



The Affordable Care Act & Racial and Ethnic Health Equity Series

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

Final Report

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Preface

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

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

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

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

This report is the second among five that THI has issued as part of the *Affordable Care Act & Racial and Ethnic Health Equity Series*, and it focuses specifically on provisions in the ACA for ***Supporting and Transitioning the Health Care Safety Net***.

Executive Summary

I. Introduction

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

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

II. Methodology

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

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

This section summarizes the implementation progress, opportunities, challenges, and road ahead for key provisions in the new law that are expected to have major implications, both positive and negative, for the nation's health care safety net in serving diverse patients. As described above,

the nine provisions are grouped into three overarching themes addressing public programs, health centers and clinics, and safety-net hospitals.

A. Expansion of Public Programs

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

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

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

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

B. Health Centers and Clinics

Given their history of service to predominantly low-income and diverse patients, health centers and clinics are expected to maintain, if not strengthen, their unique role in serving these patients starting January 1, 2014, when the ACA's major insurance provisions take effect.

- **Community Health Centers (CHCs).** The ACA creates a Community Health Center Fund (CHCF) to expand national investment in health centers by \$11 billion over five years between FY 2011 and FY 2015. This funding is in addition to discretionary funds Congress allocates to health centers each year. However, starting in FY 2011, discretionary funding for health centers was significantly reduced, translating to a \$3 billion cut over five years. In addition, the sequestration ordered by President Obama on March 1, 2013 imposed a 2% cut on the CHCF. In FY 2013 alone, this translated to a \$120 million loss in funding for health centers and is estimated to result in approximately 900,000 fewer patients being served of which 57% will be from Non-White racial and ethnic groups. Despite these cuts, however, the reality is that health centers will see a large influx of patients, including those newly covered by Medicaid and those obtaining coverage through the exchanges. At the same time, they will continue to be a major provider of care for the uninsured. As data following Massachusetts's similar health reform implementation showed, the uninsured rate among health center patients was nine times that of the state generally.

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

- **Nurse-Managed Health Clinics (NMHCs).** The ACA establishes a grants program to develop and operate NMHCs. While \$50 million was originally appropriated for this program in FY 2010, and such sums as necessary in subsequent years through FY 2014, only \$14.9 million was actually awarded to 10 grantees across nine states in 2010, with no additional funding received to date. All grantees are either located in or serve medically underserved communities, and four explicitly cite health disparities, minority health, or cultural competence as priorities in their program description. Despite the proven success of NMHCs in serving culturally and linguistically diverse populations, a major hurdle to implementing the ACA's vision to expand their role in the health care system is funding. Advocates for NMHCs continue to issue notices to educate and advocate for continued funding for this program.
- **Teaching Health Centers (THCs).** The ACA authorizes a grant program to establish new accredited or expanded primary care residency programs in community-based settings. Authorized funding includes \$125 million for FY 2010 to FY 2012, and such sums as necessary for FY 2013 to FY 2015. This section also creates a Teaching Health Center Graduate Medical Education (THCGME) payment program which allocates \$230 million for FY 2011 to FY 2015. To date, no funding has been received to establish new THC programs. Roughly \$30 million in funding has been provided to 17 THCs for the THCGME program since FY 2011. Studies show that the benefit of using health centers for residency training is the retention of graduates in health center programs in inner-city, rural, and other underserved settings. These professionals are also trained in skills necessary to ensure the provision of ambulatory care to culturally diverse and socioeconomically disadvantaged populations, often not provided in other residency programs particularly those that are academic and research-based. A closer examination of the 11 inaugural programs from FY 2011 indicates that nine explicitly cite offering cultural competency

curricula as part of their residency training. Moving forward, funding and long-term sustainability pose major challenges for THCs.

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

C. New Requirements for Safety-Net Hospitals

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

- ***Medicaid Disproportionate Share Hospital (DSH) Payment***. The ACA reduces Medicaid DSH payments by \$18 billion between FY 2014 and FY 2020. A proposed rule on the implementation of these reductions for FY 2014 and FY 2015 was issued by the Centers for Medicare and Medicaid Services (CMS) on May 13, 2013. Once finalized, the rule is expected to go into effect on October 1, 2013, unless Congress enacts the President's Budget proposal to start Medicaid DSH payment reductions in FY 2015, instead of FY 2014. The proposed rule maintains the ACA's original reductions (i.e., \$500 million for FY 2014 and \$600 million for FY 2015) and outlines five factors that must be considered in developing a state allocation methodology. These are intended to ensure that greater funding is allotted to states that are currently considered "low-DSH states", have higher rates of uninsured, and target their DSH payments to hospitals with high Medicaid utilization or high uncompensated care costs. In addition, a state's decision to expand Medicaid in 2014 will not impact DSH payment reductions as CMS will apply a two to three year lag in the data to determine allocations. States will decide how they choose to allocate these reductions across hospitals.
- ***Medicare Disproportionate Share Hospital (DSH) Payment***. The ACA reduces Medicare DSH payments by \$22.1 billion for FY 2014 to FY 2019. The law states that starting no later than FY 2014, and each subsequent year, DSH payments would be reduced by 75%, and savings from these cuts would be distributed to hospitals based on

their level of uncompensated care. A proposed rule issued by CMS on May 10, 2013 outlines how these changes will be implemented. In particular, CMS proposes to use the total of each hospital's Medicaid and low-income Medicare inpatient days to calculate each hospital's share of Medicare DSH payment allocations related to uncompensated care. Concerns are arising, however, that the use of inpatient days may not reflect a complete portrait of a hospital's low-income patient population and burden.

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

IV. The Safety Net at a Crossroads

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

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

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

restricted, and in many cases declining, state budgets and limited state-based support for the safety net.

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

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

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

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

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

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

involvement in this new role. Much depends on resources, capacity, and political will to bridge their service mission to outreach and enrollment.

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

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

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

Monitoring DSH Payment Reductions. The Supreme Court's decision resulting in the optional expansion of Medicaid among states will perhaps have one of the most deleterious effects on safety-net hospitals. Reductions in the DSH Program were written into the ACA with the assumption that all states would expand Medicaid for people with incomes below 138% of the federal poverty level. Given the altered reality, however, in states not expanding Medicaid, public

and other safety-net hospitals could see an erosion of their DSH funds, with little or no change in the amount of uncompensated care they provide. Recognizing this threat, the recently issued draft regulation and methodology for calculating DSH payment reductions suggests that a two to three year lag in data on uninsured be employed to establish such cuts. However, the size and scope of these reductions are still unclear, with uncertain impact on states and hospital systems. At the state-level, careful review and understanding of current distribution and uses of Medicaid DSH funds across hospitals is warranted to establish a methodology that has the least impact on hospitals with the greatest uninsured burden. At the same time, monitoring of these funds in the years following 2014 will be critical to understanding the impact on most hard-pressed hospitals, particularly those serving extremely vulnerable, low-income, and diverse patients.

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

I. Introduction

The nation's health care safety net is a patchwork of institutions, financing, and programs that disproportionately serve low-income, uninsured, and racially and ethnically diverse populations. Medicaid is largely the financial underpinning of the safety net, as historically it has provided financial support for the majority of insured patients cared for by safety-net providers, and subsidized a considerable portion of care for uninsured through such programs as Disproportionate Share Hospital (DSH) payments and cost-based reimbursement for health centers.¹

Safety-net providers—comprised of a spectrum of organizations from major public hospitals and community health centers to free, rural, and public health clinics—represent critical and, frequently, the only sources of primary, specialty, inpatient, and emergency care for largely uninsured, Medicaid, and other vulnerable patients. By their mission, location, and history of service, safety-net providers are well-positioned to continue to play a central role in serving low-income patients, particularly of diverse racial and ethnic heritage, following the implementation of health care reform.

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

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

Purpose and Rationale

The purpose of this report is to provide a point-in-time status and progress on the implementation of the ACA's provisions for advancing racial and ethnic health equity within the health care safety net. As such, this report describes the opportunities presented by the new law, along with challenges, lessons, and actions taken to position the health care safety net to continue

to serve a growing racially and ethnically diverse patient population. Embedded within this report are emerging programs, best practices, and resources that address racial and ethnic health equity at the core of transforming the health care safety net.

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

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

Organization of Report

This report is organized into the following four sections:

- I. **Introduction:** This section provides an overview of the goals, objectives, target audience, value, and use of this report. It also describes the *Affordable Care Act & Racial and Ethnic Health Equity Series* in greater depth.
- II. **Methodology:** The framework and design is discussed in this section, along with specific activities that were undertaken in developing this report.
- III. **Implementation Progress of the ACA's Provisions for the Health Care Safety Net:** This section is organized into three main subparts which address: (1) Medicaid and CHIP; (2) Health Centers and Clinics; (3) and Safety-Net Hospitals. Each of these subsections provides a detailed summary of each provision's legislative context, implementation progress, emerging progress and models, and challenges and next steps.
- IV. **The Safety Net at a Crossroads:** This section discusses common and distinct themes that emerged in findings on implementation progress, and discusses issues and challenges that should be considered to ensure a robust safety net for diverse, vulnerable, and virtually all populations.
- V. **Moving Forward: Assuring Health Equity in Safety-Net Priorities:** We conclude the report with a discussion of potential next steps for ensuring that advancing equity is an integral part of reforming the health care safety net.

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

Affordable Care Act & Racial and Ethnic Health Equity Series

Series Background and Context

We have been monitoring and analyzing the evolution of health care reform and its implications for reducing disparities and improving equity since shortly after the inauguration of President Obama in 2009. With support from the Joint Center for Political and Economic Studies in Washington, D.C., the project team tracked major House and Senate health care reform bills, identifying and reviewing dozens of provisions with implications for racially and ethnically diverse communities. A series of reports and issue briefs were released, providing a resource for community advocates, researchers, and policymakers seeking to understand and compare the significance and implications of these provisions. Following the enactment of the ACA, a major, comprehensive report—entitled *Patient Protection and Affordable Care Act: Implications for Racially and Ethnically Diverse Populations*⁶—was developed and released in July 2010 describing nearly six dozen provisions in the law core to advancing health equity. The report covered ACA’s opportunities and new requirements related to health insurance, the safety net and other points of health care access, workforce diversity and cultural competence, health disparities research, prevention and public health, and quality improvement.

Series Purpose and Objectives

The overall purpose of the *Affordable Care Act & Racial and Ethnic Health Equity Series* is to provide an informative, timely, user-friendly set of reports as a resource for use by health care organizations, community-based organizations, health advocates, public health professionals, policymakers, and others seeking to implement or take advantage of the ACA to reduce racial and ethnic health disparities, advance equity, and promote healthy communities.

The *Series* is funded by W. K. Kellogg Foundation and The California Endowment. The *Series* is intended to:

- Provide a point-in-time snapshot of implementation progress—or lack thereof—of over 60 provisions in the ACA with implications for advancing racial and ethnic health equity, detailing their funding status, actions to date, and how they are moving forward;
- Showcase concrete opportunities presented by the ACA for advancing racial and ethnic health equity, such as funding, collaborative efforts, and innovation that organizations can take advantage of;
- Highlight any threats, challenges, or adverse implications of the law for diverse communities to inform related advocacy and policy efforts; and
- Provide practical guidance and recommendations for audiences working to implement these provisions at the federal, state, and local levels, by documenting model programs, best practices, and lessons learned.

Series Design and Methodology

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

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

For each topic area, the project team conducted a comprehensive review of literature and reports, along with an in-depth assessment of the legislation, emerging federal rules, regulations, and funding opportunities; state models and innovations; and community and local programs and policies. To complement research, programs, and policies identified through this review, the team conducted telephone-based interviews with nearly 70 national experts and advocates, federal and state government representatives, health care providers, health plans, community organizations, and researchers in the field. A full list of participants and contributors can be found in Appendix A. Interview questions were tailored to the sectors that respondents represented and were intended to fill important information gaps as well as reinforce themes around emerging progress, opportunities, challenges, and actions not otherwise discussed in written sources. Findings from the literature review, policy analyses, and interviews were synthesized into five topic-specific reports.

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

Series Audience and Use

With the latest policy updates and research, complemented by voices and perspectives from a range of sectors and players in the field, the goal of this *Series* is to offer a unique resource and reference guide on the implementation status of the ACA’s diversity and equity provisions along with emerging opportunities and actions to reduce disparities. However, given the health care arena is rapidly evolving and expanding, with new guidance, policies, and actions emerging almost daily at all levels, this *Series* offers a point-in-time snapshot of information, perspectives, and resources that were readily available and accessible during the time this project was undertaken.

Reports issued as part of this *Series* are intended for broad audiences and use. For example, federal government agencies may utilize information on best practices, resources, and concerns in the field to inform the development of ACA-related rules and regulations addressing equity, diversity, language, and culture. Nonprofit and community organizations may look to the reports for concrete opportunities for involvement, collaboration, or funding. Health care providers, public health agencies, state exchanges, and health plans may draw on models, best practices, and resources to implement or enhance their own efforts to tailor and ensure racial and ethnic equity and diversity are core to their plans and actions. Advocacy organizations may use data or findings to advocate for appropriations, funding, or support for a variety of equity priorities supported by the ACA.

II. Methodology

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

Literature and Policy Review. We conducted a comprehensive review of literature on the safety-net system, generally and in context of both racial and ethnic health disparities and the ACA. This was complemented by a review of federal rules and guidance that have been published to date for implementing each of the nine safety-net related provisions. Given the constantly evolving nature of the field, information and research included in the first (draft) version of this report was current as of February 2013. With the introduction of new rules along with constantly changing state decisions related to the ACA, this version generally includes updates through June 14, 2013. In addition, we conducted an extensive review of research and articles on state activities along with programs and models emerging among safety-net hospitals and health centers, with the intent of identifying information and guidance that can inform what is required to effectively implement the nine provisions.

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

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

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

Synthesis and Analysis. Based on common themes and issues that affect the major players in the safety-net system, the nine provisions are organized by three overarching themes, as follows:

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

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

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

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

1. **Legislative context** of each provision, both as authorized by the ACA and also by any prior legislation.
2. **Implementation status, progress and potential impact** as documented in the Federal Register, literature and reports, government or foundation-based funding opportunity announcements and other actions.
3. **Emerging models and programs**, including those established prior to ACA that can inform current implementation, as well as those that have emerged from ACA funding and support.
4. **Challenges and next steps** to realizing the objectives of the provision and advancing health equity.

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

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

The Affordable Care Act (ACA) presents a range of opportunities and threats for transitioning and positioning the safety net to adapt to a changing health care landscape. This section describes the implementation progress, opportunities, challenges, and road ahead for nine provisions in the new law that are expected to have major implications, both positive and negative for the nation’s health care safety net, particularly in serving racially and ethnically diverse patients. Provisions are addressed in context of three safety-net priorities: (1) Expansion of Public Programs; (2) Support for Health Centers and Clinics; and (3) New Requirements for Safety-Net Hospitals. Appendix B provides an “At-A-Glance” summary of these provisions, along with their funding allocations, implementation status, and progress.

A. Expansion of Public Programs: Medicaid & CHIP

Background

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

Racially and ethnically diverse populations constitute just over one-third of the U.S. population, however they comprise over half of those who rely on Medicaid.⁷ A recent study estimated that in 2011, whereas over 11% of Non-Hispanic Whites relied on Medicaid and CHIP, 28% of African Americans, 27% of Hispanics and nearly 18% of Asians and others relied on these public programs for coverage.⁸ Expansions in Medicaid and CHIP are expected to considerably reduce racial and ethnic disparities in health insurance coverage, affecting millions of Non-White individuals across the nation. While Non-Whites comprised about one-third of the nation’s population in 2011; they made up 55% of the 48.6 million uninsured.⁹ In the same year, approximately 32% of Hispanics, 27% of American Indians, 21% of African Americans, and 18% of Asians were uninsured as compared to 13% of Non-Hispanic Whites.¹⁰ These trends generally hold true among uninsured children—nearly two-thirds of whom belong to Non-White racial and ethnic groups.¹¹

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

While many racial and ethnic minorities are enrolled in the Medicaid and CHIP programs, many more are eligible for such coverage but are not enrolled, either because they are unaware of their eligibility or face other barriers, such as limited English proficiency and enrollment process complexities. For instance, more than 80 percent of uninsured African-American children and 70 percent of uninsured Latino children are eligible for Medicaid or CHIP coverage.¹²

Insurance coverage is a significant predictor of access to medical care, and a large body of research has shown that expansions in coverage, particularly in public programs, can reduce longstanding disparities in health outcomes.^{13,14} A recent study found that the expansion of Medicaid eligibility in three states was associated with a significant decrease in mortality during a five-year follow up period when compared with states that did not expand Medicaid. Reductions in mortality were greatest among Non-White racial and ethnic groups, adults between the ages of 35 and 64, and individuals from poor counties.¹⁵ The expansion of CHIP among states has also been associated with improved health care access, continuity of care, and health outcomes for racially and ethnically diverse children.¹⁶

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

Medicaid Expansion

Legislative Context

Section 2001 of the ACA amends the Social Security Act by authorizing the expansion of Medicaid coverage among individuals under age 65 and with incomes at or below 138% of the federal poverty level (\$14,856 for an individual and \$30,656 for a family of four, based on the 2012 federal poverty level) beginning January 1, 2014. The federal government is authorized to pay 100% of the cost for these new enrollees from 2014 through 2016 and then gradually reduce its contribution to 90% by 2020 and indefinitely thereafter.¹⁷ However, the original ACA legislation stipulates that if states fail to expand Medicaid, states would lose all Medicaid funding from the federal government, not just money to pay for the expansion.

