STRETCHING STATE HEALTH CARE DOLLARS: INNOVATIVE USE OF UNCOMPENSATED CARE FUNDS

One of a Series of Reports Identifying Innovative State Efforts
to Enhance Access, Coverage, and Efficiency in Health Care Spending

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INTRODUCTION

Hospitals play a significant role in the health care safety net by providing services to the uninsured, Medicaid enrollees, and other vulnerable people who cannot pay for these services themselves. States use Medicaid Disproportionate Share Hospital (DSH) funds,[1] as well as state-based revenue streams, to reimburse hospitals for such uncompensated care. But experts warn that providing uncompensated care could become more difficult for hospitals in the coming years, as a result of rising costs and lower operating margins among hospitals, limited state revenues, cuts in Medicaid DSH,[2] and a growing uninsured population.[3] These trends have spurred several states to implement strategies intended to reduce the need for expensive uncompensated services over the long term.

One such strategy is to use a portion of the uncompensated care funds proactively to finance primary and preventive care programs that could ultimately reduce emergency and inpatient hospital care costs. By tapping the federal DSH funds—often matched by the state with Inter-Governmental Transfer [IGT] dollars)[4]—or state uncompensated care funds, they are developing programs that provide individuals with access to care in an appropriate, and often lower-cost, setting.

Some hospitals are supportive of these state efforts. In Maine, for example, hospitals favored the state's utilization of unused DSH funds to make up the state share of a Medicaid expansion aimed at poor adults without dependent children. In that case, the change (coverage expansion) meant better reimbursement to hospitals. But diverting DSH/uncompensated care funds to primary care programs is of concern to many hospitals in other states—particularly hospitals with large "free care" burdens that have depended on DSH/uncompensated funding streams for their general operations.[5] Battles among stakeholders have also arisen in states with uncompensated care pools that are financed by assessments on hospitals, providers, insurers, or other payers; disagreements frequently occur over assessment levels and the equity of those assessments.

Background

Medicaid DSH funding is the single largest public program for helping states reimburse hospitals' uncompensated care costs. States receive an annual capped DSH allotment, which they then allocate to hospitals that treat a disproportionate share of indigent patients. Combined federal and state DSH payments in FY 2002 amounted to $15.9 billion, of which $8.9 billion was federal matching funds. The majority of these payments

($12.5 billion) went to acute care hospitals (county-owned or private), and about one-fifth ($3.4 billion) was allocated to mental hospitals.[6]

States may also collect taxes and fees for the purpose of creating an uncompensated care pool to finance the delivery of care to the uninsured. Sources of funding for such a pool include assessments on providers, insurers, and hospitals, as well as local or county property taxes.[7]

This report describes ways states are leveraging DSH and other uncompensated care funds to improve health care access, delivery, and efficiency by changing the way health care is delivered to low income populations. We focus on states that are creating primary care or coverage programs by diverting a percentage of DSH or uncompensated care pool funds, and combining those with state/county/local funds or employer contributions. They are attempting to improve service delivery and patterns of care among uninsured individuals. Another option that has been pursued is expanding a public program (e.g., Medicaid) by using a DSH allocation as the state share.

Examples

Some states use a combination of DSH, state, and local uncompensated care funds to support safety-net providers working in the community—that is, to help them serve patients who would otherwise lack access to a "medical home," such as a medical group practice or a clinic. Another model involves combining DSH funds with employer and employee contributions to develop a "three-way share" coverage model. Finally, there is the model in which DSH funds were redirected to expand direct Medicaid service delivery to a broader population. Examples include the following:

- In Milwaukee County, Wisconsin, the move toward a community-based primary care coverage network was necessitated by the closure of a major hospital that had served indigent patients in and around the city of Milwaukee. In operation since 1998, the General Assistance Medical Program (GAMP) saved the county $4.2 million in calendar year 2000; it generally has some 10,000 to 12,000 enrollees at any given time.
- The Georgia Indigent Care Trust Fund, created by legislation in 1990, requires hospitals receiving DSH funds to use a portion of their allocation toward extending access to primary care. Ninety-two DSH hospitals currently participate in this program, providing services such as case management for the uninsured chronically ill, discount pharmaceutical care, and care for individuals with specific conditions such as cancer or HIV/AIDS.

