The Affordable Care Act & Racial and Ethnic Health Equity Series

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Supporting and Transitioning the Health Care Safety Net

Executive Summary

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Executive Summary

I. Introduction

The nation’s health care safety net is a patchwork of institutions, financing, and programs that disproportionately serve low-income, uninsured, and racially and ethnically diverse populations. Medicaid is largely the financial underpinning of the safety net, as historically it has provided financial support for the majority of insured patients cared for by safety-net providers. Safety-net providers—comprised of a spectrum of organizations from major public hospitals and community health centers to free, rural, and public health clinics—represent critical and, frequently, the only sources of primary, specialty, inpatient, and emergency care for largely uninsured, Medicaid, and other vulnerable patients. By their mission, location, and history of service, safety-net providers are well-positioned to continue to play a central role in serving low-income patients, particularly of diverse racial and ethnic heritage, following the implementation of health care reform.

The purpose of this report is to provide a point-in-time report on status and progress of the implementation of ACA’s provisions for advancing racial and ethnic health equity within the health care safety net. As such, it describes the opportunities presented by the new law, along with challenges, lessons, and actions taken to position the health care safety net to continue to serve a growing racially and ethnically diverse patient population. Embedded within this report are emerging programs, best practices, and resources that address racial and ethnic health equity at the core of transforming the health care safety net.

II. Methodology

We utilized a multi-pronged, qualitative approach to monitor and analyze the progress of nine key safety-net provisions in the ACA with major implications for racially and ethnically diverse communities. Our approach consisted of a systematic review and synthesis of relevant literature; an analysis of federal rules and regulations, funding opportunities, and emerging programs; and key informant interviews with state and local health officials, hospital executives from public hospitals, health center administrators, and representatives from state exchanges, health plans, and a range of community and advocacy organizations. Based on common issues that affect the major groups of players in the safety-net system, the nine provisions were organized into three overarching themes: (1) expansion of public programs; (2) support for health centers and clinics; and (3) new requirements for safety-net hospitals. For each provision, we identified legislative context and history; implementation status, progress, and potential impact; emerging models and programs; and challenges and next steps to realizing the objectives of the provision for advancing racial and ethnic health equity.

III. Implementation Progress of the ACA’s Provisions for the Health Care Safety Net

This section summarizes the implementation progress, opportunities, challenges, and road ahead for key provisions in the new law that are expected to have major implications, both positive and negative, for the nation’s health care safety net in serving diverse patients. As described above,
the nine provisions are grouped into three overarching themes addressing public programs, health centers and clinics, and safety-net hospitals.

A. Expansion of Public Programs

Racially and ethnically diverse populations constitute just over one-third of the U.S. population, however they comprise over half of those who rely on Medicaid. A recent study estimated that in 2011, whereas over 11% of Non-Hispanic Whites relied on Medicaid and CHIP, 28% of African Americans, 27% of Hispanics and nearly 18% of Asians and others relied on these public programs for coverage. Expansions in Medicaid and CHIP are expected to considerably reduce racial and ethnic disparities in health insurance coverage, affecting millions of diverse individuals across the nation.

- **Medicaid.** As of June 14, 2013, 26 states and the District of Columbia will expand Medicaid, four are participating in an alternative expansion, and one is leaning toward participating. Thirteen states are opting out and an additional six are leaning toward opting out of Medicaid. If all states expand Medicaid, it could open doors to insurance for over 15 million uninsured adults with incomes at or below 138% of the federal poverty level (FPL), nationally. Of this population, 45% or 6.8 million would be Non-Whites. However, following the Supreme Court’s decision which made Medicaid expansion optional, only two-thirds of states are expanding. Across these states, just over 3.8 million diverse adults will be eligible for Medicaid. Among states not expanding Medicaid, nearly 2.3 million diverse adults with incomes below 100% FPL will lose out on both Medicaid and premium subsidies available through the exchanges, potentially leaving them without any coverage. And states including Texas and Georgia could alone leave as many as one million predominantly poor, African American, and Hispanic adults uninsured.

Recent studies show considerable variability in impact of state Medicaid expansion decisions by race and ethnicity, with African Americans facing the biggest gaps in coverage. For example, whereas roughly one-fourth (27%) of African Americans with incomes below 138% FPL reside in states expanding Medicaid, nearly six in ten (59%) reside in states opting out of the expansion.