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

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

- American Public Health Association

In addition, the ACA tasks states with providing a coordinated and streamlined enrollment system in 2014, along with targeted outreach to vulnerable populations (§1413, §2201, and §2202). The intent of this system is to provide individuals the ability to apply for Medicaid, CHIP, and exchange coverage using a single application available to them through multiple channels, such as in-person, online, and by phone.¹⁸ Section 2201 of the ACA explicitly outlines the need to ensure these processes reach vulnerable and diverse populations:

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

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

Implementation Status, Progress, and Potential Impact

Medicaid Expansion. On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule on implementing the ACA’s provisions addressing Medicaid eligibility, enrollment simplification, and coordination.¹⁹ This final rule included details on (1) the statutory minimum Medicaid income eligibility level of 133% or (138% accounting for 5% income disregard); (2) elimination of obsolete eligibility categories and collapsing of other categories; (3) modernization of eligibility verification rules; (4) codification of the streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for individuals; and (5) ensuring coordination across Medicaid, CHIP, and the exchanges.²⁰

As of June 14, 2013, 26 states and the District of Columbia have confirmed their participation, extending Medicaid to approximately 3.8 million racially and ethnically diverse individuals.

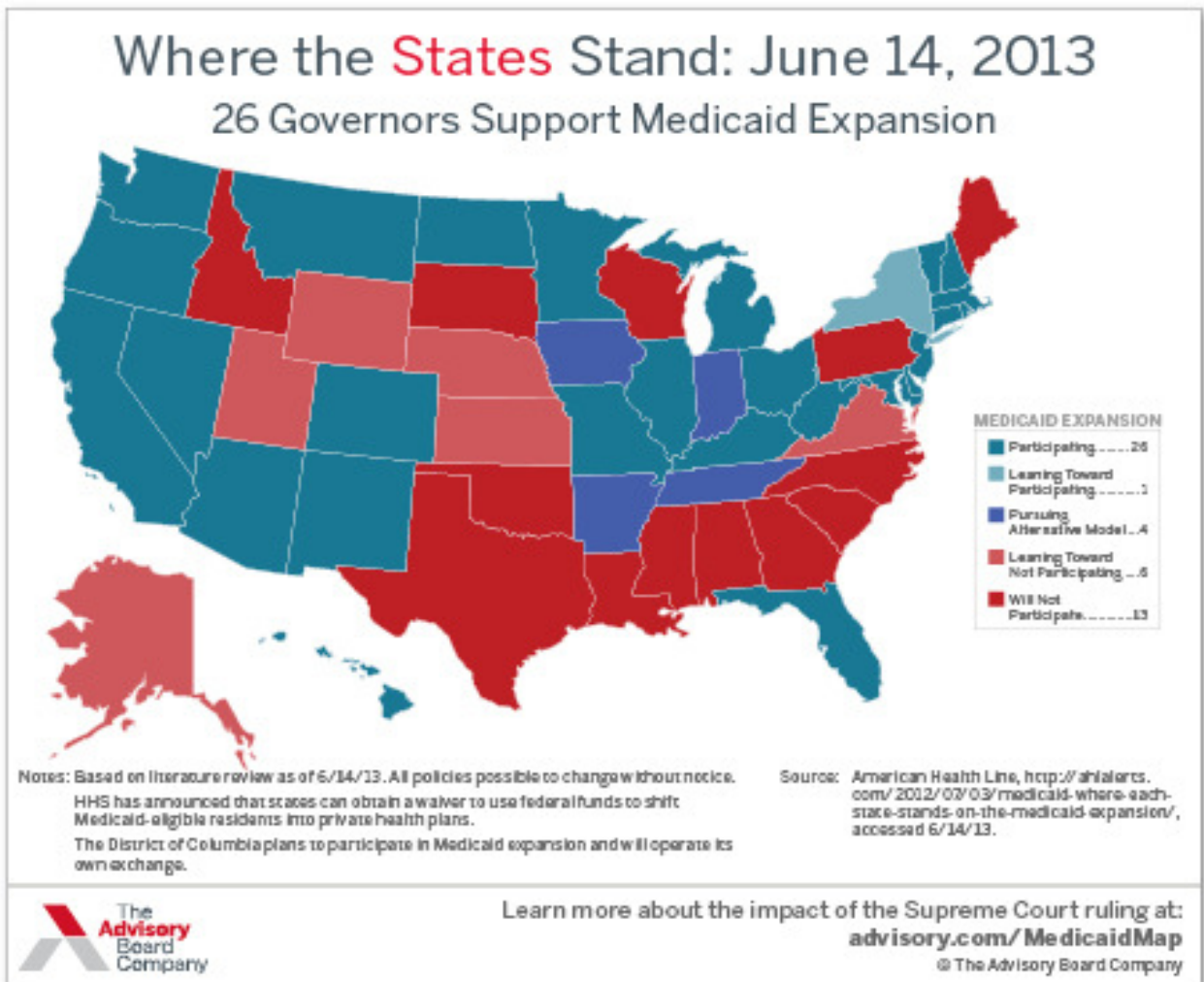
On June 28, 2012, the Supreme Court declared the ACA’s Medicaid expansion to be unconstitutional as it penalized states that did not expand Medicaid with a loss of all their Medicaid funding. By a seven-to-two margin, the Supreme Court justices declared this to be unduly coercive.²¹ “The court’s remedy was to block the potential cutoff of all Medicaid funding, in effect making the expansion of Medicaid optional for states.”²²

As of June 14, 2013, 26 states and the District of Columbia have confirmed their participation in the Medicaid expansion, with another four states participating through an alternative approach and one state leaning toward participating. Thirteen states have decided not to participate and an additional six are leaning toward not participating in the Medicaid expansion. Figure 1 illustrates where states stand in their decisions regarding Medicaid expansion.

Alternative Approaches to Medicaid Expansion. The federal government has approved or is reviewing proposals from a handful of states (Arkansas, Indiana, Iowa, and Tennessee) to pursue an alternative approach—applying federal Medicaid money to buy private insurance for otherwise Medicaid-eligible individuals. These alternative market-based plans are being considered by HHS

as demonstrations for how well they work in reality and in comparison to conventional Medicaid. States adopting this alternative approach are required to file a waiver of existing Medicaid rules and to participate in federal and state public hearings. As was recently cited, “[t]he biggest hurdle for states is making sure the private insurance option would not cost more than traditional Medicaid...[t]he administration appears eager to let states find their own way to provide health care coverage for low-income uninsured Americans that won’t cost more than Medicaid.”²³ More information on Medicaid Demonstration Waivers can be found on pages 27-28 of this report.

Figure 1.



Impact of Medicaid Expansion by Race and Ethnicity.

According to a recent report issued by the Urban Institute, state decisions regarding whether to expand Medicaid will affect an estimated 15.1 million uninsured adults with incomes below 138% FPL who would be newly eligible for coverage under the ACA Medicaid expansion.²⁴ Of this population, racially and ethnically diverse residents represent roughly 45% or 6.8 million adults with incomes below 138% FPL that would become newly eligible for Medicaid.²⁵ An estimated 2.9 million (19.4%) Hispanics, 2.8 million (18.7%) African Americans and nearly 1.1 million (7.0%) other racial minorities with incomes below 138% FPL would be newly eligible for Medicaid in 2014.²⁶

While 6.8 million racially and ethnically diverse adults would become newly eligible for Medicaid in 2014, just over half or 3.8 million of them will actually benefit in states opting to expand Medicaid coverage, as of June 14, 2013.

Applying the Urban Institute's data on newly Medicaid eligible populations by race and ethnicity and state²⁷ reveals that among the 31 states that are expanding Medicaid (either as prescribed by the ACA or through an alternative approach), an estimated 3.8 million potential enrollees would be racially and ethnically diverse adults (or Non-Whites) with incomes below 138% FPL (Table 1). Among the 19 states not expanding or leaning toward not expanding Medicaid, roughly 3 million eligible Non-White adults will lose out on this coverage opportunity (Table 2). Fortunately, those with incomes between 100% and 138% FPL will be eligible for premium subsidies through the exchanges. However, the nearly 2.3 million Non-White adults with incomes below 100% FPL will lose out on both Medicaid and the premium subsidies, potentially leaving them without any coverage. And states including Texas and Georgia could alone leave as many as 1 million predominantly poor, African American, and Hispanic adults uninsured.

A recent report issued by the Kaiser Commission on Medicaid and the Uninsured shows that the impact of state Medicaid expansion decisions varies by race and ethnicity, with African Americans continuing to face profound coverage gaps.²⁸ Whereas roughly one-fourth (27%) of African Americans with incomes below 138% FPL reside in states expanding Medicaid, nearly six in ten (59%) reside in states opting out of the expansion. Among Hispanics, more than half (53%) reside in states that will expand Medicaid, while in contrast just over four in ten (44%) are in states opting out. And among Asians and Pacific Islanders, the study finds that over two-thirds (67%) of those who would be eligible for Medicaid live in Medicaid expansion states, whereas just over one in four (27%) reside in non-expansion states.

Table 1. Uninsured Non-White Adults Newly Eligible for Medicaid under the ACA in 31 States and D.C. Participating in Medicaid, Leaning Toward Participating, or Participating through an Alternative Approach

	% Non-White <138% FPL	# Non-White <138% FPL
Arkansas**	32.3	71
Arizona	46.6	41
California	66.8	1,251
Colorado	35.8	80
Connecticut	39.7	35
Delaware	27.5	4
District of Columbia	77.9	14
Florida	51.6	668
Hawaii	70.6	28
Illinois	48.8	254
Indiana**	22.7	85
Iowa**	14.8	16
Kentucky	14.8	43
Maryland	54.1	90
Massachusetts	30.5	26
Michigan	29.4	165
Minnesota	20.8	27
Missouri	27.3	96
Montana	19.0	12
Nevada	44.7	73
New Hampshire	9.3	5
New Jersey	54.2	166
New Mexico	71.2	90
North Dakota	26.2	7
New York*	51.2	87
Ohio	23.9	138
Oregon	20.7	52
Rhode Island	27.3	11
Tennessee**	29.6	107
Vermont	##	##
Washington	29.8	93
West Virginia	7.7	10
Average or Total	36.3	3,845

* Leaning toward participating.

** Participating through alternative Medicaid expansion.

Number (#) is provided in thousands.

Adapted with data from Kenney GM et al, Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage? August 2012, Robert Wood Johnson Foundation & Urban Institute.

Table 2. Uninsured Non-White Adults Newly Eligible for Medicaid under the ACA in 19 States Not Participating in or Leaning Toward Not Participating in Medicaid

	% Non-White <138% FPL	# Non-White <138% FPL	% Non-White <100% FPL	# Non-White <100% FPL
Alaska*	51.8	22	50.8	16
Alabama	42.9	138	40.1	109
Georgia	53.6	367	54.7	292
Idaho	17.1	19	16.2	14
Kansas*	29.3	41	31.2	33
Louisiana	54.3	178	53.2	138
Maine	7.1	5	4.2	3
Mississippi	54.0	124	55.4	102
Nebraska*	25.5	19	24.5	13
North Carolina	43.8	257	43.9	192
Oklahoma	37.2	85	37.9	65
Pennsylvania	29.1	151	30.5	122
South Carolina	48.8	145	49.8	115
South Dakota	37.3	15	39.9	13
Texas	67.0	1170	66.5	883
Utah*	23.6	25	25.5	19
Virginia*	42.2	145	42.5	115
Wisconsin	22.8	41	23.8	35
Wyoming*	17.7	5	18	4
Average or Total	37.1	2,952	37.3	2,283

* Leaning toward not participating.

Number (#) is provided in thousands.

Non-Whites are comprised of African Americans, Hispanics and all other Racial populations.

Adapted with data from Kenney GM et al, *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* August 2012, Robert Wood Johnson Foundation & Urban Institute.

Medicaid Outreach and Enrollment. Beyond the decision to expand Medicaid income eligibility, states are working to streamline their enrollment systems, ensuring coordination across Medicaid, CHIP, and the exchanges, while also providing outreach to vulnerable and diverse individuals and families. The final rule issued on March 23, 2012, asserts the importance of “written translation and oral interpretation” stating that it will be “required” to establish procedures for conducting outreach to and enrolling vulnerable, underserved populations, including “racial and ethnic minorities.”²⁹ The rule specifies that information for persons with limited English proficiency be provided in an “accessible and timely manner and at no cost to the individual.” In addition, the rule maintains that “Web site[s], any interactive kiosks and other information systems established by the State to support Medicaid information and enrollment activities must be in plain language and be accessible to...persons who are limited English proficient...” The rule further states that subsequent guidance may address “assistance such as cultural competence”³⁰—or in other words, ensuring assistance provided to those with limited English proficiency is done so in a culturally appropriate manner.

On January 22, 2013, CMS issued a proposed rule to provide states more flexibility in coordinating Medicaid and CHIP eligibility notices, appeals, and other related administrative processes, along with clarifying accessibility issues related to limited English proficient populations, among other broader objectives. Specific accessibility guidance was issued to clarify provisions issued on March 23, 2012, related to communicating with limited English proficiency. The rule states that “providing language services means providing oral interpretation, written translations, and taglines (which are brief statements in a non-English language that inform individuals how to obtain information in their language).”³¹ The proposed rule also directs states to guidance published on August 8, 2003 (68 FR 47311) on parameters for language assistance services for persons with limited English proficiency.³² It further discusses guidance which was released on the availability of enhanced federal matching funds available for translation and interpretation services related to improving outreach to, enrollment of, retention of, and use of services by children in Medicaid and CHIP. In addition, Section 1902(a)(55) of the Social Security Act requires that states place an Outstationed Eligibility Worker (OEW) in Federally Qualified Health Centers and safety-net hospitals receiving DSH payments, or implement an alternative plan that is equally or more effective. While current federal funds cover 50% of the cost of these workers, in Fall 2013, the rate is expected to increase to 75%.

What is an Outstationed Eligibility Worker (OEW)?

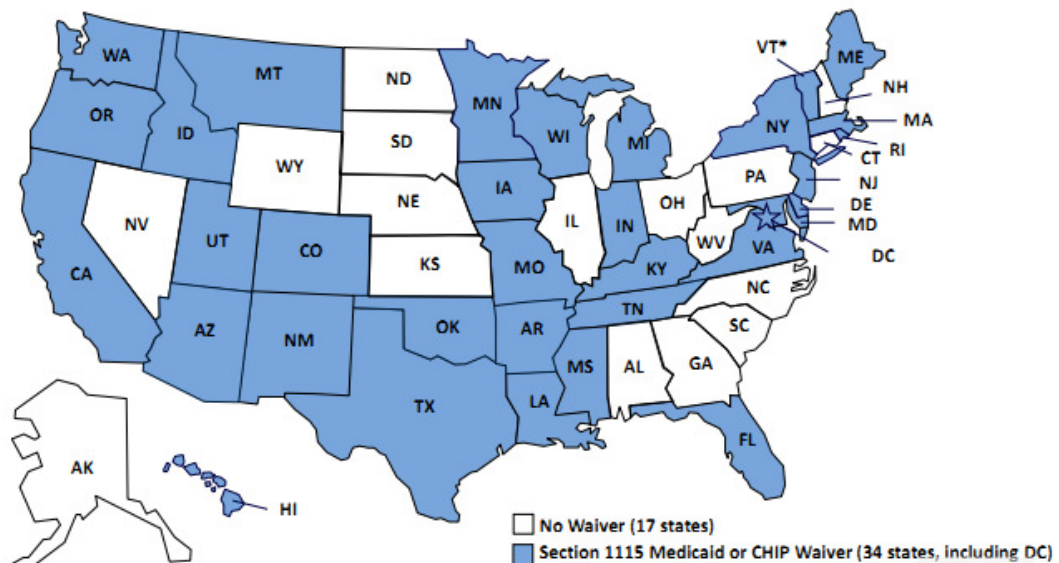
The Social Security Act requires states to outstation eligibility workers at Federally Qualified Health Centers (FQHCs) and safety-hospitals which obtain Disproportionate Share Hospital (DSH) payments to accept and process Medicaid applications.

CMS convened a meeting of the Advisory Panel on Outreach and Education (APOE) on March 23, 2013. The objective of the Panel was to advise and make recommendations to the HHS Secretary and the Administrator of CMS on opportunities and ways to enhance the effectiveness of consumer education strategies for Medicaid, CHIP, Medicare, and the exchanges. An explicit focus of the Panel was to address outreach strategies for “vulnerable and underserved communities, including racial and ethnic minorities” and those with limited English proficiency (LEP).³³ In particular, the panel reinforced the importance of “easy-to-understand information” for LEP patients and ensuring that navigators and outreach workers are “drawn from trusted community sources...[which] need to be both linguistically and culturally competent.”³⁴ Further, the Panel called for ensuring that those providing outreach are trained to provide assistance to mixed status families. They also emphasized the importance of “real time evaluation” to assess the efficacy of trainings along with track best practices for effectively reaching and enrolling LEP populations.

On May 9, 2013, HRSA issued a Funding Opportunity Announcement in the amount of \$150 million for existing Federally Qualified Health Centers to expand current outreach and enrollment assistance activities and facilitate enrollment of health center patients in Medicaid, CHIP, and health care coverage offered through the exchanges. Among its requirements is that grantees adhere to the federal standards on Culturally and Linguistically Appropriate Services (CLAS) developed by the U.S. Department of Health and Human Services Office of Minority Health. For additional details on cultural and linguistic requirements in exchanges and health insurance, generally see Report 1, “Implementing Cultural and Linguistic Requirements in Health Insurance Exchanges,” issued in March 2013 in the *Affordable Care Act & Racial and Ethnic Health Equity Series*.

