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Evolving Picture of Nine Safety-Net Hospitals: Implications of the ACA and Other Strategies

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Executive Summary

Safety-net hospitals are an integral part of the U.S. health care landscape, providing care to some of the nation's most medically vulnerable populations, including Medicaid enrollees and the uninsured. These hospitals also provide high cost services such as trauma and burn care to all populations and serve as training centers for medical professionals. With the implementation of the Affordable Care Act (ACA), the U.S. health care system is rapidly changing, and safety-net hospitals need to make major adjustments to survive in the post-reform environment.

This brief draws on interviews with executives at nine safety-net hospital systems and examines how their hospitals have fared since major coverage provisions of the ACA came into effect in January 2014. The brief also examines new and ongoing strategies that the hospitals are adopting in the face of a quickly changing health care environment. While acknowledging the importance of the ACA, executives at each system in the study noted that other non-ACA related factors have also shaped how their hospitals fared over the last year. The hospitals in the study were: Cook County Health and Hospital System (CCHHS); Denver Health (Denver Health); Harris Health System (Harris Health); New York City Health and Hospitals Corporation (HHC); Parkland Health and Hospital System (Parkland); Santa Clara Valley Health and Hospital System (SCVHHS); San Francisco General Hospital (SFGH); University Medical Center of Southern Nevada (UMC), and Virginia Commonwealth University Health System (VCU). These hospitals participated in two earlier related studies¹ that examined how the systems were preparing for health care reform. Findings as reported by hospital executives include the following:

Changes in patient mix and financing were tied to state decisions about implementation of the Medicaid expansion for most hospitals. The study hospitals are operating in very different environments in terms of the extent to which the ACA has been embraced by their state. Some of the study hospitals located in states that implemented the ACA Medicaid expansion (CCHHS, Denver Health, SFGH, and SCVHHS) reported substantial increases in Medicaid charges and declines in self-pay and charity care charges. HHC and UMC also saw increases in Medicaid charges and declines in self-pay, although these shifts were less pronounced. For HHC in New York, the state was already covering most of the ACA Medicaid target population prior to reform. And in Clark County where UMC is located, a local indigent care fund was paying Medicaid rates for inpatient services it provided to the uninsured before health reform. So although UMC reported an increase in Medicaid-insured patients, it has not experienced a significant change in overall revenue.

Study hospitals in states not implementing the Medicaid expansion (Harris Health, Parkland and VCU) did not experience large changes driven by increased coverage under the ACA, although VCU had gains related to long-term strategic investments to expand commercial business. Denver Health also had gains in commercial revenue related to long-term strategic planning. Hospital executives at each of the nine systems commented that as of fall 2014 they have not cared for many individuals who had purchased coverage through the Marketplace. In New York, executives at HHC noted that they expected that enrollees in its qualified health plans (QHPs) would eventually result in increased demand for services; however, given that a relatively small share of more than one million patients HHC has system-wide, this uptick had not yet been observed in 2014.

Systems were implementing an array of strategies to retain and attract newly insured patients, including efforts to improve the patient experience and to change the perception of safety-net hospitals. As more of the uninsured gain health insurance (primarily through Medicaid in states that have opted to implement the expansion), executives acknowledged that they were now competing with other hospitals for those newly insured patients. Efforts to retain and attract newly-insured patients included reducing waitlists, expanding system capacity, modifying hospital infrastructure, marketing the hospital, and engaging employees to better interact with patients. Executives were mixed on the extent to which they were trying to attract newly insured Marketplace enrollees. All hospitals except UMC, SFGH and CCHHS either had a QHP on the Marketplace or had contracts with QHPs.

In direct response to the ACA as well as broader market changes, systems were implementing delivery system changes to expand primary care, integrate care and broaden access. Several of the systems were increasing capacity by partnering with providers “beyond their own walls.” For example, several hospitals were opening up additional primary care clinics, broadening community-based physician networks, and partnering with neighborhood federally qualified health centers (FQHCs), mental health and dental facilities. Hospitals in California, Texas and New York were or were planning to use Section 1115 Medicaid DSRIP (Delivery System Incentive Programs) to help build a more integrated system and expand capacity.

