Toward a High Performance Health Care System for Vulnerable Populations: Funding for Safety-Net Hospitals

Prepared for the Commonwealth Fund Commission on a High Performance Health System

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TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM FOR VULNERABLE POPULATIONS: FUNDING FOR SAFETY-NET HOSPITALS

PREPARED FOR THE COMMONWEALTH FUND
COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM

Deborah Bachrach, Laura Braslow, and Anne Karl
Manatt Health Solutions

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ABSTRACT: Safety-net hospitals play an indispensable role in providing care to vulnerable populations. Yet, in the current economic environment, many safety-net hospitals face dire financial circumstances and struggle to provide care to growing numbers of low-income, uninsured, and Medicaid patients. This report, written on behalf of the Commonwealth Fund Commission on a High Performance Health System, examines the funding streams on which safety-net hospitals rely and suggests strategies—not simply to sustain these hospitals but to stimulate and reward high performance. These strategies include: increasing Medicaid rates (in states that have unreasonably low rates) to safety-net hospitals with the highest shares of Medicaid and uninsured patients and lowest shares of privately insured patients, contingent upon meeting performance benchmarks; targeting Medicaid and Medicare disproportionate share hospital payments to hospitals that serve uninsured patients; and supporting safety-net hospitals' access to the capital they need to implement large-scale delivery system reforms.

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PREFACE

The Commonwealth Fund Commission on a High Performance Health System has identified equity as a core goal of a high-performance health system. However, in the United States, vulnerable populations are at particular risk for poor health and poor health outcomes. In its October 2011 report, *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations*, the Commission laid out a policy strategy to close this health care divide: ensuring that health coverage provides adequate access and financial protection for vulnerable populations; coordinating care delivery with community-based resources, including public health services; and strengthening health care delivery systems serving vulnerable populations.

As a central component of these delivery systems, safety-net hospitals play an indispensable role in providing care to vulnerable populations. Yet, in the current economic environment, many safety-net hospitals face dire financial circumstances and struggle to provide care to growing numbers of low-income, uninsured, and Medicaid patients. Under the Affordable Care Act, these hospitals stand to benefit as currently uninsured patients are able to obtain coverage. However, their precarious financial status raises concerns about their continued viability in the near term.

In this new report, *Toward a High Performance Health Care System for Vulnerable Populations: Funding for Safety-Net Hospitals,* the Commission recommends policy approaches for sustaining the financial viability of safety-net hospitals while encouraging them to provide high-quality, coordinated, cost-effective care to vulnerable populations. These strategies include: increasing Medicaid rates to safety-net hospitals with the highest shares of Medicaid patients and lowest shares of privately insured patients, contingent upon meeting performance benchmarks; targeting Medicaid and Medicare disproportionate share hospital payments to hospitals that serve uninsured and underinsured patients; and supporting safety-net hospitals' access to the capital they need to implement large-scale delivery system reforms.

It will be essential to provide ongoing support to safety-net hospitals in a post-reform environment so they may provide care for the remaining uninsured and expanded Medicaid populations and continue to meet the complex health and social needs of vulnerable populations. We hope that this report will inform and encourage policymakers to support policies that target available funding to safety-net hospitals in ways that promote high-performance health care and that sustain safety-net hospitals as a critical source of care for the nation's most vulnerable groups.

David Blumenthal, M.D.
Chairman

Stuart Guterman
Executive Director

The Commonwealth Fund Commission on a High Performance Health System

EXECUTIVE SUMMARY

High-performance health systems must be capable of meeting the needs of vulnerable populations, who are at disproportionately greater risk for receiving inferior care and experiencing poorer health outcomes than other groups. The Commonwealth Fund Commission on a High Performance Health System has identified equity as a core goal of a high-performance health system and has proposed a three-part strategy to reduce the health care divide between vulnerable Americans—low-income families, those without health insurance, and racial and ethnic minorities—and the rest of society. First, ensure that health coverage provides adequate access and financial protection; second, coordinate care delivery with other community resources, including public health services; and finally, strengthen the safety-net delivery system serving these populations. Safety-net hospitals are central to these delivery systems and as such play a critical role in achieving high-performance health care for vulnerable populations. These hospitals serve disproprotionately large numbers of low-income patients, both insured and uninsured, and rely disproportionately on Medicaid and disproportionate share hospital (DSH) payments to sustain their operations and public funds to underwrite their capital needs. Both the financial pressures induced by dependence on these funding streams, as well as the anticipated changes in these streams due to the expected influx of Medicaid patients and reduction of DSH payments under health reform, pose challenges to the short- and long-term viability of safety-net hospitals. This report examines the funding streams on which safety-net hospitals most rely and suggests strategies to better target financial resources to these hospitals—not simply to sustain them but to stimulate and reward high performance. To address the complex health needs of vulnerable patients, safety-net hospitals must be able to provide high-quality, cost-effective care. Accordingly, the funding proposals that follow incorporate requirements of transparency and accountability.

The Distinguishing Features of Safety-Net Hospitals

Researchers and policymakers have used a range of factors to identify safety-net hospitals, all of which focus on hospitals that serve large numbers of low-income, medically vulnerable patients. These factors generally include the hospital's percentage of Medicaid patients, its uncompensated care burden, and the socioeconomic status of its patients. Occasionally, the hospital's financial condition is taken into account, as is the provision of selected services (e.g., trauma, burn, and neonatal intensive care).

The definition of safety-net hospital is important for several reasons. First, it indicates the hospitals to which federal and state resources should be targeted. In addition, it highlights the revenue streams most relevant to the financial health of safety-net hospitals and informs how these funding streams might best be configured and allocated among institutions. The ultimate goal is to ensure that low-income and medically vulnerable patients have timely access to care that is cost-effective and produces quality outcomes. In short, the challenge policymakers face is threefold: to identify safety-net hospitals, appropriately target and allocate key funding streams among these hospitals, and ensure accountability for quality and efficiency.

While policymakers and researchers do not agree on the exact determinants of safety-net hospital status, there is general agreement that Medicaid payments and Medicare and Medicaid DSH funding are all critical revenue streams. By definition, safety-net hospitals typically have disproportionately high percentages of Medicaid patients. However, a given hospital's Medicaid mix may fall along a continuum, and the baseline varies between states and local areas based on a state's Medicaid policies and the socioeconomic status of the community served by the hospital. Safety-net hospitals also serve larger numbers of uninsured and underinsured patients, resulting in larger uncompensated care burdens, reflected in their reliance on DSH payments.That said, some safety-net hospitals, most notably academic medical centers, have a greater percentage of privately insured patients and a greater ability to cross-subsidize Medicaid and uninsured losses.

Medicaid Payment Policies

Medicaid is becoming an increasingly important revenue stream at safety-net hospitals. As unemployment and poverty rates have risen, the number of Americans depending on Medicaid coverage and the number of uninsured Americans have likewise risen. When the Patient Protection and Affordable Care Act (Affordable Care Act) expands Medicaid to cover more than 52 million Americans, up from 35 million, Medicaid will become the nation's largest insurer. Massachusetts's health care reform experience suggests that under reform, Medicaid patients will continue to rely disproportionately on safety-net providers. With Medicaid constituting anywhere from 25 percent to well over 50 percent of the revenue of safety-net hospitals, states' Medicaid payment policies are a key determinant of the financial health of these institutions. In many, perhaps most, states, Medicaid payment rates are low and too often encourage costly inpatient services over more cost-effective outpatient services. With Medicaid the largest or second-largest item in a state budget, states are cutting Medicaid rates further in their efforts to balance their budgets.

The Affordable Care Act's expansion of Medicaid, coupled with its focus on cost containment and improved health outcomes, has triggered a focus on Medicaid payment levels and methodologies. State budget cuts and across-the-board rate cuts have focused attention on the adequacy of Medicaid payment rates and most particularly the relationship between payment rates and access to care. The challenge will be to channel this attention on Medicaid payment policies into sound decisions that ensure that Medicaid beneficiaries have timely access to quality, cost-effective care. At a minimum, that means rational payment methods and reasonable payment levels that support hospitals that provide value. This goal is not limited to payments to providers that serve the largest numbers of Medicaid patients. However, sound payment policies, most especially adequate payment levels, are core to the ability of these providers to deliver quality services to vulnerable populations.

Given current budget constraints, it is unlikely that states will be in a position to raise Medicaid payment levels for all services and for all providers. Therefore, targeting selective investment to enhance rates paid to safety-net hospitals that are most dependent on Medicaid revenue may be necessary. If linked to performance, this offers the best opportunity to improve care and preserve access for low-income patients and communities. At the outset, it must be acknowledged that targeting enhanced Medicaid payments to hospitals based on their safety-net status is far from ideal. However, a strategy that ties payment to performance and performance improvement offers a way to address quality and access concerns in an environment in which state Medicaid rates are otherwise low and state resources limited. If the investment is transparent and linked to quality measures, targeting can advance three important policy goals: sustaining safety-net hospitals; supporting delivery system reform at safety-net hospitals; and ensuring that vulnerable populations have access to high-quality, coordinated, and efficient care. Notably, this strategy presumes that a state's underlying payment methods and purchasing strategies are designed to promote value. With these principles in mind, the Commission recommends:

- In states where Medicaid hospital rates are below the cost of efficiently delivered care, states should increase Medicaid rates paid to hospitals with the highest share of Medicaid patients and lowest share of privately insured as a share of all their patients, contingent on meeting quality targets and delivering high-quality, accessible, cost-effective care. Because there is no clear demarcation as to when safety-net status begins, it is recommended that states consider the degree to which these rate increases accomplish the goals of preserving access to care for low-income populations and encouraging improved performance on indicators of

quality and efficiency. This additional investment should be structured consistently with the overarching goals of transparency and accountability.

- In making targeted investments in Medicaid payments, states should consider the relationship between inpatient and outpatient services, incentivizing the delivery of care in the most appropriate and efficient setting and supporting clinical integration across hospitals and community-based settings.
- States should invest in reimbursement rates for services where there is insufficient capacity to meet the needs of Medicaid beneficiaries and where increased Medicaid payments may enhance access.

This report focuses on states' Medicaid fee-for-service payment policies, although states are increasingly shifting Medicaid enrollees into managed care plans and other capitated payment and delivery models, where safety-net hospitals are reimbursed by a health plan or similar entity rather than directly by the state. However, even in state Medicaid programs with considerable managed care penetration, fee-for-service payment levels and methods remain important for several reasons. First, states continue to carve out beneficiaries with complex conditions and some services required by complex populations (e.g., behavioral health and substance abuse services) from managed care. Second, states' managed care premiums as well as plan provider rates are often built on or are informed by state fee-for-service payment policies. Third, sound Medicaid fee-for-service payment policies are an essential first step in building a pathway by which states and the federal government can ensure that safety-net hospitals have access to the revenue they need to deliver high-quality, coordinated, and efficient care and that vulnerable populations have access to the services they need. Notably, as states move additional Medicaid populations into managed care plans (or accountable care organizations), they are borrowing fee-for-service strategies to require or enable managed care plans to target additional payments to providers that advance priorities such as service to the uninsured or meeting patient-centered medical home standards.

Medicaid and Medicare Disproportionate Share Hospital Payments

Along with Medicaid, safety-net hospitals also rely on Medicaid and Medicare DSH payments, although neither funding stream is currently well targeted to hospitals providing the largest percentage of uncompensated care to low-income patients. DSH payments have traditionally been viewed as at least partially offsetting uncompensated care costs, low Medicaid reimbursement rates, and the added costs of serving large numbers of low-income patients. Under federal health reform, with more patients having access to health insurance coverage, Medicaid and Medicare DSH payments will be dramatically reduced starting in 2014. How states and the federal government target the

remaining DSH dollars will have significant implications for safety-net hospitals that continue to serve the remaining uninsured—undocumented immigrants and individuals for whom insurance remains unaffordable—as well as some number of underinsured patients. Defining "underinsured" post-reform will require consideration of the law's affordability standards and minimum essential coverage requirements. With the recent Department of Health and Human Services (HHS) announcment that until at least 2016, states will have considerable discretion in defining the essential health benefits, a national definition of underinsured may be difficult.

The Commission recommends that the remaining Medicaid DSH dollars be targeted first to hospitals that serve uninsured patients, valued on a unit-of-service basis multiplied by the applicable Medicaid rate or some percentage thereof, thereby ensuring transparency and accountability for DSH spending. Any remaining DSH funds could be spent on treatment of underinsured patients, but this would first require consideration of the definition of underinsured after implementation of federal health care reform. Finally, with respect to state dollars formerly spent on DSH, the Commission recommends investing them in Medicaid payment rates to sustain a high-performance health care system for vulnerable populations.

Under the Affordable Care Act, Medicare DSH will be cut by 75 percent in 2014. This reduction eliminates the portion of Medicare DSH spending the Medicare Payment Advisory Commission found was not empirically justified by the higher patient costs associated with low-income patients. The amount cut from Medicare DSH will be pooled and reduced somewhat to account for the anticipated decrease in uninsured patients. Hospitals will then receive a share of the new pool commensurate with their share of total uncompensated care provided by acute care hospitals nationally. In distributing this money, the Commission recommends that the HHS secretary give first priority to the uncompensated costs of care for uninsured patients. Thereafter, Medicare DSH payments could be applied to uncompensated costs of underinsured patients, with the same caveat as noted above with respect to Medicaid DSH.

