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Strategies in 4 Safety-Net Hospitals to Adapt to the ACA

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Executive Summary

Safety-net hospitals have long played an important role in the US health care system in serving vulnerable populations, providing high cost services such as trauma and burn care and often in training medical and nursing students. The Affordable Care Act (ACA) fundamentally changes the health care landscape and safety-net hospitals need to make major changes to compete. New coverage from Medicaid expansions and new Marketplace coverage provide opportunities for safety-net hospitals. However, these providers face challenges competing for newly insured patients and continuing to serve the remaining uninsured (including adults in states not expanding Medicaid and undocumented immigrants who remain ineligible for Medicaid or new ACA coverage). Safety-net hospitals also face reductions in financing for uncompensated care.

Building off of a 2012 *Health Affairs* brief that looked at early ACA preparations by safety-net hospitals,[1] this brief examines four safety-net hospitals to learn how they were preparing for the full implementation of health reform, in order to gain additional insight into the strategies being used and challenges being faced among safety-net hospitals across the country. The four hospitals are Cook County Health and Hospitals System (Cook County HHS) in Chicago, Illinois; Harris Health System (Harris Health) in Houston, Texas; Santa Clara Valley Medical Center (SCVMC) in San Jose, California; and University Medical Center of Southern Nevada (UMC) in Las Vegas, Nevada (see tables in the Appendix for additional hospital information). The findings are based on information gathered from site visits and interviews between June and September 2013 with local health care stakeholders and key hospital management. While hospitals were employing strategies with different intensity, key findings about adapting for changes from health reform include:

- Study hospitals were implementing an array of financial strategies focused on tapping Medicaid revenues (through early coverage expansion and delivery system reform waivers), improving patient billing, lowering cost structures to shore up revenues and using strategic contracting and purchasing arrangements.
- To reduce fragmentation and increase efficiency, study hospitals were adopting delivery system reforms particularly related to developing community-based partners and systems of care.
- Most study hospitals implemented changes in hospital leadership and management structure as well as efforts to better align physician incentives with hospitals and changing the culture of patient care to be more responsive to changing markets.
- Improving infrastructure and Health Information Technology (HIT) were being employed to make hospitals more attractive to consumers and to increase efficiency.

Even after full implementation of the ACA, the study hospitals, as well as other safety-net hospitals across the country, are expected to continue to serve a critical role in their communities. While safety-net hospitals must adopt new strategies to thrive under reform, policy makers at the federal, state, and local levels of government will need to monitor and evaluate how safety-net hospitals are faring as the ACA is implemented to ensure that the safety-net is sustainable for vulnerable populations and for broader community needs.

Introduction

Safety-net hospitals have long played an essential role in the US health care system. They are a major source of care for the nation's most medically vulnerable, including Medicaid beneficiaries and the uninsured, and provide services that other hospitals generally do not offer, such as trauma and burn care. In addition, many of these hospitals serve as training facilities for medical and nursing students. Safety-net hospitals face more challenges compared to other hospitals because of limited revenue streams, due to a reliance on uncompensated care financing pools and a poor payer mix, often complex governance and leadership structures, and high needs for infrastructure (IT) investments.

The ACA makes fundamental changes to the health care landscape primarily in terms of coverage and financing. First, the ACA extends coverage to many uninsured through an expansion of Medicaid for low-income adults and through premium tax credits to help people purchase insurance through new Health Insurance Marketplaces for individuals with moderate incomes. With the June 2012 Supreme Court ruling on the ACA, the Medicaid expansion became optional for states. As of May 2014, 27 states, including the District of Columbia, are implementing the Medicaid expansion and 24 states are not moving forward at this time. In states not implementing the Medicaid expansion, many adults will remain uninsured. In terms of financing, new coverage through Medicaid and the Health Insurance Marketplaces could mean additional revenues for hospitals and other providers, but the ACA also significantly reduces Medicare and Medicaid disproportionate share hospital (DSH) payments, which often represent a major revenue source for safety-net hospitals. In addition, state and local funding sources for uncompensated care could decline with reform. Finally, the ACA emphasizes value-driven care, which will challenge all hospitals to deliver quality care in a cost-effective way.

