By Peter Cunningham, Laurie Felland, and Lucy Stark

Safety-Net Providers In Some US Communities Have Increasingly Embraced Coordinated Care Models

ABSTRACT Safety-net organizations, which provide health services to uninsured and low-income people, increasingly are looking for ways to coordinate services among providers to improve access to and quality of care and to reduce costs. In this analysis, a part of the Community Tracking Study, we examined trends in safety-net coordination activities from 2000 to 2010 within twelve communities in the United States and found a notable increase in such activities. Six of the twelve communities had made formal efforts to link uninsured people to medical homes and coordinate care with specialists in 2010, compared to only two communities in 2000. We also identified key attributes of safety-net coordinated care systems, such as reliance on a medical home for meeting patients’ primary care needs, and lingering challenges to safety-net integration, such as competition among hospitals and community health centers for Medicaid patients.

Safety-net providers play a crucial role in providing health services to uninsured and low-income people. Although the Affordable Care Act is expected to expand coverage to more than thirty million uninsured people, it is generally recognized that the safety net will still be needed to provide services to an estimated twenty million people who will remain uninsured.

In addition, in all likelihood, many existing Medicaid and newly insured patients will continue to use safety-net providers rather than private mainstream providers because the safety net can better meet low-income people’s specialized needs related to language, culture, and transportation.

Delivery of health services through the safety net historically has been fragmented. Usually hospitals, community health centers, and private physicians providing charity care have operated independently of each other, with little or no coordination of the care of a patient. Such fragmentation can result in severe gaps in the availability of services, reduce quality, lead to redundant use, and increase the costs to providers who typically operate with limited resources and thin margins.

During the past decade, however, a variety of community efforts to better coordinate care for the uninsured that reduce the use of emergency departments and increase the use of primary care providers have been documented. Most community initiatives focus on providers’ efforts to better manage care for their uninsured patients; stretch limited public and private funds; and address serious gaps in services, particularly the lack of access to specialty care. Often these programs improve access to care for the uninsured at a much lower cost than either private insurance or local Medicaid programs.

This article describes safety-net coordination efforts in twelve randomly selected communities and illustrates how these efforts evolved during the past decade. In particular, we focus on initiatives that attempted to coordinate care across...
multiple providers and were often community-wide in scope. These initiatives were better able to manage the care of uninsured patients than a more fragmented system of care (for example, the initiatives used more outpatient primary care to reduce inpatient and emergency department use). Some evidence obtained from the twelve communities indicates that initiatives to coordinate care across providers reduce high levels of emergency department use and reduce the cost of providing care to the uninsured, but barriers to coordination remain.

We identify key attributes of safety-net coordinated care systems and challenges to safety-net integration. Finally, we consider how coordination efforts might be affected by increased access to insurance under the Affordable Care Act. We conclude that many programs will need to expand to include insured patients if they are to remain viable.

**Study Data And Methods**

The Community Tracking Study, conducted by the Center for Studying Health System Change, consists of in-depth tracking of health system changes in twelve randomly selected metropolitan areas from 1996 to 2010. Representative of US metropolitan areas, the communities are Boston, Massachusetts; Miami, Florida; Orange County, California; northern New Jersey; Cleveland, Ohio; Indianapolis, Indiana; Phoenix, Arizona; Seattle, Washington; Lansing, Michigan; Syracuse, New York; Greenville/Spartanburg, South Carolina; and Little Rock, Arkansas.

The first rounds of the study were fully funded by the Robert Wood Johnson Foundation. In 2010 the site visits were cofunded by the National Institute for Health Care Reform.

Findings in this article are based on interviews with approximately 180 health care providers and recognized local experts (about fifteen per site) with broad knowledge of the health care safety net in their community. Respondents typically included emergency department directors and CEOs of the largest public and private hospitals serving a disproportionately high number of low-income and uninsured people in the community; directors of four federally qualified health centers or free clinics; representatives from the largest Medicaid plans, the state Medicaid agency, and the local department of health; and representatives of local foundations or other groups involved in health care for low-income people in the community.