Executives reported on a number of on-going financing strategies to maximize Medicaid waiver funds (largely 1115 waivers, including DSRIP), to diversify revenues, reduce costs and maximize collections. Hospitals in three study states (California, Texas and New York) were benefitting from funding tied to DSRIP. Illinois’s Section 1115 Waiver allowed CCHHS to create a program to expand Medicaid to the newly eligible ACA population before 2014. Hospitals were also working to improve efficiency or to optimize billing and collection procedures.

Looking ahead, executives at the study hospitals had mixed outlooks for their systems that were not always aligned to state decisions about the ACA. For example, despite operating in a state not implementing the Medicaid expansion, VCU leadership was perhaps the most positive, maintaining its strategy to diversify its revenue streams, developing niche service lines and expanding its service area, solidly positioning VCU in its health care market for the near term. Other hospitals, particularly those in states expanding Medicaid, were more optimistic about the opportunities afforded by the new coverage under the ACA. However, several hospitals in states not implementing the Medicaid expansion (including Harris Health

and Parkland) as well as some hospitals in expansion states (like SFGH and UMC) had more concerns about the future.

Despite having different outlooks for their futures, there was considerable consistency across leadership at the nine study hospitals in the challenges they anticipate facing in the future.

Some of these challenges include concerns about maintaining or growing their market share with newly insured patients, adequacy of Medicaid reimbursement and the implications of impending Medicaid disproportionate share hospital (DSH) cuts and of sustainability of Medicaid DSRIP waivers. More broadly, executives were concerned about satisfying their mission to care for the remaining uninsured (including undocumented immigrants) at the same time when they question long-term political and public support for the safety net in a post-reform world. Despite challenges, one executive noted that safety-net hospitals that had moved toward systems of health care were in a strong position to deliver care in line with the ACA's focus on population health and social determinants of health.

Introduction

Safety-net hospitals are an integral part of the US health care landscape, providing care to some of the nation's most medically vulnerable populations, including Medicaid enrollees and the uninsured. These hospitals also provide high cost services such as trauma and burn care for the broader community, and many serve as training centers for medical professionals. With the implementation of the Affordable Care Act (ACA), the country's health care system is rapidly changing, and safety-net hospitals need to make major adjustments to survive in the post-reform environment.

As enacted, the ACA expanded Medicaid eligibility to nearly all low-income individuals with incomes at or below 138 percent of poverty (\$16,105 per year for an individual in 2014). This expansion was intended to be the foundation of coverage for low-income Americans and to fill in historical gaps in Medicaid eligibility for adults. Premium tax credits for coverage in newly established Marketplaces are available to provide coverage to people with moderate incomes. The Supreme Court ruling on the ACA effectively made the decision to implement the Medicaid expansion an option for states. For states that expand Medicaid, the federal government will pay 100 percent of Medicaid costs of those newly eligible for Medicaid from 2014 to 2016. The federal share phases down to 90 percent by 2020 and thereafter, well above traditional federal matching rate in every state. States that do not implement the ACA Medicaid expansion generally have limited Medicaid eligibility for adults and adults with incomes below poverty are not eligible for financial assistance to purchase coverage in the Marketplace. As a result, in states that do not expand Medicaid, many adults will fall into a "coverage gap" of having incomes above Medicaid eligibility limits but below the lower limit for Marketplace premium tax credits.

The ACA presents opportunities, challenges and uncertainties for safety net hospitals and health care systems. Coverage expansions under the ACA via premium tax credits for moderate income individuals and through Medicaid in states adopting the ACA Medicaid expansion provide a major opportunity for safety net systems to gain new reimbursement for patients who previously were uninsured. At the same time, safety-net providers face challenges and uncertainties due to competition for newly insured patients, low Medicaid reimbursement, and federal reductions in supplemental payments to hospitals for uncompensated care through Medicare and Medicaid DSH payments. Even with the ACA coverage expansions, an estimated 23 million individuals will

remain uninsured in 2019 because some states will not implement the Medicaid expansion, many will remain ineligible for coverage due to immigration status, and some who are eligible will not take up coverage.² The uninsured will likely turn to safety net institutions for care, and executives at safety net systems have questions about whether they will have adequate resources to care for the residual uninsured population.

This brief examines how nine safety-net hospitals and their associated health care systems have fared in the months since major coverage provisions of the ACA came into effect in January 2014. The brief also examines new and on-going strategies that hospitals are adopting in the face of a quickly changing health care environment. While acknowledging the importance of the ACA, executives at each of the nine systems highlighted that other non-ACA related factors have also shaped the how their hospitals fared over the last year.