- **Children’s Health Insurance Program (CHIP).** The ACA reauthorizes funding for CHIP until at least October 1, 2015, and requires states to maintain eligibility levels to those at the time of ACA’s enactment. Section 10203 increases outreach and enrollment funding for Medicaid and CHIP from $100 million for FY 2009 – FY 2013 to $140 million for FY 2009 - FY2015. Since the enactment of the ACA, a series of rules, regulations, and grants have emerged around CHIP, some of which address outreach and education for limited English proficiency populations. In particular, the federal campaign, “Connecting Kids to Coverage” offers a range of resources, including webinars on how to reach diverse communities through outreach and education.

B. Health Centers and Clinics

Given their history of service to predominantly low-income and diverse patients, health centers and clinics are expected to maintain, if not strengthen, their unique role in serving these patients starting January 1, 2014, when the ACA’s major insurance provisions take effect.
• **Community Health Centers (CHCs).** The ACA creates a Community Health Center Fund (CHCF) to expand national investment in health centers by $11 billion over five years between FY 2011 and FY 2015. This funding is in addition to discretionary funds Congress allocates to health centers each year. However, starting in FY 2011, discretionary funding for health centers was significantly reduced, translating to a $3 billion cut over five years. In addition, the sequestration ordered by President Obama on March 1, 2013 imposed a 2% cut on the CHCF. In FY 2013 alone, this translated to a $120 million loss in funding for health centers and is estimated to result in approximately 900,000 fewer patients being served of which 57% will be from Non-White racial and ethnic groups. Despite these cuts, however, the reality is that health centers will see a large influx of patients, including those newly covered by Medicaid and those obtaining coverage through the exchanges. At the same time, they will continue to be a major provider of care for the uninsured. As data following Massachusetts’s similar health reform implementation showed, the uninsured rate among health center patients was nine times that of the state generally.

Moving forward, key questions and challenges facing health centers include: how to compete and attract new patients, while maintaining their mission to serve low-income and uninsured patients; how to ensure continuity of care, especially given churning of low-income patients across coverage options and difficulty of linking patients to specialty care; and ensuring financial viability and sustainability in the long run.

• **Nurse-Managed Health Clinics (NMHCs).** The ACA establishes a grants program to develop and operate NMHCs. While $50 million was originally appropriated for this program in FY 2010, and such sums as necessary in subsequent years through FY 2014, only $14.9 million was actually awarded to 10 grantees across nine states in 2010, with no additional funding received to date. All grantees are either located in or serve medically underserved communities, and four explicitly cite health disparities, minority health, or cultural competence as priorities in their program description. Despite the proven success of NMHCs in serving culturally and linguistically diverse populations, a major hurdle to implementing the ACA’s vision to expand their role in the health care system is funding. Advocates for NMHCs continue to issue notices to educate and advocate for continued funding for this program.

• **Teaching Health Centers (THCs).** The ACA authorizes a grant program to establish new accredited or expanded primary care residency programs in community-based settings. Authorized funding includes $125 million for FY 2010 to FY 2012, and such sums as necessary for FY 2013 to FY 2015. This section also creates a Teaching Health Center Graduate Medical Education (THCGME) payment program which allocates $230 million for FY 2011 to FY 2015. To date, no funding has been received to establish new THC programs. Roughly $30 million in funding has been provided to 17 THCs for the THCGME program since FY 2011. Studies show that the benefit of using health centers for residency training is the retention of graduates in health center programs in inner-city, rural, and other underserved settings. These professionals are also trained in skills necessary to ensure the provision of ambulatory care to culturally diverse and socioeconomically disadvantaged populations, often not provided in other residency programs particularly those that are academic and research-based. A closer examination of the 11 inaugural programs from FY 2011 indicates that nine explicitly cite offering cultural competency
curricula as part of their residency training. Moving forward, funding and long-term sustainability pose major challenges for THCs.

