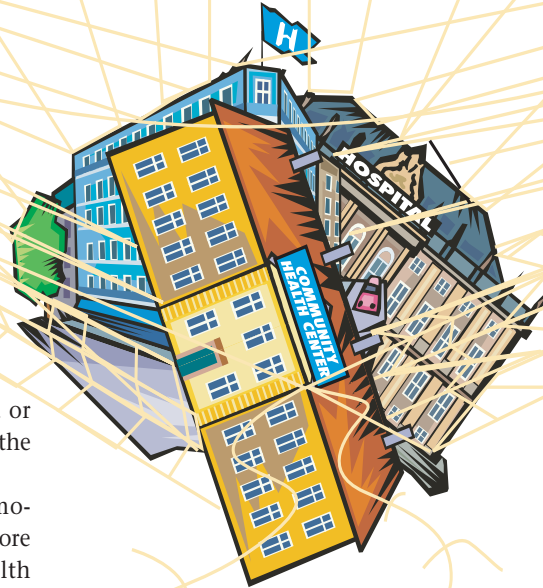


HOW SECURE IS THE SAFETY NET?

THE FUTURE OF THE NATION'S COMMUNITY HEALTH CARE CENTERS AND PUBLIC HOSPITALS IS GRAVE.

By Garry Boulard



The community health center in Council Bluffs, Iowa, serves a largely rural clientele with up to 9,000 patients a year. More than half are on Medicaid or uninsured. Almost a third are at or below the poverty level.

In the scope of its services and demographic base, it is like almost all of the more than 1,000 operating community health centers in the United States—unique to its own service area.

But in an era of historic economic challenges affecting both the nation's community health centers, public hospitals and other safety net providers, the Council Bluffs Community Health Center is hardly singular: it has had to lay off staff, close down a satellite clinic at a nearby two-year college, and even suspend a popular discounted prescription drug program.

One of the reasons for the center's woes stems from the growing number of uninsured patients it has taken on. Between 1997 and 2002, the number of patients served at community health centers grew by 36 percent while the number of uninsured users virtually doubled since 1990.

"The only way a health center can really succeed is with a mix of insured and uninsured," Dr. Bery Engebretsen, interim executive director of the center, recently remarked to the local newspaper, as reductions in the center's services were announced in early January.

"That is one of the big challenges for community health centers," says Engebretsen,

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AMERICA'S HEALTH CARE SAFETY NET: WHO ARE THEY?

Safety net providers organize and deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients. They typically include public hospital systems, community health centers or clinics, local health departments and, in some communities, teaching and community hospitals and private physicians with a demonstrated commitment to serving the poor and uninsured.

—Laura Tobler, NCSL

"to make sure they don't overextend themselves and take on too many uninsured."

IT'S SERIOUS

The picture for community health centers on a national scale is sobering. "Practically every center is financially challenged in its own way," says Amy Simmons, a spokesperson with the National Association of Community Health Centers in Bethesda.

"When you consider that more than 36 million people in this country don't even have access to health care, that is not where we want to be," she says. "We want to be expanding our services, so that we can reach

more people."

The prospects for the nation's public hospitals are similarly daunting.

More than 2,000 have minimal profit margins. "Most of these facilities are running very, very close operations right now," says Christine Burch, the executive director of the National Association of Public Hospitals and Health Systems in Washington, D.C. "About 52 percent of our members actually have negative balances."

Why are safety net providers having such a hard time of it? Reductions in state Medicaid programs combined with an increased number of uninsured due to unemployment or loss of employer sponsored insurance accounts for large parts of the problem.

Medicaid plays an important role in financing health care for the nation's low-income. Nowhere is this more apparent than with our safety net providers—public hospitals, community health centers and other providers that deliver a disproportionate level of health care to the uninsured and those on Medicaid. In 2002, Medicaid served as the largest source of revenue for community health centers and public hospitals—35 percent and 37 percent respectively. Medicaid and uninsured patients make up about 75 percent of the health center patient population compared to 11 percent seen in private practices.

Financing for some community health centers suffered an additional blow because of strapped state budgets. According to a report issued by the National Association of Community Health Centers last summer, some 18 percent of direct state funding—totaling more than \$40 million—was cut in fiscal year 2004.

"The impact was significant, particularly in

the few states where funding was completely eliminated,” contends the report, “Fighting Back—Health Centers Work to Restore State Funding and Medicaid/SCHIP Cuts.”

NO END IN SIGHT

For some states, the cuts will continue. Sixteen states report Medicaid budget overruns. What the states will spend in general fund expenditures on Medicaid this year will be exceeded only by K-12 education.

