

**An Assessment of Hospital-Sponsored
Health Care for the Uninsured in
Polk County/Des Moines, Iowa**

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INTRODUCTION

Health care providers in Polk County are faced with increasing numbers of low-income, uninsured patients who do not have the resources to pay for their health care out-of-pocket. At the same time, state and local funding sources are limited, and are insufficient to ensure that these individuals have access to the health services that they require. Community leaders are extremely interested in developing information to understand the magnitude of the uninsured problem in Polk County and to identify health care delivery strategies to better serve this population.

A Blue Ribbon Steering Committee was convened in October 2004 to examine how hospital-sponsored health care is currently delivered to the uninsured in Polk County. The Committee's goal was to create a participatory process to plan an effective and sustaining model to deliver core safety net services to the County's uninsured. To assist them with these tasks, researchers from The George Washington University's School of Public Health and Health Services, Department of Health Policy, were retained to conduct an assessment of hospital-sponsored health care services delivered to Polk County's uninsured. This assessment is designed to highlight key issues affecting access to care for uninsured and underinsured residents, and to present potential policy options for restructuring hospital-based services in the county. Specifically, the assessment:

- Identifies the amount of hospital-sponsored health care that is delivered to the uninsured in Polk County;
- Provides information on the relative contribution of each hospital organization in the overall delivery of health care services to the uninsured in Polk County;
- Compiles existing data on costs associated with delivering these services;
- Describes gaps in service delivery for uninsured residents of Polk County; and
- Examines the import of having a major safety net hospital in the community, and the potential impact of the absence of such a hospital.

This assessment was conducted between October 2004 and January 2005. It draws upon information from multiple sources. The research team visited Des Moines from October 18-20, 2004, touring hospital facilities and speaking with numerous key stakeholders in the community. During the site visit, the Blue Ribbon Steering Committee convened and was briefed on this assessment and the key issues under review. This meeting was held on October 20, 2004, at Broadlawn Medical Center (BMC). Through the site visit and a series of telephone conferences held prior to and following the visit to Des Moines, the assessment team interviewed more than 30 informants. These key stakeholders included senior leaders at hospitals and health systems, primary care providers serving the uninsured, public health and other service agencies and mental health agencies. Individual providers or provider groups, advocates, and current and former policymakers were interviewed as well. Our conversations were guided by the following five major research questions:

- What hospital-based health care services are currently available to the uninsured in Polk County?
- What does it cost to deliver health care services to the uninsured in Polk County?
- What, if any, health care service gaps exist for the uninsured in Polk County?
- How do uninsured patients perceive their access to hospital-based health care services in Polk County?
- What impact would the closure of Broadlawns Medical Center have on the uninsured patients who currently seek their care there, and other hospital-based care in Polk County?

While in Des Moines, we conducted focus groups with residents who use safety net services. We held three groups with a total of 20 participants; two focus groups were conducted in English and one was in Spanish. We also conducted a focus group with 11 physicians from several hospital systems to discuss their experiences delivering care to the uninsured. The team also drew upon secondary data sources to provide demographic information on the population in Polk County as well as data on health service utilization and coverage.

This report is organized in six sections. Section one of this assessment provides a context for the report, presenting background information, demographics and health status data on Polk County residents. Section two describes the structure of the safety net, identifying the providers and facilities that play key roles in delivering hospital-sponsored health care to the underserved. Section two also outlines the financial mechanisms that support safety net services.

Section three of the report presents financial hospital data from three of Polk County's hospital systems. These data describe the hospitals' utilization rates by payer source and provide information on the value of these services to the community. Section four discusses the status of Polk County's safety net based on our site visit, telephone conferences and in-person interviews. This section presents the major themes that evolved from our interviews. It examines the provision of hospital-sponsored safety net services, the importance of BMC and the impact its absence would have on the community, the challenges undocumented immigrants face in obtaining services, the structure of the State Papers program, and the nature of the Polk County health care market place.

Section five presents findings from the focus groups and provides insights into the challenges that uninsured and underserved residents face when trying to access services from the local health system. Finally, Section six presents key findings and public policy options that safety net providers and others in Polk County may want to consider as they work together to improve care for uninsured and underserved residents in their community.

SECTION ONE: POLK COUNTY DEMOGRAPHICS AND HEALTH STATUS

Polk County is home to Des Moines, the capital of Iowa. More than 13 percent of Iowa’s residents live in the County. Almost 90 percent of Polk County’s population is White (see Table 1). Black and African-American, Asian, and Native American residents together represent about 9 percent of the population and approximately 1 percent are categorized as belonging to other racial groups.¹ Five percent of Polk County residents categorize themselves as Latino.² When comparing against statewide totals, Polk County has a slightly higher percentage of Latinos and African-Americans.³ Polk County also has proportionally more foreign-born residents than does the state and more of Polk County’s residents speak a language other than English at home.

Table 1. A Snapshot of Polk County

	Polk County	Iowa
Population		
Size	379,657	2,839,868
Race		
White	89.2%	95.0%
Black	4.6%	2.6%
Asian	3.3%	1.8%
American Indian/Alaska Native	1.2%	0.6%
Other	1.2%	1.3%
Hispanic or Latino (of any race)	5.0%	3.1%
Language		
Foreign Born	6.8%	3.3%
Language other than English spoken at home (Population 5 years and over)	10.5%	5.6%
Age		
18 years and over	74.4%	75.8%
65 years and over	10.5%	14%
Median Age (in years)	35.7	37.8

Source: U.S. Census, 2003 American Community Survey Data

The County’s population is also slightly younger compared to population estimates statewide, with fewer elderly residents. Iowa has a fast growing population of older residents. In fact, Iowa ranks fifth highest in the nation in the percentage of residents in the 65+ age group and is exceeded in the nation only by Florida, Pennsylvania, North Dakota, and West Virginia. In 2002, Iowa had 14.7 percent of its population over age 65, compared to 12.3 percent nationally. Iowa led the nation in the percentage of individuals aged 85 and older, with 2.3 percent of its population in this age group in 2002, compared to 1.6 percent nationally.⁴ Polk County’s older population is also growing faster than is its younger population. Reasons for this statewide decline in younger age groups include the aging of the baby boomers and fewer births.

¹ These include individuals who report more than one race.

² This figure is likely an underestimate since there is reportedly a large population of undocumented immigrants in Polk County.

³ U.S. Census Bureau, 2003 American Community Survey.

⁴ Iowa Hospital Association. Profiles: Documenting the Social and Economic Importance of Iowa Hospitals and Health Systems. 20th edition. September 2004.

Table 2. Iowa Population 1990-2000

Age Group	1990 [†]		2000 [*]		Percent Change	
	Polk County	Iowa	Polk County	Iowa	Polk County	Iowa
< 15	70,062	606,758	80,024	598,497	14.2%	-1.3%
15-44	160,154	1,219,775	165,229	1,179,176	3.1%	-3.3%
45-64	59,241	524,116	81,732	644,201	38%	22.9%
65-74	21,162	226,961	21,416	210,789	1.2%	-7.1%
75-84	12,157	143,890	13,931	144,557	14.6%	.5%
85+	4,364	55,255	3,339	45,935	-23.4%	-16.8%
TOTAL	327,140	2,721,500	365,671	2,823,155	11.7%	3.7%

Source: [†]U.S. Census Bureau, American Fact Finder, 1990 Data for Iowa and Polk County

^{*}Census 2000 Supplementary Survey Profile, Iowa and Polk County.

Although the median household income is lower in Polk County than in Iowa as a whole, the county has fewer residents living in households with incomes below the federal poverty level (FPL).⁵ The percentage of non-elderly residents who were uninsured in both Iowa (11 percent) and Polk County (8 percent) in 2003 is below the national percentage of 16 percent.⁶ However, this smaller percentage still puts a considerable strain on hospitals and other providers who treat uninsured patients in the County and across the state. Furthermore, the percentage of uninsured Iowa residents is steadily increasing, having risen from 8 percent in 2000 to 11 percent in 2003 (Table 3).

Table 3. Income and Poverty Levels, and Insurance Coverage in Polk County and Iowa

	Polk County	Iowa
Income and Poverty*		
Living below poverty [^]	7.2%	9.5%
Median household income	\$48,917	\$51,336
Private Insurance #		
Private Insurance	72%	68%
Medicare	12%	16%
Medicaid/Other Public	8%	8%
Uninsured/Self Pay	8%	8%

*Source: U.S. Census, 2003 American Community Survey Data

[^] 18 years and older, percent living below poverty in past 12 months.

[#] Source: REACH Dataset National Association of Community Health Centers 2000.

Reasons for being uninsured are complex and varied. A 2001 study found that the most common reasons Iowans were uninsured were employment-related.⁷ A survey of the uninsured showed that about 74 percent of those working for someone else did not have access to employer-based coverage either because the coverage was not offered or they were ineligible for the coverage that was offered. Some participants in the study reported that they had declined coverage that was available to them through their employer. Reasons for doing so included monthly

⁵ In 2004, the FPL was \$9,310 for an individual and \$18,850 for a family of four. (US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2004).

⁶ 2004 Access to Community Health Databook: Iowa, National Association of Community Health Centers, Inc. 2005.

⁷ Iowa Department of Public Health. Iowa State Planning Grant. Final Report to the Secretary U.S. Department of Health and Human Services. October 29, 2001. pp 18, 23-24.

premiums, deductibles and co-payments that they could not afford; additionally, some respondents had the perception that the policies offered were of insufficient quality to merit participation. Some of the uninsured believed they only needed care sporadically and felt the out-of-pocket cost for services would be less than their insurance premiums.⁸

Among the uninsured, a significant percentage are eligible for Medicaid but are not enrolled, and thus are uninsured. For example, nearly a fifth of Polk County’s children were eligible for Medicaid in Polk County, but had not enrolled in the program in 2001. Medicaid enrollment of minority children is of particular concern. In 2001, only 13 percent of eligible African-American children and 39 percent of Hispanic children in Polk County were enrolled in the State Children’s Health Insurance Program, HAWK-I⁹.

The steady rise in unemployment in both the Des Moines metropolitan area and in the state has also added to the numbers of uninsured in the area. The unemployment rate in Des Moines and across the state has climbed steadily over the past five years. Slow job growth since the 2001 recession has impeded improvement in job figures. As of September 2004, the statewide unemployment rate was 4.2 percent, up from 2.3 percent just four years before. During the same period, Des Moines experienced a similar rise in unemployment, from 1.8 percent to 3.6 percent.¹⁰ Recent data available only on statewide unemployment figures indicate that Iowa’s jobless rate is now 5.1 percent, the highest it has been since 1988.¹¹

Table 4. Unemployment Statistics Des Moines Metropolitan Area and Iowa, Sept. 2000 – Sept. 2004

Year	Unemployment Rate	
	Des Moines Metropolitan Area	Iowa
2000	1.8	2.3
2001	2.4	3.1
2002	3.3	3.7
2003	3.7	4.1
2004	3.6	4.2

Source: U.S. Department of Labor, Bureau of Labor Statistics. www.bls.gov. September 2004 is the last month for which data are available for both the state of Iowa and the metropolitan area of Des Moines. Data points are for September of each year. Rates are not seasonally adjusted.

Health Status of Polk County and Iowa Residents

Polk County has the highest rate of live births in the state of Iowa. Table 5 illustrates that the county’s rate of infants born at low birth weight (under 2,500 grams), at 65.7 per 10,000

⁸ Ibid.

