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Sustaining and Advancing the Healthcare Safety Net:

Ensuring that the Healthcare Safety Net Is Not Left Behind

Recommendation Report

Advisory Committee on Minority Health

September 2013

Advisory Committee on Minority Health: Section 1707 of the Public Health Service Act, as amended, by the Minority Health and Health Disparities Research and Education Act of 2000, P. L. 106-525 authorizes the establishment of an Advisory Committee on Minority Health. The Committee also is governed by provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees. The Act directs the Advisory Committee on Minority Health to advise the DHHS, through the Deputy Assistant Secretary for Minority Health, on improving the health of racial and ethnic minorities and on the development of the program activities of the Office of Minority Health.

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Term Date: 09/2013

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Institute for Social Research
University of Michigan
Term Date: 11/2016

Barbara J. Sabol, RN
Consultant
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Term Date: 04/2014

Executive Summary

The focus of this report is on outreach and enrollment and the impact of the Affordable Care Act on the healthcare safety net. Healthcare safety net is defined to include providers such as Federal Qualified Health Centers (FQHCs), public hospitals, small racial and ethnic minority provider private practices, and local public health departments. These safety net organizations fill a critical need for uninsured, underinsured, and other vulnerable populations – the same populations that the Affordable Care Act was designed to support and benefit.

Key issues included Medicaid expansion, the vulnerability of safety net organizations in the current healthcare system and insurance climate, and the importance of protecting and strengthening safety net organizations by providing resources and accountability mechanisms to make them more efficient and competitive in the health insurance marketplace.

ACMH presents four recommendations on how the Office of Minority Health (OMH) and the Department of Health and Human Services (HHS) can ensure that the safety net organizations not only survive but thrive as the Affordable Care Act is implemented:

1. Sustain FQHCs by expanding capacity and support to ensure they can successfully compete in the health care marketplace to improve patient access to care. OMH should work with Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS) to support a Prospective Payment System, recruitment and retention of providers, and staffing mechanism for improved efficiency and quality of care.
2. Extend and/or modify Disproportionate Share Hospital (DSH) payments to ensure low-income patients have access to quality care that enables public hospitals to successfully compete in the healthcare marketplace. OMH should work with the CMS and HRSA's Bureau of Health Professions to modify and/or extend DSH funding and resources for primary care provider development and outpatient facilities in public hospital networks.
3. Support public-private collaborations to build the capacity of small racial and ethnic minority provider practices to compete in the health insurance marketplace and serve as medical homes for high-risk and minority populations. OMH should work with CMS and HRSA to ensure that racial and ethnic minority provider practices have the necessary technology, certifications, and quality assurance mechanisms to be competitive.
4. Preserve the Affordable Care Act Prevention and Public Health Fund to advance public health efforts to promote health equity and address social determinants of health. OMH should work with HHS leadership and the Centers for Disease Control and Prevention to preserve the Affordable Care Act Prevention and Public Health Fund established to provide sustained investments in prevention and health promotion.

Overview

The Advisory Committee on Minority Health (ACMH) is charged with advising the Deputy Assist Secretary for Minority Health on ways to improve the health of racial and ethnic minority groups and Tribal Nations and on the development of goals and specific program activities of the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH). The ACMH has identified as one of its majority priorities ensuring that health care reform, as embodied in H.R. 3950, *The Patient Protection and Affordable Care Act (ACA) of 2010* (P. L.111-148),[i] is implemented with the aim of achieving health equity for all populations.

At the July 2013 ACMH meeting, the committee focused on outreach and enrollment and the impact of the ACA on the healthcare safety net. Key issues discussed included Medicaid expansion, the vulnerability of safety net organizations in the current healthcare system and insurance climate, and the importance of protecting and strengthening safety net organizations by providing resources and accountability mechanisms to make them more efficient and competitive in the health insurance marketplace. These areas of focus are consistent with principles the ACMH proposed in its 2009 report on health care reform, emphasizing reform strategies that ensure sustainable access to affordable quality care, including the safety net (Appendix A contains a list of the relevant principles).[ii] Continued monitoring and analysis of the impact of health reform on eliminating health disparities and achieving health equity are imperative.

