Issue Brief
Findings from HSC

THE HEALTH CARE SAFETY NET: MONEY MATTERS BUT SAVVY LEADERSHIP COUNTS

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The nation's health care safety net—heavily reliant on external funding and support—is uniquely vulnerable to shifting and often adverse market and policy conditions. While adequate funding is essential to ensuring safety net providers can care for low-income people, the Center for Studying Health System Change (HSC) has identified a number of other factors key to building and maintaining viable community safety nets. Throughout the four rounds of HSC's Community Tracking Study (CTS) site visits, researchers have found that strong political and organizational leadership, community support, collaboration and business acumen have helped safety net providers build capacity and improve care coordination for low-income and uninsured people. These characteristics and business strategies have strengthened many community safety nets, better preparing them to weather current economic problems and providing a road map for the potentially tougher times ahead.

Fragile but Resilient: Most Community Safety Nets Stronger

Fragile by nature, the nation's health care safety net for low-income and uninsured people has grown somewhat stronger over the last eight years. Typically a patchwork that varies from community to community, the safety net can include various configurations of public and private hospitals, community health centers (CHCs), local health departments, free and school-based clinics, and physician charity care. While a range of organizations often play a role, the backbone of the safety net is providers, such as community health centers and public hospitals, whose main mission is to provide care to low-income people, including the uninsured. These are the safety net organizations tracked most closely during HSC site visits to 12 nationally representative communities (see Data Source on page 2).

Over time, community safety nets endure ups and downs. Between 1996 and 2001, safety net providers showed significant resilience to various pressures, including the 1997 Balanced Budget Act, welfare reform and the transition to Medicaid managed care—all changes that hindered safety net providers' ability to fund or cross-subsidize charity care. During the same period, the booming economy helped many states expand public coverage options, and the safety net benefited from new revenue sources as uninsured people gained coverage through Medicaid expansions and the State Children's Health Insurance Program (SCHIP).[1] New, ongoing funding also became available in 2000-01 through federal expansion grants for CHCs and federal Community Access Program (CAP) grants, which help communities integrate care delivery for the uninsured. By 2002, however, the economy in most states had slowed, and threats to critical public funding sources had returned.

Since 1996, most safety net providers in the 12 communities have become stronger and improved their business practices. They have increased capacity by enhancing and expanding facilities and services and strengthened their finances to protect future viability. Generally, these changes have increased primary care and hospital services available to low-income people, although the safety net remains much more limited in providing specialty, mental

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Data Source

Understanding the economic health and capacity of community safety nets is important and represents one of the primary areas of health system change that HSC tracks every two years (since 1996) through CTS site visits. The 12 nationally representative communities studied are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y.

HSC researchers interviewed individuals in each community who are involved directly or indirectly in providing safety net services to low-income people, including representatives of safety net hospitals, community health centers, local health departments and government officials, academics and advocates. This Issue Brief is based on analysis of these individuals' assessments of the relative strength of safety net providers, the pressures they have encountered and the strategies they have used to improve their position.

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health and dental services. Also, significant differences in availability of safety net services exist across communities, and communities with less well-established safety nets typically have more significant service gaps and financial difficulties.

Overall, local safety nets are in a relatively stronger position to weather current economic challenges. While each community's safety net is unique, several common factors have been critical to securing funding and coordinating available resources across communities. These organizational characteristics and well-executed business strategies can provide valuable lessons for other communities to improve their safety nets.

Economic Downturn Poses Safety Net Challenges

Over the past two years, the safety net has faced increasing economic pressures that are likely to intensify in the near future. Of primary concern, safety net providers' dependence on revenue from state and local governments through direct assistance and public health insurance payments leaves them highly exposed to changes in public spending and priorities.

Most states and communities managed to protect safety nets from many of the adverse effects of the emerging budget crises in fiscal years 2002 and 2003 by protecting direct provider subsidies and largely maintaining public insurance expansions key to safety net providers' financial stability. However, larger state and local budget deficits in fiscal year 2004 are often requiring deeper health care cuts. As a result, safety net providers will likely see Medicaid and SCHIP revenues decline as states limit enrollment, trim benefits and cut provider payments. In Orange County, for example, modest gains in access could be offset by Medicaid cuts to help reduce the state's budget deficit.