Study Methods

Between September and October 2014, researchers from the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured conducted semi-structured telephone interviews with executives at the nine-safety net hospitals. These hospitals had participated in two earlier related studies,³ where we examined how the systems were preparing for health care reform. In the interviews for this analysis, researchers collected information about the hospitals' experiences since January 2014. The interview protocol included questions about changes in finances and patient mix in the wake of reform, strategies the hospitals were pursuing in response to the ACA or other factors (e.g., changes in state policies, local financing or the local health care market), and challenges and opportunities that hospital leadership see for their hospitals going forward.

Background on Study Hospitals

Table 1 shows basic information on the nine study hospitals and their associated systems. While all are large, urban, academic medical centers, the systems vary considerably in terms of facility size, ranging from UMC with one acute care hospital and seven urgent care clinics to HHC with 11 acute care hospitals and more than 70 primary care clinics.

Table 1: Study Hospitals and Associated Facilities

Hospital / Health System Name	Acute Care Hospitals	Primary Care Clinics	Other
Cook County Health and Hospital System (CCHHS)	2	16 (ambulatory care centers)	Infectious disease center, correctional health facility, public health department
Denver Health (Denver Health)	1	9	4 dental care clinics, 17 school-based health centers
Harris Health System (Harris Health)	3	21 (including 5 school based health centers)	6 same-day clinics, and 5 specialty outpatient centers
New York Health and Hospitals Corporation (HHC)	11	70+	5 long-term care facilities, 6 multi-specialty diagnostic and treatment centers, home health agency, ACO
Parkland Health and Hospital System (Parkland)	1	12	12 school-based health centers
Santa Clara Valley Health and Hospital System (SCVHHS)	1	8	5 same-day clinics, public health department, correctional facility health center, healthcare for the homeless clinic program
San Francisco General Hospital (SFGH)	1	26	1 rehab hospital, public health department
University Medical Center of Southern Nevada (UMC)	1	6	7 urgent care clinics
Virginia Commonwealth University Health System (VCU)	3		20 specialty inpatient/outpatient clinics

Among our study hospitals, all but one of the systems (UMC) has an affiliated Medicaid managed care plan. Further, four of the systems (Denver Health, Harris Health, HHC, and SCVHHS) developed a QHP that was on the Marketplace in 2014.

Table 2: Study Hospital Characteristics Related to Medicaid and the Health Plans

Health System	City, State	Medicaid Expansion	System-Sponsored Medicaid Managed Care Plan	QHP on Marketplace
CCHHS	Chicago, Illinois	Yes	Yes	No
Denver Health	Denver, Colorado	Yes	Yes	Yes
Harris Health	Houston, Texas	No	Yes	Yes
HHC	New York City, New York	Yes	Yes	Yes
Parkland	Dallas, Texas	No	Yes	No
SCVHHS	San Jose, California	Yes	Yes	Yes
SFGH	San Francisco, California	Yes	Yes	No
UMC	Las Vegas, Nevada	Yes	No	No
VCU	Richmond, Virginia	No	Yes	No

Study Results

Consistent with the different environments in which the hospitals operate, hospitals had varied experiences during 2014 with regard to financing and patient mix. In addition, as documented in earlier reports,⁴ the nine study hospitals pursued a range of strategies to prepare for reform and to bolster financial performance. Some of these strategies were directly tied to the ACA; others were tied to broader efforts to improve performance. For example, strategies to maintain existing patients or expand market share are tied closely to new coverage opportunities under the ACA whereas changes in delivery systems, financing and IT strategies, while often tied in part to the ACA, also reflect broader market changes. Thus, while acknowledging the importance of the ACA, executives at each system in the study noted that other non-ACA related factors have also shaped the how their hospitals fared over the last year.

WHAT CHANGES IN PATIENT MIX AND FINANCING DID STUDY HOSPITALS EXPERIENCE?

Most study hospitals located in states that implemented the ACA Medicaid expansion reported substantial increases in Medicaid charges and declines in self-pay and charity care charges.

