNAL, and sexually transmitted disease and AIDS programs that treat patients in their homes whenever possible and for as long as possible. These initiatives, some of which are joint ventures with for-profit organizations, promise to bring in additional revenue and meet patient needs more effectively. One community clinic on the outskirts of the Metro area is attempting to generate more third-party billing by attracting more privately insured patients.

Finally, and perhaps most important, the safety net has developed a managed care organization—Colorado Access—which was designed to help it compete in the Medicaid market as capitation increases in Colorado. Effective January 1996, DHH merged its own Medicaid managed care plan with Colorado Access, a network that consists of the primary safety net providers in the Metro area (including UH, CH, and DHH), as well as the Colorado Community Managed Care Network, which includes most of the community and migrant health centers in the state.

**Outlook for the Future**

In 1997, local sources indicated that access for low-income individuals has increased significantly since the late 1980s. The Medicaid market is now considered financially attractive, and a broader range of providers are willing and even eager to serve Medicaid enrollees. But though the major safety net provider in the market has maintained its commitment to the uninsured, other providers have recently reduced services to the uninsured. UH, for example, has cut staff at its outpatient clinic that serves the uninsured. As a result, the total number of visits to the clinic has declined, the waiting time for nonemergency appointments for the uninsured has increased, and the subsidized pharmacy program, which used to serve all indigent patients, is now limited to current UH patients. FQHC staff also indicated that, as clinics attempt to increase the number of clients covered by third-party payers, the slots available for the uninsured will decrease, reducing the uninsured’s access to health services.

Despite significant pressures, safety net providers so far remain viable. For CH and UH, operating margins have actually increased in recent years. For DHH, margins have declined but are still positive. Contributing to this financial success have been efficiency gains, the development of Colorado Access, and continuing state support. Local sources indicate that safety net health clinics in Colorado are also currently faring well. Cost-based reimbursement for services, Bureau of Primary Health Care Grants, FQHC add-on payments for capitated Medicaid enrollees, and CICP funding for the low-income uninsured provide a stable financial base.

However, the success of the safety net is built on six years of unprecedented growth in the economy, a decline in the growth of health care costs, and the safety net’s current dominance in the Medicaid managed care market. The future outlook is largely dependent on four factors. First is the state’s new managed care initiative. As more providers enter the capitated managed care market, issues such as the allocation of default assignments, the distribution of patients between the primary care
case management program and HMOs, and the level of capitated rates will become very important. Moreover, unlike other states, Colorado does not yet have policies providing special protections for safety net provider–based managed care organizations. The second factor is increased competition in the Medicaid market generally, which is likely to put a strain on the safety net coalition that created Colorado Access as potentially divisive issues—such as cost control, administration of claims, and allocation of patients among institutions—emerge. The third factor is the extent to which the state continues to support the safety net. The fourth factor is the demand for safety net services. If the current growth in the economy slows down or the percentage of uninsured patients increases, the safety net hospitals risk significant increases in service demand because of the state’s limited Medicaid program.

Miami and Tampa, Florida

Highlights

Florida has one of the highest percentages of uninsured residents in the country (19.2 percent, compared with 15.5 percent for the nation). While it has the fourth-largest Medicaid enrollment (2.2 million) among all states, Florida’s per capita spending on Medicaid ranks 46th nationally—one of the lowest in the country. And despite having a nationally renowned health insurance program for uninsured children ineligible for Medicaid, nearly a half-million children remain uninsured. As a result, demand for safety net services from poor and low-income residents is very high. At the same time, safety net providers face stiff competition as a result of a significant for-profit hospital presence and mature Medicaid and commercial managed care markets.

Despite stiff competition and the high demand for safety net services, safety net providers have maintained their commitment to the uninsured, in part because local support for the safety net has increased significantly. City, county, and local health taxing districts provide the backbone of the health care safety net in Florida, providing hundreds of millions of dollars each year from local sales and property taxes that help hospitals and clinics provide free or low-cost care to the uninsured.

Structure of the Local Safety Nets

Health care for the uninsured in Florida is supported through county, city, state, and federal funds, supplemented by the provision of uncompensated care by private hospitals and physicians. By statute, Florida’s counties are responsible for providing health care to indigent citizens. However, many counties provide little or no direct funding for indigent care, particularly for hospitalization, and few counties own or operate a hospital. Since the 1930s, Florida has allowed cities and counties to establish special health care taxing districts. There are currently 21 such districts in the state, raising from $2 million to $90 million from property or local sales taxes each year. Most of the taxing districts use their revenues to support the major public hospitals, from which most uninsured people receive care. The rest distribute the funds among other hospitals providing uncompensated care.
In Dade County, which raises more funds for indigent care from local taxes than any other county in the state, virtually all the funds are allocated to the Public Health Trust, which owns and operates Jackson Memorial Hospital, one of the largest hospitals in the country and the major provider of uncompensated care in Dade County. Many private (nonprofit and for-profit) hospitals deliver uncompensated care as well. Dade County also has at least six major and numerous smaller community health centers that provide free or low-cost ambulatory care to hundreds of thousands of patients each year.

Hillsborough County uses its local health care taxes to provide health coverage to nearly two-thirds of its uninsured low-income residents through a unique program, the Hillsborough County Health Care Plan (HCHCP). Developed in 1991 and implemented in 1992, HCHCP was designed to reduce the double-digit growth rate of uncompensated care costs faced by inpatient providers. Financed through a half-cent sales tax, the program provides insurance coverage to all legal residents with incomes below 100 percent of the federal poverty level who are not eligible for Medicaid or other health insurance without premium contributions.

In 1995, the HCHCP provided services to 27,000 individuals. The program contracts on a risk basis with four provider networks (one per geographic area within the county) to provide inpatient and outpatient services to HCHCP beneficiaries within a global budget negotiated annually with the county. Tampa General Hospital (TGH) participates in all four networks as a specialty service provider, but only in one is it the primary tertiary care facility. The program has redistributed the delivery of indigent care among providers and relieved some of TGH’s indigent care load. TGH officials cited HCHCP as a key factor in its survival and further noted that the program gave TGH an advantage by requiring that all four geographic networks contract with TGH for specialty services. For those who remain uninsured, the major safety net hospitals in Hillsborough County are TGH and St. Joseph’s Hospital, while two FQHCs provide ambulatory care.

**Need/Demand for the Safety Net**

Florida’s Medicaid program is relatively limited, with eligibility standards that are low by national standards. In 1994, 40 percent of the population below 150 percent of the federal poverty level had Medicaid coverage compared with 51 percent nationally (Rajan 1998). Although the Healthy Kids program, which currently provides health coverage to uninsured low-income children in 17 counties in the state, is helping to reduce demand for free care in those counties, the program remains relatively small. At the same time, the percentage of the population with incomes below 100 percent of the federal poverty level who were covered by private insurance is lower than the national average (14.6 percent compared with 17.3 percent nationally in 1995—see table 1).

As a result, the percentage of Florida’s population that was uninsured was one of the highest in the country in 1995. The percentage of the population with incomes less than 200 percent of the federal poverty level that is uninsured—which tracks more closely with the uninsured population of major cities—was almost 30 percent, considerably higher than in the nation (nearly 25 percent—see table 1). With such
a large percentage of the population living in poverty, Miami likely has an even higher uninsurance rate. Tampa, which has a smaller percentage of the population living in poverty, would be expected to have a lower rate of uninsurance than Miami.

However, a significant extension of coverage is likely to reduce the demand for safety net services considerably. On March 5, 1998, Florida received federal approval for the state’s Children’s Health Insurance Program (CHIP) (U.S. Department of Health and Human Services, March 5, 1998). Under CHIP, Florida will expand Medicaid to cover children ages 15 through 18, up to 100 percent of the federal poverty level, and its preexisting Florida Healthy Kids Program will cover children with family incomes up to 185 percent of the poverty level (Florida Agency for Health Care Administration 1997). Since the plan’s approval, the governor and the legislature have agreed to expand health care coverage to a quarter-million children. Of the $344 million in projected expenditures for the new programs, $209 million will be provided by the federal government. The state will contribute $119 million, two-thirds of which will come from the state’s settlement with the tobacco industry (BNA, June 8, 1998).

**Public Policy**

Florida has been very aggressive in its movement toward managed care for the Medicaid population. As of 1996, approximately 400,000 out of 1.5 million Medicaid beneficiaries were enrolled under capitated contracts—27 percent compared with a nationwide average of 24 percent. This rate undoubtedly increased because of a law passed in 1997 (SB 886) that allowed Medicaid officials to mandate enrollment in either MediPass (the state’s case management program for primary care) or an HMO/prepaid health plan for all new recipients who do not make a specific enrollment choice. In addition, payment rates have decreased as the legislature has lowered the maximum rates that could be paid to HMOs/prepaid health plans. This, in turn, is likely to cause plans to pressure providers into accepting lower reimbursement rates. Although the state provides extra incentives for HMOs to contract with safety net providers, all providers indicated that the movement to managed care posed a significant threat to their revenue streams.

Other aspects of the state’s Medicaid program are changing, and their effects on the safety net are unclear. For example, the state’s recent switch to competitive bidding within its capitated Medicaid program resulted in new plans participating, including one sponsored by a statewide group of FQHCs. On the other hand, greater competition and limits on the numbers of members that can enroll in each plan may make it difficult for plans owned by safety net hospitals to maintain sufficiently high levels of Medicaid membership. Also, Florida requires that all plans become commercially licensed HMOs, and establishing criteria for licensure that could prove difficult for some of the safety net providers to meet (e.g., maintaining large financial reserves).