- The Massachusetts Uncompensated Care Pool has been operating since 1985. The state combines DSH funds with assessments on hospitals and health insurance plans to provide free and subsidized care both through hospital clinics and community health centers.
- In Michigan, Muskegon County is using DSH funds to help fund the Access Health program, which in 2003 provided subsidized health coverage for 1,500 employees in 400 small businesses. The program covers a range of primary and specialty services through a "three-way share" model in which the employer and employee each contribute 30 percent to the premium and the community contributes 40 percent. For each dollar the community contributes, it is matched by $1.29 in federal DSH funds.
- MaineCare, Maine's Medicaid program, expanded coverage in 2002 to adults living under 100 percent of the federal poverty level (FPL) who do not have dependent children; previously unused DSH dollars financed the state's share of the costs. A broad coalition of stakeholders, including the hospital association and employers, supported the expansion. Enrollment in the program has exceeded expectations, with over 15,000 individuals participating.

In the remaining sections of this report, the matrix, profiles, and snapshots summarize the ways in which states have utilized uncompensated care funds strategies to achieve better access to primary and preventive care as well as to realize cost savings. Despite the concerns that some stakeholders express, and the resulting controversies, it appears that this model is gaining traction and attracting interest and will be one to watch for the future.

Additional Resources

Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23 (March/April 2004): 245–57.

David Mirvis, *Health Care on a Tightrope: Is There a Safety Net? Part I: Uncompensated Care* (Memphis, Tenn.: Center for Health Services Research, University of Tennessee, 2000), http://www.utmem.edu/CENTER/HealthPolicyReports/TightropeI.pdf.

Petris Center on Healthcare Markets and Welfare Policy Brief Series, *Unreimbursed Care in California Hospitals: Policy Briefs #1 and #2* (Berkeley, Calif.: School of Public Health, University of California, 2003), http://www.petris.org/Briefs/Policy_Brief_1_Unreimbursed_Care_10-24-2003.htm.

Matrix: State Activity—Innovative Use of Uncompensated Care Funds

State	Program Name	Type of Strategy and Implementation Date		Participation
Current Examples				
Wisconsin (Milwaukee County)	General Assistance Medical Program (GAMP)	Leveraging DSH to provide community-based primary care coverage	1998	24,000 enrollees total in 2003; approximately 10,000–12,000 enrolled at any given time
Georgia	Indigent Care Trust Fund (ICTF)	Leveraging DSH to: • Expand Medicaid benefits and eligibility • Support providers of care to the medically indigent • Fund primary care programs	1990	92 hospitals receive funding for primary care programs
Maine	MaineCare expansion to adults without children	Transfer of unused DSH funds to expand Medicaid eligibility to adults under 100% FPL who do not have dependent children	2002	Over 15,000 enrollees as of June 2003
Michigan	Muskegon County's Access Health	Community draws down federal DSH funds to provide coverage for uninsured workers through three-way-share premium-assistance model (other Michigan counties use other models, such as primary care coverage for indigent population)	1999	400 employers participate, covering 1,500 individuals in 2003
Massachusetts	Uncompensated Care Pool	State and federal DSH funds leveraged with hospital and insurance assessments to subsidize primary and some specialty care for low-income individuals	1985	In FY2002, pool payments covered 30,000 inpatient services and 2 million outpatient services
States/Initiatives to Watch				
Louisiana	LA Choice	Reallocation of DSH funds for small-employer insurance product with subsidies for low-income workers	Planned April 2005, pending HIFA waiver approval	Pilot expected to cover up to 3,000 employees

STATE PROFILES

WISCONSIN: GENERAL ASSISTANCE MEDICAL PROGRAM'S COMMUNITY-BASED PRIMARY CARE MODEL

Purpose/Goal

The purpose of the General Assistance Medical Program (GAMP) is to provide health care coverage to indigent Milwaukee County residents who are not eligible for other forms of public coverage (such as Medicaid) and are not enrolled in private coverage. The county redesigned the GAMP program into a community-based primary care model in the late 1990s to achieve two interrelated goals: to provide increased primary care services and to establish community-based clinics. The new design was intended to improve the effectiveness and efficiency of care.

