



Forum Session Meeting Announcement

Friday, January 11, 2008
9:00–9:30am — Breakfast
9:30–11:15am — Session

Health Care Safety Net Innovators: Forging Ahead, Though Challenges Persist

A Discussion Featuring:

Robert E. Hurley, PhD
Senior Consulting Researcher
Center for Studying Health System Change
Associate Professor of Health Administration
Virginia Commonwealth University

Thomas Trompeter
Chief Executive Officer
Community Health Centers of King County

John W. Bluford III
President and Chief Executive Officer
Truman Medical Centers

Location

Reserve Officers Association of
the United States
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen Senate
Office Building)*

Registration Required

Space is limited. Please respond
as soon as possible.

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by e-mail to: nhpfmeet@gwu.edu



Health Care Safety Net Innovators: Forging Ahead, Though Challenges Persist

OVERVIEW

This Forum session will explore the challenges health care safety net providers face and the manner in which, despite these challenges, innovators are working to achieve major improvements. Representatives from a community health center and a public hospital will discuss their successes in providing comprehensive, coordinated, affordable, high-quality care to their patients, the majority of whom are uninsured or publicly insured. The pressures these providers face, including growing demand for care, changing Medicaid policies, state health reform efforts, and increasing competition will be examined.

For more information — See Robert Hurley, Laurie Felland, and Johanna Lauer, “Community Health Centers Tackle Rising Demands and Expectations,” Center for Studying Health Systems Change, Issue Brief No. 116, December 2007, available at www.hschange.org/CONTENT/958/958.pdf; and Richard Hegner, “The Health Care Safety Net in a Time of Fiscal Pressures,” National Health Policy Forum, Background Paper, April 2001, available at www.nhpf.org/pdfs_bp/BP_SafetyNet_4-01.pdf.

SESSION

The health care safety net in the United States is a patchwork of providers, financing, and programs that generally serve people outside of the medical mainstream, namely those without stable health care coverage. This includes the 47 million people who lack health insurance, those who are underinsured, the publicly insured, and other disadvantaged populations made vulnerable by poverty or poor health status. While designed to predominantly serve the most vulnerable members of society, the safety net’s importance is not confined to these individuals. Key safety net services, such as trauma care and emergency response, are critical to the population at large.

The safety net system varies dramatically across the country. It is a localized phenomenon, with different configurations, financing, and functions in states, counties, and communities. Core providers include community health centers, public and teaching hospitals, free clinics, and school-based clinics. Some community hospitals and private health care providers play key roles as well. Safety net financing involves a complex mix of direct and indirect subsidies from public and private insurance programs, graduate

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medical education funds, grant programs, philanthropic donations, and state and local government funds. Though each community's safety net financing is unique, Medicaid is the financial lifeblood of all safety nets, regardless of location. As a result, Medicaid policies have a significant and far-reaching effect on safety net providers and programs as well as the vulnerable populations they serve.

The U.S. Department of Health and Human Services lacks sufficient tools to track and monitor the condition and effectiveness of the health care safety net, making educated policymaking a challenge. Much of the available information regarding the status and adequacy of the safety net is anecdotal or limited to a single community or state. The Center for Studying Health System Change (HSC) conducts the multi-year Community Tracking Study in 12 communities¹ that examines health care markets, including their safety nets. The analysis of 2007 study data found that there are some standout successes, particularly community health centers' ability to create a medical home. However, most safety net providers are struggling against rising demand, and their ability to meet the health care needs of the impoverished and disadvantaged is seriously challenged: Many communities are experiencing crowded emergency departments; hospitals are having difficulty providing access to specialty care in their emergency departments; mental health and dental services are extremely limited; clinics struggle to provide meaningful specialty care referral. All of this is happening in an environment of increasing competition with private providers for insured patients and their related insurance payments.

