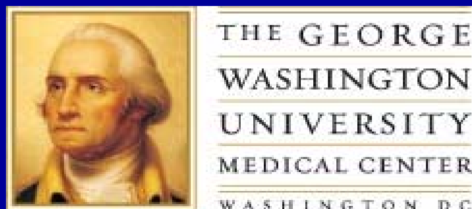

The Safety Net Landscape: An Evolving World

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Grantmakers in Health, Nov. 2011

Two Health Safety Nets

- Insurance Safety Net: Medicaid, CHIP, Medicare
- Provider Safety Net: FQHCs, public & charity hospitals, rural health and free clinics, public health departments, family planning clinics, HIV clinics, etc.
- **Insurance ≠ Access.**
- Affordable Care Act (ACA) greatly expands health insurance.
  - Planned increases for CHCs, but funds may not materialize. Cuts funding for safety net hospitals (Medicaid DSH).

Divergent Paths

- Health reform is overturned.
  - Number of uninsured will continue to escalate.
  - Health grant programs in trouble.
  - Traditional role of safety net continues, but more uncompensated care and less funding.
  - Charities and free clinics can’t fill the gaps.
- Health reform implemented, roughly as planned.
  - # uninsured & uncompensated care costs fall.
  - Role of the safety net will change, but evolve.
  - Health grant programs may still have problems.

Issues Converge at the Safety Net

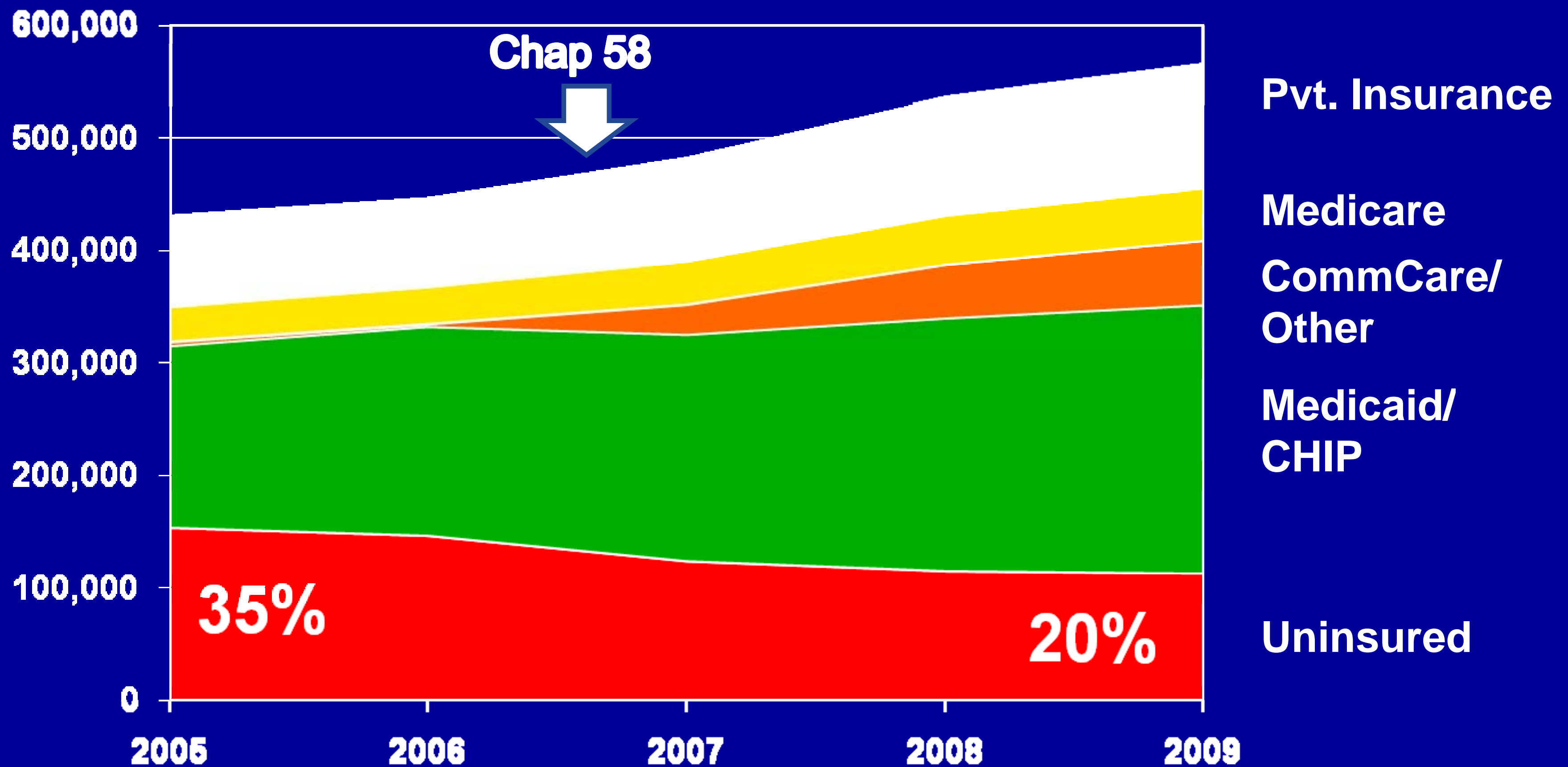
- Many of the most pressing health issues converge at the health safety net:
  - The uninsured & vulnerable
  - The newly insured
  - Access to care, including urban and rural care
  - Integrating care to improve quality and efficiency
  - Health disparities
- Foundations need to have an agenda to strengthen the safety net and to help it evolve.

