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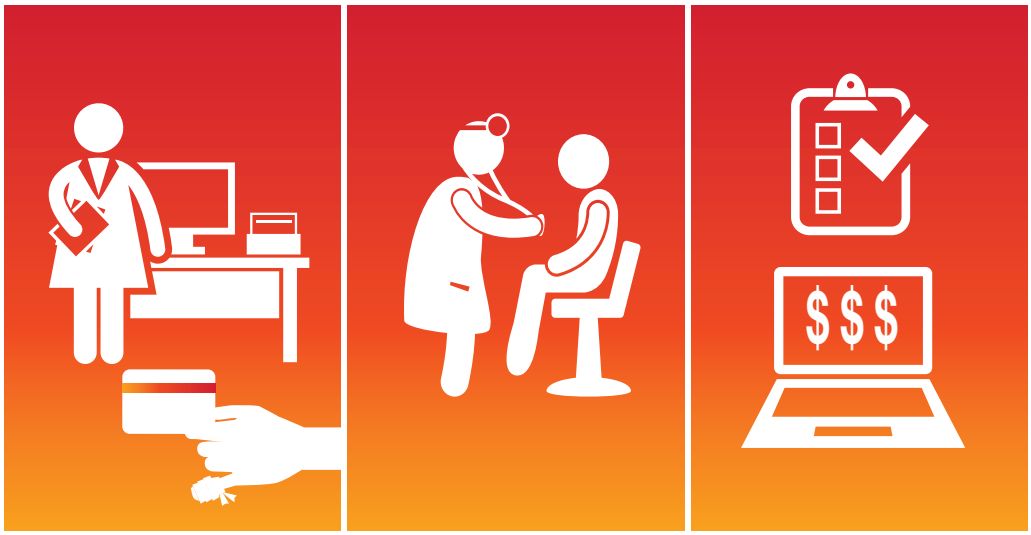

A Changing Environment: The Affordable Care Act's Early Effects on Patient Volumes and Finances at 10 Safety Net Hospitals

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About the Research

This brief presents the results of a qualitative study of 10 safety net hospitals and their early experiences with the 2014 insurance coverage expansions under the ACA. Supplemented with quantitative information from the hospitals, we examine changes in these hospitals' patient volumes, payer mix, and finances between early 2013 and early 2015. The study found that, overall, the six hospitals in states that expanded Medicaid fared better than the four in states that did not expand the program. Although the findings of this study are not generalizable to all safety net hospitals, they are useful in understanding changes other hospitals may experience under the ACA.

Findings in Brief

Among the six safety net hospitals in states that expanded Medicaid (expansion state hospitals), the research team found the following:

- Patient volumes grew markedly, especially among Medicaid patients and for outpatient services, reflecting hospital efforts to (1) help uninsured patients enroll in coverage, (2) expand primary care capacity, and (3) improve facilities and systems.
- On average, the hospitals are treating significantly more insured patients and fewer uninsured patients than they were before the ACA.
- In line with reductions in uninsured patients, uncompensated (charity care plus bad debt)—declined significantly for the expansion state hospitals.
- Hospitals' financial status improved.

Findings for the four hospitals in states that didn't expand Medicaid (non-expansion state hospitals) include the following:

- Volumes increased modestly.
- Payer mix did not markedly improve.
- Financial status declined on average.

Expansions in commercial coverage under the ACA, including coverage through the federal and state Marketplaces, had limited and somewhat mixed impacts for the hospitals. In some cases, coverage contributed to upticks in bad debt, as many new products require high levels of patient cost sharing, which can be difficult for the hospitals to collect.

Hospitals in both expansion states and non-expansion states experienced declines in their subsidies and are bracing for more cuts, so financial gains could be temporary and further challenges could be on the horizon.

INTRODUCTION

This brief presents the results of a qualitative study of 10 safety net hospitals and their early experiences with the 2014 insurance coverage expansions under the Patient Protection and Affordable Care Act (ACA) of 2010. Six of the hospitals are in states that expanded Medicaid under the ACA: Lakewood Health System (MN); Marcum and Wallace Memorial Hospital and UK Health (KY); Denver Health Medical Center (CO); Los Angeles County + University of Southern California Medical Center (CA) and Yale New Haven Hospital (CT). Four study hospitals are in states that have not expanded Medicaid under the ACA: Homestead Hospital (FL); Froedtert Hospital (WI); Regional One Health (TN) and Harris Health System (TX) (see box and Table 1 on page 3). These states started from different points in terms of the extent to which they covered childless adults through Medicaid before 2014 (see About the Methodology on page 13).

