

spotlight

Health Care Safety-Net Providers: A Look at the State of Michigan

What is the Health Care Safety Net?

The health care safety net is defined as those organizations and programs, in both the public and private sectors, which have a legal obligation or a commitment to provide direct health care services to the uninsured, underinsured, and other underserved groups.¹ This policy brief focuses on the following safety net providers: public and private hospitals that provide a disproportionate share of services to underserved groups; community and migrant health centers, and; federally qualified health centers (FQHCs).

The Demand for Safety Net Provider Services is Outpacing Their Capacity to Provide Care

Despite the rising number of people who lack health insurance, the safety net organizations that provide care for the underserved and uninsured are challenged by limited resources to meet the demands they face. Reductions in public funding have threatened key programs that provide primary care for the uninsured. Those without health insurance and a regular source of medical care are using emergency department services for non-emergency health care), thus driving up health care costs for the whole system. The revenue losses from uncompensated health care are exacerbating the health care crisis for everyone. The uninsured lack continuity of care and financial access to care while the privately insured face increasing insurance premiums and taxes to cover the costs of uncompensated care for uninsured individuals.



Buffy P., 28 years old, has four children, aged 8, 6, 4 and 2 years. Because of physical violence, Buffy recently left her partner who had fathered her two younger children. She had to find a means of providing health insurance for her four children.

The domestic violence shelter in which Buffy and her children are temporarily housed offers medical services. While Buffy applied for Medicaid and sought to obtain coverage for herself and her children, she also availed herself of the clinical services at the domestic violence shelter.

During routine health maintenance examination of her 4-year-old child, Buffy told the pediatrician that Kayla has had symptoms of joint pain in her knees and ankles for over a year. Kayla often wakes up at night crying from pain, and is limited in her daily play activities by her discomfort.

The pediatrician believed Kayla should be seen by a pediatric rheumatologist for evaluation of juvenile rheumatoid arthritis. Getting access to a pediatric specialist would not be easy for a child with no health insurance. Chronic joint pain did not seem like an appropriate reason for Kayla to go to an emergency department to access medical services in that manner.

The pediatrician coordinated phone calls to the pediatric rheumatologists at a local hospital who agreed to see Kayla if a referral is provided by a designated provider. Kayla needed to see her designated Medicaid provider in order to receive a referral to see the pediatric rheumatologist. Even with a referral, the appointment would not be for several months. In the interim, Kayla is receiving treatment for suspected juvenile rheumatoid arthritis with a medication prescribed by the pediatrician in the domestic violence shelter.

Innovative community-based programs have sought to provide primary care for the state's uninsured individuals. But providing primary care is not enough: Individuals with more complex medical needs are often unable to make connections with specialists who can provide them with timely and appropriate care.

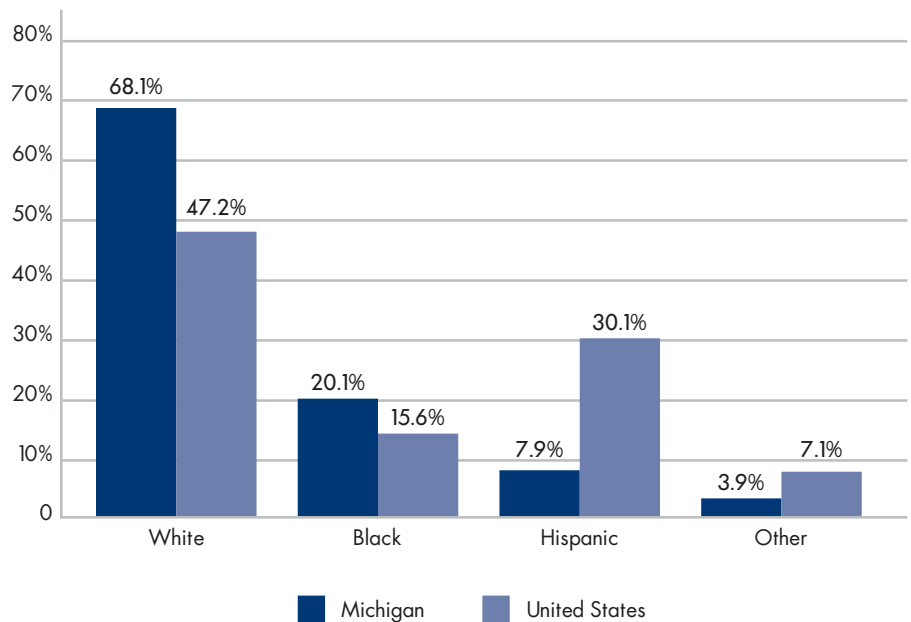
Who Relies on the Health Care Safety Net?

