

ARIZONA HEALTH FUTURES

IN THIS ISSUE:

- ▶ Squeezing the Rock: Maricopa County's Health Safety Net 1-2
- ▶ The Safety Net: What Is It? 2-3
- ▶ Who's Responsible? The Structure of Maricopa County's Safety Net . . . 4-5
- ▶ What is Primary Care? . . 5
- ▶ The Safety Net Puzzle . 6-12
- ▶ Squeezing the Rock: The Financial Support Puzzle 13-19
- ▶ Relationships: The Fragile Web of Care . 20-21
- ▶ No Margin, No Mission: The County Dilemma . 22-23
- ▶ Improving the Safety Net: Critical Issues and Action Steps 24-26
- ▶ Selected Sources 27

Squeezing the Rock:

Maricopa County's Health Safety Net

ITEM: Three young expectant mothers sit under an awning waiting to see a nurse at a mobile health clinic parked in a schoolyard in Southwestern Phoenix. None of them speaks English, none of them has health insurance. No one asks if they're in the U.S. legally.

ITEM: It's nine o'clock on a Friday night in Good Samaritan's Emergency Room in Central Phoenix. The place is packed. A woman waits with her 10-year old daughter, who is having an asthma attack. It's treatable, and with earlier primary care, it may have been preventable. The woman has health insurance, but she can't get off work to take her daughter to the clinic. Where else is she going to go?

ITEM: A disheveled looking man sits dejectedly in the Healthcare for the Homeless Clinic waiting room. He keeps passing out. Doctors want to refer him to a specialist. Calling around, they find one who will take a complicated charity case. Trouble is, the man needs an MRI and other tests. Where's the money for that?

A Crazy Quilt

All of these people, and thousands more like them, move in and out of Maricopa County's "Safety Net," a crazy quilt of emergency rooms, hospital clinics, free and reduced fee clinics, community health centers, school-based clinics, county public health services, and any number of volunteer-driven and often makeshift arrangements to deliver health care to the indigent, the uninsured, the underinsured and – increasingly – the insured.

-  Well defined, coordinated and funded? Not at all.
-  Available at all times and places for those who need care? Barely.
-  Able to get people to a specialist if they need one? Good luck.
-  Run on a shoestring, with compassion, grit and resolve? You bet.
-  In need of public attention – and public assistance? Definitely.

"Getting some people the care they need is like squeezing a rock," says Janice Ertl, Clinic Administrator at the St. Vincent de Paul Free Medical/Dental Clinic. "You just hope they don't need care you can't provide. Then they're really out of luck."

(Continued on next page.)



St. Luke's Health Initiatives

SQUEEZING THE ROCK

(Continued from front page.)

From 30,000 Feet

In this issue of *Arizona Health Futures (AHF)* we look at the composition, status and viability of the primary care safety net in Maricopa County. This is an extension of many of the themes and issues discussed in our AHF Fall 2001 issue on trauma care, but here the focus is primarily on ambulatory care – primary care and specialty referral – through what might charitably be described as a loose “system” of organizations and projects that share a common mission of addressing the needs of the poor, the indigent, the uninsured and others who for one reason or another may have trouble getting health care.

Admittedly, the view at times is from 30,000 feet. Good data and timely information are hard to come by on the street level, although there’s a wealth of anecdotal evidence and a diversity of knowledgeable views on safety net issues and what to do about them. The lack of good information is a national issue, noted by the Institute of Medicine and other groups, and is not just confined to Arizona.

Over the next several years SLHI intends to continue to work with its community partners to develop more comprehensive and useful health information and analysis in order to inform and craft intelligent public policy.

The Safety Net:

What Is It?

It’s common to hear health professionals around the country say that if you’ve seen one safety net, you’ve seen one safety net. They respond to local conditions, each is structured a bit differently, and it’s hard to make generalizations across systems without footnoting numerous exceptions and peculiarities.

There are several different ways to define the safety net:

The **ULTIMATE** Safety Net:

Some limit a definition of safety net organizations to emergency services and emergency rooms, which are available to everyone at all hours, every day of the year, regardless of the ability to pay. This approach has even more weight in light of recent trends in Arizona and elsewhere in the nation where people are flooding emergency rooms for primary care because they don’t have a regular source of care or can’t get in to see their provider. Emergency rooms are providers of the last resort: when you go there, they have to take you in.

The **CORE** Safety Net:

This expands the definition beyond emergency care providers to include community health centers, free and reduced fee clinics and other providers focused specifically on providing care to the indigent and uninsured, regardless of ability to pay. Not all organizations of this type, however, are “pure” safety net providers; they may in fact provide services to Medicaid patients and others with insurance, depending on the provider mix and economic conditions in the communities they serve.

The **COMPREHENSIVE** Safety Net:

This expands the definition beyond emergency care and core providers to include any organization that is providing significant care to Medicaid patients, the underinsured and other “vulnerable” populations. Many county and city hospitals/clinics, for example, are explicitly charged with providing services to those who are poor, indigent and unable to get health care through other means.

The Institute of Medicine (IOM) defines the safety net as:

Those providers that organize and deliver a significant level of health care and other related services to uninsured, Medicaid and other vulnerable populations. [4]

The IOM further defines two distinguishing characteristics of a “core” safety net provider:

1. *Either by legal mandate or explicitly adopted mission they maintain an “open door,” offering access to services for patients regardless of their ability to pay.*
2. *A substantial share of their patient mix is uninsured, Medicaid and other vulnerable populations.*

In trying to arrive at a definition of the safety net that makes sense in Maricopa County, we tracked the following observations:

- The passage of EMTALA (Emergency Medical Treatment and Active Labor Act, 1986), which requires that hospital emergency rooms across the country treat patients regardless of their ability to pay, essentially makes all hospitals with emergency rooms potential safety net providers. Indeed, every hospital we talked to said they provided safety net services.
- Medicaid patients (AHCCCS in Arizona) may be “vulnerable” according to their economic circumstances, but to providers they are insured, pay relatively well compared to the rates of commercial plans that have been ratcheted down by aggressive bargaining and – again compared to some commercial plans – pay on time. There’s active competition among providers in Maricopa County for AHCCCS-insured patients, and this potentially siphons off paying patients from traditional safety net providers. A provider may have a significant number of Medicaid patients, yet not be considered a “traditional” safety net provider.
- The Maricopa Integrated Health System (MIHS) is the principal safety net provider in Maricopa County, yet it’s run by a private for-profit corporation and receives minimal county tax support. Its primary purpose – its mission and public support base – is perceived differently by different groups.

In the context of these observations, SLHI uses the comprehensive definition of the health safety net suggested by the IOM, with the caveat that it’s impossible to define and document all instances of organizations and individuals providing safety net services in Maricopa County. We focus on *principal* ambulatory care safety net providers as identified, knowing full well that many other organizations provide such services to some degree. Finally, we do not discuss dental and behavioral health services in any detail, but acknowledge that they are critical pieces of core safety net health services. Some of these topics will be explored in future *Arizona Health Futures* publications.

PROJECT SCOPE

We reviewed the following institutions and projects for this report:

Maricopa County Integrated Health System

Good Samaritan Regional Medical Center

St. Joseph’s Hospital and Medical Center

Phoenix Indian Medical Center

Native American Community Health Center

Salt River-Pima Maricopa Indian Community Health Center

St. Vincent de Paul Free Medical/Dental Clinic

Mission of Mercy Mobile Health Clinic

Las Fuentes Health Clinic of Guadalupe

Maricopa Healthcare for the Homeless

Clinica Adelante

Mountain Park Health Center

School-Based/School-Linked Health Clinics

Arizona Latin-American Medical Association Health Discount Card

Medical Home Project

At A Glance:

Maricopa County’s Primary Care Safety Net*

Number of organizational providers and sites: **99**

Number of individuals served (2000): **200,564**

Number of AHCCCS/other insured: **124,619 (62%)**

Number of uninsured: **75,945 (38%)**

* These 2000/2001 numbers are derived from a survey of all *principal* providers of primary care safety net services, with the notable exception of emergency rooms, where good data across institutions are hard to get. Also not included are AHCCCS patients and the uninsured seen by other providers whose principal mission is not necessarily to serve the medically needy and indigent; physicians’ private offices, and a variety of small, informal volunteer care arrangements. The numbers are “best guess” estimates from existing data, and should be interpreted with caution.

Who's Responsible?

The Structure of Maricopa County's Safety Net

Prior to the passage of Proposition 204 in 2000, Arizona counties had responsibility for the care of the medically needy and medically indigent. Implementation of Proposition 204 relieved them of this responsibility by expanding AHCCCS coverage to all low-income citizens in Arizona (a detailed examination of county responsibilities under Proposition 204 is found in SLHI's *Step by Step* report, 2001).

But if Maricopa County no longer has *legal* responsibility for the medically indigent, who does?

One way to frame a discussion of Maricopa County's safety net is to compare its structure to other urban counties. For purposes of this report, we selected the Denver and Houston metro areas. The accompanying table outlines the key indicators.