We use the federal government’s definition of care coordination: the “deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of services.” In general, although participants might have been part of the same organization or different organizations, in this study we were primarily concerned with care coordination across different organizations within the same community.

We identified the following three general types of safety-net coordination efforts, described in more detail below: centralized referral networks, managed care programs for the uninsured, and care coordination across multiple providers. We excluded from our discussion community collaborations that focused primarily on resource sharing and capacity building but did not involve coordination among providers in the delivery of care.

**Study Results**

**TRENDS IN SAFETY-NET COORDINATION INITIATIVES**

Efforts to enhance coordination and collaboration among safety-net providers have increased substantially during the past decade. Nine of the twelve communities we studied had some type of organized safety-net program in 2010, compared to only three communities in 2000 (Exhibit 1).

The increase in community initiatives during the past decade reflected a number of factors, including growing numbers of uninsured people in these communities, greater restrictions by some providers on access to care for the uninsured, the increasing burden of uncompensated care and emergency department crowding experienced by many hospitals, and a need to share the limited resources in the community among multiple partners. More detailed trends in the three main categories of community collaborations are discussed below.

**CENTRALIZED REFERRAL NETWORKS**

Centralized referral networks are the most common type of community initiative and have grown most quickly during the past decade. They focus primarily on providing a centralized location where patients can receive referrals to physicians and schedule appointments with private practice physicians (mostly specialists) who agree to treat uninsured patients for free or at reduced costs.

For example, the Project Access initiative, a broad-based community initiative that helps low-income and uninsured people gain access to health care, began in Buncombe County (Asheville), North Carolina, in 1996 and has since spread to about fifty communities in the United States. The number of Community Tracking Study sites with centralized referral network programs increased from zero in 2000 to four in 2010.
Managed care initiatives for the uninsured were established by some communities and safety-net hospitals to reduce inpatient and emergency department use among the uninsured by connecting those patients with primary care providers, either through the hospitals’ ambulatory care facilities or through collaborations with community health centers or private practices. The premise of these programs is that resources could be used to provide additional preventive and primary care, rather than costly inpatient and emergency department care for the uninsured. Most such programs are set up to simulate a health plan, in which uninsured patients are enrolled and given membership cards that they use when they seek health care.

These initiatives began in the United States in the late 1990s. In 2000 two Community Tracking Study communities—Boston and Indianapolis—had such programs in place. In Indianapolis county tax revenue partially funds the managed care program. In Boston the state uncompensated care pool, which is used to reimburse hospitals for care provided to the uninsured, supported the programs (although, as described below, most of these programs are now obsolete due to the Massachusetts health reform). Public funding substantially expands the capacity of managed care programs and increases the number of uninsured who are served.

CARE COORDINATION ACROSS MULTIPLE PROVIDERS Managed care programs typically involve care coordination within a single provider or system—for example, coordinating visits to primary care providers and specialists within a hospital system. But communities increasingly are attempting to coordinate care of the uninsured across multiple safety-net providers.

Outside of the Community Tracking Study sites, for example, Ascension Health, a national network of nonprofit Catholic hospitals, operates the 5-Step Program to develop a community-wide infrastructure for engaging providers in the community. The aim is to improve access and health outcomes for uninsured people through fund-raising, building shared information systems, filling service gaps (such as mental health care, dental care, and prescription drugs), and recruiting primary care physicians to serve as medical homes for the uninsured by coordinating care with specialists.

Similarly, the San Francisco Department of Public Health’s Healthy San Francisco program provides a medical home and primary care physician to each program participant and creates a coordinated system of care among safety-net providers in the community.

Six of the twelve communities had safety-net programs that coordinated care across multiple providers in 2010, three times the number that existed in 2000, when only Boston and Lansing had such programs. The six programs, which we discuss in greater detail in the next section, are HealthCare Connect in Phoenix; Health Advantage in Indianapolis; AccessHealth in Spartanburg, South Carolina; Medical Services Initiative in Orange County, California; Boston HealthNet; and Ingham Health Plan, in Lansing.