The demands on safety net providers and their ability to respond depend heavily on the state and federal political and economic context in which they function. Stronger state economies are better able to finance health care. Reflecting that strength, a number of states are pursuing health insurance expansions to cover some or all of their uninsured populations. Though insurance coverage for the previously uninsured patients they serve would appear to be a boon for safety net providers, some states are proposing to fund coverage expansions by redirecting Medicaid and other state and local dollars—which would ordinarily go to safety net providers to reimburse for uncompensated care—to health plans. Many safety net providers worry that such a strategy would weaken their capacity and could potentially limit access to care for the newly insured. Depending on payment rates available under the newly expanded coverage, other providers may not be anxious to serve these beneficiaries.

In those states where the economy is not faring as well, people are losing coverage, with concomitant effect on the safety net. Because Medicaid spending is countercyclical to state revenue growth (as state economies weaken, more people enroll in Medicaid and spending for the program increases), safety net providers and the people they serve in those states face a different set of challenges. These include provider payment reductions, eligibility and benefit cuts, and other cost containment measures.

New federal Medicaid and State Children's Health Insurance Program (SCHIP) policies are also significantly affecting health care safety net providers. The citizenship documentation provisions in the Deficit Reduction Act of 2005, for example, have contributed to a drop in Medicaid enrollment and, therefore, to lost revenue to community health centers and public hospitals. Medicaid regulations that seek to cut federal Medicaid spending by \$5 billion over five years by eliminating Medicaid payments for graduate medical education, limiting payments to government providers and safety net hospitals, and restricting states' ability to fund their share of Medicaid expenditures—currently under moratorium until May 25, 2008—have also raised concerns among safety net providers. Many states argue that the workforce shortages already plaguing them, particularly in mental health, would be worsened by such cuts to training funds. Uncertainty about SCHIP reauthorization and that source of coverage for safety net clients is a further contributor to financial insecurity for many safety net providers.

Because of these pressures, in many places the health care safety net is tattered and torn. In other communities, however, it is a vibrant patchwork with safety net providers thriving and delivering comprehensive, coordinated, high-quality care rivaling that of any private system. This Forum session will provide an opportunity to look at strategies that innovative safety net leaders are employing to bolster their organizations' financial performance while expanding access to care and improving patient outcomes and satisfaction with that care. This session will also explore the federal policies that most help or hinder the ability of these top-tier organizations to sustain the momentum of innovation.

SPEAKERS

Robert E. Hurley, PhD, senior consulting researcher at the Center for Studying Health System Change and associate professor at Virginia Commonwealth University, will use the HSC site visit data to demonstrate changes in the health care safety net. **Thomas Trompeter**, chief executive officer of the Community Health Centers of King County, Washington, will discuss the Centers' work on improving care delivery and patient outcomes by better managing chronic diseases and integrating behavioral and medical care. **John W. Bluford III** is the chief executive officer of Truman Medical Centers (TMC) a two-hospital, not-for-profit health system located in Kansas City, Missouri. He will talk about TMC's successes improving patient care and satisfaction while lowering operational costs. Both Mr. Trompeter and Mr. Bluford will discuss the critical role that information technology plays in their facilities' innovation efforts, and they will highlight federal policies that help and hinder their ability to sustain innovation.

KEY QUESTIONS

- What strategies and circumstances enable safety net innovation and success?
- What is the state of the safety net in the 12 communities monitored by the HSC? What key changes have been seen in these service systems across the ten years of the survey?
- How do changes in Medicaid policy at the federal level (for example, federal payment regulations) and at the state level (for example, growth of managed care and capitated payment) affect safety net providers and the people they serve? What other federal policies are helping or hindering the efforts of top-tier safety net providers?
- What effect might states' efforts to expand health insurance coverage have on safety net providers?

ENDNOTE

1. The 12 communities are Boston; Cleveland; Greenville, SC; Indianapolis; Lansing, MI; Little Rock; Miami; Northern New Jersey; Orange County, CA; Phoenix; Seattle; and Syracuse.



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