The reductions and reconfiguration of both Medicare and Medicaid DSH spending require federal and state governments to consider anew the definitions of uninsured and underinsured patients after implementation of federal reform and how best to target DSH spending to support the cost of services provided such patients.

Capital Funding

Emerging payment and delivery system reforms are requiring hospitals to demonstrate quality and efficiency and reconfigure their care models accordingly. Safety-net hospitals must change how they deliver and finance care to survive in this new landscape. But adapting requires significant upfront investments of both human and financial capital, neither of which is readily available to many safety-net facilities. Many of these hospitals are already stretched to their limits and have little ability to raise additional funds or increase their revenues from private payers, and thus may be unable to invest the staff or funds needed to evolve. Access to capital is, therefore, a critical issue. Where operating margins are not large enough to demonstrate creditworthiness, safety-net hospitals will have limited access to capital. To the extent that Medicaid payments are adequate and DSH dollars strategically targeted, operating margins may improve. In many instances this will not be the case and alternative mechanisms to provide capital access for safety-net hospitals will be critical. One potential yet limited funding stream is the Health Care Innovation Challenge, under which the new Innovation Center at the Centers for Medicare and Medicaid Services (CMS) will award up to $1 billion in grants to providers, payers, and local government to fund new models of care delivery that provide better health, improved care, and lower costs to people enrolled in Medicaid, the Children's Health Insurance Program, and Medicare. Another broader source of funding for safety-net hospitals are Medicaid waivers under Section 1115 of the Social Security Act. These waivers enable federal and state governments to target financial support for high-priority capital projects and system restructuring at safety-net hospitals. Both California and New York have secured federal waiver funding for such initiatives, and their experiences are instructive. The Commission recommends that states consider using waiver funding to support essential investments at safety-net hospitals, especially those that support the development of accountable care systems at these facilities.

TOWARD A HIGH PERFORMANCE HEALTH CARE SYSTEM FOR VULNERABLE POPULATIONS: FUNDING FOR SAFETY-NET HOSPITALS

INTRODUCTION

High-performance health systems must be capable of meeting the needs of vulnerable populations, who are at disproportionately greater risk for receiving inferior care and experiencing poorer health outcomes than other groups.[1] The Commonwealth Fund Commission on a High Performance Health System has identified equity as a core goal of a high-performance health system and has proposed a three-part strategy to reduce the health care divide between vulnerable Americans—low-income families, those without health insurance, and racial and ethnic minorities—and the rest of society. First, ensure that health coverage provides adequate access and financial protection; second, coordinate care delivery with other community resources, including public health services; and finally, strengthen the safety-net delivery system serving these populations.[2] Safety-net hospitals are central to these delivery systems and as such play a critical role in achieving high-performance health care for vulnerable populations. These hospitals serve disproprotionately large numbers of low-income patients, both insured and uninsured, and rely disproportionately on Medicaid and disproportionate share hospital (DSH) payments to sustain their operations and public funds to underwrite their capital needs. Both the financial pressures induced by dependence on these funding streams, as well as the anticipated changes in these streams due to the expected influx of Medicaid patients and reduction of DSH payments under health reform, pose challenges to the short- and long-term viability of safety-net hospitals. This report examines the funding streams on which safety-net hospitals most rely and suggests strategies to better target financial resources to these hospitals—not simply to sustain them but to stimulate and reward high performance. To address the complex health needs of vulnerable patients, safety-net hospitals must be able to provide high-quality, cost-effective care. Accordingly, the funding proposals that follow incorporate requirements of transparency and accountability.

DISTINGUISHING FEATURES OF SAFETY-NET HOSPITALS

At the most basic level, a safety-net hospital is a hospital that provides care to individuals who otherwise would be unable to receive the care they need. Safety-net hospitals may serve patients that other providers do not serve, including low-income, uninsured, and underinsured patients. Safety-net hospitals may also provide services that other hospitals do not offer, including burn, trauma, and neonatal intensive care. Researchers and policymakers use a range of factors to define more specifically what constitutes a safety-

net hospital.[3] These factors often include the hospital's percentage of Medicaid patients, its uncompensated care burden, and the socioeconomic status of its patients. Occasionally, factors include the hospital's financial condition or whether it provides certain services, such as trauma centers, burn units, inpatient psychiatric care, and neonatal intensive care units.[4] Though there is not one generally accepted definition of a safety-net hospital, there is a common set of features and characteristics. By understanding these, policymakers will be better able to allocate limited state and federal resources to the hospitals in need of support through the funding streams most important to those hospitals.

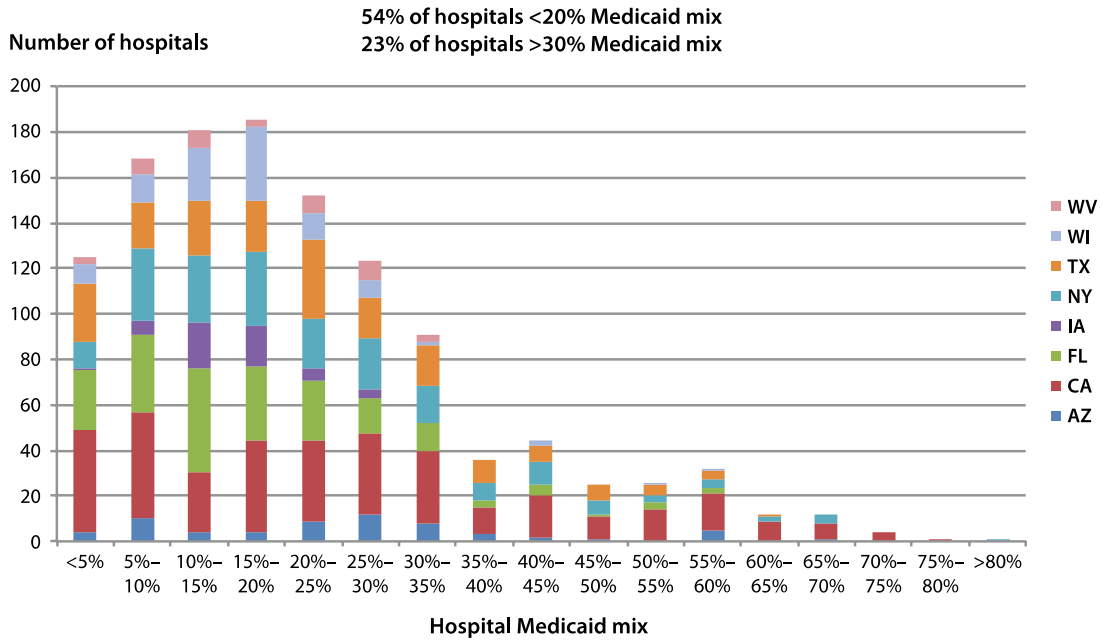
Patient Population

Safety-net hospitals serve a disproportionately high percentage of low-income, medically vulnerable patient populations. The Institute of Medicine defined the patients served by safety-net hospitals in its 2000 report as "uninsured, Medicaid, and other vulnerable patients."[5] This paper focuses on low-income and uninsured patients. Hospitals serve these vulnerable populations to varying degrees—almost all hospitals serve some patients that fit this definition, but there is wide variation among hospitals in what share these patients comprise. There is no general agreement on a threshold percentage of low-income or uninsured patients that a hospital must serve to trigger safety-net status.[6] Some researchers and policymakers have suggested that funding for safety-net hospitals should be distributed using a sliding scale, so that hospitals receive funding commensurate with their level of commitment to serving vulnerable populations.[7] As the exhibits in this report illustrate, many hospitals serve Medicaid patients and many Medicaid patients receive care at hospitals with relatively few Medicaid patients. However, there is a core group of hospitals that provides a disproportionate amount of care to Medicaid patients.

Exhibit 1 illustrates the number of hospitals in eight states (Arizona, California, Florida, Iowa, New York, Texas, Wisconsin, and West Virginia), grouped by the proportion of Medicaid patients. The largest number of hospitals have Medicaid proportions between 10 percent and 20 percent. Overall, 54 percent of all hospitals have Medicaid proportions below 20 percent, while 23 percent of all hospitals have Medicaid proportions of 30 percent or more.

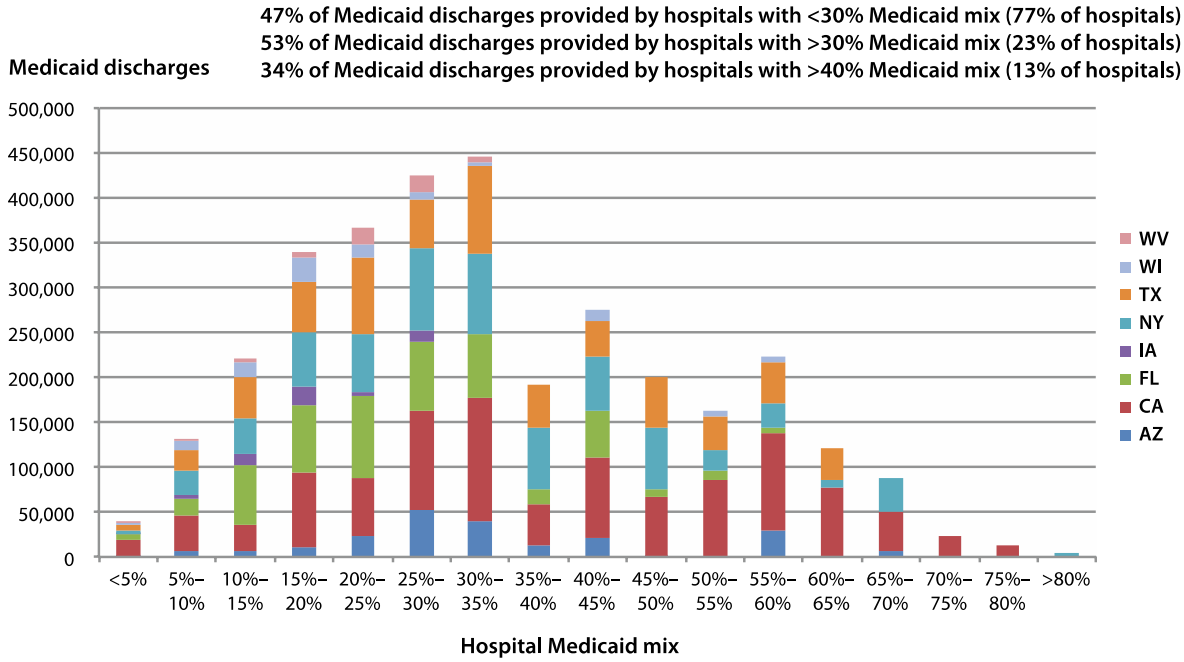
Exhibit 2 illustrates the total number of Medicaid discharges for the hospitals in the eight states, also grouped by Medicaid proportion. Hospitals with relatively high Medicaid proportions account for a disproportionate share of all Medicaid discharges. Across the eight states, the 23 percent of hospitals with Medicaid proportions above 30 percent account for 53 percent of Medicaid discharges.

Exhibit 1. Count of Hospitals by State and Hospital Medicaid Mix, Selected States, 2009



Sources: Agency for Healthcare Research and Quality (AHRQ), 2009, Healthcare Cost and Utilization Project, State Inpatient Databases (HCUP SID) for Arizona, California, Florida, Iowa, New York, Wisconsin, and West Virginia; Texas Department of State Health Services (TX DSHS), 2009, Texas Sate Health Care Information Collection, Inpatient Public Use Datafile (THCIC PUDF). Data reflect 2009 Q4 discharges from Texas hospitals, annualized to CY 2009. Data reflect all hospitals with 1,000 or more discharges during CY 2009, and discharges from these hospitals. Custom tabulation by Manatt Health Solutions.