By 2010 the Wishard Advantage program in Indianapolis—which in 2000 was focused primarily on managing care for the uninsured within the Wishard system only—had evolved into Health Advantage, a coordinated care program that included a broader network of providers and a more communitywide focus.

Similarly, the Medical Services Initiative program in Orange County—which was an offshoot of the county’s Medical Services for the Indigent Program that provided mainly episodic care to
the uninsured prior to 2007—now uses a patient-centered medical home approach. The program now includes a broad network of providers and is supported by state and local funds.

The programs in Indianapolis, Lansing, Boston, and Orange County operate with some public funding, whereas the programs in Phoenix and Spartanburg operate without any.

Phoenix’s HealthCare Connect received only start-up funding from the federal Health Resources and Services Administration. In contrast, AccessHealth in Spartanburg received initial funding from a private foundation, the Duke Endowment. Both programs are similar to Project Access programs in that they rely at least partially on recruiting a network of private practice physicians in the community to provide discounted or uncompensated care for specialty care and other services. However, these programs go beyond referral networks because they require patients to have medical homes—usually primary care physicians—that coordinate referrals to specialists.

Attributes Of Safety-Net Coordinated Care Systems

Although the six coordinated care programs vary widely in terms of sources of funding, composition of providers, size, and intensity of care coordination, they share several key characteristics. The essential similarity, of course, is an attempt to coordinate the delivery of care to uninsured people across multiple providers in the community (Exhibit 2). In addition, we identify common attributes of safety-net coordinated care systems below.

**Centralized Enrollment** A key to coordinated care systems is a centralized enrollment process, which allows program administrators to screen patients for eligibility for other public programs, such as Medicaid and the Children’s Health Insurance Program, because eligibility for the safety-net program is restricted to uninsured people not eligible for other coverage.

Centralized enrollment also facilitates the assignment of medical homes, referrals to specialists, and monitoring of medical care use through electronic health records and other methods. In most programs, enrollees receive a membership card that is similar to an insurance card, indicating their eligibility to receive covered services from participating providers.

Five of the six programs have an application process with explicit eligibility criteria. Eligibility is restricted to low-income, uninsured people who are residents of the counties or communities that the programs serve. Undocumented

<table>
<thead>
<tr>
<th>Initiative (location, start date)</th>
<th>Entity that administers the program</th>
<th>Funding source</th>
<th>Target group</th>
<th>Estimated number of enrollees</th>
<th>Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Advantage (Indianapolis, 1997)</td>
<td>Wishard Health Services</td>
<td>Local property taxes</td>
<td>Uninsured adults with incomes &lt;200% FPL</td>
<td>60,000</td>
<td>Wishard Health System, FQHCs, free clinics, private MDs</td>
</tr>
<tr>
<td>Ingham Health Plan (Lansing, 1998)</td>
<td>Ingham County Health Department</td>
<td>Hospitals and county funds</td>
<td>Uninsured adults with incomes &lt;250% FPL</td>
<td>12,000</td>
<td>Health Department clinics, free clinics, private MDs</td>
</tr>
<tr>
<td>AccessHealth (Spartanburg, 2010)</td>
<td>Spartanburg Regional Health System</td>
<td>Duke Endowment grant and matching community donations</td>
<td>Uninsured adults with incomes &lt;150% FPL</td>
<td>440</td>
<td>Hospitals, FQHC, free clinics, private MDs</td>
</tr>
<tr>
<td>Medical Services Initiative—HCCI (Orange County, 2007)</td>
<td>Orange County Health Care Agency</td>
<td>State Medicaid waiver, tobacco revenues, and local general funds</td>
<td>Uninsured adult citizens or legal immigrants with incomes &lt;200% FPL</td>
<td>Approximately 45,000</td>
<td>Hospitals, FQHCs, free clinics, private MDs</td>
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<tr>
<td>HealthCare Connect (Phoenix, 2004)</td>
<td>Arizona Association of Community Health Centers</td>
<td>Started with federal grant; now funded through enrollment fees and grants</td>
<td>Uninsured adults with incomes &lt;250% FPL</td>
<td>4,000</td>
<td>FQHCs, hospitals, private MDs</td>
</tr>
<tr>
<td>HealthNet (Boston, 1997)</td>
<td>Boston Medical Center</td>
<td>Boston Medical Center</td>
<td>Patients from the 15 FQHCs that participate in the program</td>
<td>200,000</td>
<td>Boston Medical Center and 15 FQHCs</td>
</tr>
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**Source** 2010 Community Tracking Study site visits. **Notes** FPL is federal poverty level. FQHC is federally qualified health center. HCCI is Health Care Coverage Initiative.
immigrants are eligible for these programs, with the exception of the Medical Services Initiative in Orange County.

