The Affordable Care Act &
Racial and Ethnic
Health Equity Series

Report No. 2
Supporting and Transitioning the
Health Care Safety Net

Advanced Draft for Review and Comment

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Preface

Data, research and experience have demonstrated longstanding and extensive disparities in access to, quality and outcomes of care for racially, ethnically, and linguistically diverse patients and communities in the U.S. health care system, despite efforts to address them. While lack of health insurance is a well-established and major contributor to these disparities, children and adults from diverse racial and ethnic heritage often face significantly poorer care and health outcomes than White patients even when insured.

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (together the Affordable Care Act or “ACA”) offer an unprecedented opportunity to bridge this divide. While expanding health insurance is a centerpiece in achieving this goal, the ACA includes dozens of provisions intended to close these gaps in quality and outcomes for racially and ethnically diverse and other vulnerable populations. In so doing, the new law provides important incentives and requirements to create a more equitable health care system by expanding the number of health care settings near to where people live and work, increasing diversity among health professionals, and addressing language and culture in delivery of services through innovative, clinical and community-based approaches. But taking this vision and its well-intentioned goals to reality in the short and longer-term will determine ultimate effectiveness and success.

The Texas Health Institute (THI) received support from the W.K. Kellogg Foundation and The California Endowment to monitor and provide a point-in-time portrait of the implementation progress, opportunities and challenges of ACA’s provisions specific to or with relevance for advancing racial and ethnic health equity. Given the ACA was intended to be a comprehensive overhaul of the health care system, we established a broad framework for analysis, monitoring and assessing the law from a racial and ethnic health equity lens across five topic areas:

- Health insurance exchanges;
- Health care safety net;
- Workforce support and diversity;
- Data, research and quality; and
- Public health and prevention.

This report is one of five THI has issued as part of the Affordable Care Act & Racial and Ethnic Health Equity Series, and it focuses specifically on provisions in ACA for Supporting and Transitioning the Health Care Safety Net.
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 status and progress on 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 several 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 describes the implementation progress, opportunities, challenges and road ahead for nine provisions in the new law that are expected to have major implications, both positive and negative, for the nation’s health care safety net, particularly in serving racially and ethnically diverse patients.
A. Expansion of Public Programs

- **Medicaid.** As of February 28, 23 states and the District of Columbia have decided to expand Medicaid; 14 states are opting out of the expansion; and 12 states have not issued a final decision. Should all states opt to expand Medicaid, it would open doors to insurance for over 15 million uninsured with incomes at or below 138% of the federal poverty level, nationally. Of this population, 44 percent or 6.8 million belong to Non-White racial and ethnic groups. However, given roughly half of all states are expanding Medicaid, only about 3.4 million diverse individuals will be eligible for this coverage, at this time. Among states not expanding, over 2 million diverse individuals with incomes below the federal poverty level could potentially be left with no coverage, whatsoever, in 2014.

- **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 fiscal years 2009-2013 to $140 million in for fiscal years 2009-2015. Since the enactment of the ACA, a series of rules, regulations, and grants have emerged around CHIP, some of which consider outreach and education to limited English proficiency populations.

B. Health Centers and Clinics

- **Community Health Centers (CHCs).** The ACA creates a Community Health Center Fund to expand national investment in health centers by $11 billion over 5 years between fiscal years 2011 and 2015. This funding is in addition to discretionary funds Congress allocates to health centers each year. In fiscal year 2011, discretionary funding for health centers was reduced by $600 million, from $2.2 to $1.6 billion. To offset this reduction, $600 million were diverted from the Trust Fund to support health center operations that would otherwise have been supported through discretionary funds. This reduction translates to a $3 billion cut in investment originally anticipated for health centers over the five-year period.

- **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 fiscal year 2010, and such sums as necessary in subsequent years through fiscal year 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.

- **Teaching Health Centers (THCs).** The ACA authorizes a grant program to establish new accredited or expanded primary care residency programs in community-based settings. Appropriated funding includes $25 million for fiscal year 2010, $50 million for each fiscal year 2011 and 2012, and such sums as necessary for fiscal years 2013-2015. This section also creates a Teaching Health Center Graduate Medical Education (THCGME) payment program which is allocated $230 million for fiscal years 2011-2015. 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 fiscal year 2011. A closer examination
of the 11 inaugural programs from 2011 indicates that nine explicitly cite offering cultural competency curricula as part of their residency training.

• **School-Based Health Centers (SBHCs).** A grant program is created to support the operation of SBHCs, with funding preference given to those serving medically underserved children. $50 million is appropriated for each fiscal year 2010-2013. In 2011, 278 SBHCs were awarded a total of $95 million to serve 440,000 new patients, with an additional $14 million in funding to modernize and expand facilities to serve 53,000 additional children. In 2013, an additional $75 million was awarded to SBHCs for construction and renovation.

C. **New Requirements for Safety Net Hospitals**

• **Medicaid Disproportionate Share Hospital (DSH) Payment.** Medicaid DSH spending is reduced by $18 billion between fiscal years 2014 and 2020. Guidance on methodology for percentage reduction among states is yet to be determined. Although national research and analytical organizations are weighing in on recommended strategies and approaches for determining these cuts.

• **Medicare Disproportionate Share Hospital (DSH) Payment.** Medicare DSH spending is reduced by an estimated $22 billion over 10 years. Starting no later than fiscal year 2014, and each subsequent year, DSH payments would be reduced by 75 percent.

• **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 after March 23, 2012. On July 25, 2011, the Internal Revenue Service (IRS) released anticipated regulatory provisions or guidance on process and methods for conducting a CHNA, reporting, and disseminating findings. Specific guidance is provided on defining a community, along with obtaining input from community members, including minority groups and tribal agencies. Non-governmental guidance is also emerging on best practices for conducting a CHNA. Resources include, for example, the Public Health Institute’s 2012 report on “Best Practices for Community Health Needs Assessment” and the Catholic Health Association’s “Assessing & Addressing Community Health Needs,” among others.

IV. The Safety Net at Crossroads

In an era of reform, the safety net stands at 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, however, many of these health centers and safety-net hospitals face serious challenges as well as critical actions and decisions ahead to maintain their competitive edge, while keeping their doors open to fulfill their central mission of serving poor, uninsured, and diverse populations.

**Rising Competitive Pressures.** Safety-net providers will face a set of new competitive pressures as the ACA’s major insurance provisions go into effect. 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 ease competitive pressures.

Financial Threats and Adaptive Capacity. 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 setbacks in almost 30 years when originally appropriated dollars in the ACA were significantly cut in 2011, and into 2012. For safety-net hospitals, declines to a major funding lifeline—Medicaid and Medicare Disproportionate Share Hospital payments—are scheduled to begin taking effect in January 1, 2014. 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 income. 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 over 2 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.

Uncertainty around the Safety Net Role in State Exchanges. Our review indicates that safety-net providers, in general, are concentrating their efforts on Medicaid enrollment and maintaining the population they already serve. However, we found much more variability in preparing for an active role in the exchanges. It appears that the first priority is assuring that these providers do not lose the Medicaid populations they are already serving, as well as their currently uninsured patients who will be newly enrolled in Medicaid.

Access to Subspecialty Care. While the significant investment in community health centers enhances the nation’s primary care capacity, these institutions face considerable challenges in ensuring their patients are connected with and receive 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 racially and ethnically 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. Of this uninsured population, low-income U.S. citizens may account for as many as 4 million without insurance in states that (to date) have turned down the Medicaid expansion. Approximately half—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, unlike lawfully present immigrants who in non-Medicaid expansion states will obtain this benefit.
V. Moving Forward: Ensuring Racial and Ethnic Equity is Integrated into 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 the disparities gap as the safety net transitions and adapts to a new health care environment. We identify at least four areas of priority for transitioning and preserving the safety net, particularly in its continued role of effectively and concertedly caring for racially and ethnically diverse individuals and communities, and in advancing equity in 2014 and beyond.

Addressing DSH Payment reductions in the context of optional Medicaid expansion. 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. Given the altered reality, and as federal guidelines remain to be issued on the methodology, size and scope of DSH cuts, there may be an opportunity to reevaluate and adjust the formula to mitigate the impact on safety-net providers in states that opt not to expand Medicaid. 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.

Developing integrated systems of care across safety-net settings and with other systems. 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 these integrated systems for these health care settings, such as through Pediatric Accountable Care Organizations, Patient-Centered Medical Home initiatives, and other innovative arrangements supported through the Center for Medicare and Medicaid Innovation.

Building on Community Health Needs Assessment to create healthier communities. As noted, under the ACA, nonprofit hospitals are required to conduct CHNA every three years. While sometimes viewed as “yet another added governmental requirement”, there is perhaps more than meets the eye in terms of opportunities for creating healthier communities and addressing racial and ethnic disparities. Given the resources devoted to conducting these assessments, along with an established network of partners and in many cases a replicable methodology, this federal hospital requirement holds significant opportunity to identify, measure and monitor health care needs and disparities, resources, capacity, gaps, and priorities for action on a community-wide basis for years to come.

Engaging state and local philanthropy to complement the ACA in supporting the safety net. Philanthropic leadership and support will likely be critical to helping safety-net providers transition to the new health care environment. Eleemosynary organizations 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.

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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, 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 auger 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 can offer can help ensure they can achieve that balance.
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, and subsidized a considerable portion of care for uninsured through such programs as Disproportionate Share Hospital (DSH) payments and cost-based reimbursement for health centers.¹

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 Congressional Budget Office (CBO) estimates that by 2022, approximately 30 million Americans will remain uninsured following the implementation of the Affordable Care Act (ACA). Assuming ACA is fully implemented by all states, a recent study shows that while diverse populations have most to gain from coverage expansions, uninsured rates will continue to be disproportionately higher among racially and ethnically diverse individuals and families.² Specifically, researchers estimate that almost 21 percent of Hispanics, 10 percent of Asians/Other, and 10 percent of African Americans will remain uninsured as compared to about 7 percent of Whites.³ Furthermore, for states choosing to expand Medicaid and with the reauthorization of CHIP, the largest gains in coverage can be expected for Non-Whites, particularly African Americans and Hispanics.⁴ And of the population that will be eligible for Medicaid, but unenrolled and uninsured, almost 60 percent are likely to be African American. Finally, undocumented immigrants will comprise nearly one-fourth of the uninsured population, of which over 80 percent will be of Hispanic origin.⁵

Given that diverse residents comprise a large majority of individuals and families most likely to access care at safety net institutions, it is critical to ensure the system is well-equipped to reach and serve this patient population. While the ACA includes mechanisms to address disparities and advance racial and ethnic health equity, the future of safety-net providers in this new, volatile environment is far from clear. Many opportunities are emerging that could strengthen the position of these hospitals and health centers. However, many are also likely to face significant threats that could disrupt their role, if not imperil their financial viability in continuing to serve as core providers to disadvantaged patients.

Purpose and Rationale

The purpose of this report is to provide a point-in-time status and progress on the implementation of ACA’s provisions for advancing racial and ethnic health equity within the
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 brief are emerging programs, best practices and resources that address racial and ethnic health equity at the core of transforming the health care safety net.

The Project Team identified and monitored the following nine provisions which explicitly mention or have significant relevance for racial and ethnic health equity in safety-net settings.

- Medicaid Expansion (§2001)
- CHIP Reauthorization (§2101, §10203)
- Reduction in Medicaid DSH Payments (§2551)
- Reduction in Medicare DSH Payments (§3133)
- School-Based Health Centers (§4101)
- Nurse-Managed Health Clinics (§5208)
- Teaching Health Centers (§5508)
- Community Health Centers (§5601)
- Non-Profit Hospital Community Needs Assessment (§9007)

**Organization of Report**

This report is organized into the following four sections:

I. **Introduction:** This section provides an overview of the goals, objectives, target audience, and value and use of this report. It also describes the Affordable Care Act & Racial and Ethnic Health Equity Series in greater depth.

II. **Methodology:** The framework and design is discussed in this section, along with specific activities that were undertaken in developing this report.

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

This section is organized into three main subparts which address: (1) Medicaid and CHIP; (2) Health Centers and Clinics; (3) and Safety-Net Hospitals. Each of these subsections provides a detailed summary of:

- Legislative context of provision, including appropriations, timeline and requirements as was authorized by the ACA;

- Implementation progress, detailing the emergence of federal rules, committees, grant opportunities and other programs and initiatives;

- Emerging progress and models are presented, with details on how they address race, culture and language in context of the safety net;

- Challenges and next steps are discussed, highlighting in particular areas lagging in progress, threats to the safety net in caring for diverse populations and opportunities moving forward for addressing these issues.
Confronting Reality: Changes and Challenges for the Health Care Safety Net:
This section discusses common and distinct themes that emerged in findings on implementation progress, and discusses issues and challenges that should be considered to ensure a robust safety net for diverse, vulnerable and virtually all populations.

Moving Forward: Opportunities and Actions for Assuring the Health Care Safety Net Advances Racial and Ethnic Equity: We conclude the report with a discussion of potential next steps for ensuring that advancing equity is an integral part of reforming the health care safety net.

Given health care reform is rapidly evolving, with new information and policies emerging almost daily, we emphasize this report offers a point-in-time snapshot of information, perspectives, and resources that were available during the time this project was undertaken.
Affordable Care Act & Racial and Ethnic Health Equity Series

Background and Context

We have been monitoring and analyzing the evolution of health care reform and its implications for reducing disparities and improving equity since shortly after the inauguration of President Obama in 2009. With support from the Joint Center for Political and Economic Studies in Washington, D.C., the project team tracked major House and Senate health care reform legislation, identifying and reviewing provisions on workforce diversity, language, cultural competence, data collection by race and ethnicity, and other related racial- and ethnic-specific initiatives. The team also tracked and compared the implications of broader proposals intended to improve access to insurance and health care, improve quality and contain costs for diverse populations. Nearly half a dozen summary reports and issue briefs were released, providing a resource for community advocates, researchers, and policymakers interested in understanding and comparing the significance and implications of these provisions.

With the enactment of the ACA, the project team developed a final report that identified and profiled over three dozen provisions specific to race, ethnicity, culture, and language into six major areas of priority: data collection and reporting; workforce diversity; cultural competence education and organizational support; health disparities research; health disparities prevention initiatives; and addressing disparities in insurance coverage. A second set of provisions addressed broader health reform initiatives—such as quality improvement, access, public health and social determinants—with potential relevance and implications for racially and ethnically diverse populations. As part of our analysis we summarized the importance of these provisions and raised issues or questions around implementation, federal agencies responsible for provisions, and appropriations if identified.

The final report, entitled, Patient Protection and Affordable Care Act: Implications for Racially and Ethnically Diverse Populations⁵ was released in July 2010 and was intended to offer a summary of the ACA in a user-friendly format and length as well as easily understandable language on specific priorities as they related to culture, language, and eliminating racial and ethnic disparities in health and health care. In so doing, the report demonstrated the ACA’s broadly encompassing vision and opportunities spanning a spectrum of health-related priorities.

Purpose and Objectives

Since the Supreme Court’s historic decision to uphold the ACA, and the re-election of President Obama for a second term, the implementation of health care reform has gained momentum, and many provisions face very tight and rigid timelines. While the federal government has issued rules, standards and guidance for many broader provisions in a relatively short period of time, organizations and agencies await specific guidance for others addressing diversity, language access, and cultural competence. At the same time, the complexity of the law, new and novel incentives and requirements, and fluidity of its execution create significant challenges for states, health care providers, community organizations, advocates, and others in identifying obligations as well as opportunities they can directly tap or leverage to support the diversity and equity objectives of the ACA.

The overall objective of the Affordable Care Act and Health Equity Series is to provide an informative, timely, user-friendly set of reports as a resource for use by organizations and individuals working to reduce racial and ethnic health disparities, advance equity, and promote healthy communities at the
national, state and local levels. The Series is funded by W. K. Kellogg Foundation and The California Endowment, and additional support was provided by Kaiser Permanente’s Community Benefit National Program Office to investigate health insurance exchange progress, with specific focus on seven case study states.

Following are objectives of this Series:

• To provide a point-in-time snapshot of implementation progress—or lack thereof—of over 60 provisions in the ACA with implications for advancing racial and ethnic health equity, detailing their funding status, actions to date, and how they are moving forward;

• To showcase concrete opportunities presented by the ACA for advancing racial and ethnic health equity, such as funding, collaborative efforts, and innovation that organizations can take advantage of;

• To highlight any threats, challenges or adverse implications of the law for diverse communities to inform related advocacy and policy efforts; and

• To provide practical guidance and recommendations for audiences working to implement these provisions at the federal, state and local levels, by documenting model programs, best practices, and lessons learned.

Design and Methodology

The Project Team utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities and challenges of roughly 60 provisions in the ACA, across five topic areas:

• Health insurance exchanges;
• Health care safety net;
• Workforce support and diversity;
• Data, research and quality; and
• Public health and prevention.

For each topic area, the project team conducted a comprehensive review of literature, along with an in-depth assessment of emerging federal rules, regulations and funding opportunities; state models and innovations; and community and local programs and policies. As such, the following information was extracted for each provision within a topic area:

• Legislative language and context of provision, including timeline, funding and players;
• Research evidence for importance and rationale related to addressing disparities;
• Summary of federal actions, such as issued rules, funding opportunities, and collaboration;
• Related national, state, and local models and programs as well as best practices, either informing implementation or that have emerged as a result of implementation; and
• Guidance and recommendations for implementation from the Federal Government or national think tanks and policy experts, along with challenges and next steps for implementation.

To complement research and evidence gathered through a review of literature, and to fill important gaps in knowledge and experience, the team conducted telephone-based interviews with nearly 70 national experts and advocates, federal and state government representatives, health care providers, health plans, community organizations, and researchers in the field. A full list of participants and contributors can be found in Appendix A.
A review of literature, latest policy updates, and gaps in knowledge guided the development of a series of key informant interview questions. Information gathered from each interview was manually sorted and analyzed to extract overarching common and distinct themes and sub-themes. Findings from the literature review, policy analyses and interviews were synthesized into five topic-specific, user-friendly reports.

Given each report is topic-specific and part of a larger Series, every attempt was made to cross-reference subtopics across the Series. For example, support for the National Health Services Corps is highlighted under the “Workforce” topic, although it has direct relevance for the “Safety Net” report. Organizing and cross-referencing the reports in this manner was important to streamlining the large amounts of information and ensuring the reports remained user-friendly.