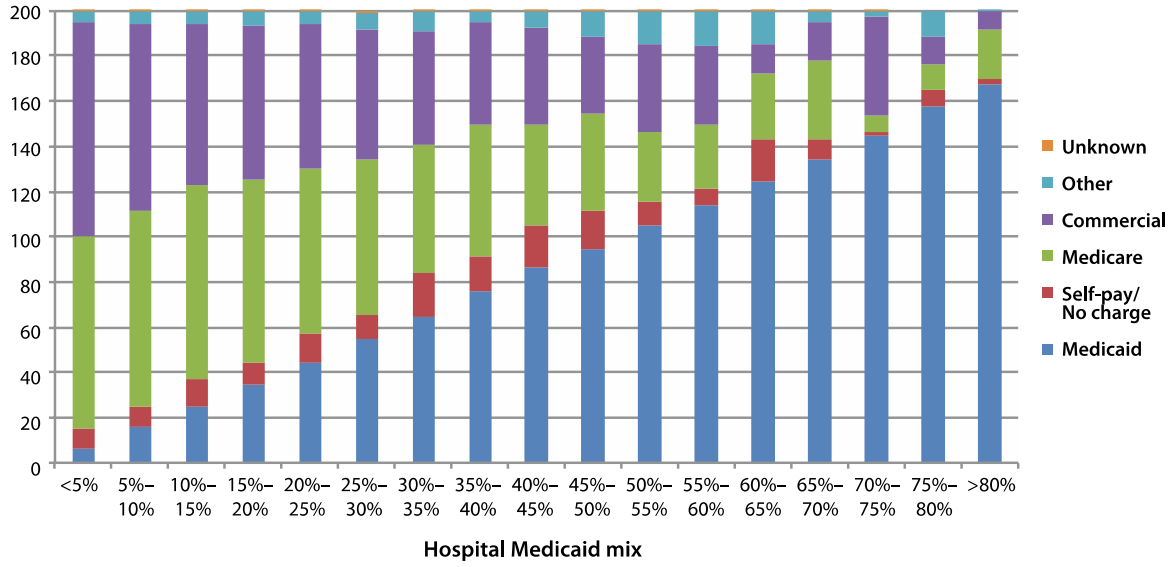
Exhibit 2. Count of Medicaid Discharges by State and Hospital Medicaid Mix, Selected States, 2009



Sources: Agency for Healthcare Research and Quality (AHRQ), 2009, Healthcare Cost and Utilization Project, State Inpatient Databases (HCUP SID) for Arizona, California, Florida, Iowa, New York, Wisconsin, and West Virginia; Texas Department of State Health Services (TX DSHS), 2009, Texas Sate Health Care Information Collection, Inpatient Public Use Datafile (THCIC PUDF). Data reflect 2009 Q4 discharges from Texas hospitals, annualized to CY 2009. Data reflect all hospitals with 1,000 or more discharges during CY 2009, and discharges from these hospitals. Custom tabulation by Manatt Health Solutions.

Exhibit 3 shows that as a hospital's percentage of Medicaid patients increases, its Medicare and commercial volume decreases. Notably, the share of commercial volume decreases at a faster rate than the share of Medicare volume.

Exhibit 3. Payer Mix by Hospital Medicaid Payer Mix Category, Selected States, 2009



Sources: Agency for Healthcare Research and Quality (AHRQ), 2009, Healthcare Cost and Utilization Project, State Inpatient Databases (HCUP SID) for Arizona, California, Florida, Iowa, New York, Wisconsin, and West Virginia; Texas Department of State Health Services (TX DSHS), 2009, Texas Sate Health Care Information Collection, Inpatient Public Use Datafile (THCIC PUDF). Data reflect 2009 Q4 discharges from Texas hospitals, annualized to CY 2009. Data reflect all hospitals with 1,000 or more discharges during CY 2009, and discharges from these hospitals. Custom tabulation by Manatt Health Solutions.

In addition, what is considered a high percentage of Medicaid patients will vary by state and community, reflecting the degree to which a state has expanded Medicaid eligibility beyond federal minimums,[8] as well as the demographics of particular communities. Under the Affordable Care Act requirement that all state Medicaid programs cover non-disabled adults under age 65 up to 133 percent of the federal poverty level, some of the variation attributable to differences in state income eligibility levels should smooth out. For example, of the eight states reviewed, only New York and Arizona currently provide Medicaid coverage to childless adults. Not surprisingly, hospitals in those states show a somewhat higher percentage of Medicaid discharges (Exhibit 4).

Exhibit 4. Inpatient Payer Mix, All Hospital Discharges, Selected States, 2009

State	Medicare	Medicaid	Commercial	Self-Pay/No Charge	Other
Arizona	34.7%	27.0%	29.7%	3.2%	5.5%
California	31.5	26.0	33.9	3.5	5.1
Florida	42.3	19.3	26.7	8.4	3.4
Iowa	45.1	15.6	34.7	3.3	1.3
New York	35.9	25.6	30.7	5.7	2.0
Texas	31.6	22.7	32.8	9.7	3.3
Wisconsin	40.1	17.1	35.8	4.0	2.9
West Virginia	44.3	20.3	27.9	4.5	3.0
Average (selected states)	35.7	22.6	32.0	6.2	3.5

Sources: Agency for Healthcare Research and Quality (AHRQ), 2009, Healthcare Cost and Utilization Project, State Inpatient Databases (HCUP SID) for Arizona, California, Florida, Iowa, New York, Wisconsin, and West Virginia; Texas Department of State Health Services (TX DSHS), 2009, Texas State Health Care Information Collection, Inpatient Public Use Datafile (THCIC PUDF). Data reflect 2009 Q4 discharges from Texas hospitals, annualized to CY 2009. Custom tabulation by Manatt Health Solutions.

Services

Another way to define safety-net hospitals is by their provision of traditionally unprofitable services, such as burn units, trauma centers, inpatient psychiatric care, and neonatal intensive care units. Proponents of using services to define safety-net hospitals argue that safety-net hospitals provide services that are unprofitable or too expensive for other hospitals to provide and should be compensated to encourage them to provide or continue providing such services.[9] More generally, some researchers argue that safety-net hospitals provide "community services"—serving large numbers of low-income patients, offering unprofitable services, and training the next generation of physicians—that other hospitals do not provide but that communities need.[10] Some researchers suggest that hospitals should be compensated for providing these services, though it is unclear whether such compensation should come through payments targeted to safety-net hospitals generally or through some other type of payment specifically linked to the community services a hospital provides.[11] This report focuses on sustaining safety-net hospitals that serve disproprotionate numbers of vulnerable patients and does not seek to define "community services" nor the funding streams that underwrite their costs.

Ability to Cross-Subsidize

Safety-net hospitals share common characteristics with respect to their disproportionately larger numbers of Medicaid and uninsured patients, but they vary in their ability to offset the costs associated with their patients and services. Some safety-net hospitals, most notably some academic medical centers (AMCs), are able to subsidize the higher costs of caring for low-income patients and offering unprofitable services, while other safety-net hospitals cannot.[12,13] The extent to which a safety-net hospital is able to cross-subsidize[14] the care it provides to low-income and uninsured patients depends on the following:[15]

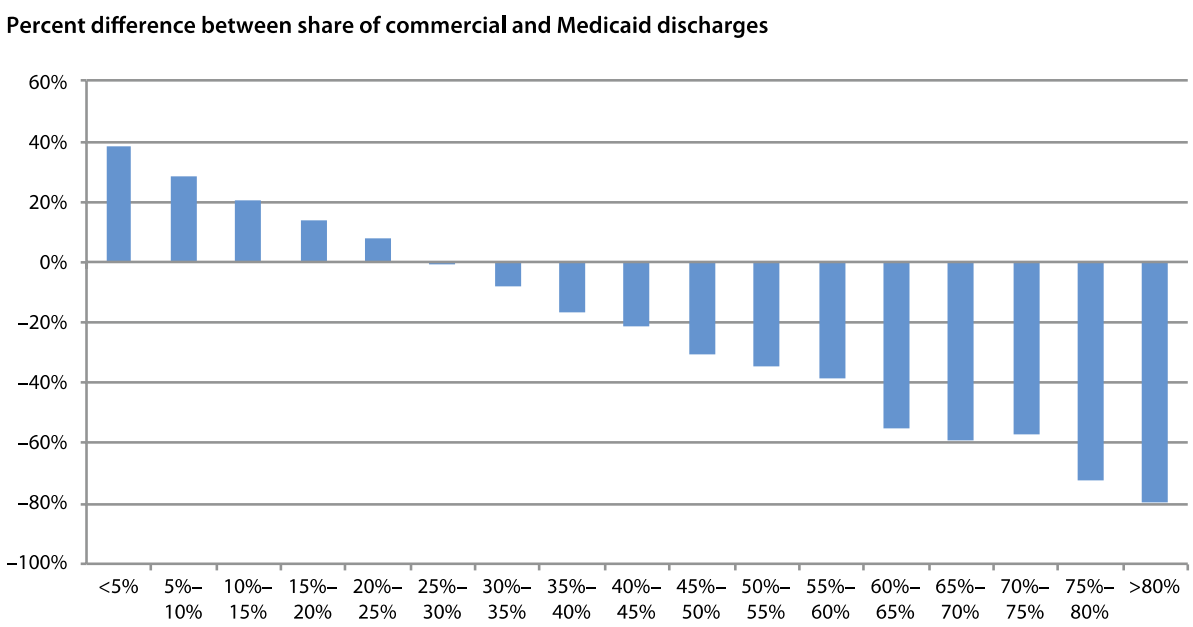
- *Patient mix.* AMCs and children's hospitals attract proportionately larger numbers of privately insured patients even when they serve a significant number of Medicaid and uninsured patients. This permits them to negotiate higher rates for a higher proportion of their patients (Exhibit 3). In addition, the AMCs and children's hospitals tend to provide more complex and intensive services—which also tend to be more profitable—than do other hospitals.[16]
- *Ability to negotiate higher rates.* Some AMCs and children's hospitals are able to negotiate higher rates from commercial payers because insurers are often compelled to include these institutions in their networks to attract members. Other safety-net hospitals do not have the market power to command high rates from private payers. Accordingly, for a given mix of payers, safety-net hospitals that are also AMCs or children's hospitals tend to have higher revenues than do other safety-net hospitals.

Depending on these factors, each hospital will fall somewhere on the spectrum—ranging from those that are able to cross-subsidize to a significant degree to those that are unable to cross-subsidize at all. Hospitals without a meaningful ability to cross-subsidize are most dependent on Medicaid and uncompensated care funding and have the most limited access to capital.[17] These hospitals are the subject of this report.

Exhibit 5 illustrates how the gap between commercial discharges and Medicaid discharges shrinks as a hospital's share of Medicaid discharges increases. By gap, we mean the amount by which Medicaid discharges exceeds commercial discharges or vice versa. To the extent that Medicaid pays less than commercial payers, this gap then becomes a proxy by which to evaluate the ability of a hospital to use the revenue from commercial payers to offset Medicaid losses. The horizontal axis represents the percentage of Medicaid discharges as a share of total discharges for hospitals in eight states. The vertical axis represents the difference in percentage points between the hospitals' share of commercial discharges and share of Medicaid discharges; for example, if commercial discharges for a group of hospitals account for 40 percent of total discharges and Medicaid discharges account for only 10 percent, those hospitals would have 30 percent reflected on the vertical axis. The exhibit illustrates that for hospitals with a lower share of Medicaid discharges (less than 25%), the share of commercial discharges exceeds that of Medicaid discharges by up to nearly 40 percentage points; whereas for hospitals with a higher share of Medicaid discharges (greater than 30%), the share of Medicaid discharges exceeds the share of commercial discharges by up to 80 percentage points.[18] As the gap between commercial and Medicaid discharges shrinks (and eventually becomes negative), a hospital becomes less able to offset relatively lower

Medicaid rates with relatively higher commercial rates, often leading to low operating margins that can threaten the hospital's financial health. Notably, the chart shows that hospitals with Medicaid proportions of more than 30 percent have so few commercial discharges that they are unable to offset shortfalls resulting from Medicaid's relatively low rates with surpluses from commercial payers.

Exhibit 5. Difference in Commercial and Medicaid Discharges, Medicaid Share of Total Hospital Discharges, Selected States, 2009



Sources: Agency for Healthcare Research and Quality (AHRQ), 2009, Healthcare Cost and Utilization Project, State Inpatient Databases (HCUP SID) for Arizona, California, Florida, Iowa, New York, Wisconsin, and West Virginia; Texas Department of State Health Services (TX DSHS), 2009, Texas Sate Health Care Information Collection, Inpatient Public Use Datafile (THCIC PUDF). Data reflect 2009 Q4 discharges from Texas hospitals, annualized to CY 2009. Data reflect all hospitals with 1,000 or more discharges during CY 2009, and discharges from these hospitals. Custom tabulation by Manatt Health Solutions.

Payer Mix of Safety-Net Hospitals, Post-2014

As major provisions of the Affordable Care Act take effect, safety-net hospitals will likely see their percentage of Medicaid patients increase and their percentage of uninsured patients decrease. Overall, an estimated 34 million Americans will become newly insured as of 2020 as a result of the law.[19] An estimated 17.2 million of the newly insured will enroll in Medicaid.[20] Roughly 4.9 million of the new Medicaid enrollees will be individuals who are currently eligible for Medicaid but are not currently enrolled, and the remaining 12.3 million new Medicaid enrollees will be newly eligible under the expansion of Medicaid.[21] An estimated 23.1 million individuals will purchase coverage through the state-run health insurance exchanges; 10.8 million of these individuals will be newly insured.[22]

Even with this coverage expansion, an estimated 22.1 million individuals will remain uninsured. Of the remaining uninsured individuals, 5.7 million (26%) will likely be undocumented immigrants; 8.4 million (38%) will be eligible, but not enrolled, for Medicaid or the Children's Health Insurance Program (CHIP); an estimated 6.2 million (28%) will be subject to the individual mandate to purchase coverage, but will decline to purchase coverage; and an estimated 1.8 million (8%) will receive a waiver of the individual mandate on the grounds that they can not afford to purchase coverage.[23]

In short, Medicaid will become an even more important revenue stream for safety-net hospitals under health reform. Uncompensated care funding should become less important, but by no means unimportant, especially for hospitals serving disproportionately larger numbers of uninsured patients.