Florida’s direct financial support for the safety net is provided through DSH funds. The state spent about $334 million in 1995 on DSH payments to hospitals serving high proportions of Medicaid and uninsured individuals ($369 million in FY 1996–97). But as of 1995, the state’s DSH spending represented only 5.5 percent
of total state Medicaid spending, considerably lower than that for the United States as a whole (12 percent). Also, Florida’s provision of DSH funds to acute care hospitals is relatively small compared with that of other states. For example, the program provided $81 per uninsured individual in the state in 1995 compared with the national average of $423 (table 1). Furthermore, almost 45 percent of Florida’s total DSH expenditures fund mental health institutions rather than acute care programs (Coughlin and Liska 1998), although the remaining funds are targeted to the public hospitals in the state. These relatively low subsidies for the uninsured leave safety net providers exposed to financial stress.

While the major safety net providers face tremendous competitive pressures, particularly for Medicaid patients, many safety net providers have weathered the storms of change reasonably well over the past few years, in large part because of increased local support for indigent care over the past five to seven years. As mentioned earlier, Hillsborough County instituted a half-cent sales tax devoted to health care in 1992; as a result, the county’s total contributions to indigent care as of February 1995 were roughly $78 million, a threefold increase over the $26 million per year contributed in 1991. A similar increase occurred in Dade County after voters approved a half-cent sales tax in 1991; in 1996, the tax raised roughly $96 million for health care.

In Dade County, the Public Health Trust and Jackson Memorial Hospital also receive ad valorem taxes, which in FY 1995–96 totaled $84 million, and federal and state grants, which total about $10 million annually. The remainder of the hospital’s $750 million budget is generated through commercial, Medicaid, and Medicare revenues, and DSH payments (Jackson Memorial Hospital receives approximately 50 percent of state DSH payments). As noted earlier, in Tampa the revenues generated through the half-cent sales tax are used to fund the Hillsborough County Health Plan.

**Competition and Safety Net Providers’ Responses**

Respondents indicated that both the penetration of commercial managed care and the presence of for-profit inpatient institutions had a significant impact on the level of pressure they experienced. The commercial managed care market is very mature in Miami and Tampa, with penetration rates of nearly 73 and 69 percent in 1996, respectively (table 1). At the same time, the for-profit presence in Dade and Hillsborough counties is large, with almost 60 percent and 45 percent, respectively, of hospitals investor-owned in 1995 (table 1). The combination of aggressive for-profit institutions and a mature managed care market means that competition for both private and public patients is fierce.

In both Miami and Tampa, hospitals have been struggling to develop affiliations that give them market strength. In response to the presence of a number of for-profit Columbia hospitals in Tampa, for example, seven Tampa Bay–area hospitals joined in 1997 to create a giant network called Baycare Health Care System. This system includes all the nonprofit institutions in the market, including St. Joseph’s, Bayfront, and St. Anthony’s, and it allows safety net providers to increase their market power.
in negotiations with HMOs and other health plans with the power to decide where patients go for treatment.

Moreover, safety net providers in our two sites have adapted to the requirements of an increasingly competitive environment by developing their own HMOs or prepaid health plans (PHPs), partnering with other HMOs or PHPs, developing networks with other health care providers to increase efficiency, and refocusing on their core missions. While the success of these initiatives is still undetermined, safety net providers expressed the hope that these strategies will help them maintain both their Medicaid and their private-pay market shares.

In Miami’s Dade County, for example, Jackson Memorial Hospital has extended its primary-care patient referral base (it now owns or affiliates with six primary care clinics); expanded an existing managed care plan (the JMH Health Plan), which recently won a contract in the Medicaid managed care bidding process; created a new managed care product in cooperation with a private managed care plan and the University of Miami Hospital; successfully lobbied the state to modify the Certificate of Need regulations so that it can convert hospital beds into swing beds; and reduced costs by cutting up to 1,000 full-time-equivalent employees. Dade County’s community clinics also have pursued a variety of strategies to maintain their competitiveness. Four major clinics formed the Health Choice Network to conduct joint purchasing, integrate management information and fiscal systems, coordinate medical directorships, and negotiate with managed care plans. The Health Choice Network has been relatively successful in negotiating contracts with hospitals and health plans because of its large base of obstetric patients on Medicaid. Meanwhile, because it no longer has to serve as a provider of last resort to Medicaid patients, the Dade County Public Health Unit has refocused its activities on family planning services, immunizations, communicable disease control, and other traditional public health services.

In Tampa’s Hillsborough County, TGH has sought to become more competitive by exploring alliances with other major hospitals, working with the University of South Florida Medical Faculty Associates to devise ways to streamline operations, creating its own Medicaid HMO, and developing an extensive network of outpatient programs and services. Except for the last strategy, however, TGH has not been very successful. In mid-1997, the hospital was privatized to help ensure its long-term survival. One possible explanation is that a significant portion of Tampa’s revenues for indigent care went to non–safety net hospitals. Also, HCHCP reduced the number of uninsured residents needing indigent care. In addition to the DSH funds it receives, the state has helped TGH survive by awarding its HMO (Heathcare), which had only about 4,000 members in early 1997, 37,000 slots in the latest Medicaid contract competition. The two FQHCs in Hillsborough County have also become more competitive. The major center recently upgraded its computer system, added staff (clinical, eligibility, and financial), revamped its quality assurance system, improved staff and physician compensation, and made a number of capital improvements. Perhaps even more significantly, both centers have become partners with, or owners of, managed care plans. For example, both centers are the designated gatekeepers for two different HCHCP networks, and the centers have contracts with several Medicaid HMOs, although they claim to be losing money on them. To reduce
their Medicaid HMO losses, the centers have joined 15 other community health centers in Florida to form the Alpha Health Plan, a prepaid health plan that won a contract in the most recent round of Medicaid HMO awards. Alpha will pay its CHCs better rates than other Medicaid HMOs, and will pursue commercial contracts as well.

**Outlook for the Future**

According to our site visit interviewees, access to care for low-income individuals has improved considerably since the late 1980s. As a result of increases in Medicaid eligibility and reimbursement that occurred in the late 1980s and early 1990s, more poor individuals can qualify for Medicaid, and a broader range of providers are willing to serve them. But among certain subgroups of the Medicaid population, access to care may be declining. For example, some state public health officials believe that Medicaid HMOs cannot adequately meet the needs of patients with chronic health problems. And while safety net providers so far are able to care for most of those who remain uninsured, access problems persist for this population as well. According to advocates for the poor in Miami, for example, a large number of low-income women and children are still not receiving health care services, especially undocumented immigrants from Central and South America and Haiti, who cannot qualify for Medicaid.

Safety net institutions, both hospitals and CHCs, face significant competitive pressures as the growth in both public and private managed care increases the interest of private health care providers in the Medicaid market. These competitive pressures, along with the large percentage of uninsured residents, places a sizable burden on local providers and on local governments. While the state maintains a relatively modest DSH program, the safety net systems in both Dade and Hillsborough counties have been fortunate to receive public support through an increase in local taxes to meet this burden.

Despite this influx of local funds, safety net providers in the two communities continue to face significant strain. In 1997, in Hillsborough County, where the local tax revenues were used to fund systems of care that include different types of providers (e.g., both inpatient and outpatient providers), most safety net providers seemed to be doing reasonably well. However, by 1998, TGH had voted for privatization, and the existing facility was slated to close and be replaced by a new 450-bed teaching hospital (American Health Line, May 28, 1997). In Dade County, where the revenues are centralized in Jackson Memorial Hospital, observers indicated that it was the community clinics, not the hospital, that were experiencing the largest strain. Without local subsidies, community clinics had less room to maneuver in such a highly competitive market. The differences in how the two areas distributed funds indicate how important it is to understand the implications of a community’s strategy for financing care for the uninsured.

An important question remains regarding local communities’ ability to maintain or increase their commitment to the safety net. The increased burden of safety net services—resulting from growth in the uninsured and competitive pressures that reduce the safety net’s ability to shoulder the burden—is likely to continue. As this
burden increases, the need for public resources will increase. Thus, the safety net systems in Hillsborough and Dade counties, which rely heavily on local taxes, are potentially very vulnerable, because the smaller the unit of government, the more circumscribed it is in raising tax revenues, particularly given recent trends in state and local relations (Kahn and Kamerman 1998). Despite its successes, for example, the HCHCP may be scaled back in the future. A significant growth in reserves (in excess of $100 million) led state lawmakers to contemplate reducing the hospital district’s ability to raise taxes in the future. This could put the HCHCP, and care for the uninsured, in jeopardy.

Moreover, it remains unclear how these financial burdens on safety net providers will affect care for the uninsured. That the largest safety net provider in Tampa voted for privatization begs a very important question: Will the institution continue to provide the same level of care to the uninsured? Just as important, will the other private institutions that provide care to patients eligible for HCHCP and Medicaid continue to do so if those patients lose their coverage? As all providers come under increasing competitive pressures, their commitment to uninsured patients will be tested.

