

HEALTH CARE REFORM

Safety-Net Providers and Preparation for Health Reform

Staff Down, Staff Up, Staff Differently

ALTHOUGH THE PATIENT PROTECTION AND Affordable Care Act (ACA) was passed in 2010, the major expansion of health insurance promulgated by the bill does not occur until 2014. At that time an estimated 23 million uninsured Americans with incomes below 133% of the federal poverty level will gain Medicaid.¹ An additional 17 million persons will be eligible for subsidized coverage under a health insurance exchange, some of whom currently have private coverage. An estimated 24 million persons will remain uninsured, including undocumented persons.

Of the various health care providers, safety-net providers will be the most affected by the health coverage expansion because they are the major providers of care for the uninsured. Safety-net providers are those that serve a disproportionate number of uninsured and publicly insured Medicaid patients. In most communities the major safety-net providers are public hospitals and clinics, private nonprofit community health centers, and hospitals in low-income neighborhoods.

See also pages 1379 and 1397

The conventional wisdom has been that the role of safety-net providers would shrink under health reform. After all, once uninsured patients have Medicaid or are covered under the exchange they will have other choices of where to receive their care. Under this scenario, safety-net providers will need to staff down.

Conventional wisdom, however, is a poor substitute for data. Fortunately, Ku et al² in this issue of the *Archives* provide us with useful data on the experience of safety-net providers in Massachusetts, where the state implemented health reform in 2006. Ku et al found that community health clinics in Massachusetts experienced an *increase* of patients during the time that the number of uninsured persons *decreased*. Similarly, clinic visits to safety-net hospitals grew as more people gained insurance.

Why the increase in visits? Uninsured persons often avoid using services because of fear that they will not be able to pay the bills. It is therefore not surprising that when people gain coverage their use of health services increases. The important lesson from Massachusetts is that the newly insured continued to seek care in the safety net. Patients reported that they sought care at safety-net providers after gaining insurance because these sites were convenient, affordable, and other services were available besides medical care.

Whether the experience of safety-net providers in other parts of the country under federal health reform will be similar to that of safety-net providers in Massachusetts will depend on 2 factors: the perceived quality and convenience of safety-net providers and the degree of competition from other providers to attract persons who newly gain insurance.

Safety-net providers have both advantages and challenges in maintaining their longtime patients.³ Besides familiarity with their traditional providers, low-income patients are likely to find better language capability and more social advocacy services at safety-net providers. However, safety-net providers have not paid as much attention to the patient experience (eg, customer service, wait times) or to patient amenities (eg, attractive facilities) as commercial providers.

How much competition there will be for the newly insured is unknown. On the one hand, the number of physicians willing to accept new Medicaid is declining.⁴ On the other hand, there have always been health care providers willing to care for the least expensive Medicaid recipients, and the ACA temporarily increases Medicaid fees for primary care to 100% of Medicare rates in 2013 and 2014.

Indeed, if federal health reform would provide coverage to all, it would not necessarily be a problem if patients choose to seek care at non-safety-net providers. The problem is that if most paying patients leave safety-net providers except for those with the highest costs (eg, homeless persons, substance users), there will not be enough revenue to support the care of those who remain uninsured.

Besides Medicaid, another major revenue received by safety-net providers is from the federal disproportionate share program, a program that funds hospitals that care for large numbers of uninsured and publicly insured patients. These dollars are scheduled to be substantially reduced in the coming years¹ on the theory that safety-net providers will not need the full subsidy because their uninsured patients will have Medicaid. But unfortunately the safety net will still be needed to catch the 24 million uninsured persons excluded from federal health reform.

Regardless of where newly insured patients seek care, the most difficult issue for the health care system under federal health reform may be how to increase capacity to care for these newly insured patients. Our current system has little excess capacity, a point well illustrated by a research letter by Cheung et al⁵ in this issue of the *Archives*. Based on data from a national interview sur-

vey they found that barriers to timely primary care increased between 1999 and 2009; this was especially true among patients who had visited an emergency department that year, suggesting that as demand for services increases, we may actually see more people turning to our already overcrowded emergency departments

Training more primary care physicians, while important, will not solve the problem. First, it will take a long time to substantially increase the number of physicians available. Second, an all physician workforce will likely only further accelerate the growth rate of health care expenditures in the United States.

A better option is develop teams of health care providers where everyone is linked with appropriate technology and working at the top of their license. For example, as internists, we need to focus on diagnosing and treating people with complicated illnesses. We need panel managers to cull through patient registries to identify patients who need screening tests (eg, colon cancer screening, mammography) and preventive treatments (eg, influenza vaccination) and to arrange these interventions through standing orders. We need case managers to teach patients how to manage their illnesses, to motivate patients to make lifestyle changes that will improve their health, to help them adhere to treatments, and to direct them to places other than emergency departments when they have nonemergent problems. We need to use our pharmacists to stop filling or supervising the filling of pill bottles, a task best done by machine, but rather to see patients on complicated medication regimens and as-

sess them for adverse effects, drug interactions, and need for simplification in regimen.

Ironically, safety-net providers have more experience working in teams than most commercial providers because low reimbursement rates have forced them to learn to be more cost-efficient. The challenge will be proving that they can also be a system of choice for their patients, not just in Massachusetts, but across the country.

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