The issues raised are especially important to address at this time as the implementation of the ACA affects safety net organizations, which fill a critical need for uninsured, underinsured, and other vulnerable populations (due to factors such as health or developmental status, age, financial circumstances, personal characteristics, and English proficiency)—the same populations that the ACA was designed to support and benefit. Furthermore, the uninsured population has grown since the passage of ACA 2010 to approximately 50 million.[iii] However, major shortages in the healthcare workforce, particularly in urban and rural areas; the delay of the employer mandate until 2015; the limited number of states implementing Medicaid expansion (25 states) and establishing state health insurance exchanges (18 states); and the slow recovery of the economy are significant threats to the sustainability of safety net organizations.[iv,v,vi,vii]

With the increase in the uninsured population and challenges around sufficient access to affordable quality care, the demand for services among our traditional safety net providers – Federally Qualified Health Centers (FQHCs), public hospitals, small racial and ethnic minority provider private practices, and local public health departments – will continue to exist for a substantial period beyond the implementation of the ACA. OMH plays a critical role in assuring that safety net organizations are viable in the new health insurance marketplace and remain a quality health care option for minority and vulnerable populations. Therefore, this report presents recommendations on how OMH and HHS can ensure that safety net organizations not only survive but thrive as the ACA is implemented to increase minority and vulnerable populations' access to quality, affordable care. This report offers specific strategies that can be used to preserve and maintain nationwide safety net provider infrastructure, thereby

increasing access to quality health care throughout the ACA implementation. The following sources informed the recommendations: presentations by the invited experts on the impact of the ACA on the safety net;[viii] presenters' supporting materials and recommendations submitted to ACMH; and existing literature on safety net organizations. Attached as an appendix (Appendix B) are detailed recommendations from the National Academy for the State Health Policy National Workgroup on Integrating a Safety Net into Health Care Reform Implementation (NASHP National Workgroup).[vi]

Recommendations

The ACMH proposes the following recommendations for four key organizations, institutions, and fields of practice to ensure the quality and sustainability of the healthcare safety net for vulnerable and minority populations:

1. Sustain *Federally Qualified Health Centers (FQHCs)* by expanding capacity and support to ensure they can successfully compete in the health care marketplace to improve patient access to care
2. Extend and/or modify Disproportionate Share Hospital (DSH) payments to ensure low-income patient access to quality care that enables *public hospitals* to successfully compete in the healthcare marketplace
3. Support public-private collaborations to build the capacity of *small racial and ethnic minority provider practices* to compete in the health insurance marketplace and serve as medical homes for high-risk and minority populations
4. Preserve the ACA Prevention and Public Health Fund to advance *public health* efforts to promote health equity and address social determinants of health

Recommendation 1: Sustain* Federally Qualified Health Centers (FQHCs) *by expanding capacity and support to ensure they can successfully compete in the health care marketplace to improve patient access to care

OMH should work with Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS) to ensure that FQHCs are successful competitors in the health insurance marketplace by supporting a Prospective Payment System, recruitment and retention of providers, and staffing mechanisms for improved efficiency and quality of care.

Discussion

Community health centers (CHCs) are valuable because of their ability to provide comprehensive, culturally responsive primary, dental, and behavioral health care for uninsured, low income individuals.[iv,v] FQHCs (over 1200 organizations with over 9,000 sites) will continue to be a major access point for culturally competent primary care and enabling services that advance prevention and health promotion thereby cutting enormous costs.[ix] However, they also will face increasing commercial competition with other types of health care systems and providers. For instance, commercial development of the Primary Care Medical Home (PCMH) will put pressure on FQHCs to cut costs for enabling services even though their service

population has many at high need for these services. There also is competition for recruitment of primary care providers (PCPs) given skyrocketing starting salaries, which FQHCs cannot afford to pay. Therefore, strengthening FQHCs' recruitment, retention, and reimbursement mechanisms can make them more competitive among health systems.

