

ISSUES AND POLICY OPTIONS
IN SUSTAINING A SAFETY NET
INFRASTRUCTURE TO MEET THE
HEALTH CARE NEEDS OF VULNERABLE
POPULATIONS

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EXECUTIVE SUMMARY

Safety net providers,¹ such as community health centers, rural health clinics, public hospitals, and other similar nonprofit and public providers and systems, traditionally have served as an important source of care for many vulnerable populations, including the uninsured, underinsured, publicly insured, and those living in underserved rural or inner city areas. When the Affordable Care Act's (ACA) insurance provisions are implemented, as many as 30 million currently uninsured individuals are expected to gain coverage.² While it is difficult to project where those newly insured under the ACA will seek care—from traditional safety net providers or from mainstream providers—safety net providers will be especially prepared to take on these vulnerable populations.

Because safety net providers care for patients with some of the most complex needs and the fewest resources, all of the stresses of health reform on the health care delivery system will be amplified within the safety net. A surge in demand is anticipated as the previously uninsured gain coverage, exacerbating current shortages of primary, specialty, mental health, and oral health care providers, particularly those who can provide culturally competent care for vulnerable populations. Simultaneously, and also as a result of coverage expansions, the mix of reimbursement to health care providers will change. While safety net providers are expected to remain an important source of care for vulnerable populations,³ the ramifications of changes in the amount and mix of insurance coverage remain unclear.

The safety net workforce is already stretched in many areas, as providers strive to meet the complex medical, behavioral, and social needs of their patients, often with limited funds. Several major issues exacerbate the strain on health care professional shortages, particularly for safety net providers. Four workforce issues in particular, while not specific to the safety net, are perhaps more acutely felt by safety net providers: 1) provider scopes of practice may limit the reach of the existing workforce; 2) reimbursement policies restrict who can provide care; 3) telehealth regulations hamper the wider adoption of this technology; and 4) the financing streams for workforce training are misaligned with need.

As a result of large-scale changes in insurance coverage enabled by the ACA, financing streams for safety net providers will shift. The law provides significant resources for further development of some safety net providers while reducing funding streams for others. The vulnerable populations served by the safety net—poor and underserved communities—may not fundamentally change, but their sources of coverage, and thus, financing for safety net providers who care for these populations, will shift dramatically. To adapt to these changing funding streams, safety net providers will need to engage in new and ongoing payment reform efforts, negotiate their roles with state Medicaid programs and qualified health plans sold through newly established insurance exchanges, and maintain an infrastructure to serve the remaining uninsured.

In this era of change, the safety net needs support to be able to continue making strides and adapting to the demands brought on by health care reform. Policies that enable the safety net to engage a diverse workforce to serve vulnerable populations are critical. States and private payers can revise their regulations and policies where needed to ensure that providers willing and able to serve in the safety net are able to do so, are empowered to work in teams and to make use of new care models, and are able to be paid for their work. Federal and state policymakers must also re-examine the financing streams that support safety net institutions. The anticipated changes to payer mix in the safety net brought on by the ACA's provisions affecting Medicaid eligibility, Disproportionate Share Hospital (DSH) reductions, and regulations for new qualified health plans will alter the payment streams that keep the safety net afloat.

These changes, if managed carefully, provide opportunities to structure payments in ways that incentivize desired outcomes. Payment reforms enacted in concert with workforce innovations can support team-based care, patient-centered medical homes, and additional care coordination and care management models that emphasize the primary care and enabling services that have the potential to bend the cost curve and improve health outcomes. In combination, support for workforce and financing models that support efficient, high-quality care in safety net settings can help ensure the safety net remains viable to serve those who will continue to depend on it.

This report is the third in a series that reflects the work of the National Workgroup on Integrating a Safety Net into Health Care Reform Implementation—comprised of community, state, and national experts—to inform national and state policy development in addressing the roles of safety net providers in implementation of the ACA. The report addresses the workforce and financing infrastructure that needs to be in place to support a sustainable safety net for vulnerable populations. Each section contains recommendations to state and federal policymakers for bolstering safety net infrastructure to help ensure the safety net remains for those vulnerable populations who will continue to depend on it.

The National Workgroup on Integrating a Safety Net into Health Care Reform Implementation

The National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (National Workgroup) selected safety net workforce development and safety net financing as two of three top priorities to address among a set of ten identified issues that confront policymakers in addressing the roles of safety net providers in health care reform. All ten of these issues are summarized in *Toward Meeting the Needs of Vulnerable Populations: Issues for Policymakers' Consideration in Integrating a Safety Net into Health Care Reform Implementation*.⁴ A second report, *Including Safety-Net Providers in Integrated Delivery Systems: Issues and Options for Policymakers*,⁵ describes the National Workgroup's deliberations on its top priority issue—integrated systems.

Established by the National Academy for State Health Policy (NASHP) with support from The Commonwealth Fund, the 22 participants of the National Workgroup include state and federal officials, national experts and organizations, and safety net providers. (See Appendix B for a complete list of National Workgroup participants.) As part of its year-long effort to identify and address the highest priority issues related to integration of the safety net into health care reform, the National Workgroup convened a number of discussions from November 2011 to April 2012 about policy issues and options related to the workforce and financing infrastructure needed to sustain the safety net. This report summarizes these issues and options to inform the decision-making of state and federal policymakers and health system stakeholders interested in promoting an effective safety net for vulnerable populations. The National Workgroup concluded its work and this report was drafted prior to the release of the Supreme Court's decision in *National Federation of Independent Business v. Sebelius* on June 28, 2012. While the report was updated to reference the decision, the National Workgroup did not fully explore its implications. We hope that this report helps inform implementation of new opportunities that arise through Affordable Care Act (ACA) implementation as well as shape future initiatives at community, state, and national levels.

This summary represents the sense of the entire group, but does not represent the specific views of any one or all of the participants or The Commonwealth Fund.

INTRODUCTION

Safety net providers,⁶ such as community health centers, rural health clinics, public hospitals, and other similar nonprofit and public providers and systems, traditionally have been an important source of care for many vulnerable populations, including the uninsured, underinsured, publicly insured, and those living in underserved rural or inner city areas. The Agency for Health Care Research and Quality defines vulnerable populations as “those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability.”⁷

When the Affordable Care Act’s (ACA) insurance provisions are implemented, as many as 30 million currently uninsured individuals are expected to gain coverage.⁸ Of those, roughly half could gain coverage through the expansion of Medicaid eligibility, though it is expected not all states will immediately or fully take up the Medicaid expansion.⁹ A surge in demand is anticipated as the previously uninsured gain coverage, exacerbating current shortages of primary, specialty, mental health, and oral health care providers, particularly those who can provide culturally competent care for vulnerable populations. At the same time, the current workforce is aging and geographically misaligned with needs,^{10,11} and both insured and uninsured health center patients have difficulty finding specialists.¹² New strategies may be needed to recruit and maintain providers in rural and other underserved areas. In addition, new types of providers and more effective use of current providers may help alleviate shortages.

Simultaneously, and also as a result of coverage expansions, the mix of reimbursement to health care providers will change. While safety net providers are expected to remain an important source of care for vulnerable populations,¹³ the ramifications of changes in the amount and mix of insurance coverage remain unclear. If the pattern seen in Massachusetts¹⁴ holds, safety net providers are likely to continue to care for many of the same populations they currently see, including the chronically ill and those with multiple conditions. In some underserved areas, safety net providers likely will continue to be the primary—and in some cases the only—source of comprehensive care. And remaining groups of the uninsured will continue to need care post-coverage expansions, even as obtaining financial support for their care may become more challenging.

