

POTENTIAL ROLES FOR SAFETY NET
PROVIDERS IN SUPPORTING CONTINUITY
ACROSS MEDICAID AND HEALTH
INSURANCE EXCHANGES

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EXECUTIVE SUMMARY

States face a significant challenge of reaching and enrolling the estimated 30 million or more uninsured individuals¹—primarily adults under 65—who will be newly eligible for health insurance through Medicaid and health insurance exchanges as a result of the Affordable Care Act (ACA). It is important that Medicaid and health insurance exchanges work together well, since a significant number of enrollees are likely to move between the two programs and disruptions in coverage can be costly.²

This report outlines potential roles safety net providers—health centers, public hospitals, rural health clinics, public health departments, community mental health clinics, school-based health centers, family planning clinics, and others—could play in facilitating continuity of coverage and care as individuals move between Medicaid and the exchanges. This report was written as part of a National Organizations of State and Local Officials cooperative agreement with the Health Resources and Services Administration, through which the National Academy for State Health Policy (NASHP) seeks to advance Medicaid policies to support care for vulnerable populations.

PROMOTING CONTINUOUS ENROLLMENT

Since many individuals who will become newly eligible currently receive care from safety net providers, these providers may be uniquely positioned to help reach and facilitate eligibility and enrollment for vulnerable populations. Safety net providers have a significant amount of outreach and enrollment experience under Medicaid and Children’s Health Insurance Program (CHIP), and this experience will be beneficial to states if continued under health care reform. Federally Qualified Health Centers (FQHCs), for example, must provide outreach, health education, and translation services as part of their “enabling services.”

Many safety net providers also have experience and expertise in providing application assistance and enrolling eligible individuals into Medicaid and CHIP. Federal law requires that Medicaid outstation eligibility staff at health centers and disproportionate share hospitals (DSH).³ Under federal statute, state Title V Maternal and Child Health programs must provide outreach and facilitate enrollment for eligible children and pregnant women.⁴ One potential new role for safety net providers is to serve as navigators to help enroll eligible individuals in coverage in the exchange, although some questions remain about whether there are conflict of interest issues if these providers assist consumers in choosing exchange plans.

PROMOTING CONTINUOUS CARE

In addition to reaching and enrolling the newly eligible, safety net providers may also be able to help states ensure continuity of care for new enrollees. Many safety net providers already participate in Medicaid managed care networks, and states are considering ways to extend the participation of these plans in state health insurance exchanges.

One important decision facing states regarding safety net providers’ participation in qualified health plans offered in exchanges concerns rules about essential community providers. Federal rules require that most qualified health plans include safety net providers, but leave considerable discretion to the states in determining which are essential community providers, and how many such providers a plan must include in order for their inclusion to be considered “sufficient.”⁵

Those safety net providers that plan to pursue participation in qualified health plans may have a variety of ways to help states and exchanges reach goals of providing continuous high-quality care for newly eligible individuals. Many safety net providers are already engaged in efforts to improve service delivery systems

through participation in initiatives such as patient-centered medical homes and accountable care organizations. Safety net providers may also be able to leverage their considerable experience with care coordination, integration of care, and providing enabling services for individuals with chronic diseases to help qualified health plans provide better care to populations newly eligible for coverage.

KEY CONSIDERATIONS

Implementation of the ACA will require all safety net providers to adapt in order to successfully engage with Medicaid and the exchange, but the particular considerations for the specific types of providers that make up the safety net will differ. Safety net providers have different levels of expertise or preparedness for reform, but larger safety net providers with more experience interacting with commercial insurance—such as FQHCs and safety net hospitals—may more easily make the adjustments called for by health care reform than smaller, specialty providers.

Both safety net providers and states will need to work together on a wide range of implementation issues to achieve the ACA's goals of seamless eligibility and enrollment and integrated health care delivery, and may need to adapt current policies and practices to do so. Safety net providers are positioned to provide care that is geographically and culturally accessible to many uninsured individuals targeted by health reform. The safety net will also remain a key source of care for individuals who have gaps in coverage or who remain uninsured. Engaging safety net providers can help ensure that low-income individuals who will become newly eligible will be enrolled in the right program and if they choose, be able to stay with their provider even as they move between programs.

INTRODUCTION

Attention in many states is currently consumed by the transformational challenges of expanding Medicaid to millions of newly eligible individuals and by setting up health insurance exchanges that will provide access to private coverage to millions more. It is important that these two systems work together well because a significant number of enrollees are likely to move between the two programs. Within six months, it is estimated that nearly 40 percent of adults under 133 percent of the federal poverty level (FPL)—the minimum threshold for Medicaid coverage under the expansions envisioned in the Affordable Care Act (ACA)—would experience a disruption in their Medicaid coverage due to changes in income or family composition. After 12 months, 38 percent would no longer be Medicaid-eligible, and an additional 16 percent would lose and regain Medicaid coverage. After four years, only 19 percent of adults would be continuously eligible for Medicaid. Among adults with incomes between 133 and 200 percent FPL who would be eligible for premium subsidies under the ACA, only 31 percent would remain continuously eligible for subsidies over four years, and many would have experienced multiple disruptions in coverage.⁶

Disruptions in coverage can lead to expensive disruptions in delivery of care. A 2008 study in California found children who lost Medicaid coverage for just three months had expenditures 1.7 times higher in the month they returned than in the months preceding their disenrollment, driven by an increase in inpatient hospital spending.⁷ As states consider strategies to minimize these gaps, they might consider how partnerships with safety net providers could help them achieve their goals.