- **School-Based Health Centers (SBHCs).** The ACA creates a grant program to support the operation of SBHCs, with funding preference given to those serving medically underserved children. A total of $200 million were authorized for FY 2010 to FY 2013, of which a total of $189 million has been awarded. As of FY 2012, 328 institutions received funding for SBHCs. States with the greatest number of grantees include California (39), New York (38), Oregon (18), Illinois (18), Michigan (15), Louisiana (15), West Virginia (12), Massachusetts (12), and North Carolina (11). Many SBHCs explicitly target diverse communities particularly to expand their access to preventive medical and dental services, behavioral health services, and counseling and social support services. Recently, SBHCs are being considered as an important player in providing education, outreach, and enrollment for the ACA. This is a natural extension of the role and purpose of existence of SBHCs for two primary reasons: (1) SBHCs serve a very diverse student population—e.g., 35.9% Hispanic or Latino, 26.3% African American, and 5.2% Asian or Pacific Islander; and (2) nearly 60% of SBHCs already assist patients to complete Medicaid or CHIP enrollment forms.

C. New Requirements for Safety-Net Hospitals

Safety-net hospitals or health systems serve large low-income, uninsured, and vulnerable patient populations. Whereas some are publicly owned, others are private, non-profit. Common among safety-net hospitals and health systems is their commitment to providing access to care for individuals with poor or no access to health care due to financial barriers, insurance status, or health condition. The ACA introduces many new opportunities, obligations, as well as challenges for safety-net hospitals in achieving their objective of serving low-income patients, many of whom are racially and ethnically diverse.

- **Medicaid Disproportionate Share Hospital (DSH) Payment.** The ACA reduces Medicaid DSH payments by $18 billion between FY 2014 and FY 2020. A proposed rule on the implementation of these reductions for FY 2014 and FY 2015 was issued by the Centers for Medicare and Medicaid Services (CMS) on May 13, 2013. Once finalized, the rule is expected to go into effect on October 1, 2013, unless Congress enacts the President’s Budget proposal to start Medicaid DSH payment reductions in FY 2015, instead of FY 2014. The proposed rule maintains the ACA’s original reductions (i.e., $500 million for FY 2014 and $600 million for FY 2015) and outlines five factors that must be considered in developing a state allocation methodology. These are intended to ensure that greater funding is allotted to states that are currently considered “low-DSH states”, have higher rates of uninsured, and target their DSH payments to hospitals with high Medicaid utilization or high uncompensated care costs. In addition, a state’s decision to expand Medicaid in 2014 will not impact DSH payment reductions as CMS will apply a two to three year lag in the data to determine allocations. States will decide how they choose to allocate these reductions across hospitals.

- **Medicare Disproportionate Share Hospital (DSH) Payment.** The ACA reduces Medicare DSH payments by $22.1 billion for FY 2014 to FY 2019. The law states that starting no later than FY 2014, and each subsequent year, DSH payments would be reduced by 75%, and savings from these cuts would be distributed to hospitals based on
their level of uncompensated care. A proposed rule issued by CMS on May 10, 2013 outlines how these changes will be implemented. In particular, CMS proposes to use the total of each hospital’s Medicaid and low-income Medicare inpatient days to calculate each hospital’s share of Medicare DSH payment allocations related to uncompensated care. Concerns are arising, however, that the use of inpatient days may not reflect a complete portrait of a hospital’s low-income patient population and burden.

- **Community Health Needs Assessment (CHNA).** The ACA strengthens the community benefit obligation by requiring all nonprofit, tax-exempt, or 501(c)(3) hospitals to conduct a CHNA every three years and to adopt an implementation strategy to address identified needs. The CHNA is to go into effect in the taxable year of each hospital beginning on or after March 23, 2012. On July 25, 2011, the Internal Revenue Service (IRS) released regulatory guidance on process and methods for conducting a CHNA, reporting obligations, and dissemination of findings. Specific guidance is provided on defining a community, along with obtaining input from community members, including minority groups and tribal agencies. On April 3, 2013, the IRS issued additional proposed regulations discussing reporting requirements for nonprofit hospitals and the consequences for failure to comply with new requirements.