Boston, Massachusetts

Highlights

Massachusetts has an extensive system of public insurance and a long and strong tradition of generous public support for the safety net. While the presence of aggressive HMOs and for-profit competition has increased in Massachusetts, Boston has remained somewhat insulated from these market changes because of the characteristics of its market. Given these propitious circumstances, hospitals and CHCs that comprise the safety net in Boston have not been overly concerned about their ability to provide care to low-income residents. Yet, faced with rising health care costs, increasing competition, and a growing percentage of uninsured residents, safety net providers have experienced strain, which has forced them to change their operations.

Almost without exception, safety net providers have responded quickly to these challenges. Two of the largest safety net hospitals attained operating authority, independent of their respective city governments, allowing them more flexibility in hiring, purchasing, and contracting. In addition, both hospitals have recently acquired or merged with other private, nonprofit hospitals, which will expand their patient base to include more private-pay patients. Almost 10 years ago, the community clinics in the state formed a managed care plan, the Neighborhood Health Plan (NHP), with the help of Boston City Hospital (BCH). NHP has allowed both the clinics and BCH to maintain their Medicaid patient base despite increased competition and the expansion of managed care. While safety net providers are well funded and well positioned, recent and proposed state policies and further changes in the market have raised concerns about the safety net’s ability to continue providing care to low-income and uninsured patients.
Structure of the Local Safety Net

Boston is unusual in that both of the primary safety net providers in the city received state authorization to merge with other nonprofit hospitals in 1996, becoming private nonprofits themselves. The Boston Medical Center (BMC) resulted from a merger between the publicly owned BCH and private, nonprofit Boston University Hospital. The new entity has maintained Boston City Hospital’s safety net mission but has expanded it to include the Boston suburbs. The Cambridge Hospital—once run as an agency of the Cambridge city government—acquired Somerville Hospital and became a private nonprofit called the Cambridge Public Health Commission (CPHC). These two new organizations remain heavily committed to the low-income population. Both provide approximately 50 percent of their services to Medicaid-eligible and uninsured patients. In 1997, this commitment represented $185 million each in charity care charges, representing more than 25 percent of all such charges in the state.

Other hospitals, particularly the large teaching hospitals, provide lower, but still significant, levels of charity care. Massachusetts General Hospital (MGH) and the Brigham and Women’s Hospital (BWH) were expected to provide approximately $40 million each in charity care in 1997. Beth Israel and Children’s Hospital were expected to provide $30 million and $13.5 million, respectively, in charity care in the same year. Each of these other institutions has a competitive advantage over other hospitals providing care to low-income, uninsured patients. MGH, BWH, and Beth Israel are renowned teaching institutions and have large private-pay patient bases. Children’s Hospital, as the primary provider of pediatrics services, has a virtual monopoly on pediatric care.

Ambulatory care for Medicaid eligibles and the uninsured is provided primarily by Boston’s extensive network of community health clinics. Massachusetts has 46 CHCs in all, with 26 in the city of Boston. These clinics, a number of which are associated with BMC, were principals in the NHP, the largest Medicaid HMO in the state. The local health department, which is now also an authority separate from the city, has maintained its population-based health services, such as surveillance and contagious disease efforts. However, it focuses on targeted “gap filling” rather than providing personal health services on a large scale.

Need/Demand for the Safety Net

Because it has a generous system of public coverage and relatively extensive private coverage of the low-income population, Massachusetts has a lower demand for charity care than the rest of the country. In 1994, the state’s Medicaid program covered 64 percent of the population below 150 percent of the federal poverty level, compared with 51 percent for the nation (Rajan 1998). In 1995, about 23 percent of the population with incomes below 100 percent of the federal poverty level had employer-based coverage, compared with about 17 percent in the nation (table 1).

The state’s Section 1115 waiver program, MassHealth, will further expand coverage by extending eligibility to children through age 18 in families with incomes up to 133 percent of the federal poverty level and providing subsidies for purchasing
employer-provided coverage to workers with family incomes up to 200 percent of the federal poverty level under the state’s Insurance Reimbursement Program. In addition to the Medicaid program, the state has developed three state-funded programs covering low-income individuals. The largest, the Children’s Medical Security Plan, covers approximately 33,000 children ineligible for Medicaid who live in families with incomes up to 200 percent of the federal poverty level. The second, the Medical Security Plan, provides insurance subsidies for 16,000 individuals receiving state and federal unemployment benefits. The third, CommonHealth, provides health benefits to approximately 3,500 individuals with disabilities who are ineligible for Medicaid coverage. On May 29, 1998, Massachusetts received federal approval to expand MassHealth as part of the newly enacted state Children’s Health Insurance Program. Under the state’s approved CHIP plan, MassHealth Standard will provide Medicaid coverage to children up to age 19 in families with income below 150 percent of the federal poverty level and some of the state-only programs will be subsumed in the MassHealth program (Massachusetts Division of Medical Assistance 1998).

While the public coverage system ensures that demand for charity care is not extraordinarily high, the charity care that is provided is concentrated in the greater Boston area. The nine largest hospitals in Boston provide more than half of the uncompensated care in the state. Within Boston, demand for charity is concentrated primarily in two hospitals. BCH provides almost 40 percent of the uncompensated care provided by the nine largest hospitals in Boston. The Cambridge Hospital (now including Somerville Hospital) provides almost 17 percent of the city’s uncompensated care. Together, these two hospitals provide almost 60 percent of the uncompensated care in the Boston area.

Public Policy

Although Massachusetts plans to expand capitated managed care rapidly in the Medicaid program, current penetration is still relatively low. Of 650,000 Medicaid enrollees, roughly 60 percent (378,000) were enrolled in managed care in 1996. About 75 percent of the managed care enrollees were in its fee-for-service Primary Care Clinician (PCC) program, however, and only 25 percent in capitated managed care. Thus, only 13 percent of Medicaid enrollees were enrolled in capitated care in 1996, compared with a national average of 24 percent.

The manner in which the state approaches the movement toward capitated managed care will influence the future stability of safety net providers. The largest share of Medicaid managed care enrollment is currently in the NHP, which was formed by the community clinics in Massachusetts but which was recently purchased by the commercial nonprofit Harvard-Pilgrim plan. In 1995, NHP had 100,000 Medicaid enrollees, of which 30 percent were capitated and the rest were still in fee-for-service Medicaid. If the state shifts all Medicaid patients into HMOs, NHP will likely face significant increases in competition. If the state maintains its current enrollment cap on capitated enrollment, NHP will be even more certain to lose a significant share of its patient base.

In addition to the state’s extensive public coverage programs, Massachusetts maintains five DSH programs. Three of these—Safety Net, Public Health Hospitals,
and the Free Care Pool—provide more than $500 million to hospitals and clinics that provide care to low-income and uninsured patients. These funds are extremely important to the safety net providers. The Free Care Pool provides approximately $300 million to safety net providers across the state. The Safety Net program ($42 million total) funds three hospitals: BMC ($24 million), Cambridge Hospital ($8 million), and University of Massachusetts Medical Center ($10 million). The Public Health Hospitals program ($143 million total) provides both Cambridge Hospital and BCH/BMC with some of its funds.

The Free Care Pool, the largest and most contentious of the three, redistributes the burden of uncompensated care across the state, providing more than $300 million to hospitals and CHCs that provide uncompensated care to individuals with family incomes below 200 percent of the federal poverty level. Under the former state hospital rate-setting system, funding for the pool came from uniform assessments on all hospitals and a state contribution of about $15 million a year.

Pool payments used to be made on the basis of total dollar amounts of uncompensated care. Under this system, BCH and Cambridge and Somerville Hospitals together received almost 47 percent of the Free Care Pool payments, and almost 85 percent went to 15 hospitals. At the same time, pool payments were capped as a result of 1991 federal legislation capping state DSH programs, and the gap between the amount distributed from the pool and actual uncompensated care burdens grew. As a result, hospitals that were not receiving significant pool payments faced growing charity burdens, which led many of them to challenge the distribution formula.

The state’s Section 1115 waiver program, MassHealth, reflected these concerns. Under the waiver, the state reduced pool payments to BMC and Cambridge Hospital by $70 million. Instead of these funds, the two hospitals would establish capitated managed care plans for uninsured individuals, funded through an intergovernmental transfer from the cities in which the hospitals resided and federal matching payments. In addition, the funding base for the pool was expanded. Hospitals’ payments into the pool were reduced by $100 million and private third-party payers—including HMOs and Blue Cross/Blue Shield (BCBS)—were to contribute $100 million where they had contributed nothing before. In addition, the state would increase its contribution to the pool from $15 million to $30 million. As a result of these changes, the state can expand its DSH program beyond its 1991 DSH caps (through the alternative financing of BMC and Cambridge Hospital), maintain the level of funding for BMC and Cambridge Hospital, and expand net payments to other hospitals through reducing hospital contributions and including third-party payers, expanding the tax base of the pool.

Consistent with a long history of local government support for the safety net, Cambridge and Boston have not only allowed their major public hospitals to separate themselves from the city but also have continued to provide subsidies. Despite the privatization of BCH into the new nonprofit BMC, the city pays $29 million directly toward uncompensated care (above and beyond the Free Care Pool payments) and will continue to make operating payments to the new medical center. Similarly, Cambridge Hospital was promised $7 million dollars annually from the city of Cambridge to maintain public health functions and support access during the seven years following its reorganization.
Competition and Safety Net Providers’ Responses

The managed care market in Boston is relatively mature, with nearly 55 percent of privately insured residents enrolled in capitated managed care (table 1). However, local observers indicated that the local culture, cooperation among the interrelated hospital systems, and the absence of a for-profit inpatient presence has held aggressive competition at bay.

