A Primer on Health Care Safety Nets

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I. What Are Health Care Safety Nets?

Health care safety nets, consisting of providers who deliver care in a variety of settings, are a critical component of the health care system because they serve patients who are otherwise unable to afford or access care. Although many people think of only *public* hospitals and clinics as safety nets, the picture is more complex. In fact, *private* providers are a major segment of the nation's safety net infrastructure. For example, the value of uncompensated or charity care, which is a type of safety net care, provided by *private* office-based physicians alone was estimated at $5.1 billion for 2001.

***Safety nets** are public and private providers that deliver care in a variety of settings to patients, who are otherwise unable to afford or access care.*

There is no one model of a health care safety net, nor is there always agreement about whom a safety net serves. However, the Institute of Medicine (IOM) report, *American's Health Care Safety Net: Intact but Endangered*, published in 2000, provides a commonly used description of safety net providers. They have two distinguishing characteristics: 1) either by legal mandate or explicitly adopted mission, the provider offers care to patients regardless of their ability to pay for services; and 2) a substantial share of the provider's patient mix consists of uninsured, underinsured, and Medicaid recipients. Many different types of health care providers meet the IOM criteria, including public hospitals, community health centers, local health departments, free clinics, special service providers, and in some cases, physician networks and school-based clinics.

II. Composition Of Safety Nets—Whom Do They Serve and How Are They Organized?

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Health care safety nets serve a diverse patient population, including inner city and rural poor, the homeless, low-income migrant workers, the uninsured and underinsured, and in some cases Medicaid patients; the last group is included because many private health care providers choose not to participate in Medicaid. In addition, because of the recent economic downturn many previously employed and insured middle-class families are relying on safety net providers as the only source of care. Many of these patients are also chronically ill and require coordinated disease management.

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Safety nets usually are community-based and are influenced in large part by economic and other characteristics of their local communities. Some safety net providers are run by hospitals or community groups, others by physicians or local governments. Some provide a high volume of uncompensated care, while others have a high percentage of Medicaid patients. Some rely on donations of time and effort by physicians, nurses and other providers, while others rely on discounted payment for caregivers. Some are a mixture of both. In sum, they are organized according to their particular patient population and financing. The local variations in financing, patient mix and workforce have resulted in a poorly coordinated and fragmented system of safety nets across the nation. Thus, while safety nets provide essential health services to individuals who otherwise would lack access to care, this patchwork system also results in common problems such as restricted access to specialty services, disruption in care, and long waiting periods for patients.

In recent years, safety nets have faced additional pressures. These include rising health care costs, Medicaid provider shortages, and facility closures. In addition, most safety net providers have reported increased demand for services, particularly following the economic downturn that began in 2007.

Despite these strains, the same fragmented local forces that create a patchwork system also open up opportunities for innovation that are highly attuned to a specific community's need. A closer look at different safety nets across the country reveals some examples that provide adequate and coordinated care. In this case, adequacy means that the provider actively screens and enrolls eligible patients, assigns them to a primary care medical home, and provides a reasonably comprehensive range of services, including essential medications, specialist referrals, chronic disease management and hospitalizations. Through such coordination of care, these adequate safety nets can also rein in health care costs.

III. Examples Of Adequate Safety Nets

The following, ranging from the relatively newly formed *Healthy San Francisco* program to those that are long-standing, are examples of adequate safety nets that provide coordinated and relatively comprehensive care to their enrollees:

A. Asheville, North Carolina has a volunteer physician referral network called ***Project Access***, for low-income uninsured. Although the program primarily focuses on coordinating referrals to office-based specialists, it is also well coordinated with local community health centers and hospital charity care. ***Project Access*** and its primary care clinic partners serve about fifteen thousand patients a year, which is a remarkable 90 percent of the area's low-income uninsured.

B. In Denver, the county operates a large safety net hospital and a set of primary care clinics called ***Denver Health***. It enrolls low-income uninsured and provides them access to the same medical-home coordinated care available to its Medicaid managed care population. ***Denver Health*** is frequently cited as a model safety net. Independent studies have shown that the uninsured receive the same access and quality of care as insured patients in this system.

