HEALTH CARE SAFETY-NET PROGRAMS AFTER THE AFFORDABLE CARE ACT

Innovative Approaches and Opportunities for States

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Prior to the Affordable Care Act (ACA), health care safety-net programs were the primary source of care for over 44 million uninsured people.[1] While the ACA cut the number of uninsured substantially, about 30 million people remain uninsured, and many millions more are vulnerable to out-of-pocket costs beyond their resources.[2,3] The need for the safety net remains, even as the distribution and types of need have shifted.

This brief reviews the effects of the ACA on the funding and operation of safety-net institutions. It highlights the challenges and opportunities that health care reform presents to safety-net programs, and how they have adapted and evolved to continue to serve our most vulnerable populations.

THE HEALTH CARE SAFETY-NET LANDSCAPE

The health care "safety net" is a patchwork of health care institutions, financing mechanisms, and programs that serve uninsured, low-income, and other vulnerable populations. By legal mandate or mission, these programs serve patients regardless of their ability to pay, and often, regardless of immigration status.[4] Safety-net providers typically include public hospital systems; federal, state, and local community health centers and free clinics; rural health clinics; local patient referral programs; and local health departments. In most communities, smaller special service providers (e.g., family planning clinics, school-based health programs, and Ryan White HIV/AIDS programs) provide core safety-net services. In other areas, teaching and community hospitals, private physicians, and ambulatory care sites committed to serving the poor and uninsured fulfill the role.[5] The

ACA designated many of these programs as "Essential Community Providers" (ECPs), and requires plans on the ACA marketplaces to include a sufficient number and geographic distribution of ECPs in their provider networks.[6]

Health care reform has altered the landscape of safety-net programs. Their constituency has changed in size and composition, especially in the 37 states (including DC) that have expanded Medicaid income limits to 138 percent of the federal poverty level (FPL).[7] From 2013-2015, the uninsurance rate fell 18.2 percentage points in expansion states and 10.7 percentage points in non-expansion states.[8] As a result, in states that did not expand Medicaid, the percentage of non-elderly adults without insurance (18.7%) is nearly double the rate in expansion states (9.9%).[9] Medicaid expansion, along with the sliding-scale tax credits available for private insurance on the ACA marketplaces, have

decreased the number of individuals who lack insurance by roughly 40 percent.[1] Increasingly, safety-net programs are serving patients who have insurance, but are "underinsured" because their high deductibles and copayments are a barrier to care.[3] By one measure, the number of underinsured more than doubled between 2003 and 2016, leaving about 41 million insured adults with considerable barriers to affordable care.[3]

Immigration status is closely tied to health coverage, with non-citizens much more likely to be uninsured than citizens.[11] While "lawfully present" immigrants can purchase insurance on the ACA marketplace, only certain categories of non-citizens are eligible for Medicaid or CHIP, and immigrants without lawful status are ineligible for ACA coverage altogether. These gaps in eligibility create a stark contrast: 45% of undocumented immigrants and 23% of lawfully present immigrants are uninsured, compared to 8% of citizens.[11] For instance, in California, an estimated 58% of people who remained uninsured in 2017 were undocumented immigrants, as were about half of the remaining 600,000 uninsured in New York City.[12,13] Non-citizens have coverage under Emergency Medicaid, which reimburses hospitals for emergency services provided to about 100,000 individuals who would qualify for Medicaid but for their immigration status.[14]

While a strong health care safety net remains essential, it does not substitute for insurance.[4] In some programs, primary care services and drug formularies are often only basic, and coverage of specialist services, behavioral health and substance abuse treatment, and dental care can be spotty. Capacity constraints can result in long wait times or eligibility limitations. Although some structured safety-net programs can meet a fairly complete range of basic health care needs, they do not provide access to the full range of services and providers covered by Medicaid or by the ACA's essential health benefits.[15]