MEDICAID

Medicaid is the single largest payer for safety-net hospitals, and it is becoming an increasingly important revenue stream as poverty and unemployment rates rise. By 2019, under federal health reform, Medicaid is expected to cover 25 percent of the American population.[24] After Massachusetts implemented its health care reform in 2006,[25] which shares many key features with the federal law, safety-net hospitals saw their Medicaid inpatient and outpatient volume increase.[26] Accordingly, any discussion of sustainable funding for safety-net hospitals must begin with a consideration of states' Medicaid payment policies. In short, the financial viability of safety-net hospitals depends on states' Medicaid payment policies and whether they are configured to cover the reasonable costs of efficient and effective care.

Current Medicaid Payment Policies Threaten the Viability of Safety-Net Hospitals

Historically, Medicaid payment levels have been low compared with Medicare and commercial payers.[27] On average, physician fees in fee-for-service Medicaid are roughly 72 percent of Medicare physician fees.[28] But Medicaid physician fees are significantly lower in some states.[29] Medicaid hospital payments have also historically been low relative to rates of other payers. According to the American Hospital Association, in 2008, the national aggregate hospital payment-to-cost ratio—reflecting the extent to which payments for services cover the costs incurred in providing those services—for Medicaid (including disproportionate share hospital payments) was 88.7 percent.[30] In other words, Medicaid payments covered only 88.7 percent of the costs that hospitals incurred in providing Medicaid services. Medicare's payment-to-cost ratio was 90.9 percent, only slightly higher than Medicaid's.[31] Private payers, by contrast, had an aggregate payment-to-cost ratio of 128.3 percent.[32] However, these data do not tell the whole story. Because

states use widely varying payment formulas and multiple add-ons, it is almost impossible to compare hospital rates across states or among services, although it is generally understood that Medicaid pays relatively more for inpatient services than outpatient services.[33]

Medicaid payment levels are getting worse as state revenues have fallen and Medicaid enrollment has grown. In 2010, 33 states reduced or froze hospital payment rates in their Medicaid programs.[34] Louisiana, for example, cut inpatient hospital rates by 3.5 percent in 2009, an additional 12.1 percent in 2010, and another 4.6 percent in 2011.[35] Michigan cut provider rates by 8 percent in 2010,[36] and California attempted to cut most provider rates in Medi-Cal, the state's Medicaid program, by 10 percent.[37] States are likewise freezing or cutting Medicaid managed care premium rates.[38]

The low level of Medicaid payment rates has not gone unnoticed. Providers have initiated litigation against states challenging across-the-board rate cuts[39] and the Centers for Medicare and Medicaid Services (CMS) has proposed regulations.[40] Both the litigation and the proposed regulations rely on Section 1902(a)(30)(A) of the Social Security Act, which requires that state Medicaid payment policies safeguard against the unnecessary utilization of care, ensure that payments are "consistent with efficiency, economy, and quality of care," and are sufficient to ensure that Medicaid beneficiaries have the same access to health care services as the general population.[41]

Additionally, the Affordable Care Act takes some limited steps to increase Medicaid payment rates. Specifically, Section 1202 mandates that states pay at least the Medicare rate as reimbursement for primary care services during 2013 and 2014.[42] The federal government will pay the full amount of the difference between a state's current reimbursement rate and the Medicare reimbursement level during that period.[43] Under the law, Medicaid managed care plans will also be required to pay the Medicare rate for primary care services in those years.[44]

Developing Sound Medicaid Payment Policies to Target Safety-Net Hospitals

In one sense, the answer to inadequate Medicaid payments is simple: increase them. But like everything else in health care, the solution is anything but simple. Medicaid payment policies are set by 50 different state legislatures, implemented by 50 different Medicaid agencies, all under the watchful eye of multiple, powerful stakeholders. Medicaid is the largest or second-largest expenditure in state budgets,[45] and when state budgets must be balanced (as they must in every state but Vermont[46]), Medicaid inevitably will be cut. While state Medicaid payment actions must be approved by CMS, this approval process has not resulted in or required more adequate Medicaid payment rates.[47]

Ideally, Medicaid would uniformly cover the reasonable cost of high-quality, cost-effective services provided to Medicaid patients. That is the goal, but it is unlikely to be achieved anytime soon. In the meantime, this paper suggests limited steps that can ensure that the hospitals that serve the largest numbers of Medicaid and other low-income, medically vulnerable patients—and disproportionately rely on Medicaid revenue—receive adequate reimbursement. The challenge is to identify the hospitals and the settings and services in which to invest limited Medicaid dollars and to target the dollars to support effective care delivery models. In other words, the fact that a hospital serves large numbers of Medicaid patients should not be sufficient to entitle it to a higher Medicaid rate. The increased payments should reflect both services to disproportionate numbers of Medicaid patients *and* the delivery of high-quality, coordinated, and efficient care. Finally, transparency and accountability should be at least as critical in developing reimbursement mechanisms for safety-net hospitals as they are in the health care system as a whole.

Paying higher rates to safety-net hospitals is not an ideal mechanism for supporting the safety-net delivery system. A far preferable approach is for Medicaid to employ sound purchasing strategies—like rational rate methodologies and appropriate payment levels—systemwide so that payment rates for all Medicaid patients, regardless of the payer mix of the facility serving them, promote value. However, until a state is able to achieve that goal, the Commonwealth Fund Commission on a High Performance Health Sytem recommends a more targeted approach to ensure a viable and high-performing health care system for the nation's most vulnerable patients.

This section includes three strategies for ensuring that limited Medicaid dollars are targeted effectively to high-performing, safety-net hospitals and the services required by Medicaid patients. It bears noting that the underlying premise of all three approaches is that Medicaid rates are intended to cover the cost of services efficiently and effectively provided by safety-net hospitals. Thus, the reported costs of any one safety-net hospital or hospital system are not necessarily the benchmark by which to judge rate adequacy. Likewise, lump-sum payments (often referred to as UPL, or upper payment limit payments) de-linked from the services rendered to specific patients may drive money to safety-net hospitals, but such payments do little to advance the delivery of high-quality, cost-effective care.[48] The importance of sound payment policies—both methodologies and levels—in improving patient outcomes and containing health care costs is currently the subject of considerable discussion and intense focus by regulators and policymakers; it is equally relevant in crafting payment mechanisms to sustain safety-net hospitals. And sound payment methodologies for safety-net hospitals will be less meaningful when a state's Medicaid policies are not consistent with overall system goals.

Recommendation: Target Medicaid Rate Increases to Hospitals Serving High Proportions of Medicaid Patients, Contingent on Provision of High-Quality, Coordinated, Cost-Effective Care

Where Medicaid hospital rates are below the cost of efficiently delivered care, states should consider strategically increasing the Medicaid rates of safety-net hospitals to support financial stability and to maintain, stimulate, and reward higher-quality care.[49] As discussed previously, safety-net hospitals have a relatively higher percentage of Medicaid patients and lower percentage of privately insured patients than do other hospitals in the community. Safety-net hopsitals also typically have an open-door policy to uninsured or underinsured patients who will be unable to pay for the costs of their care. To the extent that Medicaid rates are too low to cover the costs of efficiently provided care, such hospitals are put at risk. Unlike hospitals that can leverage private insurance rates, they have little or no ability to cross-subsidize care from more profitable lines of business. We recommend that states target limited funds toward increasing Medicaid rates to hospitals that rely disproportionately on Medicaid revenue, contingent on meeting or raising performance benchmarks and provision of evidence that they deliver high-quality and efficient care. Since there is not a clear demarcation as to when safety-net status begins, we recommend that states consider modulating their payments so that increased payments are made to hospitals with higher ratios of Medicaid to private patients and higher performance on measures of effective and efficient care.

As discussed, safety-net hospitals are heavily reliant on Medicaid as a source of revenue. Initially, when Medicaid payments are cut, providers respond by increasing efficiency. There comes a point at which additional efficiencies cannot be achieved and hospitals look to other payers—primarily private insurers—to cover the Medicaid shortfall. However, only hospitals with sufficient market power can negotiate higher prices with private payers; indeed, some safety-net hospitals report that private payer rates are lower than Medicaid rates.[50] It is important to consider the two revenue streams—Medicaid and private insurance—together to effectively target increased Medicaid reimbursement rates.

It is equally important that these increases be contingent on provision of high-quality, cost-effective care. Enhanced payment rates should be contingent on value and scaled to reflect quality indicators, with higher rates paid to the safety-net hospitals that achieve higher quality scores and that are instituting coordinated, accountable care systems. As the Commission has previously noted:

> Care delivery models for vulnerable populations should reflect the most effective strategies identified by the latest empirical research. There is evidence that much of the disparity in care experienced by vulnerable populations could be eliminated through the provision of patient- and family-centered primary care that emphasizes team-based care, care coordination, care management, and preventive services (e.g., care delivered through health homes and patient-centered medical homes).
>
> Providers serving vulnerable populations need to be especially capable of managing conditions and circumstances that are disproportionately prevalent within vulnerable populations, among them chronic disease, disability, mental illness, substance abuse, pregnancy, and low health literacy. The integration of medical care and mental health care delivery within Medicaid will be especially important.[51]

Accordingly, a state might enhance the rates of safety-net hospitals that meet standards for patient-centered medical homes or provide health home services to psychiatric patients upon discharge or have low rates of unnecessary readmissions or complications. A disproportionately large number of vulnerable patients rely on safety-net hospitals. In turn, those hospitals rely disproportionately on Medicaid revenue. As such, targeting increased Medicaid payments to safety-net hospitals that employ the most effective care delivery strategies will ensure that Medicaid patients have access to the coordinated care they need. To meet transparency and accountability goals, a state could increase the diagnosis-related group (DRG) base rate by a percentage amount that takes into account the hospital's mix of Medicaid and private-pay volume, with an added Medicaid baseline and quality score below which the hospital would not be eligible for any enhanced payment. While most states use DRG payments, about 15 state Medicaid programs still use some form of institution-specific, cost-based rates or per diems.[52] Those states might use varying multipliers to appropriately adjust payments so that rate increases account for a hospital's Medicaid and private-pay volume and quality score. The multipliers should be structured to avoid arbitrary thresholds that leave hospitals just above or below a Medicaid volume or quality threshold receiving significantly different rates. In addition, targeted adjustments to base payment rates, as compared to lump-sum payments or add-ons which are de-linked from services provided to individual patients, permit greater transparency and accountability and are adjusted to reflect patient acuity.

Recommendation: Target Resources to Appropriate Care Settings

Increasing the Medicaid rates of high-performing safety-net hospitals is fundamental to any effort to sustain these institutions. However, it is also important to determine how increases will be divided between inpatient and outpatient services. Medicaid rates generally are low, with outpatient services rates relatively lower than those for inpatient

services.[53] This difference in relative prices encourages hospitals to invest their resources in inpatient care, even when patients may be better served in outpatient settings.[54] For example, New York historically paid significantly higher relative rates for inpatient care than for outpatient care (both clinic and ambulatory surgery), and hospitals responded by focusing on providing inpatient care. In 2006, New York ranked 44th among states in the inpatient–outpatient divide of hospital payments, meaning that New York had one of the largest differences between hospital payments for inpatient care and outpatient care.[55] New York then undertook an ambitious initiative to reform its Medicaid payments, adopting new payment methodologies and shifting $600 million per year from inpatient rates to outpatient rates.[56] Increasing outpatient rates relative to inpatient rates increases the likelihood of patients receiving apppropriate outpatient care, leading to fewer hospitalizations and encouraging hospitals to provide care in the appropriate setting.

The Commission recommends targeting Medicaid rate increases to reach parity in inpatient and outpatient rates and to take into account the quality of the care provided. This approach not only encourages hospitals to provide care in the appropriate setting, but also promotes the financial health of safety-net hospitals after health care reform takes full effect in 2014. Massachusetts' experience is instructive. Massachusetts implemented its health care reform law in 2006.[57] Several key elements of the Massachusetts law became the foundation for federal health care reform in 2010. After Massachusetts implemented its law, safety-net hospitals saw significant increases in their ambulatory care use. Two important safety-net hospitals—Boston Medical Center and Cambridge Health Alliance—saw particularly large increases in the use of ambulatory care following health care reform.[58] From 2006 to 2009, Boston Medical Center saw a 19.3 percent increase in ambulatory care and Cambridge Health Alliance had 17.7 percent growth in ambulatory care.[59] Overall, demand for services at safety-net hospitals grew significantly, with a disproportionate share of growth coming from ambulatory care. This experience suggests that after federal health care reform, newly insured patients will seek relatively more ambulatory care at safety-net hospitals. Payments for outpatient services will likely become an increasingly important source of revenue for safety-net hospitals after 2014.

Finally, increased outpatient rates should be targeted to safety-net hospitals that implement the patient-centered medical home or other coordinated or integrated clinical models to stimulate and sustain high-performing, safety-net systems.