⁹ According to July 1, 2001 monthly enrollment reports filed with MAXIMUS, the state’s third party processor for HAWK-I, cited in Healthier Together: Announcing Healthy Polk 2010, Celebrating the Accomplishments of Healthy Polk 2000. www.healthypolk.org

¹⁰ U.S. Department of Labor, Bureau of Labor Statistics. www.bls.gov. September 2004 is the last month for which data are available for both the state of Iowa and the Des Moines Metropolitan Statistical Area. Rates are not seasonally adjusted.

¹¹ The Iowa Policy Project. Slow job growth holds Iowa jobless rate at 5.1 percent: State 14,500 behind pre-recession job level. News Release. March 31, 2005. www.iowapolicyproject.org.

residents, is higher than the state’s overall rate of 62.9. Polk County also has a higher rate of fetal, neonatal, and perinatal death when compared to rates for the state as a whole. The high rate of infant mortality among African-Americans in Polk County is especially troubling (27.8 per 1,000 live births).¹²

Polk County has more favorable statistics on several key health indicators. When compared to statewide data, Polk County has fewer mothers who give birth under age 20 (97.9 vs. 102 per 10,000), fewer mothers who smoked during pregnancy (166.3 vs. 177.2 per 10,000), and more mothers who begin prenatal care in the first trimester (876.9 versus 869.8).

Table 5. Prenatal and Infant Health, Polk County and Iowa, 1998-2001

Indicators	Polk County		Iowa	
	Number	Crude Rate (Rank)	Number	Crude Rate
Live Births	24,178	16.2 (01)	150,671	12.9
Out-of-Wedlock Births	6,847	283.2 (30)	425,005	278.8
Mothers Under Age 20	2,368	97.9 (49)	15,370	102.0
Low Birth Weight (<2500 grams)	1,589	65.7 (31)	9,472	62.9
Mothers Beginning Prenatal Care in First Trimester	21,202	876.9 (45)	131,060	869.8
Mothers Who Smoked during Pregnancy	4,021	166.3 (62)	26,699	177.2
Mothers Who Drank during Pregnancy	389	16.1	1,963	13.0
Fetal Deaths	123	5.1	868	5.8
Neonatal Deaths	120	5.0	582	3.9
Perinatal Deaths (includes neonatal and fetal deaths)	243	10.1	1,450	9.6
Infant Deaths	173	7.2	908	6.0

Crude Rates per 10,000 population; Rank among 99 Iowa Counties

Source: The University of Iowa and the Iowa Department of Public Health. 2003 Iowa Health Fact Book. Iowa City, IA: The University of Iowa College of Public Health. August 2003. www.public-health.uiowa.edu/FACTBOOK

According to the adjusted rates included in Table 6, Polk County has a higher incidence of mortality for all sites of cancer, for prostate cancer, and for breast cancer in women than Iowa as a whole. The adjusted incidence rates for colorectal and cervical cancer are slightly lower in Polk County than they are across the state.

An examination of some common diseases that are disproportionately present among low-income and minority populations reveals that Polk County has higher adjusted rates of heart disease, chronic obstructive pulmonary disease (COPD), and chronic liver disease and cirrhosis. Statewide adjusted rates for stroke, diabetes mellitus and atherosclerosis are higher than those for Polk County.

Adjusted incidence rates for suicide and firearms-related injury mortality are similar in Polk County and Iowa as a whole. The adjusted homicide rate in Polk County is more than twice the statewide rate.

Table 6. Cancer, Disease-Specific, and Injury Mortality, Polk County and Iowa, 1990-2000

¹² Healthier Together: Announcing Healthy Polk 2010, Celebrating the Accomplishments of Healthy Polk 2000. www.healthypolk.org.

Indicators	Polk County			Iowa		
	Number	Crude Rate (Rank)	Adjusted Rate (Rank)	Number	Crude Rate	Adjusted Rate
Cancer Mortality						
All Sites Cancer	7,269	187.4 (95)	208.4 (12)	70,234	223.2	195.1
Prostate Cancer	444	23.8 (91)	38.7 (24)	4,816	31.4	34.9
Female Breast Cancer	601	29.9 (85)	29.4 (38)	5,697	35.3	28.8
Colorectal Cancer	740	19.1 (97)	21.3 (97)	8,695	27.6	23.6
Cervical Cancer	45	2.2	2.3	461	2.9	2.6
Disease Specific Mortality						
Heart Disease	9,645	248.6 (94)	277.2 (31)	101,564	322.7	265.2
Stroke	1,717	44.3 (97)	49.4 (81)	23,709	75.3	60.2
COPD	1,444	37.2 (87)	41.7 (22)	14,795	47	39.3
Diabetes Mellitus	581	15.0 (92)	16.5 (58)	6,735	21.4	18.2
Atherosclerosis	524	13.5 (94)	15.1 (75)	8,004	25.4	20.3
Chronic Liver Disease and Cirrhosis	310	8.0	8.8	1,965	6.2	5.9
Injury Mortality						
Suicide	451	11.6	11.7	3,515	11.2	11.0
Firearms	333	8.6	8.6	2,380	7.6	7.4
Homicide	195	5.0	4.9	688	2.2	2.2

Crude Rates per 10,000 population; Rank among 99 Iowa Counties.

Adjusted Rates per 10,000 population adjusted to Year 2000 population, Rank among 99 Iowa Counties.

Source: The University of Iowa and the Iowa Department of Public Health. 2003 Iowa Health Fact Book. Iowa City, IA: The University of Iowa College of Public Health. August 2003. www.public-health.uiowa.edu/FACTBOOK

SECTION TWO: DES MOINES' HEALTH CARE SAFETY NET AND PUBLIC FINANCING SOURCES

The safety net in Des Moines is comprised of hospitals, primary care providers, and individual practitioners who provide services to uninsured and underserved patients. We define the safety net as health care providers who, through either mission or mandate, deliver a significant amount of health care to people who are uninsured, underinsured, low-income and covered by public programs such as Medicaid or HAWK-I, or otherwise largely dependent on public support for their care. This study focuses on hospital-sponsored health care services for the uninsured and does not address in detail other important sources of care provided outside of hospital sponsorship. While we do not focus on these other providers in the Des Moines safety net, we refer to and acknowledge some of the essential organizations that provide primary care services to the uninsured.

Physician Supply

The supply of primary care and specialty physicians is proportionately higher in Polk County than in Iowa as a whole (see Table 7). The County has approximately 70 primary care physicians per 100,000 adults, which is slightly higher than the rate of statewide rate of 67.2. Polk County has nearly double the amount of pediatricians per 100,000 children than does the state (nearly 62 vs. 33/100,000). The County also has a higher rate of obstetricians/gynecologists and other surgical specialists than does the state overall.

Table 7. Physician Supply in Polk County and Iowa

Physician Supply (per 100,000 population)	Polk County	Iowa
Adult Primary care providers	69.8	67.2
Pediatricians	61.7	32.9
OB/GYN	23.9	15.3
Medical Specialist	30.3	17.1
Surgical Specialist	42.0	30.8

Source: Billings, J and Weinick, R. Monitoring the Health Care Safety Net: Book II: A Data Book for States and Counties, August 2003.

Des Moines' Hospital Capacity

There are four hospital systems in Des Moines, represented by six individual hospitals. Table 8 presents a summary of their size, admissions and inpatient days, births, surgical operations and outpatient visits.

Table 8: Des Moines Hospitals: Bed Size and Utilization, 2003

Hospital System Name	Acute Beds	Total Facility		Births	Total Surgical Operations	Outpatient Visits
		Admissions	Inpatient Days			
Broadlawns Medical Center	89	4,702	17,856	381	1,845	162,262
Iowa Lutheran	201	10,601	54,183	1,314	5,741	365,957
Iowa Methodist Medical Center	461	21,763	117,788	3,625	18,035	203,528
Mercy Capitol	48	1,187	6,419	0	830	10,587
Mercy Medical Center – Des Moines	526	30,916	140,100	3,416	22,443	891,577
VA Central Iowa Health Care System	327	3662	n/a	n/a	n/a	217,980

Source: Iowa Hospital Association. Profiles: Documenting the Social and Economic Importance of Iowa Hospitals and Health Systems. 20th edition. September 2004.¹³

Mercy Medical Center – Des Moines. One of the two largest hospital systems is Mercy Medical Center – Des Moines (MMC-DM), a member of the statewide Mercy Health Network. MMC-Des Moines is a not-for-profit organization originally founded in 1893 by the Sisters of Mercy. In 2003 MMC-DM reported nearly 31,000 inpatient admissions, more than 3,400 births, over 22,000 surgical operations, and more than 890,000 total outpatient visits.¹⁴ More than 55,000 people pass through MMC-DM’s emergency department, making it the busiest in the state.¹⁵ In February 2002, MMC-DM purchased Metropolitan Medical Center, a hospital on the east side of Des Moines, and renamed it Mercy Capitol. In 2003, Mercy Capitol had nearly 1,200 inpatient admissions, conducted over 800 surgical procedures and provided more than 10,500 outpatient visits. In 2004 Mercy Clinics, Inc., MMC-DM’s ambulatory primary and specialty care component, provided more than 668,000 primary care visits, almost 249,000 hospital-based outpatient visits, over 30,000 total acute admissions, and nearly 22,500 surgical procedures.¹⁶

MMC-DM has many programs designed specifically to serve the needs of the poor and uninsured.¹⁷ One such program is the House of Mercy, which was created in 1988 to confront the high rate of infant mortality in Des Moines and Polk County. The House of Mercy serves single, pregnant, and parenting adolescent or adult women and helps them develop personal responsibility and independence through counseling, education, and primary medical care. One component of the program is the House of Mercy Medical Clinic which provides primary care services to uninsured and underinsured individuals. The clinic is open Monday through Friday and accepts appointments from 9:00 am to 2:20 p.m. each day. All clinic services are free of charge. Family practice physicians, pediatricians, and other specialty health care professionals regularly volunteer their time at the clinic. Several specialty medical services are offered on-site

¹³ Iowa Hospital Association. Profiles: Documenting the Social and Economic Importance of Iowa Hospitals and Health Systems. 20th edition. September 2004.

¹⁴ Ibid.

¹⁵ Mercy Medical Center/Des Moines, Iowa. Company Profile. Mercy Medical Center/Des Moines, Des Moines, Iowa, Information about Mercy. www.nationjob.com/company/meho

¹⁶ Mercy Medical Center. Welcome to Mercy Medical Center and Network, Des Moines, Iowa. October 2004.

¹⁷ In addition to the specific programs listed here, all the Des Moines hospitals also provide charity care services to low-income uninsured patients. This will be discussed in more detail below.

including gynecological, pediatric, diabetic, and ophthalmological care. Their services are complemented by access to specialty and sub-specialty care made possible through MMC-DM.¹⁸ Free health care services are also provided to uninsured patients through the 26 primary care clinics within Mercy Clinics, Inc. There is also a free Spanish-speaking clinic on the Mercy Capitol Campus.