Medicaid Demonstration Waivers. While not explicitly authorized by the ACA, several states are looking to Section 1115 of the Social Security Act to either replace the need for a Medicaid expansion as authorized under the ACA or supplement the expansion to support a stronger safety-net system. Under Section 1115, states can apply for a demonstration waiver to expand coverage, increase benefits, or implement innovative models of care that reduce state costs, thereby waiving certain federal Medicaid provisions.³⁵ Waivers often provide states with greater flexibility to tailor their Medicaid programs to local needs, however they must demonstrate budget neutrality—“meaning that federal Medicaid expenditures under the waiver must not exceed federal expenditures for a state in absence of the waiver.”³⁶ In addition, waivers are subject to a cap on the amount of federal funding allotted, and the state is responsible for any costs incurred above the federal cap. Although most waivers are intended to expand coverage, they can also be used to limit services or develop new payment and oversight mechanisms which could have deleterious effects on vulnerable populations. To partially address this challenge, Section 10201(i) of the ACA includes a specific provision to enhance transparency in the state waiver application and approval process. As such, it requires “public notice and comment, including public hearing, at the state level, and further public notice and comment at the federal level, before waiver programs can be approved and renewed.”³⁷

Figure 2.
States with a Section 1115 Medicaid or CHIP Demonstration Waiver, February 2012



Source: Kaiser Family Foundation. An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity, May 2012. Available online at: <http://www.kff.org/medicaid/upload/8318.pdf>, accessed February 18, 2013.

Following the enactment of the ACA, interest in Section 1115 waivers has intensified, after a relatively dormant period between 2009 and 2010. As of February 2012, there are at least 34 states which currently have 1115 Waivers (Figure 2), 15 of which were approved after the advent of the ACA, and others emerging more recently. Following is summary of major elements reflected across these waivers, and promising programs emerging among states that could have implications for low-income, diverse communities:

- **Early expansion of Medicaid to adults.** Following the ACA, at least six states (California, Colorado, Minnesota, Missouri, New Jersey, and Washington) and the District of Columbia were approved to use their 1115 waivers to expand Medicaid to adults in preparation for the 2014 expansion giving them important experience and lessons around eligibility and enrollment processes for low-income and vulnerable populations. California, in particular, has the largest 1115 waiver in the nation as it seeks to expand coverage to childless adults up to 200% FPL through the Low-Income Health Program (LIHP)—an effort being implemented on a county basis.³⁸
- **Simplifying eligibility and/or enrollment processes.** Following the enactment of the ACA, two states in particular have embarked on initiatives to simplify their eligibility and enrollment processes, particularly for children. Massachusetts, for example, received waiver approval to renew Medicaid coverage for parents using “express lane eligibility” (ELE).³⁹ To simplify the enrollment process for parents, ELE allows a state to conduct Medicaid enrollments or renewals using eligibility information from other public programs, eliminating the need for families to provide this information multiple times to multiple agencies. In New York, the waiver is being used to provide 12-month continuous eligibility regardless of income fluctuations, “helping to reduce churning into and out of coverage and promoting more reliable access to care.”⁴⁰
- **Eligibility and enrollment restrictions:** Three states recently were approved to implement eligibility restrictions—which is rarely permitted, but allowed in cases where a state is facing budget deficits. Arizona, for example, ended its Medically Needy program and closed enrollment for this program. Hawaii received approval to end coverage for adults above 133% FPL, and Wisconsin also was approved for eligibility restrictions for adults above 133% FPL.⁴¹
- **Premium or cost-sharing increases.** Four states (Arizona, New Jersey, New Mexico, and Wisconsin) have pursued proposals to increase cost-sharing and premiums to reduce program costs and increase “personal responsibility” among enrollees. For example, Arizona’s waiver allows the state to charge some higher cost sharing for adults, as the state argued it was necessary to prevent reducing coverage among its population at large. Wisconsin received approval to increase premiums for some adults with income above 133% of poverty to prevent this group from losing coverage from the state altogether.
- **Pool to support safety-net delivery system improvement.** Four states (California, Florida, Massachusetts, and Texas) have been approved to utilize federal matching funds for safety-net pools that will be used to cover uncompensated care costs as well as hospital delivery system improvement initiatives. These initiatives range from infrastructure development, new care delivery models such as medical homes, and quality improvement projects. New Mexico has submitted a similar proposal which is pending approval.
- **Other payment and delivery system reforms.** Finally, under the waiver, several states have pending proposals to restructure payment and delivery systems through such arrangements as care coordination, accountable care, and financial incentives for outcomes.

Emerging Models and Programs

Safety-net providers have considerable experience in reaching and enrolling children and families in Medicaid, CHIP, and other programs.⁴² Our interviews with individuals from community health centers, public hospitals, and other community and advocacy representatives reinforced this point, suggesting that with the advent of health care reform, safety-net providers are intensifying their outreach, education and enrollment activities. These actions include, for example, connecting patients to traditional outstationed eligibility workers, using technology to maintain strong connections with vulnerable populations, and training staff to conduct outreach as well as to serve as application assisters.^{43,44} Some providers are taking additional innovative steps to reach and enroll hard-to-reach populations. For example, one provider has trained a cadre of community outreach workers to make home visits to self-pay patients, to assist them in determining eligibility and enrolling them into Medicaid.

Health centers, safety-net hospitals, and other community clinic settings would seem to be logical partners in enrollment, given they already provide services to a large proportion of uninsured, racially and ethnically diverse, and vulnerable patient populations. These settings are frequently considered “trusted” resources for health care, thus patients often rely on them for assistance in bridging to other social and support services.⁴⁵

Challenges and Next Steps

Many states are still struggling to decide whether to expand Medicaid. Among governors opposed to expanding Medicaid, affordability and impact on state budgets were cited as top reasons.⁴⁶ In particular, many expressed concerns related to the so-called “wood-work effect” whereby the ACA could draw previously eligible but unenrolled persons into Medicaid at greater cost to the state.⁴⁷ More than half of those opposing Medicaid expansion also expressed fear that the federal government would “renege on the generous terms of the ACA and scale back its share of Medicaid.”⁴⁸

However, data and evidence emerging across states generally opposed to Medicaid expansion reveals the long-run benefits of such expanded coverage across various fronts—from state budgets and hospital uncompensated care costs to overall population health. For example, a recent study from Texas—which has the highest uninsured rate (23.8% vs. national average of 15.7%) and whose governor is strongly opposed to Medicaid expansion—shows that between 1.5 and 2.0 million individuals would obtain new coverage.⁴⁹ In addition, whereas the federal government would contribute \$100 billion over 10 years to cover these new enrollees, the state would be responsible for a relatively small portion—approximately \$15 billion—over this time period.⁵⁰ Also among states vehemently opposed to Medicaid expansion was Arizona. However, in late January 2013, the Governor reconsidered the decision given the widespread concern that a sizeable number of very low-income citizens would be left without coverage, whereas lawful immigrants would be eligible for government-subsidized private insurance not available to poor citizens.⁵¹ Arizona’s state budget statement documented the following as an important reason for expansion: “If Arizona does not expand, for poor Arizonans below (the federal poverty line), only legal immigrants, but not citizens, would be eligible for subsidies.”⁵²

While legal immigrants have to wait five years to qualify for Medicaid, a recent immigration compromise has allowed low-income legal immigrants to obtain subsidized private coverage through the health insurance exchanges. This expansion was not made for citizens below 100% FPL given the ACA assumed all states would expand Medicaid. Thus in states opting out of Medicaid expansion, there is a risk that those below 100% FPL may not have any form of coverage.

Beyond the question of whether or not to expand, some states have questioned whether the federal government will allow for a partial expansion of Medicaid.⁵³ While no such plan has been approved to date, several states resistant to Medicaid expansion are looking to alternative approaches. For example, Arkansas has been approved for a “private option” which would allow the state to use its Medicaid dollars to purchase private health insurance for its 250,000 low-income residents through the health insurance exchange. Recent reports suggest that Governors in Florida, Louisiana, Maine, Ohio, Tennessee and Texas have expressed interest in this approach.

Results from a recent qualitative study of early adopter states of the Medicaid expansion reveal seven lessons learned, of which at least four have important implications for low-income, diverse communities across states⁵⁴:

1. Expansion-related predictions are challenging, particularly in projecting enrollment and costs associated with Medicaid expansion;
2. Coverage and access barriers remain even after the expansion of Medicaid, and this held particularly true for very low-income, diverse individuals experiencing unstable socioeconomic circumstances and facing obstacles to accessing care;
3. Utilization of behavioral health services was greater-than-expected among new enrollees, particularly those at extremely low levels of poverty; and
4. Actively engaging state and local stakeholders at each step of the implementation process is critical to buying support and overcoming major obstacles.

Continued monitoring of these issues, along with advocacy around the benefits of Medicaid expansion for states and their populations will be necessary to ensure that the poorest American citizens—especially the roughly 2 million racially and ethnically diverse individuals below the federal poverty level—do not fall through the coverage cracks.

CHIP Reauthorization

Legislative Context

Section 2101 of the Affordable Care Act (ACA) extends Children’s Health Insurance Program (CHIP) funding authorized under the Children’s Health Insurance Program Reauthorization Act (CHIPRA) in 2009, until at least October 1, 2015. Should CHIP funding be reauthorized beyond this date, the federal matching rate in each state will be increased by 23% between 2016 and 2019, bringing the federal matching rate for CHIP up to at least 88% in every state.⁵⁵ In addition, the ACA requires all states to maintain their CHIP eligibility levels and enrollment policies as they were at the time of enactment (i.e., as of March 23, 2010). States are also prohibited, under the new law, from enacting policies that would prevent additional children from enrolling in CHIP. The ACA also provides additional funding—\$40 million—for states to carry out outreach activities to enroll more children in public programs, including CHIP. It also stipulates that states streamline their enrollment processes.

Implementation Status and Progress

On March 23, 2012, the Centers for Medicaid and Medicare Services (CMS) released a final rule on implementing the ACA's provisions addressing Medicaid and CHIP eligibility, enrollment simplification and coordination.⁵⁶ Beyond guidance specific to Medicaid, the final rule included details on streamlining of income-based rules and systems for processing Medicaid and CHIP applications and renewals for individuals as well as ensuring coordination across Medicaid, CHIP, and the exchanges.⁵⁷ Guidance clarifying processes pertaining to individuals with limited English proficiency were proposed by CMS on January 22, 2013, which is summarized in the previous section under *Medicaid Enrollment and Outreach*.

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

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

On September 30, 2009 (prior to the ACA), CMS awarded \$40 million in the first round of funding to 68 grantees across 42 states. Of these grantees, 49 were individual organizations or states, and 20 were groups of entities working together as a consortium. Grantees were provided two years to spend their funds and report enrollment data and information to evaluate the success of these programs. All grantees cited a commitment to reaching out to underserved populations that are more likely to be uninsured.⁵⁸

On August 18, 2011, CMS awarded a second round of \$40 million to 39 grantees in 23 states to support outreach and enrollment activities. These grants focused on one of the following five areas:

- Using technology to facilitate enrollment and renewal;
- Focusing on retention: keeping eligible children covered for as long as they qualify;
- Engaging schools in outreach, enrollment, and renewal activities;
- Reaching out to groups of children that are more likely to experience gaps in coverage; and
- Ensuring eligible teens are enrolled and stay covered.

On January 7, 2013, CMS issued a third round of solicitation for applications for Connecting Kids to Coverage Outreach and Enrollment Grants.⁵⁹ On July 2, 2013, 41 grants totaling \$32 million were awarded to state, local, community-based, and nonprofit organizations as well as Indian health care providers and tribal entities in 22 states. This round of grants supported outreach strategies as well as efforts to build community-based resources for assisting families with the application process. Among the five priority areas identified in this solicitation is a focus on "bridging health coverage disparities by reaching out to subgroups of children that exhibit lower than average health coverage rates."⁶⁰ Other priorities include engaging schools in outreach,

enrollment and retention activities; streamlining enrollment process; establishing application assistance resources within local communities; and conducting training programs that assist families in understanding the new application and enrollment process.

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

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

Emerging Programs and Models

Among grantees funded through CHIPRA and the ACA during the second cycle of the outreach and enrollment grants, at least 17 (44%) focus directly on reaching racially, ethnically, and linguistically diverse populations as described in their program summaries.⁶¹ Most commonly, these grantees are targeting outreach efforts to Hispanic or Latino communities (at least 11 grantees). In addition, these grantees specify targeting the following diverse population groups: African Americans; American Indians; Vietnamese; Chinese; Thai; Korean; Somali; and Ethiopian. Following are strategies common across these grantees:

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

In addition to these efforts, on November 15, 2012, the Federal Government launched its national campaign known as “Connecting Kids to Coverage.” The campaign’s website (www.insurekidsnow.gov) includes a series of education and outreach materials for states, health care providers, and community organizations to use as tools and guidance as they develop strategies, plans, and activities to reach and enroll children in CHIP and Medicaid. Among these resources are palm-cards and posters which reflect diverse children in playful settings and provide brief information on CHIP and Medicaid enrollment.⁶² These resources are available in English and Spanish. The campaign website also offers expertise and assistance in customizing available tools and resources to states and local communities.

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

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

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

Challenges and Next Steps

The ACA preserves the CHIP program, extends its funding through 2015, and requires states to maintain eligibility levels for children in CHIP until 2019. It also enhances funds to assist with enrollment and outreach, particularly to children and families who are eligible but not enrolled. While these actions protect and ensure that children’s health and health care access are at the core of any insurance expansion strategy, there may be a few challenges moving forward. First, ongoing economic and state budget constraints could hinder states’ ability to maintain a focus on children’s coverage and quality of care. This has led some states to take steps to reduce their program costs.⁶³ For example, Arizona and Tennessee froze enrollment in CHIP during FY 2010. Others, such as Florida, Idaho, Nevada, Oklahoma, South Dakota, and the District of Columbia reported making cuts to provider reimbursement rates to cope with budget deficits. California and New Hampshire mentioned increasing their CHIP premium amounts.

Secondly, at the patient level, there are concerns that low-income families may face a complex set of new challenges as they try to stay on top of the different kinds of coverage family members may receive. “As one member of the family moves in or out of the insurance exchange program, other family members may not be eligible for the same plans. This may be especially problematic for families whose children are insured by CHIP and thus have an entirely different set of health insurance plans than the rest of their family.”⁶⁴ This may be especially daunting for low-income and diverse families already facing language barriers or challenges with mixed immigration status.

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

In an era of increased fiscal challenges for States, focusing outreach efforts on the most effective methods is increasingly important. Although States track broad enrollment and retention numbers, many questions remain regarding the effectiveness of specific CHIP outreach activities across geographic locations and diverse populations. Distinguishing the impact of a specific outreach initiative from the impact of other factors (such as demographic or programmatic changes) that influenced enrollment at the same time continues to be a challenge.⁶⁵

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

B. Health Centers and Clinics

Background

Given their history of service to predominantly low-income and diverse patients, health centers and clinics are expected to maintain, if not strengthen, their unique role in serving these patients starting January 1, 2014, when the Affordable Care Act's (ACA) major insurance provisions take effect. Community health centers were originally established as a small demonstration program in 1965 during President Johnson's "War on Poverty." Spurred by the realization that low-income, minority, and mainly African American students were disenfranchised from the mainstream healthcare system, proposals were submitted to the federal Office of Economic Opportunity to establish health centers in medically underserved inner-city and rural areas of the country based on a model of care from South Africa.⁶⁶ "The new health center model combined the resources of local communities with federal funds to establish local community-based health care systems in both rural and urban areas all across America."⁶⁷

Today, health centers serve over 20 million people, of which racially and ethnically diverse individuals and families constitute a large majority.⁶⁸ In fact, "compared to the U.S. population overall, health center patients are nearly five times as likely to be poor, more than twice as likely to be uninsured, and two-and-a-half times as likely to be covered by Medicaid."⁶⁹ The vast majority of patients—93%—have incomes below 200% FPL. Racially and ethnically diverse individuals are over-represented among health center patients. In particular, African Americans comprise 21% of all health center patients and Hispanics or Latinos make up over one-third.⁷⁰

Given this history of service to diverse and other vulnerable patients, health centers and clinics have become trusted and leading sources of primary, dental, and mental health care for these populations. With the large influx of newly insured patients expected in 2014, as well as with the remaining 30 million uninsured in 2022, there are at least four types of centers and clinics supported by the ACA that will continue to play an important role in serving low-income and diverse patients: community health centers; nurse-managed health clinics; teaching health centers; and school-based health centers.

Community Health Centers

Legislative Context

Section 10503 of the ACA created The Community Health Centers Trust Fund—a new, mandatory funding stream—to provide for expanded and sustained national investment in community health centers, originally established under Section 330 of Public Health Service Act.⁷¹ The legislation expands funding for community health centers by \$11 billion over five years starting in FY 2011, with \$9.5 billion for expanding their operational capacity for medical, oral, and behavioral health services, and \$1.5 billion for providing capital support to build new sites and/or expand and

improve existing facilities. The Community Health Centers Trust Fund is in addition to existing discretionary funding health centers receive from Congress.