This paper, written as part of a cooperative agreement with the Health Resources and Services Administration (HRSA), attempts to capture some early thinking from state and national experts on roles that safety net providers—health centers, public hospitals, rural health clinics, public health departments, community mental health clinics, school-based health centers, family planning clinics, and others—could play in facilitating continuity of coverage and care as individuals move between Medicaid and the exchanges.⁸

This paper was informed both by a query of state Medicaid directors and exchange coordinators or planning leads about how states are engaging safety net providers in their Medicaid expansion and health insurance exchange implementation work, as well as key informant interviews. NASHP identified and interviewed national experts, safety net associations, state officials, and other stakeholders to further discuss past state experiences engaging the safety net and the potential role of safety net providers in serving as a link between Medicaid and new health insurance exchanges. The paper will discuss potential safety net roles in promoting continuous enrollment and delivering continuous care, and close with a discussion of key considerations for state policymakers about the operational and organizational changes safety net providers may need to make to adapt to the new coverage environment.

POTENTIAL SAFETY NET ROLES IN PROMOTING CONTINUOUS ENROLLMENT

By January 1, 2014, states will have the significant challenge of reaching and enrolling the estimated 30 million or more uninsured individuals, primarily adults under 65, who will be newly eligible for health insurance coverage.⁹ Since many of those individuals currently receive care from safety net providers, these providers may be uniquely positioned to help reach and facilitate eligibility and enrollment for vulnerable populations. For example, in 2010, 37.5 percent of health center patients were uninsured and 92.8 percent had incomes at or below 200 percent FPL.¹⁰ Safety net providers have a significant amount of experience around outreach and enrollment activities under Medicaid and Children’s Health Insurance Program (CHIP), roles that could be beneficial to states if continued under health care reform.

OUTREACH AND EDUCATION

States face many outreach challenges as a result of the Medicaid expansion and the introduction of subsidized coverage through the exchanges. Newly eligible individuals will need to understand what the new programs are, what they have to do to enroll in (and stay in) coverage, and what benefits they will receive. Safety net providers can help states to communicate these messages to the community.

New programs have partnered with safety net providers on outreach efforts in the past. When Alabama was first implementing CHIP, Federally Qualified Health Centers (FQHCs) and the state Title V Maternal and Child Health Program were engaged from the beginning to ensure that low-income families that had eligible children knew about and enrolled in CHIP. States and experts interviewed see a continued need for this role under health care reform. As millions of individuals become newly eligible for coverage and begin to engage with the health care system for the first time, safety net providers can help states reach the eligible but uninsured by leveraging some of these experiences.

Federally Qualified Health Centers have strong connections to the communities they serve in part due to requirements for community representation on their boards of directors. By federal mandate, FQHCs must provide outreach, health education, and translation services as part of their “enabling services.”

Family planning clinics also have experience providing outreach for Medicaid family planning waiver expansions. The Guttmacher Institute reports that in 2011, waiver programs in eight of 19 states used family planning providers to conduct all community-based outreach.¹¹ Also, family planning clinics that receive federal Title X funding have experience with outreach and education, as well as a connection to communities they serve due to federal mandates to provide community-based education and outreach activities.¹²

Since 2009, many safety net providers have successfully competed for funding from the Children’s Health Insurance Program Reauthorization Act (CHIPRA) Outreach Grants that support efforts to help reach and enroll children who are currently eligible but unenrolled in CHIP or Medicaid.¹³ Through a 2009 CHIPRA outreach grant, Oregon provided support to 18 public health departments, school-based health centers, and other safety net providers to reach and enroll these children.¹⁴ While the state was also funding other outreach efforts, much of the success in enrolling eligible but uninsured children is attributed to the application assistance provided through Oregon’s CHIPRA Outreach Grant.¹⁵ Fourteen of the 39 CHIPRA Cycle II Outreach Grants in 2011 also were awarded to or included safety net providers in outreach efforts.¹⁶ The Colorado Association of School-Based Health Centers received a CHIPRA Outreach Grant to identify and enroll 6,500 eligible but uninsured CHIP and Medicaid children at participating school-based health centers.¹⁷ While these efforts have been targeted primarily at children, much of this outreach and enrollment experience can be applied to all individuals likely to be eligible for coverage in 2014.

Many individuals who become eligible in 2014 will need help understanding how to engage with the health care system, as well as health insurance. Several interviewees emphasized the importance of educating these groups on how to become users of primary care, rather than episodic care, and highlighted that safety net providers could play a role in helping newly eligible individuals make this transition. For instance, expert interviewees mentioned that consumers who have only used the emergency room for care and are used to hours-long waits may not initially trust that an appointment will guarantee they will see a provider at a designated time. These individuals will need to re-learn what they know about health care and what to expect from their providers.

