

Issue Brief

Findings from HSC



FEDERAL AID STRENGTHENS HEALTH CARE SAFETY NET: THE STRONG GET STRONGER

by John F. Hoadley, Laurie E. Felland and Andrea B. Staiti

Two new federal initiatives—community health center expansion and Community Access Program grants—have improved access to care for low-income people and strengthened linkages among safety net providers, according to findings from the Center for Studying Health System Change’s (HSC) 2002–03 site visits to 12 nationally representative communities. Grant recipients have added services to fill safety net gaps or to improve collaboration among safety net providers. However, communities with weaker safety nets were less likely to receive federal aid, and funding for both programs is limited, hampering the potential impact on the nation’s system of care for low-income and uninsured people.

Grants Expand Safety Net Access and Increase Care Coordination

An infusion of federal funding has helped many communities expand preventive and primary care services and increase coordination among community health centers (CHCs) and other safety net providers, especially hospitals, according to findings from HSC’s 2002–03 site visits to 12 nationally representative communities (see Data Source).

Ten of the 12 HSC communities have received federal funding through CHC expansion or Community Access Program (CAP) grants (see Table 1). While the grants have financed significant safety net gains in many communities, there has been variation in grant allocation and use. Generally, communities

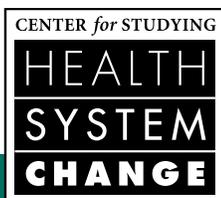
with stronger existing safety nets tended to be more successful in obtaining grants, while some communities with less well-established safety nets have not reaped as much benefit from the additional federal aid.

CHC Expansion Grants

CHC expansion grants, launched by the Bush administration in 2002, focus on adding preventive and primary care services at new or existing health centers. The administration’s goal is to increase the number of patients treated at CHCs annually from about 10 million in 2001 to more than 16 million in 2006.

Nationally, about 460 grants were awarded in 2002 reflecting \$175 million in new spending and expanding CHCs’ reach to about 1.6 million new patients. Nearly half of eligible CHCs in the 12 HSC communities received grants in 2002, ranging from \$100,000 to \$787,500.

There are several types of expansion grants that fund new centers or sites, expand medical capacity at existing centers or add new dental, mental health, substance abuse or pharmacy services. Successful applicants currently must receive federal support and meet certain other requirements that vary based on the specific type of grant. Applicants for expanded medical capacity grants, for example, must show how they will





Data Source

Every two years, HSC researchers visit 12 nationally representative metropolitan communities to track changes in local health care markets. The 12 communities are Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. HSC researchers interviewed individuals in each community who are involved directly or indirectly in providing safety net services to low-income people, including representatives of safety net hospitals, community health centers, local health departments and government officials, academics and advocates. This Issue Brief is based on an analysis of these individuals' assessments of the impact of new federal aid on local safety nets.

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treat a minimum number of new patients, increase the number of primary care providers and improve access for vulnerable populations. Applicants that are financially unstable or solely dependent on federal support are generally not considered qualified for funding.

CAP Grants

CAP was established in 2000 by the Clinton administration to enhance collaboration among safety net providers and improve coordination of existing inpatient and outpatient health care services. The idea was to create a more integrated safety net that would do a better job of providing a full array of services to a community's uninsured and underinsured residents. Congress provided \$25 million for CAP in 2000, increasing appropriations to more than \$100 million in each of the next three years. Seven of the 12 HSC communities received multi-year CAP grants in 2001, ranging from approximately \$640,000 in Lansing to \$1.3 million in Miami. Grant recipients included community health centers or an association of health centers, safety net hospital systems, local health departments or other local agencies.

CAP requires funds to be used to promote collaboration among local partners, usually a consortium that typically includes at least one CHC, safety net hospital and public health agency. Recommended strategies to increase coordination among participants include development of management information systems, referral networks, care coordination and improved outreach and enrollment processes. Grantees also must demonstrate their ability to improve the efficiency and quality of care while controlling the cost of care.