A few large cities, such as San Francisco and Los Angeles, have attempted to plug these holes by providing direct access to comprehensive care for most or all of their uninsured residents through their network of public health clinics and affiliated hospitals.[16,17] New York City, for example, recently launched a universal care plan that will provide qualifying uninsured residents with a membership card to obtain primary, specialty, and inpatient care through New York's public hospital system of 11 hospitals, a large federally-qualified health center (FQHC) with more than 70 community-based points of care, and five postacute care facilities.[18,19]
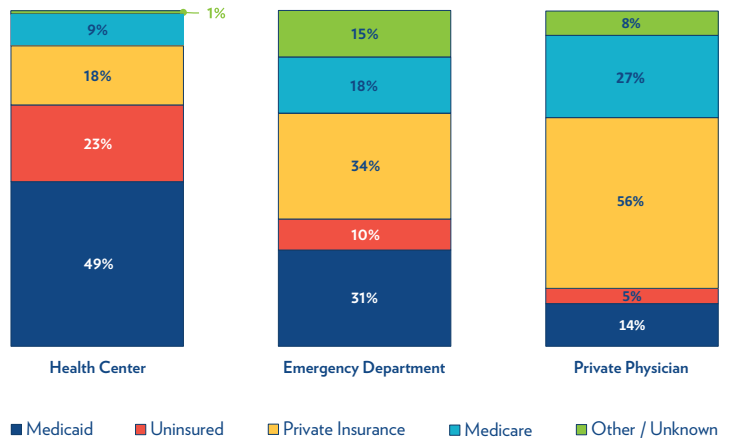
MAJOR SAFETY-NET COMPONENTS

Community Health Centers (CHCs)

CHCs are a central feature of the safety net. Typically, they are nonprofit, community-directed organizations that provide a comprehensive range of primary care and related services, funded mostly by public programs (Medicaid, Medicare, and federal grants).[20] In 2017, about 1,400 CHCs with approximately 12,000

locations across the US served more than 27 million people (1 in every 12 people, and 1 in every 3 in poverty).[21] CHC patients are disproportionately low-income, uninsured, publicly insured, and racial and ethnic minorities.[20] More than 90% of CHC patients in 2017 had incomes at or near the federal poverty level; about half had Medicaid coverage, while 23% were uninsured (Figure 1).[22]
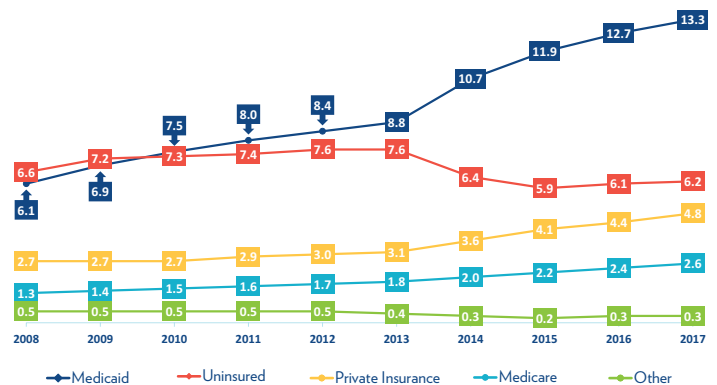
The ACA changed the composition of the CHC patient population. Since 2014, the number of uninsured patients served at CHCs has dropped, while the number of Medicaid and privately insured patients has risen (Figure 2).[23] One study of CHCs reports that many of CHCs' insured patients cannot afford their plan's cost-sharing requirements.[24]

Figure 1. Health Center Patients' Health Insurance Coverage Is Unique Among Ambulatory Care Providers

National Association of Community Health Centers, Community Health Center Chartbook, Figure 1-6. (January 2019).

Figure 2. Health Center Patients by Insurance Status, 2008–2017 (In Millions)

National Association of Community Health Centers, Community Health Center Chartbook, Figure 2-10. (January 2019).

