CUTBACKS

CONTINUED FROM PAGE 1

ing the pinch."

WINNERS AND LOSERS

When the *Philanthropy Journal* went to press, the House and Senate still were debating proposals to significantly slow the growth of Medicare and Medicaid spending in order to balance the federal budget.

Cullen Gurganus

Some Republican leaders also want to change the entitlement status of the two health programs by providing Medicare on a fixed-payment basis and transforming Medicaid into a block grant program to states.

In North Carolina, the focus of attention has been on Medicaid spending, which rose by an average of 23 percent each year between 1988 and 1993 because of higher numbers of people enrolled in the program.

The number of North Carolinians eligible for Medicaid rose from 481,100 in 1988 to more than 1 million in 1994, because of an expansion of coverage for low-income children and pregnant women.

The state spends about $3.3 billion a year - including $2.75 billion in federal funds - on Medicaid. While almost half of Medicaid recipients in North Carolina are children, nearly two-thirds of the state money spent on the program is used for treatment of the elderly and disabled.

State officials are worried that Medicaid restructuring plans being discussed in Washington are based too heavily on enrollments and don't take into account spending per patient - which in North Carolina remains among the lowest in the U.S.

Barbara Matula

"There are winners and losers under the current proposals," says Barbara Matula, the state's medical assistance director. "The winners are low-growth states with high [per-patient] costs like New York and the losers are high-growth states with low costs," like North Carolina.

Late last year, Matula and other officials successfully argued for a formula change that would allow North Carolina to include 73,000 new Medicaid recipients as a basis for distributing funds under a proposed block grant system. But even under a more favorable formula, the state could still lose up to $4.2 billion in federal funds over the next seven years.

While Medicaid block grants would give states more flexibility over spending, they also would eliminate rules covering who is eligible and what the rate of reimbursement would be to health providers, Matula says.

That's a key concern for Tar Heel hospitals, which are more dependent on Medicaid dollars than are their national counterparts.

Studies by the North Carolina Hospital Association show Medicaid discharges accounted for nearly 20 percent of the state's 1994 acute-care discharges, compared to a national average of 13.8 percent.

On the other hand, North Carolina hospitals were able to recoup only 80 percent of the costs of Medicaid services, compared to a national average of 93 percent. Medicaid reimbursements are based on a number of factors, including whether a hospital is rural or urban and the level of local market prices for medical services and salaries.

BEARING THE BRUNT

At a recent meeting of the North Carolina Health Reform Commission, hospital officials and leaders of state agencies described which institutions they believe are most vulnerable to Medicare and Medicaid cuts.

Among the most affected, they said, will be rural hospitals, community health clinics and academic medical centers that have a higher-than-average share of poor and uninsured patients or spend added money on teaching and research.

That assessment is no surprise to Leo Petit Jr., chief executive officer of Bladen County Hospital in the southeastern corner of the state.

"Most rural hospitals have a larger share of the Medicare and Medicaid business" he says. "To the extent that there is money taken out of those systems, it will really make it difficult for rural hospitals. We don't have the war chests that big urban hospitals do. And there are more uninsured in rural areas because most of the businesses here consist of five to 10 people and they can't afford insurance" for employees.

Anticipating a period of shrinking resources, Petit says Bladen County Hospital - which has 62 general and 52 nursing home beds - is working hard to reduce costs through layoffs and reassignments. The hospital also is part of a nine-hospital alliance that is seeking to attract managed care contracts.

MANAGED CARE ERA

Along with looming government cutbacks, the rapid growth of managed care in North Carolina is increasing pressure on rural hospitals, community-based clinics and academic health centers.

Under managed care, the practice of "cost-shifting" - paying for care for the uninsured or for research projects by shifting costs to other patients - is no longer an option.

And because most health maintenance organizations serve healthy populations and are attracted to urban markets with large populations, they are unlikely partners for health-care organizations in rural and under-served areas.

Some experts believe that managed care's focus on cost and efficiency makes the system a useful model for future Medicaid and Medicare service delivery.

"Many people believe that moving those programs to managed care is the way we will respond to these [proposed government] cuts and try to save money," says Ellen MacMillan, vice president of the state hospital association. "We think there's just not enough experience yet to know if that is a proven thesis."

Matula, the state's Medicaid director, says her office is trying to create interest in setting up local managed-care systems for the disabled. An experimental program that will offer managed care to Medicaid recipients in Charlotte should be off the ground in June.

WHAT'S TO BE DONE?

Until firm decisions are made in Congress about the future of Medicaid and Medicare, many North Carolina health-care leaders are adopting a wait-and-see approach to the issue. But some have responded publicly.