Grants Make a Difference

Expansion grants have played a significant role in strengthening the reach of community health centers in the eight HSC communities that received at least one grant. Some centers opened new facilities. For example, CHCs in Phoenix opened two new centers and expanded hours to include evenings and Saturdays. One northern New Jersey CHC was able to

open a new site to replace a center that had closed. In other communities, the grants have allowed health centers to add services. For example, one Miami CHC used grant money to hire a dentist, dental hygienists and a clinical social worker.

Seven HSC communities received CAP grants, and the program has helped fund various efforts that go beyond any one hospital or CHC. For instance, the CAP grant in Indianapolis was awarded to the organization that runs Wishard Advantage, a community program that coordinates health care services for low-income, uninsured people. Wishard used the grant to expand participation to all CHCs in Marion County by paying a small monthly administrative fee for each enrollee to all clinics in the county willing to accept Wishard Advantage patients, thus increasing care options for program members.

A second key CAP activity has been to foster connections and communication among safety net providers. Greenville, for example, developed central scheduling among the health department, CHCs, free clinic and hospital emergency departments to direct people to the most appropriate care site. In Boston, where safety net hospitals and CHCs are partners in programs serving the uninsured, CAP funds were used to integrate information about patients across primary care and hospital settings.

Third, communities have used CAP funds for outreach activities and information technology to help connect uninsured people to the health care system. In Miami, CAP funding was used to support "system navigators" who help low-income people find a medical home—a primary source of care—and then coordinate services across sites, including a disease management component. The Ingham Health Plan in Lansing, a managed care program for the uninsured, used grant funds to institute online enrollment and increase outreach activities, reportedly contributing to a tripling of monthly new member enrollment.

Grants' Reach Limited

The amount of funding for both expansion and CAP grants is limited. Indeed, the largest CHC in one community reported that it was not awarded an expansion grant because of

Table 1
CHC Expansion and CAP Grants in the 12 HSC Communities, 2001-2002

	NO GRANTS	UP TO \$1.5 MILLION	OVER \$1.5 MILLION
SMALL MARKETS	<i>Little Rock</i> <i>Syracuse</i>	<i>Greenville</i> <i>Lansing</i>	
MEDIUM MARKETS		<i>Northern New Jersey</i> <i>Cleveland</i>	<i>Indianapolis</i> <i>Miami</i> <i>Seattle</i>
LARGE MARKETS		<i>Orange County</i>	<i>Boston</i> <i>Phoenix</i>

Note: Small markets have a population of less than 1 million; medium markets have populations between 1 million and 2.5 million; and large markets have populations of more than 2.5 million.

Source: HSC 2002-03 Site Visits

competition from a large applicant pool, not because it fell short on the requirements.

Moreover, several communities raised concerns about the sustainability of activities initiated through the federal grants. Already there were concerns in Boston, for example, where many CHCs used federal money to expand dental coverage with a commitment from the state to support dental services through Medicaid. Centers had spent about \$7 million to build dental capacity and received what one respondent called a “shock to the system” when the state eliminated coverage of adult dental services in early 2002. Even though the new federal funds likely will continue, they alone may be inadequate to maintain the program.

Strong Get Stronger

Despite the accomplishments achieved with the grant funds, these programs appear to have had less impact in communities lacking a strong network of safety net institutions. In several of the 12 communities, the safety net has faced serious challenges in meeting the needs of uninsured and underinsured people. Yet, there were no clear examples of a fragile CHC becoming significantly stronger as a result of the new federal grants.

Across the 12 HSC sites, communities such as Boston with relatively large safety net capacity appeared more likely to receive expansion and CAP grants than communities with smaller, struggling safety nets such as

Little Rock. Financially viable safety net organizations were more likely to receive grants than those experiencing financial problems or other weaknesses. A number of factors contributed to this overall pattern, including strong infrastructure, leadership, financial viability and the ability to demonstrate ongoing needs in the community.