**Audience and Use**

With the latest policy updates and research, complemented by voices and perspectives from a range of sectors and players in the field, the goal of this Series is to offer a distinct resource and reference guide on the implementation status of the ACA’s diversity and equity provisions along with emerging opportunities and actions to reduce disparities. However, given the health care arena is rapidly evolving and expanding, with new guidance, policies and actions emerging almost daily at all levels, this Series offers a point-in-time snapshot of information, perspectives, and resources that were readily available and accessible during the time this project was undertaken. Information and updates as of February 2013 have been incorporated into this brief. However, anything more recent is not captured here. Nonetheless, information, review, and findings are intended to be helpful for a broad audience from national, state and local agencies and organizations.

Following are examples of how a range of sectors may find this Series of value and use:

- National organizations or federal government agencies may find information on emerging state and local models and practices for addressing disparities to inform rules and guidance they issue to help others implement specific provisions of the law.

- Nonprofit or community organizations may find the report to be helpful in laying out specific opportunities for collaboration with federal and state government.

- National and community advocacy organizations may draw on the report’s research and evidence to advocate for appropriations or continued funding for certain diversity and equity objectives.

- Health care providers, state public health agencies, and health plans may look to the report for guidance on “how to” effectively implement reforms related to advancing diversity, language access, and cultural competence within their systems and programs, identifying in particular funding opportunities, guidance and best practices.

- Policymakers charged with implementing or otherwise taking advantage of related provisions may find this report helpful in advancing racial and ethnic health equity nationally, in their states and communities.
II. Methodology

We utilized a multi-pronged, qualitative approach to monitor and assess the implementation progress, opportunities and challenges of the Affordable Care Act’s (ACA) safety-net provisions with major implications for racially and ethnically diverse communities. In this section, we provide a brief overview of our methodology.

**Literature and Policy Review.** We conducted a comprehensive review of literature on the safety-net system, generally and in context of both racial and ethnic health disparities and the Affordable Care Act (ACA). This was complemented by a review of federal regulations, policies, and guidance that have been published to date for implementing each of the nine safety net related provisions. Given the constantly evolving nature of the field, information and research included in this report is current as of February 2013. In addition, we conducted an extensive review of research and articles on state activities along with programs and models emerging among safety net hospitals and health centers, with the intent of identifying information and guidance that can inform what is required to effectively implement the nine provisions.

**Key Informant Interviews.** To obtain the most recent information and the perspectives from individuals currently working on these issues, we interviewed state and county health officials, hospital executives from public hospitals, health center administrators, and representatives from several community and advocacy organizations. Appendix A contains a list of individuals interviewed as key informants, and others who contributed information and feedback for our project. We gathered names and contact information for people to interview from various sources including meetings we attended, reports we reviewed, and references from other people we spoke to. Questions asked pertained to the following areas of inquiry:

- How safety net providers are positioning themselves to absorb newly insured individuals, while continuing to serve the insured;
- What specific actions they are taking to serve a growing racially and ethnically diverse patient population;
- What specific actions they are taking to reach and enroll Medicaid and exchange populations;
- What opportunities within the ACA these providers are taking advantage of—e.g., workforce support, payment reform, or delivery system change; and
- How these providers are preparing for the potential threats directly presented by the ACA, such as—Disproportionate Share Hospital payment reductions—or other broader political and financial circumstances, such as federal and state budget reductions.

These questions were tailored to different players—such as public hospitals, health centers, public health departments, community and advocacy organizations, and others. In addition, we asked additional situational and follow-up questions in some interviews, and interviewees often provided further information on other related topics as well.

**Synthesis and Analysis.** Based on common themes and issues that affect the major players in the safety-net system, the nine provisions were organized into three areas: (1) expansion of public programs; (2) support for health centers and clinics; and (3) new requirements for safety-net hospitals.
Following is how the provisions were organized within these areas:

1. **Expansion of Public Programs**
   - Medicaid Expansion (§2001)
   - CHIP Reauthorization and related outreach support (§2101; §10203)

2. **Support for Health Centers and Clinics**
   - Community Health Centers (§5601)
   - Nurse-Managed Health Clinics (§5208)
   - Teaching Health Centers (§5508)
   - School-Based Health Centers (§4101)

3. **New Requirements for Safety Net Hospitals**
   - Reduction in Medicaid DSH Payments (§2551)
   - Reduction in Medicare DSH Payments (§3133)
   - Non-Profit Hospital Community Needs Assessment (§9007)

For each provision, the Project Team compiled research, latest policy updates, regulations and guidance, along with synthesized key informant interview findings to address the following areas of inquiry:

1. **Legislative context** of each provision, both as authorized by the ACA and also by any prior legislation.

2. **Implementation status, progress and potential impact** as documented in the Federal Register, literature and reports, government or foundation-based funding opportunity announcements and other actions.

3. **Emerging models and programs**, including those established prior to ACA that can inform current implementation, as well as those that have emerged from ACA funding and support.

4. **Challenges and next steps** to realizing the objectives of the provision.

Information from the interviews can be found throughout the sections of the report, and respondents were told that their responses would not be attributed or quoted without their permission. Responses were not statistically analyzed and are not intended to be a representative sample of states, hospitals, health centers or other providers. Rather, this information is qualitative in nature and serves to further inform the implementation of the specific ACA provisions.
III. Implementation Progress of the ACA’s Provisions for the Health Care Safety Net

The Affordable Care Act (ACA) presents a range of opportunities and threats for transitioning and positioning the safety net to adapt to a changing health care landscape. This section describes the implementation progress, opportunities, challenges and road ahead for nine provisions in the new law that are expected to have major implications, both positive and negative, for the nation’s health care safety net, particularly in serving racially and ethnically diverse patients.

This section organizes the nine provisions into three areas or sub-sections—(1) Expansion of Public Program; (2) Support for Health Centers and Clinics; and (3) New Requirements for Safety-Net Hospitals.

Research and evidence is first presented for each subsection, highlighting the importance for addressing each theme—and the provisions that fall under them—in the context of advancing racial and ethnic equity in the health care safety net. Essentially, why are these actions in ACA so critical for the health of low-income and diverse patients? What is at stake if these reforms are not put into action appropriately and in a timely manner?

This summary is followed by an overview of the legislative context for each provision, including appropriations, timeline and other requirements authorized by the ACA, along with details on implementation progress, ranging from a summary of federal rules that have been issued to establishment of working groups and new funding opportunities and programs that have emerged. Related questions addressed include: to what extent have provisions intended to expand and support the safety net been carried out? Are they on track according to the original intent of the ACA and federal support?

Finally, the summary is rounded out by a discussion of challenges ahead and important next steps for ensuring the full realization of what was originally authorized and intended by the health care reform law. Table 1 provides an overall summary of these provisions, along with their implementation status and progress.
Table 1: Progress At-A-Glance on the ACA’s Safety Net Provisions with Major Implications for Diverse Populations

<table>
<thead>
<tr>
<th>Provision</th>
<th>Summary</th>
<th>Funding Authorized</th>
<th>Funding Received</th>
<th>Implementation Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expansion of Public Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid §2001</td>
<td>Authorizes state expansion of Medicaid income eligibility up to 138% FPL</td>
<td>CY’ 2014-2017: States receive 100% federal funding for new enrollees, with federal matching funds gradually reducing as follows: 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020.</td>
<td>Funding expected to begin on January 1, 2014.</td>
<td>-- As of February 27: 23 states + DC will expand Medicaid; 14 states will not expand Medicaid; and 12 states with no final decision. --This provision affects 15.1 million uninsured with incomes &lt;138% FPL, nationally, of which 44% or 6.8 million belong to Non-White racial and ethnic groups. Among states expanding Medicaid, 3.4 million diverse individuals will obtain new coverage. Among states not expanding, 2 million with incomes &lt;100% FPL will have no coverage whatsoever in 2014.</td>
</tr>
<tr>
<td>Children’s Health Insurance Program (CHIP) §2101; §10203</td>
<td>Reauthorizes funding for CHIP until at least Oct. 1, 2015, and extends the program through 2019. Requires states to maintain eligibility levels to those at the time of the ACA’s enactment.</td>
<td>The law extends CHIP funding until FY 2015, when the CHIP federal matching rate will be increased by 23%. Appropriations for CHIP extension are as follows: FY 2013: $17.4 bil; FY 2014: $19.1 bil. Changes outreach and enrollment funding from $100 mil in FY 2009-2013 to $140 mil in FY 2009-2015.</td>
<td>CHIP funding in FY 2013 is projected to be $10.2 billion, an increase of $324 million from FY 2012. Outreach &amp; Enrollment: FY 2009: $40 mil; FY 2010: $10 mil; FY 2011: $40 mil; FY 2013: $32 mil.</td>
<td>-- In April 2010, $10 million was awarded for Tribal outreach and education. In August 2011, CMS awarded $40 million to 39 grantees as part of its Cycle II outreach and enrollment grant program. At least 17 of these grants explicitly addressed diversity, language, and culture as a focus. --In March 2012, CMS issued a final rule on eligibility, enrollment streamlining, and coordination, which included specific guidance around language access issues. In November 2012, CMS launched its national outreach campaign, “Connecting Kids to Coverage.” --In January 2013, a proposed rule was issued which clarified the process for outreach to limited English proficiency populations. Cycle III outreach and enrollment funding opportunity announcement totaling $32 million was also announced.</td>
</tr>
<tr>
<td><strong>Support for Health Centers and Clinics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Centers §10503</td>
<td>Establishes a Community Health Center Fund to expand national investment in health centers by $11 bil over 5 years, FY 2011-2015.</td>
<td>Operational Capacity: FY 2011: $1 bil; FY 2012: $1.2 bil; FY 2013: $1.5 bil; FY 2014: $2.2 bil; FY 2015: $3.6 bil. Capital Development: $1.5 bil for FY 2011-2015. Discretionary (from Congress, not ACA):</td>
<td>Operational Capacity: FY 2011: $1 bil; FY 2012: $1.2 bil; FY 2013: $1.5 bil* Capital Development: FY 2011: $727 mil; FY 2012: $728 mil. Discretionary: FY 2011: $1.6 bil; FY 2012: $1.6 bil</td>
<td>--Health centers receive funding from two streams: (1) the Community Health Centers Trust Fund; (2) discretionary funding from Congress. In 2011, discretionary funding was reduced by $600 million, from $2.2 to $1.6 billion. To offset this reduction, $600 mil were diverted from the Trust Fund, each fiscal year, to support health center operations that would otherwise have been supported through discretionary funds. --In FY 2011, $1.7 billion was awarded in grants to health centers, including: $900 million to support 127 New Access Points and 1,122 Increased Demand for Services grants; $727 million for capital development to 143 centers to serve $745,000 new patients; $29 million to 67 grantees for New Access Points to serve 286,000 new patients.</td>
</tr>
<tr>
<td>Provision</td>
<td>Summary</td>
<td>Funding Authorized</td>
<td>Funding Received</td>
<td>Implementation Progress</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nurse-Managed Health Clinics (NMHC) §5208</td>
<td>Supports a grant program to develop and operate NMHCs.</td>
<td>FY 2010: $50 mil</td>
<td>FY 2010: $14.8 mil</td>
<td>--In FY 2010, $14.9 mil was awarded to 10 grantees in 9 states through the Prevention and Public Health Fund. While all grantees are located in or serve medically underserved communities, 4 explicitly cite health disparities, minority health, or cultural competence as priorities in their program description. --This program received no new funding in FY 2011 and FY 2012.</td>
</tr>
<tr>
<td>Teaching Health Centers (THC) §5508</td>
<td>Authorizes a grant program to establish new accredited or expanded primary care residency programs in community-based settings.</td>
<td>FY 2010: $25 mil</td>
<td>No THC Development funding received to date.</td>
<td>--No funding to establish new accredited THCs. --In FY 2011, HRSA funded 11 institutions for a 3-year period under the THC Graduate Medical Education Program, training an estimated 300 primary care medical residents. Nine explicitly cite offering cultural competency curricula as part of their residency training. --By FY 2013, there were a total of 17 THCGME Payment Programs, including the 11 inaugural ones from 2011. While all programs target medically underserved populations, there are at least 7 programs in 5 states which explicitly address racial/ethnic health disparities in their training (either in combination with or beyond cultural competency training).</td>
</tr>
<tr>
<td>School-Based Health Centers (SBHC) §4101</td>
<td>Creates a grant program to support the operation of SBHCs, with preference to those serving medically</td>
<td>FY 2010: $50 mil</td>
<td>FY 2010: $0</td>
<td>--While funding was not appropriated in FY 2010, in FY 2011, $95 million was awarded to 278 SBHCs to serve 440,000 new patients, with an additional $14 mil to modernize facilities and expand capacity at 45 SBHCs and to serve 53,000 more children. States with greatest number of grantees include: California; New York;</td>
</tr>
</tbody>
</table>

Estimated at $2.2 bil for each FY.

patients; $10 million to support new, future health centers; and $40 million for quality improvement efforts.

--In FY 2012, $629 million was awarded to 171 existing centers to support service to 860,000 new patients. About $99 million was awarded to 227 centers for facility needs and $129 million was awarded to 129 New Access Points to serve 1.25 million patients.

--FY 2013 budget request was $3.1 billion. Looming sequester could, however, reduce funding by as much as $115-120 million, lowering ability to serve 900,000 new patients. On January 16, 2013, HRSA issued an FOA to establish 25 New Access Points. $19 million is available; awards to be announced on August 1, 2013.
### New Requirements for Safety Net Hospitals

<table>
<thead>
<tr>
<th>Provisions</th>
<th>Summary</th>
<th>Funding Authorized</th>
<th>Funding Received</th>
<th>Implementation Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicaid Disproportionate Share Hospital (DSH) Payment §2551</strong></td>
<td>Reduces Medicaid DSH spending by $18 billion between 2014 and 2020.</td>
<td>Funding reductions are authorized as follows: FY 2014: $500 mil FY 2015: $600 mil FY 2016: $600 mil FY 2017: $1.8 bil FY 2018: $5 bil FY 2019: $5.6 bil FY 2020: $4 bil</td>
<td>N/A</td>
<td>Reductions will begin in 2014. Guidance on methodology for percentage reduction among states is yet to be determined. Although national research and analytical organizations are weighing in on recommended strategies and approaches for determining these cuts.</td>
</tr>
<tr>
<td><strong>Medicare DSH Payment Cuts §3133</strong></td>
<td>Reduces Medicare DSH spending by an estimated $22 billion over ten years</td>
<td>Starting no later than FY 2014, and each subsequent year, DSH payments would be reduced by 75%.</td>
<td>N/A</td>
<td>Reductions will begin in 2014.</td>
</tr>
<tr>
<td><strong>Community Health Needs Assessment (CHNA) §9007</strong></td>
<td>Strengthens the community benefit obligation by requiring all nonprofit, tax-exempt or 501(c)(3) hospitals to conduct a community health needs assessment every 3 years and to adopt an implementation strategy.</td>
<td>Failure to comply with the CHNA requirements in any taxable year will result in a $50,000 excise.</td>
<td>N/A</td>
<td>The CHNA is to go into effect in the taxable year of each hospital beginning after March 23, 2012. On July 25, 2011, the Internal Revenue Service (IRS) released anticipated regulatory provisions or guidance on process and methods for conducting a CHNA, reporting, and disseminating findings. Specific guidance is provided on defining a community, along with obtaining input from community members, including minority groups and tribal agencies, among others. Non-governmental guidance is also emerging on best practices for conducting a CHNA. Resources include, for example, the Public Health Institute’s 2012 report on “Best Practices for Community Health Needs Assessment” and the Catholic Health Association’s “Assessing &amp; Addressing Community Health Needs,” among others.</td>
</tr>
</tbody>
</table>

†CY denotes “Calendar Year”

* Funding request for Fiscal Year 2013.

* As originally written in the Affordable Care Act.

** Implementation progress includes updates as of February 2013.
A. Expansion of Public Programs: Medicaid & CHIP

Medicaid and the Children’s Health Insurance Program (CHIP) are critical backbones of health insurance coverage for racially and ethnically diverse and other low-income individuals and families. Medicaid was established by the Social Security Amendments of 1965 to provide coverage to low-income families, children, pregnant women, and individuals with disabilities. CHIP was created more recently by the Balanced Budget Act of 1997 to insure low-income children who are ineligible for Medicaid, but who cannot afford private insurance. Both programs are administered by states but jointly funded by federal and state governments through a matching program. While eligibility standards and enrollment vary widely across states, these programs are core to ensuring some of the poorest, and in many cases, diverse communities in the nation have coverage and access to care.

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 percent of Non-Hispanic Whites relied on Medicaid and CHIP, 28 percent of African Americans, 27 percent of Hispanics and nearly 18 percent 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 Non-White individuals across the nation. While Non-Whites comprised about one-third of the nation’s population in 2011; they made up 55 percent of the 48.6 million uninsured. In the same year, approximately 32 percent of Hispanics, 27 percent of American Indians, 21 percent of African Americans, and 18 percent of Asians were uninsured as compared to 13 percent of Non-Hispanic Whites. These trends generally hold true among uninsured children—nearly two-thirds of whom belong to Non-White racial and ethnic groups.

However, challenges in enrolling these populations are not new. As reports to date have documented:

While many racial and ethnic minorities are enrolled in the Medicaid and CHIP programs, many more are eligible for such coverage but are not enrolled, either because they are unaware of their eligibility or face other barriers, such as limited English proficiency and enrollment process complexities. For instance, more than 80% of uninsured African-American children and 70% of uninsured Latino children are eligible for Medicaid or CHIP coverage.

Insurance coverage is a significant predictor of access to medical care, and a large body of research has shown that expansions in coverage, particularly in public programs, can reduce longstanding disparities in health outcomes. A recent study found that the expansion of Medicaid eligibility in three states was associated with a significant decrease in mortality during a 5-year follow up period when compared with states that did not expand Medicaid. Reductions in mortality were greatest among Non-White racial and ethnic groups, adults between the ages of 35 and 64, and individuals from poor counties. The expansion of CHIP among states has also been associated with improved health care access, continuity of care, and health outcomes for racially and ethnically diverse children.

