

**NET GAINS & LOSSES: STATE PERSPECTIVES ON THE COVERAGE
VS. DIRECT CARE DEBATE**

**By:
Trish Riley, Executive Director
National Academy for State Health Policy**

DRAFT

Prepared for the Council on the Economic Impact of Health System Change
EXPANDING HEALTH INSURANCE / STRENGTHENING THE SAFETY NET :
POLICY OPTIONS AND TRADE-OFFS
April 5, 2000

A challenge of this paper is to present a “state perspective;” all states differ and, within state governments, there are divisions. Public health tends to support and defend the safety net, while Medicaid, S-CHIP, and other insurance-based programs are more likely to express reservations about a direct care approach to cover the uninsured. For the purpose of this paper, I shall attempt to generalize from the perspective of state officials who advance insurance-based approaches and examine some of the underpinnings of the coverage vs. direct care debate.

The roots of distrust between health financing agencies and safety net providers are old and deep. Indeed, I’d suggest the contention is a significant reason why neither states nor the federal government have solved the problem of the uninsured. Both advocates for coverage and advocates for direct care strategies agree on the problem - no one should be without medical care in America - but whenever the debate switches to how to achieve that end, these advocates become their own worst enemies. It may well be the advocates of reform who have stilled reform as they argue over how to solve the problem and whether to protect the status quo.

Regrettably, the IoM report reflects rather than informs the policy conundrum. Rather than examine the questions of how to best serve the uninsured or even how to develop an overarching, single national policy to reconcile and coordinate coverage and direct care approaches, the study’s charge was to examine “the impact of Medicaid managed care and other changes in health coverage on the future integrity and viability of safety net providers”¹

It is precisely this conviction to sustaining a set of providers - not just the services they provide - that lies at the root of much tension, particularly between safety net providers and Medicaid. The report is comprehensive and defines the safety net broadly, but for purpose of discussion, the history of Federally Qualified Health Centers (FQHC) and Medicaid might serve to illuminate the problem. When health centers were first authorized by Congress in the 1960's, they were viewed as complementary to the recently enacted Medicaid program, providing access for the new Medicaid enrollees and the uninsured and were to be a source of employment in low-income neighborhoods and communities in which they were located.²

¹ IoM Report, *America’s Health Care Safety Net: Intact but Endangered*

² K. Davis, K. Scott Collins, and A. Hall, *Community Health Centers in a Changing U.S. Health*

Policy bifurcation was evident from the initiation of the program. Medicaid was to be administered through the Health Care Financing Administration in partnership with states, while health centers and an array of other direct care programs grew from the Public Health Service Act administered by other entities of the federal government. For the most part, the safety net programs described in the IoM report are administered through various public health agencies and through the Health Resources and Services Administration directly to local providers with little, if any, role for state governments. While both HCFA and HRSA are within what is now the Department of Health and Human Services, co-location has not resulted in a fully coordinated approach to policy any more than state-based Cooperative Agreements with safety net providers have. This is not to suggest that coverage alone can assure access to care nor to impugn the integrity of either the direct care or coverage agencies. Rather, it is to suggest that there has not been a clear and workable federal policy about how coverage and care programs were to relate, particularly at the state government level.

Historically, Medicaid agencies have viewed their role as providing coverage to eligible, low-income individuals in ways that assured the cost effectiveness of the program. As an entitlement operating within the balanced budget constraints of state government, Medicaid has always been challenged to fulfill its broad charge but meet state budgetary restraints imposed by state legislatures. Medicaid agencies make decisions about how to structure the program within those budget restraints. When allocation decisions are made, Medicaid faces three choices: reduce eligible beneficiaries, eliminate benefits, or restrict reimbursement to providers. In a political environment, the latter is often the “best” choice. But when states limited funding increases or cut funding to health centers they were often confronted by a powerful lobby - the organization of health centers, centers who were funded by federal dollars that came directly to them, and not through the state.

In the late 1980's and early 1990's, as states faced a recession and the cost of new eligibles mandated by Congress, federal policy required Medicaid to reimburse FQHC's and to do so at “reasonable costs” in response to the argument that health center grants were subsidizing low Medicaid rates. State Medicaid officials were often skeptical of these claims and sometimes resented the special treatment of special providers required by federal Medicaid law. The law did not relieve dissent as states and providers struggled to define “reasonable” costs. In the report, the tables “Trends in Community Health Center Users, 1990-1998” and “Trends in Community Health Center Revenue, 1990-1998,” show clearly that in 1990 Medicaid accounted for 32% of health center users and 21% of health center revenue. By 1998, Medicaid users were 33% of health centers' population and paid 34% of their total revenues. But a Medicaid official likely looks at these figures somewhat differently.