ENROLLMENT ASSISTANCE

Many safety net providers also have experience and expertise in providing application assistance and enrolling eligible individuals into Medicaid and CHIP. These practices are supported by both federal requirements and federal and state funding for certain safety net providers. Since 1990, federal law has required that Medicaid outstation eligibility staff at health centers and disproportionate share hospitals (DSH).¹⁸ Under federal statute, state Title V Maternal and Child Health programs must provide outreach and facilitate enrollment for eligible children and pregnant women.¹⁹

Some safety net providers have eligibility counselors or application assisters on staff. In Illinois, most health centers are application agents for the CHIP ALL Kids program, through which they receive payment from the state for each complete application that results in new coverage.²⁰ The Arizona Association of Community Health Centers facilitates and provides training for application assistance and screening for state-funded programs, including Medicaid and CHIP, allowing workers at health centers to use the web-based application system Health-e-Arizona for their patients.²¹ Since the 2006 enactment of Massachusetts' health reform, safety net providers have had access to the Virtual Gateway, an online application and case system for Medicaid, CHIP, and Commonwealth Care. In addition to helping patients enroll in coverage, the Virtual Gateway also allows providers to see the status of a patient's application and when the patient's next renewal is due. (For more information on Massachusetts, see the sidebar "Case Study: Lessons Learned from Massachusetts.")

Public hospitals, including DSH hospitals, often have financial counselors to help determine eligibility or have other practices to help with applications on-site. Hospitals are choosing to provide application assistance in several different ways. Louisiana State University's Health Care Services Division hospitals have purchased laptops for their Medicaid Application Centers, enabling hospital staff to complete full Medicaid applications at the bedside.²² The New York Health and Hospitals Corporation runs its own Medicaid managed care program and puts staff in the check-in area of hospitals to help enroll patients in coverage for which they are eligible, including Medicaid. From 2000 to 2009, National Association of Public Hospital member hospitals experienced an increase in the number of Medicaid patients, which they largely attributed to their increased emphasis on hospital-based eligibility screening systems that will be important resources when 11 million are newly eligible for Medicaid under the ACA.²³

Hospitals may also be especially important to engage with after the ACA is enacted. While many hospitals currently conduct presumptive eligibility for state Medicaid and CHIP programs, hospitals will now have the ability to conduct presumptive eligibility at their own discretion. Currently, federal law allows states to choose to use presumptive eligibility to temporarily enroll potentially eligible children and pregnant women. After 2014, this option will expand to parents and other adults who appear eligible for Medicaid,²⁴ and hospitals can choose to conduct presumptive eligibility determinations regardless of whether the state is using presumptive eligibility in any other setting.²⁵ Engaging with these providers early to ensure

that presumptive eligibility is conducted well and leads to successful eligibility determinations may help states tackle the large group of newly eligible individuals in 2014.

Hospitals may also have a distinct interest not only in enrolling all eligible individuals, but also in minimizing disruptions in coverage. Individuals who transition between Medicaid and the exchange may experience a gap of days or weeks between when one coverage ends and the other begins. While routine care can potentially be delayed until the new coverage starts, accidents and emergencies cannot. Hospitals are required to provide emergency care, regardless of an individual's ability to pay or insurance status. If coverage gaps are long, hospitals are potentially at risk of greater uncompensated care costs.

NAVIGATORS

One potential new way for safety net providers to engage in outreach and enrollment is for states to use them as navigators. Navigators will receive state funding to help provide information to and enroll eligible individuals in coverage in the exchange. The final federal rules on the Establishment of Exchanges and Qualified Health Plans, released in March 2012, give states great flexibility in determining what their navigator programs will look like, but many of the requirements would support the use of safety net providers in these roles. Specifically, safety net providers may be well suited to meet several requirements for navigators under the law: that navigators provide public education and information about available coverage options; facilitate enrollment in ways that are culturally and linguistically appropriate; and demonstrate that they have or could establish relationships with employers and other insured and uninsured individuals likely to be eligible for a qualified health plan. Navigators are not required to be licensed agents or brokers. Many entities can serve as navigators, but states must use at least two types of entities, one of which must be a community and consumer-focused nonprofit group,²⁶ a requirement that could also be met by engaging safety net providers in navigator roles. Many states are still in the early development stages of navigator programs, but interviewees discussed the role that safety net providers could play in navigator programs, with some state interviewees actively considering safety net providers as navigators.

Not all interviewees agreed that safety net providers were the appropriate choice for navigators. Some concerns centered around whether limited state funds to support navigator programs were most appropriately targeted to safety net providers who already may be providing many navigator-type services or have funding for outreach and enrollment from other sources. Some informants indicated that navigator funding might instead be targeted to community organizations that deal more directly with individuals that are not currently engaged with the health care delivery system—e.g. programs that provide assistance to homeless individuals, or adult basic literacy programs. It may be necessary for safety net providers to demonstrate their ability to partner with such organizations.

Several interviewees also raised the issue of potential conflicts of interest. Navigators are intended to provide impartial assistance to help individuals apply for and select coverage, and there is a potential for any provider who is giving assistance to steer applicants toward plans the provider participates in, or even potentially sponsors. Not all interviewees saw this as a concern. FQHCs in Hawaii who formed their own Medicaid managed care plan, AlohaCare, were successfully able to work around conflict of interest issues by providing enrollment assistance without directing patients to specific plans.