Implementation Examples and Considerations

- **Continue funding for projected expansion of FQHCs to increase patient coverage.** Section 10503 of the ACA establishes a Community Health Center Fund to "provide for expanded and sustained national investment in community health centers under section 330 of the Public Health Service."[i] Supporting the expansion of FQHCs would cover an estimated additional 20 million patients, for a total of 40 million individuals covered.[x]
- **Ensure support for the Prospective Payment System (PPS)**, a method of cost-based reimbursement in which Medicaid and Medicare payment is predetermined as a fixed amount. This system is based on actual costs incurred related to services designed to address the health (e.g., physician, midlevel practitioners, nursing, behavioral health, nutrition), social (e.g., social services, case management), and accessibility (e.g., interpreters, translation, health education) needs of low-income, high-risk, and minority patient populations seen in FQHCs.[xi]
- **Assess provider satisfaction and offer professional development support for primary care, dental, and behavioral health providers to ensure their availability and continuity at FQHCs.** Training, recruitment, and retention are key areas to ensure an adequate pool of diverse, qualified, culturally and linguistically competent providers for the populations that FQHCs serve. Specific strategies to consider include:
  Recruitment
  - Expand National Health Service Corps (NHSC) and other obligatory contractual scholarships to serve in Medically Underserved Areas (MUAs)
  - Provide bridge funding to ensure competitive entry level salaries
  - Expand availability of loan forgiveness programs for years served

  Retention
  - Continue bridge funding to maintain competitive salaries
  - Continued loan forgiveness options
  - Support professional development opportunities for executive and mid-level leadership (e.g., through National Association of Community Health Centers [NACHC] Training and Technical Assistance)
  - Support fulfillment and job satisfaction strategies to prevent turnover
  - Support quality assurance and incentive reward systems that promote a culture of excellence and high performance.
- **Support alternative staffing models to improve efficiency and cost-effectiveness of primary care delivery and increase accountability of providing quality care.** HRSA should consider bridge funding for alternative staffing models. These models can include a broad array of licensed and non-licensed personnel whose roles, organization, and coordinated activity address the complex social, cultural, behavioral, and medical challenges of high risk populations. Alternative staffing models should emphasize more

efficient and cost-effective approaches and strategies that yield positive health outcomes.

Recommendation 2: Extend and/or modify Disproportionate Share Hospital (DSH) payments to ensure low-income patient access to quality care that enables* public hospitals *to successfully compete in the healthcare marketplace

OMH should work with the CMS and HRSA Bureau of Health Professions to modify and/or extend DSH funding as well as resources for primary care provider development and outpatient facilities in public hospital networks to increase access to quality care.

Discussion

Safety net hospitals serve more than 10 million individuals annually, with the majority of patients either uninsured or underinsured. Over half of safety net hospitals are located in large urban areas, serving a racially and ethnically diverse population. These facilities also offer specialty services to the entire community, such as emergency psychiatric, trauma, and burn care. [xii] Public hospitals will continue to be the place of last resort for hospital-based emergency care and hospitalization. They also provide comprehensive primary care and training programs for future safety net providers. Public hospitals provide such care in the face of workforce and financial resource shortages, which the Medicaid expansion is expected to exacerbate.[v] Maintaining DSH payments and supporting providers and public hospital facilities will reduce this resource strain.

Implementation Examples and Considerations

- **Maintain DSH funding at current levels for at least five years.** DSH provides funding to cover unreimbursed hospital cost incurred by low-income and uninsured patients. Decreases in funding such as the ACA provision to reduce DSH allocations between fiscal years 2014 and 2020 may threaten the financial stability of some public hospitals. Furthermore, additional revenue acquired from patients covered under the Medicaid expansion may not be sufficient for public hospitals to adequately serve vulnerable populations.[iv,v, xiii] Therefore, until the full impact of ACA coverage becomes clear, it is critical to maintain DSH funding to ensure the viability of public hospitals to continue to provide care for low-income and uninsured individuals.
- **Extend modified FQHC PPS funding status to outpatient departments and satellite health centers in the public hospital network.** Extending Medicaid and Medicare reimbursement to public hospital network facilities will increase options for where uninsured patients can receive comprehensive care and services.
- **Offer professional development support for primary care physicians and staff to ensure their availability and continuity at public hospitals.** As noted in Recommendation 1, enhancing recruitment and retention strategies will strengthen, diversify, and sustain the health care workforce in the safety net. For instance, primary care residency programs can aid in recruitment and retention at public hospitals. Such support will promote continuity and help providers work more effectively with

underserved populations. Thriving professionally also will contribute to increasing quality of care.