From 1990-1995 Medicaid revenues to community health centers grew by 221% while the number of Medicaid beneficiaries served grew by 68%. From 1990-1997, Medicaid expenditures for community health centers grew 288%; beneficiaries served increased by about 50%. Of course, 1990-1997 was a period of Medicaid cost explosion. For the program as a

Care System, (Commonwealth Fund Policy Brief, May 1999).

whole, enrollees grew 41% while expenditures grew 127%.³ Thus the Medicaid cost growth of services provided FQHC's exceeded overall Medicaid cost growth. Safety net providers saw this gain as "catching up" for long-term underfinancing; Medicaid saw the increase as a disproportionate increase for this one set of federally-protected providers.

During the same period, state Medicaid programs moved to establish managed care programs. As the report well documents, that move allowed states to fund patient care, not providers, and as patients moved to managed care organizations and to their provider networks, revenues to health centers were reduced. Community health centers mobilized their local advocacy to resist the diversion of direct revenues from Medicaid, arguing that these dollars were essential to subsidize the uninsured. Throughout the 1990's, even after cost-based reimbursement was established, FQHC's had used their considerable political muscle to push states for higher rates of reimbursement for Medicaid beneficiaries; now Medicaid agencies learned that, in fact,

. . . cost-based reimbursement had become a critical 'silent subsidy' to help core safety net providers pay for overhead and infrastructure, so grants can pay for the uninsured.⁴

For many Medicaid programs struggling to meet demands of their many beneficiaries within budget limits, the use of Medicaid to subsidize health center infrastructure - even toward the laudable end of serving the uninsured - fueled conflict. What was the real and appropriate cost to serve Medicaid beneficiaries? As states struggled to answer this question and learn more about health centers, they found much of the available research was funded by HRSA and/or sponsored by the National Association of Community Health Centers and, in an environment of distrust, some expressed skepticism about the independence of the research.

To generalize about a state perspective - and in such a negative way - is always dangerous. Certainly in some states relations between centers and Medicaid were stronger and it may be that the subsidies were tacitly approved by agencies eager to expand coverage. But in large measure, the environment between safety net providers and Medicaid was often unproductive, with Medicaid viewing centers as self-righteous and centers viewing Medicaid as unenlightened bean counters.

In such an environment, Medicaid became interested in allowing beneficiaries to "vote with their feet" and choose MCO network providers. In many states, as the report documents, health centers were encouraged to participate as providers within managed care. As managed care evolved, the importance of safety net providers in assuring access grew but states found that, too often, the centers lacked data capacity, had insufficient hospital affiliations for its physicians, were not able to provide a medical home of 24-hour care, 7 days a week, did not have a full array of medical services, and were often ill equipped to compete in a managed care setting. As Croke and Kenesson report,

³ Kaiser Family Foundation, *Medicaid Enrollment and Spending Trends Fact Sheet* (Kaiser Family Foundation, 1998)

⁴ IoM Study, Chapter 1.

The challenges of contract negotiations, risk-based payment arrangements, and rigorous data reporting and accountability requirements have constrained the potential of many FQHC's to enter, and succeed in, the Medicaid managed care market . . . also state purchasing agencies are reluctant to relax quality related standards imposed as conditions of managed care contracting for any subset of providers, such as FQHC's.⁵

But, as the IoM report documents, FQHC's are only one part of the safety net, with 698 operating in 1998. There are 2,500 rural health centers that also are known to state Medicaid agencies as zealous advocates for low-income and uninsured populations. Yet as the IoM report documents, these entities do not have a legal obligation to serve the uninsured and have disincentives to do so since care to the uninsured reduces their unit cost per encounter and decreases cost-based reimbursement.⁶

The report further identifies 1,157 school-based clinics and documents their need to seek Medicaid and S-CHIP funding for sustainability. But here, too, the safety net may not yet be equipped to operate in a managed care environment. Early in the development of Medicaid managed care, states learned that school-based clinics operated on school calendars. While the report notes that "70% of these clinics operate full time,"⁷ full time means only 25 hours a week. Medicaid managed care promised beneficiaries a medical home and continuity of care, but the capacity of the primary care provider to assure continuity of care was compromised when enrollees could "go out of plan" to a school-based or community clinic for care. Coordinating the safety net with managed care and grappling with issues of confidentiality of information and its exchange between the MCO and safety net providers took considerable work within Medicaid and with the safety net.

By the late 1990's, Medicaid had become the single biggest revenue source for community health centers, a reversal from 1990 when federal grant funds dominated. In the 1990's states gained new authority under Section 1915(b) and 1115 waivers to allow the Medicaid program to circumvent the FQHC requirements of the law and develop alternative delivery mechanisms. From a Medicaid perspective, the playing field was being leveled and FQHC's could be treated more like other providers. In this environment, détente grew and collaboration resulted in a growth of FQHC's participating in Medicaid managed care and the development of Center-owned plans, as documented in the report. Rhode Island, Massachusetts, Hawaii, Washington and Florida have all instituted policies to encourage the formation of center-based plans. Similarly, HRSA has recognized the importance of building safety net capacity and is awarding funds to support a Uniform Data System and help clinics meet performance indicators. HRSA and HCFA, working with the state Medicaid directors, are holding regional meetings with

⁵ Alison Croke and Mary Kenesson, *Building FQHC Capacity Within Medicaid Managed Care*. (Issue Brief, Center for Health Care Strategies, February 2000).