As a result of changes under the ACA, safety-net hospitals will need to make major changes to the way they do business in order to compete. Under reform, increases in coverage will mean that safety-net hospitals will face increases in patient demand from those newly insured through Medicaid and the Health Insurance Marketplaces. At the same time, they will need to actively compete with private hospitals for those newly insured patients, a sea change for many safety-net hospitals' organizational culture as historically they have focused on caring for the uninsured and underinsured. In states that are not implementing the Medicaid expansion, safety-net hospitals will continue to serve a high number of uninsured patients, but could also see reductions in financing for uncompensated care. This is particularly true for safety-net hospitals that serve large shares of undocumented immigrants who remain ineligible for Medicaid or tax credits to purchase coverage in the new Marketplaces.

Building on earlier work,[2] this report examines four safety-net hospitals to learn how they were adapting to changes in the ACA and what major challenges the hospitals will likely face as they enter the post-reform world. The four hospitals are Cook County Health and Hospitals System (Cook County HHS) in Chicago, Illinois; Harris Health System (Harris Health) in Houston, Texas; Santa Clara Valley Medical Center (SCVMC) in San

Jose, California; and University Medical Center of Southern Nevada (UMC) in Las Vegas, Nevada. Each of these hospitals exists within broader health systems, which often includes an extensive outpatient infrastructure. Using a semi-structured protocol, site visits and interviews were conducted between June and September 2013 with key hospital management, including the chief executive officers, chief technology officers, chief financial officers, and chief medical officers. We also interviewed local health care stakeholders.

Overview of Study Hospitals

In selecting the hospitals diversity was sought along several dimensions— geography, whether the hospital is located in a state implementing the ACA Medicaid expansion, and level of state Medicaid DSH payments prior to the ACA (Table 1). Each of the hospitals is located in an area expected to have significant numbers of uninsured remaining after ACA implementation due to high shares of immigrants (both undocumented and documented immigrants who have been in the US for less than five years) who will not be eligible for coverage under the ACA coverage expansions. For hospitals in states not implementing the Medicaid expansion, the number of uninsured will remain higher because many adults will not have a new coverage option.

Each hospital was described as the principal provider of inpatient and outpatient care in its community for the low-income and uninsured populations. For Cook County HHS and Harris Health, 85 percent of hospital discharges are either uninsured or Medicaid beneficiaries, with SCVMC and UMC somewhat lower at 76 and 63 percent, respectively (Table 2). These are substantially higher than the figure for the average US hospital (25 percent; data not shown), and higher than the average safety-net hospital (54 percent; data not shown).[3]

Characteristic of safety-net hospitals generally, the study hospitals rely heavily on revenues from Medicaid, Medicare, and state and local support (Table 2). They do differ, however, in their level of commercial revenue: Nearly 20 percent of SCVMC and UMC's revenues come from commercial sources, whereas Cook County HHS and Harris Health have very little commercial revenue. Managed care plays a role to varying degrees across the four hospitals. For example, Medicaid managed care enrollment in 2010 accounted for 14 percent of total non-elderly Medicaid enrollment in Cook County; 46 percent in Santa Clara County; 76 percent in Clark County; and 82 percent in Harris County.[4] Most individuals newly enrolled through ACA coverage initiatives in these states will receive care through managed care, providing yet another incentive for hospitals to cost-effectively coordinate and integrate care.

The study hospitals' quality performance is comparable to national averages on some measures, including an "effective care" measure related to appropriate antibiotic use after outpatient surgery and 30-day mortality and readmission rates (Table 3). All four hospitals, however, scored lower on a measure of timely care based on the wait for an admission from the emergency department and on patient willingness to recommend the hospital. Nonetheless, UMC and SCVMC were categorized regionally as a top-ranked hospital in their respective metropolitan areas, according to US News and World Report's ranking.[5]

The context in which the study hospitals are operating varies greatly, including state preparations and support for the ACA (Table 1). SCVMC and Cook County HHS have benefited from active state preparations for the ACA. California (where SCVMC is located) opted to expand Medicaid early across the state and Illinois (where Cook County HHS is located) has supported a Medicaid Section 1115 waiver that has expanded Medicaid early in Cook County (see below). While Nevada (where UMC is located) is taking up the Medicaid expansion, the

state has been less active in ACA preparations and did not seek a Medicaid waiver to expand coverage early. In contrast, Texas (where Harris Health is located) has not participated in the ACA expansion of coverage, opting not to implement the Medicaid expansion and deferring to a Federally-Facilitated Marketplace. Since Texas had a pre-ACA uninsurance rate that was the highest in the nation, Harris Health, in particular, will continue to serve a large number of uninsured adults as the ACA moves forward.[6]

Key Findings

Leading up to implementation of the ACA, the study safety-net hospitals were employing reform strategies that fell into four broad and interrelated categories—financial strategies, delivery system reforms, organizational changes, and infrastructure improvements, with all of the changes focused on insuring the long-term financial viability of the hospital in a changing market.