Supplemented with quantitative information collected from the hospitals, we examine changes in these hospitals' patient volumes, payer mix, and finances between early 2013 and early 2015.

BACKGROUND

As a central part of the U.S. health care system, hospitals defined as "safety net hospitals" are those that deliver care to some of the nation's most medically vulnerable groups, including many Medicaid enrollees and the uninsured. They also provide high cost specialty services, such as trauma, burn care, and behavioral health, to both these groups and the broader population.

The ACA created potential challenges and opportunities for these providers in two fundamental ways. First, in 2014, the ACA expanded access to insurance coverage for low-income people. States have the option to extend Medicaid eligibility to adults with incomes of up to 138 percent of the federal poverty level (FPL), or approximately $16,400 for an individual. The ACA also extended subsidies for premiums and cost sharing to people with incomes 100 to 400 percent of the FPL to defray the costs of private, commercial insurance through new federal and state Marketplaces. To the extent that uninsured people gained coverage and continued to use safety net hospitals for their care, these hospitals expected to see their revenues and potentially volumes grow. For safety net hospitals in the 19 states that have not expanded Medicaid, the extent of such growth was more uncertain.

Second, the ACA imposed significant cuts in safety net hospitals' federal subsidies—namely, the Medicaid Disproportionate Share Hospital (DSH) program, an important revenue source for these providers.[1] The justification for these cuts was that hospitals' revenues from Medicaid and other insurance programs would rise as more people gained coverage. In turn, hospitals' levels of uncompensated care (composed of charity care and bad debt) would decline. Before the ACA, Medicaid DSH paid approximately one-quarter of safety net hospitals' unreimbursed care costs.[2] Although the ACA called for a phased cut of 50 percent between 2014 and 2020, the cuts have been delayed several times and are now set to go into effect in 2018. Medicare DSH payments, typically a smaller revenue source for safety net hospitals, also declined by 75 percent nationally in 2014.[3]

The Four Categories of Hospitals Represented

Large, publicly owned or affiliated health systems. The Los Angeles County + USC Medical Center (LAC+USC), Denver Health Medical Center, Harris Health System (TX), and Regional One Health (TN) are (or are part of) dominant safety net systems in their communities.

Academic medical centers. University of Kentucky Health Care and Yale New Haven Hospital (CT) are the dominant health systems in their communities, providing both safety net and non-safety-net functions. Froedtert Hospital (WI) is an academic medical center that is a major provider of care to uninsured and Medicaid patients, but also competes with other large health systems for commercially insured and Medicare patients.

Private, not-for-profit hospital. Homestead Hospital (FL) is part of a large, private, not-for-profit system that exists in the "shadow" of a large publicly operated safety net system. It fills a gap in a part of the county that is far from the main facility and serves many uninsured patients and Medicaid enrollees.

Small, rural hospitals. Lakewood Health System (MN) and Marcum and Wallace Memorial Hospital (KY) both hold federal Critical Access Hospital designation, given their small size (25 beds), and the fact that they are sole hospital providers in their counties and relatively far from other hospitals. Lakewood is independent, while Marcum and Wallace is part of the Mercy Health System.

Table 1:
Characteristics of Study Hospitals

Hospital & location	In Medicaid Expansion State?	Number of beds[a]	Type and ownership	DSH patient percentage (pre-ACA)[a]	Share of uncompensated care in county (pre-ACA)[b]
Lakewood Health System (Staples, MN)	Yes	25	Independent Critical Access Hospital	N/A	100
Marcum and Wallace Memorial Hospital (Irvine, KY)	Yes	25	Critical Access Hospital, part of Mercy Health system	N/A	100
Homestead Hospital (Homestead, FL; So. Miami-Dade County)	No	142	Not-for-profit, community hospital part of the Baptist Health South Florida hospital system	69	6
Regional One Health (Memphis, TN)	No	325	Not-for-profit integrated delivery system affiliated with University of Tennessee Health Science Center	75	18
Denver Health Medical Center (Denver, CO)	Yes	477	Integrated delivery system owned by City and County of Denver	67	51
Froedtert Hospital (Milwaukee, WI)	No	509	Academic medical center (AMC) affiliated with Medical College of Wisconsin	32	20
Los Angeles County (LAC) + University of Southern California (USC) Medical Center (Los Angeles, CA)	Yes	600	Flagship acute care hospital of four-hospital system owned by LA County; affiliated with USC medical school	85	21
Harris Health System (Houston, TX)	No	855 (3 hospitals)	County hospital affiliated with Baylor College of Medicine and University of Texas Health	69	58
UK Health (Lexington, KY)	Yes	945 (3 hospitals)	AMC, part of the University of Kentucky	48	71
Yale New Haven Hospital (New Haven, CT)	Yes	1,541	Flagship hospital of the three-hospital Yale New Haven Health System; primary teaching hospital for Yale School of Medicine	43	72

[a] From 2013 Medicare Cost Reports. The DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and Supplemental Security Income (SSI), and the percentage of total inpatient days attributable to patients eligible for Medicaid but not Medicare Part A. Numbers rounded to nearest whole number.

