
NATIONAL ACADEMY

for STATE HEALTH POLICY

TOWARD MEETING THE NEEDS OF
VULNERABLE POPULATIONS:
ISSUES FOR POLICYMAKERS'
CONSIDERATION IN INTEGRATING A
SAFETY NET INTO HEALTH CARE REFORM
IMPLEMENTATION

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TOWARD MEETING THE NEEDS OF VULNERABLE POPULATIONS: ISSUES FOR POLICYMAKERS'
CONSIDERATION IN INTEGRATING A SAFETY NET INTO HEALTH CARE REFORM IMPLEMENTATION

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INTRODUCTION

The health care landscape is undergoing a transformation driven by many factors, including the enactment of the Patient Protection and Affordable Care Act (ACA). This transformation has many implications and potential outcomes, but perhaps none as important as those for vulnerable populations. The Agency for Health Care Research and Quality defines vulnerable populations as “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.”³ While a large proportion of vulnerable populations are currently covered by public programs such as Medicaid and CHIP, vulnerable populations also are heavily represented among the uninsured, some of whom will gain coverage through the ACA and some of whom will not. An estimated 32 million individuals, mostly low-income uninsured adults, will obtain health care coverage through Medicaid, subsidized plans offered through the exchanges or, in states which elect the option, the Basic Health Program. An estimated 22 million individuals will remain uninsured in 2019, even after ACA’s coverage provisions are largely implemented.⁴ The impact of these changes in coverage on demand for services and specific health care providers is uncertain, but a 2011 poll of national health care opinion leaders conducted by The Commonwealth Fund found that nearly all (98 percent) believe traditional safety net providers will still fulfill critical roles after implementation of the ACA.⁵

This assumption is shared by the National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (National Workgroup), which was formed by the National Academy for State Health Policy (NASHP), with support from The Commonwealth Fund. The purpose of the National Workgroup is to inform national and state policy development in addressing the role of safety net providers in implementation of the ACA. The 22 participants in the National Workgroup include state and federal officials, national experts and organizations and safety net providers. (See Appendix A for a complete list). The National Workgroup is working over the course of nearly a year to identify and generate possible state and federal policy options for addressing priority challenges in integrating safety net providers into implementation plans, with the assumption that such inclusion will contribute to achieving state and federal reform goals. These goals can be broadly described as achieving better care for individuals, improved population health and reduced per capita health care costs.⁶

This report draws on the early work of the National Workgroup. It describes ten overarching issues the National Workgroup identified that policymakers will need to consider in addressing the roles of safety net providers in achieving health care reform goals, particularly for vulnerable populations. A future brief will share additional information relevant to the work of the National Workgroup, and a final report will summarize its work from inception through May 2012.

Safety net providers,⁷ such as community health centers, rural health clinics, public hospitals and other similar nonprofit and public providers and systems, traditionally have served as an important source of care for many vulnerable populations, including the uninsured, underinsured, publicly insured, or those living in underserved rural or inner city areas. The ACA provides significant resources for further development of some safety net providers, while reducing funding streams for others. (See Appendix B for a summary of select ACA provisions related to safety net providers.) All health care providers are facing new challenges as a result of the ACA, but the specific and unique characteristics of safety net providers in terms of their financing, patient mix, scope of services and roles in communities, mean that changes brought on by reform have different implications for them as a group and as provider types within this group.

The perceived need for a continuing role for safety net providers, coupled with the unique characteristics of these providers, underlies the formation of the National Workgroup to identify and address issues in including safety net providers in health care reform implementation plans and policies at state and national levels. Working assumptions that form the framework for National Workgroup discussions include not only the continuing need for safety net providers in meeting service demands and needs of both insured and uninsured vulnerable populations, but also that many safety net providers can add value given their expertise in serving and improving outcomes for vulnerable populations.⁸ Further, the National Workgroup's discussions rest on the assumptions that safety net providers will need to adapt to the changing landscape if they are to survive and thrive as part of new systems, and that to achieve reform goals, policymakers also will need to adapt policies and health care reform implementation plans to include safety net providers. These assumptions provide important context for the issues that follow.

