Module 8: Access to Health Services

Part 6: The Safety Net

I'd like to talk today about safety net providers in our country. I'd like to start with the definition of safety net providers. The Institute of Medicine define safety net providers as those that by mandate or mission organize and deliver a significant level of healthcare and other health-related services to the uninsured Medicaid, and other vulnerable patients. Remember that we have something like 48 million people without health insurance in America. And more significantly perhaps is that the Commonwealth Fund in 2007 estimated that 116 million Americans were either uninsured, underinsured, reported a medical bill problem but could not access needed health care because of cost.

These large numbers of people are members of why we need a safety net. We have a safety net in many ways, but it's a patchwork of eligibility for different programs. It is in part because of how we finance health care in America. We have both a large public program which funds services for the elderly such as Medicare, and disabled, and very poor people through the Medicaid program. And then we also have a larger private program which funds programs for working adults usually those between 18 and 64 years of age. Because of this, people often get health care through different providers.

In addition, safety net providers often not only serve a vulnerable population, but they serve them in specific ways that are often not found in the private sector. So they have specialties in the area of culture, language, competency, and they are especially skilled in areas where there are often deep social and mental health issues. We have a patchwork of safety net providers, and we can consider them through things like the public health departments, not-for-profit organizations, health centers and hospitals, many private mission directed organizations, and religious organizations, people of faith who step up and help those who are most vulnerable in our society.

One of our great challenges though is how do we best coordinate the services from this patchwork of safety net providers. Eligibility is a very important issue for safety net providers, and some of the factors that influence the safety net is how many people actually have health insurance coverage. More people who have health insurance coverage, the less we need to depend on the safety net. However, as health insurance diminishes, the safety net will often expand. What rules we used for Medicaid and Medicare eligibility also can affect safety net in profound ways.

We're also talking more in this country about immigration reform. And whether we include health insurance in that immigration reform will also influence the safety net. And finally many private providers have expressed willingness or maybe unwillingness to see people without health insurance, and to the extent that they are willing to take care of those who are uninsured can affect the safety net.

I mentioned that the safety net is a patchwork and part of the patchwork that we have to consider are community health centers. These are often private nonprofit centers. Sometimes people call them free clinics. And they are not really fully free, because they actually usually charge a sliding scale to see services.

The most well known of these community centers in the country is a program called Volunteers in Medicine which began in the 1990s. There are about 96 of them across the nation. And they began with retired physicians and nurse practitioners who, through their charitable mission, decided that they wanted to care for many of the vulnerable in their communities. So these are often community based programs sometimes with volunteer doctors, and nurse practitioners where they provide services through a sliding scale.

There are others that are funded through missionary work, through religious organizations, through foundations, and public charities. They often are able to provide free medical services. In addition, we have a growing number of nursing centers in this country, often they are located in public housing facilities, but the nursing centers provide a very important safety net through our community health center programs. In addition to private nonprofit, there are private for profit centers, often these are called retail clinics or urgi centers. They are often found in large department stores or pharmacies, retail places where they can provide instant healthcare services for those who walk in. They do charge fees and those fees are listed at the retail clinic.

We'll talk a little bit more about government-funded centers and then hospital-funded clinics, who also provide services specifically for their community. The most important of the government-funded services is the Federally Qualified Health Centers. This is part of Section 330 of the Public Health Service Act and they're often, in fact, all located in medically underserved or health professional shortage areas. They have some particularly unusual and unique features.

One of the requirements is that more than half of the board has to be patients from that center. So consider that these centers are very directed toward patient services and patient care, and the board's composition helps assure that there's a patient focus to these federally-qualified health centers. And they reflect the needs of the communities in which they are located in. The services that we provide are primarily primary care. There are a limited number of specialty services that are available at these federally-qualified health centers.

One of the other unique features of the federally-qualified health centers, or FQHC, as we call them, is that they have a special payment through Medicaid. Usually Medicaid is often considered on the poorest or worst payers in our country. Because Congress has recognized the special role of the federally-qualified center safety net, they provide something called prospective payment which is more closer to the cost of actually providing that care. So most federally-qualified health centers actually are encouraging having more Medicaid patients as part of their patient population.