Implementation Status and Progress

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

- **New Access Points** program intends to expand new full-time service delivery sites that provide comprehensive primary and preventive health care services. As a recent funding opportunity announcement (FOA) stated, eligible applicants must be public or nonprofit private entities, including tribal, faith-based, and community-based organizations. Applications may be submitted from new organizations or organizations already receiving operational grant funding under Section 330. This grant program seeks to establish new access points that: provide comprehensive primary medical care; provide services, either directly onsite or through established arrangements, regardless of patient’s ability to pay; ensure access to services for all individuals in the targeted service area or population; and provide services at one or more permanent service delivery sites.⁷² Among other objectives, the FOA explicitly stated that applicants are expected to demonstrate that the new access point(s) will increase access to “comprehensive, culturally competent, and quality primary health care services.” The application also requests that, when appropriate, biographical sketches submitted for staff “should include training, language fluency, and experience working with culturally and linguistically diverse populations served.”
- **Health Center Planning Grant (HCPG)** is intended to “support organizations in the future development of a Section 330 health center.”⁷³ Eligible applicants include public and nonprofit private entities, including tribal, faith-based and community-based organizations. Entities not eligible to apply are those that at the time of the FOA had a current Section 330 funded health center.
- **Health Center Capital Development** grants are intended to support the renovation of existing health center facilities or to expand or establish new sites. Centers being funded are undertaking two major types of capital development projects: (1) alternation or

Quick Tip: Where to Identify Health Center Grant Opportunities

The Health Resources and Services Administration (HRSA) Homepage includes a link to “[Grants](#)” which frequently post and update open grant opportunities. As HRSA administers a range of federal programs beyond health centers—from health professions and the National Health Service Corps to Maternal and Child Health, Rural Health, HIV/AIDS, and others, a variety of related funding opportunities can also be found here. For more information, visit: www.hrsa.gov/grants.

renovation, which includes work required to modernize, improve or alter physical characteristics of an existing facility; and (2) construction, which may involve adding a new structure to an existing site to increase its square footage or to establish a new site location for an existing center. For capital development grants offered through the Immediate Facilities Improvement Program as well as the Building Capacity Program, applicants must be an existing health center that has had an application approved for grant support under HRSA's Health Center program.^{74,75} Announcements through each of these programs explicitly state that an applicant's scope project must be consistent with HRSA's Health Center Program's mission: "to provide comprehensive, culturally competent, quality primary health care services to medically underserved community and vulnerable populations." Beyond this mention, the FOA does not explicitly mention other requirements targeting racially and ethnically diverse communities—although it may be implied in references to "underserved populations".

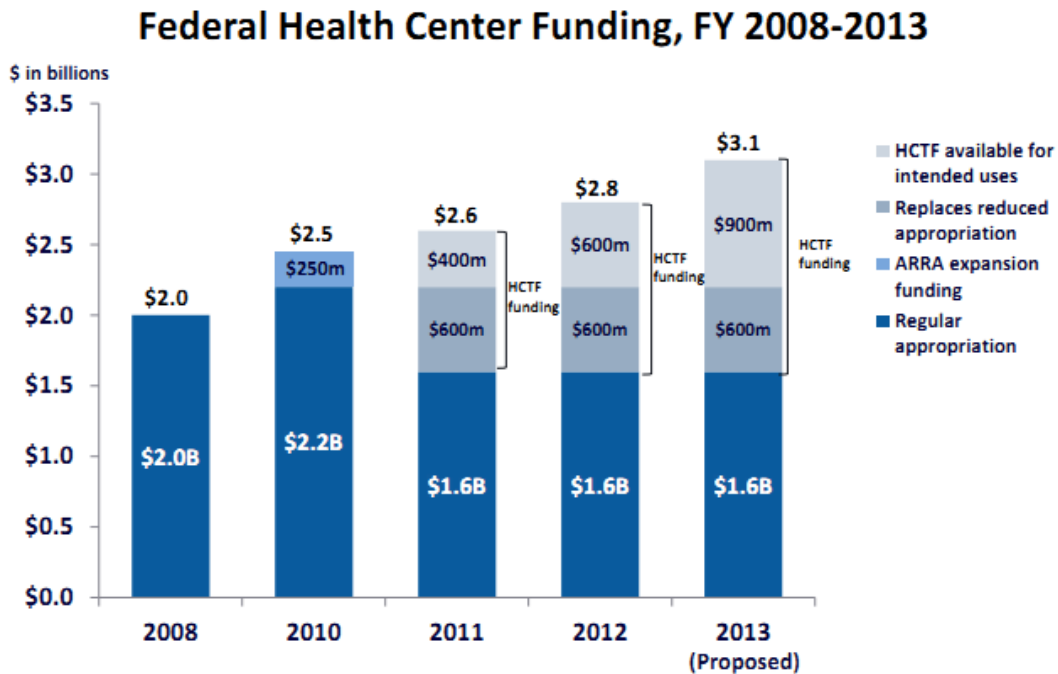
- **Increased Demand for Services (IDS) or Expanded Service (ES)** grants are aimed at expanding the number of patients that health centers serve or to provide additional types of services. In order to qualify for funding, applicants must propose to expand existing primary care medical capacity by adding new medical providers, increasing the availability of medical services, or expanding hours of operations.⁷⁶

Federal Health Center Funding. Community health centers receive two streams of funding: (1) mandatory funding under the ACA's Community Health Centers Trust Fund (CHCF); and (2) base discretionary funding from Congress. Recent federal budget cuts have severely threatened the lifeline of health centers, despite considerable support provided through the ACA. In particular, two key events have triggered major funding setbacks for health centers in almost 30 years – (1) reduction in discretionary funding in FY 2011; and (2) the sequestration which imposed an additional 5.1% reduction in discretionary spending and 2% loss in CHCF funding in FY 2013.

- **Discretionary Funding Cuts.** An unanticipated budget agreement reached by Congress and the Obama Administration in April 2011 resulted in the reduction of discretionary funds for health centers by \$600 million or 27%, from \$2.2 billion in FY 2010 to 1.6 billion in FY 2011.⁷⁷ When combined with dollars from the CHCF, the cut in appropriations reflected a 19% reduction in federal funding for centers in FY 2011, from \$3.2 billion to \$2.6 billion (Figure 3). To offset the considerable loss of this funding reduction on health center service capacity, \$600 million were diverted from the CHCF's FY 2011 appropriation to support ongoing operations at existing centers.⁷⁸
- **Sequestration.** The automatic, across the board federal spending cuts—also known as sequestration—has resulted in the loss of \$120 million in funding for health centers in FY 2013 alone.⁷⁹ This reduction is expected to be concentrated in the second half of FY 2013, and may result in steep programmatic reductions to absorb the loss across all federally funded health centers which include over 8,500 separate service locations. In fact, estimates indicate that approximately 900,000 fewer patients will be served during 2013, of which 72% will belong to families with incomes below the federal poverty level, 32% will be children under 18 years of age, and 57% will be from Non-White racial and ethnic groups.⁸⁰ The impact of sequestration on health centers is expected to vary by state. In particular, states with less generous Medicaid coverage

(and those opting out of the expansion) are generally more dependent on federal health center grants and are thus more likely to feel the impact from sequestration.⁸¹

Figure 3.



Note: HCTF refers to Health Center Trust Fund. Fiscal year funding in nominal dollars. Does not include the \$1.5 billion of the HCTF committed for capital development projects.

Source: Kaiser Family Foundation. *Community Health Centers: The Challenge of Growing to Meet the Need for Primary Care in Medically Underserved Communities*, March 2012. See: http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_3Bo43800-5056-9D20-3D5DCAA18AC4BD43.pdf.

Federal Health Center Grant Awards Summary. According to HRSA, in FY 2011, nearly \$1.7 billion was awarded through grants from the ACA for the following health center programs:⁸²

- \$900 million was awarded to support ongoing operations at health centers, including support for 127 New Access Point grants and 1,122 Increased Demand for Services grants;
- \$727 million available for Capital Development was awarded to 143 community health centers to serve an additional 745,000 new patients;⁸³
- \$10 million was also awarded to 129 organizations in Health Center Planning Grants to establish future community health centers;⁸⁴ and
- \$40 million was awarded to support quality improvement activities in more than 900 health centers across the country.⁸⁵

In addition, nearly \$29 million was awarded to 67 health center programs to support an additional cycle of New Access Points to serve 286,000 new patients.⁸⁶ While these funds provided an important opportunity to expand health care access, HRSA received 800 applications, and although 350 new sites were expected to be funded only 67 were actually awarded due to federal funding cuts.⁸⁷

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

On January 16, 2013, HRSA issued a Funding Opportunity Announcement to establish 25 New Access Points.⁸⁸ Approximately \$19 million was made available, with an average award of \$650,000. Funding for these New Access Points is expected to be awarded on August 1, 2013. Implications of the sequestration are unclear for this funding opportunity.

State Health Center Funding. While states have historically provided supplementary support to health centers for a variety of services and operating expenses, over the past five years, such support has declined across many states. In fact, a recent study shows that across 29 states there has been a 14% decline in direct state funding for health centers between State Fiscal Year (SFY) 2012 and 2013.⁸⁹

Emerging Programs and Models

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

- **St. Elizabeth Hospital** is using funding from the ACA to undertake a thorough needs assessment of Southeast Louisiana counties to determine the feasibility of a health center and to ensure that the health services provided are tailored to the specific cultural needs of the targeted population. The hospital system is also working to create sustainable and two-way relationships with community health providers and other community groups to reach its overall goal of enhancing the region's health status and quality of life.
- **Miami Dade College Medical Center Campus** is aiming to improve health care services in the County by establishing *MiHealth Community Clinic*, an interdisciplinary health clinic, to support the community with a range of preventive, educational, advocacy and treatment services, including vision and dental care. The majority of Miami-Dade County's residents are foreign-born, 61% are Hispanic or Latino, and approximately 20% are enrolled in Medicaid. The grantee has a history of recruiting a diverse and representative body of faculty and students that reflects the region's racial and ethnic make-up – in fact, 60% of the student body is Hispanic and 20% is African American – representing an important step to providing culturally competent care. The clinic is also reaching out to

community partners and other health centers to ensure success in patient communication and outreach.

- ***State University of New York Downstate Medical Center*** is using funding from the ACA to develop a Federally Qualified Health Center (FQHC) in Central Brooklyn targeted to a racially and ethnically diverse population (predominately Black and Hispanic) that experiences vast health disparities as the area's residents are disproportionately affected by diabetes, heart disease, stroke, cancers, HIV/AIDS, and behavioral disorders. Health care measures for the area are equally dismal as access to primary care is poor and emergency rooms are over-utilized. The grantee is seeking to bridge the gap in poor health care access by establishing a patient-centered primary care practice that will expand a health care workforce trained and committed to providing services in a community health setting. Funding will allow the grantee to undertake essential planning efforts from community health needs assessment to obtaining feedback and buy-in from local community representatives, churches, and civic groups.
- ***The Florida State University, Havana Health and Wellness Center*** is expanding a school-based health center into a FQHC using funding from the ACA that aims to provide services to the entire community of Havana. Funding will support development goals such as a community needs assessment and service delivery plan as well as support community involvement and local partnerships. In this community, over 800 students are unable to access primary care services, over 90% of children are low-income, and over 96% are African American. The County, which qualified as a persistent poverty county, ranks among the lowest in the state in measures of health. It ranked 62nd out of 67 in health outcomes and 64th out of 67 in overall health status.
- ***Mandan, Hidatsa, and Arikara (MHA) Nation Health Planning Venture*** is utilizing funding from the ACA to target services to Fort Berthold Reservation, which spans six North Dakota counties. Areas within this region experience significant disparities in health as its American Indian population has a significantly lower life expectancy than their White counterparts and rates of suicide, death from automobile collisions, diabetes, and addiction are substantially above the national average. New funding allows the grantee to plan for a health center and four field clinics by conducting data analysis, consulting area health care providers, collaborating with tribal leaders, and learning from successful models such as the Benewah Health Center in Idaho.

Challenges and Next Steps

The ACA had envisioned a significantly expanded role and capacity of health centers in meeting primary care needs of primarily underserved communities. While early projections showed that health centers would double the number of patients they serve between 2010 and 2019, reaching 40 million, the reality is certainly altered given declining funding.⁹⁰ Reductions in discretionary health center funding that were first initiated in FY 2011 and carried forward, coupled with sequestration and state funding cuts are amounting to a “perfect storm” that could severely impair the ability of health centers to serve and meet growing demand. These cuts are likely to have the greatest impact on low-income and diverse patients who are more likely to access care in these settings, both pre- and post-ACA insurance expansions.

Despite these cuts, however, the reality is that health centers will see a large influx of patients, including those newly covered by Medicaid and those obtaining private coverage through the exchanges. Early projections suggested that by 2019, an estimated 44% of all health center patients would be covered by Medicaid (up from 39% in 2010), and those with private insurance, including those covered through the exchanges, are projected to reach 23% (up from 16% in 2010).⁹¹ While these higher rates of coverage will increase the flow of third party payments to health centers, these institutions will also face increased competition from primary care providers in private settings also interested in serving newly insured patients. Competitive pressures for Medicaid patients will rise as the ACA requires states to pay primary care providers 100% of Medicare payment rates for Medicaid patients served in 2013 and 2014.⁹² These higher reimbursement rates are likely to entice private physicians to also tap into the Medicaid population that health centers have historically served.

Beyond insured populations, however, health centers will continue to play a primary role in serving the estimated 30 million individuals who will remain uninsured for various reasons. Recent projections from the Congressional Budget Office show that while the non-elderly uninsured rate in 2019 will be approximately 8%, uninsured patients are expected to comprise 22% of health center patients that year.⁹³ In Massachusetts, following the state's broad health insurance reform, the demand for care at health centers rose and "the uninsured rate among health center patients remained more than nine times the statewide uninsured rate among nonelderly persons—about 19% versus 2%."⁹⁴

In states that have decided not to expand Medicaid, community health centers are likely to play an even greater role in serving the uninsured, particularly those with incomes below 100% FPL, who will not qualify for any subsidies or provisions under the exchanges. Health centers in these communities, in many cases, are taking on education, outreach and advocacy roles to (a) educate state policymakers to adopt the Medicaid expansion to prevent the poorest of poor from falling through the coverage gaps; and (b) to actively seek, educate and enroll low-income, diverse populations who may be eligible, but not enrolled in Medicaid under current eligibility requirements. One key informant summarized this important and almost primary role that health centers are playing in preparation for 2014: "Our first order of business is outreach and enrollment." This responsibility is being backed by federal support as HRSA recently released a funding opportunity announcement to fund health centers to assist in enrollment and outreach for Medicaid, CHIP, and the exchanges.

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

- ***Creating a new competitive edge, while maintaining the health center mission to serve low-income, diverse, and vulnerable populations.*** As one key informant eloquently stated, "some providers [health centers] are in competitive mode versus a collaborative mode" as they gear up to serve newly insured patients. Another informant related by saying "the biggest challenge is how do health centers navigate this new system while keeping their souls intact."
- ***Financial viability and sustainability*** continue to be major concerns for health centers, notwithstanding the increased funding and support appropriated through the ACA. A

combination of funding impediments discussed previously in this section, including cuts to federal discretionary spending, state funding reductions, and sequestration have contributed to these concerns. In addition, the large investment in health centers is slated to end in FY 2015 and the Medicaid-Medicare payment parity for primary care physicians will expire in the end of FY 2014. This raises concerns about “sustainability of expanded capacity and continuity of services for those receiving care at health centers in later years.”⁹⁵ Recognizing this situation, HRSA plans to reserve funds in FY 2013 through FY 2015 to sustain the expanded capacity that has resulted from ACA’s funding in recent years.⁹⁶ Whether this strategy will be sufficient to support the expanded capacity over the years remains unclear. In fact, there are deep concerns among health center advocates regarding the fate of the Community Health Center Trust Fund, which much like the legislative battles of the Prevention and Public Health Fund, could face major cuts.

- Ensuring continuity of care, especially given patient churning and difficulty with referrals.***
 There is widespread concern—expressed generally in the literature and as shared by key informants—regarding continuity of care for low-income patients, in terms of both ensuring continuous access to primary care and linking to specialty care. First, there are concerns that low-income patients may particularly churn or shift across Medicaid, the exchanges, and being uninsured as their employment or income fluctuates, which could impact coverage and ultimately the ability to readily access and obtain both primary and specialty care. Health centers also expressed both administrative and financial challenges in serving patients with constantly changing health insurance status and payers. Secondly, connecting patients with specialty and sub-specialty care was a commonly expressed concern, and reinforced by considerable research in the field. For example, a recent Commonwealth Fund study found that 91% of health centers reported difficulty obtaining off-site subspecialty care for their uninsured patients, and access was only slightly easier for patients enrolled in public programs.⁹⁷

What is meant by “Churning”?
 A phenomenon that among low-income patients, even a small change in employment or income could lead to changes in coverage between CHIP, Medicaid, and state exchanges, potentially resulting in gaps in coverage or triggering changes in health plans and provider networks for a patient.

Nurse-Managed Health Clinics

Legislative Context

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

Implementation Status and Progress

While \$50 million were authorized to support NMHCs in FY 2010, and such sums as necessary for subsequent years through FY 2014, the program only received \$14.8 million in grant funding through the national Prevention and Public Health Fund in 2010, with no additional funding to date. A total of 10 NMHCs were funded with the purpose of increasing primary care access and developing the health care workforce (Table 3). Clinics that have received funding are expected to train more than 900 advanced practice nurses and to provide primary care to over 94,000 new patients by 2012.⁹⁸

Table 3. Nurse-Managed Health Clinic Grantees, FY 2010

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

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

Emerging Programs and Models

NMHCs are directed primarily by nurse-practitioners, with support from an interdisciplinary team of health professionals, including registered nurses, health educators, community outreach workers, and collaborating physicians. Their goal is to provide accessible, comprehensive primary care and community health programs aimed at health promotion and disease prevention in urban, suburban, and rural settings. The Institute of Medicine has recognized these health centers as an “evidence-based model that provides care to 2.5 million patients across the country.”⁹⁹ Like other safety-net providers, such as FQHCs, NMHCs see a disproportionately high percentage of uninsured patients (ranging from 30% to 60%)¹⁰⁰ and typically serve a racially and ethnically diverse patient population.¹⁰¹ Services are provided in easily accessible community settings such as schools, homeless shelters, senior centers, churches and public housing developments.

