Changes in Health Care Financing and Organization

Deriving Best Practice Models for the US Health Care Safety Net: A Cross-State Meta Analysis of Finance, Organization and Outcomes

A. Nature of the research or evaluation and its significance

One in six Americans is uninsured, underinsured, a Medicaid beneficiary, or a patient with special health care needs. These individuals obtain healthcare access (as well as the care itself) through a complex patchwork of institutions, financing sources, and programs that are collectively characterized as the nation's "healthcare safety net." However, the fact that it is portrayed as an existing network should not disguise the fact that this "system" is neither comprehensive, nor integrated.

When viewed from a national perspective, local and regional safety net implementations exhibit idiosyncratic differences that result from locally relevant socioeconomic and political conditions. These include the strength and configuration of a state's economy and tax base, the density of poor and uninsured, as well as the specific regulatory environment that governs a state's Medicaid eligibility and benefits (Altman and Levin, 2000).

What is consistent across jurisdictions is a steady increase in demand as well as a managed care mandate from Medicaid, accompanied by decreasing financial support at the state and national level. The convergence of these forces is placing ever-greater strain on the healthcare safety net. This strain leads to both a reduction in healthcare access for the most disadvantaged populations and to changes in the finance and organizational structure of Safety Net providers, predominantly through consolidation (Altman and Levin, 2000). Core "Safety Net Providers" (SNPs) in the United States are responding to these challenges with efforts to consolidate the collection of

information and the integration of services/management.[1] Presently it is not clear which types of SNPs finance and organizational structures provide the most satisfactory outcomes. On an even more basic level, it is unclear to SNPs in specific states how to best accommodate to their specific regulatory environments. Current changes in the finance and organization on the SNP level are informed by trial and error or by pilot projects. In cases where finance and organizational change has been successful, it is often difficult to determine if success is due to enabling regulatory environments, or due to SNP specific changes/characteristics that are independent of the regulatory structure.

An equally important consideration is that consolidation among SNPs, though identified as an optimal response to changing policies and financing (see, HRSA website), may in fact be nothing more than a survival strategy in response to manifest (dis)stress. It has not been studied on a national level if and how consolidation and changes in financing and organization can deliver cost savings while maintaining equal quality care. In reading through the variety of state regulations and healthcare safety net outcomes, one is struck by the complexity and variations of local SNP structure that have evolved in response to their financial circumstances. There is a clear lack of sufficient and comparable data that can be used to reach empirical conclusions that are evidenced-based (Altman and Levin 2000).

Consolidations and change in the structure of financing and organization of SNPs, either as signs of "success" or "distress", are responses to the "reduce costs and increase quality" mandate. These responses are as diverse as the environments from which they spring. However, since no national model exists to guide this consolidation process, neither the state regulators nor the community health organization executives have any data-based guidelines that can be used to inform the regulatory environment (e.g. the state level), and / or assist SNPs' efforts to identify effective and viable consolidation strategies given their regional constraints. In essence, the nation is currently engaged in a series of parallel "field trials" (e.g. uncontrolled experiments)

[1] The Institute of Medicine defined SNPs as "those providers that organize and deliver a significant level of health care and other related services to the uninsured, Medicaid, and other vulnerable patients." Core safety net providers are identified as those with "a mission or mandate to offer patients access to care regardless of their ability to pay, and a patient mix with a substantial share of uninsured, Medicaid, and other vulnerable patients." Within this context we will focus on public hospitals, community health centers and local health departments.

each of which is, in some form, a response to the unique economic and political environment of that region.

In its 2000 report the Institute of Medicine, funded by HRSA's Center for Managed Care noted a "lack of sufficient and comparable data that can be used to reach ... empirical conclusions." In the intervening years substantially more data have become available. So, for example, the RWJ funded "State Coverage Initiative" has generated extensive state-by-state summaries of changes in the regulatory environment and the responses these changes have engendered. Concurrent with this baseline analysis, the state safety net systems themselves have had sufficient time to develop to the point where it is meaningful to evaluate both financial and health outcomes.

These accumulating data sources can guide the development of a regulatory framework that provides the appropriate incentives to empower a financially viable healthcare safety net. In light of the intra-state differences, it is unlikely that universally applicable guidelines can or should be defined. Consequently, it is essential to identify not only the different types of state regulatory environments but also the associated best responses from the SNPs. This will allow states to better understand their choices in regulatory environments and to project what type of SNPs operate most successfully in their state. Similarly, SNPs can be guided by relevant experiences in other states to optimally integrate changes in organization and finance in response to specific regulations.

B. Review of similar and relevant prior policy and research studies

Individual state studies on the structure, organization and outcome profiles are numerous; the Robert Wood Johnson *State Coverage Initiative* alone provides full access to over 660 state reports. One comprehensive national study exists: the 2000 Institute of Medicine Report on the US Safety Net that is based on about 60 prior individual state and several comparative studies that investigate a subset of states. Chapter 4 of the 2000 IOM Report dramatically highlights the important insights and spotty nature of state and comparative state reports. Comprehensive national analyses do not exist; therefore we have no examples of best practices across states. The

current set of pilot studies are reported without establishing a possible link to specific regulatory environs.

