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Examining the Health Care Safety Net in the Portland Area

City Club of Portland (Portland, Or.)

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City Club of Portland
Good citizens are the riches of a city

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Examining the **H**ealth **C**are **S**afety **N**et in the Portland Area

This report was approved for publication by City Club's Research Board on October 14, 2004, and by its Board of Governors on November 8, 2004. In contrast to City Club's long-term research and ballot measure reports, this information report does not include conclusions drawn by the committee, offer recommendations or require a vote of the membership.

Prologue

Examining the Health Care Safety Net in the Portland Area is the third in a series of reports from City Club of Portland's Health Care Issue Committee. The first, published in July 2003, provides background on the Oregon Health Plan.¹ The second, published in October 2003, identifies gaps in health care access despite the implementation of the Oregon Health Plan.² This third and final report describes the Portland area's health care safety net — the source of health care for those who lack care from mainstream providers. The purpose of this report is to educate City Club members and the community about this important segment of the health care system and to furnish an understanding against which proposals for improved services and financing may be evaluated.

Examining the Health Care Safety Net in the Portland Area was authored by City Club's Health Care Issue Committee, a standing committee comprised of individuals with interest in all aspects of health care and its delivery. The committee heard testimony from more than 30 expert witnesses between December 2001 and October 2003, toured safety net facilities, and reviewed numerous written resources. The report, along with bibliographic and other resources, is posted on City Club's Web site at www.pdxcityclub.org/committees/health-care.php.

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¹ City Club of Portland Bulletin, "Background on the Oregon Health Plan," July 18, 2003, www.pdxcityclub.org/committees/documents/ohpbackgroundunder.pdf

² City Club of Portland Bulletin, "Gaps in Health Care Access," October 17, 2003, www.pdxcityclub.org/committees/documents/gapsinhealthcareaccess.pdf

³ Members of the Health Care Issue Committee are not screened for conflict of interest, as they would be for a long-term research or ballot measure study.

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I. Introduction

Examining the Health Care Safety Net in the Portland Area describes the Portland area's health care safety net — the source of health care for those who do not have access to care from mainstream providers. The report examines the safety net itself rather than the problems in the overall health care system that necessitate the existence of a safety net. County governments play a significant role in delivering safety net services in Oregon. The core safety net in Multnomah, Clackamas and Washington counties differs from those in other urban areas in Oregon and from those found in rural Oregon. This report focuses on the safety net in the Portland tri-county area.

The United States, in effect, has two health care systems: mainstream care and safety net care. The mainstream system serves people who have access to care through commercial health insurance or private payment. "Safety net care" is the term used to describe care provided for those without insurance; those who are covered by a government program but cannot find a physician who will accept lower government payments; and those who lack the capacity to navigate the mainstream health care system.

The Oregon Health Plan is not entirely synonymous with the safety net, though OHP is Oregon's effort to ensure access to health care for all Oregonians not covered by commercial health insurance. Funding for the Oregon Health Plan, and thus for safety net services, has decreased dramatically in recent years. In spite of these cutbacks, the Oregon Health Plan remains a major funding source for safety net care.

Today, about 210,000 residents of Multnomah, Clackamas and Washington counties do not have health care insurance and rely on the safety net for routine or preventive care. This gap in access to health care continues due, in part, to: (1) the absence of universal health insurance, (2) reductions in funding for the Oregon Health Plan, (3) an increasing number of uninsured and underinsured individuals (even among the employed) and (4) the limited capacity of public and charitable providers to provide uncompensated care.

What exactly is the health care safety net? How does it work? Where is it, and who uses it? This report is intended to answer these questions and serve as a primer on the operations of the health care safety net in the Portland area.

A. What Is the Health Care Safety Net?

To understand the health care safety net and why it is needed, we must first contrast it with the mainstream health care system. Mainstream health care providers primarily serve people whose medical bills are paid by commercial health insurance, by government health plans (Medicare or Medicaid) or by the patients themselves. Mainstream providers limit or deny care to patients who are uninsured or who cannot afford to pay the costs not covered by insurance. Increasingly, mainstream providers also refuse to serve the beneficiaries of government programs such as Medicaid, and sometimes Medicare, because reimbursement rates are considered too low to be profitable. Patients without adequate insurance or the cultural, mental or linguistic abilities necessary to negotiate the mainstream health care system, rely on the health care safety net.

The health care safety net is comprised of providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients. This definition of the health care safety net adopted by the Institute of Medicine, an independent advisory group, is now standard among those involved in the delivery of health care services.⁴

This report focuses on “core safety net providers,” defined by the Institute of Medicine as having two distinguishing characteristics:⁵

- i. Either by legal mandate or explicitly adopted mission, core providers offer care to patients regardless of ability to pay; and
- ii. Uninsured, Medicaid and other vulnerable patients are a substantial share of the provider’s patient population.

Core safety net providers typically include community health centers and local health departments, as well as special service providers such as AIDS clinics and school-based clinics. None of the hospitals in the Portland area are core safety net providers.

A typical list of safety net providers also includes mainstream health care providers such as hospital emergency rooms or physician clinics willing to provide some care without regard for the patient’s ability to pay. This report refers to these mainstream providers as “non-core safety net providers” (see Figure 1). While valuable to safety net patients, non-core safety net providers primarily treat patients

⁴ Institute of Medicine, *America’s Health Care Safety Net: Intact but Endangered* (2000), www.nap.edu/catalog/9612.html

⁵ *Ibid.*

with commercial health insurance. Because non-core providers primarily serve paying patients, they have the ability to shift the cost of charity care to private or third-party payers, and need to attract patients with the financial means to pay for their care, unlike core safety-net providers.

Figure 1
Core v. Non-Core Charity Providers



B. Why Do We Have a Safety Net?

The safety net exists in response to major gaps in the availability of health care and health insurance coverage in Oregon and throughout the United States. These gaps persist because of the historically limited role of public entities delivering health care in the United States, combined with limitations in both commercial health insurance and the Oregon Health Plan.⁶

Neither government agencies nor charitable organizations assure the existence of a safety net; nor does any other system, entity, association or coordinated consortium of providers. The core safety net exists only where a local community creates it. The term “safety net”

The core safety net exists only where a local community creates it.

itself is misleading, in that it suggests a seamless web that catches and saves all who fall off the tightrope of mainstream health care. In fact, the health care safety net varies considerably from place to place. As the Institute of Medicine has observed, the safety net “is a patchwork of institutions, clinics and physicians’ offices, supported with a variety of financing options that vary dramatically from state to state and community to community.”⁷ Although state and federal financing for the safety net is available, core safety net providers exist only where individuals and community leadership create them.

⁶ City Club of Portland Bulletin, “Gaps in Health Care Access,” October 17, 2003, www.pdxcityclub.org/committees/documents/gapsinhealthcareaccess.pdf

⁷ *America’s Health Care Safety Net: Intact But Endangered*, pages 3-4.

II. Why Do People Use the Safety Net Instead of Mainstream Providers?

The safety net provides health care to those who would otherwise face significant barriers when attempting to gain access to health care services from mainstream providers. Financial barriers, especially lack of adequate health insurance, create most of the gaps in access to care. Non-financial barriers also play a role, but are more difficult to quantify. In particular, access to health care can be a problem for many people, including the elderly, the mentally ill and non-English speakers. In addition, many patients have complex medical and cultural needs that are not readily or adequately met by mainstream providers.

Patients confront challenges to obtaining care from mainstream health care providers, including:

Financial Barriers

- Low income
- Unemployment
- Lack of insurance
- Under-insurance

Social Barriers

- Language
- Ethnicity
- Immigrant or undocumented status
- Homelessness
- Transportation issues

Procedural Barriers

- Changing eligibility for the Oregon Health Plan
- Paperwork for the Oregon Health Plan
- Complex charity care applications

Other Barriers

- Chronic and persistent mental illness
- Substance abuse or addiction
- Developmental disabilities

A. Financial Barriers

i. Lack of Insurance

The most significant barrier to health care is financial — chiefly a lack of consistent and adequate health insurance. People without health insurance — the uninsured — are also likely to lack the personal financial resources to pay for health care services out of pocket.

For the last 10 years, the Oregon Health Plan, Oregon's innovative Medicaid demonstration program, provided access to health care services to more than one million otherwise uninsured people and lowered the number of uninsured individuals in the state from 18 percent in 1994 to as low as 10 percent in 1998.^{8,9}

As demonstrated in Figure 2, between 85 and 100 percent of the clients of core safety net clinics in the tri-county are either uninsured or on the Oregon Health Plan.

In an effort to expand Medicaid coverage within tight fiscal constraints, Oregon redesigned the Oregon Health Plan in 2003. The goal was to expand coverage by offsetting costs with increased cost sharing. The program was modified into three Medicaid benefit packages: Plus, Standard and a premium subsidy program called the Family Health Insurance Assistance Program.

The **Oregon Health Plan Plus** benefit package and cost sharing structure is similar to the original Oregon Health Plan and serves the traditional Medicaid categories: Temporary Assistance to Needy Families (TANF), disabled individuals and low-income seniors on Medicare.