Financial Strategies

Perhaps the most important area where the hospitals devoted a significant amount of effort to prepare for reform is shoring up their financial situation. Overall, leadership from each hospital described efforts to reduce cost and improve efficiencies that would help them be successful in the post-reform world. To varying degrees, each of the hospitals undertook strategies aimed at tapping Medicaid revenues, improving patient billing and using strategic contracting and purchasing arrangements as key financial strategies. For Cook County HHS, SCVMC, and UMC, financial strategies were often tied to the Medicaid expansion and the expected gains in revenue associated with increases in the share of patients with insurance coverage. Since Harris Health is located in a state that is not expanding Medicaid at this time, it focused on expanding revenues beyond those available through the Medicaid expansion.

Study hospitals are tapping Medicaid revenues as a key financial strategy. Medicaid Section 1115 waivers for early expansions of coverage and for delivery system reforms have been an important way for the hospitals to obtain new revenues. Since 2010, California, Illinois, and Texas have each received Section 1115 waiver that have provided significant funding to three of the study hospitals—SCVMC, Cook County HHS, and Harris Health, respectively. Illinois's waiver allowed Cook County HHS to begin covering the ACA Medicaid expansion population early. Since this population was almost entirely uninsured, the early expansion allowed Cook County to access Medicaid patient revenues for this population. Similarly, under California's waiver, Santa Clara County opted to expand Medicaid early so they too were able to access new Medicaid patient revenues for a population that had previously been uninsured.

Both California and Texas also have Delivery System Reform Incentive Payment or "DSRIP" waivers. While the features and requirements of each state's DSRIP waiver is unique, these waivers provide significant amounts of federal Medicaid funding for hospitals (and other providers) that are tied to payment and delivery system reforms, including system redesign, infrastructure development, population health improvements, and quality care improvements. To receive waiver funding, the hospitals must meet specified quality and other milestones. Texas's waiver, called the Transformation and Quality Improvement Program, has the potential to increase state revenues to $30 billion during the five-year waiver period (2011 – 2016). Harris Health would be a major beneficiary of these increased funds. The funding for the California DSRIP waiver is about $3.3 billion over the

five year waiver period. Leadership at each of the hospitals readily acknowledged the importance of the funding they received from the waivers.

Although not participating in an 1115 waiver program, UMC recently availed itself to a new infusion of federal funds by expanding its use of Medicaid Upper Payment Limits (UPL) payments. This funding helped UMC underwrite its electronic health record (EHR) initiative, which was viewed by management as an essential part of preparing for the ACA. The funding also helped to fill a UMC revenue gap created by cuts in local county support during the recession, which hit Nevada quite hard.

Study hospitals are also implementing efforts to improve patient billing. Executives at each of the hospitals conceded that they left significant funds on the table because of inefficient or, in some cases, a complete lack of patient billing. Through revamping its billing processes, Harris Health, for example, now collects more than $300 million per year from patients, up from $240 million. Cook County HHS has also overhauled its billing process. Previously, billing was spread across three different billing and medical records offices, while now it is consolidated into a single office and system. Related to improving their billing practices, the hospitals have also been educating physicians and other hospital staff to record all services that they provide to each patient to support the billing process. Management explained that this sounds easier than it actually is because many hospital staff have never been required to do this and, in some cases, are philosophically opposed to billing poor people for health care. Due to increases in coverage under the ACA, these improvements in patient billing are critical to operations.

Reducing costs and improving cost-effectiveness were other financial strategies study hospitals employed. Leadership from each hospital also described a renewed focus on cost reductions and efficiencies that would help them be successful in the post-reform world. Management at three of the hospitals (Cook County HHS, SCVMC, and UMC) acknowledged that their cost structures are high, and that longer term, they needed to adjust their operating costs to be competitive. In contrast, Harris Health felt its costs are already competitive. Even so, Harris Health is also implementing efficiency strategies.