The ACA’s provisions to expand Medicaid and reauthorize CHIP offer an important opportunity to bridge longstanding gaps in coverage and care among low-income, uninsured people of color.
However, the path to implementing these expansions comes with its challenges—namely, the Supreme Court’s unexpected decision on June 28, 2012 to make the Medicaid expansion optional for states. The following section summarizes the latest developments in implementation of Medicaid and CHIP, along with discussing its opportunities, risks and challenges for the safety net.
Medicaid Expansion

Legislative Context

Section 2001 of the ACA amends the Social Security Act by authorizing the expansion of Medicaid coverage among individuals under age 65 and with incomes at or below 138% of the federal poverty level ($14,856 for an individual and $30,656 for a family of four, based on the 2012 federal poverty level) beginning January 1, 2014. The federal government is authorized to pay 100 percent of the cost for these new enrollees from 2014 through 2016 and then gradually reduce its contribution to 90 percent by 2020 and indefinitely thereafter. However, the original ACA legislation stipulates that if states fail to expand Medicaid, states would lose all Medicaid funding from the federal government, not just money to pay for the expansion.

Quick Fact: Is Medicaid Eligibility Expanding to 133% or 138% of FPL?

Some sources state that the new minimum Medicaid eligibility threshold is 133 percent FPL; other sources state it will be 138 percent. Both are correct. The text of the ACA says 133 percent, but the law also calls for a new methodology of calculating income [known as Modified Adjusted Gross Income (MAGI) tax rules] which will make the effective minimum threshold 138 percent. Now, instead of a variety of different income disregards, there will be one standard disregard for most populations: 5 percent. That means that a person's income can be up 138 percent FPL, but since 5 percent of her income will be ignored, she will effectively meet the 133 percent threshold.

-- American Public Health Association

In addition, the ACA tasks states with providing a coordinated and streamlined enrollment system in 2014, along with targeted outreach to vulnerable populations (§1413, §2201, and §2202). The intent of this system is to provide individuals the ability to apply for Medicaid, CHIP, and exchange coverage using a single application available to them through multiple channels, such as in-person, online, and by phone. Section 2201 of the ACA explicitly outlines the need to ensure these processes reach vulnerable and diverse populations:

In general, a State shall establish procedures for...(G) conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

The sections that follow discuss progress on Medicaid expansion, and related enrollment provisions, in context of the role and implications for the safety net and diverse communities.
Implementation Status, Progress and Potential Impact

Medicaid Expansion. On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule on implementing ACA’s provisions addressing Medicaid eligibility, enrollment simplification and coordination. This final rule included details on: (1) the statutory minimum Medicaid income eligibility level of 133 percent or (138% accounting for 5% income disregard); elimination of obsolete eligibility categories and collapsing of other categories into four primary groups: children, pregnant women, parents, and the new adult group; (3) modernization of eligibility verification rules; (4) codification of the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for individuals; and (5) ensuring coordination across Medicaid, CHIP and the Exchanges.

On June 28, 2012, the Supreme Court declared the ACA’s Medicaid expansion to be unconstitutional as it penalized states that did not expand Medicaid with a loss of all their Medicaid funding. By a seven-to-two margin, the Supreme Court justices declared this to be unduly coercive. The court’s remedy was to block the potential cutoff of all Medicaid funding, in effect making the expansion of Medicaid optional for states.

As of February 27, 2013, 24 states and the District of Columbia have confirmed their participation, extending Medicaid to approximately 3.6 million racially and ethnically diverse individuals.

Figure 1.

Where the States Stand: February 27, 2013
24 Governors Support Medicaid Expansion

Note: Based on literature review as of 2/27/13. All policies can change without notice. The District of Columbia is a special state which can expand its own exchange.


Learn more about the impact of the Supreme Court ruling at: advisory.com/MedicaidMap

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As of February 27, 2013, 24 states and the District of Columbia have confirmed their participation in the Medicaid expansion, with another four states expressing their intent to do so as well. Fourteen states have decided not to participate, whereas two are leaning toward not participating in the Medicaid expansion. Six states are undecided or have not offered any comments on their likely decision. Figure 1 illustrates where states stand in their decisions regarding Medicaid expansion.

State decisions regarding whether to expand Medicaid will affect an estimated 15.1 million uninsured adults with incomes below 138% of FPL who would be newly eligible for coverage under the ACA Medicaid expansion. Of this population, racially and ethnically diverse residents represent over 45 percent or 6.8 million adults with incomes below 138% of FPL that would become newly eligible for Medicaid. An estimated 2.9 million (19.4%) Hispanics, 2.8 million (18.7%) African Americans and nearly 1.1 million (7.0%) other racial minorities with incomes below 138% of FPL would be newly eligible for Medicaid in 2014.

In the 24 states (plus the District of Columbia) that have decided to participate in Medicaid expansions, an estimated 3.4 million potential enrollees would be racially and ethnically diverse adults (or Non-Whites) with incomes below 138% of FPL (Table 2). Should another four states that have expressed their intent to expand Medicaid actually follow through, an additional 327,000 Non-White adults would be eligible for coverage under the program, bringing the total to almost 3.7 million racially and ethnically diverse adults.

While 6.8 million racially and ethnically diverse adults would become newly eligible for Medicaid in 2014, roughly half or 3.4 million of them will actually benefit in states opting to expand Medicaid coverage, as of February 2013.
Table 2. Uninsured Non-White Adults Newly Eligible for Medicaid under the ACA in 28 States + DC Participating in or Leaning Toward Participating in Medicaid

<table>
<thead>
<tr>
<th>State</th>
<th>% Non-Whites &lt;138% FPL</th>
<th># Non-Whites &lt;138% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas</td>
<td>32.3</td>
<td>71</td>
</tr>
<tr>
<td>Arizona</td>
<td>46.6</td>
<td>41</td>
</tr>
<tr>
<td>California</td>
<td>66.8</td>
<td>1251</td>
</tr>
<tr>
<td>Colorado</td>
<td>35.8</td>
<td>80</td>
</tr>
<tr>
<td>Connecticut</td>
<td>39.7</td>
<td>35</td>
</tr>
<tr>
<td>Delaware</td>
<td>27.5</td>
<td>4</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>77.9</td>
<td>14</td>
</tr>
<tr>
<td>Florida</td>
<td>51.6</td>
<td>668</td>
</tr>
<tr>
<td>Hawaii</td>
<td>70.6</td>
<td>28</td>
</tr>
<tr>
<td>Illinois</td>
<td>48.8</td>
<td>254</td>
</tr>
<tr>
<td>Maryland</td>
<td>54.1</td>
<td>90</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>30.5</td>
<td>26</td>
</tr>
<tr>
<td>Michigan</td>
<td>29.4</td>
<td>165</td>
</tr>
<tr>
<td>Minnesota</td>
<td>20.8</td>
<td>27</td>
</tr>
<tr>
<td>Missouri</td>
<td>27.3</td>
<td>96</td>
</tr>
<tr>
<td>Montana</td>
<td>19.0</td>
<td>12</td>
</tr>
<tr>
<td>Nevada</td>
<td>44.7</td>
<td>73</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>9.3</td>
<td>5</td>
</tr>
<tr>
<td>New Jersey</td>
<td>54.2</td>
<td>166</td>
</tr>
<tr>
<td>New Mexico</td>
<td>71.2</td>
<td>90</td>
</tr>
<tr>
<td>North Dakota</td>
<td>26.2</td>
<td>7</td>
</tr>
<tr>
<td>Ohio</td>
<td>23.9</td>
<td>138</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>27.3</td>
<td>11</td>
</tr>
<tr>
<td>Vermont</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Washington</td>
<td>29.8</td>
<td>93</td>
</tr>
<tr>
<td>Participating Subtotal</td>
<td>--</td>
<td>3,445</td>
</tr>
<tr>
<td>Kentucky*</td>
<td>14.8</td>
<td>43</td>
</tr>
<tr>
<td>New York*</td>
<td>51.2</td>
<td>87</td>
</tr>
<tr>
<td>Oregon*</td>
<td>20.7</td>
<td>52</td>
</tr>
<tr>
<td>Virginia*</td>
<td>42.2</td>
<td>145</td>
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<tr>
<td>LT Participating Subtotal</td>
<td>--</td>
<td>327</td>
</tr>
<tr>
<td>Total</td>
<td>--</td>
<td>3,772</td>
</tr>
</tbody>
</table>

* Leaning toward (LT) participating
Number (#) is provided in 1,000s
Non-Whites are comprised of African Americans, Hispanics and all other Racial populations.
In the 14 states that have decided not to participate in ACA’s Medicaid expansion, nearly 2.7 million Non-White adults with incomes below 138% of FPL would be eligible (Table 3). Of this population, more than 2.1 million Non-White adults with incomes below 100% FPL would not be eligible for any coverage under the new law (including any subsidies offered through the Exchanges). And states including Texas and Georgia could alone leave as many as 1 million predominantly poor, African American and Hispanic adults uninsured.

Table 3. Uninsured Non-White Adults Newly Eligible for Medicaid under the ACA in 16 States Not Participating in or Leaning Toward Not Participating in Medicaid

<table>
<thead>
<tr>
<th>State</th>
<th>% Non-Whites &lt;138% FPL</th>
<th># Non-Whites &lt;138% FPL</th>
<th>% Non-Whites &lt;100% FPL</th>
<th># Non-Whites &lt;100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>42.9</td>
<td>138</td>
<td>40.1</td>
<td>109</td>
</tr>
<tr>
<td>Georgia</td>
<td>53.6</td>
<td>367</td>
<td>54.7</td>
<td>292</td>
</tr>
<tr>
<td>Idaho</td>
<td>17.1</td>
<td>19</td>
<td>16.2</td>
<td>14</td>
</tr>
<tr>
<td>Iowa</td>
<td>14.8</td>
<td>16</td>
<td>15.5</td>
<td>12</td>
</tr>
<tr>
<td>Louisiana</td>
<td>54.3</td>
<td>178</td>
<td>53.2</td>
<td>138</td>
</tr>
<tr>
<td>Maine</td>
<td>7.1</td>
<td>5</td>
<td>4.2</td>
<td>3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>54.0</td>
<td>124</td>
<td>55.4</td>
<td>102</td>
</tr>
<tr>
<td>North Carolina</td>
<td>43.8</td>
<td>257</td>
<td>43.9</td>
<td>192</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>29.1</td>
<td>151</td>
<td>30.5</td>
<td>122</td>
</tr>
<tr>
<td>South Carolina</td>
<td>48.8</td>
<td>145</td>
<td>49.8</td>
<td>115</td>
</tr>
<tr>
<td>South Dakota</td>
<td>37.3</td>
<td>15</td>
<td>39.9</td>
<td>13</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>37.2</td>
<td>85</td>
<td>37.9</td>
<td>65</td>
</tr>
<tr>
<td>Texas</td>
<td>67.0</td>
<td>1170</td>
<td>66.5</td>
<td>883</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>22.8</td>
<td>41</td>
<td>23.8</td>
<td>35</td>
</tr>
<tr>
<td>Not Particip. Subtotal</td>
<td>--</td>
<td>2,711</td>
<td>--</td>
<td>2,095</td>
</tr>
<tr>
<td>Nebraska*</td>
<td>25.5</td>
<td>19</td>
<td>24.5</td>
<td>13</td>
</tr>
<tr>
<td>Wyoming*</td>
<td>17.7</td>
<td>5</td>
<td>18</td>
<td>4</td>
</tr>
<tr>
<td>LT Not Particip. Subtotal</td>
<td>--</td>
<td>24</td>
<td>--</td>
<td>17</td>
</tr>
<tr>
<td>Total/Average</td>
<td>--</td>
<td>2,735</td>
<td>--</td>
<td>2,112</td>
</tr>
</tbody>
</table>

* Leaning toward (LT) not participating
Number (#) is provided in 1,000s
Non-Whites are comprised of African Americans, Hispanics and all other Racial populations.

States that are currently undecided regarding their Medicaid expansion decisions have a considerable opportunity to expand coverage for a large diverse population. Should these six states decide to expand coverage, roughly 290,000 Non-Whites with incomes below 138% of FPL would be eligible (Table 4). However, should these states opt not to expand Medicaid under the ACA, as many as 231,000 additional poor, racially and ethnically diverse residents (with incomes below 100% of FPL) could be left uninsured.
Table 4. Uninsured Non-White Adults Newly Eligible for Medicaid under the ACA in 6 States Undecided about Medicaid Expansion

<table>
<thead>
<tr>
<th></th>
<th>% Non-White &lt;138% FPL</th>
<th># Non-White &lt;138% FPL</th>
<th>% Non-White &lt;100% FPL</th>
<th># Non-White &lt;100% FPL</th>
</tr>
</thead>
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<td>Indiana</td>
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<td>31.2</td>
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<tr>
<td>Utah</td>
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<td>West Virginia</td>
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<td>8</td>
</tr>
<tr>
<td>Total/Average</td>
<td>--</td>
<td>290</td>
<td>--</td>
<td>231</td>
</tr>
</tbody>
</table>

Number (#) is provided in 1,000s.
Non-Whites are comprised of African Americans, Hispanics and all other Racial populations.

Medicaid Enrollment and Outreach. Beyond the decision to expand Medicaid income eligibility, states are working to streamline their enrollment systems, ensuring coordination across Medicaid, CHIP and the exchanges, while also providing outreach to vulnerable and diverse individuals and families. The final rule issued on March 23, 2012, asserts the importance of “written translation and oral interpretation” stating that it will be “required” to establish procedures for conducting outreach to and enrolling vulnerable, underserved populations, including “racial and ethnic minorities”.

The rule specifies that information for persons with limited English proficiency be provided in an “accessible and timely manner and at no cost to the individual.” In addition, the rule maintains that “Web site[s], any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and be accessible to...persons who are limited English proficient...” In addition, the rule states that subsequent guidance may address “assistance such as cultural competence”—or in other words, ensuring assistance provided to those with limited English proficiency is done so in a culturally appropriate manner.

On January 22, 2013, CMS issued a proposed rule to provide states more flexibility in coordinating Medicaid and CHIP eligibility notices, appeals, and other related administrative processes, along with clarifying accessibility issues related to limited English proficient populations, among other broader objectives. Specific accessibility guidance was issued to clarify provisions issued on March 23, 2012 related to communicating with limited English proficiency. The rule states that “providing language services means providing oral interpretation, written translations, and taglines (which are brief statements in a non-English language that inform individuals how to obtain information in their language).”

The proposed rule also directs states to guidance published on August 8, 2003 (68 FR 47311) on parameters for language assistance services for persons with limited English proficiency. It further discusses guidance which was released on the availability of enhanced federal matching funds available for translation and interpretation services related to improving outreach to, enrollment of, retention of, and use of services by children in Medicaid and CHIP. For additional details on cultural and linguistic requirements in Exchanges and health insurance, generally, see Report 1 in the Affordable Care Act & Racial and
Emerging Models and Programs

In this section, we highlight programs that have emerged following the enactment of the ACA to support, supplement or, altogether, substitute the Medicaid expansion. In particular the Medicaid Demonstration Waivers are discussed, along with promising Medicaid enrollment and outreach efforts that have emerged within the safety net for racially and ethnically diverse individuals and families. We note, that an in-depth discussion of enrollment and outreach systems is beyond the scope of this paper, however, the topic is discussed in context of the major role that safety-net providers are playing to reach diverse populations. Note that further information on enrollment, eligibility and outreach can be obtained from a complementary report within this Series, “Implementing Cultural and Linguistic Requirements in Health Insurance and the Exchanges.”

Medicaid Demonstration Waivers. While not explicitly authorized by the ACA, several states are looking to Section 1115 of the Social Security Act to either replace the need for a Medicaid expansion as authorized under the ACA, or supplement the expansion to support a stronger safety-net system. Under Section 1115 of the Social Security Act, states can apply for a demonstration waiver to expand coverage, increase benefits, or implement innovative models of care that reduce state costs, thereby waiving certain federal Medicaid provisions. Waivers often provide states with greater flexibility to tailor their Medicaid programs to local needs, however they must demonstrate budget neutrality—“meaning that federal Medicaid expenditures under the waiver must not exceed federal expenditures for a state in absence of the waiver.” In addition, waivers are subject to a cap on the amount of federal funding allotted, and the state is responsible for any costs incurred above the federal cap. Although most waivers are intended to expand coverage, they can also be used to limit services or develop new payment and oversight mechanisms which could have deleterious effects on vulnerable populations. To partially address this challenge, Section 10201 (i) of the ACA includes a specific provision to enhance transparency in the state waiver application and approval process. As such, it requires “public notice and comment, including public hearing, at the state level, and further public notice and comment at the federal level, before waiver programs can be approved and renewed.”
Following the enactment of the ACA, interest in Section 1115 waivers has intensified, following a relatively dormant period between 2009 and 2010. As of February 2012, there are at least 34 states which currently have 1115 Waivers (Figure 2), 15 of which were approved after the advent of the ACA. Following is summary of major elements reflected across these waivers, and promising programs emerging among states that could have implications for low-income, diverse communities:

- **Early expansion of Medicaid to adults**: Following the ACA, at least six states (California, Colorado, Minnesota, Missouri, New Jersey and Washington) and the District of Columbia are using their 1115 waivers to expand Medicaid to adults in preparation for the 2014 expansion giving them important experience and lessons around eligibility and enrollment processes for low-income and vulnerable populations. California, in particular, has the largest 1115 waiver in the nation as it seeks to expand coverage to childless adults up to 200% FPL through the Low-Income Health Program (LIHP)—an effort being implemented on a county basis.  

- **Simplifying eligibility and/or enrollment processes**. Following the enactment of the ACA, two states in particular have embarked on initiatives to simplify their eligibility and enrollment processes, particularly for children. Massachusetts, for example, received waiver approval to renew Medicaid coverage for parents using “express lane eligibility” (ELE). To simplify the enrollment process for parents, ELE allows a state to conduct Medicaid enrollments or renewals using eligibility information from other public programs, eliminating the need for families to provide this information multiple times to
multiple agencies. In New York, the waiver is being used to provide 12-month continuous eligibility regardless of income fluctuations, “helping to reduce churning into and out of coverage and promoting more reliable access to care.”

- **Eligibility and enrollment restrictions**: Three states recently were approved to implement eligibility restrictions—which is rarely permitted, but allowed in cases where a state is facing budget deficits. Arizona, for example, ended its Medically Needy program and closed enrollment for this program. Hawaii received approval to end coverage for adults above 133% FPL, and Wisconsin also was approved for eligibility restrictions for adults above 133% FPL.

- **Premium or cost-sharing increases**. Four states (Arizona, New Jersey, New Mexico, and Wisconsin) have pursued proposals to increase cost-sharing and premiums to reduce program costs and increase “personal responsibility” among enrollees. For example, Arizona’s waiver allows the state to charge some higher cost sharing for adults, as the state argued it was necessary to prevent reducing coverage among its population at large. Wisconsin received approval to increase premiums for some adults with income above 133% of poverty to prevent this group from losing coverage from the state altogether.

