



Ensuring Equity

A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations

COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

October 2011

THE COMMONWEALTH FUND COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

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Senior Research Associate The Commonwealth Fund Health System Scorecard and Research Project

Ashley-Kay Fryer

Research Associate The Commonwealth Fund Health System Scorecard and Research Project

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The mission of The Commonwealth Fund is to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults.

The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries.



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A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations

Edward L. Schor, Julia Berenson, Anthony Shih,
Sara R. Collins, Cathy Schoen, Pamela Riley, and Cara Dermody

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ABSTRACT: Equity is a core goal of a high performance health system. However, there is a growing health care divide in the United States, where vulnerable populations—those lacking health insurance, low-income families, and racial and ethnic minorities—are at higher risk for poor health and poor health outcomes than the rest of society. The Affordable Care Act will expand insurance coverage and bolster the parts of the health system that serve vulnerable Americans, yet much work remains. This report from the Commonwealth Fund Commission on a High Performance Health System examines the problems facing vulnerable populations and offers a framework for moving forward. It features three overarching strategies to close the health care divide: 1) ensure that health coverage provides adequate access and financial protection; 2) strengthen the care delivery systems serving vulnerable populations; and 3) coordinate care delivery with other community resources, including public health services.

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About the Authors

Edward L. Schor, M.D., is senior vice president for programs and partnerships at the Lucile Packard Foundation for Children's Health. As a vice president at The Commonwealth Fund, he directed the State Health Policy and Practices program and the Child Development and Preventive Care program. Dr. Schor, a pediatrician, has held a number of positions in pediatric practice, academic pediatrics, health services research, and public health. Dr. Schor is editor of the book *Caring for Your School-Age Child* and has chaired both the Committee on Early Childhood, Adoption and Dependent Care and the national Task Force on the Family for the American Academy of Pediatrics. He also has served on the Maternal and Child Health Bureau Child Health Survey Technical Panel, and in 2006, received the John C. MacQueen Award from the Association of Maternal and Child Health Programs. Dr. Schor has been a member of the faculties of several major university medical schools and schools of public health. He has also served on the editorial boards of a number of pediatric journals.

Julia Berenson, M.Sc., is the research associate to The Commonwealth Fund's executive vice president for programs. In this role, she provides written, analytical, and research support to the executive vice president for programs and program staff. Before joining the Fund, Ms. Berenson was a program associate at the Center for Health Care Strategies, where she worked on initiatives that enhance the organization, financing, and delivery of health systems aimed at improving the quality of care and reducing disparities among Medicaid beneficiaries. Ms. Berenson received a master's degree in health policy, planning, and financing jointly awarded by the London School of Economics and the London School of Hygiene and Tropical Medicine.

Anthony Shih, M.D., M.P.H., rejoined The Commonwealth Fund in January 2011 as executive vice president for programs. In this role, Dr. Shih serves as a member of the Fund's

executive management team and is responsible for all of The Commonwealth Fund's grants programs. From 2006 to 2008, Dr. Shih directed the Fund's Program on Quality Improvement and Efficiency. He left The Commonwealth Fund in 2008 to serve as chief quality officer and vice president of strategy for IPRO, one of the nation's leading independent, nonprofit health care quality improvement organizations. In addition to guiding the overall growth and strategy of IPRO, Dr. Shih led IPRO's Health Care Transparency Group, a leader in public reporting of health care performance information. Dr. Shih first joined IPRO in 2001, and held a variety of executive management positions there. Dr. Shih is board-certified in public health and preventive medicine, and holds an M.D. from the New York University School of Medicine and an M.P.H. from the Columbia University Mailman School of Public Health.

Sara R. Collins, Ph.D., is vice president for Affordable Health Insurance at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, Dr. Collins has led several national surveys on health insurance and authored numerous reports, issue briefs, and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University.

Cathy Schoen, M.S., is senior vice president for Policy, Research, and Evaluation at The Commonwealth Fund. Ms. Schoen is a member of the Fund's executive management team and research director of the Fund's Commission

on a High Performance Health System. From 1998 through 2005, she directed the Fund's Task Force on the Future of Health Insurance. Prior to joining the Fund in 1995, Ms. Schoen taught health economics at the University of Massachusetts School of Public Health and directed special projects at the UMASS Labor Relations and Research Center. During the 1980s, she directed the Service Employees International Union's research and policy department. In the late 1970s, she was on the staff of President Carter's national health insurance task force. She has authored numerous publications on health policy issues, insurance, and national/international health system performance and coauthored the book, *Health and the War on Poverty*. She holds an undergraduate degree in economics from Smith College and a graduate degree in economics from Boston College.

Pamela Riley, M.D., M.P.H., joined the Fund in July 2011 as program officer of the Vulnerable Populations program. Dr. Riley is a pediatrician with a long-standing commitment to improving the health of low-income, medically underserved populations. Dr. Riley previously served as clinical instructor in the Division of General Pediatrics at the Stanford University School of Medicine. In 2010, Dr. Riley became a program officer at the New York State Health Foundation, where she focused on developing and managing grantmaking programs in the areas of Integrating Mental Health and Substance Use Services, the Initiative for Returning Veterans and Their Families, and the Diabetes Campaign's faith-based initiative. Dr. Riley received an M.D. from the UCLA David Geffen School of Medicine in 2000, and an M.P.H. from the Harvard School of Public Health as a Commonwealth Fund/Harvard University Minority Health Policy Fellow in 2009.

Cara Dermody is the program associate for the Fund's Program on Vulnerable Populations. In this role, she serves in both an administrative and research role, providing grant and general administrative support to the program officer, Pamela Riley, M.D., and the program. She also provides ongoing support for existing grants

from the Child Development and Preventive Care program and the State Health Policy and Practices program. In addition, Ms. Dermody acts as liaison to the Communications department. Ms. Dermody worked previously for the Jewish Healthcare Foundation in Pittsburgh where she was program associate supporting two programs: HIV/AIDS and Health Careers Future. She chaired the internal quality management committee, served on two statewide committees under the Ryan White HIV/AIDS Program, and provided technical support to 16 nonprofit subcontracting agencies. During college, Ms. Dermody interned for U.S. Congressman Jason Altmire, providing constituent services. She graduated from Yale University in 2009 with a B.A. in the History of Science/History of Medicine and a concentration in Public Health.

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Preface

Since its establishment in 2005, the Commonwealth Fund Commission on a High Performance Health System has been working to move the United States toward a high performance health care system, one that provides accessible, high-quality, affordable care to all Americans. This objective, as well as a path to achieve it, has been laid out in a series of Commission reports, including a *Framework for a High Performance Health System for the United States* (August 2006); *A High Performance Health System for the United States: An Ambitious Agenda for the Next President* (November 2007); and *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (February 2009).

Many of the Commission's recommendations appeared in the health reform legislation, the Patient Protection and Affordable Care Act of 2010. Once fully implemented, the Act will substantially expand insurance coverage, as well as stimulate the necessary payment and delivery system reforms to improve our health system. However, although the Act will greatly benefit the most vulnerable individuals among us, there is still work to be done to ensure that we achieve true equity in our health care system.

In this new Commission report, *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations*, the Commission highlights the continuing problems facing vulnerable populations and offers a policy framework for moving forward. The framework includes three overarching strategies to close the health care divide: ensure that health care coverage results in adequate access and financial protection; strengthen the care delivery systems serving vulnerable populations; and coordinate care delivery with other community resources, including public health services.

Decades of research point to a health care divide in our society, one in which vulnerable populations—people without health insurance, low-income families, and racial and ethnic minorities—face a higher risk of poor health and worse health outcomes than the rest of the population. Our current economic environment has expanded the number of vulnerable individuals, and greater attention needs to be paid to their plight.

Equity is a core goal of a high performance health system, and we should no longer tolerate the status quo. We hope that this report will inform and encourage policymakers and other stakeholders to work toward creating a high performance health system for all.

David Blumenthal, M.D.

Chairman

Stuart Guterman

Executive Director

The Commonwealth Fund Commission on a
High Performance Health System

Executive Summary

The Commonwealth Fund Commission on a High Performance Health System has defined equity as a core goal of a high performance health system. However, in the United States, there has been a growing health care divide between vulnerable populations—defined in this report as people without health insurance, low-income families, and racial and ethnic minorities—and the rest of society. Decades of research has demonstrated that vulnerable Americans are more likely to be in poor health and to experience worse health care outcomes.

The Patient Protection and Affordable Care Act (Affordable Care Act) represents substantial progress in addressing the needs of vulnerable populations, most notably by expanding health insurance coverage and bolstering those parts of the health care system that serve the vulnerable. Yet significant additional work remains to be done. This report from the Commission examines the continuing problems facing vulnerable populations and offers a policy framework for moving forward. The framework features three overarching strategies to close the health care divide: 1) ensure that insurance coverage affords adequate health care access and financial protection; 2) strengthen the care delivery systems serving vulnerable populations; and 3) coordinate health care delivery with other community resources, including public health services.

The Post-Reform Health Care Environment for Vulnerable Populations

Insurance Coverage, Access to Care, and Financial Protection

Through the expansion of Medicaid eligibility and subsidized health coverage through health insurance exchanges, the Affordable Care Act will significantly reduce the number of vulnerable individuals defined by insurance status. Extending health insurance coverage is a critical and necessary step toward equitable access. However, insurance alone is often not sufficient and does not guarantee access to high-quality care, particularly with regard to low-income families and racial and ethnic minorities. While Medicaid coverage is a vast improvement over no insurance at all, many states struggle to maintain, much less expand, an adequate network of providers for Medicaid beneficiaries. The Affordable Care Act addresses this in part by requiring Medicaid reimbursement for certain primary care services to be at parity with Medicare reimbursement for two years, but access to specialty care in particular remains a concern.

Further, among low- and moderate-income families, changes in income and employment can lead to changes in eligibility for subsidized insurance coverage, which can in turn create gaps in coverage. Such gaps and transitions in coverage can disrupt provider relationships and continuity of care. Likewise, low-income families may be at risk for abrupt changes in out-of-pocket costs for health insurance and health care when minor fluctuations in income place them in higher income-eligibility categories.

Access to care will also depend on how insurance coverage is designed—for example, whether it

provides essential benefits and protection from high out-of-pocket costs, thus lowering the risk of medical debt and financial stress resulting from illness. The Affordable Care Act includes income-related provisions targeting affordability; it is important that these are implemented effectively to protect vulnerable populations.

Care Systems

Traditional safety-net providers—public and other mission-driven hospitals, as well as federally qualified health centers (FQHCs) and other community clinics—have historically played a critical role in providing otherwise unavailable or unaffordable care to vulnerable populations. Not only are safety-net providers able to deliver more affordable care, they are often better able to meet the complex social, cultural, and linguistic needs that are more prevalent within vulnerable populations.

In the current environment, many safety-net providers are struggling to sustain their operations and meet the increased demand caused by the economic downturn. Although the Affordable Care Act provides additional financial support to community health centers, the financial outlook for safety-net hospitals is much grimmer. Post-health reform, safety-net hospitals will receive new revenues from newly insured populations, countered by an anticipated significant drop in other revenue streams, such as disproportionate share hospital (DSH) payments from Medicare and Medicaid. For many providers, there will likely be a loss of net revenue that will not only endanger viability, but jeopardize access to care for individuals who remain uninsured post-health reform and for newly insured low-income populations whose special needs for targeted medical and social

services are often better addressed by safety-net providers.

Safety-net providers also face the same issue as all other providers in the U.S.: health care system fragmentation that hinders their ability to deliver high-quality, high-value care. For those served by safety-net providers, fragmented care delivery is especially troublesome, as these patients tend to be sicker, have more complex medical and behavioral problems, and often require legal and other social supports. Vulnerable patients may disproportionately benefit from greater clinical integration among providers and from a focus on team-based primary care and population-based strategies to improve health. The Affordable Care Act has several provisions to stimulate delivery system reform across the entire health care system, but further steps will likely be necessary.

Community Resources

The health of low-income and minority populations is heavily dependent on resources outside the traditional health care system. These include not only services that enable them to fully access health care, such as transportation and language interpretation, but also environmental factors, such as access to healthy food, a safe home and workplace, and accessible places for exercise. In addition, traditional public health activities, such as infectious disease control and community vaccination programs, are often critical for the health of vulnerable populations.