Some state and local governments also are paring back the amount of direct safety net funding they transfer to providers through uncompensated care pools and other mechanisms. For instance, the financial stability of Phoenix safety net providers has suffered as dedicated tobacco tax revenues have been diverted increasingly to close budget gaps in the state's general operating fund.

Finally, there are signs that demand for safety net care will grow as people lose private coverage due to increased unemployment and rising health insurance premiums, which are increasing much more rapidly than income.[2] One survey in Washington state estimated that the statewide uninsurance rate increased by more than 2 percentage points between 2000 and 2002. Moreover, state budget shortfalls could result in people losing public insurance coverage. At the same time, physicians' willingness and ability to provide charity care is declining. Between 1997 and 2001, the proportion of physicians nationally providing any charity care declined from 76 percent to 72 percent.[3]

Yet, local safety net providers have worked diligently to meet the growing demand. For example, a community health center in Boston has posted signs that read, "No insurance, no problem," to emphasize that patients should not skip appointments, even if they lose coverage. While most safety net organizations had not yet experienced the full effects of state cutbacks and growing demand during the most recent HSC site visits, they were worried about the future.

Key Factors of Safety Net Resilience

A combination of factors, both within safety net institutions and in the broader community, has enabled providers to make the most of available funds to organize, reinforce and expand local safety nets over the last eight years. These interrelated characteristics and strategies include strong political leadership, community support, collaboration among government agencies, providers and other organizations, as well as capable managers practicing effective business strategies.

Political Leadership. State and local political leaders can focus public attention and energy on the welfare of safety net organizations and solicit funding to support their activities. Governors can be particularly effective at supporting local safety nets throughout their states, and many have promoted and protected public insurance expansions. The governor of Arkansas, for example, brought the state Legislature back into session this year to win approval of new tax measures to avoid cuts in children's Medicaid coverage.

In many communities, mayors and other local officials initiate ways to fund and manage the local safety net. Miami-Dade County's mayor, for instance, established a health care

task force as a forum to improve the existing delivery system and expand insurance coverage options for the uninsured and, with the county council, is considering establishing a county entity to conduct more formal safety net planning.

Community Support. An important component of safety net strength, community support is essential to tap resources to fund safety net services and to secure broad consensus for political leaders' funding and organizational objectives. Passage of ballot initiatives represents one measure of community support. For example, Orange County voters have earmarked tobacco settlement and tobacco tax revenues for the safety net, producing moderate gains in access and capacity in a community that historically has had limited outpatient safety net services. In Phoenix, the public hospital system has suffered from funding cuts and an outdated facility that hinder its ability to attract insured patients. To help the hospital continue caring for the community's one in five uninsured people and a growing immigrant population, stakeholders garnered the support of the community and other hospitals to obtain the state Legislature's approval for a ballot initiative that, if passed, would establish a tax district to generate revenues for the hospital.

Additionally, advocates are able to communicate to political leaders the magnitude of community support for the safety net. In Cleveland, for instance, advocates are credited with particular skill in influencing state government policies affecting Cleveland's safety net. Advocates there resisted state cutbacks in public programs, successfully maintaining these programs while other nonhealth programs were pared back.

Collaborative Activities. Collaboration among public and private organizations also helped bolster the safety net in many communities. In Greenville, which lacked an organized safety net eight years ago, an alliance of health and business organizations and private foundations served as a catalyst to coordinate new clinic-based and private physician services for low-income people in underserved areas. In other communities, CAPs have provided resources to foster greater collaboration and clinical support among safety net providers. The CAP in Indianapolis, for example, is working to expand care options for the uninsured, create case management programs and build information technology systems among the local public hospital and community health centers.

In some communities, a particularly successful type of collaboration between policy makers and providers coordinates care for uninsured people as if they had insurance coverage by distributing a membership card to assist access to primary, specialty and, often, inpatient care within an established network of providers. Over the last few years, these virtual managed care programs in three CTS communities—Boston, Indianapolis and Lansing—have grown in enrollment and provider participation and have been replicated elsewhere. In fact, at least 12 other Michigan counties have created programs similar to Lansing's Ingham Health Plan.