Health care experts agree that safety net providers will remain an important part of the health care delivery system going forward, serving much of the newly insured population and continuing to serve as the safety net for the remaining uninsured and other vulnerable populations. The ACA provides some tools to help address workforce and financing challenges, some of them targeted specifically towards meeting the extensive needs of vulnerable populations and those who serve them. (See Appendix A). Safety net providers will need to be integrated into or coordinate with the changing health care delivery system if they are to continue to provide access for vulnerable populations—both those with insurance and those unable to access the larger system. State and federal policymakers, in turn, will need to take into account the unique characteristics of safety net providers and develop options to support their workforce and financing infrastructure if overall health reform goals are to be achieved.

This report is the third in a series that reflects the work of the National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (National Workgroup), comprised of community, state, and national experts, to inform national and state policy development in addressing the roles of safety net providers in implementation of the ACA. The report addresses the workforce and financing infrastructure

needed to support a sustainable safety net to serve vulnerable populations. Other areas of infrastructure development, notably health information technology, are equally important to the efficient functioning of the safety net—and the health care system as a whole—but are not covered here. This report begins by describing some of the major issues affecting the safety net workforce and possible solutions to address these issues. Next, the report discusses the challenges of sustainable financing for the safety net and opportunities to ensure safety net financing to meet the needs of vulnerable populations. Each section contains recommendations for state and federal policymakers to bolster safety net infrastructure to help ensure that the safety net remains viable to serve those vulnerable populations who will continue to depend on it.

CONTEXT: THE PATIENTS IN THE SAFETY NET

While data for the full spectrum of safety net providers is not readily available, information on health centers provides an example of current safety net patient demographics. Federally-funded health centers primarily serve relatively young (70 percent are under 45), low-income (71.8 percent at or below 100 percent of the federal poverty level [FPL]) populations. These populations also tend to be diverse (62.3 percent racial or ethnic minorities) and multi-lingual (24.3 percent better served in a language other than English).¹⁵ Health center patients also generally have more complex conditions, with 25 percent of health center patient visits involving serious and chronic conditions, compared to 9 percent of private physician office visits.¹⁶

PREDICTED CHANGES TO CASE MIX AT SAFETY NET PROVIDERS

Following the implementation of health reform, many of the low-income adults newly insured under Medicaid are expected to be in fair or poor health, with many complicated medical and behavioral health issues.¹⁷ At the same time, the overall caseload at safety net clinics and hospitals may grow tremendously, potentially decreasing the proportion of severely ill patients overall in some safety net settings. These shifts in case mix underline the importance of accurate risk adjustment mechanisms to ensure that providers who take on patients with complex needs are fairly compensated for the services they provide.

The experience in Massachusetts, which expanded coverage in 2006, may or may not be predictive. Following the state's health reforms, health centers there saw total caseloads grow by 31 percent between 2005 and 2009.¹⁸ Existing health center patients who gained insurance continued to seek care in these settings, and were joined by other newly insured individuals who had had no usual source of care. Safety net hospitals, which saw nonemergency ambulatory care visits grow twice as fast as visits to non-safety net hospitals from 2006 to 2009,¹⁹ also continued to see their previously uninsured patients who now qualified for insurance under Medicaid or through exchanges after Massachusetts' reform.²⁰

Responses to the 2009 Massachusetts Health Reform Survey showed that a majority of patients who used safety net providers did so because they were affordable (73.8 percent), convenient (79.3 percent), and provided needed services beyond just medical care (52 percent), while only a quarter of respondents reported they used safety net facilities because they had problems getting an appointment elsewhere.²¹ Meanwhile, wait times at private primary care physicians' offices grew²² and a shortage of these providers was a concern,²³ indicating that mainstream primary care providers may not have been prepared to take on large numbers of new patients. While it is difficult to project where those newly insured under the ACA will seek care—from traditional safety net providers or from mainstream providers—safety net providers will be especially prepared to take on these vulnerable populations.

MAJOR ISSUES AND POLICY OPTIONS FOR SUSTAINING AND BUILDING THE WORKFORCE NEEDED FOR THE SAFETY NET

The safety net workforce is already stretched in many areas as providers strive to meet the complex medical, behavioral, and social needs of their patients, often with limited funds. A surge in demand is anticipated as the previously uninsured gain coverage, exacerbating current shortages of primary, specialty, mental health, and oral health care providers, particularly those who can provide culturally competent care for vulnerable populations. At the same time, the current workforce is aging and geographically misaligned with needs.^{24,25} In addition, as the health care delivery system evolves to make more extensive use of team-based care, electronic medical records, and care coordination, the health care workforce must acquire new skills not historically taught in health professional schools. Many of the factors that affect the intensifying health care workforce shortage are not unique to the safety net, and many of the solutions proposed to ease shortages within the safety net may also benefit the health care system as a whole. Optimally, safety net providers would employ similar types of health professionals and ensure the same quality and level of care as other health care providers, regardless of location or insurance status of the individuals served. In reality, workforce shortages are already acute within the safety net. Both insured and uninsured health center patients have difficulty accessing specialists.²⁶

Several major issues exacerbate the strain on health care professional shortages, particularly for safety net providers. Four workforce issues in particular, while not specific to the safety net, are perhaps more acutely felt by safety net providers: 1) provider scopes of practice may limit the reach of the existing workforce; 2) reimbursement policies restrict who can provide care; 3) telehealth regulations hamper the wider adoption of this technology; and 4) the financing streams for workforce training are misaligned with need. This section describes these issues and also proposes possible solutions that can extend the existing safety net workforce to meet the needs of vulnerable populations and begin to train providers who can serve effectively in the safety net in the near term. Longer-term solutions that expand the health care workforce pipeline, while also important, are beyond the scope of this report.

PROVIDER SCOPES OF PRACTICE

Scopes of practice are state licensing rules that define the activities that different health care providers may perform. In many states, scopes of practice for non-physician clinicians are more restrictive than is suggested by the educational and national certification standards for these providers.²⁷ In contrast, the Institute of Medicine recommends, “scope-of-practice regulations in all states should reflect the full extent... of each profession’s education and training.”²⁸ Some models already have been developed and tested to expand and strengthen a state’s health care workforce by revising scope of practice regulations. For example, through a series of bills passed in 2009, Pennsylvania removed restrictions that had prevented licensed health care providers from practicing to the fullest extent of their education and training. Scopes of practice were broadened in discreet, specific areas for providers including: nurse practitioners, physician assistants, nurse midwives, physical therapists, and dental hygienists.²⁹ These changes were part of a broader initiative, called “Prescription for Pennsylvania,” focused on alleviating workforce shortages, particularly for primary care providers.

Scope of practice regulations may require physician oversight of non-physician providers, which can unintentionally limit the reach of the health care workforce. In 17 states and the District of Columbia, Nurse Practitioners (NPs) can practice independently, but in the remaining 33 states, they must practice either in collaboration with or under the supervision of a physician.³⁰ States vary in their requirements

for that supervision, and regulations can be crafted to make supervision less of a barrier. For example, Michigan allows the physician supervision of NPs to be conducted telephonically. More independent practice by NPs can help ease provider shortages, particularly in underserved areas where it can be difficult to find physicians willing and able to take on practice agreements with advanced practice nurses. States may wish to adjust scopes of practice along the continuum of supervision towards more independent roles for NPs.