[b] Computed as total uncompensated care for the hospital/total uncompensated care across all hospitals in the county.

FINDINGS

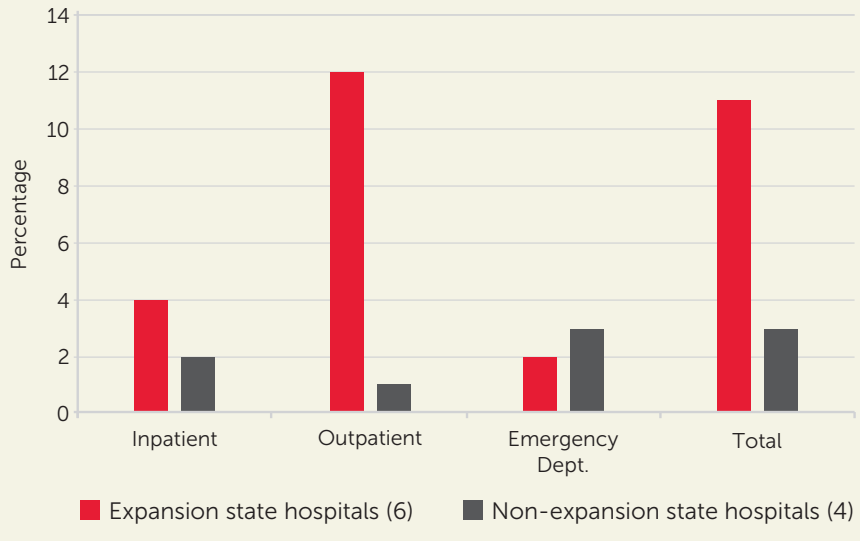
Patient Volume and Mix

Patient volume grew more for expansion state hospitals, which reported an average 11 percent overall increase versus 3 percent for hospitals in non-expansion states (Figure 1). Inpatient admissions, outpatient visits, and emergency department visits all increased to varying degrees between the first quarter of 2013 and the first quarter of 2015. In states that expanded Medicaid eligibility, patient volumes for the hospitals in this study increased substantially. This growth partly reflects hospitals' efforts to help uninsured patients enroll in coverage as well as efforts to improve facilities and systems to attract and retain existing patients who gained coverage (discussed in detail on page 7). The growth at the non-expansion state hospitals may have resulted from outreach activities that led people already eligible for Medicaid to apply (often referred to as a "woodwork" or "welcoming mat" effect). Additional varied factors reportedly contributed to individual hospitals' volume changes, including population growth, capacity increases and, for Froedtert, a change in state policy that added more people to Medicaid from a waiting list.[4]

Patient volume increases were especially notable for outpatient care, which grew an average 12 percent for the hospitals in expansion states. This growth reflects a variety of factors. Most of the Medicaid expansion population receives in these states care through a health plan that requires new enrollees to choose a medical home to provide primary care and coordinate follow-up care. Many hospitals expanded outpatient capacity (discussed in detail below) as they sought to redirect patients from emergency departments and reduce or shift care away from inpatient facilities.[5] This redirection reportedly took place because of limited capacity and because hospitals are striving to provide care in less costly settings in preparation for new payment arrangements that reward value over volume—that is, better outcomes at lower costs.

Figure 1:

Average change in patient volumes by service type, Q1 2013–Q1 2015



Source: Quarterly information collected from study hospitals. Hospitals are weighted equally in the calculations.