Even so, safety net providers in the Boston area have adopted many strategies to position themselves effectively in the new health care market. In addition to the mergers and administrative separations from local government, they have expanded outpatient care, developed managed care organizations and, for the CHCs that had already formed a managed care organization, modernized their physical facilities. From 1990 to 1997, BCH expanded its clinic operations, increasing the number of ambulatory visits from 100,000 to 400,000. It also has employed a total of 70 primary care physicians and formed a primary care physician hospital organization. BCH and Boston University Hospital created Boston HealthNet together with a number of affiliated CHCs to compete in managed care and capitation. The NHP board of the CHCs is currently involved in discussions with both BMC and CPHC about partnering to prepare for the proposed expansions in Medicaid.

All safety net providers are also attempting to cut costs. Without cutting services, CPHC plans to cut costs at its merged institution by 15 percent in 1997–98 through reorganization and attrition. BMC expects to consolidate clinical services and increase efficiency by combining administrative operations. The two facilities are downsizing dramatically. Three hundred and fifty jobs have already been eliminated after the merger. BCH had already cut 200 through early retirement just before the merger. Now they are closing floors and implementing more layoffs.

Another important strategy has been to lobby the state legislature, Congress, and the Health Care Financing Administration (HCFA) for support under the Section 1115 waiver. BMC and CPHC successfully lobbied HCFA for the supplemental provision of the waiver that allowed them to maintain the state funding level despite the reduction of funds from the Free Care Pool. BMC appears to have been successful at ensuring that these supplemental payments would go directly to the hospitals and not pass through any managed care organizations as state officials would have preferred, according to reports.

Outlook for the Future

According to site respondents, access to care for both Medicaid-eligible and uninsured patients is generally good. Increased competition for Medicaid patients suggests that access for Medicaid patients is probably better than in the past. However, whether particular subsets of Medicaid-eligible patients such as the disabled have experienced any changes in access is unclear. Regarding the state’s movement toward greater use of managed care, observers indicated that access through managed care is good, though concerns were raised about the future accessibility, given the level of HMO payment rates. Because the state’s extensive uncompensated care pool reimburses hospitals for charity care, interviewees indicated that unin-
sured patients have good access to inpatient care at most institutions across the state. In Boston and Cambridge, both hospital officials and outsiders indicated that there is very good access for uninsured patients through the two safety net hospitals in the area.

Massachusetts’s safety net is one of the best funded in the United States, and the state (and cities) have been willing to maintain this financial support. In addition, safety net providers have shown themselves able to both restructure and reorganize to increase efficiency and lobby for support at the federal and state levels. Moreover, inpatient safety net providers have been able to increase their share of the Medicaid market, unlike safety net providers in many other communities.

Although the safety net is currently well positioned and well protected, a variety of factors will have a significant impact on future survival. First, how the state approaches the transition to pure capitation from primary care case management (PCCM) will have a significant impact on providers’ Medicaid patient base. If the state maintains its caps on capitated enrollment, patients who previously received care from the safety net hospitals under the PCCM program will have to seek care elsewhere. Low-income patients who are uninsured, in particular, could suffer as Medicaid funds used to subsidize the uninsured follow patients to other organizations.

Second, despite the lack of aggressive competition in the Boston market, because of the geographic overlay of hospital catchment areas, the possibility of significant competition for patients is ever present. One safety net hospital, positioned between two Boston giants, expressed concern that one of them would mount a significant challenge for patients receiving care in its system. While the local culture and cooperation among the interrelated hospital systems have apparently held such competition at bay, there is no guarantee that increasing market pressures will not undermine the unwritten compact.

What impact the increasing demands for efficiency and the transition from public to private ownership will have on the major safety net providers’ care to the uninsured is perhaps the biggest unanswered question. BCH maintains focus on community benefit by requiring any mission change to be approved by a two-thirds majority of its board—which includes city and university members and CHCs. But such approval is not impossible, given the emphasis on efficiency, information, and utilization management necessary for survival in the new market.

---

Detroit, Michigan

**Highlights**

As a state with a relatively low rate of uninsurance, one would expect to find the safety net in Michigan to be managing fairly well. Indeed, hospitals reported relatively low levels of uncompensated care, and community-based clinics in Detroit were holding their own. But with the state’s plan to enroll nearly all Medicaid enrollees in an HMO or another type of capitated managed care organization by 1999, Detroit providers and health plans—especially those that serve large numbers
of Medicaid patients—were scrambling to develop strategies that would secure them a piece of the Medicaid market.

This transition to Medicaid managed care pressured the major safety net hospitals and clinics serving Detroit’s large population of poor, uninsured individuals. Some feared that capitated Medicaid managed care would divert Medicaid patients from their institutions, as managed care organizations steered more patients toward lower-cost providers. This would diminish overall revenues and make it harder for providers to bear the costs of uncompensated care.

Most safety net providers, however, believed that they would fare well under capitated Medicaid managed care and that they would be able to continue serving the uninsured. Hospitals in particular are well positioned because of their increasing ties with physicians and clinics in the community; the relative lack of competition from for-profit hospitals (though competition among nonprofits is not insignificant); implicit financial support from the largest private health insurer in the state (Blue Cross/Blue Shield of Michigan) to cover hospital bad debt, which helps offset uncompensated care costs; and DSH payments from the state targeted to the hospitals with the greatest need.

Structure of the Local Safety Net

The uninsured population in Detroit seeks emergency and inpatient hospital care from three large hospitals: the Detroit Medical Center (DMC), Henry Ford Health System, and Mercy Hospital of Detroit. DMC is by far the largest of the three, providing about $100 million in uncompensated care. Henry Ford provides between $45 million and $50 million in uncompensated care annually, while Mercy Hospital provides $11 million.

DMC, a nonprofit academic medical center, was formed through the 1985 consolidation of six hospitals affiliated with Wayne State University. As part of this consolidation, DMC was authorized to operate Detroit Receiving Hospital (DRH), which was formerly owned by the city and at that time was in severe financial distress. When DRH was sold to the DMC system, DMC was required to carry out DRH’s mission and provide care to all who needed it, regardless of ability to pay. DMC now includes these seven hospitals, more than 40 ambulatory centers, and several ancillary operations. DMC is also the largest private employer in the city.

To provide ambulatory care to Medicaid and uninsured patients, the city-operated Detroit Health Department (DHD) runs six neighborhood primary care centers, two of which are FQHCs, and delivers a wide array of other public health services. Unlike some other large health departments, DHD has not retreated from providing direct primary care services for the uninsured, in part because the unionized labor force would oppose any mass layoffs that might result from this change in mission, but more important, because DHD is committed to ensuring access to primary care for the uninsured. Another three FQHCs operate in the city and nearly a dozen school-based clinics, sponsored by public and private health care organizations, meet the uninsured’s need for primary care services.
In early 1996, DHD began forming partnerships among four of its clinics and four other safety net hospitals (DMC, Mercy, St. John’s, and Henry Ford) to reduce the number of emergency room visits by the uninsured and resolve staffing problems at DHD clinics. DHD clinics have also established alliances with other neighborhood hospitals, both to divert cases from emergency rooms to ambulatory care settings and to facilitate referrals.

**Need/Demand for the Safety Net**

Michigan has relatively low levels of uninsurance (10.4 percent compared with 15.5 percent in the national nonelderly population in 1995) as a result of significant public and private coverage. In addition, the percentage of the population who have incomes below 200 percent of the federal poverty level and who are uninsured—which tracks more closely with the population of major cities—was lower in Michigan (19.4 percent) than in the nation (24.7 percent) (table 1). This suggests that the demand for safety net services in Detroit may be lower than in other communities across the country.

The relatively low levels of uninsurance result from a variety of factors. First, there is a strong union presence, which means that more employees have insurance. In 1995 in Michigan, 74.5 percent of all nonelderly individuals had employer-sponsored insurance, compared with a national mean of 66.2 percent (Liska et al. 1998). Second, the state has relatively broad eligibility standards for its Medicaid program. The state’s Aid to Families with Dependent Children (AFDC) income limits equal about 50 percent of the federal poverty level, compared with a national mean threshold of 39 percent. This, in combination with several other optional eligibility categories, results in 67 percent of the poor and near-poor qualifying for Medicaid, compared with a national mean of 60 percent in 1995 (Rajan, 1998). Furthermore, a pilot program was recently launched to allow former welfare recipients to buy into Medicaid by paying part of the premium.

Third, Blue Cross/Blue Shield of Michigan serves as an “insurer of last resort”; it is required by state law to provide coverage to anyone who applies during an open enrollment period once a year, and it is required to sell these individual policies on a community-rated basis. Blue Cross/Blue Shield of Michigan also operates a Caring Program for Children, a small program providing limited health benefits to about 4,500 low-income children.