	DENVER	HOUSTON	PHOENIX
Metro area population	2.4 million	3.4 million	3.2 million
Growth (1990-2000)	30%	25%	45%
Medicaid eligibility – federal poverty limit (adult)	42% FPL (parent) non-parent adults not eligible	32% FPL (parent) non-parent adults not eligible	100% FPL (as of 10/01)
Percentage of non-citizens in state	7.5%	9.0%	9.8%
Prevalence of undocumented immigrants (est.)	Mod-High	High	High
Responsibility for indigent care	County-based	County-based	State-based
Financing – public component	Colorado Indigent Care Program Medicaid/SCHIP, City/County funds	Property tax, DSH payments, Medicaid/SCHIP	Tobacco Tax funds, DSH payments, Medicaid/SCHIP
Dominant safety net model	Integrated public health system	County hospital district	Public/nonprofit hospital/clinics

DENVER [5]

Denver Health, an integrated public health hospital and ambulatory clinic system (11 community clinics and 12 school-based clinics), is the dominant provider of indigent care. Three nonprofit clinic networks, all of which are federally qualified health centers (FQHCs), provide ambulatory services in the suburban counties. Private hospitals make up the balance of the system by providing care through emergency rooms and outpatient departments.

Denver Health operates independently of the city and county as a quasi-public hospital authority, and has great flexibility in allocating resources to areas of greatest need and efficiency. Funding comes primarily from the Colorado Indigent Care Program, which covers both ambulatory and inpatient services

for indigent adults and children who don't qualify for Medicaid. Other major sources of funding include Medicaid/SCHIP, federal dollars for the FQHCs, and significant local city and county funding – roughly one-half – of Denver Health's uncompensated care.

HOUSTON [5]

The Harris County Hospital District (HCHD), a public entity financed through property taxes, is primarily responsible for providing health care to the indigent. The District consists of three hospitals and 11 community clinics, health departments run separately by the county and city, several private clinics, and eight school-based clinics for screening, immunizations and referrals. Other parts of the safety net include a number of nonprofit clinics (none of which are FQHCs), which depend on grants and volunteers.

HCHD is funded through a mix of property taxes, Medicaid, disproportionate share hospital (DSH) payments and Medicare graduate medical education payments (GME). The local property tax funds account for approximately 38 percent of the budget.

PHOENIX

Up until 2000, Arizona, like Colorado and Texas, chose to provide only minimal protection for safety net providers under Medicaid managed care and placed the burden of indigent care squarely with the counties. Prior to Proposition 204, which extends Medicaid up to 100 percent of the federal poverty limit (FPL), the Medicaid rate in Arizona was 36 percent FPL, similar to Colorado and Texas.

The net effect of Proposition 204 and Arizona's recent waiver from the Centers for Medicaid and Medicare Services (CMS) to include childless adults up to 100 percent FPL in the Medicaid population was to move the responsibility for the medically indigent from the counties to the state.

But who then is responsible for providing care to the uninsured, the underinsured, and those who, for one reason or another, are unable to get health care?

The paradoxical answer is everyone and no one.

What is Primary Care?

In 1999 SLHI published *P-CAT: A Primary Care Community Assessment Tool* (available at SLHI or www.slhi.org). In that publication we reviewed several definitions of primary care and developed a tool communities can use to determine their need for primary care services.

One working definition of primary care found there comes from the Maternal and Child Health Bureau (1994):

Primary care is the integration of services that promote and preserve health; prevent disease, injury and dysfunction; and provide a regular source of care for acute and chronic illnesses and disabilities.

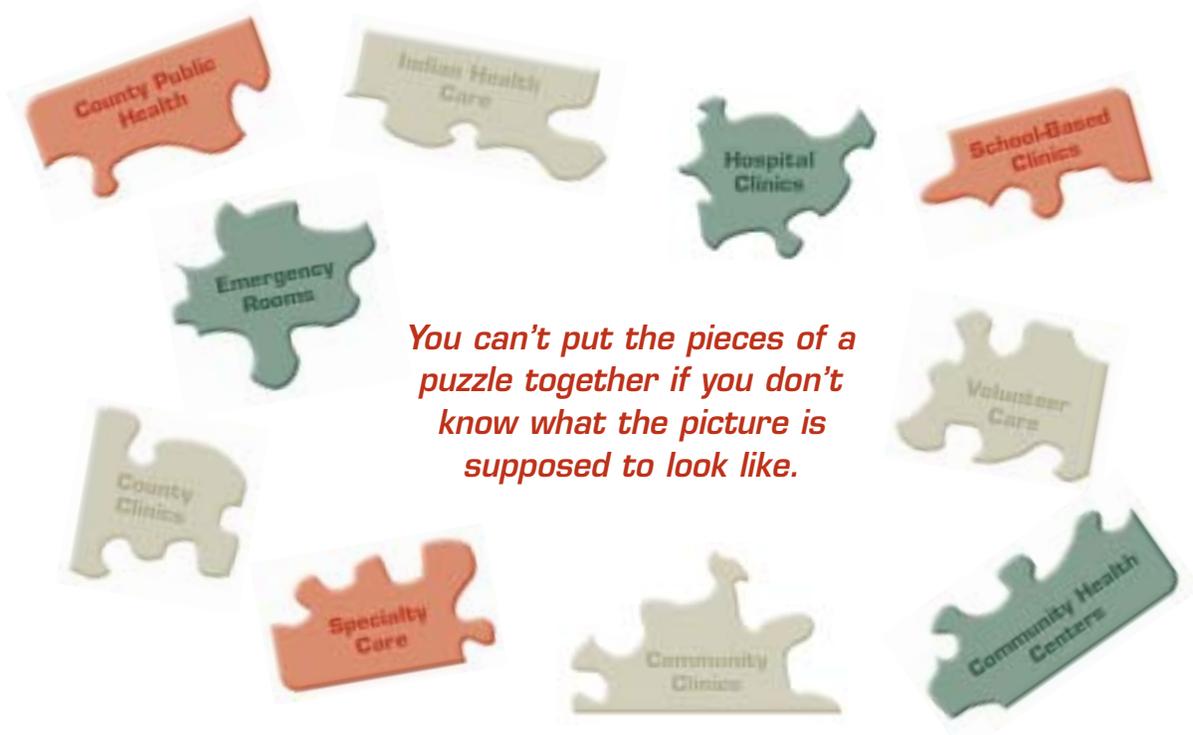
But what we're interested in is not primary care per se, but access to primary care. In *P-CAT*, we developed a concise definition that we follow here:

Access to Primary Care: An individual's ability to obtain entrance into the health care system through care from a family practitioner, general practitioner, pediatrician, general internist, obstetrician, gynecologist, nurse practitioner or physician assistant. Ability to access the system is influenced by the following characteristics, which can serve as either barriers or facilitators: Socio-cultural, financial, geographical, organizational. The outcome of successfully accessing primary care is improvement in health status.

P-CAT contains more information on community indicators of need for better access to primary care services, and the relationship between various population descriptors (financial, socio-cultural, geographical) and access. In this report, we focus primarily on *financial* and *organizational* factors linked to access, and don't discuss geographical and socio-cultural factors. Clearly, however, things like transportation, language barriers and culturally appropriate services are important factors in the safety net equation.

It's important to note that primary care, because it focuses on prevention (early screening, immunization, chronic disease management, etc.), generally costs less per visit than acute and specialty care, and is more efficient in terms of overall health system performance than systems that rely primarily on acute, episodic care. How the United States compares to other countries on the integration of primary and preventive care into the total health system is another subject entirely.

The Safety Net Puzzle



You can't put the pieces of a puzzle together if you don't know what the picture is supposed to look like.

Emergency Rooms



There are 29 emergency rooms in Maricopa County, ranging from comprehensive Level I trauma centers to small rooms with emergency supplies and limited staff (see *AHF's* Fall 2001 issue on trauma centers). Emergency departments (EDs) are the only element of the health care safety net whose function is defined by federal law (EMTALA), which mandates that all EDs provide screening, stabilization and/or appropriate transfers to all patients with any medical condition.

Not All Emergencies

While all EDs provide safety net services, those located in parts of Maricopa County with high concentrations of low income, uninsured and other vulnerable populations provide the bulk. According to the Arizona Hospital and Healthcare Association (AzHHA), emergency room visits in Arizona increased 11 percent in 1999 and 8.7 percent in 2000. How many of these were true emergencies, how many were emergencies that could have been avoided with earlier access to primary care, and how many could have been treated in an outpatient primary care facility are unknown.

According to D. Kent Layton, a Tempe emergency room physician, "if all we treated in emergency rooms were true emergencies, three-fourths of them would close." This front-line assessment is echoed in a Commonwealth Study of

emergency room use in New York City, which documented that "nearly 75 percent of all visits to an ER that do not result in admissions are for non-emergencies, reflecting to some degree poor access to primary care."^[3]

But to what degree is lack of access to primary care a contributing factor to crowded emergency rooms and their financial difficulties? Depending on the issue and advocacy group, other factors are singled out as the scapegoat: onerous EMTALA regulations, professional workforce shortage, low reimbursement rates, high numbers of uninsured, too many undocumented persons, too few specialists, too few (or too many) EDs in one area, ambulance diversion or a shortage of pediatric beds.

