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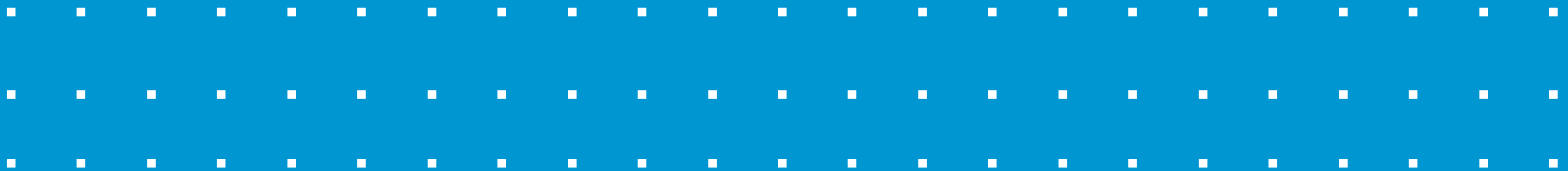
Safety Net Hospitals Post ACA Implementation: Risks and Rewards in a Period of Rapid Change

Teresa A. Coughlin

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Safety Net Hospitals: Background

Safety net hospitals long been important part of US health care system

- care for nation's most vulnerable (e.g., Medicaid, uninsured)
- some offer high-cost services that other hospitals don't (e.g., burn, trauma, neonatal)
- some provide training for medical professionals