Most study hospitals located in states that implemented the ACA Medicaid expansion (CCHHS, Denver Health, SFGH, SCVHHS, and UMC) reported substantial increases in Medicaid charges and declines in self-pay and charity care charges, a category typically associated with care for the uninsured. HHC also experienced increases in Medicaid charges and declines in charity care charges, although these changes were more modest. These findings are consistent with other reports.⁵ Although UMC has seen an uptick in Medicaid insured patients and a decline in self-pay and charity care patients, this trend has not been accompanied by significant increases in Medicaid revenue (see below).

While data were not available for all systems, from the 2nd quarter of 2013 to the 2nd quarter of 2014, Denver Health reported that Medicaid as a percent of total charges across the hospital system grew by 17 percentage points, increasing from 35 percent to 52 percent while self-pay charges dropped by 14 percentage points. Similarly, SCVHHS reported that Medicaid as a percent of total charges across the hospital system grew by 18 percentage points, increasing from 42 percent to 60 percent, while self-pay charges fell by 21 percentage points. Similar shifts in Medicaid and self-pay patient mix were reported by CCHHS and SFGH. Executives at CCHHS noted that 2014 was the first time where more than half of the patients were insured as a result of coverage expansions in the ACA (mostly Medicaid). While there were shifts in payer mix and revenue, none of these hospitals experienced major increases in overall volume of care that were attributed to the ACA. Hospital executives noted that the shifts in payer mix were preliminary and that other changes might become apparent after more time had passed.

HHC experienced modest changes in the share of Medicaid, self-pay and charity care discharges between the 2nd quarter of 2013 and the 2nd quarter of 2014. Medicaid discharges increased by slightly, going from 59.3 percent to 61.7 percent. At the same time, uninsured discharges decreased slightly from 9.3 percent to 6.8 percent. Comparable shifts were observed in the outpatient setting. HHC executives attributed these relatively modest changes to the fact that ACA Medicaid coverage gains were small in New York since the state had comparatively generous Medicaid eligibility standards before health reform. HHC executives further noted that many uninsured in New York are undocumented and not eligible for coverage under the ACA. HHC leadership

also noted that a broader focus on delivery system reform efforts have resulted in declines in inpatient hospital and emergency room use along with a corresponding drop in hospital revenue.

Overall, UMC has experienced an increase in Medicaid patient volume and, to a lesser extent, revenue since January 2014. The increase, however, has been somewhat tempered by the fact that some new Medicaid enrollees are being drawn to other preferred providers that also contract with the state's recently implemented Medicaid managed care program. UMC leadership also noted that reimbursement from Medicaid managed care plans matched the county reimbursement it had received from the indigent care program prior to the ACA, resulting in relatively flat Medicaid revenues.

Study hospitals in non-expansion states did not report significant changes in Medicaid or uninsured patient volume or revenue. As expected and also consistent with other reports,⁶ study hospitals in non-expansion states (Harris Health, Parkland, and VCU) did not report significant changes in Medicaid or uninsured patient mix or charges over the past year that they attributed to the ACA.

Hospital executives at each of the nine systems commented that as of fall 2014, they have not cared for many individuals who had purchased coverage through the Marketplace. Various explanations were offered including: a short observation period; sluggish Marketplace enrollment because the tax penalty for forgoing insurance in 2014 was not sufficiently high to compel individuals; hospitals' charity care policies, which effectively discourage individuals from purchasing insurance coverage (e.g., Denver Health, Harris Health, Parkland), and decisions not to establish a QHP plan to attract enrollees given their limited focus on the private market prior to the ACA (e.g., CCHHS, SFGH).

VCU, Denver Health and SCVHHS were pursuing new service lines, but did not attribute these changes to the ACA. VCU attributed recent volume growth to its long-term business strategy to expand its service area and service lines, with a particular focus on developing niche markets to serve the commercially insured patients. Similarly, in an effort to diversify its revenue stream, Denver Health has also pursued the commercial insurance market in recent years, posting strong increases in revenues and volume from commercial payers. SCVHHS has been similarly developing specialty care services to serve commercially insured individuals, including oncology and maternal & child health services.

WHAT STRATEGIES DID STUDY HOSPITALS IMPLEMENT TO MAINTAIN AND ATTRACT NEWLY INSURED PATIENTS?

As uninsured individuals gain health insurance (primarily through Medicaid in states that have opted to implement the expansion), executives acknowledged that they are finding themselves in the unfamiliar position of having to compete with other hospitals for "their" patients.

