THE SAFETY NET

Kim VanPelt, MPA

Safety net systems, providers and clinicians – including public and private hospitals serving the indigent, community health centers and school-based clinics – will be greatly affected by healthcare reform.

Even though the number of uninsured will decrease, there will still be strong demand for safety-net services. Financial constraints, changed incentives and new payment models will result in providers collaborating to compete. New funding will also be available for community health center and school-based health clinic expansion. The state may want to play a role in monitoring the impact of reform on the safety net and fostering systems development to improve access to care.

KEY REFORM CHANGES

- **Decreases uncompensated care through the expansion of Medicaid and subsidized coverage through the exchange.**
- **Reduces Medicare payment rates.**
- **Reduces Disproportionate Share Funding for safety-net hospitals.**
- **Penalizes hospitals for preventable readmissions.**
- **Provides new funding for the expansion of community health centers and their workforce.**
- **Establishes new grant programs for community-based teaching programs and a new program for the development of primary care residency trainings programs.**

NEED FOR SAFETY-NET SERVICES WILL CONTINUE

Healthcare reform will expand the number of people with health insurance dramatically. However, some will remain uncovered. These include low-income people exempt from insurance mandates; unqualified legal immigrants and undocumented immigrants; those eligible for Medicaid who are unable to overcome enrollment barriers; and those who refuse or are unable to meet the new mandate.

A recent analysis of the uninsured in Massachusetts, where health insurance reform measures enacted in 2006 have left only 4.1 percent of the state's population without coverage, found that those who continue to be uninsured were more likely to be:

- Male, young and single
- Racial/ethnic minorities and non-citizens
- Unable to speak English well or very well
- Living in a household in which there was no adult able to speak English well or very well[1]

Given the demographics of Arizona's population, a sizable number of uninsured Arizonans will likely remain even after mandates for coverage are imposed. Arizona's population is far younger than the national median. A high percentage of our population is also made up of ethnic minorities or non-citizens. (Recent reports of many leaving the state because of SB 1070 may alter this somewhat – but the precise impact of that change is yet to be determined.)

Enrollment barriers to public health coverage will also likely have an impact on the number of people insured. Historically, state policy makers have imposed numerous barriers, making it challenging for people to enroll in or renew their public (AHCCCS, KidsCare) health coverage, such as onerous renewal and cost-sharing requirements. These barriers, if continued, will likely keep many Arizonans uninsured and dependent on the safety net for care.

Many of those who are newly insured as a result of reform will continue to receive care where they did in the past. Indeed, when Massachusetts implemented healthcare reform, many of those newly insured continued to receive services at community health centers and safety-net hospitals.

Care delivery patterns will also likely stay somewhat static – at least in the short run – due to challenges people may face in accessing other types of providers. For example, Massachusetts found that people continued to visit emergency rooms in that state after healthcare reform, likely due to challenges accessing services in the community.[2] A long-existing federal law requires hospitals to screen ER patients, and if the patient needs urgent or emergency care, provide that care or transfer the patient to a facility than can provide it – regardless of the ability to pay.

KEY TAKEAWAYS:

- Healthcare reform will decrease the amount of uncompensated care.
- There will continue to be high demand for services delivered by safety-net providers.

FINANCIAL FUTURE IS UNCLEAR

Under healthcare reform, local safety net providers will gain and lose revenue, making the net result difficult to predict.

The Act expands eligibility for AHCCCS, resulting in providers (hospitals, community health centers, school-based health centers) being able to recoup dollars that have long been uncompensated.

Hospitals, for example, are expected to earn approximately $40 billion more in new revenues nationally, due to eligibility expansion, by 2019.[3] Similarly, Massachusetts officials interviewed noted that community health centers saw increases in clients – and revenues – post reform.

The Act also contains significant new monies for community health center operations and graduate medical education. Such money comes on the heels of recent stimulus money awarded for both Disproportionate Share Hospital funding (DSH) and community health center operations.[4] To ensure that the Federally Qualified Community Health Centers are adequately reimbursed for providing a full range of services, Medicare will begin paying health centers, prospectively beginning October 2014.

However, the financial impact of reform is not completely rosy for safety-net providers. For example, coverage expansions included in healthcare reform were paid for, in part, by hospitals being willing to accept lower Medicare payment rates and forgo other revenues.