Lessons of Massachusetts Health Reform

- Level of uninsured fell greatly, but safety net utilization **rose.**
- Expanded insurance led to higher demand for care, particularly ambulatory care.
- Regular system of physician care couldn’t keep pace.
- Safety net patients generally satisfied with safety net providers. When the uninsured got insurance, they typically continued to use safety net providers.

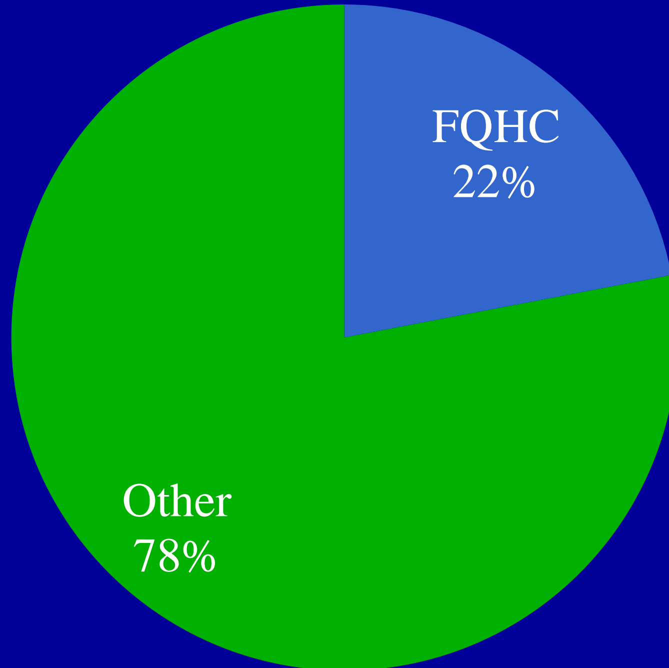
Source: Ku, et al. Arch Intern Med, Aug. 2011

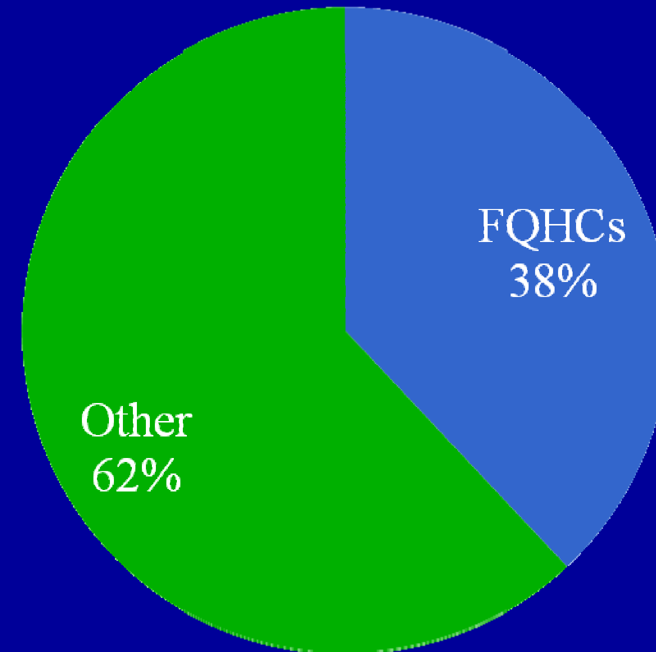
Massachusetts CHC Caseloads. 31% Growth from 2005 to 2009.