PRIORITY ISSUES FOR INTEGRATING A SAFETY NET INTO HEALTH CARE REFORM
IMPLEMENTATION

The following ten overarching issues were identified by NASHP through interviews with each National Workgroup member in June and July 2011. At the National Workgroup's first meeting in July 2011, the NASHP-developed list of ten themes was reviewed, and the first three issues below were selected as priorities for the National Workgroup's focus over the course of its work through May 2012. The following list, including the identification of the top three priorities for National Workgroup focus, represents the sense of the group, and not the views of all or any one member or organization represented in the group. Each overarching issue is followed by brief discussion of some of the specific questions informants suggested need to be addressed in policymaking. While the three priority issues are presented first, no ranking or relative importance is implied by the order in which the remaining seven issues are presented.

1. INCLUDING SAFETY NET PROVIDERS IN NEW, INTEGRATED SYSTEM MODELS

Integrated systems of care are viewed by many experts as a way to help promote quality, improve outcomes and bend the cost curve by ensuring appropriate care, avoiding duplication and reducing fragmentation. An integrated system can be defined as "a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served."⁹ The ACA proposes several models of integrated systems, including Accountable Care Organizations (ACOs), Community Care Networks (authorized in the ACA but not funded), and CO-OP plans modeled on non-profit integrated delivery systems such as Group Health in Seattle and HealthPartners in Minneapolis.¹⁰ In addition, the ACA established a new Center for Medicare and Medicaid Innovation (Innovation Center) to further test new models of payment and care delivery aimed at reducing health care costs and enhancing quality.¹¹

The development of new models through the Innovation Center, other federal agencies, and in states and communities raises a host of questions about whether and how safety net providers can be part of, or even form the core of, such new systems, or transform current models to best serve vulnerable populations. Designing and implementing integrated systems is inherently complex, and inclusion of safety net providers raises some specific design questions. Some of the issues that National Workgroup key informants raised relative to safety net providers include:

- incentives designed for both primary and tertiary care organizations to join integrated systems;
- governance and shared financing of integrated systems;
- financial risk;
- performance measurement; and
- the role of states in fostering and evaluating integrated systems that include safety net providers.

A number of safety net systems already are pursuing integrated delivery models for vulnerable populations.¹² For example, the Cambridge Health Alliance in Massachusetts provides primary care, pharmacy services and behavioral health care for Medicaid and uninsured populations. The Alliance has taken on financial risk for a group of its patients through a wholly-owned managed care plan. Similarly, in Los Angeles County, California, Federally Qualified Health Centers have partnered with Independent Practice Associations to take on risk for primary care and specialty care for certain Medicaid managed care popu-

lations. Integrated fee-for-service delivery models, such as Hidalgo Medical Services in New Mexico and Medical Home Network in Chicago, Illinois, are also serving the preventive, primary and specialty care needs of vulnerable populations.¹³ These models and others offer lessons for designing integrated delivery systems that include safety net providers and are effectively meeting the needs of vulnerable populations.

The Innovation Center is supporting various ACO models within Medicare; additional models with a primary focus on Medicaid and inclusive of the safety net are also needed.

While not issued until after the initial interviews and meeting of the National Workgroup, it is important to note that the final rule governing the Medicare Shared Savings Program ACOs authorized under the ACA allows Federally Qualified Health Centers and rural health clinics to both participate in and sponsor ACOs, and also provides for limited upfront infrastructure development funds for certain providers, to be recouped later from shared savings.¹⁴

2. OPTIMIZING WORKFORCE CAPACITY TO MEET THE INCREASED DEMAND FOR CARE

A surge in demand is anticipated as the previously uninsured gain coverage, exacerbating current shortages of primary, specialty, mental health and oral health care providers, particularly those who can provide culturally competent care for vulnerable populations. At the same time, the current workforce is aging and geographically misaligned with needs,^{15,16} and both insured and uninsured health center patients have difficulty finding specialists.¹⁷ New strategies may be needed to recruit and maintain providers in rural and other underserved areas. In addition, new types of providers and more effective use of current providers may help alleviate shortages.