In contrast to NPs, Physician Assistants (PAs) practice under physician supervision in all states. But similar to the relationship with NPs, state regulations defining physician supervision of PAs vary.³¹ In each state, the regulations governing NPs and PAs may influence employment preferences at community health centers and other safety net providers. States may wish to review NP and PA regulations together to ensure no unintentional regulatory burdens deter these professionals from full workforce participation, or influence a practice's preference for one professional type over another in unintentional ways.

Licensing New Health Professional Types

In addition to imposing practice restrictions on established provider types, state licensing processes can impede the diffusion of new types of health care providers. State licensing boards may be slow to recognize new provider types or may write scope of practice laws narrowly. The evolving health care delivery system will require new kinds of professionals such as dental aides, patient navigators, and community health workers to help efficiently deliver care, particularly within community settings. Massachusetts, New Mexico, and other states are developing a role for community health workers in health care systems by investing in their formal training, supervision, and integration into the health care setting.³² As new provider types join health care teams, their scopes of practice can be defined to maximize the efficient provision of quality care.

Inter-State Licensing

Another strategy for alleviating provider shortages is inter-state licensing reciprocity. The Nurse Licensure Compact allows nurses to have one multistate license, with the ability to practice in both their home state and other states that are party to the Compact.³³ Although model legislation to facilitate its adoption has been available since 1998, only 24 states currently recognize the Compact. The Compact increases nurses' mobility and ability to practice across state lines, including through telehealth. Reciprocity agreements can also be extended to other providers, such as pharmacists.

Health care providers who are federal employees, such as those working in the Veteran's Administration (VA) system, are allowed to practice in all 50 states without needing to obtain individual state licenses. This can help facilitate diffusion of new provider types. One example is the recently developed "clinical nurse leader." This master's degree-level trained nurse generalist works as part of an inter-professional team to coordinate care, collect and evaluate patient outcomes, and assess risk.³⁴ Clinical nurse leaders are already practicing in the VA system.³⁵ One related strategy to alleviating provider shortages may be to "deem" providers working at Federally Qualified Health Centers (FQHCs) to be federal employees.

Future Roles for State Licensing Boards

In the future, there may be a need to reconsider the roles state licensing boards play as the health care system evolves to more integrated models of team-based care. Historically, licensing boards are organized around single professions but practice today is moving to team-based care. Over the longer term, states may wish to re-examine how licensing is conducted. Select data from the boards could be shared across and within states to increase efficiencies and lessen administrative burden. Unified licensure applications

or credentialing databases, like the Federation Credentials Verification Service and Federation Physician Data Center, both maintained by the Federation of State Medical Boards,³⁶ could serve as a foundation for a common set of licensing standards. This common set of standards could then be approved by the National Committee for Quality Assurance (NCQA) or Medicare to provide quality oversight and legitimacy. Caution is merited, however, as current state licensing regulations are greatly influenced by professional associations, raising concerns that a national standard might be influenced toward more, rather than less, restrictive scopes of practice. This would obviously thwart the goal of having all providers practice at the top of their qualifications. Ideally, licensing bodies would be nimble enough to respond to changing practice needs, and licensing standards would continually be updated based on new evidence as the health care system evolves.

REIMBURSEMENT POLICIES

In some circumstances in which scope of practice regulations clearly permit the provision of care by non-physician providers, it is reimbursement policies requiring physician involvement that can restrict the most efficient use of these other professionals. Like scope of practice updates, reimbursement policies often lag behind the development of new health care professional types. For example, the federal Health Resources and Services Administration (HRSA) invested in supporting the training of PAs beginning in 1971, but Medicare began uniformly reimbursing these providers in all settings only in 1997.³⁷ (Medicare previously reimbursed limited physician assistant services in certain settings, such as rural areas and nursing homes.) Without Medicare recognition, private payers also did not reimburse for PA services.

Today, health plans and health systems that are implementing creative care delivery teams continue to struggle with the inability to reimburse for treatment services delivered by non-physician provider types. Current laws and regulations often specify that a physician must deliver or supervise services in order to receive reimbursement, or otherwise specify service limits that may unnecessarily hamper the use of non-traditional provider types. As a first step towards a remedy, Centers for Medicare and Medicaid Services (CMS) policies included in managed care regulations and the checklist for actuarial soundness could be reviewed for the limitations they place on states and providers.

Going forward, workforce models and payment models can be developed in concert to promote the use of the full spectrum of providers. The appropriate use of non-physician providers on care teams could be supported through payment models such as bundled payments or monthly care management payments, which do not rely on individual providers submitting claims through fee-for-service systems. Payment for non-clinical services or to unlicensed members of a care team, such as community health workers, could be included in these payment models. In contrast to additional fee-for-service payments to newly evolving provider types, bundled payment methodologies afford greater flexibility to a care team to meet patient needs. In addition, the recent recognition of roles for non-physician providers such as NPs and PAs in patient-centered medical home (PCMH) models provides additional avenues to test payment models that support non-physician providers in expanded roles.³⁸

States are already implementing bundled payments to support the development of community-based multi-disciplinary care teams. A good example of this is Vermont's Blueprint for Health medical home model. In Vermont, both commercial and public payers share in the costs of multi-disciplinary, community health teams that include community health workers, behavioral health staff, nutritionists, care managers, and others.³⁹ The Rhode Island Chronic Care Sustainability Initiative, a multi-payer medical home project, provides another example of how payers can share in the proportional costs of nurse care managers at the practice site.⁴⁰ Section 2703 health homes authorized by the ACA offer states yet additional opportunities to support the development of multi-disciplinary teams to care for Medicaid enrollees

with chronic illnesses. Health home state plan amendments approved in Missouri⁴¹ and Rhode Island⁴² demonstrate how non-primary care providers (community mental health centers and family centers, respectively) can receive payments to support their new roles as health home providers for vulnerable populations.

At the federal level, integration of care for Medicare and Medicaid dual eligibles is beginning to allow development of new workforce models to respond to care needs. Under the State Demonstrations to Integrate Care for Dual Eligible Individuals, 15 states received funding to implement models that coordinate primary, behavioral, and long-term supports and services for dual eligible individuals.⁴³ Through this grant program, Michigan has successfully brought new providers—patient advocates, certified peer support personnel, care coordination staff—onto care teams that work with dually eligible populations.⁴⁴

As new provider types are created throughout the health care system to increase efficiency, payers should evaluate which provider types improve efficiency and quality in care delivery and develop reimbursement systems that best incentivize their appropriate deployment. Payment strategies for public programs should be designed to function within both Medicaid and exchange systems so that providers, insurers, and managed care plans can participate in both systems. This can help maintain continuity of providers and care management as vulnerable populations cycle through different insurance coverage sources.

TELEHEALTH REGULATIONS AND THE ROLE OF VIRTUAL HEALTH CARE

Telehealth and virtual health are becoming more prevalent throughout the health care system. Consultations between providers and patients, or between primary care providers and specialists, may take place via phone, email, or webcam. Clinic-based telehealth services include teleradiology and telepsychiatry. Use of telehealth can extend the capacity of existing providers in the safety net in two ways. First, using virtual methods to communicate with patients frees providers to see those patients who need in-person attention. Second, telehealth technology is used to connect practitioners and clinical experts in large hospitals or academic medical centers with patients and their primary care providers in smaller hospitals or critical access hospitals, which are typically located in more remote locations. Employing virtual health technologies is not without challenges, as existing laws and reimbursement policies can make it difficult to adopt these strategies.