The Act will reduce the amount of federal funding (called "Disproportionate Share Hospital" funding or DSH) provided to states for hospitals currently delivering a high percentage of their services to Medicaid recipients and the uninsured. Medicare Disproportionate Share payments will be reduced by 75 percent beginning in 2014, and gradual subsequent adjustments will be based on the remaining number of uninsured. Medicaid Disproportionate Share Hospital funding will also begin reducing gradually beginning in 2014. By 2020, national Medicaid Disproportionate Share funding will be reduced by $20 billion annually.[5]

The theory behind these reductions is that the decrease in the uninsured and increases in Medicaid eligibility will balance each other out.[6] However, the exact methods for determining the reductions are yet to be determined. What we do know is that the new

method is supposed to take into account the percentage of the state's population that is uninsured, current levels of DSH spending and the use of DSH funding in Medicaid waiver programs. Given these factors, Arizona's DSH reduction may not be too dramatic if the state continues to have a large number of uninsured.

Other factors are more likely to financially strain safety-net providers.

- State funding cuts will continue to take their toll. The state recently reduced Medicaid provider rates, and additional rate reductions are possible. State funding (including federal match) for DSH was also reduced by nearly $40 million over the past two years. Primary care dollars (which provided basic health services, prenatal care and dental checkups to low-income residents at community health centers serving 51,000 people in 2008 at a cost of $14.5 million) has been sliced in recent budgets and is unfunded for fiscal 2011.[7]

  Staff interviewed at the Arizona Department of Health Services (responsible for overseeing the primary care program) noted that recent budget cuts and the end of federal stimulus dollars are already weighing on community health centers. Some have noted that they are having challenges making payroll.

- Providers will also be impacted by a changing client mix. As safety-net providers' patients become increasingly comprised of Medicaid (versus private insurance) clients, providers will be less likely to shift healthcare costs onto private payers. Such a shift now occurs due to Medicaid's lower reimbursement for health services. Increasingly, providers will have to shift service delivery and reduce their costs and adjust to lower Medicaid reimbursement.

KEY TAKEAWAYS:

- Safety-net providers will see both financial gains and losses as a result of healthcare reform.
- State cuts to DSH may add to financial strains – and potentially affect the viability of some providers.

Collaborate to Compete

Under health reform, squeezed budgets and lower reimbursement will not be the only factors driving cost-containment and service delivery changes.

The Act creates new penalties for excess preventable hospital readmissions. Hospitals wanting to prevent such readmissions will be incentivized to form partnerships with care providers and organizations that support patients' recovery and overall health in less expensive, community or home-based settings. A hospital executive interviewed noted that even though hospitals cannot control whether people follow up on a doctor's instructions after they leave the hospital, hospitals may ultimately be held responsible for ensuring that appropriate care was delivered. Thus, they need to have those partnerships in place to protect their bottom line.

New models of care delivery will also be incentivized under reform, rewarding providers who improve the quality and cost-effectiveness of care delivered. (See Quality and Efficiency section of report.)

Increasingly, safety-net providers will have to "collaborate to compete." To survive under health reform, safety-net providers and clinicians will have to focus on cost-containment, care coordination and delivering care in the most appropriate, cost-effective setting possible.

New collaborations, joint ventures, mergers and acquisitions are likely both horizontally as well as vertically. Hospitals will increasingly link themselves with community health centers, school-based health clinics, primary care practices, outpatient (including retail and urgent care) clinics and allied-health professionals.

A new requirement in the reform law also requires that insurance plans operating under health insurance exchanges contract with essential community providers, including community health centers, again driving collaboration.

Community health centers, which will likely see increased demand for their services, will also be incentivized to form new relationships. Community health centers often report challenges accessing specialty services for their uninsured or publicly insured patients. Thus, they too will be interested in forming new relationships.[9]

KEY TAKEAWAYS:

- New incentives, payment models and financial pressures will force safety-net providers to collaborate to compete.
- New collaborations, mergers and acquisitions among safety-net providers will result.
- Hospitals will partner with community health centers, school-based health centers and others to help ensure that care is delivered in the right place, at the right time.

New Monies for Expansion

The Act recognizes the important role that community health centers and school-based health centers will play in a reformed healthcare system, and provides vital resources for their support and expansion.

Federally funded community health centers are located in or serve high-need communities designated as being underserved areas or populations. They provide comprehensive primary healthcare services as well as supportive services (education, translation, transportation, etc.) that promote access to health care. These organizations are governed by a community board composed of a majority (51 percent or more) of health center patients who represent the population served.

The Act allocates $12.5 billion for the expansion of community health centers and placement of healthcare professionals in underserved areas beginning in 2011. It also establishes new grant programs for community-based teaching programs and a new program for the development of primary care residency training programs. This money is coming on the heels of other new monies for community health center expansion that were also awarded as part of the Recovery Act (ARRA). These included $3.9 million for three new Federally Qualified Health Centers located in Phoenix and Flagstaff.[10]

The Act's new grant opportunities are already beginning to become available. $250 million in grants for existing community health centers was announced in mid-August.[11]

The Act also provides new funding for school-based health centers. Such funding includes $200 million over four years for construction and equipment, and authorization (but no current appropriation) for school-based health center operations (such as salaries for medical professionals).[12]

Grant applications were recently announced for $50 million in funding for equipment, only to be canceled due to concerns related to limited application development time and concerns related to the application criteria and caps for multi-state school-based health centers. [13] Nonetheless, grants are expected to be released again sometime during the federal fiscal year 2011. If similar to the previous grant opportunity, school-based health centers, hospitals and community health centers are among those that could apply.

