

Improving Coverage



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Strengthening the Health Care Safety Net

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Concerned about the problem of people who have no health insurance coverage, states have taken steps to expand access to coverage. In addition to expanding coverage through public and private health insurance programs—covered in the first two reports in the Improving Coverage series—states can help low-income people who are uninsured by financing direct care programs that provide low-cost services. In 2007, two-thirds of the nation's uninsured had incomes below 200 percent of federal poverty guidelines. Many of the low-income uninsured (sometimes called the “medically indigent”) cannot afford coverage unless they obtain government assistance or their employer contributes to the cost of coverage. For the medically indigent, programs that provide low-cost or free care provide an informal safety net. In many cases, the providers that operate these programs also are a major source of care for Medicaid and Children's Health Insurance Program (CHIP) enrollees.

Because of their mission and the growing number of uninsured, safety-net providers, those serving a disproportionate share of the poor and uninsured, walk a financial tightrope. In a report by the Institute of Medicine, researchers concluded that safety-net providers are at risk of not being able to care for vulnerable populations. Today's health care marketplace—with its emphasis on managed care, combined with eroding subsidies for safety net providers and reduced Medicaid disproportionate share funds—is making it difficult for safety-net providers to finance uncompensated care.

Uncompensated care is that provided (mostly) by hospitals for which no payment is received from the patient or insurer; it is the sum of “bad debt” and charity care. This report examines state options to improve health care access by expanding direct care programs and support for local safety net initiatives.

Medicaid plays an important role in financing health services for the nation's low-income population; nowhere is this more apparent than with our safety net providers. In 2007, Medicaid served as the largest source of revenue for

Snapshot of Health Centers

Community health centers provide affordable primary and preventive care to the nation's poor and underserved people, regardless of whether the patient is insured or can pay. Nearly 1,200 community health centers served more than 18 million low-income and uninsured people in 2008. These health centers are community-owned and -operated facilities financed by payments from Medicaid, Medicare and private insurance along with other federal, state and local contributions. In 2007, 91 percent of health center patients had incomes at or below 200 percent of federal poverty guidelines, and 44 percent lived in rural areas. About one in five low-income, uninsured U.S. residents relied on health centers for their care in 2007.

community health centers and public hospitals, providing 37 percent of revenue. The nation's public hospitals depend on Medicaid reimbursements and Medicaid disproportionate share payments—payments made with Medicaid dollars to certain hospitals treating large numbers of low income uninsured people and Medicaid patients—to survive.

Medicaid enrollees and uninsured patients make up about 75 percent of the health center patient population. Health centers depend upon Medicaid reimbursement for financial stability, since Medicaid represents the largest stream of revenue. With about 35 percent of all health center patients enrolled in Medicaid—and approximately the same percentage of total revenue from Medicaid reimbursement—centers rely on Medicaid reimbursement to stay afloat. As a result, changes to Medicaid—and, specifically, Medicaid reimbursement policies—directly affect safety net providers. For example, safety net provider Denver Health Medical Center anticipates that the costs for treating the uninsured will jump from \$275 million in 2007 to \$350 million in 2009. Without additional federal funding, the hospital may have to cut back on services, according to chief executive officer Dr. Patricia Gabow. “We're the canary in the mine shaft,” she said. “When something bad happens in the economy, we tend to see it on our doorstep.”

Although state funding for health centers has increased—as has federal funding—these gains are expected to be overshadowed by the economic downturn, which has increased demand for services and strained state Medicaid budgets as more people lose their jobs and the associated health insurance. The American Recovery and Reinvestment Act of 2009 (ARRA), signed into law by President Obama on February 16, provides some relief to fiscally strapped states. Among many other things, the law provides an estimated \$87 billion over the next two years in additional federal matching funds to help states maintain Medicaid programs in the face of massive state budget shortfalls. All states received an increase in the Medicaid federal matching rate, or the federal medical assistance percentage (FMAP), by 6.2 percentage points. States with high levels of unemployment may qualify for an additional increase in the FMAP. The law also provides for a temporary increase in disproportionate share hospital payments. ARRA also provides \$1.5 billion in funding for health center infrastructure and \$500 million for operating costs, to be dispersed by the federal Health Resources and Services Administration. The law’s significant funding for health information technology is also expected to have benefits for health centers.