The Safety Net Puzzle

A Bleak Picture

While all of these factors conspire to paint a bleak picture for Arizona emergency rooms – and for emergency rooms across the country – we are primarily interested here in the relationship between emergency rooms and access to primary care for vulnerable populations in Maricopa County. We uncovered a great deal of anecdotal and site-specific information to suggest that emergency room use by population, payer source and type of service is similar to New York and other urban areas. Physicians, nurses and administrators told us that:

- + Valley emergency rooms are crowded in the evenings and weekends with people who should be seeing a primary care provider, but they aren't open for business.
- + Many of the uninsured, homeless, undocumented persons and other special groups are used to going to the ER. It's the first, last and only stop for health care.

- + People without regular access to care wait too long before they seek care and end up in emergency rooms with expensive-to-treat conditions that could have been prevented with earlier primary care.

SLHI hopes to pursue further research in this area later this year. In the meantime, a good overview of emergency room issues in Arizona is found at the Arizona College of Emergency Room Physician's web site (www.azcep.org).

"Doctors are health care providers now, not physicians. Health care has become a commodity. People don't say, 'I need to see my doctor.' They say, 'I need some health care.' And where is health care 24 hours a day? It's the emergency room."

D. KENT LAYTON, M.D.
EMERGENCY PHYSICIAN, TEMPE

Community Health Centers



There are 13 federally qualified health centers (FQHCs) in Arizona that receive significant support from Health Resources and

Services Administration (HRSA) through the Bureau of Primary Health Care. These are spread across 50 locations, served over 200,000 patients in 2000, and operate on a collective budget of \$20 million. They are core safety net providers, focusing on the medically uninsured and indigent. This includes AHCCCS patients. For those without insurance, they offer a sliding fee scale based on ability to pay.

In Maricopa County, Mountain Park Health Center and Clinica Adelante operate in seven sites, the most recent of which is Mountain Park's new clinic site in Maryvale. Other sites and services are expected to be added throughout Arizona as a result of a Presidential community health center initiative, which will make about \$175 million available nationally in 2002.

Another primary care clinic, Maricopa Health Care for the Homeless (MHCH), also receives HRSA support and serves the primary health care needs of approximately 15,000 homeless people in Maricopa County.

Some numbers from the clinics and HRSA:

	Current HRSA Funding	Users (2000)
Clinica Adelante	\$1,893,671	17,000
Mountain Park	\$2,383,902	25,000
MHCH	\$1,741,124	5,120

HRSA funding, along with Arizona tobacco tax funding, private grants and contributions make it possible to offer care to people without insurance on a sliding scale basis. Even with the prospect of a significant increase in support for community health centers on the federal level, Andrew Rinde, Executive Director of the Arizona Association of Community Health Centers, reports that the state and local funding scene is particularly bleak in the light of budget cuts and a stagnant economy. Depending on their location and patient mix, some FQHCs are experiencing significant financial and organizational stress, fueled in part by an increase in patient volume of 5-10 percent annually.

In the first half of 2001, for example, Clinica Adelante provided uncompensated care at a rate of 113 percent of funds

The Safety Net Puzzle

available to pay for services provided. Mountain Park, which is in better financial shape than Clinica Adelante, reports that 15 years ago, uncompensated care was only 12 percent of the total budget. Today, it's almost half.

The other issue facing FQHCs – and all health care providers, for that matter – is a serious shortage of trained nurses, physicians, and other health professionals (pharmacists, techs), especially at clinics in some of the outlying areas of the County. SLHI will look more closely at health work force issues in the next edition of *Arizona Health Futures*.

Community Clinics



There are a number of community clinics in Maricopa County that offer free and/or reduced fee primary care services to the medically uninsured and indigent. For the most part, they are

funded primarily through community grants and donations, and rely to a greater or lesser extent on volunteer providers.

For purposes of this report, we looked at three such providers – St. Vincent de Paul, Mission of Mercy Mobile Clinics and Las Fuentes – as proxies for a larger and highly informal system of providers, some of which are more formally structured, such as Centro de Amistad in Guadalupe and Arizona State University's Community Clinic; and others which are more informal and often ad hoc, such as part-time clinics in churches and neighborhood centers. Accurate information is hard to get in this less formally structured group, and it's virtually impossible to track everyone who receives primary care on either a regular or sporadic basis through such clinics.

All of these clinics are experts at “squeezing the rock”:

 **St. Vincent de Paul** runs a primary care and dental clinic in Central/South Phoenix, where they had about 10,000 uninsured and low-income patient visits in 2000 (4,200 medical, 5,800 dental). They rely on a volunteer network of 55 physicians and 35 dentists, plus another 55 physicians as back-up who see patients in their own offices. Fully 100 percent of funding is from private sources, although they are beginning to see patients on AHCCCS dental contracts.

 **Mission of Mercy** provides primary health care services through a mobile health clinic that visits various parts of the metro region four times a week. Like St. Vincent de Paul, they are staffed primarily by volunteers – 22 physicians, 64 nurses, and a host of drivers, interpreters and greeters – and funded through private contributions and grants. In the 2001 fiscal

year they had approximately 12,000 patient visits, 98 percent of these patients had no health insurance and limited ability to pay for services.

 **Las Fuentes Health Clinic** provides primary care services to a predominately Hispanic and Yaqui Indian population in Guadalupe. Some medical staff are paid, and the Clinic also relies on volunteer services and private grants/contributions. In addition, they have an AHCCCS contract and an IHS subcontract to serve the Pasqua Yaqui. In 2000 they had approximately 4,000 patient encounters.

All of these clinics stressed the same themes:

- **Heavier patient loads.** The clinics are seeing more, not fewer, patients each year.
- **A trend of seeing sicker patients.** With more people uninsured and facing tough economic times, people are waiting until they're really sick – sometimes too sick – before they seek care.
- **Lack of specialty care.** Everyone talked about how difficult it is to find specialists who will take their referrals on a volunteer or reduced fee basis. Those who are lucky enough to make a connection with a specialist are often forced to ration their availability: some get referred, some don't.
- **The need for sustainable funding.** Grants and contributions ebb and flow with the economy and competition among charities. Las Fuentes, which operates on a \$50,000/month budget, runs a \$12,000/month deficit in patient-generated cash flow, which they cover with a major corporate grant.
- **Burnout.** You can only squeeze a rock for so long before you need a break. Some were more pessimistic than others, but many stressed burnout as a problem, both among volunteers and paid staff.

The Safety Net Puzzle

Hospital Clinics



Outside of all hospital emergency departments, certain hospitals in Maricopa County provide some measure of ambulatory safety net services through outpatient clinics that are directly tied to residency programs.

In addition to MIHS, which is the largest teaching hospital in Maricopa County and the second largest in the state (we discuss MIHS separately in this report), hospitals in Maricopa County with residency programs include Good Samaritan, St. Joseph's, Phoenix Children's Hospital, Baptist Hospital and Scottsdale Healthcare.

Good Samaritan Regional Hospital, for example, reported 1,755 patients (12,616 visits) in their outpatient clinic and 2,123 patients (8,181 visits) in their women's health clinic in

2000. St. Joseph's Hospital operates a general clinic and several specialty clinics (the traveling Mom Mobile, etc.), and estimates they saw almost 12,000 patients in 2001. The great majority of these patients are uninsured/self-pay.

At least one of the hospital clinics doesn't take undocumented patients because of charitable care guidelines. According to their administrator, "If they [undocumented immigrants] need hospitalization or surgery, we incur a cost to the hospital for the operating room and other services that we can't write off as charity."

Hospital clinics occasionally refer patients to the specialty clinics (orthopedics, etc.) at Maricopa Medical Center, but have the same experience as others: long waiting lists and great difficulty in getting people in.

County Clinics



Prior to the passage of Proposition 204, Arizona counties were responsible for providing health care for the medically needy and indigent. In Maricopa County this was accomplished through the Maricopa County Integrated Health System (MIHS), which remains today as the County's main provider of primary care safety net services to the uninsured and medically indigent.

MIHS consists of the Maricopa Medical Center and four health plans. The Medical Center itself is a 621-bed tertiary care hospital that includes a 172-bed psychiatric care facility as well as a regional burn center, a Level I trauma center and other special facilities. What is of interest here is the Medical Center's comprehensive health center and ambulatory specialized clinics for the surrounding Phoenix community – an area heavily populated by minorities and low income persons – and a network of an additional 12 family care centers around the County.

This system of care treated approximately 64,000 patients through 340,000 outpatient visits in 2000. Approximately two-thirds of these patients are insured through Medicaid (AHCCCS) and Medicare; about 29 percent are uninsured/self-pay (see table on funding sources in different types of safety net facilities, p. 18).

Additionally, the Maricopa Medical Center is the second largest teaching hospital in the state, and as such they train and place a number of physicians at other hospitals, clinics and private practices around the Valley. This creates an informal network of contacts between MIHS and other safety net providers, which is often called on for referrals to specialty care at the Maricopa Medical Center and specialty clinics. Time and time again, we were told by people at the community clinics that "we wouldn't be able to get these people the care they need if we didn't know somebody at County."