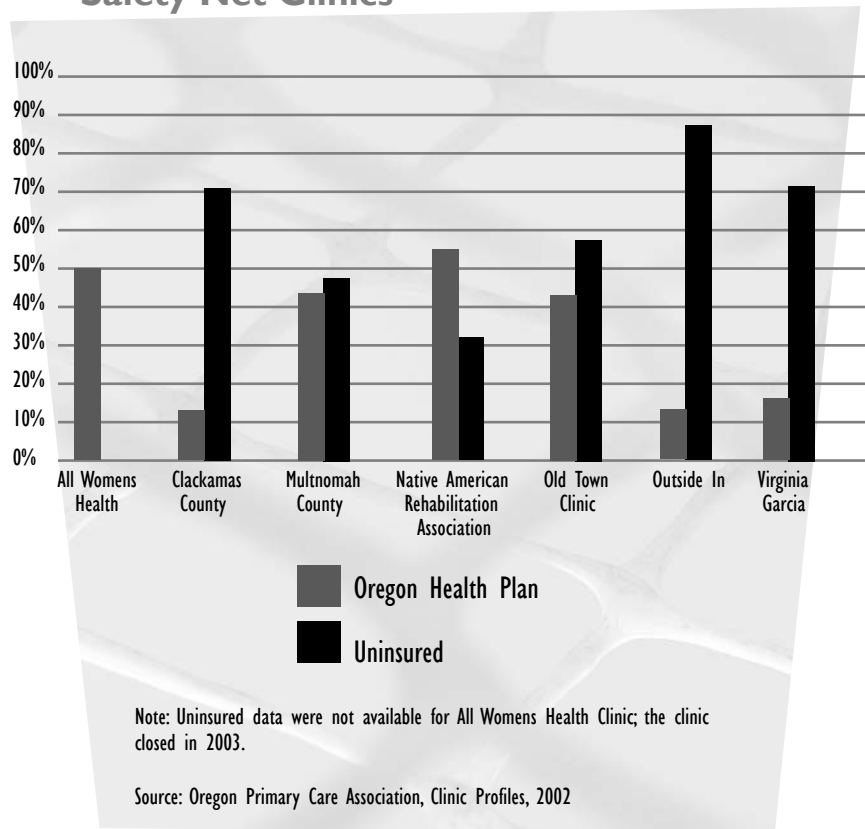
The **Oregon Health Plan Standard** benefit package, designed for OHP's expansion population (adults, age 19-64, earning up to 100 percent of the federal poverty level), has a leaner benefit package, increased premiums and tighter administrative rules. Oregon's lingering fiscal crisis has prevented expansion and, in fact, has resulted in additional changes and cuts to the Oregon Health Plan Standard benefit package in 2003 and 2004. Enrollment in Oregon Health Plan Standard benefit package is now capped at 25,000 individuals. Because the cap has been met, enrollment is closed.

The **Family Health Insurance Assistance Program** covers people who don't have employer-provided health insurance or are

⁸ *HRSA State Planning Grant Final Report*, Office for Oregon Health Policy and Research, October 2001

⁹ Vaidya, K.L., *2000 Oregon Population Survey: Summary of Findings*, Office of Economic Analysis, Department of Administrative Services, State of Oregon, January 12, 2001

Figure 2
Oregon Health Plan Members and
Uninsured Individuals Using Core
Safety Net Clinics



offered insurance at work but need help paying the premium for themselves or family members. Applicants must be uninsured for six months (or transfer directly from the Oregon Health Plan) and meet income requirements. The Family Health Insurance Assistance Program pays 50 to 95 percent of its members' share of monthly premiums, depending on family size and income. The Family Health Insurance Assistance Program serves households earning up to 185 percent of the federal poverty level, meaning a family of four earning as much as \$2,906 monthly would qualify. The program is financed largely by the federal government, which pays 72 cents of each dollar spent.

Even with the Oregon Health Plan insuring most of the state's poorest people, one-quarter of Oregonians whose income is at or below the federal poverty level are uninsured (see sidebar below for federal poverty levels). Some are dropped from the Oregon Health

Even with the Oregon Health Plan insuring most of the state's poorest people, one-quarter of Oregonians whose income is at or below the federal poverty level are uninsured.

Plan for failure to pay the premiums required for the Standard benefit package. Nineteen percent of those earning 101 to 200 percent of the federal poverty level — about 124,000 people — are also uninsured.¹⁰ The raw number and percentage of uninsured people decrease as income rises above 200 percent of the federal poverty level.

People with household incomes of less than 200 percent of the federal poverty level have virtually no disposable income to spend on health care, according to economic studies.¹¹ In the tri-county area, 25.4 percent, or 380,000 people, have household incomes below 200 percent of the federal poverty level (see Figure 3).

Federal poverty level is the federally established income guide for measuring poverty. Income levels for 2004 are shown below:

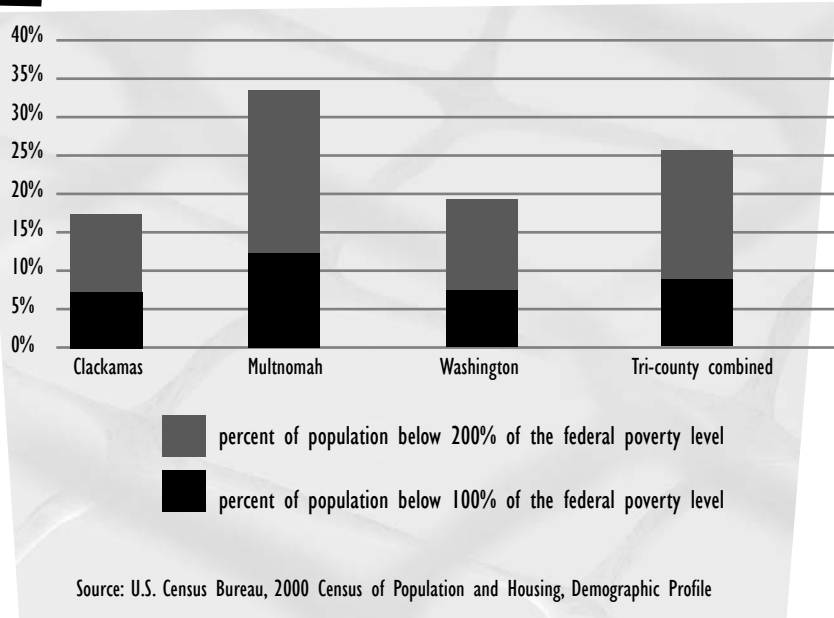
2004 Federal Poverty Level (FPL)

Family size	Annual income	Hourly rate (40-hour work week)
1	\$9,310	\$4.48
2	12,490	\$6.00
3	15,670	\$7.53
4	18,850	\$9.06

¹⁰ Oregon Population Survey, Office for Oregon Health Policy & Research, 2002

¹¹ "Preserving America's Health Care Safety Net: An Imperative for Us All," American College of Emergency Physicians, September 19, 2000

Figure 3
Tri-County Low-Income Population

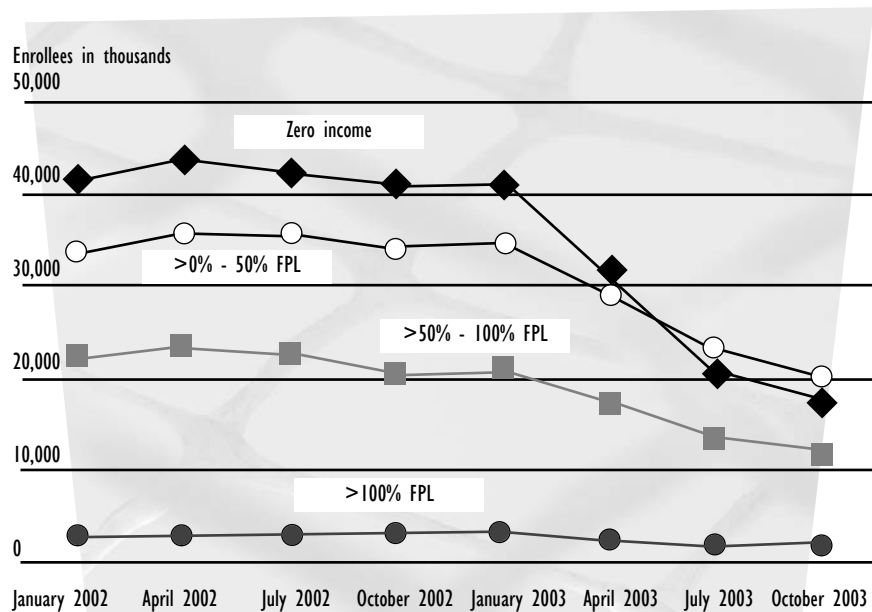


Weak economic conditions have increased pressure on the safety net by increasing the number of people who are not covered by commercial health insurance or the Oregon Health Plan. According to the 2002 Oregon Population Survey, 13.7 percent of tri-county residents are without health insurance. Multnomah County has the highest percent of uninsured in the tri-county area, at 14.9 percent. Washington County and Clackamas County are slightly better off, at 12.8 percent and 12.5 percent respectively.¹²

In 2003, Oregon Health Plan enrollment was reduced statewide by 75,500 people as a result of budget cuts. This decline is partially depicted in Figure 4, which demonstrates the number of enrollees that were dropped from the Oregon Health Plan due to their inability to pay the premiums for the Standard benefit package. With commercial insurance coverage also declining, as documented in the U.S. Census Bureau report of August 2004, the percentage of uninsured individuals in the tri-county area most likely exceeds 15 percent. Thus about 210,000 uninsured people live in the tri-county area.

¹² Oregon Population Survey, Northwest Research Group, Inc. for the Oregon Progress Board, January 21, 2003

Figure 4
Decline in Oregon Health Plan “Standard”
Enrollment by Federal Poverty Level



Source: Office of Oregon Health Policy and Research, Research Brief: Changes in Enrollment of Oregon Health Plan Standard Clients, January 2004.

ii. Under-insurance

Increasingly, even those who have insurance face financial barriers to care. While reliable data about the number of uninsured people in our community exist, a good measure of the under-insured population — those who have health insurance that is insufficient to meet their needs — is not known. However, because health care costs are rising more rapidly than incomes, the under-insured population is also believed to be increasing.¹³ This trend has forced employers to shift

co-payment and co-insurance costs to employees and reduce coverage for benefits such as prescription drugs and preventive care. In addition to the 15 percent of the tri-county population estimated to be uninsured, an increasing number of people with insurance cannot afford medical care and are potential users of the safety net.

Under-insured Oregonians face financial barriers to care such as:

- resistance by health care providers to accept low reimbursement rates from government health plans, particularly the Oregon Health Plan
- high deductibles and co-payments for commercial health insurance
- insurance that does not cover a needed product or service, such as drugs or mental health care
- “catastrophic” or “medical savings account” insurance policies that pay for major injuries and hospitalizations, but not for preventive or chronic care.

