The Impact of Obamacare on Safety Net Hospitals

Safety net hospitals—as the name implies—play a critical role in the nation's health care system by serving low-income, uninsured and medically and socially vulnerable patients regardless of their ability to pay.

Yet because they serve such a high proportion of patients who are uninsured or enrolled in Medicaid (Medi-Cal in California), many safety net hospitals face an uncertain financial future. Such uncertainty results from government funding changes, increased performance and service expectations and rising labor costs.

While many safety net hospitals have been able to remain afloat—barely—others have not been as fortunate. In

California, Doctors Medical Center in the Northern Bay Area closed in April 2015. And Daughters of Charity Health System, a network of charity hospitals and providers in Los Angeles and the San Francisco area, continues to look for a buyer to stay in business.

The reality is that many safety net hospitals will likely need to reposition themselves in the healthcare market, including reorganizing their operations and care delivery, to remain financially viable and continue to fulfill their core missions.

The Institute of Medicine defines safety net hospitals as the following:

• By legal mandate or explicitly adopted mission, they maintain an 'open door' offering patients access to services regardless of their ability to pay; and

• A 'substantial share' of their patient mix is uninsured, Medicaid and other vulnerable patients.

The definition of 'substantial share' will become increasingly important to safety net hospital systems as their Medicaid/Medicare Disproportionate Share Hospital (DSH) and uncompensated care payments may depend on it. In the past, a significant amount of their funding was obtained through these payment programs.

President Obama signed the Patient Protection and Affordable Care Act (ACA) in March of 2010; that legislation, along with the Health Care and Education Reconciliation Act of 2010, made health insurance coverage available and more affordable to millions of uninsured people across the country. One of the most important provisions of the ACA was to provide some of the healthcare coverage through the expansion of Medicaid; it was expected that reductions in DSH and uncompensated care payments, as a result of having more insured Americans, would help fund the expansion. However, the Supreme Court later ruled that the states who provide Medicaid could not be 'required' to expand coverage. Consequently, as of 2015, 30 states and the District of Columbia decided to expand Medicaid coverage, while 19 states opted not to expand coverage; Utah still remains undecided. 1

The states' decisions on whether or not to expand Medicaid is one of the major determinants of the number of Americans who will gain access to healthcare coverage. Not increasing the number of patients with Medicaid, coupled with a decrease in DSH and uncompensated care payments, could result in funding shortfalls for safety net hospitals. According to information gathered from the US Census Bureau, for a state like California, that chose to expand Medicaid coverage, the number of insured people could rise by 2,113,000 people. At the same time, it could also mean that for states like Florida or Texas, that chose not to expand coverage, the number of people who will not gain coverage could be as high as 1,253,000 or 1,186,000 people, respectively. One thing that is certain is that over the next few years, whether the number of insured Americans increases or remains the same, the number of DSH and uncompensated care payments are expected to decrease – which may present a challenge for states that have chosen not to expand their Medicaid programs.

Other Challenges and Potential Strategies to Improve Revenue for Safety Net Hospital Systems:

Despite the degree to which various states have adopted the ACA, safety net hospital systems recognize that they are operating in a different healthcare environment and must employ different strategies to remain financially viable. The 'patient experience' has become increasingly more important as healthcare systems compete for the newly insured, and may address challenges such as improving customer service skills, decreasing appointment wait times, improving the scheduling procedures, developing marketing plans, and even building and marketing new state-of-the-art hospitals to patient populations that might not normally consider a safety net hospital for services.

As the number of newly insured patients continues to increase, the need for primary care services is also expected to increase; in safety net hospital systems, due to the patient population it serves, the need for some specialty clinics is also expected to increase. The ACA addressed this issue in a number of ways, including incenting the use of various types of health centers instead of the ED and expanding the use of nurse practitioners and physician assistants. CMS had also targeted funds for use in hospital systems serving the indigent population through the expansion of Medicaid managed care programs in the form of the 1115 Waiver; some safety net hospital systems have dramatically expanded their plans for 1115 Waiver projects in an effort to maximize waiver funds. In some safety net hospital systems in Texas, for example, 1115 Waiver projects have been given top priority status throughout the healthcare system and have included initiatives such as opening new primary care clinics and improving access to specialty clinics, including mental health and AIDs clinics; funding from the 1115 Wavier is expected to be one of the major sources of income in safety net hospitals in this state.

Health information technology (HIT) has played an important part in healthcare for a number of years now, but it will become increasingly important as hospitals attempt to increase patient safety, boost quality of care, improve efficiencies and decrease costs. The HITECH Act of 2009 encouraged the use of HIT and electronic health records, and many hospitals were quick to improve or upgrade their systems in an effort to avoid future penalties and maximize economic stimulus funds. The essence of the HITECH act is not only to implement the systems, but to promote the adoption and meaningful use of them, as described in Stage 1, 2 and 3 requirements. The HITECH Act was thought by many to be the foundation for healthcare reform, where hospitals and providers would start managing population health by moving from volume-based reimbursement to value-based reimbursement; however capitation payment rates are often inadequate and often don't sufficiently take into account tools for adjusting risk based on the population served, resulting in safety net hospitals assuming a substantial amount of the risk for a sicker patient population. HIT has automated the ever increasing need to capture, analyze and report on data, supporting the ability of hospitals and providers to quickly respond to new regulatory requirements while lessening the negative financial impact.

In addition to more aggressively pursuing available outside incentives, many safety net hospitals are looking

internally for ways to decrease costs and increase revenues. These changes have come in the form of staffing productivity assessments resulting, at times, in adjustments at the leadership level, and staff restructuring/reductions. Additionally, improving financial management through initiatives such as revenue cycle improvement projects have become commonplace to attempt to optimize billing and collection procedures. HIT has also played a role in improving financial performance by automating enrollment and eligibility processes, online adjudication of claims, assistance with proper coding and supply chain management.

Despite the states' decisions on whether or not to expand Medicaid and the pending DSH and uncompensated care funding cuts that accompany healthcare reform, there are many strategies that safety net hospital systems can employ to improve the financial performance and increase revenue in the coming years. Many of these hospitals now have the infrastructure, systems and processes in place to adapt to the changing healthcare landscape. Changes in the way services are delivered and reimbursed can lead to improved patient safety, quality of care and efficiencies in the safety net hospital system.