Key Participants

GAMP is administered by the Milwaukee County Division of County Health Programs, Office of Health-Related Programs. The county contracts with a network of providers, including all of the community's hospitals, and at least 15 independent community-based clinics that run more than 25 service sites across the county. Also included in the network are 240 specialty care providers and 25 pharmacies.

Program Description

In order to promote primary care and discourage the use of emergency facilities, the "new" GAMP was created in 1998 as a community-based primary care model whereby community clinics play a greater role in the care management of GAMP enrollees. Prior to this innovation, indigent patients were reliant on the emergency room of the county hospital, located outside the city of Milwaukee, which resulted in access barriers for enrollees and cost inefficiencies for the county.

Under the redesigned model, GAMP enrollees select a participating clinic as their primary care provider, which is then responsible for supplying and coordinating services. When patients require specialty care not offered by the clinic, it works with appropriate specialists and hospitals that participate in the GAMP network. The network is composed of 30 provider sites, including Federally Qualified Healthcare Centers (FQHCs), FQHC "look-alikes," private practices, community health agencies, and community hospitals.

Target Population

GAMP targets mainly low-income residents within the City of Milwaukee. However, 5 percent of enrollees report a zip code outside the city; this reflects the need for safety-net medical services in suburban areas, according to the state.

Eligibility

GAMP enrollees may not be eligible for any other public program, such as Medicaid or Medicare. There is no age-eligibility requirement for enrollment in GAMP, and in fact some children (mainly immigrants) are enrolled. Most enrollees, however, are between 22 and 65 years of age. The county applies a sliding scale based on family size for determining income eligibility—an individual, for example, must earn no more than $902 per month to be eligible. The income scale is not tied directly to the federal poverty level, but the GAMP income limit is just under 125% FPL for a family of one and just over 115% FPL for a family of three.[8] Finally, applicants must be able to demonstrate 60 days of Milwaukee County residency, and must be seeking health care services at the time of application (see below).

Application Process

Individuals must present themselves for health care services at a participating primary care clinic or a hospital emergency room in order to apply. In other words, enrollment in GAMP is based on need for health care services. Thus the county has outstationed workers, in several of the clinics, who can determine eligibility quickly and at the point of service. Those who do not enroll in this fashion mail their application to a central processing facility, which responds within 15 days. Re-certification of eligibility is required every six months.

Enrollment

The program covered a total of 24,000 individuals in calendar year 2003, with some 10,000 to 12,000 individuals enrolled at any given time.

Benefits

Benefits include primary care and clinical services, inpatient and outpatient hospital care, lab, medications, and specialty care. GAMP is prohibited from paying for mental-health, alcohol, or substance-abuse treatment. Dental coverage is limited to emergency extractions.

Cost-Sharing

There is a $20 copayment for emergency department visits. In addition, as of January 1, 2004, enrollees are responsible for a $1 copayment for generic drugs and a $3 copayment for brand-name drugs on the formulary. There is also an application fee of $35 per enrollment period, which is waived for homeless individuals.

Time Frame

GAMP has been available in the state of Wisconsin since the early 1980s, when Milwaukee County purchased health care services from the county-owned-and-operated John L. Doyne Hospital and its clinics to serve the indigent population. At that time, GAMP had an annual budget of approximately $40 million, most of which was paid to Doyne Hospital for services.[9] In 1994, the state legislature removed a mandate that had required Wisconsin counties to operate public hospitals. But Milwaukee county policymakers were determined to maintain their commitment to helping the indigent access health care, and in fact this change in policy inspired them to rethink the delivery of that care so that it would become more effective.