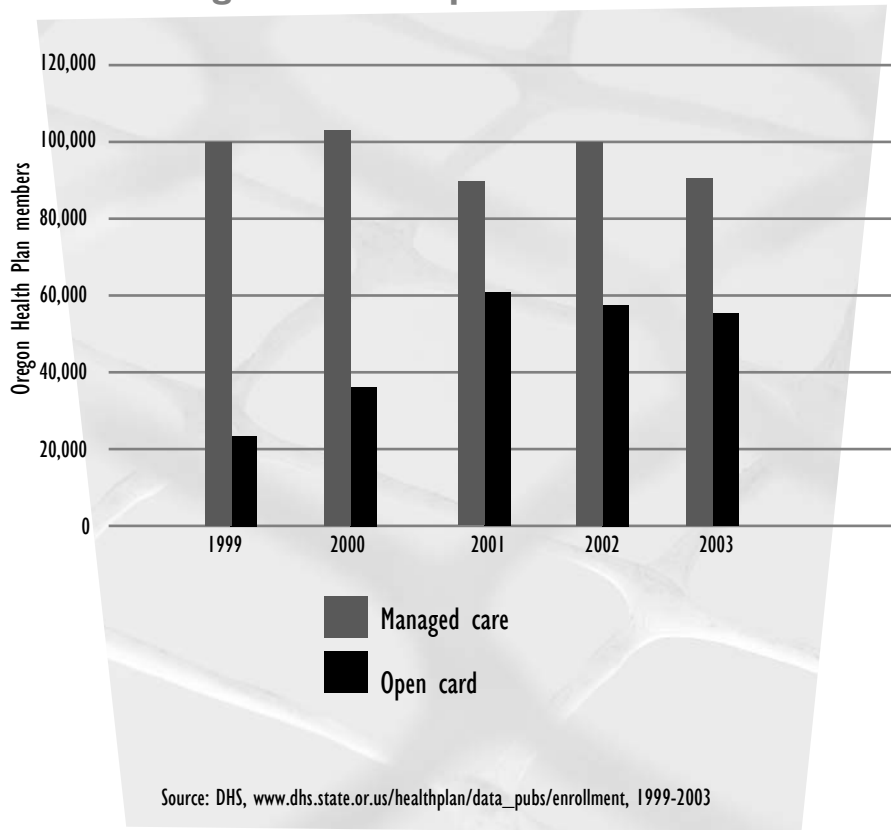
iii. Limited Access to Mainstream Care Providers

Oregon Health Plan members receive medical care either by enrollment in mainstream managed care insurance plans or by an “open card.” In managed care plans, they are assigned to a mainstream primary care provider through commercial health plans (e.g., Regence Blue Cross Blue Shield of Oregon, Providence Health Plans, Kaiser Permanente Health Plans, HealthNet, The ODS Companies, and PacifiCare of Oregon) or health plans established to serve Oregon Health Plan members (e.g., CareOregon or Family Care). Commercial health plan options are shrinking, as a number of commercial plans have withdrawn from the Oregon Health Plan.

“Open card” members are not assigned to a managed care plan, but may utilize any provider that will accept Oregon Health Plan patients. In some cases this allows an individual who enrolls in Medicaid to continue receiving care through an established relationship with a mainstream provider. Many open card members, however, have trouble finding providers who will treat them, due to the Oregon Health Plan’s relatively low fee-for-service payments.

Between 1999 and 2004, the number of tri-county Oregon Health Plan members in managed care declined from 99,939 to 90,666, and the number of open-card members increased from 24,000 to 55,000 (see Figure 5). Paths to mainstream care have limited capacity, and often none of them is available to open card members. In such cases, safety net providers are the only option.

Figure 5
Tri-County Oregon Health Plan Members:
Managed Care v. Open Card



B. Social Barriers

Social factors — such as culture, language, transportation, location, unfamiliarity with the health care system, mental capacity, homelessness and ethnicity — also can be significant barriers to receiving care. When people lack education, face language barriers or are unfamiliar with customary access procedures, other barriers are compounded. Anecdotal evidence indicates that many uninsured Oregonians face social barriers to health care, including those described below:

i. Cultural and Language Barriers

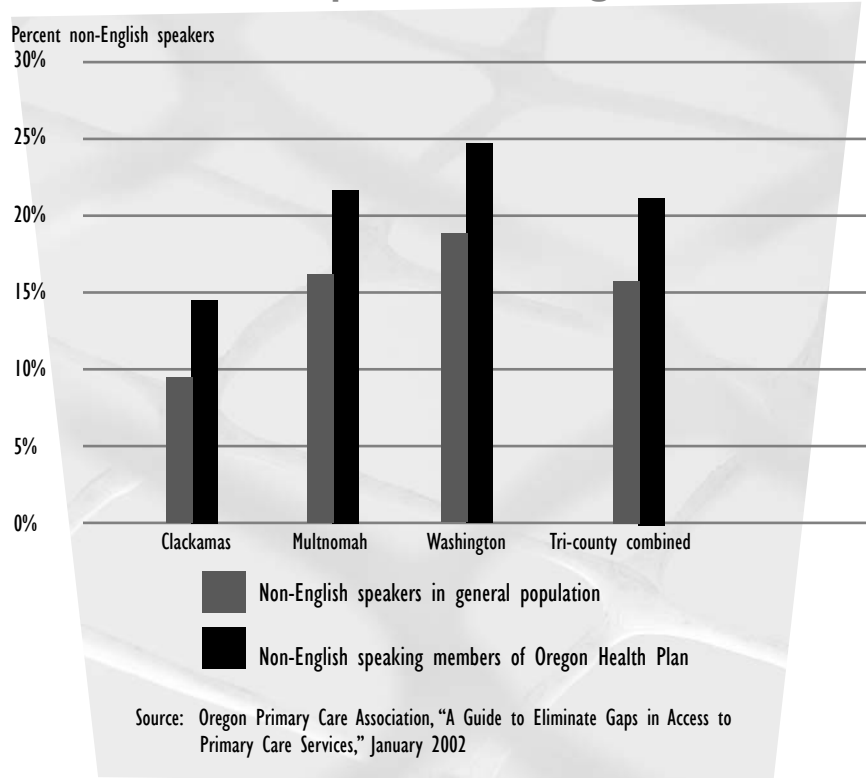
Cultural barriers to health care providers and insurance coverage are interconnected. Barriers include differences in race, ethnicity and language. For example, in some cultures, people traditionally do not seek routine medical care. In other cases, undocumented workers may fear being reported to authorities when visiting a doctor (although they are likely to feel safer at safety net clinics) or contacting an insurance company. Racial and ethnic minorities who fear prejudice or discrimination are also more likely to lack access to health care.¹⁴ According to a study by George Washington University, “minorities were significantly more likely to report being treated with disrespect or being looked down upon in the patient-provider relationship. Specifically, 14.1% of blacks, 19.4% of Hispanics, and 20.2% of Asians perceived being treated with disrespect or being looked down upon, compared with only 9.4% of whites. Persons who thought that they would have received better treatment if they were of a different race were significantly less likely to receive optimal chronic disease screening and more likely to not follow the doctor's advice or put off care.”¹⁵

Approximately 25 percent of Washington County residents enrolled in the Oregon Health Plan are non-English speakers, similarly, 22 percent in Multnomah County and 14 percent in Clackamas County are non-English speakers (see Figure 6). These patients require supportive services as well as interpretation services, not only during office visits, but also when scheduling appointments and receiving treatments and medications. The growing number of non-English-speaking-patients in the tri-county area puts heavy demands on health care providers to develop cultural competence and employ multi-lingual staff.

¹⁴ Oregon Health Council, *The Role of Health Care Safety Net Clinics in Oregon*, Attachment A, August 2002

¹⁵ Blanchard, J., Lurie N., George Washington University, *Journal of Family Practice*, 2004 Sep;53(9):721-30

Figure 6
Percentage of Non-English Speaking Persons
in General Population v. Oregon Health Plan



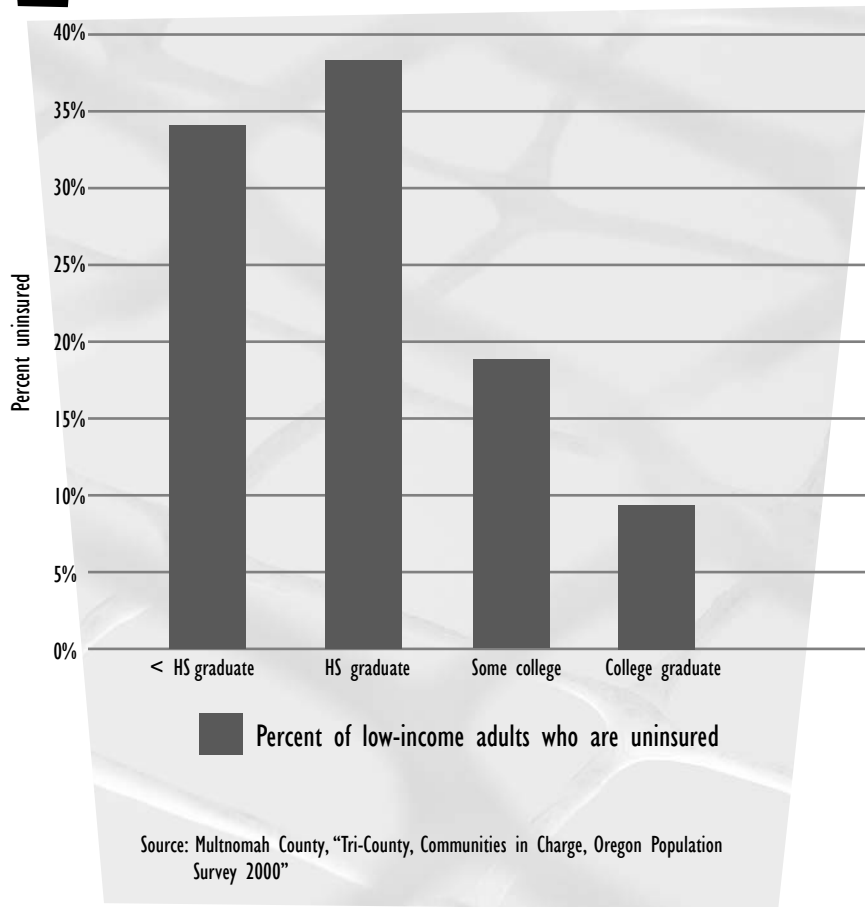
ii. Location and Transportation

Inconvenient provider locations and lack of flexibility in scheduling appointments are also barriers to health care. Patients who reside far from their nearest health care provider or lack convenient and affordable transportation sometimes find that the time involved in getting to and from their provider costs them income or even their jobs.

iii. Education

Many safety net users lack the education and skills necessary to navigate the complexities of obtaining health care. According to the Oregon Population Survey, the uninsured population in the tri-county area has less formal education than the insured population. Figure 7 illustrates the correlation of education to insurance in the tri-county area.

