New Directions in Health Care: The Commonwealth Fund Podcast

What Health Reform Means for Safety Net Providers

This is New Directions in Healthcare, the Commonwealth Fund's podcast, and today we're talking about the Affordable Care Act and its implications for the nation's safety net health care providers—clinics and hospitals that serve low-income patients and those who have no insurance.

In 2014, more than 30 million people who now lack health coverage will qualify for Medicaid or affordable insurance. Some might think the safety net will no longer be needed. In fact, experts say it will still play an important role:

"There will definitely be people who remain uninsured, even after health care reform takes effect."

That's Dr. Pamela Riley, Vulnerable Populations Officer at The Commonwealth Fund.

Riley: "It's estimated that approximately 34 million people will gain health insurance under reform, but there will be approximately 23 million people who will remain uninsured. Now some of those folks are just people who choose not to acquire insurance. Some of them are people who insurance would be unaffordable for them, so they are exempt from the individual mandate to purchase insurance, and about a third of those folks will be undocumented immigrants."

Safety net providers may also serve newly-insured patients who are happy with the care they now receive—often for complex medical problems—because they like their providers, and because the clinic or hospital is sensitive to their social and cultural needs.

Those patients will provide new revenue, but Dr. Bruce Siegel, president and CEO of the National Association of Public Hospitals and Health Systems, says safety net providers will face another big challenge as people who had stayed away from doctors and hospitals, unable to pay, now have the means to get care:

Siegel: "There are some communities in America where literally a third of the people there will now have coverage for the first time. Places in Texas, in Mississippi and Alabama – especially in the South. Those communities today don't have enough physicians or enough providers of all sorts to care for these folks. How are they going to cope with this new demand?"

The Affordable Care Act offers several answers to that question. First, it contains money to help the safety net grow—$11 billion in new, dedicated funding over five years for the operation and expansion of community health centers. It also provides incentives for medical students who choose primary care and for those who opt to practice in underserved communities.

The law supports a change in the way health care is delivered, offering higher rates of Medicaid compensation to medical homes, where teams of healthcare professionals track and coordinate care, teach patients how to better manage chronic conditions and catch medical problems early—when treatment is most effective and least expensive.

George Washington University Health Policy Professor Leighton Ku says teams of professionals—nurses, health educators, physical therapists, nutritionists, psychologists and so on—may be more efficient than a system that relies heavily on physicians:

Lots of the things that doctors do could be done by a nurse, could be done by a physician's assistant, and in some cases they may do a better job – if it's providing counseling to someone or education about how to take your medications or how to take care of your wounds, others may actually do a better job than a doctor, because they'll have more time to explain these things.

Dr. Pamela Riley agrees.

Riley: Vulnerable populations tend to have greater medical needs, more prevalence of chronic disease such as diabetes, asthma, higher rates of mental illness, higher rates of substance abuse, disability—just generally have greater need for healthcare, and there's really a role for team-based coordinated care for this population in particular.

Safety-net providers may also evolve into patient-centered medical homes thanks to a new office, established by the Affordable Care Act. The Center for Medicare and Medicaid Innovation recently launched a demonstration project to identify resources needed for Federally Qualified Health Centers to make the transition.

Finally, in 2013 and 14, safety net providers may see their revenue rising, as the law requires Medicaid to pay as much as Medicare for primary services.

But under the Affordable Care Act, challenges remain for safety net providers. Again, Leighton Ku:

Ku: "It doesn't increase the payment levels for surgeons, other sorts of specialists, so they might not be quite as eager to see Medicaid patients. The fear that some hospitals have is that states, when they're trying to afford some of the expansions, or when they're still trying to cope with budget shortfalls they have, will reduce the payment rates for hospitals."

And with 16–17 million more Medicaid patients expected to enter the system, Bruce Siegel won't be surprised if individual payments from that program fall:

Siegel: "There is nothing in the Affordable Care Act that tells a state how much it must pay for Medicaid, so we would hate to see a situation where suddenly there are many more people on Medicaid, but the payment that the state gives to a doctor, or a hospital, or anybody else is so low that it's almost meaningless."

In addition, safety-net hospitals have, for many years, received extra money from Medicaid, because they provided free care to the poor. The Affordable Care Act assumes there will be fewer charity patients, so it calls for lower Disproportionate Share Hospital or "DSH" payments. Riley worries that some medical centers could suffer as a result:

Riley: "There's great concern among many safety net provides that the new revenue they'll have from the expanded coverage will not offset the cuts that they experience with the DSH cuts, putting many safety net providers, particularly safety net hospitals, in precarious financial situations."

Safety net providers also worry that many people may lose insurance coverage as their income fluctuates. Ku says states, which are charged with implementing the Affordable Care Act, must recognize the unique problems of vulnerable populations and craft rules that work in their favor:

Ku: As their income changes and goes up and down, for one month they might be eligible for Medicaid, and the next month they may be eligible for the health insurance exchanges, so they might have to change insurance plans. The hope is that we'll have a smoothly operating system, so it's fairly easy to transition from one type of plan to another. Hopefully in many cases they can keep their same doctor, but how well some of these things are going to work we're not going to know until 2014.

One thing we do know is that the need for a safety net will remain—that as many as 23 million people will still be without coverage and many of the newly insured will be vulnerable—so it's essential that policymakers at the state and federal level find ways to support these clinics and hospitals, so the Affordable Care Act can achieve its full potential.

You've been listening to New Directions in Healthcare, the Commonwealth Fund's podcast. I'm Sandy Hausman.