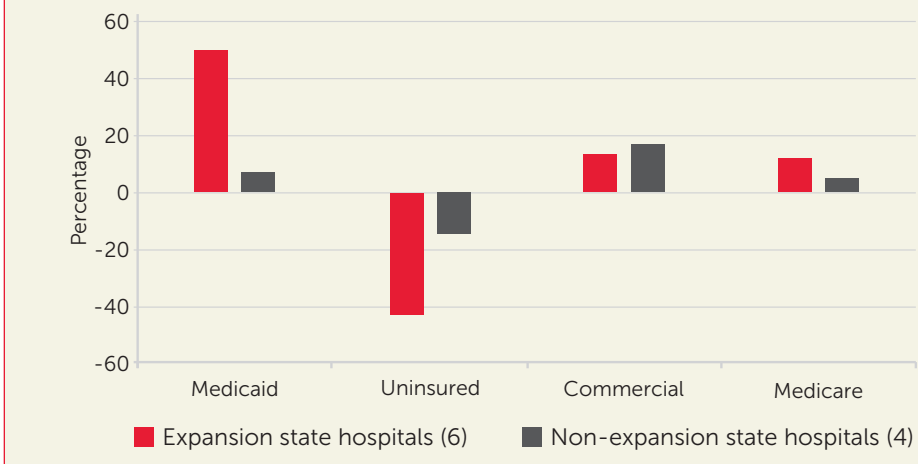
On average, emergency department (ED) volumes grew modestly for both types of hospitals. However, two expansion state hospitals saw somewhat large (11 to 12 percent) increases. The growth in ED use is consistent with studies showing that Medicaid patients use emergency care more than uninsured patients do.[6] Hospitals in non-expansion states cited several reasons for their ED growth, including the modest growth in Medicaid and commercially insured patients, overall population growth, and more delays in receiving routine care, which allowed conditions to become more serious and urgent.

Inpatient volumes and average length of inpatient stay (data not shown) did not increase much, on average, for hospitals in expansion or non-expansion states. This finding is consistent with the national trends as hospitals treat more needs in ambulatory settings. It may also suggest that new patients were not significantly sicker than previous patients were. Although hospitals reported that newly insured patients were likely to have chronic conditions and needs that had gone unaddressed previously, many of these conditions reportedly were addressed on an outpatient basis.

Medicaid growth outpaced Marketplace growth. Overall, Medicaid expansion appeared to drive more growth in patient volume than the new Marketplace coverage options did. For non-expansion state hospitals, the modest volume growth was primarily generated by commercially insured patients (Figure 2). Yet Marketplace coverage reportedly did not significantly affect hospitals in either expansion states or non-expansion states. This is not especially surprising because, in states that expanded Medicaid, enrollment in Medicaid typically far outpaced Marketplace enrollment. Also many safety net hospitals serve a very low-income population, so existing patients qualified for Medicaid rather than Marketplace coverage. In non-expansion states, many patients have incomes below the federal poverty line and are ineligible for Marketplace subsidies. Also, a few hospitals reported challenges in obtaining contracts with Marketplace health plans, in some cases because they were not deemed "Essential Community Providers" and were not included in these plans' provider networks.

Figure 2:

Average change in patient volume by payer source, Q1 2013–Q1 2015



Source: Quarterly information collected from study hospitals. Hospitals are weighted equally in the calculations.

Payer mix improved for expansion state hospitals. As a result of Medicaid growth, expansion state hospitals' payer mix improved markedly (Figure 3). Medicaid encounters became a much larger portion of inpatient, outpatient, and emergency department services, and uninsured 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). Medicaid volume grew more in states that previously had no or minimal Medicaid coverage for childless adults (California, Colorado, and Kentucky). Two hospitals experienced dramatic increases in Medicaid encounters and significant (but lesser) drops in encounters from uninsured patients during this period. At LAC+USC, Medicaid encounters jumped by 150 percent, and uninsured encounters plummeted 85 percent. For UK Health, Medicaid encounters grew by 80 percent, and uninsured encounters fell 55 percent.

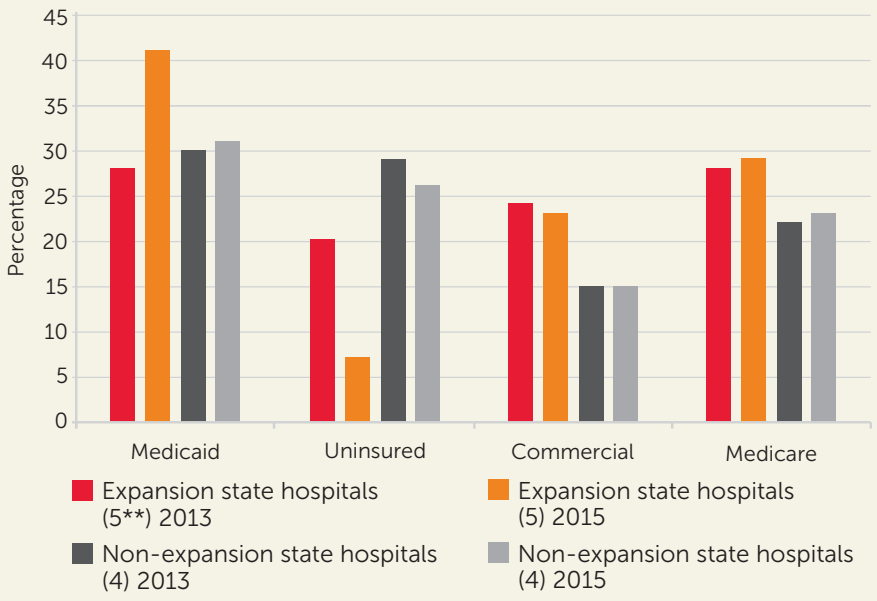
In contrast, the modest growth in Medicaid volumes for hospitals in non-expansion states typically had little effect on Medicaid as a proportion of overall encounters. These hospitals experienced little change overall in their patient mix between the first quarter of 2013 and the first quarter of 2015.