Current resources limit the extent to which safety net providers can conduct outreach and enrollment. Providers that do not have federal mandates to provide these services may be limited to providing them only when funded to do so, or in the case of school-based health centers, if the sponsoring institution has the capacity to do so. As states move towards trying to enroll the 30 million newly eligible individuals under health care reform, taking advantage of these providers' expertise may also mean supporting their efforts monetarily or through infrastructure support.

POTENTIAL SAFETY NET ROLES IN PROMOTING CONTINUOUS CARE

In addition to reaching and enrolling the newly eligible, safety net providers may also be able to help states ensure continuity in the care that enrollees receive. States have an interest in ensuring that individuals who move between Medicaid and health insurance exchanges are able to make those transitions with minimal disruption to their health care. How states choose to design their exchange plans and provider networks could have major implications for achieving a seamless health care system, and interviewees saw the potential for states to engage safety net providers in helping to bridge coverage transitions. Interviewees representing safety net providers expressed that safety net providers should strive to be a first choice for people seeking high-quality care, rather than merely a last resort.

PARTICIPATING IN PLANS IN BOTH MEDICAID AND THE EXCHANGE

One tool states have to promote continuity between Medicaid and the exchanges is to require or incentivize plans to provide coverage under Medicaid managed care and in the exchange as a qualified health plan. Medicaid managed care plans, which may have more familiarity serving low-income individuals than most commercial plans, commonly also have the experience of contracting with safety net providers to serve these populations. In 2002, of the 41 states with Medicaid managed care programs, plans in 37 of them included FQHCs, 25 included mental health centers, and 20 included school-based health centers.²⁷ Using Medicaid managed care plans in the exchange could provide more continuity for individuals moving between Medicaid and the exchange, and coverage that is easier to navigate for families with coverage split across multiple sources. Higher eligibility thresholds for Medicaid and CHIP among children may mean that, in a single family, parents will receive tax credits and purchase coverage through an exchange, while children will receive coverage from Medicaid or CHIP.

Some states, such as Hawaii, are considering requiring their Medicaid managed care contractors to participate in their exchange. Since there are often contractual requirements that Medicaid managed care organizations include safety net providers in their networks, participation by Medicaid plans could facilitate safety net providers' participation in the exchange. Some precedent already exists. When health reform was enacted in Massachusetts in 2006, the state originally allowed only Medicaid managed care plans—including health plans sponsored by a public hospital and the Massachusetts League of Community Health Centers—to offer plans in the Commonwealth Care program, the state's subsidized insurance product for individuals under 300 percent FPL.

Safety net providers in Maine are experimenting with another way to engage with health insurance exchanges. In March 2012, the Maine Primary Care Association received a federal low-interest loan to facilitate the development of Maine Community Health Options, a new CO-OP (Consumer Oriented and Operated Plan).²⁸ Of the \$62.1 million in loan funding, \$7.1 million will assist with the creation of the plan, and \$55 million will go toward helping the plan meet the requirements for financial reserves necessary in order to qualify for participation in a health insurance exchange.²⁹ While the plan will have a strong health center base to provide care to enrollees, it will also contract with other non-safety net providers in order to offer an attractive package to a diverse group of potential enrollees. The plan will go into operation in 2014, and is still in the early stages of development.

The move from Medicaid managed care plan to qualified health plan in an exchange may be more difficult for some safety net health plans. Interviewees raised concerns about financial reserve requirements and certification standards that insurance plans must adhere to, but that do not necessarily apply to non-

profit Medicaid managed care plans. Since CO-OP requirements preclude current insurers from applying for the available loan funds, current Medicaid managed care plans cannot access these loans. If states opt to require or encourage their Medicaid managed care plans to also be qualified health plans, states will need to consider what support these plans will need as they transition into the exchange.

Several interviewees also noted that the Basic Health Program could provide a natural place for safety net providers to participate in coverage expansions. Because the Basic Health Program is designed to more closely resemble Medicaid in regard to its target population and covered services, interviewees affiliated with safety net providers indicated it would feel like a more natural extension of their current role than programs for higher-income individuals that look more like private insurance.

Tennessee has proposed a special type of participation in its exchange for Medicaid managed care plans that is intended to keep individuals and families enrolled in the same plan even as they transition between Medicaid and the exchange. (See text box “Tennessee’s Bridge Option.”)

Tennessee’s Bridge Option

Tennessee is looking to support seamlessness for families by constructing qualified health plans to provide continuity for individuals and families who leave Medicaid and move into the exchange, or for families who have income that would place parents in the exchange and their children into Medicaid or CHIP. Tennessee’s proposed “Bridge Option” would allow Medicaid managed care organizations to offer a qualified health plan, and restrict their enrollment only to individuals who had been enrolled in Medicaid within the previous year. From a beneficiary perspective, this would allow an individual or family to transition between funding sources (Medicaid vs. subsidized exchange coverage) without experiencing a change in managed care organization or provider.³⁰ The participating plans would be required to maintain identical networks in the “Bridge Option” and in TennCare (Medicaid), meaning health centers, health departments, school-based health centers, and other providers that currently operate in Tennessee’s Medicaid managed care networks would also be included in the new product.