- **Pool to support safety net delivery system improvement**. Four states (California, Florida, Massachusetts, and Texas) have been approved to utilize federal matching funds for safety-net pools that will be used to cover uncompensated care costs as well as hospital delivery system improvement initiatives. These initiatives range from infrastructure development, new care delivery models such as medical homes, and quality improvement projects. New Mexico has submitted a similar proposal which is pending approval.

- **Other payment and delivery system reforms**. Finally, under the waiver, several states have pending proposals to restructure payment and delivery systems through such arrangements as care coordination, accountable care, and financial incentives for outcomes.

**Safety-Net Provider Role in Medicaid Outreach and Enrollment**. Safety-net providers have considerable experience in reaching and enrolling children and families in Medicaid, CHIP and other programs. Our interviews with individuals from community health centers, public hospitals, and other community and advocacy representatives reinforced this point, suggesting that with the advent of health care reform, safety-net providers are intensifying their outreach, education and enrollment activities, particularly for Medicaid. These actions include for example: connecting patients to traditional out-stationed eligibility workers; using technology to maintain strong connections with vulnerable populations; and training staff to conduct outreach as well as to serve as application assisters. Some providers are taking additional innovative steps to reach and enroll hard-to-reach populations. For example, one provider has trained a cadre of community outreach workers to make home visits to self-pay patients, to assist them in determining their eligibility and enrolling them into Medicaid.

Health centers, safety-net hospitals and other community clinic settings would seem to be logical partners in enrollment, given they already provide services to a large proportion of uninsured, racially and ethnically diverse and vulnerable patient populations. These settings are frequently
considered “trusted” resources for health care, thus patients often rely on them for assistance in bridging to other social and support services.\textsuperscript{41}

**Challenges and Next Steps**

Many states are still struggling to decide whether to expand Medicaid as authorized by the ACA, but made optional by the Supreme Court. Among governors opposed to expanding Medicaid, affordability and impact on state budgets were cited as top reasons.\textsuperscript{42} In particular, many expressed concerns related to the so-called “wood-work effect” whereby the ACA could draw previously eligible but unenrolled persons into Medicaid at greater to cost to the state.\textsuperscript{43} More than half of those opposing Medicaid expansion also expressed fear that the federal government would “renege on the generous terms of the ACA and scale back its share of Medicaid.”\textsuperscript{44}

However, data and evidence emerging across states generally opposed to Medicaid expansion reveals the long run benefits of such expanded coverage across various fronts—from state budgets and hospital uncompensated care costs to overall population health. For example, a recent study from Texas—which has the highest uninsured rate (23.8\% vs. national average of 15.7\%) and whose Governor is strongly opposed to Medicaid expansion—shows that between 1.5 and 2.0 million individuals would obtain new coverage.\textsuperscript{45} In addition, whereas the federal government would contribute $100 billion over 10 years to cover these new enrollees, the state would be responsible for a relatively small portion—approximately $15 billion—over this time period.\textsuperscript{46}

Also among states vehemently opposed to Medicaid expansion was Arizona. However, in late January 2013, the Governor reconsidered the decision given the widespread concern that a sizeable number of very low-income citizens would be left without coverage, whereas even immigrants would be eligible for government-subsidized private insurance not available to poor citizens.\textsuperscript{47} Arizona’s state budget statement documented the following as an important reason for expansion:

\begin{quote}
If Arizona does not expand, for poor Arizonans below (the federal poverty line), only legal immigrants, but not citizens, would be eligible for subsidies.\textsuperscript{48}
\end{quote}

While legal immigrants have to wait five years to qualify for Medicaid, a recent immigration comprise has allowed low-income legal immigrants to obtain subsidized private coverage through the health insurance exchanges. This expansion was not made for citizens below 100\% of the poverty level given the ACA assumed all states would expand Medicaid.

Beyond the question of whether or not to expand, some states are asking: “Will the federal government pay for newly eligible beneficiaries if a state carries out a partial expansion of Medicaid? Will it pay 90 percent to 100 percent of the costs? Will it pay any of the costs? And if the administration concludes that the new health care law does not allow a partial expansion of Medicaid, will it nevertheless grant waivers allowing states to try such an approach?”\textsuperscript{49}

Continued monitoring of these issues, along with advocacy around the benefits of Medicaid expansion for states and their populations will be necessary to ensure that the poorest American citizens—over 3 million of whom are from racially and ethnically diverse backgrounds—do not fall through the coverage cracks.
CHIP Reauthorization

Legislative Context

Section 2101 of the Affordable Care Act (ACA) extends Children’s Health Insurance Program (CHIP) funding authorized under the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in 2009, until at least October 1, 2015. Should CHIP funding be reauthorized beyond this date, the federal matching rate in each state will be increased by 23 percent between 2016 and 2019, bringing the federal matching rate for CHIP up to at least 88 percent in every state. In addition, the ACA requires all states to maintain their CHIP eligibility levels and enrollment policies as they were at the time of enactment (i.e., as of March 23, 2010). States are also prohibited, under the new law, from enacting policies that would prevent additional children from enrolling in CHIP. The ACA also provides additional funding—$40 million—for states to carry out outreach activities to enroll more children in public programs, including CHIP. It also stipulates that states streamline their enrollment processes.

Implementation Status and Progress

On March 23, 2012, the Centers for Medicaid and Medicare Services (CMS) released a final rule on implementing the ACA’s provisions addressing Medicaid and CHIP eligibility, enrollment simplification and coordination. Beyond guidance specific to Medicaid, the final rule included details on streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for individuals as well as ensuring coordination across Medicaid, CHIP and the Exchanges. Guidance clarifying processes pertaining to individuals with limited English proficiency were proposed by CMS on January 22, 2013, which is summarized in the previous section under Medicaid Enrollment and Outreach.

Together, the ACA and CHIPRA have provided a total of $140 million in outreach and enrollment funding for enrolling and maintaining eligible children in Medicaid and CHIP coverage. Through fiscal year 2015, the following funding is available:

- $14 million for a National Outreach Campaign;
- $14 million in grants for Indian Tribes and health care providers that serve Tribes;
- $112 million in Connecting Kids to Coverage Outreach and Enrollment grants to community-based organizations, states, community health centers, faith-based organizations, school districts, and Tribal organizations.

On September 30, 2009, (prior to the ACA) CMS awarded $40 million in the first round of funding to 68 grantees across 42 states. Of these grantees, 49 were individual organizations or states, and 20 were groups of entities working together as a consortium. Grantees were provided two years to spend their funds and report enrollment data and information to evaluate the success of these programs. All grantees cited a commitment to reaching out to underserved populations that are more likely to be uninsured.

On August 18, 2011, CMS awarded a second round of $40 million to 39 grantees in 23 states to support outreach and enrollment activities. These grants focused on one of the following five areas:
• Using technology to facilitate enrollment and renewal;
• Focusing on retention: keeping eligible children covered for as long as they qualify;
• Engaging schools in outreach, enrollment and renewal activities;
• Reaching out to groups of children that are more likely to experience gaps in coverage; and
• Ensuring eligible teens are enrolled and stay covered.

On January 7, 2013, CMS issued a third round of solicitation for applications for Connecting Kids to Coverage Outreach and Enrollment Grants. A total of $32 million is available for grants to states, local governments, community-based and nonprofit organizations as well as Indian health care providers and tribal entities. Proposals were due on February 21, 2013, with grant award notification anticipated on June 1, 2013. Grants are expected to range in size from $250,000 to $1 million for a two-year period beginning June 1, 2013. This round of grants will support outreach strategies as well as efforts to build community-based resources for assisting families with the application process. Among the five priority areas identified in this solicitation is a focus on “bridging health coverage disparities by reaching out to subgroups of children that exhibit lower than average health coverage rates”. Other priorities include engaging schools in outreach, enrollment and retention activities; streamlining enrollment process; establishing application assistance resources within local communities; and conducting training programs that assist families in understanding the new application and enrollment process.

Beyond these grants, on April 16, 2010, CMS awarded $10 million in funding for Indian tribes, Tribal health providers, and Indian Health Service providers to conduct outreach and enrollment efforts to increase Medicaid and CHIP coverage among American Indian and Alaska Native children. This funding was awarded to 41 organizations in 19 States, for a 5-year period.

The following section on Emerging Programs and Models highlights some of the promising programs and efforts that have emerged among grantees, particularly in reaching racially and ethnically diverse families and children.

Emerging Programs and Models

Among grantees funded through CHIPRA and the ACA during the second cycle of the outreach and enrollment grants, at least 17 (44%) focus directly on reaching racially, ethnically, and linguistically diverse populations as described in their program summaries. Most commonly, these grantees are targeting outreach efforts to Hispanic or Latino communities—i.e., at least 11 grantees. In addition, these grantees specify targeting the following diverse population groups: African Americans; American Indians; Vietnamese; Chinese; Thai; Korean; Somali; and Ethiopian. Following are strategies common across these grantees:

• Use of multilingual, multicultural application assitores— also known as promotores in Hispanic or Latino communities— who provide one-on-one education and enrollment assistance;
• Establishing renewal reminders in multiple languages and utilizing various modes of communication to deliver them, such as Websites, phone, e-mail, text messaging, direct person-to-person contact, and social media such as Facebook and Twitter;
• Working with trusted community sites to reach and enroll new individuals and children, including schools, faith-based organizations, community health centers and clinics; and
• Utilizing “train-the-trainer” approaches, training community members to provide education and outreach, along with teens who can provide “peer-to-peer” outreach.

In addition to these efforts, on November 15, 2012, the Federal Government launched its national campaign known as “Connecting Kids to Coverage.” The campaign’s website (www.insurekidsnow.gov) includes a series of education and outreach materials for states, health care providers and community organizations to use as tools and guidance as they develop strategies, plans and activities to reach and enroll children in CHIP and Medicaid. Among these resources are palm-cards and posters which reflect diverse children in playful settings and provide brief information on CHIP and Medicaid enrollment. These resources are available in English and Spanish. The campaign website also offers expertise and assistance in customizing available tools and resources to states and local communities.

Furthermore, the national campaign focuses major attention on states with large numbers of children and teens who are eligible, but not enrolled in Medicaid and CHIP. Work is being targeted in the following sites:

• **California:** Fresno and Riverside/San Bernardino
• **Florida:** Orlando and Tampa
• **Georgia:** Atlanta/Atlanta Suburbs
• **New York:** Capital District (e.g., counties surrounding Albany)
• **Ohio:** Cincinnati and Youngstown
• **Texas:** Dallas and Houston

Finally, in efforts to educate and train community health workers, assisters and navigators, as well as others working to educate and enroll children into Medicaid and CHIP, the campaign has developed a series of webinars. These webinars cover topics such as “Reaching Hispanic and Latino Audiences” (scheduled for March 2013) and “Media Outreach and Digital Engagement” (scheduled for April 2013). Strategies on “how to” reach, educate, and enroll children and their families are also provided for community health centers, private businesses and schools.

**Challenges and Next Steps**

The ACA preserves the CHIP program, extends its funding through 2015, and requires states to maintain eligibility levels for children in CHIP until 2019. It also enhances funds to assist with enrollment and outreach, particularly to children and families who are eligible, but not enrolled. While these actions protect and ensure that children’s health and health care access are at the core of any insurance expansion strategy, there may be a few challenges moving forward. First, ongoing economic and state budget constraints could hinder states’ ability to maintain a focus on children’s coverage and quality of care. This has led some states to take steps to reduce their program costs. For example, Arizona and Tennessee froze enrollment in CHIP during fiscal year 2010. Others, such as Florida, Idaho, Nevada, Oklahoma, South Dakota, and the District of Columbia reported making cuts to provider reimbursement rates to cope with budget deficits. California and New Hampshire mentioned increasing their CHIP premium amounts.

Secondly, at the patient level, there are concerns that low-income families may face a complex set of new challenges as they try to stay on top of the different kinds of coverage family members may receive. “As one member of the family moves in or out of the insurance exchange program, other
family members may not be eligible for the same plans. This may be especially problematic for families whose children are insured by CHIP and thus have an entirely different set of health insurance plans than the rest of their family.\textsuperscript{59} This may be especially daunting for low-income and diverse families already facing language barriers or challenges with mixed immigration status.

In addition, in an interim report to Congress from December 2011, state challenges were cited related to outreach and enrollment in CHIP:

In an era of increased fiscal challenges for States, focusing outreach efforts on the most effective methods is increasingly important. Although States track broad enrollment and retention numbers, many questions remain regarding the effectiveness of specific CHIP outreach activities across geographic locations and diverse populations. Distinguishing the impact of a specific outreach initiative from the impact of other factors (such as demographic or programmatic changes) that influenced enrollment at the same time continues to be a challenge.\textsuperscript{60}

Finally, states have voiced their challenges to meeting the rapid growth in CHIP enrollment in recent years. In a declining economy, many states have cited staff shortages and delays in application processing times as hindering the ability to effectively meet growing demand and enrollment in CHIP.
B. Health Centers and Clinics

Community health centers were originally established as a small demonstration program in 1965 during President Johnson’s “War on Poverty.” Spurred by the realization that low-income, minority, and mainly African American students were disenfranchised from the mainstream healthcare system, proposals were submitted to the federal Office of Economic Opportunity to establish health centers in medically underserved inner-city and rural areas of the country based on a model of care from South Africa. "The new health center model combined the resources of local communities with federal funds to establish local community-based health care systems in both rural and urban areas all across America." Today, health centers serve over 20 million people, of which racially and ethnically diverse individuals and families constitute a large majority. In fact, “compared to the U.S. population overall, health center patients are nearly five times as likely to be poor, more than twice as likely to be uninsured, and two-and-a half times as likely to be covered by Medicaid.” The vast majority of patients—93 percent—have incomes below 200% FPL. Racially and ethnically diverse individuals are over-represented among health center patients. In particular, African Americans comprise 21% of all health center patients and Hispanics or Latinos make up over one-third.

Given their history of service to diverse and other vulnerable, low-income patients, health centers and clinics have become trusted and leading sources of primary, dental and mental health care for these populations. With the large influx of newly insured patients expected following the implementation of the Affordable Care Act (ACA), as well as with the remaining 30 million uninsured in 2022, these centers and clinics will continue to play a central role in providing access to care for some of the nation’s most vulnerable populations.

The sections that follow discuss the implementation status, progress and potential impact of the following provisions of the ACA:

- Community Health Centers;
- Nurse-Managed Health Clinics;
- Teaching Health Centers; and
- School-Based Health Centers.
Community Health Centers

Legislative Context

Section 10503 of the ACA created The Community Health Centers Trust Fund—a new, mandatory funding stream—to provide for expanded and sustained national investment in community health centers, originally established under Section 330 of Public Health Service Act. The legislation expands funding for community health centers by $11 billion over five years starting in fiscal year 2011, with $9.5 billion for expanding their operational capacity for medical, oral, and behavioral health services, and $1.5 billion for providing capital support to build new sites and/or expand and improve existing facilities. The Community Health Centers Trust Fund is in addition to existing discretionary funding health centers receive from Congress.

Implementation Status, Progress and Potential Impact

Health Center Programs. Following the enactment of the ACA, the Health Resources and Services Administration (HRSA)—the primary federal authority charged with administering and awarding health center grants—has rolled out sizeable funding to create new centers, as well as to support operations at existing health center sites. Through dollars appropriated by the ACA, along with discretionary funds, HRSA has supported a range of health center programs, ranging from supporting new sites and operations to quality and information technology. Following is an overview of major health center programs:

- **New Access Points** program intends to expand new full-time service delivery sites that provide comprehensive primary and preventive health care services. As a recent funding opportunity announcement (FOA) stated, eligible applicants must be public or nonprofit private entities, including tribal, faith-based, and community-based organizations. Applications may be submitted from new organizations or organizations already receiving operational grant funding under Section 330. This grant program seeks to establish new access points that: provide comprehensive primary medical care; provide services, either directly onsite or through established arrangements, regardless of patient’s ability to pay; ensure access to services for all individuals in the targeted service area or population; and provide services at one or more permanent service delivery sites. Among other objectives, the FOA explicitly stated that applicants are expected to demonstrate that the new access point(s) will increase access to “comprehensive, culturally competent, and quality primary health care services.” The application also requests that, when appropriate, biographical

Quick Tip: Where to Identify Health Center Grant Opportunities

The Health Resources and Services Administration (HRSA) Homepage includes a link to “Grants” which frequently post and update open grant opportunities. As HRSA administers a range of federal programs beyond health centers—from health professions and the National Health Service Corps to Maternal and Child Health, Rural Health, HIV/AIDS, and others, a variety of related funding opportunities can also be found here. For more information, visit: www.hrsa.gov/grants.
sketches submitted for staff “should include training, language fluency, and experience working with culturally and linguistically diverse populations served.”

- **Health Center Planning Grant (HCPG)** is intended to “support organizations in the future development of a Section 330 health center”.

Eligible applicants include public and nonprofit private entities, including tribal, faith-based and community-based organizations. Entities not eligible to apply are those that at the time of the FOA had a current Section 330 funded health center.

- **Health Center Capital Development** grants are intended to support the renovation of existing health center facilities or to expand or establish new sites. Centers being funded are undertaking two major types of capital development projects: (1) alternation or renovation, which includes work required to modernize, improve or alter physical characteristics of an existing facility; and (2) construction, which may involve adding a new structure to an existing site to increase its square footage or to establish a new site location for an existing center. For capital development grants offered through the Immediate Facilities Improvement Program as well as the Building Capacity Program, applicants must be an existing health center that has had an application approved for grant support under HRSA’s Health Center program. Announcements through each of these programs explicitly state that an applicant’s scope project must be consistent with HRSA’s Health Center Program’s mission: “to provide comprehensive, culturally competent, quality primary health care services to medically underserved community and vulnerable populations.” Beyond this mention, the FOA does not explicitly mention other requirements targeting racially and ethnically diverse communities—although it may be implied in references to “underserved populations”.

- **Increased Demand for Services (IDS) or Expanded Service (ES)** grants are aimed at expanding the number of patients that health centers serve or to provide additional types of services. In order to qualify for funding, applicants must propose to expand existing primary care medical capacity by adding new medical providers, increasing the availability of medical services, or expanding hours of operations.