Although many hospitals in the study experienced some increase in commercially insured patients, this was more prevalent among the four hospitals in non-expansion states. Commercial insurance as a percentage of the overall patient payer mix did not increase.

Hospitals worked to attract more patients. Growth in patient encounters aligns with the hospitals' efforts to retain and attract patients who gained coverage. Both expansion

Figure 3:

Average payer mix, Q1 2013 and Q1 2015*



*Calculated based on average of inpatient, outpatient, and emergency department patient mix.

** Payer mix unavailable for Denver Health.

Source: Quarterly information collected from study hospitals. Hospitals are weighted equally in the calculations.

state and non-expansion state hospitals identified existing patients eligible for coverage and conducted outreach to find additional uninsured people, and helped them apply for coverage. Some 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.

Many respondents referred to improvement efforts as strategies to become "providers of choice, not last resort."

Hospitals made efforts to improve their facilities, simplify appointment scheduling, reduce wait times, and enhance customer service so that newly insured patients would select them over other providers. Many respondents referred to improvement efforts as strategies to become "providers of choice, not last resort." Another factor that drew patients: many states direct Medicaid enrollees who do not choose a health plan or a medical home to the large safety net providers.

Hospitals expanded ambulatory care capacity. Many of the hospitals reportedly were operating close to or at capacity in their ED and outpatient services before the ACA expansions. As a result, they had to grow in order to treat more patients. By focusing on outpatient services, they did not need to add inpatient beds; some even reduced them.

Hospitals in the study typically provide a wide range of primary care services, which they expanded between 2013 and 2015. Primary care capacity is vital for a hospital serving as a medical home in insurance networks; it also helps hospitals gain referrals for other outpatient and inpatient services. In addition, primary care is an important component as a hospital prepares to transition to value-based payments. The study hospitals mainly boosted primary care by adding physicians and other staff (for example, nurse practitioners); at least one hospital (Yale) acquired physician practices in the community.

Some hospitals also expanded their facilities on their campus or at clinics in the community, or they extended their primary care presence by collaborating with other community clinics. For instance, Homestead had not traditionally provided primary care, but recently started a clinic to provide comprehensive visits to patients after they leave the hospital in order 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). Some hospitals with a large number of patients presenting in emergency departments for behavioral health issues reported adding social workers and psychiatric staff and/or working to integrate behavioral health into primary care.

A couple of non-expansion state hospitals increased primary care services substantially in anticipation of a Medicaid expansion that did not take place. For example, Harris Health built two large primary care clinics before Texas opted out of the Medicaid expansion. The clinics now serve many more uninsured patients who need follow-up care; addressing their specialty care needs has strained Harris's capacity and financial status.

Given the costs of adding physical capacity and staff, some hospitals have turned to telehealth strategies for extending primary care and other services. For example,

Froedtert started a virtual urgent care service, using FaceTime and Skype technology. Some of these efforts are not captured in the hospital volume data. In a key example, LAC+USC has boosted use of telephonic medical advice and its eConsult online system that has reduced the need for face-to-face specialty visits.

"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."

–Executive at Expansion State Hospital

Financial Impacts

Higher patient volumes brought about a growth in revenue. Largely linked to the growth in patient volumes from insured patients, operating revenues increased for expansion state hospitals and, to a lesser extent, for non-expansion state hospitals between the first quarter of 2013 and the first quarter of 2015. For expansion state hospitals, this increase came largely from Medicaid.

Revenue growth was especially large for hospitals that receive cost-based Medicaid reimbursement; these include rural critical access hospitals and, more recently, LAC+USC. While some other hospitals received slight rate increases, Medicaid reimbursement remains lower than the cost of providing services; however, since hospitals had been treating many of these patients as uninsured, they had received lower funding levels in the past to support these services.