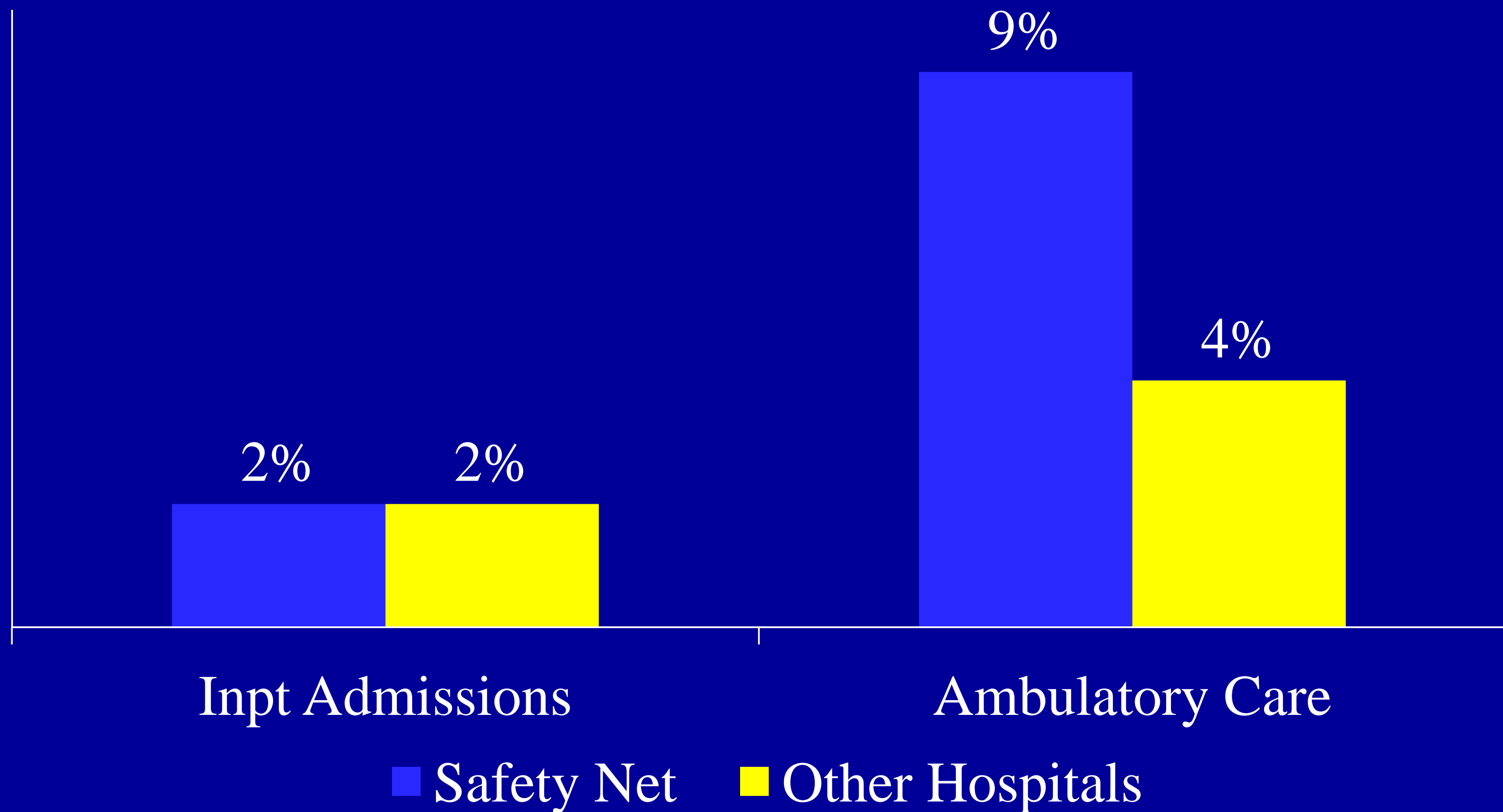
Source: UDS data

% of State Uninsured Residents Receiving Care at CHCs





Growth in Hospital Utilization by Safety Net Status 2006-2009



Source: Data from Mass Dept of Health Care Finance & Policy

Reasons for Using Safety Net Provider

Reason	Percent
Convenient	79%
Affordable	74%
Availability of Other Services	52%
Problem Getting Appointment Elsewhere	25%
Staff Able to Speak Patient’s Primary Language	8%

Source: 2009 MA Health Reform Survey

CHCs Can Lower Overall Medical Costs

- Analyses of 2006 Medical Expenditure Panel Survey shows that CHC patients have 24% lower annual medical expenditures than non-users, after controlling for health status, insurance, age, gender, etc.
- Lower ambulatory, ED and inpatient costs
- Previous research also shows impact of good quality primary care at CHCs
- Can greatly reduce medical care costs in the future if CHCs are able to expand as planned.