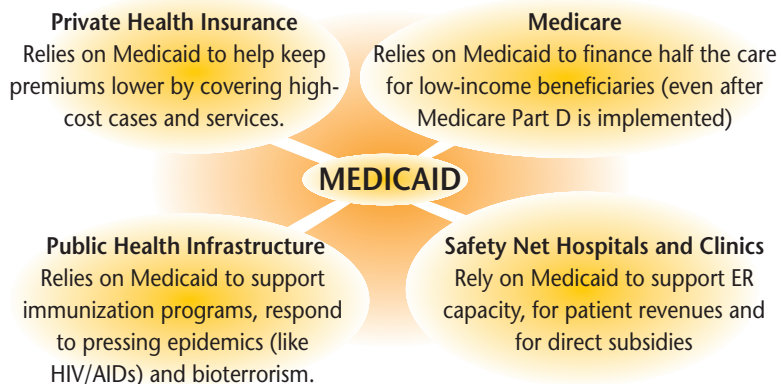
Meanwhile, state Medicaid spending is predicted to jump by 12.8 percent this year. This is in contrast to the relatively low rate of growth—0.6 percent—last year because the federal government assumed a greater share of total Medicaid spending. The growth rate in 2003 was 8.6 percent.

None of the states’ 50 Medicaid directors expect the situation to improve within the foreseeable future, according to an October 2004 survey by the Kaiser Commission.

TOUGH CHOICES

“It is an awful situation for all of us to be in,” says Iowa Senator Maggie Tinsman. “Essentially we are forced to decide between education and health care, between trying to

MEDICAID ENABLES OTHER PARTS OF THE HEALTH CARE SYSTEM TO WORK



Source: The Kaiser Commission on Medicaid and the Uninsured, 2005

provide education for the young, while also maintaining health care services that take care of a tremendous number of older people.”

“A lot of us at the state level don’t think it should come to a war between education and health care,” says Tinsman. “We think it is only reasonable that we should be able to fund both.”

Senator Joseph Vitale of New Jersey agrees. “When we restricted our Medicaid program, the one sure result was a lot of sick kids and

sick adults, versus healthy kids going to school and their healthy parents working where they have access to affordable health care.”

But increasingly, many states are being forced to make such decisions—and each decision carries with it no small amount of controversy.

“I really think in the long run that the Medicaid program needs to be modernized. As it is right now, Medicaid programs cannot afford cuts of any kind,” Rosenbaum says.

One of the reasons it cannot afford cuts, say health experts, is not just because of its current level of coverage—which is already at an all-time high—but because of the anticipated need in the years to come.

“The trend is all in the direction of growth,” says Simmons, who notes that the number of uninsured is going to increase before the decade is out.

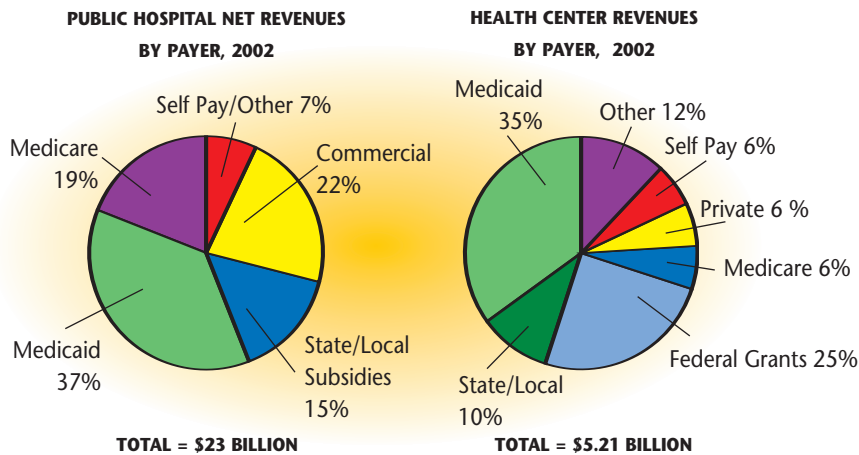
Inevitably, that will mean a significant expansion in patient loads for safety net providers. “That is where the real crisis is going to take place,” says Iowa’s Tinsman. “If we do not have enough money to fund these facilities now, how are we going to do it for double the number of people?”

In addition, adds Burch, budget-cutting by the federal government could make it impossible for the states to do anything else but reduce Medicaid services. “If the feds decide to tighten things up. If we, as a country, are not able to put more people on the insurance rolls. If Washington reduces both Medicaid and Medicare, then it is hard to see how we are going to provide any level of care for that growing number of uninsured.”

A self-described supporter of community health centers, President Bush increased



SAFETY NET PROVIDERS RELY ON MEDICAID FUNDING



Source: The Kaiser Commission on Medicaid and the Uninsured, 2005.

funding specifically for those facilities in the fall of 2002. "Community health centers are America's health care safety net," he said after signing legislation to provide money for the expansion of more centers, particularly in rural and central city areas. This five-year \$2.2 billion initiative will add an additional 1,200 new health center sites to serve at least 6 million new patients by 2006.