Recommendation 3: Support public-private collaborations to build the capacity of* small racial and ethnic minority provider practices *to compete in the health insurance marketplace and serve as medical homes for high-risk and minority populations

OMH should work with CMS and HRSA to support public-private collaborations to ensure that racial and ethnic minority provider practices have the necessary technology, certifications, and quality assurance mechanisms to be competitive. Such capacity building support will enable these provider practices to successfully participate in state exchanges and provide patient-centered medical homes for underserved populations.

Discussion

Racial and ethnic minority providers often work within small private practices, providing services to diverse local populations that are underserved.[xiv] Although minority providers in these settings are commonly overlooked as a core component of the safety net, they serve as an invaluable cultural and linguistic resource, particularly in regions with large racial and ethnic minority populations and patients on Medicaid or Medicare.[xv] In most cases, they are held in high esteem and provide community leadership that is both trusted and influential. Small practice minority providers that continue to see Medicaid and uninsured patients will face increasing demands to serve more patients of color in their communities. However, these minority providers risk being excluded as Essential Community Providers[xvi] for Qualified Health Plans (QHPs) in state exchanges, not having the resources necessary to serve as medical homes to address the complex medical and social problems of their patients. Small practice minority providers are insufficiently organized locally to advocate for themselves in a marketplace increasingly driven by larger sophisticated medical groups and independent practice associations. These risks to minority providers also place patients and ethnic communities in jeopardy of not having needed access to culturally and linguistically familiar safety net providers.[xvii] Establishing and strengthening partnerships to build the capacity of minority provider practices will address these risks.

Implementation Examples and Considerations

- **Guarantee inclusion as Essential Community Providers for Qualified Health Plans in federal and state exchanges to enhance access and quality of care.** Recognizing small racial and ethnic minority provider practices as Essential Community Providers will facilitate quality improvement that will increase their competitiveness. Under the Health Information Technology for Economic and Clinical Health (HITECH) Act, Medicaid eligible providers, which often are small practices, can receive technical assistance and incentives for implementing electronic health records that build their capacity to collect data and monitor service delivery and outcomes. Given this support to Medicaid eligible providers, groups such as the National Council of Asian Pacific Islander Physicians (NCAPIP) recommend that CMS and states require inclusion of these providers in provider networks as Essential Community Providers.[xviii] The ACMH specifically

recommends the inclusion of small racial and ethnic minority practices to increase their access to these resources as well.

- **Provide patient-centered medical home service and partnership support to expand their capacity to serve high-risk populations.** Specific considerations include:
    - Providing technical assistance on quality improvement using collaborative networks[xvii].
    - Public and private organizations receiving CMS innovation grants should make support services (e.g., enabling services, PCMH models, etc.) available to small private practice referrals, thereby expanding safety net capacity to address behavioral and social determinants of health.
- **Support local and state racially and ethnically organized medicine partnerships to offer business development and advocacy strategies for minority providers and small private practices to be competitive in the health insurance marketplace.** As with FHQCs and public hospitals, small racial and ethnic minority provider practices need recruitment, training, and retention support to have the capacity to meet the demand for services that they provide. Safety net providers that are part of integrated systems and develop the use of health information technology are among those most likely to succeed in the future.[iv,xix,xx] Furthermore, the NASHP National Workgroup recommends increasing the consistency of reporting and measurement across the healthcare delivery system. As such, strategies including PPS development options for practices that have difficulty recruiting, CMS training and technical assistance support for Accountable Care Organizations and electronic medical record implementation, and alternative staffing models are particularly important for small ethnic provider practices.
    - For example, providing funding to support public-private collaboration with national, state, and local racial and ethnic minority provider and health associations (e.g., Association of American Indian Physicians, NCAPIP, National Hispanic Medical Association, National Medical Association, Network of Ethnic Physician Organizations) as well as state primary care associations, local medical societies, and FQHCs can serve as a model for ensuring the advantages racial and ethnic minority provider /small private practices offer are enriched with state-of-the-art approaches to quality, cost-effective care. This support will enable them to be a competitive and sustainable community resource.

