Michigan's Health Care Safety Net Providers: *Current Capacity and Future Outlook*

"So much of what we see at the clinic can be prevented – dialysis, amputation, blindness, not being able to breath. Society pays for it eventually, but we won't pay to prevent it."[1]

- **Medical Director of a Free Clinic**

"There are not enough providers, whether it's doctors, nurse practitioners or PAs. Half the people who come to the center here don't have a primary care physician because there is no one who can take them on their panel. So this means they have no continuity of care. They don't see the same person every time they come. So, each time, the doctor starts from ground zero, taking the whole history over again."[2]

- **Nurse at County-Funded Clinic**

"While there is not a formal change in mission, we are now saying, for the first time, that the clinic can't serve all the uninsured who come through the door."[3]

- **CEO of a Rural FQHC**

"When the ER is overcrowded, it's because people don't have access to primary care… or to specialty care because the waits are long or it's too expensive, or they're uninsured and there's no one willing to take an uninsured or an under-insured patient, or even a Medicaid patient.[4]

- **Senior Research Scientist for an Emergency Department Report**

Michigan's safety net providers are the last thread in the health care delivery system, the providers of last resort. They deliver a sizable amount of health care to the uninsured, underinsured, and other underserved groups. According to a report by the Institute of Medicine, core safety net providers have two distinguishing characteristics:

- Either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
- A substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.[5]

The health care safety net, at the national or state level, is neither uniformly available nor financially secure. Michigan's safety net patchwork of providers includes: nonprofit hospitals that provide a disproportionate share of services to underserved groups, federally qualified health centers (FQHCs), community health plans, free clinics/volunteer programs, school-based health centers, and local public health departments.

The goal of this paper is to provide the Advisory Council to Michigan's State Planning Project for the Uninsured with an understanding of current safety net provider services,

and the need for strengthening the system while pursuing the State's ultimate goal of health insurance coverage for all Michigan residents. The following sections cover: the populations served by the safety net, a description of core safety net providers and their current capacity, and the future outlook.

Populations Served by the Safety Net

In the absence of national universal health insurance, the health care safety net has served as a default system of care for millions of low-income uninsured and underinsured Americans. Nationally, the number of uninsured is close to 45 million people, or 15.6% of the U.S. population.[6] In Michigan, 7.8% of residents, or almost 800,000 people are uninsured at any one time.[7] Estimates of the total number uninsured at any time in the year range upwards to over one million, or about 11% of Michigan's population.[8]

The uninsured include individuals of all ages and the majority are employed. Persons aged 65 and older are least likely to be uninsured due to Medicare coverage. About 26% of Michigan's uninsured are young adults between the ages of 20 and 29.[9] In terms of the labor market, 80% of uninsured households have at least one adult who is employed or self-employed and 73% of these households have at least one adult who works 40 or more hours/week.[10]

Safety net providers serve a range of populations, including: the uninsured, working poor whose employers do not offer insurance, adults who cannot afford employer-sponsored coverage, Medicaid beneficiaries, chronically ill individuals, people with disabilities, minorities, legal and undocumented immigrants, homeless people, veterans, and non-Medicaid-covered unemployed poor.[11] These subgroups may rely on safety net providers for various reasons. For instance, some Medicaid beneficiaries must resort to the safety net for health care because they cannot locate a provider who accepts Medicaid. Other individuals may live in geographically or economically disadvantaged communities, concentrating the number of uninsured in the region. Additionally, there are some who choose to receive care from health care safety net providers. In Michigan, the City of Detroit has the highest rate of the uninsured at 17.5%, followed closely by the Northern Lower Peninsula at 16.5%.[12]

Safety Net Providers and Current Capacity

Michigan safety net organizations provide an array of health care services to persons who otherwise could not get the health care they need. These services include: urgent care, primary care, preventive care, mental health, dental, vision, and enabling services such as language interpretation, transportation and outreach.

The safety net has had a tremendous impact on the lives of those who fall outside the medical and economic mainstream, providing access to primary and preventive care for many vulnerable populations. However, as a recent Kaiser Commission report on America's health care safety net points out, "At best, the safety net is threadbare and the demands placed on it are simply too great."[13] Further, the patchwork of services

provided by the safety net frequently require patients to jump from one facility or program to another to locate medications, medical equipment, lab and x-ray services, rehabilitative therapies, specialty care, and hospital care.