Recommendation: Target Resources to Services with Limited Access

To allocate limited state dollars in a manner that facilitates access to needed services, states should determine for which services Medicaid enrollees have limited access and determine where increased reimbursement may increase capacity. For example, when setting 2008 rates for inpatient care, the Mississippi Medicaid program noted the importance of Medicaid funding in ensuring continued access to acute mental health care. Consequently, rates were set so that payment-to-cost ratios for inpatient psychiatric care were higher than for inpatient care overall.[60] Such a service-specific approach does not necessarily target dollars to safety-net hospitals; however, these are services needed by Medicaid beneficiaries and, in most instances, provided by safety-net hospitals. In certain cases, safety-net hospitals are the only facilities providing needed services to Medicaid beneficiaries—for example, they are the only providers in the traditional safety-net system that provide specialty care. Finally, targeting dollars to services for which Medicaid beneficiaries have limited access is consistent with and required by federal law—state Medicaid payment policies must be sufficient to ensure that Medicaid beneficiaries have at least the same access to services as the general population in the geographic area.[61]

In sum, Medicaid is a critical funding stream for safety-net hospitals, but Medicaid rates often fail to cover the costs of services provided to Medicaid patients, potentially undermining the financial viability of these institutions and access to care for millions of low-income patients. It is hard to imagine a sustainable business model for safety-net hospitals without increased Medicaid rates. With only limited dollars to invest in Medicaid rates, the Commission recommends that states strategically target rate increases to safety-net hospitals in a manner that reflects their payer mix, meets the needs of Medicaid patients, and promotes and sustains efficiency and quality. With state Medicaid agencies increasingly relying on Medicaid managed care plans, it will be important to consider how to cross-walk these fee-for-service strategies to managed care models, where provider payment levels are set by plans, not the state. To the degree that plans mirror Medicaid fee-for-service policies, enhanced fee-for-service rates for safety-net providers may translate into managed care payment policies. Beyond that, states could impose requirements in their contracts with Medicaid managed care plans, much as the Affordable Care Act does with the primary care rate increase in 2013 and 2014 for fee-for-service and Medicaid managed care payments to qualifying clinicians. While a number of states provide payment incentives to plans that meet performance measures, few require that plans share those payment incentives with high-performing hospitals and even fewer require that plans share such payments with safety-net hospitals.[62] The Texas Medicaid managed care waiver, approved by CMS on December 12, 2011, takes another

approach to sustaining safety-net hospital revenue streams in a managed care system by pooling UPL supplemental payments and targeting them to hospitals that serve large numbers of uninsured patiens, as well as to public hospitals that meet certain performance metrics.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Another central characteristic of safety-net hospitals is their service to uninsured patients, resulting in significant uncompensated care burdens for these institutions. Safety-net hospitals rely on federal and state funding to cover the uncompensated costs of care provided to uninsured and underinsured patients. The challenge is how best to target uncompensated care funding to hospitals providing the greatest amounts of care to Medicaid, uninsured, and underinsured patients and how to do so in a manner consistent with transparency and accountability.

Congress has sought to ease the burden of providing uncompensated care through both Medicare and Medicaid disproportionate share hospital (DSH) policies. Medicare DSH payments were originally intended to offset the higher costs of treating low-income Medicare patients, but they are now seen as mechanisms to ensure access to care for Medicare beneficiaries or to subsidize hospitals' uncompensated care costs.[63] Similarly, since 1981, Congress has required states to make Medicaid DSH payments to take into account the situation of hospitals serving a disproportionate number of low-income patients to protect the viability of hospitals serving large numbers of Medicaid patients.[64] Unlike standard reimbursement payments that are intended to pay for services provided to specific patients, Medicare and Medicaid DSH payments are intended to partially offset hospitals' uncompensated care costs associated with providing care to both insured and uninsured low-income patients.

States have created additional funding streams to cover hospitals' costs of uncompensated care. Many states provide supplemental payments without the assistance of federal matching funds to cover the costs of providing uncompensated care. In 2008, state and local governments spent an estimated $10.6 billion to cover hospitals' uncompensated care costs.[65] Many states also make Medicaid supplemental UPL payments to hospitals.[66] Some states direct UPL payments to safety-net hospitals,[67] but many do not, using UPL payment add-ons to backfill low Medicaid rates across all hospitals.

Medicare and Medicaid DSH payments, state-only uncompensated care funds, and Medicaid UPL payments offer a patchwork of programs that to some degree cover the uncompensated care costs of safety-net hospitals, which is a growing problem at these insitutions.

During the economic downturn, the number of uninsured Americans has grown as increasing numbers of Americans become unemployed and lose access to employer-sponsored coverage.[68] In 2009, 4.4 million Americans—a 16.7 percent increase in the newly uninsured from the previous year—became uninsured, bringing the nationwide number of uninsured to 50.7 million.[69] With increasing numbers of uninsured Americans relying on safety-net hospitals, funding and targeting uncompensated care dollars to safety-net hospitals has never been more critical.[70]

When certain provisions in the Affordable Care Act are implemented in 2014, the number of uninsured will decrease. However, it is estimated that more than 22 million people will remain uninsured,[71] including individuals for whom the federal government has waived the individual mandate to purchase health coverage because such coverage is deemed unaffordable;[72] individuals who choose not to comply with the individual mandate to purchase insurance;[73] and undocumented immigrants.[74] Although the number of uninsured will fall significantly after 2014, safety-net hospitals will continue to care for a disproportionate number of uninsured patients,[75] and, as a result, funding sources to offset the costs of caring for uninsured patients will remain important to their finanical health.

While the Affordable Care Act reduces federal funding for both Medicare and Medicaid DSH, it also includes provisions to ensure that the remaining dollars are better targeted to hospitals with the greatest uncompensated care burdens.

Medicare Disproportionate Share Hospital Payments

In 1986, Medicare implemented a DSH adjustment to its payments for inpatient hospital services to offset the higher cost of treating low-income patients.[76] When Congress enacted the Medicare DSH adjustment, there was evidence that poor patients were more costly to treat—hospitals serving significant numbers of low-income Medicare patients would have higher costs than similar institutions serving fewer low-income Medicare patients.[77] Today, policymakers are more likely to argue that the adjustment is intended to protect access to care for Medicare beneficiaries to hospitals that serve a high proportion of low-income patients[78] or to subsidize the uncompensated care hospitals provide to uninsured and underinsured patients.[79] In 2004, Medicare DSH payments totaled $7.7 billion, accounting for roughly 5.3 percent of Medicare's $145 billion in payments to hospitals.[80]

Medicare DSH payments are distributed through a hospital-specific percentage increase to the DRG base rate. The percentage increase is determined based on the

hospital's "disproportionate share patient percentage," which accounts for inpatient days attributable to Medicaid patients and to Medicare beneficiaries receiving Supplemental Security Income.[81] As a hospital's proportion of Medicaid patients and low-income Medicare beneficiaries increases, its disproportionate share patient percentage increases. To qualify for DSH payments, a hospital's disproportionate share patient percentage must exceed certain thresholds.[82]

For hospitals that qualify for Medicare DSH payments, CMS calculates the percentage increase in the DRG using one of 12 distribution formulas. Which distribution formula applies depends on the type of hospital, the hospital's number of beds, and its disproportionate share patient percentage.[83] Regardless of the distribution formula applied, a hospital's DSH adjustment increases as its disproportionate share patient percentage increases. In general, urban hospitals with more than 100 beds receive higher DSH payment rates than other hospitals, and hospitals with the largest shares of low-income patients receive higher DSH payment rates than hospitals with smaller shares of low-income patients.[84] Seventy-five percent of hospitals—roughly 3,750 of the nation's 5,008 hospitals[85]—receive some Medicare DSH payments, but 200 hospitals receive 38 percent of all DSH payments.[86] Although a relatively small number of hospitals receive a significant portion of Medicare DSH payments, the Medicare Payment Advisory Commission (MedPAC) nevertheless has found that Medicare DSH payments are not well-targeted.

MedPAC addressed the skewing of Medicare DSH dollars in its 2007 *Report to Congress*. First, MedPAC found that roughly three-quarters of Medicare DSH payments—roughly $5.5 billion—were not empirically justified by higher patient care costs associated with low-income patients.[87] MedPAC also found that Medicare's DSH payments were not well-targeted to hospitals with higher shares of uncompensated care (defined to include both charity care and bad debts),[88] with hospitals receiving the largest DSH adjustments reporting uncompensated care burdens below the average for all hospitals. Specifically, MedPAC found that the top 10 percent of hospitals in terms of the share of resources devoted to furnishing uncompensated care provided 41 percent of all uncompensated care, but received only 10 percent of all Medicare DSH payments.[89] In contrast, the bottom 10 percent of hospitals in terms of resources devoted to uncompensated care provided only 2 percent of all uncompensated care but received 8 percent of Medicare DSH payments.[90] Based on these findings, MedPAC concluded: "It appears that the hospitals most involved in teaching and in treating low-income Medicaid and low-income Medicare patients are not, by and large, the ones that devote the most resources to patients unable to pay their bills."

Citing MedPAC's 2007 findings, the Affordable Care Act calls for Medicare DSH payments to be reduced by 75 percent, beginning in 2014.[91] The funds raised will be used to create a pool of funding for additional payments to acute care hospitals receiving Medicare DSH payments.[92] However, the funding in the pool will be reduced to account for the percentage decrease in the uninsured population plus a further reduction of 0.1 or 0.2 percentage points, as set out in the law.[93] A hospital will receive a share of the new pool equal to its share of all uncompensated care provided by acute care hospitals nationwide. Because there is no universally accepted definition of uncompensated care, the Department of Health and Human Services (HHS) secretary will be required to determine whether uncompensated care includes only care provided to uninsured patients or whether it also includes the bad debts of underinsured patients. In any event, under this new allocation methodology, Medicare DSH payments should be better targeted to hospitals that provide larger amounts of uncompensated care.

Medicaid Disproportionate Share Hospital Payments

In 1981, in an effort to incentivize efficiency and to curtail rapidly rising Medicaid expenditures, Congress permitted states to shift from cost-based Medicaid reimbursement rates to prospective payment systems.[94] Concerned that the shift away from cost-based rates might threaten the viability of hospitals serving large numbers of Medicaid and uninsured patients, Congress required states to take into account the situation of hospitals serving a disproportionate share of low-income patients when designing their payment systems.[95] In 1987, Congress strengthened this mandate, requiring states to make payments in excess of standard Medicaid rates to these facilities. These payments are known today as Medicaid DSH payments.[96] In 2006, Medicaid DSH payments totaled $17.1 billion, accounting for more than one-quarter of the $63 billion in fee-for-service Medicaid payments to hospitals.[97]

States have considerable discretion in deciding which hospitals receive Medicaid DSH payments and how much each hospital receives. All hospitals with high Medicaid inpatient utilization rates or high low-income utilization rates must qualify for DSH payments.[98] In addition, states may designate in their state plans additional hospitals eligible to receive DSH payments, as long as the additional hospitals have Medicaid inpatient utilization rates of at least 1 percent—a benchmark far below any usual standard for safety-net status.[99]

Although federal law affords states a great deal of flexibility in determining which hospitals qualify for Medicaid DSH payments and how those funds are allocated among the designated hospitals, states are subject to both statewide and hospital-specific caps on

DSH payments. If a state exceeds either cap, the excess payment is not eligible for federal matching dollars. Under the facility-specific cap, DSH payments to any specific hospital may not exceed the hospital's uncompensated care costs.[100] Uncompensated care costs are for this purpose defined as the sum of the costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients.[101]

To increase accountability in the Medicaid DSH program, Congress in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 imposed new requirements that each state have its DSH payment programs independently audited and that the audit verify that DSH payments complied with applicable federal law and rules.[102] Under the final audit rules, CMS also clarifies that "uninsured uncompensated . . . care costs" for purposes of calculating the DSH caps do not include bad debt related to individuals who have health insurance or another third-party payer.[103] Notably, on January 18, 2012, CMS issued a proposed rule clarifying that the definition of uninsured uncompensated care costs includes the costs of providing inpatient and outpatient services to individuals who do not have coverage for the specific services they require. This would include situations where certain services are excluded from the patient's coverage as well as where the patient has exceeded his or her coverage limits.[104]

The first audit reports under the new rules were due in early 2012[105] and are available to the public. While the audit reports were just emerging at the time of this report's publication, numerous commentators have noted that states distribute DSH payments through a wide range of fomulas, many of which do not target payments to safety-net hospitals as that term is defined above.[106]

Beginning in 2014, the Affordable Care Act will dramatically reduce Medicaid DSH payments, presenting an opportunity to revisit the rationale for DSH payments and to reconsider how best to allocate them.[107] Under the law, federal matching fund levels for Medicaid DSH payments will be reduced by $500 million in 2014. The reductions increase annually to $5.6 billion in 2019—a nearly 50 percent decrease in federal matching funds available for DSH payments relative to the amount that otherwise would have been available in that year.[108] The cuts in federal matching funds available for DSH payments will not be allocated evenly across states; instead, the HHS secretary will develop a methodology to apply funding reductions across the states.[109] When crafting the DSH reduction allocation methodology, the secretary is required by statute to apply the largest reductions to states that have the lowest uninsured rates, have the lowest levels of uncompensated care (excluding bad debt), and do not target DSH payments to hospitals with high volumes of Medicaid inpatient care.[110] Since the reduction allocation

methodology will favor states that target their Medicaid DSH dollars to high-volume Medicaid providers serving the largest number of uninsured patients, states have an incentive to target their DSH dollars to such hospitals in an effort to avoid substantial reductions.[111]

Recommendation: Target Medicaid DSH Payments to Cover Uncompensated Care Costs of Uninsured Patients