**Health Center Funding.** Community health centers receive two streams of funding: (1) mandatory funding under the ACA’s Community Health Centers Trust Fund; and (2) base discretionary funding from Congress. An unanticipated budget agreement reached by Congress and the Obama Administration in April 2011 resulted in the reduction of discretionary funds for health centers by $600 million or 27 percent, from $2.2 billion in fiscal year 2010 to 1.6 billion in fiscal year 2011. When combined with dollars from the Community Health Centers Trust Fund, the cut in appropriations reflects a 19 percent reduction in federal funding for centers in fiscal year 2011, from $3.2 billion to $2.6 billion (Figure 3). To offset the considerable loss of this funding reduction on health center service capacity, $600 million were diverted from the Trust Fund’s fiscal year 2011 appropriation to support ongoing operations at existing centers.
According to HRSA, in fiscal year 2011, nearly $1.7 billion was awarded through grants from the ACA for the following health center programs:

- $900 million was awarded to support ongoing operations at health centers, including support for 127 New Access Point grants and 1,122 Increased Demand for Services grants;
- $727 million available for Capital Development was awarded to 143 community health centers to serve an additional 745,000 new patients;
- $10 million was also awarded to 129 organizations in Health Center Planning Grants to establish future community health centers; and
- $40 million was awarded to support quality improvement activities in more than 900 health centers across the country.

In addition, nearly $29 million was awarded to 67 health center programs to support an additional cycle of New Access Points to serve 286,000 new patients. While these funds provided an important opportunity to expand health care access, HRSA had received 800 applications and had originally anticipated funding 350 new sites, prior to scaling back to just 67 awards due to federal funding cuts.

Federal funding setbacks for health centers continued and intensified into fiscal year 2012. As such, the majority of funds in 2012 were used to sustain operational capacity, and only a marginal amount to support new investment in health centers. Approximately $629 million was awarded...
to 171 existing health centers to support them in expanding facilities and enhancing services to serve 860,000 new patients. Just over $99 million was awarded to 227 existing community health centers to assist them with pressing facility improvement needs. And $129 million in funding was awarded to establish 219 New Access Points across the nation to expand full-time delivery sites and provision of primary care services to an additional 1.25 million patients.

Figure 4 geographically displays the amount of funding each state received between FY 2011 and December 3, 2012 for the expansion of health centers. The top five states with the greatest amount of health center funding include: California ($288 million), Texas ($112 million), New York ($112 million), Massachusetts ($87 million), and Illinois ($71 million). States with the least health center funding include Nevada, North Dakota, Delaware, and South Dakota, all of which were awarded grants totaling well below $4 million.

For fiscal year 2013, the President’s Budget Request includes just over $3 billion for health centers “to provide preventive and primary health care services to an estimated 21 million patients nationwide, adding 25 new health center access points.” However, given the looming “sequester”—or across the board cuts for all government programs—there is still uncertainty regarding the final amount of funding that will be received in the remaining months of fiscal year.
2013. It is projected that sequestration could result in a loss of funding between $115 million and $120 million to health centers, resulting in lowering their capacity to serve 900,000 patients going forward.\textsuperscript{82}

Despite the looming sequester, on January 16, 2013, HRSA issued a Funding Opportunity Announcement to establish 25 New Access Points.\textsuperscript{83} Approximately $19 million was made available, with an average award of $650,000. Funding for these New Access Points is expected to be awarded on August 1, 2013.

**Emerging Programs and Models**

Community health centers are primary providers of care for disadvantaged and underserved populations, particularly low-income, racially and ethnically diverse populations in urban and rural areas. In many communities, health centers have become the provider of choice given the trusted and effective role they play in reaching and serving diverse patients through their various enabling services, language access support and other social services. In this section, we highlight examples of community health centers which are positively progressing in meeting the needs of diverse communities, particularly in the wake of both the ACA’s enhanced opportunities, as well as major funding cuts in almost 30 years. As such, they offer details on how selected health centers are making a concerted effort to target diverse populations or provide culturally competent care:

- **St. Elizabeth Hospital** is using funding from the ACA to undertake a thorough needs assessment of Southeast Louisiana counties to determine the feasibility of a health center and to ensure that the health services provided are tailored to the specific cultural needs of the targeted population. The hospital system is also working to create sustainable and two-way relationships with community health providers and other community groups to reach its overall goal of enhancing the region’s health status and quality of life.

- **Miami Dade College Medical Center Campus** is aiming to improve health care services in the County by establishing *MiHealth Community Clinic*, an interdisciplinary health clinic, to support the community with a range of preventative, educational, advocacy and treatment services, including vision and dental care. The majority of Miami-Dade County’s residents are foreign-born, 61 percent are Hispanic or Latino and approximately 20 percent are enrolled in Medicaid. The grantee has a history of recruiting a diverse and representative body of faculty and students that reflects the region’s racial and ethnic make-up – in fact, 60 percent of the student body is Hispanic and 20 percent is African American – representing an important step to providing culturally competent care. The clinic is also reaching out to community partners and other health centers to ensure success in patient communication and outreach.

- **State University of New York Downstate Medical Center** is using funding from the ACA to develop a federally qualified health center (FQHC) in Central Brooklyn targeted to a racially and ethnically diverse population (predominately Black and Hispanic) that experiences vast health disparities as the area’s residents are disproportionately affected by diabetes, heart disease, stroke, cancers, HIV/AIDS and behavioral disorders. Health care measures for the area are equally dismal as access to primary care access is poor and emergency rooms are over-utilized. The grantee is seeking to bridge the gap in poor
health care access by establishing a patient-centered primary care practice that will expand a health care workforce trained and committed to providing services in a community health setting. Funding will allow the grantee to undertake essential planning efforts from community health needs assessment to obtaining feedback and buy-in from local community representatives, churches, and civic groups.

- **The Florida State University, Havana Health and Wellness Center** is expanding a school-based health center into a FQHC using funding from the ACA that aims to provide services to the entire community of Havana. Funding will support development goals such as a community needs assessment and service delivery plan as well as support community involvement and local partnerships. In this community, over 800 students are unable to access primary care services, over 90 percent of children are low-income, and over 96 percent are African American. The County, which qualified as a persistent poverty county, ranks among the lowest in the state in measures of health. It ranked 62nd out of 67 in health outcomes and 64th out of 67 in overall health status.

- **Mandan, Hidatsa and Arikara (MHA) Nation Health Planning Venture** is utilizing funding from the ACA to target services to Fort Berthold Reservation, which spans six North Dakota counties. Areas within this region experience significant disparities in health as its American Indian population has a significantly lower life expectancy than their White counterparts and rates of suicide, death from automobile collisions, diabetes and addiction are substantially above the national average. New funding allows the grantee to plan for a health center and four field clinics by conducting data analysis, consulting area health care providers, collaborating with tribal leaders, and learning from successful models such as the Benewah Health Center in Idaho.

**Challenges and Next Steps**

The overall investment in health centers, as authorized by the ACA, is expected to significantly expand capacity across the country. While projections prior to the Supreme Court decision showed health centers would double the number of patients they serve between 2010 and 2019, reaching 40 million, the reality may be slightly altered given health centers faced their first federal funding setbacks in almost 30 years. Reductions in health center funding, that were first initiated in fiscal year 2011 and carried forward, has meant slower expansion of new health center sites, as funds in many cases were diverted to support ongoing operations at existing centers.

Despite these cuts, health centers will see a large influx of patients—including those newly covered by Medicaid, with private coverage through the exchanges as well as those with no insurance coverage. Early projections suggested that by 2019, an estimated 44 percent of all health center patients would be covered by Medicaid (up from 39% in 2010), and those with private insurance, including those covered through the exchanges, are projected to reach 23 percent (up from 16% in 2010). While these higher rates of coverage will increase the flow of third party payments to health centers, these institutions will also face increased competition from primary care providers in private settings also interested in serving newly insured patients. Competitive pressures for Medicaid patients will rise as the ACA requires states to pay primary care providers 100% of Medicare payment rates for Medicaid patients served in 2013 and 2014.
These higher reimbursement rates are likely to entice private physicians to also tap into the Medicaid population that health centers have historically served.

Beyond insured populations, however, health centers will continue to play a primary role in serving the estimated 30 million individuals who will remain uninsured for various reasons. Recent projections from the Congressional Budget Office show that while the non-elderly uninsured rate in 2019 will be approximately 8 percent, uninsured patients are expected to comprise 22 percent of health center patients that year. In Massachusetts, following the state’s broad health insurance reform, the demand for care at health centers rose and “the uninsured rate among health center patients remained more than nine times the statewide uninsured rate among nonelderly persons – about 19 percent versus 2 percent.”

In states that have decided not to expand Medicaid, community health centers are likely to play an even greater role in serving the uninsured, particularly those with incomes below 100% of the federal poverty level, who will not qualify for any subsidies or provisions under the exchanges. Health centers in these communities, in many cases, are taking on education, outreach and advocacy roles to: (a) educate state policymakers to adopt the Medicaid expansion to prevent the poorest of poor from falling through the coverage gaps; and (b) to actively seek, educate and enroll low-income, diverse populations who may be eligible, but not enrolled in Medicaid under current eligibility requirements. One key informant summarized this important and almost primary role that health centers are playing in preparation for 2014:

Our first order of business is outreach and enrollment.

When asked what major challenges lay ahead for community health centers in this era of reform, two major themes emerged, largely reinforcing concerns discussed by policy experts:

- **Creating a new competitive edge, while maintaining the health center mission to serve low-income, diverse, and vulnerable populations.** As one key informant eloquently stated, “some providers [health centers] are in competitive mode versus a collaborative mode” as they gear up to serve newly insured patients. Another informant related by saying “the biggest challenge is how do health centers navigate this new system while keeping their souls intact.”

- **Financial viability and sustainability** continue to be major concerns for health centers, notwithstanding the increased funding and support authorized through the ACA. As with prior cuts to health center funding, President Obama’s budget for fiscal year 2013 reinforced the reduced level of grant support for health centers. Further complicating matters, sequestration—a process by which automatic federal spending cuts are imposed—took effect on January 1, 2013, with final impacts still looming. “While most discretionary programs will experience an 8 percent cut under sequestration, special language was included to cap cuts to [community health centers] at 2% in FY 2013...” In addition, the large investment in health centers is slated to end in fiscal year 2015 and the Medicaid-Medicare payment parity for primary care physicians will expire in the end of fiscal year 2014. This raises concerns about “sustainability of expanded capacity and continuity of services for those receiving care at health centers in later years”. Recognizing this situation, HRSA plans to reserve funds in fiscal years 2013 through 2015 to sustain the expanded capacity after the bolus of funding that has come through in recent
Whether this strategy will be sufficient to support the expanded capacity over the years remains unclear. Finally, there is concern among health center advocates regarding the fate of the Health Center Fund, which much like the legislative battles of the Prevention and Public Health Fund, could face major cuts.

Among other concerns were: obtaining specialty care referrals for health center patients; supply of well-trained and experienced health center workforce; and volatility of patient coverage. Connecting patients with specialty and sub-specialty care was a commonly expressed concern, and reinforced research findings on this priority. For example, a recent Commonwealth Fund study found that 91 percent of health centers reported difficulty obtaining off-site subspecialty care for their uninsured patients, and access was only slightly easier for patients enrolled in public programs. Regarding workforce, as one key informant summarized of community health centers: “On the workforce side, it’s tough…the ability to have competent and engaged health care providers is tough to find.” Others spoke about challenges that health centers will face, both administratively and financially, in serving patients with changing health insurance status and payers (moving across having no insurance, to being covered by Medicaid or the exchanges, potentially many times in a single year).
Nurse-Managed Health Clinics

Legislative Context

Section 5208 of the ACA amends the Public Health Service Act by inserting a grants program for the development and operation of nurse-managed health clinics, where are defined as “nurse-practice arrangement[s], managed by advanced practice nurses, that provide primary care or wellness services to underserved or vulnerable populations and that [are] associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit or social services agency.” The law appropriated $50 million for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014.

Implementation Status, Progress and Potential Impact

While $50 million were authorized to support Nurse-Managed Health Clinics (NMHCs) in fiscal year 2010, and such sums as necessary for subsequent years through fiscal year 2014, the program only received $14.8 million in grant funding through the national Prevention and Public Health Fund in 2010, with no additional funding to date. A total of 10 NMHCs were funded with the purpose of increasing primary care access and developing the health care workforce (Table 5). Clinics that have received funding are expected to train more than 900 advanced practice nurses and to provide primary care to over 94,000 new patients by 2012.94

<table>
<thead>
<tr>
<th>Grantee</th>
<th>County</th>
<th>State</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Illinois at Chicago</td>
<td>Cook</td>
<td>Illinois</td>
<td>$1,499,995</td>
</tr>
<tr>
<td>University of Mississippi Medical Center</td>
<td>Hinds</td>
<td>Mississippi</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>Fair Haven Community Health Clinic, Inc.</td>
<td>New Haven</td>
<td>Connecticut</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>East Tennessee State University</td>
<td>Washington</td>
<td>Tennessee</td>
<td>$1,400,998</td>
</tr>
<tr>
<td>St. Mary’s Health Wagon, Inc.</td>
<td>Dickenson</td>
<td>Virginia</td>
<td>$1,493,634</td>
</tr>
<tr>
<td>Regents of the University of Michigan</td>
<td>Washtenaw</td>
<td>Michigan</td>
<td>$1,498,577</td>
</tr>
<tr>
<td>University of Colorado Denver</td>
<td>Arapahoe</td>
<td>Colorado</td>
<td>$1,498,206</td>
</tr>
<tr>
<td>Tides Center - Women’s Community Clinic</td>
<td>San Francisco</td>
<td>California</td>
<td>$1,459,366</td>
</tr>
<tr>
<td>The University of Texas Medical Branch At Galveston</td>
<td>Galveston</td>
<td>Texas</td>
<td>$1,500,000</td>
</tr>
<tr>
<td>The Regents of the University of California, San Francisco</td>
<td>San Francisco</td>
<td>California</td>
<td>$1,497,320</td>
</tr>
<tr>
<td><strong>Total Funding</strong></td>
<td></td>
<td></td>
<td><strong>$14,848,096</strong></td>
</tr>
</tbody>
</table>

Source: Health Resources and Services Administration. Active Grants for HRSA Program(s): Affordable Care Act: Nurse Managed Health Clinics (T56).

Emerging Programs and Models

Nurse-managed health centers are directed primarily by nurse-practitioners, with support from an interdisciplinary team of health professionals, including registered nurses, health educators, community outreach workers, and collaborating physicians. Their goal is to provide accessible, comprehensive primary care and community health programs aimed at health promotion and
disease prevention in urban, suburban, and rural settings. The Institute of Medicine has recognized these health centers as an “evidence-based model that provides care to 2.5 million patients across the county.”

Like other safety-net providers, such as FQHCs, nurse-managed health centers see a disproportionately high percentage of uninsured patients (ranging from 30 percent to 60 percent) and typically serve a racially and ethnically diverse patient population.

Services are provided in easily accessible community settings such as schools, homeless shelters, senior centers, churches and public housing developments.

A foundational study conducted on Pennsylvania’s nurse-managed programs in 2004, as mandated under Public Law 107-116 and funded by the Centers for Medicaid and Medicare Services (CMS), found the significant contribution these centers make in serving poor and diverse patients. The study found that centers located in urban settings predominantly served African Americans (more than 85 percent of patients at that time), whereas those in suburban settings served a diverse patient mix. This diversity in suburban nurse-managed health centers is evidenced by the numbers: 38 percent of African Americans, 35 percent of Hispanics, 21 percent of Whites and 5 percent of Asians in Pennsylvania. Moreover, a recent study by Barkauskas (2011) found that, overall, quality measures for nurse-managed health centers compared favorably with national benchmarks, with particularly high quality demonstrated in chronic disease care management.

The Institute of Medicine’s 2010 report on the Future of Nursing also supports this finding:

Nurse-managed health clinics offer opportunities to expand access; provide quality, evidence-based care; and improve outcomes for individuals may not otherwise receive needed care. These clinics also provide the necessary support to engage individuals in wellness and prevention activities.

Despite the promise of nurse-managed health centers, particularly in serving low-income diverse populations, only 10 centers were funded through the ACA. While all funded clinics are located in and serve medically underserved communities, four grantees explicitly cite “health disparities,” “minority health” and “cultural competence” as priorities in their program descriptions.

Following is a summary of these programs:

- **The University of Mississippi Medical Center’s School of Nursing** intends to expand health care services at its first Nurse Managed Center-UNACARE—in Jackson, Mississippi “to increase access to primary care for adults and children who are socially neglected, economically deprived and where health disparity is ubiquitous...the Midtown Community is a medically underserved area of an African American (94.2%) population with a poverty rate of 47 percent, twice that of the city of Jackson...[and] an uninsured rate of 50 percent.” Leading health concerns include highest rates of AIDS, hepatitis A and enteric disease. With funding through the ACA, the center intends to add staff and hours to improve access to primary care; develop and expand clinical practice sites to provide “culturally structured learning experiences for nurse practitioner students”; enhance the implementation and integration of electronic health records.

- **University of Colorado in Denver** is utilizing its federal funding to expand Sheridan Health Services to a second site to provide expanded access to primary care services, along with expanding case management, adding clinical training sites, enhancing electronic data
and health records, and applying for FQHC look-alike status to more effectively serve a large low-income and minority population.

- **The University of Texas Medical Branch in Galveston** is using new federal funds through the ACA to support St. Vincent’s Nurse-Managed Health Center, a clinic operated by the School of Nursing in partnership with St. Vincent’s House, a faith-based community center. New federal support will significantly expand the Center’s primary care practice for vulnerable residents in the community and will help the Center explicitly address health disparities through the application of Intensive Primary Care (IPC). The IPC model is supported by evidence which suggests that three kinds of interventions can help to reduce disparities: (1) multi-level interventions (i.e., patient, family, provider and community); (2) culturally tailored quality improvement; and (3) nurse-led interventions.

- **The University of California School of Nursing in San Francisco** intends to expand and enhance comprehensive primary health care and wellness services provided to a medically underserved, predominantly homeless client population through an arrangement with Glide Health Services. Through funding from the ACA, the Center will improve access to quality, comprehensive, culturally competent primary care and wellness services, along with expanding student clinical nursing experiences that emphasize cultural competence among other priorities. In addition, these funds are being used to enhance the electronic health record system.

**Challenges and Next Steps**

Despite the proven success of nurse-managed health centers 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. As a key informant stated:

> The efforts to support nurse-managed health clinics [have] seen good outcomes and there is some support in ACA for this. One challenge for nurse-managed health clinics is that there is not enough funding across the country to expand them [despite] increasing enrollment and the vast number of people who [will be] newly insured.