A "Capacity Assessment of Michigan's Safety Net", conducted by the Michigan Primary Care Association and Access to Health Care Coalition, indicates that many of the safety net organizations are at capacity, as 49% of the respondents reported being forced to turn away patients that they did not have the capacity to serve in the last year.[14]

Hospitals:
Michigan's nonprofit community hospitals are an essential component of the safety net for the uninsured and underinsured, providing nearly $1.1 billion in uncompensated health care to Michigan residents in FY 2003, according to the American Hospital Association.[15] Further, the Michigan Health and Hospital Association 2005 Hospital Community Benefits Report highlights an additional $313 million of nontraditional community contributions during FY 2003 (reported by 116 of Michigan's 144 nonprofit hospitals); the total impact of these contributions affected the lives of nearly 5 million Michigan residents.[16] Providing uncompensated care without the financial resources to cross-subsidize these losses makes the situation for these safety net hospitals especially critical. Pressure from private payers and Medicare to contain costs further limits the cross-subsidization of unprofitable services by hospitals. A total of 20 Michigan hospitals closed their doors between 1996 and 2002.[17]

Although Michigan's hospitals take great pride in providing compassionate care for all, rising health care costs combined with an increasing number of uninsured patients and low Medicaid reimbursement threaten their ability to operate. In 2002, the average operating margins for Michigan hospitals was only 1.6%, compared to 3.7% nationally.[18] Thirty-two percent of Michigan's hospitals had negative operating margins.[19] This demonstrates an unhealthy financial state, given that a 5% margin is the ideal for maintaining a financially viable non-profit hospital. Five percent is the minimum annual return necessary on net patient revenue to invest in new technologies, facilities, and employees to keep the system or hospitals from becoming obsolete.[20] Positive financial margins are necessary to fund care for the uninsured.

Federally Qualified Health Centers (FQHCs):
Michigan currently has 27 FQHCs and three FQHC 'look-alikes' providing care to over 400,000 patients at 143 delivery sites.[21] [22] They are located in medically underserved communities, serving the low-income, uninsured, underinsured, elderly, minority, migrant and seasonal farm workers, homeless, and persons living with HIV/AIDS. FQHCs are funded by federal grants through the Health Resources and Services Administration (HRSA), Medicare/Medicaid, state and local grants, contracts, private funds, insurance, and patient fees (on a sliding fee scale).

FQHCs concentrate on prevention, and are mandated to provide primary health services, either directly or through referrals. They are legally obligated to serve all those who approach their door. FQHCs can be cost effective; they improve access to care, reducing

the number of emergency visits, hospital admissions, and length of hospital stays.[23] However, FQHCs face major challenges and threats. The needs of existing and predicted clients exceed capacity for most FQHCs.[24] Increases in unemployment, small businesses dropping health insurance benefits, and employers increasing employee cost-sharing are all contributing factors to this problem. The resultant growth in the uninsured population, coupled with the rising costs of prescription drugs, exacerbate this threat. Further, managed care growth and federal, state and private payers' strategies to reduce cost have important consequences, given that funds from these sources act as a cross-subsidy for the uninsured.[25] Practically speaking, the excess demand places too much stress on systems designed and funded to function at lower capacities.

Rural Health Clinics(RHCs):
As of January 2006, there are 158 certified Rural Health Clinics in Michigan.[26] RHCs can function as free-standing independent practices, or be affiliated with a hospital or other provider. These clinics offer significant amounts of care to the Medicaid and Medicare populations and are located in medically underserved rural communities.

Community Health Plans:
Many communities in Michigan have developed community-based initiatives to offer health care coverage programs for the uninsured and the working poor. Supported by local, state, and federal funding, these programs include: Adult Benefit Waiver programs (Plan A), Low-Income Uninsured Program/ County Health Plans (Plan B), and Third Share Programs.

- *Adult Benefit Waiver - State Administered (Plan A)*:
  In January 2004, the U.S. Department of Health and Human Services approved Michigan's HIFA waiver and replaced the State Medical Program with the Adult Benefit Waiver (ABW) program. This has allowed the State of Michigan to use SCHIP funds to expand health care coverage. The ABW provides health care benefits for childless adult residents with income at or below 35% of the Federal Poverty Level.[27] The State defines eligibility requirements and benefit structure; the ABW is administered through County Health Plans (see below), which most Michigan counties now have. The ABW was designed to cover approximately 62,000 childless adults over a five year period.[28] Current enrollment has peaked at capacity, with almost 64,000 enrolled as of December 2005; thus, oversubscribing the program.[29]

- *County Health Plans (Plan B)*:
  The Low-Income Uninsured Program, more commonly termed County Health Plans, are local health coverage programs for the working poor. While eligibility requirements vary across County Health Plans, the targeted non-elderly adults must not exceed 200% of the FPL.[30] Health benefits covered are also determined locally. This program is funded from special Medicaid DSH payments that are comprised of state, local, and federal dollars. Thus, capacity and potential number of enrollees are directly linked to the level of available funds. There are currently 49 counties in

Michigan with Plan B programs. As of December 2005, estimated enrollment is between 50,000 to 52,000 Michigan residents.[31]

- *Third Share Program*:
  This program provides employer and county-subsidized insurance coverage for employees working for small employers paying low wages. Under this initiative, premium costs are split between the employer, employee and the community health plan. Thus, this insurance product limits the monthly premium for employees to $160-$180, with affordable copayments.[32] The scope of benefits offered is more comprehensive than that offered by Plan B County Health Plans, and includes an inpatient benefit in addition to ambulatory benefits and prescription drug coverage. This program is unique because it combines an affordable product with an attractive benefit package. Employer and employee eligibility, as well as benefit design, are determined locally. There are six Third Share Programs offered in five counties. Current enrollment in this program is about 5,000 members.[33] The scope of this insurance design is linked to the capacity of local community health plans.

