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Health Reform Holds Both Risks And Rewards For Safety-Net Providers And Racially And Ethnically Diverse Patients

DOI: 10.1377/hlthaff.2011.0661
HEALTH AFFAIRS 30,
NO. 10 (2011): -
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Foundation, Inc.

ABSTRACT The Affordable Care Act of 2010 creates both opportunities and risks for safety-net providers in caring for low-income, diverse patients. New funding for health centers; support for coordinated, patient-centered care; and expansion of the primary care workforce are some of the opportunities that potentially strengthen the safety net. However, declining payments to safety-net hospitals, existing financial hardships, and shifts in the health care marketplace may intensify competition, thwart the ability to innovate, and endanger the financial viability of safety-net providers. Support of state and local governments, as well as philanthropies, will be crucial to helping safety-net providers transition to the new health care environment and to preventing the unintended erosion of the safety net for racially and ethnically diverse populations.

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Achieving health equity—defined as the elimination of potentially avoidable differences or disparities in health between socially advantaged and disadvantaged groups¹—is a primary goal of the Affordable Care Act of 2010.² The law's array of requirements, incentives, and funding for program innovation are intended to support actions to bridge racial and ethnic gaps in health and health care.² Safety-net providers, by their mission, location, and history of service, may be especially well positioned to play a central role in advancing the health equity goals embodied in the Affordable Care Act.

As stated in an influential Institute of Medicine report, safety-net providers “organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients.”³ They represent a spectrum of organizations from major teaching hospitals and community health centers to free, rural, and public health clinics. Collectively, they represent sources of primary, specialty, inpatient, and emergency care for a disproportionate number of racially and ethnically diverse

patients.^{4,5} For this article we focus on two major providers of care for poor and racially and ethnically diverse patients: public and nonprofit safety-net hospitals and community health centers. Racial and ethnic minorities make up nearly two-thirds of the population served by these institutions.^{4,6}

Although many health care reform provisions support the goals of eliminating disparities and achieving health equity, the future of safety-net providers in this new environment is far from clear. Many opportunities may emerge that could strengthen the position of these hospitals and health centers. But many are also likely to face major risks that could disrupt their role, if not imperil their financial viability in continuing to serve as core providers to disadvantaged patients.

In this article we discuss opportunities and risks for safety-net providers in relation to four areas of reform that are central to the Affordable Care Act and integral to achieving equity: health insurance expansion; financing reform; health care workforce support; and delivery and payment innovation. We consider how timing and dynamics, such as the political environment and

budgeting decisions affecting health care reform, and attitudes toward remaining uninsured may consequently influence how safety-net institutions adapt in caring for racially and ethnically diverse populations. Finally, we discuss the future of the safety net and its transition in the context of assuring continued access to care for these populations.

The Affordable Care Act And The Safety Net

HEALTH INSURANCE EXPANSION Health insurance reforms in the Affordable Care Act offer new opportunities for safety-net providers to expand their base of insured patients. By 2019 there will be an estimated thirty-two million newly insured individuals, half of whom are to be insured through expanded public programs, such as Medicaid, and the other half through state-based health insurance exchanges.⁷

Racially and ethnically diverse people in America represent more than 50 percent of the uninsured,⁸ and people with limited English proficiency are two to three times more likely to lack health insurance than their English-speaking counterparts.⁹ Effective outreach to these populations will be essential to augmenting their ability to understand and navigate the enrollment process and to ensuring their participation in new health insurance opportunities. Toward this end, the Affordable Care Act includes specific provisions—such as support for navigators, or public and private entities that conduct public education activities—to ensure that outreach, education, and information regarding exchanges, health benefit plans, and enrollment processes are provided in a culturally and linguistically appropriate manner.²

Safety-net providers, by the nature of their mission and experience, are well positioned to both respond to these needs and take advantage of the new requirements.¹⁰ Moreover, their participation will be pivotal in caring for many low-income enrollees who may transition between Medicaid and the exchanges based on how their income is measured and how it changes over time.