A foundational study conducted on Pennsylvania's nurse-managed programs in 2004, as mandated under Public Law 107-116 and funded by the Centers for Medicaid and Medicare Services (CMS), found the significant contribution these centers make in serving poor and diverse patients. The study found that centers located in urban settings predominantly served African Americans (more than 85% of patients at that time), whereas those in suburban settings served a more diverse patient mix.¹⁰² This diversity in suburban NMHCs is evidenced by the demographic

data—i.e., 38% African Americans, 35% Hispanics, 21% Whites, and 5% Asians.

Moreover, a recent study by Barkauskas (2011) found that, overall, quality measures for NMHCs compared favorably with national benchmarks, with particularly high quality demonstrated in chronic disease care management.¹⁰³ The Institute of Medicine's 2010 report on the *Future of Nursing* also supports this finding:

Nurse-managed health clinics offer opportunities to expand access; provide quality, evidence-based care; and improve outcomes for individuals may not otherwise receive needed care. These clinics also provide the necessary support to engage individuals in wellness and prevention activities.¹⁰⁴

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

- ***The University of Mississippi Medical Center's School of Nursing*** intends to expand health care services at its first Nurse Managed Center-UNACARE—in Jackson, Mississippi “to increase access to primary care for adults and children who are socially neglected, economically deprived and where health disparity is ubiquitous...the Midtown Community is a medically underserved area of an African American (94.2%) population with a poverty rate of 47 percent, twice that of the city of Jackson...[and] an uninsured rate of 50 percent.” Leading health concerns include highest rates of AIDS, hepatitis A and enteric disease. With funding through the ACA, the center intends to add staff and hours to improve access to primary care; develop and expand clinical practice sites to provide “culturally structured learning experiences for nurse practitioner students”; and enhance the implementation and integration of electronic health records.
- ***University of Colorado in Denver*** is utilizing its federal funding to expand Sheridan Health Services to a second site to provide expanded access to primary care services, along with expanding case management, adding clinical training sites, enhancing electronic data and health records, and applying for FQHC look-alike status to more effectively serve a large low-income and minority population.
- ***The University of Texas Medical Branch in Galveston*** is using new federal funds through the ACA to support St. Vincent's Nurse-Managed Health Center, a clinic operated by the School of Nursing in partnership with St. Vincent's House, a faith-based community center. New federal support will significantly expand the Center's primary care practice for vulnerable residents in the community and will help the Center explicitly address health disparities through the application of Intensive Primary Care (IPC). The IPC model is supported by evidence which suggests that three kinds of interventions can help to reduce disparities: (1) multi-level interventions (i.e., patient, family, provider and community); (2) culturally tailored quality improvement; and (3) nurse-led interventions.
- ***The University of California School of Nursing in San Francisco*** intends to expand and enhance comprehensive primary health care and wellness services provided to a

medically underserved, predominantly homeless client population through an arrangement with Glide Health Services. Through funding from the ACA, the Center will improve access to quality, comprehensive, culturally competent primary care and wellness services, along with expanding student clinical nursing experiences that emphasize cultural competence among other priorities. In addition, these funds are being used to enhance the electronic health record system.

Challenges and Next Steps

Despite the proven success of NMHCs in serving culturally and linguistically diverse populations, a major hurdle to implementing the ACA's vision to expand their role in the health care system is funding. As a key informant stated:

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

Given efforts to reduce federal spending, funding for this program was not renewed in FY 2011 and FY 2012. There is still considerable uncertainty around whether this program will receive any new funding through the ACA. In addition, as the large majority of these centers are affiliated with schools of nursing, they often do not meet eligibility requirements to become Federally Qualified Health Centers, and thus do not benefit from many federal funding opportunities. Another salient challenge facing NMHCs is that many managed care organizations are unwilling to credential nurse practitioners as primary care providers, thus making it difficult for these centers to obtain reimbursement from private insurers.¹⁰⁵

Advocates for NMHCs continue to issue notices to educate and advocate for continued funding for this program. Recently, for example, the American Association of Colleges of Nursing issued a Policy Brief highlighting the promise of NMHCs in serving underserved populations and providing quality, evidence-based care. They also advocated for \$20 million in funding for FY 2013.

Teaching Health Centers

Legislative Context

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

In addition, Section 5508(c) authorizes the creation of a Teaching Health Center Graduate Medical Education (THCGME) Payment Program to provide payments directly to Teaching Health Centers (THC) operating a primary care residency program. A total of \$230 million was authorized for the period of FY 2011 to FY 2015. Eligible health centers are those that expand

existing or establish new accredited residency programs in primary care fields, which the act defines as family medicine, pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and general and pediatric dentistry.”¹⁰⁶

Implementation Status and Progress

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

Table 4 summarizes the total appropriations that were authorized under the Act and funds that have actually been disbursed for this program.

Table 4. Authorized Funding in the ACA and Actual Funding for Health Centers, FY 2010-2013

	FY 2010		FY 2011		FY 2012		FY 2013	
	Authorized	Actual	Authorized	Actual	Authorized	Actual	Authorized	Actual
THC Develop.	\$25 m	\$0	\$50 m	\$0	\$50 m	\$0	SSAN	\$0
THCGME Program	n/a	n/a	\$230 m*	\$2.3 m	n/a	\$12.2 m	n/a	\$15.6m

*Total appropriations authorized for 5-year period.

Source: <http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf>

Emerging Programs and Models

As of FY 2013, 17 THCs have received THCGME funding. Of these, 11 have been funded for a three-year period, training a total of 300 primary care medical residents (Table 5). These centers offered mainly family medicine residency training, while a few also included general dentistry and internal medicine slots. A majority of these centers are either located in rural, underserved settings or large metro areas such as New York City and Chicago, with significant poverty and formidable challenges to accessing affordable health care. Of the 11 inaugural THCs that were funded in 2011, nine explicitly offered cultural competency curricula as part of their residency training.¹⁰⁷

In addition, while virtually all programs explicitly state that they target underserved or medically underserved patients, there are some that stand out in addressing racial and ethnic health disparities in their training and other efforts as described in program abstracts submitted to HRSA. For example, the University of Arkansas intends to use its funding not only to increase the number of primary care residents, but also to incorporate education and training on compassionate and culturally competent care for specific populations—such as African Americans, Hispanics, and those with limited English proficiency, among others. Programs in Oklahoma and Washington state are explicitly targeting their THC programs to effectively serve large Native American communities. In particular, these programs intend to increase the number of outpatient physicians practicing in community sites serving Native Americans, while also offering training in ensuring cultural sensitivity and competence. Other programs are focusing their funding on tailoring their clinical and didactic training to incorporate lessons and

experiences working with diverse populations across various medical disciplines and settings. For example, Yakima Valley Farm Workers Clinic intends to integrate cultural competency in its dental residency program targeting low-income rural communities and migrant seasonal farm workers.

Table 5. 17 Teaching Health Center Graduate Medical Education Program Grantees, FY 2011-2013

Grantee	State	County	2011 Funding (\$)	2012 Funding (\$)	2013 Funding (\$)	Total (\$)
University of Arkansas System	AR	Pulaski	--	75,000	225,000	300,000
Valley Consortium for Med. Edu.	CA	Stanislaus	625,125	2,541,375	1,912,500	5,079,000
Family Med. Residency of Idaho	ID	Ada	150,000	637,500	562,500	1,350,000
Northwestern University	IL	Cook	600,000	2,700,000	2,700,000	6,000,000
Penobscot Community Health Ctr.	ME	Penobscot	150,000	600,000	675,000	1,425,000
Greater Lawrence Family Health	MA	Essex	150,000	675,000	675,000	1,500,000
Ozark Center	MO	Jasper	--	75,000	225,000	300,000
Montana Family Med. Residency	MT	Yellowstone	37,500	187,500	225,000	450,000
Long Island FQHC, Inc	NY	Nassau	--	262,500	787,500	1,050,000
The Institute for Family Health	NY	New York	150,000	1,050,000	1,650,000	2,850,000
Osteopathic Med. Edu. Consortium of Oklahoma	OK	Tulsa	--	600,000	2,025,000	2,625,000
Wright Ctr. for Graduate Med. Ctr.	PA	Lackawanna	202,800	1,275,000	1,800,000	3,277,800
Lone Star Community Health Ctr.	TX	Montgomery	37,500	262,500	450,000	750,000
Puyallap Tribe of Indians	WA	Pierce	--	75,000	225,000	300,000
Community Health of Central Washington	WA	Yakima	--	525,000	900,000	1,425,000
Community Health Systems, Inc	WV	Raleigh	150,000	621,139	562,500	1,333,639
Total			2,252,925	12,162,514	15,600,000	30,015,439

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

Challenges and Next Steps

The THCGME program is a unique arrangement that aligns the graduate medical education mission of preparing competent and skilled professionals with that of health centers which intend to provide comprehensive and quality care in accessible settings.¹⁰⁸ Studies show that the benefit of using health centers for residency training is the retention of graduates in health center programs who are trained in inner-city, rural, and other underserved settings.^{109,110} These professionals are also trained in skills necessary to ensure the provision of ambulatory care to culturally diverse and socioeconomically disadvantaged populations, often not provided in other residency programs particularly those that are academic and research-based.

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

Whereas the THCGME program now provides support for successful applicants, the ACA guarantees funding for only five years; in contrast, annual Medicare GME support is guaranteed as part of a federal entitlement program...Because the average length of a primary care residency is three years, at the end of the five-year period, THCs may have residents in the middle of their training without guaranteed GME payments to support them.¹¹¹

Finally, while the ACA authorized a THC development program to complement the THCGME Payment Program, it has not received funding to date. Despite this grim reality, however, THCs are growing and emerging with support outside the federal government and to date, there are an estimated 36 non-HRSA and HRSA-funded THCs.¹¹²

School Based Health Centers

Legislative Context

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

Implementation Status and Progress

In July 2011, \$95 million was awarded to 278 school-based health centers, enabling them to serve an additional 440,000 patients beyond the approximately 790,000 they already serve. In August 2011, an additional \$14 million was awarded to 45 school-based health centers to expand their capacity and modernize their facilities, allowing them to treat an estimated additional 53,000 children in 29 states in FY 2012. An additional \$80 million was awarded to 197 SBHCs in FY 2013 to fund construction and renovation. Table 6 summarizes the total funding authorized through the ACA, and what was actually funded.

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

	FY 2010		FY 2011		FY 2012		FY 2013	
	Authorized	Actual	Authorized	Actual	Authorized	Actual	Authorized	Actual
School-Based Health Center	\$50 m	\$0	\$50 m	\$95 m	\$50 m	\$14	\$50 m	\$80 m

Source: Health Resources and Services Administration. *The Affordable Care Act and Health Centers*. Available at: <http://www.hrsa.gov/about/organization/bureaus/bphc/bphc.pdf>.

Emerging Programs and Models

As of FY 2012, 328 institutions have been funded for SBHCs. Among states with the greatest number of grantees are California (39), New York (38), Oregon (18), Illinois (18), Michigan (15), Louisiana (15), West Virginia (12), Massachusetts (12), and North Carolina (11). While virtually all grantees describe the provision of services to medically underserved populations, there are some that explicitly target racially and ethnically diverse communities particularly to expand their access to preventive medical and dental services, behavioral health services, and counseling and social support services. For example, the Family Health Care Centers of Greater Los Angeles serves an urban area where the targeted high school's study body is predominantly Latino (98%). Funds received through the ACA will allow this Center to build a SBHC to provide local students and their families with primary and preventive care, health education (including family planning and teen pregnancy prevention), well-baby checks and mental health services. As data show, many families who will be served by this center suffer higher rates of obesity, diabetes, asthma, anxiety and depression while teen birth rates and sexually transmitted disease rates among the high school's students are higher than the average for Los Angeles County in general.

Access Health Louisiana, a FQHC network that serves four Louisiana counties, will use its funds to construct SBHCs at four schools serving over two-thirds Black and Hispanic students. The Children's Home Society of Florida intends to use its funding to target an extremely low-income and linguistically diverse community—where, over 80% of the student body qualifies for a free or reduced lunch, 46% live below poverty, and 20% have limited English proficiency as the school has a large Haitian Creole population. And TCA Health in Southern Chicago is using ACA funds to support a Mobile Student Health Clinic targeting an otherwise hard-to-reach community with 98% low-income African Americans troubled disproportionately by childhood obesity, asthma, diabetes, HIV/AIDS and other sexually transmitted infections.

Beyond such direct support for the expansion of these centers in diverse communities, SBHCs are also being considered in another important role in context of the ACA—that is, education, outreach, and enrollment of hard-to-reach families, particularly with Medicaid expansion and the new exchanges in 2014. This seems to be a natural extension of the role and purpose of existence of SBHCs for two primary reasons: (1) SBHCs serve a very diverse student population—e.g., 35.9% Hispanic or Latino, 26.3% African American, and 5.2% Asian or Pacific Islander; and (2) nearly 60% of SBHCs already assist patients to complete Medicaid or CHIP enrollment forms.¹¹³ The federal government also seems to recognize this important role that SBHCs can play. In fact, in recent grant awards that HHS announced on July 2, 2013 as part of its “Connecting Kids to Coverage and Enrollment Grants,” \$1.4 million was given to school-based health centers to facilitate in the enrollment process for Medicaid and CHIP.¹¹⁴ As Neighborhood Health of Washington State, a SBHC which received such funding, recently stated: “[We] will use these funds to ensure that Washington's low-income families with limited English proficiency have the assistance and resources they need to enroll their children in Medicaid and CHIP. We will build on our previous success by hiring bilingual and bicultural eligibility specialists to help the families we serve.”¹¹⁵

Challenges and Next Steps

The ACA's support for SBHCs has led to renewed opportunities for expanding access to care, enrolling families in 2014, and improving overall health in poor, diverse, and hard-to-reach communities. However, this expansion and support does not come without its challenges. In

particular, SBHCs are generally concerned about their long-term sustainability given the ACA only provided initial support for their expansion. As the California School Health Centers Association shared on a news report recently, “[School-based health centers] which used to be concentrated in urban areas, are now opening throughout the state, including the Central Valley and Central coast...But while the ACA provided an initial investment, it did not set aside additional money to continue supporting the centers.”¹⁶ States such as Connecticut and Massachusetts provide state grants to fund SBHCs, but this is not the case for many states such as California or others facing steep budget cuts. In addition to funding, there are concerns of integrating SBHCs into the health care delivery system as managed care organizations generally do not recognize them as eligible providers and thus do not reimburse for care provided. These salient issues must be addressed for the long term sustainability and efficacy of SBHCs.

C. New Requirements for Safety-Net Hospitals

Background

Safety-net hospitals or health systems serve large low-income, uninsured, and vulnerable patient populations. Whereas some are publicly owned, others are private, non-profit. Common among safety-net hospitals and health systems is their commitment to providing “access to care for people with limited or no access to health care due to their financial circumstances, insurance status, or health condition.”¹⁷ The Institute of Medicine’s seminal report—*America’s Health Care Safety Net: Intact but Endangered*—identifies two distinguishing characteristics of safety-net providers: (1) They maintain an “open door” policy, in other words, they offer patients access to care regardless of their ability to pay; and (2) Uninsured, Medicaid, and other vulnerable patients comprise a “substantial share” of their patient mix.¹⁸ The ACA introduces many new opportunities, obligations, as well as challenges for safety-net hospitals in achieving their objective of serving low-income patients, many of whom are racially and ethnically diverse. In this section we discuss three key provisions in the ACA with major implications for the safety net:

- Decline in Medicaid Disproportionate Share Hospital (DSH) payments;
- Decline in Medicare DSH payments; and
- Community Health Needs Assessment (CHNA) requirements.

We note that innovations, demonstrations, workforce initiatives, and related activities authorized by the ACA for safety-net health systems are discussed in other reports released (or soon to be released) as part of the *ACA & Racial and Ethnic Health Equity Series*.

Medicaid Disproportionate Share Hospital Payments

Legislative Context

Section 2551 of the ACA reduces Medicaid DSH spending by \$18 billion between 2014 and 2020. While DSH reductions begin in 2014, the steepest cuts are pushed to later years. Medicaid DSH payments will be reduced by \$500 million in 2014, \$600 million in 2015, \$600 million in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The Middle Class Tax Relief and Job Creation Act of 2012 and the American Taxpayer Relief Act of 2012 extended the DSH payment cuts to FY 2021 and FY 2022.

Implementation Status and Progress

A proposed rule on the implementation of DSH payment reductions for FY 2014 and FY 2015 was issued by CMS on May 13, 2013. Once finalized, the rule is expected to go into effect on October 1, 2013, unless Congress enacts the President's FY2014 Budget proposal to delay the onset of Medicaid DSH payment reductions to FY 2015. The proposed rule maintains the ACA's original reductions (i.e., \$500 million for FY 2014 and \$600 million for FY 2015), and outlines five factors that must be considered in developing a state allocation methodology. These are intended to ensure that greater funding is allotted to states that are currently considered "low-DSH states," have higher rates of uninsured, and target their DSH payments to hospitals with high Medicaid utilization or high uncompensated care costs. In addition, a state's decision to expand Medicaid in FY 2014 or FY 2015 will not impact DSH payment reductions as CMS will apply a two to three year lag in the data to determine allocations. However, Medicaid expansion could impact DSH reduction allocations across states starting in FY 2016. States will decide how they choose to allocate these reductions across hospitals.