The use of telehealth raises the legal question of where the patient-provider interaction is taking place. Current state laws and CMS regulations often assign the interaction to the location of the patient. This interpretation requires that the provider be licensed in the state where the patient is located, potentially requiring the provider to maintain multiple state licenses.⁴⁵ If the interpretation were reversed—such that the encounter were considered to occur at the location of the provider rather than the patient—this licensing issue could be eliminated.

Similar barriers to the diffusion of telehealth are erected by regulations that require providers to be credentialed at each care site where a patient seeks telehealth services. Under these regulations, providers must maintain credentials with potentially myriad care sites. A recent CMS rule simplifies how hospitals partner with hospital and non-hospital telehealth entities (such as teleradiology facilities) to deliver care to their patients. The final rule allows hospitals and critical access hospitals to rely on the host site's credentialing of providers. However, the final rule continues to require that providers who render telehealth services must be licensed in the state where the patient is seeking care.⁴⁶

Finally, reimbursement restrictions may limit the optimal use of telehealth care delivery methods. Some insurers require a face-to-face encounter between a patient and a provider before subsequent telehealth encounters can be reimbursed. Elimination of this requirement could vastly expand the use of telehealth technology precisely in those underserved rural areas where it might be most usefully employed. In addition, the cost-based reimbursement paid to FQHCs complicates payments for telehealth delivered from one community health center or rural health clinic to another, because often, only one site is allowed to bill for the service.⁴⁷ Finally, specialty care providers who consult virtually with primary care providers have difficulty being reimbursed unless both providers are part of a single integrated system.

Updated state regulations and private payer rules could do much to facilitate the use of telehealth to serve more patients, particularly in rural areas where provider shortages are most extreme. Importantly, telehealth policies could be aligned across states wherever possible to ensure that patients can receive care from the most appropriate provider regardless of location.

SUPPORT FOR WORKFORCE TRAINING IN PRIMARY CARE AND SAFETY NET SETTINGS

States, the federal government and private foundations have all historically invested in health care workforce training. States fund university, community college, and other institutions to train a wide range of health professionals in hospital and community-based locations. At the federal level, HRSA provides funding for scholarships, loan repayment, and other training opportunities. This includes support for the expansion of the primary care workforce through grants to educational institutions (some of which, in turn, support scholarships and loans to individuals) that support training in primary care medicine, dentistry, optometry, podiatry, pharmacy, and nursing.⁴⁸ Foundation involvement includes both direct support and research. For example, the Robert Wood Johnson Foundation provides support to nursing faculty and nursing students⁴⁹ and the Commonwealth Fund Mongan Fellowship trains physicians to serve vulnerable populations.⁵⁰ In addition, the Commonwealth Fund supports research to help understand health care workforce dynamics, recently releasing a study that investigated factors that might contribute to primary care physicians deciding to discontinue their practices.⁵¹

Safety net providers, especially major public and other safety net hospitals, already serve as important training centers for health professionals. The ACA provides additional opportunities to improve training for health care providers who serve within the safety net. The law includes funding for training, scholarships, and loan repayments for primary care providers working in underserved areas that expand existing HRSA programs. The ACA also allowed HRSA to expand eligibility for faculty loan repayment programs to schools offering PA education programs and to increase loan repayments to nurse faculty.⁵² Finally, the ACA authorizes HRSA to fund teaching health centers that allow training of more primary care residents and dentists in community-based ambulatory patient care settings that include FQHCs, community mental health clinics, rural health clinics, and others.⁵³

While a full-time, accredited residency may not be a viable option at every community-based practice, models exist that expose residents to training rotations at smaller health centers or community-based programs instead of requiring the usual three-year residency at a single institution. At Hidalgo Medical Services in New Mexico, physician trainees from the University of New Mexico can complete portions of their residencies at a community health center. Similarly, the A.T. Still dental and medical school in Arizona allows students to spend three of their four training years at community health centers.⁵⁴ With funding available through the Health Care Innovation Challenge issued by the Innovation Center at CMS,⁵⁵ six pharmacy residents will gain experience in safety net settings in California.⁵⁶

Existing workforce training funds, whether authorized through the ACA or from other avenues, could be targeted specifically to build the safety net workforce. For instance, funds to support workforce development—loan repayment programs or Medicare graduate medical education (GME) payments—could be preferentially awarded to institutions within health professional shortage areas (HPSAs) and medically underserved areas (MUAs) or that serve medically underserved populations (MUPs). States could likewise target their Medicaid GME payments to underserved areas through the use of waivers. Additional support for primary care workforce development could be achieved by removing residency caps for certain primary care specialties, such as family medicine. This could be done nationwide or for federal HPSA or MUA designations. This strategy has proven successful in the past, as when dental residency slots were exempted from caps to encourage additional training of dentists.

Training Interdisciplinary Care Teams

Delivery system models that incorporate interdisciplinary care teams require a workforce that has different skills than the current primary care model. As new types of health care professionals enter the workforce, interdisciplinary training will be an effective way to introduce physicians to these providers and the value of their skill sets. For both new and existing providers, training focused on how to work in a team setting, including communication, responsibilities, and information management, will be important to meeting the needs of vulnerable populations. At Loyola University in Chicago, physician and nursing students conduct training simulations together in multi-disciplinary teams.⁵⁷ The development of medical homes has provided another venue that promotes team-based care. For example, states including Minnesota, Pennsylvania, Massachusetts, and Vermont have provided for learning collaboratives (a method to accelerate practice performance in a group setting) to learn about core elements of the medical home model.⁵⁸ Previous learning collaboratives sponsored by HRSA, such as the Break Through Quality Collaborative⁵⁹ focused on health disparities, could also be replicated to help develop team-based models of care.

MAJOR ISSUES AND POLICY OPTIONS IN SAFETY NET FINANCING

As a result of large-scale changes in insurance coverage as the ACA is implemented, financing streams for safety net providers will shift as the ACA provides significant resources for further development of some safety net providers, while reducing funding streams for others. For example, federal funding in the form of DSH payments will be substantially reduced as those dollars are “recycled” into expanding Medicaid and providing federal subsidies to support the purchase of health insurance.⁶⁰ The repercussions of financing stream shifts will be different—and potentially more severe—in states that choose not to take up the Medicaid expansion compared with states that do expand their Medicaid programs to cover adults without dependent children. Due to differences in current funding streams, impacts of that decision will also be different for safety net hospitals than for safety net clinics. In either case, the financial stresses of adapting to the changing health care delivery system are magnified for safety net providers. The vulnerable populations served by the safety net—poor and underserved communities—may not fundamentally change, but their sources of coverage, and thus, financing for safety net providers who care for these populations, will shift dramatically.

To adapt to these changing funding streams, safety net providers will need to engage in new and ongoing payment reform efforts, negotiate their roles with state Medicaid programs and qualified health plans (QHPs) sold through newly established insurance exchanges, and maintain an infrastructure to serve the remaining uninsured. This section describes some payment reform options generally, and then outlines the challenges and opportunities to ensure safety net financing necessary to meet the needs of vulnerable populations who receive coverage through Medicaid, through QHPs, or remain uninsured.