C. In San Francisco all residents, age 18-64, with incomes up to 500 percent of the Federal poverty level, who have been uninsured for at least 90 days and who are ineligible for other public programs, are eligible for a program called ***Healthy San Francisco*** that provides comprehensive care through a coordinated medical home model. Through 29 participating

clinics and five local hospitals the program provides access to basic and ongoing medical services, including primary and specialty care, inpatient care, diagnostic services, mental health services, and prescription drugs. Large and medium employers with more than 20 workers are required to contribute to the program. Non-profit organizations with less than 50 employees and small businesses (< 20 workers) are exempt from the requirement.

D. The Health Safety Net in Massachusetts that replaced the state's Uncompensated Care Pool after comprehensive health reform was enacted is a program for those who are not eligible for health insurance or who cannot afford it. The program is financed through a pool of funds that was set aside to reimburse hospitals and community health centers (CHC) for services delivered to low-income uninsured, including undocumented immigrants. The program also pays for specialty care services, if they are not available at CHCs, and for outpatient services such as emergency and maternity care at the hospitals. Wrap-around services are available to low-income privately insured patients if provided by the CHCs or hospitals.

IV. Future Of Safety Nets

Even if the federal government enacts health reform, the proposals being currently considered would leave many millions of Americans uninsured, either because of eligibility restrictions, insufficient subsidies, or because of social, geographic, and language barriers. The future of safety nets will depend greatly on the availability of ongoing and sustainable funding streams. Currently, safety nets usually receive funding from a combination of block grants, disproportionate share hospital (DSH) payments, Medicaid, sliding scale user fees, donated services, community public and private funds, and other state and federal sources. The economic downturn and other external pressures mentioned above have caused safety net hospitals and physicians to focus aggressively on reducing costs and on increasing net revenue, forcing many providers to drop or limit services, including some services to the poor and uninsured that provide little or no financial benefit. In addition, federal health reform is likely to increase stress on safety net providers as funding is diverted to cover the newly insured, even while tens of millions of Americans who remain un- or underinsured continue to rely on safety nets.

It is important to note that even the best safety net is not a perfect substitute for comprehensive health insurance because it necessarily limits patients' abilities to choose from a variety of options and is less comprehensive. Still, the adequate safety nets described above are good models for the kind of efficient, coordinated care that many Americans currently lack.

Safety nets *are facing pressures because of rising health care costs, Medicaid provider shortages, and facility closures among other factors. In addition, most safety net providers have reported increased demand for services, particularly following the economic downturn that began in 2007.*

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For this reason, strengthening safety nets through sustainable funding will continue to be a policy imperative even if health reform expands health insurance coverage to most Americans. For those Americans who remain ineligible or who cannot afford coverage even with subsidies under health reform or who cannot get care because of other barriers, a well-coordinated network of safety net providers will be critical. Safety nets that function as a first-resort source of adequate and coordinated care for patients by screening, enrolling, and assigning them a primary care home with access to relatively comprehensive care will complement public and private expansions of health insurance coverage that are currently under consideration. The safety nets described above provide policymakers with sound models that can serve as good starting points for bolstering existing safety nets and creating new ones.

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References

"America's Health Care Safety Net: Intact but Endangered," Institute of Medicine. March 2000.

P. Cunningham. "The Healthcare Safety Net: What is It, What Good Does It Do, and Will It Still Be There When We Need It?" Harvard Health Policy Review. Vol. 8, No. 2, Fall 2007.

"Healthy San Francisco Key Facts," The Kaiser Commission on Medicaid and the Uninsured. February 2009.

M. Hall. "After Insurance Reform: An Adequate Safety Net Can Bring Us to Universal Coverage," Hastings Center Report. Nov-Dec 2009.

C. Hoffman and S. Sered. "Threadbare: Holes in America's Health Care Safety Net," The Kaiser Commission on Medicaid and the Uninsured. November 2005.

R. Hurley, L. Felland, and J. Lauer. "Community Health Centers Tackle Rising Demands and Expectations," Center for Studying Health Systems Change. Issue Brief No. 116, December 2007.

M. McHugh, R. Kang, and R. Hasnain-Wynia, "Understanding the Safety Net: Inpatient Quality of Care Varies Based on How One Defines Safety-Net Hospitals," Medical Care Research and Review. Published online April 27, 2009.