Free Clinics/ Volunteer Programs:
Michigan's 48 free clinics, located across the State, use volunteer health professionals to provide primary health care and prescription assistance to the uninsured poor.[34] According to recent data from the Free Clinics of Michigan (FCOM), 41% of services provided are "enabling services".[35] These clinics are privately-sponsored by a broad array of civic organizations, including charities, local medical societies, church groups, and local government agencies. Free clinics vary in the range of services they offer, the patients they serve, the hours they are open, and their staff, who are usually unpaid volunteer clinicians. The dependence on volunteer physicians and nurses presents free clinics with the challenge of delivering a consistent standard of care. Free clinics across Michigan unanimously attest to an increase in demand for their services due to the rise in the number of uninsured.[36] While many free clinics are forced to impose restrictions on available services due to capacity constraints, more free clinics continue to spring up across the state due to the critical need for care.

Volunteer Provider Programs are operating in several Michigan counties. Such programs coordinate volunteer provider services, which are scheduled in the regular facilities of physicians, testing labs, dentists, and other healthcare providers. Volunteer programs are often initiated as supplemental capacity in areas that already have a County Health Plan, Third Share Plan, and/or Free Clinic.

School-Based Health Centers:
The State of Michigan presently funds 31 school-based/linked health centers, delivering primary, preventive, and early intervention services to approximately 60,000 children.[37] In 2004, a Medicaid match of $3.7 million allowed for expansion of services to a greater number of children. There are an additional 23 school-based health centers in Michigan that are not state funded, but are supported by their communities. School-based/linked health centers are a primary health care link for many low-income youth and families, predominantly situated in medically underserved communities with multiple access

barriers. Capacity for these centers will continue to be linked to financial support and approval from the school-system, the community, and the State.

Local Public Health Departments:
The Michigan Public Health Code stipulates that the State must support a system of local public health services which are required to be managed by city, county, or district governments. The Code further states that the costs for providing safety net, or core public health services, are to be shared between the State and local governments.

Given the difficult budget situation over the past several years, the State has been forced to reduce its support to local health departments. These local health departments have already been paying about 64% of the costs of maintaining their safety net services such as immunizations, family planning, and nutrition programs.[38] In response to reduced State support, many local health departments have been forced to close programs. In addition, many local health departments are moving away from providing direct health care services and towards providing core public health services, such as surveillance, policy development, and assurances.[39]

Future Outlook

The majority of Michigan's safety net providers are concerned about their ability to continue providing historical levels of uncompensated care in an increasingly competitive marketplace.[40] The primary threat to organizational survival is the increasing demand for services, far exceeding their financial and delivery capacity. This threat is exacerbated by the trend toward serving a sicker patient population.[41]

Michigan, like the nation, has a safety net that is neither comprehensive, nor well-integrated. Many of the safety net providers described above have established fairly high quality services and offer care that meets the unique medical and social needs of an increasingly diverse group of patients. However, these providers are limited in what each can inherently deliver or afford.

The Institute of Medicine's 2000 report on "America's Health Care Safety Net: Intact but Endangered" forewarned:
"A resurgence of inflation in health care costs, an economic downturn, or further increases in the rolls of the uninsured could further destabilize the safety net and place essential care for America's vulnerable populations at the risk of significant peril."[42]
Over the past five years, Michigan has witnessed all of these threats come to fruition.

As with State funding, the federal commitment to the health care safety net has not been able to keep pace with the growth in the uninsured. A recent report by the Kaiser Commission on Medicaid and the Uninsured states that, "As the number of uninsured Americans increased by 4.6 million from 2001 to 2004, federal safety net spending per uninsured person fell from $546 to $498 during the same period. After adjusting for inflation, total federal spending for care for the uninsured increased by 1.3% from 2001-

2004, while the number of uninsured increased by 11.2%. These trends resulted in an 8.9% decline in spending by the federal government per uninsured person."[43] Financial pressures throughout the health care delivery system and the growing ranks of the uninsured put tremendous strain on safety net providers. As an extensive study on coping strategies for Michigan's health care safety net reports, "We have no way of knowing whether the safety net will survive in its present form, especially since resources in the private sector cannot compensate for reductions in public funding."[44] An equally important assessment is that, initially, many of the safety net organizations viewed themselves as a temporary solution to a short-term problem, awaiting some version of universal health insurance. The goal of many, particularly the free clinics, is to go out of business. However, given the nature of today's health care marketplace, most of these providers realize that they are here to stay. They have, by default, become a permanent part of the safety net's institutional structure.

In summary, the above assessment of the state of Michigan's health care safety net and the populations they serve strongly supports the Advisory Council's recommendation to maintain and strengthen the safety net. Many Michigan residents will continue to depend on safety net health care services during the interval required to achieve 100% health insurance coverage.

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