Iowa Health Des Moines. Another major hospital system is Iowa Health Des Moines (IHDM), established in 1993 with the merger of Lutheran Hospital, Blank Children's Hospital and Iowa Methodist Medical Center. IHDM is a member of Iowa Health System (IHS), which was created in 1993 and is the state's largest integrated healthcare system. In 2003, Iowa Lutheran and Iowa Methodist Medical Center reported a combined total of more than 32,000 inpatient admissions, nearly 5,000 births, almost 24,000 surgical operations, and just under 570,000 outpatient visits.¹⁹ In 2004, IHDM hospitals provided more than 69,000 emergency visits combined.²⁰

IHDM operates La Clinica de la Esperanza in collaboration with Des Moines University. The clinic has been operational since 1993 and was expanded in 2001 to be a primary care clinic.²¹ The clinic is in its fourth and final year of grant funds from The Robert Wood Johnson Foundation. The clinic treats approximately 4,000 patients through approximately 10,000 visits annually. Approximately 275 of the clinic's obstetrics patients deliver each year. The clinic is at capacity and about 35-75 patients are turned away each week.²² The clinic provides bilingual services and accepts undocumented immigrants. In addition to providing medical services, staff also developed and implemented a grassroots outreach program to increase access to health care for the Asian, African-American, Hispanic, and other vulnerable populations in the inner city of Des Moines. The clinic's staff includes nurse practitioners, bilingual medical assistants, a case manager, a Medicaid Specialist, and a receptionist.

Broadlawns Medical Center (BMC) is the county's public hospital. Opened 81 years ago, BMC is a primary care hospital, where basic primary care, hospital and emergency care services are provided. The medical center also has several primary care clinic programs: the Walk-In Clinic; the Doctor's Clinic, which serves as a medical home and provides continuity of care; and the Family Practice Residency Clinic, which enrolls families. BMC is also an important source of behavioral health care for Polk County residents. BMC houses the Sands wing which provides both inpatient and outpatient psychiatric services (e.g., targeted case management for adults with chronic mental illness, group therapy, and two group homes for adults with chronic mental illness). Since the hospital provides only small specialty clinics run on designated days each month, most patients with specialty care needs are referred to the University of Iowa Hospital and Clinics (UIHC) in Iowa City. Compared to other hospitals in Des Moines, BMC

¹⁸ Mercy Medical Center-Des Moines. Services: House of Mercy. www.mercydesmoines.org/services/houseOfMercy.asp

¹⁹ Iowa Hospital Association. Profiles: Documenting the Social and Economic Importance of Iowa Hospitals and Health Systems. 20th edition. September 2004.

²⁰ Iowa Health Des Moines. 2004 Profile Information for Iowa Methodist, Iowa Lutheran and Blank Children's. www.ihsdesmoines.org/body.cfm?id=349

²¹ Iowa/Nebraska Primary Health Care Association.

<http://www.ianepca.com/home/LaClinicadelaEsperanza.php?PHPSESSID=4de16073424a39e3efb71794ef3913f3>

²² Personal communication with interviewees. Interviews held in Fall 2004.

has a small daily inpatient census. On any given day, the hospital has about 40 medical/surgical inpatients and between 19 and 21 psychiatric patients. In 2003, BMC reported just over 4,700 inpatient admissions, 381 births, more than 1,800 surgical operations, and over 162,000 outpatient visits.

BMC is widely regarded as the safety net hospital in Polk County. The overwhelming majority of BMC's patients are uninsured. In 2003, 62 percent of BMC's inpatients and 64 percent of its outpatients were uninsured.²³ An examination of 2002 data²⁴ from BMC compared to other public hospitals that are members of the National Association of Public Hospitals and Health Systems (NAPH) indicates that BMC has a payer mix that includes greater proportions of uninsured patients and lower proportions of patients covered by either commercial insurance or Medicaid. BMC's proportion of patients on Medicare is comparable to national figures.

Table 9: BMC's Payer Mix Versus Other US Public Hospitals, 2002.

Payer Source	Broadlawns	Average NAPH Member
<i>Inpatient Discharges by Payer</i>		
Commercial	7%	19%
Medicare	21%	21%
Medicaid	14%	37%
Self Pay	58%	23%
<i>Outpatient Visits by Payer</i>		
Commercial	8%	20%
Medicare	13%	15%
Medicaid	17%	27%
Self Pay/Other	62%	38%

Source: National Association of Public Hospitals and Health Systems. America's Safety Net Hospitals and Health Systems, 2002.

Nearly all (97 percent) of the total prescriptions filled at Broadlawns are provided at no charge to patients; 75 percent of BMC's patients ride public transportation; and BMC staff can speak and/or translate/interpret in 19 different languages.

VA Central Iowa Health Care System. Des Moines is home to a hospital that is part of the nation's Veteran's Administration; the hospital provides acute and specialized medical and surgical services as well as intensive outpatient treatment programs and post traumatic stress care. The VA Central Iowa Health Care System is the result of a merger between two VA Medical Centers, one located in Des Moines and another located 40 miles away in Knoxville. The Knoxville division offers a full range of mental health, rehabilitation, and long-term care to veterans from a large area of the Midwest.²⁵ In 2003, the system reported a total of 3,662 inpatient admissions and nearly 218,000 outpatient visits.²⁶ The VA Central Iowa Health Care System provides free care to veterans who qualify based on income and/or service-related injury.

²³ Broadlawns Medical Center. 2003 Annual Report.

²⁴ This is the most recent data from which comparisons can be made.

²⁵ About VA. Health Care Facilities. VA Central Iowa Health Care System Description. www.vacareers.com/FacilitiesInfo.cfm?FacID=555

²⁶ Iowa Hospital Association. Profiles: Documenting the Social and Economic Importance of Iowa Hospitals and Health Systems. 20th edition. September 2004

The hospital system likely serves a disproportionate share of Polk County's homeless, many of whom are veterans and qualify for services.

Other Safety Net Providers of Note

There are several important safety net providers in Des Moines/Polk County. Although the focus of this study is on hospital-sponsored health care services for the uninsured, we also acknowledge the contribution of these providers to uninsured patients in Polk County.

Primary Health Care, Inc. (PHC) is a federally qualified health center (FQHC) that has been operational since 1981.²⁷ Until October of 2002, PHC was a part of BMC and had more than 22,400 patients (for both medical and dental care).²⁸ PHC became independent from BMC in 2002 and since that time, its patient population has decreased, as have its visit volumes. In 2003, PHC had just over 13,200 patients, a 40 percent drop.²⁹ Total patient visits fell from 63,000 to 45,000. PHC is reportedly growing its patient base as it expands into new sites and word-of-mouth spreads about its new locations.³⁰ Nearly half (48 percent) of PHC's patients are uninsured/self pay, 28 percent are enrolled in either Medicaid or SCHIP, 14 percent have private insurance and 10 percent have Medicare.³¹ As an FQHC, PHC is not precluded from serving undocumented immigrants; therefore PHC is an important source of health care for this population in Polk County.

PHC is the only FQHC in Polk County; statewide there are eight FQHCs. Recently there have been efforts to increase the number of FQHCs across the state of Iowa and specifically in Polk County. Given the federal government's commitment to double the number of FQHCs across the country, there have been local efforts focused on an FQHC expansion in Iowa. A bill was proposed in the state senate to provide appropriations for five years to support the incubation of new community health centers, as well as provide direct services funding for existing FQHCs across the state.³²

Free Clinics. There are a variety of free clinics available to serve uninsured patients in Polk County/Des Moines. In addition to those mentioned earlier (i.e., the clinics at Broadlawns, La Clinica de la Esperanza and House of Mercy Medical Clinics), some others include the Corinthian Baptist Church, Margaret Cramer Free Medical Clinic, Jim Ellefson Free Clinic and

²⁷ FQHCs are health centers which receive PHS Act Section 330 funds and serve medically underserved areas (MUAs), or serve a medically underserved population (MUP), or meet the statutory requirements for receiving federal community health program funds. FQHC's can receive cost-based reimbursement for Medicaid and Medicare patients.

²⁸ 2002 Uniform Data System, U.S. Bureau of Primary Health Care.

²⁹ Ibid.

³⁰ Personal communication with interviewees. Interviews held in Fall 2004.

³¹ 2003 Uniform Data System, U.S. Bureau of Primary Health Care.

³² Senate File 156. The bill did not make it out of the Appropriations Committee. There may be renewed interest within the Iowa legislature to appropriate funds to develop an Iowa collaborative safety net network to encourage expansion of community health centers, rural health clinics, free clinics and other safety net providers.

Mae E. Davis Free Medical Care.³³ Many of the free clinics provide episodic care since they are open only on discrete days and periods of time during the week; a few have evening or weekend hours. Most rely heavily on volunteer physicians to treat patients.

A 2004 study of the 25 Free Clinics of Iowa uncovered information on six clinics located in Des Moines. The six Des Moines Free Clinics saw more than 21,000 patients in the previous full year; 60 percent of these patients were Hispanic, 32 percent were White and 5 percent were African-American. Of those Free Clinics that described the level of care delivered to patients, 46 percent was for basic services, 38 percent was for chronic conditions, and 14 percent was for urgent needs. Clinics estimated that 77 percent of their patients were uninsured, 19 percent were underinsured, 2 percent were covered by private insurance, and 2 percent were covered by some form of government insurance.³⁴

The Health Access Partnership (HAP). Although the HAP is not a direct service provider, it plays an important role in the Polk County safety net. The HAP is a partnership of over 30 representatives from medical, human service, corporate, academic, philanthropic, public, faith-based and neighborhood organizations. HAP is an initiative of the Healthy Polk 2010 program that seeks to improve the health care system for uninsured families in Polk County. Since it was organized in spring 2000, HAP has raised or leveraged over \$5 million to support activities including the Neighborhood Health Initiative for expansion and relocation of La Clinica de la Esperanza and placement of community health advisors in the Des Moines Enterprise Community to better connect residents to health services and providers. HAP also received over \$950,000 dollars in 2002 from the federal Health Resources and Services Administration through the Community Access Program. Funds were to: 1) develop a management information system (MIS) for collaborating providers for eligibility, case management, and referrals; 2) establish a comprehensive, centralized community pharmacy; 3) create a centralized and coordinated referral system for voluntary specialty medical care; and 4) improve the cultural competence of service providers (e.g., interpreting, translation, and cultural understanding).³⁵ At the time of our interviews and data gathering, HAP was still working on these efforts.

³³ Many other churches and community based organizations also provide medical clinics that provide screenings, basic health care for all ages, dental, and behavioral health services for free, with a donation, or on a sliding scale. See a list of Free and Subsidized Clinics available on the Healthy Polk 2010 website.

<http://www.healthypolk.org:8080/downloads/freeclinic.pdf>

³⁴ Spielbauer Christa. Iowa Free Clinic Profile Review, 2004. A Joint Publication of Department of Health Management and Public Health, College of Health Sciences, Des Moines University and The Iowa Primary Care Office, Bureau of Health Care Access, Iowa Department of Public Health. Original report available at <http://www.dmu.edu/cohs/Iowa%20Free%20Clinics%20Review%20feb%2007.pdf> Calculations presented here prepared by GWU Research Team on raw data from six Des Moines Free Clinics responding to survey conducted from May – September 2004. Raw data obtained from authors/project supervisor of report.

³⁵ Health Access Partnership: Building and Maintaining Effective Coalitions.

http://www.infoweb.state.ia.us/idph/powerpoint/day_two/256,1, See also Healthy Polk 2010 website for more information about HAP. www.healthypolk.org

Public Financing Sources for Safety Net Services

Until recently there were two major sources of public funding that provided revenue to cover the uninsured in Polk County. In this section we discuss the Polk County tax levy and the Indigent Patient Care Program, also known as the State Papers program. The Medicaid Reform legislation³⁶ signed by Governor Vilsack on May 12, 2005, eliminated the State Papers Program, and changed the way the Polk County tax levy is used. Even with this change, it is still relevant to discuss these two programs since they will continue to have a major impact on the way that indigent patients across Iowa access care. We also discuss some other aspects of the state's Medicaid program and the reform changes that will expand eligibility for the program, and institute policy changes to the state's Disproportionate Share Program (DSH).