The county embarked on the following four-step process to implement a new system, ultimately leading to the current GAMP model: close the public hospital; establish a "bridge" contract with nearby Froedtert Memorial Hospital to ensure no loss of services to the indigent while the new program was being designed; focus on the development of a community-based primary care system; and establish a community task force to help the county administrators move its initiative forward. Over three years, the county developed a new model for delivering care, through which its role would change from providing services to *purchasing* services. The redesigned GAMP began in April 1998.

Required Legislation/Authority

The current source of state-level funding for GAMP comes from the Relief Block Grant Program (RBGP), which was authorized by the Wisconsin legislature in 1996 to transform the state's mandatory general relief program into a block-grant program to counties. The RBGP legislation supported a transformation already under way in Milwaukee County—the shift from being a provider of health care services to becoming a purchaser. Another important aspect of the legislation was that it required the county to create a plan for providing RBGP participants with better access to services in the City of Milwaukee itself. The Doyne Hospital had been located in Wauwatosa, a town in Milwaukee County but not in the City of Milwaukee, which made access difficult for the city's indigent population.

Financing Mechanisms

The funding stream is unique and complex. The county applies to the state for a block grant of $16.6 million a year, which the county matches with at least $20 million. The state's share of the program is made up of a combination of sources, including federal Medicaid DSH funds and general revenue. Part of the county's share comes in the form of intergovernmental transfers,[10] through which the county and the state have leveraged

almost $7 million, bringing the share from county tax revenue down to $13 million. The total capped budget for the program was $38.4 million in 2003.

The county contracts with providers to supply all services. At clinics, providers are given the full Medicaid reimbursement rate, while hospital-based providers are reimbursed at 80 percent. Providers are prohibited from seeking additional payment for services from either the county or the client. The majority of spending in GAMP is on inpatient hospital care, pharmacy, and specialty services.

Efficiencies

All in all, GAMP estimated that it saved $4.2 million in 2000 (in comparison to the projected costs had the previous system remained in place).[11] Administrators believe that inpatient and outpatient costs have been controlled largely through a "Utilization Management" (UM) program that ensures delivery of care in the appropriate settings and using appropriate resources. A source of confidence in the UM program is the quality assurance mechanism of having its charts reviewed for "adherence to medical record and service standards" established by the National Committee for Quality Assurance (NCQA).

In addition to the efficiencies designed into the program's delivery system, the GAMP administrator cites the capped budget (of which all vendors and providers are aware) as another significant cost-control measure. Despite this cap, or perhaps because of it, GAMP enjoys the participation of a diverse range of providers. In addition, the program secured the participation of all 10 community hospitals operating in the county, under the philosophy that health care for the indigent was a community problem that required a community solution.

GAMP endeavors to limit administrative costs to less than 7 percent. It does so by maximizing its use of technology, such as Web-based eligibility programs, and maintaining a mutually supportive relationship with the program's third-party administrator.

Challenges and Future Plans

The biggest challenge for the program is securing funding each year. With costs rising for all services—pharmaceutical benefits in particular—the administrators' concerns are focused on how to stretch a limited budget. One solution, which began on January 1, 2004, has been to institute a closed formulary for prescription drugs: enrollees are responsible for a $1 copayment for generic drugs and a $3 copayment for brand-name drugs on the formulary. Prescriptions not on the formulary are not covered. Another challenge will be the refinement of the program's patient-education services, which so far

have shown mixed results. Finally, the program will continue to work on quality assurance efforts in order to continue meeting NCQA standards.

For More Information

Web sites:
http://www.milwaukeecounty.org/Service/organizationDetail.asp?id=7251
http://www.legis.state.wi.us/lab/Reports/97-15summary.htm

Contact: Robert Henken, Acting Director of Health and Human Services, Milwaukee County. Phone: (414) 289-6816. E-mail: rhenken@milwcnty.com.