As of June 2012, the state reports that it has not yet received the Centers for Medicare and Medicaid’s (CMS) approval to pursue the Bridge Option.³¹ Decisions on details of the program, such as whether plans participating in the Bridge Option would be required to pay FQHCs Medicaid rates for Bridge Option enrollees, or whether payment rates could be open to negotiation in the exchange, are being delayed until the state receives approval.

ESSENTIAL COMMUNITY PROVIDERS

One of the most important decisions that states will have to make regarding safety net providers’ participation in qualified health plans regards rules about essential community providers. The ACA requires that qualified health plans include in their provider networks “...a sufficient number and geographic distribution of essential community providers, where available...” These providers are defined as those who “...serve predominately low-income, medically underserved individuals...”³² The federal Center for Consumer Information and Insurance Oversight (CCIIO) issued final regulations regarding key facets of exchange operation in March 2012. In the final rule, CCIIO chose not to prescribe the exact number and types of providers that must be considered essential community providers. Likewise, it did not require that qualified health plans accept any willing safety net provider into their network as an essential community provider.³³ Instead, the rule left considerable discretion to the states in determining who is an essential community

provider and how many essential community providers a plan must include in order for their inclusion to be considered “sufficient.” While many states are not yet in a position to make these decisions, interviewees were able to identify several considerations for states to keep in mind.

A central tension will be between making sure safety net providers can be considered for participation in qualified health plan networks, and that plans have the ability to manage their provider networks. More prescriptive requirements for essential community providers enhance safety net providers’ ability to continue to serve patients who become eligible for coverage through exchanges, but reduce a plan’s control over its network; less prescriptive requirements give plans more flexibility to craft their offerings, but leave the potential for safety net providers, particularly more specialized providers, to be excluded.

In regard to who is eligible to be an essential community provider, the statute stated that essential community providers included, but were not limited to, providers participating in the Section 340B discount prescription drug program.³⁴ Some interviewees noted that not all of the providers commonly considered to be part of the safety net are eligible to participate in the 340B program.³⁵ Rural health clinics, for example, do not participate in 340B. If a state uses only the suggested definition, rural health clinics may be at a disadvantage in their ability to get into provider networks of qualified health plans.

Interviewees also highlighted the need for network adequacy standards to consider more than just a provider-to-population ratio. In particular, interviewees said existing rules set by state departments of insurance about geographic standards for care may allow qualified health plans to offer products in rural areas that do not include rural health clinics—often the only source of care. For example, geographic adequacy is defined in many states as requiring an in-network provider within 30 miles of an enrollee, or by requiring a certain ratio of physicians to enrollees.^{36,37} Stronger network adequacy standards for qualified health plans that take into account not only provider ratios, but also types of providers required, may ensure that all populations, including low-income or individuals in rural areas, have access to appropriate providers. There may be a need to educate policymakers responsible for creating network adequacy rules—potentially departments of insurance—about the role of the safety net in providing quality care to low-income populations.

KEY CONSIDERATIONS FOR STATE POLICYMAKERS

Implementation of the ACA will require all safety net providers to change their practices and possibly their business structures to successfully engage with Medicaid and the exchange, but the particular considerations for the specific types of safety net providers will differ. Safety net providers have different levels of expertise and readiness for reform, but interviewees generally expected that larger safety net providers with more experience interacting with commercial insurance, such as FQHCs and safety net hospitals, would more easily make the adjustments necessitated by health care reform than smaller, specialty providers. Which safety net providers thrive after health care reform will depend in part on the individual provider, its objectives, and its leadership in determining the role it will play in a reformed health care delivery system.³⁸

The expansion of coverage to millions of formerly uninsured individuals through insurance exchanges that depend on private health plans could present a challenge to specialized safety net providers whose previous experience has mainly been with Medicaid and grant funding. These providers may have to significantly adapt their operations, including developing new skills in billing for their services. Providers will also need to consider what role they will play in a new health care framework, and whether or how they will make themselves attractive to plans in the exchange.

ADAPTING TO THE NEW COVERAGE ENVIRONMENT

Smaller safety net providers, like family planning clinics, may have large changes to make in the wake of reform. While formerly uninsured individuals will now be covered for a range of essential health benefits—including reproductive health services—there may be an expectation among policymakers and payers that individuals should shift to seeking those services from primary care providers. Also, the availability of reimbursement for family planning services through insurance coverage will likely contribute to continued downward pressure on federal grant funding.