We discuss the larger health system issues concerning MIHS and its future role on p. 22-23.

The Safety Net Puzzle

Native American Health Care



Safety net services targeted to American Indians and Alaska natives in Maricopa County are provided through the Phoenix Indian Medical Center (PIMC), which is part of Indian Health Services (IHS), and by the Native American Community Health Center, a non-IHS clinic, which saw 9,335 patients in 2000 through 56,910 outpatient visits. In addition to a 137-bed hospital, PIMC has outpatient clinics for both primary care and selected medical specialties.

While PIMC provides comprehensive primary care and preventive services, and receives funding through HIS and Title XIX, among other sources, Dr. Vincent Berkley, PIMC's medical director, observes that "more money is allocated to the Bureau of Prison Health per inmate than by IHS per patient."

He also observes that even though PIMC has a number of specialty clinics, it remains a challenge to refer patients to specialists that aren't available through PIMC.

"More money is allocated to the Bureau of Prison Health per inmate than by IHS per patient."

**DR. VINCENT BERKLEY
MEDICAL DIRECTOR, PIMC**

Who Uses the Safety Net?

All of us may have need of the health safety net at one time or another, especially when it comes to trauma and emergency care. But the chief users of the primary care safety net, day in and day out, are the uninsured, the underinsured and special populations like the homeless and mentally ill.

Ironically, people who are working but lack health insurance have a harder time getting care than people who aren't working. If you are unemployed in Maricopa County, chances are you'll qualify for AHCCCS health insurance benefits and have access to a number of plans and providers. But if you're employed in a job that provides you with an income above the AHCCCS eligibility ceiling – up to 100 percent of the federal poverty level (FPL – \$17,650 for a family of four) – then your options are limited unless your employer provides a health insurance benefit.

The Working Poor

At community clinics like St. Vincent de Paul, the majority of patients are the "working poor" – they make too much to qualify for Medicaid and other public programs, but not enough to allow them to purchase coverage on their own, where insurance premiums can equal more than 20 percent of their take home pay.

To no great surprise, the number of uninsured – and underinsured – correlates highly with local economic conditions. Numbers are up at all safety net clinics – roughly in the 5-10 percent range – and providers informally note that the general population seems to be sicker and in greater need of immediate medical attention than in the past.

In addition to the working poor, other regular users of primary care safety net services are vulnerable populations like the homeless, the mentally ill, drug abusers, the frail elderly, low-income children and pregnant women, people whose medical condition makes them uninsurable (AIDS, etc.), and those who, in the words of one nurse at a community clinic, "just can never seem to get their life together."

The final irony is that it's easier for some of these people to get the care they need in jails and prisons than it is in the community.

The Safety Net Puzzle

County Public Health



The Maricopa County Department of Public Health (MCDPH) receives federal, state, county and private dollars to fund a variety of population-based and personal health programs and services to the medically needy and indigent.

Personal health services are generally targeted to vulnerable populations and include such things as adult and

child immunizations, comprehensive health care for persons with AIDS, community nursing services, WIC (Women, Infants and Children Program), family planning, and testing and treatment services for a variety of communicable diseases.

While we do not review county public health services in any detail, it's important to note that they are an important part of the preventive, early warning, and public education component of ambulatory safety net services in Maricopa County.

Volunteer Care



There are an unknown number of programs in Maricopa that deliver health services to uninsured adults and children entirely through volunteers. These tend to be more ad hoc, temporary and subject to the difficulty of finding and sustaining volunteers – a perennial problem for even the largest of health and social service providers with professional staff who work exclusively with volunteers.

Even with the help of volunteers, private funding is still necessary for things like supplies, transportation, record keeping, general administration, phone bills and the like.

Some volunteer care occurs in a more structured way, such as health services provided through paid, part-time parish nurses who utilize the resources of church communities,

many of which are located in low income areas. Other services are often quickly arranged and temporary: the physician who agrees to see a certain number of patients after hours so long as “no one finds out about it;” the church that agrees to host a makeshift clinic for a group of refugees until they become better integrated in the community; nurses who make home visits between scheduled shifts, and so on.

One example of a structured volunteer care program is the Medical Home Project (MHP), which hooks up uninsured children referred by school nurses with volunteer physicians. But as LeAnn Corbin, MHP's director, points out elsewhere in this issue brief (see “Relationships: The Fragile Web of Care,” p. 20), successful referrals to volunteer physicians increases demand for services, resulting in burnout and the need for more volunteers. It's a closed circle with no way out.

School-Based/School-Linked Clinics



There are 95 school-based/school-linked clinics in Arizona, 68 of which are in Maricopa County. All are located in schools with concentrations of low income families. Most are staffed by nurse practitioners, but school-linked clinics deliver care off-site through providers which are often affiliated with hospitals. Over 75 percent of the children seen are Hispanic; 20 percent of the patients are over 12 years old.

During the 2000-2001 school year, these clinics saw 14,148 patients through more than 27,000 visits. Of those, 90 percent were uninsured. Most funding comes from private

contributions, including support from hospitals and hospital foundations; other funders include Tobacco Tax, HRSA, and schools. If the families are charged for services at all, it is done on a sliding fee basis.

The clinics provide basic primary care and prevention services; conditions treated most frequently are ear and upper respiratory infections and asthma. The school-based clinics are popular with parents and provide an efficient way to deliver primary care services to low-income children. Even with the commitment and support of hospitals and other organizations, however, funding streams are precarious, and establishing referrals and links to specialty care, behavioral health and other parts of the health system is difficult at best.

The Safety Net Puzzle

Specialty Care



Specialty care – referrals to medical specialists for diagnosis and treatment that are not part of the basic primary care system – is the missing piece of the safety net puzzle. In addition to the medical specialties, it also includes referrals to dentists and behavioral health specialists, where needs are especially acute.

The county clinics are tied into a system of medical specialists as part of the MIHS system, but because 70 percent of the patients they see are insured (Medicaid-Medicare, for the most part), some argue that the uninsured and other special populations, because they have difficulty making appointments at the county clinics, are effectively shut out of that system.

For those clinics and other providers whose great majority of clients are uninsured (and sometimes undocumented), getting referrals to specialists who are willing to provide care for free or a reduced fee is a major problem. Even if a specialist can be found, someone has to pay for hospital services, surgical suites, prescriptions, special tests with expensive equipment, and the like. SLHI was told of instances where patients who were unable to get specialty care and faced a life-threatening situation were told to go to the emergency room, where hospitals are *required* to provide care.

Access to specialty services for the uninsured, like primary care, has also suffered as a result of cuts in Tobacco Tax funding. An example is the Children’s Hospital Program which provided inpatient and specialty care for uninsured children. It’s elimination has left a serious rip in the specialty care safety net.

Good Luck

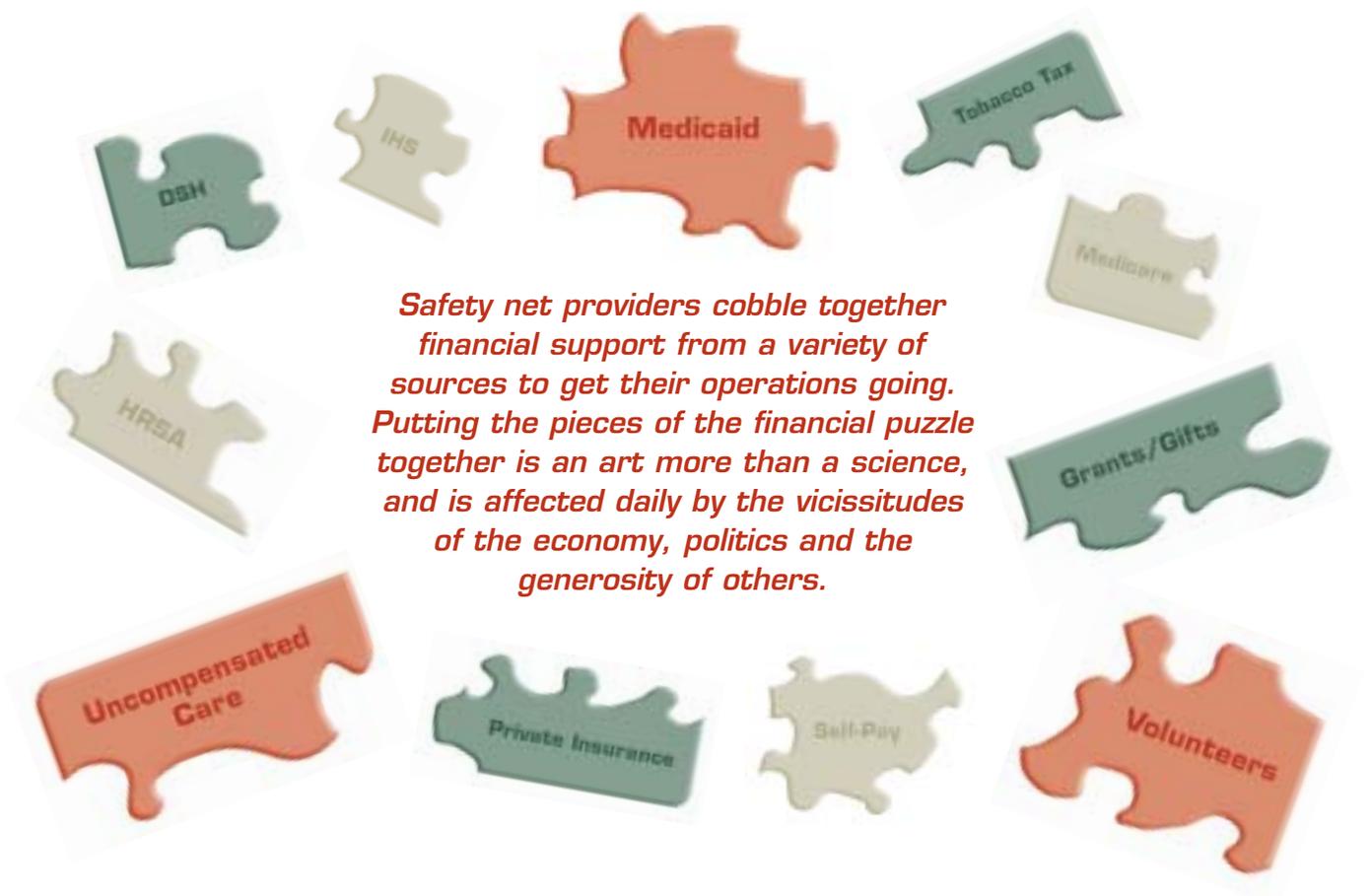
The fact that specialty care is uncompensated, of course, is a critical issue facing our health care system.

