



## FORUM SESSION

# Examining the Condition of the Health Care Safety Net:

## Time to Re-Cast?

MAY 18, 2012

### OVERVIEW

*This Forum session explored the current status of the health care safety net. A health policy researcher along with representatives from a federally qualified health center and an academic medical center discussed how safety net providers have fared through the economic downturn and shared strategies for strengthening financial performance while expanding access to care and improving patient outcomes. The pressures these providers face and their future plans, given the uncertain health care landscape, were examined.*

### For additional information:

- Jessamy Taylor, "The Primary Care Safety Net: Strained, Transitioning, Critical," National Health Policy Forum, Background Paper No. 79, September 28, 2010, available at [www.nhpf.org/library/details.cfm/2822](http://www.nhpf.org/library/details.cfm/2822)
- Christie Provost Peters, "Medicaid Disproportionate Share Hospital (DSH) Payments," National Health Policy Forum, The Basics, June 15, 2009, available at [www.nhpf.org/library/details.cfm/2745](http://www.nhpf.org/library/details.cfm/2745)
- See Aaron B. Katz *et al.*, "A Long and Winding Road: Federally Qualified Health Centers, Community Variation and Prospects Under Reform," Center for Studying Health System Change, Issue Brief No. 21, November 2011, available at [www.hschange.com/CONTENT/1257/](http://www.hschange.com/CONTENT/1257/)

### SESSION

Millions of people who would otherwise have little or no access to care rely on the safety net for health care services. This includes the uninsured, those who have low incomes and are underinsured, Medicaid beneficiaries, and other disadvantaged populations made vulnerable by poverty or poor health status. The

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safety net is difficult to define nationally because the providers and funding streams that constitute it vary from community to community. Despite this variability, wide use of the Institute of Medicine's (IOM's) 2000 report, *America's Health Care Safety Net: Intact but Endangered*, has produced some definitional consensus. The IOM report defines safety net providers as "those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."<sup>1</sup> These include federally qualified health centers (FQHCs), free clinics, public hospital systems, and local health departments. In some communities, school-based health centers, nurse-managed health centers, retail clinics, rural health clinics, emergency departments, private not-for-profit hospitals, academic medical centers, and private providers also play a significant safety net role.<sup>2</sup>

Safety net providers spend a lot of energy scraping together funds from multiple streams, including local, state, and federal governments and private sources, to pay for the care they provide. However, the financial complexity and status of safety net providers varies greatly.<sup>3</sup> For example, the majority of free clinics do not receive any local, state, or federal government revenue; they rely primarily on volunteers and charitable donations. On the other hand, FQHCs and safety net hospitals rely heavily on Medicaid, and any related policy changes significantly affect them. Medicaid is required to pay FQHCs using a prospective payment system (PPS) based on each center's costs from federal fiscal year 1999–2000, indexed for inflation. This payment method results in FQHCs often receiving higher payments for the same services provided to Medicaid beneficiaries by community-based physicians. Safety net hospitals receive Medicaid disproportionate share hospital (DSH) payments to help cover the uncompensated hospital care they provide.<sup>4</sup> While these hospitals also serve a significant number of uninsured people, they tend to serve more privately insured and Medicare patients than FQHCs. The varied types of funding, differing levels of payment, and range of local expertise and capacity to acquire funding mean that safety net capacity across the country is uneven, leaving significant gaps in access to care in many places.

Like all health care providers, safety net organizations anxiously await the outcome of the Supreme Court's decision on the health reform law. Health insurance expansions could be a boon for safety net providers if they go forward, particularly through Medicaid for low-income people. However, safety net providers may face increased competition for newly insured patients, and Medicaid payment rates

as well as the rates and terms of contracts with private insurers will be critically important to their financial viability. At the same time, an estimated 23 million nonelderly people living in the United States will remain uninsured and will continue to depend on those providers' willingness to serve them, regardless of their ability to pay.