The ACA's effect on CHC populations differs across states. In Medicaid expansion states, clinics have experienced a 40% decrease in the rate of uninsured visits after expansion and a 36% increase in the rate of visits covered by Medicaid. By contrast, there was a 16% decrease in the rate of uninsured visits and no change in the rate of Medicaid-covered visits among clinics in states that did not expand Medicaid.[25]

Recognizing the important role of CHCs in providing and expanding primary care capacity, the ACA enhanced federal funding for CHCs with $11 billion over an initial five years.[26] Although subsequent federal budgets so far have extended this funding, it remains at risk without a more permanent appropriation.[27] The additional funding, and the increased revenues available from Medicaid expansion, have strengthened the capacity to meet the needs of vulnerable populations.

One study found that every additional million dollars in federal grants to CHCs was associated with about 8,000 more patients served each year per center, and that Medicaid expansion was associated with an additional 1,000 patients per center compared to non-expansion states.[28] Another study found that since the ACA, CHCs in expansion states were more likely to report improved capacity and financial stability; participate in value-based payment arrangements; and address patients' behavioral health and social needs.[29] With these new resources, CHCs have continued to engage in outreach and enrollment services, linking patients to Medicaid and marketplace coverage, and key services such as mental health, substance abuse treatment, and dental care.[30,31] Seventy-five percent of all CHCs are now considered "medical homes" that provide comprehensive primary care services and coordinate patients' care across other providers.[22]

Charity Care Programs

Community-based charity programs offer care to low-income individuals through free and charitable clinics, or arrange donated care through referral programs to community physicians. More than 1,400 free and charitable clinics and charitable pharmacies, formed by a variety of civic or religious institutions, treat about two million people each year. These programs rely mostly on volunteer providers and donations from individuals or foundations.[32,33] Many free clinics serve uninsured patients and seek no payment for service, but some are labeled "charitable" clinics rather than simply "free" because they also treat patients under Medicaid or on a sliding fee scale.[34]

The impact of the ACA on free and charitable clinics has differed between Medicaid expansion and non-expansion states. In preliminary findings from a 2015-2017 national survey, 43% of clinics in expansion states reported a lower demand for clinical services, while only 20% reported an increase. In contrast, 18% of clinics in non-expansion states reported a decreased demand, while 35% reported a greater demand for their services. Further, the composition of the population has changed, as clinics report that an increasing proportion of their clientele are *under*insured.[35]

Some safety-net programs have concluded that the best way to serve this more socioeconomically diverse population is to offer services on a membership or sliding fee basis.[36] Although community health centers have always offered services at sliding fees, free clinics typically have not because they prize the simplicity and clarity of not dealing with any payments.[37] However, some charitable clinics are charging fees to make up for reduced support or to serve a population in need that can pay a portion of their own care.[38,39]
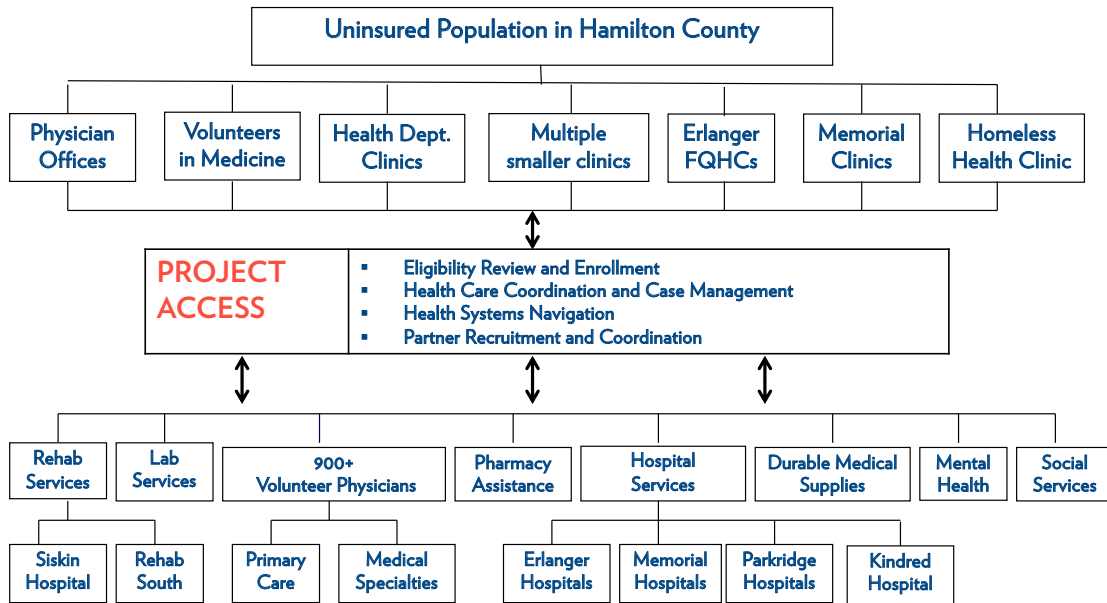
Some free and charitable clinics, especially in Medicaid expansion states, have shifted their focus to helping low-income clients enroll in health insurance.[40] A 2016 study found that 87% of free clinic patients were uninsured, but more than half were eligible for Medicaid, Medicare, or subsidies on the health insurance marketplaces. The majority of these patients completed health insurance applications during their visit with in-person assistance.[41] In response to this need, many free clinics and other safety-net programs have allocated multiple staff positions to enrollment assistance.[40]