PAYMENT REFORM IN THE SAFETY NET

Safety net providers are supported by various funding streams from federal agencies, local tax levies, and other sources, as well as by third-party reimbursements or prospective payments. Many of these financing methods are specific to a certain provider type or to a unique health care service. These targeted financing approaches can pose barriers to payment reforms that promote care coordination. Since care coordination would benefit patients, financing mechanisms that allow for care coordination while providing adequate resources to serve vulnerable populations are needed. To be successful, such efforts require capital expenditures to purchase electronic medical records systems, reconfigure delivery systems, and update care protocols. Low margins at many safety net providers prohibit such investments with current funding; select opportunities available through the ACA, like grants to expand community health center infrastructure,⁶¹ may provide an avenue for financing system upgrades.

Payment Reform Challenges and Opportunities for FQHCs

States have been challenged with how to include FQHCs in systemic reform initiatives. The required Prospective Payment System (PPS) for FQHCs was developed as a bundled payment based on detailed data on costs and services collected by health centers. This detailed data collection allowed FQHCs to demonstrate the value of the services they deliver. Alternative payment methodologies (APM) to PPS are permissible under current law as long as FQHCs agree to the APM and receive a rate that equals or exceeds the PPS rate, allowing states some flexibility that could help them partner with these safety net providers in incentive-based payment reforms.

More needs to be done to help states understand the possibilities for permissible APMs and to share successful examples that already exist. For example, in Michigan, the primary care association negotiated

an alternative payment methodology with Medicaid on behalf of FQHCs. Under this methodology, the state's payments to each FQHC are capped, with caps adjusted for rural and urban areas. Using a different model, Molina Health Care in New Mexico has saved millions of dollars by paying a monthly care coordination fee on top of the PPS rate for high-cost Medicaid enrollees.⁶² The initial outlay of a care coordination fee generates savings from a resulting decreased need for more expensive subspecialty and tertiary care. In yet another approach, Oregon Medicaid is currently developing with their state primary care association a global budget for FQHCs in 2012, providing a per-member-per-month payment that gives the FQHCs the flexibility they want to better care for their patients' physical and psychosocial needs. This global budget will be offered in exchange for a cap set to the FQHCs 2011 PPS budget.⁶³ This proposed payment strategy is a part of the state's plans to implement an accountable care model statewide known as Coordinated Care Organizations.⁶⁴

Additional alternative payment strategies for FQHCs may be developed as QHPs negotiate rates with FQHCs. The final rule issued by CMS allows QHPs to contract with FQHCs at the Medicaid PPS rate or by "mutually agreeing upon payment rates" less than PPS as long as they are at least equal to the "generally applicable payment rates of the issuer." The rule does not specify a payment floor.⁶⁵

Payment Reform Challenges and Opportunities for Safety Net Hospitals

Safety net hospitals serve a disproportionate number of low-income, medically vulnerable patients, many of whom are uninsured, underinsured, or covered by Medicaid.⁶⁶ Even as a greater share of patients are insured, safety net hospitals will continue to need funding for services, people, and infrastructure costs not covered by insurance reimbursement. As a result of the ACA, DSH funds are calibrated to decrease as more people gain insurance coverage,⁶⁷ theoretically lessening the proportion of uncompensated care. This could potentially add strain to those safety net hospitals that continue to deliver large amounts of uncompensated care.

Recommendations from The Commonwealth Fund Commission on a High Performance Health System suggest that states should target remaining DSH payments to support hospitals that provide the greatest amount of uncompensated care. To do so, the Commission suggests DSH funds could be linked specifically to services provided to uninsured patients. In this scenario, safety net hospitals would "bill" a state's DSH pool for services rendered to uninsured patients and receive reimbursement valued at some fraction of the Medicaid rate.⁶⁸ Many operational details remain to be determined if these policy recommendations for targeting DSH payments are implemented. Targeting DSH funds to pay for the uninsured requires agreeing to a definition of the term 'uninsured' after 2014. Would the underinsured whose insurance does not cover a needed service qualify? Would those who are eligible for but not enrolled in Medicaid or other insurance qualify? Finally, targeting DSH funds requires a decision about how to allocate DSH funds currently included in various state waivers.

Safety net hospitals could also use support in participating in integrated delivery system efforts. One recommendation from The Commonwealth Fund Commission on a High Performance Health System is to target section 1115 waivers to capital expenditures, as has been done in New York and California.⁶⁹ Already, safety net hospitals are participating in Health Care Innovation Awards projects supported by CMS' Innovation Center to improve integration in areas such as patient-centered medical homes, post-acute care transitions, and chronic disease management.⁷⁰

Additional Payment Reform Opportunities

There are additional opportunities to develop and test alternative payments for safety net providers in a reform context. Through the State Demonstrations to Integrate Care for Dual Eligible Individuals, the CMS Innovation Center awarded 15 states up to \$1 million each to help coordinate care for people eligible for both Medicaid and Medicare. The program will support payment strategies that fully coordinate primary, acute, and behavioral care with long-term supports and services in an effort to provide individuals with higher-quality, cost-effective care.⁷¹ Additional funds will be available from the CMS Innovation Center in late 2012 through the State Innovation Models Initiative to design and test multi-payer payment and delivery system models that include commercial, employer-sponsored, and public health plans. Up to 25 states will receive awards to design models, while up to five states will receive support to test models that have already been developed.⁷² Mental health parity may be another lever that encourages safety net providers to formally coordinate around care delivery and payment; providers who formerly worked independently may find that mental health parity gives them a rationale to create more formal partnerships, or even accept bundled or shared payments for their services.

REVENUE MIX CHANGES IN THE SAFETY NET FOLLOWING HEALTH REFORM

Currently, safety net providers rely heavily on Medicaid for financing. In 2010, the majority of federally-funded health center patients either had Medicaid coverage (38.5 percent) or were uninsured (37.5 percent).⁷³ Public hospitals had a similar composition, with Medicaid enrollees and the uninsured making up more than half of outpatient visits (27 percent Medicaid, 30 percent uninsured) and hospital discharges (36 percent Medicaid, 18 percent uninsured).⁷⁴ As the proportion of people with Medicaid coverage increases after 2014 in states that take up the Medicaid expansion, safety net health centers and hospitals will become even more dependent on Medicaid financing. At the same time, total DSH payments to hospitals are projected to decrease. All safety net hospitals will be affected by reduced DSH payments. In states that do not take up the Medicaid expansion, safety net hospitals will see no offsetting increase in reimbursements for services provided to still-uninsured patients. These changes, in combination with the added pressure of difficult state and federal budgets, are likely to exact a toll on financing for the safety net.

In 2014, many currently uninsured individuals will gain coverage. For the vulnerable populations among them, the biggest challenge will no longer be health insurance coverage, but access to needed services. Changes in economic circumstances and family status will lead some of these vulnerable populations to cycle through different coverage sources—Medicaid and qualified health plans—and even through periods of uninsurance. Safety net providers can play a significant role in providing consistent care even as coverage status changes. But to do so, safety net providers must be able to obtain reimbursement from different payers.