Given efforts to reduce federal spending, funding for this program was not renewed in fiscal years 2011 and 2012. There is still considerable uncertainty around whether this program will receive any new funding through the ACA. In addition, as the large majority of these centers are affiliated with schools of nursing, they often do not meet eligibility requirements to become federally qualified health centers, and thus do not benefit from many federal funding opportunities. Advocates for nurse-managed health centers continue to issue notices to educate and advocate for continued funding for this program. Recently, for example, the American Association of Colleges of Nursing issued a Policy Brief highlighting the promise of nurse-managed health centers in serving underserved populations and providing quality, evidence-based care. They also advocated for $20 million in funding for fiscal year 2013.
Teaching Health Centers

Legislative Context

In Section 5508(a), the ACA creates a grant program to establish new accredited or expanded primary care residency programs in community-based settings. Grants awarded under this section are authorized for a term of no more than 3 years, with a maximum award of $500,000, which is to be used for costs associated with: curriculum development; recruitment, training and retention of residents and faculty; accreditation; faculty salaries during development phase; and technical assistance. The law appropriated $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012, each, and such sums as may be necessary for each fiscal year thereafter.

In addition, Section 5508(c) authorizes the creation of a Teaching Health Center Graduate Medical Education (THCGME) Payment Program to provide payments directly to Teaching Health Centers (THC) operating a primary care residency program. A total of $230 million was authorized for the period of fiscal years 2011-2015. Eligible health centers are those that expand existing or establish new accredited residency programs in primary care fields, which the act defines as family medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and general and pediatric dentistry.

Implementation Status, Progress and Potential Impact

Section 5508(a), which establishes new accredited THCs is yet to be funded, and there have been no updates on the status of funding as of this writing. Nonetheless, in fiscal year 2011, HRSA funded 11 institutions for a total of $2.3 million under the Teaching Health Center Graduate Medical Education Payment Program. An additional $12.2 million and $15.6 million were made available for the payment program in fiscal years 2012 and 2013, respectively.

Table 6 summarizes the total appropriations that were authorized under the Act and funds that have actually been disbursed for this program.

Table 6. Authorized Funding in the ACA and Actual Funding for Health Centers, FY 2010-2013

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012</th>
<th>FY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Authorized</td>
<td>Actual</td>
<td>Authorized</td>
<td>Actual</td>
</tr>
<tr>
<td>THC Develop.</td>
<td>$25 m</td>
<td>$0</td>
<td>$50 m</td>
<td>$0</td>
</tr>
<tr>
<td>THCGME Program</td>
<td>n/a</td>
<td>n/a</td>
<td>$230 m*</td>
<td>$2.3 m</td>
</tr>
</tbody>
</table>

*Total appropriations authorized for 5-year period.

?? Reflects uncertainty of funding as of this writing for FY 2013 for THC development.
Source: [http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf](http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf)

Emerging Programs and Models

As of FY 2013, 17 THCs have received THCGME funding. Of these, 11 have been funded for a 3-year period, training a total of 300 primary care medical residents (Table 7). These centers offered mainly family medicine residency training, while a few also included general dentistry and
internal medicine slots. A majority of these centers are either located in rural, underserved settings or large metro areas such as New York City and Chicago, with significant poverty and formidable challenges to accessing affordable health care. Of the 11 inaugural THCs that were funded in 2011, nine explicitly offered cultural competency curricula as part of their residency training.102

Table 7.17 Teaching Health Center Graduate Medical Education Program Grantees, FY 2011-2013

<table>
<thead>
<tr>
<th>Grantee</th>
<th>State</th>
<th>County</th>
<th>2011 Funding ($)</th>
<th>2012 Funding ($)</th>
<th>2013 Funding ($)</th>
<th>Total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Arkansas System</td>
<td>AR</td>
<td>Pulaski</td>
<td>--</td>
<td>75,000</td>
<td>225,000</td>
<td>300,000</td>
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<tr>
<td>Valley Consortium for Med. Edu.</td>
<td>CA</td>
<td>Stanislaus</td>
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<td>2,541,375</td>
<td>1,912,500</td>
<td>5,079,000</td>
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<tr>
<td>Family Med. Residency of Idaho</td>
<td>ID</td>
<td>Ada</td>
<td>150,000</td>
<td>637,500</td>
<td>562,500</td>
<td>1,350,000</td>
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<tr>
<td>Northwestern University</td>
<td>IL</td>
<td>Cook</td>
<td>600,000</td>
<td>2,700,000</td>
<td>2,700,000</td>
<td>6,000,000</td>
</tr>
<tr>
<td>Penobscot Community Health Ctr.</td>
<td>ME</td>
<td>Penobscot</td>
<td>150,000</td>
<td>600,000</td>
<td>675,000</td>
<td>1,425,000</td>
</tr>
<tr>
<td>Greater Lawrence Family Health</td>
<td>MA</td>
<td>Essex</td>
<td>150,000</td>
<td>675,000</td>
<td>675,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>Ozark Center</td>
<td>MO</td>
<td>Jasper</td>
<td>--</td>
<td>75,000</td>
<td>225,000</td>
<td>300,000</td>
</tr>
<tr>
<td>Montana Family Med. Residency</td>
<td>MT</td>
<td>Yellowstone</td>
<td>37,500</td>
<td>187,500</td>
<td>225,000</td>
<td>450,000</td>
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<tr>
<td>Long Island FQHC, Inc</td>
<td>NY</td>
<td>Nassau</td>
<td>--</td>
<td>262,500</td>
<td>787,500</td>
<td>1,050,000</td>
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<tr>
<td>The Institute for Family Health</td>
<td>NY</td>
<td>New York</td>
<td>150,000</td>
<td>1,050,000</td>
<td>1,650,000</td>
<td>2,850,000</td>
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<tr>
<td>Osteopathic Med. Edu. Consortium of Oklahoma</td>
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<td>Tulsa</td>
<td>--</td>
<td>600,000</td>
<td>2,025,000</td>
<td>2,625,000</td>
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<td>Wright Ctr. for Graduate Med. Ctr.</td>
<td>PA</td>
<td>Lackawanna</td>
<td>202,800</td>
<td>1,275,000</td>
<td>1,800,000</td>
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<td>Montgomery</td>
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<td>750,000</td>
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<tr>
<td>Puyallap Tribe of Indians</td>
<td>WA</td>
<td>Pierce</td>
<td>--</td>
<td>75,000</td>
<td>225,000</td>
<td>300,000</td>
</tr>
<tr>
<td>Community Health of Central Washington</td>
<td>WA</td>
<td>Yakima</td>
<td>--</td>
<td>525,000</td>
<td>900,000</td>
<td>1,425,000</td>
</tr>
<tr>
<td>Community Health Systems, Inc</td>
<td>WV</td>
<td>Raleigh</td>
<td>150,000</td>
<td>621,139</td>
<td>562,500</td>
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<td>Total</td>
<td></td>
<td></td>
<td>2,252,925</td>
<td>12,162,514</td>
<td>15,600,000</td>
<td>30,015,439</td>
</tr>
</tbody>
</table>

Source: Health Resources and Services Administration. Active Grants for HRSA Program(s): Affordable Care Act Teaching Health Center (THC) Graduate Medical Education (GME) Payment. Last Accessed January 26, 2013.

While virtually all programs target underserved or medically underserved patients, there are at least seven programs across five states which are explicitly addressing racial and ethnic health disparities as part of their training. Following is a brief overview of the diversity and equity related programs at these THCs:

- **University of Arkansas** is expanding the number of residents in training using funds from the ACA. Among its primary goals is to incorporate training objectives in compassionate and culturally competent care for populations of racial and ethnically diverse heritage. These include diverse communities such as Black and Hispanic patients,
those with limited English proficiency and those who are medically underserved. The program intends to expand upon the number of primary care physicians practicing in the state and to improve health care access for populations currently underserved.

- **Long Island FQHC** is made up of five community-based sites that provide primary care services in areas such as Internal Medicine and Obstetrics and Gynecology. This new funding will allow the establishment of a Family Practice residency program among other goals. The grantee has designed its program to reduce health disparities within the medically underserved areas of Nassau County and is targeting care to groups from diverse racial, ethnic and linguistic backgrounds.

- **Osteopathic Medical Education Consortium of Oklahoma, Tahlequah Medical Group Internal Medicine THCGME Residency Program** is establishing an Internal Medicine Residency Program that serves a primarily rural area designated as both a Health Professional Shortage Area (HPSA) and a critically underserved area. This grantee is focusing its program to provide care to a largely Native American and medically underserved patient population that makes up 32 percent of the county.

- **Osteopathic Medical Education Consortium of Oklahoma, Choctaw Nation Family Medicine THCGME Residency Program** is developing a new Family Medicine Residency Program with ACA funds. The Choctaw Nation clinic, the Choctaw Nation Hospital and Oklahoma State University Medical Center serve as training sites for residents to train future physicians in a broad array of skills in primary care. Skills described include those targeting diverse populations such as those in medically underserved and rural areas using models such as the patient-centered medical home.

- **Lone Star Community Health Center** is expanding its Family Medicine residency program to train more residents and is offering enhanced educational opportunities that focus on reducing the gap of primary care physicians practicing in underserved populations. The program’s overall goal is to reduce health disparities and improve outcomes for these vulnerable populations as a large proportion of their graduates go on to practice in these communities.

- **Puyallup Tribe of Indians** is developing a Family Medicine residency program with the overall goal of increasing the number of practicing physicians in community-based outpatient sites. Takopid Health Center, an Indian Health Service supported clinic, is serving as the sponsoring site for this program. This teaching health center’s focus is on providing appropriate health and social services for Native American and Alaska Native populations through increased training opportunities related to language and culture and the encouragement of residents to undergo additional training in community health centers, rural health centers or tribal organizations.

- **Yakima Valley Farm Workers Clinic** is expanding its dental residency program through funding from the ACA. This grantee is tailoring its clinical and didactic training opportunities to focus on diverse populations and will include training in culturally competent care. Populations of focus include rural communities, low-income individuals, the uninsured, the homeless, migrant seasonal farm workers, and otherwise underserved
populations. Through these unique educational experiences, residents will be prepared and supported for future careers in community health center settings.

**Challenges and Next Steps**

The Teaching Health Center Graduate Medical Education (THCGME) program is a unique arrangement that aligns the graduate medical education mission of preparing competent and skilled professionals with that of health centers which intend to provide comprehensive and quality care in accessible settings. Studies show that the benefit of using health centers for residency training is the retention of graduates in health center programs they are trained in, particularly 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.

Funding, however, continues to be a critical issue in establishing, expanding and maintaining medical education and training programs in community-based settings. Chen and colleagues (2012) summarize the looming challenges for the teaching health centers program:

"Whereas the THCGME program now provides support for successful applicants, the ACA guarantees funding for only five years; in contrast, annual Medicare GME support is guaranteed as part of a federal entitlement program...Because the average length of a primary care residency is three years, at the end of the five-year period, THCs may have residents in the middle of their training without guaranteed GME payments to support them."

Finally, while the ACA authorized a THC development grant to complement the THCGME Payment Program, it has not received funding to date.
School Based Health Centers

Legislative Context

A grant program under Section 4101 of the ACA was established to support the operation of school-based health centers, with preference to those serving a large population of medically underserved children. The law outlines its preference for awarding grants to communities that have evidenced barriers to primary and mental health care for children and adolescents, as well as high per capita numbers of children and adolescents who are uninsured, underinsured or enrolled in a public insurance program. The law appropriates $50 million for each of the fiscal years 2010 through 2013 to support these centers.

Implementation Status and Progress

In July 2011, $95 million was awarded to 278 school-based health centers, enabling them to serve an additional 440,000 patients beyond the approximately 790,000 they already serve. In August 2011, an additional $14 million was awarded to 45 school-based health centers to expand their capacity and modernize their facilities, allowing them to treat an estimated additional 53,000 children in 29 states. An additional $75 million was available for fiscal year 2013 to fund construction and renovation of school-based health centers.

Table 8 summarizes the total funding authorized through the ACA, and what was actually funded. While in FY 2010, HRSA did not fund any school-based health centers, it made up for this lack of funding by increasing the total award amount in FY 2011 to $100 million.

Table 8. Appropriated Funding in the ACA and Actual Funding for Health Centers, FY 2010-2013

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<tr>
<th>FY 2010</th>
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<td>Authorized</td>
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<td>School-Based Health Center</td>
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Source: Health Resources and Services Administration. The Affordable Care Act and Health Centers. Available at: [http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf](http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf)

Emerging Programs and Models

As of FY 2012, 328 institutions have been funded through the School-Based Health Centers program accounting for $109 million (See Figure 5). Among states with the greatest number of grantees are California (39); New York (38); Oregon (18); Illinois (18); Michigan (15); Louisiana (15); West Virginia (12); Massachusetts (12); and North Carolina (11). While virtually all grantees describe the provision of services to medically underserved populations, examples are given below for those that explicitly describe school-based health centers that focus their care on racially and ethnically diverse populations:
• **Family Health Care Centers of Greater Los Angeles** serves an urban area where the targeted high school's study body is predominantly Latino (98%). The ACA funding is allowing Family Health Care Centers of Greater Los Angeles the ability to build a school-based health center to provide local students and their families with primary and preventative care, health education (including family planning and teen pregnancy prevention), well-baby checks and mental health services. Families in the community suffer higher rates of obesity, diabetes, asthma, anxiety and depression while teen birth rates and sexually transmitted disease rates among the high school's students are higher than the average for Los Angeles County in general.

• **Access Health Louisiana (AHL)** is a FQHC network that serves four Louisiana counties. The grant is allowing AHL to construct medical buildings that will serve approximately 2,700 children at four schools with highly racially and ethnically diverse student bodies (27% are Black and 10% are Hispanic). The county is also designated as both an Health Professional Shortage Area (HPSA) and a Medically Underserved Area (MUA) and faces barriers to care that are common throughout the New Orleans area such as poverty, high rates of uninsured, few medical providers to serve low-income populations and overall poor access to health care.

• **Children’s Home Society of Florida** is serving a highly diverse high school and their families. Over 80 percent of the student body qualifies for a free or reduced lunch, 46 percent live below the federal poverty level (FPL), and 20 percent have limited English proficiency as the school has a large Haitian Creole population. The ACA funding allows this grantee to establish preventive medical and dental services, behavioral health services, counseling and social support services in the area which is both designated as HPSA and MUA.

• **Oklahoma Community Health Services (Variety Care)** offers services from oral health to case management to a patient population that is largely at or below 200% of the FPL. The Capitol Hill School Based Health Center is centered in a low-income urban and highly diverse area as the high school's students are 61 percent Hispanic, 17 percent Black and 4 percent Native American and 88 percent of the students are eligible for a free or reduced lunch.

• **TCA Health** is providing services such as screenings, disease prevention, immunization, and chronic disease management through its Mobile Student Health Clinic with funding from the ACA. The targeted area in Southern Chicago suffers disproportionately from diseases such as childhood obesity, asthma, diabetes, cardiovascular disease, influenza/pneumonia, HIV/AIDS and other sexually transmitted infections. The mobile clinic strives to serve hard-to-reach populations in the area's elementary and high schools including those who are racially and ethnically diverse. Approximately 98 percent are low-income African American students experiencing poor access to quality care.
Figure 5. School-Based Health Center Capital Development Grantees as of FY 2012

Number of Grantees

Source: Kaiser Family Foundation. School-Based Health Center Capital Grantees, as of FY 2012. Available at: http://www.statehealthfacts.kff.org/comparemapreport.jsp?rep=99&cat=17
C. New Requirements for Safety Net Hospitals

Medicaid Disproportionate Share Hospital Payments

Legislative Context

Section 2551 of the Affordable Care Act (ACA) reduces Medicaid Disproportionate Share Hospital (DSH) spending by $18 billion between 2014 and 2020. While DSH reductions begin in 2014, the steepest cuts are pushed to later years. Medicaid DSH payments will be reduced by $500 million in 2014, $600 million in 2015, $600 million in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. The amount of cuts imposed on each state will be based on a methodology that requires the largest percentage reductions on the states that: (1) have the lowest percentages of uninsured individuals (determined on the basis of data from the Bureau of the Census, audited hospital cost reports, and other information likely to yield accurate data) during the most recent year for which such data are available; or (2) do not target their DSH payments to hospitals with high volumes of Medicaid inpatients and hospitals that have high levels of uncompensated care (excluding bad debt).

Implementation Status, Progress and Potential Impact

As DSH payment reductions are scheduled to start in 2014, there have been no implementation updates. Also, guidance on the methodology for the percentage reduction among states is yet to be determined.

Emerging Programs and Models

Although subject to federal guidelines, which are forthcoming, states have considerable discretion in deciding how to allocate Medicaid DSH funds. National research and analytical organizations as well as experts have generated recommendations and guidance to inform the process for determining reductions in the Medicaid DSH payment programs. In all they reinforce that any methodology designed to reallocate funds will need to start with a full understanding of current Medicaid DSH distributions for each state. Such an assessment will require each state to address at least the following questions generally about their payments and, in particular, for providers who historically have received DSH funds:

- How do states define the goals and objectives of their Medicaid DSH programs?
- What have been the historical uses of funding by states?
- How do Medicaid DSH funds flow to hospitals and providers within states?
- How do hospitals and health providers use these funds?
- What populations and communities benefit from Medicaid DSH?
- What are the volume and types of services financed through these payments?
- How does Medicaid DSH funding complement or interact with Medicare DSH program?

Our review has also identified recommended strategic actions in determining DSH payment cuts for safety net hospitals that should follow such an assessment:
• **Target Medicaid DSH Payments to cover uncompensated care costs of serving uninsured patients:** Recent estimates suggest that nearly 30 million individuals (mainly adults) will remain uninsured in 2022, and in states not choosing to expand Medicaid, the uninsured will comprise a much higher percentage of the population than in states opting to expand. As such, it will be critical for states—particularly without Medicaid expansion—to target remaining Medicaid DSH dollars to sustain hospitals with a disproportionate burden of uninsured patients.

• **Consider linking DSH payments to specific services provided disproportionately to uninsured patients:** This strategy can be adopted to ensure that hospitals that serve the greatest numbers of uninsured for particular services receive the greatest proportion of the state’s DSH funds.

