

Forum Session

Perspectives on the Financial Underpinnings of the Health Care Safety Net: “No Margin, No Mission”

Tuesday, June 5, 2001

9:30 to 10:00 am - Refreshments

10:00 am to noon - Discussion

Noon to 1:00 pm - Lunch and Informal Discussion

Congressional Hall of Honor, Fifth Floor

Reserve Officers Association Building

One Constitution Avenue, N.E.

(Across from Dirksen Senate Office Building)

A discussion featuring

Frank Barrett

Chief Financial Officer
Denver Health
Denver, Colorado

John Megenhausen

Chief Executive Officer
Horizon Health Care, Inc.
Howard, South Dakota

Jim Dearth, M.D.

President and Chief Executive Officer
Children's Health System
Birmingham, Alabama

Paul Offner, Ph.D.

Research Professor
Institute for Health Care Research
and Policy
Georgetown University

Ronda Kotelchuck

Executive Director
Primary Care Development
Corporation
New York, New York

Registration: Please call **Dagny Wolf** at **202/872-1392** as soon as possible.

Financial Underpinnings of the Safety Net

A wide variety of institutions and individual providers comprise the safety net that is key to serving America's uninsured, underinsured, and medically vulnerable populations. While many are specifically charged to fulfill this mission, others take it on to the extent they can or need to in the face of ever-changing market conditions. And virtually all must depend on a collection of funding sources, only some of which are specifically geared to safety net support. As the Institute of Medicine observed in its March 2000 report, "The funding and organization of the safety net have always been tenuous and subject to the changing tides of politics, available resources, and public policies."¹

A lack of stable funding and the difficulties inherent in managing various funding streams, each with its own eligibility provisions and administrative requirements, make performance of safety net functions difficult, even when conditions are good. But it is also clear that those who take on this function do so at financial risk. As Stephen A. Norton and Debra J. Lipson noted in a paper published by the Urban Institute in September 1998:

Ultimately, the safety net is never fully supported, as the institutions are not fully compensated for care to the uninsured. Thus, no matter how high or low the level of pressure they experience, these institutions will be under some stress.²

Indeed, no matter how committed they are to charitable missions, individual and institutional safety net providers must consider how many indigent and/or uninsured patients they can accept and still achieve a positive bottom line—hence the conventional wisdom "no margin, no mission." Because certain third-party payers tend to underpay, safety net providers must pursue a mix of third-party payers and cannot rely solely on the government payers that tend to be the principal sources of support for the uninsured, the indigent, and other traditional safety net populations. Many of these sources, which include Medicaid, Medicare, Section 330 of the Public Health Services Act, Indian Health Service funds, Ryan White grants, and Stuart McKinney funds, as well as state and local subsidies, are facing unprecedented fiscal pressures, which make them less than reliable sources of support. Ideally, safety net providers must be able to cross-subsidize the care of those without insurance or without adequate insurance by tapping into revenue surpluses that accrue from more remunerative payers.

Complicating the balance sheets of safety net providers are a number of recent economic developments, highlighted by the IOM in its report:

The financial viability of core safety net providers is even more at risk today than in the past because of the combined effects of three major dynamics: (1) the rising number of uninsured individuals; (2) the full impact of mandated Medicaid managed care in a more competitive health care marketplace; and (3) the erosion and uncertainty of major direct and indirect subsidies that have helped support safety net functions.

While the number of uninsured Americans suddenly stopped increasing in 1999, many observers remain skeptical that this is more than a momentary aberration. Although many safety net providers have attempted to accommodate Medicaid managed care, all are affected by the broader forces of managed care in both public and private markets, which are starkly limiting their capacity to shift costs to other payers. Moreover, there are disturbing signs that the Medicaid budgets in at least 23 states are currently out of balance³—an especially ominous portent in light of the IOM's observation that "Medicaid has become the financial underpinning of the safety net." Given the heightened levels of competition among providers for patients with any insurance coverage, safety net providers are finding that they are now confronted with competition for the Medicaid patients that only a few years ago no other providers would treat.

FORUM SESSION

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As Congress considers ways to strengthen the safety net and protect those served by it, long-standing tensions in philosophy and approach are apparent. To a large extent, current subsidies have been explicitly targeted to maintaining safety net functions by focusing principally on the requirements of traditional or other critical safety net providers as opposed to helping safety net patients more directly. But with federal budget surpluses available and various efforts underway to expand insurance coverage, both federally and in the states, there may be reason to explore the merits of each approach and especially the need for flexibility as federal and individual state circumstances change over time.