Populations Gaining Coverage through Medicaid

The expansion of Medicaid to new populations in 2014 will provide many of them for the first time with a comprehensive package of health care benefits. This expansion also poses challenges for providers to build capacity to meet the needs of newly insured individuals. For current safety net providers, it is difficult to predict which newly insured patients will continue to seek care in these settings and which may move to other providers. While safety net providers may have special competency in linguistic, psychosocial, and community services that help in caring for the uninsured, Medicaid is premised upon the concept that “any

willing provider” may provide services and emphasizes freedom for enrollees to choose their providers. Whether newly eligible Medicaid recipients will choose to receive their care from safety net providers remains to be seen, although it was largely the case in Massachusetts.

At the same time that the ACA’s Medicaid expansion is being implemented in many states, some large states—including Florida, Texas, and California—are expanding their Medicaid managed care programs to cover more Medicaid enrollees. (Notably, not all states are expanding commercial Medicaid managed care. Connecticut, for example, chose to replace its commercial managed care delivery model in 2012 with a state-run plan administered by a safety net network.)⁷⁵ Safety net providers may find it difficult to continue serving their existing clients if those clients are enrolled in Medicaid managed care plans that do not include the safety net provider in their networks. Medicaid agencies may wish to consider the role that safety net providers can play in serving Medicaid enrollees. Where relevant, Medicaid agencies could design managed care contracts to ensure inclusion of safety net providers.⁷⁶

Regardless of the service delivery model—fee-for-service or managed care—state Medicaid programs face significant financial strains in a tight economy. State legislatures often enact across-the-board cuts to provider rates as a way to align outlays with available funds. However, cutting payments on a more differentiated basis may have better health and long-term financial outcomes. In North Carolina, for example, primary care providers were protected from the deepest cuts to provider rates. The ACA’s increased Medicaid payments for primary care services may help alleviate some of the financial strain on Medicaid-participating primary care providers.⁷⁷

Populations Gaining Coverage through Qualified Health Plans

Approximately 20 million individuals will gain coverage through qualified health plans sold on newly established health insurance exchanges.⁷⁸ Though essential health benefits requirements will assure that QHPs offer a minimum level of coverage, the benefits provided in these plans are expected to be less comprehensive than those offered through Medicaid, and individuals will be responsible for cost-sharing through premiums and co-payments.

Many questions remain about how health centers and other safety net providers will participate in the networks of QHPs and how they will be paid by those QHPs. The final rule on qualified health plans issued by CMS on March 27, 2012, requires that a QHP have a “...sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area...” These providers are described as those that serve predominantly low-income, underserved populations including, but not limited to, providers who qualify for the 340B drug discount program or other federal funding (i.e., Federally Qualified Health Centers, family planning centers, DSH hospitals, etc.). While states can—and were encouraged to in the preamble of the rule—issue more stringent or specific requirements regarding provider inclusion, CMS chose not to include a comprehensive list of providers or require specific essential community providers in QHP networks.⁷⁹

Since many states are likely to delegate the enforcement of QHP standards to departments of insurance, there is a need to educate staff at these agencies about the role the safety net has historically played in serving Medicaid and the uninsured. State departments of insurance could consider updating network adequacy standards for QHPs in ways that incentivize contracting with safety net providers. For example, instead of setting standards as simply a ratio of physicians to enrollees, departments of insurance could require that network adequacy take into account types of providers, segments of the market that each

serves, and wait times for appointments, thereby helping ensure that networks are adequate to provide needed care to vulnerable populations.

In addition to providing several other pieces of information, insurance exchanges will be required to publish provider directories for QHPs, either by linking to QHP websites or compiling a full list of providers.⁸⁰ Current state experience implementing the Children's Health Insurance Program Reauthorization Act (CHIPRA) requirement to list all dental providers that accept Medicaid and CHIP on the U.S. Department of Health and Human Services (HHS) Insure Kids Now website⁸¹ demonstrates that keeping these lists up-to-date and accurate can be an extremely difficult task.⁸² Patients who are unable to access QHP-affiliated providers may access services in the safety net regardless of whether that safety net provider is part of the QHP network.

Populations Who Remain Uninsured

Despite gains in coverage through Medicaid and exchanges, approximately 30 million individuals are projected to remain uninsured after implementation of the ACA.⁸³ The numbers of uninsured will be higher in states that opt not to take up the Medicaid expansion, which will pose special challenges to the financial viability of safety net providers—hospitals, primary care clinics, and other safety net providers—in those states. Of the remaining uninsured, approximately five million may be undocumented immigrants who are ineligible for Medicaid and federal subsidies.⁸⁴ When a significant proportion of the uninsured seeking care in the safety net are undocumented immigrants, discussing financing for the safety net with policymakers becomes a politically challenging issue. Simultaneously, as the overall number of uninsured decreases, support for the overall constituency of the uninsured may weaken, making it more difficult to secure funding to serve them. Who the uninsured are—or are perceived to be—may influence political and financial support for safety net providers as much as the medical needs of safety net clients and the abilities of various safety net or mainstream providers to meet those needs. This may influence many of the current funding streams that support safety net providers, from federal grants to local tax levies to allocation of funds to support uncompensated care in public hospitals.

There is wide agreement that federal grants that support care for the under- and uninsured should be targeted to providers that serve a significant number or proportion of uninsured patients. However, there is less agreement as to the other criteria to use for targeting. Some feel that only certain provider types should be eligible, while others advocate for grant funds to be distributed to any provider—public or private—with a significant share of Medicaid or uninsured patients. Some suggest that the makeup of the community be taken into account, so that grants are targeted to areas of high need. This must be balanced against accountability for funds that require a minimum infrastructure.

Variability Among Safety Net Providers

Financing issues and sustainability of the safety net are not the same across all safety net providers. Full-service safety net providers, like community health centers, face different challenges than do either safety net hospitals or safety net providers specializing in care for a particular population or providing a unique service, e.g. Maternal and Child Health providers, HIV clinics, school-based health centers, family planning clinics, and some mental health providers. Throughout the safety net, providers are preparing for the changes that will be brought on by health reform implementation. For example, FQHCs are building on their experience in providing care coordination services and serving as medical homes. Leading hospitals are building on their information technology systems, developing integrated systems with primary and subspecialty care providers, and aligning their safety net and academic missions.⁸⁵

Specialized provider types are already thinking about how to prepare for the shift in payer mix as patients gain insurance. They are considering options including adding additional primary care services, aligning with larger health centers or other systems, or becoming full-service health centers themselves. In Michigan, free clinics are working with the state's Blue Cross Blue Shield plans to plan for adjusting their practices to fit the changing health care landscape. Other free clinics, including those supported by local tax levies, will similarly need to restructure. Which safety net providers thrive after health reform may depend in part on whether providers can adapt to changing payer mix and form partnerships with new payers when needed.

CONCLUSION

Health care experts agree that safety net providers will remain an important part of the health care delivery system, serving much of the newly insured population and continuing to serve as the safety net for the remaining uninsured and other vulnerable populations. Because safety net providers care for patients with some of the most complex needs and the fewest resources, all of the stresses of health reform on the health care delivery system will be amplified within the safety net. At the same time, safety net providers have historically demonstrated creativity in meeting those needs, which has put some of them at the forefront of progressive patient care models such as medical homes or integrated behavioral and physical health care. Based on these experiences, safety net providers can bring a wealth of lessons to the mainstream health care delivery system about providing high quality, efficient patient care.

