

REPORT

FINAL REPORT

Effects of the Affordable Care Act on Safety Net Hospitals

November 2016

Laurie Felland
Peter Cunningham*
Annie Doubleday
Cannon Warren

Submitted to:

The Assistant Secretary for Planning and Evaluation
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
Project Officer: Andrew Sommers, PhD
Contract Number: HHSP23320095642WC/HHSP23337039T

Submitted by:

Mathematica Policy Research
1100 1st Street, NE
12th Floor
Washington, DC 20002-4221
Telephone: (202) 484-9220
Facsimile: (202) 863-1763
Project Director: Laurie Felland, MS

*Virginia Commonwealth University

CONTENTS

I.	INTRODUCTION / EXECUTIVE SUMMARY.....	1
II.	OVERVIEW OF PROJECT OBJECTIVES AND PROCESS.....	3
	A. Policy context.....	3
	B. Project team.....	3
	C. Planning stage.....	4
	D. Conceptual framework.....	4
	E. Study scope and methodology.....	5
	F. Dissemination of findings.....	6
III.	KEY FINDINGS.....	7
	A. Summary.....	7
	B. Changes in patient volumes and mix.....	7
	C. Experiences with alternative payment models and value-based payment initiatives.....	12
	D. Financial impacts.....	17
	E. Additional observations about differences between the 2014 and 2015 semi-structured discussions.....	23
	1. Quantitative findings.....	23
	2. Qualitative findings.....	24
	F. Limitations and challenges.....	24
IV.	CONCLUSIONS.....	27
	APPENDIX 1: CONCEPTUAL FRAMEWORK.....	28
	APPENDIX 2: TABLE OF HOSPITAL CHARACTERISTICS.....	32
	APPENDIX 3: METHODOLOGY OVERVIEW.....	36
	APPENDIX 4: FINANCIAL TABLE TEMPLATE.....	45
	APPENDIX 5: 10 SITE SUMMARIES.....	49
	APPENDIX 6: HOSPITAL PERFORMANCE ON CMS QUALITY MEASURES.....	94

FIGURES

1 Average change in patient volumes by service between 2013 and 2015..... 8

2 Average change in patient volume by payer source between 2013 and 2015..... 9

3 Average patient mix, 2013 and 2015 10

4 Average payer mix, 2013 and 2015 18

5 Average financial margins, 2013 and 2015..... 21

I. INTRODUCTION / EXECUTIVE SUMMARY

The Affordable Care Act (ACA) is expected to have profound effects on the health care system in the United States, including the safety net hospitals that care for many low-income uninsured people, Medicaid enrollees, and other vulnerable populations. Given the important role safety net hospitals play in their communities, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the Department of Health and Human Services (HHS) contracted with researchers from Mathematica Policy Research and Virginia Commonwealth University to study the early effects of the ACA on 10 safety net hospitals, both in states that expanded income eligibility for Medicaid under the ACA and those that did not. This primarily qualitative research study, conducted between September 2013 and March 2016, provides an on-the-ground assessment of the extent and nature of early changes in patient demand for services; hospital capacity; preparations for payment and delivery system reforms; and changes in hospital revenues, costs, and overall financial status.

In this final report, we summarize the objectives and process for designing and conducting this study; the key findings, challenges, and limitations faced; the ways in which the results have been disseminated; and the major conclusions and policy implications of these findings. Overall, our research found that, on average, safety net hospitals in states that expanded Medicaid under the ACA are treating significantly more insured and fewer uninsured patients than in 2013, and that this shift has helped the hospitals financially. In contrast, the hospitals in states that did not expand Medicaid typically experienced little change in their patient mix and increased financial challenges. Overall, hospitals in both types of states experienced little effect from new Marketplace coverage, faced declining subsidies, and are bracing for additional cuts, although experience varied within the study set. The study also identified a number of challenges that safety net hospitals face in adapting to payment and delivery system reforms; several of the study hospitals have made progress in developing integrated delivery systems capable of assuming financial risk, but others lag behind. The future viability of safety net hospitals may hinge on potential changes to financial supports, as well as strategies to reduce hospital costs and better manage care.

II. OVERVIEW OF PROJECT OBJECTIVES AND PROCESS

A. Policy context

Policymakers, health care providers, researchers, and others have expected the ACA to have profound effects on the U.S. health care system, including the safety net hospitals that provide health services to many low-income uninsured people, Medicaid enrollees, and other vulnerable populations. Based on the assumption that as more people gain insurance coverage, hospitals will receive increased revenue from insured patients and reductions in uncompensated care, the ACA reduces Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, although these reductions have been delayed until 2018. To avoid a negative financial impact, safety net hospitals likely will need to attain substantial changes in payer mix—that is, more insured patients and fewer uninsured patients—to offset the loss of these subsidies. The degree to which safety net hospitals fare well under health reform will also depend in part on whether they are considered “essential community providers”¹ by health plans and the extent of competition with other hospitals for newly insured patients.

The ACA also has called for major changes in the delivery and financing of health care. These changes include a shift from paying for volume to paying for value and encouragement for health care providers to accept greater financial risk for the care of patients. The ACA encourages new forms of payment and care delivery—such as Accountable Care Organizations (ACOs), value-based payment, bundled payments, and patient-centered medical homes (PCMH). Given many of these new models are still in the relatively early stages of implementation, limited evidence exists to date that alternative payment models can successfully improve quality of care and lower health care costs on a national scale. In 2015, the Secretary of Health and Human Services announced ambitious delivery system reform with the goals of tying 90 percent of all Medicare fee-for-service payments to value-based payment programs by 2018, and making 50 percent of Medicare payments via alternative payment models in the same time frame.² Success under alternative payment models will require hospitals to function differently than before, as payment is tied to performance on measures of quality and costs of care, and accountability is shifted to the hospital for patient outcomes across the care continuum.³ Safety net hospitals in particular face a number of challenges to success under value-based payments and alternative payment models, including more limited financial resources and a patient population with more complex clinical and social needs.

B. Project team

The research team worked closely with Office of the Assistant Secretary for Planning and Evaluation (ASPE) staff throughout all stages of the project. The principal investigators (Laurie

¹ National Academy for State Health Policy. “Essential Community Providers: Tips to Connect with Marketplace Plans.” April 2013. Available at <http://www.nashp.org/sites/default/files/ecp.tips.connect.marketplace.plans.pdf>.

² Burwell, S.M. “Progress Towards Achieving Better Care, Smarter Spending, Healthier People.” Available at <http://www.hhs.gov/blog/2015/01/26/progress-towards-better-care-smarter-spending-healthier-people.html>.

³ Centers for Medicare & Medicaid Services. “Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System.” Available at <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html>.

Felland from Mathematica and Peter Cunningham, formerly from Mathematica and now at Virginia Commonwealth University)—collectively called the “project team” throughout this report—discussed the project in regular biweekly calls with the project officer to provide updates and seek guidance. The purpose of these calls was to report on progress, discuss issues that arose over the course of the project, and seek input and comment from ASPE on key aspects of the project and all deliverables. During the field period for the case studies, these calls also provided an opportunity to share our early impressions with ASPE and report on any difficulties encountered as we conducted our research. We also held several additional in-person meetings at ASPE after the kickoff meeting, including one to discuss site selection, another to discuss the earlier proposed quantitative study, and one on early findings from the qualitative data collection effort.

C. Planning stage

Under Mathematica’s contract with ASPE, “Building Analytical Capacity for Policy Analysis and Decision-Making,” the research team led a separate planning task in early 2013 for conducting the case studies for this project. The planning phase consisted of four main components: (1) an environmental scan to identify the key research questions and conceptual framework for understanding the effects of health reform on safety net hospitals; (2) the metrics and potential data sources that would be available for case studies; (3) a plan for conducting case studies; and (4) convening an eight-member technical expert panel (TEP) meeting to provide input to the plan. These activities informed the overall strategy as well as the specific methodology for selecting the individual hospitals to study, identifying the types of organizations and individuals with whom to speak, and specifying the content of the semi-structured discussions and other information collected. In September 2013, Mathematica received the contract to conduct the study and held a kickoff meeting with ASPE in November 2013.

D. Conceptual framework

The project team developed a conceptual framework during the planning stage to guide the project (see Appendix 1). The framework draws on other efforts to develop a monitoring strategy for safety net hospitals, such as the Agency for Healthcare Research and Quality’s (AHRQ’s) Safety Net Monitoring Initiative, and an initiative by the Health Resources and Services Administration (HRSA) to monitor the effect of state health insurance expansions on safety net organizations.⁴ We used the Institute of Medicine’s (IOM’s) definition of safety net providers: “providers that organize and deliver a significant level of both health care and other health-related services to the uninsured, Medicaid, and other vulnerable populations,” as well as providers “who by mandate or mission offer access to care regardless of a patient’s ability to pay and whose patient population includes a substantial share of uninsured, Medicaid, and other vulnerable patients.”⁵

⁴ Agency for Healthcare Research and Quality. “The Safety Net Monitoring Initiative: Fact Sheet.” August 2003. Available at <http://archive.ahrq.gov/data/safetynet/netfact.pdf>; Harrington, Mary E., and Vivian L. Byrd.

“Monitoring the Impact of State Health Insurance Expansion on Safety Net Organizations. Final report submitted to the Department of Health and Human Services, Health Resources and Services Administration, July 2009.

⁵ Institute of Medicine. “America’s Health Care Safety Net: Intact but Endangered.” Washington, DC: National Academies Press, 2000.

We adapted the conceptual frameworks used in these previous efforts to account for both specific provisions of the ACA and recent changes in the health care delivery system, along with issues specific to safety net hospitals. We also incorporated comments from the TEP. The framework identified the key policies (other state and local policies and funding streams in addition to the ACA provisions) that affect hospital demand, revenues, and costs, as well as the types of contextual or “market” factors that influence hospitals’ responses to health reform, such as community characteristics, the structure of the local health care delivery system, and individual hospital attributes. Taken together, these policy and market factors contribute to changes in the number of uninsured people in the community, which in turn affects demand for care at safety net hospitals, and thus changes in these hospitals’ revenues and costs. These changes, along with care delivery and payment reforms, affect a hospital’s “outcomes”; these outcomes include its financial viability, ability to remain a safety net provider, array of service offerings, and quality of care.

E. Study scope and methodology

ASPE and the research team purposively selected for study 10 safety net hospitals or systems that range in size, role in their local safety net, ownership, and geographic location. Some are single hospitals, some are hospital systems with several hospitals included in the analysis (and other outpatient or other facilities), while others are part of larger hospital systems, for which the other hospitals are separate from the analysis (either because they are in a different community, focus on a limited set of services and/or are not deemed safety net hospitals). Appendix 2 provides a table displaying key characteristics of these hospitals in more detail; Appendix 3 provides details of our methodology.

Six hospitals are in states that expanded Medicaid under the ACA:

- LAC+USC Medical Center in Los Angeles, California (flagship hospital of a four-hospital county system)
- Yale-New Haven Hospital in New Haven, Connecticut (part of the three-hospital Yale New Haven Health System)
- Denver Health in Denver, Colorado
- University of Kentucky HealthCare (UK Health, three hospitals) in Lexington, Kentucky
- Marcum and Wallace Memorial Hospital in Irvine, Kentucky
- Lakewood Health System in Staples, Minnesota

Four hospitals are in states that have not expanded Medicaid:

- Harris Health System (three hospitals) in Harris County (Houston), Texas
- Regional One Health in Memphis, Tennessee
- Froedtert Hospital in Milwaukee, Wisconsin (part of a three-hospital Medical College of Wisconsin system)

- Homestead Hospital in Dade County, Florida (part of the Baptist Health South Florida system)

The research team primarily used qualitative methods to understand the effects of the ACA on these hospitals between early 2013 and 2015. Using a mix of in-person and telephone semi-structured discussions, we spoke with the six hospitals from states that expanded Medicaid (“Medicaid expansion states”) in both 2014 and 2015, and the other four hospitals in 2015 only.

The semi-structured discussions covered the following key topics: the hospitals’ role in the local safety net; changes in their operational and financial well-being (including changes in patient volumes for different service types, patient mix, system capacity, revenues and expenses, and overall financial performance); factors contributing to these changes (ACA and other); and the hospitals’ strategies, goals, and expectations for the future. The 2015 semi-structured discussions also covered the hospitals’ experiences with Medicare value-based payment initiatives—specifically, the Hospital Readmissions Reduction Program, Hospital-Acquired Conditions (HAC) Reduction Program, and Hospital Value-Based Purchasing Program⁶—and involvement in alternative payment arrangements, in which hospitals take on more financial risk. We also gathered quantitative indicators directly from each hospital on patient volumes and financial performance for the same time period, which informed both the semi-structured discussions and the analysis (see Appendix 5). We analyzed the findings in two main stages: by individual site (see Appendix 5 for the 10 summaries) and across sites (see below).

F. Dissemination of findings

We presented study findings (see next section) to several important audiences during the last year of the project. Laurie Felland presented early findings from the original 6 sites at the June 2015 AcademyHealth Annual Research Meeting. Peter Cunningham presented key findings across the 10 sites at the Annual AHRQ Research Conference in October 2015. We also conducted a final study briefing for ASPE staff in April 2016.

The project team also summarized the findings of the cross-cutting analyses in two research briefs. One paper examines the early effects of the ACA on the study hospitals’ patient volumes and finances, while the second brief explores how the study hospitals are preparing for payment and delivery system reforms.

⁶ See the CMS website for more information on these programs at <https://www.cms.gov/Medicare/Medicare.html>.

III. KEY FINDINGS

A. Summary

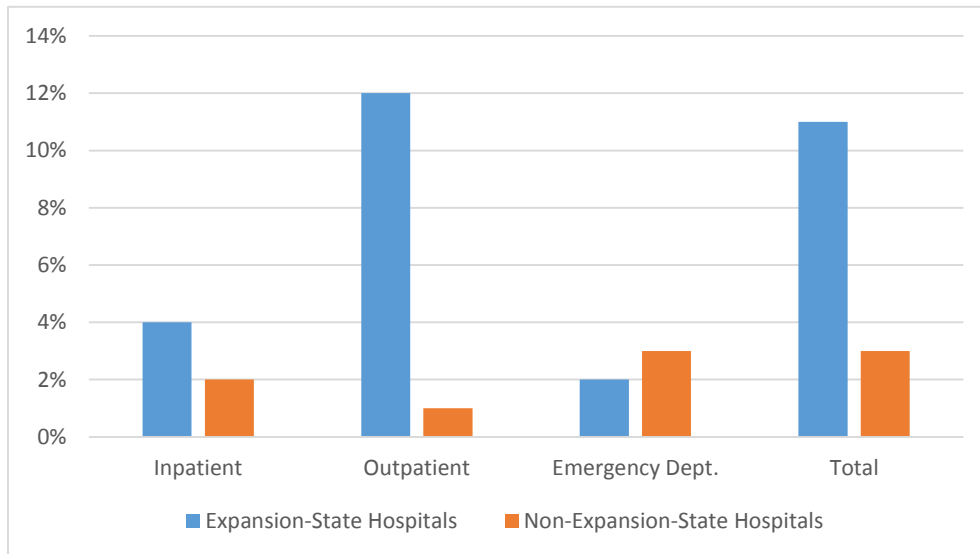
Study hospitals (Appendix 2) in states that expanded eligibility for the Medicaid program experienced considerable patient volume increases from Medicaid enrollment expansions, whereas they experienced little volume change from the ACA's expansion of commercial coverage through the federal and state Marketplaces. Despite concerns that they might lose many newly insured patients to other providers, these study hospitals largely retained existing patients and gained new ones. The growth in patient volume was especially notable for outpatient care, and there were corresponding marked increases in the proportion of their patients with insurance coverage. The growth in outpatient visits reflects in part safety net hospitals' active efforts to help uninsured patients enroll in coverage, expand primary care capacity, and improve their facilities and systems to attract or retain patients as they gained coverage. Respondents (the hospital executives and staff we spoke with for the study) reported that these changes both supported their patients and the hospitals' overall financial health. The words of one hospital executive captured the sentiment of many: "The biggest success of the ACA is reducing our self-pay [uninsured] patients and getting people the health care that they need. That to me has been a great thing financially and a great thing for patients ... we have anecdotal stories that people are accessing care and identifying issues and getting better."

In contrast, study hospitals in states that did not expand eligibility for Medicaid experienced, on average, more modest increases in patient volumes and no overall change in patient mix, with many of their patients remaining uninsured. On average, they experienced greater financial challenges compared to the hospitals in states that expanded Medicaid ("expansion state hospitals"); these challenges increased over the study period. Although hospitals in both types of states experienced some declines in their subsidies to support care for the uninsured, all of them are bracing for additional cuts.

B. Changes in patient volumes and mix

Patient volume grew overall but more so among expansion state hospitals. Most of the study hospitals provided a higher volume of patient care in the first quarter of 2015 relative to the first quarter of 2013. Respondents reported that this growth represents a mix of additional services provided to existing patients who had previously been uninsured and services to new patients. Overall, patient volumes increased more for expansion state hospitals than non-expansion state hospitals, with the former reporting an average 11 percent increase and non-expansion state hospitals reporting an average of 3 percent (Figure 1). The degree of increase varied widely, from 2 percent to 22 percent, across all study hospitals. Outpatient volumes grew more than other services (inpatient admissions and emergency department encounters) for expansion state hospitals, by an average of 12 percent (the increases ranged from 4 percent to 24 percent across expansion state hospitals). In contrast, outpatient volumes did not change much at non-expansion state hospitals: 1 percent on average (change across non-expansion state hospitals ranged from -9 percent to 12 percent).

Figure 1. Average change in patient volumes by service between Q1 2013 and Q1 2015



Expansion state hospitals' outpatient growth reflects a variety of factors. Most of the Medicaid expansion population receives care through managed care arrangements; the health plans typically require new enrollees to choose a medical home (which provides primary care and coordinates additional follow-up care) and encourage them to seek an appointment soon after enrolling.⁷ Also, many of the study hospitals had expanded outpatient capacity (see *Hospitals expanded ambulatory care* section below) as they sought to redirect patients from their emergency departments (EDs) and reduce or shift care away from inpatient facilities.⁸ This redirection occurred because of capacity constraints and the hospitals efforts to provide care in less costly settings in preparation for new payment arrangements that reward value (better outcomes at lower costs) over volume of services provided (see *Experiences with Value-Based Purchasing and Alternative Payment Models* section.)

Overall, the study hospitals observed a 3 percent increase in ED volumes. Whereas changes generally ranged from only small increases to small decreases, a couple of expansion state hospitals saw larger (11–12 percent) increases in ED use. These increases are consistent with studies that find that insured patients use EDs more than uninsured patients because EDs are convenient and Medicaid patients typically face no cost sharing to use one;⁹ access to primary

⁷ The extent to which Medicaid managed care plans use a strict gatekeeper model that authorizes referrals for follow-up care varies by state/community, but the general concept is typically in place, whether the primary care physician (PCP) has strict authorization authority or not.

⁸ Some apparent changes in volumes represent shifts among service categories. For Froedtert, part of the apparent rise in outpatient cases is that the Medicare “two-midnight rule” shifted cases previously categorized as inpatient into observation or outpatient cases.

⁹ Cunningham, Peter J., and Jessica H. May. “Insured Americans Drive Surge in Emergency Department Visits.” Issue Brief No. 70, Washington, DC: The Center for Studying Health System Change, October 2003.

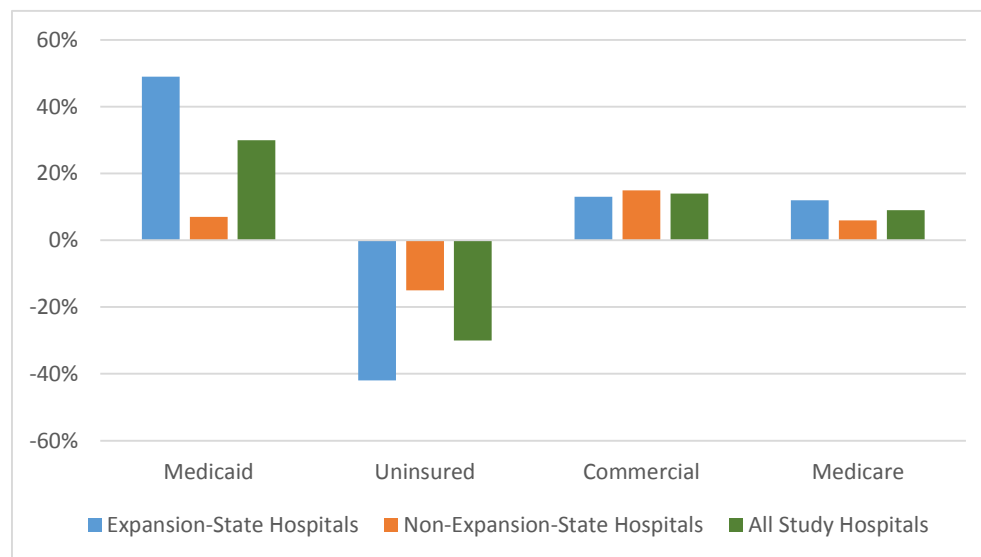
and specialty care in outpatient settings may be more difficult. Some respondents were surprised that ED visits did not increase more as people gained coverage.

ED use among non-expansion state hospitals also increased slightly. In addition to the slight Medicaid volume increases, each non-expansion state hospital provided additional reasons for the increase, from growth in commercially insured patients (Homestead), to population growth (Harris) and greater severity in patients’ conditions, possibly linked to delayed care (Froedtert).

Inpatient volumes and average length of inpatient stay also did not increase much for expansion state or non-expansion state hospitals.¹⁰ This finding suggests that new patients were not significantly sicker than previous patients. Although hospital executives reported more chronic conditions and pent-up demand among their newly insured patients, many of those needs reportedly were addressed on an outpatient basis.

Medicaid growth outpaced Marketplace growth. Overall, the Medicaid expansion was a more significant contributor to volume growth at the safety net hospitals than the new Marketplace coverage options for low-income people. The growth in patient volumes stemmed from different sources for expansion state hospitals and non-expansion state hospitals: for the former, primarily from Medicaid patients; for the latter, primarily from commercially insured patients (Figure 2).