Figure 7
Correlation of Education to Insurance



C. Procedural Barriers

i. Information Required to Obtain Care is Complex

To access mainstream care, uninsured or indigent patients must provide detailed information about their income, assets, residence and family. To make this less onerous, charity care providers in the Portland area implemented a standard application in 2002. This was the result of an effort led by Oregon Health Action Campaign to have all Portland-area hospitals and safety net clinics adopt a common form and impose common charity-care requirements. In spite of its intended purpose, completing this form requires a good deal of personal and financial information that most people would not routinely bring to a medical appointment. In contrast, a person who is insured shows only a member identification card to be financially eligible for care.

ii. Requirements for Oregon Health Plan Enrollment are Complicated

Medicaid enrollment has always been complex, and recent changes to the Oregon Health Plan have exacerbated the procedural barriers. For example, patients formerly could begin receiving care before paying their first premium and were allowed to “catch up” if their premium was paid late. Now, failure to pay the monthly premium, no matter how small, results in a six-month exclusion from the Oregon Health Plan.¹⁶ The situation is worsened by Oregon Health Plan regulations that change frequently, producing unexpected losses of coverage. As a result, many persons cycle on and off the Oregon Health Plan. Individuals must reapply or recertify Oregon Health Plan eligibility as frequently as monthly, depending on the program. If family income rises above the maximum income level limits for a particular program, the family loses coverage. If their income falls back below the federal poverty level limits, they must reapply.

D. Other Barriers

It seems paradoxical to call a person too sick for the health care system to treat effectively, but this is precisely the situation for many safety net users. The consequences of poverty, poor nutrition, advanced and untreated medical conditions, little or no health maintenance or prevention, and inability or reluctance to follow treatment instructions complicate individuals' medical needs and make it impossible for some to obtain care in traditional settings. Safety net users "struggle with conditions and circumstances that necessitate close coordination among multiple caregivers, benefits managers, or other public and community based agencies: e.g., chronic and persistent mental illness, drug and alcohol addictions, developmental disabilities, complex medical conditions, work-related injuries and/or legal problems."¹⁷ Multiple facilities may have records of an individual patient's visits and health history without a mechanism for sharing information among providers.

In general, safety net users are an expensive and difficult population to serve, due to many patients with multiple chronic health problems and specialized needs. Their vulnerabilities make them a more time-consuming and challenging population to treat than the average privately insured patient.¹⁸

Among homeless youth, for example, one finds:

- mental illness at twice the rate of children in school
- 98 percent have used drugs and 40 percent have injected drugs
- 20 percent of girls become pregnant every year
- 11 percent of boys have Hepatitis C.¹⁹

Historically, safety net users have been primarily women and children; however changes in employment and, consequently, insurance coverage, often force others to rely on the safety net as well. A typical adult safety net user may be:

¹⁷ *A Guide to Eliminate Gaps in Access to Primary Care Services: January 2002* from Oregon Primary Care Association, page 47

¹⁸ Report of Washington County Department of Health and Human Services. Contact: Laura Grandin, Ph.D., Washington County Jan. 2, 2002

¹⁹ Oregon Research Institute quoted by *A Guide to Eliminate Gaps in Access to Primary Care Services: January 2002* from Oregon Primary Care Association, page 14. Figures are for Portland.

- a single mother who works part-time and struggles to maintain a permanent residence
- a 50-year-old worker who was laid off and cannot afford insurance payments
- an immigrant who is working toward citizenship
- an individual who does not have the mental capacity to navigate the mainstream health care system
- an individual covered by the Oregon Health Plan who does not have a primary care physician
- a homeless youth.

III. Who Provides Safety Net Care?

A. Core Safety Net Providers

The structure and strength of the health care safety net varies “depending on the political environment of a state or community, as well as the number of uninsured people and the types of health care institutions in the area.”²⁰ A centralized system for planning, establishing or operating safety net clinics does not exist in the Portland metropolitan area.

i. Types of Providers

In the tri-county area, most core safety net patients receive care in community health centers designated as Federally Qualified Health Centers. In addition, some smaller clinics operate as free clinics, or are sponsored by a provider or provider group committed to reaching under-served populations.

Each county in the Portland area has its own approach to providing indigent care. Multnomah and Clackamas County health departments have multiple county clinics, while Washington County relies primarily on one nonprofit health center with multiple locations.

Federally Qualified Health Centers are eligible for federal grants and enhanced Medicaid reimbursement. In order to be designated as a Federally Qualified Health Center, a clinic must:

- serve an area with a federally designated health professional shortage or a medically under-served area or population
- provide services to all patients regardless of insurance status or ability to pay
- use a sliding-fee scale for uninsured or under-insured patients based on income status
- operate as a nonprofit corporation
- be governed by a board of directors, the majority of whom are users of the health center.²¹

The following four types of Federally Qualified Health Centers are found in the tri-county area:

a. **Community and Migrant Health Centers** provide comprehensive primary health care for adults, children and families. The health centers of this type in the tri-county area are Multnomah County Health Department, Virginia Garcia Memorial Health Center in Washington County, and Clackamas County Health Department.

b. **Health Care Programs for the Homeless** are federally funded programs that provide outreach and case management services, primary medical and dental care, 24-hour emergency services, mental health and substance abuse counseling and treatment to homeless individuals. They also provide referrals to other services, such as emergency food, clothing and shelter programs, placement services for long-term employment, and housing. Under these programs, homeless people are not charged directly for health services, and they may remain in the program for up to one year following placement in permanent housing. In Multnomah County, Central City Concern and Outside In are examples of facilities that receive funding to serve homeless people.

c. **School-Based Health Centers** are located in schools or on school grounds and operate year-round for at least 30 hours per week. School-based health centers are located in areas with a high percentage of low-income and uninsured children in the school. Services focus on preventive and developmentally appropriate care. Clinics are easy to access and are available during school hours, services are free and confidential, and staff members are knowledgeable and aware of students' needs. Fifteen school-based health centers operate in the tri-county area.

²¹ Bureau of Primary Health Care, U.S. Department of Health and Human Resources

d. **Tribal Health Programs** encourage tribal, inter-tribal and interagency collaboration, coordination and communication to provide health care to Oregon's Native American population. In Multnomah County, the Native American Rehabilitation Association of the Northwest is an Indian Health Services clinic that provides health care to Native Americans.

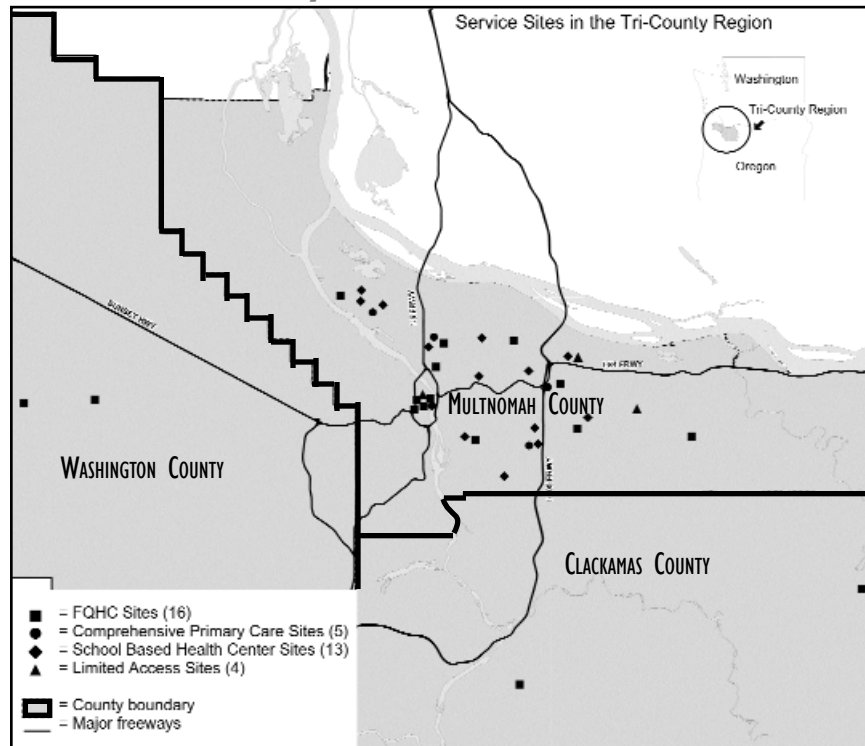
In addition to the Federally Qualified Health Centers, some clinics are sponsored by a provider or provider group that is committed to reaching under-served populations. These clinics are **Non-Federally Qualified Health Centers**. Examples including the following:

Volunteer and Other Clinics tend to be small, nominally financed and provide primary care rather than the comprehensive care and the enabling services typical of Federally Qualified Health Centers. Examples include Portland Adventist Community Services and The Wallace Medical Concern in Multnomah County, and the Essential Health Clinic in Washington County. Another program, Neighborhood Health Clinics, provided several thousand clinic visits per year using volunteer staff and Multnomah County clinic facilities after office hours, until the clinic closed in 2002 for lack of funding.

Other small clinics are sponsored by mainstream providers or provider groups. Examples of this type of clinic include the Providence Mission Clinics and the West Burnside Chiropractic Clinic.

Figure 8 maps the core safety net providers in the tri-county area.

Figure 8
Map of Core Safety Net Locations
in Tri-County Area



Source: Oregon Primary Care Association, 2003

ii. Services Offered by Core Safety Net Providers

Services offered by core safety net providers include:²²

- primary care
- preventive care including well-child care
- urgent care
- acute and chronic disease treatment
- services based on local community need (mental health, dental and vision)
- enabling services (translation/interpretation, case management, transportation and outreach).

²² Oregon Health Council, The Role of Health Care Safety Net Clinics in Oregon, August 2002

Figure 9 Outreach by Virginia Garcia Health Center



Source: Virginia Garcia Memorial Health Center

Primary care consists of family medicine, internal medicine, pediatrics, obstetrics and gynecology. It may be furnished by physicians or by other health professionals, such as physician assistants, nurse practitioners and certified nurse midwives. The clinics also may provide diagnostic laboratory services, radiology, preventive dental services and medications. Many of the patients are women and children who come to the clinics for prenatal and perinatal care, voluntary family planning, well-child services, pediatric vision and hearing screenings, and immunizations.²³ Safety net clinics provide patient case management services with referrals for secondary care, such as specialist, hospital, surgical services; tertiary care; and substance abuse and mental health services. Core safety providers in the tri-county area do not offer tertiary care.