Safety net providers serve several populations. Different subgroups may rely on safety net providers for different reasons. For example, a few of the many who depend on the safety net for health care include Medicaid beneficiaries who are unable to locate a provider who accepts Medicaid, the working poor, individuals who live in geographically or economically disadvantaged communities, and the uninsured. This brief will focus on the uninsured in Michigan as a group that faces significant barriers to adequate health care.

Who Are The Uninsured in Michigan?

The uninsured include individuals of all ages, races/ethnicities, and educational levels.

Percentage of Uninsured by Race in Michigan and U.S., 2001



Source: Urban Institute and Kaiser Family Foundation. March 20001 and 2002 Current Population Surveys.

Populations Served by the Safety Net in Michigan

- Uninsured
- Working poor whose employers do not offer insurance
- Adults who cannot afford employer-sponsored coverage
- Medicaid beneficiaries
- Chronically ill individuals
- People with disabilities
- Minorities
- Legal and undocumented immigrants
- Homeless people
- Veterans
- People with communicable diseases (e.g. HIV infections/AIDS or tuberculosis)
- Non-Medicaid-covered unemployed poor

Source: Adapted from *The Future of the U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* By S. Altman, U. Reinhardt, and A. Shields. (Chicago; Health Administration Press, 1998).

Age

Individuals 65 and older are least likely to be uninsured due to Medicare coverage. Young adults 18 to 34 years old are the most likely to be uninsured. In 1999, 45.7% of the uninsured in Michigan were in this age group. Young adults are more likely to be uninsured because public and employment-based coverage for children usually ends at age 19.⁵ Compared with older workers, teenagers and recent college graduates are less likely to have a job with health benefits.

Employment

Typically, full-time employment provides the best opportunity for families to obtain health insurance. Both private insurance and eligibility for public programs are closely tied to employment and income criteria.² However, employment does not guarantee health insurance. In 2000, only 54.2% of Michigan firms with fewer than 50 employees offered health insurance.³ In the same year, 8% of Michigan families with at least one full-time worker were uninsured; the number increases to 25% of uninsured families with part-time workers.

Race

While minorities are at greater risk of being uninsured due to employment status and income, non-Hispanic Whites make up more than half of the uninsured population (47.2% nationally and 68.1% in Michigan in 2000-2001).⁴

Safety Net Hospitals

Hospitals nationwide face increasing financial pressures which threaten their ability to provide timely and appropriate health care in their communities.⁶ These pressures are especially acute for safety net hospitals. The growing number of uninsured Americans and the rising demand for emergency services strain hospitals' resources.⁷ At the same time, rising costs, decreased access to capital and continued reduction of Medicaid and Medicare payments further threaten the financial stability of safety net providers.⁸

A Nationwide Forecast?

In the past, hospitals have used patient care surpluses derived from Medicare and private insurer payments to subsidize uncompensated care and other "unprofitable but beneficial services" for their communities.⁹ Because the number of uninsured in the United States remains high—and continues to grow—safety net hospitals devote an ever larger share of their resources to uncompensated care. At the same time, pressures to contain costs from private payers and Medicare mean that the surplus to cover unprofitable services is shrinking.¹⁰ In addition, trends toward Medicaid managed care reveal increasing Medicaid reimbursement shortfalls.¹¹

In an April 2001 report, the Kaiser Commission on Medicaid and the Uninsured provided a forecast for our safety net hospitals. Unfortunately, that forecast bears out in today's uncertain economy: "...if...pressure from private payers continues to increase, Medicaid payments decline, the number of uninsured continues to rise, or the stock market falls, hospitals could be facing more difficult times."¹²

The Financial Health of Michigan Hospitals

By and large, the health of Michigan hospitals appears to be failing. For safety net hospitals—which provide uncompensated care without the financial resources to cross-subsidize these losses—the situation is especially critical. Between 1996 and 2002, 20 Michigan hospitals closed their doors.¹³ In 2001, the average patient margin was -3.27% while the average operating margin was only 1.34%.¹⁴ As the Michigan Health & Hospital Association (MHA) points out, positive financial margins are necessary to fund care for the uninsured, to maintain and purchase new technologies, to meet increasing labor costs and to demonstrate to lenders the ability to repay debt.¹⁵

A series of reports by the Citizens Research Council of Michigan provides a closer look at the financing of Michigan's hospitals. Specifically, reimbursement for inpatient and outpatient care does not cover hospitals' costs for providing that care.¹⁶ Thus, hospitals must rely on income from other sources, including contributions and investments, to cover their operating expenses. In 1998, 65 of 150 surveyed hospitals demonstrated a surplus in net income from patient care, while only 45 of 150 showed a surplus in 2000.¹⁷

