Role of the Health Care Safety Net

The health care safety net supports a significant portion of Oregonians who are uninsured or on the Oregon Health Plan (OHP). Although no common definition of the safety net exists,[1] this document uses the definition created by Oregon's Committee on Health Care Safety Net Support. According to the Committee, Oregon's safety net is comprised of a broad range of local non-profit organizations, government agencies, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care they need. In addition, safety net providers have a substantial share of their patients as the uninsured, Medicaid and other vulnerable Oregonians. The safety net does not turn anyone away because of an inability to pay. [2] These providers are committed to keeping Oregonians healthy and productive members of the state's work force. In 1999, an estimated 146,000 Oregonians received safety net services.[3] Specifically, 56,000 OHP enrollees and 90,000 uninsured were served.[4]

Delivery

The health care safety net serves people who face barriers to care and whose unmet health needs represent a growing cost to people throughout the nation. The health care safety net includes:

- Federally qualified health centers
- School-based health centers
- Indian/tribal clinics
- County health departments
- Community health clinics
- Rural health clinics
- Other providers committed to serving the underserved

These clinics vary in terms of size, number/types of professionals employed, client characteristics, service area population density and demographics, diversity and stability of revenue sources, and sophistication in business management practices

Safety net clinics in Oregon are staffed by physicians, nurses, dentists, social workers, community health workers, other health care providers, and volunteers. These clinics offer health services to low-income people, including those without insurance. Most patients, however, do pay a sliding discounted fee or receive care covered by OHP, Medicare and private insurance. Primary care services provided by the safety net include, but are not limited to:

- Urgent care
- Acute and chronic disease treatment
- Services based on local community need (mental health, dental, and vision)
- Preventive care
- Well childcare
- Enabling services (translation/interpretation, case management, transportation and outreach)

[1] Institute of Medicine (2000). America's health care safety net: Intact but endangered. National Academy Press.
[2] Oregon's Committee on Health Care Safety Net Support consists of over 100 providers from throughout Oregon.
[3] Oregon Primary Care Association estimate
[4] Based on date from Oregon Primary Care Association and Department of Human Services

Although Oregon's safety net clinics are not yet part of a fully integrated system and are often financially unstable, they play a critical role in providing primary and preventive health care to those who do not access health services through the mainstream health care system.

Financial Issues

Safety net services reduce the number of hospital admissions and decrease inappropriate use of emergency department services[5] which saves the health care system millions of dollars.[6,7] Despite providing substantial savings, some of Oregon's safety net clinics have difficulty gaining access to resources needed to deliver quality health care to their patients.[8] In part, this is related to a lack of financial reserves.

Providing quality services within the dynamic, complex and expensive health care arena requires expensive and advanced technology, systems and infrastructure. In order to provide care in the sophisticated health care industry, the safety net is financially supported by:

- Federal grants
- OHP/SCHIP reimbursements
- Medicare reimbursements
- State and local government grants/contracts
- Private insurance reimbursements
- Patient fees
- Foundation grants
- Private donations[9]

OHP, however, as well as other means of financial support, are becoming more restricted at the same time that the demand on the safety net is increasing.[10] At times, this adds to the financial instability among safety net providers who struggle to continue to provide care to Oregonians in need.

In addition to providing needed services, health care workers, including those employed by safety net clinics, serve as an important component of a community's economy. For example, the safety net is part of Oregon's health care industry that has more than 118,000 people employed and which grew by 25% between 1988 and 1998.[11] Despite the safety net's economic significance to a community, many clinics struggle financially and are at risk of no longer providing health care to the underserved. To address such concerns, Oregon's Committee on Health Care Safety Net Support, which includes more than 100 providers, advocates, and government officials from throughout Oregon, are working collaboratively and strategically in order to strengthen, support and expand the role and financing of the safety net.

---

[5] In Indianapolis, a managed care program for the uninsured was established in 1997. Within the first 18 months of the program, inpatient use dropped from 800 to 400 days per thousand annually, and emergency room use fell by 30%. See Community Report: Indianapolis, IND, Winter 1999, Center for Studying Health System Change

[6] Hawkins D. & Rosenbaum, S. 1998. The challenges facing health centers in a changing healthcare system. In: Who will take care of the poor and uninsured? Altman, S. Reinhardt, U., and Shields, A. (eds). Chicago, IL: Health Administration Press.