Broadlawns Medical Center Tax Levy

BMC is a county-owned hospital that is required to provide free care to county residents who are sick and indigent.³⁷ Although BMC is a county hospital, it is a legally separate entity that is independent from state or local government.³⁸ It has an autonomous governing board of seven elected Trustees who serve six-year terms.³⁹

Currently BMC is funded primarily through a tax levy⁴⁰ that helps to offset a major portion of the costs associated with caring for the uninsured. The tax levy does not, however, provide enough funding to keep up with the rising number of uninsured patients seen by BMC. For example, in 2003, BMC received \$33 million in tax levy funding; even with this funding, the hospital was left with a \$5 million shortfall for the year.⁴¹

BMC is located in an aging set of buildings and its infrastructure is crumbling in places. Despite being only 23 years old, one section of the facility, the Sands building, has dangerous flaws that needed "immediate" repair in 2003. A consultant hired in 2001 informed the hospital's administration that BMC needed \$85 million in renovations.⁴² In addition, much of the medical center's equipment is outdated and needs to be updated. However, due to the constant pressure to provide services to an ever increasing number of uninsured patients, BMC has little or no revenue to repair and renovate its facilities or to invest in new equipment. In 2001, BMC

³⁶ Iowa House File 841 Iowacare Medicaid Reform Act.

³⁷ Iowa Code Ann. § 347.16

³⁸ National Association of Public Hospitals and Health Systems. *America's Safety Net Hospitals and Health Systems*, 2002.

³⁹ Iowa Code Ann. § 347.9.

⁴⁰ Iowa Code Ann. § 347.7 Counties can levy a tax of no more than 54 cents per thousand dollars of assessed value in any one year to erect and equip a new hospital, and also a tax of no more than 27 cents per thousand dollars of value for the improvement, maintenance, and replacements of the hospital. Counties with populations of more than 250,000 people can levy a tax of \$2.05 per thousand dollars of assessed value for improvements and maintenance of assessed value in any year.

⁴¹ Dominick, Andie. Broadlawns provides health care; It could teach other hospitals about stretching dollars. *The Des Moines Register*. December 14, 2003.

⁴² Leys, Tony. Broadlawns wing crumbles as search for funds fall short; The hospital needs more than \$1 million to repair flaws in the building. *The Des Moines Register*. June 2, 2003.

requested permission from the state legislature to levy an additional tax to renovate and repair several buildings. The legislature agreed and BMC levied a \$3 million annual property-tax increase to renovate buildings. Faced with operating shortfalls, however, BMC's administration has used the funds to cover direct service delivery and other operating costs every year since the funds were levied.⁴³

BMC's administration has put several measures in place to reduce the medical center's expenses and reduce or eliminate shortfalls. For example, a program that sold low-cost pharmaceuticals to Medicaid recipients was eliminated in February 2002 because the program cost BMC \$1.3 million dollars.⁴⁴ In January 2003, BMC laid off 16 employees, including two vice presidents, and eliminated six open positions.⁴⁵

As a result of the recent Medicaid Reform legislation, Broadlawns will be required to transfer \$34 million annually in property tax collections to the Iowacare Account⁴⁶. This \$34 million will provide the state match for approximately \$53.2 million in Federal matching funds for the state's Medicaid program.⁴⁷ After the state match is levied, and the requisite federal funds are raised, BMC will receive up to \$40 million dollars annually,⁴⁸ allocated over 12 monthly payments.⁴⁹

Indigent Patient Care Program

The Indigent Patient Care Program, also known as the State Papers program, has existed since 1915. As a result of the Medicaid reform legislation discussed above, the State Papers program was eliminated. However, as we discuss later, even with the elimination of the State Papers program, there will be few practical changes in the way many patients access care, at least in the short term. This is due to the changes in the state's Medicaid program. Therefore, it is still relevant to provide a discussion on the State Papers program.

Under the State Papers program, the State of Iowa provided care to indigent and State Institution residents through the University of Iowa Hospitals and Clinics (UIHC). Under Iowa law, any legal resident of the state who was pregnant or suffered from an illness or deformity that could be alleviated through medical or surgical treatment and was unable to pay for such care was eligible for care through the program.⁵⁰ Each county was assigned a quota of treatment slots at

⁴³ Leys, Tony. Broadlawns shelves plan for using tax increase; Money that was meant for facility renovation is needed just to keep the hospital running, its board says. *The Des Moines Register*. March 5, 2003.

⁴⁴ Santiago, Frank. Broadlawns to cut pharmacy; The county hospital has lost \$1.3 million filling low-cost prescriptions. February 5, 2002.

⁴⁵ Leys, Tony. Broadlawns lays off 16 workers. *The Des Moines Register*. January 31, 2003.

⁴⁶ The Iowacare Account is a pass-through account for appropriations to UIHC, BMC, and the state Mental Health Institutions (MHIs) under the Iowacare Program. The funding sources for the appropriations are state matching funds and federal revenues which come from: 1) federal Medicaid funds for the new Medicaid expansion program; 2) federal disproportionate share hospital (DSH) funds; and 3) federal indirect medical education (IME) funds.

⁴⁷ The county's annual transfer of \$34 million may be reduced by an amount dependent upon the federal matching funds requirement.

⁴⁸ BMC is guaranteed \$37 million annually by the legislation, any amount over \$37 million will be allocated if federal matching funds are available, up to \$40 million.

⁴⁹ House File 841 Iowacare Medicaid Reform Act.

⁵⁰ Iowa Code Ann. § 255.1 *et seq.*

UIHC based upon the county's population⁵¹ and each county established its own eligibility criteria and assigned its own State Papers. There were no quotas on obstetric care or orthopedic care. Counties exceeding their quota by more than 10 percent were liable for the actual costs of treating additional patients admitted under the program. The quota could be waived by the Governor in the event of a statewide or regional economic emergency.⁵² The UIHC routinely provided care to State Papers recipients valued significantly in excess of the appropriation received and no payment was provided for physician services. Although Polk County received a total of 592 quota slots, the highest number of any Iowa county in 2004, it used only half of these slots. State Papers slots served essentially as vouchers for uninsured patients to receive care at UIHC in Iowa City, which is 120 miles from Des Moines. As a result of the Medicaid reform legislation, the State Papers program will be eliminated effective July 1, 2005.

Medicaid

In calendar year 2004 there were more than 298,000 people who received Medicaid services in any given month in Iowa. The state provided over \$2.2 billion in Medicaid benefits to recipients statewide in 2004. Twelve percent of those who received Medicaid services in Iowa in 2004 lived in Polk County. Expenditures for Polk County's Medicaid beneficiaries exceeded \$270 million in 2004.

Table 10. Average Monthly Medicaid Recipients and Benefits, Iowa and Polk County, 2004

Area	Average Monthly Recipients*		Total Annual Medicaid benefits	Average benefits per person per month
	Eligible	Served		
Iowa	290,027	298,710	\$2,284,380,643	\$637.29
Polk County	34,618	36,764	\$270,610,423	\$613.40

*Payment amounts include payments to recipients who are currently eligible for services as well as to recipients who were eligible at the time they received a service but who are not currently eligible.

Source: Iowa Department of Human Services, Division of Results Based Accountability, Bureau of Research Analysis. <http://www.silo.lib.ia.us/specialized-services/datacenter/datatables/CountyAll/coXIX20012004.pdf>

Half the state's Medicaid population (51 percent) consists of children. The remaining half are made up of adults with children (21 percent), the disabled (17 percent), and persons over age 65 (11 percent). Children are the fastest growing group of Medicaid beneficiaries, accounting for 72 percent of the program's growth between 2001 and 2003.⁵³

Iowa's Medicaid program has grown significantly since 2000. Increases in both expenditures and enrollment have been attributed to the state's lagging economy and increases in the cost of prescription drugs. Iowa's Medicaid expenditures increased 23.5 percent from the beginning of FY 2001 through FY 2003, an average of 7.3 percent each year. Enrollment increased 29.2 percent over the same period, an average of 8.9 percent per year. Medicaid increases have

⁵¹ Iowa Code Ann. § 255.16.

⁵² National Health Law Program. NHLP's Analysis of State and Local Responsibility for Indigent Health Care. Iowa (Fall 1997) pps. IA-3-4. <http://www.healthlaw.org/pubs/statepdf/iowa.PDF>

⁵³ Iowa Legislative Services Agency Fiscal Services. Issue Review: Medicaid Update. December 19, 2003. <http://staffweb.legis.state.ia.us/lfb/docs/IssReview/2004/IRJHV000.PDF>

consistently outpaced budgeted estimates and have required supplemental appropriations each year.⁵⁴

The state's Medicaid program will also face an additional shortfall of \$65 million due to the elimination of inappropriate Intergovernmental Transfers (IGT) in FY 2006.^{55,56} IGTs are transfers of funds either between one level of government and another (e.g., from counties to the state) or within the same level of government (e.g., from a state hospital to the state Medicaid agency). Conducted properly, IGTs have long been recognized by the federal government as an allowable method for states to help generate their share of Medicaid spending. Problems arise with IGTs when they: 1) raise the federal share of total Medicaid funding far above their nominal statutory federal matching rate; 2) make federal matching funds available for purposes other than purchasing covered health care services for Medicaid eligible individuals; 3) inflate the overall Medicaid spending growth rates without a commensurate increase in spending for services for Medicaid enrollees; or 4) create incentives for states to reduce their own funding for the hospitals and nursing homes they operate and replace their funds with federal dollars.⁵⁷ Some of the IGTs employed by Iowa have been deemed inappropriate, and therefore, the state is required to reform its Medicaid program.

In response to the increasing growth and cost of the Medicaid program, and to deal with the loss of IGTs, the state is pursuing an 1115 waiver.⁵⁸ The Iowacare Demonstration program will temporarily expand eligibility and introduce novel cost control methods. The state has been working with the federal Centers for Medicare and Medicaid Services (CMS) to develop the new waiver program. This 1115 waiver was authorized by the legislation for the Iowacare Medicaid Reform Act.⁵⁹

Iowacare will expand eligibility for the Medical Assistance (Medicaid) program for adults ages 19-64 to 200 percent of the federal poverty level (FPL). As many as 30,000 currently uninsured, low-income Iowans could qualify for this program. Enrollment for this population may be capped and services may be limited to ensure the program's costs remain within the amount appropriated. The legislation specifically states that adults enrolled in this program are not recipients of an entitlement program. The program limits covered providers to the UIHC, BMC,

⁵⁴ Iowa Legislative Services Agency Fiscal Services. Issue Review: Medicaid Update. December 19, 2003. <http://staffweb.legis.state.ia.us/lfb/docs/IssReview/2004/IRJHV000.PDF>

⁵⁵ House File 841 Iowacare Medicaid Reform Act, As Amended by House Appropriations Committee, Executive Summary. Distributed April 18, 2005.

http://www3.legis.state.ia.us/noba/data/81_HF841_HFA.pdf;jsessionid=ECF648DE79092F3333A0B881B24344CE

⁵⁶ The Bush Administration's FY 2006 budget proposed \$15.2 billion in federal savings over 10 years by restricting states' use of certain IGTs and limiting payments to state and local hospitals and nursing homes to the cost of services provided to Medicaid patients. This effects states nationwide, not just Iowa. See Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity. February 2005. www.kff.org, publication #7282.

⁵⁷ Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity. February 2005. www.kff.org, publication #7282.