An important alternative, or sometimes complement, to free and charitable clinics are "Project Access" programs, where community physicians accept safety-net referrals in their office-based practices. Usually run by local medical societies, these programs focus on coordinating specialist referrals and often affiliate with one or more hospitals willing to take admissions and provide more complex diagnostic testing.[42] For instance, since 2004, Project Access of Hamilton County, Tennessee has connected more than 80,000 uninsured, low-income people to care (Figure 3). In 2016-17, it enlisted nearly 1,000 volunteer physicians and served 3,375 people.[43]

Referral programs are adapting to the ACA's coverage expansions by increasing their capacity to help their clients find and enroll in affordable health insurance. For example, in 2017, the 10-year-old Project Access NOW of Portland (Oregon) deployed 14 certified application assisters at 20 sites and 80 events to provide enrollment assistance, and successfully enrolled more than 17,000 individuals in coverage. Even further, to help clients afford private insurance premiums, it now offers premium assistance to patients ineligible for Medicaid. It continues its "Classic Program," which served more than 3,000 uninsured people and made more than 5,000 appointments in 2017.[44]

Charitable programs are also moving to address the "social determinants of health" by acting as screening and referral locations for various forms of social services beyond direct provision of health care.[40] For example, the Episcopal Health Foundation (EHF) funds efforts in 57 Texas counties to support the creation of healthier communities. Serving over 11 million Texans, EHF is using clinics to address the community conditions that result in poor health, including poverty, inadequate housing, lack of affordable healthy food, and few safe places to exercise.[45]

Figure 3. Hamilton County Project Access

Tennessee Charitable Care Network, Physician Recruitment and Retention for Charity Care. (May 2017).

Safety-Net Hospitals

Although no one definition of a safety-net hospital exists, more than 800 hospitals meet the criteria for automatic bonus payments under Medicaid's "Disproportionate Share Hospital" (DSH) program because they serve a high percentage of Medicaid or low-income patients.[46,47] These so-called "deemed DSH" hospitals comprise just under one-third of all hospitals that receive DSH payments, but account for more than two thirds of DSH payments. These payments fund not only hospital inpatient services for the uninsured (and compensate for Medicaid payment shortfalls), but also outpatient specialty procedures and services on which other safety-net programs rely. In FY 2019, the government allotted $12.6 billion in federal DSH funds to states.[47]
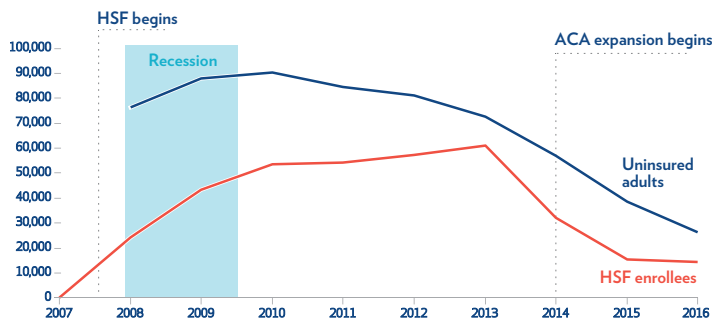
Anticipating that coverage expansions would reduce levels of uncompensated care, the ACA called for a substantial cut in Medicaid DSH payments. This cut, premised on anticipated expansion of Medicaid in all states, has been repeatedly delayed. If cuts are implemented, this will reduce the amount of funds that states and hospitals have to support safety-net programs for the uninsured – both in states that have and that have not expanded Medicaid.[48] The Medicaid and CHIP Payment and Access Commission (MACPAC) has recommended that Congress phase in these cuts more gradually and distribute reductions in a way that better aligns DSH allotments with the number of low-income individuals in a state.[49] The ACA also revised the methodology for calculating hospitals' Medicare DSH payments to more accurately reflect the number of uninsured patients served.[50] Accordingly, the Administration proposed a year-over-year increase of $1.6 billion in Medicare DSH funding, suggesting an expected increase in the uninsured rate.[51]