In this era of change, the safety net needs support to be able to continue making strides and adapting to the demands brought on by health care reform. Policies that enable the safety net to engage a diverse workforce to serve vulnerable populations are critical. States and private payers can revise their regulations and policies where needed to ensure that providers willing and able to serve in the safety net are able to do so, are empowered to work in teams and to make use of new care models, and are able to be paid for their work. Federal and state policymakers must also re-examine the financing streams that support safety net institutions. The anticipated changes to payer mix in the safety net, brought on by the ACA's provisions affecting Medicaid eligibility, DSH reductions, and regulations for new qualified health plans, will alter the payment streams that keep the safety net afloat.

These changes, if managed carefully, provide opportunities to structure payments in ways that incentivize desired outcomes. Payment reforms enacted in concert with workforce innovations can support team-based care, patient-centered medical homes, and additional care coordination and care management models that emphasize the primary care and enabling services that have the potential to bend the cost curve and improve health outcomes. In combination, support for workforce and financing models that support efficient, high-quality care in safety net settings can help ensure that the safety net remains viable to serve those vulnerable populations who will continue to depend on it.

APPENDICES

APPENDIX A – SELECT PROVISIONS OF THE AFFORDABLE CARE ACT RELEVANT TO SUSTAINING A SAFETY NET INFRASTRUCTURE TO MEET THE HEALTH CARE NEEDS OF VULNERABLE POPULATIONS

PROVISION	SUMMARY OF PROVISION	IMPLEMENTATION STATUS AS OF AUGUST 2012
<p>Health Centers and Clinics</p> <p>§ 5601, § 10503, § 4101, § 5208, § 10504</p>	<p>Provides \$11 billion for Health Center Program Expansion, beginning in FY2011, including \$9.5 billion to expand operational capacity and enhance medical, oral and behavioral health services, and \$1.5 billion to expand and improve existing facilities and construct new sites. Also permanently authorizes the program.</p> <p>Establishes grant programs for the establishment or operation of school-based health centers (SBHCs).</p> <p>Authorizes Nurse-managed health clinics (NMHC) and establishes a grant program to fund the operation of these clinics.</p> <p>Authorizes a three-year demonstration project in up to 10 states to provide access to comprehensive health care to the uninsured at reduced fees.</p>	<p>On October 8, 2010, HHS announced grant awards of \$727 million to 143 community health centers for infrastructure improvements.</p> <p>On June 20, 2012, HHS announced \$128.6 million in new grants to health centers in 41 states, DC, Puerto Rico, and the Northern Mariana Islands.</p> <p>On July 14, 2011, HHS announced awards of \$95 million to 278 SBHCs across the country. On December 8, 2011, another \$14 million was awarded to 45 SBHCs.</p> <p>On September 27, 2010, HHS announced \$14.8 million to fund 10 grantees for three years to operate NMHCs to provide primary care.</p> <p>No funds have been appropriated for the demonstration project to provide access to affordable care.</p>
<p>National Health Service Corps</p> <p>§ 5207, § 10503, § 10503, § 5508(b), § 5602</p>	<p>Provides \$1.5 billion in supplemental funding for National Health Service Corps (NHSC) for FY2011 – FY2015. The ACA also increases the amounts authorized for NHSC under the regular annual appropriations process and permanently authorizes the NHSC program. Makes programmatic changes to the NHSC program such as permitting NHSC clinicians to fulfill service commitments through part-time work, encouraging medical residency training in community-based sites (teaching health centers), and allowing providers to count time spent teaching toward fulfillment of NHSC commitment.</p> <p>The ACA also requires the Secretary of Health and Human Services to redefine how medically underserved populations and health professional shortage areas are calculated.</p>	<p>On February 13, 2012, HHS announced the NHSC had awarded \$9.1 million in funding to medical students in 30 states and DC who will serve as primary care doctors in communities with limited access to care. Funds for scholarships and loan repayments were authorized through FY2015.</p> <p>The maximum award amount under the NHSC loan repayment program that a NHSC member can receive annually (subject to a determination by the HRSA Administrator) is increased from \$35,000 to \$50,000, plus beginning in FY2012 the award amount can be increased annually by the HHS Secretary to reflect inflation.</p> <p>HRSA officials released recommendations for redefining medically underserved populations and health professional shortage areas on October 31, 2011.</p>

PROVISION	SUMMARY OF PROVISION	IMPLEMENTATION STATUS AS OF AUGUST 2012
Physician Workforce § 5301, § 5508(a) and (c), § 10501 (l), § 10502	<p>Authorizes and expands the primary care education and training programs under Title VII of the Public Health Services Act.</p> <p>Establishes the new Teaching Health Centers Development Grants to establish newly accredited or expanded primary care, community-based residency programs.</p> <p>Authorizes Rural Physician Training Grants to provide training to medical students interested in rural practice.</p> <p>Authorizes to be appropriated, upon receipt of an application from a governor, funds for debt service on, construction, or renovation of a hospital affiliated with a state's sole public medical and dental school.</p>	<p>On September 27, 2010, \$167.3 million was awarded to 82 primary care residency training programs under the Primary Care Residency Expansion.</p> <p>Since 2012, 13 centers have received funding under the teaching health center graduate medical education payment program.</p> <p>On May 26, 2010, HHS released an interim final rule defining “underserved rural community” for purposes of this grant. The ACA authorized \$4 million for each of FYs 2010 – 2013.</p>
Dental Workforce § 5303, § 5304	<p>Authorizes grants or contracts with entities to support training, provide financial assistance, and fund projects for dental students, residents, hygienists, practicing dentists, or dental faculty. Establishes a faculty loan repayment program.</p> <p>Authorizes Secretary to establish demonstration project awarding grants to 15 entities to train or employ alternative dental health care providers to increase access in rural and other underserved communities.</p>	<p>The ACA authorized \$30 million in FY2010 for these grants and contracts, but only \$15 million was appropriated. In FY2011 \$17 million was appropriated, in FY2012 \$20 million was appropriated, and \$20 million was requested to be appropriated for FY2013.</p> <p>HRSA has distributed approximately \$1 million per year in FYs 2010 – 2012 to institutions of higher learning as part of the dental faculty loan repayment program.</p> <p>HHS requested \$4.9 million for alternative dental care providers demonstration project in FY2012, but funds were not appropriated.</p>
Nursing Workforce § 5202, § 5310, § 5311, § 5309, § 5312, § 10501 (e)	<p>Increases available loan amounts for nursing students, and expands eligibility for the nursing student loan repayment and scholarship program to nurse faculty.</p> <p>Creates new Nurse Retention Grants to be provided to eligible entities for nurse retention and promotion “career ladder” programs.</p> <p>Requires Secretary to establish a demonstration program to provide recently qualified Nurse Practitioners with 12 months of training for careers as primary care providers in FQHCs and NMHCs.</p>	<p>On July 29, 2011 HHS announced \$71.3 million in grants to expand nursing education, training, retention, and diversity.</p> <p>109 awards totaling \$23.4 million dollars were awarded as part of the Nurse Faculty Loan Program, which assists registered nurses in completing their graduate education to become qualified nurse faculty. Through grants to eligible entities, awards offer partial loan forgiveness for borrowers that graduate and serve as full-time nursing faculty for the prescribed period of time.</p> <p>In March 2012, CMS called for applications for a new initiative designed to increase the nation's primary care workforce by supporting facilities that train Advanced Practice Registered Nurses (APRNs). Under this new initiative, CMS will begin making payments from the \$200 million of funds available in 2012 to the five eligible hospitals – Hospital of the University of Pennsylvania, Duke University Hospital, Scottsdale Healthcare Medical Center, Rush University Medical Center, Memorial Hermann-Texas Medical Center Hospital.</p>