Figure 2. Average change in patient volume by payer source between Q1 2013 and Q1 2015



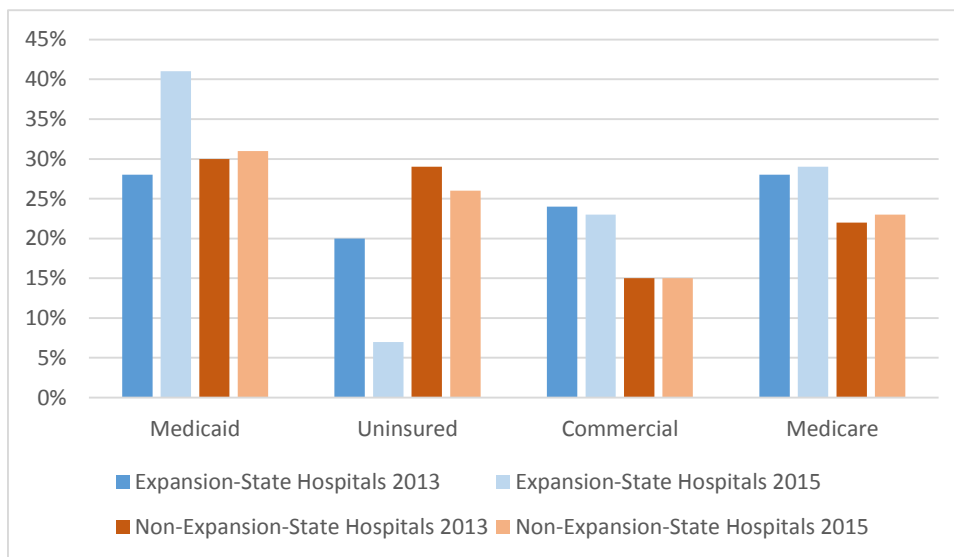
Medicaid volume grew more among expansion state hospitals in states that previously had no or minimal Medicaid eligibility or other public coverage programs for childless adults (California, Kentucky, and Colorado). A couple of the expansion state hospitals experienced

¹⁰ Only Marcum and Wallace had a significant increase (18 percent) in inpatient volumes, which mostly was unrelated to the ACA or patient demand; rather, it reportedly represented a change in categorizing patients as inpatients rather than observation stays.

dramatic increases in Medicaid encounters¹¹ and significant (but lesser) drops in encounters from uninsured patients: for LAC+USC, Medicaid encounters jumped by 150 percent, whereas uninsured encounters plummeted 85 percent; for UK Health, Medicaid encounters grew by 80 percent, whereas uninsured encounters fell 55 percent.

As a result of the shifts in volume, the patient mix changed markedly (Figure 3). Medicaid encounters (inpatient, outpatient, and ED) became a much larger portion of the services provided in some expansion state hospitals, whereas uninsured encounters as a portion of total encounters dwindled. On average, Medicaid grew from 28 to 41 percent of total patient encounters (a 46 percent increase); the proportion of uninsured encounters fell from 20 percent to 7 percent (a 65 percent decrease).

Figure 3. Average patient mix, Q1 2013 and Q1 2015*



*Calculated based on average of inpatient, outpatient and emergency department patient mix. Patient mix unavailable for Denver Health.

For non-expansion state hospitals, Medicaid volumes grew modestly for some hospitals, but typically with little effect on Medicaid as a proportion of overall encounters (on average, non-expansion state hospitals experienced little change in their overall patient mix between 2013 and 2015). Respondents attributed some of this growth to the ACA sparking more outreach activities that led people already eligible for Medicaid to apply (often referred to as a “woodwork” or “welcoming mat” effect). Reportedly, general population growth and increased capacity contributed to Harris’s increase, whereas a change in Wisconsin’s Medicaid program that brought people from a waiting list into the program led to growth at Froedtert.¹² However,

¹¹ Total volume of inpatient admissions, outpatient, and ED visits.

¹² Wisconsin allowed childless adults to enroll in Medicaid before the ACA but, with implementation of the ACA, reduced income eligibility from 133 percent to 100 percent to align with the income level at which federal subsidies for Marketplace coverage kick in; the state then opened its enrollment cap. Many people who had been on the waiting list reportedly lived in the Milwaukee area, contributing to a net increase in Medicaid patients and a reduction in uninsured patients for Froedtert.

Medicaid volumes declined at Regional One, which executives attributed partially to Medicaid patients aging into the Medicare program.

Although many study hospitals experienced some increase in commercially insured patients, this source comprised more of non-expansion state hospitals' volume growth than Medicaid (but on average commercial as a percentage of overall patient mix remained stable and declined in terms of overall revenue (Figure 4). Yet Marketplace coverage did not significantly affect either expansion state or non-expansion state hospitals.¹³ This finding is not especially surprising because, in states that expanded Medicaid, enrollment typically far outpaced Marketplace enrollment. Many of the study hospitals serve a very low-income population, so many existing patients at expansion state hospitals qualified for Medicaid rather than Marketplace coverage, and many non-expansion state hospitals' patients live below the poverty line and are thus ineligible for Marketplace subsidies. Also, a few hospitals reported challenges in obtaining contracts with Marketplace health plans, either because they were not deemed "Essential Community Providers" in their states and/or because they have historically lacked commercial contracts as a basis for negotiation for inclusion in these plans' provider networks.

Hospitals proactively worked to attract more patients. The growth in patient encounters aligns with reported efforts by the study hospitals to retain and attract patients as they gained coverage. Both expansion state and non-expansion state hospitals conducted in-reach (to existing uninsured patients) and outreach (to find additional uninsured people in the community) to help people apply for coverage. Some study hospitals gained ACA funding to assist in these efforts. For example, UK Health participated in testing and implementing state outreach efforts in its facilities, and a federally funded insurance navigator in Marcum and Wallace's ED reportedly helped many uninsured patients gain coverage.

The study hospitals made concerted efforts to improve their facilities, processes (for example, appointment scheduling, wait times for appointments), and customer service so that newly insured patients would select them over other providers. Many respondents referred to these efforts as strategies to become "providers of choice, not last resort." Also, some states direct a large proportion of Medicaid enrollees who do not choose a health plan to those owned by safety net providers; they also direct those who do not choose a medical home to safety net providers. The study hospitals reported retaining many of their patients once they gained coverage and also receiving new ones.

Hospitals expanded ambulatory care. Since many of these hospitals reportedly were already operating close to or at capacity in their EDs and outpatient services before the ACA coverage expansions, they needed to expand to treat more patients. With their focus on outpatient services, most hospitals did not add inpatient beds; some even reduced staffed beds.

Whereas the study hospitals displayed a wide range in the extent of primary care they provide, most had expanded primary care services between 2013 and 2015. As noted, primary care capacity is vital if hospitals are to serve as medical homes in insurance networks; it also helps them gain referrals for additional outpatient and inpatient services. In addition, primary

¹³ Many hospital executives noted difficulties in precisely parsing out Marketplace coverage from overall commercial volumes to provide a percentage estimate of its total prevalence among commercial businesses.

care is an important component of preparing for value-based payments (see next section). The study hospitals mainly boosted primary care by adding physicians and other staff (for example, nurse practitioners) on site; at least one hospital (Yale) acquired physician practices in the community.

Some hospitals also added physical capacity on the hospital campus or at clinics in the community, or extended their primary care reach by collaborating with other community clinics. Homestead had not traditionally provided primary care but recently started a clinic that provides comprehensive visits to patients after they leave the hospital so as to reduce their reliance on the ED for follow-up care. Froedtert is developing more community clinics and partnering with a federally qualified health center (FQHC). With many patients presenting in their EDs for behavioral health issues, some of the study hospitals also have added social workers and psychiatric staff (Denver) and/or are working to integrate behavioral health into primary care (Lakewood).

A couple of non-expansion state hospitals substantially increased their primary care services in anticipation of a Medicaid expansion, which then did not occur; Harris Health built two large primary care clinics. With Texas opting out of the Medicaid expansion, the clinics serve many more uninsured patients than before and identifies many specialty care needs; addressing these needs has reportedly strained Harris's capacity and financial status.

Given the costs of adding physical capacity and staff, some hospitals increasingly have turned to other ways to extend primary care and other services outside of traditional patient-provider visits. For example, Froedtert started a virtual urgent care clinic, using Facetime and Skype Internet technology. Some of these efforts are not captured in the hospital volume data. In a key example, LAC+USC makes greater use of telephonic medical advice as well as an EConsult system, in which PCPs consult with specialists electronically to gain advice on how to treat a patient's condition or refer the patient to the specialist; this system reportedly has reduced the need for face-to-face visits with specialists by one-third.

C. Experiences with alternative payment models and value-based payment initiatives

Although adapting to changes in volume, patient mix, and service capacity, the study hospitals (Appendix 2) also were responding to payment and delivery system reforms, both in the ACA and through other federal and state initiatives. Unlike the changes in patient volume and mix, we did not find clear distinctions between hospitals in states that expanded Medicaid and those that did not regarding their participation in and readiness for these new payment arrangements.

Varied participation in alternative payment models. The eight study hospitals (we did not include the two rural hospitals in this analysis because of their small size and exemption from Medicare value-based purchasing requirements) vary considerably in the extent to which they are moving toward risk-based payments under managed care or alternative payment models. The two county hospitals with a broad set of integrated services appeared more advanced in these arrangements for the Medicaid population than the smaller hospitals and the academic medical centers.

LAC+USC and Denver Health are much further along the continuum of providing care under risk-based payment arrangements than the other study hospitals. They already accept full risk for their Medicaid patients (through capitation). Denver Health estimates that it currently receives capitated payments for about 40 percent of patients (primarily through their Medicaid and employee health plans). It is not pursuing ACO arrangements (typically involving sharing risk with other providers) for any patient populations because “we think we are a bit ahead of accountable care; we do full population health for the Medicaid population.” Crucially, both hospitals exist in a state policy environment that is aggressively promoting payment and delivery system reforms for Medicaid and public hospital systems. These reforms are Colorado’s statewide Accountable Care Collaboratives for Medicaid beneficiaries and California’s Delivery System Reform Incentive Payment (DSRIP) program targeting safety net hospitals, which provides extra payments for these hospitals if they achieve quality improvement goals.^{14,15} Also, California provides the county hospitals with cost-based reimbursement for inpatient services for new Medicaid enrollees, thus providing some protection from the risk-based arrangement.

Other study hospitals are participating in ACOs for their Medicare and/or commercially insured patients but have yet to extend this approach to Medicaid patients. Froedtert in Milwaukee is participating as a tertiary care provider in the Integrated Health Network of Wisconsin, a “super ACO” comprising eight regional health systems and targeting Medicare and commercially insured patients.¹⁶ Northeast Medical Group, a physician practice owned by Yale-New Haven Health System, is involved in a Medicare Shared Savings Program ACO. Homestead has entered into an ACO with a major private insurance carrier (Florida Blue) for the care of cancer patients. These hospitals tend to have higher volumes of Medicare and commercially insured patients compared to the publicly operated systems described above.

The other study hospitals (UK HealthCare, Harris Health, and Regional One) are less involved with alternative payment models for any payer type. They are more wary of accepting greater financial risk for patients due to high uncompensated care levels and lack of Medicaid expansion in their states (Harris Health and Regional One), or low Medicaid payment and lack of integration with primary care and other services needed to manage and coordinate the care of patients (UK HealthCare). These hospitals also cited a lack of political interest (both historically and currently) at the state level in pursuing innovative Medicaid managed care programs and payment models.

Patients’ social and clinical needs pose challenges. A major challenge for safety net hospitals in value-based purchasing arrangements and new alternative payment models is that many of the patients they serve are poor and low income, and have complex clinical and social needs that require greater coordination with social services as well as other medical services. These hospitals encounter greater difficulties with patients who are homeless or lack a permanent address, lack social and family support in the community, have significant co-morbid mental

¹⁴ Colorado Department of Health Care Policy and Financing. Accountable Care Collaborative. Available at <https://www.colorado.gov/pacific/hcpf/accountable-care-collaborative>.

¹⁵ California Department of Health Care Services. Delivery System Reform Incentive Payments (DSRIP). Available at <http://www.dhcs.ca.gov/provgovpart/Pages/DSRIP1.aspx>.

¹⁶ Integrated Health Network of Wisconsin. Available at <http://www.ihnwi.com/>.

health and substance abuse problems, or have inadequate transportation to get to medical appointments.

The socioeconomic mix of patients they serve creates challenges for safety net providers to perform well on measures of quality of care and hospital readmission rates, which can lead to higher penalties on their Medicare payments.^{17,18} Respondents across the study hospitals reported that the lack of adjustment for socioeconomic status puts them at a disadvantage relative to other hospitals with respect to the quality measures used for the Centers for Medicare & Medicaid's (CMS's) value-based purchasing programs. One specific example cited by multiple hospitals is the relatively high rate of pressure ulcers in their facilities (included as a metric under the HAC Reduction Program). Hospitals face more difficulty in preventing pressure ulcers among patients who have been immobilized—for example, due to neurological injuries and wounds resulting from violence, accidents, or other trauma; these hospitals care for many such patients.

Despite the hospitals' concerns about the lack of adjustment for socioeconomic factors and their perceived disadvantage, the study hospitals typically did not perform substantially worse on the CMS quality measures compared to hospitals nationally (see Appendix 6). In cases in which scores were relatively low, the penalties assessed tended to be modest and were of less concern to these hospitals than other financial issues. In fact, some study hospitals have a low volume of Medicare patients, which also limits the financial impact of these programs, either because these hospitals are ineligible due to their small volume (the two rural hospitals in particular fall under this category) or the amount of their penalty or bonus is modest.

In contrast, the challenges this set of safety net hospitals face tend to affect factors related to patient satisfaction more than the quality of care provided. These hospitals tended to have relatively low patient satisfaction scores based on the Hospital Consumer Assessment of Health Plans (HCAHPS), which is administered to a sample of all patients, not just those under Medicare.¹⁹ Respondents believed that low HCAHPS scores reflected problems of access to care, crowding in emergency and inpatient departments, and other resource constraints (for example, inadequate staffing and customer service training, administrative and clinical information systems) that affect patients' experiences with the hospital. Initiatives were underway at a number of hospitals to address these issues. In addition, many of them have been proactive in improving interactions between clinicians and patients, including the use of outside consulting groups that specialize in improving the patient experience.

Integrating primary care and addressing nonmedical needs are important. The difficulty of transforming their delivery systems to improve integration and coordination with other services and providers is a significant challenge for many of the study hospitals. Follow-up for discharged patients who have no “medical home” was cited as particularly challenging,

¹⁷ Gilman, M., E.K. Adams, J.M. Hockenberry, A.S. Milstein, I.B. Wilson, and E.R. Becker. “Safety Net Hospitals More Likely than Other Hospitals to Fare Poorly Under Medicare's Value-Based Purchasing.” *Health Affairs*, vol. 4, no. 3, 2014, pp. 398–405.

¹⁸ Joynt, K.E., and A. Jha. “Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program.” *Journal of the American Medical Association*, vol. 309, no. 4, 2013, pp. 342–343.

¹⁹ Chatterjee, P., K.E. Joynt, E.J. Orav, and A.K. Jha. “Patient Experience in Safety-Net Hospitals.” *Archives of Internal Medicine*, vol. 172, no. 16, 2012, pp. 1204–1210.

especially for a patient population with a high prevalence of mental and physical disabilities, low health literacy, and inadequate transportation and housing.

Most study respondents felt that highly integrated delivery systems with a closed network of providers was the optimal arrangement for managing the wide array of care needs for Medicaid and uninsured populations. Among the study hospitals, the county-operated or supported systems are more equipped for this approach. LAC+USC, Denver Health, Harris Health, and Regional One typically employ their physicians (versus contracting with physicians in the community) to align incentives. Also, they essentially “own the entire continuum of health care,” which helps them achieve a high degree of integration between inpatient, primary care, and other outpatient facilities. All of these hospitals believe that operating as an integrated system has allowed them to keep 30-day inpatient readmission rates lower than they would be if the systems were more fragmented—primarily because they facilitate greater communication and smoother handoffs between different sectors within the system (see Appendix 6, which shows how the county-operated hospitals tended to face lower readmission penalties than the private hospitals in the study).

Denver Health, LAC+USC, and Harris Health have taken advantage of ACA-related grants and programs to further increase the degree of integration and coordination of services they provide. For example, Denver Health received a \$19 million Center for Medicare and Medicaid Innovation (CMMI) grant that supports patient navigators, programs to manage high utilizers, co-location of primary and behavioral health services, and clinical pharmacists embedded in primary care clinics. A major emphasis has been the use of patient navigators and dedicated staff to proactively schedule primary care visits for patients with chronic illnesses who are at high risk of readmission.

As part of reforms through California’s Medicaid waiver and DSRIP programs, LAC+USC has focused on expanding access to primary care and assigning patients to medical homes in its network, as well as greater integration of primary care and behavioral health. Also, LAC+USC rented 600 units of supportive housing and opened 300 recuperative care beds for homeless patients being discharged from the hospital. The estimated cost for the health system of providing such housing, along with primary care and other supportive services (\$1,200 per patient per month), was less than the higher cost for inpatient readmissions and ED services that could result without such support. However, capacity for these efforts remains limited, reportedly leaving many patients with unmet primary care and behavioral health needs.

Harris Health has expanded primary care capacity and access within its system under Texas’s DSRIP initiative, including the addition of nine primary care clinics. “Super-utilizers” are being managed by sending medical teams out to patients’ homes to teach them how to manage their chronic conditions. Care delivery reforms at the hospital also include identifying patients at high risk for readmission and using case managers to follow up and encourage these patients to see their primary care physician.

In contrast, the three academic medical centers in the study are much more limited in both integration with primary care and other services used to address population health for their Medicaid and/or uninsured populations. In general, their main strategy is to position themselves as the tertiary and quaternary providers in ACO networks for Medicare and commercially

insured patients, rather than developing vertically integrated systems for these patients. These systems have embraced ownership of physician practices in the community as a way to increase their footprint for primary care and other specialties; however, these physicians primarily serve Medicare and commercially insured patients. Instead of building primary care capacity within their systems, they have focused on developing relationships with FQHCs to provide medical homes for Medicaid and uninsured patients who use their EDs. For example, Froedtert recently donated \$15 million to a local FQHC to build an additional clinic site to expand access in the community, and it has agreed to provide inpatient and specialty care for patients at the new facility.

The Baptist Health Care System in South Florida (of which Homestead Hospital is a part) also has little primary care capacity within its system. As a result, providing patients with follow-up care after hospital discharge poses a major challenge for Homestead. In response, the hospital has set up a “gap clinic”—a primary care center managed by a nurse practitioner and intended to serve as a transitional center between inpatient and primary care for recently discharged patients. Homestead has also tried to strengthen affiliations with local FQHCs to provide their patients with a medical home for the longer term.

Electronic health record systems are essential for organizational and clinical integration. All study hospitals agreed that having a system that maintains a single, integrated electronic health record (EHR) for each patient throughout their system was essential for coordinating patient care, documenting and analyzing the quality and costs of care, and identifying operational changes that might be needed. Some hospitals were further along than others in developing their EHR systems. With the exception of Regional One, all study hospitals had (or had definite plans to implement) single EHRs linked to all providers in their system. Some of the hospitals are also using outside consultants to develop systems for population health management and patient engagement. Among the study hospitals, Regional One in Memphis appears to lag furthest behind in adapting its information systems and enhancing its administrative capabilities. It is the only study hospital that used different EHRs for different departments, and still relies to some extent on paper records.

Despite system upgrades, the study hospitals appear to be limited in their understanding of and ability to address cost drivers—both of which are key to long-term success under value-based purchasing. For example, all facilities cited difficulties in attributing costs to patients, service lines, or particular providers, which makes it challenging to understand the major cost drivers in their health systems. The ability to hire staff devoted to collecting and analyzing data on cost and quality performance varied across the hospitals; Harris Health and Regional One identifying it as one of their major challenges, largely because of financial constraints.

For some hospitals, accurate documentation of patients’ condition(s) upon arrival and care received can be as much of a challenge as implementing sophisticated EHR systems and expanding analytical capabilities. For example, one hospital reported that it appeared to have a high rate of accidental bowel lacerations during surgery (which factors into a CMS quality indicator), which upon further investigation was a result of miscoding patients who arrived at the hospital with that condition (for example, stabbing victims who arrived at the ED).

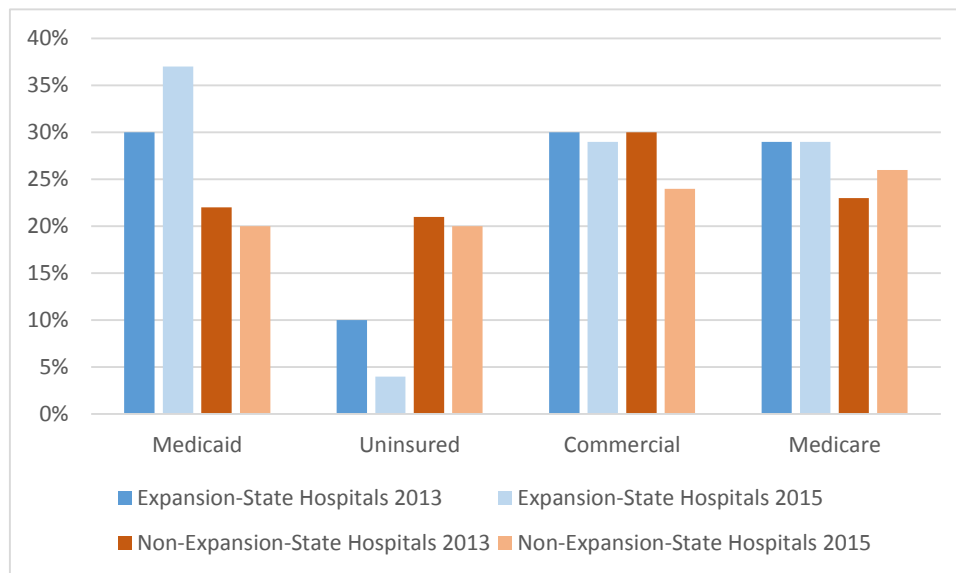
D. Financial impacts

Patient service revenue grew. Largely linked to the growth in patient volumes from insured patients, operating revenues increased for expansion state hospitals (by an average of 17 percent) and, to a lesser extent, for non-expansion state hospitals (11 percent on average) between 2013 and 2015. For expansion state hospitals, this increase came largely from Medicaid. Revenue growth was especially large for the study hospitals that receive cost-based Medicaid reimbursement (for at least some patients and/or services) from their states; these hospitals include the rural critical access hospitals and LAC+USC (Appendix 2). For others, Medicaid reimbursement is less than the costs of providing the services; however the hospitals previously had been treating many of these patients as uninsured patients and so had received even less reimbursement in the past.

Some hospital executives expressed concern that Marketplace products tend to reimburse providers at rates considerably lower than traditional commercial coverage—at or closer to Medicaid payment rates. One hospital detected lower payments as some patients switched from employer-sponsored commercial coverage to Marketplace plans. Because Marketplace patient volumes have been relatively low for these hospitals to date, however, the revenue impact has been small overall.

Hospitals' payer mix based on total patient revenues followed similar patterns to the shifts in patient mix based on encounters (Figure 4). For both expansion state hospitals and non-expansion state hospitals, commercial insurance revenues comprise a significantly larger proportion of total revenues than commercial insurance encounters as a proportion of total patient encounters, reflecting the higher payment rates for these services.