During the application process, prospective members are screened for eligibility for Medicaid and other social service programs, which would disqualify the applicants from participating. Some programs use a common application form such as the web-based Indeapp system in Indianapolis—a version of California’s One-App system—which enables people to apply for multiple social service programs (for example, Medicaid; the Supplemental Nutrition Assistance Program, formerly known as the food stamp program; and the earned income tax credit) from a single location.

HealthNet in Boston is unusual in that all of the patients of the fifteen federally qualified health centers that are part of the HealthNet provider network are members, and there is no formal application process per se. HealthNet also is unique in that it does not specifically target uninsured patients, whose numbers decreased substantially after the implementation of the Massachusetts health reform. Rather, the program focuses on integrating the care processes of Boston Medical Center and the fifteen federally qualified health centers for all patients, regardless of insurance status.

Of the six programs, HealthNet serves the largest number of patients (Exhibit 2). Among programs that exclusively serve the uninsured, Ingham Health Plan has the largest enrollment relative to the total number of uninsured in the community (12,000 out of an estimated 32,000 uninsured in Ingham County), followed by Health Advantage (60,000 out of an estimated 146,000 uninsured in Indianapolis), and Medical Service Initiatives (45,000 out of approximately 560,000 uninsured in Orange County).

By comparison, enrollment in AccessHealth in Spartanburg and HealthCare Connect in Phoenix is small relative to the number of uninsured people in those communities. One reason for this is the fact that AccessHealth is new. Both programs also rely on uncompensated and discounted care from providers rather than on public funding that can be used to compensate providers. This feature probably limits the amount of time and practice resources that providers are willing to devote to the programs. High cost-sharing amounts in HealthCare Connect may also contribute to low enrollment.

**Provider Networks** Safety-net hospitals play the lead role in administering the program and providing services in Indianapolis, Boston, and Spartanburg (Exhibit 2). In contrast, HealthCare Connect in Phoenix is administered by the primary care association for the state that represents federally qualified health centers. Ingham County Health Department clinics form the core of the Ingham Health Plan network.

However, major safety-net providers in the community are not always included in these networks, particularly in the larger communities included in the Community Tracking Study, such as Boston and Phoenix. For example, Cambridge Health Alliance—a major safety-net hospital system in Boston—is not included in Boston Medical Center’s HealthNet.

Another example is the major safety-net hospital system in Phoenix. The Maricopa Integrated Health Care System has its own financial assistance program for uninsured patients and does not formally participate in the HealthCare Connect network of providers (although the hospital allows HealthCare Connect patients to be referred there for specialty care).

Most safety-net coordinated care provider networks include private practice physicians in addition to safety-net providers. HealthNet in Boston is an exception. And Health Advantage in Indianapolis contracts with the Indiana University Medical Group to provide all primary care needs and pays a capitated rate to these physicians for primary care services.

Respondents in the community interviews report that the use of private physician practices is growing in the Lansing and Orange County programs, perhaps partly because both programs pay fee-for-service rates that are comparable to or somewhat better than state Medicaid rates.