Proponents of facility-directed funding have argued that entitlement programs like Medicaid and the State Child Health Insurance Program (SCHIP) fail to reach all those who are eligible, while omitting from eligibility sizeable numbers whose incomes fall below the federal poverty line. And they see entitlement as ephemeral when payment levels are too low relative to costs. Instead, they put more emphasis on the importance of geographic convenience and cultural competence in assuring access and quality of care. Proponents of insurance expansions, on the other hand, worry about a two-tier system of health care that diverts safety net patients from mainstream providers willing and able to care for them. They also are concerned that unless the full continuum of care required is adequately funded, a lack of access to specialists and subspecialists will compromise quality for chronic patients in particular. In the end, this may be something of a false dichotomy, with the potential under both approaches to under-fund and thereby compromise quality of care and/or reduce access. As the current debate continues through budget reconciliation and appropriations decisions, it appears that some combination of the two approaches will be considered, with attention to the need for state or regional variation and the degree to which federal funding will constitute the principal support of safety net functions and providers.

A recently published Forum background paper, “The Health Care Safety Net in a Time of Fiscal Pressures,” provides greater detail on safety-net providers, patients, and funding sources, as well as the public policy and the socioeconomic trends affecting the safety net’s viability. (The background paper is available at <http://www.nhpf.org>.)

THE FORUM SESSION

This Forum session will bring together a group of knowledgeable, experienced speakers from a variety of

settings to discuss the financial challenges confronting safety net providers, including both urban and rural venues, community health centers and hospitals—both public and community. The speakers will address how their programs have dealt with the challenges of managed care, market competition, and variations in public funding and support.

Key Questions

Among the questions to be considered by the speakers are the following:

- Looking at safety net providers as a group, are there differences in their individual financial capacities to carry on their missions? In the aggregate, do safety net providers have the financial resources to maintain their missions?
- Earlier this year, the National Governors’ Association (NGA) proposed to reform Medicaid by expanding eligibility while curtailing benefits at higher income levels. If the NGA proposal to restructure Medicaid along these lines were adopted, what would be the net effect on the safety net?
- In the 2000 presidential campaign, George W. Bush made a commitment to expand the number of community and migrant health centers by 1,200 over the course of five years, yet the president’s proposed fiscal year 2000 budget calls for only a modest increase in funding for health centers. Will Congress accept this level of increase or is it likely to push for increased funding for health centers more in keeping with that originally proposed by the president?
- Are adequate sources of capital available to renovate the aging physical plant of many safety net providers?
- Do state Medicaid managed care initiatives jeopardize or positively challenge safety net providers?
- To what extent are other providers competing for Medicaid patients who were formerly cared for by safety net providers?
- To what extent has the expansion of managed care in the private insurance market reduced the opportunity for cross-subsidization that is the foundation of uncompensated care?
- To what extent has the facility-based orientation of many safety-net subsidies been helpful? To what extent do we need to recognize instead the variety of insurance-based approaches being taken by state governments in addressing the problems of uninsurance and lack of access to health care?

- What can the federal government do to improve its support of the safety net?

Speakers

Ronda Kotelchuck will lead off by speaking about the financial challenges faced by primary care providers serving safety net populations in New York City, including the vicissitudes of public funding for safety net providers. She has been executive director of the Primary Care Development Corporation (PCDC) since 1993, when it commenced its operations. PCDC is a public-private partnership that provides technical assistance and capital financing for the expansion of primary care in underserved areas throughout New York City. Since 1993, PCDC has provided over \$100 million for the construction or expansion of 27 facilities which, combined, will offer new capacity of 700,000 new visits per year. From 1981 to 1993, Kotelchuck served with the New York City Health and Hospitals Corporation (HHC), rising from assistant director of reimbursement to vice president of corporate planning and intergovernmental relations. Prior to her tenure at HHC, she held a variety of health-related positions, including associate analyst at the New York State Financial Control Board, director of acute care for the Health Planning Council of Greater Boston, and director of the Health Policy Advisory Center and managing editor of its *Bulletin*. Kotelchuck received her master's degree in regional planning from Cornell University.