Safety net clinics also provide enabling services that set them apart from mainstream providers. Those services promote access to care and include transportation, outreach, interpretation, Oregon Health Plan enrollment, and education to enhance effective use of the health center's services. Core safety net providers also offer signage, brochures and forms in multiple languages. The safety net clinic is more likely to offer support services, treatment of mental health issues, culturally sensitive treatment and non-traditional forms of medical care. Most core safety net clinics are in locations convenient to public transportation and have schedules that accommodate hourly employees.

The Migrant Outreach Program of Virginia Garcia Memorial Health Center is an example of how safety net services target specific populations. "Through this program the center provides screening, medical

²³ Comprehensive well-child care includes preventive services, such as health and developmental history; physical examination; appropriate immunizations; laboratory assessments; health education and anticipatory guidance; and screening tests for vision, hearing, and dental problems.

treatment and health education to migrant and seasonal farm workers living and working in migrant labor camps. During the year, a nurse and a health educator make weekly visits to survey the camps and screen people for illness. From late April through August, the center sends a team of doctors, nurses, health educators and outreach workers twice weekly to the camps to provide on-site treatment and health education.”²⁴

iii. Performance of the Core Safety Net

Without the safety net, many people would not have a doctor to visit when they need care. People who use the safety net are more likely to receive prompt comprehensive care than if they were to try to use a mainstream provider. The safety net also improves the health and economy of the community by reducing risks of communicable disease and substance abuse, increasing worker and student productivity, and protecting the health of children and mothers.²⁵

Data suggest the core safety net is better able to adapt to high-need users than the mainstream charity segment. A 2003 report concluded Federally Qualified Health Centers have experienced “... sustained and improved clinical care quality and patient satisfaction levels over a decade, even as health centers have experienced a significant growth in the proportion of uninsured and vulnerable patients they serve.”²⁶ Another report concluded that in Oregon, “School-Based Health Centers are extremely cost effective.” With an investment of “\$6,944 in School-Based Health Centers the state is contributing to the delivery of \$12,778 worth of health care to Oregon’s students.”²⁷ The actuarial firm Milliman & Robertson states that, “safety net clinics may be better prepared to serve patients who have special needs and that those patients receive more valuable services at safety net clinics.”²⁸

Despite their demonstrated value, safety net clinics have deficiencies as well. The Milliman & Robertson study also concluded that safety net clinics need to improve administrative, financial and data management services. The Oregon Community Health Information Network was established in 2000 to stabilize the infrastructure of Oregon’s health care safety net system (see Section V).

²⁴ www.virginiagarcia.org/outreach.asp

²⁵ Oregon Primary Care Association, A Guide to Eliminate Gaps in Access to Primary Care Services, January 2002, page 9

²⁶ “Exploring Healthcare Quality and Effectiveness at Federally-funded Community Health Centers,” National Association of Community Health Centers, Inc., March 2003, page 2

²⁷ 2002 report of School-Based Health Centers in Oregon

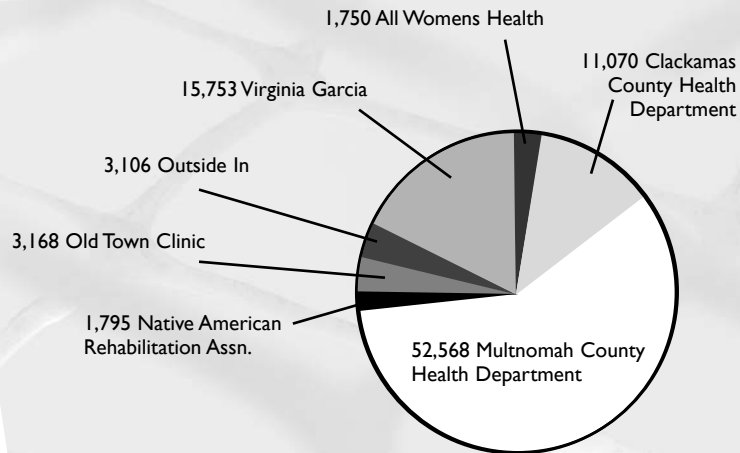
²⁸ Analysis of Oregon Health Care Safety Net Services, February 1999, Office for Health Policy and Research

iv. Capacity of the Core Safety Net

According to witnesses interviewed by your committee, the current capacity of the core safety net is insufficient to meet the needs of the uninsured and vulnerable population. The Oregon Primary Care Association reported that in 2002, approximately 89,000 Oregonians in the tri-county metro area made 343,000 visits to receive care from safety net providers (see Figure 10). According to the findings in the Communities in Charge report (see Section V, Subsection C), the clinics met the needs of less than one-half of the eligible population in 2002.

The capacity of the safety net is growing, but not as fast as the need for it, primarily due to limited state funding that has forced clinic closures as stated earlier in this report. Federally Qualified Health Centers are eligible to compete for grants through the Bureau of Primary Health Care. Several grants have been awarded to tri-county safety net clinics to increase capacity and serve more people (see Section IV, Figure 12).

Figure 10
Patients Served by Major Core Safety Net Providers in the Tri-County Area (2002)



Note: All Womens Health Clinic closed in 2003 and Old Town Clinic is now part of Central City Concern.

B. Non-Core Safety Net Providers

Although this report focuses on core safety net providers, the significant contribution of the non-core safety net providers should not be overlooked. Potential safety net users who lack access to the core safety net either turn to the non-core mainstream safety net or forgo health care. The non-core safety net complements the care provided by the core safety net by providing inpatient, emergency, primary and specialty care in mainstream settings.

Unlike many other U.S. communities, the tri-county area has no public hospital designated to provide care to uninsured patients. Hence, most of the uncompensated care is spread among all of the hospitals and their emergency rooms. These facilities are obligated by the federal Emergency Medical Treatment and Labor Act and by their tax-exempt status to care for anyone in need. Every hospital in the Portland area has an emergency room open to all patients regardless of their ability to pay. However, the care available through emergency rooms generally is limited to diagnosis and stabilization of emergency conditions. Emergency rooms do not provide primary or preventive care, or coordinated care outside their confines. As such, emergency rooms are not adequate substitutes for core safety net providers.

Primary and preventive care provided to safety net users by the mainstream charity segment can be excellent, but access to such care is limited. When available, primary and preventive care from mainstream charity providers may be marred by uncoordinated efforts, greater expense and lack of supporting services. Most non-core safety net providers are not prepared to meet the unique needs of the safety net population. Among mainstream providers, enabling services are weak or absent. Consequently, the care provided to the indigent population is often fragmented and sporadic, resulting in outcomes inferior to those of patients who are able to pay for and manage their own care.²⁹

Hospitals within the tri-county area contributed \$113 million of charity care in 2003. This represents a 300 percent increase in the dollar volume of charity care over the past three years.³⁰ Charity care among tri-county hospitals was 5.1 percent of their revenue in 2003, up from 3.2 percent in 2000 and 2001, though still well below 14.1 percent in 1993, the year before the Oregon Health Plan went into effect.

²⁹ Office of Oregon Health Plan Policy & Research, "Analysis of Oregon Health Care Safety Net Services", February 1999

³⁰ Oregon Association of Hospitals and Health Systems, "OAHHS Uncompensated Care for Web Project," 2004

In addition to hospitals, private practitioners have traditionally provided some uncompensated care. However, preliminary results of the 2004 Workforce Survey conducted by the Oregon Medical Association suggest that the uninsured or under-insured cannot rely on mainstream physicians for uncompensated or government-financed care.³¹ According to the study, almost 60 percent of primary care physicians either limit (40.6 percent) or do not see (17.9 percent) Medicaid patients and more than 40 percent of primary care physicians limit or do not see Medicare patients. Physicians cited increased costs related to reimbursements, overhead and professional liability as the primary reasons for limiting services to Medicare and Medicaid patients. Patient compliance and patients' social needs also contributed to physicians' decisions to limit or close their practices to Medicaid patients.

IV. How Is the Safety Net Financed?

The financial viability of the safety net is in question today. The lack of a systematic approach to safety net financing, cutbacks in state and local funding, a weak economy, the reduction in benefits of commercial health insurance, and the rapidly rising costs of health care are all factors that threaten a perfect storm capable of upsetting the financial stability of the safety net.

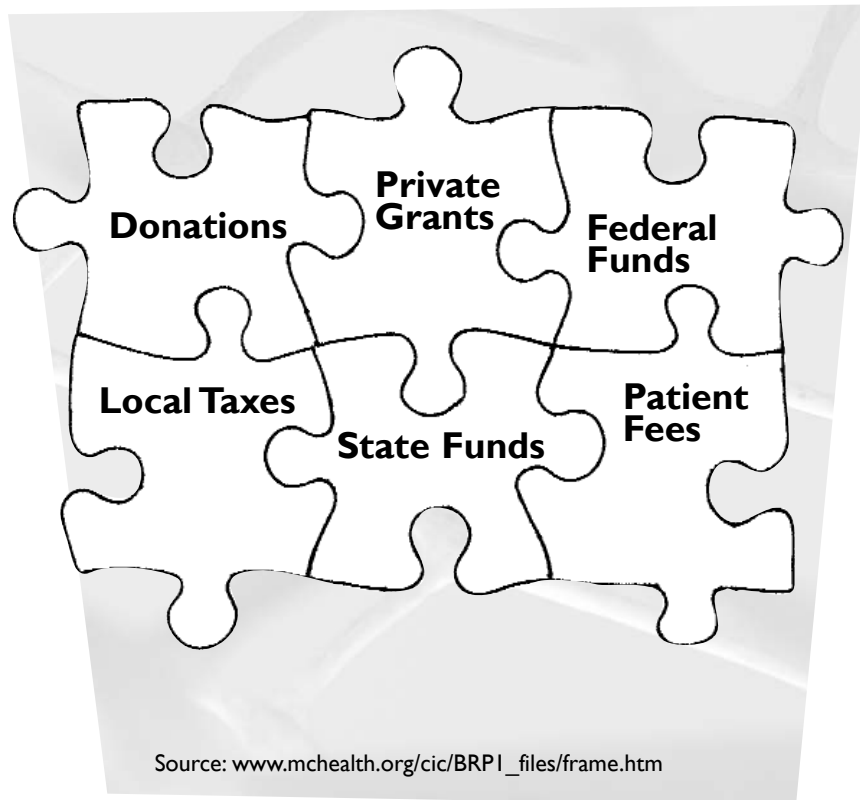
As shown in Figure 11, funding for the safety net is a puzzle of interlocking sources.