Workforce capacity challenges are significant and there is a limited amount of best practices, evidence and tools showing the way forward to an increased, more efficient, more effective workforce,¹⁸ yet many strategies and federal and state policy barriers and facilitators could be examined to address the issues. National Workgroup members identified many of these, including:

- analysis of and support for the use of rate adjustments to influence provider distribution;
- support for providers practicing to the fullest extent of their education and training;
- payment policies for and licensing of non-physician providers;
- multi-disciplinary team models that make most efficient use of each discipline's specific competencies;
- reimbursement for alternative care delivery models, such as electronic and group visits;
- incentives for nurses to return to the direct care workforce and to increase the capacity to train new nurses; and
- allocation of Graduate Medical Education training slots.

Current laws and regulations often specify that a physician must deliver or supervise services in order to receive reimbursement, or otherwise specify service limits that may unnecessarily hamper the use of other provider types and of creative solutions like group visits. Workforce models and payment models could be developed in concert to promote the use of the full spectrum of providers, expanding the capacity of the workforce. Strategies for recruiting young providers to underserved areas, retaining older providers and assisting volunteer providers (e.g. with liability insurance costs) also could be helpful.

Some models already have been developed and tested to expand and strengthen a state's health care workforce. Pennsylvania removed legislative restrictions that prevented licensed health care providers from practicing to the fullest extent of their education and training, helping the state successfully address workforce shortages.¹⁹ Massachusetts and other states are developing a role for community health workers in health care systems by investing in their formal training, supervision and integration into the health care setting.²⁰ The ACA recognizes the potential role of community health workers in enrollment, chronic disease management and maternal and child health, and authorizes grants to promote a community health workforce.²¹ Developing training for, and the capacity of, other health care providers, such as care managers, also will be important to meeting the needs of vulnerable populations and achieving the aims of better care for individuals, improved population health and lower per capita health care costs.

3. ADDRESSING SAFETY NET FUNDING AND DEVELOPING STRATEGIES TO MAINTAIN ACCESS TO CARE FOR THE REMAINING UNINSURED AND THOSE LIVING IN UNDERSERVED AREAS

Despite large gains in insurance coverage, millions will remain uninsured even when the ACA is fully implemented. These uninsured individuals will include those who will be eligible for Medicaid but are not expected to enroll; undocumented immigrants who are not eligible for Medicaid or for coverage through the insurance exchanges; and individuals who are ineligible for subsidies, are exempt from the mandate to obtain insurance, choose not to comply with the mandate, or have some combination of those characteristics.²² Also within the uninsured group are people churning between insurance coverage programs and individuals with high cost sharing who will be unable to pay.

As a result of large-scale changes in insurance coverage, safety net patient volume, demographics and health concerns will change and financing streams will shift. It will be important to address the implications of these changes for the safety net and those who rely on it. As the number of uninsured decreases, support for the constituency of the uninsured may weaken, making it more difficult to secure funding to serve them. Sites and sources of care for vulnerable populations may shift, with unclear consequences for patients or safety net systems. If newly insured patients shift from safety net providers to other providers, some safety net providers may face insufficient volume to maintain access for the uninsured and other vulnerable populations. These may include those enrolled in inadequate provider networks or individuals seeking confidential care for specific needs or conditions outside the insurance system (e.g. family planning services, AIDS treatment). In some rural and inner city areas, safety net providers may be the only care providers available for both insured and uninsured alike.

Even should the newly insured stay with their safety net providers post reform implementation, as happened in Massachusetts,²³ funding will be needed for services, people and infrastructure costs not covered by insurance reimbursement. Traditional safety net funding streams – Medicaid payment methods including Disproportionate Share Hospital (DSH) payments and the Prospective Payment System (PPS) for Federally Qualified Health Centers, federal and state grants and local support – may need to be reassessed for their adequacy in supporting access to safety net providers where they are needed. Risk adjustment among plans and other methods such as “safety net reinsurance pools” may be needed to appropriately align funding.

Health care experts agree that safety net providers will remain an important part of the health care delivery system going forward, serving much of the newly insured population and continuing to serve as the safety net for the remaining uninsured and other vulnerable populations. Maintenance of funding streams for the safety net and inclusion of safety net providers in new programs and demonstration projects will begin to ensure sustainability and support greater integration of the safety net into the larger delivery system.