• **Consider a strategy for reimbursing hospitals for care provided to underinsured patients:** To the extent possible, states will also need to establish a plan for allocating limited Medicaid DSH dollars for underinsured patients. Should the costs for these patients be considered in allocating DSH dollars, and if so, to what extent? Underinsured patients are those for whom cost-sharing levels are unaffordable or the benefit package does not pay for critical services. While it is expected that the underinsured population will decline starting in 2014 (from 29 million in 2010), this may not be the case in states not choosing to expand Medicaid where people with incomes below the 100% federal poverty level will not benefit from the “essential health benefits” package.

• **Consider investing previously committed DSH dollars to increase Medicaid payments for safety-net hospitals:** Finally, while Medicaid DSH payment cuts will reduce federal matching funds for DSH, state dollars previously committed to DSH will remain untouched. States may consider investing these dollars to increase Medicaid payments for safety-net hospitals, possibly triggering higher matching rates available for newly eligible Medicaid patients.

**Challenges and Next Steps**

Reductions in the Medicaid DSH program were written into the ACA with the assumption that all states would expand Medicaid coverage for low-income populations with incomes below 138% of FPL, and low-income individuals ineligible for Medicaid would obtain subsidies to purchase coverage through the exchanges. However, with the Supreme Court decision making Medicaid expansion optional, concerns are rising that a state that does not expand its Medicaid program could reduce its uninsured rate by covering people with incomes above the federal poverty level through the insurance exchange, leaving the extremely poor or those with incomes below poverty level uninsured. This decline in the uninsured rate would trigger DSH cuts, and it could result in a substantial erosion of DSH funds in safety-net hospitals that may see “little or no change in the amount of uncompensated care they provide.”
Under this scenario, states forgoing the Medicaid expansion, but seeing DSH payment reductions, are likely to leave a substantial uncompensated-care burden on hospitals. Following is an account of Massachusetts’s experience with similar reforms:

In Massachusetts, after similar insurance reforms, 98 percent of the population was insured, however the two largest safety net hospitals (Boston Medical Center and Cambridge Health Alliance) had hundreds of millions of dollars in operating losses because lower Medicaid and private payment rates were insufficient to offset the loss of institutional subsidies after the enactment of reforms. Those funds were diverted to provide individual insurance subsidies and later to offset state budget shortfalls during the recession.
Medicare Disproportionate Share Hospital Payments

Legislative Context

Section 3133 of the ACA reduces Medicare DSH payments by an estimated $22 billion over ten years. Starting no later than fiscal year 2014, and each subsequent fiscal year, Medicare DSH payments would be reduced by 75 percent. “A portion of these cuts would be restored through an additional payment made to reflect hospitals’ continued uncompensated care costs. The funding available for these additional payments would be reduced proportionate to each percentage point reduction in uninsured based on projected national rates of uninsurance.”

Implementation Status, Progress and Potential Impact

Medicare DSH payment reductions are scheduled to begin in fiscal year 2014, and it is expected that they will result in over $22.1 billion decrease in Medicare DSH expenditures between 2014 and 2019.

Emerging Programs and Models

Roughly 3,750 or 75 percent of the nation’s hospitals receive some Medicare DSH payments, but 200 hospitals receive nearly 40 percent of all DSH payments. Although the number of hospitals that receive DSH payments is relatively small, a 2007 report from the Medicare Payment Advisory Commission (MedPAC) revealed that Medicare DSH payments were not well-targeted. The report highlighted that “roughly three-quarters of Medicare DSH payments—roughly $5.5 billion—were not empirically justified by higher patient care costs associated with low-income patients” and that these payments in many cases did not target hospitals with higher shares of uncompensated care. In fact, hospitals receiving the largest DSH payments reported having uncompensated care costs below the average for all hospitals. MedPAC therefore concluded:

It appears that the hospitals most involved in teaching and in treating low-income Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to patients unable to pay their bills.

Under the new allocation methodology for Medicare DSH payments, as outlined in the ACA, a hospital will receive a share of dollars depending on its share of uncompensated care provided by acute care hospitals across the country. However, the application and impact of this methodology is uncertain given there is no universally accepted definition of uncompensated care—i.e., does it include only care provided to uninsured patients or does it also encompass bed debts from underinsured patients? Leading policy experts suggest these cuts “should be better targeted to hospitals that provide larger amounts of uncompensated care.”

Challenges and Next Steps

As cuts to Medicare DSH payments take effect in October of 2013, safety-net hospitals are concerned with its damaging financial impact. There is widespread uncertainty regarding what these payment cuts will look like, especially as the HHS Secretary has yet to determine how it defines uncompensated care and what formula will be used to determine how much of the reduced Medicare DSH payments will be restored. While private, nonprofit urban safety-net
hospitals comprise just 15 percent of all acute-care hospitals covered by Medicare’s inpatient prospective payment system, they will absorb roughly half of these cuts (Figure 6). It is estimated that “the average private urban safety-net hospital will lose more than $8 million in Medicare DSH revenue in fiscal year 2014, alone,” and “over five years this will amount to a loss of more than $53 million in Medicare DSH revenue for the average private urban safety-net hospital.” In addition to the impact on revenues, there is widespread concern that these cuts could cost hospitals over 73,000 direct jobs in fiscal year 2014. Private, nonprofit urban safety-net hospitals are expected to bear a disproportionate burden of these projected job losses. Many of these hospitals are located in extremely diverse settings, serving and employing a large percentage of racially and ethnically diverse individuals.

Figure 6.

Community Health Needs Assessment

Legislative Context

The Internal Revenue Service (IRS) first established the concept and requirement of community benefit in 1969. In 2009, the IRS required all nonprofit hospitals to report on their community benefit activities on a “Schedule H” worksheet which was appended to Form 990 that all tax-exempt entities were required to complete annually. Section 9007 of the ACA further strengthens the community benefit obligation by requiring all 501(c)(3) or nonprofit hospitals to conduct a community health needs assessment every three years and to adopt an implementation strategy to meet the needs of the community identified through the assessment.

As a requirement for maintaining a hospital’s tax-exempt status, Section 9007 is authorized to go into effect in the taxable year of each hospital beginning after March 23, 2012. If a hospital system operates more than one hospital, each hospital is required to conduct a distinct community health needs assessment. In addition, on an annual basis, each hospital must provide the Secretary of Treasury a description of how the organization is addressing the needs of the community identified in the assessment, along with any needs which are not being addressing including reasons for not being able to address them. In turn, the Secretary of Treasury is required to review the community benefit activities of each hospital once every three years. As the ACA warns, failure to comply with these new requirements in any taxable year will result in a $50,000 excise tax as well as possible revocation of the tax-exempt status.

The law also outlines specific requirements for the assessment including that “[it] takes into account input from persons who represent broad interests of the community served by the hospital..., including those with special knowledge of or expertise in public health; and is made widely available to the public.”

Implementation Status and Progress

On May 27, 2010, the IRS released Notice 2010-39, 2010-24 I.R.B. 756, which requested comments regarding the new requirements under the ACA for tax-exempt hospitals to maintain their status, including the need, if any, for guidance regarding such requirements. In response to Notice 2010-39, the IRS received numerous requests for guidance on the community health needs assessment requirements. Therefore, in Notice 2011-52, issued on July 25, 2011, the IRS released a set of “anticipated regulatory provisions” or guidance on process and methods for conducting an assessment, reporting and dissemination requirements, as well as direction on developing an implementation plan to address needs.128

The Notice, in particular, defines the required components of a written report on the assessment. Specifically, any written report must provide a description of the community served by the hospital facility. Community can be defined in terms of geographic location (e.g., a particular city, county, or metropolitan region); target populations served (e.g., children, women, or the aged); or hospital facility’s principal functions (e.g., focus on a particular specialty area or targeted disease). In addition, the notice states that a “community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically
underserved populations, low-income persons, minority groups, or those with chronic disease needs." 

In addition, Notice 2011-52 requires hospitals to define their methodology and obtain input from persons who represent the broad interests of the community. These representatives include public health experts and federal, state, tribal and local agencies as well as members of medically underserved, low-income and minority populations. In addition, hospitals are permitted to conduct community health needs assessment in collaboration with other organizations as well as to base their assessment and information on data and findings collected by other organizations, such as a public health agency or nonprofit organization.

Finally, the Notice includes guidance on broadly disseminating findings from the assessment, along with direction on establishing an “implementation strategy” to meet the community health needs identified through the assessment.

**Emerging Programs and Models**

The community benefit requirement has been in existence for over 50 years, and many states have adopted their own statues to address this. Currently, there are 17 states with community benefit statutes, and the majority requires some form of a community health needs assessment. A review of programs across states revealed that the primary form of community benefit or charitable contributions by hospitals involved the “provision of free and/or discounted medical services to the uninsured and underinsured populations.” While there are programs which have started to take a broader public health approach, these have been smaller projects spread over a wide geographic area, “most insufficient in scale, targeting, or design elements necessary to produce measurable outcomes.”

A 2012 study commissioned by the Centers for Disease Control and Prevention (CDC) and undertaken by the Public Health Institute tracked the science, methods, and current practices in meeting the community benefit requirement for nonprofit hospitals. Findings were generated from a two and a half day expert panel meeting held in 2011, along with roughly 50 key informant interviews conducted. The report entitled, *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*, includes a range of best practices, lessons and tools that can inform and assist hospitals as they plan to develop, conduct, report and take action on their community health needs assessments. Specifically, the report focuses on two areas of the assessment process: (1) Conducting the Community Health Needs Assessment; and (2) Developing and Executing an Implementation Strategy. For each of these two requirements, a set of recommended practice areas were established and key steps, recommendations, tools and strategies were presented. Table 9 provides an overview of key recommendations and steps for addressing each practice area.
Table 9. Key Elements of Community Health Needs Assessment and Implementation Strategy Development and Execution

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<thead>
<tr>
<th>Community Health Needs Assessment</th>
<th>Implementation Strategy Development and Execution</th>
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<tr>
<td>• Shared ownership for community health: Establish a common agenda, shared metrics, a structured process, and jointly funded infrastructure with diverse stakeholders in the community.</td>
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<tr>
<td>• Defining community - jurisdictional issues: Consider unique issues across geographic areas (e.g., urban, suburban, and rural) and concentrations of populations with unmet health needs; and establish multi-jurisdictional partnerships between nonprofit hospitals and community health centers, public health agencies, rural hospitals, and others.</td>
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<tr>
<td>• Data collection and analysis: Combine secondary data from sources such as the U.S. Census Bureau at the sub-county level to identify unmet needs with hospital utilization data and GIS technology to display geographic distribution of need and capacity. Ensure that social determinants of health are a part of the assessment.</td>
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<tr>
<td>• Community engagement: Engage community stakeholders as equal partners with shared accountability and investment in addressing health concerns, on an ongoing basis to foster trust and meaningful contribution.</td>
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<tr>
<td>• Priority setting: Engage community stakeholders at the center of priority setting and limit a top-down or agency-based approach to identify comprehensive and sustainable approaches to health improvement which address both the symptoms and causes of health concerns.</td>
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<td>• Alignment opportunities: Align the assessment with opportunities from the ACA, along with unique expertise and contributions of teaching hospitals and academic affiliates to address key issues such as health disparities.</td>
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<td>• Monitoring and evaluation: Consider and define metrics, consider audiences, potential roles of community members, and innovative ways to track progress in addressing health disparities.</td>
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<td>• Institutional oversight: Consider importance of governance and oversight of nonprofit hospitals, along with ways to involve other settings in extra-institutional oversight.</td>
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<tr>
<td>• Shared accountability and regional governance: Consider establishing regional partnerships and shared governance and accountability between hospitals, local public health agencies, and other stakeholders.</td>
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<tr>
<td>• Strategic investment and funding patterns: Consider role of other public and private sector funders in facilitating more comprehensive, sustainable, and strategic approach to community health improvement.</td>
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<td>• Public reporting: Align public reporting of community benefit with broader national health reform process and move from an emphasis on “compliance with minimum standards” to “meaningful actions that transform institutions and produce measurable health improvement in communities.”</td>
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A range of other tools and resources with guidance on planning for and conducting a Community Health Needs Assessment have recently emerged in response to the ACA’s new requirements. These include, for example:

- **Assessing & Addressing Community Health Needs:** Issued by the Catholic Health Association in February 2012, this guidance document includes comprehensive step-by-step recommendations, examples and practices for effectively carrying out an assessment. The report includes some modest steps highlighting the need to explicitly address health disparities—such as identifying racial and ethnic data, obtaining community input which is reflective of the racial and ethnic makeup of the community, and mapping health disparities indicators.

- **Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals:** On March 13, 2012, a coalition of organizations representing a range of public health associations and institutes issued a set of consensus recommendations about how hospitals can most effectively work with public health agencies and experts to maximize the impact of community benefits. Explicitly included in these recommendations is a focus on health equity—e.g., “community health needs assessment and implementation strategies should aim to increase health equity through consideration of social determinants of health.”

- **A Healthcare Advocate’s Guide to Community Health Needs Assessments** which highlights a range of practices and examples of assessments explicitly addressing community health needs of diverse populations, the findings they have yielded and what they mean for community health improvement.

**Challenges and Next Steps**

The expanded and strengthened requirement for hospitals to conduct a community health needs assessment, report findings, and develop community-based solutions represents a significant shift in the focus and scope of impact from beyond the individual to a more population-based approach. While this represents the opportunity for positive community-wide impact, there are a range of challenges that lie ahead. First, the understanding of this opportunity is not universal among hospitals across the country. Secondly, states with community benefit statutes (a total of 17) have differing definitions of what comprises a community benefit, and thus there is likely to be a ranging scope of initiatives across the country—some more population-based, while others less so. Among other questions and concerns cited in the field are: how to effectively ensure ongoing engagement of community stakeholders, particularly in overcoming negative perceptions and lack of trust in certain providers involved in these assessments; and how to overcome obstacles associated with shared accountability, regional governance, and multi-jurisdictional issues.
IV. The Safety Net at Crossroads

While the implementation of the health care reform law is transforming the health care landscape, the safety net will need to continue playing a critical role in serving nearly 30 million people who are estimated to remain uninsured. What will change, however, are the mechanisms by which the safety net is funded, arrangements by which care is delivered, places where care is provided, and new populations who will be served.

The ACA had intended to make health care coverage uniform and virtually universal for all childless adults. However, the Supreme Court’s decision on Medicaid abrogated the fate of the health care safety net into the hands of states. As noted, the Court decided that states could not be coerced into expanding Medicaid—thus making it optional—and arguably perpetuating a state-by-state patchwork of programs and providers that, especially for states refusing to participate in this expansion, may have severe adverse consequences for low-income, racially and ethnically diverse populations. And even if most states do participate in Medicaid expansions, the safety net will likely see a large influx of low-income and diverse patients. By 2019, an estimated 37 million new patients will be served by health centers and clinics, of which 44 percent will be enrolled in Medicaid, 23 percent will be privately insured, and 22 percent will be uninsured. Racially and ethnically diverse residents are likely to comprise a large majority of these patients—at least two-thirds, if not more.

Given these rapidly changing dynamics, the safety net will be confronted by a new set of challenges that will impact diverse patients, and will require planning and adaptation to continue to serve both newly insured—through Medicaid, CHIP and the exchanges—as well as the uninsured, mainly those with incomes at low levels that exempt individuals from the insurance mandate, along with lawfully present immigrants fulfilling their 5-year waiting periods and undocumented populations.

Historically, the status, circumstances and challenges facing public hospitals, community health centers and other safety-net organizations have varied greatly. While some have thrived and improved their position as major providers of care for diverse and other vulnerable populations, others have faced formidable financial and service system obstacles or struggled to meet growing population needs, competitive pressures and changes in the health care environment.

Our review of these settings indicates that the ACA introduces new dynamics and opportunities—for example, many providers have applied for new support through the Centers for Medicare and Medicaid Innovation, or have begun to recast their strengths as a way to ensure that they remain attractive to traditional populations they serve, especially Medicaid. A number are considering, many for the first time, new alliances and formal collaborations such as between safety net hospitals and FQHCs as a way to attract enrollees into a system of care, provide continuity of care, and perhaps pursue new funding streams or organizational arrangements such as Accountable Care Organizations. In other areas, for example, New York City practitioners in safety-net hospitals will need to meet new performance requirements intended to improve quality and lower costs. At the same time, key informant responses indicated that the ACA-related consequences—both intended, and unintended—will reinvigorate and renew some providers, while for others they will inject significant uncertainty into their future role and capacity to attract populations, innovate and adapt.
In the narrative that follows, we discuss the opportunities, experiences and challenges the safety net is likely to face as it transitions and adapts to a new health care environment. This discussion builds on the progress the safety net has made to date in implementing major provisions of the ACA—such as expanding health centers—as well as the reforms the system anticipates will take effect in fiscal year 2014. 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 racially and ethnically diverse patients:

- Rising competitive pressures;
- Financial threats and adaptive capacity;
- Continuity of coverage and care;
- Uncertainty of the safety net role in state exchanges;
- Access to subspecialty care; and
- Populations remaining at the margins.

The following section expands on these issues.

**Rising Competitive Pressures**

Safety-net providers—public and nonprofit hospitals and health centers alike—will face a set of new competitive pressures as the ACA’s major insurance provisions go into effect. Over the next decade, the expansion of Medicaid along with the individual mandate and subsidies available through the exchanges are expected to convert millions of formerly uninsured to insured patients. This opportunity presents a competitive threat for safety-net providers, as insured patients—especially in very competitive markets—will have more options on where to obtain care. Some safety-net hospitals and health centers “will need to transform their organization's culture to become attractive to insured patients.”

As interviews with key informants revealed, a primary concern and priority for many safety-net hospitals and health centers is to minimize the erosion of their existing market—including both current Medicaid patients and those who are currently uninsured—but will be newly enrolled in Medicaid or private insurance. Much of the focus for many of these providers has been to take steps to mitigate this threat. For example, one key informant described steps that a safety net institution is taking to preserve its current uninsured patients expected to be newly insured in 2014. As this individual stated:

> We need to be a provider of choice. We are focusing a lot on patient satisfaction. We had staff undergo service excellence training...Our goal is to retain [existing patients]. We are not trying to attract everyone, but to retain the uninsured who we already see, based on our services, quality of services, cultural competency, language services and customer services.