Hospital subsidies are on the decline. Longstanding federal, state, and local subsidies—for example, from DSH programs, state provider taxes, or general county revenues—to safety net hospitals began declining over the last few years, tempering their revenue growth. However, to date some of these cuts have not been as large as the hospitals expected because of policymaker decisions to phase them in more gradually, allowing hospitals to adjust to reform. Also payment schedules typically lag behind the time frame during which the services are provided and shifts in payer mix have occurred. That is, some safety net hospitals are temporarily benefiting from stable subsidies based on a time frame during which they served more uninsured patients, even as their uninsured numbers have since declined; in other words they are paid retroactively for services provided. Some executives expect to have to repay some of these funds once the state and/or federal government fully account for patient and payer mix changes.

Figure 4. Average payer mix, Q1 2013 and Q1 2015

In addition to direct patient revenues received from Medicaid programs and health plans, safety net hospitals also typically receive additional Medicaid revenues through DSH. Most of the study hospitals experienced either stable or declining Medicaid DSH payments between 2013 and 2015. Although the federal government has delayed the planned cuts to Medicaid DSH several times (primarily because the initial schedule for reducing the payments preceded the Supreme Court decision to allow states to opt out of the Medicaid expansion), states play a large role in how these funds are allocated; some states changed their allocation formulas. Also, some safety net hospitals' allocations changed because their patient mix had changed.

Yet Medicaid DSH has not been a large funding source for some of the hospitals. Lakewood and Homestead both receive less than \$10,000 per year (less than 1 percent of revenues). Marcum and Wallace reported the greatest decline in Medicaid DSH funds (55 percent between 2013 and 2015), but from a relatively small amount (from approximately \$148,000 to \$66,000). Regardless of the amount, some of the study hospitals decided to no longer recognize DSH payments as revenue; this strategy is intended to prepare for the upcoming cuts and out of concern that they will need to repay much of the funds once their state assesses the change in volumes and patient mix.

Medicare DSH payments to the study hospitals were either insignificant or did not change substantially. However, Regional One's Medicare DSH funds increased recently (amount not available), reportedly related to the new allocation formula that distributes a portion of the 75 percent Medicare DSH fund reduction to hospitals with large numbers of uninsured patients.²⁰

Other common sources of Medicaid revenue for safety net hospitals are state programs that redistribute funds generated by charging a fee to a broad set of providers; after receiving federal

²⁰ Disproportionate Share Hospital (DSH). "The Medicare DSH Adjustment." Accessed at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/dsh.html>.

Medicaid matching funds, the state redistributes the funds to safety net hospitals. Denver Health's payments from such a fee program have been rising in the last few years. Homestead's \$400,000 from Florida's Low Income Pool has been stable over this period. After lengthy negotiations over the future of the program, the state and federal governments came to an agreement to continue this funding source, but at a lower level;²¹ it is too early to know the impact on Homestead's funding levels. Yale's experience with Connecticut's provider fee program differed, as the fee assessed on the hospital totaled more than the hospital received back in enhanced Medicaid payments during the study period.

Federal Medicaid waivers are also important sources of funding for some safety net hospitals. LAC+USC and Harris receive funds through the DSRIP component of their state's 1115 Medicaid waivers, which has helped them to expand capacity in new ways, particularly for primary care. The California waiver ended in October 2015, but a new waiver will extend the DSRIP concept to 2020, with more expectations that hospitals will demonstrate that these funds are helping them achieve better patient outcomes at lower costs. The Texas DSRIP program is slated to end in 2016, unless the state's Medicaid waiver (and the DSRIP program) is renewed.

The county-owned hospitals in the study appear more vulnerable than others because they rely on additional state and local subsidies that also have started to decline. LAC+USC now receives less funding through so-called realignment funds (sales tax and vehicle licensing fee revenue that the state historically has provided to counties to provide health care to low-income uninsured people); the state now directs more of these funds to social services.

Expansion state hospitals typically expected such funding reductions as their uninsured populations declined, but the cuts are more painful for non-expansion state hospitals. County funds (largely from property tax revenues) had made up almost half of Harris's operating revenue, but the county cut these funds by 13 percent (a reduction of \$75 million annually) starting in 2011. Reportedly, the county made this cut in anticipation of Texas expanding Medicaid, which has not occurred. In contrast, Regional One's county appropriation has been steady over the last few years, and the hospital expects to receive an estimated 2 percent increase this year. As a non-expansion state hospital executive suggested: "Medicaid expansion would provide a better and more predictable funding stream" than the various subsidies on which the hospital currently relies.

Uncompensated care expense fell. In line with reductions in uninsured patients, uncompensated care (comprising both charity care and bad debt) declined by almost one-third for expansion state hospitals.²² Charity care tended to fall more than bad debt. In fact, some study hospitals reported increases in bad debt, which hospital executives attributed to the presence of more commercial insurance products with relatively high-cost sharing requirements (deductibles and copayments) that patients cannot afford. The growth of such products started before the ACA but has continued with the new Marketplace plans. Also, some of the newly

²¹ Associated Press. "Florida, Fed Agree to Extend Hospital Low-Income Pool Funds." *Modern Healthcare*, June 24, 2015. Available at <http://www.modernhealthcare.com/article/20150624/NEWS/306249975>.

²² Although we attempted to gather uncompensated care costs in a consistent way across the study hospitals—as the sum of charity care and bad debt—Yale also uses Medicaid shortfalls in its uncompensated care calculation, which reportedly led to an increase in the amount.

insured patients might now be incurring bad debt for unpaid expenses that previously qualified for charity care when the patient was uninsured.

The non-expansion state hospitals experienced mixed changes in uncompensated care. Both Homestead and Harris experienced increases in uncompensated care—as much as 25 percent for Harris—reflecting volume increases, general medical inflation, and the same bad debt issue. However, Froedtert’s uncompensated care expense fell significantly (even as it increased the upper-income limit for charity care eligibility) as more people gained coverage.²³ Overall changes in uncompensated care at Regional One varied depending on time period (see Appendix 5).

Medicaid expansion helped financial performance. Most of the study hospitals started with low or negative operating and total margins, and most of the expansion state hospitals saw improved financial performance by 2015 (Figure 5). Reportedly, these improvements primarily reflected gains in Medicaid patient revenue, but also some cost reductions (primarily through staffing cutbacks). Between the first quarters of 2013 and 2015, average operating margins across the six expansion state hospitals increased from -4 to 2 percent, and total margins increased from 2 to 6 percent. Given their particularly large Medicaid enrollments in Kentucky, UK Health and Marcum and Wallace stood out as experiencing significant gains, with margins improving to more than 5 percent. LAC+USC’s margins improved but remained negative. However, Yale faced declining margins, which executives attributed to reductions in the hospital’s Medicaid reimbursement rates.

For most expansion state hospitals, much of the improvement in financial margins came between 2013 and 2014; by 2015, margins typically had increased only slightly or even declined from 2013. This fact likely reflects declining subsidies and increased costs, especially as hospitals invested in more infrastructure to serve more patients and prepare for value-based payments.

Non-expansion state hospitals’ average operating margins declined over the study period and remained negative; total margins also fell but remained positive. The hospitals typically attributed these losses to expenses (including investments in information technology, quality improvement activities, and staff salaries) that outpaced relatively flat revenues. In contrast, Froedtert had strong and improving operating margins, reflecting its relatively large growth (for a non-expansion state hospital) in Medicaid volumes.

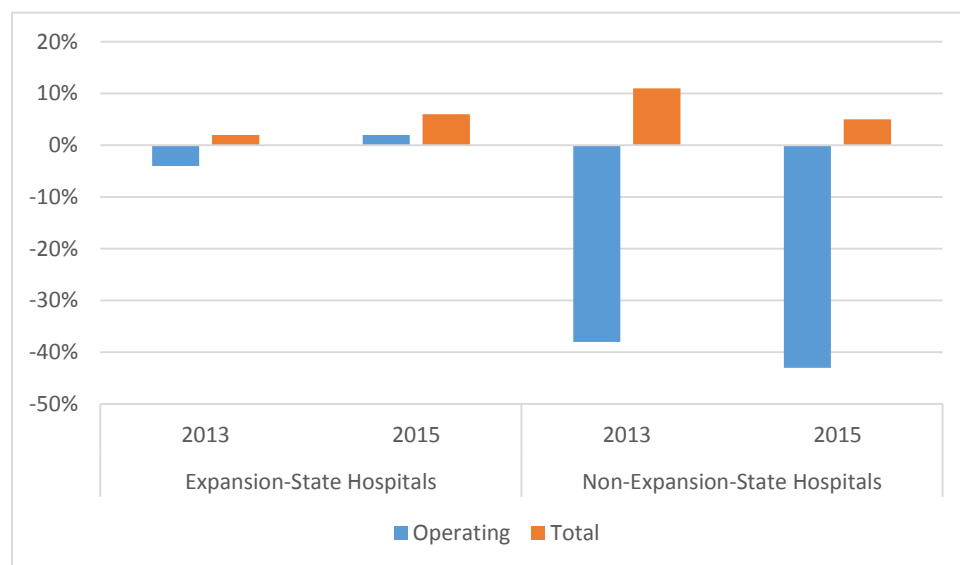
Financial constraints inhibited payment and delivery system reforms. Study hospitals in states that expanded Medicaid have benefited financially from increased public insurance revenue, which helped them address the new costs to develop infrastructure and implement other needed changes to participate in value-based purchasing programs and alternative payment models. As noted, participation in value-based purchasing programs has had little financial effect

²³ Although Regional One’s uncompensated care appears to have increased in the quantitative data, the qualitative information suggested an actual slight decline over the last few years (with the discrepancy attributed to the hospital accounting for these expanses in batches throughout the year; also, the hospital first categorizes these accounts as bad debt, then later determines what portion qualifies for charity care).

on the study hospitals; for the hospitals engaged in alternative payment models, it is too soon to know the longer-term financial impact.

The financially weaker hospitals lacked the resources to make these new investments and are more focused on remaining viable and avoiding reductions in services. Harris Health and Regional One reported that the lack of Medicaid expansion in their states significantly contributed to their inadequate staffing and inability to upgrade electronic medical records (EMRs) to improve quality and efficiency of care. One respondent summed up the trade-off between costs and quality improvement efforts as follows: “When you are a safety net hospital, you put [full-time equivalents] FTEs where they have to be, which is the clinical and regulatory, and when you are trying to work on safety and quality, that’s where the FTEs are soft and you start knocking the proposed ones off the budget.”

Figure 5. Average financial margins, Q1 2013 and Q1 2015*



*Margins unavailable for Homestead Hospital

Medicaid expansion also affected the study hospitals’ ability to continue with quality improvement and other delivery system reform activities after initial funding through grants or pilot programs had ended. Aided by its increase in Medicaid revenues, Denver Health intends to continue with most of the activities funded by its CMMI grant—which ends in 2016—because hospital leaders think that many of these changes pay for themselves through reductions in inpatient admissions, ED visits, and other services.

In contrast, the DSRIP program in Texas has had mixed effects for Harris Health. DSRIP funds enabled the hospital to expand primary care capacity in 2011 (by leasing space to operate nine additional community clinics), with the expectation that the state would expand Medicaid—but this preceded the 2012 Supreme Court ruling that made Medicaid expansion optional. Texas’s decision not to expand Medicaid has meant that the hospital must now absorb increased uncompensated care costs associated with its expanded network of primary care clinics and the increase in specialty care and other referrals generated from primary care visits. The state’s

current Medicaid waiver ends in September 2016; if it is not renewed, the funding to operate these clinics also could cease.

The level of Medicaid payment to hospitals affects not only their financial viability, but also their willingness to assume financial risk for Medicaid patients and transform their delivery systems. LAC+USC and other major safety net hospitals in California receive cost-based Medicaid reimbursement for the Medicaid expansion population, which helps them to make changes to their delivery systems. By contrast, Yale-New Haven faced recent cuts to its Medicaid reimbursement (to address state budget deficits), which it estimates has decreased Medicaid payment from 59 percent of costs in 2013 to 39 percent in 2015.

Active preparations for the future. Overall, improved financial stability has helped expansion state hospitals to prepare for the future. The hospitals with greater financial security now have more resources to help them continue expanding outpatient capacity, invest in strategies to improve care coordination, and develop better infrastructure to monitor costs. All of these actions are important for new payment arrangements, under which hospitals expect to assume more financial risk for patient care and outcomes.

All of the study hospitals are cautious about spending, however. Many hospital executives expressed concern that their recently improved financial status might be fleeting as subsidies decline, and because Medicaid enrollment and payments could decline after 2017, when the federal government no longer covers the full cost of the expansion.²⁴ As one said, “We’re in the sweet spot of health reform.” Many non-expansion state hospitals have less of a financial margin to pursue such investments; their executives express less confidence about their future.

Indeed, both expansion and non-expansion state hospitals are focused on ways to raise additional revenues, primarily by diversifying their payer mix. Most hospital executives did not expect to see many more of their uninsured patients gain coverage. Instead, they are focused on pursuing new Marketplace and other commercially insured patients and, to a lesser extent, Medicare patients. The academic medical centers have focused on expanding inpatient and/or outpatient specialty services (tertiary and quaternary care) that appeal to a broader population. For example, UK Health has added a new ambulatory building and inpatient beds to support this strategy. Better branding and marketing is also important, respondents reported. For instance, Regional One previously was known as Regional Medical Center and referred to as “the Med” in the community; it adopted its new name as part of a rebranding strategy to reflect the broader system of services it now provides (for example, primary care, outpatient surgery, and rehabilitation).

The study hospitals are also focused on ways to cut costs. Those in non-expansion states are more likely consider more significant changes to policies that could affect access. For example,

²⁴ Starting in 2017, states must take on a portion of the cost, which will increase to 10 percent by 2020.

Harris Health has contemplated changing its charity care policy to reduce the number of people eligible for free care.²⁵

E. Additional observations about differences between the 2014 and 2015 semi-structured discussions

Although the research team collected qualitative and quantitative information at two points in time—2014 (reflecting back on 2013) and 2015 (reflecting back on both 2013 and 2014)—the cross-site analyses discussed above generally focused on the overarching changes that the study hospitals (Appendix 2) experienced between 2013 and 2015, rather than providing detail about changes between 2014 and 2015. In response to ASPE’s request for more information about the extent to which our findings differed between the 2014 and 2015 data collection periods, here we summarize some common themes from both the quantitative and qualitative information (for the qualitative piece, this summary represents only the six hospitals in the expansion states because in 2014 we had not yet included the four hospitals in the non-expansion states).

1. Quantitative findings

The 2015 patient volume and financial indicators generally showed a continuation of what had occurred in 2014. For hospitals in expansion states, Medicaid was a growing presence (in patients and revenues); uninsured patients and uncompensated care costs were declining. Some of those hospitals experienced more significant change between 2013 and 2014 than between 2014 and 2015. For others, the Medicaid expansion took more time to result in changes in coverage and/or demand for care, and the degree of change between 2014 and 2015 exceeded that of 2013 to 2014. However, these patterns often varied across service lines within an individual hospital.

Still, many of the study hospitals in non-expansion states (and some in the expansion states) experienced some fluctuation among the different time periods on different indicators. That is, in a number of cases, patient volume in a certain category actually dipped a bit between the first quarter of 2013 and 2014 but then showed more increase by 2015. Some respondents attributed this development to more gradual coverage expansions in their states (especially if the state did not expand Medicaid eligibility) but also to factors unrelated to the ACA. Such fluctuations tended to be more prevalent among the Medicare and commercial volumes and payer/patient mixes than in the Medicaid and uninsured categories.

Among hospitals in Medicaid expansion states, charity care steadily fell, but bad debt fluctuated, in many cases rising between 2013 and 2014 and then falling to below 2013 levels in 2015. This finding could reflect initial increases in bad debt related to Marketplace and other commercial insurance products that placed more cost-sharing requirements on consumers (for example, through high-deductible products); whereas those products remained in place by 2015 and sometimes even grew more prevalent, coverage expansions may have caught up by 2015 to reduce the number of people generating bad debt because they were uninsured (but did not

²⁵ Hawryluk, Markian, “Harris Health considers cutting free care to close budget gap,” *The Houston Chronicle*, July 31, 2015. Available at <http://www.houstonchronicle.com/news/health/article/Harris-Health-considers-cutting-free-care-to-6416197.php>.

qualify for charity care). Indeed, respondents generally seemed more concerned about rising bad debt during the 2014 semi-structured discussions than semi-structured discussions in 2015.

For most of the study hospitals in expansion states, much of the improvement in financial margins came between 2013 and 2014; by 2015, margins typically had increased only slightly or even declined from 2013. This finding likely reflects declining subsidies and increased costs, especially as hospitals invested in additional infrastructure to serve more patients and prepare for value-based payments.

2. Qualitative findings

Overall, hospital executives' thoughts about how the ACA was or was not affecting their hospitals remained relatively consistent between 2014 and 2015. That is, for those areas about which they were hopeful in 2014, they tended to remain hopeful in 2015 (for example, shifting payer mix and revenues, preparations for value-based payments); for those areas about which they were concerned in 2014, they generally remained concerned (for example, DSH cuts, not receiving more commercially insured patients or even losing some of these patients).

However, there were some exceptions to this overall pattern. By 2015, hospital executives reported less concern about competition with other providers for Medicaid patients. Also, some had made less progress toward participating in alternative payment models than they had expected in 2014. Whereas most hospitals did not expect their uninsured patient volumes/mix to decline much more because they perceived most of these patients to be ineligible for coverage based on their immigration status, at least one hospital (Denver Health) found it had initially underestimated the number of people still eligible for coverage. Although not directly related to the ACA, in 2014, the two rural hospitals were worried about potential changes to the definition of a Critical Access Hospital (CAH) that might make them no longer eligible and were concerned that their cost-based payments for Medicaid and Medicare would end even if they remained a CAH; these concerns waned by 2015 because respondents perceived the changes were no longer a focus of Congress.

F. Limitations and challenges

Given the limited research to date on the effects of the ACA on safety net hospitals, this study provides an early look at the types of experiences these hospitals are experiencing in a more timely way than larger evaluations. These larger evaluations typically take longer due to the time needed for survey or other quantitative data to become available. Also, the in-depth qualitative approach we used is valuable for understanding the varied contexts in which safety net hospitals operate. This type of approach also provides a good view of how and why hospitals' experiences with the ACA may differ, as well as hospitals' responses to new pressures and other changes, which cannot be readily obtained through surveys or other quantitative means. The study findings should be useful for forming hypotheses and research questions for future quantitative and qualitative research.

Still, the study faced two key limitations. First, given the small sample size and purposive sampling approach, the findings from these 10 study hospitals (Appendix 2) are not representative of all safety net hospitals in the United States. Qualitative studies that rely on open-ended semi-structured discussions with multiple respondents per study site are necessarily

limited in sample size and representativeness to allow for more in-depth understanding and analysis of individual hospitals, and how they compare to hospitals that differ on important organizational, regional, and state policy attributes. The findings cannot be generalized to all safety net hospitals and should not be regarded as conclusive.

Second, the quantitative hospital data collected posed some limitations. Because we collected quarterly rather than annual data, respondents cautioned that some changes could represent normal period-to-period variation, rather than changes with practical significance. To guard against overstating a level of change, we generally reported averages and ranges across hospitals. Also, the research team was unable to obtain the release of information for some indicators for certain hospitals, despite several attempts. However, the qualitative research process enabled the researchers to offset some of these data omissions and other limitations by capturing hospital executives' perceptions of key changes and additional context and information.

IV. CONCLUSIONS

Overall, the future viability of safety net hospitals may hinge on potential changes to their financial supports, as well as adoption of strategies to reduce hospital costs and better manage care so they can continue to serve both insured and uninsured patients, and fare well under expanded payment reforms.

Although the hospitals in this study do not represent all safety net hospitals across the country, their experiences highlight the types and degree of changes related to the ACA that others might encounter. Overall, our findings suggest that the Medicaid expansion was a significant, helpful change for these hospitals; also, this expansion in more states could help bolster both the safety net hospitals operating in those states and access to care for their low-income residents. Regardless of the state in which they operate, however, other Medicaid-related funds and subsidies remain important to hospitals' financial bottom lines, and they will face challenges as they work to adapt to changes in funding streams and reduce costs of care—particularly to fare well under payment and delivery system reforms.

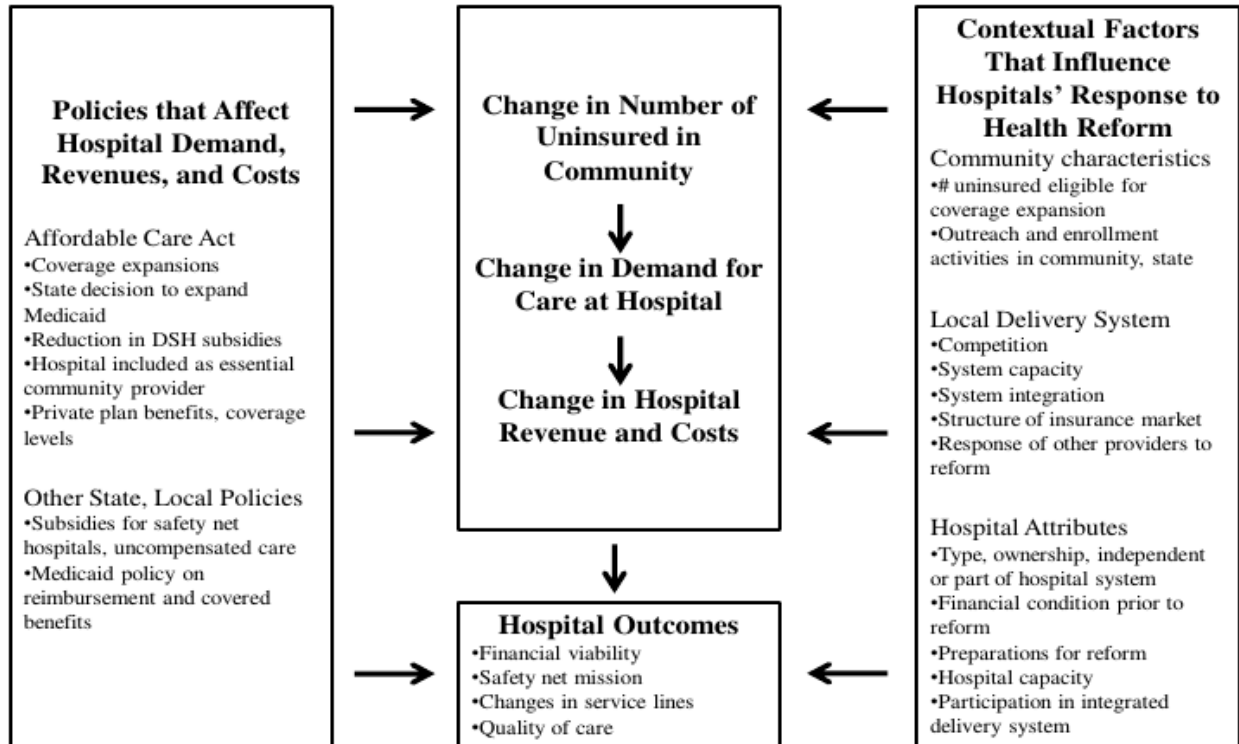
Indeed, the study hospitals are trying to implement strategies that expand capacity and access to new Medicaid enrollees and potentially attract other new patients while also adapting to federal value-based purchasing programs and alternative payment models. Fortunately, many of these strategies—including developing more primary care, creating information technology systems to better track patient care and costs, and treating patients in new, more efficient ways and for non-medical needs—appear consistent with both of these aims. Still, safety net hospitals will need to be cognizant not to overextend their capacity or infrastructure in a way that generates additional costs without bringing in adequate revenues, as well as not to economize to the point of harming patient care.