STATE APPROACHES TO SUPPORT THE HEALTH CARE SAFETY NET

In a landmark 2000 report, the Institute of Medicine called America’s safety net a “fragile patchwork of providers.” The health care safety net consists of providers that serve a disproportionate share of the poor and uninsured. Examples include public hospitals, community health centers (CHC), local health departments and health professionals who work in medically underserved areas where large numbers of people are uninsured. Together, they fill the gaps in medical care and provide a high percentage of the care for those who lack insurance or rely on Medicaid or other public insurance.

- According to the National Association of Public Hospitals and Health Systems, in 2006 public hospitals provided 24 percent of their services to uninsured patients; an additional 32 percent of people served were Medicaid patients.
- In 2007, 39 percent of CHC patients were uninsured, and an additional 35 percent were on Medicaid. Research shows that CHCs provide high-quality patient

care, despite evidence that many are in a financially fragile situation.

The American Recovery and Reinvestment Act provided \$2 billion to community health centers to expand access to primary care in medically underserved areas; to serve more patients during this time of increased demand due to the economic crisis; and to create and save jobs in local communities. This temporary funding will last through the next two fiscal years.

There are major variations in safety net providers from state to state. The organization, funding and adequacy of the safety net varies not only state-by-state but community-by-community. States help maintain the safety net by direct funding and through state-funded programs to create financial incentives for more health professionals to serve medically indigent people.

State Examples

States have developed various methods to support their health care safety nets, ranging from building new facilities to increasing the health care workforce in underserved areas. Some of these activities are described below.

Direct Support for Safety Net Providers

Thirty-five states and the District of Columbia funded health centers for a total of \$590 million in 2008, and 26 states increased their funding in 2008. State funds for health centers come primarily from state general funds, and tobacco taxes and tobacco settlement money. According to the National Association of Community Health Centers, state funds are used for various purposes, including uninsured care, capital needs and operating costs. As shown in Figure 1, Colorado, Hawaii, Indiana, Massachusetts, New Hampshire, New Jersey, New Mexico, West Virginia and the District of Columbia each provided more than \$4 per capita in state funding for CHCs in 2008.

Since 1995, Indiana has provided financial support for CHCs in the state. State funding for health centers doubled from \$15 million in 2007 to \$30 million in 2008. The state’s goals are to establish medical homes for the uninsured in medically underserved areas and to increase access to primary and preventive health care services. Several other states began funding health centers in recent years. In 2007, Montana passed the Community Health Center Support Act (Chapter No. 436), which appropriates \$650,000 to provide competitive grants for health center start-ups or expansions. The law’s purpose is to improve access to primary and preventive care and strengthen and support state community health centers.

Other states support the safety net by funding certain facilities, equipment and personnel (Figure 1). Between 2008

The New Mexico Legislature enacted several laws to establish and fund programs that provide financial incentives—such as tax credits, stipends and loan repayment—for providers who practice in underserved areas. The New Mexico Higher Education Department administers a Health Education Loan for Service Program and the Health Professional Loan Repayment Program that help to repay educational loans for health professionals in underserved areas. In addition, the Rural Health Practitioner Tax Credit Act provides a personal income tax credit of up to \$5,000 per year for rural physicians and other providers who serve in rural, underserved areas. The credits are available to full- and part-time practitioners.

Several states support safety net providers through technology, since many believe it is an important tool for improving efficiency, reducing medical errors and achieving cost savings. Examples include promoting electronic prescribing, using technology to support telemedicine services and incorporating technology in quality reporting. According to the eHealthInitiative's 2008 survey, state health information exchange initiatives fall along a continuum of activity, with some in the awareness phase and others with statewide implementation. The state's role in health information exchange initiatives varies. Most states are convening or participating in the dialogue to develop a health information exchange plan. Other roles include providing funds to support state and local efforts and taking the lead in statewide initiatives.