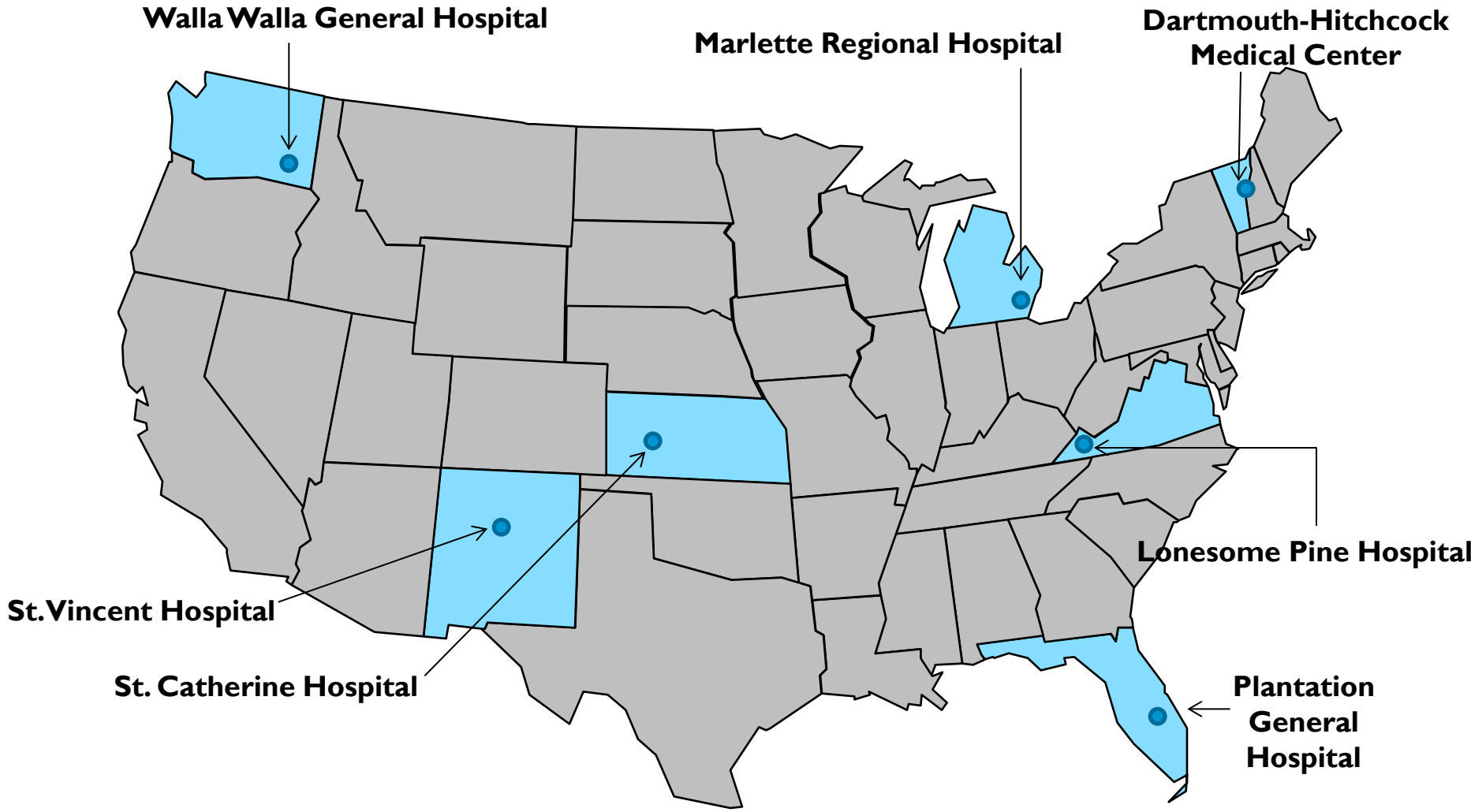
Safety Net Hospitals: Background

No universally accepted definition of what makes a hospital a safety net hospital

- Institute Of Medicine's description commonly used:
 - by legal mandate or mission, a safety net hospital offers services to patients regardless of their ability to pay
 - *substantial* share of patients are uninsured, underinsured and Medicaid

Some major safety net hospitals systems: Health and Hospital Corporation in NYC; Parkland Health and Hospital System in Dallas, and Cook County Health and Hospital System in Chicago

Wide Variety of Hospitals Make Up Nation's Hospital Safety Net



Difficult Financial Condition Common for Safety Net Hospitals

Safety net hospitals have challenging payer mix

- high shares of Medicaid patients; Medicaid not a great payer
- high shares of uninsured patients who tend to be low-income
- limited privately insured patients

Many also provide costly services (e.g., trauma, neonatal) that benefit community at large

In 2013, hospitals nationwide estimated to have \$44.6 billion in “uncompensated” care costs (Coughlin, Holahan et al. 2014)

Government Financial Support of Safety Net Hospitals

Federal, state and local governments long provided funds to help defray hospitals' uncompensated care costs

Complicated web of public funding sources. Major ones:

- Medicaid disproportionate share hospital (DSH) payments
- Medicaid upper payment limit (UPL) payments
- Medicare DSH payments
- Medicare indirect medical education (IME) payments
- state/local indigent health programs

In 2013, ~ \$30 billion in public dollars went to help offset hospitals' uncompensated care costs (Coughlin, Holahan et al. 2014)

- most through Medicaid and Medicare
- payments not well targeted
- state/local support varies widely across country