For those who do not qualify for Medicaid, are not covered by their employer, and cannot afford Blue Cross/Blue Shield of Michigan’s individual coverage, there are a number of other options, all quite limited in scale. The State Disability Assistance and State Family Assistance programs, which replaced the former General Assistance Medical program, provide medical assistance to just under 12,000 low-income people. Wayne County, which includes the city of Detroit, has two programs for the uninsured: PlusCare, which serves about 40,000 poor, unemployed individuals through a managed care approach; and Health Choice, which enrolls about 4,000 low-wage workers in small firms with premiums funded in equal shares by employers, employees, and the county.
Public Policy

After failing to achieve sufficient cost reductions in the Medicaid program through a fee-for-service primary care case management program called the Physician Sponsor Program (PSP), the state announced in April 1996 its plan to enroll nearly all Medicaid beneficiaries into capitated managed care plans. Michigan’s effort goes further than managed care initiatives in many other states by enrolling groups that typically remain in fee-for-service plans, such as long-term care patients and those with developmental disabilities.

The expansion of capitated care was expected to significantly increase the percentage of the Medicaid population enrolled in capitated care, which was only 25 percent in 1996, and it caused significant concern among safety net providers. The plan was slated to begin in July 1997 in five counties in southeast Michigan, which includes Detroit. While nearly all Medicaid recipients in Detroit had been required to participate in some form of Medicaid managed care since 1990, either through an HMO or the PSP, the capitation plan caused a tremendous jolt to the Detroit health care system.

By the fall of 1996, providers and HMOs were preparing bids to serve as participating plans for the AFDC and SSI populations in southeast Michigan. Because the state simultaneously began a process to award contracts through competitive bids, plans had to make concerted efforts to submit bids with competitive rates. Competition was also heightened because all health care providers could submit bids to deliver services to Medicaid patients on a full-risk basis, on condition that they would obtain an HMO license within 12 months. (Previously, only providers already licensed as HMOs could bid.) In an effort to promote quality of care, those plans with higher points for proposed quality-of-care improvements would receive greater shares of the patients who did not choose an HMO.

Some of the FQHCs feared that their higher cost structures would force them to lose out as competitive bidding drove down capitation rates. They also feared being left out of primary care networks, as some of the managed care organizations were setting up their own physician groups. Their fears may be valid, given that the state Medicaid program did plan to allow managed care plans to pay FQHCs at rates less than full costs (which the FQHCs and the DHD believed was a violation of federal rules for 1915(b) waivers). The state has tried to assist safety net providers, however, by adding bonus points to Medicaid HMO bids that included safety net clinics in their provider networks.

Michigan’s direct financial support for the safety net is provided through DSH funds. These funds totaled more than $900 million in 1996, nearly 20 percent of the state’s total Medicaid budget. However, the vast majority of that total is returned to the state via intergovernmental transfers, financing the overall Medicaid program. Only $45 million is “real” DSH money—that is, payments made in proportion to each hospital’s volume of care for low-income patients—although it is targeted to safety net hospitals in Detroit. DMC, for example, gets about two-thirds of the $45 million, which covers almost a third of its uncompensated care burden each year. DMC officials also note that because the state agreed to keep DSH funds separate from the rates paid to capitated managed care plans and allocate the DSH funds...
directly to qualifying hospitals, hospitals do not have to negotiate with HMOs for payments to which they believe they are entitled.

While the city of Detroit provides substantial funds to the DHD (one-third of its $100 million budget), it provides no direct funds to DMC or to any other hospital for uncompensated care, although it is paying off bonds for Detroit Receiving Hospital (now the trauma care center at DMC). Wayne County provides important support for care of the uninsured through a $15 million allocation, which helps finance the PlusCare program.

**Competition and Safety Net Providers’ Responses**

Although the penetration of commercial HMOs in Michigan has grown, managed care has yet to challenge the dominance of traditional indemnity insurance products—specifically, Blue Cross/Blue Shield of Michigan. As of 1996, 17.6 percent of the privately insured were enrolled in capitated plans in the Metro area, compared with an average of 32.2 percent nationally (table 1). Although the hospital market has become more concentrated as a result of recent acquisitions, mergers, and some closures, observers indicated that aggressively competitive practices were still relatively rare. Some attributed this to the low number of for-profit hospitals in the Wayne County market.

Even so, the large safety net hospitals in Detroit (DMC, Henry Ford Health System, and Mercy Hospital of Detroit) felt pressure from third-party purchasers and from the impending Medicaid capitation plan to control costs. They have responded in four major ways: reorganizing, developing patient information systems, and streamlining internal operations; expanding primary care capacity; developing other techniques to manage the care of Medicaid patients; and forming alliances to compete for Medicaid managed care contracts.

The DMC, for example, was making tremendous organizational changes in 1996. Corporation officials announced that they would close two hospitals (Hutzel and Rehabilitation Institute) and cut 2,500 jobs over the next three years. These cuts, along with management changes, were designed to save nearly $250 million and reduce costs by 20 percent over three years. Over the past two years, DMC also has consolidated its separate governing boards, created a new management structure, started a physician-hospital organization, invested heavily in information systems, and developed both a management services organization and an independent practice association to support the physicians associated with it. Henry Ford Health System’s Health Alliance Plan (the biggest commercial HMO) has viewed the expansion of capitated Medicaid managed care as an opportunity for growth in its current Medicaid contract. At the same time, it is improving its case management systems and increasing primary care sites in certain neighborhoods to withstand potential competition. Mercy Hospital, which contracts with several HMOs, cited its biggest challenge as learning how to manage care for the SSI population, which hitherto has been served largely through the fee-for-service PSP.

The FQHCs and the DHD are concerned about the potential loss of Medicaid revenues because of likely reductions in cost-based reimbursement payments. These and other ambulatory clinics serving the poor in Detroit have responded to this con-
cern in various ways. For example, one clinic is aggressively trying to maintain or increase its managed care contracts and operations, expand and improve its facilities, and negotiate partnerships with the plans or groups that ultimately win Medicaid managed care contracts. The DHD is strengthening its ability to provide traditional public health services, though it is still firmly committed to providing direct personal care services to those insured and uninsured who have nowhere else to go.

**Outlook for the Future**

The consensus among interviewees was that access for Medicaid patients had improved considerably over the last several years, largely because of increased competition among providers for a share of the Medicaid business—both fee-for-service and managed care. However, this competition had not extended to extremely vulnerable populations such as the homeless or those with AIDS. And community health center managers were unanimous in their view that the uninsured and very high risk populations still face considerable problems gaining access to ambulatory care and specialty services.

DMC officials insist that its hospital closures and staff cuts do not pose access problems for the uninsured because all critical services (e.g., obstetric and gynecological services, now at Hutzel Hospital) will be moved elsewhere within the system. Nonetheless, service to the uninsured may be harmed if downsizing is not managed carefully.

The shift to capitation leaves two major questions. First, will the safety net be able to compete effectively enough to maintain its Medicaid clientele? Second, will the state achieve its targeted savings from capitation? If not, will it initiate cuts in Medicaid or its programs for the uninsured?

---

**El Paso and Houston, Texas**

**Highlights**

The primary safety net providers in El Paso and Houston have been able to maintain their mission to provide care to the uninsured despite a large uninsured population, a modest DSH program, and declining support from local governments for their mission. The state maintains a relatively limited Medicaid program and does not operate any other state-subsidized programs. As a result, the state has a very high rate of uninsured residents. Cities and local hospital taxing districts have traditionally provided the lion’s share of resources necessary to provide care for the state’s large population of uninsured residents. Together with DSH funds (funded through the state’s intergovernmental transfer program), these revenues account for as much as 50 percent of the safety net providers’ revenues in some areas.

But safety net providers are now facing serious challenges to serving the medically indigent. Recent reductions in local revenues and the need to compete for patients in Medicaid managed care as the state begins to implement statewide man-
aged care have increased safety net providers’ fears. Serious concerns were also expressed regarding reductions in DSH revenues.

The largest safety net providers in Houston and El Paso that were visited appeared ill-prepared to deal with an increasingly competitive market and anticipated expansions in Medicaid managed care. So far, competition for Medicaid patients has focused mostly on pregnant women in the fee-for-service system, and safety net providers have lost many of these Medicaid patients to other hospitals who market and advertise more aggressively. Further losses in Medicaid market share are expected, as safety net providers’ efforts to organize managed care systems and plans have been largely unsuccessful.

**Structure of the Local Safety Nets**

In Texas, unlike most states, a significant share of the public hospitals are hospital districts. Of these, 102 provide care to the low-income population in 113 of Texas’ 254 counties. They are freestanding government entities permitted by the state constitution to assess ad valorem taxes for providing care in their jurisdiction. These public hospitals do not receive direct grant funds from the state. Rather, a significant share of their revenues is generated locally or through the Medicaid program. In the remaining 141 counties without a public hospital district, care for the indigent is financed through the county rather than through the hospital districts.

In Houston, care for the uninsured is highly concentrated in the public medical center operated by the Harris County Hospital District (HCHD). In 1994, HCHD provided $400 million in charity care, more than double the amount provided by other providers in Houston. HCHD includes two general teaching hospitals (Ben Taub and Lyndon B. Johnson) and one rehabilitation hospital. The vast majority of ambulatory care provided to the indigent is also delivered by the HCHD, through 11 affiliated freestanding health centers (all but two of which are owned by HCHD), a dental center, and an AIDS clinic. Two other Houston hospitals provide smaller but significant amounts of charity care: the University of Texas’s Anderson Medical Center (UT) and Hermann Hospital, also affiliated with the University of Texas. UT provided $146 million and Hermann Hospital almost $91 million in charity care in 1994. The Texas Children’s Hospital, a teaching hospital affiliated with the Baylor Medical School, provided $14 million.