Michigan's Safety Net Hospitals

The majority of Michigan hospitals incur costs for uninsured and uncompensated care, and nearly all provide services for Medicaid beneficiaries.¹⁸

Uninsured and Uncompensated Care

According to the Citizens Research Council, Michigan hospitals provided over 450 million dollars in uninsured and uncompensated care in 2000: "Total hospital charges for uninsured and uncompensated care in 2000 were some \$1.1 billion. The costs associated with these charges were \$620.0 million and hospitals received \$163.8 million in funds against these charges. The resulting net cost was \$456.2 million."¹⁹

Of the 150 hospitals surveyed, 129 showed losses in 2000 from uninsured and uncompensated care, while 10 hospitals reported no losses and only 12 hospitals showed positive income as receipts exceeded costs.²⁰

Medicaid and Michigan Hospitals

The Medicaid program provides health care coverage for its beneficiaries and reimburses Michigan hospitals for costs incurred while providing care to these beneficiaries. However, Medicaid reimbursement shortfalls and a trend toward managed care plans threaten the financial viability of hospitals that provide care for a disproportionate share of low-income, underserved individuals. According to the MHA, the Medicaid program reimburses Michigan hospitals only 73 cents for every dollar spent on patient care for Medicaid beneficiaries.²¹ During fiscal year 2000, hospital days of care provided to Medicaid beneficiaries represented 13.5% of total hospital days statewide.²² In addition, state payments to hospitals for Medicaid, Maternal and Child Health and MICHild programs were 9.0% of total hospital payments from all sources.

Lisa C. is a 34-year-old single working mother with two school-age children, 8-year-old Jacob and 6-year-old Caleb. She recently took a job showing model houses, which has given her enough income to move out of her parents' two-bedroom apartment and to afford a small apartment on her own. Her new job, however, does not provide health insurance either for herself or for her two children, and her income is too high to qualify for the MI-Child program. Consequently, she has told her children that they are not allowed to play outside because she wouldn't be able to afford the cost of emergency healthcare in case of accident. In addition, Lisa has not seen a physician or a dentist in over three years.

Juan R. is a Mexican-born migrant worker who has recently taken a job in a local produce store during the off-season months when work on farms is not available. He is a tax-paying, legal resident of Michigan, but his income is a little too high to qualify for Medicaid. Neither he nor anyone in his immediate family of six has health insurance. When they are sick, they go to the local community health center for medical care.

Disproportionate Share Hospitals

One way to identify safety net hospitals is through the annual allocation of Medicaid Disproportionate Share Hospital (DSH) payments. The DSH payment program allocates funding to hospitals with a disproportionately large share of low-income patients.²³ Because Medicaid beneficiaries and low-income individuals are not distributed equally throughout the state, the Michigan Department of Community Health (MDCH) applies a formula to establish an institution's volume of indigent care, with 20% serving as a threshold for DSH funding. This formula is used as a factor in determining the annual allocation of DSH payments.²⁴

In addition to establishing the volume of care provided to indigent patients, Michigan hospitals must meet additional federal and state criteria for DSH funding. For example, each hospital must have a minimum Medicaid inpatient utilization rate and must also meet state criteria regarding the volume of indigent care. In 2001, the "indigent volume factor" for Michigan hospitals was based on Medicaid charges (fee for service and managed care), other state medical plan charges (including Children's Special Health Care Services) and total uncompensated charges, less any recoveries or offset charges.²⁵

In 2000, \$45 million in DSH funds were allocated to over 40 Michigan hospitals, with the majority of funding distributed to providers in the Southeast Region.²⁶ Within this region, the bulk of DSH funding went to hospitals in the Detroit Medical Center (DMC) system.²⁷

Community Health Centers

"Community Health Centers (CHCs) deliver health services to poor and medically underserved patients through a network that includes migrant health centers, homeless health centers, and other community-based centers...CHCs serve as the entry point to the healthcare system for millions of Medicaid beneficiaries, the uninsured, and people residing in medically underserved areas."²⁸

Detroit's Safety Net Strained Under Increased Financial Stress

There are roughly 180,000 uninsured Detroit residents. They receive their care either through the city's network of free clinics or Medicaid. However, the city's network of free clinics is equipped to treat between 47,000 to 48,000 people, and many primary care physicians do not take Medicaid recipients because the payment is too low. As a result, many uninsured individuals rely on emergency rooms to receive their care. This in turn puts undue financial strain on the city's hospitals. This financial strain can ultimately lead to the closing of community hospitals, shifting the burden of care onto the few remaining hospitals.