"That was a great thing that Bush did," says Rosenbaum. "But if there is a move towards the administration cutting Medicaid funding, then the president's health center growth initiative will be much less successful mainly because it is Medicaid that sustains these health centers."

ANY SOLUTIONS?

So far, Medicaid solutions from Washington, D.C., have been varied. The Bush administration has floated proposals that it says are designed to ultimately reduce the

COMMUNITY HEALTH CENTERS

Since the first one opened its doors 40 years ago, community health centers have specialized in providing affordable primary and preventive care services to our nation's poor and underserved people, regardless of whether the patient is insured or can pay. They serve about 15 million people in nearly 3,600 communities across the country. These health centers are local, community owned and operated facilities financed by Medicaid, Medicare and private insurance payments along with other federal, state and local contributions. Medicaid payments serve as the largest source of revenue for health centers, at 35 percent. Of those centers that are "federally qualified," about one quarter of their revenue comes from federal grants.

Because of their patient population and the contribution that health centers make to the care of the uninsured, Medicaid provides cost-based reimbursement for services provided. In other words, the health centers are reimbursed based on the average cost of the service unlike other providers who are paid a fixed rate. This allows the federal and state grants to be used for uninsured patients and not to offset payment shortfalls.

—Laura Tobler, NCSL

cost of Medicaid by allowing states greater flexibility—with co-payments, eligibility and benefit packages for instance—but by also cracking down on improper payments with prescription drugs on the hit list in this area. There has even been talk of "capping" federal Medicaid spending.

To somehow match Medicaid reserves with the growing Medicaid need, another solution, is to revisit the spending formulas for the states. Under the Federal Medical Assistance Percentage (FMAP), the federal share of Medicaid varies from state to state depending upon each state's per capita income. In the richest states, the federal government currently covers half of the costs of Medicaid. That percentage rises to as high as 80 percent for the poorest states.

Of the \$246 billion spent by both the feds and the states on Medicaid in 2002, for example, the states collectively paid 43 percent compared with Washington's 57 percent. But in that same year, federal Medicaid payments for nearly 30 states actually declined despite the economic downturn. Why were there fewer federal dollars during a time when states were struggling to balance their budgets? Because the FMAP formula was based on the economies of the states in the late 1990s, before the economic downturn of 2001 and 2002.

Many organizations, both liberal and conservative, have called for a rethinking of FMAP formulas. The argument being that per capita income—which the FMAP is based on—is not the best measure of a state's ability to finance Medicaid.

AN EYE ON THE BIG PICTURE

Tinsman says states should approach every issue connected with Medicaid with an eye for what she calls "the big picture."

"What we are going to do today is going to have a major effect on our situation tomorrow and 10 years from now."

New Jersey's Senator Vitale says the big picture is one of the driving forces behind his push to expand Medicaid benefits. He says in 2004 New Jersey spent hundreds of millions to cover uninsured patients.

An expansion of the program, Vitale admits, may result in short-term costs, but the price of not providing preventive care may eventually prove to be far greater.

"It comes down to how you want to spend your money—on episodic care or regular care

TAKING CARE OF THE POOR AND UNINSURED

Public hospitals are the health care safety net for millions of Americans. They:

- ◆ Provide \$5.4 billion worth of uncompensated care, which represents 21 percent of their total costs, as compared to 5.4 percent of costs for hospitals nationally.
- ◆ Report triple the volume of emergency department visits and non-emergency ambulatory care visits than the average acute care hospital nationally.
- ◆ Play a vital role in emergency and disaster preparedness; in 23 communities they are the only Level 1 trauma center.
- ◆ Are the sole provider of burn care in 16 communities.
- ◆ Receive 71 percent of their net revenues from Medicaid (37 percent), Medicare and state and local governments.

Source: 2002 survey of members of the National Association of Public Hospitals and Health Systems.

for working parents and their children, people who will most likely never have health insurance on their own?" he says. As an added bonus, providing insurance coverage also "stabilizes the environment for providers serving a disproportionate number of uninsured."

Tinsman remains convinced that the states should do all they can to bolster community health centers and other safety net providers. "These facilities are the safety net," she says. "We may be facing a lot of other tough economic decisions, but you take away that safety net and there is no telling where it all might lead."

Experts agree. The survival of America's health care safety net is especially sensitive to Medicaid policies—both federal and state—in all areas: eligibility, enrollment, benefits and provider payment rates.

The Institute of Medicine suggests, in its report "America's Health Care Safety Net: Intact but Endangered," that while policy-makers go about the business of fixing the Medicaid program, they "take into account and address the full impact both intended and unintended of changes in Medicaid policies on the viability of safety net providers and the populations they serve" before adopting those changes.