The Affordable Care Act provides limited funds to strengthen the overall public health infrastructure, which has been under financial stress during the current economic crisis. Largely unaddressed, however, is the need for explicitly linking

and aligning the health care delivery system with community resources and public health services for vulnerable populations.

A Policy Framework for Moving Forward

If we are to achieve equity in our health care system, additional policy interventions are required to address remaining gaps in care for vulnerable populations post-health reform. To that end, the Commission on a High Performance Health System offers a framework to help guide the development of specific policies and practices that will be required to ensure vulnerable populations receive care from high performance health care delivery systems, ones that provide high-quality health care at a reasonable cost and achieve good health for all. The key tenets of the framework are:

1. **Ensure that insurance coverage results in adequate access and financial protection.**

It is clear that insurance coverage is necessary but not sufficient to guarantee access. Key issues to address include:

- *Creating enough willing providers for Medicaid beneficiaries.* There is a shortage of providers, particularly specialty providers, to care for Medicaid beneficiaries. To some extent, these shortages may be reduced through more efficient and effective models of referral and care coordination. Underlying barriers can potentially be addressed through payment reforms that financially reward provider networks for delivering optimal care to Medicaid beneficiaries (e.g., Medicaid accountable care organizations (ACOs), or ACOs that include Medicaid

providers; Medicaid health homes and medical homes; and enhanced payments for caring for vulnerable populations); through more equitable Medicaid payment rates; and through other policy levers, such as requirements relating to Medicare Conditions of Participation or nonprofit status, to encourage provider participation in Medicaid. Additional efforts may be required to develop the workforce pipeline, such as an expansion of medical education debt relief for primary care providers, specialists, dentists, and others practicing in health centers, safety-net hospitals, and medically underserved areas. Ensuring adequate and high-quality provider networks for vulnerable populations may also require helping providers to develop the capacity to care for and meet the complex needs of vulnerable populations; an example might be supporting networks of shared resources among communities of safety-net providers.

- *Making insurance more stable, so that gaps and abrupt changes in coverage can be reduced.* Vulnerable individuals are at risk for significant disruptions in their care when their income or employment changes, often because it could alter their eligibility for subsidized insurance. This could be a particular challenge when transitions occur between Medicaid and private health plans in the exchanges. There are a number of possible steps that can be taken to ensure continuity of care: guaranteeing year-long coverage periods, providing access to the same insurance plans in exchanges and in Medicaid, merging small-group and

individual exchanges, placing a high priority on coordinating eligibility and enrollment for all forms of subsidized insurance through the exchanges, and ensuring that adequate numbers of essential community providers are included in both Medicaid and the subsidized plans.

- *Affordability and protection from high out-of-pocket health care costs.* Even if health insurance premiums are made affordable, low-income families and patients may remain at high risk for medical debt or unable to access medical services if there are major gaps in plan benefits or high cost-sharing. To protect consumers from excessive out-of-pocket health care costs, insurance benefit designs should have positive incentives to use more-effective care and have reasonable income-related limits on overall out-of-pocket cost exposure.

2. Strengthen the care delivery systems serving vulnerable populations. Traditional safety-net providers and other providers serving vulnerable populations must strive to deliver high-performance care. Key issues to address include:

- *Ensuring the financial stability of the safety net while stimulating higher performance.* We believe that the traditional safety-net system—including health centers, clinics, and hospitals serving a high share of uninsured and Medicaid patients—will continue to play a critical role in our health care delivery system by serving local communities with comprehensive,

high-quality care. These organizations will continue to furnish access to those people who remain uninsured. Steps need to be taken, especially in the current rapidly evolving health care environment, to ensure that adequate resources remain for the safety-net system to continue to deliver services to vulnerable populations. These may include maintaining and/or consolidating current funding streams and re-examining reimbursement formulas. That said, financial resources must be used to maintain, stimulate, and reward higher performance among safety-net providers.

- *Promoting greater clinical integration in safety-net health care systems.* The clinical integration of services across settings—clinics, hospitals, specialty care providers, and long-term care facilities—is essential for the delivery of high-quality, coordinated, efficient care. This is true whether integration occurs within the context of an actual integrated health care delivery system or it is achieved less formally. Efforts should be made to promote greater integration through payment reform and regulatory changes that explicitly encourage collaboration and affiliation, both among traditional safety-net providers and with other health care providers and systems in low-income communities. Safety-net providers should also be encouraged to participate in, and the federal government and state Medicaid programs should promote, emerging efforts to establish accountable care systems that serve vulnerable populations.

- *Focusing on comprehensive, coordinated, team-based primary care for all providers serving vulnerable populations.* Care delivery models for vulnerable populations should reflect the most effective strategies identified by the latest empirical research. There is evidence that much of the disparity in care experienced by vulnerable populations could be eliminated through the provision of patient- and family-centered primary care that emphasizes team-based care, care coordination, care management, and preventive services (e.g., care delivered through health homes and patient-centered medical homes).

It is important to note that providers serving vulnerable populations need to be especially capable of managing conditions and circumstances that are disproportionately prevalent within vulnerable populations, among them chronic disease, disability, mental illness, substance abuse, pregnancy, and low health literacy. The integration of medical care and mental health care delivery within Medicaid will be especially important. In addition, provider and patient incentives, together with technical assistance and supports, can facilitate the adoption of appropriate care models for vulnerable populations, including those with long-term care needs. The effectiveness of such incentives will be maximized through the participation of both government and private payers and the alignment of their incentives. Additionally, efforts may be needed to increase the number of physicians

and allied health professionals available to deliver such care.

3. Coordinate health care delivery system efforts with other community resources, including public health services. Improving the health of vulnerable populations will require not only improving health care delivery systems, but also linking these systems with non-health service providers and aligning them with public health efforts. Key issues to address include:

- *Fostering an infrastructure of community-based support services.* Because of the non-health services that many vulnerable individuals require to fully access and benefit from the health care system, all providers serving these populations should be able to link their practices with community-based services, including transportation, language interpretation, social services, housing assistance, nutritional support, and legal services. Additional evidence needs to be generated to identify the most effective ways to link to and deliver these services.
- *Aligning efforts between the health care delivery system and public health services.* Many of the medical issues that disproportionately affect vulnerable populations, such as obesity, diabetes, asthma, depression, and smoking-related illnesses, can be prevented or mitigated with effective public health and community-focused strategies. To develop effective approaches for improving population health, providers serving vulnerable populations and state

and federal government agencies should promote coordination between the health care delivery system and local public health resources and programs.

The Commission on a High Performance Health System believes that this framework is only an initial step in closing the health care divide for vulnerable populations. Utilizing this framework as a starting point, the Commission will identify, evaluate, and offer specific policy recommendations in the months and years ahead. While we recognize that additional resources are scarce, it is imperative that we address the needs of our vulnerable populations, whose problems are exacerbated

by current economic conditions. At the same time, not all of the policy solutions discussed in this report increase health care spending. Some, such as delivery system changes to promote clinical integration and foster team-based primary care, and better alignment of efforts between health care and public health, may even hold the potential of slowing the growth of health care spending in the future.

A core founding value of the United States is equality of opportunity to live a healthy and productive life. We believe that our nation can and must do better to care for our vulnerable populations, and we are committed to taking action to achieve this goal.

Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations

Who Are the Vulnerable Populations?

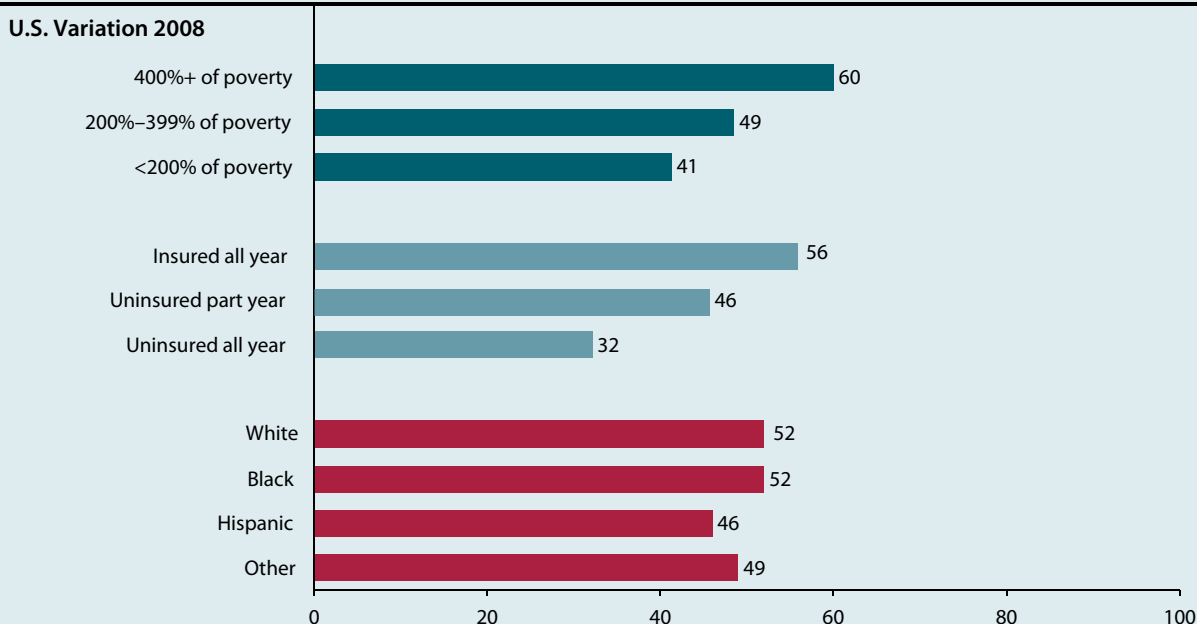
The Commonwealth Fund Commission on a High Performance Health System has defined equity as a core goal of a high performance health system. We know, however, that in the United States there is a substantial health care divide between vulnerable populations—including uninsured people, low-income families, and racial and ethnic minorities—and the rest of society. These populations are at higher risk for being in poor health, having inadequate health care, and experiencing worse health outcomes than other groups. These disparities are evidenced in mortality rates

among the uninsured that are 10 percent to 15 percent higher than among the insured,¹ as well as in the approximately 18,000 deaths each year in the United States that can be attributed to a lack of health coverage.² Likewise, racial and ethnic minorities, the uninsured, and low-income individuals receive fewer preventive services, have more poorly controlled chronic diseases, and experience worse health outcomes. As just one example, people in these groups are more likely to be hospitalized for conditions that are generally preventable with good primary care and community health outreach (Exhibits 1, 2, and 3).

During the past decade, with two economic recessions, there has been a surge in the number and proportion of vulnerable Americans,³ with a disproportionate impact on racial and ethnic minorities.⁴ In 2009, about 99 million nonelderly

Exhibit 1. Receipt of Recommended Screening and Preventive Care for Adults, 2008

Percent of adults age 18+ who received all recommended screening and preventive care* within a specific time frame given their age and sex



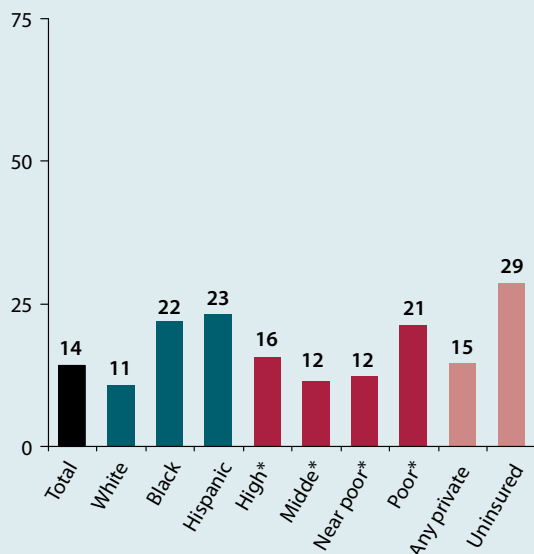
* Recommended care includes at least six key screening and preventive services: blood pressure, cholesterol, Pap, mammogram, fecal occult blood test or sigmoidoscopy/colonoscopy, and flu shot.

Data: N. Tilipman, Columbia University analysis of Medical Expenditure Panel Survey.