A. Funding Sources for the Core Safety Net

Core safety net providers are funded through a variety of sources, including:

- federal grants for Federally Qualified Health Centers
- Medicaid (Oregon Health Plan)
- Medicare
- other federal and state funding
- commercial insurance
- patients payments (some based on ability to pay)

Figure 11
Funding of the Safety Net



- uncompensated care or “charity care” donated by organized providers
- individual volunteerism
- foundation grants
- county general funds.

Funding sources for the core safety net are more varied and unstable than those of non-core safety net providers. Piecing together revenues from these sources gives core providers funds for fulfilling their mission to treat all patients without regard for their ability to pay.

Only for Federally Qualified Health Centers is funding reasonably stable. In addition, aggregate information about financing of the core safety net is available only for Federally Qualified Health Centers.

i. Federal and State Funds for Federally Qualified Health Centers

Federally Qualified Health Centers receive federal financial assistance in several ways:

1. **Federal grants** fund the infrastructure necessary to deliver services to under-served populations. Awards range from \$500,000 to \$650,000 per year.

In 2002, President Bush, suggesting that Federally Qualified Health Centers are a viable delivery system for vulnerable populations, pledged to double the number of patients served at these centers over the next five years. He recommended that Congress increase federal funding to health centers by 11 percent or \$169 million. Congress responded with a budget increase of \$161 million. These funds were earmarked to allow Federally Qualified Health Centers to increase nationally by nearly 800,000 patients above the 2003 total. The additional funding is for 170 new and expanded sites and to stabilize the financial condition of existing health centers.³²

Financing for expansions of existing and new Federally Qualified Health Centers became available in 2002, and many centers have been competing for these grants and trying to open new access points for medically under-served populations. Figure 12 lists grants received under this initiative by safety net providers in the tri-county area.

According to the Bureau of Primary Health Care, approximately \$355 million is expected to be available during the 2005 federal fiscal year to fund an estimated 277 awards.³³ The grants are awarded through a national competitive grant process. Funding beyond the first year is dependent on the availability of appropriated funds and satisfactory performance by the grantee.

2. **Enhanced payments for Medicaid and Medicare services**, also received by Indian Health Service and Tribal clinics, are based on the average cost per visit. Community health centers have higher costs per visit than other providers because they provide more enabling services, including interpretation, chemical dependency treatment, and outreach. These visits are reimbursed at the average visit rate for Medicaid and at-cost up to an upper limit rate for Medicare.

³² Bureau of Primary Health Care: www.bphc.hrsa.gov/programs

³³ Bureau of Primary Care: www.hrsa.gov/grants/preview/guidanceprimary/hrsa05086.htm#1

Figure 12
Bureau of Primary Health Care Grants to
Tri-County Safety Net Providers

Year	Health Center	Type	City	Amount
2002	Multnomah County	Dental	Gresham	\$100,000
2002	Outside In	New org.	Portland	418,460
2002	Virginia Garcia	Pharmacy	Cornelius	150,000
2003	Central City Concern	New org.	Portland	\$650,000
2003	Clackamas County	New site	Molalla	541,667
2003	NARAIHC	New org.	Portland	553,780
2003	Virginia Garcia	New site	Beaverton	759,500
2004	Multnomah County	Medical capacity	Portland	\$149,805

Total BPHC Grants \$3,323,212

NARAIHC = Native American Rehabilitation Association Indian Health Clinic
 New org. = New organization means newly awarded Federally Qualified Health Center status, not necessarily newly created organization.

Source: Oregon Primary Care Association

3. Malpractice Insurance is a significant expense for any health care provider. Federally Qualified Health Centers are considered federal employers for purposes of medical malpractice.³⁴ With this designation, Federally Qualified Health Centers are protected from malpractice litigation, under the Federal Tort Claims Act. Although their exposure to malpractice is limited, they are not completely immune. Therefore, Federally Qualified Health Centers incur the cost of supplemental insurance.³⁵ These are policies that fill in coverage gaps for medical or dental malpractice claims that are not included in the specific coverage outlined by the Bureau of Primary Health Care guidelines.

³⁴ Bureau of Primary Health Care: www.bphc.hrsa.gov/programs/FTCAProgramInfo.htm

³⁵ Bureau of Primary Health Care Policy Information Notice: 97-6, bphc.hrsa.gov/quality/manual/CLINICAL16.doc

ii. Medicaid and Medicare

In stark contrast to mainstream providers, core safety net providers rely on Medicaid as their primary source of revenue, aside from federal grants. In 2003, Federally Qualified Health Centers in Oregon received 83.3 percent of their patient revenues from Medicaid. Medicare provided 3.5 percent (see Figure 13).³⁶

iii. Other Federal and State Funding

Community Health Centers also receive federal and state grants for specific services. Many provide services under the Women, Infants and Children (WIC) program of the U.S. Department of Agriculture, which focuses on nutrition for pregnant women and young children. The Oregon Department of Human Services at times offers funding for specific projects, such as improving care for diabetes or depression.

iv. Commercial Insurance

Some users of the safety net have commercial insurance. In Oregon, 3.2 percent of patient revenues for Federally Qualified Health Centers in 2003 came from commercial insurance.³⁷ This revenue is generally from individuals who have used the centers in the past and prefer to stay with the health care professionals whom they know and trust.

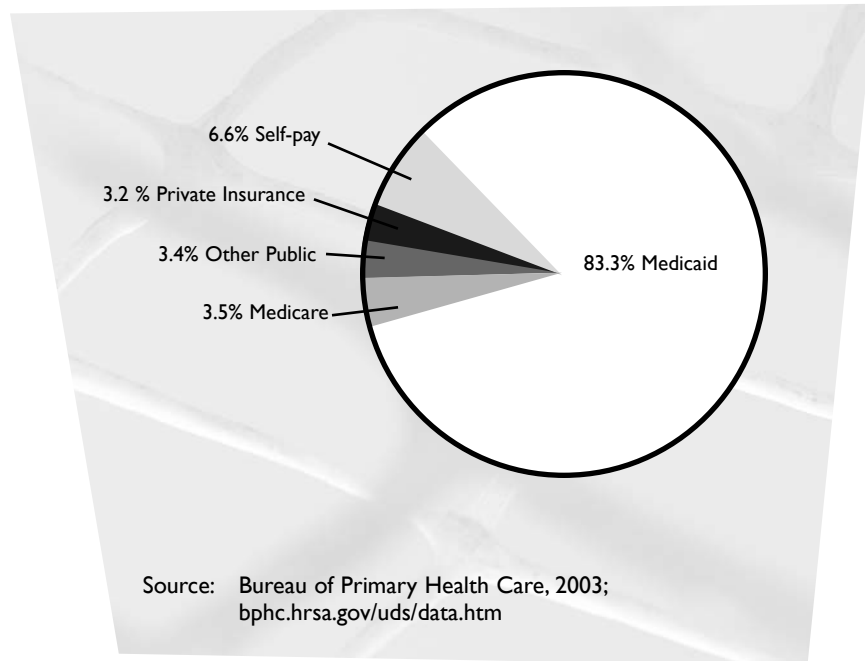
v. Direct-Pay Patients

All Federally Qualified Health Centers are required by federal regulations to bill for every service performed. They bill uninsured patients on a sliding fee scale. In 2003, Federally Qualified Health Centers in Oregon collected 21 percent of charges billed to self-paying patients, which accounted for 6.6 percent of the regional total for patient revenues.³⁸

vi. Volunteers

Free clinics, such as The Wallace Concern and Essential Health Clinic, are supported largely by the volunteer services of health care providers. As stated earlier, the core safety net exists only where a

Figure 13
Patient Revenue Sources for Federally Qualified Health Centers in Oregon



local community creates it. Health care practitioners who recognize that a segment of the population will not receive proper care from the mainstream system staff these clinics. These professionals create and maintain a portion of the safety net, in addition to their own practice, for the benefit of the community.

vii. Grants

Federally Qualified Health Centers and other community health centers often receive grants and county funds for special programs. These funds are typically for new or short-term programs, not ongoing operating support. Some grant makers will not make grants to government agencies; therefore, certain funds are available only to private nonprofit clinics. Others, like the Robert Wood Johnson Foundation, have supported government agencies such as the Multnomah County Health Department.

viii. County General Funds

Multnomah and Clackamas counties provide county general funds for their county safety net facilities. For example, in years past Multnomah County clinics have received as much as 22 percent of their revenue from county general funds. Future funding levels are uncertain due to limited county resources. Washington County does not provide county general funds for the safety net. In 2003, however, it provided \$50,000 from the county's primary care budget to Virginia Garcia Memorial Health Center.

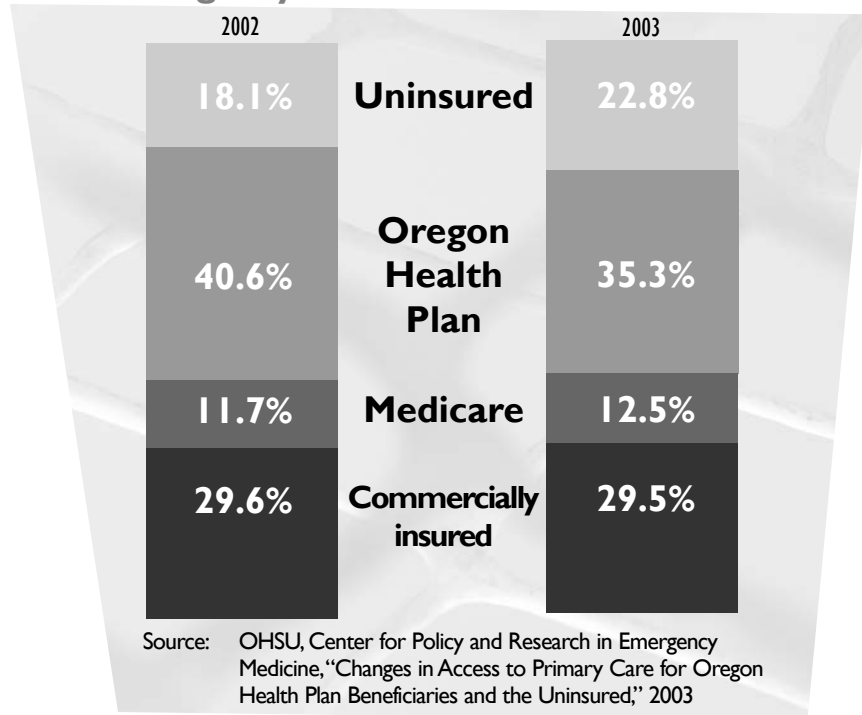
B. How Are Costs Being Shifted?