Recommendation 4: Preserve the ACA Prevention and Public Health Fund to advance* public health *efforts to promote health equity and address social determinants of health

OMH should work with HHS leadership and the Centers for Disease Control and Prevention (CDC) to preserve the ACA Prevention and Public Health Fund established to provide sustained investments in prevention and health promotion.[xxi] The Fund's investment in evidence-based practices, research, and surveillance and tracking are important accountability measures that can enhance health care quality and health equity.

Discussion

Only 10% of preventable deaths could be avoided through access to medical care,[xxii] underscoring the importance of public health services. Public health provides an array of services from direct health care delivery to epidemiology and surveillance, maternal and child health, disabled children services, emergency medical services, communicable disease control, HIV/AIDS services, community health needs assessment, and prevention and health promotion services. All of these services heavily intersect with safety net providers and services. Because public health takes on many of our most challenging health issues, there is an even closer connection with vulnerable populations. In 2012, the Prevention and Public Health Fund to advance and promote prevention strategies and strengthen our public health infrastructure was cut by $5 billion over 10 years and faces the threat of more cuts, with the rationale of covering increased Medicare expenditures.[xxiv] However, public health services will face increasing demands as health care delivery systems become more attuned to the triple aim of patient centered care, cost-effectiveness, and population health management, and the subsequent focus on comprehensive prevention through addressing the social determinants of health and health equity. This shift will force a growing emphasis on interdisciplinary and inter-sectoral collaboration and leadership (including the integration of health delivery systems and public health), which local health departments and other public health services are well positioned and experienced to promote with the adequate Prevention and Public Health Fund support to sustain them.

Implementation Examples and Considerations

- **Support health care delivery systems within local public health departments.** The NASHP National Workgroup recommends integration among primary care, behavioral health, specialty care, and public health services to promote the wellbeing of vulnerable populations.[vi] Support for such services as HIV/AIDS and school-based care particularly should be strengthened to enhance community-based services for the most vulnerable populations. Additionally, the considerations in Recommendation 2 are appropriate as public hospitals often are under the jurisdiction of public health departments.
- **Preserve Community Transformation Grants (CTGs),** which are maximizing leverage of community funds and resources through collaborative, interdisciplinary, and inter-sectoral public-private partnerships to improve population health. Therefore, OMH should work with CDC and HHS leadership to develop strategies to preserve this funding.
- **Preserve the ACA provisions that advance health equity**, for example:
    - Health workforce development – ensuring our health workforce reflects the demographics, cultures, languages of our population.
    - Health disparities research and data – ensuring demographic, socioeconomic and health data collection can be done in ways that provide an accurate health status report on all of America's subpopulations. Support should be provided for research that leads to effective strategies to address health disparities.
    - Cultural and linguistic competence – support for continuous training and recruitment of a culturally competent health workforce.

- National Partnership for Action to End Health Disparities and the *National Stakeholder Strategy for Achieving Health Equity*[xxv] – support the efforts to gain focus and alignment of national, state, and local public and private partners in achieving health equity.
- Quality improvement – ensure investment in quality improvement approaches, strategies, and programs that focus on the unique aspects of low-income minority populations.
- Cost containment – continue to explore cost-effective and efficient approaches towards health care delivery and improving community health.
- Social determinants of health (SDOH) – support efforts that recognize and validate SDOH and corresponding strategies to achieve health equity

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Appendix A: ACMH Proposed Principles for Minority Health Equity Related to Access to Affordable Comprehensive Care and Health Promotion

Equitable and Sustainable Access to Comprehensive and Affordable Health Care Coverage and Services

Principle 5: High quality health care coverage that is affordable and comprehensive must be equally accessible to all individuals regardless of nativity or citizenship, age or health history. Coverage should be portable to eliminate gaps in coverage due to transitions in employment or life circumstance. Minority and vulnerable communities are disproportionately affected by lack of coverage and access and the consequences of poor health status.