⁵⁸ Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid statute. 1115 waivers offer states flexibility to implement and experiment with new policy ideas that are evaluated by the Centers for Medicare and Medicaid Services (CMS).

⁵⁹ House File 841, Iowacare Medicaid Reform Act.

and four state mental health institutes (MHI). Enrollees between 100 - 200 percent FPL will be required to pay a monthly premium that does not exceed a twelfth of five percent of the member's annual income for a minimum of four months. Enrollees with incomes under 100 percent FPL will pay a twelfth of two percent of the member's family income. The state's Department of Human Services is required to waive required out-of-pocket expenditures based upon hardship.

The legislation requires that Disproportionate Share Hospitals (DSH)⁶⁰ and Indirect Medical Education (IME)⁶¹ funds be allocated to UIHC and BMC.⁶² It is understood that the new program is unlikely to cover all 30,000 of those potentially eligible for the expansion. The DSH and IME funding is intended to offset what is not covered by the Medicaid expansion, and ensure that the hospitals are held harmless by the new program. The exact amount of the DSH and IME funds is unknown now, since the state is still developing a new funding mechanism to distribute these funds.⁶³

The legislation also established the Iowacare Account to eliminate IGTs as revenue, and creates individual accounts for UHIC, BMC and the MHI. As discussed earlier, BMC will be required to transfer the proceeds of its tax levy to the Iowacare Account, not to exceed \$34 million annually.⁶⁴ It also requires the state and any county using BMC mental health services to continue to pay⁶⁵ BMC for these services to the Medicaid expansion population. Appropriations from the Iowacare Account for FY 2006 include: \$27.3 million to UIHC, up to \$40 million to BMC,⁶⁶ and \$43.9 million for the four MHIs. These appropriations are a combination of state and federal matching funds.

The source of the state portion of these funds is the BMC tax levy of \$34 million. Federal matching funds are derived from the Medicaid expansion, DSH and IME. If necessary, 100 percent state funds will be used to cover any gaps in funding.

The legislation also eliminates the Indigent Patient Care Program, or the State Papers program, and replaces it with the eligibility expansion for the Medical Assistance Program for adults under the Iowacare Program. The program is also supplemented by the new DSH and IME programs.

⁶⁰ Disproportionate Share Hospitals (DSH) payments provides additional funding to hospitals that provide a disproportionate amount of care to Medicaid and uninsured populations.

⁶¹ Indirect Medical Education (IME) funding covers the indirect costs associated with training residents (e.g., including ordering more tests, longer patient stays, sicker patient populations, greater technological needs) and to offset the lack of private insurance's contribution to graduate medical education.

⁶² Other hospitals that currently receive DSH funding will continue to receive it. At some point they may become eligible to provide services to the expansion population to the extent that population is currently provided with uncompensated care. Legislative Services Agency and the Department of Human Services. A Plan for Iowa Medicaid Reform: Frequently Asked Questions. Updated 3/30/05.

<http://staffweb.legis.state.ia.us/lfb/medicaid/FAQ.pdf>

⁶³ The former distribution mechanism has been determined to be an inappropriate IGT.

⁶⁴ The \$34 million annual transfer may be reduced by an amount dependent upon the federal matching funds requirement.

⁶⁵ Payment is based on the per day amount per patient paid in FY 2005.

⁶⁶ Of this amount \$37 million is allocated in 12 equal, monthly payments. Any amount above \$37 million is allocated if federal matching funds are available, up to \$40 million.

SECTION THREE: POLK COUNTY HOSPITAL FINANCIAL DATA

As we have already seen, each of the hospitals in Des Moines provides an important community benefit by providing services to the uninsured. In this section we will provide more in-depth information on the number and type of hospital-sponsored services delivered to the uninsured in Polk County. We will also present data from the three major hospital systems⁶⁷ on the costs of these services.

Cost of Hospital-Sponsored Safety Net Services

The three hospital systems provided a combined total of more than 1.7 million visits to Polk County Residents in FY 2004 (Table 11). The bulk of these visits were to hospital system clinic/physicians (62 percent), and other outpatient visits (19 percent). Emergency department visits accounted for just 6 percent of hospital visits, and inpatient medical services accounted for only 2 percent of visits. IHDM provided the largest number of total visits to Polk County residents (803,775), followed by MMC-DM (752,831) and BMC (165,410).

When we analyze hospital utilization data according to payer source,⁶⁸ we find that self-pay and charity care patients at BMC accounted for 59 percent of that institution's visits from Polk County residents in FY 2004. Medicaid visits represented 20 percent of BMC's Polk County patients, while Medicare accounted for only 9 percent. The opposite is true at IHDM where 20 percent of the health system's visits were to Medicare patients in the County, and 9 percent of the visits were delivered to Polk County Medicaid patients. Self-pay patients accounted for 2.5 percent of IHDM's visits to Polk County residents. MMC-DM had a much higher percentage of Medicare visits (41 percent) than the other hospitals. Its Medicaid and self-pay visits were similar to IHDM's utilization patterns (7 percent and 3 percent respectively).

⁶⁷ The VA Central Iowa Health Care System did not provide financial or utilization data for this study.

⁶⁸ We did not receive utilization data for all payer sources from every hospital (e.g., two did not supply visit data for commercial/private insurance); however, we did receive utilization data for Medicaid enrollees, Medicare beneficiaries and self pay patients.

Table 11. Utilization by Payer Source in Number of Visits: Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Polk County, FY 2004

Visit Type	Medicaid			Medicare			Self Pay/Charity Care/Bad Debt			TOTAL POLK COUNTY [§]		
	BMC	IHDM	MMC-DM	BMC	IHDM	MMC-DM	BMC	IHDM	MMC-DM	BMC	IHDM	MMC-DM
Inpatient Medical	1,119	2,971	1,214	529	7379	7,335	1,343	286	616	3,084	21,117	18,112
Inpatient Psychiatric/Substance Abuse	215	591	59	289	405	356	275	262	30	1,117	2,228	878
Outpatient - Other	5,112	10,808	8,554	3,000	39,149	51,705	24,883	4,205	4,341	37,658	167,271	127,666
ED Outpatient	4,006	11,234	2,589	942	5,925	15,652	16,545	3,582	1,314	22,538	45,728	38,648
Outpatient Psychiatric/Substance Abuse	4,266	494	45	1343	123	273	3,091	70	23	12,279	2,680	675
Clinics/Physician Revenues	19,174	43502	35,773	9185	97,419	216,239	51,244	11,766	18,153	88,734	564,751	533,924
Other	--	--	2,206		--	13,336	--	--	1,120	--	--	32,928
TOTAL	33892	69,600	50,440	15,287	150,400	204,896	97,382	20,171	25,597	165,410	803,775	752,831

[§]Total includes utilization by commercial and other patients; therefore the amount presented here exceeds the sum of Medicaid, Medicare, and Self Pay/Charity Care Bad Debt columns. Source: FY 2004 Hospital Utilization Data, Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Des Moines.

Table 12. Gross Charges and Net Revenue by Payer Source: Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Polk County, FY 2004

Visit Type	Medicaid			Medicare			Self Pay			TOTAL POLK COUNTY [§]		
	Gross Charges	Net Revenue	% Collected	Gross Charges	Net Revenue	% Collected	Gross Charges	Net Revenue	% Collected	Gross Charges	Net Revenue	% Collected
BMC	15,202,654	10,269,795	68%	11,562,361	7,994,838	69%	41,954,049 ^H 18,236,667 [♦]	2,954,359 ^H 2,933,381 [♦]	7% 16%	78,385,694	27,450,996	35%
IHDM	55,636,416	21,520,652	39%	192,526,790	78,197,534	41%	9,813,098 [♦]	2,139,270 [♦]	22%	562,044,727	297,991,638	53%
MMC-DM	50,776,444	19,084,973	38%	354,865,114	85,615,831	34%	29,447,374	8,115,521 [♦]	28%	715,410,059	302,386,316	42%

[§]Total includes charges and revenue by commercial and other patients; therefore the amount presented here exceeds the sum of Medicaid, Medicare, and Self Pay/Charity Care Bad Debt columns. ^HThis is a combination of Free Service (patients who apply for and meet BMC's guidelines to receive free or discount services based on financial need, i.e., under 200 percent of poverty) and Self Pay patients (those who don't meet BMC's guidelines or who choose not to provide the proper paperwork). [♦]Self-pay (uninsured) only. Source: FY 2004 Hospital Utilization Data, Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Des Moines.

In FY 2004, more than \$1.3 billion dollars worth of care (in gross charges) was delivered to Polk County residents by BMC, IHDM, MMC-DM combined (see Table 12). The three hospitals received over \$627 million in net revenues, a 46 percent recovery overall. MMC-DM had the highest gross charges (\$715 million) for Polk County patients and collected 42 percent in net revenues. IHDM's gross charges exceeded \$560 million for Polk County patients, and net revenues were just under \$300 million; IHDM collected 53 percent in net revenues. BMC collected the smallest percentage on its gross charges compared to the other hospital systems (35 percent).

A review of gross charges and net revenues by payer source indicates that Medicare is an important source of revenue for both IHDM and MMC-DM. Medicare accounts for 36 percent of MMC-DM's total gross charges, and 34 percent of IHDM's gross charges for Polk County patients. Medicare makes up a comparatively small portion of BMC's gross charges, just 15 percent. However, BMC collects a larger portion of Medicare charges than the other hospital systems. In 2004, BMC collected 69 percent of its Medicare charges, while IHDM collected 41 percent and MMC-DM collected 34 percent.

BMC had the highest percentage of gross Medicaid charges (19 percent) of the three Des Moines hospitals, compared to 10 percent for IHDM, and 7 percent for MMC-DM. In this case, BMC collected the highest percentage of gross charges. BMC's net revenues represented 68 percent of its gross charges for Polk County residents. This is compared to 39 percent for IHDM's Polk County gross charges, and 38 percent for MMC-DM's gross charges.

BMC sees a higher percentage of self-pay and free service patients than the other two hospital systems. Polk County free service patients⁶⁹ accounted for 30 percent of BMC's gross charges, and self-pay patients⁷⁰ accounted for an additional 23 percent of the medical center's gross charges. By comparison, self-pay patients made up just 2 percent of IHDM's gross charges for Polk County residents and 4 percent of MMC-DM's gross charges.

BMC recoups a smaller percent of free service and self pay charges than do the other hospital systems. For example, in FY 2004, BMC collected only 16 percent of gross self-pay charges. When both self pay and free service categories are combined, BMC collects only 7 percent of those gross charges for Polk County residents. In contrast, IHDM collected 22 percent of gross charges for county residents who were in the self-pay category. MMC-DM's rate of collection on self-pay charges was 28 percent.

When the three hospital systems' gross charges for charity care and bad debt are examined, the results are also noteworthy. (Table 13) Charity care and bad debt account for 50 percent of BMC's gross charges. In comparison, gross charges for charity care and bad debt make up just 2.6 percent of MMC-DM's gross charges for all Polk County patients, and 1.8 percent of IHDM's gross charity and bad debt charges for county residents.

⁶⁹ Patients who apply for and meet BMC's guidelines to receive free care based on financial need, (i.e., have incomes under 200 percent of the federal poverty level).

⁷⁰ Patients who either do not meet BMC's guidelines to receive free or discounted care, or patients who choose not to provide the proper information to be approved. Most of this ultimately becomes bad debt.