The Affordable Care Act's reductions in Medicaid DSH allocations to hospitals were justified by the anticipated drop in the number of uninsured individuals after 2020, estimated at 34 million individuals receiving coverage under the Affordable Care Act.[112] However, over 22 million people are expected to remain uninsured, and these individuals will continue to rely on safety-net hospitals for their care. Thus, the first question becomes how best to target the remaining Medicaid DSH dollars to sustain hospitals continuing to serve significant numbers of uninsured patients or more specifically to cover uncompensated care costs of uninsured patients. Again, consistent with the goals of accountability and transparency, the best approach might be to have the hospital "bill" for each uninsured patient and receive in return some percentage of the Medicaid rate it would otherwise receive. Although this approach is not ideal as it perpetuates the use of a fee-for-service model, it is likely the most realistic approach to targeting DSH funds to hospitals serving uninsured patients, since a global or capitated payment model would be much more difficult to design and implement. Further, to incentivize outpatient care, DSH payments might be relatively higher for outpatient services or for higher-quality outpatient services than for inpatient services. Linking DSH payments to specific services provided to specific uninsured patients ensures that hospitals serving the greatest numbers of uninsured patients receive the greatest proportion of the state's DSH funds and that the payment methods promote transparency and accountability. Moreover, to the extent that a state has increased Medicaid inpatient and outpatient rates for high performing safety-net hospitals, those higher rates will be the basis of the DSH payment.[113]

When allocating their limited DSH funds, states must also consider whether and to what extent to reimburse hospitals for care provided to underinsured individuals. An insured individual is considered underinsured if either cost-sharing levels are unreasonably high or the benefit package does not cover critical services.[114] In 2010, an estimated 29 million adults were underinsured.[115] After implementation of health reform, there should be far fewer underinsured individuals. The law defines "essential health benefits" and requires health plans in state exchanges to offer such benefits. However, states will have considerable discretion in defining essential health benefits.[116] The law

also establishes an affordability schedule, providing Medicaid to individuals with incomes below 133 percent of the federal poverty level and tax credits and cost-sharing reductions to individuals with incomes up to 400 percent of poverty. Individuals who would have to spend more than 8 percent of their household income to purchase coverage are exempt from the individual mandate. The coverage scheme set out in the Affordable Care Act establishes maximum cost-sharing and minimum benefit requirements along with affordability schedules. If these standards are reasonable and state essential health benefit requirements adequate, the number of underinsured should decrease dramatically.

If the number of underinsured patients does not decrease significantly or if the coverage and affordability definitions under the law are not reasonable, there may not be sufficient DSH dollars to spend on underinsured and uninsured patients in 2014. Moreover, some costs associated with caring for the underinsured are not uncompensated care costs for the purposes of calculating a facility-specific DSH cap under the new audit rules, and thus states may find that they quickly reach the facility-specific DSH limit if they compensate hospitals for costs of underinsured patients.[117] Additionally, states that target DSH funds to hospitals for costs of underinsured individuals may receive larger reductions in their federal DSH allocation. The issue of the underinsured and the related uncompensated care burdens of the hospitals that disproportionately serve them is one that will require further attention as the effects of the coverage provisions of the Affordable Care Act are evaluated.

Finally, while the cut in DSH payments under the Affordable Care Act will reduce federal matching funds for DSH, the state dollars previouly committed to DSH will be untouched. Assuming that the remaining federal DSH funds—if targeted toward the uninsured—will be adequate to cover the uninsured at rates equal to or just below Medicaid levels, states may want to invest dollars previously committed to DSH to increasing Medicaid payments for safety-net hospitals.[118] As these dollars were previously targeted to safety-net hospitals, it would make sense to invest them in higher Medicaid rates for safety-net hospitals. By doing so, the state investment in Medicaid rates will trigger the higher matching rates available for newly eligible Medicaid beneficiaries, which DSH payments do not.

FUNDING FOR CAPITAL

The health care environment is highly dynamic, with payment and delivery system reforms requiring hospitals to reconfigure their care models and supporting infrastructures and demonstrate quality and efficiency. The Affordable Care Act requires reductions in Medicare and Medicaid payments to hospitals that do not meet certain

quality standards. It also establishes demonstrations and grants to test and rapidly deploy new care delivery models that focus on primary and preventive care and are accountable for quality and efficiency.[119] The use of electronic health records (EHRs) will be essential as hospitals are required to report quality, utilization, and financial information to inform decision-making by federal and state governments, consumers, and payers.[120] To succeed in the future, hospitals will have to radically change their delivery processes. However, safety-net hospitals generally do not have the operating margins to fund the capital investment required to purchase sophisticated EHR systems, reconfigure their delivery models, and adopt new care protocols.

Thirty-six percent of safety-net hospitals have negative total margins.[121] In one survey of senior leaders at public hospitals, all respondents indicated their facilities had difficulty investing in current or new facilities and equipment, including information technology.[122] In another survey of executives at safety-net hospitals, nearly all respondents stated they were skeptical that safety-net hospitals could successfully participate in pay-for-performance programs and other payment initiatives because of difficulties investing in technology and gaining buy-in from physicians.[123]

With extremely limited access to capital,[124] safety-net hospitals will require public support to adapt to the changing dynamics of the health care marketplace. Notably, while the Affordable Care Act provides funding to underwrite the capital needs of community health centers,[125] it does not provide comparable amounts for safety-net hospitals. One potential yet limited source of funding is the Health Care Innovation Challenge grants that the CMS Innovation Center will award in March 2012. These grants will support providers, payers, and local governments in implementing delivery and payment models that will deliver better health, improved care, and lower costs to Medicaid, CHIP, and Medicare enrollees. Although awards cannot be used to fund major capital improvements, a proportion of the award—the lesser of $150,000 or 25 percent of the total direct costs of the project—may be used toward minor renovations that are directly related to implementing the proposed service delivery or payment innovation.

Recommendation: Consider Using Section 1115 Waivers to Provide Capital for Safety-Net Hospitals

Medicaid waivers under Section 1115 of the Social Security Act offer another potential solution for safety-net hospitals. Under Section 1115, the HHS secretary has broad discretion to authorize experimental projects that promote the goals of the Medicaid statute and demonstrate an approach that has not yet been implemented on a widespread basis. The secretary may either waive a required element of a Medicaid state plan or may

authorize federal matching funds for costs that could not otherwise be matched under the Medicaid program.[126] It is this latter authority that has enabled states to secure and channel "capital" dollars to safety-net hospitals and more generally drive delivery system reform.

New York and California have used Section 1115 waivers to assist safety-net hospitals—and in some cases, hospitals more broadly—in meeting the challenges of a dynamic health care environment (see Appendix for further detail). For example:

- From 1995–2005, the State of California obtained $1.2 billion in federal waiver funds over five years to underwrite capital investments needed to restructure the Los Angeles County Department of Health to improve efficiency and its long-term financial health.[127] The waiver provided funding to reduce unnecessary emergency room and inpatient utilization by building an integrated system of public and private clinics that provide community-based primary, specialty, and preventive care.[128] In 2010, California created the Delivery System Reform Incentive Program included in its most recent Section 1115 waiver.[129] The program provides funding for participating hospitals to undertake projects in infrastructure development, delivery system innovation and redesign, population-focused improvement, and quality improvement projects.

San Francisco General Hospital's Delivery System Reform Incentive Program Plan

San Francisco General Hospital (SFGH) illustrates how the California 1115 Medicaid Waiver Delivery System Reform Incentive Program has allowed innovative programs to be implemented in safety-net hospitals that may otherwise have not been funded. Since the 2007 implementation of Healthy San Francisco, the city's universal health care program, SFGH has taken steps to enhance access to primary care and preventive services. However, this has been insufficient to meet the existing demand for services or the anticipated growth in demand under federal health reform. Recognizing the challenges of inadequate access to primary and specialty care services, inconsistent access to patient-centered coordinated care, and insufficient infrastructure for robust performance improvement activities, SFGH has made plans to use funds made available by the incentive program to implement delivery system reforms to improve the quality and efficiency of care.

SFGH has enacted several initiatives focused on bolstering its infrastructure to provide primary and specialty care services and on implementing delivery system innovations. To expand primary care capacity, SFGH is increasing the number of residents in its family medicine and primary care residency programs and training these residents in the principles of patient-centered medical homes, with the goal of creating effective physician leaders of safety-net medical homes.

SFGH is also extending weekend clinic hours as part of efforts to increase the annual visit volume at primary care clinics. To improve specialty care access, SFGH is conducting an assessment of its current capacity to provide specialty care and hiring additional physicians and support staff as needed, expanding its existing electronic referral system, and implementing telemedicine consultations. SFGH is also using waiver funding to implement delivery system innovations such as expanding an existing patient-centered medical home pilot program to transform all of its primary care clinics into medical homes. The hospital is hiring additional physicians to help lead this transformation.

As part of its quality improvement efforts under the incentive program, SFGH used waiver funds to hire additional physician hospitalists. The hospital recognized it needed greater involvement of attending physicians as a key component of achieving its performance improvement goals. These hospitalists serve as physician champions, leading multidisciplinary teams focused on addressing the hospital's specific quality improvement aims set under the incentive program, such as preventing central line and surgical site infections. The hospital has also used waiver funds to establish a leadership training academy to provide team members with more formal training in performance improvement and patient safety. The incentive program funding made available through California's 1115 Waiver has provided SFGH with the necessary capital resources and flexibility to implement these and other innovations to advance the quality and efficiency of care provided in San Francisco's safety-net delivery system.

For more information, see *San Francisco General Hospital and Trauma Center Delivery System Reform Incentive Pool Plan*.

- In New York, CMS approved the original New York Partnership Plan 1115 waiver in 1997, establishing a mandatory Medicaid managed care program for certain populations.[130] To enable the restructuring of safety-net providers, the waiver included funding for the New York Community Health Care Conversion Demonstration Project,[131] which targeted funds to safety-net hospitals to increase linkages with existing freestanding clinics, create hospital-based outpatient clinics, expand linkages with local health departments, and create hospital-affiliated primary care physician group practices. In 2006, New York obtained federal matching funds for its Health Care Efficiency and Affordability Law for New Yorkers capital grant program as part of its Federal–State Health Reform Partnership Section 1115 Waiver,[132] which created a competitive grant process to fund initiatives to "right size" acute care infrastructure, reform long-term care, and improve primary and ambulatory care.[133] Finally, as part of its most recent waiver request, New York created the Hospital Medical Home Waiver Program, a demonstration project to improve the coordination, continuity, and quality of care for individuals receiving primary care at clinics operated by teaching hospitals.[134]

Ultimately, the success of the waivers must be judged by the projects they supported, the reforms they enabled, and the extent to which they enabled access to cost-effective, high-quality care.

CONCLUSION

Safety-net hospitals serve a disproportionately large share of Medicaid and uninsured patients, many with chronic and debilitating medical and behavioral health conditions. The challenge is to ensure that these facilities have the operating and capital dollars required to provide the coordinated, high-quality, high-value care required by their patients. This report examines the key revenue streams on which safety-net hospitals rely and proposes mechanisms to target those dollars consistent with transparency and accountability. The Commission on a High Performance Health System offers the following recommendations:

1. **Invest in Medicaid payment rates.** Medicaid is the single largest payer for safety-net hospitals and is notorious for paying rates that are well below the cost of care. While across-the-board Medicaid increases may be warranted, state budget constraints make that nearly impossible in the short term. Accordingly, the Commission recommends investing in the Medicaid rates of safety-net hospitals, especially those with the largest numbers of Medicaid patients and fewest numbers of commercial patients. In all cases, rate increases for safety-net hospitals should be tied to quality metrics to incentivize and sustain high-performance health care systems for vulnerable populations. In addition, rate increases should be targeted to the settings and services most appropriate to the care needs of Medicaid enrollees. Increased payments should promote transparency and accountability.

2. **Target Medicaid and Medicare DSH payments.** Both Medicare and Medicaid DSH payments should be applied to cover the uncompensated care costs of uninsured patients and should be paid out based on services provided to uninsured patients. Assuming sufficient DSH funds to cover the uncompensated care costs of uninsured patients, states should invest state dollars no longer eligible for federal matching funds under DSH in the Medicaid rates of high-performing safety-net hospitals.

3. **Consider using funding under Section 1115 waivers.** To enable safety-net hospitals to build the infrastructure necessary for clinical integration and team-based primary care—models that are especially crucial in serving vulnerable

patient populations—it is recommended that states consider using Section 1115 waivers to target financial support for system restructuring at safety-net hospitals.

The Commission believes that closing the health care divide for vulnerable populations is a core goal of a high-performance health system. Safety-net providers play a central role in any effort to ensure that Medicaid and uninsured patients have access to the coordinated care and services they need. However, unless public payers target resources to these institutions and hold them accountable for high performance, these institutions may not survive—much less achieve desired outcomes for patients.