4 ADDRESSING SAFETY NET PROVIDERS' ROLES IN EXCHANGES' QUALIFIED HEALTH PLANS

Safety net providers potentially could play a role in providing individuals and their families with a consistent source of care as income and source of coverage changes or varies among family members, from Medicaid to the exchange to the Basic Health Program to other coverage options or to uninsured status. Federal exchange regulations, and state and plan decisions (where there is flexibility), will affect how Qualified Health Plans (QHPs) contract with providers to serve vulnerable populations, and will have an impact on the financing of the safety net.²⁴

Proposed federal regulations released in July 2011 provide flexibility for states in defining how QHPs offered through the exchanges may contract with essential community providers, a group defined in the ACA that overlaps with but may not encompass all safety net providers. The proposed federal rules require that a “sufficient number” of essential community providers be included “where available” in QHPs’ provider networks, but do not require contracts with all available essential community providers.²⁵ The rules also stress the importance of designing provider networks to offer incentives for high quality and cost-effectiveness.

Defining a “sufficient number” of essential community providers will be important to ensuring access to care for vulnerable populations, as will payments and risk adjustments for safety net providers. Some safety net health systems may themselves become certified as QHPs, while other safety net providers will likely join larger QHP networks. Safety net providers and commercial health insurance providers offering QHPs will need to communicate about their goals and expectations to ensure a successful partnership.²⁶

5. ADDRESSING SAFETY NET PROVIDERS' ROLES IN ELIGIBILITY AND ENROLLMENT

The ACA provides increased access to affordable health care coverage, primarily through the expansion of Medicaid to 133 percent of the federal poverty level (FPL) for all citizens and legal residents under age 65 and the establishment of health insurance exchanges in every state. Medicaid and the Children’s Health Insurance Program (CHIP) are estimated to cover an additional 16 million individuals and the exchanges are estimated to cover 22 million individuals by 2016.²⁷ Many of these newly insured individuals are currently receiving care through safety net providers. Safety net providers could play an important role in linking these individuals to the new coverage options under the ACA and helping them retain coverage.

Vulnerable populations will need information on their options, rights and responsibilities for coverage, as well as enrollment assistance. Consumer assistance grants have been made available to states, and exchange regulations proposed in July 2011 cover the requirements and state options for navigators and web portals.²⁸ Additionally, proposed rules for eligibility and enrollment in Medicaid, CHIP and the exchanges released in August 2011 provide details on how individuals may be enrolled seamlessly in the appropriate insurance program – Medicaid, CHIP, the Basic Health Program, or premium tax credits and cost-sharing reduction payments.²⁹ The need to reach vulnerable populations – both newly eligible and those already eligible for programs – will continue throughout health care reform implementation, and new methods of reaching these populations may be needed.

Assisting in enrolling eligible populations in health subsidy programs is not new for safety net providers. Through a 2009 CHIPRA outreach grant,³⁰ Oregon provided support to public health departments, school-based health centers and safety net providers to reach and enroll eligible but uninsured children.³¹ In 2009, Oregon’s uninsurance rate for children ages 0-18 was 11.3 percent, but by 2011 it had decreased significantly to 5.6 percent.³² Much of the success in enrolling eligible but uninsured children is attributed to the application assistance provided through the CHIPRA outreach grant.³³ To meet the substantial enrollment aims and coverage requirements of the ACA and to ensure access to care for vulner-

able populations, it will be important to look at how safety net providers can reach and facilitate eligibility, enrollment and retention for their patients and other vulnerable populations.

6. ADDRESSING ESSENTIAL BENEFITS FOR VULNERABLE POPULATIONS AND THE SAFETY NET

The ACA requires the Secretary of Health and Human Services to define an “essential health benefits package” that includes a set of 10 required benefit categories and is equal to the scope of benefits provided under a typical employer plan.³⁴ Qualified health plans offered through the exchanges must provide the essential benefits package, and all state Medicaid plans must cover these services by 2014. The Center for Consumer Information and Insurance Oversight released a bulletin on December 16, 2011 that outlines the Department of Health and Human Services’ intended regulatory approach to defining the essential health benefits. This approach uses a reference plan based on employer-sponsored coverage in the existing health insurance market, and allows states much flexibility in choosing among four benchmark plan types.³⁵ States must supplement the chosen benchmark plan, when needed, so that all 10 categories of essential benefits defined by the ACA are covered.