Pharmacy services are provided through federally-qualified health centers on a limited basis, but one of the advantages that FQHC have is that they can get special pricing through a government negotiated pharmacy price called the 340 B program. And then they, in turn, can contract with the different pharmacists to provide some of these pharmaceuticals for their patients.

We also recognize that there are special populations who have very special needs in our communities. And the federally qualified health centers have a special population program. These special populations include individuals and families who are homeless and there are health care for the homeless programs. Migrant agricultural workers represent an important segment of our society and the dependence and they can get programs through this special population health center.

Those who live in public housing and native Hawaiians are special categories. Our public hospitals represent an important part of our safety net. So while the health centers largely do outpatient care and primary care services, the public hospitals otherwise we refer to them as America's Central Hospitals provide an important safety net for those who need hospital care. They are largely funded through city, county, or state governments. And they also can do third-party billing to provide services for those who have private insurance. They are often, in fact, all mission directed, and they are specifically created to help serve the poor in the communities in which they are located.

Because they are hospitals and because of the special needs of the vulnerable populations, they have special services around language competencies, cultural competencies, and social services which are a major challenge for many of the people that come to these hospitals. One of the challenges for us in our society is the challenge of our mission in serving the poorest in our communities with the finances that are needed to help sustain these public hospitals. And we have seen some public hospitals in this country close because there have not been sufficient funds available to maintain them.

An important role that many private hospitals have is if they serve a large under-served population but they are not specifically public hospitals. These we refer to as disproportionate share hospitals meaning; that they take a disproportionate share of the Medicaid and Medicare population as part of their patient population. They are often academic medical centers among the most prestigious hospitals in our country. And they are known as places where they provide indirect or graduate medical education and train many of our residences and fellows who go into the medical profession. They are often located in urban and rural locations, and they have an advantage of also getting special 340 B pharmacy pricing so that they can actually provide more services and more medication for the patients that they serve.

One of the major challenges is that because under the Affordable Care Act, we expect to actually greatly expand the number of patients who can now get health insurance. There have been major cuts in the disproportionate share of funding through these hospitals. Unfortunately some states have not chosen to expand the Medicaid program which would represent one of the major sources of funding to replace this disproportionate share and those states are right now challenged in trying to find the additional funds necessary to provide for disproportionate share hospitals who do serve large numbers of our most vulnerable populations.

Rural parts of our country also are challenged, and it is important for us to have programs for these rural health clinics. So we've located many of these rural areas beginning with a law that started in 1977. One of the requirements for rural health centers is that they have a midlevel practitioner like an advanced practice nurse practitioner or a physician assistant on staff at least half of the time. And they provide basic primary care services and limited laboratory services at these clinics. They, in general, do not have the comprehensive type of services that can be offered at a federally

qualified health center, but they do provide an important safety net in rural parts of our country where the number of practitioners available is quite limited.

It's important also to recognize those who have provided service in our military and armed forces, and the Veterans Administration is an important safety net to those who have served this country. Those who attend the Veterans Administration's Program have to be veterans. They have to have service connected disabilities, and the types of benefits they receive are largely related to how long they have served in the military to the type of discharge they received. This is not an insignificant program having served something like 8.7 million vets across the country and some 1700 sites. Not surprisingly, they have specialty services around trauma, prosthetic care, mental health, and substance abuse which are major issues for those who have served in the military.

The VA has actually now been touted as one of the most important examples of an antiquated delivery system, and their success is largely through an electronic medical record system that has been developed at the VA that allows veterans to share the same type of electronic medical record across the country. So, for example, you could actually be a veteran in California and go to Maine and get care there, and your medical record will be displayed within minutes of your arrival.

The National Health Service Corp is one of our important ways in which we try to train primary care providers to serve in some of the most difficult communities that are trying to recruit primary care providers. So this program has been in existence since 1972, and we use it to attract medical, dental, nurse practitioners, midwife, physician assistance, mental and behavioral health students who are seeking loans or scholarships to help fund their education. In exchange for their agreement to participate in the National Health Service Corp Program and receiving these scholarships or loans, they commit to two to four years of service at over 14,000 approved sites in this country.