Like safety-net hospitals, administrators at health centers are also concerned about possible increased competition with private health care providers. As coverage expansion turns many charity patients into paying patients, private physicians and hospitals may compete for these traditional health center patients. Although this concern has not played out at large in the past, and did not occur in Boston after Massachusetts enacted health reform, the ACA’s Medicaid-
Medicare parity in primary care payment rates in 2013 and 2014, are likely to make these patients more attractive to both public and private providers. In states that do expand Medicaid coverage to 138% of the federal poverty level, health centers and other community clinics will benefit from the reimbursement that serving more insurance patients brings. However, they may face increased competition from private primary care providers interested in serving newly insured Medicaid patients.

What could potentially ease these competitive pressures for safety-net providers is 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. An analysis of safety-net providers after health reform in Massachusetts found that “most patients use safety-net facilities willingly rather than as a last resort.” As such, these providers have considerable opportunity and strength in continuing to serve many of these populations.

Financial Threats and Adaptive Capacity

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 setbacks in almost 30 years when originally appropriated dollars in the ACA were significantly cut in 2011, and into 2012. For safety-net hospitals, declines to a major funding lifeline—Medicaid and Medicare Disproportionate Share Hospital payments—are scheduled to begin taking effect in January 1, 2014. 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. In this section, we describe the financial circumstances affecting health centers and safety-net hospitals, and discuss their implications for continuing to play a major role in serving racially and ethnically diverse patients.

Health Centers. As noted under Section III of this report, community health centers received considerably lower funding in 2011 than was originally anticipated with the enactment of the ACA. This cutback was severely compounded by state funding reductions for health centers experienced across the nation. As a study by the National Association for Community Health Centers revealed, as of November 2011, 35 states provided supplemental grants to support health center operations, however, health center funding in these states declined for the fourth straight year, hitting a seven-year low. “From its high point of $626 million in fiscal year 2008, state grant funding dropped more than 40 percent to an estimated $335 million for fiscal year 2012, and in six of the 35 states, health centers faced a one-year decline in state funding of 30 percent or more for fiscal year 2012.”

Recent state decisions to cut Medicaid benefits have also had an adverse effect on health center financing. For example, in 2009, California opted to eliminate dental benefits for adult Medicaid beneficiaries, which led many health centers to close their sites or to scale back their services and staff.

Safety-Net Hospitals. While there is generally widespread concern among safety-net hospitals about the impact of the scheduled Medicaid and Medicare DSH payment reductions, at least three scenarios seem to be emerging in determining the ability of safety-net hospitals to effectively position themselves to be viable providers in their communities. These scenarios are
largely dependent on two factors: (1) state politics and decisions related to Medicaid expansion and the exchanges; and (2) the financial and operational health of safety-net hospitals and systems.

- **Scenario 1: Progressive states, strong institutions and active adaptation.** Two primary circumstances generally describe these providers. First, they tend to be in states that are more active in exchange development and Medicaid expansion. As such, providers are actively undertaking efforts to retain and attract those eligible for Medicaid. Secondly, these settings tend to work from a position of financial strength and use that position to take advantage of opportunities arising through or concurrent with the ACA. For example, many of these institutions are involved with groundbreaking demonstrations or innovation programs through CMS and AHRQ. Given this momentum, many of these institutions are seeing cuts in DSH payments as less draconian as they feel they may be able to position themselves to be effective in competing for Medicaid patients, and those eligible through the exchanges. This was reinforced by a key informant who stated:

> The issue in our state is how quickly can we get Exchanges up and what will final arrangements look like for expanded Medicaid coverage. What’s the payment level going to look like for that? We are moving forward quickly on the Exchange, so we can get programs ahead of DSH cuts. We are building capacity in the system to handle these things.

Also expressed by a key informant regarding these hospitals was that DSH payment cuts “were not a priority right now” as these reductions are “more backend” and these institutions are likely to be able to offset them in the coming years.

- **Scenario 2: Strong institutions, but more reactive adaptation.** Under this scenario institutions that are currently financially stable may be slower to become actively engaged with health care reform or to innovate and test new models of care. Compounding their circumstance, they may also be located in states that, to date, have been slower to develop their exchanges or are opting for federal partnership or administration. As a key informant suggested, these institutions take more of a “wait-and-see” approach. Nonetheless, these hospitals are more concerned about the impact of DSH payment reductions than settings in Scenario 1. As a response from a key informant concluded:

> We are certainly concerned about the reductions. Feds have to determine the allocation of cuts, and we are not sure how much the cut will be for our state or our system. We don’t know what the hit will be for us.

- **Scenario 3: Challenged settings in a less supportive environment.** These institutions tend to be located in states less supportive of Medicaid expansion and exchange development or, in some cases, actively resistant to participation—positions that may directly discourage state and provider innovation. At times state legislatures as well as Governor’s positions may literally work against state offices or health care settings who seek to take advantage of the ACA funding opportunities. In this scenario, safety-net hospitals may see the consequences of DSH payment reductions as potentially cutting into core services and having a major effect on the ability to provide care. As one respondent commented, “if [our hospital] gets left out in the cold we would have to cut our core
services...there will be major implications.” These institutions are particularly fearful that whatever new revenue they will receive from expanding coverage—both Medicaid and private—will not offset the cuts they are expected to experience with DSH payment cuts.

**Continuity of Coverage and Care**

Populations using the exchanges or eligible for expanded Medicaid coverage are likely, at some point in their lives, to be using both. For example, it is expected that individuals enrolled and insured through the exchanges may become unemployed, lose their private insurance coverage and become eligible for Medicaid. Safety-net providers are particularly concerned about the financial and administrative implications of low-income patients whose coverage eligibility will fluctuate with their income. It is possible, that as income fluctuates, these patients could have Medicaid one month, be eligible for subsidies through the exchanges the next month, and could even risk losing coverage should they become unemployed or if their income falls below the federal poverty level in any subsequent months. A recent study of adults with incomes below 200% of the federal poverty level found that 35 percent of adults would experience a change in insurance eligibility within 6 months, and 50 percent would see a change within a year. Among the poorest populations, the percentage fluctuating in their eligibility is likely to be much higher.

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 over 2 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. Safety-net institutions, therefore, are likely to continue to carry the burden of those switching back and forth from being insured to uninsured, adding another layer of financial complexity to their ability to effectively compete with other providers.

Safety-net settings may expect to see variability in the populations covered and cared for. However, lack of engagement with exchange mechanisms and populations may lead to challenges in changing enrollment, lack of experience in services coverage, established networks and overall continuity. “One key opportunity to reduce coverage and access disruption for individuals, and ensure continuity as well, would be to have the same health insurance plans participating in the exchange and Medicaid.” This, however, is yet to unfold and, should it occur will likely play out on a state-by-state basis.

**Uncertainty around the Safety Net Role in State Exchanges**

Our review indicates that safety-net providers, in general, are concentrating their efforts on Medicaid enrollment and maintaining the population they already serve. However, we found much more variability in preparing for an active role in the exchanges. It appears that the first priority is assuring that these providers do not lose the Medicaid populations they are already serving, as well as their currently uninsured patients who will be newly enrolled in Medicaid. As such, these providers are concentrating their resources on enrollment of these populations and, where possible, by working to expand and to potentially attract those newly enfranchised through Medicaid. This is an especially important undertaking for diverse communities, given that while
“many racial and ethnic minorities are enrolled in Medicaid and CHIP programs, many more are eligible for such coverage but are not enrolled, either because they are unaware of their eligibility or face other barriers, such as limited English proficiency and enrollment process complexities.”49

However, our analysis and information from key informants indicate a much less clear outlook for the exchanges. When asked, many informants indicated that they had not been using resources or reaching out to health plans or others to be better positioned to enroll or serve these populations. As one respondent summarized—“we have a very small role with the exchange right now, beyond advocacy”—suggesting that looming questions remain around affordability. This early trend is not uniform across all communities, however. Some settings with greater resources and perhaps with potentially greater opportunities within their states, are taking steps to be active players in enrolling and serving those who will be insured through the exchanges.

**Access to Subspecialty Care**

While the significant investment in community health centers enhances the nation’s primary care capacity, these institutions face considerable challenges in ensuring their patients are connected with and receive subspecialty care.50 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 racially and ethnically diverse. First, the scheduled Medicaid and Medicare DSH payment cuts could make it difficult for financially-strapped hospitals to continue to offer subspecialty care. This could be especially deleterious for poor and diverse communities where a safety-net hospital is the sole provider of subspecialty services. In addition, while the law requires Medicaid to pay providers as much as Medicare pays for primary care services, payment levels for surgeons and other subspecialists have not changed. As such, many of safety-net hospitals—particularly those in better financial condition—may not be eager to see Medicaid patients for subspecialty care.

A Commonwealth Fund study found that 91 percent of health centers reported difficulty obtaining off-site subspecialty care for their uninsured patients, and access was only slightly easier for patients enrolled in public programs.51 Specifically, 71 percent of health centers reported difficulty connecting Medicaid patients with subspecialty care. The study found that health centers were taking innovative, but piecemeal, steps to arrange subspecialty care for their patients. These ranged from personal requests from health center providers for a subspecialist (which was the most common method) to contractual partnerships with safety-net hospitals for subspecialty care, and more formal but rare arrangements such as integrated health systems. However, given little consideration for access to subspecialty care or lack of specific funding within the ACA, these challenges and arrangements are likely to persist, if not potentially intensify with the large influx of newly insured patients. Support for the Teaching Health Center, for example, was one vehicle the ACA had envisioned as adding a potential new source of subspecialty care. However, only 17 THCs were supported through the ACA for medical residency programs, and while the ACA had authorized funding for the establishment of new THCs, this provision received no funding, as of this writing.

Our key informant interviews revealed that many financially sound safety-net hospitals are beginning to make a concerted effort to expand not only primary care, but specialty care, particularly in outlying areas beyond inner cities. As one safety-net hospital respondent stated:
We are setting up ambulatory centers including specialty services in outlying areas beyond the metro. Currently a lot of specialty care is concentrated in the metro area...and now we are planning to expand to suburban areas.

However, as safety-net settings focus their resources on enrollment and working to maintain their patient base, their capacity and incentives to seek out, create, or actively participate in network development and integrated systems—such as Accountable Care Organizations (ACOs)—may be limited.

**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. Of this uninsured population, U.S. citizens with incomes below the federal poverty level may account for as many as 4 million without insurance in states that (to date) have turned down the Medicaid expansion. Approximately half—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, unlike lawfully present immigrants who in non-Medicaid expansion states will obtain this benefit. Known as the “immigration glitch”—unintended consequence of the Supreme Court’s ruling on Medicaid—individuals with incomes below the federal poverty level residing in a state that turns down Medicaid expansion can only receive government-subsidized coverage if they are legal immigrants—“U.S. citizens are out of luck.” Recognizing that a potentially large number of citizens could be marginalized, Arizona modified its staunch position against Medicaid expansion to support it in mid-January 2013. Arizona’s state budget documents cited the following:

> If Arizona does not expand, for poor Arizonans below (the federal poverty line), only legal immigrants, but not citizens, would be eligible for subsidies...That's because the immigrants would be eligible for government-subsidized private insurance, while low-income citizens would not.

In addition to the poorest citizens who will be left without coverage, approximately 11 million undocumented immigrants will be barred from public programs and the exchanges under the current law. And this policy was further reinforced in August 2012, when the White House ruled that young immigrants who will be allowed to stay in the country as part of the government’s new policy will not be eligible for Medicaid, CHIP or federal subsidies in the exchanges, and they also do not have the option of purchasing coverage at full cost.

Safety-net hospitals and health centers have served as core providers of care for undocumented immigrants. By mission and necessity, these institutions will continue to play this role in the face of rising competitive pressures and declining federal, state, and local financing. Particularly vulnerable will be safety-net providers in states expanding Medicaid, as these providers will continue to serve a large uninsured population—including poor citizens below the poverty line along with both lawful and undocumented immigrants—as concurrently they experience shrinking DSH funding. And in states such as Texas, which as of this writing, is not opting for Medicaid expansion and where the undocumented population is second largest, the strain will be even greater. As the President of the American Hospital Association, Rich Umbdenstock, wrote in a letter to Obama:
In communities where the number of undocumented immigrants is greatest, the strain has reached the breaking point...In response, many hospitals have had to curtail services, delay implementing services, or close beds.157

In addition to federal support through the DSH payment program, many state and local governments have contributed significantly to the safety net, combining health care assistance for undocumented immigrants with charity or uncompensated care for low-income populations. However, there are two primary reasons why continued state and local safety-net financing may be in greater jeopardy in the coming years. First, in some communities, undocumented immigrants may be the primary population remaining uninsured. With a greater number of people insured, garnering or maintaining political support for undocumented immigrants may be untenable given the current immigrant antipathy, including a belief in some quarters that they are a taxpayer burden “undeserving” of assistance. Second, many policy makers and others may conclude that “the uninsured problem is solved” and that there is no need for further support. For example, with the expansion of health insurance through the ACA, some may inadvertently believe that safety-net providers, such as health centers and free clinics, will no longer be needed. Such a response may leave the safety net with uncertain support for uninsured people generally, and especially for millions of undocumented immigrants.158
V. Moving Forward: Ensuring Racial and Ethnic Equity is Integrated into Safety-Net Priorities

In an era of reform, the safety net stands at 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, however, many of these health centers and safety-net hospitals face serious challenges as well as critical actions and decisions ahead to maintain their competitive edge, while keeping their doors open to fulfill their central mission of serving poor, uninsured, and diverse populations. 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 the disparities gap as the safety net transitions and adapts to a new health care environment.

Through a synthesis of leading research, policy reviews and expertise in the field, and as reflected in this report, we identify at least four areas of priority for transitioning and preserving the safety net, particularly in its continued role of effectively and concertedly caring for racially and ethnically diverse individuals and communities, and in advancing equity in 2014 and beyond. These priority areas include:

- Addressing DSH payment reductions in the context of optional Medicaid expansion;
- Developing integrated systems of care across safety-net settings and with other systems;
- Building on the Community Health Needs Assessment to create healthier communities; and
- Engaging state and local philanthropy to complement the ACA in supporting the safety net.

**Addressing DSH Payment reductions in the context of optional Medicaid expansion.** As previously discussed, 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 Disproportionate Share Hospital 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 (a total of 14 as of this writing), 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. However, as federal guidelines remain to be issued on the methodology, size and scope of these cuts, there may be an opportunity to reevaluate and adjust the formula to mitigate the impact on safety-net providers in states that opt not to expand Medicaid. For example, could federal DSH payment reductions be scaled to take into account states rejecting the Medicaid expansion, with special requirements to ensure that safety-net hospitals with potentially the greatest uninsured and uncompensated burden in these states receive a higher proportion of funds? While such adjustments may be met with resistance from some, as it may seem to financially reward or incentivize the rejection of Medicaid expansion, failure to do so may leave both providers and their patients in a situation more precarious than before the enactment of the ACA.
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. Such monitoring should also include specific measures related to disparities to ensure that cuts do not inadvertently expand differences in access to or outcomes of care for racially and ethnically diverse communities. This will be especially important in states rejecting Medicaid that also have a disproportionately large poor and diverse population—such as Texas, Louisiana, Georgia and Mississippi. As states determine their methodology for adjusting and allocating new DSH dollars, they should consider (adapted from recommendations put forth by Deborah Bachrach and colleagues in 2012)\textsuperscript{159}:

- Target Medicaid DSH Payments to cover uncompensated care costs at hospitals serving a disproportionately high number or percentage of uninsured patients;
- Consider linking DSH payments to specific services provided disproportionately to uninsured and low-income, diverse patients, particularly where there may be evidence of large or growing disparities;
- Consider a strategy for reimbursing hospitals for care provided to underinsured patients; and
- Consider investing previously committed DSH dollars to increase Medicaid payments for safety net hospitals.

\textit{Developing integrated systems of care across safety-net settings and with other systems.}

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 these integrated systems for these health care settings. At least four provisions provide assistance for or facilitate development of collaborations to create such arrangements. For example, Pediatric Accountable Care Organizations, and new programs supported by the Center for Medicare and Medicaid Innovation would support the creation of new integrated system programs and models, while Patient-Centered Medical Home initiatives would encourage more effective health and health related coordination.\textsuperscript{160} 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 layout 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.\textsuperscript{161} Safety-net models such as the Cambridge Health Alliance integrated network, the Colorado Regional Collaborative Organizations, and Los Angeles County health center partnerships which entered into collaborations with independent practices for Medi-Cal patients currently offer lessons learned and guidance for these new efforts. Still, as these opportunities arise, coming to terms with longstanding concerns will remain. As noted by one health center informant, there is a need
to balance integration innovation while allaying concerns that health centers and other settings will have to compromise core tenets for fear that they will “lose their soul”.

**Building on Community Health Needs Assessment to create healthier communities.** As noted, under the ACA, nonprofit hospitals are required to conduct community health needs assessments (CHNA). While viewed by many as “yet another added governmental requirement” and an added administrative burden to rationalize the nonprofit status of a hospital, there is perhaps more than meets the eye in terms of opportunities for creating healthier communities and addressing racial and ethnic disparities. 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 have involved a systematic approach to collecting and measuring data. Given the resources devoted to conducting these assessments, along with an established network of partners and in many cases a replicable methodology, this federal hospital requirement holds significant opportunity to identify, measure and monitor health care needs and disparities, resources, capacity, gaps, and priorities for action on a community-wide basis for years to come. “Advocates will be able to use CHNAs not only to identify unmet needs or various racial inequities, but to outline the existence or inadequacy of the infrastructure of health systems, either through a lack of necessary institutions or a lack of bodies capable of achieving the coordination and collaboration improved healthcare depends upon.” Nonprofit hospitals have a real opportunity to transform this mere federal paperwork requirement into a valuable analysis and roadmap for comprehensive community planning and action.

**Engaging state and local philanthropy to complement the ACA in supporting the safety net.** Philanthropic leadership and support will likely 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 layout 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. Eleemosynary organizations 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, clinics, state and local health departments, and advocacy organizations, can also help safety-net providers leverage limited resources and attract new funding.

* * *

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, 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 auger 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 can offer can help ensure they can achieve that balance.
Appendix A. Key Informants & Contributors

The Texas Health Institute would like to acknowledge and thank the many individuals who contributed valuable information, feedback, and perspective on various topics covered under the Affordable Care Act and Racial/Ethnic Health Equity Series. Nearly 70 individuals were interviewed or consulted. They represented a range of sectors—from federal, state, and local agencies to hospitals, health centers, health plans, professional associations, health policy experts, advocates, and community-based representatives. Note: Opinions expressed in this report are of the authors only and are not to be attributed to the individuals or organizations listed below unless noted as such in the report.

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