Hospital executives reported that they were implementing an array of strategies to help improve the patient experience. CCHHS, for example, is introducing a call center in 2015 so that patients can more easily schedule appointments. Denver Health has recently implemented a number of strategies to optimize admission and utilization patterns to improve inpatient flow and bed capacity, and, for their outpatient clinics, to help reduce the patient waitlist. For example, it opened a ten-bed transitional unit designed for longer stay patients preparing for post-acute care, which made available ten beds for patients with

more acute conditions. Denver Health has also expanded inpatient and outpatient operations by hiring staff and expanding operating hours. Executives estimate that Denver Health's outpatient clinic waitlist has been cut in half due, in part, to these measures. SCVHHS and Harris Health also reported initiatives aimed at expanding capacity and bolstering patient experience.

Systems were also working to change the perception of safety-net hospitals. Executives reported efforts to change the culture of safety-net hospitals to try to shift away from being perceived as the hospital only for the low-income and uninsured to one that serves the community at large. This work pre-dated health reform, but continues to be a top priority for executives at each of the systems. These efforts entail physical modifications and undertaking efforts to advertise and market the hospital. CCHHS, for example, recently hired community outreach and patient experience staff to attract new patients and to improve the community's perception of the system. In 2015, SFGH and Parkland will each be opening new hospitals and SCVHHS will open a new bed building. Executives at each of these institutions hoped that the new facilities would help enhance the patient experience as well as improve public perceptions of their institutions.

Efforts to shift the culture of safety-net hospitals also involve engaging employees in how they care for and interact with patients. As SCVHHC realizes new revenues from the ACA enrollees, executives said that they have adjusted compensation packages for front-line workers to help improve employee morale. VCU has recently changed its compensation package for physicians (who are employed by the system) to provide significant incentives for performance. In a similar strategy to improve performance, HHC recently consolidated its physician contracts from several independent medical school affiliation contracts to contracting with one large physician group while maintaining only two of its affiliation contracts.

A major ACA-related decision hospital systems had to make was the extent to which they were going to participate in the Marketplace and try to attract Marketplace enrollees. To participate in the Marketplace, hospitals could develop their own QHP for enrollees to choose, operate as a participating provider in the network for another QHP or do both. The Marketplace provides an opportunity to retain and bring new patients and revenue to the hospital, especially for systems that have their own QHP. Hospital executives at each of the nine systems, however, expressed some concerns that the Marketplace and QHPs were new and untested in 2014 and felt there was some risk and uncertainty in participating since patient healthcare needs were not known. In addition, even though each of the study systems (but UMC) has an affiliated Medicaid managed care plan, most safety net systems lack experience with commercial health insurance products. Executives noted that putting up a QHP for the Marketplace entailed considerable development time, effort and resources for most systems as well as a change in state law for some.

The nine systems examined adopted very different strategies in their approach to the Marketplace. HHC actively pursued Marketplace enrollees, both through its own managed care plan and through contracts with other QHPs. HHC's QHP enrolled 56,062 individuals - the largest number among all New York QHPs. Denver Health, Harris Health, and SCVHHS also developed a QHP but only achieved modest enrollment. Some of the low enrollment, however, was purposeful. Executives said they were uncertain about the overall risk profile of the Marketplace population and that they worried about getting a disproportionate share of high-risk enrollees.

Denver Health, Harris Health, Parkland, SCVHHS, and VCU all contracted with QHPs. Despite having a Medicaid managed care plan, VCU elected not to offer a QHP on the Marketplace. According to VCU executives, the rationale behind this decision was that by putting up its own QHP it system would be competing with insurers that the system was to trying to get commercial business from, a situation they wanted to avoid.

While also having Medicaid managed care plans both SFGH and CCHHS did not develop a QHP and also did not contract with any QHPs in 2014. Executives cited concerns about risk selection and a decision to focus on Medicaid expansion enrollees (rather than Marketplace enrollees) as reasons.

WHAT DELIVERY SYSTEM REFORMS ARE STUDY HOSPITALS PURSUING?

The study hospitals had undertaken a number of delivery system reforms both in the months leading up to - and continuing through - ACA implementation. Many of these changes focused on increasing primary care, providing integrated care and expanding access. A number of study hospitals were operating in states where they were able to pursue delivery system reforms as part of Medicaid waivers (often DSRIP) and a few were in states making major shifts to Medicaid managed care.