HealthCare Connect in Phoenix is not publicly subsidized, but private practice physicians receive discounted fees from patients that vary by type of service and physician specialty. Of the six communitywide coordinated care programs, AccessHealth in Spartanburg is the only program for which private physicians agree to provide services free of charge to uninsured patients.

**Medical Homes** Five of the six programs explicitly require patients to have a medical home that they use for all primary care needs. A primary care physician practice that serves as a medical home is generally responsible for authorizing referrals for specialty care. Generally, a single primary care physician serves as the medical home for program participants. An exception is HealthNet in Boston, which is organized around the fifteen participating federally qualified health centers that serve as medical homes for the patients who are referred to Boston Medical Center (the safety-net hospital that administers HealthNet) for specialty and inpatient care.

An explicit objective of most of the programs is to offer a coordinated care system in which the
medical home provides case management and coordinates care with other providers and services. HealthNet coordinates inpatient care with member health centers through a system in which both hospital- and clinic-based physicians see patients while they are in the hospital and participate in planning for their discharge.

Boston Medical Center places some specialists and residents from the hospital at the health centers, and all fifteen participating health centers have access to clinical information systems at the hospital, enabling them to view patient clinical histories, schedule appointments electronically with specialists at the hospital, and track no-show rates. HealthNet also provides transportation assistance to transport health center patients to their scheduled appointments at Boston Medical Center.

Care coordination activities in some programs are also aimed at reducing the use of emergency departments for nonurgent health problems. For example, the Medical Services Initiative in Orange County includes a system called ER Connect. In this program, emergency departments and primary care physicians are connected electronically. With ER Connect, physicians in the emergency department can access medical histories for patients who arrive at the emergency department and later refer these patients back to their medical home for follow-up care if needed. The objective is to improve continuity of care, avoid duplication of services, and reduce emergency department visits, especially among frequent users.

Similarly, Ingham Health Plan in Lansing recently implemented a program in which case managers receive lists of their patients who visited the emergency department during a specified time period. The case managers use the information to educate patients and redirect some of their patients’ future care away from the emergency department and back to their primary care physician.

A few of the programs use provider incentives, such as capitation or enhanced fees, to encourage appropriate utilization of services for patients. For instance, the Medical Services Initiative in Orange County offers financial incentives for physicians to join the network. The program also includes extra payments for medical homes to provide at least one visit for each patient per year (two for people with chronic conditions), pay-for-performance incentives for medical homes to improve utilization of preventive services, and incentives for providers to reduce emergency department utilization.

Health Advantage in Indianapolis pays capitated rates to primary care physicians to motivate physicians to encourage appropriate use of services and build relationships with their patients. It is unknown, however, whether these incentives are inadvertently discouraging the use of appropriate or necessary services.

**Benefits Of Safety-Net Coordination**

The coordinated care programs also have the shared objective of assessing their effectiveness and benefits by tracking and monitoring program costs, utilization (especially of the emergency department), and patient adherence to appointments and treatment regimens. Some of the programs also measure patient and provider satisfaction.

However, results of these monitoring efforts are not always available, either because the program itself is new (for example, AccessHealth in Spartanburg, which was launched in 2010) or because tracking efforts are new (for example, Ingham Health Plan in Lansing, which only recently started tracking emergency department visits and inappropriate inpatient stays).

To our knowledge, formal evaluations of the six coordinated care programs have not been conducted or are not publicly available. One reason may be a lack of staff availability or other resources. However, available data show that Health Advantage in Indianapolis has been successful in decreasing inpatient use and emergency department use. In the first eighteen months after the program began, inpatient days for uninsured people decreased by 50 percent, and emergency department use decreased by 30 percent.

In addition, in collaboration with researchers from the University of California, Los Angeles, the Medical Services Initiative in Orange County found that the ER Connect program reduced emergency department visits and increased the number of visits to primary care providers. Recent research on similar programs not included in the Community Tracking Study found that their patient costs were 25–50 percent lower than for patients enrolled in local Medicaid programs or through private insurance.

**Challenges To Safety-Net Integration**

Despite their successes, challenges remain for safety-net coordinated care programs.