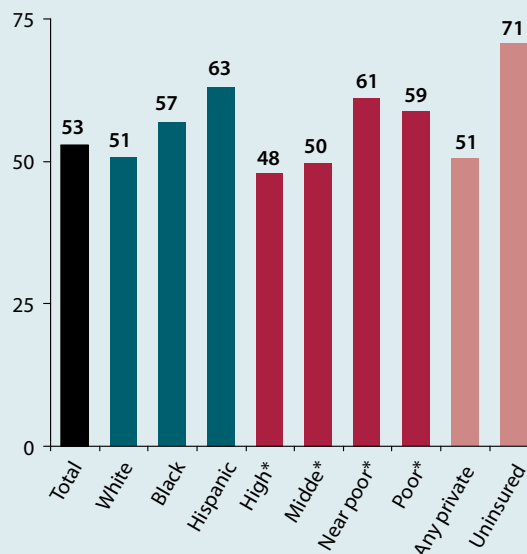
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011 (forthcoming Oct. 2011).

Exhibit 2. Adults with Poorly Controlled Chronic Diseases, by Race/Ethnicity, Family Income, and Insurance Status, 2005–2008

Percent of adults age 18+ with diagnosed diabetes with hemoglobin A1c level \geq 9%



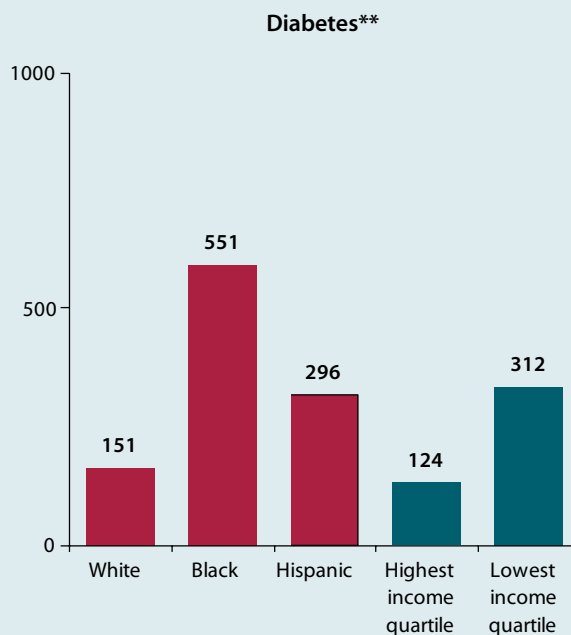
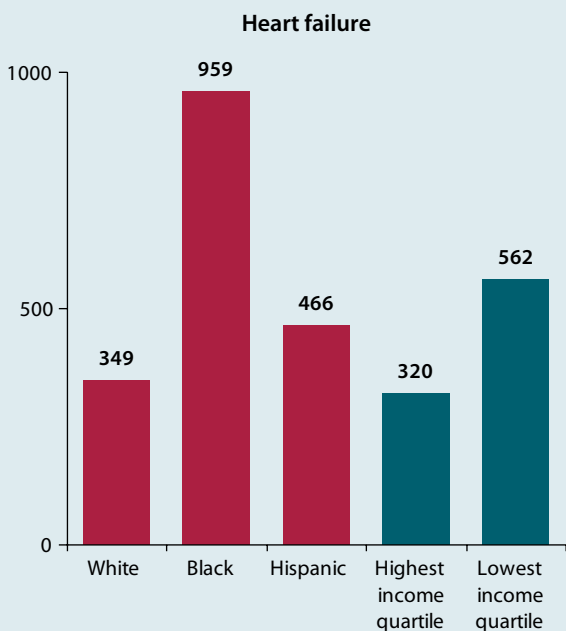
Percent of adults age 18+ with hypertension with blood pressure \geq 140/90 mmHg



* High refers to household incomes \geq 400% of federal poverty level (FPL); middle to 200%–399% FPL; near poor to 100%–199% FPL; and poor to <100% FPL.
 Data: J. M. McWilliams, Harvard Medical School analysis of National Health and Nutrition Examination Survey.
 Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011 (forthcoming Oct. 2011).

Exhibit 3. Hospital Admissions for Select Ambulatory Care–Sensitive Conditions, by Race/Ethnicity and Patient Income Area, 2007

Adults age 18+, adjusted rate per 100,000 population*



* Rates are adjusted by age and gender using the total U.S. population for 2000 as the standard population.

** Combines three diabetes admission measures: uncontrolled diabetes without complications, diabetes with short-term complications, and diabetes with long-term complications.

Patient Income Area = median income of patient zip code.

Data: Healthcare Cost and Utilization Project, State Inpatient Databases (AHRQ 2010).

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2011 (forthcoming Oct. 2011).

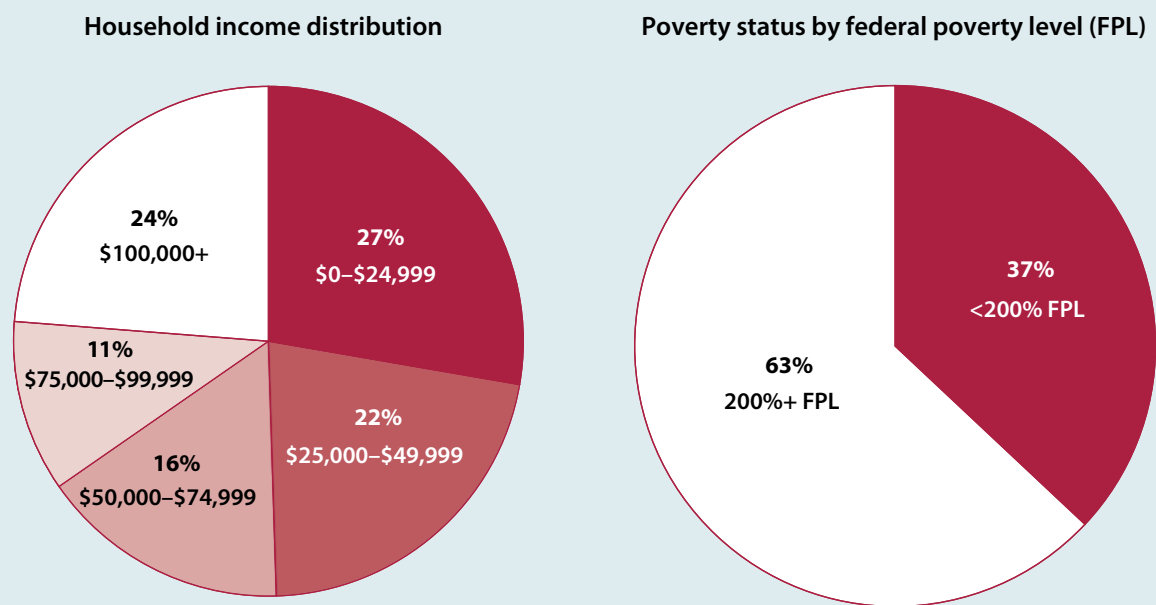
individuals (under age 65) had low income (defined here as below 200 percent of the federal poverty level for a family of four, or \$44,700) (Exhibit 4), an estimated 50 million nonelderly individuals lacked health insurance, and about 99 million nonelderly individuals were members of racial or ethnic minorities.⁵

Although any one of these characteristics is associated with vulnerability to poor health and health outcomes, there is substantial overlap among the groups. In 2009, 66 percent of uninsured nonelderly people were below 200 percent of the poverty level. Furthermore, racial and ethnic minorities are overrepresented in both groups: in 2009, 59 percent of Hispanic nonelderly households and 54 percent of black nonelderly households were below 200 percent of poverty, compared with 28 percent of white nonelderly households (Exhibit 5). In addition, the 2009 uninsured rate was 23 percent for nonelderly blacks and 34 percent for

nonelderly Hispanics, compared with 14 percent for non-Hispanic nonelderly whites (Exhibit 6).

The Patient Protection and Affordable Care Act (Affordable Care Act) significantly changes the landscape for vulnerable populations. Several of the law's provisions are designed to address the health gap and could help mitigate disparities in health and health care for vulnerable populations.⁶ In particular, beginning in 2014, the vast majority of the currently uninsured will become insured. This is a major achievement: as this Commission has argued, extending health insurance coverage to all Americans is the most important step in improving access to quality health care.⁷ Insurance coverage alone, however, is not sufficient to eliminate inequities in health and health care for vulnerable populations. Thus, the Affordable Care Act also provides a new platform to close the health care divide by bolstering the care delivery system serving these populations and by supporting

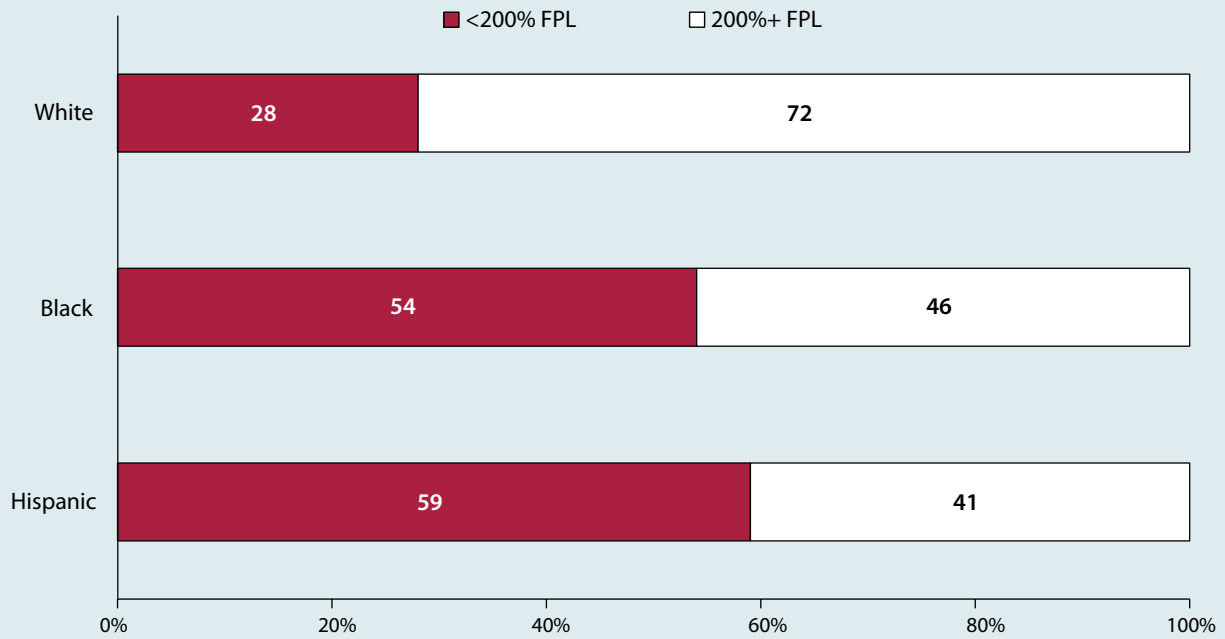
Exhibit 4. U.S. Income and Poverty Distribution, Adults Under Age 65, 2009



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.

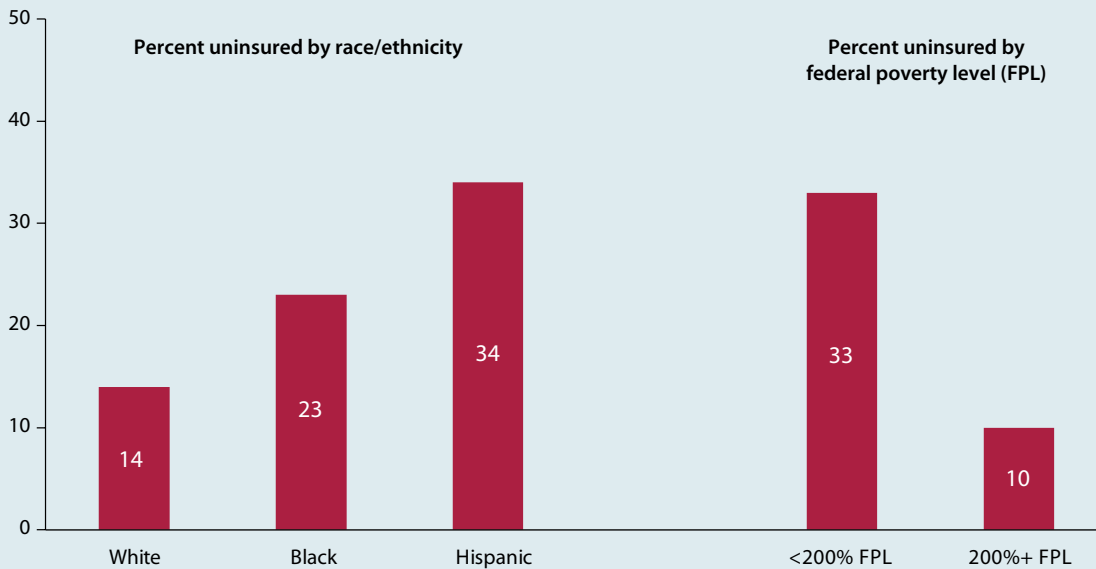
Exhibit 5. Poverty Status by Race/Ethnicity, Adults Under Age 65, 2009

Poverty status by federal poverty level (FPL)



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.