Emerging Programs and Models

Although subject to federal guidelines, which are yet to be finalized, states have considerable discretion in deciding how to allocate Medicaid DSH funds. National research and analytical organizations as well as experts have generated recommendations and guidance to inform the process for determining reductions in the Medicaid DSH payment programs. In all they reinforce that any methodology designed to reallocate funds will need to start with a full understanding of current Medicaid DSH distributions for each state.¹¹⁹ Such an assessment will require each state to address at least the following questions generally about their payments and, in particular, for providers who historically have received DSH funds:¹²⁰

- How do states define the goals and objectives of their Medicaid DSH programs?
- What have been the historical uses of funding by states?
- How do Medicaid DSH funds flow to hospitals and providers within states?
- How do hospitals and health providers use these funds?
- What populations and communities benefit from Medicaid DSH?
- What are the volume and types of services financed through these payments?
- How does Medicaid DSH funding complement or interact with Medicare DSH program?¹²¹

Our review has also identified recommended strategic actions in determining DSH payment cuts for safety-net hospitals that should follow such an assessment. We note that some of these recommendations have been folded into the proposed methodology put forth by CMS:

- ***Target Medicaid DSH payments to cover uncompensated care costs of serving uninsured patients:***¹²² Recent estimates suggest that nearly 30 million individuals (mainly adults) will remain uninsured in 2022, and in states not choosing to expand Medicaid, the uninsured will comprise a much higher percentage of the population than in states opting to expand. As such, it will be critical for states—particularly without Medicaid expansion—to target remaining Medicaid DSH dollars to sustain hospitals with a disproportionate burden of uninsured patients.

- **Consider linking DSH payments to specific services provided disproportionately to uninsured patients:**¹²³ This strategy can be adopted to ensure that hospitals that serve the greatest numbers of uninsured for particular services receive the greatest proportion of the state's DSH funds.
- **Consider a strategy for reimbursing hospitals for care provided to underinsured patients:**¹²⁴ To the extent possible, states will also need to establish a plan for allocating limited Medicaid DSH dollars for underinsured patients. Should the costs for these patients be considered in allocating DSH dollars, and if so, to what extent? Underinsured patients are those for whom cost-sharing levels are unaffordable or the benefit package does not pay for critical services. While it is expected that the underinsured population will decline starting in 2014 (from 29 million in 2010), this may not be the case in states not choosing to expand Medicaid where people with incomes below 100% FPL will not benefit from the "essential health benefits" package.
- **Consider investing previously committed DSH dollars to increase Medicaid payments for safety-net hospitals:**¹²⁵ Finally, while Medicaid DSH payment cuts will reduce federal matching funds for DSH, state dollars previously committed to DSH will remain untouched. States may consider investing these dollars to increase Medicaid payments for safety-net hospitals, possibly triggering higher matching rates available for newly eligible Medicaid patients.

Challenges and Next Steps

Reductions in the Medicaid DSH program were written into the ACA with the assumption that all states would expand Medicaid coverage for individuals with incomes below 138% FPL, thus reducing the uninsured rate and the need to pay hospitals to cover uncompensated care costs. However, with the Supreme Court decision making Medicaid expansion optional, there are salient concerns that safety-net systems in states not expanding Medicaid will be hit financially on two fronts. First, they will lose out on income produced from Medicaid patients. Secondly, regardless of their decision, they will still feel the brunt of DSH payment cuts as the uninsured rate is also impacted by activity in health insurance exchanges and changes to employer-sponsored coverage. For example, in non-expansion states with high uninsured rates (e.g., Georgia, Louisiana, Mississippi, South Carolina, and Texas) there is a possibility that the percentage uninsured could be impacted considerably by coverage through the exchanges (especially as these states have more to gain than states with already low uninsured rates and generous Medicaid eligibility).¹²⁶ However, in such a case, very low-income individuals (below 100% FPL) not covered by Medicaid, the exchanges, or employers, may remain uninsured and continue to seek care at safety-net hospitals. Such a scenario could result in a substantial erosion of DSH funds in safety-net hospitals that may see "little or no change in the amount of uncompensated care they provide."¹²⁷ These are likely to be the very hospitals that serve large low-income, racially and ethnically diverse communities.

Recently issued proposed federal regulations could allay some of these fears around DSH payment cuts. First, as discussed, the proposed rule that came out in May 2013 stated that a state's decision to expand Medicaid in FY 2014 or FY 2015 will not impact DSH payment allocations, though it would in FY 2016. And secondly, the President's latest budget proposal could delay the start of these cuts to FY 2015. Either or both scenarios, however, do not eliminate—but merely delay—the

concern that safety-net institutions have about continuing to face substantial uncompensated-care burdens.¹²⁸ Following is an account of what happened in Massachusetts when similar reforms were implemented:

In Massachusetts, after similar insurance reforms, 98 percent of the population was insured, however the two largest safety-net hospitals (Boston Medical Center and Cambridge Health Alliance) had hundreds of millions of dollars in operating losses because lower Medicaid and private payment rates were insufficient to offset the loss of institutional subsidies after the enactment of reforms. Those funds were diverted to provide individual insurance subsidies and later to offset state budget shortfalls during the recession.¹²⁹

In states not expanding Medicaid, safety-net hospitals will need to strengthen their voice and advocacy to encourage states to make this expansion, otherwise, they may feel the brunt. A brief advocacy piece from the National Association of Public Hospitals and Health Systems (NAPH), released in October 2012, highlights the importance and benefits of Medicaid expansion.¹³⁰

Medicare Disproportionate Share Hospital Payments

Legislative Context

Section 3133 of the ACA reduces Medicare DSH payments by an estimated \$22.1 billion over ten years. Starting no later than FY 2014, and each subsequent fiscal year, Medicare DSH payments would be reduced by 75%. The Medicare DSH program was established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 to make add-on adjustments to existing Medicare diagnosis related group (DRG) payments to support hospitals serving a significantly disproportionate number of low-income patients. The rationale, as stated by the Medicare Payment Advisory Commission (MedPAC), was that “poor patients are more costly to treat, so that hospitals with substantial low-income patient loads would likely experience higher costs for their Medicare patients than otherwise similar institutions.”¹³¹ Hospitals eligible for the Medicare DSH add-on adjustment must meet a low-income share threshold or be a “pickle” hospital, defined as “an urban hospital with at least 100 beds that receives more than 30% of net inpatient care revenue from state or local government entities for inpatient care of low-income patients not reimbursed by Medicare or Medicaid.”¹³²

Implementation Status and Progress

CMS issued a proposed rule on May 10, 2013, which outlines how Medicare DSH payment changes will be implemented. In particular, CMS proposes to use the total of each hospital’s Medicaid and low-income Medicare inpatient days to calculate each hospital’s share of Medicare DSH payment allocations related to uncompensated care. Concerns are arising that the use of inpatient days may not reflect a complete portrait of a hospital’s low-income patient population and burden. CMS requested comments to its proposed rules by June 25, 2013, and potential updates to the rule are expected soon.

Emerging Programs and Models

Roughly 3,750 or 75% of the nation's hospitals receive some Medicare DSH payments, but 200 hospitals receive nearly 40% of all DSH payments.¹³³ Although the number of hospitals that receive DSH payments is relatively small, a 2007 report from MedPAC revealed that Medicare DSH payments were not well-targeted. The report highlighted that “roughly three-quarters of Medicare DSH payments—roughly \$5.5 billion—were not empirically justified by higher patient care costs associated with low-income patients”¹³⁴ and that these payments in many cases did not target hospitals with higher shares of uncompensated care. In fact, hospitals receiving the largest DSH payments reported having uncompensated care costs below the average for all hospitals. MedPAC therefore concluded:

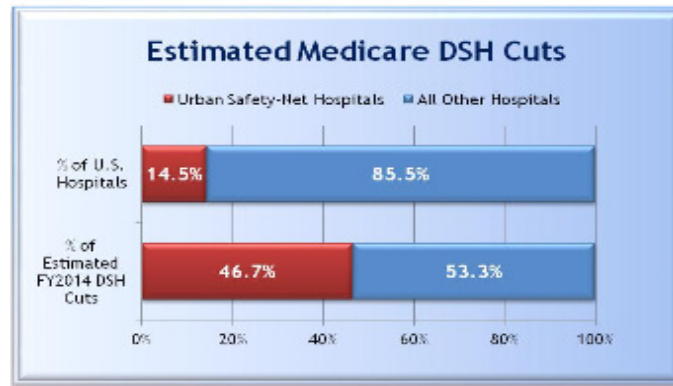
It appears that the hospitals most involved in teaching and in treating low-income Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to patients unable to pay their bills.¹³⁵

Under the new allocation methodology for Medicare DSH payments, as outlined in the ACA, a hospital will receive a share of dollars depending on its share of uncompensated care provided by acute care hospitals across the country. However, the application and impact of this methodology is uncertain given there is no universally accepted definition of uncompensated care—i.e., does it include only care provided to uninsured patients or does it also encompass bed debts from underinsured patients.¹³⁶ Leading policy experts suggest these cuts “should be better targeted to hospitals that provide larger amounts of uncompensated care.”¹³⁷

Challenges and Next Steps

As cuts to Medicare DSH payments take effect on October 1, 2013, safety-net hospitals are concerned with its damaging financial impact. There is widespread uncertainty regarding what these payment cuts will look like, especially as the HHS Secretary has yet to determine how it defines uncompensated care and what formula will be used to determine how much of the reduced Medicare DSH payments will be restored.¹³⁸ While private, nonprofit urban safety-net hospitals comprise just 15% of all acute-care hospitals covered by Medicare's inpatient prospective payment system, they will absorb roughly half of these cuts (Figure 4).¹³⁹ It is estimated that “the average private urban safety-net hospital will lose more than \$8 million in Medicare DSH revenue in FY 2014, alone,” and “over five years this will amount to a loss of more than \$53 million in Medicare DSH revenue for the average private urban safety-net hospital.”¹⁴⁰ In addition to the impact on revenues, there is widespread concern that these cuts could cost hospitals over 73,000 direct jobs in FY 2014.¹⁴¹ Private, nonprofit urban safety-net hospitals are expected to bear a disproportionate burden of these projected job losses. Many of these hospitals are located in extremely diverse settings, serving and employing a large percentage of diverse individuals.

Figure 4.



Reproduced from: National Association of Urban Hospitals. The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals. September 2012.

Community Health Needs Assessment

Legislative Context

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

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

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

Implementation Status and Progress

On May 27, 2010, the IRS released Notice 2010-39, 2010-24 I.R.B. 756, which requested comments regarding the new requirements under the ACA for tax-exempt hospitals to maintain their status, including the need, if any, for guidance regarding such requirements. In response to this notice, the IRS received numerous requests for guidance on the CHNA requirements. Therefore, in Notice 2011-52, issued on July 25, 2011, the IRS released a set of “anticipated regulatory provisions” or guidance on process and methods for conducting an assessment, reporting and dissemination requirements, as well as direction on developing an implementation plan to address needs.¹⁴²

The Notice, in particular, defines the required components of a written report on the assessment. Specifically, any written report must provide a description of the community served by the hospital facility. Community can be defined in terms of:

- Geographic location (e.g., a particular city, county, or metropolitan region);
- Target populations served (e.g., children, women, elderly, and minorities); or
- Hospital facility’s principal functions (e.g., focus on a particular specialty area or targeted disease).

In addition, the notice states that a “community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by a hospital facility by excluding, for example, medically underserved populations, low-income persons, minority groups, or those with chronic disease needs.”¹⁴³

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

On April 3, 2013, the IRS issued additional proposed regulations discussing reporting requirements for nonprofit hospitals and the consequences for failure to comply with new requirements.¹⁴⁴ In context of diversity and equity, the proposed rule included the following clarifications and guidance:

- Medically underserved populations are defined as “populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers.”¹⁴⁵
- In assessing the health needs of a community it serves, a hospital facility must identify significant health needs in the community, prioritize those health needs, and identify potential measures and resources available to address them. Health needs include

“requisites for improvement or maintenance of health status in both the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities).”¹⁴⁶

- In prioritizing the health needs of a community, the proposed rule offers examples of criteria, one of which explicitly highlights “health disparities.” However, the rule states that each hospital facility has the authority and flexibility to use any criteria it deems appropriate for prioritizing community health needs.

Emerging Programs and Models

The community benefit requirement has been in existence for over 50 years, and many states have adopted their own statutes to address this. Currently, there are 17 states with community benefit statutes, and the majority requires some form of a CHNA.¹⁴⁷ A review of programs across states revealed that the primary form of community benefit or charitable contributions by hospitals involved the “provision of free and/or discounted medical services to the uninsured and underinsured populations.”¹⁴⁸ While there are programs which have started to take a broader public health approach, these have been smaller projects spread over a wide geographic area, “most insufficient in scale, targeting, or design elements necessary to produce measurable outcomes.”¹⁴⁹

A 2012 study commissioned by the Centers for Disease Control and Prevention (CDC) and undertaken by the Public Health Institute tracked the science, methods, and current practices in meeting the community benefit requirement for nonprofit hospitals. Findings were generated from a two and a half day expert panel meeting held in 2011, along with roughly 50 key informant interviews. The report entitled, *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*, includes a range of best practices, lessons, and tools that can inform and assist hospitals as they plan to develop, conduct, report, and take action on their CHNA. Specifically, the report focuses on two areas of the assessment process: (1) Conducting the Community Health Needs Assessment; and (2) Developing and Executing an Implementation Strategy. For each of these two requirements, a set of recommended practice areas were established and key steps, recommendations, tools, and strategies were presented. Table 7 provides an overview of key recommendations and steps for addressing each practice area that emerged from this work.

Table 7. Key Elements of CHNA and Implementation Strategy

Community Health Needs Assessment	Implementation Strategy
<ul style="list-style-type: none"> • Shared ownership for community health: Establish a common agenda, shared metrics, a structured process, and jointly funded infrastructure with diverse stakeholders in the community. • Defining community – jurisdictional issues: Consider unique issues across geographic areas (e.g., urban, suburban, and rural) and concentrations of populations with unmet health needs; and establish multi-jurisdictional partnerships between nonprofit hospitals and community health centers, public health agencies, rural hospitals, and others. • Data collection and analysis: Combine secondary data from sources such as the U.S. Census Bureau at the sub-county level to identify unmet needs with hospital utilization data and GIS technology to display geographic distribution of need and capacity. Ensure that social determinants of health are a part of the assessment. • Community engagement: Engage community stakeholders as equal partners with shared accountability and investment in addressing health concerns, on an ongoing basis to foster trust and meaningful contribution. 	<ul style="list-style-type: none"> • Priority setting: Engage community stakeholders at the center of priority setting and limit a top-down or agency-based approach to identify comprehensive and sustainable approaches to health improvement which address both the symptoms and causes of health concerns. • Alignment opportunities: Align the assessment with opportunities from the ACA, along with unique expertise and contributions of teaching hospitals and academic affiliates to address key issues such as health disparities. • Monitoring and evaluation: Consider and define metrics, consider audiences, potential roles of community members, and innovative ways to track progress in addressing health disparities. • Institutional oversight: Consider importance of governance and oversight of nonprofit hospitals, along with ways to involve other settings in extra-institutional oversight. • Shared accountability and regional governance: Consider establishing regional partnerships and shared governance and accountability between hospitals, local public health agencies, and other stakeholders. • Strategic investment and funding patterns: Consider role of other public and private sector funders in facilitating more comprehensive, sustainable, and strategic approach to community health improvement. • Public reporting: Align public reporting of community benefit with broader national health reform process and move from an emphasis on “compliance with minimum standards” to “meaningful actions that transform institutions and produce measurable health improvement in communities.”

Adapted from content in: Barnett, K. *Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential*. Public Health Institute, February 2012.

A range of reports and tools have emerged following the ACA to assist and inform hospitals on effectively conducting a CHNA and implementing an action strategy. Following are examples of a few recent reports with helpful guidance and Figure 5 highlights emerging tools in the field for CHNA.

- ***Principles to Consider for the Implementation of a Community Health Needs Assessment Process.*** Developed by Sara Rosenbaum at the George Washington University School of Public Health and Health Services and released in June 2013, this latest report offers guiding principles to assist nonprofit hospitals in conducting an evidence-based CHNA and prioritization using a collaborative communitywide approach.¹⁵⁰ The principles emphasize multi-sector collaboration, proactive community engagement, addressing disparities, transparency and accountability, use of evidence-based interventions, evaluation for continuous improvement, and use of high quality, shared data.
- ***Assessing & Addressing Community Health Needs:***¹⁵¹ Issued by the Catholic Health Association in February 2012, this guidance document includes comprehensive step-by-step recommendations, examples and practices for effectively carrying out an assessment. The report includes some modest steps highlighting the need to explicitly address health disparities—such as identifying racial and ethnic data, obtaining community input which is reflective of the racial and ethnic makeup of the community, and mapping health disparities indicators.
- ***Maximizing the Community Health Impact of Community Health Needs Assessments Conducted by Tax-exempt Hospitals***¹⁵²: On March 13, 2012, a coalition of organizations representing a range of public health associations and institutes issued a set of consensus recommendations about how hospitals can most effectively work with public health agencies and experts to maximize the

Figure 5. Helpful Tools for Conducting A Community Health Needs Assessment

Community Commons CHNA Toolkit (www.chna.org) is a free web-based platform designed to assist hospitals and organizations seeking to better understand the needs and assets of their communities, and to collaborate to make measurable improvements in community health and well-being. The Toolkit includes a range of data and mapping resources, including a “Vulnerable Populations Footprint” to map disparities in communities.