Table 13 Uncompensated Care: Gross Charity Care and Bad Debt as a Percentage of Gross Revenue. Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Polk County, FY 2004

Hospital	Gross Charity Care and Bad Debt	Total Gross Charges	Charity Care/Bad Debt as Percentage of Gross Charges
Broadlawns Medical Center	\$39,400,266	\$78,385,694	50.0%
Iowa Health Des Moines	\$10,215,492	\$562,044,727	1.8%
Mercy Medical Center – Des Moines	\$18,785,006	\$715,410,059	2.6%

^HCharity/BD writeoffs (net) at charges. ^ICharity/BD writeoffs (net) at cost

Source: FY 2004 Hospital Utilization Data, Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Des Moines.

In fact, BMC has the dubious distinction of having more than twice the percentage of gross charges attributable to self-pay patients that is seen on average in public hospitals (see Table 14). In 2002, self-pay patients accounted for 56 percent of BMC’s gross charges versus an average of 25 percent for the public hospital industry. In the same year, BMC’s collection rate from self-pay patients (net revenues as a percent of gross charges) was 7 percent, the same as an average public hospital.

Table 14 BMC’s Gross and Net Revenues versus Other US Public Hospitals, 2002.

Payer Source	Gross Charges		Net Revenues	
	Broadlawns	Average NAPH Member	Broadlawns	Average NAPH Member
Commercial	7%	22%	8%	22%
Medicare	19%	21%	20%	19%
Medicaid	18%	32%	13%	37%
Self Pay/Other	56%	25%	7%	7%
State/Local Subsidies	--	--	52%	15%

Source: National Association of Public Hospitals and Health Systems. America’s Safety Net Hospitals and Health Systems, 2002.

Like all hospitals in the US, the Des Moines hospital systems experience significant shortfalls in Medicaid and Medicare reimbursements (see Table 15). In 2004, IHDM experienced more than \$34 million in gross shortfalls for Polk County patients on Medicaid. During the same year, MMC-DM had just under \$32 million in gross shortfalls for Medicaid services. BMC experienced a smaller, but still significant shortfall of nearly \$5 million on gross charges for county patients.

These hospitals also experience shortfalls in Medicare reimbursements. MMC-DM reported a shortfall of nearly \$170 million on gross charges for all Medicare patients in Polk County. IHDM’s shortfall was just over \$114 million on all Medicare patients in Polk County, and BMC’s shortfall was \$3.5 million on gross Medicare charges.

Table 15 Medicaid and Medicare Shortfalls: Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Des Moines, FY 2004.

Hospital	Medicaid			Medicare		
	Gross Charges	Net Revenues	Shortfall (Gross)	Gross Charges	Net Revenues	Shortfall (Gross)
Broadlawns Medical Center	\$15,202,654	\$10,269,798	\$4,932,856	\$11,562,361	\$7,994,838	\$3,567,523
Iowa Health Des Moines	\$55,636,416	\$21,520,652	\$34,115,765	\$192,526,790	\$78,197,534	\$114,329,256
Mercy Medical Center – Des Moines	\$50,776,444	\$19,084,973	\$31,688,471	\$254,856,114	\$85,615,831	\$169,240,283

Source: FY 2004 Hospital Utilization Data, Broadlawns Medical Center, Iowa Health Des Moines, Mercy Medical Center – Des Moines.

These data illustrate the important role all the hospitals play in serving the uninsured and Medicaid beneficiaries in Polk County. All provide care to patients in both these categories. Although IHDM and MMC-DM provide more modest amounts of charity care when compared to BMC, their contribution is significant. Together, the three hospitals provided more than \$66 million in gross charity care and bad debt to Polk County patients in FY 2004 (shown in Table 13). Clearly, these hospital systems deliver an important community benefit.

SECTION FOUR: STATUS OF THE SAFETY NET

The GWU researchers conducted interviews with key stakeholders in the Polk County health care community and visited safety net facilities in October 2004. This analysis of the Polk County safety net, and hospital-sponsored health care services for the uninsured, was greatly informed by the interviews with hospital and other safety net providers as well as various local stakeholders. Informants discussed the current status of the Polk County health care market place, the amount and scope of services generally available to the County's uninsured, issues relating to access to care, and significant barriers that uninsured patients face in seeking health care services in Polk County.

BMC is the primary hospital-based safety net provider in Polk County. Nearly all the people we spoke with reported that BMC is the primary safety net provider in Polk County. BMC provides a wide range of services needed by the County's uninsured. As a primary care hospital with several outpatient clinics, BMC can provide patients with comprehensive primary care and limited routine specialty and hospital care. BMC is also a significant source of behavioral health care. Despite the fact that BMC has providers and staff who provide translation in many languages, interpreter services are still insufficient to meet demand, especially for behavioral health care.

A large percentage of BMC's patients cope with serious needs for basic human and social supports such as housing, food assistance, clothes, and job training. BMC has come to specialize in linking patients with the critical social and human services they desperately need. BMC's administrative and clinical staff are trained to integrate these human and social service concerns into their daily interactions with patients.

The other hospital systems in Des Moines also have excellent case management and care coordination programs that serve low-income and uninsured patients. While these organizations provide supportive services, their core business is not designed around a low-income and uninsured patient population. The majority of the patients at these hospitals are covered by Medicare or commercial insurance. The difference here is that BMC *specializes* in caring for uninsured and underserved residents; the other hospitals do not.

A large number of informants expressed their concern that other Polk County hospital systems are not currently acculturated to take on a safety net mission. Most informants agreed that the other hospital systems in Polk County could subsume BMC's daily inpatient load. There is no question that the other Des Moines hospital systems are outstanding medical institutions that could provide high quality care to BMC's inpatients. However many informants expressed concern that these other hospital systems are not currently prepared to provide BMC's high volume of outpatient visits, nor are they equipped to provide the necessary enabling services that BMC does. If one of the other hospital systems in Des Moines were to build a viable partnership with BMC, core safety net services, including supportive and enabling services, would have to be explicitly addressed in the partnership so that they could be sustained.

BMC is viewed as the provider of last resort. It is widely understood that the general population of Polk County regards BMC as a provider of last resort for indigent patients. Many

informants suggested that BMC is thought to provide substandard care. However, patients who actually use BMC expressed their appreciation for the high quality of its services and the professionalism of its providers. Patients believe that BMC needs to spread the word about its services to attract more patients.

Many informants described a general reluctance to invest too much in BMC's infrastructure. This perception is tied in many ways to BMC's identity as a health care provider for the poor. Many described their personal opinion (that they presumed they shared with policy makers) that as a public entity, BMC should not look too grand. Informants expressed their feeling that BMC should appear to be a humble organization so as not to arouse suspicion that public funds were being misused.

The vast majority of informants told us it would be “devastating” for BMC to close. BMC is an essential source of care for the uninsured in Polk County. For many of the uninsured, BMC is the only option available for hospital care. The other area hospitals do not deny services to patients based on their insurance status. Uninsured patients in need of non-emergency hospital services can access a wide variety of services in Polk County if they can afford the out-of-pocket expense. Unfortunately, many of the uninsured are low-income and cannot pay for the health care services they need. Since there are no public funding programs available to subsidize the cost of care at other Polk County hospital providers, BMC is the only available option in the community. Of course, the uninsured can access hospital services at any Polk County hospital via the emergency room. However, this is the costliest option, especially when less expensive preventive services could have been obtained earlier. In addition, it does not provide patients with a medical home, but rather episodic care. Although primary care services can be obtained through some hospital-sponsored clinics and other free clinics in Polk County, in many cases these too offer only limited and episodic care. Besides BMC, only Primary Health Care, Inc., an FQHC formerly affiliated with BMC, provides uninsured patients with comprehensive primary health care in a medical home. If BMC were to close, uninsured patients would be left with few viable options for care.

Many informants reported that if BMC were to close, there would also be negative consequences for the other Polk County hospitals. Currently BMC is the repository of a vast majority of the County's uninsured. If BMC were to close, these patients would have nowhere else to turn but the other hospital systems in the community. This would likely increase non-emergent visits to the hospital's emergency department. There would also likely be an increase in emergency visits that could have been prevented had the patient had access to timely and affordable medical care. The other hospital systems would likely experience significant increases in their percentages of self-pay patients, with concomitant increases in charity care and bad debt.

Undocumented immigrants have few options for obtaining health care in Polk County.

Many informants reported that BMC's policies requiring upfront payment from undocumented patients result in many immigrants forgoing care at BMC. Undocumented patients could previously obtain free or discounted services at BMC prior to the separation between BMC and PHC. This is because as an FQHC, PHC is not precluded from serving undocumented immigrants. However, since the separation of the two organizations, this is no longer the case. Under federal law, public hospitals are precluded from providing free services to undocumented

immigrants. BMC's existing primary care clinics are also prohibited from providing free or reduced price services to undocumented residents of Polk County. Although undocumented residents can still access free or low-cost services at clinics such as PHC, Mercy Clinics, Inc, and a number of area free clinics including La Clinica del Esperanza and House of Mercy, there is limited supply even across the sum of all of these providers. In addition, although services were widely regarded as high quality, the majority of these clinics provide only episodic care and are not medical homes. (The exception to this is PHC, which operates as a full-service community health center and offers a medical home to patients in need of primary and preventive health services.) As a result of the separation between BMC and PHC, undocumented residents of Polk County who cannot cover the costs of health care out of pocket have fewer access points for health care.

There is tremendous unmet need for specialty care among the uninsured. Despite the existence of the State Papers program, specialty care has remained a critical unmet need for many uninsured patients in Des Moines. As a primary care hospital, BMC provides only limited specialty care services. Ample specialty care resources exist at other hospital systems in Polk County; however, the uninsured have little access to them due to the lack of public funding sources to cover the cost of the care. Although they are not turned away because they are uninsured, only those uninsured patients who can afford the cost of care can be seen. Even under the new Medicaid reform program, Iowacare, the UIHC will often be the only option for uninsured patients needing specialty care. However, traveling to UIHC may be a hardship for some patients and their families despite the fact that transportation and lodging are provided.

There are similarities between the State Papers program and how IowaCare will operate. Under the State Papers program, uninsured patients were able to obtain specialty and tertiary care at UIHC Iowa City. As a result of the state's Medicaid reform legislation, House File 841 Iowacare Medicaid Reform Act, the State Papers program was eliminated and will be terminated effective July 1, 2005.

In 2004 Polk County was allotted 592 quota slots for the Indigent Patient Care Program, and roughly half were used. A major reason reported by many sources for the gap in issued-versus-used quota slots is that patients declined a slot because of the need to travel to Iowa City for care. However, representatives of UIHC note that residents of Iowa's other counties routinely seek care at the UIHC. The UIHC attempted to mitigate this hardship by consolidating appointments and treatments, and by providing transportation, lodging and meals for patients who make the trip.

Some informants indicated that since there is a quota, program slots are meant to be used only for patients with the most extreme conditions that cannot be adequately or appropriately addressed in their own communities. In reality, we learned from many informants that patients are offered State Papers slots for routine/general specialty and tertiary needs that could be addressed in the community but that such care was not accessible to them. This has undoubtedly reduced the charity care burden for Des Moines providers. BMC is a safety net hospital that provides only limited specialty services. There are ample specialty and tertiary care services available at other Des Moines hospitals; however, they are difficult for uninsured patients to access because they cannot afford to pay for them out-of-pocket, and because there are no

local/state funding sources available to subsidize care at these hospitals. Therefore, many uninsured patients are left with two choices: travel to Iowa City for specialty/tertiary care, perhaps having to spend the night; or forgo care.