Affordable Care Act and Safety Net Hospitals

ACA poses both opportunities and challenges to safety net hospitals

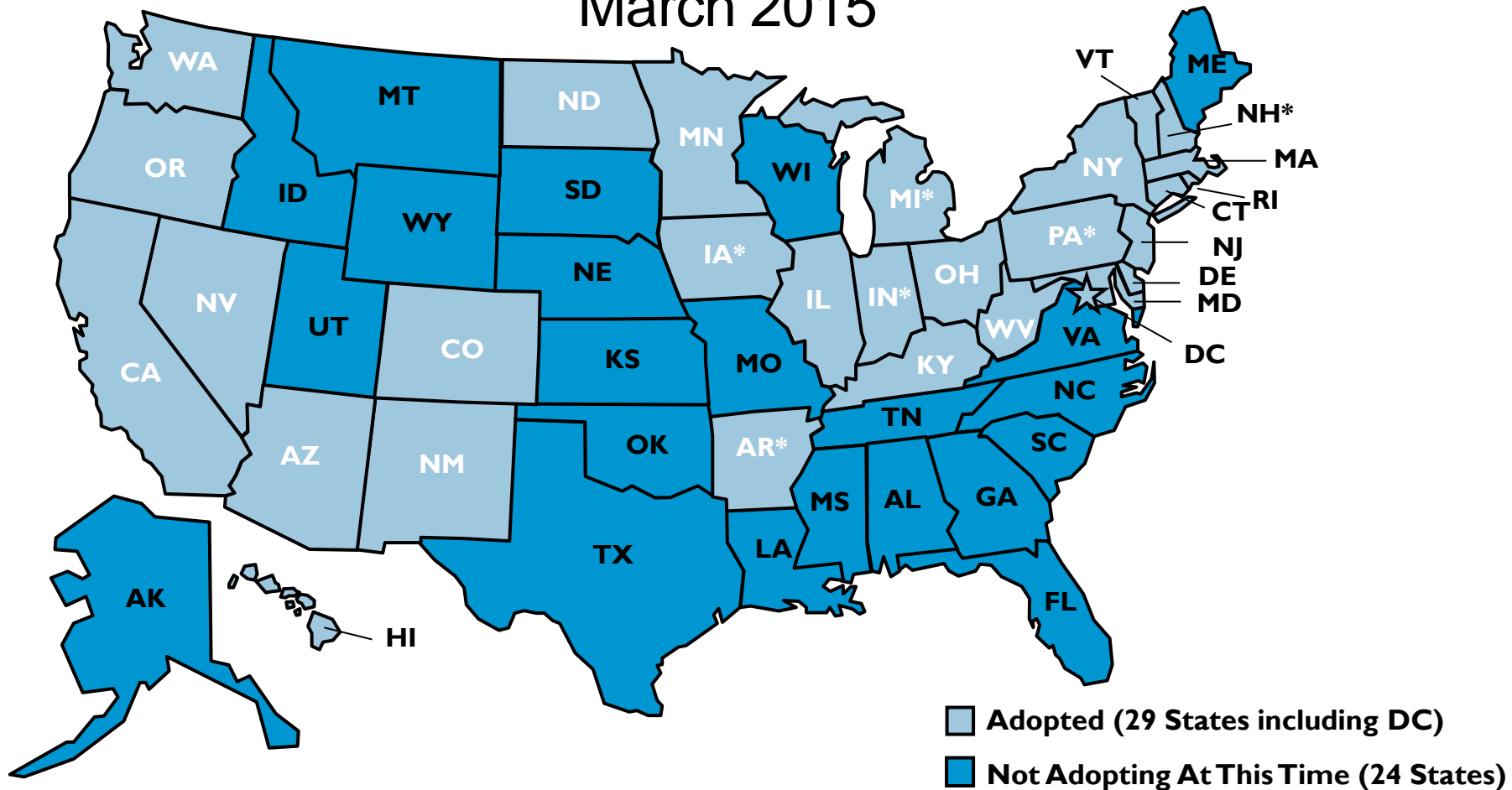
- Opportunities:
 - more insured; increased hospital revenue from patients
 - largest coverage effect is through Medicaid expansion
 - Marketplace coverage important for some
 - developing/expanding managed care plans
 - federal demonstrations to improve efficiency/quality

Affordable Care Act and Safety Net Hospitals

■ Challenges:

- ACA reduced Medicare DSH (2014) and Medicaid DSH (September 2017);
- State/local cutbacks in safety net hospital support
- Significant number of uninsured even with full ACA implementation
 - With full implementation CBO estimated some 20 million uninsured post reform, include immigrants, individuals for whom private insurance is unaffordable, persons eligible for Medicaid but not enrolled
 - many uninsured will continue to rely on safety net hospitals
- Absorbing costs due to underinsurance
- With newly available coverage people have choice; hospitals now have to compete for “their” patients

Current Status of State Medicaid Expansion Decisions, March 2015



NOTES: *AR, IA, IN, MI, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on 1/1/15, but the newly-elected governor has stated he will transition coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15.