Association for Community Health Improvement’s (www.communityhlth.org) “Advancing the State of the Art in Community Benefit” is a demonstration project of the Public Health Institute which brings together 70 hospitals in California, Texas, Arizona, and Nevada to develop a more strategic approach to community benefit.

ACHI Community Health Assessment Toolkit (www.assesstoolkit.org) is a guide for planning, leading and using community health needs assessments to better understand -- and ultimately improve -- the health of communities. It presents a suggested assessment framework from beginning to end in six steps, and provides practical guidance.

Hilltop Institute Hospital Community Benefit Program (www.hilltopinstitute.org/hcbp.cfm) is a central resource created specifically for state and local policymakers who seek to ensure that tax-exempt hospital community benefit activities are responsive to pressing community health needs.

impact of community benefits. Explicitly included in these recommendations is a focus on health equity—e.g., “community health needs assessment and implementation strategies should aim to increase health equity through consideration of social determinants of health.”¹⁵³

- ***A Healthcare Advocate’s Guide to Community Health Needs Assessments***,¹⁵⁴ which highlights a range of practices and examples of assessments explicitly addressing community health needs of diverse populations, the findings they have yielded and what they mean for community health improvement.

In addition to these broader CHNA tools and resources, guidance is also included in the enhanced National Standards on Culturally and Linguistically Appropriate Services (CLAS) issued by the federal Office of Minority Health at the U.S. Department of Health and Human Services in April 2013.¹⁵⁵ These standards offer a unique opportunity to align CHNA obligations with requirements to assure the needs of racially, ethnically, and linguistically diverse communities and populations are effectively considered and integrated throughout the process. Standard 12 explicitly focuses on conducting an assessment of community health assets and needs, while Standard 11 offers guidance on how to collect and maintain demographic data, and Standard 13 includes strategies for effectively partnering with diverse communities, among other standards which can potentially inform a range of activities for the CHNA to assure cultural and linguistic appropriateness.

Challenges and Next Steps

The expanded and strengthened requirement for hospitals to conduct a community health needs assessment, report findings, and develop community-based solutions represents a significant shift in the focus and scope of impact from beyond the individual to a more population-based approach. While this represents the opportunity for positive community-wide impact, there are a range of challenges that lie ahead. First, the understanding of this opportunity is not universal among hospitals across the country. Secondly, states with community benefit statutes have differing definitions of what comprises a community benefit, and thus there is likely to be a ranging scope of initiatives across the country—some more population-based, while others less so. In addition, state laws around community benefit are more broadly defined and lack the clarity of the IRS approach in terms of requirements and reporting.¹⁵⁶ Among other questions and concerns cited in the field are: how to effectively ensure ongoing engagement of community stakeholders, particularly in overcoming negative perceptions and lack of trust in certain providers involved in these assessments; and how to overcome obstacles associated with health information transparency, shared accountability, regional governance, and multi-jurisdictional issues.

IV. The Safety Net at a Crossroads

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

The ACA had intended to make health care coverage uniform and virtually universal for all childless adults. However, the Supreme Court's decision on Medicaid abrogated the fate of the health care safety net into the hands of states. As noted, the Court decided that states could not be coerced into expanding Medicaid—thus making it optional—and arguably perpetuating a state-by-state patchwork of programs and providers that, especially for states refusing to participate in this expansion, may have severe adverse consequences for low-income, racially and ethnically diverse populations. And even if most states do participate in Medicaid expansions, the safety net will likely see a large influx of low-income and diverse patients. By 2019, an estimated 37 million new patients will be served by health centers and clinics, of which 44% will be enrolled in Medicaid, 23% will be privately insured, and 22% will be uninsured.¹⁵⁷ Racially and ethnically diverse residents are likely to comprise a large majority of these patients—at least two-thirds, if not more.

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

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

Our review of these settings indicates that the ACA introduces new dynamics and opportunities—for example, many providers have applied for new support through the Centers for Medicare and Medicaid Innovation, or have begun to recast their strengths as a way to ensure that they remain attractive to traditional populations they serve, especially Medicaid patients. A number are considering, many for the first time, new alliances and formal collaborations such as between safety-net hospitals and FQHCs as a way to attract enrollees into a system of care, provide continuity of care, and perhaps pursue new funding streams or organizational arrangements such as Accountable Care Organizations. In other areas, for example, New York City practitioners in safety-net hospitals will need to meet new performance requirements intended to improve quality and lower costs.¹⁵⁸ At the same time, key informant responses indicated that the ACA-related consequences—both intended and unintended—will reinvigorate and renew some providers, while for others they will inject significant uncertainty into their future role and capacity to attract populations, innovate, and adapt.

In the narrative that follows, we discuss the opportunities, experiences, and challenges the safety net may face as it transitions and adapts to a new health care environment. This discussion builds on the progress that the safety net has made to date in implementing major provisions of the ACA—such as expanding health centers and conducting CHNAs—as well as the reforms the system anticipates will take effect in FY 2014 and beyond, such as Medicaid and DSH payment reductions. Adapting to at least the following circumstances and challenges will be at the core of ensuring safety-net providers prosper and can continue to serve poor, uninsured, and racially and ethnically diverse patients:

- Rising competitive pressures;
- Financial adjustments and threats;
- Continuity of coverage and care;
- Access to specialty care; and
- Populations remaining at the margins.

Rising Competitive Pressures

Safety-net providers—public and nonprofit hospitals and health centers alike—will face a set of new competitive pressures as the ACA’s major insurance provisions go into effect. Over the next decade, the expansion of Medicaid along with the individual mandate and subsidies available through the exchanges are expected to convert millions of formerly uninsured to insured patients. This opportunity presents a competitive threat for safety-net providers, as insured patients—especially in very competitive markets—will have more options on where to obtain care. Some safety-net hospitals and health centers “will need to transform their organization’s culture to become attractive to insured patients.”¹⁵⁹

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

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

Like safety-net hospitals, administrators at health centers are also concerned about possible increased competition with private health care providers. As coverage expansion turns many charity patients into paying patients, private physicians and hospitals may compete for these traditional health center patients. Although this concern has not played out at large in the past, and did not occur after Massachusetts enacted health reform, the ACA’s Medicaid-Medicare parity in primary care payment rates in 2013 and 2014, are likely to make these patients more attractive to both public and private providers.¹⁶⁰ In states that do expand Medicaid coverage to

138% FPL, health centers and other community clinics will benefit from the reimbursement that serving more insurance patients brings. However, they may face increased competition from private primary care providers interested in serving newly insured Medicaid patients.

What could potentially ease these competitive pressures for safety-net providers is their reputation in the community as being trusted providers of care, their experience providing enabling services and delivering quality care in culturally and linguistically appropriate ways, as well as their active and effective outreach and engagement efforts. An analysis of safety-net providers after health reform in Massachusetts found that “most patients use safety-net facilities willingly rather than as a last resort.”^{161,162} As such, these providers have considerable opportunity and strength in continuing to serve many of these populations. In addition, ensuring that safety-net providers are considered as “essential community providers” within qualified health plan networks can also help position them to compete with other providers in the market as they will be seen as preferred providers.

Financial Adjustments and Threats

Despite a bolus of support for health centers in the ACA, the safety-net system faces major federal and state financing shortfalls, both at present and in the years to come. Health centers experienced their first major federal funding setbacks in almost 30 years when originally appropriated dollars in the ACA were significantly cut in 2011, and into 2012. For safety-net hospitals, declines to a major funding lifeline—Medicaid and Medicare DSH payments—are scheduled to take effect on January 1, 2014—although they may be delayed to 2015. Adding to these safety-net financing concerns are restricted, and in many cases, declining state budgets and limited state-based support for the safety net. In this section, we describe the financial circumstances affecting health centers and safety-net hospitals, and discuss their implications for continuing to play a major role in serving racially and ethnically diverse patients.

Health Centers. As noted under Section III of this report, community health centers received considerably lower funding in 2011 than was originally anticipated with the enactment of the ACA. This cutback was severely compounded by state funding reductions for health centers experienced across the nation. As a study by the National Association for Community Health Centers revealed, as of November 2011, 35 states provided supplemental grants to support health center operations, however, health center funding in these states declined for the fourth straight year, hitting a seven-year low.¹⁶³ “From its high point of \$626 million in FY 2008, state grant funding dropped more than 40% to an estimated \$335 million for FY 2012, and in six of the 35 states, health centers faced a one-year decline in state funding of 30% or more for FY 2012.”¹⁶⁴ Recent state decisions to cut Medicaid benefits have also had an adverse effect on health center financing. For example, in 2009, California opted to eliminate dental benefits for adult Medicaid beneficiaries, which led many health centers to close their sites or to scale back their services and staff.¹⁶⁵

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

systems. Figure 5 depicts how safety-net hospitals are likely to respond to these two factors moving into 2014. This response framework draws on research and literature in the field along with what we heard in our interviews with safety-net systems. It is therefore not a conclusive depiction in any way of safety-net adaptation, but certainly offers a general sense of what is happening.

Figure 5.
Safety-Net Hospital Response to State Medicaid & Exchange Decisions
by Financial Performance of Hospital

	Strong Systems	Stable Systems	Challenged Systems
Medicaid Expansion + State Exchange	Active	Active	Reactive
No Medicaid + State/Partnership Exchange	Active	Reactive	Struggling
No Medicaid + Federal Exchange	Reactive	Struggling	Struggling

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

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

Also expressed by a key informant regarding these hospitals was that DSH payment cuts “were not a priority right now” as these reductions are “more

backend” and these institutions are likely to be able to offset them in the coming years.

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

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

- ***Struggling Response and Adaptation.*** These institutions tend to be located in states less supportive of Medicaid expansion and exchange development or, in some cases, actively resistant to participation—positions that may directly discourage state and provider innovation. At times state legislatures as well as governor's positions may literally work against state offices or health care settings who seek to take advantage of the ACA funding opportunities. At the same time, institutions struggling to adapt may also be those that are already financially challenged. The ultimate “perfect storm” for a safety-net institution would be both struggling financially, while also being located in a state highly resistant to the ACA.

In this scenario, safety-net hospitals view the consequences of DSH payment reductions as potentially deleterious, cutting into core services and having a major effect on the ability to provide care. As one respondent commented, “if [our hospital] gets left out in the cold we would have to cut our core services...there will be major implications.” These institutions are particularly fearful that whatever new revenue they will receive from expanding coverage—both Medicaid and private—will not offset the cuts they are expected to experience with DSH payment cuts.

Continuity of Coverage and Care

Populations using the exchanges or eligible for expanded Medicaid coverage are likely at some point in their lives to be using both. For example, it is expected that individuals enrolled and insured through the exchanges may become unemployed, lose their private insurance coverage, and become eligible for Medicaid. Safety-net providers are particularly concerned about the financial and administrative implications of low-income patients whose coverage eligibility will fluctuate with their income. It is possible that as income fluctuates, these patients could have Medicaid one month, be eligible for subsidies through the exchanges the next month, and could even risk losing coverage should they become unemployed or if their income falls below the federal poverty level in any subsequent months.¹⁶⁶ A recent study of adults with incomes below 200% of the federal poverty level found that 35% of adults would experience a change in insurance eligibility within six months, and 50% would see a change within a year.¹⁶⁷ And among the poorest populations, the percentage fluctuating in their eligibility is likely to be much higher.

Patient churning will be of major concern to safety-net providers in states choosing not to expand Medicaid, where low-income individuals, particularly those with incomes below the federal poverty level, will be especially vulnerable to experiencing changes in coverage—and in many cases remaining uninsured. This could potentially impact over 2 million poor, racially and ethnically diverse individuals with incomes below the federal poverty level who are residing in states not opting for Medicaid expansion as of this writing. Safety-net institutions, therefore, are likely to continue to carry the burden of those switching back and forth from being insured to uninsured, adding another layer of financial complexity and administrative burden to their ability to effectively compete with other providers.

Safety-net settings may expect to see variability in the populations covered and cared for. However, lack of engagement with exchange mechanisms and populations may lead to challenges in changing enrollment, lack of experience in service coverage, established networks and overall continuity. “One key opportunity to reduce coverage and access disruption for individuals, and ensure continuity as well, would be to have the same health insurance plans participating in the exchange and Medicaid.”¹⁶⁸ This, however, is still unfolding across states and is likely to play out on a state-by-state basis.

Access to Specialty Care

While the significant investment in community health centers enhances the nation’s primary care capacity, these institutions face considerable challenges in ensuring their patients are connected with and receive specialty care.¹⁶⁹ As health centers and clinics often rely on safety-net hospitals to provide specialty care, recent safety-net financing changes could further threaten this access for the nation’s most vulnerable patients, including those who are racially and ethnically diverse. First, the scheduled Medicaid and Medicare DSH payment cuts could make it difficult for financially-strapped hospitals to continue to offer specialty care. This could be especially deleterious for poor and diverse communities where a safety-net hospital is the sole provider of specialty services. In addition, while the law requires Medicaid to pay providers as much as Medicare pays for primary care services, payment levels for surgeons and other subspecialists have not changed. As such, many of safety-net hospitals—particularly those in better financial condition—may not be eager to see Medicaid patients for specialty care.

A Commonwealth Fund study found that 91% of health centers reported difficulty obtaining off-site subspecialty care for their uninsured patients, and access was only slightly easier for patients enrolled in public programs.¹⁷⁰ Specifically, 71% of health centers reported difficulty connecting Medicaid patients with subspecialty care. The study found that health centers were taking innovative, but piecemeal, steps to arrange subspecialty care for their patients. These ranged from personal requests from health center providers for a subspecialist (which was the most common method) to contractual partnerships with safety-net hospitals for subspecialty care, and more formal but rare arrangements such as integrated health systems. However, given little consideration for access to subspecialty care or lack of specific funding within the ACA, these challenges and arrangements are likely to persist, if not potentially intensify with the large influx of newly insured patients. Support for the Teaching Health Center, for example, was one vehicle the ACA had envisioned as adding a potential new source of specialty care. However, only 17 THCs were supported through the ACA for medical residency programs, and while the ACA had

authorized funding for the establishment of new THCs, this provision received no funding, as of this writing.

Our key informant interviews revealed that many financially sound safety-net hospitals are beginning to make a concerted effort to expand not only primary care, but specialty care, particularly in outlying areas beyond inner cities. As one safety-net hospital respondent stated:

We are setting up ambulatory centers including specialty services in outlying areas beyond the metro. Currently a lot of specialty care is concentrated in the metro area...and now we are planning to expand to suburban areas.

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

Populations Remaining at the Margins

Following the U.S. Supreme Court's ruling on the optional expansion of Medicaid, the Congressional Budget Office estimated that nearly 30 million non-elderly adults will remain uninsured in 2022, eight years following the full implementation of the ACA.¹⁷¹ Of this uninsured population, U.S. citizens with incomes below the federal poverty level may account for as many as 4 million without insurance in states that (to date) have turned down the Medicaid expansion.¹⁷² Approximately half—or 2 million—will be citizens of color. With incomes below the federal poverty level, these individuals will not qualify for federal subsidies through the exchanges, unlike lawfully present immigrants who in non-Medicaid expansion states will obtain this benefit. Known as the “immigration glitch”—unintended consequence of the Supreme Court's ruling on Medicaid—individuals with incomes below the federal poverty level residing in a state that turns down Medicaid expansion can only receive government subsidized coverage if they are legal immigrants—“U.S. citizens are out of luck.”¹⁷³ Recognizing that a potentially large number of citizens could be marginalized, Arizona modified its staunch position against Medicaid expansion to support it in mid-January 2013. Arizona's state budget documents cited the following:

If Arizona does not expand, for poor Arizonans below (the federal poverty line), only legal immigrants, but not citizens, would be eligible for subsidies...That's because the immigrants would be eligible for government-subsidized private insurance, while low-income citizens would not.¹⁷⁴

In addition to the poorest citizens who will be left without coverage, approximately 11 million undocumented immigrants will be barred from public programs and the exchanges under the current law. And this policy was further reinforced in August 2012, when the White House ruled that young immigrants who will be allowed to stay in the country as part of the government's new policy will not be eligible for Medicaid, CHIP or federal subsidies in the exchanges, and they also do not have the option of purchasing coverage at full cost.¹⁷⁵

Safety-net hospitals and health centers have served as core providers of care for undocumented immigrants. By mission and necessity, these institutions will continue to play this role in the face of rising competitive pressures and declining federal, state, and local financing. Particularly

vulnerable will be safety-net providers in states not expanding Medicaid, as these providers will continue to serve a large uninsured population—including poor citizens below the poverty line along with both lawful and undocumented immigrants—as concurrently they experience shrinking DSH funding. And in states such as Texas, which as of this writing, is not opting for Medicaid expansion and where the undocumented population is second largest, the strain will be even greater. As the President of the American Hospital Association, Rich Umbdenstock, wrote in a letter to Obama:

[In communities] where the number of undocumented immigrants is greatest, the strain has reached the breaking point...In response, many hospitals have had to curtail services, delay implementing services, or close beds.¹⁷⁶

In addition to federal support through the DSH payment program, many state and local governments have contributed significantly to the safety net, combining health care assistance for undocumented immigrants with charity or uncompensated care for low-income populations. However, there are two primary reasons why continued state and local safety-net financing may be in greater jeopardy in the coming years. First, in some communities, undocumented immigrants may be the primary population remaining uninsured. With a greater number of people insured, garnering or maintaining political support for undocumented immigrants may be untenable given the current immigrant antipathy, including a belief in some quarters that they are a taxpayer burden “undeserving” of assistance. Second, many policy makers and others may conclude that “the uninsured problem is solved” and that there is no need for further support. For example, with the expansion of health insurance through the ACA, some may inadvertently believe that safety-net providers, such as health centers and free clinics, will no longer be needed. Such a response may leave the safety net with uncertain support for uninsured people generally, and especially for millions of undocumented immigrants.¹⁷⁷

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

In an era of reform, the safety net stands at a crossroads: on the one hand, opportunities are wide as states set up their exchanges, expand Medicaid, enroll new children in CHIP, and take advantage of new support for health centers, physician reimbursement, and innovation. On the other hand, however, many of these health centers and safety-net hospitals face serious challenges as well as critical actions and decisions ahead to maintain their competitive edge, while keeping their doors open to fulfill their central mission of serving poor, uninsured, and diverse populations. Although there is no question that racially and ethnically diverse communities have much to gain from the enactment of the ACA—including expanded coverage and new access points to care—local, state, and federal policy must work to ensure that unintended consequences do not widen the disparities gap as the safety net transitions and adapts to a new health care environment.