Exhibit 6. Percent of Under-65 Population Uninsured, by Race/Ethnicity and Poverty Status, 2009



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2010.

community-based and public health efforts that go beyond medical care.

Although the Affordable Care Act has made substantial progress, additional work is needed to ensure that vulnerable populations have access to high-quality, patient-centered care. The remainder of this report examines the post-reform environment for health care for vulnerable populations, and ends with a policy framework for moving forward.

The Post-Reform Health Care Environment for Vulnerable Populations

Insurance, Access, and Financial Protection

The Affordable Care Act will significantly reduce the number of uninsured with the expansion of Medicaid eligibility and new subsidized insurance coverage options through health insurance exchanges (exchanges).^{8,9} Reforms are projected to insure an additional 34 million nonelderly Americans by 2021, leaving about 23 million (5%) nonelderly residents uninsured.¹⁰

Under health reform, Medicaid will play a critical role in extending coverage to millions of vulnerable Americans. Starting in 2014, the Affordable Care Act extends Medicaid coverage eligibility to nearly all residents under age 65 with incomes below 133 percent of the federal poverty level (\$29,726 for a family of four).¹¹ With this expansion, Medicaid will grow to cover millions of low-income adults without children, more low-income parents, and some children who do not currently qualify for coverage. Moreover, since the Affordable Care Act includes an individual coverage mandate¹² and requires seamless eligibility and enrollment processes,¹³ states anticipate that many

vulnerable children and adults who are eligible for but not currently enrolled in Medicaid will become aware of and newly enroll in the program.¹⁴

The Affordable Care Act also protects current Medicaid beneficiaries against the loss of coverage through the maintenance of eligibility and enrollment provisions,¹⁵ which will help sustain Medicaid coverage until the law expands coverage in 2014. To receive federal Medicaid funds, states will be required to maintain Medicaid eligibility and enrollment standards that were in place at the time the Affordable Care Act was enacted. As a result of health reform, Medicaid is expected to cover an additional 17 million low-income people by 2021 and grow to cover approximately 25 percent of the total U.S. population.¹⁶

The other major source of coverage expansion for the currently uninsured will be the new exchanges—state-based health insurance marketplaces that offer affordable and regulated coverage options for purchase. For people purchasing insurance through the exchanges, income-based subsidies will be available to reduce the cost of premiums.¹⁷ Beginning in 2014, premium tax credits will be available to individuals and families with family incomes up to 400 percent of poverty (\$89,400 for a family of four) who do not have access to public insurance or affordable employer-based insurance.¹⁸ Such subsidies will be a critical tool for helping vulnerable populations purchase affordable health insurance coverage. It is estimated that an additional 24 million people will have health coverage by 2021 through the subsidized health insurance options offered in the exchanges.¹⁹

Extending health insurance to all populations is a critical and necessary step in improving

access to quality health care and a crucial component of a high performance health system.²⁰ The most recent evidence establishes that expanding access to public health insurance creates positive effects on access to care, health care use, financial strain, and health for low-income adults.²¹ While making health coverage more available to vulnerable individuals and families is essential, coverage expansion is not sufficient to guarantee access to high-quality care. Although health reform is likely to decrease financial barriers to care, other barriers will persist:

- First, there is a shortage of willing providers, particularly specialty providers, to care for Medicaid and other low-income populations.
- Second, vulnerable populations are at risk for changes in eligibility for subsidized coverage because of income and employment changes that may lead to gaps and transitions in coverage, potentially disrupting continuity in care. Low-income families may also be at risk for abrupt changes in out-of-pocket health insurance and health care costs when minor changes in income place them in a higher income eligibility category.
- Third, despite the expected coverage expansions, 23 million nonelderly Americans are expected to be uninsured in 2021 (about 5% of U.S. residents).²² Noncitizen residents will constitute approximately one-third of the remaining uninsured, since under the Affordable Care Act, undocumented immigrants are ineligible for premium subsidies and expanded Medicaid coverage.²³ Public funds available to support care for uninsured people will become increasingly

scarce as expenditures for insurance subsidies increase. This will make access to affordable care for uninsured people more difficult.

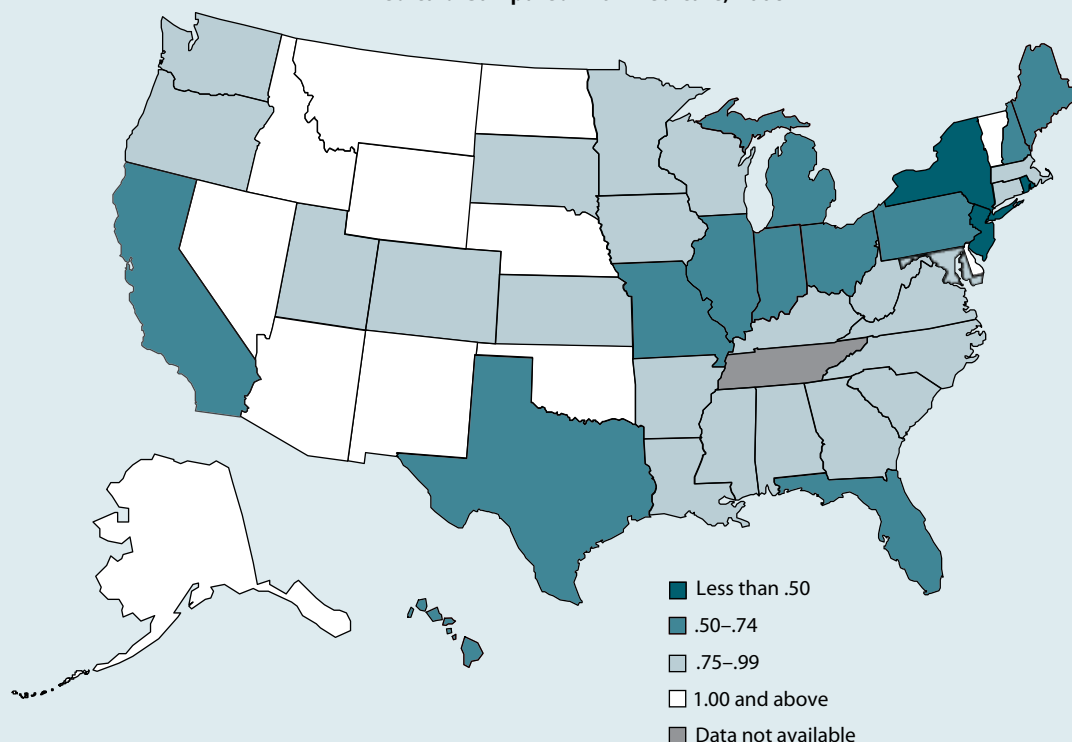
- Finally, insurance that does not include essential benefits and financial protection from high out-of-pocket health care costs may lead to medical debt or hinder access to medical services.

Shortage of Medicaid Providers. Many states struggle to maintain and expand an adequate network of providers for Medicaid beneficiaries. Low reimbursement rates have discouraged physician participation over the past decade.²⁴ Historically, Medicaid has reimbursed physician services at a significantly lower level than have private payers and Medicare. In 2008, Medicaid fee-for-service payments nationally averaged only 66 percent for primary care and 72 percent for all other services of the rates paid by Medicare (Exhibit 7).²⁵ In addition to lower reimbursement, administrative processes associated with Medicaid, such as delayed reimbursement, limit physician participation.²⁶ As a result, fewer primary care physicians and specialists accept Medicaid patients than Medicare or privately insured patients—in 2004–05, 14.6 percent of physicians reported that they received no revenue from Medicaid, an increase from 12.9 percent in 1996–07.^{27,28}

Consequently, care for Medicaid patients is becoming increasingly concentrated among the smaller proportion of physicians who have the financial scale, or are obligated by their mission, to serve Medicaid patients—typically those who practice in large groups, hospitals, or the safety-net system.²⁹ Patients with Medicaid or Children’s Health Insurance Program (CHIP) coverage

Exhibit 7. Medicaid–Medicare Reimbursement Rate Ratios by State

Medicaid Compared with Medicare, 2008



Note: Data not available for Tennessee.

Source: Urban Institute 2008 Medicaid Physician Survey, in S. Zuckerman, A. F. Williams and K. E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs Web First*, April 28, 2009, w510–w519.

accounted for 44 percent of primary care visits to community health centers, compared with 13 percent of primary care visits to physician offices.³⁰

On the other hand, physicians in solo and small-group practices, which provide a substantial amount of care in the U.S., are increasingly refusing to care for vulnerable patients. Of office-based primary care physicians in 2009, only 65 percent were accepting new Medicaid patients, as compared with 74 percent and 88 percent for Medicare and private insurance patients, respectively.³¹ Although large provider groups or safety-net providers may be better equipped to serve the special needs of vulnerable populations, access and quality of care may be compromised as these providers experience increased patient demand and fiscal pressures.

A limited Medicaid provider network jeopardizes access to primary and specialty care services for vulnerable populations. Low-income and uninsured patients less often have an accessible primary care provider.³² Socioeconomic disadvantage diminishes access to specialty care as well—black, less educated, and low-income patients are less likely to receive specialty services.^{33,34} Although access to primary care facilitates referral to a specialist, primary care physicians who serve Medicaid patients report difficulty referring patients to specialty care, and such challenges contribute to why they see few Medicaid patients.³⁵ Additionally, while health centers provide critical primary care services to vulnerable populations and enhanced access to on-site care for selected specialty services,

these providers still find it difficult to refer Medicaid and vulnerable patients to specialty services.³⁶ Medicaid will need to explore sustainable options to maintain and expand its physician network, especially given health reform's eligibility expansion and subsequent new demands for care.

Recognizing the challenges of access to Medicaid providers, the Affordable Care Act, as amended by Section 1202 of the Health Care and Education Reconciliation Act, requires Medicaid reimbursement rates to be at parity with Medicare rates in 2013 and 2014 for certain evaluation and management services provided by primary care physicians.³⁷ As a result, Medicaid primary care physicians are estimated to gain an additional \$8.3 billion in reimbursement between 2013 and 2019.³⁸

However, because states set Medicaid provider payment rates, the new policy will have widely different impacts on physicians in different states. Primary care physicians in states with lower Medicaid-to-Medicare fee ratios will benefit more from the policy than those in states where there is greater parity between the two programs' reimbursement rates. Not only will the impact of the enhanced reimbursement vary by state, it may also be limited in scope because of the policy's temporary status. While federal funding will cover 100 percent of the costs of increased reimbursement, such funding expires in 2015.

The enhanced payment may not do much to mitigate current physician shortages for Medicaid patients when eligibility expands. Given that the primary care supply is already strained, ensuring adequate provider networks for vulnerable populations will require strategies beyond enhanced reimbursement. These may include:

- changing the way we pay for primary care to make careers in service of vulnerable populations more attractive and sustainable;
- supporting new ways to deliver primary care for vulnerable populations, such as team-based care with creative and expanded use of nonphysician staff, such as nurse practitioners and other primary care clinicians; or
- using new processes and approaches—whether open- or advanced-access scheduling, after-hours care, telephone and e-mail consultation for non-face-to-face care, or group visits—to provide multiple points of access and new technologies, including Web portals, electronic health records, registry reports and panel management, and e-prescribing, to facilitate population-based care management for vulnerable populations.