El Paso is similar to Houston in that care for the uninsured is provided primarily by one source, the R.E. Thomason Hospital. In 1994, Thomason provided $70 million in uncompensated care. Hospital officials indicated that half of their patient load is uninsured, accounting for almost 30 percent of the facility’s expenses. Providence Memorial Hospital and Columbia Medical Center provided $22 million and $14 million in uncompensated patient care, respectively. The principal ambulatory care providers to the Medicaid and uninsured populations in El Paso are clinics associated with Texas Tech University Health Sciences Center at El Paso, as well as with a number of stand-alone community clinics including Project Vida, Centro De Salud Familiar La Fe, Centro Medico, and Maternidad La Luz.
Need/Demand for the Safety Net

Texas has one of the highest rates of uninsured residents in the country (23.9 percent compared with 15.5 percent in the nation in 1995), suggesting that the potential demand for safety net services is very high. According to a locally sponsored survey in El Paso, approximately one-third of El Paso’s residents are uninsured. This is not surprising because El Paso is more depressed economically than many areas in the state. While no reliable information was available showing whether the percentage of uninsured residents in Houston is significantly different from that in the state as a whole, the percentage of the population with incomes below 200 percent of the federal poverty level that is uninsured—which tracks more closely with the population of major cities—was almost 40 percent in Texas in 1995, considerably higher than the national average of about 24 percent (table 1).

A major reason for its high uninsurance rate is the state’s small Medicaid program. Although the state has chosen to cover pregnant women up to 185 percent of the federal poverty level, the state’s AFDC threshold is among the lowest in the country, yielding state Medicaid enrollment of only 36 percent of the population with incomes below 150 percent of the federal poverty level (compared with the national average of 44 percent) (Rajan, 1998). The state also has one of the lowest concentrations of employer-sponsored insurance (58 percent, compared with a national average of 66.2 percent).

Recent proposed expansions could significantly reduce demand for services faced by safety net providers. In June 1998, Texas received approval to expand children’s health insurance coverage under the federal CHIP legislation. The initial plan will expand coverage to children through age 18 with family incomes up to 100 percent of the federal poverty level, in effect accelerating the Medicaid phase-in for older children (Department of Health and Human Services, June 15, 1998). Further expansion is planned, subject to approval by the legislature and the governor. So far, there are enough federal funds to cover between 800,000 and 925,000 children, assuming that the state can generate the matching funds required to draw down the federal allotment (Ullman et al., 1998). In an effort to help the state move forward with its CHIP plans, a group of public hospitals in Texas has offered to fund more than half of the state’s match requirement under CHIP (BNA, Nov 3, 1997).

Public Policy

Medicaid managed care penetration is relatively limited in Texas, with only 2 percent of Medicaid enrollees in managed care as of 1996. The state plans to increase Medicaid managed care enrollment substantially, however. In 1993, the state implemented two small pilot managed care programs in a number of counties. In 1996, mandatory managed care was expanded to three additional geographic areas, and in 1998 managed care will be expanded to Houston and Dallas. Most enrollees in the state will be phased into managed care by 2000.

The proposed expansion of managed care has raised serious concerns among safety net providers and state officials. Two hospital districts, Tarrant County and Lubbock, and a CHC-based managed care organization unsuccessfully sued the state
to halt the expansion of managed care. Moreover, although the public system in Houston expanded its clinic network, it had no commercial managed care contracts, and it failed to win a Medicaid contract in 1997. In El Paso, Thomason Hospital has been unable to develop much outpatient capacity, which bodes ill for its participation in managed care networks. Since the state saw that the failure of safety net providers to participate in Medicaid managed care would be catastrophic for these institutions, given the importance of Medicaid for their revenues, the state intervened by passing a law requiring Medicaid to contract with licensed HMOs formed by safety net providers.

The state’s Medicaid DSH program is small relative to the need for such funds. Total DSH expenditures were $1.5 billion, or 17 percent of Medicaid program expenditures in 1995, with almost 20 percent of the total used to fund mental health institutions (Coughlin and Liska 1998). Acute care DSH subsidies per uninsured were $301, compared with a national average of $423 (table 1). Even so, DSH funds are an important source of revenue for safety net providers. For the HCHD, for example, DSH funds net of intergovernmental transfers to the state were $67 million in 1996, and this constituted 20 percent of net patient revenues.

Although DSH funds are still important, safety net providers view the DSH program as an increasingly unreliable source of revenue. DSH funds have traditionally been distributed to hospitals based on the provision of Medicaid services—which, in effect, meant that those institutions that provided most of the care for the uninsured received most of the DSH funds. However, non–safety net hospitals increasingly are competing for Medicaid patients. As a result, the DSH funds are being distributed to hospitals that provide care to the Medicaid population but may not be providing care to uninsured patients at the same level as safety net providers. This situation will be exacerbated as greater numbers of Medicaid recipients are enrolled in capitated plans, because safety net providers are not yet well equipped for participation in managed care.

As noted, the taxing authority of hospital districts plays an extremely important role in providing health care for the uninsured in Texas. About 38 percent of HCHD’s revenues were generated through ad valorem taxes in 1996, as were almost 16 percent of Thomason’s. Because so much of their revenue comes from local taxes, these hospital districts and their associated hospitals are particularly vulnerable to the dynamics of local policy. In El Paso, the county commissioners appoint Thomason Hospital’s governing board and approve the hospital budget, tax rate, and debt issuances. But since, as noted, hospital relations with the county commissioners have been strained, Thomason has been kept from marketing its services and from hiring personnel with medical expertise or managed care experience.

Neither in El Paso nor in Houston have local revenues grown with need. In Houston, HCHD has seen a reduction of almost 70 percent in its local revenues between 1992 and 1995, a result of significant rollbacks in property taxes. In El Paso, the hospital district has not issued bonds since 1990. The district has been able to use DSH funds for capital improvements, but if these shrink, even capital funds would be hostage to local funding decisions.
Competition and Safety Net Providers’ Responses

Safety net providers expressed concerns about both the penetration of managed care and the presence of for-profit hospitals, both of which increase competition and reduce reimbursement. While the HMO enrollment rate among Medicaid-eligible patients remains low, certain markets have experienced significant increases in commercial managed care. In Houston, for example, the overall HMO enrollment rate nearly doubled between 1994 and 1996, increasing competition among hospitals: By 1996, 26 percent of the privately insured were enrolled in capitated plans in Houston, whereas only about 8 percent of the privately insured were enrolled in capitated plans in El Paso (table 1).

In both sites, safety net providers expressed concerns about the presence of for-profit hospitals with a reputation for aggressively competitive practices. In Houston, almost 65 percent of hospitals are for-profit institutions. In El Paso, nearly 67 percent of hospitals are for-profit (table 1). With the penetration of managed care and the presence of for-profit hospitals, competition for Medicaid patients is intense, because Medicaid is viewed as a desirable payer in both Houston and El Paso.

The primary safety net providers in El Paso and Houston are ill-prepared to compete in this market. In Houston, HCHD has been increasing its primary care capacity by adding and enlarging community health centers. Services have been shifted to these health centers to make a broader range of services available outside of the hospital. The hospital has also been attempting to develop systems to monitor care, perform utilization reviews, develop protocols, and coordinate care. But HCHD is staffed by two local medical schools, Baylor and Taub. Although the medical staff of both schools have formed a combined nonprofit organization that could potentially staff a new HMO created by the hospital, the two medical schools have not integrated their services and the clinics are divided between the two institutions. In addition, the hospital has no current managed care contracts and no experience contracting with other plans.

Other hospitals in the Houston market are better prepared for the impending movement toward Medicaid managed care. Children’s Hospital, for example, in a very sophisticated response to market changes and cost pressures, has formed five corporations—a physician network, a holding company, an internal firm, an offshore corporation, and the Texas Children’s Health Plan, a pediatric HMO. Already, 35 percent of this conglomerate’s patient days are in managed care. Hermann Hospital formed a primary care physician network, OneCare, which purchased more than 100 physician practices and signed contracts with 200 other physicians. In 1995, about half of OneCare’s revenue came from five HMO contracts paying on a capitated basis. This network is now expanding into lower-income areas, and the plan is considering such options as expanding the physician network to include more high-Medicaid practices and collaborating with other clinics, including HCHD.

In El Paso, Thomason Hospital has undertaken similar, though less extensive, initiatives. In 1996, the hospital opened its first primary care center, Centro Rayos de Esperanza. At the same time, Thomason was attempting to significantly cut costs. Staff levels have been cut for each of the past seven years, and staff have been put on “exempt status” to avoid paying for costly overtime. Moreover, the hospital is refer-
ring patients in its emergency room to its newly opened primary care facility in order to lower emergency room costs. Even so, Thomason Hospital may be even more disadvantaged than its counterpart in Houston. It has very little ambulatory care capacity and has relied on Texas Tech for physician services and patient referrals. But Texas Tech physicians have developed relationships with other private hospitals and are increasingly referring patients to those institutions rather than to Thomason Hospital. Though the hospital has opened its first primary care center, the county commissioners have still not allowed it to recruit high-level staff experienced with managed care.