APPENDIX: SECTION 1115 WAIVERS

- *Los Angeles 1115 Waiver, 1995–2005.* The State of California obtained $1.2 billion in federal waiver funds over five years to underwrite capital investments to restructure the Los Angeles County Department of Health to improve efficiency and its long-term financial health.[135] The waiver funds were targeted only to facilities operated by the Los Angeles County Department of Health or facilities and providers that entered into public–private partnerships with the department.[136]

  Among other things, the Los Angeles waiver provided funding for the department to reduce unnecessary emergency room and inpatient utilization by building an integrated system of public and private clinics and by providing community-based primary, specialty, and preventive care.[137] The demonstration project focused on increased access to county-funded ambulatory care services by creating a public–private partnership through which private providers would either provide primary care services at a county health center or expand services at their private clinic sites. The county also used waiver funds to create referral centers to schedule and coordinate specialty care, improving access to care for patients and increasing coordination between primary and specialty care providers. To improve the efficiency of inpatient care at county hospitals, the department invested waiver dollars in more than 450 projects to reengineer inpatient care delivery, including clincal resource management systems and group purchasing of supplies.[138]

  By 2000, the county had successfully improved delivery of care to its low-income population, but the public health system's financial status did not improve significantly. The county expanded access to primary care through partnerships with providers, although it failed to reach its goal of increasing ambulatory primary care visits by 50 percent.[139] The county also reduced its dependence on hospital-based care, eliminating 29 percent of inpatient beds in the county and reducing inpatient days by 27 percent.[140] Despite the reforms to promote efficiency and improve patient care, the Urban Institute, charged with evaluating the success of the waiver, concluded that it did not create a stable financial environment for the county's future.[141] In its evaluation report, the Urban Institute noted that Los Angeles County has large numbers of uninsured individuals and, absent broad federal or state health reform to reduce the number of uninsured patients, it was unclear whether the county's health system could achieve financial stability.[142]

- *California 1115 Waiver Delivery System Reform Incentive Program.* In 2010, California created the Delivery System Reform Incentive Program included in its most recent Section 1115 waiver.[143] Only public hospitals are eligible to participate in this incentive program.

  In the program, public hospital systems submit five-year plans to the state for approval.[144] The five-year plans outline the projects that each public hospital system has selected, as well as the public hospital's request for funding.[145] Participating hospitals must undertake projects in each of the following four categories: infrastructure development; delivery system innovation and redesign, including medical homes and integrated physical and behavioral health care; population-focused improvement, including preventive care and chronic disease management; and quality improvement projects, including reducing hospital-acquired infections. Under this program, each hospital system is simultaneously undertaking 12 to 19 major delivery system improvement projects. Alameda County Medical Center, for example, plans to establish a clinic that serves at least 400 patients with complex medical needs, implement care management for patients at high risk for readmission, and improve severe sepsis detection and management.

  To receive a portion of the $3.3 billion of federal funding available over a five-year period, public hospital systems must achieve hundreds of project milestones.[146] The public hospital systems must also provide the funding for the nonfederal share. If a public hospital system fails to meet its milestones, it will not receive its full share of federal funding, even if it invested significant resources in the project. By the end of the first year of the program, the public hospital systems had achieved all of the 298 year 1 milestones.

- *New York Community Health Care Conversion Demonstration Project.* In 1997, CMS approved the original New York Partnership Plan 1115 waiver, establishing a mandatory Medicaid managed care program for certain populations in the state.[147] To aid in the restructuring of safety-net providers, the waiver included $250 million annually from October 1997 through March 2004 and $100 million through March 2005 for the New York Community Health Care Conversion Demonstration Project (CHCCDP).[148]

  Hospitals with total annual discharges of at least 5,000 and Medicaid and self-pay patients accounting for at least 20 percent of total discharges were eligible to receive funds under CHCCDP.[149] Beginning in the second year of the project,

hospitals had to participate in the Medicaid managed care program to be eligible to receive funding.[150]

Each eligible hospital received a portion of the total available funds based on the its relative share of Medicaid and self-pay discharges, provided that the hospital submitted an application describing how the funds would be used. Hospitals with larger relative shares of Medicaid and self-pay discharges received larger amounts of funding, meaning that CHCCDP funds were targeted to safety-net providers but unconnected to specific projects.

New York encouraged hospitals to use CHCCDP funds to increase linkages with existing freestanding clinics, create hospital-based outpatient clinics, expand linkages with local health departments, and create hospital-affiliated primary care physician group practices, among other initiatives. Several hospitals used funds to convert inpatient space into primary care clinics; others added primary care staff.[151] The applications for years 2 through 5 of the demonstration project required that hospitals describe their success in meeting prior years' objectives, and funding was contingent on achieving earlier objectives,[152] creating at least some accountability for hospitals receiving funds through the program.

- New York Health Care Efficiency and Affordablity Law for New Yorkers Capital Grant Program. In 2006, New York obtained federal matching funds for its Health Care Efficiency and Affordablity Law for New Yorkers (HEAL–NY) capital grant program as part of its Federal–State Health Reform Partnership Section 1115 Waiver.[153] The HEAL–NY program created a competitive grant process to fund initiatives to "right size" acute care infrastruture, reform long-term care, and improve primary and ambulatory care.[154] Beginning in 2005, New York State released 17 separate requests for grant applications to fund a wide variety of projects, commiting a total of $2.37 billion in state funding for these projects.[155] HEAL–NY funds were used to support provider investment in health information technology, including interoperable electronic health records.[156] HEAL–NY funds were also used to underwrite restructuring of facilities, including through mergers or downsizing, as recommended by New York's Commission on Health Care Facilities in the 21st Century.[157]

- *New York Hospital Medical Home Waiver Program.* As part of its most recent waiver request, New York created a hospital–medical home demonstration project to

improve the coordination, continuity, and quality of care for individuals receiving primary care at clinics operated by teaching hospitals.[158]

All teaching hospitals may participate in the hospital–medical home demonstration project.[159] Because the waiver funding is targeted to teaching hospitals, hospitals need not be safety-net hospitals to receive funding, but virtually all safety-net hospitals in New York are teaching hospitals.

The $650 million[160] in funding for the hospital–medical home demonstration progam will be distributed as follows: 80 percent of a hospital's funding will be based on the number of Medicaid patients served; the remaining 20 percent will be based on the number of primary care residents trained at the hospital.[161] Because the allocation formula heavily weights the hospital's Medicaid volume, the waiver funding will be targeted at teaching hospitals with high levels of Medicaid patients. For the most part, these are New York's safety-net hospitals.

Hospitals receiving funding will be required to achieve National Committee for Quality Assurance medical home level 2 or level 3 recognition within two years.[162] Hospitals will also be required to meet three interim process-based milestones. Namely, submitting a detailed work plan, completing a formal baseline assessment after six months, and submitting an interim report at the end of the first year.[163] Finally, hospitals must develop at least five clinical performance metrics to track the success of the initiative.[164] It is not clear whether hospitals will be at risk of losing funding if they fail to meet those targets.

Hospitals receiving funding through this demonstration project will also be required to implement system improvement projects. For example, hospitals receiving funding must implement an initiative to restructure operations to enhance patients' continuity of care, and hospitals may choose whether such initiatives involve increasing resident time in ambulatory settings, expanding sites beyond the hospital environment, or other, similar changes.[165] Hospitals receiving funding must also undertake an initiative from one of the following four categories: 1) care transitions and medication reconciliation programs, 2) integration of physical and behavioral health care, 3) improved access and coordination between primary and specialty care, and 4) enhanced interpretation services and culturally competent care.[166] Within each of the four broad categories, hospitals have latitude in structuring the initiative, but each category has several specific project requirements.

Finally, hospitals must implement at least two quality and safety improvement projects. They may choose from the following six projects: severe sepsis detection and management, central line–associated bloodstream infection prevention, surgical complications core processes, venous thromboembolism prevention and treatment, neonatal intensive care unit safety and quality, and prevention of avoidable preterm births by reducing elective delivery prior to 39 weeks' gestation.[167] Each quality and safety improvement project has specific elements that hospitals must implement and key evidence-based performance measures they must track. For each quality and safety improvement project, hospitals will be placed in one of three performance bands according to their baseline performance as compared to state or national data. Hospitals in the lower two bands—those in the 1st-to-66th percentile for performance—will be expected to move into the next band of performance by the end of the third year of the demonstration. Hospitals in the top band will be expected to move into the top quartile of performers.[168]

During each year of the demonstration, hospitals will receive one-fourth of their share of the funding at the beginning of the year. Hospitals will receive the balance of their allocation after meeting the applicable milestones.[169]

NOTES

[1] E. L. Schor, J. Berenson, A. Shih, S. R. Collins, C. Schoen, P. Riley, and C. Dermody, *Ensuring Equity: A Post-Reform Framework to Achieve High Performance Health Care for Vulnerable Populations* (New York: The Commonwealth Fund, Oct. 2011).

[2] Ibid.

[3] See, e.g., Institute of Medicine (IOM), *America's Health Care Safety Net* (Washington, D.C.: National Academies Press, 2000); J. Zwanzinger and N. Kahn, "Safety-Net Hospitals," *Medical Care Research and Review,* Aug. 2008 65(4):478–55; B. Wynn, T. Coughlin, S. Bondarenko et al., "Chapter 2: A Policy Framework for Targeting Financially Vulnerable Safety-Net Hospitals," in Analysis of the Joint Distribution of Disproportionate Share Hospital Payments (Santa Monica, Calif.: RAND, Sept. 2002).

[4] Ibid.

[5] IOM, *America's Health Care Safety Net*, 2000.

[6] Zwanzinger and Kahn, "Safety-Net Hospitals," 2008, p. 478.

[7] Ibid.

[8] For example, today 17 states limit Medicaid coverage for parents to those with incomes less than half of the Federal Poverty Level (FPL); another 16 states limit coverage to parents with incomes below 100% of the FPL. Only five states provide any Medicaid coverage to non-disabled childless adults. Kaiser Commission on Medicaid and the Uninsured, *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults* (Santa Monica, Calif.: Henry J. Kaiser Family Foundation, Feb. 2011).

[9] Wynn, Coughlin, Bondarenko et al., "A Policy Framework," 2002.

[10] B. C. Vladeck, "Paying for Hospitals' Community Service," *Health Affairs*, Jan./Feb. 2006 25(1):34–43.

[11] Ibid.

[12] U. E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, Jan./Feb. 2006 25(1):57–69.

[13] AMCs and other major teaching hospitals also receive Medicare indirect medical education (IME) payments that, to some extent, also cover the costs of treating greater numbers of low-income and uninsured patients. In fact, the 90% of major teaching hospitals that receive both DSH and IME payments have been found to have the highest Medicare margins. (Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare Payment Policy*, March 2007, pp. 70–87.) The role of IME payments in supporting safety-net hospitals and services is beyond the scope of this paper; however, these payments are another reason why AMCs and major teaching institutions are better able to manage (i.e., cross-subsidize) the cost of greater numbers of Medicaid and uninsured patients.

[14] Some refer to cross-subsidizing the costs of care as "cost-shifting." As others have noted, the term "cost-shifting" implies that the provider responds to some reduction in rates by one payer by increasing rates on other payers. There is some question as to whether providers do cost-shift in such a responsive way. J. S. Lee, R. A. Berenson, R. Mayes et al., "Medicare Payment Policy: Does Cost Shifting Matter," *Health Affairs*, 2003, w3-480. Here we use the term "cross-subsidize" to capture generally the different rates that providers receive from different payers.

[15] See generally Reinhardt, "Pricing of U.S. Hospital Services," 2006.

[16] MedPAC, *Report to the Congress: Variation and Innovation in Medicare* (June 2003); United Hospital Fund, Hospital Watch, February 2001.

[17] Many safety-net hospitals with a significant ability to cross-subsidize are AMCs, and changes in how graduate medical education (GME) is funded will affect these hospitals. Although changes in GME funding will be a major issue for AMCs over the next several years, the effect of these changes is outside the scope of this paper.

[18] Exhibit 5 reflects only discharges and not revenues; it does not capture the extent to which groups of hospitals are able to offset, on a dollar-for-dollar basis, relatively low Medicaid rates with higher commercial rates. Despite this limitation, the chart does provide some insight into how a hospital's ability to attract commercial patients and offset Medicaid losses changes as Medicaid mix increases.

[19] Congressional Budget Office, March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Washington, D.C.: CBO, 2011).

[20] M. Buettgens, J. Holahan, and C. Carroll, *Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid* (Princeton, N.J.: Robert Wood Johnson Foundation and Urban Institute, March 2011), p. 1.

[21] Ibid.

[22] M. Buettgens, B. Garrett, and J. Holahan, *America Under the Affordable Care Act* (Princeton, N.J.: Robert Wood Johnson Foundation and Urban Institute, Dec. 2010).

[23] Ibid.

[24] See Center for Medicare and Medicaid Services, Office of the Actuary, 2010 Actuarial Report on the Financial Outlook for Medicaid (2010), IV (projecting that Medicaid will cover 78 million Americans in 2019).

[25] Chapter 58 of the Laws of 2006.

[26] L. Ku et al., *Safety-Net Providers After Health Care Reform: Lessons from Massachusetts*, Archives of Internal Medicine, Vol. 171, Aug. 2011, pp. 1379, 1381.

[27] Providers have been challenging low payment rates since at least the late 1980s. *See* Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498 (1990). Researchers and policymakers, too, have argued since the 1980s that provider rates in Medicaid are too low. *See, e.g.*, Kenneth R. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U. L. REV.1, 4 (1983).