Although the advent of the state exchanges and broader Medicaid eligibility may create unprecedented opportunity for providers, safety-net providers may face challenges on two fronts. First, many may encounter increased competition for previously uninsured people who will become eligible for Medicaid as other clinics and hospitals seek new opportunities to increase their patient base. Second, the competition will probably escalate for enrollees insured through the exchanges.

In both scenarios, private providers may be better positioned to use available capital to identify potentially new, more lucrative markets among this patient population, protect if not increase operating and profit margins, and minimize losses. However, safety-net providers could be left with insufficient revenues to care for a disproportionate number of high-risk, costly, and complex patients. There may well be a need for safeguards for these institutions, such as continued federal support for hospitals serving large numbers of uninsured. An alternative may be risk-adjusting payment for these institutions based on the health status of the patient population served.

FINANCING REFORMS The Affordable Care Act contains provisions that bolster the role of the safety net; at the same time, it also places many safety-net providers at greater risk for economic loss. Support is especially strong for community health centers, as the health reform law increases their funding by \$11 billion for fiscal years 2011–14. The increased funding is aimed at allowing the centers to expand operational capacity, enhance health services, and meet capital needs to serve nearly twenty million new patients.¹¹ The new law also offers opportunities to further expand the role and presence of the local safety net by supporting school-based, nurse-managed, and rural clinics; primary care residency training programs in health centers; increases in Medicaid reimbursement for primary care; and state grants for service in medically underserved areas and for improving universal access to safety-net trauma care.

Other financing reforms affecting safety-net hospitals, however, are at risk of adversely affecting them, if not endangering their fiscal viability. Of special concern are scheduled changes in the Medicaid disproportionate-share hospital program, which will be reduced by \$18 billion over a seven-year period starting in 2014. This program funds states to subsidize hospitals, particularly safety-net hospitals, for unreimbursed costs incurred in treating uninsured and Medicaid patients. In 2009 Medicaid allocated more than \$11 billion for this program,¹² financing approximately 22 percent of the total unreimbursed care provided by public hospitals.⁴ Expanding health insurance could reduce the need for these subsidies. However, similar reforms in Massachusetts strained the health care safety net as low-income patients, both uninsured and newly insured, increasingly relied on safety-net hospitals and their emergency departments for care.¹³

Furthermore, there is widespread concern among safety-net hospitals that they may lose more in these subsidies than they will gain in revenue from newly insured patients, at a time

when they will have to continue to provide uncompensated care for many uninsured people. It is estimated that approximately twenty-three million people will remain uninsured in 2019—of whom nearly eleven million will be undocumented immigrants. This situation is likely to impose a large burden on providers in US-Mexico border states and areas with large concentrations of undocumented immigrants or other uninsured people. In response to this concern, some safety-net hospitals have suggested that subsidies should be reduced only after a measurable decline in uncompensated costs is seen, as opposed to reducing subsidies on the assumption that these costs will decline.¹⁴

HEALTH CARE WORKFORCE SUPPORT The Affordable Care Act reauthorizes and expands a number of workforce programs that promote greater diversity and cultural competence of health care providers—both objectives central to reducing racial and ethnic disparities.¹⁵ Growing evidence suggests that racial and ethnic concordance between patients and their practitioners leads to greater patient satisfaction and improved quality of care.¹⁶ Furthermore, racial or ethnic minority practitioners are more likely to practice in medically underserved areas and treat minority patients who are publicly insured or uninsured.¹⁷

Safety-net institutions serve as training ground for a large percentage of the nation's physicians, nurses, and other health professionals, including a disproportionate share, in many cases, from racially, ethnically, and linguistically diverse backgrounds. For example, racial and ethnic minorities make up more than two-thirds of the population served by Massachusetts' fifty-two community health centers, which have a health care staff that can communicate in thirty-nine languages.¹⁸ Similarly, racial and ethnic diversity in the health care workforce at public hospitals is common, if not predominant.⁴ For example, more than 88 percent of health care professionals at Coler-Goldwater Memorial Hospital in New York City are from racial or ethnic minority groups.¹⁹