PROVISION	SUMMARY OF PROVISION	IMPLEMENTATION STATUS AS OF AUGUST 2012
Public Health Workforce § 5204, § 5206, § 5313, § 10501 (m)(2)	<p>Authorizes the public health workforce loan repayment program to support public health or health professions students or degree holders who agree to work in public health agencies or a related training fellowship.</p> <p>Authorizes the Secretary to make grants to eligible educational entities to award scholarships for the training of mid-career professionals in public and allied health.</p> <p>Requires CDC to award grants to entities to promote health behaviors and outcomes through the use of community health workers (CHWs).</p> <p>Establishes preventive medicine and public health training grants for preventive medicine residency training.</p>	<p>Funds have not been appropriated for the public health workforce loan repayment program, for mid-career training scholarships, or for the use of Community Health Workers (CHWs) to promote healthy behaviors and outcomes.</p> <p>The preventive medicine residency program received \$9 million from the Prevention and Public Health Fund and 27 Public Health Training Centers were funded at \$16.8 million in FY2010 (\$15 million from Prevention and Public Health Fund). In FY2011, \$29.6 million was appropriated to HRSA for this provision (\$20 million from the Prevention and Public Health Fund).</p> <p>In FY2012, \$25 million was designated from the Prevention and Public Health Fund for Public Health Training Centers to provide preventive medicine training and establish a national coordinating center for Integrative Medicine Residency.</p> <p>On June 15, 2012, HRSA announced that \$2.5 million in grants were available to qualifying government entities and academic entities for preventive medicine resident training. 2012 grant proposals were reviewed in mid-August for grants to begin on September 30, 2012.</p>
Workforce Diversity § 5307, § 5403, § 5404	<p>Reauthorizes and amends a number of programs to increase the diversity of the health care workforce, including the nursing workforce, and create interdisciplinary community-based training. Also expands the role of the Area Health Education Center (AHEC) program, focused on increasing and improving health personnel services in medically underserved communities.</p>	<p>\$241 million was appropriated in FY2010 in discretionary funds for all Title VII Health Professions and \$200 million was appropriated from the Prevention and Public Health Fund for primary care training. \$241 million in discretionary funds was appropriated in FY2011.</p> <p>New grants for the AHEC program will be awarded on September 1, 2012.</p>
Allied Health Workforce Recruitment and Retention Programs § 5205	<p>Expands loan forgiveness to allied health professionals employed in federal, state, local or tribal public health agencies. Also includes allied health professions in acute care and ambulatory care facilities, and settings located in HPSAs, MUAs, or MUPs.</p>	<p>No funds have been appropriated.</p>

PROVISION	SUMMARY OF PROVISION	IMPLEMENTATION STATUS AS OF AUGUST 2012
Mental and Behavioral Health Education and Training Grants § 5306	Creates a new grant program that provides funding to educational institutions to support the recruitment and education of students in social work programs, interdisciplinary psychology training programs, and internships or field placements related to child and adolescent mental health; or to state licensed mental health organizations to train paraprofessionals.	On May 2, 2012, applications became available for this grant opportunity. Funding will be awarded on September 30, 2012.
Health Workforce Evaluation and Assessment § 5101, § 5102, § 5103	Establishes a National Health Care Workforce Commission to lead an evaluation and planning initiative for the nation's workforce. Establishes a grant program for states to undertake state-level health workforce planning and creates a National Center for Health Workforce Analysis to centralize data collection and analysis.	Appointments to the Commission were announced in September 2010. On September 27, 2010, \$5.6 million was awarded to 26 states to begin comprehensive health care workforce planning or implementation. Planning grants were to assess a state's current health care workforce, including through collection and analysis of data, and the examination of current resources, policies, and practices. Implementation grants are to convene stakeholders at state and regional levels to create development plans that address workforce needs. The National Center was established in 2010 and oversees a variety of projects that examine the nation's health workforce.
Essential Community Providers § 1311 (c)(1)(C)	Requirement that exchange plans contract with a sufficient number and geographic distribution of essential community providers.	HHS released a final rule on March 27, 2012 finalizing this provision. There are no requirements to contract with a specific number or type of provider.
FQHC Medicare Payments § 10501 (i)	Adds preventive services to the Federally Qualified Health Center Medicare payment rate and eliminates the Medicare payment cap on FQHC payments.	This provision applies to services furnished on or after January 1, 2011.
Disproportionate Share Hospital Payments § 2551, <i>Reconciliation Act</i> §1203	Reduces Disproportionate Share Hospital payments to states by \$18.1 billion by 2020.	Reductions in funding will begin in 2014.

PROVISION	SUMMARY OF PROVISION	IMPLEMENTATION STATUS AS OF AUGUST 2012
Payments to Primary Care Physicians <i>Reconciliation Act</i> § 1202	Increases Medicaid reimbursements for primary care and pediatric providers to Medicare levels in 2013 and 2014.	Proposed rule to implement the provision was released on May 11, 2012.
Improved Coordination for Dual Eligible Beneficiaries § 2601, § 2602	Authorizes a new Federal Coordinated Health Care Office that will oversee projects related to individuals eligible for both Medicaid and Medicare programs. Allows states to submit waivers for five-year demonstration projects around coordinating care for dual eligibles.	On April 14, 2011, HHS announced awards under the State Demonstrations to Integrate Care for Dual Eligible Individuals to 15 states for \$1 million each to design new approaches to better coordinate care for people eligible for both Medicaid and Medicare. States will design person-centered models that coordinate primary, acute, behavioral, and long-term supports and services for Medicare-Medicaid enrollees.
Medicaid Health Homes § 2703	Provides states with the option to receive an enhanced federal matching rate for expanding or implementing “health home” programs for Medicaid beneficiaries with chronic conditions.	As of June 2012, 14 states and DC had received planning grants, 4 states had submitted SPAs to CMS for approval, and 8 SPAs from 6 states had already been approved. <ul style="list-style-type: none"> • Approved – 6 states, 8 SPAs: IA; MO (2); NC; NY; OR; RI (2) • Submitted – 4 states: AL; NY [second]; OH; WI • States with Planning Grants – 14 and DC: AL, AR, AZ, CA, ID, ME, MS, NC, NJ, NM, NV, WA, WI, WV, DC

APPENDIX B – PARTICIPANTS IN A NATIONAL WORKGROUP ON INTEGRATING A
SAFETY NET INTO HEALTH CARE REFORM IMPLEMENTATION

National Workgroup Members

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ENDNOTES

- 1 The National Workgroup's definition of safety net providers is based on the work of the Institute of Medicine: Safety net providers are providers that deliver a significant level of health care to uninsured, Medicaid and other vulnerable patients. In its report, the committee focuses on "core safety net providers." These providers have two distinguishing characteristics: 1. Either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and 2. A substantial share of their patient mix are uninsured, Medicaid, and any other vulnerable patients. Core safety net providers typically include public hospitals, community health centers, and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers. (Institute of Medicine, *America's Health Care Safety Net: Intact But Endangered* (Washington, DC: National Academy Press, 2000), 21.)
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