The National Family Planning and Reproductive Health Association is actively engaging its members in thinking through strategies to adapt to the changing coverage environment and the renewed emphasis on primary care. It is developing case studies on viable future paths for family planning clinics, which may also be instructive to other safety net providers. One set of paths involves closer integration with primary care by expanding the clinic's services to provide more comprehensive primary care or by integrating with a larger entity such as a health center. A second set of envisioned paths would maintain a more singular focus on the distinct services family planning clinics provide, for example by expanding to provide obstetric and gynecological care in order to become a comprehensive women's health provider, or by affiliating with other providers of sensitive services like behavioral health or HIV/AIDS services to become a specialty provider group.³⁹

Similarly, providers like county and city health departments that directly provide clinical health care services are faced with a decision. Now that many of their clients will have a regular source of health coverage, does it make sense for them to continue to provide some or all of these services directly, to bill for some that have historically been provided for free, or to discontinue most, if not all, direct service delivery to better focus on population-based public health strategies? For health departments in rural or frontier areas which may be the only providers of certain services, continuing to be direct providers could be important, but it will require adjustments to business practices to be able to participate in plans' provider networks, bill, and be reimbursed for services.

Several interviewees identified a need for smaller safety net providers to develop greater ability to bill insurances, including Medicaid, as critical to adapting to and surviving in the new coverage environment. Providers like community mental health clinics, school-based health centers, and family planning clinics will need to be able to bill accurately, completely, and timely. They will need to be aware of each plan's coverage limitations, and they will need to know how the services they provide can appropriately be translated into billing codes. They will also need to have a greater awareness of their patients' coverage status, something especially challenging in school-based health centers where children and adolescents are seen without much interaction from parents.

Some states have systems that enable safety providers to easily check the eligibility status of clients. For example, in Massachusetts, application assisters (which include many health centers) have access to Virtual Gateway, an online tool that identifies when an individual is coming up for renewal. It is important to both the provider and the patient that those renewals be navigated successfully, so that the patient maintains insurance, and so that the provider can be reimbursed.

FINANCING CONSIDERATIONS

Even larger safety net providers will need to make adjustments as coverage expansions go into effect. Particularly, both FQHCs and public hospitals will need to consider how the expansions affect important funding streams.

Medicaid and CHIP must ensure that FQHCs and rural health clinics are reimbursed in accordance with the Prospective Payment System (PPS), whether the state delivers care through managed care organizations or a fee-for-service system.⁴⁰ The Prospective Payment System is an all-inclusive per-visit rate paid by Medicaid and CHIP intended to compensate clinics for their reasonable costs to provide care. Less is certain about the extent to which these payment provisions will apply to qualified health plans. The final exchange regulation indicated FQHCs should be paid according to PPS rates, but it also indicated qualified health plans and individual FQHCs may mutually agree upon payment rates other than the PPS. Interviewees indicated that payment considerations were key to determining the viability of FQHCs' participation in qualified health plans.

Disproportionate share hospital payments, which offset some of the cost of providing care to the uninsured and underinsured (as well as costs uncompensated by Medicaid), are slated to be reduced, with the expectation that coverage expansions will reduce the need for these funds. It is, however, important to keep in mind that there will still be almost 30 million uninsured non-elderly people remaining after reform, and others will experience periods of uninsurance during the course of a year.^{41,42} Additionally, the Supreme Court's ruling that CMS may not withhold all federal matching funds to states who do not expand Medicaid to low-income childless adults may affect the number of remaining uninsured.⁴³ While the need to subsidize hospitals' uncompensated care to the uninsured will be diminished, it will not disappear.

IMPROVING ACCESS TO HIGH-QUALITY CARE

For safety net providers planning to pursue participation in qualified health plans, interviewees noted at least four ways they can help states and exchanges reach their goals of providing access to high-quality care for newly eligible individuals.

First, safety net providers are already engaged in efforts to improve delivery systems for care. Both the National Association of Community Health Centers and the National Assembly on School-Based Health Care are encouraging their members to actively pursue participation in initiatives like patient-centered medical homes and accountable care organizations. Recent case studies of six communities feature various

ways that safety net providers have formed or joined integrated systems to provide high-quality, coordinated care for Medicaid and uninsured patients. While the report does not comment on whether safety net providers as a whole are well positioned to form or join accountable care organizations, it does highlight the MDwise nonprofit Medicaid managed care plan in Indianapolis, Indiana, which covers eight integrated delivery systems that effectively function this way. A hospital, which serves as each system's hub, is responsible for care coordination and patient management, and is connected to at least one primary care clinic, some of which are FQHCs.⁴⁴

In Oregon, the state primary care association's strategic goals for 2012 include participation in the state's development of patient-centered primary care homes and Coordinated Care Organizations (CCOs).⁴⁵ CCOs are local health entities that will govern and administer care for all Medicaid enrollees in a community. The role of safety net providers, including FQHCs, rural health clinics, and school-based health centers, among others, in delivering care to underserved populations is recognized in the legislation that enables the CCO program.⁴⁶ These state initiatives are aimed at changing the health care financing system to improve quality, improve access, and reduce cost by focusing on prevention and chronic illness management, and by managing costs within a global budget.⁴⁷ The state is planning to introduce an alternative methodology in select sites that would significantly change payment for FQHCs, whereby FQHCs opting into the program will be paid a bundled per-member per-month rate, rather than a per-visit rate, for care provided to patients. Under this alternative payment model, the understanding is that the clinic will provide care coordination, health promotion, and support services, and the state will provide supplemental "wrap-around" payments to bring total FQHC reimbursement under Medicaid to no less than the level it would have been under standard PPS.⁴⁸