Safety net hospitals across states face several potential funding challenges. With the federal government soon passing along a portion of the cost of the Medicaid expansion to the states, non-expansion state hospitals expressed concern that their states will become less inclined to expand their Medicaid programs. Also, respondents at expansion state hospitals felt that this new cost could lead some of their states to reduce Medicaid eligibility, benefits, or provider payments. This possibility was a particular concern for the Kentucky study hospitals because their Medicaid expansion was so large and because of a change in governor.²⁶ Such changes, along with planned reductions in subsidies, could place some safety net hospitals in particularly vulnerable positions.

²⁶ Since the site visit, Kentucky has elected Matt Bevin as governor; he ran on a platform of repealing the Medicaid expansion. Since his election, however, the governor has stated that he plans to retain the expansion but potentially reduce benefits for new enrollees; he also plans to remove the state's Marketplace (Kynect) and instead have residents purchase coverage through the federal exchange. Barton, Ryland. "Kentucky Governor Tells Feds He Will Dismantle State's Insurance Exchange," National Public Radio, January 12, 2016.

APPENDIX 1

CONCEPTUAL FRAMEWORK



APPENDIX 2

TABLE OF HOSPITAL CHARACTERISTICS

Key Features of Study Hospitals

Hospital	Number of Beds	Type	Position in local health care market	DSH patient percentage prior to ACA ¹	Share of total uncompensated care in county prior to ACA ²
Denver Health Medical Center	477	Publicly operated integrated delivery system.	Dominant safety net system in community	67.0	50.8
Froedtert Memorial Lutheran Hospital (Milwaukee, WI)	509	Academic medical center (AMC) affiliated with Medical College of Wisconsin.	Competes with other major health systems in area	31.7	20.3
Harris Health System (Harris County, TX)	855 (3 hospitals)	Publicly operated integrated delivery system	Dominant safety net system		
Homestead Hospital (Southern Miami-Dade County, FL)	142	Part of not-for-profit system, affiliated with Baptist Health South Florida hospital system	Serves southern part of Dade county not easily accessible to major public system (Jackson Memorial)	68.7	6.3
LAC + USC Medical Center (Los Angeles, CA)	600	Integrated delivery system that is part of the LA County Department of Health Services	Part of dominant safety net system in community	84.9	20.6
Lakewood Health System (Staples (Todd County), MN)	25	Independent, not-for-profit Critical Access Hospital in an independent,	Integrated System includes primary, specialty, behavioral health, and long-term care and Level-3 trauma center.	N/A	100
Marcum and Wallace Memorial Hospital (Irvine (Estill County), KY)	25	Critical Access Hospital part of not-for-profit Mercy Health system	community's sole health care facility; limited outpatient and hospital services (e.g., does not offer surgical services)	N/A	100
Regional One Health (Memphis, TN)	325	Not-for-profit system receiving support from the county. Integrated delivery system affiliated with University of Tennessee Health Science Center	Dominant safety net system	75.0	18.3
University of Kentucky HealthCare (Lexington, KY)	945 (3 hospitals)	Academic Medical Center	Dominant health system in community (safety net and otherwise)	48.1	71.3
Yale New Haven Hospital (New Haven, CT)	1,541	Academic Medical Center, primary teaching hospital for Yale School of Medicine	Dominant health system in community (safety net and otherwise)	42.9	72.2

APPENDIX 3

METHODOLOGY OVERVIEW

STUDY METHODOLOGY

A. Site and respondent selection

Key decisions regarding the selection of hospitals as sites for the 2014 case studies included (1) the definition of a site; (2) whether to select the sites randomly or purposively; (3) whether to include sites only in states that expanded Medicaid in 2014 or also include sites in states that did not do so; and (4) whether sites should be restricted to the large public hospital systems or include a diverse group of public hospitals, academic medical centers, and private not-for-profit hospitals that provide an important safety net function.

Definition of a site. “Sites” could be defined either as individual hospitals or entire communities (which would potentially include all safety net hospitals in those communities). The community context (including population characteristics, organization of the health system, and state and local policies) is important for understanding the effect of the ACA on safety net hospitals, although the budget for this project precluded the amount of data collection needed for understanding the effect of health reform on an entire community. Thus, this study defined sites as individual hospitals, although we considered the context of the community when selecting sites and in the analysis, to the extent possible.

Random versus purposive sampling of sites. Consistent with ASPE’s request for proposal (RFP) for this project, the project budget initially covered four to five case study sites for 2014. Although random selection typically has the advantage of greater representativeness and generalizability of the study sites to other safety net hospitals in the U.S., such a small number of sites would fall short of being statistically representative. Random selection of a small number of sites also carries the risk that one or more hospitals would be selected that experienced little or no change (for example, if there was little change in insurance coverage in the population despite an expansion of Medicaid eligibility), thus reducing our ability to comment on how changes in coverage are affecting safety net hospitals. For these reasons, we chose a purposive sampling approach for site selection.

Restricting sites for 2014 discussions to states that expanded Medicaid in 2014. We limited the sample for the 2014 case studies to states that expanded Medicaid in 2014 (at that time, approximately half of the states). Although the research team and ASPE wanted to compare the experiences of hospitals in expansion states with those in non-expansion states, the small number of sites to be included for the 2014 case studies precluded analysis of differences between these two groups. Including one or more hospitals from non-expansion states would also greatly reduce our ability to examine change across a diverse group of hospitals facing the same policy change.

Selection of hospitals in metropolitan areas. We selected four of the six study sites from metropolitan areas. Based in part on input from the TEP convened in 2013 to help plan the project, we restricted our selection of four of the sites to large hospitals or large hospital systems in the top 100 metropolitan areas, since we expected that these hospitals were likely to be experiencing the most change from the ACA. Because many metropolitan areas lack a county-owned or -operated hospital system that typically serves a very strong safety net role by design,

we also included academic medical centers and private hospitals that provided an important safety net function in the sample frame from which we selected the final case study sites.

We started the site selection process with a large universe of hospitals. Using data from the Medicare Cost Reports, we computed the DSH patient percentage and uncompensated care costs for all non-federal short-term general hospitals in the largest 100 counties in states that expanded Medicaid. Within each county, we identified hospitals that provided the largest amount of uncompensated care in the county and also had a high DSH patient percentage ((Medicare SSI Days / Total Medicare Days) + (Medicaid, Non-Medicare Days / Total Patient Days)).

A variety of considerations guided the final selection of the four metropolitan hospitals for study: how much state policy change likely was occurring (based on media reports, previous research, and consultation with outside experts), with more change preferred; diversity by region and type of hospital; and familiarity with various hospitals by project staff at Mathematica and ASPE. Based on the project staff's knowledge of specific hospital executives from other studies, and in consultation with Bruce Siegel, President and Chief Executive Officer (CEO) of America's Essential Hospitals, we also considered the likelihood of hospital executives' willingness to participate and how knowledgeable they would be about the effects of the ACA and health policy in general.

The four metropolitan hospitals selected include the following: LAC+USC Medical Center in Los Angeles, California; Yale-New Haven hospital in New Haven, Connecticut; Denver Health in Denver, Colorado; and University of Kentucky HealthCare in Lexington, Kentucky. California and Connecticut expanded Medicaid before 2014, and thus were likely to be experiencing changes already due to coverage expansions. Denver Health is a large, fully integrated safety net provider in a state active in promoting delivery system reform in its Medicaid program through Regional Care Collaborative Organizations. University of Kentucky HealthCare is the largest safety net hospital in one of the few southern states to expand Medicaid in 2014. Also, the state-run health insurance marketplace in Kentucky (Kynect) reportedly was highly successful in enrolling eligible uninsured people in coverage.

Selection of rural hospitals. The ASPE RFP requested that at least one of the 2014 study sites be in a rural location. Selecting a suitable rural hospital presented special challenges due to the large number and diversity of these hospitals; their small size (for example, CAHs have fewer than 25 beds); and uncertainty as to how willing and able hospital officials would be to participate, and their knowledge of the ACA and health policy in general. For this reason, we consulted with rural health experts at the University of Iowa, University of Minnesota, the National Rural Health Association, and the Health Resources and Services Administration about suitable candidates for rural hospital sites.

We selected Lakewood Health System in Staples, Minnesota. Lakewood is an independent CAH located about 135 miles northwest of Minneapolis and was highly recommended by rural health experts we consulted because of its proactive implementation of a medical home model, innovations in quality, health information technology, and value-based care. These rural health experts also thought that Lakewood's executives would be willing and knowledgeable study participants. Lakewood has a particularly broad set of services for its size, from primary care to long-term nursing care.

The rural health experts also recommended Marcum and Wallace Memorial Hospital in Irvine, Kentucky, a CAH on the western edge of the Appalachian Mountains. This hospital is part of the Mercy Health system and offers a fairly limited scope of services (inpatient and emergency but no surgery, for example). The hospital president had recently won an American Hospital Association Leadership award for rural hospitals. Although the original study objectives called for only a single rural hospital, we decided to include Marcum and Wallace, given its close proximity to the University of Kentucky HealthCare in Lexington, Kentucky, which could be combined into a single site visit at a relatively low additional cost.

Selection of hospitals for the 2015 case studies. ASPE decided to exercise an option in the contract (which coincided with a decision to divert resources from a previously planned quantitative task) to conduct a second round of site visits in 2015. Neither the RFP nor our proposal to ASPE specified whether we would conduct this second round of site visits with the same group of hospitals we spoke with in 2014, or with a new group.

Based on the early findings from the 2014 site visits, ASPE and the research team decided that it would be important to once again conduct semi-structured discussions with the initial set of six study hospitals to determine whether their early experiences with the ACA were continuing or had changed after an entire year had passed.

ASPE project staff also wanted to learn about the experiences of hospitals in states that did not expand Medicaid and hear more about their experiences with payment and delivery system reforms. They expected that hospitals would have valuable information to share about the latter, even if they had experienced little change in utilization and payer mix due to a state's reluctance to expand Medicaid. The budget allowed the addition of four sites for 2015 if we conducted the semi-structured discussions for all 10 sites by telephone. Apart from the new focus on hospitals in states that had not expanded Medicaid, the same considerations that guided the selection of sites in 2014 guided that of the four new sites.

The sites for 2015 were the following: Harris Health System in Harris County (Houston), Texas; Regional One Health in Memphis, Tennessee; Froedtert Hospital in Milwaukee, Wisconsin; and Homestead Hospital in Dade County, Florida. Harris Health and Regional One are large county-operated or -supported safety net systems; Froedtert Hospital is an academic medical center affiliated with the Medical College of Wisconsin; and Homestead Hospital is a private, not-for-profit hospital that is part of Baptist Health South Florida hospital system. Homestead exists in the shadow of a large county-operated system in Dade County (Jackson Memorial Health System) but is located in a part of the county with significant need that is far away from Jackson's main facilities.

Selection of site visit respondents. The RFP and case study plan called for approximately five to eight semi-structured discussions per site in 2014. We spoke with several types of executives at each study hospital to capture the breadth and depth of information needed to investigate the research topic areas, and to triangulate responses to ensure accuracy. The executives typically included the CEO, the Chief Financial Officer (CFO), and the Chief Medical Officer (CMO), but we included other executives, such as emergency department directors and strategy executives, in some cases per the hospital's suggestion. We also spoke with other health care experts in the community to get an outsider's perspective of a safety net hospital and further

triangulate our findings, capture the structure dynamics of the local health care system and state and local health care policy, and understand the broader effect of the ACA on the community. The organizations for which these individuals worked differed to some extent across the six study sites but included the state Medicaid agency, community health centers, local health foundations, and state hospital associations. We held semi-structured discussions with 46 individuals between June and August 2014.

We limited the 2015 semi-structured discussions to the core set of hospital executives. (Based on the 2014 semi-structured discussions, we often targeted a smaller set of executives, as we were familiar with their expertise from the first round or had developed more focused discussion topics.) This decision was driven by budget limitations and because of the new emphasis on hospital quality improvement initiatives and payment and delivery system reforms taking place within a hospital; thus, we deemed the perspective of other community organizations less critical. We held semi-structured discussions with 25 individuals between May and September 2015.

B. Data collection

The 2014 semi-structured discussions focused on changes between the first part of 2013 and first part of 2014 in patient demand and use of services, system capacity, revenues (operating and non-operating), expenses (including uncompensated care), patient and payer mix, and financial performance, and whether these changes were a result of the ACA or other factors. We also discussed the hospital's role in the local safety net; key strategies and goals with respect to the ACA, including quality improvement initiatives, delivery system reforms, and the use of health information technology; and how the mission and role of the hospital was likely to change following implementation of the ACA. We asked about hospital executives' expectations for the future with respect to the ACA, especially the expected effects of the pending reductions in Medicaid DSH payments.

Based on ASPE's key areas of interest, the 2015 semi-structured discussions placed considerably more focus and emphasis on the hospital's experiences with Medicare value-based payment initiatives, such as the hospital readmissions reduction and Hospital Acquired Conditions programs. We also focused on the hospital's experiences and plans regarding alternative payment arrangements that pass more financial risk to the hospital, such as ACOs, bundled payments, or capitation. To provide time in the semi-structured discussions to cover these areas, we scaled back our focus on the general community context/local health care market environment in which the hospital operates.

In both 2014 and 2015, we customized the discussions somewhat to fit the respondent type. For example, the CFO semi-structured discussions focused primarily on changes in hospital utilization, the payer mix and acuity level of patients, revenue and uncompensated care, and hospital financial performance. The CMO semi-structured discussions focused primarily on quality improvement initiatives, experiences with Medicare value-based payment initiatives, and alternative payment models. The CEO semi-structured discussions covered many of these same issues, but focused particularly on their view of the longer-term impacts of the ACA, how it affects the hospital's position in the local health care system, and the hospital's strategy for successfully adapting to it.

Quantitative hospital information. In advance of the semi-structured discussions, the research team collected quantitative information on patient volumes and financial indicators from each study hospital. To capture comparable and current information, the team requested financial and performance data from the first quarters (January through March) of 2013 and 2014. Metrics included the number of inpatient admissions, ED visits and other outpatient visits, as well as patient revenues, other operating and non-operating revenues, operating and other expenses, and net margins. To maintain consistency across all hospitals as to the types and time periods of information collected, we provided each hospital with a template to complete (see Appendix 4). The researchers referred to this information during the hospital discussions to learn about the degree of change across the volume and financial indicators, and the reasons behind these changes or lack of changes.

The 2015 semi-structured discussions also asked for these same metrics. For the six hospitals included in the 2014 semi-structured discussions, we ascertained whether the trends observed between 2013 and 2014 continued into 2015, and the reasons for any change in the trends. For the four new hospitals included in 2015, we obtained information on utilization and finances for the first quarters of 2013, 2014, and 2015.

Conducting the site visits and semi-structured discussions. We conducted the site visits between June and August 2014. Most semi-structured discussions occurred in person over two days, with some conducted by phone for respondents who were not available during the two days on site. The research teams for each site consisted of a senior researcher who led the semi-structured discussions and a research assistant who took verbatim notes on a laptop computer. (To facilitate respondent candor, we did not record the discussions.) Senior researchers included the principal investigators for this project and, in 2014, Emily Carrier, at the time a senior researcher at Mathematica. To facilitate a broad and deep understanding of each site, the same senior researcher and research assistant team conducted all semi-structured discussions for a given site. The discussions typically lasted an hour. At the start of each, we reminded respondents that we would name their hospitals in our final publications, but in our public documents we would not name the individuals we spoke with or attribute specific comments to any particular individual. We also offered to keep confidential any information they shared with us that they did not want included in a public document.

The research assistant cleaned and coded the notes from each discussion. (Coding involved applying a code to each paragraph to indicate which topics the respondent discussed in that paragraph.) The senior researcher reviewed and edited the notes to ensure they were complete and accurate. We organized the notes using Atlas.ti, a qualitative software package, which allows researchers to readily search semi-structured discussions for key topics and generate queries of responses across respondents on a given code.

As noted earlier, we conducted all 2015 semi-structured discussions by phone. The semi-structured discussions for each site took place over a two- to three-week period. The principal investigators conducted all of the 2015 discussions. Otherwise, all of the procedures described here for the 2014 site visits held for the 2015 discussions.

C. Analysis

The research team synthesized and analyzed the qualitative and quantitative information through several steps and iterations. First, we synthesized the semi-structured discussions for each site individually. Following each site visit, we reviewed the discussion notes and supplemental information (for example, media reports, information provided by the study respondents), and wrote a site summary synthesizing the major findings related to the key objectives of the project. These site summaries also identified the three or four major themes that described the effect of the ACA on the hospital. We repeated this process for the 2015 semi-structured discussions; for the original six hospitals, the 2015 summaries essentially updated and replaced the previous 2014 summaries to reflect the more recent semi-structured discussions (see Appendix 5).

Comparing and contrasting key findings across the site summaries allowed us to identify cross-cutting themes. In October 2014, the research team shared with ASPE a preliminary set of five themes (on changes in payer mix, slight shifts from inpatient to outpatient utilization, improving financial positions, concerns about the future, and strategies for the future) that emerged from the 2014 visits and would be candidates for further cross-site analysis and dissemination. Upon deciding to pursue additional sites and semi-structured discussions in 2015, we determined, in collaboration with ASPE, to delay the development of the cross-site products until those semi-structured discussions and site summaries had been completed.

In June 2015, we proposed four potential topics to develop for cross-cutting products. They included the following: the effect of the ACA on the financial performance and viability of safety net hospitals; experiences with quality improvement and care delivery innovations; efforts by safety net hospitals to integrate with primary care and other providers in the community; and how the role of safety net providers is changing as a result of the ACA. Discussions of these topics with ASPE led to the decision to focus only on the first two topics and develop them as research briefs. In collaboration with ASPE, we decided to pursue two cross-cutting analyses that aligned closely with the major research questions for the project: (1) the effect of the ACA on changes in demand for care, payer mix, uncompensated care, and financial performance; and (2) experiences with payment and delivery system reforms. To analyze these topics in depth, the research team organized and analyzed the qualitative and quantitative information in a variety of ways. We analyzed the site summaries, reviewed the coded text from the discussion notes by topic area, and created a table to examine the changes in volumes and finances across the hospitals. We explored possible explanations as to why the safety net hospitals differed in their experiences with the ACA through a review of the text and data, grouped by whether or not the site was in a state that had expanded Medicaid, the type of hospital (county-owned or -operated, academic medical center, private not-for-profit), and the hospital's position in the local health care system.

APPENDIX 4

FINANCIAL TABLE TEMPLATE

ASPE Study of Safety Net Hospitals

Financial Information

Please fill in the boxes (note that some cells have formulas built in to help generate totals and sub-totals)

	Three Months Ended March 31, 2013	Three Months Ended March 31, 2014	Three Months Ended March 31, 2015
A. Total Operating Revenue			
Inpatient revenue (total)			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Outpatient revenue (total)			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Operating revenue from state govt.			
Operating revenue from city/county govt.			
Other operating revenue			
B. Total Non-Operating Revenue			
C. Total Operating Expenses			
Total Uncompensated Care Costs			
Charity care costs			
Bad debt			
Other operating expenses			
D. Total Non-Operating Expenses			
Operating margin			
Total margin	0	0	0

ASPE Study of Safety Net Hospitals

Utilization/ Patient Volume

Please fill in the non-shaded boxes (note that some cells have formulas built in to help generate totals and sub-totals)

	Three Months Ended March 31, 2013	Three Months Ended March 31, 2014	Three Months Ended March 31, 2015
Total Admissions			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Average Length of Stay (Days)			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Deliveries			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Emergency Department Visits			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			
Other Outpatient Visits			
Medicaid			
Medicare			
Commercial insurance			
Self-pay/uninsured			
Other			

APPENDIX 5

10 SITE SUMMARIES

ASPE Safety Net Hospital Study 2015 Site Summary for Denver Health

A. Summary of Denver Health

- Denver Health is described as a vertically integrated delivery system with an acute care hospital with some 500 beds, a level-1 trauma center, 8 federally qualified health centers (FQHCs), and 15 school-based, dental, and other specialty clinics. The system also operates the medical component of the Denver Department of Public Health.
- Denver Health is the main safety net hospital in the city. The University of Colorado Health system provides more specialized tertiary and quaternary services that Denver Health does not provide.

B. Summary of the impact of the Affordable Care Act (ACA)

- As a result of the ACA coverage expansions, Denver Health has seen substantial increases in the number of patients, use (especially outpatient), patient revenues, total and operating margins, and decreases in uninsured patients and uncompensated care.
- The expansions in coverage and use have permitted expansions in capacity, including hiring new staff, expanding certain service lines (for example, behavioral health, dental), and building new facilities.
- Denver Health has performed relatively well under the Centers for Medicare & Medicaid Services (CMS) value-based purchasing (VBP) initiatives, which the health center attributes to a relatively low number of Medicare fee-for-service patients, and an integrated delivery system that stresses strong coordination between inpatient and primary care, and other services. The Center for Medicare and Medicaid Innovation (CMMI) award has been helpful with this.
- Denver Health has no plans to start or join an ACO or bundled payment initiative. Instead, they are focusing on full capitation in which they will be at full-risk for the cost of care to their patients.

C. Changes in demand (Q1 2013 to Q1 2015)

- Outpatient visits have increased 10 to 12 percent since 2013, and inpatient visits have increased about 4 percent since then. Most of this increase reflects increased demand among Medicaid patients.
- Increased demand among Medicaid patients reflects new users as well as those who were previously uninsured who enrolled in Medicaid. There was an increase of 27,000 new patients in 2014 compared to 2013 (a 14 percent increase between 2013 and 2014), most of whom were Medicaid patients. The number of uninsured patients has decreased commensurately.
- Service use related to behavioral health care has increased disproportionately. This reflects a change in state Medicaid reimbursement policy, which allows providers to bill for behavioral health and medical visits on the same day.