The ACA has had variable effects on safety-net hospitals, depending on whether a state expanded Medicaid. From 2012-2015, safety-net (deemed DSH) hospitals in expansion states had greater increases in Medicaid patient volume and revenue, lower uncompensated care, and improved financial margins relative to safety-net hospitals in other states. These data suggest that the ACA had a significant positive financial impact on safety-net hospitals in states that expanded adult Medicaid eligibility compared to those in states that did not expand. Despite this positive impact, safety-net hospitals in expansion states continue to have lower operating margins than their non-expansion counterparts, perhaps due to an increased demand for care.[52]

Direct Access Programs

A few cities and counties, including New York, San Francisco, Los Angeles, and Harris County (TX), have cast a fairly wide safety net around their uninsured residents by providing direct access to care, typically through public hospital systems and affiliated outpatient clinics.[17,18,53,60] These programs are not insurance, in that services are not contractually guaranteed and they do not extend to care beyond city or county limits. While they do not obviate the need for comprehensive insurance, direct care programs provide a level of access to care that can be broadly equivalent to basic access provided by actual insurance. One study, for instance, found that people enrolled in programs like those in San Francisco and New York City perceive themselves as being covered as if they were insured, and another found that people enrolled in a comprehensive safety-net program in Houston reported levels of access and service similar to people covered by Medicaid.[54,55]

Figure 4. Number of uninsured adults ages 18-64 in San Francisco and of Healthy San Fransisco (HSF) enrollees, 2007-16

Health Affairs, [Universal Health Care: Lessons From San Francisco](). (September 2018).

San Francisco implemented the first city-wide direct access program in 2007, as part of its "[City Option]()" program requiring employers to provide insurance or contribute to a pool to fund health care programs for eligible San Francisco residents.[56] [Healthy San Francisco]() provides uninsured residents with income up to 500 percent FPL with a Participant ID card that indicates [their medical home]() for primary care, with quarterly fees ranging from $0 to $150. Participants then receive specialist care and inpatient care through six area hospitals, on a sliding fee scale.[56,57] After the ACA was implemented, Healthy San Francisco saw a [significant drop]() in enrollees as many participants were able to receive Medicaid or subsidized insurance through the California marketplace (Figure 4).[58]

In November 2016, San Francisco adapted its City Option program to include [SF Covered Medical Reimbursement Accounts]() (MRAs) in response to concerns about the affordability of coverage through the marketplace.[59] Employers contribute to a pool that funds MRAs to subsidize premiums and cost-sharing on the ACA marketplace, with deductibles limited to 5 percent of income. In its first year, 489 people received an average subsidy of $2,461 — or $205 per month, assuming a full year of coverage.[59] Over time, San Francisco estimates that it will help [3,000 residents]() afford coverage on the California state marketplace.[16]