Detroit hospitals are in crisis. As Eliot Joseph, CEO of St. John's Health stated, "The health care model in Detroit is unsustainable." Brooks Bock, Chief of Emergency Services at DMC echoes this statement: "We not only will fall behind, we won't even be able to operate if we don't solve this problem."

As a result, the three remaining, competing systems are working together to figure out how they can cooperatively provide service to uninsured or low-income residents. They are seeking additional funding from local, state and federal governments. While they have not received any funding yet, they will continue to submit funding applications at both the state and federal level.

Source: Kaiser Network Org. Daily Policy Reports.
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=17058

The Role of CHCs in the Health Care Safety Net

According to a number of studies, CHCs can improve access to care and decrease use of the emergency department without increasing costs. Community Health Centers are particularly successful in providing clinical preventive services and primary care. For example, some studies have shown that female CHC patients are as likely to receive cancer screening such as mammograms and Pap tests, and that diabetic CHC patients are as likely to regularly test their blood sugar levels, as those in the general population. In addition, CHC patients report high levels of satisfaction with the primary preventive care that they receive.²⁹

While CHCs do a great job in providing primary care, they cannot guarantee a continuum of care for their patients. In a study of approximately 20 CHCs, many had difficulty providing necessary diagnostic care, and in many cases, patients required specialty care that was not provided on site. For uninsured patients, the cost associated with an outside specialist referral may be a barrier to following through with their treatment. CHC Physicians and Executive Directors do what they can to bridge this gap by negotiating lower fees, enrolling their patients in Medicaid, and relying on their professional network to arrange specialty care.³⁰

The Financial Health of Community Health Centers

CHCs are specifically designed to serve underserved populations that typically would have difficulty accessing health care. CHC patients include those who do not have health insurance, those who have health insurance and those who are Medicaid beneficiaries. A very small percentage of people who have private insurance visit CHCs. Of those who do not have health insurance, some pay out-of-pocket based on a sliding fee scale. Since many people cannot afford care, CHCs subsidize their care through Medicaid reimbursement, but this source of funding is threatened by Michigan's Medicaid Managed Care program.

When eligible individuals are enrolled in Medicaid, they are assigned a primary care physician in a pre-established network. This network typically does not include physicians in CHCs, as they often are not part of the managed care plans in the network. Therefore, these patients and the reimbursement they typically bring are diverted to other health centers. As a result, many CHCs are facing fiscal instability.

Federally Qualified Health Centers

Federally qualified health centers, or FQHCs, are private, non-profit, or public institutions whose mission is to provide quality health care to underserved populations. These organizations are funded by federal grants through the Health Resources and Services Administration (HRSA – Section 330 of the Public Health Service Act), Medicare/Medicaid, state and local grants, contracts, private funds, insurance, and patient fees. The four types of FQHCs include community health centers, migrant health centers, health care for the homeless, and health care for residents of public housing. The type of center determines the level of funding from HRSA. According to the Kaiser Family Foundation, there were 2,054 FQHCs in the U.S. in 2000 and 59 of those were located in Michigan.

FQHCs must adhere to very specific regulations and requirements. For example, centers must serve all clients, regardless of their ability to pay, and offer services on a sliding fee scale. They also must be located in an area deemed medically underserved. Furthermore, the board of directors must reflect the demographic make-up of the area, and should be clients of the center, as well.

The Fragile Nature of Michigan’s Health Care Safety Net: Five Reasons To Be Concerned

- Uninsured individuals make up just one subgroup of those who are medically underserved.
- Employment does not guarantee health insurance. In Michigan, 8% of families with at least one full time worker were uninsured.
- The revenue losses from uncompensated health care are exacerbating the health care crisis for everyone. Privately insured individuals face increasing insurance premiums to cover the costs of uncompensated care for those who are uninsured.
- Safety net hospitals have to devote an even larger share of their resources to cover the costs of uncompensated care. As a result, hospitals are forced to stop providing beneficial services for their communities, like free screening clinics, counseling services and health education.
- Community health centers do a great job providing primary care, but lack the resources to provide diagnostic and specialty care for serious health problems.

FQHCs focus on prevention, and are required to provide primary health services, either directly or through referrals. Some of these services include physician care, diagnostic laboratory and radiology, perinatal services, pediatric eye and dental screening, immunizations, family planning, and pharmacy. Although not required, centers have excelled at improving utilization of preventive screening procedures, such as pap smears, mammograms, and glaucoma screening. Furthermore, FQHCs have been credited with lowering infant mortality and low birth rates in served areas.