The structure of the former State Papers program has implications for some uninsured patients that continue to be relevant even in the context of the new Medicaid expansion program. Notwithstanding that the uninsured receive excellent care at UIHC if they consent to go, they are required to leave their communities, and miss work in order to obtain that care. This possibly poses a hardship for some uninsured patients and their families.

The Medicaid reform changes described earlier eliminate the State Papers program as part of the Iowacare Medicaid expansion. However, it is not clear whether there would be a practical change in the way that patients from Polk County receive specialty and tertiary care. For example, under the Medicaid expansion, UIHC, BMC and four State Mental Health Institutes (MHIs) are the only approved Iowacare providers. According to staff from the Legislative Services Agency and the Department of Human Services, residents of Polk County who qualify for the expansion program will access appropriate services at BMC and those with tertiary medical needs could also access their care at the UIHC.⁷¹ Since BMC provides only limited tertiary (and specialty care), and because the other providers in Polk County are not approved providers, patients may still have no other choice but to travel to Iowa City for care.

Although programs like the State Papers program and a Medicaid expansion clearly confer benefits, patients would be better served by replacing the specialty care provided through these programs with options for accessing specialty care within Polk County itself. Regardless of the quality of UIHC's care, which is reputed to be excellent, and regardless of its cost, which may be quite reasonable, programs like these offer a model of care that is built on the separation of the patient from family and community.

The debate about the State Papers program did not originate with this study; in fact, arguments for decentralizing the State Papers program are not new and have been debated for years.⁷² Despite these debates, the structure and operation of the program have been maintained over time, with the Iowa hospital industry indicating its support for the current arrangement.

The health care market in Des Moines is very competitive, but providers are also willing to collaborate. Many informants characterized the Des Moines health care market as competitive. Informants described the healthy and sometimes aggressive competition that exists between Polk County's two largest hospital systems, IHDM and MMC-DM. For example, in February 2004, the Iowa Health Facilities Council voted unanimously to deny Iowa Methodist Medical Center's (part of IHDM) request to build a hospital in West Des Moines. The action came after Mercy Medical Center had previously vowed not to pursue plans to build its own West Des Moines

⁷¹ Legislative Services Agency and the Department of Human Services. A Plan for Iowa Medicaid Reform: Frequently Asked Questions. March 30, 2005. <http://staffweb.legis.state.ia.us/lfb/medicaid/FAQ.pdf>

⁷² See Legislative Service Bureau, Iowa General Assembly. Final Report of the Treatment of Indigent Persons through University of Iowa Hospitals and Clinics. January 1999. See Testimony by James Zahnd, Vice President of Public Affairs, Iowa Health System. www.legis.state.ia.us/GA/77GA/Interim/1998/comminfo/indig/final.htm

hospital for at least five years if the state rejected Iowa Methodist's proposal.⁷³ Despite this competition, the two hospital systems have come together, with a wide range of other provider organizations and agencies, to find solutions to the financing and delivery of health care to the County's uninsured. Informants described the efforts undertaken by the Blue Ribbon Steering Committee as unprecedented in Polk County.

⁷³ Suk, Tom. WDM copes with hospital decision; One city leader calls it 'politics at its worst'. The Des Moines Register. February 10, 2004.

SECTION FIVE: FOCUS GROUP RESULTS

The GWU researchers conducted focus groups with residents who receive their care from safety net providers in Polk County. Although most were current patients of BMC, they indicated that they had experience obtaining health care services from other Polk County hospitals/clinics as well. The focus groups were held on October 18 and 19, 2004, at BMC. Focus group participation was voluntary. Participants were recruited with the help of BMC's case management/care coordination program.⁷⁴ Recruitment efforts involved inviting individual patients to participate and distributing flyers announcing the sessions and their schedules. Participants each received \$25 gift cards to a local supermarket/pharmacy chain in appreciation of their time and candor. A total of 20 individuals participated in the focus groups. One group comprised of Latino participants was conducted in Spanish and two groups were conducted in English.

The focus group discussions highlighted difficulties that many uninsured and underserved residents have in accessing timely and affordable health services in Polk County. Participants addressed issues such as primary care and prevention, access to specialty and inpatient services, their understanding of the local health care system and the opportunities that are available to them, and their feelings about the provider community.

Highlights from the Patient Focus Groups

- **Accessing Health Care.** Patients expressed their confusion about the number and type of primary care clinics at BMC and the differences among each of them. Some also described their reservations about the quality of primary care delivered through the walk-in clinic. Participants' experiences obtaining dental care were mixed, with some having good access to care at BMC and others having difficulty accessing dental services. Some respondents indicated that they received dental services through private dental providers.
- **Service Fragmentation.** Several participants spoke about the difficulty of piecing together different types of health care services, often from different providers or locations. One focus group participant summarized many of the statements with the comment: "The big problem is that the system is fragmented. Unless you know someone who has had the same problem and knows the answers, you waste a lot of time trying to find how to access services. This is not only a problem with all human service programs but also with the programs here at BMC."
- **State Papers Program.** In general, focus group respondents were either unfamiliar with the State Papers program, or reported that they were offered a slot but declined because they found it too burdensome, often because of family responsibilities. Specifically, respondents

⁷⁴ This represents a purposive and limited sample of patients. Participants may have been motivated to participate based on their satisfaction or dissatisfaction with BMC or any other provider in Des Moines. The results can not necessarily be construed to represent the views of all low-income uninsured patients in Des Moines. However, the views expressed by focus group participants offer valuable insight on their opinions and experiences with accessing health care services in Polk County.

reported that traveling to Iowa City can be a challenge. For example, one woman who needs rheumatology services has five children at home and cannot leave them overnight to seek care in Iowa City. She indicated that her only option is to continue to delay getting the care that she recognizes that she desperately needs. One of the focus group participants reported a positive experience with and knowledge of the State Papers program. She was well versed in the program's transportation system, and the overnight accommodations that are provided for early morning appointments.

- **Perceptions of BMC.** Respondents were generally very happy with the care they received at BMC, and spoke about the organization as if it were part of their family. Many described feeling at home at BMC and considered staff to be extremely talented and supportive of their needs. One patient stated, "There is value to the care here [BMC] that goes beyond technical expertise. Patients are treated with dignity and respect and are able to get wrap-around services. Another patient reported that he can choose which hospital he goes to, but continues to choose BMC because other hospitals and their staff treat him poorly and are "not up on [his] care like they are at BMC." One patient felt that the phlebotomists at BMC are superior at BMC. Another patient new to BMC had a previous impression that BMC had subpar care and doctors were inexperienced. She was scared to step foot in the door because of negative stereotypes. When she was uninsured she needed mental health care and got it at BMC. She's changed her mind about the care, and continues to BMC even though she now has Medicaid and can go elsewhere. Still, several respondents described BMC's run-down facilities and other problems accessing care. One patient stated, "BMC does not have the same resources as other hospitals. BMC has old beds, no privacy in certain rooms and the equipment is outdated. A while ago, the hospital looked run-down and matched the stigma. Lately the inside has been kept up better." Another patient stated: There are levels of care at BMC. If you can get in, great. Otherwise you're on your own."
- **If BMC were to close...**the participants were not sure what they would do. One said he would need to move out of state. Another patient did not know much about other hospital services for the uninsured. One patient stated, "There would be nowhere for me to get my medication." Another said, "I wouldn't know where else to go." One patient admitted that he had considered suicide before he was treated at BMC because of severe health issues and pain and he was not able to get treated. Since coming to BMC, he now has a doctor and is determined to do what he can to get healthy. He stated: "If BMC was closed I would try and find a way to get care, but I hope I won't have to do that."
- **Public Relations Campaign.** Many of the focus group patients agreed that BMC needs a positive public relations campaign to bolster its position in the community. One patient said that BMC "needs to buck community stigma." Others advised that BMC advertise that it serves people as human beings, not numbers. Most respondents felt that the community did not really know about BMC and the quality of its services.
- **Immigrants described their experiences trying to obtain health care at BMC.** They reported that they are asked to provide a social security card, green card and residency documentation to establish that they are legal residents of Polk County. Undocumented

immigrants are required to pay for services up front (or make a significant down payment and pay the remaining balance in monthly installments).

The GWU Researchers also convened a focus group of physicians to learn about their experiences in delivering care to uninsured patients in Polk County, and to obtain their impressions about the opportunities and barriers faced by this population. The questions posed to the physicians addressed access to care for uninsured and underinsured residents and their access to a variety of health services across the County.

Highlights from the Physician Focus Group

- **Behavioral health:** is non-existent for Hispanic populations and others who do not speak English. Because of the nature of behavioral health services, which requires an enormous amount of trust and communication between provider and patient, there is a desperate need for bilingual behavioral health providers. For most uninsured patients, BMC is the only option for behavioral health services.
- **Immigrants:** Physicians felt that their immigrant patients were not at all familiar with the U.S. health care system; consequently, they did not know which services to get and how to access them in Polk County. They generally sought care at a free clinic, if anywhere at all. According to the physicians in the focus group, the common assumption is that “if I don’t have insurance, I don’t have health care.” If they understand the American system, they know that they can go to the emergency department. However, there is still the fear of being identified and detained by immigration officials. The physicians felt that free clinics were the only location in Des Moines where immigrants could receive care without providing a social security number. However, one physician stated, “Free care at clinics is not good care because it does not provide a medical home, or continuity. Free clinics are only for episodic care.” Other physicians agreed with this assessment.
- **State Papers:** The physicians felt strongly that BMC does not use its State Papers slots because patients do not want to travel to Iowa City. Reportedly, the transportation provided under the program can be inconvenient.
- **Strategies to Help BMC Survive:** The physicians agreed that there is a real need to protect and fund BMC. Some of the strategies suggested include: 1) developing a niche to help BMC pull some of the weight of the uninsured; 2) reaching out to private hospitals for their assistance in sharing the burdens of the uninsured; and 3) developing a specialty training program in Des Moines. Physicians reported that BMC used to have multiple specialty programs. Some of these programs are no longer in operation and thus patients with needs for various specialty services cannot access them at BMC.

SECTION SIX: KEY FINDINGS AND PUBLIC POLICY OPTIONS

After examining key components of the Polk County's health care safety net, we offer the following key findings:

Key Findings

- **Des Moines' community-wide effort to focus on the safety net is extraordinary.** Key stakeholders and representatives from nearly all facets of the community have come together to address the needs of the Polk County health care safety net. The composition of the Blue Ribbon Steering Committee reflects the wide interest in and commitment to the health care needs of the County's uninsured. The community appears to be serious about addressing the pressing needs of the safety net and developing a meaningful set of solutions. We received tremendous cooperation from the community in undertaking this study and were granted unlimited access to many key stakeholders. We were encouraged to provide the Committee with a candid and objective assessment of hospital-sponsored health care services for the uninsured. In addition, the Committee has also requested a set of public policy options that offer solutions on how best to reorganize the County's health care safety net.
- **Des Moines' health care market is mature and sophisticated, and those with insurance generally have substantial access to care.** Des Moines has a number of outstanding health care facilities and providers with tremendous expertise. It appears that those with private health insurance or those on Medicare generally have access to a broad range of health care services delivered by numerous providers in the community. In many communities across the country, this is not the case, where even those with health insurance encounter barriers for some types of services. Polk County's safety net, however, is not as robust as the private health care market for insured patients. Nor is it as robust as safety nets in many other parts of the country. Uninsured Polk County residents have a limited set of options to receive health services. They can pay for care out-of-pocket; they can gain entry to health services through the emergency room; or they can access care through established safety net providers. With demand for services far outstripping supply, each of these options falls short of meeting the needs of County residents. Because many of the County's uninsured residents are low-income, accessing care through the private sector is generally beyond their reach. Accessing care through the emergency department is a poor substitute for coordinated care from primary care medical homes. And relying on the safety net in Des Moines offers extremely limited access to specialty services and is often fragmented and poorly coordinated.
- **The community's large non-profit hospital systems provide an important community benefit.** Both of the major non-profit health care systems in Des Moines provide a modest amount of charity care and incur unreimbursed costs providing services to Medicaid patients. In 2004, Iowa Health Des Moines (IHDM) provided more than \$10 million in charity care and bad debt to patients in Polk County, which was 1.8 percent of the system's gross revenues associated with care for patients in Polk County. During the same period, Mercy Medical Center – Des Moines provided just under \$19 million in charity care and bad debt to county residents, which represented 2.6 percent of the system's gross revenues for Polk County patients. In addition, like most hospitals in the US, both of these Des Moines

hospital systems experience significant shortfalls in Medicaid reimbursements. Clearly, these hospital systems deliver an important community benefit. Any contributions on behalf of uninsured residents on top of those already made by the systems would be extremely beneficial to uninsured residents in the County.