Los Angeles launched [My Health LA]() (MHLA) in 2015 in the wake of the ACA, to provide access to "residually uninsured" residents at or below 138 percent of poverty. Because California expanded Medicaid up to these income limits, the program focuses on the remaining uninsured who are ineligible for Medicaid, primarily because of their immigration status. MHLA served more than 147,000 people in 2017-2018, at 213 medical home sites. Specialty and inpatient care are provided in LA county facilities at no charge to participants.[17]

Direct access programs, however, are not limited to states that have expanded Medicaid. In Houston, Texas, the "[Harris Health]()" financial assistance program, run by the county hospital district system, provides low-income, uninsured county residents with comprehensive services in county-operated inpatient and outpatient facilities on a sliding-scale basis. Enrolled members are issued a "gold card" that identifies their eligibility for these services.[60] [Depending on income](), fees for clinic visits range from $3-$38, and for hospital stays from $50-$1,000. Services are free to those who are homeless.[61] In [2015](), the program served nearly 100,000 people up to the federal poverty level (FPL), and more than 50,000 between 100-200 percent FPL, of which 38,000 were eligible for subsidies on the health insurance marketplace. In 2016, the eligibility cutoff was reduced from 200 to 150 FPL.[60] A 2019 [report]() indicated that 55 percent of people in the gold card program would be eligible for Medicaid if Texas expanded its Medicaid program.[62]

The success of these model programs cannot always be replicated or scaled up. Nevertheless, they demonstrate that the safety net is capable of delivering good care and access for people who inevitably fall through the cracks of our complex insurance system.

INNOVATION ACROSS THE SAFETY NET

Safety-net organizations are not only spreading and expanding established programs; they are also testing or launching innovative programs that adapt to the post-ACA landscape. For instance, safety-net organizations in some states have formed larger networks that include both providers who charge no fees as well as others who charge sliding-scale fees. One example is the Ohio Association of Free Clinics, which changed its name to the [Charitable Healthcare Network]() in 2018, allowing more safety-net providers to join the network and linking patients to additional care through rural health clinics, charitable pharmacies, substance abuse clinics, case management services, and cancer care clinics.[63]

A sliding fee scale approach is similar to the "[direct primary care]()" model that has emerged outside of the safety net, in which a patient pays a membership fee to access primary care services without going through insurance — the main difference being the safety net's reduction of the fee for people in financial need.[64]

Conceivably, a safety-net clinic could offer both a commercially-priced direct primary care program alongside a program for lower-income uninsured populations whose enrollment fee is on a sliding scale. For instance, Camino, a large free clinic near Charlotte, North Carolina, recently began offering its services to [employers]() for $420 a year, as a supplement to high-deductible health insurance. Employees receive all-inclusive primary care services, including email access to providers, and reduced rates for lab tests.[65] In addition to employer membership, individuals can [enroll]() (for $240 a year) to receive substantial discounts. As of October 2019, members pay $25 for sick visits and $45 for extended visits; they receive 50 percent discounts on a wide range of other clinic and lab services.[66]

Even more ambitiously, a network of safety-net clinics could be formed to serve a broader geographic region, potentially by contracting either with state Medicaid programs or with managed care organizations that serve either the private or public sectors. Such a [consortium]() has been proposed in North Carolina in response to the state's move to Medicaid managed care.[67]

Under current law, sliding-scale fees in formerly free programs might compromise one or more of the social or legal bases on which these programs have been built.[68] To resolve uncertainties, states should clarify that membership fees charged by safety-net programs do not result in these programs engaging in the regulated business of insurance, and they should remove any perceived state-level legal barriers to third-party "premium-support" programs that help lower-income people pay their insurance premiums.[69] Additionally, states with liability protection for charitable clinics should clarify that accepting fees from some patients does not undermine that protection.[38]

In addition to these financial and structural innovations, safety-net programs have participated in, and sometimes led, delivery system transformation.[70] Although this aspect lies beyond the scope of this brief, many states have used Medicaid waivers and funding available through the "Delivery System Reform Incentive Payment" (DSRIP) program to change the way various safety-net programs organize and deliver care.[71,72] These innovations include a focus on delivering care in community settings, addressing the social determinants of health, and integrating behavioral health into comprehensive primary care.[73] The Administration has signaled that five-year waivers in the DSRIP program will not be renewed, and safety-net institutions will need to replace or recapture that funding to continue making progress towards high-value care.[72]