Source: Richard, et al. *J Ambul Care Mgmt* forthcoming, Ku, et al. 2010

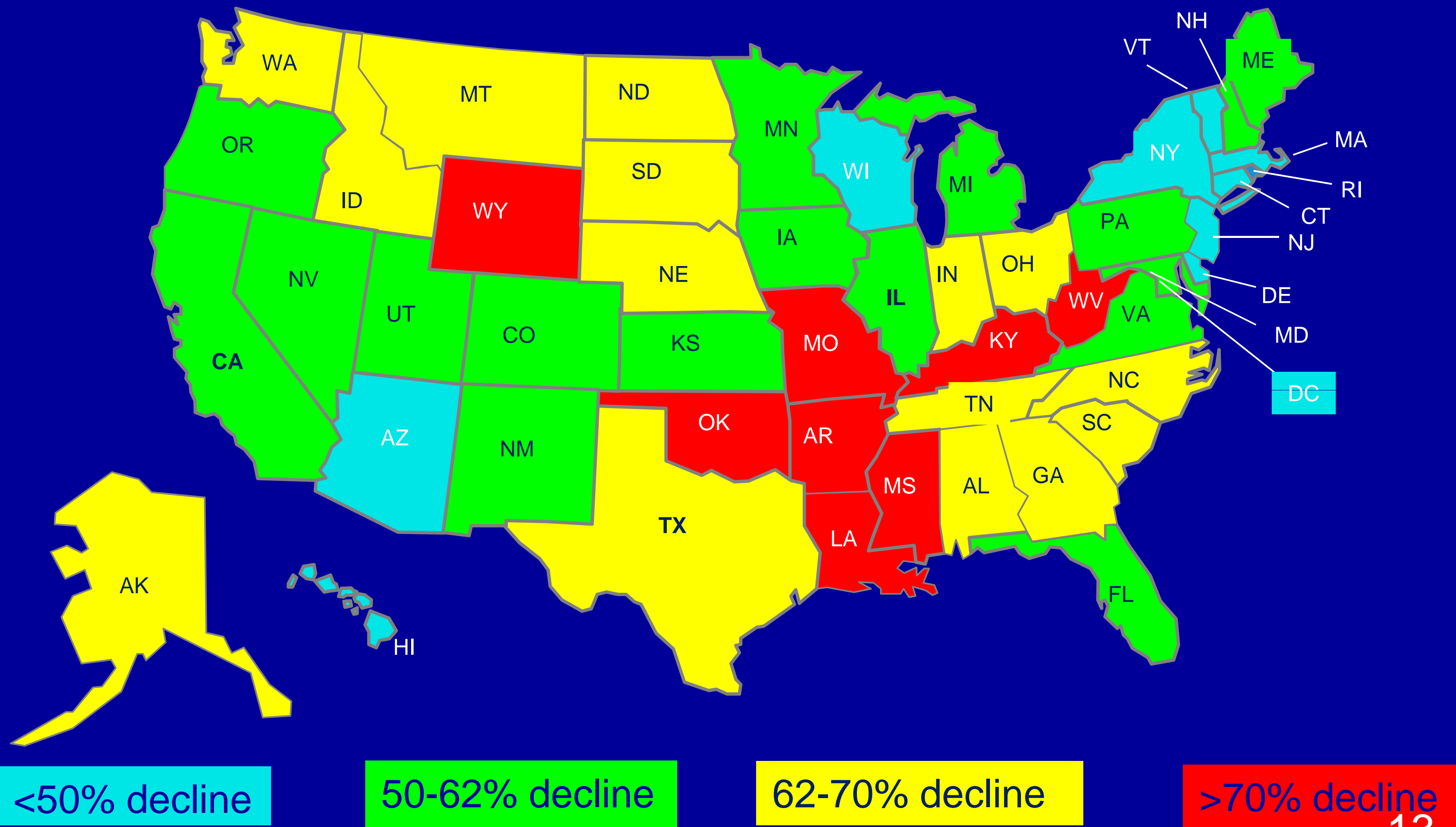
Near Term Issues

- Can safety net providers survive state/local budget cuts? Some hospitals in trouble. Local health depts shrinking. FQHCs more stable, but not growing as planned.
- Safety net providers want to improve quality: patient-centered medical homes, EHRs, integration of behavioral and physical care. Will they have resources and staff to attain these goals?
- What about other system transformations like ACOs? (Managed care growth may be more important.)