Several interviewees noted that it will be important, going forward, for safety net providers to do even more to demonstrate they can provide outcomes that are competitive with those attained by leading health care providers. In Oregon, CCO participants must all submit data on uniform quality measures as well as participate in a learning collaborative to share best practices and information on quality improvement.⁴⁹

Safety net providers may need financial and technical support from state and federal governments in order to participate fully in integrated delivery systems.⁵⁰ A forum of groups involved with Colorado's Accountable Care Collaborative Program reported that it will be important for states and safety net providers to work collaboratively on measurement tools, payment methodologies, and health information technology infrastructure development.⁵¹

Second, safety net providers may be able to help make qualified health plans more attractive to populations who are newly eligible for coverage. Plans with large safety net networks may be able to better serve people with disabilities, or individuals with more extensive needs who currently rely on safety net providers as a source of specialty care. Safety net providers can also leverage their considerable experience with care coordination, integration of care, and the provision of enabling services for individuals with chronic diseases. For instance, many individuals with HIV/AIDS rely on Ryan White Clinics, and many individuals with behavioral health or substance abuse needs—who may be likely to fall into the expansion of Medicaid for childless adults, or the lower end of subsidized coverage in the exchange—rely on community mental health clinics. A qualified health plan that includes a provider like a community mental health clinic would be more attractive to that clinic's patients, allowing them to continue their care at the same location. From the perspective of a plan, however, the concentration of patients with complex needs cuts both ways. If a state does not ensure that adequate protections are in place around reinsurance and risk adjustment for higher-than-expected utilization, plans could be discouraged from seeking out providers such as these.

Third, several interviewees noted that safety net providers could help states meet their challenges in regard to ensuring an adequate health care workforce. As was seen in Massachusetts following the implementation of its state health reform, shortages of primary care providers will continue to be a challenge,⁵² and can even be exacerbated, following the expansion of health insurance coverage. States will need to think about setting up an effective workforce to deliver primary health care, and safety net providers can help. Providers like FQHCs and many safety net hospitals have access to federal programs like the National Health Service Corps. And providers like school-based health centers can help to ensure that vulnerable children, and especially teens, have convenient access to primary care and specialty services like behavioral and reproductive health.

Fourth, there may be an opportunity for states to leverage the knowledge and expertise of participants in the safety net, particularly public health departments, in helping Medicaid agencies and exchanges to meet their goal of achieving improved population health outcomes. Public health agencies can be an important source of surveillance data, and both public and private insurers could make better use of public health data in formulating and evaluating their prevention and treatment strategies. Moreover, public health agencies often can affect non-health care systems through programs related to topics such as early literacy and housing, which have been recognized as having an effect on health care outcomes.⁵³

PARTICIPATION IN STATE PLANNING EFFORTS

As states consider how to implement rules around essential community providers and standards for network adequacy for qualified health plans, interviewees noted it is important for safety net providers and those who fund these providers—such as state Title V MCH programs—to have a voice in the discussion. In particular, it may be important for states to seek out engagement with smaller safety net providers, such as school-based health centers, which may have more limited resources to engage in coordinated policy advocacy at the state level. Providers such as health centers and public hospitals, which have more robust state-level organizations, may be better situated to engage in planning efforts.

Safety net providers can engage in health reform planning in a variety of ways. In North Carolina, the state Institute of Medicine empanelled a Health Reform Safety Net Workgroup, jointly chaired by representatives from the state Office of Rural Health and the state primary care association, to explore the potential effect of health reform on safety net providers.⁵⁴ In Hawaii, the safety net has strong representation on the board of directors for the state's exchange, called the Connector. Of the 13 board members, three are current or former officials of the state primary care association, and one is a former member of a health center board.⁵⁵ While the Connector has just been established, and is still hiring staff, interviewees from the state indicated an eagerness to address health reform implementation issues relating to safety net providers in future.

CONCLUSION

Both safety net providers and states will need to work together to achieve the goals envisioned in the ACA of a seamless eligibility and enrollment system, where individuals can transition between sources of coverage with minimal disruption to their health care. Each may need to adapt current policies and practices to do so. Safety net providers are positioned to provide care that is geographically and culturally accessible to many of the uninsured individuals targeted by health reform. Engaging safety net providers can help ensure that low-income individuals who become newly eligible under health care reform will be enrolled in the right program and, if they choose, be able to stay with their provider even as they move between programs. The safety net will also remain a key source of care for individuals who have gaps in coverage or who remain uninsured.

Safety net providers will be affected by state decisions on a wide range of ACA implementation issues. Among the most prominent issues are decisions about navigators and essential community providers, but decisions about things such as reinsurance, risk adjustment, network adequacy rules, the Basic Health Program, and payment for uncompensated care will affect the adjustments that safety net providers must make, and the feasibility of their participation in exchanges. The changes required will differ among members of the safety net, and the transitions may be especially challenging for more specialized safety net providers.

Though states are all at different stages of state and national reform planning and implementation, now is an opportune time to consider how to partner with safety net providers, and to include the safety net in planning efforts. As state and federal policymakers begin to consider these questions, they should keep in mind the potential for safety net providers to act as partners in creating and promoting a seamless system of care between Medicaid and health insurance exchanges.