The cost of care that is not reimbursed is passed on by medical providers as a cost of doing business to insured health care consumers and employers who purchase health care plans for their employees. A typical example is a hospital emergency room visit by an uninsured person. The hospital does not recover its costs for the care provided and in turn raises its prices to paying patients (e.g., insurers and direct-pay patients). In turn, insurers raise premiums to cover their costs and employers and individuals pay the increased premiums. Employers in turn shift this cost either to the employee (in the form of higher deductibles, co-pays and premium-sharing) or to their customers. In 2003, when the Oregon Health Plan reduced the number of people it covered in the tri-county area by 11,000, the percentage of uninsured patients at a typical hospital emergency room increased from 18 to 23 percent (see Figure 14). Paying patients picked up the cost for treating these additional uninsured patients.

Providers also shift the uncompensated expense of under-insured patients to commercially insured patients. Since the reimbursement for the Oregon Health Plan and Medicare are lower than commercial rates, many providers have stopped participating in these government programs; other providers recoup their expenses by shifting costs to commercial insurance companies that pay higher rates.

Cost-shifting to taxpayers results from increased taxes required to support Medicaid, Medicare and other government healthcare programs that are not funded by the users of the services. In addition, taxpayers pay for government employee health care plans whose costs are inflated by the same forces affecting private-sector employers.

Figure 14
Distribution of Patients Seeking
Emergency Room Care



C. Financial Instability

The financing of the safety net is fragmented, tenuous and heavily intertwined with Medicaid — an unreliable source of revenue that does not keep pace with costs.³⁹ As a result, one private safety net provider, Neighborhood Health Clinics, closed in 2002 due to lack of funding; and Multnomah County closed its Southeast Health Center in July 2004 following state budget cuts. According to the Oregon Primary Care Association, Medicaid (Oregon Health Plan) does not reimburse Federally Qualified Health Centers for their full costs. The rate for 2001 was the average of costs from 1999 and 2000 adjusted by the Medicare Economic Index every year after. The increase of two to three percent annually does not keep pace with increasing health care costs.

³⁹ Oregon Health Council, *The Role of Health Care Safety Net Clinics in Oregon*, August 2002, page 8

Ideally, safety net financing would be counter-cyclical, strengthening as the economy weakens. The opposite is true. Shortfalls in state rev-

Ideally, safety net financing would be counter-cyclical, strengthening as the economy weakens. The opposite is true.

enue seriously threaten funding of the safety net. The Oregon Health Plan tries to spread available Medicaid dollars to a larger segment of safety net users; however, as health care costs increase and unemployment reduces state revenues, the Oregon Health Plan's existence is threatened. The Legislature has reduced covered benefits to members, increased qualifications for membership and reduced reimbursement rates to providers. The result is fewer providers willing to provide services and fewer citizens with access to services covered by the Oregon Health Plan. The situation is exacerbated by similar reductions in federal Medicare reimbursement. Decreases in federal and state tax resources available to the safety net in weak economic times increase the strain on safety net providers to adequately satisfy the increased demand.

V. What Forces Are Changing the Safety Net?

A. Coordinated Information and Management Tools

In 1999, a state study identified ineffective information systems as a root cause of the financial weakness of safety net clinics.⁴⁰ A group of Portland-area safety net clinics has since developed a jointly operated management services organization to provide information systems for safety net clinics. Known as the Oregon Community Health Information Network, the goal of this coordinated effort is to create better data for understanding the issues safety net users face and to promote financially sound clinics by using shared information and management tools to improve planning, coordination and financial administration.⁴¹

⁴⁰ Oregon Office for Health Plan Policy and Research, "Analysis of Oregon Health Care Safety Net Services," February 1999, page 38

⁴¹ OCHIN, A Collaborative Organization of Oregon Health Safety Net stakeholders; www.careoregon.org/pages/OCHIN/ochin.html

OCHIN completed its first installation of a safety net clinic information system in July 2002. Originally hosted by CareOregon, OCHIN spun off and became independent in October 2003.⁴² OCHIN's viability will be enhanced through a cost-sharing agreement, allowing reimbursement to OCHIN for serving Oregon Health Plan clients.

OCHIN now serves 11 safety net health centers in Oregon, Washington and California, including the major safety net provider in each of the three Portland-area counties. It processes over 50,000 medical and dental visits monthly. As of July 2004, its database included more than 400,000 unduplicated patient records.

OCHIN uses software that allows safety net clinics to bill for services, schedule appointments, report on performance, enhance their financial management and share best practices. The second phase of the project is the rollout of medical record software that will help facilitate continuity of care for uninsured Oregonians. The final stage of the OCHIN project is the activation of a data warehouse on the health demographics of the populations served by the safety net. This is a compilation of non-personal health statistics that will allow for a better understanding of the health-related issues faced by vulnerable Oregon residents.⁴³

B. Collaboration and Experience of Other Communities

Safety net leaders are attempting to improve quality and efficiency through collaborative programs and by learning from the experience of other communities. Two examples illustrate these efforts:

The Yakima Valley Farm Workers Clinic opened in Yakima, Washington in 1975 primarily to serve migrant farm workers with a Federally Qualified Health Center. It expanded to 22 clinics from Spokane to Salem, serving 44,000 members with 125 physicians. Under the leadership of Executive Director Carlos Olivares, Yakima Valley Farm Workers Clinic reduced its reliance on government funds. Olivares attributes the clinic's success to designing services that meet customer needs and to adopting a business model for billing and collection and applying good management principles. He believes low-income patients who pay what they can afford are more likely to follow caregiver instructions, come to follow-up appointments and take advantage of education. Also, patients who are paying tend to be

⁴² OCHIN Update (October, 2003), furnished by Tom Fronk, Multnomah County Health Department

⁴³ OCHIN, A Collaborative Organization of Oregon Health Safety Net stakeholders; www.careoregon.org/pages/OCHIN/ochin.html

more demanding, causing staff to respond with a higher level of service. In July 2004, Yakima Valley Farm Workers Clinic opened its first Portland-area clinic: the Rosewood Family Health Center, a 10,000-square-foot-facility.

The Virginia Garcia Clinic, a Federally Qualified Health Center headquartered in Cornelius, Oregon serves 15,000 patients a year through modern facilities. It, too, has a very active executive director, Gil Muñoz, who leverages resources creatively, as exemplified by Virginia Garcia's purchase of a mobile clinic at a bargain price. Like other Federally Qualified Health Centers, Virginia Garcia relies on federal grants but also receives 43 percent of its revenue from patient payments. Seventy percent of patients are uninsured, most of the remainder are on the Oregon Health Plan, and a few are commercially insured. Virginia Garcia provides educational courses, has bilingual staff, provides home nursing visits for post-partum care and has a parenting program. In August 2003, Virginia Garcia opened a pharmacy in Cornelius and is considering "tele-prescribing" by videoconference at other sites. Virginia Garcia added a site in Beaverton in early 2004.

C. The Safety Net Enterprise

Multnomah, Clackamas and Washington counties have a common problem: a fragmented, uncoordinated approach to the safety net, producing duplication of effort, lost opportunity and unknown results. Recognizing this, these three counties began a joint planning effort in January 2000. Under a grant from the Robert Wood Johnson Foundation known as Communities in Charge, the counties sought

Multnomah, Clackamas and Washington counties have a common problem: a fragmented, uncoordinated approach to the safety net, producing duplication of effort, lost opportunity and unknown results.

ways to improve health care access for low-income uninsured residents of the tri-county area. Its specific objectives were to: (1) improve enrollment in state-subsidized insurance programs (e.g., the Oregon Health Plan); (2) enhance systems for access to charitable care provided by hospitals; and (3) establish a joint organization to align health care safety net providers into a system of care for low-income and uninsured people.

Key leaders of the three counties joined a blue-ribbon panel directing the Communities in Charge project. Their recommendation was to "develop a regional approach, led by local government, to allow for all concerned to impact the directions, finances and activities taken to

assure access for low-income and uninsured people.”⁴⁴

In May 2004, Multnomah, Clackamas and Washington counties created the Tri-County Health Care Safety Net Enterprise. The enterprise is charged with creating a framework for a comprehensive regional approach to improving health care access. It is expected to plan for expansion, attract its own funding and work for a sustainable safety net. It has already had some success in attracting grants. Major components of its work plan include organizing the regional intergovernmental entity, developing common information systems, producing system efficiencies that will expand safety net capacity, assuring long-term financial sustainability and improving the quality of safety net services.

D. Tax Revenue and the Future of the Oregon Health Plan

Two principles of the Oregon Health Plan are the expansion of Medicaid to populations beyond the federal minimum and the use of managed care to assure access to care.

The 2003 Legislature attempted to save the Oregon Health Plan’s coverage for the expansion population by imposing additional taxes, including a provider tax, an income tax surcharge and an extension of the cigarette tax. The latter two taxes were referred to the citizens by the Legislature as Ballot Measure 30 and rejected by voters in February 2004.

The rejection of Measure 30 eliminated the funding budgeted for the expansion population of the Oregon Health Plan (Oregon Health Plan Standard, the plan meant to cover adults who don’t automatically qualify for Medicaid but whose incomes fall below the federal poverty level — \$1,571 a month for a family of four). Therefore, as of August 1, 2004, no state funds are available for the expansion program and enrollment will be decreased from the current 50,700 to fewer than 25,000 members statewide.⁴⁵ Approximately 37 percent, or 9,250 members, are in the tri-county area.

Since safety net providers depend on the Oregon Health Plan for approximately 80 percent of their patient revenues, a major cut in the Oregon Health Plan budget affects many safety net providers by significantly reducing their Oregon Health Plan revenues. Many of their patients currently covered by the Oregon Health Plan will become uninsured, thus imperiling the financial solvency of the safety net.