In addition to coverage changes that impact safety net providers, the Patient Protection and Affordable Care Act (PPACA) features a number of efforts to improve health care delivery by strengthening the coordination and integration of care. Accountable care organizations (ACOs) and primary care medical homes are two examples. On the primary care front, many safety net clinics are pursuing patient-centered medical home recognition from the National Committee for Quality Assurance (NCQA). The Center for Medicare & Medicaid Innovation at the Centers for Medicare & Medicaid Services (CMS) is also promoting primary care through the Federally Qualified Health Center Advanced Primary Care Practice Demonstration. By improving the quality of care they provide—and being recognized for it—safety net organizations hope to maintain and even increase their service to the newly insured. Safety net providers' mission to serve the community and coordinate care also aligns well with the goals for ACOs, but some have expressed concerns about the readiness of safety net systems to join such organizations or create their own.<sup>5</sup> Although CMS's ACOs target Medicare patients and safety net providers do not typically serve large numbers of them, some states are adapting the concept of the ACO pursuing similar initiatives in their Medicaid programs.<sup>6</sup>

This Forum session explored the current state of safety net providers, particularly how they have fared during the most recent economic downturn. It looked at strategies that safety net providers are using to bolster their organizations' financial performance while expanding access to care and improving patient outcomes and satisfaction. The session also considered their future plans, given the uncertain fate of the health reform law, and the many ways its reversal or upholding would affect them.

## KEY QUESTIONS

- What is the current financial status of safety net providers? How have they fared during the recent recession? What has been their experience in terms of demand for services? Capacity for capital improvements? To what degree do these circumstances vary across the country?

- What are the capacities of safety net providers in responding to these economic pressures? What strategies are they pursuing?
- What are the greatest challenges safety net providers face? Areas of greatest opportunity?
- Given the uncertainty around the health reform law, how are safety net providers approaching the future?

### SPEAKERS

**Peter Cunningham, PhD**, is a senior fellow and director of quantitative research at the Center for Studying Health System Change. He has participated in the Community Tracking Study, a longitudinal study of the U.S. health care system funded by the Robert Wood Johnson Foundation that has been tracking changes in the health systems of 12 communities since 1996. As part of site visits to these communities, Dr. Cunningham has interviewed many safety net providers, and he described the financial and competitive pressures they encounter and their effect on access to care in their communities.

**Sheldon Retchin, MD, MSPH**, is chief executive officer of the VCU Health System and vice president for health sciences at Virginia Commonwealth University. VCU Health System is a major academic health center and safety net provider in Richmond, Virginia, with 865 licensed beds; close to 34,000 admissions; and 550,000 outpatient visits annually. He commented on the financial pressures confronting the academic health center and described strategies for addressing them.

**Zara Marselian** is the president and chief executive officer at La Maestra Community Health Centers, a federally qualified health center (FQHC) that serves a diverse refugee and immigrant population in San Diego, California. She described the opportunities and challenges involved in leading an FQHC in the current economic environment.

### ENDNOTES

1. Institute of Medicine, *America's Health Care Safety Net: Intact but Endangered*, Marion Ein Lewin and Stuart Altman, Eds. (Washington, DC: National Academies Press, 2000), p. 21; available at [www.nap.edu/catalog.php?record\\_id=9612](http://www.nap.edu/catalog.php?record_id=9612).
2. For more information on these safety net providers see Jessamy Taylor, "The Primary Care Safety Net: Strained, Transitioning, Critical," National Health Policy Forum, Background Paper No. 79, September 28, 2010, available at [www.nhpf.org/library/details.cfm/2822](http://www.nhpf.org/library/details.cfm/2822).

3. Financial information for the safety net as a whole is not available. For information by provider type, among other information, see Taylor, "The Primary Care Safety Net: Strained, Transitioning, Critical."
4. Christie Provost Peters, "Medicaid Disproportionate Share Hospital (DSH) Payments," National Health Policy Forum, The Basics, June 15, 2009, available at [www.nhpf.org/library/details.cfm/2745](http://www.nhpf.org/library/details.cfm/2745).
5. Mary Takach, Katherine Witgert, and Catherine Hess, "Are Safety Net ACOs a Good Idea? Views from Key Stakeholders," The Commonwealth Fund blog, January 16, 2012, available at [www.commonwealthfund.org/Blog/2012/Jan/Safety-Net-ACOs.aspx](http://www.commonwealthfund.org/Blog/2012/Jan/Safety-Net-ACOs.aspx).
6. Rich Daly, "Sincerest form of flattery: Mimicking Medicare, states want to try accountable care models for Medicaid," *Modern Healthcare*, January 9, 2012, available with subscription at [www.modernhealthcare.com/article/20120109/MAGAZINE/301099972#](http://www.modernhealthcare.com/article/20120109/MAGAZINE/301099972#).