For example, the Tennessee Governor's eHealth Advisory Council—created by Executive Order in 2006—coordinates statewide electronic health initiatives aimed at developing and implementing electronic medical records. In 2008, Minnesota's eHealth Grant Program, administered by the Department of Health, awarded \$3.5 million in matching grants for electronic medical records and health information exchange initiatives. Minnesota's Office of Rural Health and Primary Care administers the Electronic Health Record Loan Program, which provides six-year, no-interest loans to help community clinics and other providers pay for interoperable health record systems.

Support Safety Net Providers' Preparedness

Finally, as part of their overall preparedness planning, states are strengthening health center capacity to respond during disasters. The Alabama Legislature, for example, authorized \$22 million to purchase antivirals needed for pandemic influenza. According to the Association of State and Ter-

ritorial Health Officials, health centers have engaged in preparedness planning through various activities, such as participating in assessments, drills and staff training. In 2006, 20 states provided disaster planning funds to health centers. The California Department of Health Services, for example, contracts with the California Primary Care Association to ensure that health centers are engaged in the emergency planning process. The New York State Department of Health contracts with the Community Health Center Association of New York State to ensure active involvement by health centers in emergency planning.

Evidence of Effectiveness

No studies have been conducted that assess the effect of state support for safety net providers on access to health care services. However, several studies have shown that the presence of safety net providers improves both access to care and results. According to a 2007 report by the Commonwealth Fund, "... CHCs provide better quality care than other health care segments as measured by reduced hospitalizations and emergency department visits, higher rates of vaccination among children and the elderly, and higher rates of cancer screening among the poor and elderly." Compared to communities that have no health centers, those with health centers have higher immunization rates, significantly lower infant mortality rates, and make greater use of preventive services. Moreover, uninsured health center patients are more likely to receive preventive screenings (e.g., mammograms, Pap smears), health education services and counseling than the rest of the uninsured population. Research also shows that health centers reduce health disparities and improve results for those who have chronic illnesses.

Research also suggests that safety net providers deliver cost-effective care, in addition to their promising effects on access and health care quality. A 2007 study by the National Association of Community Health Centers found that medical expenses of patients who use CHCs as their medical homes were 44 percent lower than expenses of patients seen elsewhere, saving the health care system between \$9.9 billion and \$17.6 billion annually.

Finally, the Institute of Medicine's landmark report, America's Health Care Safety Net, concluded that, "Until the nation addresses the underlying problems that make the health care safety net system necessary, it is essential that national, state and local policy makers protect and perhaps enhance the ability of these institutions and providers to carry out their missions."

NOTES

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THE *IMPROVING COVERAGE* SERIES

In 2004, the National Conference of State Legislatures published *State Options for Expanding Health Care Access* by Barbara Yondorf, Leah Oliver and Laura Tobler, a report that outlined the plethora of state strategies for expanding health care access. Although many of the strategies described in that report remain the same, much has changed at the federal and state levels during the past five years. The *Improving Coverage* briefs provide new data about the uninsured, update information about state approaches, and describes how recent federal and state developments—including a worsening economy and federal policy changes—are expected to affect state programs. The format also has changed. Unlike the original publication, which contained all strategies in one document, this report is presented in two issue briefs that cover specific topics and one web page.

- *Using Public Programs to Expand Health Insurance Coverage* examines state options for increasing health insurance coverage rates by expanding government health programs. It examines options that expand Medicaid and the Children's Health Insurance Program (CHIP); establish or expand state-only health insurance programs; and establish or expand public-private initiatives, such as premium assistance and buy-in programs.
- *Improving Coverage: Strengthening the Health Care Safety Net*, describes strategies that increase access to care through an expanded health care safety net.

In addition to the issue briefs, NCSL has developed an accompanying web page to summarize new programs that address the uninsured. *State Programs to Cover the Uninsured* is a new web page that provides a 50-state description of programs that provide health insurance coverage. These programs change frequently in response to federal policy, economic conditions and state experiences. For state coverage profiles of the 50 states and the District of Columbia, go to www.ncsl.org/programs/health/statecoverage.htm.

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