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

Hospital subsidies are on the decline. Long-standing federal, state, and local subsidies to safety net hospitals—for example, from the DSH program, state provider taxes, or general county revenues—have waned in the past few years, tempering revenue growth. Some of these cuts have not been as large as hospitals expected, however, because policymakers decided to phase them in gradually while hospitals adjusted to reform. Some hospitals are benefiting temporarily from being paid retroactively based on a period when they served more uninsured patients. Some respondents expect that they will have to repay some of these funds once the state and federal government fully account for changes in the mix of patients and payers.

Most of the hospitals experienced either stable or declining Medicaid DSH payments between 2013 and 2015. Congress has delayed planned cuts several times, but states also play a large role in how these funds are allocated, and some changed their distribution formulas. In addition, some hospitals' allocations changed when their patient mix shifted. Some hospitals reportedly plan to not recognize future DSH payments as revenue; this strategy prepares them for upcoming cuts and originated out of a concern that they will lose more DSH funds—and potentially need to repay funds they already received—once their state assesses changes in volumes and patient mix. However, Medicaid DSH has not been a large funding

source for some hospitals. This is especially true, for instance, in the case of Homestead (FL) and the critical access hospitals in the study, Lakewood (MN) and Marcum and Wallace (KY). Across the study hospitals, Medicare DSH payments were either insignificant or did not change substantially.

Federal Section 1115 Medicaid waivers are also important, though inconsistent, sources of funding.[7] A common source of Medicaid revenue for study hospitals are state programs that charge a fee to a broad set of providers, obtain federal Medicaid matching funds, then redistribute the funds to hospitals serving many low-income patients. Denver Health's payments from such a program have been rising, while Homestead's have been stable over this period. After lengthy negotiations, the federal government and Florida came to an agreement to continue this funding source, but at a lower level and it is too early to know the impact on the state's safety net providers.[8] Yale's experience was different, with the fee assessed on the hospital reportedly totaling more than the hospital received in enhanced Medicaid payments.

LAC+USC and Harris receive other funds through their state's 1115 Medicaid waivers. This includes the Delivery System Reform Incentive Payment (DSRIP) program, which has helped the hospital systems expand capacity in new ways, particularly for primary care. Although California's waiver ended in October 2015, a new waiver will extend the program (renamed PRIME) to 2020, and hospitals will need to demonstrate that these funds are helping achieve better patient outcomes at lower costs. The Texas program is slated to end in 2016, unless the state's Medicaid waiver is renewed.

"Medicaid expansion would provide a better and more predictable funding stream."

–Executive at Non-Expansion State Hospital

County-owned hospitals are particularly vulnerable because they rely on additional state and local subsidies that also have started to decline. LAC+USC saw its so-called "realignment funds" (sales tax and vehicle licensing fee revenue) cut; the state now directs more of these funds to social services. Expansion state hospitals expected funding reductions as their uninsured populations declined, but the cuts are more painful for non-expansion state hospitals. For example, county funds (largely from property taxes) that make up almost half of Harris's revenue were cut by 13 percent (or $75 million annually) starting in 2011. The county made this cut in anticipation of Texas expanding Medicaid, which did not happen. In contrast, RegionalOne's county appropriation has been steady over the past few years, and the hospital expects to receive a slight increase this year.

Levels of uncompensated care fell. Commensurate with reductions in uninsured patients, uncompensated care—made up of charity care and bad debt—declined by almost one-third for the expansion state hospitals. Charity care dropped more than bad debt. In fact, some expansion state hospitals reported slight increases in bad debt, which hospitals attributed in part to commercial insurance products with high cost-sharing for deductibles and copayments that patients cannot pay. Although the growth of these products started before the ACA, it has continued with the Marketplace plans.

Changes in uncompensated care levels were mixed for hospitals in non-expansion states. Both Homestead and Harris experienced growing levels of uncompensated care—as much as 25 percent for Harris—reflecting volume increases, general medical