GEORGIA: INDIGENT CARE TRUST FUND

Purpose/Goal

In 1990, the Georgia legislature created the Indigent Care Trust Fund (ICTF) and directed it to accomplish three general goals, largely through the leveraging of DSH funds:

- Expand Medicaid eligibility and benefits
- Support rural and other providers—mainly nursing homes and hospitals—that serve the medically indigent population[12]
- Fund primary care programs both for the medically indigent and children.

Key Participants

The ICTF is administered by the state's Department of Community Health (DCH), which oversees collection and disbursement of funds, hospitals' usage of primary care programs, and data gathering. Other stakeholders include the state's 92 hospitals that receive DSH funds, the district departments of community health (which work with hospitals to create their primary care plans, as described below), and the Georgia Hospital Association.

Program Description

The ICTF is funded through a variety of sources, with the federal DSH allotment accounting for the largest percentage of total revenue. Additional sources include intergovernmental transfers (IGTs) from local governments,[13] nursing-home provider fees, ambulance licensure fees, Certificate of Needs (CON) noncompliance penalties, and breast-cancer license-plate fees, among others. All in all, the state collected and planned to expend $731.4 million in FY 2004 on the following activities:

- *DSH payments to hospitals/primary care programs:* $424.7 million (or 58.1%) of the fund went to 92 qualifying hospitals to support services provided to indigent care patients. Fifteen percent of these DSH payments, or approximately $63.7 million, was earmarked for primary care services in the community. Every year, the DCH chooses a number of priority areas to which hospitals can direct these funds. In the past, such priorities have included provision of "comprehensive primary care," discount pharmaceutical clinics, and services dedicated to specific populations (e.g., pregnant women) or to specific conditions, such as HIV/AIDS or diabetes. (Comprehensive primary care activities typically involve the hospital's support of community safety-net providers operating through FQHCs or of other clinics that serve the uninsured.)

After being notified of the level of their DSH funding for the following fiscal year, hospitals are given one month to develop a primary care plan—in collaboration with local departments of community health—which they then submit to the DCH for approval and release of the 15 percent DSH payment. Hospitals are allowed to spend 5 percent of their primary care program funds on capital costs, such as those incurred in building a primary care center.

- *Medicaid expansion:* Eight percent of the FY 2004 ICTF went to expanding eligibility under Medicaid to pregnant women and children,[14] as well as to support an increased number of eligibility caseworkers.

- *Nursing-home payments:* Georgia policymakers realized that some nursing homes shoulder as costly a burden as do hospitals when it comes to taking care of indigent patients. The state's solution was to collect fees from all of Georgia's nursing homes, and then draw down federal matching funds, to support nursing homes that treat a disproportionate share of indigent patients. Thus in FY 2004, these facilities received almost 33 percent of the ICTF.

- *Access to care initiatives:* One-half of 1 percent of the fund is allocated to initiatives that support services to indigent patients being treated for cancer or other high-cost chronic illness.

Time Frame

The Indigent Care Trust Fund, being part of the general Medical Assistance budget, is re-appropriated each budget cycle.

Required Legislation/Authority

The Indigent Care Trust Fund was created by the Official Code of Georgia Annotated, Title 31, Chapter 8, Article 6. In addition to the authorizing legislation, the Department of Community Health issues annual rules (Chapter 350-6) regarding the operation of the fund.

Financing Mechanisms

Georgia collects fees from hospitals, nursing homes, ambulances, and other sources, and it uses these revenues to make up the state share of its Medicaid DSH payment. The state then draws down matching funds from the Centers for Medicare and Medicaid Services (CMS) and distributes a portion of the total to the programs described above. CMS

matches 60 percent of the state's share for benefit expenditures and 50 percent of its share for administrative expenditures. The program does not utilize any general-fund dollars.