The unique demographic makeup of safety-net providers allows them to take advantage of the opportunities offered by the Affordable Care Act to serve a growing diverse patient population. For example, the law authorizes \$1.5 billion during 2011–15 for the National Health Service Corps to provide scholarships and to forgive loans for primary care providers practicing where health care professionals are in short supply. Such areas include inner-city and rural communities with large racial and ethnic minority patient populations.²⁰

The law also establishes a primary care train-

ing and enhancement program, with priority given to institutions training practitioners from underrepresented minority groups and a track record in cultural competence and health literacy. Other opportunities include grants for community health workers to provide culturally tailored health education and a redistribution of unused graduate medical education training slots—or residency positions—to hospitals in regions with health professional shortages.

Despite the support for workforce enhancements, questions are likely to arise over whether these programs are sufficient to address the anticipated increased demand for primary care resulting from health insurance expansions. Also, there is uncertainty about provisions that currently do not have appropriations, such as support for community health teams to assist in developing medical homes, community health workers, and programs to develop and evaluate cultural competence training.²

DELIVERY AND PAYMENT INNOVATIONS The Affordable Care Act offers opportunities for safety-net providers to improve access to and quality of care through delivery and payment innovations. For example, the new law provides support for demonstration projects for pediatric accountable care organizations to share responsibility in delivering high-quality, cost-effective health services; medical homes serving chronically ill Medicaid beneficiaries; and community-based collaborative care networks to coordinate care for low-income populations.

These innovations are important to bridging access and quality gaps. But they are also critical to the fiscal survival of safety-net providers, particularly their ability to attract newly insured patients and compete with other providers for them. To be attractive to new patients and participate in health care innovations, safety-net providers will need to adapt to a rapidly evolving environment that uses health information technology; coordinates and delivers patient-centered care; supports customer service; and monitors, assesses, and pays providers based on outcomes and quality of care.²¹

One of the greatest challenges facing the safety net is finding the resources to modernize and update their systems. Many safety-net organizations operate with minimal or negative operating margins, which historically have limited their capacity to innovate. The Affordable Care Act offers new funding for capital expansion of community health centers—a key component of the safety net. However, questions remain about whether they will have ongoing revenues to support necessary infrastructure improvements.

Health information technology, for example, is an important requisite for coordinating care

and measuring provider performance based on quality and outcomes. However, safety-net providers, particularly health centers that serve disproportionately high numbers of uninsured people, are much less likely to have implemented technology such as electronic medical records than are hospitals, centers, or private practices with fewer uninsured patients.⁶ And although financial incentives through Medicaid and Medicare are provided to encourage the use of electronic medical records at health centers, the costs of doing so exceed the available funding.²¹

Similarly, safety-net hospitals with low or negative operating margins and few capital reserves may also be handicapped in their ability to adapt to or benefit from delivery and payment innovation. A 2011 study found that poorly financed hospitals that adopted pay-for-performance (systems that reimburse or reward providers for their performance on quality, outcome, or other benchmarks) were less effective in improving quality than were more financially sound institutions.²² For hospitals with limited resources, such payment innovation could further undermine their financial status.

Nonetheless, some safety-net hospitals have embraced certain delivery reforms, such as serving as a medical home—in other words, becoming the usual provider of primary care to particular patients, while also coordinating needed additional services. Many of these institutions have reaped positive benefits, both for their bottom lines and for the populations they serve.