Furthermore, this provision of the law limits which services and which providers can receive the enhanced reimbursement. In particular, it excludes specialists; as a result, the current shortage of specialists accepting Medicaid beneficiaries will likely persist.

Beyond enhanced payments to providers serving Medicaid patients, the Affordable Care Act has additional provisions to encourage providers to care for Medicaid and other low-income populations. Certain provisions create financial incentives for medical students to choose primary care specialties and practice in underserved areas. One provision authorizes \$1.5 billion over 2011 to 2015 for the National Health Service Corps to provide scholarships and loan forgiveness for primary care physicians, nurse practitioners, and physician assistants practicing in health

professional shortage areas.³⁹ Another creates a loan repayment program for pediatric subspecialists and child or adolescent mental or behavioral health providers working in underserved areas.⁴⁰

The Affordable Care Act also supports the development and training of primary care physicians in underserved areas. Notably, it expands a number of training programs under Title VII, Section 747, of the Public Health Services Act that encourage health care workers to practice in underserved areas.⁴¹ Title VII training programs are critical, since physicians trained in these programs are more likely to remain in underserved communities and practice at health centers that serve a disproportionate share of vulnerable populations.⁴²

Lastly, the Affordable Care Act provides grants to states for enhanced reimbursement to primary care sites designated as health homes (medical homes) for Medicaid patients with chronic conditions.⁴³ This provision helps create incentives for primary care providers to implement a health home and work in teams with other health care professionals to provide care to vulnerable populations.

Medicaid and states will need to build on such health reform efforts and develop additional policy strategies to create enough willing providers for low-income populations. Expanding the workforce and engaging the private sector's providers to serve vulnerable populations is critically important as people gain health insurance under the Affordable Care Act.

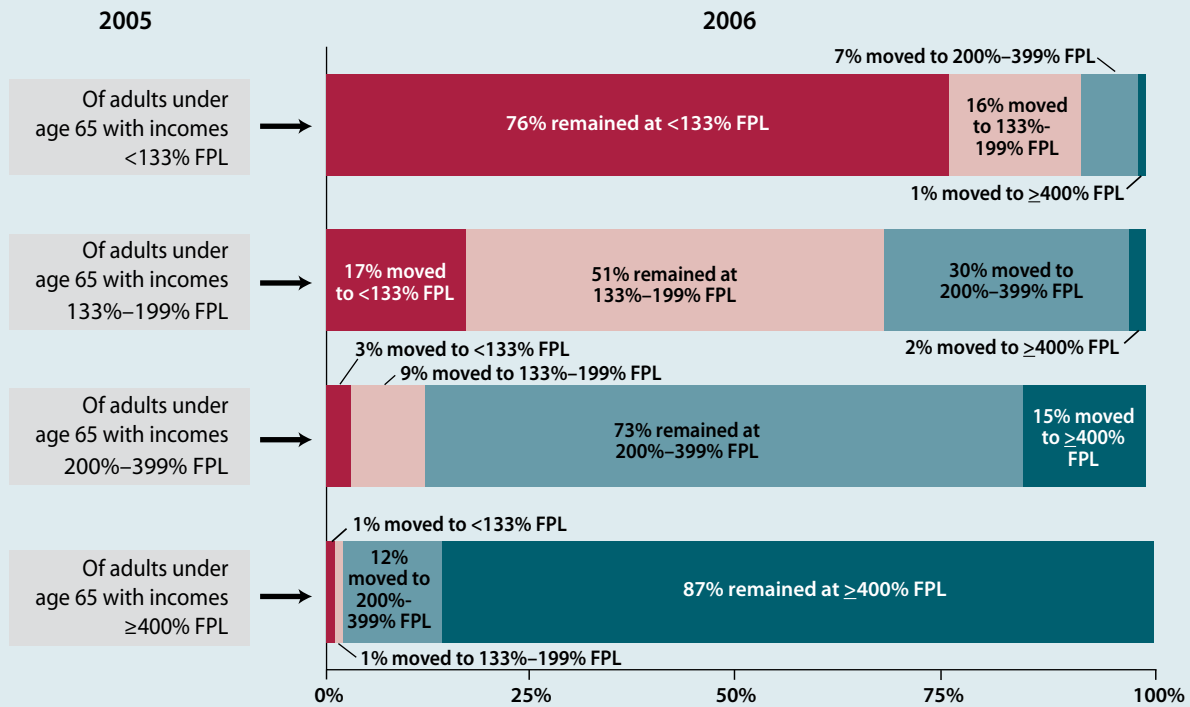
Changes in Coverage May Disrupt Continuity of Care. The income-sensitive approach to coverage expansion under the Affordable Care Act may put vulnerable populations at risk for

abrupt and frequent changes in coverage stemming from changes in eligibility for subsidized insurance when income or employment changes. The movement in and out of various health insurance options—particularly between Medicaid and private plans in the exchanges—may compromise continuity of care.

Vulnerable populations disproportionately experience shifting life circumstances that affect their eligibility for coverage and put them at risk for abrupt and frequent changes in health insurance coverage. In particular, income fluctuations are quite common among Medicaid-eligible adults, with increases in income often resulting in the loss of Medicaid eligibility and thus coverage. A recent study demonstrated that about 25 percent of sampled individuals with 2005 incomes below 133 percent of the poverty level experienced income increases during the following year and would not have qualified for Medicaid under the Affordable Care Act, based on their 2006 income (Exhibit 8).⁴⁴

Furthermore, individuals and families eligible for subsidies with incomes just above Medicaid eligibility (133%–199% of poverty) may experience the greatest income fluctuations. The same study found that within one year, 17 percent of sampled adults with income just above Medicaid eligibility as defined by the Affordable Care Act dropped below 133 percent of poverty to become Medicaid-eligible, and 30 percent of sampled adults moved up to an income level where they would be eligible for less-generous premium subsidies. Increases in income for subsidy-eligible individuals or families may mean that they must repay some or all prior subsidies received, making coverage prohibitively expensive. Additionally, the same study found that vulnerable populations are more

Exhibit 8. Changes in Family Income, U.S. Population Under Age 65, by Poverty Status, 2005 to 2006



Note: FPL refers to federal poverty level.

Source: P. F. Short, K. Swartz, N. Uberoi et al., *Realizing Health Reform's Potential: Maintaining Coverage, Affordability, and Shared Responsibility When Income and Employment Change* (New York: The Commonwealth Fund, May 2011).

likely to experience changes in employment that could affect their continuity of coverage; only 79 percent of sampled individuals with incomes below 133 percent of poverty who worked for small firms in 2005 were still working at small firms in 2006.

Such income and employment shifts among Medicaid and subsidy-eligible individuals and families are most likely to result in millions of Americans moving between Medicaid and private insurance plans in the exchanges. Historically, when individuals and families have lost eligibility for Medicaid, they often became uninsured.⁴⁵ The newly available subsidies under the Affordable Care Act will help protect vulnerable populations from lapses in coverage when their income changes.⁴⁶

Yet despite this lifeline, vulnerable populations are likely to experience movement in and out of the various coverage options. A recent study demonstrated that 35 percent of sampled adults under 200 percent of poverty would have experienced a change in eligibility within six months, and 50 percent of sampled adults under 200 percent of poverty would have experienced a change within one year.⁴⁷ Changes in coverage may cause a shift between plans and provider networks. Therefore, income fluctuations can result in significant disruptions to continuity of benefits, providers, and care, creating negative health and health care consequences. Moreover, the confusion, uncertainty, and hassle of switching plans because of life changes will likely discourage people

from enrolling in health insurance coverage altogether.

Unstable health insurance coverage compromises health care access and quality. Patients who lose insurance are less likely to have a regular doctor, more likely to delay seeking care, and less likely to receive preventive health services.⁴⁸ Furthermore, a transition between being insured and uninsured or between insurance plans can put vulnerable populations at risk, because health plan benefits and provider networks are also likely to change. In fact, patients who transition between one insurance plan and another are more likely to delay seeking follow-up care.⁴⁹ Unstable insurance coverage also matters for vulnerable populations, since they are least likely to be able to pay out-of-pocket for medical expenses.

It is critically important to establish more stable insurance coverage and continuity of care for vulnerable populations. The Affordable Care Act and proposed regulations for the new health insurance exchanges released by the U.S. Department of Health and Human Services describe the exchanges as central to coordinating eligibility and enrollment.⁵⁰ For most vulnerable populations, the exchanges will be the main portals for finding and enrolling in a health plan and learning about and applying for any federal subsidies or public coverage for which they are eligible. Thus, the Affordable Care Act and proposed regulations require that states create coordinated and streamlined eligibility, enrollment, and outreach processes, so that there is “no wrong door of entry” into coverage for individuals and families eligible for Medicaid and subsidies in the exchanges.⁵¹ States have a certain amount of flexibility in how they design the exchanges, and this can be used to make coverage

continuous for vulnerable populations.⁵² The exchanges will be responsible for determining eligibility for premium credits as well as enrolling individuals in Medicaid, CHIP, and other public programs available locally.

For families whose incomes fluctuate around the Medicaid eligibility level, the exchanges provide an opportunity to create a seamless transition between public programs and subsidized private insurance. If the exchanges coordinate the eligibility and enrollment processes and allow plans that participate in Medicaid and CHIP to be available in the exchanges, individuals might be able to move between Medicaid and subsidized private insurance without coverage gaps and without having to change plans or provider networks.⁵³

Furthermore, the health reform law requires qualified health plans participating in the exchanges to include in their provider networks a sufficient number of “essential community providers” that care for predominantly low-income and medically underserved populations.^{54,55} This provision can facilitate continuity of care for enrollees with existing relationships with essential community providers. In addition, to the extent that essential community providers serve people who are eligible for Medicaid, the presence of those providers in networks of qualified health plans would allow people to maintain provider relationships in the event that an income change made them eligible (or no longer eligible) for tax credits and private plans in the exchange. Still, despite such efforts, there remains a substantial risk that insurance instability will result in provider–patient discontinuity.

Coverage with Major Gaps in Benefits or Cost-Sharing Discourages Access to Essential Care for Vulnerable Populations.

Insurance coverage will also need to be designed so that essential benefits are available, with financial protection from high out-of-pocket health care costs. Evidence shows that low- and modest-income patients forgo or delay needed care, including care for chronic conditions, when faced with cost-sharing that is high relative to limited incomes.^{56,57,58} Benefit designs that encourage people to seek health care that is known to be effective, by reducing or eliminating cost-sharing, will therefore be instrumental in ensuring affordable access. Similarly, benefits will need to be broad in scope and provided without cost-sharing that discriminates by condition or disease, and there will need to be caps on total

out-of-pocket costs to prevent patients from falling into medical debt and avoiding needed medical care.

The Affordable Care Act creates new insurance market regulations that establish consumer protections for individuals and families purchasing coverage. First, there are new regulations against underwriting on the basis of health or preexisting health conditions that apply to all plans sold inside and outside of the exchanges. Protections against discrimination based on health status will be particularly relevant to vulnerable populations, who disproportionately suffer from chronic conditions, disability, substance abuse, and mental illness. Second, health plans sold in the exchange and in the individual and small-group markets will be required to provide an essential benefits package, similar in scope to a typical employer plan. In

Exhibit 9. Premium and Cost-Sharing Tax Credits Under the Affordable Care Act

Federal poverty level	Income for a family of four	Premium tax credit cap as a share of income	Average cost-sharing as a share of medical costs
<133%	<\$29,327	Medicaid	Medicaid
133%–149%	\$29,327–<\$33,075	3.0%–4.0%	6%
150%–199%	\$33,075–<\$44,100	4.0%–6.3%	13%
200%–249%	\$44,100–<\$55,125	6.3%–8.05%	27%
250%–299%	\$55,125–<\$66,150	8.05%–9.5%	30%
300%–399%	\$66,150–<\$88,200	9.5%	30%
≥400%	≥\$88,200	—	—

Four levels of cost-sharing

- 1st tier (Bronze) actuarial value: 60%
- 2nd tier (Silver) actuarial value: 70%
- 3rd tier (Gold) actuarial value: 80%
- 4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people who cannot find plan premium ≤8% of income

Annual OOP limits (individual/family)

- 100%–200% FPL: 1/3 HSA limit, \$1,983/\$3,967
- 200%–300% FPL: 1/2 HSA limit, \$2,975/\$5,950
- 300%–400% FPL: 2/3 HSA limit, \$3,967/\$7,933

Cost-sharing is eliminated for preventive services

Note: FPL refers to Federal Poverty Level. OOP refers to out-of-pocket costs. HSA refers to health savings account. Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan. Source: Federal poverty levels are for 2010; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111-148 and 111-152), <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.

addition to a benchmark for benefits, health reform establishes four different levels of cost-sharing for health plans from which individuals can select. The law also places caps on out-of-pocket costs based on income (Exhibit 9).