Organizational Leadership, Business Acumen. Effective management of safety net hospitals and community health centers can be critical to meeting organizational missions, garnering support for safety net services and strengthening safety net providers' financial viability. For example, Boston, a community with several dozen community health centers, benefits from experienced CHC directors who have become more nimble at adapting to changed circumstances, such as budget cuts.

There has been more recognition over the last few years that commitment to a mission is not enough to develop a stable safety net, and the often-heard mantra is, "No margin, no mission." Similar to what is seen in thriving businesses, the leaders of safety net organizations have developed into or been replaced by entrepreneurial business managers who are more effective at day-to-day operations and ensuring long-term organizational viability. For example, a new administrator at a Seattle community health center improved the financially strapped organization by focusing on strategies commonly identified among safety net hospitals and community health centers in all 12 communities:

- Streamline operations and improve productivity by, for example, increasing use of clinical support staff and nonphysician clinicians, upgrading information technology and transitioning to same-day patient scheduling.
- Improve payment collection from insurers and patients.
- Leverage economies of scale and share technical expertise with other safety net providers.

A combination of factors, both within safety net institutions and in the broader community, has enabled providers to make the most of available funds to organize, reinforce and expand local safety nets over the last eight years.

While the challenges facing the nation's safety net are real, most communities' safety nets are in a better position to weather tough times.

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- Enroll uninsured patients in public insurance coverage at the provider site.

- Attract more privately and publicly insured patients to improve payer mix.

- Raise funds and apply for grants, such as federal CHC expansion grants, particularly to develop mental and dental health services.

These strategies have helped many safety net organizations become more sophisticated and businesslike over the last eight years, often with improved operations and revenues. For example, managers at a struggling public hospital in northern New Jersey improved the hospital's financial accounting and reporting information systems to demonstrate the need for additional state charity care funds—monies that helped to stabilize the hospital's finances and generate positive margins. And, in Syracuse, a community with historically low uninsurance and a stable safety net, significant increases in demand for services prompted the sole community health center to create a foundation to raise money for equipment and capital projects and to form partnerships with mainstream providers to strengthen access to care.

To become more efficient and financially viable organizations, safety net providers in many communities have become more aggressive in collecting payments. For the most part, evidence to support concern that these efforts may curtail patients' access to needed care has not emerged, and many providers report they do not require payment from anyone who is unable to pay. However, there are still concerns among advocates for the poor that more aggressive collection policies may deter some low-income and uninsured patients from seeking services.

Lessons Learned

While safety nets in the 12 communities have grown somewhat stronger, even strong community safety nets can fray under the dual pressures of funding cuts and increased demand for services.

With the help of a host of organizational characteristics and well-executed business strategies, safety net providers are creatively adapting to a changing environment. Policy makers, safety net providers, health care foundations, advocates and others can apply a number of lessons from the 12 communities to help sustain and improve health care services for low-income and uninsured people. First, while funding is vitally important to strengthening the safety net, providers can learn to leverage limited dollars through capable management and effective business strategies. Second, while safety net providers can do much on their own to improve their capacity and viability, collaboration across public and private entities is increasingly important to provide and coordinate care throughout communities. Third, even communities that historically lacked support for safety net care can develop and support new revenue sources and strategies to reinforce the safety net.

Expanding current efforts and creating new initiatives will be important to maintaining and improving access to primary care and hospital services as well as to narrowing access gaps in specialty, mental health and dental services. While the challenges facing the nation's safety net are real, most communities' safety nets are in a better position to weather tough times than they were eight years ago. ●

Notes

1. Felland, Laurie E., Cara S. Lesser, Andrea B. Staiti et al., "Resilience of the Health Care Safety Net, 1996-2001," *Health Services Research*, Vol. 38, No. 1, Part II (February 2003).

2. "Tracking Health Care Costs: Trends Stabilize but Remain High in 2002," *Health Affairs* Web Exclusive (June 11, 2003), *www.healthaffairs.org.*

3. Cunningham, Peter J., *Mounting Pressures: Physicians Servicing Medicaid Patients and the Uninsured, 1997-2001*, Tracking Report No. 6, Center for Studying Health System Change, Washington, D.C. (December 2002).