For example, a study of forty-six medical home programs in thirty-eight public hospitals found that more than 90 percent of the patients served by these homes were racial and ethnic minorities.²³ Nearly a quarter of these programs improved access to culturally competent care by employing bilingual staff; providing on-site language services; partnering with culturally oriented community organizations; and offering mobile care in diverse settings.²³

In addition, approximately one-third of these medical homes reduced emergency department overcrowding and overuse of the emergency department for primary care.²³ Indeed, the leadership of safety-net providers in addressing language and cultural needs of their patients; the diversity of their workforce; and their reputation as providers of primary, emergency, and trauma care are strengths that may help attract and retain patients in the new environment.

Populations Remaining At Or Beyond The Margins

As noted above, nearly eleven million of twenty-three million people likely to remain uninsured

after 2014 will be undocumented immigrants, who under current law will be barred from public programs and the exchanges.⁷ Safety-net hospitals and health centers have served as core providers of care for undocumented immigrants. By mission and necessity, these institutions will continue to play this role in the face of rising competitive pressures and declining federal, state, and local financing.

In addition to federal support through the disproportionate-share hospital program, many state and local governments have contributed greatly to the safety net, combining health care assistance for undocumented immigrants with charity or uncompensated care for low-income populations. However, there are two primary reasons why continued state and local safety-net financing may be in greater jeopardy in the coming years.

First, in many communities, undocumented immigrants may be the primary population remaining uninsured. With more people insured, garnering or maintaining political support for undocumented immigrants may be untenable given the current antipathy toward immigrants, including a belief in some quarters that they are a taxpayer burden “undeserving” of assistance.

Second, many policy makers and others may conclude that “the uninsured problem is solved” and that there is no need for further support. For example, with the expansion of health insurance through the Affordable Care Act, some may inadvertently believe that safety-net providers, such as health centers and free clinics, will no longer be needed.²⁴ Such a response may leave the safety net with uncertain support for uninsured people generally, and for millions of undocumented immigrants in particular.

Timeline For Reform

Time will play a potentially important role in the fate of the safety net. Major provisions of the Affordable Care Act, such as expanded insurance, employer requirements, and state exchanges, will not take effect until 2014. For several more years, then, safety-net organizations will remain the primary providers of care for the nearly fifty-two million people who are currently uninsured.²⁵ But these organizations’ ability to maintain their efforts is far from clear given the sheer size of the uninsured population, growing demand, and financial pressures in the wake of the recent recession.

Both community health center and public hospital reports confirm increases in use, primarily among low-income populations.²⁶ A recent study of public hospitals found that between 2000 and 2009, inpatient discharges and emer-

gency department visits increased by 14 percent and 16 percent, respectively—a rate higher than acute care hospitals that do not primarily serve safety-net populations.²⁷ Nonetheless, capacity at public hospitals has not kept pace with growing demand. In many cases, increases in uncompensated care, low profit margins, and location in high-poverty areas have resulted in the closure of emergency departments or even entire hospitals.²⁸ For example, in 2011 the Cleveland Clinic decided to close Huron Hospital because of financial losses; the hospital served an impoverished, primarily black population in East Cleveland.²⁹ Further erosion of the hospital safety net could also exacerbate other problems such as availability of and access to specialty and inpatient referrals.

Furthermore, because many of these institutions are located in underserved areas with high proportions of racially and ethnically diverse populations, closures or reductions in services could encumber access for low-income residents in these areas. In 2014 new enrollees may have insurance cards but may also have very limited options for hospital care, far from the places where they live.

Federal, State, And Local Budgets

Both Capitol Hill and the White House have intensified rhetoric about the need to greatly reduce government spending or raise taxes. Renewed calls for cuts are likely to leave many health reform provisions vulnerable to major funding reductions, including those that affect safety-net institutions and low-income, racially and ethnically diverse patients. These effects are already reflected in the fiscal year 2011 federal budget, in which funding for community health centers was cut by \$600 million, affecting as many as five million people.³⁰

Many states are also experiencing uncertainty about funding and large budget reductions before insurance expansions under the Affordable Care Act go into effect. For example, the Florida legislature could add to the burden of uncompensated care because of proposed reductions in Medicaid and other services of more than \$700 million per year.³¹ In Washington State, funding for health centers will be reduced by \$86.3 million as part of the 2011–13 operating budget. This represents nearly 11 percent of payments to community and public health centers (Jennifer Muhm, legislative affairs officer, Public Health—Seattle and King County, Washington, personal communication, June 1, 2011).