The state hospital association has joined its national counterpart in lobbying against government health-care reductions that it says are "too deep, too fast" and unrestricted Medicare block grants that could hurt the quality of health care. The association also has called for an independent commission to handle restructuring of Medicare and Medicaid.

And the deans of North Carolina's four academic medical centers have been meeting monthly to discuss developments and plan ways to keep state legislators "informed of the value of academic medicine," in the words of James Thompson, dean of the Bowman Gray School of Medicine in Winston-Salem.

Despite the anxiety over federal reductions, the state's leading health-care funders say they have not yet experienced a noticeable increase in requests for grant money from hospitals and other health-care institutions.

"I think the increased numbers of requests we have received are simply because hospitals are doing more in their communities, not because of what is happening in Washington," says Eugene Cochrane, head of the hospital division at the Charlotte-based Duke Endowment.

Although Medicaid and Medicare cuts will have an impact on the state's hospitals, Cochrane is optimistic that most will survive.

"I have been doing this for 15 years and the issue of hospitals closing and going away has come up in several different studies," he says. "In all honesty, we have not seen that. Of course, the [hospital] institution today is very different in terms of the services and kinds of patients being taken care of. That's going to be interesting to watch."

One problem with the current debate over Medicare and Medicaid is that it ignores the issue of the uninsured, says Petit of Bladen County Hospital.

Beverly Perdue

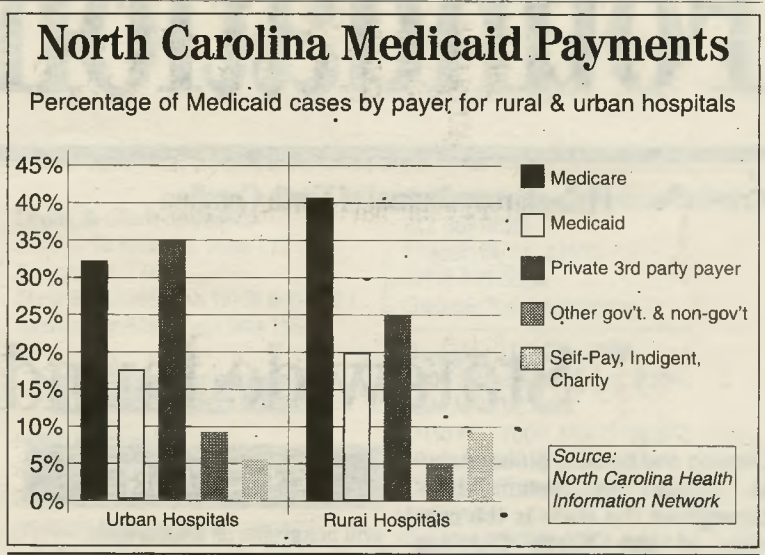
"From everything we see and understand, the number of uninsured is going to rise," he says. "If Medicaid and Medicare are cut back, where do we get the money to provide services for them?"

Others are concerned that decisions on Medicare and Medicaid funding are being made based on misunderstandings about which populations the programs actually serve.

"The citizens of this country have not been able to separate the discussion of welfare reform and Medicaid cuts," says state Sen. Beverly Perdue, D-Craven. "Less than 25 percent of the Medicaid dollar goes to that dependent mother [on welfare]. Most of it goes to health care for the mentally ill and the elderly. That's been my dilemma, trying to raise the consciousness of those in the General Assembly that what we are actually talking about is somebody's mother in a rest home or nursing home."

For Remmes of the Rural Health Group, the key issue is not so much whether government-funded health programs will change, but how fast and far-reaching that change will be.

"I can do fine the way we are now, we will survive. And I can do OK in four to five years when everything has shaken out," he says. "I'm just not sure how the transition will go."



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MCKEE

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take a look at the increasingly complex system of home-loan origination and closing, and how it can be streamlined.

McKee has worked for Self-Help since 1986. From December 1994 through June 1995, she took a leave to serve as transition director for the Community Development Financial Institutions Fund in the U.S. Treasury Department. The Clinton Administration created the program to provide capital and assistance to such lenders throughout the U.S.

Coincidentally, McKee and Lawrence Lindsey, the Fed governor who serves as liaison to the council, were classmates at Bowdoin College, where they studied economics.

Among nine new members named to the Fed's Consumer Advisory Council is Margot Saunders, managing attorney for the Washington office of the National Consumer Law Center and a former attorney with the North Carolina Legal Services Resource Center and the Governor's Advocacy Council for Children and Youth, both in Raleigh.

Todd Cohen