Public knowledge of, and attention to, the difficulty in getting specialty care for the medically indigent hasn’t kept pace with changes in the health care system itself. Formerly, indigent patients who needed specialty services were admitted to the hospital. Because of a shift to outpatient surgical suites and specialty care, and because of increasing financial pressures on hospitals, these admissions are less common, especially with no identifiable source of payment. Many procedures that used to be inpatient are now outpatient or day-surgery procedures. This restricts access to care for the uninsured, who must not only find a physician to see them, but also come up with funds for the setting and services.

In the words of one physician we talked to, often the only thing she can tell these patients is, “Good luck.”

Squeezing the Rock:

The Financial Support Puzzle



Safety net providers cobble together financial support from a variety of sources to get their operations going. Putting the pieces of the financial puzzle together is an art more than a science, and is affected daily by the vicissitudes of the economy, politics and the generosity of others.



Medicaid payments – the largest source of funding for Maricopa County’s safety net – flows to providers through a number of channels: direct payments for emergency care, capitation payments under managed care plans or indirect subsidies such as DSH and GME payments. Until recently, Arizona’s federally qualified community health centers received favorable cost-based reimbursement rates from Medicaid, but this favored payment status is being phased out.

Medicaid direct payment funds require state matching funds at roughly a 1:2 ratio – for every \$2 of federal Medicaid funds, states have to put in \$1. This is financially attractive to Arizona, but with AHCCCS enrollments increasing as a result of Proposition 204, a slow economy and major budget shortfalls, the state’s portion of Medicaid is a significant financial burden. In 2001, AHCCCS represented about 11% of the state’s total budget, or \$588 million.

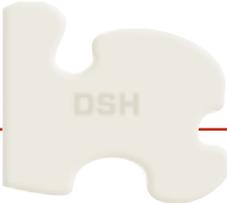
Squeezing the Rock



Compared to Medicaid, federal Medicare payments are a relatively minor source of funding for safety net providers in Maricopa County, although they represented about 16 percent of the funding in MIHS clinics in 2000 (see table on p. 18). In addition to direct payments for care, teaching hospitals receive indirect payments through the Medicare portion of DSH.



Federally qualified community health centers (FQHCs) in Maricopa County receive federal financial support through the Health Resources Service Administration (HRSA), specifically through its Bureau of Primary Health Care (see table on p. 18). Significant HRSA funding for Arizona’s FQHCs – most of it for construction of new clinics in underserved areas – is expected as a result of President Bush’s \$800 million community health initiative over the next five years, but Washington politics will determine how much of this will actually end up flowing to the states.



The Dish on DSH

Medicaid’s disproportionate share hospital program (DSH) was intended to provide supplemental payments to safety net hospitals that serve large numbers of low-income Medicaid and uninsured patients. Total Medicaid DSH payments to Maricopa County providers alone in fiscal 2001 was approximately \$26 million, \$13 million of which went to MIHS. This does not include \$12 million that was allocated to the Arizona State Hospital.

Deciphering how and why DSH payments flow – or do not flow – to certain hospitals is one of the more arcane and convoluted exercises in health policy research. There have been numerous uses/abuses of DSH funds over the years, federal investigations of idiosyncratic state allocation practices, and a number of reforms introduced.

In Arizona, a certain amount of budget juggling has gone on as the result of changes in Medicaid payments in recent years, both before and after the passage of Proposition 204. For example, prior to 204, MIHS appeared on paper to receive \$40 million plus in DSH funds, but ended up getting only \$13 million. Others point to examples of institutions that receive DSH payments out of proportion with perceived amounts of safety net services. How these funds flow – how much institutions actually receive from what is allocated to them and for what reasons – is a tangled web of finance and politics that we can’t begin to unravel here.

Proposition 204 legislation eliminates public hospital eligibility for DSH payments, but appropriates approximately \$10 million over 2001-2004 to offset losses from eliminating DSH.* The establishment of an AHCCCS uncompensated care pool, hospital uncompensated care requirements and related matters are described in more detail in SLHT’s *Step by Step* report. ^[7]

We note in passing that DSH payments, like Graduate Medical Education payments (GME), are based on hospital discharge data and so may present an incentive to admit patients to hospitals rather than treat them in the community, even though these funds can be used for the cross-subsidy of outpatient services.

* As a result of actions taken in the special 2001 fall legislative session, Arizona’s two county hospitals – MIHS and Kino in Pima County – received an additional DSH payment because AHCCCS enrollment was not as brisk as predicted, and the state did not near its Title XIX cap for federal budget neutrality. Since that time, AHCCCS enrollment has picked up considerably.

Squeezing the Rock

Tobacco Tax

A portion of sliding fee scale care is subsidized by state Tobacco Tax funding. As a result of economic conditions, and in anticipation of increasing enrollment into AHCCCS and KidsCare due to recent changes in eligibility, Tobacco Tax primary care funding is being pared back. Part A funds took a \$500,000 cut last year; and Part B funds, the primary source for sliding fee scale services, went from \$9 million to \$5.5 million in the past several years.

While Tobacco Tax funds play a significant role in the budgets of some safety net providers, they are also a source of frustration. Payments flow slowly, and the reimbursement process is cumbersome.

As one clinic administrator explained, "Their reporting system is different than other billing systems. They ask for as much information as a commercial plan does. The easiest thing would have been to set it up as a commercial plan and have us send in the CMS 1500 [a standard billing form] because we're familiar with it. Instead, they use a flat file of encounters and a separate file for people declared eligible. There is a rolling roster. We need a full-time staff person just to do the paperwork."

An Unreliable Funding Stream

In addition to the administrative headaches in getting the funds, the funding stream itself is unreliable. As funding levels are cut, clinics are left with the dilemma of cutting the number of services available, increasing the clients' share of the cost, or decreasing the number of people served.

At Clinica Adelante, Tobacco Tax funding was cut \$23,000 per month in July 2001, *before* the Fall legislative special session, and an additional \$4,000 per month in January 2002. According to Linda Gorey, Clinica Adelante's executive director, this will cause a hardship in providing sliding fee scale services. Currently, some services are no longer subsidized to the same extent as they were in the past. The Clinic was forced to increase client fees rather than continue with the old subsidy rates and risk financial ruin.

State officials point out that cuts in Tobacco Tax subsidy were made in anticipation of increased AHCCCS enrollment as a result of Proposition 204, which is expected to result in a decreased need for subsidized services. But, as Gorey asks, "How many patients enrolled in AHCCCS at a \$10 to \$12 per month capitation rate will it take to make up for a \$27,000 per month cut in Tobacco Tax funding?"

TOBACCO IN A BOX*



* Projections and numbrs are taken from SLHI's *When the Smoke Clears* report on tobacco taxes and the FY 02/03 Legislative Appropriations Report.

THE GOOD NEWS: People are smoking less. Tobacco education is working.

THE BAD NEWS: Tobacco tax revenues are going down. Fewer dollars will be available to fund health safety net services.

Question: Should we be happy or sad?

How much TT \$\$ will Arizona have available to spend in 2005?

1999 projection	\$95,399,700
2002/03 projection	\$30,009,400
<i>Bottom Line:</i>	<i>69% reduction</i>

A few FY 02 examples:

Funding Cuts	
Primary Care	\$500,000
Community Health Centers	\$500,000

Funding Eliminated	
Prescription Medication Program	\$4.3 million
Primary Care Capital Construction	\$3.0 million

(fifteen)

Squeezing the Rock

Uncompensated Care

Uncompensated care – the amount of care “written off” by hospitals and other providers – is generally treated in health policy literature as a proxy for how much care is provided to people who, for one reason or another, can’t pay for it. Over the years, it has become a standard measure for tracking access to care for the medically indigent, even though its definition and economic components are subjects of much debate and open to various uses/abuses.