**Outlook for the Future**

Houston has seen increased access to care for specific subsets of Medicaid patients (largely a result of increased eligibility among pregnant women). But there are still significant gaps in services for both Medicaid patients who are disabled or otherwise at high risk and for the uninsured in specific geographic areas. For example, although infant mortality declined in Harris County across all racial and ethnic groups between 1988 and 1992, a needs assessment conducted by a consortium of health care providers raised concerns about substance-abusing pregnant women and high infant mortality among the black community. El Paso faces unique access problems because of its deep poverty and proximity to the Mexican border. More than 10 percent of those living in El Paso live in colonias. These are neighborhoods with very poor housing and limited or no access to potable water, wastewater, disposal systems, or garbage collection—all of which greatly increase health risk. And 20 percent of persons interviewed by telephone in a 1996 Paso del Norte Health Foundation survey reported being unable to see a doctor in the past year.

Four factors are likely to have a significant impact on the future status of the safety net in Houston and El Paso. First, given relatively high demands on the safety net resulting from a meager Medicaid program, local government plays an extremely important role in funding services. Local support for the safety net appears to be waning in both of the sites we visited as ad valorem revenue has either remained constant or declined. In Texas, some counties have sought to limit their role in providing indigent care through public hospitals. In Austin, Corpus Christi, and Amarillo, for example, three hospitals have shifted to private management. In Fort Worth, the hospital district was contemplating a merger with a nonprofit hospital at the time of our site visit. Second, DSH dollars are now beginning to flow to private providers who serve Medicaid patients, and “leak” out of the providers who have traditionally received the lion’s share of DSH funds and who are badly positioned to compete.

Third, the speed with which the state moves to managed care and the help provided to safety net providers during the transition will determine the continuing viability of the safety net. Here again, lack of competitive strength could spell disaster for the safety net providers in both El Paso and Houston. A swift movement into managed care in El Paso, in particular, could leave Thomason Hospital without any significant source of revenue. The state has shown its commitment to ensuring that the safety net will not lose all of its Medicaid business as a result of moving to managed care, by passing legislation requiring that Medicaid contract with public-
hospital-formed HMOs. It remains to be seen whether this state support will be enough.

Fourth, with few exceptions, respondents felt that changes in the immigration law will have profound negative consequences on health status and health care costs in both Houston and El Paso. If the 1996 federal welfare reform forces some immigrants to lose basic necessities funded through public programs, such as food and shelter, their health will deteriorate. At the same time, immigrants are likely to avoid seeking public coverage and care for fear their immigration status will be revealed. This is particularly troubling because more than half of the obstetric deliveries in Thomason are estimated to be for undocumented aliens. If women choose not to seek timely prenatal care because of their immigration status, it could negatively affect health outcomes and raise uncompensated costs for acute and emergency care. As providers of the last resort, safety net providers will feel this burden the most acutely.

**Milwaukee, Wisconsin**

**Highlights**

Unlike other communities, Medicaid managed care is not a primary influence on the safety net in Milwaukee. Capitated Medicaid managed care has been in effect in Milwaukee for more than 12 years and nearly all AFDC-related Medicaid beneficiaries are enrolled in such plans. Safety net providers have succeeded in contracting with most Medicaid managed care provider networks. In addition, the FQHCs secured a wraparound payment from the state that ensures cost-based reimbursement from Medicaid even if they accept lower payments from HMOs.

The more important force for change was the county’s attempt to develop a market for the uninsured. Legislation in 1996 allowed the county to close the public hospital, and, at the same time, the county government revamped Milwaukee’s general assistance medical program (GAMP), which serves as the conduit for the majority of local, state, and federal funds for indigent care, and implemented a program designed to encourage the low-income population to use primary care facilities. In 1997, Froedtert Memorial Lutheran Hospital, which shared a medical campus with (and took over the functions of) the closed public hospital, was in its second year as the county’s designated safety net hospital, providing care to uninsured and GAMP-eligible patients. As of 1998, the safety net system has moved away from a single-provider model to one that will use the FQHCs and other clinics as the foundation of the system, providing primary care, acting as gatekeepers, and distributing GAMP-eligible patients among all the hospitals in the county for inpatient care rather than to Froedtert alone.

**Structure of the Local Safety Net**

Until January 1996, the county ran a public hospital, John Doyne Hospital, and its related outpatient services to fulfill its state-mandated responsibility to provide for
the care of indigent people. The hospital served as the primary source of inpatient, emergency, and, to a lesser extent, outpatient care for the uninsured. Doyne received partial payment for serving in this capacity. The county’s general assistance medical program, which had a budget of approximately $40 million annually, subsidized care for a limited group of very poor, uninsured individuals. Other selected hospitals associated with Doyne, including Froedtert Hospital and Children’s Hospital, as well as a mental health and a rehabilitation hospital, were also authorized to deliver services and to bill GAMP. Other hospitals that served the uninsured were not eligible to bill GAMP.

After Doyne’s closure at the end of 1995, Froedtert Memorial Lutheran Hospital, a nonprofit hospital located on the same medical campus as Doyne, took over the functions of the county hospital and received most of the $40 million in GAMP funds. Because most of the uninsured population was familiar with the locale, they likely sought similar free care at Froedtert. Froedtert data suggest that self-pay patients (regarded as a proxy for those who are uninsured) increased from 3 percent in 1995 to 5 percent in 1996, with uncompensated care rising from $9 million in 1995 to $26 million in 1996. Those who are uninsured and not eligible for GAMP also go to other hospitals for emergencies and sometimes for less urgent care. Apart from Doyne, Sinai Samaritan Medical Center provided the greatest amount of charity care in FY 1995 ($6.9 million).

In March 1996, the county commissioners allocated $1 million of Froedtert’s GAMP funds for a pilot program in which five community-based primary care clinics would bill for services rendered to a limited number of GAMP patients. By April 1997, 2,100 GAMP patients were in the pilot project. In early 1997, the county voted to expand the enrollment in the pilot program, added Froedtert/Medical College of Wisconsin clinics, and allowed for “other and future providers” to be included in the primary care network.

In July 1997, the county board approved the new GAMP program countywide. The program will no longer rely exclusively on Froedtert Hospital as the preferred hospital provider. Instead FQHCs and other clinics will act as the foundation of the system and provide primary care and act as care gatekeepers. The clinics will spread GAMP-eligible patients among all the hospitals in the county for inpatient care, according to their current referral patterns. Funding for each of the next two years was approved at $36.6 million, the county portion of which was $20 million.

Milwaukee has three well-established FQHCs that serve the uninsured in ambulatory care settings. These three centers run nine clinic sites serving a diverse population that includes Hispanics, Asian/Indochinese (Hmong and Laotian), African Americans, and Native Americans, as well as whites. The Milwaukee City Health Department also delivers personal and public health services to the indigent population through three clinics throughout the city and sponsors a CHC with three clinic sites. There is also a large Health Care for the Homeless program in Milwaukee.

Need/Demand for the Safety Net

Wisconsin has one of the lowest rates of uninsured residents in the country, at just 8.6 percent of all nonelderly persons in 1995. The high coverage rate of the pop-
ulation is attributable to a variety of factors. First, the state has one of the highest rates of employer-sponsored coverage and low-income private coverage in the nation. Second, it has slightly broader eligibility standards for its Medicaid program than the national average. The Medicaid program may become even broader, as the state has proposed a Section 1115 waiver program, BadgerCare, designed to provide coverage to 22,700 uninsured children and 26,100 parents.\textsuperscript{14}

While the low rate of uninsured residents translates into relatively low demand for charity care around the state, Milwaukee’s rate of uninsured residents is double that of other metropolitan areas in the state. Although Milwaukee county accounted for only 19 percent of the state’s population in 1990, county hospitals accounted for almost 40 percent of charity care statewide.

Milwaukee County’s rate of uninsured residents dropped between 1994 and 1995, probably because of a declining unemployment rate. However, it may have increased again since 1995, because of two welfare-related trends. First, the county government has reported that undocumented aliens losing AFDC coverage are increasingly utilizing GAMP services. Second, and of potentially greater significance, Medicaid is reportedly losing welfare clients because of Pay for Performance, the state’s pilot welfare reform program that started in Milwaukee in July 1996. While individuals losing welfare eligibility are still eligible for Medicaid, many former welfare recipients reportedly do not understand this. In addition, some welfare clients were removed from the Medicaid rolls inadvertently by the county’s eligibility computer system. Officials at Sinai Samaritan Medical Center believe that this error has increased its uncompensated care charges.

**Public Policy**

Medicaid managed care started in Wisconsin in 1984 in Milwaukee and Dane counties, and expanded to three other counties by 1995. Initially, only AFDC-related populations were required to enroll in managed care plans. But in 1992, the state mandated HMO enrollment for pregnant women and children who were eligible for Medicaid but were not receiving cash assistance. Those not required to enroll in HMOs include the SSI population, women who are seven or more months pregnant, and persons with severe mental health needs.

Before a statewide Medicaid managed care expansion effort that started in the fall of 1996, 150,000 Medicaid clients were enrolled in HMOs, representing 30 percent of all Medicaid-eligible residents in the state and 48 percent of all AFDC recipients, non-AFDC pregnant women, and children. Managed care penetration rates were higher in Milwaukee County than in the state generally. Efforts to enroll Milwaukee SSI recipients into managed care have been limited to voluntary enrollment in a new “primary provider program,” in which primary care providers are responsible for authorizing all referrals to most emergency, inpatient, and specialty services. Another program, called I-Care (Independent Care), coordinates medical and social services for about 2,500 SSI-related Medicaid recipients in Milwaukee.