- As of March 2015, Denver Health had 22,000 uninsured patients. Of this number, about 8,000 were estimated to be eligible for Medicaid; 1,000–2,000 were estimated to be eligible for the health insurance exchanges; and 9,500 were undocumented immigrants. The principal reason Medicaid-eligible patients are not signed up for the program is that they do not follow through with the screening and enrollment process.
- Take-up of private insurance through the health insurance marketplaces has been slower than expected among Denver Health patients, but respondents believe it is now beginning to accelerate due to efforts to improve patient experience, customer satisfaction, marketing, and partnering with insurance companies.

D. Changes in capacity

- Denver Health started ramping up for the ACA in 2013. They have focused especially on expanding primary care and other specialty areas, such as behavioral health. They have added physicians, advanced care nurse practitioners, psychiatric staff, social workers, optometrists, and dental staff. (Colorado Medicaid began covering dental care in July, 2014.) In 2016, Denver Health will open a new outpatient clinic.

E. Changes in finances

- Overall, inpatient revenues increased 8 percent between the first quarter of 2013 and 2015, while outpatient revenues increased 22 percent. Most increased patient revenue is attributed to Medicaid.
- Consistent with the decrease in uninsured patients, self-pay revenue has decreased by more than half since 2013, while charity care costs have decreased by 75 percent.
- In terms of payer mix, Medicaid now comprises more than half of patient revenue (up from 35.8 percent in 2013), while self-pay revenue comprises 11.5 percent of revenue (down from 27.4 percent in 2013).
- Revenue from commercial payers has also increased for outpatient care, although the share of revenue from commercial insurance has not changed significantly (about 16 percent).
- Colorado has a provider fee used to fund Medicaid Disproportionate Share Hospital (DSH) and higher Medicaid reimbursement through the upper payment limit. This helps subsidize care to the uninsured and allows Denver Health to receive close to 100 percent of Medicaid costs. Revenue related to the provider fee has been increasing in the past few years, although there is expectation that Medicaid DSH payments will begin to decrease in 2016 because of decreases in uninsured patients (followed by additional ACA-related cuts that have been delayed to 2018).
- Financial performance has improved markedly since 2013, when the health system was incurring losses and laying off staff. Operating margins improved from -1.5 percent in the first quarter of 2013 to 3.4 percent in the first quarter of 2015. The improvement was attributed mostly to the ACA coverage expansions.

F. Experience with Medicare VBP

- Denver Health has relatively few Medicare fee-for-service patients, so the impact of VBP on the health system has not been great. The financial impact has been about \$400,000 annually (out of total operating revenues of about \$900 million in 2014).
- Nevertheless, Denver Health has performed relatively well on VBP quality indicators for a safety net hospital. They were only slightly above average for hospital readmissions and incurred only a small penalty. Respondents attribute the relatively good performance on readmissions to the fact that Denver Health is an integrated delivery system, which includes primary care physicians, FQHCs, school-based clinics, and Denver’s Department of Public Health. They are able to achieve a seamless flow of patients from the inpatient to outpatient setting, good communication between inpatient and primary care providers, and a single health information system. Respondents also attribute relatively low readmissions to programs initiated with their \$19 million CMMI award. Initiatives with this award focused on better management of high-utilizing patients, funded patient navigators, medication management, and integration of behavioral health into primary care settings.
- Denver Health was not penalized under the hospital-acquired conditions (HAC) reduction program in 2014. Although they did not identify any new programs as responsible for helping to keep HAC rates low, they have emphasized that preventing falls as well as controlling central and associated blood stream infections and surgical site infections as key factors in reducing HAC.
- Patient satisfaction scores have not been good in the past, but they have improved in the past year. Respondents cited improved access to care (due to hiring of more staff) and shorter waiting times as the main reasons for the improvement. Also, Denver Health has contracted with the Studer group to redesign their approach to patient interactions. (The Studer group has worked with about 900 hospitals in the country on this issue and reportedly has shown good results.) This program just started, so it is too early to assess results.
- Respondents mentioned some difficulty with CMS core measures based on chart review, which they attributed to errors in documentation because their information systems are not yet fully electronic. They expect this to improve with a new electronic health records system coming online in 2016.
- Respondents believe that having an integrated network of care and a single medical record for every patient is crucial to being able to perform well under VBP. An emphasis on population health, and being able to keep track of and contact patients when they are not in the health system is also crucial. Being able to understand and analyze the data they have acquired is also important.
- Among the challenges of VBP, respondents expressed some frustration with the “explosion” of quality metrics, and the frequency with which the measures change. They also report that different reporting requirements between CMS and the Joint Commission take up considerable staff time and resources. Respondents also believe that socioeconomic status adjustments for safety net hospitals are required because of the unique needs of their patients. One area that Denver Health struggles with is getting patients into post-acute care, such as assisted living facilities and skilled nursing facilities, along with being able to discharge patients with serious mental illness to a safe level of care.

G. Experiences with alternative payment arrangements

- Denver Health does not participate in an ACO or bundled payment arrangements, and has no plans to do so. But they are participating in full-risk capitation, primarily through their Medicaid managed care plan, Medicaid Choice, which has 67,000 enrollees. Along with commercially insured and Medicare patients, they estimate that 40 percent of their patients are in fully capitated health plans in which the health system is at full risk—and they would like to greatly expand that in the future. Because of their integrated care model, Denver Health believes they do well under full capitation and are ahead of the curve with respect to ACOs and other models.
- To this end, Denver Health is implementing a care management program that is combining social workers and use management so that a single case manager is working with patients on all of their care transitions.

H. Participation in CMMI projects

- As mentioned above, Denver Health received a \$19 million award from CMMI to fund its 21st Century Care program, which includes a heavy emphasis on team-based care, care coordination, integration of physical and behavioral health, and focusing on high-utilizing patients. The grant ends this year (2015), but Denver Health is planning to continue with much of the program (paid for through hospital operating costs) because they believe the programs have great value and are self-sustaining.

I. Expectations for the future

- Denver Health expects to see an increase in patients enrolled through the Marketplaces, which is key to their strategy of diversifying their payer mix and changing their safety net hospital image. However, they believe the state's indigent care program, funded through Medicaid DSH, discourages some people from enrolling in Marketplace plans because they can essentially receive free care at Denver Health while uninsured. At the same time, cutting or ending the indigent care program (of which there has been some discussion in the state) will also negatively impact the health system.
- Reductions in Medicaid DSH are a concern, not just the reductions related to the ACA that have been delayed to 2018, but reductions based on their decreasing number of uninsured patients. Denver Health is skeptical that increases in Medicaid patients—which they are compensated for close to cost because of the provider fee and upper payment limit—will fully offset the decrease in DSH funds used to pay for care for the uninsured.

ASPE Safety Net Hospital Study

2015 Site Summary for Froedtert Hospital

A. Overview of Froedtert Hospital

- Froedtert Hospital is an academic medical center affiliated with the Medical College of Wisconsin. Located in downtown Milwaukee, Froedtert is the flagship campus for this health system, which also includes two other hospitals (St. Joseph and Community Memorial), located in suburban areas. The health system also operates 25 specialty care and primary care clinics throughout the Milwaukee metropolitan area.
- Froedtert is a safety net hospital, primarily by virtue of its size. It provides about 20 percent of all hospital uncompensated care in the county, although the proportion of uninsured and Medicaid patients at the hospital is not as high as some other, smaller hospitals in the community. A county-owned hospital that served as the main safety net hospital for the county closed in 1995.
- Froedtert views itself as the premier hospital system in the area that also provides a safety net function, rather than viewing care for low-income people as its primary mission. Froedtert is a strong competitor of the other major hospital systems in the Milwaukee area, such as the Aurora health system and Columbia St. Mary's (part of Ascension Health).
- Froedtert is a tertiary and quaternary care provider in the Integrated Health Network of Wisconsin (IHNW), a "super-ACO" comprising eight health systems throughout Wisconsin.

B. Summary of the impact of the Affordable Care Act

- Wisconsin did not expand Medicaid coverage as part of the ACA coverage expansions of 2014. In 2014, however, the state expanded its BadgerCare program (a Medicaid expansion from the late 1990s to cover uninsured children and families) by removing a cap on enrollment for adults with family incomes up to the federal poverty line.
- As a result of the BadgerCare expansion, Froedtert experienced changes in utilization and finances similar to those in hospitals in Medicaid expansion states. Medicaid volumes and revenue increased, whereas uninsured volumes and uncompensated care decreased.

C. Changes in demand (Q1 2013 to Q1 2015)

- Froedtert's overall patient volumes increased modestly, including 5 percent for inpatient admissions, 3.3 percent for ED visits, and 2.7 percent for outpatient visits. The increase in inpatient admissions occurred despite the implementation of Medicare's "two-midnight" rule, which resulted in more encounters being classified as outpatient rather than inpatient.
- Despite Wisconsin not expanding Medicaid through the ACA, it changed its BadgerCare program to allow more adults to enroll. The state removed the enrollment caps for adults with incomes of less than 100 percent of poverty, which had resulted in a long waiting list, especially in the Milwaukee area. As a result, Medicaid admissions increased by 21 percent, Medicaid ED visits by 39 percent, and Medicaid outpatient visits by 13 percent. Utilization

by self-pay/uninsured patients declined commensurately, reflecting the fact that many of these patients gained coverage through BadgerCare.

- As a result, Froedtert's patient mix also shifted. The share of admissions comprising Medicaid patients increased from 17.5 percent to 20.2 percent, whereas the share of ED visits comprising Medicaid patients increased from 29.8 percent to 40.1 percent.
- Despite some previous types of inpatient stays now being classified as observation stays (which tends to increase the length of inpatient stays because those remaining classified as inpatients are sicker), Froedtert's average length of stay actually decreased by about 5 percent. Hospital executives mostly attributed this to a concerted effort at better discharge planning and "multidisciplinary rounding" since 2014 (explained more in the Medicare value-based purchasing (VBP) section below).

D. Changes in capacity

- One of Froedtert's main strategies over the last few years has been to expand access points in the community for both new and existing patients. It opened new clinics for primary and specialty care in suburban Milwaukee (Oak Creek and New Berlin), implemented "virtual urgent care" through FaceTime and Skype phone calls, and is considering partnerships with grocery stores and pharmacies to establish retail clinics.
- Froedtert donated \$12 million to a local FQHC to open a new site, both to increase access to care in the community and generate referrals for the hospital.
- The hospital opened a new Center for Advanced Care in 2015, which will increase capacity for outpatient and inpatient care, including a vascular and transplant center.
- Froedtert also purchased an interest in an insurance plan (Network Health), which hospital executives expect will help the hospital transition to a VBP system and allow them to contract directly with employers.

E. Changes in finances (Q1 2013 to Q1 2015)

- Froedtert's total patient service revenue increased 32 percent between Q1 2013 and Q1 2015. This increase includes a 13 percent increase in inpatient revenue and a 38 percent increase in outpatient revenue (reflecting expansions in outpatient capacity).
- Medicaid inpatient revenue increased 77 percent, but Medicaid outpatient revenue was stable (likely because the outpatient capacity expansions occurred in suburban areas where fewer Medicaid patients live). As a result, the hospital's percentage of inpatient revenue from Medicaid increased from 9 to 14 percent, whereas its percentage of outpatient revenue from Medicaid decreased from 8 to 6 percent.
- According to a hospital executive, the hospital's revenue growth is driven primarily by increases in volume and, to some extent, higher patient acuity.
- Froedtert's uncompensated care costs declined 60 percent, reflecting the shift of many uninsured patients to the BadgerCare program.
- The hospital's operating margins increased from 8.4 percent in Q1 2013 to 15.3 percent in Q1 2015. However, a hospital executive expects revenues to decrease in the future (despite

higher volumes) due to decreased support from Medicaid DSH payments and the move away from fee-for-service payments in Medicare and commercial insurance.

F. Experience with Medicare VBP

- Froedtert’s quality-of-care measures as reported on Hospital Compare are generally similar to or better than state and national averages. One problem area for the hospital has been readmissions for hip/joint replacements, although the hospital’s executives believe this issue has been resolved and subsequent years will show improvement.
- The hospital also has patient satisfaction scores comparable to state and national averages; Froedtert received four out of five stars on the new star rating system. To help its scores in this area, Froedtert hired the Studer Group (a health care consulting/training organization) to provide coaching and tutoring for providers.
- Despite average performance, Froedtert executives see the hospital as at a disadvantage for Medicare VBP because, as an academic medical center, it has higher risk scores than other hospitals. They also cite a large indigent patient population as a disadvantage and suggest the need for some type of socioeconomic risk adjustment.
- Froedtert executives credit Wisconsin’s statewide health information exchange with supporting quality improvement efforts. The exchange allows the hospital to view data on service utilization at other health care providers in the state.
- A major quality improvement effort for Froedtert has been to improve discharge planning to reduce the length of stays. The hospital is using “multidisciplinary rounding,” which involves a team of different medical providers visiting the patient at the same time rather than different providers seeing the patient at different times during the day, thereby improving communication and coordination among the providers. Froedtert attributes its decrease in length of stay between 2014 and 2015 to this initiative.

G. Experiences with alternative payment models (APMs)

- Froedtert Hospital is part of the IHNW, a “super ACO” that began in 2010 and comprises eight largely hospital-based systems—including 45 hospitals and 5,700 providers throughout the state.
- From Froedtert’s perspective, the goal of IHNW is to “help us to move in the right direction so that when Wisconsin converts to value-based care we have a system set up for rationalization and have enough volume for all the systems to survive the change.” (Reportedly, providers in Wisconsin still largely receive fee-for-service payments.) The vision is of a horizontally integrated system with uniform care and quality improvement processes that can be marketed to insurance companies.
- IHNW has shared-savings contracts with Humana and United Healthcare. The organization would like to expand such contracts to other plans and Medicare, but currently does not plan to include Medicaid enrollees. Nevertheless, Froedtert executives stress that all patients will benefit from the quality improvement processes they implement as part of the IHNW.

- Executives report that care quality has improved since Froedtert joined IHNW, with key examples including improvements in colonoscopy screening and pneumococcal vaccination rates. However, they have yet to see any impact on costs.

H. Expectations for the future

- As exemplified by its participation in the IHNW, Froedtert is pursuing a long-term strategy to position itself to perform under VBP and other APMs for Medicare and commercially insured patients. This strategy is partially in response to what hospital executives perceive will be tighter revenue due both to the shift away from fee-for-service and decreasing Medicaid payments (DSH).
- Froedtert appears to be using a two-track approach to prepare for VBP and APMs: the IHNW for commercially insured and Medicare patients, and affiliations with local FQHCs for Medicaid and uninsured patients. Froedtert's increase in inpatient, but stable outpatient Medicaid revenues likely reflects the fact that (1) the majority of the hospital's Medicaid patients either are referred by FQHCs or come through the ED, and (2) Froedtert has expanded outpatient capacity in suburban areas rather than in parts of the city where many Medicaid patients live.

ASPE Safety Net Hospital Study 2015 Site Summary for Harris Health System

A. Summary of Harris Health System

- Harris Health System is the primary safety net provider for Harris County, Texas, which includes the city of Houston. It comprises three hospitals (Ben Taub, LBJ, and Quenyin Mease) that include a total of 855 licensed beds. The system also includes 21 primary care clinics, school-based clinics, dental clinics, mobile vans, and other services. It is affiliated with two medical schools—Baylor College of Medicine and University of Texas Health—that supply most of the medical staff.
- The county provides about \$600 million in tax support annually to Harris Health, accounting for 47 percent of its operating revenue. The vast majority of patients (85 percent) are either Medicaid or uninsured patients. Respondents believe that about one-third of the uninsured are undocumented immigrants.

B. Summary of the impact of the Affordable Care Act

- Given that the state of Texas has not expanded Medicaid, the Affordable Care Act has not significantly affected Harris Health.
- In anticipation of Medicaid expansion, which never materialized, Harris Health experienced decreases in Medicaid disproportionate share hospital payments and county tax support. At the same time, uncompensated care and other costs have increased, resulting in substantial financial losses for the system and potentially leading to service cuts.
- The Delivery System Reform Incentive Payment (DSRIP) program allowed Harris Health to expand its primary care capacity, which contributed to increased patient volume. With the expectation that Medicaid would be expanded, the system is now experiencing difficulty in meeting the increased demand for specialty services generated by an increasing volume of primary care visits (i.e., which lead to more referrals for specialty care).
- The large uninsured and Medicaid population and relatively small number of Medicare patients mean that Harris Health has limited exposure to penalties related to Medicare Value-Based Purchasing Initiatives or opportunities to participate in alternative payment methods, although respondents believe that, as an integrated health care system, Harris Health is in a favorable position to perform well under these payment and delivery system reforms.

C. Changes in demand (Q1 2013 to Q1 2015)

- Despite the state's failure to expand Medicaid, volume at Harris Health has increased since Q1 2013 by 12 percent in inpatient stays and outpatient visits and by 5 percent in emergency room visits.
- Respondents attribute the increase to internal decisions to expand capacity (see below), initiatives under the DSRIP program to increase access to care, and Harris County's general population growth (an increase of about 80,000 persons per year).

- The number of commercially insured patients has been historically low (e.g., 2 percent of inpatient stays in 2013) but is responsible for the greatest increase in patient load (66 percent increase in inpatient stays), which, according to respondents, is the result of enrollment in the new insurance marketplaces.
- Nevertheless, respondents believe that marketplace enrollment has not been as great as it could be because of Harris Health’s generous eligibility requirements for charity care (200 percent of poverty or lower); in fact, Harris Health is considering a reduction of the eligibility requirement to 100 percent of poverty in order to encourage more enrollment in the marketplaces.

D. Changes in capacity

- Harris Health has been expanding capacity for the past 10 years or so with the goal of increasing access to care in the community. Between 2007 and 2014, Harris Health built two new “mega” clinics capable of handling 100,000 primary care visits per year.
- Harris Health has also used the DSRIP program awarded to Texas to expand capacity, including the addition of nine clinics that the health system leases. However, the health system may lose the increased capacity if the program is not renewed in 2016.
- Respondents mentioned that, without Medicaid expansion, they are unable to meet the increased demand for specialty care generated by the increase in primary care capacity and volume. Waiting times for primary care have decreased, but they have increased for specialty care.
- Given the system’s financial problems, Harris Health recently had to lay off 239 employees and reduce the outsourcing of some services to other providers by about \$7 million.

E. Changes in finances (Q1 2013 to Q1 2015)

- Over the past several years, Harris Health has been experiencing financial losses—\$24 million in 2013, \$17 million in 2014, and an expected \$14 million in 2015. The system will need to cut costs if it is to remain financially viable. Even after reducing staff, the system has few options to cut more “fat” and instead is looking to cut back or limit services in the future to cope with the financial problems. In fact, the system proposes a reduction in the eligibility for charity care from 200 percent of poverty to 100 percent of poverty in order to encourage patients to sign up for the health insurance exchanges.
- Uncompensated care has been increasing (12 percent in the past two years) while Medicaid DSH payments have been decreasing (13 percent). The increase in uncompensated care is attributable to the general increase in volume, and reductions in Medicaid DSH funding reflect decreases in the statewide pool that were negotiated as part of the Section 1115 waiver that also implemented the DSRIP. The reductions in DSH anticipated Texas’s expansion of Medicaid (before the Supreme Court ruling made expansion an option).
- Further compounding the system’s financial problems was a decrease in support from the county beginning in 2011 (also in expectation of Medicaid expansion), resulting in a revenue loss of \$75 million.

F. Experience with Medicare Value-Based Purchasing

- CMS's programs have had only a small impact on Harris Health because Medicare represents only about 9 percent of Harris Health patients.
- Nevertheless, Harris Health has performed fairly well, with readmission rates and hospital-acquired infection rates comparable to state averages. The system faced only a small penalty associated with readmissions and no penalty associated with hospital-acquired conditions (HAC). It expects HAC rates to increase along with an associated penalty, although the reason at this point is not clear.
- Respondents cite the advantage of Harris Health as an integrated system that is committed to clinical coordination and case management for discharged patients. Efforts include telephone calls within 48 hours after discharge, scheduling follow-up appointments with primary care providers within 7 to 10 days of discharge, and managing "super utilizers." Under a DSRIP initiative (called Chronic Care/House Call), physicians and their teams visit patients at home in cases of transportation or health barriers. Better utilization management and review has reduced inpatients' lengths of stay.
- The one problem area is low patient satisfaction scores, which, according to respondents, are attributable to resource constraints. Respondents believe that assigning four patients to a room causes significant problems, particularly as related to noise and crowding. Satisfaction scores are much better when only two patients occupy a room. As a result, the system has undertaken a major initiative to increase semiprivate rooms throughout Harris Health.
- Respondents view strong care coordination and discharge planning and follow-up as crucial to performing well under value-based purchasing. In this respect, they believe that Harris Health has an advantage, but they also cite resource constraints as barriers to expanding care coordination/case management efforts. Lack of good data in understanding the system's patient population is another a barrier to improving quality-of-care measures.

G. Experiences with alternative payment arrangements (APM)

- Harris Health does not participate directly in any ACOs or bundled payments despite some interest in doing so. Respondents mention the poor payer mix (e.g., 64 percent uninsured and 22 percent Medicaid) as a major barrier. In addition, Harris Health is not allowed by law to accept capitation, although the Medicaid managed care plan (Community Health Choice) operated by the system is able to accept capitation.
- Harris Health is participating indirectly in an ACO through the faculty of the Baylor College of Medicine, which, along with University of Texas Health, provides staff for Harris Health facilities. Baylor is participating in an ACO with St. Luke's Hospital in Houston, although without realizing that some Harris Health patients would be attributed to Baylor physicians. Baylor is trying to limit its ACO exposure to Harris Health's uninsured patients by creating two tax IDs: one for the public hospital it serves and another for its private side.
- Other than poor payer mix, respondents believe that Harris Health can build on several advantages that would allow it to perform well with APMs. First, it is an integrated system that encompasses the entire continuum of care, including clinics that have earned NCQA certification as patient-centered medical homes. Second, Harris operates a standardized

electronic health record throughout its system (Epic) and has learned how to operate efficiently and on lean budgets. Third, it also believes that its Medicaid managed care plan (which can accept capitation) offers potential opportunities for bundled payments or other APMs.

- In addition to citing poor payer mix and legal limits on compensation methods, respondents mention difficulty in determining the true cost of services as a barrier to participating in APMs. Further, the existing agreements with the two medical schools that staff Harris's facilities do not allow for incentives to reduce costs. Harris Health pays them on a salary basis with a small "production incentive," with no quality or performance incentives in the contract.

H. Expectations

- The greatest concern by far is that, without Medicaid expansion, Harris Health will continue to be financially strained, leading to cuts in services and reduced access to care in the community.
- In addition to the cuts in county support and Medicaid DSH, respondents are bracing for the ACA-related cuts in Medicaid DSH beginning in 2018.
- Respondents are unsure about the renewal of DSRIP in 2016. Nonrenewal likely means that the nine primary care clinics leased with DSRIP funding will cease operation.