Efficiencies

The ICTF's primary care program component perhaps demonstrates best how the fund stretches dollars and creates cost efficiencies in service delivery. An examination of 82 ICTF-participating hospitals yielded numerous instances of the 15 percent set-aside for primary care programs leading to measurable cost savings. Examples include:[15]

- Using a data-tracking system, a rural medical center documented significant cost savings attributable to its disease-management programs for patients with hypertension, diabetes, and chronic obstructive pulmonary disease. The hospital attributes these savings to the fact that patients are receiving preventive care and having their needs managed, thereby needing fewer high-cost services to treat their conditions. Much of the high-cost care patients had previously received was financed through uncompensated care funds, for which the hospital was not reimbursed fully for its costs.

- Another hospital that set up a disease-management program for chronically ill patients reported a 55 percent decrease in hospitalizations among those who participated in the program, compared to those who did not participate.

- Three urban hospitals spent their primary care program dollars to hire a staff person to coordinate patients' enrollment into pharmaceutical companies' pharmacy-assistance programs, which provide discounted and sometimes free prescriptions to the elderly—at least, in principle. But because each program requires a separate enrollment process and can be difficult for the sick or elderly to navigate, they are not always utilized to the patient's advantage. By hiring someone to serve as a liaison between the hospital, the patient, and the pharmaceutical company, these three hospitals realized savings of $500,000, $1.1 million, and $5 million.

Challenges and Future Plans

Given its broad base of state funding and its ability to draw down federal DSH matching funds, the ICTF appears to be a stable and sustainable program. However, there are concerns among some hospitals regarding the 15 percent primary care program mandate. Although it supports the ICTF as a whole, the Georgia Hospital Association has opposed the primary care program, arguing that hospitals should be allowed to decide for themselves how to use *all* of their DSH dollars. Much of the opposition is from urban

hospitals that see a higher volume of uncompensated care patients and have less flexibility to set aside 15 percent of their ICTF funds. Conversely, rural hospitals tend to favor the set-aside because it finances activities that relieve some of the pressure on their emergency departments.

In the most recent rule-making cycle, the Department of Community Health proposed a compromise by reducing the percentage of set-aside funds for primary care from 15 percent of *gross* DSH transfer to 15 percent of *net* DSH transfer, which would have reduced the total level of primary care funds by almost 50 percent (from $63.5 million to $34 million in 2003). If passed, the new rule would have left hospitals with more of their DSH funding to be used toward financing general service delivery, and less to put aside for primary care programs. The proposed rule change did not pass, however, and the funding equation will remain as it is for 2004.

For More Information

Web sites:
http://www.dch.state.ga.us
http://www.gsu.edu/%7Ewwwghp/publications/coverage/ICTF.pdf

Contact: Julie Kerlin, Communications Director, Department of Community Health. E-mail: jkerlin@dch.state.ga.us.

SNAPSHOTS OF ADDITIONAL INNOVATIVE DSH FUND INITIATIVES

MAINE: COVERAGE EXPANSION TO ADULTS WITHOUT DEPENDENT CHILDREN

Implemented October 2002

Through an 1115 HIFA waiver, Maine is transferring unused DSH funds, supplemented with tobacco-tax revenues, to finance a Medicaid expansion to adults without dependent children. Adults with income up to 100% FPL are eligible, and as of June 2003 over 15,000 adults had enrolled in Medicaid as a result of the expansion. Enrollees obtain the full Medicaid benefit package through a primary care case-management program. Since the expansion, the state has passed legislation to raise eligibility to 125% FPL in the target population of adults and also to include parents at or below 200% FPL. These efforts are part of Maine's Dirigo plan to achieve universal coverage in the state (described further in *Building on Employer-Based Coverage* report).

For More Information: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46180.

MICHIGAN: ACCESS HEALTH

Implemented 1999

Developed by the Muskegon [County] Community Health Project, Access Health is a subsidized health coverage program that targets the working uninsured in small and medium-sized businesses. The program can ultimately serve up to 3,000 full- or part-time workers; as of 2003, it enrolled 1,500 workers in 400 businesses. Access Health covers physician services, inpatient and outpatient hospital services, emergency-department care, ambulance service, testing and lab procedures, and home-health measures.