The essential benefits package is required to take into account the needs of vulnerable populations. The degree to which the essential benefits package covers the services needed by vulnerable populations will be important to determining the resources available to safety net providers to meet the needs of these populations. Whether or not health services such as dental care or enabling services such as transportation that are high on the list of needs for vulnerable populations are included will have a strong impact on the degree to which these needs can be met.

A significant challenge in defining an essential benefits package is setting a standard that will meet the needs of the entire patient population, including vulnerable populations, while remaining affordable for all individuals and families obtaining insurance coverage. Defining what is “essential” may prove to be as challenging as defining concepts such as “medical necessity” and “reasonable and necessary.”³⁶ Some important considerations when focusing on the needs of patients, particularly those who are vulnerable, include a balance of cost and quality, cost sharing and continuity of care protections and the inclusion of care coordination and management practices in the package.³⁷

CMS plans to issue additional guidance about specific benefits including habilitative services, pediatric oral care and pediatric vision care, as well as future guidance on cost sharing and on essential health benefit implementation in the Medicaid program. Comment periods following the release of these guidance documents will provide additional opportunities to address whether the needs of vulnerable populations are adequately considered.

7. ALIGNING REPORTING AND MEASUREMENT REQUIREMENTS FOR SAFETY NET PROVIDERS AND ACROSS THE HEALTH CARE DELIVERY SYSTEM

States and safety net providers report that multiple reporting and measurement requirements across the health care system – emanating from federal and state levels as well as from the private sector – hinder alignment and integration.³⁸ Differing priorities of various players and payers in the health system can work against alignment. The challenges in reporting and measurement and the limited resources available for such efforts underscore the need for establishing priorities to ensure consistency across the health care system – between states, payers, plans and providers.³⁹ A focus on the importance of how public benefit, utilization and quality are measured, the defining of functional measures relevant to safety net systems and integrated systems, and the alignment of metrics to further quality and accountability throughout the health care system will be important to reducing the burden on the system and promoting quality of care and good outcomes for vulnerable populations.

States have made progress in using measurement to align incentives across systems to achieve quality and cost goals. In Rhode Island, all providers participating in a multi-payer medical home pilot are required to report on common measures agreed to at the pilot's inception. These efforts have given providers in this pilot the opportunity to learn from other providers and practice types, and to engage in efforts to be accountable for overall population health and system improvements.⁴⁰ In California, the California Health-Care Foundation (CHCF) has developed strategies to publicly report health care information in order to help consumers make informed health care choices and drive improved quality across the health care system.⁴¹ Key players in Washington State, including the Medicaid agency, also are using public reporting on performance measurements to inspire better quality in the health care delivery system.^{42,43}

More work is needed to align reporting and measurement requirements with the aim of maximizing resources spent in this area and limiting the variation and complexity of these requirements, as well as the related bureaucracy and cost within a health system. Federal and state agencies can help by aiming for consistency in the development of measures and by aligning performance measures with commercial payers where possible.⁴⁴ Safety net organizations also could consider the benefits of sharing information about the populations they serve with one another to improve efficiency and quality of care.

8. PROMOTING COLLABORATION AT STATE AGENCY AND COMMUNITY LEVELS AROUND A SAFETY NET

Collaboration across agencies and disciplines at federal, state and community levels in regard to safety net systems is one key to coordination and integration. Thinking beyond the typical stakeholders in a safety net system to include public health, oral health and social services agencies and providers, as well as alternative care delivery sites, such as schools and correctional institutions, in coordination and integration efforts can improve care for vulnerable populations. Federal and state policies can facilitate or impede relationships and collaboration between safety net providers and with these other stakeholders.

Collaboration across state agencies and programs can be a precursor to meaningful integration among providers: agency collaboration facilitates the development of coordinated policies for reimbursement and reporting, which in turn supports providers to work together to serve the multifaceted needs of vulnerable populations.⁴⁵ As both payers and providers of health care – through Medicaid, mental health and public health departments – and of health and social supports – through the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF) and the Supplemental Nutritional Assistance Program (SNAP) – state agencies and their policies have immediate and downstream influence on safety net providers and the health of vulnerable populations. State policies and regulations also can facilitate or impede the ability and interest of providers outside the safety net to engage with the safety net in developing coordinated systems of care.