Longer Term Issues

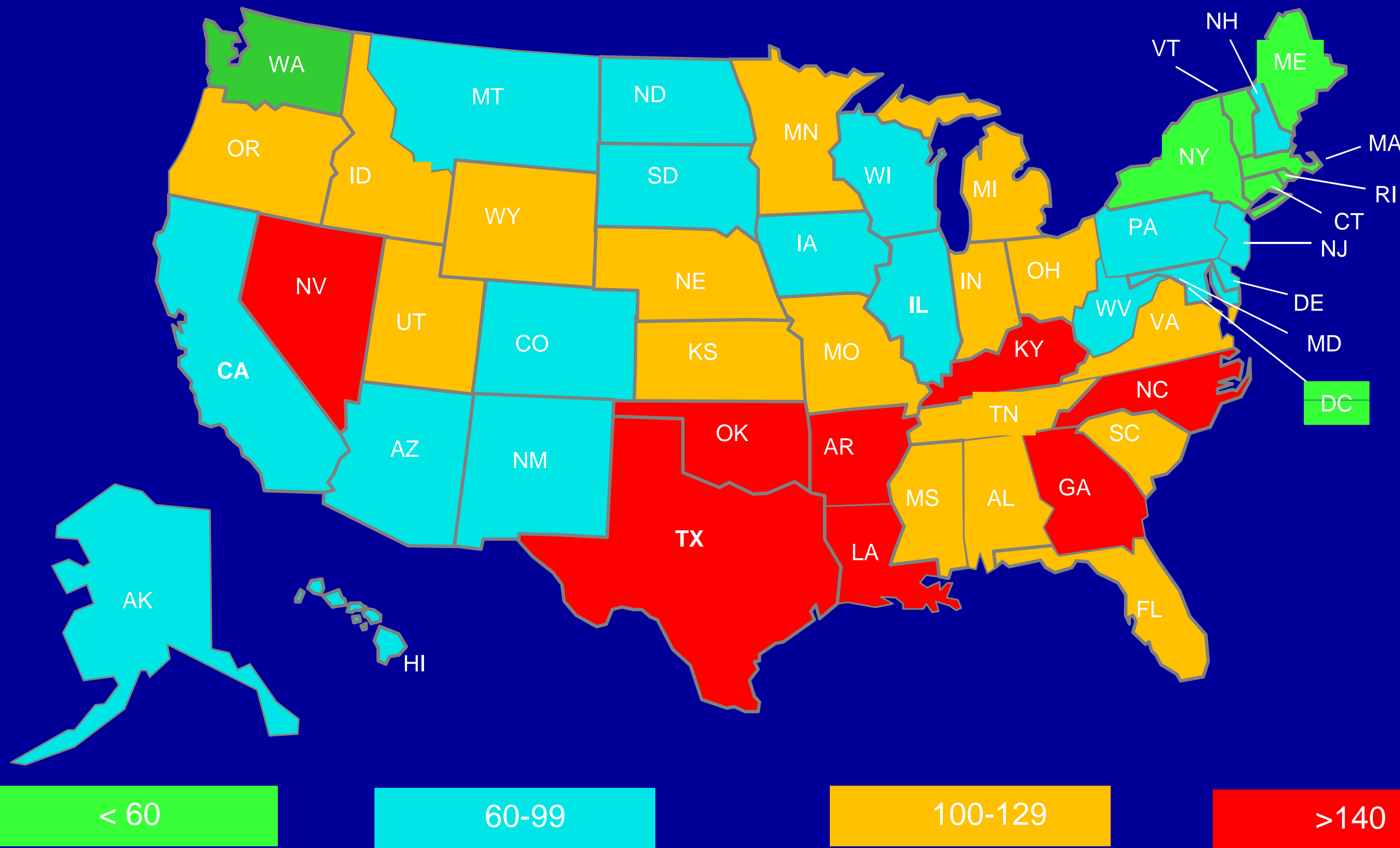
- How much will safety net providers be able to participate in new exchange plans?
- Even if Medicaid eligibility grows, will Medicaid payment rates be adequate?
- Which safety net providers will be able to compete in performance-based payment systems?
- Will there be enough primary care manpower?
- Needs will vary by state.

Changes in Number of Uninsured Women 18-64, Before and After Insurance Expansions Are Implemented



Preliminary GW estimates – unpublished

Level of State Primary Care Challenges: Ratio of Medicaid Expansion to Primary Care Capacity



Source: Ku, et al. NEJM 2/11

Expand Primary Care Clinicians

- Need to expand pool of all primary care clinicians, including MDs, DOs, NPs, PAs, as well as RNs and medical assistants.
- Must increase use of team-based care.
- Non-physician clinicians used less in states with lower primary care supply.
- Need for expansion of community health centers. Serve medically underserved areas, inexpensive and efficient use of health care providers.