**CAPACITY AND FINANCING**

Many of the programs lack the capacity to serve all of the eligible uninsured. Providers’ practices are often full, and they have limited availability to see new patients, especially uninsured patients for whom they provide care for free or for reduced fees. For example, in its first year AccessHealth in Spartanburg set a modest goal of enrolling 1,000
uninsured people out of an estimated eligible 39,000 people.

In part this goal reflected uncertainty about the ability of providers in the community to accommodate an increase in demand for care by uninsured patients, which for the most part would be uncompensated. As of the beginning of 2012, only about 700 uninsured people were enrolled in the program, although this number reflects the fact that some who were screened for eligibility for AccessHealth were eligible for and enrolled in Medicaid.

Publicly subsidized programs are vulnerable to cuts in funding, especially given the strained local and state budgets of recent years. For example, enrollment in Ingham Health Plan in Lansing has decreased during the past several years, despite an increase in the number of uninsured in the community. This occurred primarily because budget deficits led officials to be more aggressive about reassessing eligibility yearly, which resulted in about 4,000 enrollees being dropped.

**Fragmentation and Competition** Despite efforts at greater community collaboration, fragmentation and competition among safety-net providers remains. There are inherent challenges in creating integrated care systems because of the legal, mission-related, and financial constraints of the various providers included in the network. For instance, federally qualified health centers are required by law to treat all patients regardless of their ability to pay. This requirement extends to all providers the centers collaborate with, which could inhibit closer collaboration with private providers who do not wish to serve the uninsured.13

In addition, competition among safety-net providers for Medicaid patients can inhibit closer cooperation. Most safety-net hospitals and federally qualified health centers depend on Medicaid patients for their financial viability both because reimbursements are based on the cost of care (and therefore are considerably higher than reimbursement rates to private physicians) and because grant revenue often doesn’t cover the full cost of care to the uninsured.

Community health centers may be reluctant to participate in collaborative arrangements if they think that such cooperation could result in a loss of Medicaid patients. For example, interview respondents from Miami noted that some federally qualified health centers in the community were concerned that efforts by Jackson Health System (the main public hospital) to convert some of its primary care clinics to federally qualified health centers would increase competition for Medicaid patients, given the higher Medicaid rate that the hospital-based clinics receive.

In Detroit, federally qualified health centers compete with hospital emergency departments for Medicaid patients. The result is that some health centers struggle with low Medicaid volumes despite high demand for care in the community, whereas some hospitals openly encourage Medicaid patients to use their emergency departments for all of their health care needs, including nonurgent and primary care.14

Furthermore, although safety-net hospitals are often the natural leaders for community integration efforts given their size and broad service area, not all safety-net hospitals are willing or able to assume that role. For example, Jackson Health System is the primary safety-net hospital for Miami-Dade County but generally does not provide a leadership role in coordinating care and services with other safety-net providers in the community.

Part of this reflects Jackson’s financial troubles at the time of the site visit (Jackson lost about $240 million in 2009 and $100 million in 2010), which forced it to cut back on some services. But it also reflects the fragmented nature of Miami’s safety net, which respondents characterize as having more competition than coordination and collaboration among providers to provide care to low-income Medicaid and uninsured patients.

**Implications For Health Reform** Looking forward, provisions in the Affordable Care Act that promote greater integration of providers and care coordination could build on these nascent community collaboration efforts. For example, safety-net providers—including health centers and hospitals—can form accountable care organizations to participate in Medicare’s Shared Savings Program, in which networks of providers that jointly take responsibility for the cost and quality of care provided to their patients can share in Medicare savings.