[7] http://www.nachc.com/state_affairs/

[8] http://bphc.hrsa.gov/oppd/

[9] www.bphc.hrsa.gov

[10] Clinician's Handbook On the Federal Tort Claims Act. Last modified on 05-Sep-2000. www.bphc.hrsa.gov

[11] Bureau of Health Professions National Center for Health Workforce Information and Analysis (December 2000). HRSA State Health Workforce Profile: Oregon. US Department of Health and Human Services.

Models for Integrated Community-Based Delivery Systems

To address financial, infrastructure, and quality issues, safety net clinics are sharing their expertise as community based providers in order to develop collaborative community based networks with other providers, hospitals, academic medical centers, and private group practices. Ultimately, the resources that flow from these collaborations allow safety net providers to continue to provide care for the underserved, including the uninsured, as well as develop the structure necessary to operate as part of an integrated system of care.[12]

Safety net providers across the country recognize the importance of forming or being part of a comprehensive and integrated health care delivery system in order to continue serving their patients in the dynamic health care market. In some states and communities, Medicaid managed care uses a primary care case management model with the primary care provider acting as a gatekeeper for all services. Safety net clinics contract directly with the state Medicaid agency as primary care case managers. Safety nets usually receive payments based on their reasonable costs and, in some instances, receive an additional case management fee.

Still other safety net clinics are subcontractors for the provision of primary care services to managed care organizations. This is the most common networking approach for safety net clinics and other providers. The clinic's services and risk associated with the contract is limited to primary care. Health centers are reimbursed on a capitated or fee-for-service basis. Reimbursement methods and rates vary with each contract.

Only a few safety net providers in the United States have full risk arrangements with their State Medicaid agencies and/or commercial HMOs. Those that have this arrangement were established long ago. Under this arrangement, a single clinic contracts for the full range of services, including primary, specialty and hospital care. The health center accepts a capitated rate for these services. This method of participation in managed care results in high financial risk.

In some parts of the country, where the safety net is strongest, safety net clinics have joined with other providers to form a managed care network that contracts either for comprehensive health services (e.g., primary, specialty and hospital care) or some services (e.g., primary care).[13] These clinic-based networks have formed delivery systems of care that can contract with state Medicaid agencies, commercial payers, and other managed care organizations. The network entity contracts back for primary care with safety net clinics as well as with specialists and hospitals. Some networks include only safety net clinics, while others are partnerships with other providers. In Hillsborough County, Florida, safety net providers have partnered with local hospitals and county government to create "one-stop shops" that provide comprehensive integrated health, social, and mental health services to low-income community members. Hospital admissions and emergency room visits have all dropped since the launch of this community based delivery system. Safety net clinics in El Paso, Texas participate in a similar integrated model to meet the unmet health care needs in their community.

The Access Model

Noting that 15% of OHP enrollees and 28% of Oregonians without health insurance are served by Oregon's safety net, it is worth considering how Oregon's safety net can be strengthened and expanded.[14] Although "coverage" or insurance is the most frequent method to access health care,

[12] ibid

[13] Information gathered from and based on Bureau of Primary Care

[14] Based on date from Oregon Primary Care Association and Department of Human Services

not all Oregonians are willing, wanting, or able to be insured.[15] For a variety of reasons there remains an estimated 85,000 people below the federal poverty level who are uninsured and yet are potentially eligible for a publicly funded health insurance program in Oregon. Furthermore, there are Oregonians who are above 100 percent of the federal poverty level and still may be eligible for a public heath insurance program. And yet, not accessing health care services when needed often leads to unnecessary and expensive complications that impact all consumers of health care.[16] In order to meet their health care needs, many Oregonians without insurance access safety net providers who often are not adequately compensated for their services.

Oregon's Committee on Health Care Safety Net Support is examining the safety net's role in the health care delivery system. They are sharing their expertise and resources to develop a strategic plan to stabilize, strengthen, and expand its ability to provide access to quality health care to the underserved. One strategy to provide access to health care, as well as to assist the safety net in their stabilization efforts, is to compensate the safety net for care provided to people who are eligible for the OHP/SCHIP but not enrolled.

The Access Model would *not* replace the OHP/SCHIP insurance coverage model; it would compliment OHP. The safety net would encourage enrollment into insurance plans through culturally appropriate education regarding both private and public insurance, OHP eligibility screening, assistance with the OHP application, and outreach. For those individuals who do not enroll in OHP/SCHIP despite their eligibility, the safety net would be the point of primary care access. The safety net would develop formal relationships with secondary and tertiary service providers in their community to ensure comprehensive and integrated health care. Safety nets would have a formal agreement to refer patients, when appropriate, to local specialty outpatient care, outpatient surgery, and inpatient care. Furthermore, secondary and tertiary providers would refer uninsured patients to the safety net. If an uninsured community member, for example, inappropriately accessed an emergency department, the emergency department provider would refer them to their local safety net provider. Safety net services provided to individuals who are eligible but not enrolled in publicly funded insurance programs would be compensated by the State. In-patient care, for those eligible but not enrolled, would continue to be compensated through Medicaid hospital hold policy.