To a greater or lesser extent, all safety net institutions provide uncompensated care, but the most reliable data is available from hospitals, which are tracked both nationally and by state. This data is broken down into two divisions:

charity care – services provided with no intention of being compensated – and *bad debt* – services provided for which payment is intended but not received.

According to an Arizona Hospital and Healthcare Association (AzHHA) survey of Arizona hospitals, a total of \$387 million in uncompensated care was provided in 2001: \$306 million in bad debt, and \$81 million in charity care. This is based in some cases on 9-month and 11-month annualized data, with 29 institutions reporting (Phoenix Children’s Hospital did not provide data).

TOP 5 HEALTH SYSTEMS

Percentage of Total Uncompensated Care in Maricopa County (2001)

	TOTAL	%
1 Banner Health System	\$ 112 million	29.0%
2 MIHS	\$ 89 million	22.9%
3 Vanguard Health System	\$ 42 million	11.2%
4 Catholic Healthcare West	\$ 41 million	11.1%
5 John C. Lincoln Health Network	\$ 34 million	8.8%

Squeezing the Rock

TOP 5 HEALTH SYSTEMS

Uncompensated Care as Percentage of Hospital System Gross Charges (2001)

	GROSS CHARGES	% UNCOM-PENSATED CARE
1 MIHS	\$472 million	18.8%
2 John C. Lincoln Health Network	\$555 million	6.1%
3 Vanguard Health System	\$ 1 billion	4.1%
4 Iasis Healthcare Group	\$479 million	3.8%
5 Banner Health System	\$ 3.3 billion	3.4%

Further analysis of uncompensated care data reveals just what common sense would predict: hospitals in low-income areas have higher rates of uncompensated care per gross charges than those in more affluent areas. The data clearly demonstrates that uncompensated care is prevalent throughout the valley, and is not confined to just a few institutions. In that sense, all hospitals are safety net providers, although some are more central to the core safety net system than others.



The amount of money received by Maricopa County safety net providers from private grants and contributions varies by type of institution and use. Grants and contributions are literally the lifeblood of the free and reduced fee clinics like St. Vincent de Paul and Las Fuentes; they are less a financial factor in FQHCs and hospital clinics. All safety net institutions, however, seek grants and contributions for capital and infrastructure expenses: buildings, equipment, information systems and the like.

St. Luke's Health Initiatives' own medical assistance program is illustrative. Approximately \$800,000 is dispensed annually through a network of approximately 20 community partners for a variety of safety net health services and equipment: eye exams, dental care, hearing aids, drug abuse treatment, etc. A portion of these funds is administered by St. Vincent de Paul to offset hospital and related costs associated with inpatient surgery. Physicians volunteer their time to do the procedures, and the charitable funds pay for the surgical suite and other costs at 90 percent of Medicare rates.

Back to the Well

Generally speaking, less private money is available for direct operating costs than for "new projects." For example, SLHI's community grants program occasionally provides direct grants to safety net institutions for capacity building and community development: information systems, mobile health clinics, volunteer recruitment and retention, etc. Other private, public and corporate foundations provide grants for safety net needs, depending on their guidelines; the providers also engage in active fund- and friend-raising through campaigns and social events.

As important as grants and contributions are, they provide only a small fraction of the care needed by the at-risk population. Providers can only go back so many times to the same charitable well until it runs dry. What the clinics really need is a sustainable source of funding.

Squeezing the Rock



As the chart on payer mix at different types of clinics illustrates, self-pay and sliding fee scale payments vary widely. The degree to which a safety net clinic can provide some type of sliding fee arrangement depends on being able to secure some type of financial subsidy, such as grants and tobacco tax payments.

Clinics like St. Vincent de Paul, which is funded entirely through grants and donations (or offers care through a self-pay/sliding fee scale model), always try to have the patient pay something, even if it's only a few dollars. "None of the people we see is looking for a handout," Janice Ertl, St.

Vincent de Paul Clinic director explains. "They have dignity. They want to pay, as long as they can afford it."

There's another huge irony here. If sliding fee scale services are not available, uninsured people are charged the full price for services and not some reduced rate. In effect, they end up subsidizing the care of those with insurance whose rates have been negotiated down by the health plans.

In effect, people *without* health insurance end up subsidizing those *with* health insurance.

Comparison of Funding Sources in Different Clinic Models

	Clinica Adelante Community Health Center	St. Vincent de Paul Community Clinic	MIHS Emergency Room	MIHS Outpatient Clinic
Commercial Insurance	21.3%		3%	4%
Medicaid (AHCCCS)	35%		33%	49%
Medicare	4.3%		5%	16%
Sliding Fee Scale*	39.1%	100%	0%	7%
Self-Pay*	.4%		57%	22%
Other			2%	2%

* Sliding fee scale and self-pay care can be provided only if they are subsidized by a different funding source, such as grants and contributions.

Squeezing the Rock



Indian Health Services (IHS)

In addition to the Phoenix Indian Medical Center, IHS also provides support for several tribal primary clinics. However, the IHS budget is not broken down into separate inpatient and outpatient components, so we are unable to track it separately here.



Private Insurance

Private commercial insurance is not a major source of funding for safety net providers compared to public insurance. However, as safety net clinics are forced to look for more patients with insurance and adopt more of a “margin” approach to achieving their charitable mission, they invariably seek to attract more commercial insurance plans. This brings them into direct competition with other private health care providers in the community, which is the situation MIHS finds itself in today. One also sees more commercial insurance patients in community health centers and other outpatient clinics that are the sole source of primary care services in a particular geographical region.



Volunteers

It's clear from even a cursory examination of Maricopa County's health care safety net that literally thousands of people donate their time and skills to provide care to those unable to pay for it. Physicians, nurses, technicians, drivers, greeters, administrators – if safety net providers in Maricopa County had to provide cold cash for their services, the bill would run easily into the tens of millions of dollars. We can't put a price tag on it, but no one doubts the importance of volunteers to the bottom line of most safety net providers.

Relationships: *The Fragile Web of Care*

When we asked safety net providers to describe how care for the medically indigent is distributed across the system, they invariably replied, “it’s distributed to us.”

MIHS officials believe that the care is distributed to them; so do the community health centers, the community clinics and hospital emergency rooms. But if responsibility for indigent care is distributed to everyone, it is in effect the responsibility of *no one*.

This is nowhere more apparent than in the relationship between primary care and specialty care.

The Arizona Department of Health Services (ADHS) takes on the responsibility for developing a system of primary care

services through grants for direct care (Tobacco Tax) and support of clinic development in medically needy areas. But there is no formal system to develop a network for specialty care, and no county-wide information system available to coordinate services or even to alert other safety net providers of new services available.

MIHS offers specialty care, but according to anecdotal evidence from numerous sources, uninsured clients must have cash up front to access specialty outpatient care at MIHS, and the waiting lists can be long.

It’s Who You Know

This brings us to the critical importance of relationship-based care: relying on “who knows who” to get people the care they need.

People who know how to “work the system” know whom to call when a patient needs care. For example, physicians who train at MIHS and then end up in outlying community clinics often are plugged into an informal web of reciprocity that allows them to refer patients to MIHS specialty clinics ahead of others; administrators who become acquainted with colleagues in physician offices and hospitals often are able to ask a favor of a friend or have an intermediary make a contact with a specialist who will see the patient.

This informal web of relationships is the grease of the health safety net system. It’s how a lot of things get done. Indeed, it’s how things get done in all systems where human dynamics and relationships play off a system of formal rules and regulations.

We encountered a wealth of stories about the importance and use of personal relationships to move uninsured people from primary to specialty care (see accompanying portrait of Dr. Earl Baker). There’s no way of documenting how many people receive care as a result of personal relationships, but it’s clearly a significant number. The good news is that

children and adults who need to see a specialist are often hooked up through a phone call, a lunch, a chance meeting or any number of other social encounters. It’s informal, unregulated and effective.

The Downside

But there’s a downside to relationship-based care. For starters, while it is built on collaboration, it can also discourage it. LeAnn Corbin, director of the Medical Home Project, is responsible for hooking up children referred by school nurses with volunteer physicians, yet she feels conflicted when other people ask for her physicians’ names to make referrals. A case in point is referrals to orthopedic specialists. She explains it this way:

“At one point I was getting three or four fracture calls a day. We can’t meet that kind of demand. Fractures are an outpatient visit with lots of follow-up. The volunteer docs can’t accept this kind of free care volume. They were overwhelmed.”

Others reported similar experiences. Janice Ertl at the St. Vincent de Paul Clinic says they have limited funding for specialty procedures such as surgery and are forced to ration

care on the basis of what impact it is likely to have. Some clinicians reported the conundrum of offering primary and preventive care services such as cancer screening when there is nowhere to send patients for treatment if a problem is found.