[28] S. Zuckerman, A. F. Williams, and K. E. Stockley, "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs*, May/June 2009 28(3):w510–w519.

[29]*See* Medicaid and CHIP Payment and Access Commission, *Report to Congress* (March 2011), p. 169.

[30] AHA TrendwatchChartbook 2010 Appendix 4 Supplementary Data Tables, tbl. 4.4.

[31] Ibid.

[32] Ibid.

[33] MACPAC report to Congress (2011).

[34] V. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured, 2010, p. 34 (hereinafter "*Hoping for Economic Recovery*").

[35] V. Smith et al., *Hoping for Economic Recovery*, p.34.

[36] See 2009 Mich. Pub. Act 129, enacted Oct. 30, 2009 (Enacted budget for Department of Human Services; *see also* Doug Trapp "Michigan slashes Medicaid fees for doctors by another 8%," *American Medical News*, Nov. 12, 2009, *available at* http://www.ama-assn.org/amednews/2009/11/09/gvsc1112.htm (describing 8% reduction in Medicaid rates). Assembly Bill 97, enacted March 24, 2011.

[37] California Assembly Bill 97, enacted March 24, 2011.

[38] Ten states cut Medicaid managed care rates in FY 2010, and nine states cut Medicaid managed care rates in FY 2011. V. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends*, Kaiser Commission on Medicaid and the Uninsured, 2010, p 35.

[39] See, e.g., Gonzaga University v. Doe, 576 U.S. 273 (2002); Equal Access for El Paso v. Hawkins, 509 F.3d 697 (5th Cir. 2007); Sanchez v. Johnson, 416 F.3d 10501 (9th Cir. 2005); Methodist Hospital v. Sullivan, 91 F.3d 1026 (7th Cir. 1996); Rite Aid v. Houstoun, 171 F.3d 842 (3d Cir. 1999); Orthopedic Hospital v. Belshe, 103 F.3d 1491 (9th Cir. 1997). The Supreme Court will consider whether providers may challenge rate cuts under Section (30)(A) this term in Douglas v. Independent Living Center of Southern California, Docket No. 09-958.

[40] 76 Fed. Reg. 26342 (May 6, 2011).

[41] Social Security Act § 1902(a)(30)(A).

[42] Affordable Care Act, Pub. L. 111-48, § 1202.

[43] Affordable Care Act, Pub. L. 111-48, § 1202.

[44] Ibid.

[45] National Association of State Budget Officers/National Governors Association, State Expenditure Report 2009; *see also* D. Bachrach, *Payment Reform: Creating a Sustainable Future for Medicaid*, CHCS (2010), 3.

[46] U.S. General Accounting Office, *Balanced Budget Requirements: State Experiences and Implications for the Federal Government* (1993).

[47] D. Bachrach, *Payment Reform: Creating a Sustainable Future for Medicaid*, CHCS (2010).

[48] UPL payments are add-ons to Medicaid rates. Because the nonfederal share is often funded with taxes on providers, providers have considerable influence on how the money is allocated such that a primary goal is often paying back the contributing hospitals or backfilling inadequate payment rates rather than driving sound payment policies. D. Bachrach & M. Dutton, *Medicaid Supplemental Payments: Where Do They Fit in Payment Reform*, Center for Health Care Strategies (2011).

[49] See generally, Schor, Berenson, Shih et al., *Ensuring Equity*, 2011.

[50] U. Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy*, Health Affairs (2006) 25:57; A. Dobson, J. DaVanzo & N. Sen, *The Cost Shift Payment Hydraulic: Foundation, History & Implications*, Health Affairs (2006); J. S. Lee, R. A. Berenson, R. Mayes, & A. K. Gauthier, Medicare Payment Policy: Does Cost Shifting Matter, *HealthAffairs*, 2003, w3-480;*Massachusetts Health Care Cost Trends: Price Variation in Health Care Services*, Boston, MA: Division of Health Care Finance and Policy, May 2011, revised June 2011.

[51] Schor, Berenson, Shih et al., *Ensuring Equity*, 2011, p. 14.

[52] K. Quinn and C. Courts, *Sound Practices in Medicaid Payment for Hospital Care*, Center for Health Care Strategies (2010).

[53] Ibid., p. 18.

[54] Ibid., p. 14; P. B. Ginsburg and J. M. Grossman, *When the Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care*, Health Affairs, W5-376.

[55] Quinn and Courts, *Sound Practices,* 2010, p. 14.

[56] Ibid.

[57] Chapter 58 of the Massachusetts Laws of 2006.

[58] L. Ku et al., *Safety-Net Providers After Health Care Reform: Lessons from Massachusetts*, Archives of Internal Medicine, Vol. 171, Aug. 2011 pp. 1379, 1381.

[59] Ibid.

[60] Ibid.

[61] Section 1902(a)(30)(A) of the Social Security Act

[62] Kaiser Commission, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*,(September 2011; D. Bachrach & P. Boozang, *Medicaid Managed Care: How States Experience Can Inform Exchange Qualified Health Plan Standards*, Center for Health Care Strategies (November 2011)

[63] P. Davis et al., *Medicare Provisions in the Patient Protection and Affordable Care Act: A Summary and Timeline,* Congressional Research Service, 2010, p. 6; MedPAC, *Report to Congress: Medicare Payment Policy,* 2007.

[64] 42 U.S.C. § 1396r-4.

[65] J. Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, Health Affairs, 27 (2008) w399-w415.

[66] U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614 (2008). D. Bachrach & M. Dutton, *Medicaid Supplemental Where Do They Fit in Payment Reform,* Center for Health Care Strategies, Inc. (2011) p. 6.

[67] U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614 (2008). D. Bachrach & M. Dutton, *Medicaid Supplemental Payments: Where Do They Fit in Payment Reform,* Center for Health Care Strategies, Inc. (2011) p. 6.

[68] V. Smith et al., *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends,* Kaiser Commission on Medicaid and the Uninsured, 2010, p. 15; *Income, Poverty, and Health Insurance Coverage in the United States: 2009.* United States Census Bureau. September 2010.

[69] Ibid.

[70] L. Felland et al., The Economic Recession: Early Impacts on Healthcare Safety-Net Providers, Center for Studying Health Systems Change, (2010).

[71] Buettgens, Garrett, and Holahan, *America Under the Affordable Care Act,* 2010. See Affordable Care Act, Pub. L. No. 111-148, § 2001 (expanding Medicaid eligibility); Affordable Care Act, Pub. L. No. 111-148, § 1501 (as modified by Health Care Education Reconciliation Act, Pub. L. No. 111-152, § 1002 and § 10106) (requiring all individuals to obtain insurance); Affordable Care Act, Pub. L. No. 111-152, § 1401 (creating a refundable tax credit to subsidize coverage purchased through a health insurance exchange).

[72] Affordable Care Act, Pub. L. No. 111-148, § 1501(b).

[73] Affordable Care Act, Pub. L. No. 111-148, § 1501.

[74] Buettgens, Garrett, and Holahan, *America Under the Affordable Care Act*, 2010.

[75] See L. Ku et al., *Safety-Net Providers After Health Care Reform: Lessons from Massachusetts*, Archives of Internal Medicine, Vol. 171, Aug. 2011 pp. 1379, 1384.

[76] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007, p. 70.

[77] Ibid.

[78] P. Davis et al., *Medicare Provisions in the Patient Protection and Affordable Care Act*, 2010, p. 6.

[79] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007.

[80] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007, p. 51.

[81] Section 1886(d) of Social Security Act. A hospital's so-called "disproportionate share percentage" is the sum of the following two ratios:

$$\frac{\text{Days Attributable to Medicaid Patients Not Also Eligible for Medicare}}{\text{Total Patient Days}}$$

and

$$\frac{\text{Days Attributable to Medicare Beneficiaries Receiving SSI}}{\text{Total Medicare Patient Days}}$$

Because the denominators of the two ratios differ, a hospital can have a disproportionate share percentage that exceeds 100%.

[82] SSA § 1886(d)(5)(F), 42 U.S.C. 1395ww, SSA § 1886(d)(5)(F)(i)(II).

[83] SSA § 1886(d)(5)(F).

[84] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007, p. 71.

[85] American Hospital Association, Fast Facts on U.S. Hospitals (2010), *available at* http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf (stating that there are 5,008 nonfederal, short-term hospitals in the United States).

[86] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007, p. 73.

[87] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007.

[88] Ibid.

[89] MedPAC, *Report to Congress: Medicare Payment Policy*, 2007, p. 78.

[90] Ibid.

[91] Affordable Care Act § 3133.

[92] Ibid.

[93] Affordable Care Act § 3133. The Congressional Budget Office projects that the reductions in Medicare DSH will save an estimated $22.1 billion over ten years. Congressional Budget Office, Letter to Hon. Nancy Pelosi, March 20, 2010, table 5.

[94] Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35. Among other provisions in OBRA of 1981 was the so-called "Boren Amendment."

[95] 42 U.S.C. § 1396a(a)(13)(A)(iv). *See also* L. Fagnani & J. Tolbert, *The Dependence of Safety-Net hospitals and Health Systems on the Medicare and Medicaid Disproportionate Share Hospital Payment Programs*, The Commonwealth Fund (1999) p. 7.

[96] 42 U.S.C. § 1396r-4.

[97] U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614 (2008); D. Bachrach & M. Dutton, *Medicaid Supplemental Payments: Where Do They Fit in Payment Reform*, Center for Health Care Strategies, Inc. (2011) p. 3.

[98] 42 U.S.C. § 1396r-4(b).

[99] 42 U.S.C. § 1396r-4(c); 42 U.S.C. § 1396r-4(c)(3)(B).

[100] 42 U.S.C. § 1396r-4(g). The hospital-specific limits were enacted through the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13621(b)(1).

[101] E.g., 42 U.S.C. § 1396r-4(g); 42 C.F.R. § 447.299(c)(15).

[102] Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1001(d).

[103] 42 C.F.R. § 447.299(c).

[104] 77 Fed. Reg. 2500 (Jan. 18, 2012).

[105] State Medicaid Director Letter of July 27, 2009, *available at* https://www.cms.gov/MedicaidRF/Downloads/CMSDSHReportsandAuditsLetter.pdf.

[106] U.S. Government Accountability Office, *CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, Pub. No. GAO-08-614 (2008); U.S. Department of Health and Human Services, Office of the Inspector General. Review of Medicaid Disproportionate Share Hospital Payment Distribution (A-07-09-04150), June 22, 2010.

[107] Health Care and Education Reconciliation Act of 2010, § 1203.

[108] Ibid.

[109] Affordable Care Act § 2551, as amended by HCERA § 1203.

[110] Ibid.

[111] D. Bachrach and M. Dutton, *Medicaid Supplemental Payments: Where Do They Fit in Payment Reform*, Center for Health Care Strategies, Inc. (2011) p. 8.

[112] Congressional Budget Office, March 2011 Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Washington, D.C.: CBO, 2011).

[113] A thorny issue that states will have to confront is whether to consider an individual who is subject to the mandate but nonetheless does not purchase coverage as "uninsured" for DSH allocation purposes.

[114] C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, "Insured But Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive, June 14, 2005, w5-289–w5-302.

[115] C. Schoen, M. M. Doty, R. H. Robertson, and S. R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 Percent," *Health Affairs*, Sept. 2011 30(9):1762–71.

[116] Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, December 16, 2011 at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[117] 42 C.F.R. § 447.299(c).

[118] D. Bachrach and M. Dutton, *Medicaid Supplemental Payments: Where Do They Fit in Payment Reform*, Center for Health Care Strategies (2011)

[119] Affordable Care Act, Pub. L. No. 111-148, § 3022 (establishing the Medicare Shared Savings Program to share savings with accountable care organizations); 76 Fed. Reg. 19,528 (April 7, 2011) (notice of proposed rulemaking); Affordable Care Act, Pub. L. No. 111-148, § 3023 (establishing Medicare bundled payment pilot); Affordable Care Act, Pub. L. No. 111-148, § 2704 (establishing a demonstration project to evaluate integrated care around a hospitalization); Affordable Care Act, Pub. L. No. 111-148, § 3025 (reducing Medicare payments to hospitals with high rates of readmission); 10 N.Y.C.R.R. § 86-1.37 (reducing Medicaid rates in New York State to hospitals with high rates of potentially preventable readmissions); Affordable Care Act, Pub. L. No. 111-148, § 1202 (requiring that Medicaid payment rates are at least equal to Medicare payment rates for primary care services); Affordable Care Act, Pub. L. No. 111-148, § 1001 (adding Section 2713 to the Public Health Service Act, requiring plans to provide coverage for certain preventive services with no consumer cost-sharing requirement); Affordable Care Act, Pub. L. No. 111-148, § 10503 (establishing additional funding for federally qualified health centers).

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[121] Agency for Healthcare Research and Quality, *Serving the Uninsured: Safety-net hospitals, 2003*, HCUP Factbook No. 8 (2007).

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[123] L. E. Goldman et al., *Public Reporting and Pay-for-Performance: Safety-Net Hospital Executives' Concerns and Policy Suggestions*, Inquiry, 44 (2007), p. 137.

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[134] CMS, Partnership Plan Medicaid Section 1115 Demonstration, Special Terms and Conditions, 11-W00114/2, p. 15.

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