KEY THEMES AND RECOMMENDATIONS

This brief has demonstrated the evolving role of heath care safety-net programs, which remain vitally important in the post-ACA landscape. In many instances, these programs have expanded beyond traditional care provision to help individuals secure and maintain coverage. Although safety-net programs continue to serve low-income and uninsured individuals, they are now increasingly serving insured individuals who are unable to afford the costs of coverage and care. The safety net is adapting to address the changing needs of vulnerable populations such as immigrants, and to fill gaps in affordable insurance and access. To ensure that safety-net programs can continue to meet the needs of these populations, it will be critical for policymakers to address looming threats to funding and other policy changes.

Enrollment assistance. Almost all health care safety-net programs are actively engaged in helping uninsured people enroll in either Medicaid or subsidized private coverage, and FQHCs are specifically required to provide outreach and enrollment assistance.[74] Enrollment assistance has assumed increased importance in the past few years as federal funding for navigators, outreach, and advertising has been reduced; the open enrollment period on the federal marketplace has been shortened from 90 to 45 days; and new barriers to Medicaid enrollment have emerged.[75,76,77]

Serving immigrants. Many of the "residually uninsured" are non-citizens, some of whom are ineligible for the ACA's coverage expansions. Safety-net programs report that non-citizens constitute a larger portion of their uninsured clients.[78] States and localities are working to increase coverage and care for non-citizens. For example, California will become the first state to extend health coverage to low-income, undocumented adults.[79]

Emergency Medicaid (EM), which reimburses hospitals about $2 billion a year for emergency care of low-income, non-citizens, might be redirected to increase its medical, economic, and public health benefits.[14] Most of the current EM spending goes to pregnancy-related care. A recent commentary urged that the program be expanded and refocused to include services that might keep people out of the emergency department, such as routine prenatal care.[14]

Changes in so-called "public charge" policies may threaten immigrants' ability to access safety-net services, which continue to be a lifeline for this population. In August 2019, the Administration announced a final rule that allows the federal government to consider participation in Medicaid and other public programs in its decisions about immigrants' admissibility and legal permanent resident status.[80] The change will likely have a chilling effect on immigrants' access to care, and is being challenged in court.[81]

Serving the *under*insured. Health care safety-net programs are seeing an increasing number of lower-income, insured people who have trouble paying their premiums, deductibles, or copayments. In response, some programs have increased their use of sliding-scale or membership fees, or premium support. This represents an opportunity to stabilize funding sources and expand the socioeconomic diversity of the population covered by the safety net. These safety-net innovations must be evaluated, however, under a state's insurance laws to ensure that they do not constitute the unregulated business of insurance. States should also review their charitable immunity laws to ensure that these innovations do not impose new liability risks.[38]

Funding opportunities and challenges. The ACA and Medicaid expansion strengthened some parts of the safety net, while weakening others. Increased federal funding for community health centers has bolstered their capacity to serve their communities and extend their services, but future funding uncertainty remains. In states that expanded Medicaid, the bottom line in safety net hospitals and clinics has improved; in states without expansion, the safety-net is experiencing a net increase in demand at a time when private voluntary support may be lagging.[33] Additionally, all states face large, looming federal "disproportionate share hospital" (DSH) funding cuts. If these cuts go into effect, states may need to be more targeted in how they use their reduced and reallocated DSH funding. One possibility is to target these funds more directly to hospitals that work with safety-net programs to improve care, access, and social services for people who remain uninsured or underinsured.[82] States can also use the flexibility in federal waiver provisions under both Medicaid and the ACA to devise various ways to support and enhance safety-net programs — both in their traditional functions of serving uninsured and Medicaid populations, and also in the variety of expanded functions profiled here.[47,55]

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ACKNOWLEDGEMENTS

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