KEY TAKEAWAY:

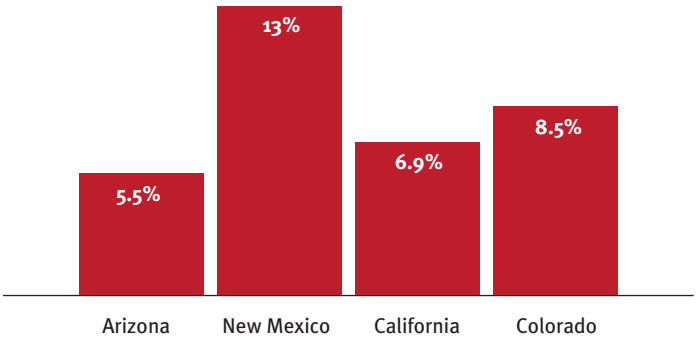
- New federal monies may allow Arizona to greatly expand capacity at existing community health centers and school-based health clinics. It can also allow Arizona to increase the number of community health centers and (potentially) school-based health clinics.

Planning and Monitoring Needed

As noted above, healthcare reform provides new funding to expand and create new community health centers. Some of these monies may be used to help federal health center "look-alikes"[14] gain Federal Qualified Health Center (FQHC) status, allowing the centers to garner increased federal funding.

Changing guidelines on how medically underserved and health professional shortage areas are designated also may result in new opportunities to place community health centers and National Health Service Corps workers in new geographic areas, resulting in greater access to care. In 2008, fewer Arizonans received services at a community health center than neighboring states. (See chart above.)

Percent of People Served by a Community Health Center[15]



The state may want to help play a role in facilitating creation of these new facilities, ensuring that they are located in areas with the highest healthcare needs. In 2006, the U.S. General Accounting Office (GAO) reported that 39 percent of medically underserved areas in Arizona lacked a community health center.[16] Such efforts could be guided by some form of state needs assessment. The effort could be overseen by the Arizona Department of Health Services or a neutral community partner.

The state may also want to facilitate partnerships among community members planning new health centers and others. Partnerships could be made with foundations or other entities to build organizational capacity, such as has been done recently with St. Luke's Health Initiatives, the Office of Health Systems Development and some nascent community health centers. The state could also facilitate partnerships with other community healthcare providers, such as hospitals, encouraging care coordination and support.

Monitoring may also be needed to gauge the financial health of safety-net providers. As previously noted, the financial impact of health reform on safety-net providers is unclear. Where people will ultimately receive services is also uncertain.

Arizona (and other states) will have an interest in monitoring the financial health and viability of its providers. While consolidation and integration among providers (both horizontally and vertically) may lead to better cost containment, incentivize creation of accountable care organizations or other such models, and benefit consumers, it is important to ensure that market share does not become too concentrated, potentially driving up costs for consumers.[17] It is also important to ensure that Arizonans living in rural areas have adequate access to healthcare services.

Arizona may want to consider collecting additional hospital and provider data to more closely monitor their financial health. The Massachusetts Division of Health Care Finance and Policy began collecting and analyzing data on hospital margins quarterly after reform was implemented in that state, informing many state policy decisions. State law currently requires hospital and other providers to submit annual financial statements to the Arizona Department of Health Services (ADHS). However, ADHS performs no analysis of such data. (AHCCCS does use such data currently to help determine provider payments, and such data is also available to the public.)

KEY TAKEAWAYS:

- Arizona may want to help identify areas where the state might most benefit from community health center expansion, and facilitate or support creation of centers in those areas.
- The state, foundations, and others may want to provide support or resources for community boards to build organizational capacity and solicit federal funding for community health center creation or expansion.
- The state may want to play an expanded role in monitoring the viability of safety-net providers as reform is implemented.

ABOUT THE AUTHOR

Kim VanPelt, MPA is an Associate Director at St. Luke's Health Initiatives, where she is responsible for analyzing local, state and national health and social policy issues and engaging the community to further SLHI's goals. She also directs the Arizona Health Survey, a survey of over 10,000 Arizonans on topics including physical and mental health, physical activity and nutrition, substance abuse, community health, access to care and well-being. Previously, she was a regional manager for First Things First, where she oversaw more than $34 million in grants. She has served as Director of Health Policy at Children's Action Alliance, the Strategic Planning and Quality Improvement Manager for the Arizona Department of Health Services, and an evaluator for the Arizona Office of the Auditor General. She is currently a member of Arizona's State Medicaid Advisory Committee.