ASPE Safety Net Hospital Study

2015 Site Summary for Homestead Hospital

A. Summary of Homestead Hospital

- Homestead Hospital is a 142-bed hospital in the not-for-profit Baptist Health South Florida hospital system. Homestead is the only hospital within a 20-mile radius in southern Miami-Dade County. The hospital was rebuilt in 2007 and focuses on inpatient medical, emergency, obstetrical, and diagnostic services. It provides little other outpatient care or surgeries and no post-acute or long-term care. Homestead Hospital, which is located in a low-income area, is part of a system that has a religious mission to serve the poor. Consequently, the majority of its patients are low-income.
- Respondents consider Homestead a de facto safety-net hospital because hospital receives little public funding to support its safety-net role. Instead, the large county health system, Jackson Health System, is the main safety-net hospital and receives dedicated local sales tax revenues and significant state and federal funds. Jackson's main campus is in downtown Miami, but has a small hospital, Jackson South, in suburban Miami, the hospital closest to Homestead.
- Respondents reported a significant lack of primary care in Homestead's service area. Reportedly, it is economically difficult for physicians to survive in private practice here because there are few commercially insured patients. A federally qualified health center (FQHC) and three Baptist-operated community clinics serve the low-income population. Homestead has not traditionally provided primary care services, but has recently started a clinic in response to the population's greater reliance on its emergency department (ED) for non-emergency care. Approximately two-thirds of Homestead's ED visits are for low-acuity conditions.

B. Summary of the impact of the ACA

- The ACA has had minimal impact on Homestead Hospital, primarily because Florida has opted out of the Medicaid expansion. Homestead has many patients with incomes under 138 percent of poverty and would qualify for Medicaid, and many earn under the poverty level so are ineligible for subsidies in the marketplace and remain uninsured. Although the hospital receives little dedicated safety net funding, it is concerned about potential reductions in its payments from the state's Low Income Pool, as Florida's governor renegotiates this program with the Centers for Medicare & Medicaid Services (CMS).
- The hospital has also struggled with patients who have gained coverage through the federal marketplace. They report that a number of patients cannot afford the cost-sharing requirements. And they have found that some patients are incurring bad debt or not using their insurance and opting for the hospital's sliding fee scale; that is, effectively acting as uninsured patients. Also, the hospital reports challenges with some of their patients continuing to present in their ED for care, even if they now have an assigned primary care medical home provider elsewhere and/or Homestead is not in their health plan's network for hospital care.

- Homestead performs well on quality indicators and has enjoyed bonuses from most of the federal value-based payment (VBP) programs, although they do not represent a significant amount of revenue to the hospital, which has relatively low numbers of Medicare patients. Through its parent organization, Baptist Health, Homestead has entered an alternative payment model through an accountable care organization (ACO) arrangement for cancer care.

C. Changes in demand (Q1 2013 – Q1 2015)

- Homestead has experienced little change in the volume of services it has provided over the past two years, which respondents attribute to the lack of a Medicaid expansion and little take-up of marketplace coverage. The hospital reports that over half of their patients have incomes less than 200 percent of poverty and many of those earn less than 100 percent of federal poverty so do not qualify for subsidies in the marketplace plans.
- Homestead actually experienced a decline in Medicaid volume over the last two years, which respondents attribute to the state's 2014 expansion of Medicaid managed care to virtually all Medicaid enrollees. Because Homestead participates in only 3 of the 10 Medicaid managed care plans in its region, the hospital lost some Medicaid volume. Between Q1 2014 and Q1 2015, total Medicaid admissions declined almost 6 percent and overall outpatient visits (ED, diagnostics and therapeutic services) fell 8 percent.
- Respondents have somewhat different explanations for Homestead's lack of managed care contracts, with some stating that the health plans are losing money so they have renegotiated contracts and narrowed their provider networks, choosing in many cases to exclude Homestead. Another respondent thought it was more Baptist's decision—that contracting decisions are made at the system level with all products (commercial, Medicaid, and such) of a given carrier in a single contract. As a result, these decisions affect each of the individual hospitals in the system differently, depending on their payer mix.
- ED visits increased 7 percent between FY2013 and FY2014²⁷ and the hospital expects a 3 percent increase this year. ED visits have been rising gradually since 2007 when the hospital was rebuilt, with a larger ED, and relocated. With approximately 90,000 visits this past year, the ED has significantly exceeded its planned capacity of 50,000 annual visits. Respondents had not expected the recent spike in ED visits and reported that much of the increase is related to a lack of primary care in the community and issues with insurance contracts:
 - Some Medicaid and marketplace enrollees seek care in Homestead's ED even though Homestead is not their primary care medical home or possibly not in their covered provider network at all. In a study of high ED users, Homestead discovered most of these patients had Medicaid or other insurance, but they had never seen their designated primary care physician (PCP). Some even provided the name of a Homestead ED physician when asked who their PCP is. The hospital then has to refer these patients to a contracted provider for ongoing care.

²⁷ Note: much of the information the hospital provided on patient volumes and finances was not in the categories we requested and difficult to interpret, so we relied heavily on information respondents provided in the semi-structured discussions and follow-up emails.

- Respondents also detected patients coming to the ED who at that time had marketplace coverage, but could not afford the cost sharing so instead use the sliding fee scale at Homestead.
- The Baptist primary care clinics in the area are overwhelmed and uninsured patients face high copayments at the local FQHC (reportedly typically \$25 per visit), whereas Homestead does not charge a copayment. Homestead tried to create a voucher program in which they wanted to devote the \$200,000 per year Baptist had been donating to help support the FQHC's general operations to instead help patients pay the out-of-pocket costs of seeking care there, but, reportedly, the FQHC lost interest in this arrangement.

D. Changes in capacity

- In response to rising ED volumes, Homestead recently started venturing into primary care by creating a new clinic near the hospital called Baptist Health Follow-Up Care, which handles post-discharge medical, pharmaceutical, and social needs for patients in comprehensive 45-minute visits. These patients are then linked to a more permanent primary care medical home in the community. Clinic staff also refer uninsured patients to a community organization, Catalyst Miami, to determine their eligibility for coverage.
- The Baptist system is providing funds to expand physical capacity and programs to help provide more primary care and address the issues identified in a recent community needs assessment that Baptist conducted as required by the ACA. That assessment identified access to primary care and chronic disease prevention and management are areas for the whole Baptist system to focus on, with Homestead needing to focus specifically on maternal and child health and socioeconomic issues. New programs will include promoting breastfeeding through lactation consultants and creating an OB/GYN hospitalist program so there is an OB/GYN specialist on duty at all times).

E. Changes in finances (Q1 2013 – Q1 2015)

- Homestead's 2015 payer mix is roughly a third each Medicaid and commercial, Medicare in the high teens, and uninsured in the low teens. The hospital had hoped to attract more commercially insured patients when it rebuilt its facility because there was a lot of residential development going on at the time, but then the housing bust and recession followed and the area did not develop as many had anticipated. Payer mix has not changed much in the past two years.
- New marketplace coverage represents only 1.7 percent of Homestead's overall business and has not boosted hospital revenues. Homestead also found that many of its marketplace patients were not newly insured, but rather switched from other commercial coverage to the subsidized marketplace plans. And the hospital's reimbursement from the marketplace plans is lower than other commercial coverage. The hospital receives reimbursement for the out-of-network care provided to the marketplace and Medicaid patients in its ED, but does not have the opportunity to get the revenue from any needed admissions or follow up care because those patients would be transferred to another hospital. Respondents report some increase in uncompensated care expense due to patients with marketplace plans who cannot afford to pay their cost sharing and incur bad debt.

- The Florida Low Income Pool (LIP) is a sizable source of federal/state funding to help with Homestead's costs of caring for the uninsured. Respondents are relieved that the state legislature finally approved a budget that keeps its LIP funds intact for now at approximately \$400,000 annually in the form of enhanced Medicaid payments. CMS and the governor of Florida have been embroiled in a debate about these funds because the federal government has plans to pare them back over the next few years, which the governor contends is an effort to coerce the state into expanding Medicaid under the ACA.
- Homestead receives a very small amount of disproportionate share hospital (DSH) funds annually: approximately \$6,000 this year. Respondents think they should be eligible for more DSH and LIP funds because they reportedly provide more charity care as a percentage of total revenues than Jackson Health System provides.
- Homestead generally operates at a financial loss, which has not changed over the past two years. Baptist subsidizes Homestead from the positive margins its other hospitals generate. And, because these hospitals are larger and located in higher-income areas, they attract more commercially insured patients.

F. Experience with VBP programs

- Homestead performed better than average on VBP indicators. As one respondent said, "We can't do well financially because of our demographics, so we try to do well on quality." While Medicare is a relatively small portion of the hospital's business, it did earn a \$45,000 bonus this past year. Patient experience/satisfaction scores were particularly strong.
- Respondents attributed the strong performance to good nursing and medical staff, as well as case managers who not only work with patients but also conduct chart documentation and review. The hospital has hardwired as much of the reporting requirements as possible into its electronic health records.
- Homestead incurred a slight penalty based on high diabetes and heart failure readmission rates. Respondents think the lack of primary care in the community contributes to high readmission rates and thinks the new clinic, and the addition of a certified diabetes educator there, will turn this around next year. They cited a best practice of getting patients an appointment with their PCP within 48 hours of discharge, which takes a heavy lift by their social workers to achieve.
- Respondents are concerned that Homestead will struggle with the new throughput measure because of their high ED volumes/crowding.

G. Experience with alternative payment models

- A few years ago, Homestead partnered with Florida Blue, a commercial Blue Cross Blue Shield health plan, to create one of the first disease-specific ACOs. The health plan wanted to reduce the high costs of caring for cancer patients by identifying best practices for care management. The effort resulted in reduced ED visits and imaging in the patient population as well as ensuring that ED visits made were necessary. Respondents think that trusted relationships, very forward thinkers and data sharing were vital to the success of this ACO. Also, walk-in appointment availability at the oncology physician group in the ACO reduced demand on the ED. Respondents considered this a great success from the utilization

standpoint, but Homestead itself assumed little financial risk. The hospital will replicate the program and take on more financial risk with AvMed, another plan.

- As a way of improving quality of care and encouraging efficiencies to reduce costs, Homestead started an integrated network of physicians to reduce variation in how physicians treat patients. The hospital plans to have physicians share in savings.

H. Participation in CMMI demonstration projects

- Homestead does not participate in any CMMI demonstration projects.

I. Expectations for the future

- Respondents do not expect significant changes in Homestead's patient volume or financial status over the next year, unless they lose LIP funds, which depends on the outcome of negotiations between the state and the federal government. Even if these payments continue, respondents indicated the state may require a hospital to contract with at least half of the Medicaid HMOs to qualify for payments.
- Homestead is looking into pursuing FQHC look-alike status for its new primary care clinic to help both the hospital's finances, through enhanced Medicaid payments, and patient access, through low copayments, which are about \$3. They think the health plans might be more likely to contract with them if have this primary care structure in place, so patients could select Homestead as a medical home.
- Respondents were not aware of the essential community-provider designation and whether it could help them gain inclusion in more marketplace plan provider networks.
- As part of their strategic planning, Homestead is analyzing their outreach and enrollment strategies for marketplace coverage so they can make any improvements for the next open enrollment period. However, they are conflicted about encouraging patients to sign up because they know many cannot afford the premiums, which are expected to increase, and cost-sharing requirements.
- In response, the hospital is looking for a way to provide patients financial assistance with their out-of-pocket costs. The hospital has received conflicting guidance from different branches of HHS about whether hospitals are allowed to do this, and respondents were awaiting the US Supreme Court's decision the constitutionality of providing insurance subsidies through the federal marketplace (*King v. Burwell*) before pursuing the venture further.

ASPE Safety Net Hospital Study 2015 Site Summary for LAC+USC

A. Summary of LAC+USC

- LAC+USC remains the flagship acute care hospital of the four-hospital system owned and operated by the Los Angeles County Department of Health Services. Under the Affordable Care Act (ACA), this 600-bed, level-1 trauma center continues its role as the main safety net hospital for Medicaid and uninsured patients in the county. The governance and operations of the health department and LAC+USC are intertwined as an integrated delivery system, which also includes 17 primary care clinics and an array of specialty care providers.

B. Summary of the impact of the ACA

- The Medicaid expansion in the ACA has had a positive financial impact on LAC+USC to date, mostly related to existing uninsured patients gaining Medicaid coverage in 2014; the hospital has experienced little change in volume of services provided. Respondents caution, however, that the hospital remains financially reliant on other funding streams in the state's Medicaid waiver, which is up for renewal this year, both to cover the costs of serving Medicaid patients as well as the large number of immigrants not expected to gain coverage.
- The hospital has struggled with patient satisfaction and some quality indicators and has faced small penalties in the federal value-based payment (VBP) programs, but these have had little financial impact because LAC+USC serves relatively few Medicare patients. The county, which owns LAC+USC, assumes financial risk for Medicaid managed care patients, so other alternative payment models (such as accountable care organizations) hold little interest for the hospital.

C. Changes in demand (Q1 2013 to Q1 2015)

- LAC+USC has experienced little overall change in patient volumes over the past two years. Hospital data from the first quarters of 2013, 2014 and 2015 suggest a slight shift from inpatient and emergency department (ED) care to outpatient visits in the last year. Inpatient admissions changed little in the last two years, but declined about 4 percent over the past year (related, in part, to a new state system to screen appropriateness of inpatient admissions), and ED visits increased 3 percent over the past two years, but declined 4 percent over the past year. Outpatient visits grew 4 percent over the past two years.
- However, respondents cautioned that these changes are small and were more comfortable with concluding that these volumes are largely flat. In fact, one respondent detected a slight recent dip in outpatient visits due to capacity constraints and efforts to decrease unnecessary face-to-face visits with physicians (see later).
- Volume by payer mix showed more change. Use by Medicaid patients grew across service lines, while use by uninsured patients declined between 2013 and 2015. Medicaid admissions increased 77 percent, deliveries 25 percent, ED visits grew 76 percent, and outpatient visits almost doubled. Medicaid now represents about 3/4 of all inpatient

admissions and outpatient visits (compared to less than half of admissions and a third of outpatient visits in 2013), and over half of ED visits (compared to a third in 2013).

- These volume increases were larger between 2013 and 2014 than between 2014 to 2015 (after the Medicaid expansion) because of the Low Income Health Program (LIHP), implemented in 2011 under California’s Bridge to Reform 1115 Medicaid waiver, which put uninsured people into a Medicaid-like program to help them adjust to coverage and more readily transition to Medicaid in 2014. LIHP patients were included in the Medicaid volume numbers in 2013.
- The commercial insurance expansions under the ACA have had little impact on the hospital. Use by patients with commercial insurance was largely flat or even declining, except for ED visits, which grew 23 percent. A respondent indicated that fluctuations in commercial volume are typical and often related to their volume of trauma cases.
- Although the hospital remains quite busy, respondents detect some competition with other providers. As patients gain Medicaid, they need to select a medical home and become empaneled to a primary care provider and network. Respondents report that they have gained some Medicaid patients and lost others, perhaps because they have selected medical homes closer to where they live. Also, LAC+USC is new to contracting with commercial health plans and the private community health centers’ IPA, so the hospital has struggled to receive referrals to provide specialty care or inpatient care to additional insured patients.
- LAC+USC’s average inpatient length of stay increased 8 percent over the past two years (although, again, one respondent considered it “steady”).

D. Change in capacity

- Changes in capacity have been directed mainly at primary and specialty care. The county added 10–15 primary care physician (PCP) full-time equivalents over the past year. Respondents report that outpatient care volume has increased more than the numbers indicate because the county has added capacity by implementing ways to treat patients outside of traditional face-to-face visits, which are not reflected in volume indicators. Telephone consults and programs in the community for primary care, as well as eConsult for specialty care, are major examples of this.²⁸

E. Changes in Finances (Q1 2013 to Q1 2015)

- LAC+USC’s overall financial status has improved slightly over the past two years, but the hospital remains vulnerable, with a negative operating margin and no total margin. The hospital experienced a 27 percent growth in total operating revenue, with outpatient revenue increasing more than inpatient revenue (60 percent and 27 percent, respectively). Much of this growth was from LIHP, then Medicaid, with LIHP/Medicaid inpatient revenues increasing by 46 percent and outpatient revenues by 80 percent.

²⁸ The eConsult system screens referrals online, with a specialist either informing a PCP how to proceed with a patient’s condition or scheduling the patient for a consult. Approximately one-third of patients served through this system are found to not need a face-to-face appointment with a specialist. Wait times for appointments reportedly have improved from approximately nine months to 30 days for many specialties.

- A respondent cited the new hospital presumptive eligibility policy as helping the hospital's finances significantly. The policy pays hospitals for services provided to patients who meet Medicaid eligibility criteria but are awaiting official enrollment (up to 60 days).
- The hospital did not see larger margins however because overall operating expenses also grew (by 8 percent), even as uncompensated care expense declined 40 percent between FY2011 and FY2013–14, mostly from declining charity care.
- Also, while disproportionate share hospital (DSH) funding had been on the rise during the several years leading up to the Medicaid expansion, Medicaid DSH then fell by over a third between FY2013 and FY2014, from \$167 million to \$106 million. Medicare DSH grew slightly between those years (from \$24 million to \$25 million). A respondent reported that the county cannot draw down all of the DSH funds commensurate to the volume of services provided because of a state cap.

F. Experience with VBP programs

- VBP programs have had little impact on LAC+USC because the hospital has little Medicare volume and the penalties have been small. The VBP penalty was 0.08 percent in 2014-15, compared to the national average of 0.30 percent. The penalty for the county was about \$600,000, with LAC+USC's share only about \$150,000 (on total operating revenues of approximately \$325 million). As a respondent said, "We are making sure clinically that we are providing the best care we can, but value-based payment penalties don't drive that."
- While LAC+USC's performance on many indicators was about average, it struggled with patient satisfaction scores (received 2 out of 5 stars in 2014-15) and ED care, with patients waiting longer than average among similar hospitals to be seen and admitted.
- LAC+USC's readmissions penalty was 0.13 percent compared to a national average of 0.49 percent. While the hospital's readmission rate overall was relatively high, its readmission rates for specific conditions tended to be average. The hospital treats many psychosocially complicated patients, many of whom are homeless, and/or seriously mentally ill. It is difficult to find skilled nursing facilities, other post-acute care services, and housing options for them upon discharge from the hospital, which could lead to readmissions.
- VBP could have more financial impact in the future because the hospital is trying to grow its Medicare volumes, which have increased slightly. In fact, Medicare inpatient revenue grew more than Medicaid inpatient revenues on a percentage basis over the last two years.

G. Experience with alternative payment models (APMs)

- The county takes on full risk in Medicaid managed care, of which LAC+USC is a part. However, the hospital receives cost-based reimbursement for some Medicaid patients, which provides some financial protection, although these payments arrive approximately 18 months after the actual service is provided. Previous efforts to form Medicaid accountable care organizations (ACOs) among other safety net providers in the county have not been successful. Respondents questioned whether an ACO model would add value because the county and LAC+USC already assumes risk for many lives.

- One respondent reported that achieving the following was important for successfully participating in APMs: attract a broader mix of patients (not just the sickest); be able to provide care efficiently; use specialty care efficiently; avoid admitting patients when possible; and discharge patients in a timely manner. Another respondent indicated that having salaried physicians (which they have) as the key factor to ensure physicians do not face incentives to produce more services than necessary.
- To fare well under both VBP and APM, the hospital is devoting considerable effort to customer service to retain and attract more patients over time. They have adopted the patient-centered medical home model by placing patients with specific providers and providing services in a more team-based model. These require internal culture and workforce changes, new performance expectations, new work flows and labor issues (the hospital is unionized), which they have found all take time to implement.
- To both reduce readmissions and manage risk broadly, the hospital is making a “huge effort” to develop complex case management and develop recuperative care and housing for this population. The hospital opened 300 recuperative care beds and rented 600 units of supportive housing and has saved money by housing patients who are heavy users of health care services (e.g., a cost of \$1,200 per month to house someone and provide community services, compared to \$3,500 per inpatient day). The hospital still struggles with the upfront investment because housing is not an acceptable cost in the Medicaid program.

H. Participation in CMMI projects

- LAC+USC has a small CMMI grant—\$3-4 million over three years for a Strong Start grant for maternal and prenatal care. One respondent considers it too much work to apply for these grants and meet the ongoing reporting requirements for a small amount of money.
- About three years ago, the hospital applied for a larger CMMI grant (\$30 million over three years) to develop a program to transition high users of ED care into outpatient care; they received positive feedback but still were not selected.

I. Expectations for the future

- LA County expects to have a large population (an estimated one million) who remain uninsured due to immigration status or other reasons. Respondents do not expect the current bill proposed by the California legislature to extend Medicaid (with state funds only) to undocumented immigrants to pass.
- LA County is heavily reliant on the state’s current Medicaid waiver for the funding sources that to support not only care for the remaining uninsured but the costs of caring for the Medicaid population, because the county is responsible for paying the state’s half of the Medicaid matching funds. The state is in the process of renewing the waiver, which otherwise will expire this fall. Because of expected declined in Medicaid managed care payment rates (utilization by new Medicaid enrollees is lower than the state expected), DSH and “realignment funds” (from state sales tax revenues and vehicle licensing fees) and other funds, the hospital hopes a new waiver will, for example, extend its cost-based Medicaid reimbursement and DSRIP funds, increase or remove the DSH cap and provide ways to support housing and recuperative care. Respondents are concerned, however, with proposed

provisions that would distribute available funds more among private hospitals as well, essentially diluting the county hospitals' portion.

- Still, in preparation for a potential net reduction in revenues, LAC+USC is trying to operate more efficiently to reduce costs. It is focused on collecting and analyzing data in order to fare well under insurance contracts and APMs, for example by implementing an electronic medical record and improving other information systems to help calculate the costs of providing a given service and document the volume of non-face-to-face visits provided.

ASPE Safety Net Hospital Study

2015 Site Summary for Lakewood Health System

A. Summary of Lakewood Health System

- Lakewood Health System is an independent 25-bed CAH in Staples, Minnesota, approximately 135 miles northwest of the Twin Cities of Minneapolis and St. Paul. As the only provider in its immediate rural community, Lakewood serves the entire population and plays a safety net role, given the relative low-income nature of the population. Lakewood offers a broad spectrum of services, including primary care, behavioral health, medical and surgical inpatient care, Level 3 trauma services, and post-acute and long-term care. As a small hospital, it lacks highly specialized tertiary and quaternary care, however. Despite its CAH status, Lakewood faces some competition from health systems in surrounding counties, primarily over primary care clinics. Lakewood maintains a strong desire to remain independent and avoid the need to merge with a larger health system, as many hospitals in rural Minnesota reportedly have done.