- **BMC is widely seen as a core safety net provider in Des Moines.** Broadlawns patients who participated in focus groups for this study spoke of their devotion to BMC and its providers, highlighting Broadlawns' commitment to serve the uninsured with dignity and respect. Some patients reported that when they were insured, they avoided BMC because of its reputation as a "poor person's hospital." However, after they become uninsured and sought care there, they were impressed with the staff's professionalism, the depth of their dedication, and their kindness towards patients. Many patients maintained that they would continue receiving care at BMC even if they obtained private health insurance. Nearly all the patients we spoke with said they would be devastated if BMC were to close because they would have no other source of affordable care.
- **The other hospital systems in Des Moines are not currently acculturated to take on a core safety net mission.** Although the other Des Moines hospital systems are outstanding medical institutions that could provide care to BMC's inpatients, they are not currently prepared to assume BMC's role as a safety net provider. Iowa Health Des Moines and Mercy Medical Center offer many of the same types of services that Broadlawns provides that are designed to support care for vulnerable patients. For example, Iowa Health and Mercy operate outstanding case management and care coordination programs designed to support patients in need of complex human and social services. Still, while they provide supportive services, their core business is not designed around a low-income and uninsured patient population. The majority of the patients at these hospitals are covered by Medicare or commercial insurance. BMC's core clientele is uninsured and low-income. If one of the other hospital systems in Des Moines were to build a viable partnership with BMC, core safety net services, including supportive and enabling services, would have to be explicitly addressed in the partnership so that they could be sustained.
- **The community wants BMC to survive but not thrive.** There is clear consensus among nearly all key stakeholders, patients, and providers that a safety net hospital must survive in order to provide essential care for uninsured residents of Polk County. Most people associate this function with Broadlawns and therefore speak about the need for Broadlawns to maintain its existence and its mission as a safety net hospital. Even with this commitment to Broadlawns, however, there is widespread resistance to providing BMC with enough capital, resources, and infrastructure development to allow it to thrive as a financially stable health care provider in the community.

- **The separation between BMC and Primary Health Care, Inc. (PHC) has resulted in more limited access to services for undocumented patients.** When PHC was part of BMC, undocumented immigrants were able to access services at BMC. However, since the separation between the two organizations, this is no longer the case. Under federal law, public hospitals are precluded from providing free services to undocumented immigrants. BMC's existing primary care clinics are also prohibited from providing free or reduced price services to undocumented residents of Polk County. Although undocumented residents can still access free or low-cost services at clinics such as Mercy Clinics, Inc, and a number of area free clinics including La Clinica del Esperanza and House of Mercy, there is limited supply even across the sum of all of these providers. In addition, although services were widely regarded as high quality, the majority of these clinics provide only episodic care and are not medical homes. (The exception to this is PHC, which operates as a full-service FQHC and offers a medical home to patients in need of primary and preventive health services.) As a result of the separation between BMC and PHC, undocumented residents of Polk County who cannot cover the costs of health care out of pocket have fewer access points for health care.
- **The safety net in Des Moines lacks adequate access to specialty services for uninsured and underserved residents, who cannot afford to cover the costs of specialty services out of pocket.** Even with the elimination of the State Papers program, Polk County residents will still be required to access specialty services at the University of Iowa hospital campus in Iowa City. Further study is required to understand the full implications of the Iowacare Medicaid expansion program, its effects on the delivery of specialty care, and patients' access to these services.
- **Des Moines' safety net is insufficient and extremely fragmented.** Health care safety nets are fragmented in their nature, but Des Moines' is more fragmented than most. In addition, the need for safety net services sharply exceeds existing supply. There are several reasons for this: 1) BMC, a primary care hospital, is limited in the amount of subspecialty and tertiary care it can provide; 2) a very lean community health center network limits opportunities for uninsured and underserved patients to have a medical home that can identify referral arrangements and serve as an advocate; 3) the way in which specialty care is provided in Des Moines further fragments the care provided to the uninsured; and 4) the large non-profit systems play a very limited role in the safety net. Several communities have tried to address some of these issues by creating an electronic system that follows patients as they navigate through a complex and fragmented system. To date, no such system exists in Des Moines; however the Healthy Access Partnership (HAP) is working towards developing this type of system.
- **Radical changes are needed to avoid BMC's further decline.** The challenges facing BMC are monumental. The organization faces ever-increasing demands to serve more uninsured Polk County residents; much of the medical center's physical plant is aging and in need of renovation; its medical equipment needs updating; and BMC's revenues are extremely limited. Unfortunately, there are no easy and readily available solutions to address these financial and infrastructure challenges. For example, improving efficiencies is unlikely to

provide sufficient resources to ameliorate BMC's situation. Radical changes are necessary to maintain BMC's presence (and the tax levy funds associated with it) in the community.

Public Policy Options

Option One: Strengthen BMC through increased public support.

Under this option BMC remains as it is – a primary care hospital that treats a majority of the county's uninsured patients. This option assumes that no additional services will be developed or expanded. If this option is undertaken, the community must come to grips with the fact that BMC will not generate enough funds to be self-sufficient. BMC faces increasing numbers of uninsured patients who have moderate to severe health conditions. Simultaneously, BMC does not have service lines (e.g., trauma center, high volume labor/delivery, cardiac care) that may generate sufficient revenues to offset losses in other types of care. Furthermore, BMC's infrastructure requires serious attention and renovation. The community must embrace the reality that its public hospital is a public good that requires a greater commitment of public funds.

Public policy considerations must be examined to determine how BMC can improve its share of disproportionate share hospital (DSH) and upper payment level (UPL) payments. Careful analysis should also be given to the impact that the new Medicaid reform legislation will have on patient referral and utilization patterns at BMC. Given the fact that BMC is one of only two hospital systems that are covered providers for the Medicaid expansion's 30,000 potential eligibles, analysis should be undertaken to determine whether payments under the program are adequate to cover the costs associated with caring for these patients. Safety net financing is complicated and always requires strong relationships with state and county legislators and other key stakeholders. Some communities have created health authorities to consolidate and maximize Medicaid funding; others go directly to the tax payer and seek enhanced revenues through tax supports. The precise strategy for Des Moines depends on many different factors including political feasibility, local preferences, and availability of federal or state sources of revenue.

Option Two: Strengthen BMC through targeted growth in its training programs.

Under this option efforts would be undertaken to build-up and expand BMC's teaching programs. BMC's family practice residency program has been a strong asset to BMC, and the institution should integrate other specialties into its existing training programs. There appear to be enormous opportunities to increase BMC's teaching programs by including more specialty physicians, nurses, pharmacists, and dentists. We recommend commissioning a comprehensive assessment of "Specialty Care in the 21st Century" to examine how specialty residency and other training programs should be integrated into BMC's already successful family practice residency program specifically; and reorganized across Iowa generally. This study should also examine the costs associated with medical education and what funding is required to sustain such a program.

Based on the results of this study, targeted efforts should be undertaken to enhance BMC's residency and teaching programs.

Option Three: Develop partnerships with one of the existing Des Moines hospital systems.

The community could consider a public-private partnership that could result in giving patients access to a full complement of specialty and tertiary care. It would also allow BMC to share in economies of scale. BMC's inpatient capacity could easily be served by one of these hospitals; however, that hospital would face challenges in delivering services to BMC's patients. A substantial portion of BMC's patients require a comprehensive set of health, psycho-social, and supportive services delivered in a culturally and linguistically appropriate manner. In order to retain the tax levy funding and keep the governmental entity intact, a clearly articulated charter would need to be written emphasizing the hospital's responsibility to maintain a safety net mission. This is especially true of mental health services, a primary strength of BMC. Many other public hospitals have successfully converted or partnered with other health care systems. Such a conversion/partnership requires that the new hospital entity reorient its culture and expectations to appropriately serve low-income underserved patients.

Option Four: Expand and Strengthen Community Health Center Networks.

Any type of reorganization of the Des Moines safety net should consider and support an expansion of FQHCs in Polk County and surrounding areas. A consolidated effort to develop a network of FQHCs in cooperation with Primary Health Care, Inc. (PHC) should be led by a community-wide coalition of providers, state and local agencies, community based-organizations, business interests, advocates, patient representatives and others. Additional FQHCs will provide medical homes for the delivery of preventive and chronic disease management care that requires less expensive inpatient, emergent and specialty care. They also provide opportunities to share resources and reduce service duplication. Obtaining FQHC designation and Section 330 grant funding could help to maximize Medicaid revenue and provide funding to offset at least a portion of the costs associated with serving uninsured, underserved and undocumented patients. Since FQHCs are generally limited to providing only primary care services, it will be essential to evaluate potential sources of funding for FQHC patients' specialty care needs which are addressed by other providers.

APPENDIX A: BLUE RIBBON STEERING COMMITTEE MEMBERS

Governor Robert Ray

Theodore Boesen Jr.
Executive Director
Iowa Nebraska Primary Care Association

Governor Terry Branstad
President
Des Moines University

Max Cardenas
Director of Partnerships and Training
New Iowans Program

Angela Connolly
Polk County Supervisor

Donald Cooper
Director
VA Central Iowa Health Care System

Frank Cownie
Mayor
City of Des Moines

Eric Crowell
President and CEO
Central Iowa Health System

Lynn Ferrell
Executive Director
Polk County Health Services

Merritta (Margi) Florence
Member
Broadlawns Foundation

Senator Jack Hatch
Iowa Senate

Susan Hunsaker
President and CEO
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Anne Kinzel
State Planning Grant
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Raymond A. Kuthy, DDS
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Josh Mandelbaum
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Dave Merritt
Past Chair
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Kirk Norris
President and CEO
Iowa Hospital Association

Lyndon Peterson
Vice President of Provider Relations
Wellmark Blue Cross and Blue Shield

Jeff Riese
Executive Director
Polk County Taxpayers Association

Stephen W. Roberts
Member of Chairman's Council
Broadlawns Foundation

Jean E. Robillard, MD
Dean
University of Iowa College of Medicine

Walt Tomenga
Iowa House of Representatives
Representative, Greater DSM Partnership

Roger Tracy
Assistant Dean/Director of Statewide Programs
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David Vellinga
President and CEO
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Senator Pat Ward
Iowa Senate

Eric Witherspoon, Ph.D.
Superintendent
Des Moines Public Schools