The Access Model would be implemented in three phases. The first phase would be the implementation of the proposed CHIP Too waiver. The CHIP Too waiver proposes to financially compensate safety net clinics for health care services provided to uninsured children eligible for SCHIP who cannot or will not enroll in pubic insurance programs. The second phase would be providing the Access Model to Oregon's children living in families with incomes below 200 percent of the Federal Poverty Level. The third phase of the Access Model would be the integration of adults from 100 to 200 percent of the federal poverty level.

Community Access Workers

In order to assist with the provision of primary health care and link people to insurance, the safety net would use the services of Community Access Workers (CAWs) to assist in the OHP/SCHIP eligibility screening process. CAWs would be members of underserved communities, employed by the safety net, and trained to identify and address the needs of their community. They would assist the safety net in educating the community about how to appropriately access the health care delivery system. In addition to their many roles assisting

[15] See Attachment: "Barriers to Access and Utilization"
[16] No Health Insurance? It's Enough to Make You Sick: Scientific Research Linking the Lack of Health Coverage to Poor Health. Decision 2000. American College of Physicians-American Society of Internal Medicine (ACP-ASIM).

safety net clinics and the community they serve, CAWs would educate community members on the importance and availability of both public and private health insurance. They would assist with OHP eligibility and enrollment, while sharing their expertise to simplify the eligibility and enrollment process. Safety net clinics, in collaboration with CAWs, would provide population based primary care as well as refer patients in need to secondary and tertiary providers.[17]

Conclusion

Safety net providers throughout Oregon are committed to providing quality and comprehensive health care to the 363,000 Oregonians without health insurance as well as to the 345,000 Oregon Health Plan enrollees. In order to continue to provide services to Oregonians who do not access the mainstream health system, the Committee on Health Care Safety Net Support has come together to address stabilization and expansion. One way to assist in sustaining and strengthening the safety net and to ensure access to health care for all Oregonians is to reimburse the safety net for services provided to OHP/SCHIP eligibles.

The Access Model is a community and population based delivery system designed to provide comprehensive and integrated services to the underserved. The Access Model encourages private and public partnerships, cost and risk sharing, and promotes the concept that communities working together can create quality and affordable health care for all Oregonians.

This is one of a series of papers discussing issues related to universal health coverage for low-income uninsured Oregonians. This work is supported by a grant from the Health Resources and Services Administration. As more information is gathered, the papers will change. Views and ideas expressed within these papers are not intended to reflect those of any particular group, unless so noted, but are intended to inform and stimulate discussion and debate on critical health care coverage strategies. For the most recent revision, please visit the grant team's Web site: http://www.ohppr.org/hrsa/index_hrsa.htm, or call 503/418-1067 to request the paper in an alternate format.

[17] See diagram: "Community-Based Delivery System"

Attachment A

Barriers to Access and Utilization

Even within the context of insurance reform, some people continue to rely on safety net providers for their health care services. Furthermore, because many safety net providers have expertise in meeting the particular needs of low-income uninsured and other vulnerable populations, they are often the "provider-of-choice," not simply the provider of last resort.

Children and families may encounter barriers when attempting to access publicly funded insurance programs. Some of the barriers to access and utilization of health care include:

Racial and Cultural Issues

- Legal immigrants who arrived after August 1996 and those who are undocumented are not eligible for OHP/SCHIP or other publicly funded health insurance programs except for Citizen/Alien-Waived Emergent Medical (CAWEM), the emergency Medicaid program for non-U.S.-citizens who have a life-threatening need for medical help.
- The changing demographics of Oregon require culturally competent health services that are not always available.

Provider Access

- People sometimes lack access to health services despite coverage.
- The number or providers is limited in frontier (less than six people per square mile) and rural Oregon.
- Fully capitated health plans and other providers across Oregon are limiting the number of OHP and SCHIP patients they enroll/serve.

Regulatory and Procedural Issues

- Some people find the re-application process burdensome or confusing.
- Although the application is written at a sixth grade reading level, the OHP/SCHIP application still poses literacy and comprehension issues for some Oregonians.
- The requirement to provide proof of income for three months is an obstacle for some.
- In some cases, people experience a slight increase in income and are no longer eligible.