B. Overview of ACA impact

- Lakewood has not seen some of the more dramatic volume increases and patients shifting from uninsured to Medicaid status that some study hospitals have experienced over the past two years. This difference is largely because Minnesota had among the lowest rates of uninsurance in the country before the ACA, due to relatively expansive Medicaid eligibility, a state limited coverage program, and high rates of employer-sponsored coverage. Still, Lakewood's payer mix and financial margins have been helped by the state's participation, as of January 2014, in the full Medicaid expansion to all eligible adults with incomes under 138 percent of poverty.
- On the other hand, the hospital is concerned about its loss of some commercial business, attributed to higher patient cost-sharing requirements in employer-sponsored coverage and the Marketplace plans.
- As a CAH, Lakewood is exempt from participation in Medicare value-based purchasing (VBP) programs, but reports some indicators and expects such participation to become a requirement.
- Lakewood has been preparing for alternate payment models (APMs) for the last few years, primarily through leadership changes and other efforts to improve care coordination. Earlier this year, it joined two ACOs, one for Medicare and one for Medicaid.

C. Changes in volumes (Q1 2013 to Q1 2015)

- Lakewood's total patient volumes increased 5 percent between 2013 and 2015, primarily due to growth in outpatient care, which hospital respondents expected and hoped to see because of their focus on PCMH and care coordination activities aimed at directing patients to less expensive care settings. Indeed, ED visits fell 6 percent, but inpatient admissions did not really change overall (a 1 percent increase). Average length of inpatient stay declined 14

percent. Deliveries declined 17 percent, which could be due to increased competition from other hospitals (see below).

- Lakewood did not provide actual breakdowns of volume by coverage type, although it verbally reported an increase in Medicaid volumes and some decline in uninsured patients, and reported that its revenues are a better indicator of how the payer mix has changed (see Section E below).
- Respondents were concerned about a loss of commercial inpatient stays and ED visits. They think some of the loss could be attributed to patients going to other providers, but a more prevalent situation is that more patients are forgoing care due to high out-of-pocket costs, particularly as so many Marketplace plans have high patient cost-sharing requirements. (As a sign of the prevalence of high deductible plans in this region, Lakewood now offers only health savings accounts (HSAs) with high deductible plans to its own employees.)

D. Changes in capacity

- Lakewood has moderately increased outpatient capacity. As part of its efforts to enhance outpatient services and care coordination in preparation for new payment arrangements (see below), the hospital has added a same-day clinic, increased care coordination staff (a manager and several care coordinators), added 12 mental health providers, and integrated behavioral health into the primary care setting. To help attract more commercial and Medicare business, Lakewood has improved its oncology service, recruited two new surgeons, added a dermatology clinic with a spa, and is selling more durable medical equipment. Despite these changes, one respondent said that the overall number of physicians has not really changed because some physicians have left.

E. Changes in finances (Q1 2013 to Q1 2015)

- Overall, Lakewood received more revenue from Medicaid between 2013 and 2015, whereas revenues from uninsured, commercial, and Medicare patients either were stable or had declined.
- Medicaid inpatient revenues increased 22 percent, whereas outpatient revenues increased 32 percent. As a proportion of total revenues, Medicaid grew from 17 to 21 percent on the inpatient side and from 18 to 24 percent on the outpatient side. As a CAH, Lakewood receives cost-based reimbursement for Medicaid outpatient services.
- Lakewood has very little revenue associated with uninsured stays and visits; this situation does not appear to have changed considerably over the last two years. Still, uncompensated care costs fell 50 percent. Charity care declined significantly due to a reduction in people applying for the program, even as the hospital expanded eligibility. Bad debt increased overall between 2013 and 2015 (although declined between 2014 and 2015); respondents reported that this number fluctuates considerably based on cyclical attempts to recover debt. Lakewood is technically a district hospital but does not receive local tax revenues. Due to this status, it does receive payments on debt through patients' state tax returns, however.
- Meanwhile, commercial inpatient revenues fell 35 percent or, as a portion of total, from 31 to 20 percent. However, commercial revenues from outpatient services were substantially higher than for inpatient services, increasing 8 percent or, as a proportion of total outpatient

revenues, from 35 to 37 percent. Respondents attributed the decline in commercial inpatient revenue to several factors: high cost sharing that might prevent some patients from seeking care; a 30 percent cut in reimbursement rates from Blue Cross, its largest commercial insurer; and reimbursement rates from Marketplace plans that are lower than typical commercial rates. Although total commercial revenues did not really change over this period, respondents were concerned that these changes signaled a growing issue.

- Indeed, Lakewood does not receive any other subsidies to support care for the uninsured or for Medicaid services not reimbursed at cost. Medicaid DSH payments remain very low—about \$10,000 annually since 2011. The hospital estimates that the cost of staff time to report and claim these dollars exceeds \$10,000, so it is considering forgoing these funds completely. The hospital does not receive any Medicare DSH payments.
- In total, Lakewood’s revenues increased 5 percent, whereas expenses increased 3 percent, generating a slightly better operating margin—from -2 percent in 2013 to 0.23 percent in 2015. Respondents attributed the improvement mainly to changes in staff costs. Facing relatively low patient volumes and negative margins in 2013, the hospital cut expenses (mostly through layoffs of managers and other administrative staff) and generated a 4 percent margin in the first quarter of 2014. Since then, the hospital has added back staff (mostly in care coordination and data/financial analysis), thus extracting some of the margin.

F. Experience with VBP programs

- As a CAH, Lakewood currently is ineligible to participate in the Medicare VBP programs but does report some indicators and expects that participation eventually will be required of CAHs. Hospital executives think that the hospital provides high quality care but that its current processes are not yet sufficiently standardized to appropriately “present the best picture of what we are doing.”
 - Lakewood’s performance on the measures it reported to Hospital Compare in 2014 were mixed—at or above the national average on patient experience measures, at or slightly below average on appropriate antibiotic prescribing, average for readmissions indicators, and below average for appropriate imaging rates.
- Respondents named several related investments needed for success in VBP programs (and the same for APMs): one respondent stressed the importance of having an EHR and strong data collection and analysis; another emphasized good cost management and care coordination. A key strength Lakewood reportedly possesses is a strong relationship between hospital executives and physicians. Indeed, administration worked with physicians to encourage them to better document their patient care activities, which reportedly has contributed to better scores in many areas—from the bottom decile to the 70th percentile.

G. Experience with APMs

- In January 2015, Lakewood began participating in two ACOs, which currently cover about 10 percent of its total patient population:
 - **Accenture Medicare ACO.** Lakewood joined in this ACO’s third year of a three-year period. This initial period offers upside risk only, but in 2016, up to 15 percent of Lakewood’s reimbursement in the ACO will be at risk. Lakewood has 1,000 attributed patients; given its small size, the hospital is pooled with other providers.

- **Minnesota’s Medicaid Integrated Health Partnership** is used by Lakewood for 3,000 of its Medicaid patients (both fee-for-service and managed care patients). The hospital is not pooled with other providers; it chose to take “a little bit of risk” in this first period.
- The hospital is still in the early stages of transitioning to ACOs, but respondents state they have “come a long way in a year.” The main ways it hopes to generate savings in the ACOs are by increasing preventive/primary care visits and reducing ED, inpatient, and other high-cost services.
- Key activities to achieve this goal revolve around improved care coordination, both for patients that need ongoing monitoring and healthy ones who still should be seen regularly. In addition to the capacity changes mentioned earlier, Lakewood has restructured its senior leadership team to align care coordination staff under a single vice president and added a physician leader to each division; the CEO reportedly has relinquished some authority so as to encourage new and creative ideas from others. It has also implemented a new EHR so all providers are on the same system and is expanding and reconfiguring clinical space into pods that house whole care teams, with the aim of promoting more use of nonphysician clinicians.
- Respondents named several challenges to doing well in APMs:
- The hospital is still operating in a fee-for-service world, in which it faces financial incentives to provide more services across the care spectrum. Some of the services they aim to use less (for example, imaging, surgery) help subsidize primary care, so reducing utilization in these areas also reduces revenues.
 - Although reporting that Lakewood’s key strength for APMs is the strong relationship between respondents and physicians, a respondent noted that getting and keeping physician buy-in is difficult, as the preparations for APMs require a lot of work with no immediate financial reward. Physicians reportedly have considerable leverage over the hospital because it is difficult to recruit providers to this part of the state; also, they could choose to move to another nearby provider organization. It reportedly took 10 months to negotiate a new compensation model in which physician pay is linked to performance on quality and value measures.
 - Sorting out initial glitches with Medicare data and getting patients properly attributed to Lakewood has taken time and investment. The hospital has started receiving claims data on the patients attributed to these ACOs but is not sure it has the resources to adequately analyze the data in house.
 - Respondents expect initial data to show that the hospital has relatively low quality and high costs. The former is because of inadequate documentation, as mentioned above. They attributed the latter issue to the receipt of cost-based Medicare and Medicaid reimbursement as they invest in care coordination. Lakewood’s cost structure reportedly has made it less attractive to commercial ACOs.
 - One respondent noted the need to rely less on adding staff to do more and instead find tools to adjust processes for greater efficiency.

H. Participation in CMMI demonstration projects

- Lakewood is not involved in any CMMI demonstration projects.

I. Expectations for the future

- Respondents expressed considerable concern that more employers will drop their coverage and instead have their workers enroll in Medicaid or purchase coverage through the Marketplace, thus further reducing commercial hospital revenues. This is a particular concern, since respondents expect cost-based Medicare and Medicaid reimbursement for CAHs to be phased out in the next few years.
- As a next step in achieving value-based care, the hospital is starting to engage in more population health activities to prevent health care problems and drive down costs; these activities include collaborating with schools on nutrition and obesity education, and pursuing development of a wellness center, in which the costs of physical fitness and other activities would be offset by physical therapy services for which the hospital can bill insurers.
- To the extent that Lakewood successfully shifts services from high- to low-cost venues, it plans to downsize the higher-cost areas (for example, inpatient services). To help offset the losses in revenues from those services, the hospital is considering adding more senior services to incorporate into their ACO contracts, thus attracting more patients.

ASPE Safety Net Hospital Study

2015 Site Summary for Marcum and Wallace Memorial Hospital

A. Summary of Marcum and Wallace Memorial Hospital

- Marcum and Wallace, a 25-bed critical access hospital (CAH) in rural Estill County, KY, continues to be the community's sole health care facility. Its primary and specialty care clinics serve the broader region, as do a federally qualified health center (FQHC) and independent private practice physicians. The hospital does not offer surgical services, so patients must seek this type of care elsewhere; often this is in nearby Richmond, KY or farther to Lexington, KY.

B. Overview of Affordable Care Act (ACA) impact

- Kentucky's large increase in Medicaid enrollment as a result of the ACA has had a more consistently positive impact on Marcum and Wallace over the past year compared to the year before, with payer mix continuing to improve as people gained coverage and financial indicators stronger than before. "Our financial status has been great," said one respondent. This represents a considerable turnaround from pre-ACA when hospital finances were strained related to rising numbers of uninsured patients. However, some of the financial improvement is related to a growth in inpatient admissions that is not ACA related.
- As a CAH, Marcum and Wallace is not required to participate in federal value-based payment (VBP) programs, but it does report some indicators and would like to participate more fully to better showcase its high-quality services. The hospital is also preparing for ways it could take on more financial risk, although it considers itself too small to take full risk or form an accountable care organization (ACO) on its own.

C. Changes in demand (Q1 2013 to Q1 2015)

- Marcum and Wallace reports having only about 3 percent self-pay/uninsured patients now, down from 13 percent at the end of 2012. The hospital largely credits the growth in covered patients to its enrollment navigator stationed in the emergency department (ED), which was supported through a Health Resources and Services Administration (HRSA) grant, as well as help from enrollment staff from their hospital parent (Mercy Health) and collaboration with the local FQHC.
- The hospital reports seeing "some" patients with coverage from the state exchange. Anecdotally, one respondent reported hearing of more residents considering early retirement because they have the opportunity to buy insurance coverage that is not tied to an employer.
- Volume growth has been mainly on the inpatient side and mostly by Medicaid patients. Medicaid admissions more than doubled, compared with under 20 percent for all patients.²⁹ This growth does not, however, indicate that the hospital is now caring for sicker patients. Instead, much of the growth in admissions is associated with the hospital's adoption of a

²⁹ Given the overall small numbers of patients the hospital treats, respondents guard against putting too much weight on the precise percentage change numbers.

tool in the past year to help them determine when an admission is appropriate, rather than keeping them in observation beds, which are counted as outpatient visits. Another contributor to inpatient growth is the hospital's increased use of swing beds as a way to keep beds full and keep patients with longer-term needs in the community.

- The switch from observation to inpatient status and other changes likely have masked the growth in outpatient demand and utilization. Respondents think people are more likely to seek appointments and procedures now that they have coverage. Outpatient visits grew just 5 percent over the two years, but had fallen in 2014, then increased about 15 percent by 2015.
- Particularly bad winters in both 2014 and 2015 also may have tempered outpatient use. Many patients live in the mountainous areas of Appalachia, and treacherous roads can significantly impede travel. Also, radiology volumes decreased after the departure of a primary care physician who tended to order tests at a higher rate than average.
- While ED visits declined about 5 percent overall, Medicaid ED visits increased by a quarter.

D. Changes in capacity

- Marcum and Wallace has not made major changes in capacity. However, the number of physicians the hospital employs fluctuates. The more recent decline in outpatient visits is attributed to a couple of physicians departing; more physicians have since been hired. A key strategy for the hospital has been to improve physician alignment, primarily through employing them, to both boost outpatient capacity and increase inpatient referrals.

E. Changes in finances (Q1 2013 to Q1 2015)

- The hospital's financial picture has improved considerably. Operating margin increased from 1 percent to 7 percent and total margin increased from 4 percent to 17 percent (confirm) (and does not include the hospital's investment income).
- A growth in Medicaid revenue linked to serving more Medicaid patients as well as the change in observation/admissions policy, were the key factors in the improved financial picture. As a CAH, the hospital receives cost-based reimbursement from both Medicaid and Medicare.
 - Between 2013 and 2015, gross Medicaid inpatient revenues increased almost three-fold and gross outpatient revenues, including ED, increased 20 percent. Outpatient revenue from other payers actually declined, which a respondent attributes to changes in their charges. They had been out of compliance with some supply costs.
 - The hospital gained considerable inpatient revenues from Medicare and commercial payers as well, which is linked to the shift in admissions versus observation status mentioned earlier.
 - A respondent reported that overall net patient revenue increased almost 50 percent between 2014 and 2015.
- Uncompensated care costs fell 80 percent, with much of the decline due to plummeting charity care costs. The hospital reported almost \$1.9m in charity care in Q1 2013 and only \$300,000 in Q1 2015. Bad debt declined as well, but it fluctuates reportedly because the

collection activities are more “batched” now through outsourcing the collection activities. Consequently, precisely matching debt to provision of services is difficult to do.

- The hospital receives only Medicaid, not Medicare or disproportionate share hospital (DSH). This funding appears to have been cut in half between 2013 and 2015, dropping from approximately \$148,000 to \$66,000.
- The hospital continues to struggle with payment denials or delays from Medicaid managed care companies, but the situation appears to have improved somewhat from last year.

F. Experience with VBP programs

- As a CAH, Marcum and Wallace is not required to participate in federal VBP programs. However, for example, the hospital does submit patient-experience data to Hospital Compare, on which it performs fairly well. Other indicators have been more difficult for the hospital to collect, presumably because it would involve different charting and chart abstracting. However, they just went live with Epic, an electronic health record (EHR), which has all of the Hospital Compare indicators built in. ED physicians have started documenting information with this system. The hospital is starting to monitor readmission rates and other information because they want to be “ahead of the game” if reporting becomes a requirement in the future.
- Marcum and Wallace wants to be able to participate fully in VBP programs, that is, be eligible for bonuses or penalties, because they believe they do provide high-quality care and want to be able to demonstrate that a person can receive quality care in a small community hospital. Participation would also help cover some of the costs of participation. Said one respondent, “It would be nice to be rewarded for behavior and the positive things you’re doing, as it does require resources. And maybe that would be a motivation to help others. Maybe you could get 103 percent of costs versus someone who didn’t do as well and only got 100 percent of costs.”
- A respondent reported that care management, employing (rather than contracting with) physicians, and a focus on primary care are important to faring well in VBP programs. But having a small staff is a challenge. The hospital has one staff member who is focused on quality improvement and care management and is spread thin across paperwork and patient-care activities. Marcum and Wallace recently added a diabetic coordinator to work closely with physicians.
- The hospital is also implementing a patient-centered medical home (PCMH) initiative (see below) to improve quality in its clinics. But having sufficient resources is a challenge because the costs of many of these added initiatives in the community are not allowable costs under the cost-based reimbursement structure.
- A respondent named the National Rural Health Resource Center as a great resource for strategies around quality and tools to help CAHs fare well on VBP indicators and to implement PCMH initiatives.

G. Experience with alternative payment models (APMs)

- Marcum and Wallace is not currently involved in APMs, but is trying to prepare for them with the help of a consultant. Respondents expect that their new EHR will help obtain and

analyze the data needed to take on some degree of financial risk. However, because of the hospital's small size, they do not expect to have sufficient resources or patients to become an ACO on its own or otherwise take full risk.

- The hospital would be interested in participating in an ACO with a tertiary hospital in the future—in an arrangement in which Marcum and Wallace could provide more of the routine services. Respondents note, however, that some tertiary hospitals are interested in aligning with more doctors, not necessarily with hospitals.
- Marcum and Wallace is developing its primary care providers and pursuing a PCMH effort in to attract more patients to choose Marcum and Wallace as their medical home, which respondents think will also make the hospital an attractive partner to ACOs. The PCMH effort is internal and the hospital currently receives no outside payments to support it. However, respondents are trying to demonstrate cost savings to insurers and negotiate payments to cover some of these investments by contending they could reduce costs to insurers in the long run.

H. Participation in CMMI demonstration projects

- Marcum and Wallace is not involved in any CMMI grants.

I. Expectations for the future

- Marcum and Wallace respondents seem less concerned about the hospital's future than they were a year ago. Concerns about changing CAH payments/regulations remain, but have subsided. The hospital is engaged in some strategic planning to continue to improve their revenues and cut costs, but respondents do not expect payer mix to change much more.
- One respondent noted concern about the “two-midnight rule,” which could hurt their Medicare inpatient volumes. The rule requires physicians to certify that the patient would need to stay in the hospital at least two nights to be considered an inpatient. The respondent does not consider this good patient care, and is awaiting a Congressional fix. Note that Medicare pays more for short inpatient stays than observation services.³⁰
- Going forward, the hospital has made a decision to no longer recognize the DSH funds they continue to receive as a revenue source because they expect the state to take back some of the funds once they reconcile payments with actual volumes/costs of caring for the uninsured. It is too early to know whether the increase in Medicaid revenues is balancing out the loss in DSH. But it appears to be doing so as DSH funding is not that high.
- Marcum and Wallace is also bringing in a new ED physician group this year, which they hope will further improve quality scores and bring in more volume.
- A respondent noted concern that the Medicaid expansion could be in jeopardy under a potential change in governors and once full federal funding ends.

³⁰ Cassidy, Amanda. “Health Policy Brief: The Two-Midnight Rule.” *Health Affairs*, January 22, 2015.

ASPE Safety Net Hospital Study 2015 Site Summary for Regional One Health System

A. Summary of Regional One

- Regional One is the dominant safety net system in the Memphis area. It recently changed its name from Regional Medical Center at Memphis (nicknamed “the Med). Historically, it has served as a public hospital for the community but now is officially a 501(c)3 not-for-profit system. Regional One is county supported and affiliated, as its board is appointed by the Shelby County mayor and confirmed by the county commission. The county also provides some financial support, especially in covering the costs of care to uninsured people.
- Regional One also serves as a regional safety net provider for uninsured people in neighboring counties in Tennessee, Arkansas, and Mississippi.
- Regional One executives describe the organization as an integrated delivery system. The system consists of an acute care hospital (the Regional Medical Center), extended care and rehabilitation hospitals, an outpatient surgery center, four primary care centers, and other outpatient services. Regional One has Centers of Excellence for trauma, burn, high-risk obstetrics, and neonatal intensive care.

B. Summary of the impact of the Affordable Care Act

- As the state of Tennessee elected not to expand Medicaid, study respondents reported that the ACA has had virtually no impact on Regional One. (The governor had proposed a Medicaid expansion in 2015, but it was voted down by the state legislature.)
- Regional One has had mixed experiences with CMS value-based payment initiatives, performing relatively well on measures of hospital readmissions but more poorly on measures of HACs and patient satisfaction. Due to the low volume of Medicare patients at the hospital, Medicare penalties are not large enough to pose a serious concern, although the hospital has implemented a number of initiatives to improve performance.
- Respondents cited the lack of Medicaid expansion as contributing to increasing financial stresses that are impeding delivery system transformation, quality improvement initiatives, and needed investments in physical plant, IT, and staff.

C. Changes in demand (Q1 2013 to Q1 2015)

- Regional One’s service utilization, payer mix, and acuity level of patients reportedly have been essentially flat for the past five to six years, with some year-to-year fluctuation.
- The financial and utilization data that Regional One provided for this study differed from what respondents reported (one executive attributed this difference to considerable fluctuations in the quarterly data). Financial data provided by the health system show a 4.4 percent decrease in inpatient admissions between Q1 2013 and Q1 2015, but little change in ED and outpatient visits (despite some fluctuation over the two-year period).

- According to the financial data, Medicaid admissions decreased by almost 10 percent, whereas Medicare admissions increased 20 percent. A hospital executive speculated that these are related (that is, the Medicaid population is aging and transitioning to Medicare).
- Inpatient admissions for commercial and self-pay (uninsured) patients also decreased (17 percent and 8 percent, respectively). Again, one executive's own observation of trends in volume seemed to contradict this decline, as he reported that volumes across all payers have been flat.

D. Changes in capacity

- In 2014, Regional One began a partnership with the University of Tennessee (UT) to create UT Regional One Physicians, consisting of about 180 physicians and advanced care practitioners. Most of the physicians are specialists who will practice at the Regional One hospital and its other settings.
- As part of "rebranding" its image as a public hospital over the past five years, Regional One started a long-term care hospital, outpatient ambulatory care center, and outpatient surgery center; expanded rehabilitation services; and added some beds, especially for burn patients.