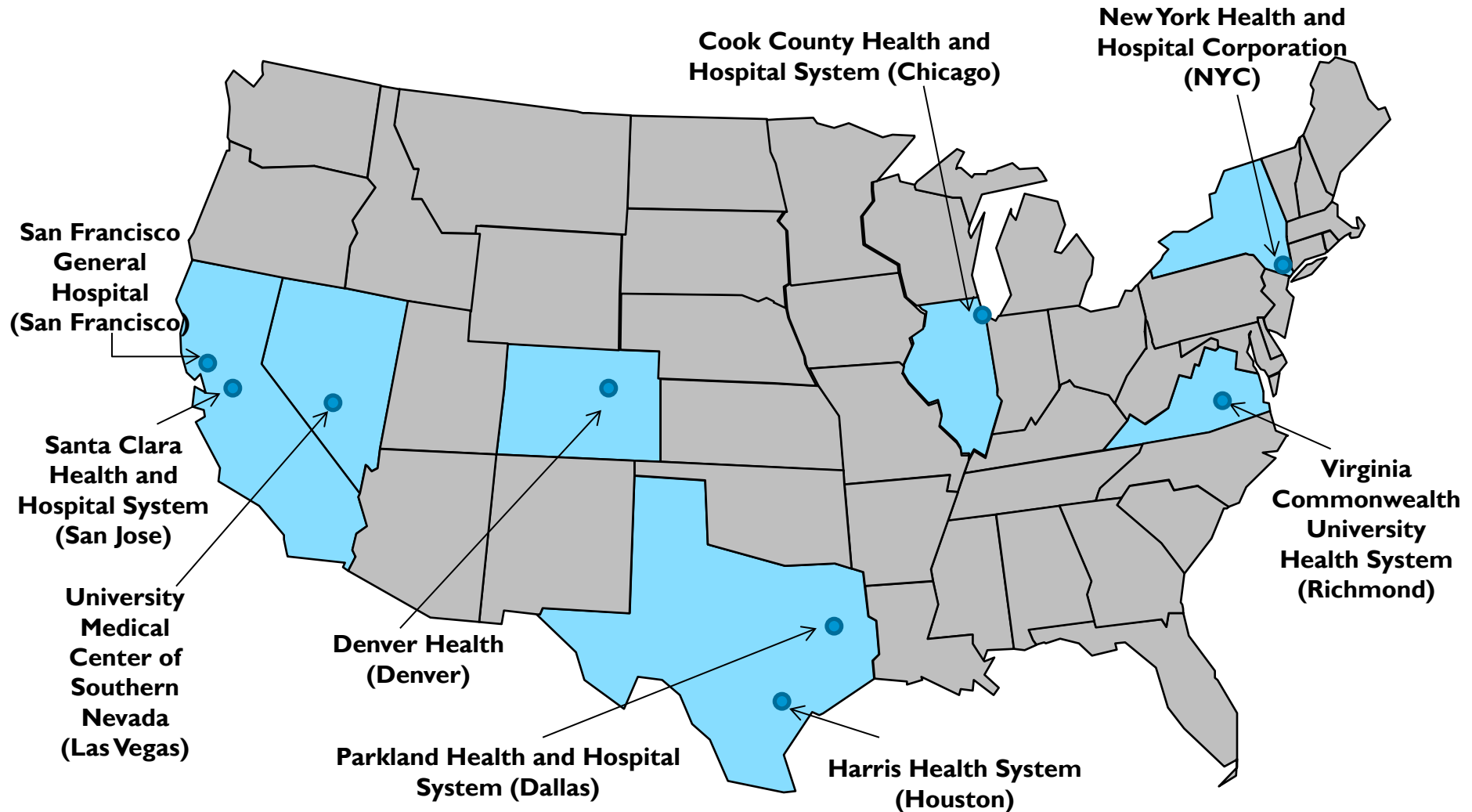
SOURCE: Adapted from "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 6, 2015. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