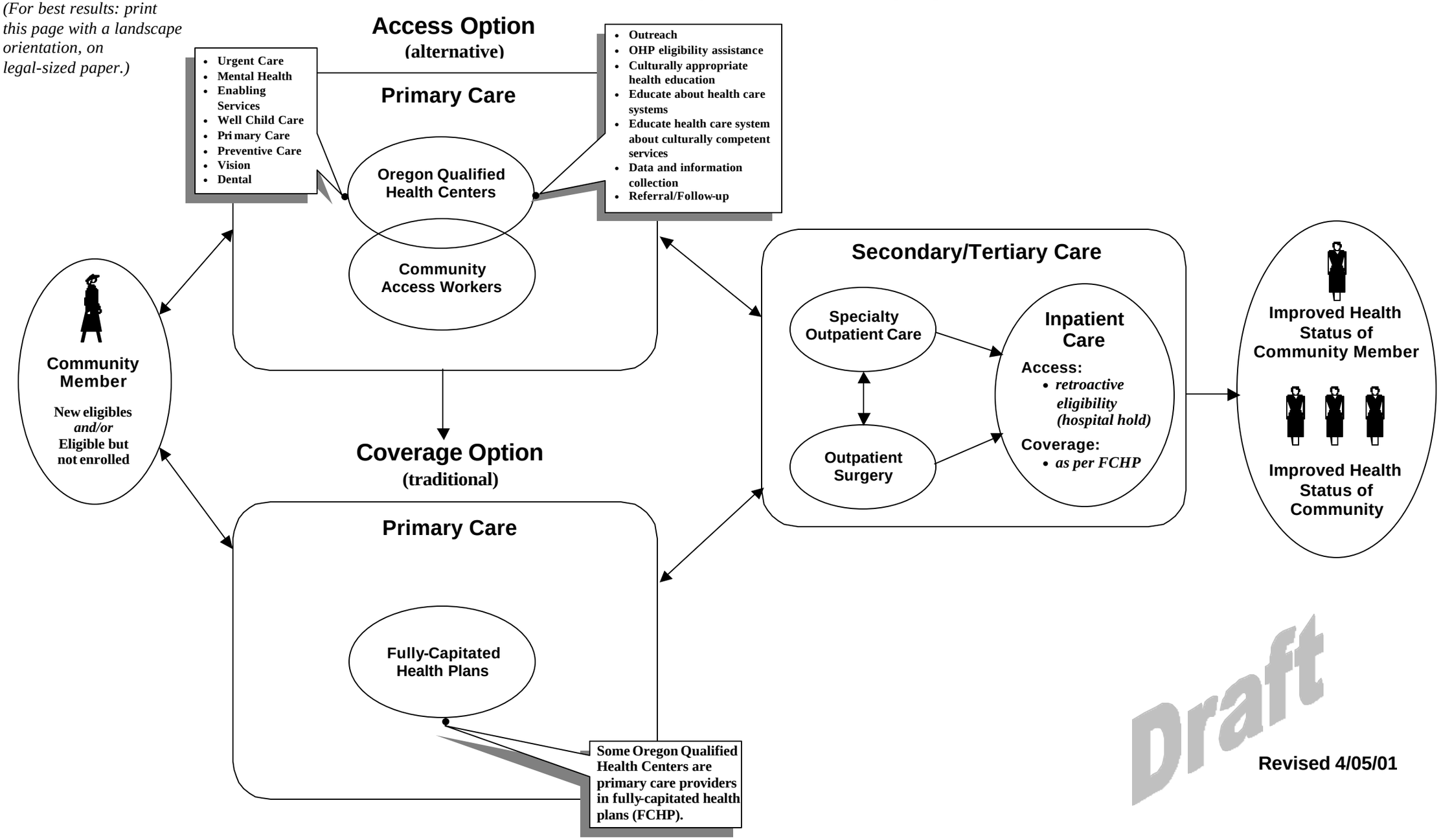
"Backlash of Welfare"

- Some people distrust government and therefore avoid all public programs including OHP and SCHIP.
- Some perceive governmental assistance as an indicator of weakness. They don't want a "hand-out".
- Some people dealing with complex psychosocial issues (e.g., illiteracy, alcohol and drug issues, and mental illness) avoid enrolling in insurance.

Attachment B

(For best results: print this page with a landscape orientation, on legal-sized paper.)

Community-Based Delivery System



Draft

Revised 4/05/01