Last, provisions in the Affordable Care Act establish premium and cost-sharing credits to help individuals and families with the purchase of coverage and the costs for health care services. There are federal tax credits to help individuals and families pay for the cost of premiums for plans sold in the exchanges. In addition, people with low and moderate incomes will benefit from cost-sharing credits that reduce out-of-pocket exposure. Such credits are more generous for individuals and families at lower income levels.

Although the Affordable Care Act includes provisions that reduce cost-sharing and out-of-pocket cost exposure for those with lower incomes, the risk remains that low-income families with incomes above 133 percent of the poverty level who are not eligible for Medicaid could face plan choices with deductibles and cost-sharing that are high relative to their incomes. While the vast majority of low-income families will be able to afford health insurance premiums and typical out-of-pocket health care costs under the schedules specified by the Affordable Care Act, affordability remains a concern for families with high out-of-pocket spending, particularly those between two and three times the poverty level.^{59,60}

Care Systems for Vulnerable Populations

Since vulnerable populations are at higher risk for poor health, experience worse-quality care, and face significant barriers to access, the health care system serving them needs to be specifically

designed and financed to meet their health needs, care utilization, and social circumstances. Exhibit 10 depicts the special needs of vulnerable populations and important components of care systems that address those needs. The generally poorer health status of vulnerable populations—substantially higher rates of chronic health problems, disability, mental illness, and substance abuse—requires an integrated and coordinated health system featuring professionals from many disciplines who have the capacity for preventive care, early identification of health needs, and management of complex health problems. Vulnerable populations' financial situations require care systems that do not exacerbate care barriers with prohibitive cost-sharing. Additionally, care systems must be developed and integrated with community-based and public health services to overcome personal and social factors that adversely affect health and act as barriers to accessing and fully benefiting from care.

Although many vulnerable patients are cared for outside the traditional safety-net system—such as at academic medical centers, private not-for-profit hospitals and health systems, and private providers—the traditional safety-net system plays a critical role by providing otherwise unavailable care to millions of vulnerable individuals. For the purposes of this report, the traditional safety-net system consists of providers that either are required by federal law to serve all patients regardless of ability to pay or do so because it is their explicit mission. Core safety-net providers include public and other mission-driven hospitals, community health centers and clinics such as federally qualified health centers (FQHCs), and state and local health departments that receive direct public financing.

Exhibit 10. Safety-Net Service Characteristics to Address Disproportionate Needs of Patients Served

	Disproportionate Needs	Safety-Net System Characteristics
Health-related needs	Chronic conditions Disability Mental illness Substance abuse Reproductive health care	Team care Care management Care coordination/Integration Medical home Co-located services Integrated services
Personal and social factors adversely affecting health	Dangerous work Unhealthy environments Unsafe environments Chronic stress Shortage of personal time Illiteracy Low social support Homelessness Poor nutrition Health risk behaviors (smoking, substance abuse, inactivity) Disability	Social services Patient education Outreach services Facilitated enrollment in public programs Wraparound services
Personal and social factors affecting health care access	No sick leave Language barriers Cultural disparities Transportation Nontraditional work hours Transient residence Disability	Extended hours of service Language services Transportation services Cultural sensitivity Electronic health records Home visits Home health care Telephone advice lines Electronic visits

The traditional safety-net system operates within a unique financing and legal framework that sets it apart from the other providers serving medically underserved communities. While the Affordable Care Act does much to strengthen the safety-net system, including the creation of potential new sources of financial revenue, additional work needs to be done.

Financial Challenges for the Safety-Net System. In the current economic environment, the safety-net system has become severely strained by changes in the demand for care, the populations seeking care, and the care needs of new patients. Safety-net providers report recent increases in

demand for services by patients not able to fully pay for their care. Although on average U.S. hospitals are seeing fewer patients seeking services, safety-net hospitals have experienced an increase in overall patient volumes in emergency department and inpatient care since the economic contraction.⁶¹ As workers lose their jobs and health insurance coverage, more people are turning to safety-net providers as a critical source of care. Health centers and public hospitals, among other safety-net institutions, have reported an increase in their low-income, uninsured, and Medicaid patient caseloads.

Since the beginning of the economic downturn, public hospitals that care for a disproportionate share of low-income patients are treating more uninsured and Medicaid patients—11 percent and 15 percent more uninsured and Medicaid patients, respectively.⁶² As a result, safety-net hospitals are providing a greater amount of uncompensated care; members of the National Association of Public Hospitals and Health Systems (NAPH) have reported a 17 percent increase in uncompensated care costs, on an average member basis, during the third quarter of 2009 when compared with the beginning of the recession.⁶³ However, the safety-net system lacks the financial resources to meet these new and growing demands.

With the increased demand, safety-net providers are increasingly financially strained. Since they serve a disproportionate share of low-income, uninsured, and Medicaid beneficiaries who do not have the financial means to pay for care, these institutions receive little or no payment from patients for a large portion of services provided. NAPH member hospitals represent only 2 percent of the acute care hospitals in the country yet account for 20 percent of uncompensated hospital care costs nationally.⁶⁴ Sixteen percent of NAPH member hospital costs are uncompensated, compared with the national average of 6 percent for all other types of hospitals.⁶⁵

Historically, federal, state, and local grants or special tax levies have helped to support the needs of uninsured patients served by the safety net. However, the poor performance of the economy, combined with reduced revenue from taxes, has led to federal, state, and local budget cuts in funding for safety-net providers. As a result, many safety-net providers are struggling to cover the costs for

uncompensated care. For example, the increase in uncompensated care costs averaged more than \$4.6 million per NAPH member hospital, with some members incurring in excess of \$30 million in additional costs during the third quarter of 2009 when compared with the beginning of the recession.⁶⁶

Safety-net providers also struggle with financial viability because they serve a large number of public health insurance beneficiaries and receive most of their patient revenue from public sources. Medicaid serves as the largest source of health center revenue, accounting for 37 percent of total operating revenue (63% of patient-related revenue) for health centers and 35 percent of total net revenues for NAPH member hospitals in 2009.^{67,68} However, Medicaid is a payer with historically low reimbursement rates compared with Medicare or private insurers.⁶⁹ While federally qualified health centers receive a modified cost-based reimbursement, other safety-net providers, most notably hospitals and non-FQHC clinics, receive Medicaid fees that are state-determined. With many states facing significant budget deficits, they are cutting reimbursement rates in Medicaid and other state-funded health insurance programs.⁷⁰ Not only do the reimbursement cuts threaten the viability of safety-net providers, but the low Medicaid reimbursement rates may also make it difficult to refer patients to specialists and other auxiliary providers.⁷¹

The Affordable Care Act has numerous provisions to help safety-net providers meet the growing demand, but it falls short of securing their financial sustainability, both in the interim before coverage expansion provisions are implemented in 2014 as well as post-2014. In general, health

reform coverage expansions mean that safety-net providers will serve fewer uninsured patients and provide less uncompensated care. New financial resources will come from previously uninsured patients who will become insured in 2014. However, it is likely that most of the growth in coverage for vulnerable Americans will come from Medicaid, a weak source of revenue as previously discussed.

While the Affordable Care Act, as amended by Section 1202 of the Health Care and Education Reconciliation Act, requires that Medicaid reimburse primary care providers (excluding FQHCs) at parity with Medicare rates in 2013 and 2014, other safety-net providers such as hospitals and specialists that serve vulnerable populations are excluded.⁷² Thus, as states expand Medicaid, they may reduce payment rates to safety-net providers that are not required to receive the enhanced rate. Moreover, many uninsured patients will not be eligible for Medicaid coverage until 2014, making it difficult for the safety net to sustain operations in the interim.

The Affordable Care Act does provide health centers with additional financial support that will enhance their capacity to better serve vulnerable populations. Health reform includes \$11 billion in new, dedicated funding over five years for the operation and expansion of health centers.⁷³ In particular, \$9.5 billion of this total will fund the development of new health centers for communities in need and expand capacity at existing health centers. Furthermore, \$1.5 billion will go toward capital improvements to modernize existing health centers and build new facilities.⁷⁴ In addition to making \$11 billion in mandatory funding available to health centers, health reform establishes a

higher authorized level of funding that may be appropriated in future years.⁷⁵ The bulk of new mandatory and authorized funds will allow health centers to expand their operational capacity to accommodate an expected increase in patient volume, with the potential of increasing current capacity to 50 million patients by 2019, if funding reaches higher authorized levels.⁷⁶ In addition, health reform requires insurance plans offered in the exchanges to include essential community providers such as health centers and requires that their payments to health centers be at least as high as Medicaid payments.⁷⁷

For safety-net hospitals, while health reform will increase the number of insured patients, the impact on their finances is much more tenuous, given their reliance on supplemental funding, which the Affordable Care Act requires to be reduced. Safety-net hospitals have historically received Medicaid and Medicare disproportionate share hospital (DSH) payments to offset the cost of care to uninsured patients and underpayments. In 2006, at least one-third of fee-for-service Medicaid payments to hospitals were through some form of supplemental payment, either DSH payments or “upper payment limit” (UPL) payments.⁷⁸ The Affordable Care Act, beginning in 2014 and continuing to 2020, substantially reduces DSH payments, according to a formula not yet determined.⁷⁹

While the reduction in DSH payments is meant to offset the sources of revenue from patients with new insurance coverage, the new sources of revenue may not be sufficient for the safety-net system to meet the growing needs of vulnerable Americans. The phasing in of new funding and reduction of existing payments creates

a period during which safety-net hospitals may experience further financial stress. Furthermore, during this same gap, public hospitals may find themselves in competition with the private sector in trying to capture the market of newly insured, especially those with commercial insurance.

Since the safety-net health care system will continue to play a critical role, steps need to be taken to ensure that adequate and sustainable resources remain for it to serve vulnerable populations. There are emerging examples of creative avenues for sustainably financing safety-net providers, such as California's 1115 Medicaid waiver, which uses financial incentives to stimulate delivery system reform for higher performance.⁸⁰ Additional, more widespread solutions are needed, however. While health reform provides an influx of financial support and new revenues to health centers, much more needs to be done to meet the growing needs of public hospitals that will continue to care for vulnerable patients.

Organizing Care Systems Serving Vulnerable Populations. The complex medical and social needs of vulnerable populations make it critical for them to receive care from organized delivery systems, with a focus on comprehensive, coordinated primary care. Clinical integration of services across settings (e.g., clinics, specialty care, hospitals, behavioral health providers, and long-term care), whether achieved within actual integrated delivery systems or through less formal mechanisms, such as networks of independent providers, is essential to delivering high-quality, coordinated, efficient care.⁸¹ For example, integration can help ensure coordinated physical and behavioral health services for chronically ill patients with behavioral comorbidities, such as substance

abuse or mental health problems. Because such patients tend to incur significantly higher medical costs than their healthy counterparts, an integrated clinical care model that addresses behavioral comorbidities along with physical health problems can lower overall health care costs for these patients.⁸²

The integration of safety-net providers with each other, with public and private community hospitals, and with small primary care practices has the potential to improve the quality and efficiency of health care provided to vulnerable populations. In particular, such partnerships can help safety-net providers expand the scope of and enhance the quality of services. Legal and governance barriers, however, often inhibit collaborations between health centers and their potential partners. Health centers must meet complex statutory laws and policies, and failure to comply may lead to a loss of federal funding and legal protections; moreover, such requirements may apply to providers that partner with health centers.⁸³ In addition, there are numerous barriers to clinical integration for other providers, ranging from antitrust policies to patient referrals law to Internal Revenue Service rules.⁸⁴

The fragmentation of health care payment in the U.S. also serves as a barrier to greater integration. The majority of providers are currently reimbursed through fee-for-service arrangements (e.g., payment for each visit or service) or for bundled payments that pertain only to care delivered in their setting (e.g., hospital DRG payments). As currently designed, these systems provide little or no financial incentive to coordinate care across the continuum of services. Even without requiring formal integration, adjusting payment to reward better health for populations of patients, as well as

better delivery of health care across longitudinal episodes of care, would help promote collaboration and coordination.