⁴⁴ Communities in Charge Update (October 2003), furnished by Tom Fronk, Multnomah County Health Department

⁴⁵ The Oregonian, *Access to Oregon Health Plan Shrinks*, Patrick O’Neill, June 9, 2004 www.oregonlive.com/news/oregonian/index.ssf?/base/front_page/10867822952338

VI. Summary of Findings

- Approximately 210,000 uninsured people live in the Portland tri-county area.
- The health care safety net consists of providers that deliver a significant level of health care to uninsured Oregonians, to many of those covered by the Oregon Health Plan (Medicaid) and to other vulnerable patients.
- Increasingly, even those who are employed face issues of affordable health insurance — and thus — affordable health care.
- Anyone may be one paycheck away from needing the health care safety net.
- The term “safety net” is misleading in that it suggests a seamless web that catches and saves all who fall off the tightrope of mainstream health care.
- The core safety net exists only where a local community creates it, and with no assurance that it will continue to exist.
- The current capacity of the core safety net meets the medical needs of approximately one-half of the eligible population, and the demand is growing.
- Without the safety net, and a limited supply of mainstream “charity care,” one-quarter of the tri-county population would not have access to medical care.
- Core safety net providers are funded through a variety of sources, which allow them to treat patients without regard for ability to pay.
- Among non-core safety net providers, charity care costs are largely shifted to commercially insured patients and direct payers.
- The financial solvency of the safety net is at risk. Decreases in federal and state tax resources available to the safety net during weak economic times increase the strain on safety net providers as they try to adequately satisfy an increasing demand.
- The safety net improves the health of the people who use it and the health and economy of the entire community.

- Data suggest the core safety net is better able to adapt to high-need users than the mainstream charity segment.
- Through the Oregon Community Health Information Network, the Portland area safety net is developing shared information and management tools that will help improve planning, coordination and financial administration.
- In 2004, Multnomah, Clackamas and Washington counties created the “Safety Net Enterprise,” a new tri-county structure to coordinate and improve the quality of their safety net services and work for a sustainable safety net.

Respectfully submitted,
City Club of Portland, Health Care Issue Committee

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Appendix A: Tri-County Health Care Safety Net Providers

<u>County</u>	<u>Federally Qualified Health Centers</u>	<u>School-Based Health Centers</u>	<u>Others</u>
Multnomah	<p>County Health Department providing access through the following sites:</p> <ul style="list-style-type: none"> - After Hours Access Clinic - East County Health Center - HIV Clinical Services - La Clinica de Buena Salud - Mid-County Health Center - Northeast Health Center - North Portland Health - Parkrose Neighborhood Health and Family Resource - Rockwood Neighborhood Access Clinic - Westside Health Center <p>Other Federally Qualified Health Centers:</p> <ul style="list-style-type: none"> - Central City Concern - Native American Rehabilitation Association Indian Health Clinic - Outside In 	<p>High Schools:</p> <ul style="list-style-type: none"> Cleveland Grant Jefferson Madison Marshall Parkrose Roosevelt <p>Middle Schools:</p> <ul style="list-style-type: none"> Binnesmead George Lane Portsmouth Whitaker <p>Elementary School:</p> <ul style="list-style-type: none"> Lincoln Park 	<ul style="list-style-type: none"> - Portland Adventist Community Services Family Health Center - The Wallace Medical Concern - West Burnside Chiropractic Clinic - Adventist Community Healthvan Program - National College of Naturopathic Medicine - North Portland Nurse Practitioner Community Health Center - New Avenues for Youth

<u>County</u>	<u>Federally Qualified Health Centers</u>	<u>School-Based Health Centers</u>	<u>Others</u>
Clackamas	County Public Health Division operating the Oregon City Clinic and the Sandy Clinic	Oregon City High School	
Washington	Virginia Garcia Memorial Health Center, with locations in Cornelius, Hillsboro, McMinnville (Yamhill County) and Beaverton	Merlo Station High School	Essential Health Clinic, Hillsboro

Appendix B: Glossary

Charity providers: Health care providers who provide sliding-scale or charity (uncompensated) care to uninsured or under-insured individuals.

Core health care safety net: Health care providers that organize and deliver a significant level of health care and related services to uninsured, Medicaid and other vulnerable patients.

Family Health Insurance Assistance Program: A component of the Oregon Health Plan, created to help low-income families afford private health insurance by subsidizing premiums.

Federal poverty level: Federally established income levels for measuring poverty. Figures for 2004 are shown in the table below.

2004 Federal Poverty Level (FPL)		
Family size	Annual income	Hourly rate (40-hour work week)
1	\$9,310	\$4.48
2	12,490	\$6.00
3	15,670	\$7.53
4	18,850	\$9.06

Federally Qualified Health Center: Public or nonprofit, consumer-directed health care organizations that provide primary and preventive care to medically underserved and uninsured people. This nationwide network of safety-net providers is supported by federal grants under the U.S. Public Health Service Act. Provider types include community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs and urban Indian and tribal health centers.

Health care safety net: Health care providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients.

Mainstream charity providers: Mainstream health care providers who provide charity care (see **charity providers**).

Mainstream health care providers: Health care providers that mainly serve insured or self-paying patients.

Managed care: In the Oregon Health Plan, private organizations that deliver a comprehensive package of benefits in exchange for a monthly premium for each Medicaid beneficiary.

Medicaid: Federal program created in 1965 to provide health care through state-administered programs to low-income persons defined as categorically needy.

Medicaid expansion: The expansion of Medicaid launched in 1994 by the Oregon Health Plan to cover all individuals up to a designated income level, not just the categorically needy covered by traditional Medicaid.

Medicare: Federal program that pays for medical care for U.S. citizens who are 65 or older. Costs are paid by a national payroll tax on current wage earners and employers. Other groups have been added (e.g., end-stage renal disease sufferers and disabled persons qualifying for Social Security).

Non-core safety net providers: Safety net providers that mostly provide mainstream care.

Open card: Oregon Health Plan members who are not assigned to a medical provider in a managed care plan. Open card members can go to any provider who accepts the Oregon Health Plan rate for services.

Oregon Health Plan: Oregon's plan for achieving universal health insurance, now primarily covering the population eligible for Medicaid.

Oregon Health Plan Plus: The Oregon Health Plan benefit package and cost sharing structure that serves individuals falling within the traditional Medicaid categories.

Oregon Health Plan Standard: The Oregon Health Plan benefit package that covers people whose income is low but exceeds the Medicaid maximums. Oregon Health Plan Standard beneficiaries pay a monthly premium based on income and have lower benefits than under Oregon Health Plan Plus.

Primary care: Medical care that

is oriented toward the daily, routine needs of patients, such as initial diagnosis and continuing treatment of common illness.

School-based health centers: Clinics in high, middle and elementary schools that provide access to primary care and health education.

Secondary care: Routine hospitalization and specialized outpatient care generally provided by subspecialists and more highly trained support personnel. These services are more complex than those of primary care and include many diagnostic procedures as well as complex therapies.

Tertiary care: Includes the most complex services, such as open heart surgery, burn treatment and organ transplants, and is provided in inpatient hospital facilities.

Tri-country area: Includes Multnomah, Clackamas and Washington counties in Oregon.

Under-insured: Persons who have health insurance that is insufficient to assure access to health care.

Uninsured: People who have no health insurance or prepaid health benefits. This group does not include people who have Oregon Health Plan or Medicare benefits.

Vulnerable populations: Populations that have diminished access to health care services and poorer health outcomes because they face economic, social and cultural barriers to care.

Appendix C: Witnesses Consulted and Bibliography

Your committee expresses tremendous gratitude to the witnesses who, by sharing their time and expertise, made this report possible.

Witnesses

Kent Ballantyne, Senior Vice President, Oregon Association of Hospitals and Health Systems

Ralph Crawshaw, M.D., psychiatrist, Oregon Health Assessment Project

Peter Davidson, M.D., Director, Multnomah County Division of Mental Health and Addictions Services

Robert Drake, Vice President, Administration and Network Development, Interhospital Physicians Association

John Duke, Chair, Coalition of Community Health Clinics

Tom Fronk, Senior Health Services Manager, Multnomah County Health Department

Bruce Goldberg, M.D., Administrator, Office of Oregon Health Plan Policy and Research

Mitch Greenlick, Ph.D., Dean Emeritus, OHSU School of Public Health

Tracy Grotto, Tri-County Communities in Charge

Ruby Haughton, Communications Director, CareOregon

Mary Lou Hennrich, CEO, CareOregon

Craig Hostetler, Executive Director, Oregon Primary Care Association (as of April 1, 2003)

Susan Irwin, Director, Washington County Department of Health and Human Services

Maryclair Jorgensen, Consultant, PACE Clinic

Michael Leahy, Executive Director, Oregon Community Health Information Network

Priscilla Lewis, Director of Physician Services, Providence Health System

Kathy Loretz, Assistant Manager, Program and Policy, Oregon Office of Medical Assistance Programs

Alan Melnick, M.D., M.P.H., Health Officer, Clackamas County

Gil Muñoz, Executive Director, Virginia Garcia Clinic
Robert Nystrom, Manager, Adolescent Health Section, Oregon
Department of Human Services
Carlos Oliveras, Executive Director, Yakima Valley Farm Workers
Clinic
Chris Palmedo, Oregon Health Assessment Project
Peter F. Rapp, M.H.A., Executive Director, OHSU Hospitals and Clinics
Neal Rendelman, M.D., Former Medical Director, Old Town Clinic
Carole Romm, Director, Health Partnerships, CareOregon
John Santa, M.D., Administrator, Office of Oregon Health Plan Policy and
Research
Lillian Shirley, Director, Multnomah County Health Department
Michael Sorensen, Project Director, Tri-County Communities in Charge
Mary Stoneman, Senior Planning Assistant, Providence Health System
Kim Tierney, Clinic Manager, Multnomah County Health Department, Westside
Health Clinic
Ian Timm, Executive Director, Oregon Primary Care Association

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2002	BM	<i>Oregon State Ballot Measure 23: Oregon Comprehensive Health Care Finance Plan, www.pdxcityclub.org/m23.pdf</i>
1988	INFO	<i>Medical Indigency in Oregon</i>
1972	BM	<i>Five Year Serial Ad Valorem Tax Levy (County Hospital)(County Measure No. 7)</i>
1970	LT	<i>Emergency Care Facilities</i>
1966	LT	<i>Emergency Care to the Injured and Stricken in the Portland Area</i>
1960	LT	<i>Voluntary Health Agencies</i>
1922	LT	<i>Public Health Methods and Their Application in Portland</i>



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