Collaboration through relationship-based care raises expectations, which in turn increases demand; increased demand pressures the volunteer system itself, which then pulls back under the pressure. Even when physicians and other health care volunteers can be found to perform services at no charge, funds still have to be located for surgical suites, diagnostics, pharmaceuticals, follow-up visits and the like. Individuals have relationships, but the providers need cold cash to keep the doors open.

In the end, relationship-based care may be the grease of the safety net engine, but it lacks the sustaining power to provide care to all those who need it.

CAN'T SAY NO: THE WIZARD OF CONNECT

Earl Baker, M.D., used to make a good living as a cardiovascular surgeon at St. Luke's Hospital in Central Phoenix.

Then he retired and really went to work.

Today, Dr. Baker is medical director at the St. Vincent de Paul Clinic where he oversees medical matters and lines up the volunteer physicians that both staff the clinic and "do favors" on their own time in their own offices. In the opinion of those around him, he's a "wizard" when it comes to personal relationships.

Unlike the "just say no" mantra of the abstinence-based approach to personal health risks, Baker's mantra is "You can't say no."

In his own words:

"The trick to getting physicians to volunteer is that you have to ask the best. The top of the line physician is always willing to volunteer. They love treating patients. They love what they do. It's a calling.

I make maybe 6-10 calls a month to get volunteer physicians for specialty services. That's in addition to almost 150 doctors and dentists who either see patients at our clinic on a regular basis or in their own offices.

A key to recruiting physicians is having the infrastructure in place for them to put their assets on the line in a volunteer situation. That means you have to follow up on the lab work, check on medication compliance, follow up after the procedure, and so on. The patient is at considerable risk, as is the doctor, without this kind of infrastructure. Basically, you take away the administrative and procedural hassle, and let the doctor do his best work.

For some patients, we use the Maricopa Integrated Health System [MIHS] to help set up long-term payment plans for patients who can't afford to make one payment for things like elective procedures, such as fixing a bad knee. Another thing that helps is finding someone who can pay hospital bills and other charges, so the physicians don't have to absorb those costs themselves.

Occasionally we hear from older physicians, 'I've had it, I'm getting out.' With the younger physicians, the complaints are more around the heavy workload and time schedules. It's more of a lifestyle issue.

We're seeing sicker and sicker patients. That's the big difference from 5-6 years ago. There are more people without health insurance, and they're waiting a longer time before they come in.

Retired physicians generally aren't the happiest bunch. There's only so much golf you can play. The really good physicians like to practice medicine, they like to stay involved. We make that possible.

Doctors have a tough time saying, 'Earl, I just can't do this.' All around I see a rising level of communication, a greater degree of connectivity in the world. Read Tielhard de Chardin. You have to be optimistic about the future."

No Margin, No Mission:

The County Dilemma

It's common to hear the "no margin, no mission" refrain from executives who are charged with "doing good" by "doing well." Their core mission may be to help the poor and underserved, but they also have to keep their doors open, pay staff, keep equipment up to date and keep the creditors at bay.

Free medical care for the indigent is a noble calling. The problem is, it doesn't pay the bills.

The Recent Past

All providers find this out, some the hard way. In the mid-90s, Maricopa Integrated Health System experienced a financial crisis and was close to bankruptcy. Even with an operating subsidy from the County that averaged between \$20-30 million a year in the early and mid-90s, the system was losing money. The County Board of Supervisors considered a number of options; eventually in 1997 they turned over the day-to-day management of MIHS to Quorum Health Group, Inc., a for-profit hospital management company.

Today, with no direct subsidies from the County, MIHS is financially healthier than it was five years ago, although the Medical Center itself continues to suffer from lack of capital funds for modernization and expansion. Some attribute the financial turnaround to Quorum's skills at reorganizing operations, negotiating favorable contracts with physicians, developing new product lines and good management generally. Others believe that in the process Quorum cut too many staff and programs, making it harder for the uninsured to get care.

A closer examination of MIHS's financial picture reveals that even though the total system has posted positive net gains in recent years (\$18 million in 2000, \$4.5 million in 2001), the performance has come from three of the County's four health plans, especially MLTCP, its long term care plan, which used to be Maricopa County's sole long-term plan but has recently dropped about 20 percent of its business after the state initiated a competitive bidding process. In effect, the insurance plans subsidize the Medical Center, which posted a loss of approximately \$15 million in 2001.

In the current fiscal year, MIHS officials predict they'll be lucky to break even.

The Present

Rehashing this past generates more heat than light. A more useful line of inquiry is to review the larger reasons why MIHS – and all safety net providers, for that matter – face a precarious future without fundamental changes in Maricopa County's safety net system:

- +** **Changes in health care financing.** Hospitals and other providers in the past employed a complicated system of cross-subsidies to absorb uncompensated care and spread it across other payers. That's harder to do now under a system of intense price competition, where plans want to make sure they're paying only for their members and not somebody else. Providers have fewer places where they can pass the buck for charity care.

- + Market dynamics.** The Phoenix metro area has seen major consolidation among providers in the past decade. Big systems like Banner, Catholic Healthcare West and Vanguard compete for market share with MIHS and smaller local health systems. Everybody wants paying customers, and that includes those insured by Medicaid, the low income population that MIHS was initially set up to serve. MIHS believes the bigger systems are siphoning off an important source of patient revenue for their core charitable mission; other hospitals, in turn, believe MIHS is siphoning off their paying patients in order to improve its financial picture.
- + The privatization of charity care.** With the implementation of Proposition 204, Arizona removed the counties' responsibility for indigent medical care and transferred it to the state, where it is theoretically spread across private providers in the form of AHCCCS health plans (Medicaid). With the exception of Tobacco Tax funds – which are subject to the political and budgetary vicissitudes of the moment – there is no ongoing and sustainable source of funding for those who don't qualify for Medicaid and other federal/state programs, such as the working poor; or those who, for a variety of reasons, find it difficult to access care, such as the homeless, the mentally ill and – yes – immigrants working in Arizona both legally and illegally.

The Future

MIHS finds itself between a rock and a hard place:

ON THE ONE HAND, they have to compete with other providers for patient revenue, absent any other source of revenue dedicated to serving the uninsured and medically indigent. This means they have to do what the competition is doing: access capital, upgrade facilities, improve services and efficiency.

ON THE OTHER HAND, MIHS is still a public hospital, even though they're under private management. They can't easily access capital without the ability to raise public dollars, such as their plan to create a health care district that could sell bonds or impose taxes. Other hospitals in the County, however, believe that they would be at a competitive disadvantage if MIHS were to get a tax subsidy to upgrade facilities and then continue to attract paying patients that they themselves are now serving. It's worth pointing out that some of these hospitals are nonprofit and tax exempt, while others are for-profit organizations.

What are the alternatives?

DO NOTHING. Let the market work. Under this scenario, MIHS would either have to find other sources of capital than public funds, develop new service streams to generate revenue, or continue a slow slide to insolvency.

CLOSE MIHS. Sell off the assets, or find other uses for the facilities. Some believe other health systems have the capacity and interest in absorbing their patients and services, especially those that produce a revenue stream. The other side of this scenario is whether there's a "buyer" for MIHS's \$88 million uncompensated bill – 23% of all reported uncompensated care in Maricopa County in 2001.

CREATE A SUSTAINABLE SOURCE OF PUBLIC FUNDING. Restrict MIHS activities exclusively to their historical public charity mission, with regulations and safeguards to insure that the uncompensated costs of serving the medically indigent are not spread across other private providers in any significant way.

In our view, MIHS is a critical and necessary piece of Maricopa County's health safety net. If they are to remain a public hospital for the medically needy and indigent, then they need a dedicated public revenue stream spread across the County. This will allow them to continue to serve their core charitable mission, and not dilute it by focusing on the insured at the expense of other private hospitals that have the capacity to absorb them.

Improving the Safety Net:

Critical Issues and Action Steps

In preparing this overview of Maricopa County's primary care safety net, we didn't encounter one person who thought the system was in good shape, or even merely adequate to meet increased demand for services.

In fact, we didn't encounter one person who thought we could call it an organized *system* of care at all.

But while everyone agrees there are major problems in providing both primary and specialty services to the County's uninsured and medically indigent, there is considerable disagreement as to what to do about it.

We distill this down to what we believe are the critical issues and suggest a few next steps for collective action.

The Issues

System Capacity

Primary care system capacity in the County for the uninsured and medically indigent is not adequate. New staff are maxed out with scheduled visits within days after they are added; long waiting lists exist at many clinics; nursing, medical technician and even physician shortages are common. In parts of the County, safety net providers are few and far between; transportation is a major issue. The result, in part, is greater reliance on emergency rooms for basic care, which further strains that already overburdened system. It's hard to determine optimum system capacity and build out if you can't put the pieces of the system puzzle together in the first place.