Despite such barriers to clinical integration, potential opportunities for health center collaboration do exist within the legal framework.⁸⁵ Recognizing that health centers may not be able to provide all required services directly to their patients, statutory law permits collaborative arrangements with other providers, including hospital referral arrangements, affiliations with specialty providers, admitting privileges and established arrangements for hospitalization, discharge planning and patient tracking, after-hours coverage, and participation in integrated delivery systems.⁸⁶ As a result, some health centers are, within the legal framework, currently using collaborative and clinical integrative arrangements between health centers and other providers.^{87,88} However, health centers still face challenges in achieving clinical integration.

The Affordable Care Act presents the safety-net care system with numerous policy opportunities to promote greater clinical integration through:

- federal demonstrations and initiatives that promote partnership through delivery system and payment reforms that create financial incentives to align providers;
- regulatory changes that explicitly encourage collaboration and affiliation; and
- the creation of accountable care organizations.

Through the new Center for Medicare and Medicaid Innovation (CMMI), the Affordable Care Act has created the opportunity to test and disseminate innovative delivery system and

payment models.⁸⁹ In particular, the CMMI will test care coordination and fully integrated care models for Medicaid and Medicare “dually eligible” beneficiaries, who can greatly benefit from clinical and financial integration. With regard to care systems that serve vulnerable populations, there are several Medicaid-led demonstrations, including one project that will test global capitated payments to large safety-net hospitals or networks in up to five states,⁹⁰ and another that will evaluate the use of bundled payments for integrated care for Medicaid beneficiaries in up to eight states.⁹¹ In addition, there are authorized but as-yet-unfunded initiatives, such as grants for the co-location of community mental health and community health clinics,⁹² and an opportunity to create a “Community-Based Collaborative Care Network,” a consortium of providers with a joint governance structure—including a hospital and all FQHCs in the community—that would provide coordinated and integrated health care services for low-income populations.⁹³

In addition to such demonstrations and initiatives, there are health reform provisions that make regulatory changes specific to health centers to encourage integration. In particular, one Affordable Care Act provision permits health centers to engage in financial collaborations with rural primary care providers that agree to accept health center patients without discrimination and prospectively discount their charges in accordance with the health center’s fee schedule.⁹⁴

Last, health reform established the Medicare Shared Savings program, which provides incentives for improved quality and efficiency to a new category of provider, the accountable care organization (ACO).⁹⁵ It is uncertain to what the extent, if any,

safety-net providers will be included in these new networks and organizations, or whether there will be a significant increase in affiliations among safety-net providers in an effort to create their own ACOs. While the Affordable Care Act has numerous opportunities, it will be important for health policy leaders to raise awareness of and encourage safety-net providers to participate in such emerging efforts for greater clinical integration.

Irrespective of the organizational structure of care delivery systems, vulnerable populations are likely to disproportionately benefit from team-based primary care. Among low-income patients, access to primary care is associated with better preventive care, better management of chronic conditions, and reduced mortality.⁹⁶ In particular, health care settings that provide patients with a patient-centered medical home—timely, well-organized care and enhanced access to provider teams—have demonstrated that racial and ethnic disparities in access and quality can be reduced or even eliminated.⁹⁷ While it is important to support a strong primary care foundation and adoption of the medical home model by safety-net providers that serve a disproportionate share of vulnerable populations, smaller nonaffiliated practices are less likely to have the capabilities of a medical home and may require a greater investment of resources to become one.⁹⁸ Therefore, strategies must be developed to help providers beyond the safety net to become medical homes and more effectively care for vulnerable populations.

Several provisions in the Affordable Care Act test and promote the spread of delivery system reforms to improve quality of care within the safety net and across the entire health care system to better meet the needs of vulnerable patients.⁹⁹ In

particular, health reform provides an enhanced federal match rate to support “health home” programs for Medicaid patients with chronic conditions.¹⁰⁰ Health homes are very similar in concept to medical homes. In the law, health homes are defined as designated primary care providers—physicians, nurse practitioners, or physician assistants—who work in teams with other health care professionals and provide services to eligible patients, including comprehensive care management, care coordination and health promotion, appropriate transitions between hospital and primary care, referral to community and social services, patient and family engagement, and use of information technology to link services. The Affordable Care Act gives states flexibility to design their payment approaches in the way that works best for them. If states spread the health home/medical home concept throughout Medicaid, more than 15 million chronically ill Medicaid beneficiaries could have a health home in 2014 to help them manage their chronic conditions and improve their health outcomes.¹⁰¹

Continued efforts to promote greater organization, clinical integration, and team-based primary care in the safety net, as well as among providers outside the safety net that serve vulnerable populations, will be necessary to ensure vulnerable populations receive high-quality, coordinated care. Government and private payers should develop and support programs aimed at assisting safety-net providers in moving from traditional, fragmented practices to more organized care systems.

Beyond Insurance and Care Systems: Community Resources for Vulnerable Populations

The health and well-being of vulnerable populations depend on numerous factors beyond insurance coverage and the traditional care delivery system. Community-based support services and public health interventions can help vulnerable populations fully access health care and overcome environmental issues and personal and social factors affecting health. Here we briefly focus on two issues related to accessing health care and health care behaviors: community-based support services and public health activities. The Affordable Care Act has numerous provisions that help to strengthen the overall public health infrastructure as well as grants to states for establishing community health teams that can provide an array of community-based support services. Although the Affordable Care Act does bolster public health and prevention efforts, additional steps are needed to ensure that these efforts are aligned with the delivery systems caring for vulnerable populations.

Community-Based Support Services.

Because they face more barriers to care and tend to be sicker than the general population, vulnerable populations may require community-based support services to enable them to fully access and benefit from the health care system. Community-based support services (some of which are provided directly by hospitals and health centers) are non-clinical services—such as language interpretation and translation, outreach, case management, eligibility assistance, transportation, and child care—that facilitate access to health care and promote patient well-being.¹⁰² Additional common areas of

need include legal assistance and other social support services.

Community-based support services can help address access barriers by linking care to vulnerable individuals who would otherwise go without needed care. Foremost, eligibility assistance and enrollment in health insurance programs are critical to ensuring that vulnerable populations sign up for affordable coverage options that meet their unique needs. In a national survey of community health centers, health centers most often (90%) cited the inability to pay for services as a barrier to care for patients.¹⁰³ Transportation services may also be necessary to bring vulnerable patients to sites of care; 14 percent of surveyed health center patients indicated that transportation problems had kept them from getting needed medical care in the previous six months.¹⁰⁴ In addition, individuals who work numerous low-wage jobs often do not have the flexibility to take time off to go see a doctor, and child care is often not affordable; in fact, 6 percent of surveyed health center patients said they had missed needed medical care because of a lack of child care.¹⁰⁵ Community-based services like onsite child care and shared after-hours clinics will therefore likely prove valuable in facilitating access.

The prevalence of poor health literacy, as well as language or other cultural barriers to care, means that vulnerable populations also at times require assistance in navigating the health system and access to interpretation and translation services.¹⁰⁶ Health literacy—the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions—can help patients more fully access and benefit from the health system.¹⁰⁷ However, national

data suggest that only 12 percent of adults have proficient health literacy, and low health literacy disproportionately affects vulnerable populations.¹⁰⁸ Furthermore, since many vulnerable populations are underserved racial and ethnic minorities and immigrants to the U.S., they require culturally and linguistically appropriate care if they are to use and benefit from the health system. In a survey of health centers, 82 percent cited cultural and language needs as barriers to care.¹⁰⁹

In addition to facilitating access, community-based support services can help vulnerable populations prevent and better manage complex and disproportionate health needs. As previously noted, vulnerable populations tend to be sicker than the general population, more often suffering from multiple chronic conditions, mental illness, disabilities, substance abuse, obesity, high-risk behaviors, and daily functional limitations. For community health centers serving vulnerable populations, patient visits for treatment of chronic conditions account for approximately one-quarter of all recorded visits¹¹⁰—evidence that frequent care oversight and chronic care management are crucial. Vulnerable populations can therefore benefit from a community-based team of nonphysician professionals—such as nurse care managers, pharmacists, dietitians, and behavioral health professionals—as a complement to their medical care.

Acknowledging their importance, Medicaid provides coverage for a wide range of community-based support services. First, most Medicaid managed care organizations cover these services, and where they do not, enrollees often have access to such services through their state Medicaid program.¹¹¹ Second, many safety-net providers provide access to a variety of these services. In

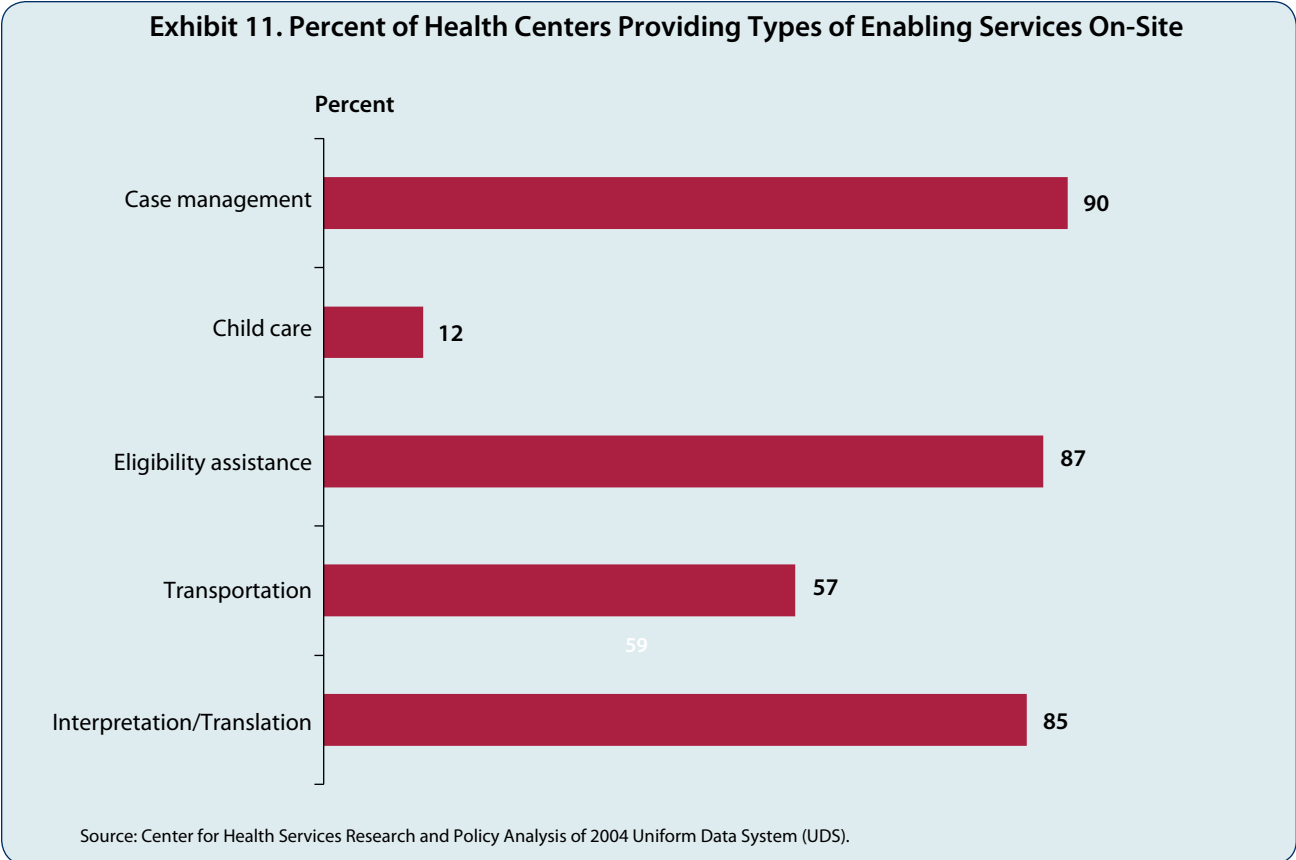
particular, health centers are required by law to provide nonclinical community-based “enabling” services¹¹² and can access federal, state, and private sources of funding for them. According to an analysis of the Uniform Data Set reported by health centers in 2004, 87 percent provide eligibility assistance, 57 percent provide transportation, 12 percent provide child care, 85 percent provide interpretation and translation on site, and 90 percent provide case management services (Exhibit 11).¹¹³

While Medicaid and safety-net providers reimburse and directly provide community-based support services, there is considerable variation in the manner in which they do so and the type and scope of such services.¹¹⁴ Funding and provision are often disjointed, temporary, and severely short of what is necessary to meet demand for vulnerable populations. Enabling services make up only 7 percent of all health center services, and such services cost health centers \$1.2 billion in 2008.¹¹⁵ Community-based services are particularly jeopardized during economic downturns, since Medicaid and financially strained safety-net providers struggle with financing such “supplemental” services in light of state and federal efforts to contain costs. Furthermore, private-sector providers often do not receive sufficient reimbursement and have not developed the capacity to link patients to community-based services. Providers outside the safety net often practice in isolation and may require connections to safety-net provider networks that can share and deploy community-based support services.¹¹⁶ As a result, whether vulnerable populations have access to such critical nonmedical services varies depending on what coverage source they have and where they seek care.