In addition, new demonstration projects to test new payment and care delivery models have a potential impact on safety-net coordination.15 For instance, the bundled payment model involves a single payment to multiple providers for an episode of care, which motivates providers to coordinate and deliver care more efficiently. Safety-net coordination initiatives are also well poised to facilitate the insurance coverage expansions and health insurance exchanges created in the Affordable Care Act because of their established centralized enrollment systems that screen for eligibility for other public insurance.16

However, potential barriers and challenges exist for these community initiatives to maintain
their viability after the major provisions of the Affordable Care Act take effect. A major concern is the potential loss of funding for programs that have relied on Medicaid’s disproportionate-share hospital payments, extra payments to hospitals that serve a large number of Medicaid and uninsured patients, which are to be reduced under the Affordable Care Act.17

Some community respondents are also concerned that safety-net coordination programs could face a loss of private funding and community interest if the perception is that they are no longer needed due to greater access to affordable health insurance coverage,18 or if the perception is that the remaining uninsured are undeserving of coverage, for example, undocumented immigrants who are ineligible for coverage expansions under the Affordable Care Act.

For a telling example of the potential fate of safety-net coordinated care programs after health care reform, we looked to the situation in Massachusetts. In 2006 Massachusetts enacted a health care reform law designed to expand health insurance coverage to nearly all state residents, a law that has served as a model for the coverage expansions in the Affordable Care Act.

Since 2006 the Cambridge Health Alliance and Boston Medical Center safety-net hospitals ended their managed care programs for the uninsured, largely because the insurance expansions reduced the need for these programs. However, the HealthNet safety-net coordinated care program, run separately by Boston Medical Center, remains relevant in a postreform environment because it involves the coordination of care for all patients of participating health centers, rather than just the uninsured.

In Orange County, local officials view the Medical Services Initiative safety-net program as a way to prepare uninsured people for adapting to a managed care environment when many become eligible for Medicaid in 2014. California’s “Bridge to Reform” Medicaid demonstration waiver, approved by the federal government in 2010 to expand coverage and prepare for national reform, continues and expands on these preparations for implementation of the Affordable Care Act by extending coverage to low-income adults and providing subsidies to public hospitals.19

The continued viability of safety-net programs in other communities, such as Spartanburg and Phoenix, is less certain. These communities have much higher rates of uninsured patients than Massachusetts and also rely on private funding and voluntary efforts by providers. In these communities, health insurance coverage expansions in the Affordable Care Act may create the perception that the uninsured problem has been solved and these programs are no longer needed, potentially bringing an end to such efforts.

However, in all likelihood, these communities will continue to have relatively high numbers of uninsured patients compared to Massachusetts, which had low uninsured rates even prior to the state reform. In large part because of the lack of public funding for the programs in Spartanburg and Phoenix, those programs might need to transition from serving only the uninsured to serving low-income patients with insurance and those on Medicaid.

Including Medicaid patients in safety-net programs could be challenging because many states have started separate patient-centered medical home initiatives for their Medicaid programs that would overlap with safety-net initiatives.20 In the Community Tracking Study, these efforts appear to be entirely separate from safety-net integration efforts that are occurring on the local level and that target the uninsured in states that implement or experiment with patient-centered medical home initiatives in their Medicaid programs.

If states and Medicaid plans prefer to develop their own networks of Medicaid providers independent of the networks that have been established as part of local safety-net initiatives, these local initiatives could be disrupted and care to the uninsured could be compromised.

Separate systems of care for Medicaid patients, the uninsured, and those enrolled in plans through the state health insurance exchanges will be especially difficult to navigate for people who switch to Medicaid from private insurance (or vice versa) because of changes in their economic or employment circumstances. This could create new forms of care fragmentation that the reforms in the payment and delivery system of the Affordable Care Act are designed to eliminate.

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Peter Cunningham is a senior fellow and director of quantitative research at the Center for Studying Health System Change. In this month’s Health Affairs, Peter Cunningham and coauthors report on trends under way in the past decade to better coordinate and integrate care within safety-net health systems. Focusing on twelve communities in the Community Tracking Study—a national, longitudinal study of changes in twelve local health care systems—they found that half of the communities had formal efforts to link uninsured people to medical homes and coordinate care with specialists in 2010, compared to only two communities in 2000. The authors also identified key attributes of safety-net coordinated care systems and challenges to further integration, such as competition among hospitals and community health centers for Medicaid patients.

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