References

1 Long, S.K., Phadera, L., & Lynch, V. (2010, August). Massachusetts health reform in 2008: Who are the remaining uninsured adults? [SHARE]. Princeton, NJ: The Robert Wood Johnson Foundation. Retrieved August 17, 2010 from http://www.rwjf.org/files/research/67248.MassReform2008UninsuredBrief.pdf

2 Long, S.K. & Stockley, K. (2009, September). Emergency department visits in Massachusetts: Who uses emergency care and why? Washington, DC: The Urban Institute. Retrieved August 17, 2010 from http://www.rwjf.org/files/research/48929.pdf

3 Berenson, R. & Zuckerman, S. (2010, July). How will hospitals be affected by healthcare reform? Washington, D..C: The Urban Institute and the Robert Wood Johnson Foundation.

4 Governor's Office of Economic Recovery. Program funding: Health. Phoenix: AZ. Retrieved August 17, 2010 from http://az.gov/recovery/programs-health-federal.html

5 Foster, R. Estimated financial effects of the "Patient Protection and Affordable Care Act as amended. Washington, DC: Office of the Actuary. Centers for Medicare and Medicare Services. Retrieved August 20, 2010 from https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

6 Katz, M. H. (2010, August 11) Future of the safety net under health reform. *JAMA*, 304(6), 679.

7 Rough, G. (2010, August 19). Arizona nonprofit clinics fear lost funds, flood of uninsured patients. *The Arizona Republic*.

8 Alltucker, K. (2010, August 16). Arizona funding cuts imperil pipeline for new doctors. Retrieved August 16, 2010 from http://www.azcentral.com/news/articles/2010/08/16/20100816arizona-doctors-shortage-funding.html#ixzzowlsWg55O

9 Doty, M. M., Abrams, M. K., Hernandez, S. E., Stremikis, K., & Beal, A.C. (2010, May). Enhancing the capacity of community health center to achieve high performance. New York, NY: The Commonwealth Fund.

10 HRSA. Recovery act (ARRA): Health centers: New access point grant awards. Washington, DC: U.S. Department of Health and Human Services. Retrieved June 4, 2010 from http://www.hhs.gov/recovery/hrsa/applicant.html

11 Fears, D. (2010, August 18). Health centers to get $250 million in grants to build clinics, boost services. *The Washington Post*. Retrieved August 19, 2010 from http://www.washingtonpost.com/wp-dyn/content/article/2010/08/17/AR2010081705285.html

12 Samuels, C.A. (2010, August 3). School clinics await funds from health-care reform. *Education Week*. Retrieved August 16, 2010 from http://www.edweek.org/login.html?source=http://www.edweek.org/ew/articles/2010/08/03/37health.h29.html&destination=http://www.edweek.org/ew/articles/2010/08/03/37health.h29.html&levelId=2100

13 HRSA. Affordable Care Act school-based health centers capital program. Washington, DC: U.S. Department of Health and Human Services. Retrieved August 16, 2010 from https://grants.hrsa.gov//webExternal/FundingOppDetails.asp?FundingCycleId-BC31b322

14 A Federally Qualified Health Center Look-Alike is an organization that meets all of the eligibility requirements of an organization eligible to receive federal funding to serve underserved populations (PHS Section 330 grant), but does not receive grant funding.

FQHC Look-Alikes receive many of the same benefits as FQHCs, including: enhanced Medicare and Medicaid reimbursement; eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost through the 340B Drug Pricing Program; and automatic designation as a Health Professional Shortage Area (HPSA). The HPSA designation provides eligibility to apply to receive National Health Service Corps (NHSC) personnel and eligibility to be a site where a J-1 visa physician can serve.

15 Adashi, E. Y, Geiger, H. Jack & Fine, M.D. (2010, April 28). Health care reform and primary care: The growing importance of the community health center. *New England Journal of Medicine*. Retrieved June 4, 2010 from http://healthcarereform.nejm.org/?p=3377

16 Bascetta, C. (2009, April 30). Health Resources and Services Administration: Many underserved areas lack a health center site, and data are needed on service provision at sites [Testimony]. [GAO-09-667T.] Washington, DC: Government Accounting Office.

17 Connor, R. A. Feldman, R. D., Dowd, B. E. & Radcliffe, T.A. (1997: November/December). Which types of hospital mergers save consumers money? *Health Affairs*, 16(6):62-74.

SLHI

ST. LUKE'S HEALTH INITIATIVES | 2929 N Central Ave, Suite 1550, Phoenix AZ 85012 | www.slhi.org | 602.385.6500