A major way the systems increased capacity in 2014 was to partner with providers “beyond their own walls.” Nearly all of the study hospitals provided examples of how they were partnering with other community providers. For example, CCHHS recognized the strain that the early Medicaid expansion population placed on its system and, in response, made efforts to ramp up its primary care capacity. It contracted with FQHCs, mental health and dental facilities in the area. Through its 2011 Section 1115 Medicaid DSRIP waiver, Harris Health has opened up several primary care clinics, adding some 50,000 primary care encounters in 2014. Executives highlight that this expansion has had a “downstream impact” and the system has experienced a volume increase in specialty care referrals, outpatient procedures and inpatient hospital care.

Similarly, motivated in part by its success in garnering a sizable number of QHP enrollees and the need to expand capacity, as well as its recently approved Section 1115 Medicaid DSRIP waiver, HHC broadened its community-based physician network and pursued collaborative relationships with providers outside its system.

SCVHHS is also looking to change its delivery systems by building several “neighborhood” clinics. While having been long focused on community-based care, SCVHHS executives explained that the system is “going down one level further” and opening smaller clinics that will serve as satellites to SCVHHS’s larger clinics. Given the geographic reach of its system and the diverse population it serves, SCVHHS leadership felt having clinics in neighborhoods would more effectively serve patients, providing patients easier access as well as building a strong community connection for the system.

In 2014 the San Francisco Department of Health, which SFGH is part of, launched an effort to develop an integrated delivery model akin to the Kaiser Health Plan. But instead of including community providers, the effort focuses on building a network across department providers including SFGH, a rehab hospital, primary care and behavioral health clinics. As part of this endeavor, certain administrative functions, such as human resources and contracting, are also being centralized.

More broadly, VCU recently purchased a hospital to help free up capacity in its main hospital to treat more medically complex patients and to also diversify its revenue streams (see below). Eighty miles to the south of VCU's flagship hospital in Richmond Virginia, the newly acquired hospital is closer to where many of VCU's patients live. Apart from buying a hospital, VCU has recently extended its service region by deploying its workforce into other hospitals in outlying communities as a way to reach new markets.

Some study hospitals were further developing IT systems to better communicate with community partners and to improve quality of care. While executives at VCU noted that they had well-operating IT systems and were not undertaking new initiatives in this area, others reported new IT efforts to support their larger aims. After launching an integrated electronic health record (EHR), Denver Health, HHC and SCVHHS were moving to an Epic-based IT system. Leadership at these hospitals explained that this switch would enable them to better communicate with their community partners, many of whom also use Epic-based systems, and thus will help improve patient quality of care and facilitate population health management. CCHHS has nearly completed implementation of an EHR, a system which allows for some transfer of patient data and care plans for providers within its own network; however, only limited information sharing is available with outside providers at this point. Parkland is leveraging its existing IT system to better support integration with community partners and social services – specifically, it is developing a program to electronically share certain health information with community based organizations that provide social services to Parkland patients.

Leadership at two of the hospitals (SFGH and UMC) acknowledged that their IT is not meeting their needs. SFGH, for example, has yet to implement an integrated EHR, with executives noting that they had not capitalized on Meaningful Use funding opportunities. SFGH leadership worries that the lack of an integrated EHR will limit the system in the future. UMC also does not have a fully integrated EHR, and is navigating funding challenges that impede IT expansion efforts.

WHAT FINANCING STRATEGIES ARE STUDY HOSPITALS USING?

Executives noted undertaking several financial strategies in the wake of reform and in response to local market conditions. Leadership at each institution described efforts aimed at cost reduction as well as strategies to help them compete in their respective markets.

Tapping Medicaid revenues through Section 1115 waivers (primarily DSRIP) continues to be a major financing strategy for several of the systems. Since 2010, California, New York and Texas have each received Section 1115 waivers that include DSRIP initiatives that have provided significant funding to Harris Health, HHC, Parkland, SFGH, and SCVHHS. Executives at each of these systems commented on the importance of DSRIP funds in preparing for reform and to help transform how they deliver health care. New York's DSRIP waiver was most recently approved and implementation is underway. While recognizing the importance of the funding and objectives of the waiver, HHC executives expressed some concerns that DSRIP funding is contingent upon meeting certain targets and there are no guarantees. Illinois's Section 1115 waiver allowed CCHHS to begin covering the ACA expansion population early, bringing Medicaid revenues to the system for this population.