First, safety net organizations with a stronger infrastructure often have the staffing and expertise needed to prepare grant applications and evaluate their success in serving more people or achieving efficiencies. As a result, they are likely more able to develop a compelling grant proposal to start a new site, expand services or develop new approaches for outreach or collaboration with other providers. In contrast, a community such as Little Rock—which only has one CHC, struggling safety net hospitals and few community organizations focused on the uninsured—may not be a good match for CAP or have the resources or expertise to obtain an expansion grant.

Second, safety net organizations led by particularly talented directors who take an active approach to seeking new funding are likely more skilled at gaining support and grants.¹ For example, several CHCs in Boston—a community with an extensive network of centers and relatively low uninsurance rates—benefit from experienced directors who have been able to respond adeptly to changing economic circumstances.

Third, because long-term sustainability of a project is a critical factor considered in grant awards, a financially stable CHC with



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600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258
www.hschange.org

President: Paul B. Ginsburg
Vice President: Len M. Nichols
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multiple revenue sources and less reliance on direct federal funds likely has a better chance of receiving a grant. Indeed, a northern New Jersey respondent reported that this requirement deterred a local health center from applying for an expansion grant because the center lacked a paying patient base and, thus, the revenues to maintain a new facility. By contrast, Phoenix-area CHCs have benefited from several sources of safety net support, such as increased Medicaid revenues from eligibility expansions, tobacco tax monies, local foundations and private donations, making them better candidates to receive grants.

Fourth, safety net organizations have to show there is community need. For instance, CAP guidelines require applicants to demonstrate how they will improve efficiency and control costs, and the expansion grants require health centers to show how they will serve additional people. Given the inherent frailty of the safety net and reports of growing demand for services amid state and local budget cuts, even relatively strong safety net organizations can demonstrate the need for additional safety net services in their communities. As a result, many have applied successfully for grants.

Another factor limiting some health centers' ability to win grants is that CHC expansion grants are only available to federally qualified health centers or other organizations already receiving federal support under the Consolidated Health Center Program.² Respondents in Orange County—a community with higher than average uninsurance—reported increasing demand for charity care yet noted that it is difficult to win grants because only one of the county's 19 health centers is federally qualified.

Policy Implications

The CHC expansion and CAP grants have had significant benefits for the safety net in the communities where they were awarded. New funding has enabled safety net providers to add services, increase outreach to vulnerable populations and build better connections among providers.

Nevertheless, the reach of these programs has been limited. Safety net organizations need to have a number of characteristics and strengths—that many do not have—to apply for and obtain federal grants. In sum, these grant programs have been a success for many communities, but they are not a panacea for bridging significant gaps in safety net infrastructure or filling some of the largest holes in services for low-income people.

These findings suggest a number of lessons for policy makers. If policy makers want to bolster safety nets in some of the nation's neediest communities, changes will be needed.

For example, safety net organizations with less-established infrastructure and fewer resources could benefit from technical assistance to apply for, obtain and use grants. This is a riskier strategy for those who administer the grant programs, since higher rates of failed grants are likely, but it may be necessary to take these risks to address communities with the greatest needs.

In addition, while both grant programs received new appropriations in 2004, their future remains uncertain in a time of budget deficits. While some organizations may be able to integrate improvements spurred by the grants into their ongoing budgets, policy makers should consider the potentially negative ramifications of ending or scaling back expansion and CAP grant funding, especially as community safety nets face growing demand for services. ●

Notes

1. Felland, Laurie E., J. Kyle Kinner and John F. Hoadley, *The Health Care Safety Net: Money Matters But Savvy Leadership Counts*, Issue Brief No. 66, Center for Studying Health System Change, Washington, D.C. (August 2003).
2. To be designated as a federally qualified health center, a health center must serve a federally designated health professional shortage area, medically underserved area or medically underserved population; provide services to patients regardless of insurance status; use a sliding fee scale for uninsured patients based on income; and operate as a nonprofit corporation governed by a board of directors of which a majority are health center users.