E. Changes in finances (Q1 2013 to Q1 2015)

- Regional One's patient revenues have been essentially flat over the past four to five years, with some fluctuations by payer source. The system experienced a 58 percent increase in Medicare revenue (starting from a very low amount), which a hospital executive attributed to increased Medicare volume and the new Medicare DSH formula (likely the fact that 75 percent of Medicare DSH funds are now redistributed to hospitals with large numbers of uninsured patients).
- A hospital executive reported that uncompensated care expenses have decreased slightly, although the financial information provided to us showed a sizeable increase (24 percent) between Q1 2013 and Q1 2015. A respondent attributed this discrepancy to the fact that the financial information we requested shows only quarterly revenues and costs, which might not include certain expenses documented in other quarters. Looking at annual data, the respondent reported that charity care decreased by \$3 million between 2014 and 2015, whereas bad debt increased \$6 million during the same period. The respondent did not know the reason for the increase, other than suggesting that changes related to the new UT physician group might have affected the payer mix.
- Regional One has been receiving about \$12 million in Medicaid DSH payments annually. Tennessee is the only state in the country that does not have a permanent Medicaid DSH program (due to a waiver negotiated to create the TennCare program in the 1990s). A DSH pool was negotiated with the federal government in 2005, when TennCare coverage was cut for about 300,000 people. With the advent of the ACA, respondents had been concerned that CMS would not renew the DSH pool in 2015 as a way to pressure the state into expanding Medicaid. Subsequently, the funding was renewed for 10 years, although Regional One believes that funding levels will be reduced in future years.

- Regional One receives an annual appropriation of about \$27 million from the county to pay for care for prisoners and indigent residents. The funding is expected to increase slightly (by about 2 percent) in 2016.
- Regional One's operating margins have been decreasing in recent years, from a positive \$51 million in FY 2012 to a projected loss of \$7.9 million for FY 2016. This reflects stagnant revenues and increased costs. A hospital executive attributes higher costs as being due to investments in IT, quality improvement, deferred maintenance, and general increases in salaries and supplies. Operating costs increased from \$290 million in 2011 to \$357 million in 2014.

F. Experience with Medicare value-based pricing

- Regional One has managed readmissions reasonably well, with readmission rates only slightly above the national average, and incurring a Medicare penalty in FY 2015 of -0.01 percent. Hospital executives attributed the relatively low documented readmission rates in part to low volumes of Medicare patients—the number of cases for many of the readmission measures was too small to report.
- The hospital system performed less well with HACs, particularly with respect to Methicillin-resistant *Staphylococcus aureus* (MRSA) infections and pressure ulcers, and was among 718 hospitals that received penalties for HACs in FY 2015. A hospital executive cited the low socioeconomic status of the patient population, the high number of accidents and injuries coming through the trauma center, problems with coding arising from lack of resources, and the types of patients they see as reasons for the high rates. For example, rates of pressure ulcers are higher and more difficult to prevent among trauma and burn patients, who often need to be immobilized.
- Low patient satisfaction scores are also a problem, with the hospital scoring two stars on the new five-star rating system. One hospital executive believes that low patient satisfaction in part likely reflects some prejudices among hospital staff regarding low socioeconomic strata patients, which need to be addressed (that is, the need to change the “public hospital” mentality). To improve its scores, the hospital has hired the Studer Group (a health care consulting/training organization) to provide coaching and tutoring for managers and nurses. A respondent reported that the hospital's scores had improved during the second quarter of 2015.
- Regional One has implemented a number of other quality improvement initiatives. Among the most important are medication reconciliation to reduce medication errors, changing the culture to encourage more reporting of errors, and a program called TeamSTEPPS, an AHRQ initiative designed to improve communication and teamwork skills among the medical staff.
- Hospital executives lamented that financial constraints have hampered their ability to hire new staff to work on quality improvement (QI) initiatives and improve quality outcomes.
- The lack of an EMR system across all hospital departments also hinders quality improvement efforts. Although respondents reported that a single system interoperable across all departments is desperately needed, the health system reportedly cannot afford it at this time.

G. Experiences with alternative payment models (APM)

- Regional One was not participating in any APMs at the time of our discussions with them. However, the hospital is mandated to participate in the bundled payments initiative for hip and knee replacements, which is set to begin April 1, 2016 (changed from January 1, 2016).
- Hospital officials are concerned that they will not perform well in the joint replacement initiative and will be penalized. This concern is due to the high number of these procedures they perform on trauma patients, who are more costly and difficult to manage.
- Respondents believe Regional One is at a disadvantage in being able to perform well under alternative payment models due to the low socioeconomic status and poor payer mix of its patient population, as well as an inability to invest in needed quality improvement and cost-tracking activities, and an EMR.
- As an example, the hospital has been making efforts to reduce the length of inpatient stays. It has been unsuccessful, reportedly because of the difficulty in getting indigent care patients placed in an appropriate setting following discharge, and because of some inefficient throughput processes that the hospital has been unable to improve by hiring more staff.
- Respondents believe that Regional One's potential strength with APMs is its recent affiliation with the University of Tennessee medical group. These physicians are currently salaried, and there has been discussion about changing their compensation to be more risk based and include performance-based incentives.

H. Expectations for the future

- The biggest concern for Regional One executives is the lack of Medicaid expansion in the state and the possibility that subsidies from federal, state, and county governments will decrease, thereby putting the hospital in an untenable financial situation.
- Medicaid expansion would provide the hospital with a better and more predictable revenue stream, thereby making it easier to make the necessary investments in physical plant, IT, and quality improvement to better position it for payment and delivery system reforms and allow it to compete more actively for privately insured patients.
- As part of its "re-branding" efforts, Regional One plans to continue efforts to change its public hospital image, especially by trying to attract more privately insured patients in the areas of cardiology, gastroenterology, and outpatient surgery.

ASPE Safety Net Hospital Study

2015 Site Summary for UK Health in Lexington, KY

A. Summary of UK Health

- UK Health, part of the University of Kentucky, remains the main safety net system in the Lexington area. This hospital, with almost 1,000 beds, is both the major provider for Medicaid and uninsured patients as well as a tertiary/quaternary academic medical center for the region at large.

B. Summary of the impact of the Affordable Care Act (ACA)

- The ACA has continued to have a large, mostly positive, financial impact on UK Health, stemming from many of the hospitals' uninsured patients gaining Medicaid coverage and from treating new Medicaid patients. Respondents attribute this growth to the significant increase in Medicaid eligibility as well as to the state's and UK Health's strong outreach and enrollment strategies and systems. The increase in Medicaid patients surpassed expectations. As one executive said, "The degree and pace of Medicaid expansion has surprised everyone here."
- UK Health has invested in improving performance for value-based payment (VBP) programs and is in the early stages of exploring how it might fit into alternate payment models. As one respondent said, the ACA has also "accelerated the path to value-based care."

C. Changes in demand (Q1 2013 to Q1 2015)

- Over the past two years, total patient volumes increased in the emergency department (ED) by 11 percent, while the volume of other outpatient visits increased by 15 percent. Inpatient admissions increased just 3 percent. Medicaid patients accounted for most of the growth with a 90 percent increase in outpatient visits, a 74 percent increase in ED visits, and a 39 percent increase in admissions.
- Marketplace coverage has had less impact on UK Health. Indeed, commercial patient volumes were negative, on the inpatient side, or rose only slightly on outpatient and in the ED. Respondents reported that some patients moved from commercial to Medicaid coverage.
- UK Health is seeing many patients who are seeking care for the first time, are quite ill, or have less severe but chronic issues. However, average length of stay for Medicaid patients increased less than for Medicare and commercial patients. Respondents attribute the increase to higher acuity and difficulty discharging patients, especially because the supply of post-acute care beds in the community is relatively fixed.

D. Changes in capacity

- The increased demand for care has led to strained capacity, largely demonstrated by increased wait times for appointments and a greater increase in the ED over outpatient volumes in the past year. In response, UK Health moved some practices to its new, larger

ambulatory center to provide them with more space. The hospital is adding “a lot of” physicians and mid-level staff, and is working to improve clinic efficiency. Still, as a primarily tertiary/quaternary hospital, UK Health has very limited primary care capacity.

- UK Health also received certificate-of-need approval from the state to add 120 additional beds (a 15 percent increase) over the past year to help ease their inpatient capacity constraints.

E. Changes in finances (Q1 2013 to Q1 2015)

- UK Health’s margins reached record levels over the past two years, with greatest gains between 2013 and 2014, right after the Medicaid expansion. Its operating margin increased from 6.7 percent to 10.4 percent, while total margins rose more, from 5.7 percent to 12.5 percent.
- Medicaid outpatient (ED included) revenue increased 41 percent, compared to 50 percent across all payers, and Medicaid inpatient revenue increased 58 percent, compared to 28 percent across all payers. Revenue increases align with changes in patient volumes and payer mix. Self-pay/uninsured patients plummeted from 12-13 percent of patients before the Medicaid expansion to about 2 percent this year.
- The hospital has not yet faced cuts in disproportionate share hospital (DSH) funding because the state payments lag actual activity level by about a year. The figures are incorporated in the Medicare/Medicaid revenue numbers, so we are not able to determine its percentage of the revenue.
- Uncompensated care expense, especially charity care, fell significantly from about \$55 million to \$20 million during this period, while overall operating expenses rose in step with rising patient volumes. These expenses are also linked to a new pharmacy initiative and rising costs of specialty drugs.

F. Experience with VBP programs

- UK Health has experienced little financial impact from federal VBP programs, but these programs still create incentives to improve, from a patient care perspective. Respondents are optimistic that they are responding in ways that will improve their performance.
 - The hospital received a small bonus of 0.3 percent for VBP indicators, performing well on most measures except timely ED care. A respondent reported that the main problem is related to boarding patients who need to be admitted. UK Health recently opened up an observation unit just off the ED and new cardiovascular floor to remove pressure from the ED and reduce the need for inpatient beds.
 - The hospital’s readmissions penalty was small at 0.42 percent (compared to a maximum of 3 percent), slightly up from last year. According to a respondent, poor socioeconomic status of many patients is a “huge factor” affecting readmissions and possibly other VBP indicators. Risk adjustment helps in terms of accounting for age, gender, comorbidities, but not past health care use (for example, if patient has never before seen a PCP). In one key way to help reduce readmissions, UK Health is participating in Project Boost, a Society of Hospital Medicine program to improve the discharge process.

- The hospital faced the largest possible hospital acquired conditions penalty at 1 percent. The penalty was for the problem of catheter-associated urinary tract infections. The problem has been tackled and the hospital is not expecting another penalty next year for this problem.
- UK Health expects to improve performance by focusing on two main components:
 - Leadership will focus on the defined measures, set goals for these measures, and establish a deliberate method to achieve them through tools such as LEAN or Six Sigma
 - Leadership will ensure that administrative and clinical data can be accessed and is analyzed thoroughly. In this spirit, UK Health recently launched an Office of Value and Innovation in Healthcare Delivery, led by the chief medical officer and another physician who have hired data engineers and analysts. The facility does have a data warehouse.
- A respondent thinks the Centers for Medicare & Medicaid Services (CMS) has demonstrated due diligence in selecting the right measures to track but could do more to help hospitals' performance on them. A respondent reported that the Agency for Healthcare Research and Quality (AHRQ) as being helpful by arranging collaboratives and other strategies.

G. Experience with alternative payment models (APMs)

- Commercial payers in the Lexington market have continued to demonstrate interest in moving towards APMs and reportedly are discussing this with UK Health, but the hospital has not yet adopted new payment arrangements.
 - UK Health expressed interest in bundled payments because of the significant level of tertiary/quaternary work they do, but noted the hospital is protected/isolated from needing to take on full risk because they are the only hospital in the area offering trauma, neonatal intensive care unit, and transplant services so they have significant negotiating leverage with health plans on payment types and levels.
 - Respondents indicate wanting to treat patients who are in others' ACOs, but do not have the full suite of services (namely significant primary care, post-acute care) to focus on population health necessary to be a full partner in an ACO or form their own ACO.
 - UK Health might experiment with APMs within its own employee health plan.
- Kentucky Medicaid does not seem advanced enough yet to consider APMs. Medicaid managed care is fairly new and health plans are focused on reducing overutilization (a problem in the state) through strict payment authorizations. Payment delays and denials have improved for UK Health over the past year.
- UK Health is preparing for APMs, focusing on several key areas:
 - Respondents visited Intermountain Healthcare and learned a hospital needs a lot of confidence in care delivery and cost accounting systems to fare well
 - One respondent named health information technology (HIT) infrastructure to integrate data and the ability to manage patients across the care continuum as the most important factors to faring well under APMs. UK Health has done a lot on HIT internally and has

electronic health records, but the state's efforts to establish a health information exchange have not been that robust. One respondent thinks a lot more work needs to happen to control where services are provided across the care continuum and the hospital is in the process of developing post-acute care relationships.

- Another respondent named patient compliance and education as the most important factors to doing well. The hospital has put a lot of effort into medication compliance and educating patients on when and where to seek care and reduce high utilization.
- Respondents think these components are important even if APMs do not proceed.

H. Participation in CMMI demonstration projects

- UK Health is not involved with any CMMI grants.

I. Expectations for the future

- UK Health does not expect much more change in payer mix: as one respondent said, “For the most part those that would sign up [for coverage] are signed up.”
- The respondents' biggest concern is that the state might reduce Medicaid reimbursement once the federal government no longer covers the full cost.
- The respondents expect DSH funding to decline next year, but are unsure by how much, and that it will eventually reach zero.
- The hospital is working on a strategic plan to prioritize future spending by using the surplus, most of which appears to be around saving some and expanding capacity. The hospital continues to grapple with whether it should provide more primary care—either create their own or partner with CHCs—even as they focus on becoming a tertiary hub. They also are considering creating a clinic for chronically complex patients as a way to reduce readmissions and ED visits.

ASPE Safety Net Hospital Study

2015 Site Summary for Yale New Haven Health System

A. Summary of Yale New Haven Hospital

- Yale New Haven Hospital (Yale NH) is the flagship hospital of the three-hospital Yale New Haven Health System. It is one of the largest hospitals in the country at 1,541 beds, and the only hospital system in New Haven—one of the poorest cities in the state. It is the only level-1 trauma center in southern Connecticut.
- Yale NH is affiliated with Northeast Medical Group, which includes physicians employed by the hospital (most of whom are primary care providers), and the Yale Medical Group, the clinical faculty for the School of Medicine. The hospital has recently acquired other physician practices.

B. Summary of the impact of the Affordable Care Act (ACA)

- Although Yale NH has seen some increase in Medicaid patients, volume, and revenues due to the ACA, these changes have been fairly small compared to most of the other hospitals in the study that are in states that expanded Medicaid.
- Although financial performance has generally been strong, a major concern for the hospital is the increase in Medicaid shortfalls due to increases in provider taxes and cuts in state subsidies to hospitals. An increase in patients in high deductible plans is also contributing to an increase in hospital uncompensated care.
- Yale NH has not performed especially well on Medicare quality measures and value-based purchasing (VBP), which respondents attribute to the low socioeconomic status of their patient population. The health system is active in alternative payment models, although it is still too early to draw conclusions about the success of these initiatives.

C. Changes in demand (Q1 2013 to Q1 2015)

- The patient population has remained largely stable since the implementation of the ACA. There have been some increases in Medicaid and people enrolled in the marketplace plans, and a small decrease in self-pay patients, but payer mix has remained largely stable. This may reflect both a relatively small uninsured population prior to the ACA, and that Connecticut began expanding its Medicaid program in 2010.
- Respondents reported they were seeing a shift from employer-sponsored to marketplace plans (“employers are creating a path for employees to access insurance through the exchanges”), although they were not able to quantify the shift.
- Inpatient and emergency department volumes have not changed much.
- Outpatient use increased about 20 percent between Q1 2013 and Q1 2015, which respondents attributed to the acquisition of mostly specialty physician practices by the health system.

- Respondents attribute some of the increase in Medicaid to investments by the hospital in tertiary and quaternary care. They also attribute it to a new inter-hospital helicopter transport for patients with complex needs, which has brought in more Medicaid patients as transfers from other hospitals, and sizeable cuts in Medicaid reimbursements, which is causing private practice specialists to no longer accept Medicaid patients. This is also resulting in a much sicker and more complex patient mix that is contributing to increased length of stay.
- Respondents reported that most of the remaining uninsured in the state are undocumented immigrants, and therefore they do not expect to see major changes in payer mix in the future due to the ACA.

D. Changes in capacity

- The hospital has focused primarily on expanding tertiary and quaternary care capacity, focusing especially on oncology and gastrointestinal diseases.
- The hospital has been acquiring physician practices, focusing especially on specialists. Some of this is in support of expanding oncology and GI services, but also appears to be part of a strategy to have a wide network of hospitals and physician practices under a single umbrella to provide more efficient and higher quality of care. This has generated some negative criticism in the community and from state policymakers who are concerned that independent physician practices are being squeezed out.
- Yale NH has also started an inter-hospital transport for complex patients, which adds about 18-19 patients per day.

E. Changes in finances (Q1 2013 to Q1 2015)

- Patient revenue increased by 5.3 percent over the two-year period, but most of this is driven by increases in revenue from patients with commercial managed care.
- Despite some increase in Medicaid revenue, Medicaid shortfalls have increased. The reason for this is complicated, but it appears to be a combination of increased provider taxes, which the state has used to match with federal funds, and cuts in the amount that the state is sending back to hospitals (presumably in the form of Medicaid Disproportionate Share Hospital (DSH). This has resulted in hospitals being taxed more than they receive in DSH payments. As a result, Yale New Haven estimates that Medicaid payments have effectively decreased from 59 cents on the dollar to 39 cents on the dollar.
- The hospital has been able to offset lower Medicaid payments by increasing volume and payment from private payers.
- Uncompensated care costs increased 26 percent. Respondents attribute this to an increased number of patients in high deductible plans (both employer plans and marketplace plans), but it may also reflect the increase in the Medicaid shortfall, which they include as part of their uncompensated care calculation.
- Total and operating margins have fluctuated over the past two years, but they have remained positive. Respondents expect margins to become smaller over the next few years, in large part because of the Medicaid payment cuts.

E. Experience with Medicare VBP

- In 2014, Yale NH lost about \$3 million in penalties related to Medicare quality measures. The largest penalties related to excessive readmissions, hospital-acquired conditions, and HCAHPS scores on the patient experience. There has been some recent improvement in readmission rates. Respondents believe they are at a disadvantage on these measures because of the low socioeconomic status of much of their patient population. Specifically, they feel they have little control over what happens to these patients when they are discharged from the hospital, and there are few resources in the community to care for them.
- To improve scores, respondents mentioned a major initiative to improve the patient experience, although they did not give specific details. They also mentioned that they were trying to create more integrated networks of providers that they believe will allow them to perform better on quality scores, although they view this as a more long-term goal rather than being geared toward producing results in the short term.
- Respondents believe that in order to perform well in VBP programs, a hospital should have a relatively homogeneous patient population that is well resourced (that is, well insured) along with risk-based contracts and incentives to create closed medical systems with a high level of care coordination. They mentioned Kaiser Permanente in California as an example, but do not believe this model would work in Connecticut or other states. For example, payment at Yale NH is virtually all fee for service, with only about 2 to 3 percent of the revenue in some form of risk.
- Respondents were adamant about the need to include a socioeconomic risk adjustment in the quality measures. Moreover, they mention the difficulty of getting ahead of the measures because they are constantly changing, and the measurement period has already passed by the time the new measures come out.
- Respondents also mentioned that it is important to address population health, but they do not believe their hospital is set up or has the resources to address problems in the community that contribute to low-quality scores, nor is it being compensated to address population health issues.

F. Experiences with alternative payment arrangements (APMs)

- Yale NH has been fairly active in pursuing alternative payment arrangements. Their physician-owned practice, Northeast Medical Group that includes about 1,000 physicians, participates in a Medicare Shared Savings ACO as well as shared savings programs with some other commercial payers. This is fairly recent and so they do not know how it has affected quality or costs, although their preliminary experience suggests they are having difficulty meeting the medical loss ratio targets for the Centers for Medicare & Medicaid Services (CMS) shared savings.
- Yale NH is also participating in a CMMI bundled payment project for orthopedic services, focusing especially on major lower joints. Although it is still too early to assess results, their experience has not been very good, mentioning that “CMS is still working through many of the operational logistics of the program.”
- Yale NH cites a number of advantages they have in being able to perform well under APMs, including a history of success in cross-continuum care management, dedicated physician

leadership, a single electronic medical record (Epic) across all parts of the system, an employed physician group, engagement of third party technology for population management (Conifer), and patient engagement (Emmi). Disadvantages or limitations include a lack of a shared organization structure between inpatient and ambulatory care with which to engage physicians, higher costs due to the academic focus, and lack of experience among payers and providers in the state regarding risk or value-based contracts.

- Respondents believe that to succeed with APMs, a hospital system needs a strong care management staff (mix of registered nurses, social workers, and nonclinical navigators), physician leadership in transforming clinical processes, technology such as outreach call tools and patient portals, and actionable data analytics.
- Respondents mentioned that CMS could better facilitate hospital participation in APMs by providing timely and robust claims files for analysis, as well as funding for care management infrastructure.
- Yale NH is also participating in several PCMH initiatives focusing on their Medicaid and uninsured populations, as well as a care management program for their employees, which they are also attempting to expand to large employers.

G. Expectations for the future

- By far the biggest concern among respondents is the future of Medicaid reimbursement. Respondents believe that there will be difficulty in running the facility for the following reasons: the recent increase in provider taxes and decreases in the amount of DSH funds they are receiving in return, a sluggish economy, and what they view as a highly taxed and regulated state (for example, Certificate of Need laws that require state approval for a change in hospital ownership). For now they are able to essentially cost shift the Medicaid shortfalls to private payers, but are concerned they will not be able to do so in the future. The ACA-related Medicaid DSH cuts that begin in 2018 are viewed as “just piling on more bad news based on a faulty premise.” They believe they can manage the planned cuts in Medicaid DSH, but it is the unexpected cuts in Medicaid payment by the state that they have the most difficulty and concern with.

APPENDIX 6

HOSPITAL PERFORMANCE ON CMS QUALITY MEASURES

Appendix 6. Medicare quality bonuses and penalties

Hospital	Value-based purchasing Penalties, Oct. 2014–Sept. 2015	Readmissions penalty Oct. 2014–Sept. 2015	Received HAC penalty for Oct. 2014–Sept. 2015
LAC+USC Medical Center	-0.08%	-0.13%	Yes
Denver Health Medical Center	-0.20%	-0.01%	No
Regional One Health	-0.46%	-0.01%	Yes
Harris Health System	-0.15%	-0.13%	No
Froedtert Hospital	-0.22%	-1.10%	No
University of Kentucky HealthCare	0.14%	-0.42%	Yes
Yale-New Haven Hospital	-0.39%	-0.71%	Yes
Homestead Hospital	0.85%	-0.39%	No

Source: CMS.

Note: Medicare exempts Marcum and Wallace Memorial Hospital and Lakewood Health System from reporting on these indicators due to their small size as Critical Access Hospitals.

www.mathematica-mpr.com

**Improving public well-being by conducting high quality,
objective research and data collection**

PRINCETON, NJ ■ ANN ARBOR, MI ■ CAMBRIDGE, MA ■ CHICAGO, IL ■ OAKLAND, CA ■ WASHINGTON, DC

MATHEMATICA
Policy Research

Mathematica® is a registered trademark
of Mathematica Policy Research, Inc.