Nationally, community health centers saw direct state funding decline by \$200 million in 2010 from the 2008 level of \$650 million.³² Sup-

port was also reduced for workforce placement and training for health professionals.

In 2011 at least twenty-six states filed lawsuits challenging the Affordable Care Act. Many of these states, such as Florida, Virginia, and Texas, have large numbers of low-income, uninsured blacks, Hispanics, and other diverse residents.³³ Should the states' actions be successful, it could create a "one-two punch" in that it would slow or halt insurance expansion at a time of fiscal contraction—and lower safety-net support—among states, counties, and cities. Finally, if the Supreme Court finds the fundamental insurance mandate provision unconstitutional, or if a change in presidential leadership occurs in 2012, safety-net providers could be left in a potentially untenable position of greatly diminished federal, state, and local support for millions of uninsured people, and with minimal incentive for system change to distribute this burden.

The Safety Net's Uncertain Future

The future of the safety net in the era of health reform is double-edged. On the positive side, as traditional providers of care for racially and ethnically diverse patients and communities, many safety-net providers could benefit greatly from their own legacy and considerable experience of serving these populations.

Safety-net settings that have strong balance sheets and are already active in program innovation may be well positioned to survive by diversifying their funding base, implementing innovative programs, using capital to update infrastructure such as electronic medical records, and working to establish themselves as a provider of "first choice" within their communities. But for many, their ability to compete, as well as continuing to serve in a safety-net capacity and, indeed, survive, will depend largely on funding.

The support of state and local governments, as well as philanthropies, will be crucial to helping safety-net providers transition to the new health care environment. These institutions will need assistance in adopting new infrastructure such as information technology; in reinforcing their competence in addressing the needs of culturally and linguistically diverse patients; and in positioning themselves to take advantage of new federal funding opportunities. In addition, collaboration with other providers, including hospitals, clinics, state and local health departments, and advocacy organizations, can help safety-net providers leverage limited resources and attract new funding.³⁴

At the same time, from a less positive stand-

point, with large numbers of immigrants and others already likely to remain uninsured after 2014, ongoing efforts to undermine or erode health reform run the risk of making matters

worse. Safety-net providers would be threatened; so would progress in reducing disparities and the health and well-being of the nation's most vulnerable. ■