9. PROMOTING INTEGRATION AMONG PRIMARY CARE, MENTAL HEALTH AND SPECIALTY CARE PROVIDERS

Complex co-morbidities between physical and mental health are increasingly common among vulnerable populations served by safety net providers, yet many safety net systems struggle to provide access to affordable prescription drugs, behavioral health services and oral health care. The populations that receive health care from safety net providers also face social and economic barriers to well-being. Having a safety net and health care system that considers the social determinants of health and supports efforts that address disparities in such areas as food access and high school graduation rates will be important for improving the health of the population. Safety net systems can help address social and economic barriers directly – e.g. by establishing health homes, by utilizing community health workers, by providing transportation to appointments or by assisting with prescription drug management – as well as indirectly, through involvement with community development activities.

Safety net providers have developed care models that address the multifaceted needs of the populations they serve. At Clinica Family Health Services (Clinica), a Federally Qualified Health Center in Denver, Colorado, patients receive care from a multidisciplinary team that includes a behavioral health provider and a case manager, and there is direct, on-site access to oral health and pharmacy services at several of its clinics. In addition, Clinica has developed a strong group visit structure for some vulnerable populations – pregnant women and individuals with asthma, depression and other chronic conditions. These groups have been very effective; group members provide care and support that an individual provider would be unable to offer, and these visits have resulted in significant positive clinical outcomes. Women who received care through Clinica’s Centering Pregnancy group visit model have a low-birthweight rate of just 5.3 percent compared to Colorado’s statewide rate of 8.9 percent.⁴⁶

There is much that can be learned from these innovative care models, and a role for state and federal agencies in fostering and supporting these efforts at a local level can contribute to achieving reform goals.

10. ADDRESSING THE ROLES OF SAFETY NET PROVIDERS AS PATIENT-CENTERED MEDICAL HOMES

Many safety net providers are leaders in patient-centered medical home delivery of care. A patient-centered medical home is an enhanced model of primary care in which a care team, lead by a primary care provider, attends to “the multifaceted needs of patients and provides whole-person, comprehensive, coordinated, and patient-centered care.”⁴⁷ More than 38 states already are using the patient-centered medical home model to change the way primary care is delivered.⁴⁸ As health care reform is implemented, there are many questions around the role for safety net providers in this model of care. Is there a need for specific criteria for safety net providers regarding patient-centered medical homes? How will reimbursement work within medical home models?

A significant aspect of the patient-centered medical home is aligning payments with increasing expectations that primary care practices improve the way they deliver care. Many states have used Medicaid programs to promote this model, providing new Medicaid payments to providers that meet qualification standards aimed at improving care delivery at the practice level, while helping states meet population and delivery system reform goals.⁴⁹ The ACA includes medical home pilots for Medicaid enrollees with chronic conditions.⁵⁰ Safety net providers can be key partners for a state that chooses this option, bringing to the table not only their knowledge of the needs of the Medicaid population, but also their strengths in many of the areas of care emphasized in the patient-centered medical home model. It will be important that the specific needs of safety net providers are addressed as this opportunity and others are developed to implement patient-centered medical homes in states.

CONCLUSION

Health care reform will have profound and both intended and unintended consequences for health care providers and consumers. The potential benefits and risks are especially high for vulnerable populations and for safety net providers who are expected to remain an important source of care for them. Safety net providers will need to adapt to the changing health care landscape if they are to continue to meet needs effectively. State and federal policymakers will need to take into account the unique characteristics of these providers and consider their roles in contributing to achievement of health care reform goals. This brief outlined ten overarching issues that interviews with members of the National Workgroup on Integrating a Safety Net into Health Care Reform Implementation suggest policymakers should consider in health care reform implementation as it relates to safety net providers.