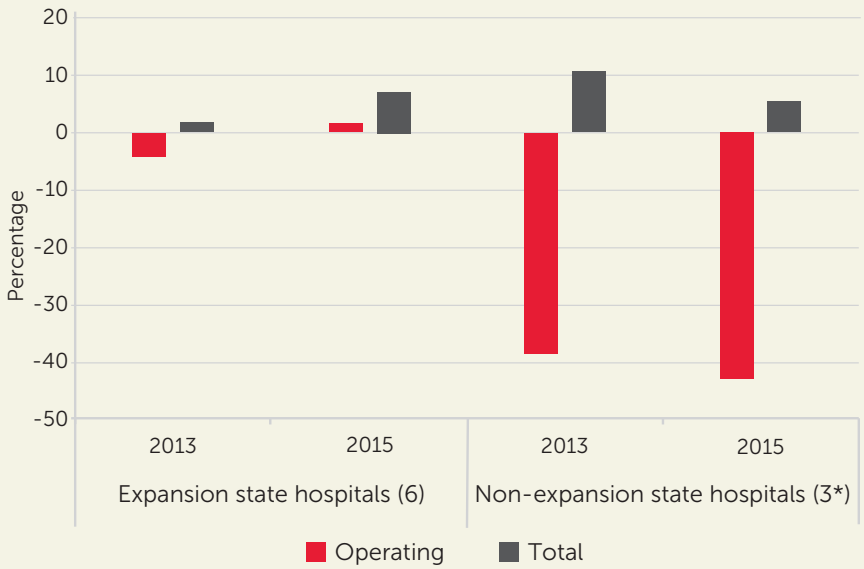
inflation, and growing bad debt. Regional One's uncompensated care level reportedly declined slightly while Froedtert's levels dropped significantly (even as it increased the upper-income limit for charity care eligibility) as more people gained coverage.

Medicaid expansion helped hospitals achieve better financial performance. Most of the expansion state hospitals started with low or negative operating and total margins (Figure 4).[9] By 2015, most expansion state hospitals reported improved financial performance, reportedly reflecting gains in Medicaid patient revenue as well as some cost reductions (primarily through staffing cuts). 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 the particularly large Medicaid enrollment jump 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, a gap the county helps fill with local revenues. However, Yale faced declining margins, attributed to reductions in Medicaid reimbursement levels.

On average, non-expansion state hospitals reported quite negative operating margins that declined further over the study period; total margins also fell but remained positive. Most of these hospitals face significant operating deficits, but local tax and general revenues help their overall financial picture (i.e., some subsidies are counted as non-operating revenue instead of operating revenue). They attributed losses to growing expenses—including investments in information technology, quality improvement activities, and staff salaries—that outpaced revenues. There were exceptions, however—Froedtert had strong and improving operating margins, reflecting its relatively large growth (for a non-expansion state hospital) in Medicaid volumes.

Figure 4:

Average operating and total margins, Q1 2013 and Q1 2015*



Source: Quarterly information collected from study hospitals. Hospitals are weighted equally in the calculations.

*Margins unavailable for Homestead Hospital.

"We're in the sweet spot of health reform."

–Executive at Expansion State Hospital

Improved financial stability helped hospitals prepare for the future. The expansion state hospitals' greater financial security has provided more resources to help them continue expanding outpatient capacity, invest in strategies to improve care coordination, and develop better infrastructure to monitor costs. These actions are important for new payment arrangements that will shift more financial risk for patient care and outcomes to hospitals.

Hospitals did express caution about spending, however. Many worry that increased revenue may be offset by, or overwhelmed by, cuts in subsidies. In addition, Medicaid enrollment and payments could decline after 2017, when states will need to start paying part of the cost of expanding their Medicaid programs (the portion gradually increases to 10 percent by 2020). This possibility was a particular concern for the Kentucky hospitals in the study, because their Medicaid expansion was so large and because of a new state governor.[10] Many hospitals in states that did not expand Medicaid lack the financial margin to pursue these investments; they expressed less confidence that they would be able to create the infrastructure to integrate care delivery and fare well under new payment arrangements.

All of the hospitals are focused on ways to raise additional revenues, primarily by diversifying their payer mix. Most do 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. Academic medical centers have concentrated on expanding inpatient and outpatient specialty services (tertiary and quaternary care) that appeal to a broader population. For example, UK Health added a new ambulatory building and inpatient beds to support this strategy. Better branding and marketing are also important. For instance, Regional One was known as Regional Medical Center and referred to as "the Med" in the community; its new name is part of a strategy to reflect the broader system of services, including primary care, outpatient surgery, and rehabilitation, it now provides.

Hospitals are also looking at new ways to cut costs. Some hospitals in non-expansion states are considering changing their policies in ways that could affect patients' access to care. For example, Harris Health has contemplated modifying its charity policy so fewer people are eligible for free care.[11]

LOOKING AHEAD

Experiences of the hospitals in this study illustrate the changing environment that many safety net hospitals face under the ACA. For the expansion state hospitals, the Medicaid expansion was a significant, positive transformation because it generated more revenue and reduced the burden of uncompensated care. Meanwhile, the non-expansion state hospitals have faced growing struggles linked to eroding state and federal subsidies and additional uncompensated care burden and/or other expenses.