NOTES

- 1 Braveman P. Health disparities and health equity: concepts and measurements. *Annu Rev Public Health*. 2006;27:167–94.
- 2 Andrulis DP, Siddiqui NJ, Purtle JP, Duchon L. Patient Protection and Affordable Care Act of 2010: advancing health equity for racially and ethnically diverse populations. Washington (DC): Joint Center for Political and Economic Studies; 2010.
- 3 Lewin ME, Altman S, editors. America's health care safety net: intact but endangered. Washington (DC): National Academies Press; 2000. p. 3–4.
- 4 Zaman OS, Cummings LC, Spieler SS. America's public hospitals and health systems, 2009: results of the Annual NAPH Hospital Characteristic Survey. Washington (DC): National Association of Public Hospitals and Health Systems; 2010.
- 5 National Association of Community Health Centers. Health centers' role in reducing racial and ethnic health disparities [Internet]. Bethesda (MD): NACHC; 2008 May [cited 2011 Sep 20]. (Fact Sheet). Available from: http://www.nachc.com/client/documents/Health_Disparities_Fact_Sheet_updated_08_FINAL.pdf
- 6 Shields AE, Shin P, Leu MG, Levy DE, Betancourt RM, Hawkins D, et al. Adoption of health information technology in community health centers: results of a national survey. *Health Aff (Millwood)*. 2007;26(5):1373–83.
- 7 Congressional Budget Office. H.R. 4872, Reconciliation Act of 2010 [Internet]. Washington (DC): CBO; 2010 Mar 18 [cited 2011 Sep 20]. Available from: <http://www.cbo.gov/doc.cfm?index=11355&zzz=40566>
- 8 Perry S. Health coverage in communities of color: talking about the new census numbers [Internet]. Washington (DC): Families USA; 2008 Sep [cited 2011 Aug 3]. (Fact Sheet from Minority Health Initiatives). Available from: <http://www.familiesusa.org/assets/pdfs/minority-health-and-the-census-numbers.pdf>
- 9 Ku L, Waidman T. How race/ethnicity, immigration status, and language affect health insurance coverage, access to care, and quality of care among the low-income population [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2003 Aug [cited 2011 Aug 15]. Available from: <http://www.kff.org/uninsured/upload/How-Race-Ethnicity-Immigration-Status-and-Language-Affect-Health-Insurance-Coverage-Access-to-and-Quality-of-Care-Among-the-Low-Income-Population.pdf>
- 10 National Association of Public Hospitals and Health Systems. Public hospitals focus on reducing health care disparities [Internet]. Washington (DC): NAPH; 2008 Dec [cited 2011 Aug 3]. (Research Brief). Available from: <http://www.naph.org/Main-Menu-Category/Publications/Reducing-Disparities-Brief-08.aspx?FT=.pdf>
- 11 National Association of Community Health Centers. Community health centers and health reform: summary of key health center provisions [Internet]. Bethesda (MD): NACHC; [cited 2011 Aug 8]. Available from: <http://www.nachc.com/client/Summary%20of%20Final%20Health%20Reform%20Package.pdf>
- 12 Peters CP. Medicaid disproportionate share hospital payments. Washington (DC): National Health Policy Forum; 2009.
- 13 National Association of Public Hospitals and Health Systems. Massachusetts health reform: lessons learned about the critical role of safety net health systems. Washington (DC): NAPH; 2009.
- 14 National Association of Public Hospitals and Health Systems. The health care reform dialogue: key questions about coverage and access. Washington (DC): NAPH; 2009.
- 15 Smedley BD, Butler AS, Bristow LR. In the nation's compelling interest: ensuring diversity in the health-care workforce. Washington (DC): National Academies Press; 2004.
- 16 Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. *Health Aff (Millwood)*. 2002;21(5):90–102.
- 17 Kington R, Tisnado D, Carlisle DM. Increasing racial and ethnic diversity among physicians: an intervention to address health disparities? [Internet]. Sacramento (CA): Network of Ethnic Physicians Organizations; 2001 [cited 2011 Aug 3]. Available from: <http://www.ethnicphysicians.org/publications/NAP%20Article.pdf>
- 18 Massachusetts League of Community Health Centers. CHCs today: adapting to change, sustained by mission [Internet]. Boston (MA); The League; c2011 [cited 2011 Aug 3]. Available from: <http://www.massleague.org/CHC/History/HistoryToday.php>
- 19 National Association of Public Hospitals and Health Systems. Safety net health systems: an essential partner in reducing health care disparities [Internet]. Washington (DC): NAPH; [cited 2011 Aug 3]. Available from: <http://www.naph.org/Main-Menu-Category/Publications/Disparities/HCR-Health-Disparities.aspx?FT=.pdf>
- 20 Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. *Health Aff (Millwood)*. 2005;24:w5-97–107. DOI: 10.1377/hlthaff.w5.97.
- 21 Katz MH. Future of the safety net under health reform. *JAMA*. 2010; 304(6):679–80.
- 22 Werner RM, Kolstad JT, Stuart EA, Polsky D. The effect of pay-for-performance in hospitals: lessons for quality improvement. *Health Aff (Millwood)*. 2011;30(4):690–8.
- 23 Siegel-Spieler S, Swink KA, Cummings L. Strategies used by safety net medical homes to reduce disparities in health care. Poster presented at: 7th National Conference on Quality Healthcare for Culturally Diverse Populations; 2010 Oct 18–20; Baltimore, MD.
- 24 Gibbs RD, Gibbs PH. Free clinics: a personal journey. *Arch Intern Med*. 2010;170(11):953–4.
- 25 Commonwealth Fund [Internet]. New York (NY): Commonwealth Fund; c2004–11. Press release, New health insurance survey: 9 million adults joined the ranks of uninsured due to job loss in 2010; few viable health insurance options exist for unemployed; 2011 Mar 16 [cited 2011 Aug 4]. Available from: <http://www.commonwealthfund.org/Content/News/News-Releases/2011/Mar/New-Health-Insurance-Survey.aspx>
- 26 Felland LE, Cunningham PJ, Cohen GR, November EA, Quinn BC. The economic recession: early impacts on health care safety net providers. Washington (DC): Center for Studying Health System Change; 2010.
- 27 National Association of Public Hospitals and Health Systems. Study reveals NAPH members are “providers of choice” for all patients [Internet]. Washington (DC): NAPH; 2011 May [cited 2011 Sep 16]. (Research Brief). Available from: <http://www.naph.org/Main-Menu-Category/Publications/Disparities/HCR-Health-Disparities.aspx?FT=.pdf>