**IV. The Safety Net at a Crossroads**

In an era of reform, the safety net stands at a crossroads: on the one hand, opportunities are wide as states set up their exchanges, expand Medicaid, enroll new children in CHIP, and take advantage of new support for health centers, physician reimbursement, and innovation. On the other hand, many of these health centers and safety-net hospitals face serious challenges as well as important decisions ahead to maintain their competitive edge while keeping their doors open to fulfill their central mission of serving poor, uninsured, and diverse populations. Adapting to at least the following circumstances and challenges will be at the core of ensuring safety-net providers prosper and can continue to serve poor, uninsured, and diverse patients:

**Rising Competitive Pressures.** Safety-net providers will face a set of new competitive pressures as the ACA’s major insurance provisions go into effect on January 1, 2014. As formerly uninsured are converted to newly insured patients through Medicaid and the exchanges, they could present a competitive threat for many safety-net providers. Priority among many safety-net hospitals and health centers is to minimize the erosion of their existing market. Many providers also expect that their reputation in the community as being trusted providers of care, their experience providing enabling services, and delivering quality care in culturally and linguistically appropriate ways, as well as their active and effective outreach and engagement efforts may facilitate this process and ease competitive pressures.

**Financial Adjustments and Threats.** Despite a bolus of support for health centers in the ACA, the safety-net system faces major federal and state financing shortfalls, both at present and in the years to come. Health centers experienced their first major federal funding cuts in almost 30 years when originally appropriated dollars in the ACA were significantly reduced in FY 2011 and subsequent years. Additional financial woes came to play with sequestration. For safety-net hospitals, decreases to a major funding lifeline—Medicaid and Medicare DSH payments—are scheduled to take effect on October 1, 2013, unless Congress enacts the President’s Budget proposal to delay these reductions to FY 2015. Adding to these safety-net financing concerns are
restricted, and in many cases declining, state budgets and limited state-based support for the safety net.

**Continuity of Coverage and Care.** Safety-net providers are particularly concerned about the financial and administrative implications of low-income patients whose coverage eligibility will fluctuate with their incomes. Patient churning will be of major concern to safety-net providers in states choosing not to expand Medicaid, where low-income individuals, particularly those with incomes below the federal poverty level, will be especially vulnerable to experiencing changes in coverage—and in many cases remaining uninsured. This could potentially impact nearly 2.3 million poor, racially and ethnically diverse individuals with incomes below the federal poverty level who are residing in states not opting for Medicaid expansion as of this writing.

**Access to Specialty Care.** While the significant investment in community health centers and related primary care workforce enhances the nation’s primary care capacity, these institutions face considerable challenges in ensuring their patients are connected with and receive specialty and subspecialty care. As health centers and clinics often rely on safety-net hospitals to provide specialty care, recent safety-net financing changes could further threaten this access for the nation’s most vulnerable patients, including those who are low-income and diverse.

**Populations Remaining at the Margins.** Following the U.S. Supreme Court’s ruling on the optional expansion of Medicaid, the Congressional Budget Office estimated that nearly 30 million non-elderly adults will remain uninsured in 2022, eight years following the full implementation of the ACA. Low-income U.S. citizens who would otherwise be eligible for Medicaid, but are not because their state is opting out of expansion, may account for as many as 4 million of this uninsured population. Approximately half of these individuals—or 2 million—will be citizens of color. With incomes below the federal poverty level, these individuals will not qualify for federal subsidies through the exchanges. In addition, approximately 11 million undocumented immigrants will remain uninsured.

**V. Moving Forward: Assuring Health Equity in Safety-Net Priorities**

Although there is no question that racially and ethnically diverse communities have much to gain from the enactment of the ACA—including expanded coverage and new access points to care—local, state, and federal policy must work to ensure that unintended consequences do not widen disparities as safety-net institutions transition and adapt to a new health care environment. We identify at least five areas of priority for transitioning and preserving the safety net, particularly in its continued role of effectively and concertedly caring for diverse individuals and communities, and in advancing equity in 2014 and beyond.

**Outreach and Enrollment for Medicaid and the Exchanges.** With the prime focus and thrust of the ACA being on Medicaid and the exchanges, many safety-net providers are shoring up their efforts around advocacy, outreach, and enrollment. The first order of business, as many safety-net providers indicated in interviews, is to maintain the Medicaid populations they already serve as well as the uninsured who will become newly eligible for coverage. In early July 2013, HRSA announced a total of $150 million in grant awards to 1,159 health centers across the country. In addition, several private sector initiatives to promote and advance education, outreach, and enrollment have emerged. Despite this thrust, however, there is some variability in safety-net
involvement in this new role. Much depends on resources, capacity, and political will to bridge their service mission to outreach and enrollment.