CASE STUDY: LESSONS LEARNED FROM MASSACHUSETTS

The Massachusetts experience is very relevant to conversations about the impact of health reform on the safety net. Since Chapter 58, the state's landmark health reform law, went into effect in 2006, Massachusetts has seen a dramatic reduction in the number of uninsured individuals: coverage rates among non-elderly adults jumped from 87.5 percent in 2006, prior to reform, to 95.2 percent in 2009.⁵⁶ Increased access to health insurance and decreasing numbers of uninsured residents have presented boons as well as challenges to Massachusetts' safety net providers; these are well documented, particularly in the case of the state's health centers and public hospitals.^{57, 58}

Since the first health center was started in Dorchester in 1965, Massachusetts has had a long and successful history of engaging these safety net providers in delivery of care. The state has 50 health center organizations with 280 sites,⁵⁹ which represent the largest primary care network in the state, providing care to one out of every eight residents. These providers are especially important in urban areas, with 25 health center organizations in the Boston area alone.⁶⁰ The state also makes significant use of other safety net providers, such as school-based health centers. The state Department of Public Health funds 17 sponsoring agencies that operate 34 school-based health centers.⁶¹ While the overall experience may be unique, Massachusetts can provide valuable lessons for states as they consider the role of safety net providers in outreach and enrollment functions, continuity of care, and caring for the remaining uninsured.

OUTREACH AND ENROLLMENT

Safety net providers in Massachusetts play a key role in application and enrollment assistance, both for new or first-time enrollees and during the reenrollment process. The state funds community-based entities, including safety net providers, to provide application assistance to applicants for public and publicly-subsidized coverage products, including MassHealth (Medicaid) and Commonwealth Care, the publicly-subsidized program which provides access to private managed care plans for otherwise uninsured low-income individuals. (Individuals ineligible for subsidies can purchase insurance via the Massachusetts Health Connector, the state's insurance exchange.) MassHealth and Commonwealth Care use a common application process, managed by MassHealth; consumers complete one form to determine eligibility for either program.⁶² In 2004, the state launched the Virtual Gateway,⁶³ which simplifies the application process and helps community-based organizations, including many safety net providers, provide application assistance and check application status for a variety of state programs, including health insurance programs, in real time. Access to this information allows safety net providers to inform their patients of upcoming renewal deadlines, periods of open enrollment, and other events key to retaining enrollment and minimizing gaps in coverage.⁶⁴ However, reimbursement for this function is limited; providers report that this and other administrative functions associated with health reform have caused a significant increase in costs.⁶⁵

CONTINUITY OF CARE

State policy decisions have supported continuity of care for low-income patients, particularly those who receive care from the safety net. Initially, all plans offered through Commonwealth Care were required to be Medicaid managed care plans as well. Consistency between MassHealth and Commonwealth Care allowed for strong continuity of plans and provider networks for patients who might churn between Medicaid and other state-subsidized insurance. In addition, many of the state's Medicaid plans have strong affiliations with the state's major safety net health systems, particularly its large public hospitals and health centers. Medicaid managed care plans are required to include health centers in provider

networks. Though the same is not true for Commonwealth Care plans, health centers have historically been well represented in these insurers' networks.⁶⁶ In more recent years, the state has added a for-profit plan to Commonwealth Care.⁶⁷

These policies have supported newly insured Massachusetts residents who sought to stay with safety net providers following reform. Safety net providers experienced a substantial increase in number of patients served following state health reform: a 2011 analysis found that Massachusetts health centers experienced a 31 percent increase in patients served (134,000 individuals) between 2005 and 2009.⁶⁸ Many of the health centers' previously uninsured patients have continued to receive care there after gaining insurance, indicating that for some patients, health centers are not providers of last resort, but rather providers of choice.⁶⁹ National organizations representing major groups of safety net providers, including health centers and public hospitals, report that they expect these trends to continue on a national scale in 2014 when major provisions of the ACA's insurance expansion are implemented.⁷⁰

CARE FOR REMAINING UNINSURED

Though state health reform greatly decreased the number of uninsured in the state, a significant number of residents continue to lack insurance for a variety of reasons.⁷¹ The proportion of health center patients who were uninsured decreased from 35.5 percent of total health center patients in 2005 to 19.9 percent in 2009 as people moved into coverage through Medicaid or Commonwealth Care.⁷²

Prior to state health reform implementation, care to the uninsured delivered by health centers and acute care hospitals was reimbursed by the state's Uncompensated Care Pool; with health reform, this was replaced by the Health Safety Net Fund, a more limited program financed through payments by insurers and providers which subsidizes care costs for some low-income uninsured patients who enroll in the program. In comparison to the Uncompensated Care Pool, the Health Safety Net Fund represents a significant drop in payment rates for care for the uninsured for hospital-based health centers, but an increase in funding for freestanding health centers because of differences in rules governing the two programs.⁷³ Funding for the Health Safety Net Fund will decrease over time to reflect decreases in the number of uninsured. Massachusetts' recognition that there will continue to be a population of people without insurance is instructive for other states considering the potential effect of coverage expansions on safety net providers.

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