The National Workgroup's goal is to inform state and federal health care reform implementation policy-making to support inclusion of providers competent in serving vulnerable populations. While the members of the National Workgroup and their organizations and agencies will continue to work independently on health reform implementation issues, the National Workgroup will concentrate on issues where the group's collective ideas can illuminate possible paths forward. Further resources and information will be released as the National Workgroup develops ideas and policy options in relation to its priority areas of focus: developing new integrated system models; optimizing the workforce; and financing for the safety net.

APPENDICES

APPENDIX A – PARTICIPANTS IN A NATIONAL WORKGROUP ON INTEGRATING A
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APPENDIX B – SELECT PROVISIONS OF THE AFFORDABLE CARE ACT AFFECTING THE
SAFETY NET

- \$11 billion for Health Center Program Expansion, beginning in FY2011, including \$9.5 billion to expand operational capacity to serve nearly 20 million new patients and enhance medical, oral and behavioral health services, and \$1.5 billion to expand and improve existing facilities and construct new sites.
 - *Patient Protection and Affordable Care Act (ACA)*, PL 111-148, sec 10503(c)
 - *Health Care and Education Affordability Reconciliation Act (Reconciliation Act)*, PL 111-152, sec. 2303
- \$1.5 billion for the National Health Service Corps over five years, which will place an estimated 15,000 primary care providers in provider-short communities. The bill also makes programmatic improvements to the Corps.
 - ACA, secs. 5101(d); 5508(b); 10503(b)(2)
- Funding for school-based health centers and authorization for nurse managed centers.
 - ACA, secs. 4101 and 5208
- Requirement that health centers receive no less than their Medicaid PPS rate from private insurers offering plans through the new health insurance exchanges.⁵¹
 - ACA, sec. 10104(b)(2)
- Requirement that exchange plans contract with essential community providers, including health centers, family planning clinics, DSH hospitals and children's hospitals, among others.
 - ACA, sec. 1311(c)(1)(C)⁵²
- Adding preventive services to the Federally Qualified Health Center (FQHC) Medicare payment rate and eliminating the Medicare payment cap on FQHC payments.
 - ACA, secs. 5502(a) and 10501(i)
- Authorization for a new grant program for the development of residency programs at health centers and a new program that would provide payments to community-based entities that operate teaching programs, with \$230 million over five years for these programs.
 - ACA, sec. 5508
- Authorization for Community-Based Collaborative Care Networks, which are defined as a consortia of providers with a joint governance structure that provide a comprehensive range of coordinated and integrated health care services for low-income patient populations. Each Network must include a safety net hospital that serves a high volume of low-income patients and all FQHCs within the Network's geographic area.
 - ACA, sec. 10333
- A reduction of \$18 billion in Disproportionate Share Hospital (DSH) payments.
 - ACA, sec. 2551
 - *Reconciliation Act*, sec. 1203

NOTES

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- 5 Kristof Stremikis, Julia Berenson, Anthony Shih and Pamela Riley, *Health Care Opinion Leaders' Views on Vulnerable Populations in the U.S. Health System*.
- 6 Donald M. Berwick, Thomas W. Nolan and John Whittington, "The Triple Aim: Care, Health, And Cost," *Health Affairs*, 27, no. 3 (2008): 759-769.
- 7 The National Workgroup's definition of safety net providers is based on the work of the Institute of Medicine: Safety net providers are providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients. In its report, the committee focuses on "core safety net providers." These providers have two distinguishing characteristics: 1. Either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and 2. A substantial share of their patient mix are uninsured, Medicaid, and any other vulnerable patients. Core safety net providers typically include public hospitals, community health centers and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers. (Institute of Medicine, *America's Health Care Safety Net: Intact But Endangered* (Washington, DC: National Academy Press, 2000), 21.)
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- 10 For more information, visit <http://www.ghc.org/> (Group Health) and <http://www.healthpartners.com/public/> (HealthPartners).
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51 Proposed regulations point out that two ACA provisions [secs. 1311 (c)(2) and sec. 1302(g)] may conflict in regard to payment for essential community providers and FQHCs. HHS is asking for comments on the conflicting sections before making a final interpretation. NACHC, *Issue Brief #4: Summary of Key Provisions of a Proposed Rule Relating to the Establishment of Exchanges and Qualified Health Plans* (Washington, DC: NACHC, September 2011).

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