Access Health is based on the "three-way share" model: an employer share (30%), an employee share (30%), and a community share (40%). Each dollar of the community's contribution is matched by $1.29 in federal DSH funds. The county anticipates that with full enrollment, the program will generate approximately $5 million in new funding that could support the 97 percent of county providers who participate in the program. While enrollment has not yet hit the maximum capacity, the state's Medicaid agency is hoping to receive approval from CMS for more DSH dollars to fund this program, as well as others around the state that would emulate it.

For More Information: http://www.mchp.org/html/ah.html.

MASSACHUSETTS: UNCOMPENSATED CARE POOL

Pool implemented 1985; 12 demonstration projects funded since 1997

Massachusetts' Uncompensated Care Pool reimburses hospitals and community health centers that provide care to eligible low-income uninsured people.[16] In FY 2004, the pool was financed through assessments on hospitals ($157.5 million) and insurers ($157.5 million), intergovernmental transfers, state funds ($30 million), federal matching DSH dollars ($110 million), tobacco settlement funds, and other sources for a total of $693 million. Hospitals and community health centers submit bad-debt charity-care expenses to the state, and they receive a portion back to promote the use of primary care. The two largest providers, Boston Medical Center and Cambridge Health Alliance, created "health plans" for the uninsured and issued membership cards that provide access to primary care. To patients, these programs provide access that insurance would provide, though care is paid for by the pool.

The pool has also funded a number of demonstration projects to test methods for improving access, care, and health outcomes and for reducing costs among uninsured people with chronic conditions. The projects have had mixed results on reducing costs. But they have generally shown that case management, emphasis on primary care, patient/family education, and other interventions for high-risk patients have improved care and health outcomes.

While successful in improving access, the pool has suffered chronic shortfalls and unsustainable funding, thus requiring many revisions in its financing structure over the years. Reforms have included a recent switch to prospective reimbursement (payments for specific diagnoses set in advance) and use of one application both for the pool and Medicaid (enabling the state to screen and enroll eligible people into Medicaid, thereby potentially reducing the number of individuals for whom the pool subsidizes care). Another reform has been the cessation of funding for outpatient primary care services performed in a hospital setting if the hospital is within 15 miles of a community health center (unless the patient's condition requires a hospital setting).[17]

For More Information: http://www.mass.gov/dhcfp/pages/dhcfp_22.htm.

SNAPSHOT OF INITIATIVE TO WATCH

LOUISIANA: LA CHOICE

Under development, pending HIFA waiver submission and approval

The Louisiana Department of Health and Hospitals is planning to submit a HIFA waiver proposal to CMS that would enable it to expand coverage to several populations. One component of the waiver involves creating an insurance-type product for small employers; it would use reallocated DSH dollars to help subsidize premiums for workers with income lower than 200% FPL.[18] In order to assess the impact of such a reallocation, the state is conducting a survey to determine the demographics and utilization needs of those who are now being served with DSH funds. A pilot program, called "LA Choice," is expected to begin enrolling employees in April 2005. Planners hope to cover approximately 3,000 individuals.

NOTES

[1] DSH funds are associated both with Medicaid and Medicare, and states have virtually no role in the allocation of Medicare DSH funds.

[2] Medicaid DSH was cut by more than $1 billion in 2003, affecting 35 states (Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, "States' Use of Medicaid UPL and DSH Financing Mechanisms," *Health Affairs* 23 [March/April 2004]: 245–57).

[3] David Mirvis, *Health Care on a Tightrope: Is There a Safety Net? Part I: Uncompensated Care* (Memphis, Tenn.: Center for Health Services Research, University of Tennessee, 2000), http://www.utmem.edu/CENTER/HealthPolicyReports/TightropeI.pdf.

[4] An IGT is a fund exchange within or between different levels of government. In the context of DSH payments, IGTs generally refer to payments made by public institutions (e.g., state psychiatric facilities or county, metropolitan, or university hospitals) to the state to help draw a federal match; the funds are generally distributed back to the institutions in the form of DSH payments. In a study of 34 states in FY 2001, IGTs made up approximately 45 percent of those states' share of DSH dollars.