Projected Consequences of States Not Expanding Medicaid

| | Uninsured not qualifying for coverage (thousands) | Federal Medicaid funding lost (billions) | | Hospital reimbursement lost (billions) | |
|-----------------------|---|--|----------------|--|----------------|
| | 2016 | 2016 | 2013–2022 | 2016 | 2013–2022 |
| Alabama | 254 | \$1.5 | \$14.4 | \$0.7 | \$7.0 |
| Alaska | 25 | \$0.1 | \$1.5 | \$0.1 | \$0.6 |
| Florida | 1,060 | \$6.7 | \$66.1 | \$2.1 | \$22.6 |
| Georgia | 572 | \$3.4 | \$33.7 | \$1.2 | \$12.8 |
| Idaho | 78 | \$0.3 | \$3.3 | \$0.1 | \$1.5 |
| Kansas | 109 | \$0.5 | \$5.3 | \$0.2 | \$2.6 |
| Louisiana | 287 | \$1.6 | \$15.8 | \$0.8 | \$8.0 |
| Maine | 30 | \$0.3 | \$3.1 | \$0.1 | \$0.9 |
| Mississippi | 201 | \$1.5 | \$14.5 | \$0.5 | \$4.8 |
| Missouri | 274 | \$1.8 | \$17.8 | \$0.6 | \$6.8 |
| Montana | 50 | \$0.2 | \$2.1 | \$0.1 | \$1.1 |
| Nebraska | 57 | \$0.3 | \$3.1 | \$0.1 | \$1.6 |
| North Carolina | 414 | \$4.0 | \$39.6 | \$1.1 | \$11.3 |
| Oklahoma | 182 | \$0.9 | \$8.6 | \$0.4 | \$4.1 |
| South Carolina | 237 | \$1.6 | \$15.8 | \$0.6 | \$6.2 |
| South Dakota | 34 | \$0.2 | \$2.1 | \$0.1 | \$0.8 |
| Tennessee | 257 | \$2.3 | \$22.5 | \$0.7 | \$7.7 |
| Texas | 1,552 | \$6.6 | \$65.6 | \$3.2 | \$34.3 |
| Utah | 98 | \$0.5 | \$5.3 | \$0.3 | \$3.1 |
| Virginia | 268 | \$1.5 | \$14.7 | \$0.6 | \$6.2 |
| Wisconsin | 11 | \$1.3 | \$12.3 | \$0.4 | \$3.7 |
| Wyoming | 20 | \$0.1 | \$1.4 | \$0.0 | \$0.4 |
| Total: | 6,068 | \$37.3 | \$368.5 | \$14.0 | \$148.0 |

Source: Dorn, S. McGrath, M. and Holahan, J. 2014 *What Is the Result of States Not Expanding Medicaid?*
<http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid.pdf>

2014 Case Study of Nine Safety Net Hospitals



Highlights from 2014 Case Studies of Nine Safety Net Hospitals

Interviews with executives at hospitals (Coughlin, Long et al. 2015); follow on to two earlier studies (Coughlin, Long et al. 2012; Coughlin, Long et al. 2014)

Found complex picture of how safety net systems are faring:

- ACA identified as a major factor but not only one
- Hospitals in expansion states described increased Medicaid charges and declines in self-pay and charity care in 2014. Counterparts in non-expanding states did not report this.
- Experience with Marketplace enrollment varied widely: some secured sizable Marketplace enrollment whereas others decided not to participate in the Marketplace
- Beyond ACA, other critical factors shaping study hospitals included ongoing efforts to implement strategic vision; integration of safety net system with community providers, pursuit of private market revenues, highly competitive local market for some, and changes in local/state support
- Executives universally asserted the importance of continuing their safety net mission, “providing safety net services is who we are and what we do”
- But different models seemed to be emerging, ranging from maintaining traditional safety net focus to expanding the system’s reach by diversifying revenues, developing new service lines and moving into new market areas

Major Issues Going Forward

Executives had mixed outlook for the future

- not always aligned with extent of ACA implementation

Issues to track:

- How will Medicaid DSH cutbacks affect safety net hospitals?
- Will support for safety net mission continue in post reform world at the federal, state and local levels as the composition of uninsured/underinsured changes?
- How will safety net hospitals balance their mission while competing in the rapidly changing and increasingly competitive market?
- Will safety net hospitals be able to retain their traditional patients and expand to serve the newly insured?
- What new models of safety net hospitals will emerge? Which will be successful and why?