Several of the study hospitals are also looking at ways to diversify their revenue sources to reduce their dependence on government funding. Denver Health, SCVHHS and VCU were the most explicit about strategies designed to grow new revenue streams with the aim of expanding their business and local market share. VCU has perhaps been the most aggressive in this regard, with a particular focus on building up commercial revenue. As of the second quarter of 2014, nearly half (46 percent) of VCU's system charges came from private payers. A major way VCU has been able to bring in commercial payers is by pursuing medically complex patients, on which executives note the system makes 85 percent of its margin, and by developing “niche” service lines such as transplants, an artificial heart program, oncology and pediatric subspecialties. Most recently, VCU added neurological and musculoskeletal rehabilitation services.

For the other two systems looking to diversify their revenues and expand business, Denver Health has been trying to bring more county employees into its health plan whereas SCVHHS is looking to expand its Medicare revenue, a patient group that leadership acknowledges as having difficulty retaining once they qualify for Medicare. To that end, SCVHHS is expanding its services to include sub- and post-acute care and long-term care services. Similar to VCU, SCVHHC also has been gradually making investments in specialty care services. Long a regional center for burn, trauma and rehabilitative services, SCVHHC has recently added oncology to the list. In addition, building off its high quality scores on maternal and child health care services, in 2014 SCVHHS launched a Women's and Children's Center as a way to draw new patients to its system. Finally, UMC is pursuing new technology and specialized equipment, such as robotic surgery, to enhance its efforts to attract more surgical subspecialists to the medical staff.

Cost reduction and optimizing collections continue to be financial strategies most study hospitals were pursuing. While pushing forward on its long-standing Lean management program, Denver Health, for example, has also conducted a staffing productivity evaluation and restructured staff to reduce costs and improve efficiency. The reorganization included the addition of a Chief Acceleration Office to help the system respond more quickly and adeptly deal with emerging issues. In addition, Denver has recently established two strategy committees – one that is focused on a five-year plan while the other is focused on implementing an annual plan.

SFGH, within the last two years and HHC, seven years ago, started using Lean and other strategies to optimize efficiency and financial structures throughout their systems. In addition, HHC is seeking FQHC status for its clinics and has pushed to make optimal use of providers by pursuing Level 3 PCMH for its clinics and revamping physician contracts as discussed above. HHC also eliminated about 1500 fulltime staff positions as a cost-saving measure. While not aimed at improving operational efficiency, as mentioned, UMC closed clinics and laid off staff to improve operational efficiency as well as address a reduction in patient volume and revenue in 2014.

The hospitals are also taking action to optimize financial collection processes. For example, Parkland has focused on improving its revenue cycle over the past six months and has seen some uptick in payments from commercial insurers as a result. CCHHS has worked to optimize billing procedures and other collection procedures. It has also worked to improve its revenue cycle by reducing its accounts receivable.

In an effort to improve its difficult financial situation, UMC plans to develop a robust academic relationship with the soon to be established University of Las Vegas School of Medicine. With the anticipated addition of the local medical school affiliation, UMC hopes that an academic program centered around UMC on its home turf (Las Vegas) coupled with developing strategic relationships with physicians will draw more business to the system.

Some systems were restructuring charity care policies given other available coverage options.

Several systems (e.g., Denver Health, Harris Health, Parkland) have long-standing indigent care programs where patients with incomes under a certain threshold are offered free or discounted health care services. Given availability of new coverage in the Marketplace, executives were rethinking these policies. Hospitals are discussing ways to transition individuals who qualify for Marketplace coverage from receiving benefits from charity programs. In 2014, SCVHHS, for example, adjusted its indigent care program so that cost sharing starts for individuals with incomes above 138 percent of the federal poverty limit, the income cutoff for the ACA Medicaid expansion population. Harris Health maintained its charity care policies in 2014 but recently proposed an option to encourage qualifying individuals in its indigent care program to purchase coverage through the Marketplace, aided by premium support from local foundations. Parkland has altered its financial assistance categories to incentivize people to gain coverage through the Marketplace while providing some income-based financial support for cost-sharing. In addition, patients with incomes above 100 percent of poverty who do not purchase Marketplace coverage will be responsible for modest cost-sharing if they receive services through Parkland's indigent care program. Hospitals acknowledged that changing their indigent care policy is a tough issue for local decision-makers. Many charity care programs have been in place for decades making it difficult to reduce eligibility and support.