Safety net providers in Milwaukee have fared quite well under Medicaid managed care. All three FQHCs have contracts with seven of the eight Medicaid HMOs in the county. (The eighth plan, the Family Health Plan, is a staff-model HMO, and all ser-
services are delivered by its own salaried staff.) Through their state association, the FQHCs negotiated an agreement with the state Medicaid agency in 1989 requiring the state to make wraparound payments to FQHCs if the HMO rates paid to them do not equal their full costs. Over the past several years, these cost-based reimbursements have benefited the FQHCs, allowing them to build new facilities, improve existing ones, add staff and services, and increase staff salaries.

State and federal Medicaid funds provide about half of all the funds that help Milwaukee’s hospitals provide care to low-income, uninsured persons. These funds are granted through three programs. The first and biggest is the state’s matching of Milwaukee County GAMP funds via a Medicaid supplemental payment mechanism. In 1995–96, the state provided about $20 million, or half of the GAMP budget, 60 percent of which came from federal Medicaid revenues. This will decline to $17.6 million for 1997–98 and $16.6 million for 1998–99. The other two programs are relatively small. The “regular” Medicaid DSH program provides supplemental payments to hospitals serving disproportionate numbers of Medicaid and indigent patients. Only Sinai Samaritan Medical Center is eligible for the third state program, Essential Access Community Hospital (EACH), which provides funds to Milwaukee inner-city hospitals with high Medicaid and charity care loads. Sinai Samaritan receives about $4 million in EACH grants, which does not cover its entire uncompensated care deficit (including its Medicaid shortfall). Hospital officials maintain that without the special payments, Sinai would be forced to close or at least move out of the city.

Why did Doyne close? The immediate reason was state legislation that relieved the county from having to run a public hospital. But there were several more fundamental reasons for the hospital’s closure. Its costs were high because many of its patients had serious illnesses and required many of the most expensive treatments. In addition, as the designated hospital for serving the county’s GAMP patients, it attracted a share of the city’s uninsured patients that was much higher than the state average, 10 percent of its payer mix by some estimates. These trends, combined with lack of effective leadership, led to unsustainable budget deficits. Another adverse development was that Doyne’s Medicaid market share had dropped from 29 percent to 23.5 percent between 1990 and 1995, even though its share of Medicaid days out of total inpatient days rose. Thus, when Froedtert made an offer to buy the hospital, the county commissioners readily accepted once state law allowed them to do so.

**Competition and Safety Net Providers’ Responses**

Safety net providers in Milwaukee were not, as yet, concerned about the impact of market competition on their ability to provide care to uninsured residents. This may be a result of the relatively low rate of uninsured residents in the state and the GAMP program, both of which limit the burden safety net providers face. Approximately 23 percent of the privately insured were in capitated arrangements for care in the Milwaukee metropolitan area as of 1996, less than the national average of 32.2 percent (see table 1). At the same time, the presence of for-profit inpatient institutions was relatively limited. Only 7 percent of the hospitals in Milwaukee County were for-profit in 1995, compared with 14.1 percent nationally (see table 1).
With Milwaukee County no longer legally responsible for a public hospital, Froedtert Hospital, as the primary GAMP-designated hospital, had to find a way of meeting the sudden increase in demand for indigent care, using cost-cutting strategies and other means, such as cost-shifting, to supplement GAMP dollars. It has managed to maintain its financial viability through several advantages it gained at the time of Doyne’s closing. In particular, Froedtert Hospital was able to maintain Doyne’s large patient base and provide a full range of services under one administrative structure with much lower costs. For example, Froedtert Hospital maintains only 2,400 employees, compared with the 3,500 employees that used to work at Froedtert and John Doyne combined.

At the same time, Froedtert Hospital believed it could not withstand any further growth in its uncompensated care load. Thus, it favored the step the county took of equalizing the load across hospitals and moving to community-based care. Other hospitals wanted GAMP payments to be shared without changing the conditions for serving the uninsured. But Froedtert Hospital’s view was that they should accept all uninsured patients who come to them, not just those who are eligible for GAMP. In the meantime, Froedtert Hospital loaned doctors and provided other professional expertise to one of the CHCs, diverting patients from the emergency room to a primary care setting. Sinai Samaritan Medical Center was also pushing the state and county governments to do more Medicaid outreach and do a better job of determining Medicaid eligibility among those people who were leaving welfare.

Finally, to improve their negotiating position and their ability to manage care, the three FQHCs formed an organization called Milwaukee Choice, Inc., in 1996. Their goals were to offer some joint services (e.g., an urgent care/extended hours clinic and shared specialty care) that would benefit all of them, develop the infrastructure for an organization to contract for Medicaid dental coverage, and contract collectively on a risk basis with managed care organizations.

**Outlook for the Future**

As one of the few areas of the country in which a major public hospital has closed in recent years, it will be important to track changes in access for the uninsured in Milwaukee. Preliminary observations indicate that, for GAMP-eligible residents, the new primary care system may have maintained or even improved access to care. For uninsured residents who do not qualify for GAMP, the situation may be worse.

In the short term, many respondents are optimistic that care for uninsured and GAMP-eligible residents will improve because of the new focus on community-based delivery of primary care. However, in the long term, many respondents are concerned about the reductions in the Medicaid rolls (and the consequent rise in uninsured patients) that is expected to continue as a result of welfare reform. Several respondents also believed that the Milwaukee county commissioners’ commitment to provide GAMP funding for the uninsured over the long haul is tenuous, particularly in light of their decision to close the public hospital. Without local funding, state and federal matching funds would disappear.
Bibliography


Notes

1. In Colorado, our site visits revealed that expenditures presented in table 1 on DSH expenditures from HCFA data include extraordinary payments that were provided to hospitals in the early to mid-1990s. As a result, actual expenditures in 1995 were considerably lower. See note h in table 1.

2. Unless otherwise noted, information is based on Moon et al., Health Policy for Low-Income People in Colorado (Washington, DC: The Urban Institute, 1998).

3. Data from the 1990 census indicate that the percentage of the population with incomes below 125 percent of the federal poverty level is higher in Denver (22.2 percent) than in the state as a whole (15.9 percent) (Bureau of the Census 1991). More recent data were unavailable.

4. Unless otherwise noted, information is based on Lipson et al., Health Policy for Low-Income People in Florida (Washington, DC: The Urban Institute, 1998).

5. The percentage of the city population with incomes below 125 percent of the federal poverty level was higher in both Miami (39.3 percent) and Tampa (24.8 percent) than in the state as a whole (17.4 percent) in 1990 (Bureau of the Census 1991). More recent data were not available.

6. Before this, mandatory assignment could only be into MediPass. The only exceptions to mandatory enrollment are for dual eligibles, presumptively eligible pregnant women, the medically needy, and those in skilled nursing facilities or intensive care facilities.

7. Unless otherwise noted, information is based on Holahan et al., Health Policy for Low-Income People in Massachusetts (Washington, DC: The Urban Institute, 1998).

8. Unless otherwise noted, information is based on Lipson et al., Health Policy for Low-Income People in Michigan (Washington, DC: The Urban Institute, 1998).

9. The proportion of the population with incomes below 125 percent of the federal poverty level was 52.1 percent in Detroit, compared with 28.9 percent in the state as a whole in 1990 (Bureau of the Census 1991). More recent data were not available.

10. Unless otherwise noted, information is based on Wiener et al., Health Policy for Low-Income People in Texas (Washington, DC: The Urban Institute, 1997).

11. The County Indigent Health Care Program served 22,300 individuals in FY 1995 in counties where a hospital district had not been established. Counties seeking these funds must first spend 10 percent of general county revenues, and state funds are then available for subsequent services with a 20 percent local match.

12. The percentage of the city population with incomes below 125 percent of the federal poverty level was higher in both Houston (26.7 percent) and El Paso (32.6 percent) than in the state as a whole (23.6 percent) in 1990 (Bureau of the Census 1991). More recent data were not available.

13. Unless otherwise noted, information is based on Lipson et al., Health Policy for Low-Income People in Wisconsin (Washington, DC: The Urban Institute, 1998).

14. Wisconsin has received only partial approval for BadgerCare, because the program was designed to use CHIP funds to subsidize coverage for families rather than for children only. Thus, HCFA approved only that portion of the program which covered children ages 15 to 18 in families with incomes below 100 percent of the federal poverty level, which state estimates suggest would cover roughly 2,000 children—less than one-tenth of the population BadgerCare was designed to reach (BNA, November 3, 1997).
About the Authors

Stephen A. Norton is a research associate at the Urban Institute’s Health Policy Center, where he specializes in research on the Medicaid program, maternal and child health, and those institutions providing care to the medically indigent. He is the author of a number of articles on health care. Most recently, his work has focused on assessing the impact of the Medicaid expansions to pregnant women and children on access to care, the displacement of private insurance, and provider uncompensated care burdens.

Debra J. Lipson, currently a health policy consultant in Geneva, Switzerland, at the World Health Organization, continues her work on projects related to safety net providers. She was formerly associate director of the Alpha Center, where she managed research studies on state and local health care reform, with an emphasis on the financing and organization of health services for the poor and uninsured.