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Future of the Safety Net Under Health Reform

Mitchell H. Katz, MD

LOCAL SAFETY-NET SYSTEMS PROVIDE CARE FOR UNINSURED and low-income persons with Medicaid. Passage of the Patient Protection and Affordable Care Act (PPACA), which promises to expand health insurance to 34 million persons by 2019,¹ in large part by widening eligibility for Medicaid, raises fundamental questions about the future of local safety nets in the United States.

Local Safety-Net Systems

Although there is tremendous variation among local safety nets, public (governmental) hospitals and clinics and community health centers constitute the core safety-net system in most communities.² Beyond these core centers, uncompensated care is provided by private hospitals and physicians. For these private hospitals and clinicians, uninsured and Medicaid patients may represent a relatively small portion of the total practice; however, in aggregate, they deliver a significant amount of uncompensated care.³ Hospital emergency departments play a large role in the care of uninsured and Medicaid patients because federal law requires that they screen patients, and if the patient requires urgent or emergency care, the hospital must provide it or transfer the patient to a facility that can provide it, regardless of the patient's ability to pay. No similar requirement exists in other settings.

In addition to serving the uninsured and Medicaid populations, safety-net centers serve a vital education function, providing teaching sites for academic institutions and performing services that lose money but are vital to community health (eg, trauma centers, burn centers).

Need for Safety-Net Systems Will Remain

Despite the passage of health reform, local safety-net systems will still be needed after 2019. Of the estimated 57 million uninsured persons, 23 million will remain uninsured under the PPACA.¹ Individuals who will remain uninsured include undocumented immigrants and some persons who are eligible for coverage but who will not enroll. For example, negative perceptions of Medicaid as a welfare program and its complicated enrollment procedures will likely

result in many eligible persons (those with income below 133% of poverty) not enrolling. Additionally, the cost of health insurance available for higher-income persons through exchanges may be unaffordable to some patients; others who can afford coverage may choose to pay the less costly penalty instead.

Safety-net systems also will be needed to care for persons who newly gain insurance. In many areas, safety-net centers and clinicians are the main source of health care for Medicaid patients, often because they provide services not generally provided in private physicians' offices (eg, language translation, case management).⁴

Uncertain Financial Future

Under health reform, local safety nets will gain and lose revenue; the net result is difficult to predict. In the gain column, the expansion of Medicaid will result in payment for patients who had been taken care of free. In addition, the PPACA allocates \$12.5 billion for expansion of community health centers and placement of health care professionals in underserved areas.⁵

In the loss column, the PPACA reduces Medicaid disproportionate share hospital funding annually by \$20 billion by 2020.¹ Safety-net hospitals, especially public hospitals, are highly dependent on these payments, which compensate them for caring for a disproportionate number of uninsured patients and Medicaid recipients compared with other hospitals. The theory behind the reduction is that safety-net hospitals will not need as much funding because there will be fewer uninsured persons. However, because the methods for implementing the reduction are yet to be determined, it is unclear whether the decrease in disproportionate share dollars will match increases in Medicaid funding.

Besides federal funding losses, it may be difficult to maintain local governmental support for the safety-net system once it is clear to the public that the majority of the remaining patients are undocumented immigrants. Private philanthropy also may evaporate as the problem of the uninsured is perceived as having been solved by health reform.

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See also p 664.

Challenge for Safety-Net Centers and Clinicians

To survive under health reform, safety-net centers and clinicians will need to focus on customer service, coordination of care, infrastructure, and cost containment.

Because safety-net systems evolved to care for persons who had no choice about where to receive health care, they have historically paid less attention to service than systems that had to compete for patients. To be attractive to individuals who newly acquire health insurance, especially in areas in which private clinicians are willing to care for Medicaid beneficiaries, safety-net systems will need to focus more on issues such as wait time and availability of parking.

In the private sector, strong referral relationships (eg, between physicians and hospitals) are an important business tool. In contrast, linkages between primary care clinicians and hospitals and specialists in the safety net are weak⁴ because there is no or little reimbursement for treating referred uninsured patients. The result is that patients who need specialty care may have to wait a long time, pay in advance for services, or forgo services because they cannot find a clinician willing to treat them.⁶ At the same time, hospital emergency departments may be burdened with patients who make repeated visits for conditions that could be cared for in primary care sites, were those sites easily accessible (eg, open evenings and weekends, short appointment lags).⁷ To survive under health reform, safety-net systems will need to coordinate the care of their patients, including strengthening primary care homes to avoid unnecessary hospitalizations and emergency department visits.^{8,9}

Under health reform, safety-net centers will need to improve their infrastructure, especially in the area of health information technology.⁵ Although federal funding is available for safety-net centers and clinicians to adopt electronic medical records, the cost exceeds available funding. Safety-net systems may have difficulty raising the capital to support these systems; yet without electronic medical record systems, they will not be able to compete.

To survive under health reform, safety-net centers and clinicians will need to contain costs within the low reimbursement rates of Medicaid. This will be a major change for some systems because previous federal reimbursements for the care of the uninsured have been tied to expenditures, so there has been no incentive to spend less. Change for some governmental systems will be difficult because of entrenched civil service rules or union agree-

ments. On the other hand, through necessity, many safety-net systems and clinicians know how to provide care at a lower cost, including how to use allied health professionals to extend clinical services.¹⁰

Conclusion

Health reform places safety-net systems at a crossroads. Down one path, safety-net centers and clinicians are further marginalized: their newly insured patients seek care at mainstream centers, they are left caring only for undocumented persons and those too impaired to be accepted by other centers and clinicians, and they are unable to generate sufficient revenue to provide this care. Down the other path, safety-net centers and clinicians rise to the challenge of providing comprehensive care to low-income persons by improving customer service, strengthening referral networks and primary care homes, and investing in infrastructure, all while keeping costs down. Regardless of the future of health care after implementation of the PPACA, a robust safety-net system may offer the best chance of providing quality care to those excluded from health reform and those who newly acquire health insurance.

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