

# INSTITUTE OF MEDICINE

Shaping the Future for Health



## AMERICA'S HEALTH CARE SAFETY NET

### INTACT BUT ENDANGERED

In the absence of universal health insurance, a health care “safety net” is the default system of care for many of the 44 million low-income Americans with no or limited health insurance as well as many Medicaid beneficiaries and people who need special services. This safety net system is neither uniformly available throughout the country nor financially secure. Rather, it is a patchwork of institutions, clinics, and physicians’ offices, supported with a variety of financing options that vary dramatically from state to state and community to community. Its structure and strength likewise often vary depending on the general political environment of a state or community, as well as according to the number of uninsured people and the types of health care institutions in the area. The safety net system has never been financially robust, but it has continued to survive. Recently, however, a series of changes in the structure and financing of the health care system in the United States has inadvertently caused serious problems for the safety net system and has raised the possibility that in some or even many areas, the providers that make up the safety net could be at risk.

To determine how serious these problems are and whether they really threaten the safety net system, the Institute of Medicine established a committee of experts to address the issue. The Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers was asked to examine the impact of managed care and changes in the structure of Medicaid and health care coverage and financing on the future integrity and viability of safety net providers. The committee’s report, *America’s Health Care Safety Net: Intact but Endangered*, outlines the effects of these structural and coverage changes and offers a number of recommendations that address the support of the safety net system and the need to ensure access to care for the nation’s most disadvantaged and underserved populations.

**The health care safety net serves as the default system of care for many people who fall outside the medical and economic mainstream.**

#### Safety Net Providers—Who Are They?

Safety net providers are providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients. In its report, the committee focuses on “core safety net providers.” These providers have two distinguishing characteristics:

1. either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
2. a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.

Core safety net providers typically include public hospitals, community health centers, and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers.

**Because Medicaid is the largest revenue source for many safety net providers, recent changes to the program have placed added strain on the safety net.**

## **The Changing Face of Health Care**

The health care marketplace is undergoing a major transformation characterized by a market-driven focus on competition, consolidation, cost control, and the ascendancy of managed care. Many states have converted their Medicaid programs—the single largest funding source for many safety net providers—to managed care in an effort to control budgets and expand coverage. While Medicaid managed care could potentially allow safety net providers to form provider networks as well as improve their efficiency, customer service, and general accountability to patients and payers, many safety net providers are not well equipped or flexible enough to respond to the operational demands of competitive managed care. In addition, managed care programs are not always implemented in a way that adequately ensures continuous care, provides the necessary enabling services, and supplies patients with information to allow them to make informed choices. Providers for the uninsured are at particular risk as care for Medicaid beneficiaries becomes increasingly separated from care for uninsured populations. Inadequate capitation rates and the absence of adequate risk-adjustment tools may also be forcing many safety net providers to assume substantial risk without sufficient reserves or other protections.

## **Safety Net Providers at Financial Risk**

As many of the direct and indirect subsidies that help finance health care for indigent populations are eroding, the demand placed on the safety net is increasing. For example, the Balanced Budget Act of 1997 cut Medicaid disproportionate share hospital payments—a program designed to assist hospitals that serve low-income patients—by \$10.4 billion over 5 years. The act also phases out over 5 years a subsidy that reimburses community health centers for Medicaid services on a cost-related basis. Numerous state and local funds are also being cut or frozen. Although the full implications of these changes are still unfolding, safety net providers in many communities are already feeling the impact of increasing financial pressures.

## **Geographic Variation and Monitoring of Safety Net Providers**

The strength and viability of a community's safety net are highly dependent on state and local support, state Medicaid policies, the structure of the local health care marketplace, and the community's economic health. While devolution of responsibilities to state and local governments has encouraged the development of innovative programs to care for the uninsured, geographic variation has made data tracking more difficult. Important data are often missing or inadequate. Given these circumstances, there is a compelling need for a stronger ongoing capacity to monitor the changing status of the safety net and thus generate adequate data upon which effective policies can be developed.

**Availability of care is increasingly dependent on local factors.**

## **Recommendations of the IOM Report**

### **1. Consider and address the effects of changes in Medicaid policies on safety net providers and the populations they serve, including**

- the financial stability of core safety net providers,
- the continuity of care for Medicaid patients,

- the adequacy and fairness of Medicaid managed care rates, and
- the declining ability or willingness of non-core safety net providers to provide care to uninsured populations.

**2. Review all federal programs and policies targeted to support the safety net for their effectiveness in meeting the needs of the uninsured.**

Major changes in the health care market may be altering the effectiveness of these programs. These changes include increased competition for insured patients, separation of care for Medicaid patients from that for uninsured patients, concentration of care for uninsured patients among fewer providers, and reduction of the subsidies that help support care for uninsured patients. Analysis and modification of safety net programs are essential.

**3. Take steps to improve the nation’s ability to monitor and assess the safety net’s capacity, structure, and financial stability.**

The committee recommends the formation of an oversight body that would be independent, nonpartisan, expert, and organized as an ongoing entity. Its initial activities should include

- analyzing and tracking the effects of changes in the major safety net funding programs;
- linking existing data systems and supporting the development of new data systems to assess the status of the safety net and health outcomes for vulnerable populations;
- informing federal, state, and local policymakers of failures of safety net systems and providers; and
- identifying and disseminating best practices.

**4. Establish a new targeted federal initiative to support providers that care for a disproportionate number of uninsured and other vulnerable patients.**

Competitive 3-year grants could fund infrastructure improvements and systems-building efforts that would help safety net providers strengthen their ability to survive, as well as pay for medical care for vulnerable populations. Mirroring the geographic variation of safety net programs, multiple safety net models and collaboration among providers should be encouraged.

**Mirroring the geographic variation of safety net programs, multiple safety net models and collaboration among providers should be encouraged.**

**5. Enhance and coordinate technical assistance programs targeted to improving the operations and competitive position of safety net providers.**

Technical assistance programs should promote rather than prevent the development of partnerships to build safety net capacity and improve the management and operating capabilities of safety net providers. Technical assistance programs should give specific attention to the management of service delivery, the development of new business skills, the collection of reliable data on which to calibrate reimbursement rates, and nonmedical issues that affect utilization and health outcomes of low-income and other vulnerable patients.

## For More Information . . .

Copies of *America's Health Care Safety Net: Intact but Endangered* are available for sale from the National Academy Press; call (800) 624-6242 or (202) 334-3313 (in the Washington metropolitan area), or visit the NAP home page at [www.nap.edu](http://www.nap.edu). The full text of the report is available on line at [www.nap.edu](http://www.nap.edu).

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