⁶ IoM Report, Chapter 2.

⁷ IoM Report, Chapter 2.

providers to improve collaboration.

And as states have implemented S-CHIP and reflected upon 25 years of state initiatives in achieving access for the uninsured, they increasingly conclude that no matter how effective outreach and coverage initiatives, at least a portion of the population will always require the availability of safety net providers. But what's needed is a mechanism to build systems that coordinate care and coverage strategies.⁸

As the marketplace churns and the future of risk-based managed care grows less certain, the potential for such partnerships between the safety net and Medicaid grows. But to do so, it may be wise to reflect on the rocky history of the two parties and seek new ways to develop policy.

As states implement S-CHIP, the problem of parallel, uncoordinated initiatives again becomes apparent. Safety net providers are generally accountable to federal, not state, governments, which complicates state health planning. While safety net providers have often been active in S-CHIP outreach and provision of care, in a series of site visits NASHP learned that some states believe enrollment in S-CHIP may be compromised by the safety net.⁹ States commented on the complexity of the "mixed message" that exists when insurance and direct delivery vehicles are not coordinated. Specifically, states have noted the difficulty in educating certain previously uninsured populations about insurance and how it is used in the face of direct care providers for whom one does not need to engage in intrusive and complicated eligibility determination. Those unfamiliar with insurance may elect simply to continue using providers that serve the uninsured. Others may fail to re-enroll because they haven't used any services and remain without insurance coverage, knowing the safety net is there to serve them. In these instances, the safety net providers become important outreach vehicles to secure S-CHIP coverage. However, in some instances, it was felt that safety net providers were reluctant to identify children eligible for S-CHIP, fearing they would be "mainstreamed" into managed care and lost to the safety net providers. One respondent even suggested that safety net providers needed uninsured to justify federal grant awards and, therefore, had little incentive to enroll S-CHIP-eligible children.

In 1997 the Balanced Budget Act called for an end to cost-based reimbursement, phased out by 2003. Health centers sought and won a moratorium on the phase out.

The battle lines are again being drawn and the rhetoric heating up. The National Association of Community Health Centers (NACHC) reports that among other provisions, the new law:

"Ensures Minimum Protection for Health Centers in Most States - other than health centers in 1115 states, this provision ensures that the federal mandate for cost-based reimbursement continues and is extended and allows NACHC and health centers to fight another day." (emphasis added)

⁸ Trish Riley and Barbara Yondorf, *Access for the Uninsured: Lessons from 25 Years of State Initiatives*. (The Flood Tide Forum, NASHP, January 2000).

⁹ Trish Riley and Cynthia Pernice, *If You Build It, Will They Come? Case Studies on CHIP Implementation*. (NASHP, July 1999).

The memo goes on to applaud the Congressional scrutiny of 1115 waivers, stating, “NACHC and health centers can now argue the devastating impact of the waivers on safety net providers to a Congressional audience,”¹⁰ thereby again circumventing state policy makers.

Checks and balances are a critical underpinning of our democracy and advocacy for the safety net has won critical resources that would likely not otherwise exist. But the time has come to end this divisiveness that pits advocate for insurance expansions against those who seek to secure the safety net. Unfortunately, the IoM study - with its narrow focus on providers - could fuel the conflict and once again protect safety net providers in a way that creates disincentives for them to cooperate and coordinate with state-based initiatives for the uninsured, notably Medicaid and S-CHIP.

As the report eloquently makes clear, the nation needs to address the broader issue of financing coverage for the uninsured. But until it does, states remain on the front line in administering Medicaid and S-CHIP. To do so effectively requires a level playing field and cooperation with the safety net. The IoM recommendations sadly do nothing to improve the relationship of the safety net and state policy makers.

For example, how would an independent federal oversight entity, proposed in Recommendation 3, assist in building state-based Medicaid partnerships? Indeed, the recommendation calls Medicaid and S-CHIP “major safety net funding programs” and calls for federal monitoring. States view these programs as financing eligible beneficiaries, not providers.

Recommendation 4 calls for another direct grant program to support the safety net and proposes using unspent S-CHIP funds for such a purpose. If surpluses exist, state S-CHIP programs have expressed interest in expanding coverage to the parents of S-CHIP eligible children. Further, another grant program that provides states no administrative control or involvement will continue to fragment state-based policy and program administration.

Surely, the report is a strong one with many important and less contentious recommendations but these two will likely draw a battle line that could return us to conflict. What is needed is a better road map and a system to better coordinate safety net, Medicaid and S-CHIP at a state and local level. Collaboration and coordination between the safety net and Medicaid show much promise, which could be strengthened and nurtured by IoM attention and support.

¹⁰ *Compromise Delays Phase-out of Health Center Payment System.*
([www.nachc.com/FSA/Federal/Agenda/PPS/Compromise Announcement.htm](http://www.nachc.com/FSA/Federal/Agenda/PPS/Compromise%20Announcement.htm),1/26/00).