John Mengenhausen will discuss his experience as chief executive officer (CEO) of a coalition of community health centers in east-central South Dakota and the special challenges of funding safety net services in a rural setting. He has been CEO of Horizon Health Care, Inc., in Howard, South Dakota, since October 1983. Horizon Health Care is an organization of seven federally funded community health centers with a total budget of \$3 million. Mengenhause is also the chair-elect of the board of the National Association of Community Health Centers. For the last 14 years, he has served on numerous workgroups and task forces, assisting the federal Bureau of Primary Health Care in developing new policies and procedures for community and migrant health centers. He is a graduate of Nettleton College in Sioux Falls, with a degree in business.

Frank Barrett has been chief financial officer of Denver Health, Denver's public health care system, since August 1995 and has almost 20 years of experience as a chief financial officer (CFO) at public hospitals. He will describe his institution's overall fiscal strategy, including the Denver Health Medical Plan, its wholly owned

managed care subsidiary, and the mix of payers within its \$350 million budget. Among the departments that report to him are information systems and telecommunications, medical records, budget and reimbursement, accounting and finance, billing, admitting and registration, and materials management. From 1987 to 1995, Barrett served as CFO of Santa Clara Valley Health and Hospital System in California; for the preceding five years, he was CFO at Kern Medical Center in Bakersfield, California. Prior to that, he spent three years as corporate accounting manager at Advanced Health Systems in Irvine, California. Barrett has a B.S. degree in accounting from San Diego State University.

Jim Dearth, M.D., is president and CEO of the Children's Health System, which includes the Children's Hospital of Alabama, a private, nonprofit hospital licensed for 225 beds. He will discuss the safety net role played by children's hospitals as well as the particular role played by the Children's Hospital of Alabama in its fiscal environment. Over the past 13 years, the hospital—a research and teaching hospital affiliated with the University of Alabama at Birmingham (UMAB)—has grown into one of the 20 largest pediatric medical centers in the United States. Based at the Children's Hospital, Dearth's career has centered on clinical practice and health care administration. In 1984, he became vice chairman of the UMAB Department of Pediatrics. In 1985, he was appointed the hospital's medical director and in 1987 became its CEO. Dearth's medical degree is from the University of Wisconsin. Trained as a pediatric hematologist/oncologist, he completed his residency and fellowships at the Mayo Graduate School of Medicine. Dearth has served as an executive committee member of the National Children's Hospitals and Related Institutions (NACHRI) and was chairman from 1996 to 1997. He has also chaired NACHRI's Council on Child Advocacy. He currently serves on the board of Child Health Corporation of America and the Children's Miracle Network Board of Trustees.

Paul Offner is research professor at Georgetown University's Institute for Health Care Research and Policy. He will discuss the merits of subsidies for safety net facilities as opposed to funding insurance for individuals and will reflect on various Medicaid safety-net reimbursement policies, such as cost-based reimbursement for health centers and disproportionate-share hospital funding. Offner headed the District of Columbia's Commission on Health Care Finance from August 1995 to October 1999, where he was responsible for directing the District's Medicaid program. From 1993 to 1995, he served as chief health and welfare counselor

for the Senate Finance Committee, and from 1991 to 1992, he was legislative assistant to Sen. Daniel Patrick Moynihan (D-N.Y.). From 1984 to 1994, Offner was deputy director of the Ohio Department of Human Services, in which capacity he was responsible for Aid to Families with Dependent Children, food stamps, general assistance, child support, and Medicaid, with a budget totaling \$4 billion. From 1975 to 1984, he served in the Wisconsin legislature. Offner has a Ph.D. in economics and an M.P.A. from Princeton University.

ENDNOTES

1. Marion Ein Lewin and Stuart Altman, eds., *America's Health Care Safety Net: Intact but Endangered*, National Science Foundation, Institute of Medicine. (Washington, D.C.: National Academy Press, 2000), vii.

2. Stephen A. Norton and Debra J. Lipson, *Public Policy, Market Forces, and the Viability of Safety Net Providers*, Occasional Paper 13, Urban Institute, September 1998, 2; accessed October 10, 2000, at <http://newfederalism.urban.org/html/occa13.html>.

3. Pamela Belluck, "Free Spending in Flush Times Is Coming Back to Haunt States," *New York Times*, March 9, 2001, A14. Twenty-three states indicate that their Medicaid budgets were running deficits at the time of this report: Arizona, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Missouri, Montana, New Mexico, North Carolina, Ohio, Oklahoma, Texas, Vermont, Virginia, and Washington.