Looking Ahead

Executives at the study hospitals had mixed outlooks for their systems going forward into 2015.

CCHHS, Denver Health, HHC, SCVHHS and VCU executives were optimistic about the near future given the myriad of changes with the ACA. Despite operating in a state not implementing the Medicaid expansion, VCU leadership was perhaps the most positive, maintaining its strategy to diversify its revenue streams, developing niche service lines and expanding its service area, solidly positioning VCU in its health care market for the near term. Optimism among executives at CCHHS, HHC, Denver Health and SCVHHS was tied to a great extent to their systems' performance under health reform. As one executive put it, the ACA has given them the "revenue oxygen" to have a fighting chance in the changing health care market. Further, over the next couple years, many of these hospitals hope to realize even more ACA-related revenues by enrolling more Marketplace-covered individuals in their system health plans or building stronger ties with commercial QHPs.

In contrast, despite enrolling a sizable number of ACA Medicaid beneficiaries in its health plan in 2014, leadership at SFGH were less sanguine about the future. Executives expressed some concern about how SFGH has positioned itself in the post-reform market and worry that this may affect its long-term ability to continue being a leading safety net system. Even though Nevada implemented the ACA Medicaid expansion, UMC has not benefitted from increased Medicaid revenues, since the new ACA Medicaid related income stream has only replaced funding from the pre-existing county indigent care program. With the recent change in its local medical school affiliation, however, UMC executives hope it can improve its current very challenging financial situation over time.

Parkland and Harris Health executives expressed concern about the future, particularly related to Texas’s decision not to take up the ACA Medicaid expansion since many of their patients would qualify for coverage that would have brought new revenue to their systems. Further, owing to a change in state policy, Parkland and Harris Health have seen recent reductions in their Medicaid DSH payments. In addition, Harris Health has experienced a drop in local tax support revenue and expects further reductions in the future. Maintaining that they are already low-cost providers, Parkland and Harris Health executives worry that they will have to reduce services and programs unless some financial relief is provided.

Despite having different outlooks for their futures, there was considerable consistency across leadership at the nine study hospitals in the challenges they anticipate facing in the future.

These include concerns about maintaining/growing market share with newly insured patients; concerns about adequacy of Medicaid reimbursement levels; implications of federal cuts in Medicaid DSH; the financial implications of Section 1115 Medicaid waivers, and concerns about continued political and public support for the safety net in a post-reform world. Hospital executives also universally asserted they would continue to satisfy their mission to care for the uninsured. One interviewee shared the sentiment widespread among the study hospitals that “providing safety net services is who we are and what we do”. That said, they acknowledged the very difficult challenge of balancing the safety net mission with the realities of the emerging health care market is not easy, especially as the share of the population without coverage shrinks, leaving a larger share of undocumented immigrants as the core uninsured. Despite challenges, one executive noted that safety-net hospitals that had moved toward systems of health care were in a strong position to deliver care in line with the ACA’s focus on population health and social determinants of health.

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Endnotes

¹ Coughlin TA, Long SK, Sheen E, Tolbert J. 2012. How five leading safety-net hospitals are preparing for the challenges and opportunities of health care reform. *Health Affairs*. 8(2012):1690-1697. Coughlin TA, Long SK, Peters R, Arguello R. 2014. Strategies in 4 safety-net hospitals to adapt to the ACA. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

² Elmendorf DW. CBO's analysis of the major health care legislation enacted in March 2010: statement before the Subcommittee on Health, Committee on Energy and Commerce, US House of Representatives,

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⁴ Coughlin TA, Long SK, Sheen E, Tolbert J. 2012. How five leading safety-net hospitals are preparing for the challenges and opportunities of health care reform. *Health Affairs*. 8(2012):1690-1697. Coughlin TA, Long SK, Peters R, Arguello R. 2014. Strategies in 4 safety-net hospitals to adapt to the ACA. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

⁵ See for example, DeLeire T, Joynt K and R McDonald. 2014. Impact of Insurance Expansion on hospital uncompensated care costs in 2014. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation, September 24.

⁶ Ibid.