Funding

There is no dedicated and stable funding stream for primary care safety net services. Tobacco taxes, which are predicted to decline over the years, are hardly adequate to meet increased demand for services. Arizona's approach to this perennial problem has been to increase public insurance enrollment through Medicaid and KidsCare, but this misses a significant number of persons who either don't qualify for public programs or, for a variety of legal, behavioral and economic reasons, find it hard to get and keep health insurance. Other urban areas combine health insurance with public subsidies for the direct provision of care through a defined network of safety net providers. Maricopa County should pursue the latter approach to insure that more safety net providers don't go out of business providing uncompensated care, and more people don't flood emergency rooms for care that could have been more efficiently provided in an ambulatory setting.

Of all the issues we investigated, lack of access to specialty care is the most immediately critical.

Specialty Care

There is no coordinated, funded system of specialty referral and care for uninsured persons in Maricopa County. The hit and miss approach of relationship-based care is insufficient to meet the need; even when volunteer providers are willing, patients can't pay for the medical infrastructure that goes along with their services. Of all the issues we investigated, lack of access to specialty care is the most immediately critical.

Continuity of Care

As more safety net providers are forced to attend to their margins in order to serve their mission, they look to attract more paying patients. This results in significant churning in patients and patient loads; people drop in and out of Medicaid with regularity. When people are shuffled between providers and plans, continuity of care is disrupted. The extent of this varies among populations, and also among providers. It is most apparent among special populations like the homeless and mentally ill.

Preventive Care and Chronic Disease Management

In a health system premised on episodic and acute care, preventive care and chronic disease management are difficult at best. Clinics like St. Vincent de Paul do exemplary work considering the circumstances, but with little money, high patient turnover and no structured and stable integration with other community health providers, the uninsured are often left to fend for themselves. The result: more visits to emergency rooms and other acute care settings.

Excessive Administrative and Regulatory Requirements

This issue popped up everywhere. Providers told us of hiring administrative staff just to keep up with the paperwork to get state Tobacco Tax funding; local emergency rooms verified the American Hospital Association's claim that for every hour spent on patient care, another hour is spent on paperwork. The regulatory requirements of EMTALA on emergency rooms, the ultimate safety net, are by now well known.

Insufficient Monitoring and Tracking

One would think that with all the reporting and data collection required of safety net providers, we would know more about system characteristics and performance than we do. Our conclusion: we define and track data to satisfy regulators, advocates and professional bodies that are more concerned with accountability to their constituents and funders than with performance. This results in data that is more focused on providers than on patients – data with a strong institutional bias, proprietary data and lack of standard definitions.

Action Steps

- 1. *Come together.*** Maricopa County officials, private hospitals and other safety net providers need to come together and sort out their differences. There's a common ground here beneath the political rhetoric, as well as a number of cooperative models to explore that have the potential to improve safety net services for the uninsured and medically indigent.
- 2. *Aggressively pursue subsidies for care.*** Maricopa County receives a relatively small amount of federal community health center funding. President Bush's proposed community health center expansion initiative is worth pursuing for both existing FQHCs and safety net clinics that could partner with them in creative ways. The other item that should be on our collective agenda is to develop a publicly subsidized source of funding for the uninsured in Maricopa County. Market-based reforms such as tax incentives and subsidies for individuals and small employers are also worth pursuing.
- 3. *Pay attention to specialty care.*** The links between primary care safety net services and specialty care need immediate community attention. The lack of on-call specialists in emergency rooms is only the front end of this. In addition to more community education and advocacy around this issue, we suggest looking at various financial and/or legal incentives to attract specialists to high need areas.
- 4. *Streamline administration and regulation.*** The dawn of e-health is likely to change everything. The technology is in place to move medical records, application forms and all manner of administrative and regulatory paperwork to a web-based, real time electronic network. Pilot projects are underway now in Arizona; more need to be encouraged.
- 5. *Develop an independent source of quality information and analysis of safety net issues.*** Better monitoring and evaluation can lead to improved performance and outcomes. We encourage the development of community partnerships to move this issue up the health policy agenda.
- 6. *Continue efforts to insure as many citizens as possible through a multi-pronged approach.*** Strong safety net or not, it's health insurance that is often the deciding factor on how and when someone gets care. The issue of access to specialty services is best addressed through health insurance coverage. For those who are unable to take advantage of health insurance, we should develop a stable source of public funding for the direct provision of health services.

SELECTED SOURCES

1. American College of Physicians-American Society of Internal Medicine: *No Health Insurance? It's Enough to make You Sick*. Philadelphia: American College of Physicians-American Society of Internal Medicine; 2000: White Paper.
2. Fronstin, Paul. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2000 Current Population Survey*. Employee Benefit Research Institute Issue Brief No. 228. December 2000.
3. Hegner, Richard E. *The Health Care Safety Net in a Time of Fiscal Pressures*, National Health Policy Forum background paper, April 2001.
4. Lewin, Marion and Stuart Altman (eds). *America's Health Care Safety Net: Intact but Endangered*. Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Washington, DC: National Academy Press, 2000.
5. Ormond, Barbara A. and Amy Westphal Lutzky. *Ambulatory Care for the Urban Poor: Structure, Financing, and System Stability*. Occasional Paper No. 49. The Urban Institute. 2001.
6. *P-Cat: A Primary Care Assessment Tool*. St. Luke's Health Initiatives, 1999.
<http://www.slhsi.org/ahf/studies/p-catweb.pdf>.
7. *Step by Step: An Analysis of Proposition 204*. St. Luke's Health Initiatives, October 2001.
<http://www.slhsi.org/ahf/studies/prop204.pdf>.
8. Stoll, Kathleen. 2001. *The Health Care Safety Net: Millions of Low-Income People Left Uninsured*. Families USA Special Report No. SR-104. Families USA Foundation. www.familiesusa.org.

We wish to thank the following individuals for providing valuable information and perspectives on health safety net issues in Maricopa County:

Earl Baker, M.D., Medical Director, St. Vincent de Paul Medical Clinic
Joyce Benjamin, RN, MSN, Director, Patient Services Administration, Scottsdale Healthcare
Vincent Berkley, M.D., Clinical Director, Phoenix Indian Medical Center
LeAnn Corbin, RN, BSN, Manager, Medical Home Project
Gail Davis, RN, Lead Nurse, Phoenix Elementary School District 1
Anthony Dekker, M.D. Director, Ambulatory Care, Phoenix Indian Medical Center
Sherry Delio, RN, Director of Hospital Clinic Programs, St. Joseph's Hospital and Medical Center
Adolfo Echeveste, Executive Director, Arizona Latin-American Medical Association
Janice Ertl, RN, MHSA, Executive Director, St. Vincent de Paul Free Medical/Dental Clinic
Linda Gorey, Executive Director, Clinica Adelante
Kristin Greene, former Director of Government Affairs, Arizona Association of Community Health Centers
Joan Heater, Director, Emergency Department, Mesa Lutheran Hospital
Susan McCraw Helms, Health Director, Salt River-Pima Maricopa Indian Community
Mark Hillard, CEO, Maricopa Integrated Health Systems
Doug Hirano, former Deputy Bureau Chief, Arizona Department of Health Services

D. Kent Layton, M.D., Tempe Emergency Physicians
Phil Lopes, Executive Director, Arizona School-Based/School-Linked Health Care Council
Brenda Mastropietro, Clinic Manager, Outpatient Surgery, Good Samaritan Regional Medical Center
Brett McClain, Administrator, Ambulatory Services, Maricopa Integrated Health Systems
John Molina, M.D., Director, Las Fuentes Health Clinic of Guadalupe
John Olson, Director, Mission of Mercy Mobile Health Clinic
Maryetta Patch, Executive Director, Arizona Advisory Council on Indian Health Care
Andy Rinde, Executive Director, Arizona Association of Community Health Centers
John Rivers, CEO, Arizona Hospital and Healthcare Association
Loren Sekayumptewa, Executive Director, Native American Community Health Center
Barbara Spilman, Clinic Manager, Outpatient Clinics, Good Samaritan Regional Medical Center
Mary Lou Stanton, Deputy Director, Phoenix Area Indian Health Service
Annette Stein, Administrator, Maricopa County Healthcare for the Homeless
Sylvia Echave-Stock, President/CEO, Mountain Park Health Center
Paul Strauss, Vice President, Planning and Development, Maricopa Integrated Health System
Pat VanMaanen, Consultant, School-Based/School-Linked Health Clinics
Jonathan Weisbuch, M.D., Chief Health Officer, Maricopa County Department of Public Health



Arizona Health Futures

is published three times a year by St. Luke's Health Initiatives.

© All Rights Reserved.

Material may be reproduced without permission when proper acknowledgement is made.

Analysts:

Peggy Stemmler, M.D.

Roger Hughes, Ph.D.

Graphic Design:

Dona Shaver Graphic Design

The purpose of **Arizona Health Futures** is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at www.slhi.org. If you would like to receive extra copies or be added to the list, please call (602) 385-6500 or e-mail us at info@slhi.org.

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially our state's most vulnerable citizens.



A Catalyst for Community Health

St. Luke's Health Initiatives

2375 East Camelback Road
Suite 200
Phoenix, Arizona 85016

www.slhi.org
info@slhi.org

Phone: (602) 385-6500
Fax: (602) 385-6510

PRSR STD
U.S. POSTAGE
PAID
Phoenix, Arizona
Permit No. 4288