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

- Outreach and enrollment for Medicaid and the exchanges;
- Developing integrated systems of care;
- Using the CHNA for broader community impact;
- Leveraging the ACA with philanthropic support; and
- Monitoring DSH payment reductions.

Outreach and Enrollment for Medicaid and the Exchanges

With the prime focus and thrust of the ACA being on Medicaid and the exchanges, many safety-net providers are shoring up their efforts around advocacy, outreach, and enrollment. The first order of business, as many safety-net providers indicated in interviews, is to maintain the Medicaid populations they already serve as well as the uninsured who will become newly eligible for coverage. This latter role is also being supported by the Federal Government through supplemental grants. In early July 2013, HRSA announced a total of \$150 million in grant awards to 1,159 health centers across the country “to expand current outreach and enrollment assistance activities and facilitate enrollment of eligible health center patients and service area residents into affordable health insurance coverage” through the exchange, Medicaid, or CHIP.¹⁷⁸ This is an especially important undertaking for diverse communities, given that while “many racial and ethnic minorities are enrolled in Medicaid and CHIP programs, many more are eligible for such coverage but are not enrolled, either because they are unaware of their eligibility or face other barriers, such as limited English proficiency and enrollment process complexities.”¹⁷⁹ Compounding this challenge is the fact that an estimated three in four uninsured Americans do not know about the ACA’s new affordable coverage options coming October 1, 2013.¹⁸⁰

Beyond supplemental federal support, several private sector initiatives to promote and advance education, outreach, and enrollment have emerged. Prominent among them is an effort by Enroll America, a national nonpartisan, nonprofit organization, which is partnering with health centers, hospitals, health plans, and other key stakeholders to reach potentially new enrollees through its national campaign “Get Covered America” focused on public education, awareness, and engagement in local communities. The role of safety-net providers in this campaign is central as they are seen as “trusted sources” of information and education on health insurance in many low-income and diverse communities.

Despite this thrust, however, there is some variability in safety net involvement in this new role. Much depends on resources, capacity, and political will to bridge their service mission to outreach and enrollment. Systems with greater resources and perhaps with potentially greater opportunities within their states, are taking steps to be active players in enrolling and serving those who will be newly insured, while others may be taking more reactive or passive approaches. Resources, nonetheless, are emerging to assist safety-net hospital systems in adopting this role. For example, the California Hospital Association recently released a Guidebook on “Outreach and Enrollment Strategies for California Hospitals.”¹⁸¹

Developing Integrated Systems of Care

The ACA’s attention to continuity of care and systems of care presents both obligation and opportunity to community health centers, safety-net hospitals, and related organizations. Many community health centers, for example have faced formidable challenges in coordinating specialty care they do not provide, while safety-net hospitals may not have the community scope and reach well established by centers.

The ACA offers new ways to support and develop these integrated systems for these health care settings. At least four provisions provide assistance for or facilitate development of collaborations to create such arrangements. For example, Pediatric Accountable Care Organizations, and new programs supported by the Center for Medicare and Medicaid Innovation would support the creation of new integrated system programs and models, while Patient-Centered Medical Home initiatives would encourage more effective health and health related coordination.¹⁸² However, for such efforts to be successful safety-net organizations will need to consider and work to resolve questions around governance and control; technology, physical capacity, and other infrastructure; design of payments to encourage use of appropriate services and adequacy of financial incentives including risk sharing; effective adaptation of new models of care that use multidisciplinary teams; and development of appropriate measures of effectiveness.¹⁸³ Safety-net models such as the Cambridge Health Alliance integrated network, the Colorado Regional Collaborative Organizations, and Los Angeles County health center partnerships that entered into collaborations with independent practices for Medicaid patients currently offer lessons learned and guidance for these new efforts. Still, as these opportunities arise, coming to terms with longstanding concerns will remain. As noted by one health center informant, there is a need to balance integration innovation while allaying concerns that health centers and other settings will have to compromise core tenets for fear that they will “lose their soul.”

Using the CHNA for Broader Community Impact

As noted, under the ACA, nonprofit hospitals are required to conduct community health needs assessments (CHNA). While viewed by many as “yet another added governmental requirement”

and an added administrative burden to rationalize the nonprofit status of a hospital, there is perhaps more than meets the eye in terms of opportunities for creating healthier communities and addressing racial and ethnic disparities. A review of nonprofit community health needs assessments conducted recently in response to the ACA's requirements reveals that they are "brimming with indicators that advocates can use to drive attention to community health issues."⁸⁴ A core and common ingredient across these community health needs assessments has been collaboration and a comprehensive, community-wide process which has typically involved a wide range of public and private partners, including educational institutions, health-related professionals, government agencies, human service agencies, and faith-based and other community organizations.

In addition, these assessments have involved a systematic approach to collecting and measuring data. Given the resources devoted to conducting these assessments, along with an established network of partners and in many cases a replicable methodology, this federal hospital requirement holds significant opportunity to identify, measure, and monitor health care needs and disparities, resources, capacity, gaps, and priorities for action on a community-wide basis for years to come. "Advocates will be able to use CHNAs not only to identify unmet needs or various racial inequities, but to outline the existence or inadequacy of the infrastructure of health systems, either through a lack of necessary institutions or a lack of bodies capable of achieving the coordination and collaboration improved healthcare depends upon."⁸⁵ Nonprofit hospitals have a real opportunity to transform this mere federal paperwork requirement into a valuable analysis and roadmap for comprehensive community planning and action.

Leveraging the ACA with Philanthropic Support

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

Monitoring DSH Payment Reductions

As previously discussed, the Supreme Court's decision resulting in the optional expansion of Medicaid among states will perhaps have one of the most deleterious effects on safety-net hospitals. Reductions in the Disproportionate Share Hospital Program were written into the ACA with the assumption that all states would expand Medicaid for people with incomes below 138% of the federal poverty level. Given the altered reality, however, in states not expanding Medicaid, public and other safety-net hospitals could see an erosion of their DSH funds, with little or no change in the amount of uncompensated care they provide. Recognizing this threat, the recently issued draft regulation and methodology for calculating DSH payment reductions suggests that a

two to three year lag in data on uninsured will be employed to establish such cuts. However, the size and scope of these reductions are still unclear, with uncertain impact on states and hospital systems.

At the state-level, careful review and understanding of current distribution and uses of Medicaid DSH funds across hospitals is warranted to establish a methodology that has the least impact on hospitals with the greatest uninsured burden. At the same time, monitoring of these funds in the years following 2014 will be critical to understanding the impact on most hard-pressed hospitals. Such monitoring should also include specific measures related to disparities to ensure that cuts do not inadvertently expand differences in access to or outcomes of care for racially and ethnically diverse communities. This will be especially important in states rejecting Medicaid that also have a disproportionately large poor and diverse population—such as Texas, Louisiana, Georgia, and Mississippi. As states determine their methodology for adjusting and allocating new DSH dollars, they should consider the following (adapted from recommendations put forth by Deborah Bachrach and colleagues in 2012)¹⁸⁶:

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

* * *

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

Appendix A. Key Informants & Contributors

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

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Appendix B. ACA Safety Net & Equity Progress At-A-Glance

Provision	Summary	Funding Authorized	Funding Received	Implementation Progress
Expansion of Public Programs				
Medicaid §2001	Authorizes state expansion of Medicaid income eligibility up to 138% FPL	CY [†] 2014-2017: States receive 100% federal funding for new enrollees, with federal matching funds gradually reducing as follows: 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020.	Takes effect on January 1, 2014.	-- As of June 14, 2013: 26 states + DC will expand Medicaid; 4 states will expand using an alternative approach; 13 states will not expand Medicaid, and 7 have not made a final decision. --This provision affects 15.1 million uninsured with incomes <138% FPL, nationally, of which 45% or 6.8 million belong to Non-White racial and ethnic groups. Among states expanding Medicaid, 3.8 million diverse adults will obtain new coverage. Among states not expanding, 3 million uninsured adults will be impacted of which 2.3 million with incomes <100% FPL will not be eligible for subsidies in the exchanges.
Children's Health Insurance Program (CHIP) §2101; §10203	Reauthorizes funding for CHIP until at least Oct. 1, 2015, and extends the program through 2019. Requires states to maintain eligibility levels to those at the time of the ACA's enactment.	The law extends CHIP funding until FY 2015, when the CHIP federal matching rate will be increased by 23%. Appropriations for CHIP extension are as follows: FY 2013: \$17.4 bil FY 2014: \$19.1 bil Changes outreach and enrollment funding from \$100 mil in FY 2009-2013 to \$140 mil in FY 2009-2015.	CHIP funding in FY 2013 is projected to be \$10.2 billion, an increase of \$324 million from FY 2012. Outreach & Enrollment: FY 2009: \$40 mil FY 2010: \$10 mil FY 2011: \$40 mil FY 2013: \$32 mil	-- In April 2010, \$10 million was awarded for Tribal outreach and education. In August 2011, CMS awarded \$40 million to 39 grantees as part of its Cycle II outreach and enrollment grant program. At least 17 of these grants explicitly addressed diversity, language, and culture as a focus. --In March 2012, CMS issued a final rule on eligibility, enrollment streamlining, and coordination, which included specific guidance around language access issues. In November 2012, CMS launched its national outreach campaign, "Connecting Kids to Coverage." --In January 2013, a proposed rule was issued which clarified the process for outreach to limited English proficiency populations. Cycle III outreach and enrollment funding opportunity announcement totaling \$32 million was also announced.

Support for Health Centers and Clinics				
Community Health Centers §10503	Establishes a Community Health Center Fund to expand national investment in health centers by \$11 bil over 5 years, FY 2011-2015.	Operational Capacity: FY 2011: \$1 bil FY 2012: \$1.2 bil FY 2013: \$1.5 bil FY 2014: \$2.2 bil FY 2015: \$3.6 bil Capital Development: \$1.5 bil for FY 2011-2015. Discretionary (from Congress, not ACA): Estimated at \$2.2 bil for each FY.	Operational Capacity: FY 2011: \$1 bil FY 2012: \$1.2 bil FY 2013: \$1.5 bil* Capital Development: FY 2011: \$727 mil FY 2012: \$728 mil Discretionary: FY 2011: \$1.6 bil FY 2012: \$1.6 bil FY 2013: \$1.6 bil*	--Health centers receive funding from two streams: (1) the Community Health Centers Trust Fund which is considered mandatory funding; and (2) discretionary funding from Congress. In 2011, discretionary funding was reduced by \$600 million, from \$2.2 to \$1.6 billion. To offset this reduction, \$600 mil were diverted from the Trust Fund, each fiscal year, to support health center operations that would otherwise have been supported through discretionary funds. In addition, the sequestration ordered by President Obama on March 1, 2013 imposed a 2% cut on the Trust Fund.
Nurse-Managed Health Clinics (NMHC) §5208	Supports a grant program to develop and operate NMHCs.	FY 2010: \$50 mil FY 2011: SSAN FY 2012: SSAN FY 2013: SSAN FY 2014: SSAN	FY 2010: \$14.8 mil FY 2011: \$0 FY 2012: \$0 FY 2013: \$0	--In FY 2010, \$14.9 mil was awarded to 10 grantees in 9 states through the Prevention and Public Health Fund. While all grantees are located in or serve medically underserved communities, 4 explicitly cite health disparities, minority health, or cultural competence as priorities in their program description. --This program received no new funding in FY 2011 – FY 2013.
Teaching Health Centers (THC) §5508	Authorizes a grant program to establish new accredited or expanded primary care residency programs in community-based settings. Authorizes the creation of a Teaching Health Center Graduate Medical Education (THCGME) payment program to provide direct payments to THCs operating a primary care residency program.	THC Development: FY 2010: \$25 mil FY 2011: \$50 mil FY 2012: \$50 mil FY 2013: SSAN FY 2014: SSAN FY 2015: SSAN THCGME Program: FY 2011-2015: \$230 mil	No THC Development funding received to date. THC Graduate Medical Education Program: FY 2011: \$2.3 mil FY 2012: \$12.2 mil FY 2013: \$15.6 mil	--No funding to establish new accredited THCs. --In FY 2011, HRSA funded 11 institutions for a 3-year period under the THC Graduate Medical Education Program, training an estimated 300 primary care medical residents. Nine explicitly cite offering cultural competency curricula as part of their residency training. --By FY 2013, there were a total of 17 THCGME Payment Programs, including the 11 inaugural ones from 2011. While all programs target medically underserved populations, there are at least 7 programs in 5 states which explicitly address racial and ethnic health disparities in their training (either in combination with or beyond cultural competency training).

School-Based Health Centers (SBHC) §4101	Creates a grant program to support the operation of SBHCs, with preference to those serving medically underserved children.	FY 2010: \$50 mil FY 2011: \$50 mil FY 2012: \$50 mil FY 2013: \$50 mil	FY 2010: \$0 FY 2011: \$109 mil FY 2012: \$0 FY 2013: \$75 mil	--While funding was not appropriated in FY 2010, in FY 2011, \$95 million was awarded to 278 SBHCs to serve 440,000 new patients, with an additional \$14 mil to modernize facilities and expand capacity at 45 SBHCs and to serve 53,000 more children. States with greatest number of grantees include: California; New York; Oregon; Illinois; and Washington. While all serve underserved populations, some explicitly address issues specific racially and ethnically diverse children and families. --In 2013, an additional \$75 million was available for SBHC construction and renovation.
<i>New Requirements for Safety-Net Hospitals</i>				
Medicaid Disproportionate Share Hospital (DSH) Payment §2551	Reduces Medicaid DSH spending by \$18 billion between 2014 and 2020.	Funding reductions are authorized as follows: FY 2014: \$500 mil FY 2015: \$600 mil FY 2016: \$600 mil FY 2017: \$1.8 bil FY 2018: \$5 bil FY 2019: \$5.6 bil FY 2020: \$4 bil	N/A	-- CMS issued a proposed rule on May 13, 2013 on implementation of cuts in FY 2014-2015. However, President Obama's budget proposal intends to start Medicaid DSH payment reductions in FY 2015, instead of FY 2014. The rule outlines five factors that must be considered in developing a state allocation methodology intended to ensure that greater funding is allotted to states that are currently considered "low-DSH states", have higher rates of uninsured, and target their DSH payments to hospitals with high Medicaid utilization or high uncompensated care costs. In addition, a state's decision to expand Medicaid in 2014 will not impact DSH payment reductions as CMS will apply a two to three year lag in the data to determine allocations. States will decide how they choose to allocate these reductions across hospitals.
Medicare DSH Payment Cuts §3133	Reduces Medicare DSH spending by an estimated \$22 billion over ten years	Starting no later than FY 2014, and each subsequent year, DSH payments would be reduced by 75%.	N/A	--CMS issued a proposed rule on May 10, 2013 outlining how these changes will be implemented. CMS proposes to use the total of each hospital's Medicaid and low-income Medicare inpatient days to calculate each hospital's share of Medicare DSH payment allocations related to uncompensated care. Concerns are arising that the use of inpatient days may not reflect a complete portrait of a hospital's low-income patient population and burden. CMS requested comments to its proposed rules by June 25, 2013, and potential updates to the rule are expected soon.

Community Health Needs Assessment (CHNA) §9007	Strengthens the community benefit obligation by requiring all nonprofit, tax-exempt or 501(c)(3) hospitals to conduct a community health needs assessment every 3 years and to adopt an implementation strategy.	Failure to comply with the CHNA requirements in any taxable year will result in a \$50,000 excise.	N/A	<p>-- The CHNA is to go into effect in the taxable year of each hospital beginning after March 23, 2012.</p> <p>-- On July 25, 2011, the Internal Revenue Service (IRS) released anticipated regulatory provisions or guidance on process and methods for conducting a CHNA, reporting, and disseminating findings. Specific guidance is provided on defining a community, along with obtaining input from community members, including minority groups and tribal agencies, among others.</p> <p>-- On April 3, 2013, the IRS issued additional proposed regulations discussing reporting requirements for nonprofit hospitals and the consequences for failure to comply with new requirements.</p> <p>-- Non-governmental guidance is also emerging on best practices for conducting a CHNA. Resources include, for example, the Public Health Institute's 2012 report on "Best Practices for Community Health Needs Assessment", Catholic Health Association's "Assessing & Addressing Community Health Needs," and www.CHNA.org, among others.</p>
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†CY denotes "Calendar Year"

^ Funding request for Fiscal Year 2013.

*As originally written in the Affordable Care Act.

** Implementation progress includes updates as of June 2013.

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