www.naph.org/Main-Menu-Category/Publications/May-2011-Trends-Brief.aspx?FT=.pdf

- 28** Hsia RY, Kellermann AL, Shen YC. Factors associated with closures of emergency departments in the United States. *JAMA*. 2011;305(19):1978–85.
- 29** Abelson R. Taps for a community hospital. *New York Times*. 2011 Jun 6.
- 30** National Association of Community Health Centers [Internet]. Bethesda (MD): NACHC. Press release, NACHC statement on the recently released budget deal; 2011 Apr 12 [cited 2011 Sep 20]. Available from:

<http://www.nachc.com/press-release-detail.cfm?PressReleaseID=670&fid=1924>

- 31** Halifax Health. Safety net hospitals, patients fear that Florida Senate budget cuts will threaten healthcare [Internet]. Daytona Beach (FL): Halifax Health; 2011 Apr 7 [cited 2011 Aug 4]. Available from: <http://www.halifaxhealth.org/aboutus/newsdetail.aspx?storyid=6936>
- 32** Marcy J. Community health centers to “turn the promise of coverage” into better care—the KHN interview [Internet]. Washington (DC): Kaiser Health News; 2011 May 4 [cited 2011 Sep 20]. Available from: <http://>

www.kaiserhealthnews.org/Stories/2011/May/05/Hawkins-Q-and-A-Community-Health-Centers.aspx

- 33** Vaida B, Eisenhower K. Scoreboard: tracking health law court challenges [Internet]. Washington (DC): Kaiser Health Network; 2011 Sep 13 [cited 2011 Aug 4]. Available from: <http://www.kaiserhealthnews.org/Stories/2011/March/02/health-reform-law-court-case-status.aspx>
- 34** Felland LE, Ginsburg PB, Kishbauch GM. Improving health care access for low-income people: lessons from Ascension Health’s community collaborative. *Health Aff (Millwood)*. 2011;30(7):1290–8.

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In this month’s *Health Affairs*, Dennis Andrulis and Nadia Siddiqui write that the Affordable Care Act of 2010 creates both opportunities and risks for safety-net providers in caring for low-income racially and ethnically diverse patients. They enumerate a number of the likely benefits and challenges, and they argue that these providers will need more support from state and local governments and philanthropies to transition to the postreform world and to maintain access for diverse populations.

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