Recognizing that the health and well-being of vulnerable populations depend on numerous factors beyond insurance coverage and the traditional delivery system, the Affordable Care Act establishes (but does not appropriate funding for) a grant program to states for establishing community health teams that can provide an array of support services to vulnerable populations.¹¹⁷ Intended to bring together a broad spectrum of community-based professionals, from medical specialists to dietitians to alternative medicine practitioners, these teams will contract with local primary care practices to provide support for services to patients with chronic conditions, including pharmacist medication management, treatment planning and decision support, and a continuum of health care services in the most appropriate setting. However, it is uncertain whether the community-based

services required under this program are effective, and whether delivery systems participating in such programs are well-prepared to meet the special needs of vulnerable populations. Additional evidence needs to be generated to identify the most effective services, and systems need to be in place to deliver these.

Public Health Activities. Improving the health of vulnerable populations also requires aligning the health systems serving vulnerable populations with public health efforts. A person's health and well-being are heavily influenced by factors that are outside the realm of the health care system. In particular, many of the health problems that disproportionately affect vulnerable populations, such as obesity, diabetes, asthma, and smoking and substance abuse-related conditions originate from social, economic, physical, and



environmental factors. Vulnerable populations are more often socially deprived—they lack access to higher education, stable sources of employment, have fewer financial resources, and have poor social cohesion. Vulnerable populations also more often engage in risky and unhealthy behaviors, such as tobacco use, poor diet, physical inactivity, and substance/alcohol abuse. In addition, they more frequently live and work in unhealthy environments marked by high levels of violence, crime, and hazardous materials. Not only do these factors increase their stress, but they also serve as barriers to healthy behaviors—as when there are no safe places to exercise, and few places to purchase healthy foods. Since the health of vulnerable populations is a product of these intersecting and confounding factors, it is important to look beyond medical care, to public health interventions that use interdisciplinary approaches to improve vulnerable populations' health and well-being.

National, state, and local public health interventions play a critical role in monitoring population-based health targets, preventing and treating disease, and promoting behavioral choices, social circumstances, and environmental conditions that are conducive to better health for vulnerable populations. On a national level, the Department of Health and Human Services launched Healthy People, a comprehensive, nationwide health promotion and disease prevention initiative.¹¹⁸ Since its inception in 1979, Healthy People has established and monitored national population-based targets for health improvement that serve as a framework for promoting health, preventing disease and disability, eliminating disparities, and improving quality of life. In addition to national public health efforts, state and local public health

departments play a critical role in promoting healthier lives of the people within their community, by monitoring local disease patterns such as outbreaks of infectious disease, preventing disease through vaccination campaigns, and encouraging healthy behaviors, such as with tobacco control programs.

Despite the substantial role of public health interventions in achieving better health for all, and especially for vulnerable populations, there is a significant underinvestment in public health and prevention activities when compared with medical care. Currently, only approximately 3 percent of national health expenditures in the U.S. are devoted to government public health activities.¹¹⁹ Moreover, the current economic environment has further depleted public health resources. From 2008 to 2010, 80 percent of state health agencies reported budget cuts, resulting in many program reductions that disproportionately affect vulnerable populations, such as HIV/AIDS and tuberculosis programs and community immunization initiatives.¹²⁰

Although the Affordable Care Act provides some funding to strengthen the capacity of public health with the establishment of the Prevention and Public Health Fund, it is unlikely to address the concerns of the public health community about their ability to continue to perform core public health functions. In the current poor economic environment, it is even more important that explicit attention be paid to linking and aligning the efforts between the health care delivery system and public health in order to maximize their impacts on improving health and health outcomes.

A Policy Framework for Moving Forward

Vulnerable populations—low-income, uninsured, and racial and ethnic minorities—in the U.S. have more difficulty accessing health care, receive worse overall care, and experience poorer health outcomes when compared with the general population. Addressing the needs of vulnerable populations is critical to achieving a high performance health system in our nation. Although the Affordable Care Act will make substantial progress toward this goal, additional work needs to be done. To that end, the Commission on a High Performance Health System offers a framework to help guide the development of specific policies and practices that will be required to ensure vulnerable populations receive care from high performance health care delivery systems, ones that provide high-quality health care at a reasonable cost and achieve good health for all. The key tenets of the framework are:

1. Ensure that insurance coverage results in adequate access and financial protection. It

is clear that insurance coverage is necessary but not sufficient to guarantee access. Key issues to address include:

- *Creating enough willing providers for Medicaid beneficiaries.* There is a shortage of providers, particularly specialty providers, to care for Medicaid beneficiaries. To some extent, these shortages may be reduced through more efficient and effective models of referral and care coordination. Underlying barriers can potentially be addressed through payment reforms that financially reward provider networks for delivering

optimal care to Medicaid beneficiaries (e.g., Medicaid accountable care organizations (ACOs), or ACOs that include Medicaid providers; Medicaid health homes and medical homes; and enhanced payments for caring for vulnerable populations); through more equitable Medicaid payment rates; and through other policy levers, such as requirements relating to Medicare Conditions of Participation or nonprofit status, to encourage provider participation in Medicaid. Additional efforts may be required to develop the workforce pipeline, such as an expansion of medical education debt relief for primary care providers, specialists, dentists, and others practicing in health centers, safety-net hospitals, and medically underserved areas. Ensuring adequate and high-quality provider networks for vulnerable populations may also require helping providers to develop the capacity to care for and meet the complex needs of vulnerable populations; an example might be supporting networks of shared resources among communities of safety-net providers.

- *Making insurance more stable, so that gaps and abrupt changes in coverage can be reduced.* Vulnerable individuals are at risk for significant disruptions in their care when their income or employment changes, often because it could alter their eligibility for subsidized insurance. This could be a particular challenge when transitions occur between Medicaid and private health plans in the exchanges. There are a number of possible steps that can be taken to ensure continuity of care: guaranteeing year-long

coverage periods, providing access to the same insurance plans in exchanges and in Medicaid, merging small-group and individual exchanges, placing a high priority on coordinating eligibility and enrollment for all forms of subsidized insurance through the exchanges, and ensuring that adequate numbers of essential community providers are included in both Medicaid and the subsidized plans.

- *Affordability and protection from high out-of-pocket health care costs.* Even if health insurance premiums are made affordable, low-income families and patients may remain at high risk for medical debt or unable to access medical services if there are major gaps in plan benefits or high cost-sharing. To protect consumers from excessive out-of-pocket health care costs, insurance benefit designs should have positive incentives to use more-effective care and have reasonable income-related limits on overall out-of-pocket cost exposure.

2. Strengthen the care delivery systems serving vulnerable populations. Traditional safety-net providers and other providers serving vulnerable populations must strive to deliver high-performance care. Key issues to address include:

- *Ensuring the financial stability of the safety net while stimulating higher performance.* We believe that the traditional safety-net system—including health centers, clinics, and hospitals serving a high share of uninsured and Medicaid patients—will continue to play a critical role in our

health care delivery system by serving local communities with comprehensive, high-quality care. These organizations will continue to furnish access to those people who remain uninsured. Steps need to be taken, especially in the current rapidly evolving health care environment, to ensure that adequate resources remain for the safety-net system to continue to deliver services to vulnerable populations. These may include maintaining and/or consolidating current funding streams and re-examining reimbursement formulas. That said, financial resources must be used to maintain, stimulate, and reward higher performance among safety-net providers.

- *Promoting greater clinical integration in safety-net health care systems.* The clinical integration of services across settings—clinics, hospitals, specialty care providers, and long-term care facilities—is essential for the delivery of high-quality, coordinated, efficient care. This is true whether integration occurs within the context of an actual integrated health care delivery system or it is achieved less formally. Efforts should be made to promote greater integration through payment reform and regulatory changes that explicitly encourage collaboration and affiliation, both among traditional safety-net providers and with other health care providers and systems in low-income communities. Safety-net providers should also be encouraged to participate in, and the federal government and state Medicaid programs should promote, emerging efforts

to establish accountable care systems that serve vulnerable populations.

- *Focusing on comprehensive, coordinated, team-based primary care for all providers serving vulnerable populations.* Care delivery models for vulnerable populations should reflect the most effective strategies identified by the latest empirical research. There is evidence that much of the disparity in care experienced by vulnerable populations could be eliminated through the provision of patient- and family-centered primary care that emphasizes team-based care, care coordination, care management, and preventive services (e.g., care delivered through health homes and patient-centered medical homes).

It is important to note that providers serving vulnerable populations need to be especially capable of managing conditions and circumstances that are disproportionately prevalent within vulnerable populations, among them chronic disease, disability, mental illness, substance abuse, pregnancy, and low health literacy. The integration of medical care and mental health care delivery within Medicaid will be especially important. In addition, provider and patient incentives, together with technical assistance and supports, can facilitate the adoption of appropriate care models for vulnerable populations, including those with long-term care needs. The effectiveness of such incentives will be maximized through the participation of both government and private payers and the alignment of their incentives. Additionally, efforts may be

needed to increase the number of physicians and allied health professionals available to deliver such care.

3. Coordinate health care delivery system efforts with other community resources, including public health services. Improving the health of vulnerable populations will require not only improving health care delivery systems, but also linking these systems with non-health service providers and aligning them with public health efforts. Key issues to address include:

- *Fostering an infrastructure of community-based support services.* Because of the non-health services that many vulnerable individuals require to fully access and benefit from the health care system, all providers serving these populations should be able to link their practices with community-based services, including transportation, language interpretation, social services, housing assistance, nutritional support, and legal services. Additional evidence needs to be generated to identify the most effective ways to link to and deliver these services.
- *Aligning efforts between the health care delivery system and public health services.* Many of the medical issues that disproportionately affect vulnerable populations, such as obesity, diabetes, asthma, depression, and smoking-related illnesses, can be prevented or mitigated with effective public health and community-focused strategies. To develop effective approaches for improving population health, providers serving vulnerable populations and state

and federal government agencies should promote coordination between the health care delivery system and local public health resources and programs.

The Commission on a High Performance Health System believes that this framework is only an initial step in closing the health care divide for vulnerable populations. Utilizing this framework as a starting point, the Commission will identify, evaluate, and offer specific policy recommendations in the months and years ahead. While we recognize that additional resources are scarce, it is imperative that we address the needs of our vulnerable populations, whose problems are exacerbated by current economic conditions. At the same time,

not all of the policy solutions discussed in this report increase health care spending. Some, such as delivery system changes to promote clinical integration and foster team-based primary care, and better alignment of efforts between health care and public health, may even hold the potential of slowing the growth of health care spending in the future.

A core founding value of the United States is equality of opportunity to live a healthy and productive life. We believe that our nation can and must do better to care for our vulnerable populations, and we are committed to taking action to achieve this goal.

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**One East 75th Street
New York, NY 10021
Tel 212.606.3800**



**1150 17th Street NW
Suite 600
Washington, DC 20036
Tel 202.292.6700**

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