The good news is that many people, once they provide services often in rural or hard to fill locations, find that it's very rewarding for them and actually choose to stay beyond their two to four year commitment. And many of them have actually set up their private practice and services in these underserved communities. It's one of our most successful programs for trying to redistribute our medical health care providers across the country.

We also have some categorical programs as part of this patchwork way for providing our safety net, and they are often directed around specific conditions or diseases. So, for example, HIV-AIDS have actually special funding through something called the Ryan White Act. The Ryan White Act was a young boy who actually had hemophilia and contracted HIV through blood transfusions, and at a time when we weren't actually able to determine the HIV status in blood.

Subsequently though in honor of him, we have greatly expanded the number of programs available to help serve this very needed population. We also have through Title V, the Public Health Service Act, maternal child health funding, which funds a whole range of MCH programs for pregnancy and early childhood development. Title X is a specific fund that provides funding for family planning services and many of our family planning clinics across the country are funded through this Title X program which serves family planning services not just for women but also for men. And finally, one of the divisions of the family health services is Indian Health Services which specifically provides funding for the Native American Indians on reservations across this country.

Many of you know that people who need emergency medical care are told that they can always go to a hospital emergency room and that they can get evaluated at that time. Why do we know this? It's because of this law called EMTALA or the Emergency Medical Treatment and Labor Act which this 1986 requires that hospitals that receive federal dollars provide emergency care regardless of ability to pay. However, you are only required at the emergency room to triage patients and stabilize patients prior to their discharge. It is not a substitute for genuine primary care, because there is no continuity of care as part of the EMTALA law. And so people who have chronic health conditions need to be able to go to a true primary care safety net provider.

However, this law is very important because it allows us to take care of anybody, regardless of ability to pay, but emergency rooms will charge patients for that care. It is not free, and health care through emergency rooms is very expensive, so we do not encourage people to use emergency rooms in this fashion, but rather to try to use primary care safety net providers.

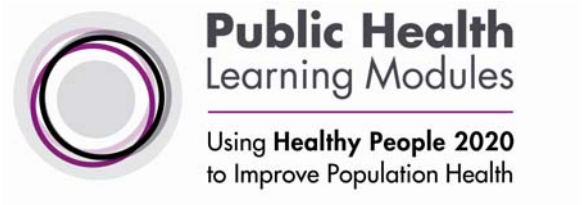
We should also recognize that there are many private doctors who have long-standing relationships with patients or families. And because of the vagaries of health insurance, this country or employment, people often lose their health insurance, and private doctors have often stepped up and have been willing to take care of family members and patients who have longstanding relationships with them.

However, we recognize that this cannot go on forever and many of them are often referred to other safety net providers in order to receive their care. This is also referred to as uncompensated care that is generously provided by physicians and also hospitals. Many hospitals often will send bills to patients, but many bills are often written off simply because they are unable to collect funds to help cover those hospital bills.

Recall the fact that other people, mainly those who have insurance, are to cover those who are uninsured. We call that call shifting, and a study done in 2009 by Families USA and it estimates the average health insurance family plan spends about a thousand dollars extra for that plan simply to help cover the cost shift for those who are uninsured and $368 for individual plans. That additional amount that those who have insurance pay is probably higher today because of the increase in healthcare costs.

All of this is to say is that coordination also is very important. We have a patchwork of safety net providers, but our ability to communicate well between safety net providers and those who go through other private providers is important so that we can maintain continuity of care for individuals. There is a responsibility here, both by the providers and by patients, in order to help facilitate this coordination.

One of the goals of the Affordable Care Act is to greatly expand health information technology so that we can actually track what type of services have been provided to individuals so that we can do a better job of this coordination. Finally it's important for us to recognize that health care reform like the Affordable Care Act has provided an important step for trying to provide health insurance for everyone. However, there are still important significant gaps even with the Affordable Care Act and there is an estimate of some 30 million Americans who will not have health insurance for various reasons.



Ultimately our goal as a nation should be that everyone has some type of health coverage either an expanded Medicare for all, or a national health insurance program, or something similar in order to make sure that those of us who are most vulnerable can get the coordinated and comprehensive care services that they deserve. Thank you.

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