At the same time, all of the study hospitals confront the challenge of providing more cost–effective, high quality services, particularly in response to the broad scale move

towards value-based payments and accountable care. Many hospitals' strategies to enhance primary care capacity to reduce ED and inpatient use, to create information technology systems to better track patient care and costs, and to treat patients in new ways for non-medical needs—appear consistent with these aims but may be insufficient.

About the Methodology

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services sponsored a qualitative study of 10 safety net hospital systems, including 8 urban and 2 rural hospitals, in 2014-2015. The study objective was to examine these hospitals' early experiences with expanded insurance coverage, changes in funding supports, and payment and delivery system reforms under the Affordable Care Act (ACA).

The hospitals were selected purposively to ensure diversity in geographic region, ownership, size, and affiliations with other hospitals (see Table 1). Six of the hospitals are in states that expanded Medicaid and four are in states that have not expanded Medicaid. The states varied in the extent to which they covered non-disabled childless adults through Medicaid before 2014. Colorado extended eligibility to this group with incomes below 10% of the federal poverty level (FPL) in 2009. Connecticut provided eligibility to 56% FPL in 2010, and Minnesota to 75% FPL in 2011. Kentucky and California did not cover non-disabled childless adults before 2014, although California gave counties the option to create a Medicaid-like program called the Low Income Health Program, with income eligibility levels set by individual counties. In 2009, Wisconsin extended eligibility to childless adults living below 200% FPL but had capped enrollment; in 2014, the state reduced income eligibility to 100% FPL but removed the enrollment cap. Texas, Tennessee and Florida have not covered childless adults.

The team conducted approximately 50 semi-structured discussions for this study. These included discussions in 2014 with executives at the six expansion state hospitals as well as other knowledgeable respondents from state Medicaid agencies, state hospital associations, community organizations, local foundations, and universities. The discussions focused on preparation for and early experiences with the ACA, especially 2013–2014 trends in utilization, revenue, uncompensated care, and finances, based on quarterly utilization and finance data the hospitals provided.

In 2015, the research team again met with the expansion state hospital executives to determine whether earlier trends in utilization, revenue, and finances persisted or new ones were emerging. The research team also held semi-structured discussions with executives at the four non-expansion state hospitals. The 2015 discussions included more detail about hospitals' experiences with payment and delivery system reforms, including value-based purchasing initiatives from the Centers for Medicare & Medicaid Services (CMS) and alternative payment models. Findings and analyses related to these topics are presented in a companion brief.[12]

The study's primary limitation is that the sample is small and purposively selected, so is not representative of all safety net hospitals. In addition, although the researchers attempted to understand how the ACA had affected the hospitals, it typically was not possible to isolate the ACA's effects from the effects of other policy and market changes. Still, the findings are consistent with those from other studies focused on safety net hospitals during the same general time frame.[13, 14, 15, 16] Further, because the sample represents hospitals with executives who agreed to participate, it may underrepresent hospitals facing leadership turnover, acute financial distress, or other factors that could have prevented them from participating.

Some respondents also cautioned that the quarterly patient volume and financial data they provided offer only preliminary, unaudited representations of their hospitals' experience. Some changes in the quantitative information from one period to another could represent normal variation over time, rather than significant changes. Also, some differences in how hospitals report volume and financial information could affect comparisons among hospitals. To guard against overstating the level of change, this brief reports averages and ranges across hospitals; hospital-specific numbers are only estimates. Although some indicators from individual hospitals are missing, the qualitative research process offset some of these data omissions by capturing additional context and information, including hospital executives' perceptions of key changes.

REFERENCES

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4. However, Medicaid volumes declined at Regional One, which reportedly is related in part to Medicaid patients aging into the Medicare program.
5. Some policy changes also affected the classification of inpatient and outpatient cases. For example, part of Froedtert's rise in outpatient volume was related to the Medicare "two-midnight rule," which increased the number of cases categorized as observation or outpatient cases rather than inpatient.
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7. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that gives states flexibility to design and improve their programs, including broad changes in eligibility, benefits, cost sharing, and provider payments. Waiver projects must also be budget neutral to the federal government, over the waiver period (typically five years).
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9. A hospital's operating margin is the net of revenues received for patient services (e.g., reimbursement from insurers) and other operations (e.g., cafeteria, gift shop) minus the hospital's expenses for providing those services. A hospital's total margin provides a broader view of financial health, representing total expenses and revenues from all sources, including investment income, philanthropic contributions and certain state and local funds received (e.g., tax revenues). Operating margin can be a better measure of the hospital's sustainability because it reflects the ongoing business of the hospital, rather than income from other potentially less dependable or more variable sources.

10. Since the site visit, Kentucky has elected Matt Bevin as governor, who 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," NPR, January 12, 2016.

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