These health centers are further required to enhance access and utilization of services. Such efforts include case management, referrals for substance abuse/mental health, transportation, translation, and health education. FQHCs can be cost effective: They improve access to care, reducing the number of emergency room visits, hospital admissions, and length of hospital stays. However, like other safety net providers, FQHCs face significant challenges. Managed care growth, federal, state and private payers’ strategies to reduce cost have important consequences for the uninsured. Since these funds act as a cross-subsidy for the uninsured, a decline in funds would mean a reduction in comprehensive services.³¹ This problem would be exacerbated by the expected growth in the uninsured population.

Nicholas S. is a 5-year-old boy who came to the FQHC for a regular check up. On physical exam, the pediatrician noted that Nicholas had a hernia. The hernia was not life threatening, because at the present time, it was not strangled. He needed to have the hernia fixed, but as it was not an “emergency,” the pediatrician did not want to send him to the emergency department. Nicholas was put on a list of children who would be evaluated by a general surgeon on a voluntary basis. After a six week delay, he saw the general surgeon who admitted him through the emergency department so Nicholas would be covered by emergency Medicaid and his parents would not owe the full hospital bill for surgeon’s fees, anesthesia, and inpatient hospitalization.

Current Safety-Net Initiatives in Michigan

Several local initiatives focused on the uninsured are currently in place in Michigan.

In Detroit, the **Voices of Detroit Initiative (VODI)** constitutes a collaborative partnership between the City of Detroit Health Department, Henry Ford Health System, Mercy Hospital-Detroit, St. John Health System, and the Detroit Medical Center. This partnership is funded by a grant from the W.K. Kellogg Foundation. The purpose of VODI is to improve access to the underserved in Detroit, establishing a medical home for the 14% of Detroit residents who are uninsured. The services offered include primary care, prevention, case management and health education. Eligible individuals must not qualify for Medicaid or employer-based commercial insurance, and must have incomes under 250% of federal poverty limit. In 2003, VODI has enrolled approximately 27,000 uninsured residents of Detroit.

A Muskegon County program called the **“3-Share” Program** uses employers, employees and the community to help finance health care for the working uninsured. Participants are served through a network of health providers in Muskegon County, focusing on primary care, referral services and limited co-pays for pharmaceuticals. The program is geared to employees and employers in smaller businesses that cannot afford to purchase commercial insurance packages. The 3-Share Program community match is financed through Disproportionate Share Hospital (DSH) payments, a W.K. Kellogg Foundation grant and local funds.

Two **comprehensive health plans** were created in Ingham County and Hillsborough County. The plans provide managed care-type health benefits to low-income, uninsured residents through established provider networks of non-profit hospitals, area FQHCs and community physicians. These programs—serving 14,000 and 36,000 uninsured individuals in each county respectively—cover a full spectrum of services including specialty care and prescription drug services. Both county-level programs are supported through federal funds (mainly DSH payments), state and county financing, and grants from the Robert Wood Johnson and W.K. Kellogg Foundations.

Nationally, states have developed several initiatives to expand access for the uninsured. These initiatives include:

- Creating state funded insurance programs
- Expanding and restructuring Medicaid
- Experimenting with individual and small business subsidies
- Reforming the individual and small group insurance markets
- Creating medical savings accounts (MSA)
- Establishing purchasing alliances, high-risk pools and indigent care programs
- Crafting the best approach to children's health coverage³²

Six states have engaged in comprehensive reforms, implementing either combined or expansive versions of the above initiatives. The majority of states have developed more incremental policies building on established Medicaid programs. The differences in state reforms are reflective of limitations on states' budgets and administrative capacity. Overall, the keys to a successful state initiative have been to offer affordable, carefully marketed, simplified and accessible health options to members of the uninsured population.

In Michigan, community-based programs tap into local resources—physicians, hospitals, and clinics—to combat the problem of the uninsured. Tailored to the needs of a particular county, these programs have successfully created networks between health care financing and delivery. Potential statewide solutions may need to mirror key aspects of these initiatives on a larger scale and for a more diverse uninsured population.

Prepared for:

Michigan Public Policy Initiative (MPPI) is a program of the Michigan Nonprofit Association and is affiliated with the Council of Michigan Foundations.

Started in 1998, the goals of the Initiative are to:

1. Educate policymakers and the media on issues impacting Michigan nonprofits;
2. Act as an advocate for the nonprofit community;
3. Engage nonprofits in advocacy; and
4. Promote research on the sector.

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