**Developing Integrated Systems of Care.** The ACA’s attention to continuity of care and systems of care presents both obligation and opportunity to community health centers, safety-net hospitals, and related organizations. Many community health centers, for example have faced formidable challenges in coordinating specialty care they do not provide, while safety-net hospitals may not have the community scope and reach well established by centers. The ACA offers new ways to support and develop integrated systems for these health care settings—e.g., Accountable Care Organizations, Patient-Centered Medical Homes, and other programs through the Centers for Medicare and Medicaid Innovation. However, for such efforts to be successful safety-net organizations will need to consider and work to resolve questions around governance and control; technology, physical capacity, and other infrastructure; design of payments to encourage use of appropriate services and adequacy of financial incentives including risk sharing; effective adaptation of new models of care that use multidisciplinary teams; and development of appropriate measures of effectiveness.

**Using the CHNA for Broader Community Impact.** A review of nonprofit community health needs assessments conducted recently in response to the ACA’s requirements reveals that they are “brimming with indicators that advocates can use to drive attention to community health issues.” A core and common ingredient across these community health needs assessments has been collaboration and a comprehensive, community-wide process which has typically involved a wide range of public and private partners, including educational institutions, health-related professionals, government agencies, human service agencies, and faith-based and other community organizations. In addition, these assessments typically involve a systematic approach to collect and evaluate data, and offer a new and unique opportunity to measure and monitor health disparities across various access, quality, and health outcome measures within communities.

**Leveraging the ACA with Philanthropic Support.** Philanthropic leadership and support will be critical to helping safety-net providers transition to the new health care environment. For example, foundations can assist these institutions in adopting new infrastructure to meet related Medicaid, exchange, or other requirements around information technology, physical capacity or staffing, in helping to build workforce competence in addressing the needs of culturally and linguistically diverse patients, and in positioning themselves to take advantage of new federal funding opportunities. Philanthropic organizations and foundations can support and work with these settings to ensure that priorities around improving equity and addressing social determinants affecting individual and community health, as well as reducing disparities in access to and quality of care are part of adaptive strategies. Encouraging and incentivizing collaboration with other providers, including hospitals, health centers, state and local health departments, and advocacy organizations, can also help safety-net providers leverage limited resources and attract new funding.

**Monitoring DSH Payment Reductions.** The Supreme Court’s decision resulting in the optional expansion of Medicaid among states will perhaps have one of the most deleterious effects on safety-net hospitals. Reductions in the DSH Program were written into the ACA with the assumption that all states would expand Medicaid for people with incomes below 138% of the federal poverty level. Given the altered reality, however, in states not expanding Medicaid, public
and other safety-net hospitals could see an erosion of their DSH funds, with little or no change in the amount of uncompensated care they provide. Recognizing this threat, the recently issued draft regulation and methodology for calculating DSH payment reductions suggests that a two to three year lag in data on uninsured be employed to establish such cuts. However, the size and scope of these reductions are still unclear, with uncertain impact on states and hospital systems. At the state-level, careful review and understanding of current distribution and uses of Medicaid DSH funds across hospitals is warranted to establish a methodology that has the least impact on hospitals with the greatest uninsured burden. At the same time, monitoring of these funds in the years following 2014 will be critical to understanding the impact on most hard-pressed hospitals, particularly those serving extremely vulnerable, low-income, and diverse patients.

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Congressional and administrative debates and deliberations are likely to intensify around continuing support for the safety net and for efforts that would enable them to adapt. And while the vision of health care under reform may offer the promise of reduced need for safety-net settings to provide care for uninsured and underinsured individuals, federal and state pressures to constrain costs, varied state participation in Medicaid and the exchanges, questions beyond enrollment that remain around service access and capacity, and the potential for millions still without adequate if any insurance, may augur a reality where great need and great demand will remain. And so the national safety-net providers face a daunting balance: preparing for a new world of health care while continuing to confront the limits and disparities perpetrated by the past. Working to effectively apply and direct what the ACA offers can help ensure they can achieve that balance.