Principle 6: A redesigned health care system must be patient-centered and promote a medical home or more broadly a health home for everyone. To improve access for minority and vulnerable communities, financing and reimbursement policies must incentivize and ensure that all persons residing in the US have a health home that emphasizes prevention, primary care, chronic care management and care coordination, and providing patient-centered, culturally and linguistically sensitive/competent care.

Principle 7: Health care reform must support the enhancement and availability of a wide range of community-based interventions and programs that are responsive to diverse populations, in particular, minority and vulnerable communities. Coordination of patient-centered, culturally and linguistically sensitive/competent care across primary care and medical specialties and sub-specialties must be encouraged through financing and reimbursement systems.

Principle 8: While health care reform must create a financially sustainable health care system, new or revised financing and reimbursement policies must not adversely and/or disproportionately affect minority and vulnerable communities. Indeed, such financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status.

Preserve the Safety Net, Focus on Community Engagement and the Social Determinants of Health, Promote Partnerships with Public Health

Principle 9: A robust safety net must be maintained to insure that vulnerable and minority populations do not fall through the cracks. Minority and vulnerable communities are those who not able to access affordable health care coverage and/or services and thus disproportionately rely on the safety net, e.g., children in immigrant families, low-income parents, low-wage working adults with no children, some lawfully residing residents, and undocumented residents in the U.S.

Principle 10: Health care reform must include minority communities as key stakeholders to provide direct input as to how health care should be structured and delivered. Strong and active minority and vulnerable community engagement is the essential foundation for establishing successful strategies to eliminate health disparities that include meaningful prevention strategies and that account for/address the social determinants of health (SDOH).

Principle 11: The public health infrastructure must be strengthened to assure that its primary functions and activities are responsive to a diverse population, especially minority and vulnerable communities, and account for/address the social determinants of health (SDOH). Health departments must have the ability to hold their agencies accountable for health disparities as well as the capacity to deal/work with diverse populations in public health emergencies. Minority and vulnerable communities represent a particular challenge/responsibility for public health because these communities disproportionately lack access to health care and health homes.

Appendix B: Summary of Recommendations from the National Academy for the State Health Policy National Workgroup on Integrating a Safety Net into Health Care Reform Implementation

1) **Include safety net providers in Integrated System Models**, which work towards providing vulnerable populations with coordinated and comprehensive services through a network of healthcare organizations.
2) **Develop new strategies to optimize workforce capacity**, especially for maintaining and recruiting providers who serve in urban and rural areas.
3) **Maintain support for individuals who will remain uninsured and live in underserved areas** even following Medicaid expansion, and therefore will rely heavily on the safety net. "These uninsured individuals will include those who will be eligible for Medicaid but are not expected to enroll; undocumented immigrants who are not eligible for Medicaid or coverage through the insurance exchanges; and individuals who are ineligible for subsidies, are exempt from the mandate to obtain insurance, choose not to comply with the mandate, or have some combination of those characteristics" (p. 6).
4) **Address the role of safety net providers in the Health Insurance Marketplace**.
5) **Examine how safety net providers can play a role in linking newly insured patients to new coverage options under the Affordable Care Act**, such as education concerning healthcare options and assistance with enrollment in health subsidy programs.
6) **Define the essential health benefits that qualified health plans must provide** and assure that the scope of these benefits is in line with the needs of vulnerable populations, while also balancing quality of services with affordability.
7) **Align reporting and measurement across the healthcare delivery system**, as currently there is a lack of consistency in this area.
8) **Promote collaboration within the safety net system across federal, state, and community level agencies**.
9) **Promote integration among primary care, mental health services, specialty care, and public health services** in an effort to address the overall well-being of vulnerable populations. Such ties are crucial for maximizing community health improvements, as complex co-morbidities between mental and physical health are especially common within vulnerable populations that safety net providers serve. Therefore, it is essential to have a multi-dimensional and comprehensive safety net that takes into account the social determinants of health and actively works to address health disparities in areas such as food access and education in order to improve the overall health of local populations.
10) **Address the role of safety net providers as patients-centered medical homes**, examining issues such as whether there should be criteria for safety net providers concerning medical homes and how healthcare reimbursement should work within the medical home model.