In addition to the Robert Wood Johnson *State Coverage Initiative* reports studies like Felland et al (2003) or Westpfahl Lutzky, Holahan, and Wiener , (Urban Institute 2002) produce comparative surveys of multiple SNP sites, while comparative analyses like Bernstein et al (2000), Gusmano et al (2002), Richardson et al (2001) or Waitzkin (2002) examine one specific feature of the Safety net system across states (Medicaid, Health Plans, Emergency Departments, or Rural Health Performance, respectively). The establishment of meaningful Health Policy/outcomes and Socioeconomic/demographic summary statistics will be greatly aided by the recently released Kaiser Foundation's *State Health Facts Database* (2003), which provides a unique basis for cross state comparisons in socioeconomic backgrounds and health services and outcomes. Connecting the wealth of socioeconomic background and health outcome data with organization and finance structures combines the Robert Woods Johnson's State Coverage Initiatives and the Kaiser Foundations State Health Facts for a unique perspective that links organization and outcomes.

A literature survey, extensive inquiries at the Commonwealth Fund, and with a leader in the field, such as Sara Rosenbaum (George Washington University) have produced encouragement but no leads to recent or ongoing research on a national synthesis of the nation's cross-state regulations or SNP structures.

C. The project's approach and methodology

The accumulating data sought by the IOM 2000 to enable a comprehensive, national comparative inter-state analysis are now available. To that end we propose a meta-analysis of the existing regulatory environs and diverse SNP responses in the 50 United States to outline and synthesize best practice regulations and best policy responses.

Our proposed study consists of 3 major parts: first, the identification of a regulatory and outcome characteristics matrix. Second, a meta-analysis of the matrix will be conducted to identify

associations between regulatory environs and outcomes. Finally, best practice regulatory environs and best response finance and organizations structures will be developed.

The outcomes of the study can then be summarized as follows:

1) Development of a national Safety Net regulation, finance, organization and quality characteristics matrix
2) Established correlations between specific regulatory characteristics with SNP outcomes
3) Identified best policy practices and best SNP response strategies to a given regulatory environment.

Identification of Relevant Characteristic Variables

The meta-analysis requires an organizing framework that enables study selection and data collection. Before the meta analysis can be conducted, the research project must establish a set of variables that identify a set of descriptive dimensions and shared characteristics that can be used to effectively and succinctly summarize (a) the existing policies and regulations by which state agencies distribute available funds, (b) the demographics and health care needs of the population to be served, (c) state level SNP organization, financing and health outcomes. Common characteristics may possess qualitative or quantitative attributes. The definition of the variables then guides study selection and the actual data collection.

The qualitative data currently available on state SNP regulation and performance (see review of the literature) will be utilized to establish the relevant variables. The project team will examine the literature from a Health Policy/outcomes and Socioeconomic/demographic perspective to establish meaningful measures as a basis for summary statistics.

It maybe necessary to augment the existing data to produce conforming information sets across states. We anticipate the need to generate some additional information to be relatively small.

Meta Analysis: Linking regulations with organization and outcomes.

Once the variables of interest are established they can be used to identify the dimensions of a characteristics matrix. The meta-analysis codes each state's data using the derived variables and dimensions to subsequently identify homogeneous clusters that can be regarded as the current national prototypes of the a) regulatory environments, b) population(s) being served, and c) the resulting SNPs' financing, organization and outcomes. This allows us to transform the individual state studies' regulatory and SNP outcomes to a common metric so that they can be compared. The meta-analysis then allows an interpretation of the results of individual state studies in the context of a distribution of regulations and outcomes, partially determined by study characteristics/variables and partially random. This can be used to establish correlations between regulations and outcomes. These relationships are crucial for the determination of best practices.

Devising best practice SNP models

We anticipate that specific regulatory clusters will be found to engender several different SNP prototype responses. When this occurs, an analysis of outcomes specific to each of these SNP will be conducted (e.g. financial and patient health, service record/capacity, etc…). This will enable us to develop a set of "good, better, best" suggestions associated with specific local constraints. The criteria for interpreting the findings will be the SNPs financial health and health outcomes.

Establishing best practices from existing successes and failures is important to provide guidance to SNPs in their attempts to survive the ever-greater financial. The proposed study thus transforms the wealth of existing individual study regulation/outcomes studies into a common metric that links clusters of regulatory categories with ranked health organization and service outcomes. This analysis will enable state and federal regulators to match policies with desired outcomes. To our knowledge this will be the first time that successful performance of the national safety net will be linked to specific policies and their associated environments. At the same time the study can serve as a roadmap for individual SNPs to guide their efforts to successfully launch consolidation / integration transformations.

The nature of case studies is that they inform general theory that applies under given situations. The next step is to synthesize the information in the case studies in a first effort to move from antidote to evidenced practice.

The detailed work plan

A key strength of the proposal is the multi-disciplinary group that has gathered to perform this qualitative analysis. Participants have been selected from diverse disciplines (e.g. economics, health sciences (providers and advisors), and informatics/information systems). This diverse mix of skills, backgrounds and disciplines enables a multidimensional examination of currently intractable problems. Team members will independently summarize the existing data contained in state reports based on their area of expertise. Subsequently the group will meet to formulate consensus collectively, identifying dimensions that adequately describe relevant components and distinctive features of the states' safety net.

Timeline

Month	Activity
1 - 2	Subset of researchers read all state reports, (all researchers read at least 25 percent of the reports) to identify organizational characteristics and outcome patterns.
3 - 4	Establish a matrix of investigative categories
5 –6	Code and categorize all reports
7 – 8	Establish links between categories and outcomes
9 - 11	Devise policy implications for best practice outcomes

D. Barriers impeding implementation

None known barriers of implementation exist

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