[5] These concerns are compounded by reductions in Medicare and Medicaid reimbursements and private-insurance/managed-care payments that in the past have helped subsidize uncompensated services ("Expanding Health Care Coverage and Access," American Hospital Association Advocacy Paper, 2001, http://www.aha.org/aha/advocacy-grassroots/advocacy/advocacy/Advoc2001Expanding.html).

[6] FFY 2002 Form CMS-64 Expenditure Reports. Amounts are unadjusted by CMS. April 14, 2003.

[7] New Mexico, for example, uses revenues collected through the local county property tax (a.k.a. "mill levy") to create county-level indigent care funds. In Bernalillo County, this fund provided approximately $50 million (FY 2002) for the operation of the UNM Care Program—a primary care program, run by the University of New Mexico Health Science Center, for the uninsured below 235 percent of the federal poverty level.

[8] Wisconsin State Planning Grant Briefing Paper No. 5, September 2001.

[9] Teresa A. Coughlin et al., *Health Policy for Low-Income People in Wisconsin* (Washington, D.C.: Urban Institute, December 1998).

[10] Intergovernmental transfers (IGTs) involve a transfer of funds within or between different levels of government. Wisconsin Act 9 of 1999 authorized the Department of Health and Family Services to receive an IGT, which is then matched with federal Medicaid funds and distributed to two GAMP hospitals: Froedtert and Sinai Samaritan Hospital (Rachel Carabell and Richard Megna, *Medical Assistance and Badger Care,* Informational Paper #43 [Madison, Wisc.: Wisconsin Legislative Fiscal Bureau, January 2001]).

[11] *Healthy People . . . A Healthy Return on Investment,* Milwaukee County Division of Health Related Programs, Department of Administration, 2003. Figure is based on year 2000 client volume and 1997 average-claims-per-client numbers and average costs per claim (adjusted for inflation).

[12] Rules Chapter 350-6 of the Indigent Care Trust Fund defines "medically indigent" as someone with income no greater than 200 percent of the federal poverty level.

[13] The transfer funds are provided by units of government that own hospitals.

[14] Income eligibilities for these populations are as follows: pregnant women, 235% FPL; birth to age 1, 185% FPL; ages 1 to 6, 133% FPL; and ages 6 through 18, 100% FPL.

[15] "Review of the Primary Care Portion of the Indigent Care Trust Fund: Final Report," The Georgia Health Policy Center, for the Georgia Department of Community Health, Master Contract 0209, January 2004.

[16] Individuals with incomes below 200% FPL qualify for full free care from the Uncompensated Care Pool; and those with income between 201% and 400% FPL qualify for partial free care, which requires an annual deductible. Under extraordinary medical hardship, individuals of any income level can have the pool pay for services beyond the patient's ability to pay.

[17] The latter restriction reflects regulations released on July 16, 2004. See http://www.hcfama.org/_uploads/documents/live/Summary_UCP_Regs.pdf.

[18] Other components of the first phase of waiver activities include: coverage expansion to employed parents of children enrolled in the State Children's Health Insurance Program; and expansion, using federal dollars, of a currently state-funded high-risk pool for the medically indigent. The state's legislature has signaled that it would appropriate the $1.5 million requested for Phase One in the FY 2005 budget, pending CMS approval of the waiver. The state is considering dropping a second phase of the waiver, which would have created a limited Medicaid benefit for uninsured people who do not meet the required cost-effectiveness test for receiving premium assistance through the Medicaid Health Insurance Premium Program.

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Medicaid Coverage for the Working Uninsured: The Role of State Policy (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs,* vol. 21, no. 6 (*In the Literature* summary). The authors conclude that insurance coverage rates for low-income workers would increase if state governments chose to do more for their uninsured workers. But states decline to tackle this issue for several reasons. Federal law requires them to cover many low-income nonworkers before they insure workers. As well, poorer states cannot afford much coverage for their low-income workers.