Strategic contracting and purchasing arrangements is a cost-saving strategy the hospitals have employed. Hospitals are also looking to develop partnerships with community providers, in part to better serve patients, but also to reduce costs. Harris Health and Cook County HHS were most explicit about these plans, which included subcontracting certain services to community-based centers, like FQHCs and outpatient surgery centers. One hospital executive emphasized the cost motivations underlying this strategy – “some services will have to be contracted out; we can’t do everything ourselves and, even if we could, it would be too expensive. The best strategy is to have community partners.” In a similar strategy, SCVMC is contracting with primary care providers outside their system to expand its network and to more effectively control expenses.

Delivery System Reforms

Another critical area of change among these hospitals was delivery system reforms, particularly related to developing community-based partners and systems of care. These efforts are highly inter-related with some of the financing strategies described above.

Management at study hospitals view strategies to enhance community-based care systems as critical to reduce fragmentation and improve efficiency. Overall, the goal of each of the hospitals is to create a more cooperative community-based system that leverages the strengths of the hospital with other resources in its area to reduce fragmented care and eliminate duplication of effort. Cooperation and coordination, however, are new to the hospitals in some cases (e.g., Cook County HHS, Harris Health, and UMC) as well as to community providers.

SCVMC is the furthest along, among the study hospitals, in developing a community-based care system. The hospital has long-standing relationships with community providers, dating back to when Santa Clara County implemented Medicaid managed care in the mid-1990s. In preparations for reform, SCVMC has further expanded and enhanced these partnerships through various efforts, such as integrating community providers into the hospital's IT systems and jointly sponsoring community clinics that offer primary and specialty care. These well-established relationships forged as part of Medicaid managed care provided a strong foundation for SCVMC to cultivate deeper relationships with local providers, particularly aligning community physicians and the hospital.

Both Harris Health and Cook County HHS's efforts to coordinate with community providers are being driven to a great extent by their recent Medicaid Section 1115 waivers, which, among other things, incent both hospitals to move from a system focused on inpatient and acute care toward one focused on outpatient care and community-based providers. Under its waiver, Cook County HHS has contracted with community-based providers and other area hospitals to start a managed care plan so there are now more than 150 access points to its network. In addition to expanding risk-based managed care, Texas's waiver also calls on local areas to improve care delivery. As part of those efforts, Harris Health has developed contractual relationships with "same day" clinics, ambulatory care surgery centers, and began taking referrals from local FQHCs. Harris Health is expanding beyond its relatively well-established local integrated care system toward a more regional model of care delivery with the goal of developing an Accountable Care Organization (ACO) that serves a broad geographic region in the state.

In contrast, UMC has engaged in only very preliminary efforts to identify potential partners. Interviewees attributed this lack of development of a community-based system of care, in large measure, to UMC operating in the highly competitive Las Vegas hospital market, one that is dominated by private, for-profit hospitals that are wary of coordinating care with their competitors and have little interest in working together or supporting a safety-net. In addition, UMC, with its long-standing financial challenges, was not viewed as having the resources to take on the major system change that would be needed to create broad collaborative models in Las Vegas. Even so, in early 2013, UMC began conversations with community providers about how they might begin to create a system of collaboration in the future.

Study hospitals were also focused on strengthening primary care and better integrating services. Central to strengthening primary care capacity was a push to certify primary clinics as patient-centered medical homes. Hospitals planned to enhance preventive services through medical home implementation, and coordinate care efficiently in order to reduce unnecessary spending. Study hospitals were at various points of achieving medical home recognition for their primary care facilities. Harris Health was

leading the way with its primary care clinics having reached NCQA Level 3 Certification. Harris Health is also working to integrate services and build "one big medical home" across its hospitals and clinics.

SCVMC is working to better integrate its mental health and alcohol services, which have historically operated in siloes. In addition, SCVMC is currently trying to unify its two county-sponsored managed care plans, as well as, take on more risk and narrow provider networks in an effort to retain more of the public health dollars in its system. Through its new managed care plan Cook County HHS is establishing relationships with hospitals and clinics across the county.

Hospital Organizational Changes

Significant organizational overhauls have occurred at each of the hospitals, due both to the lingering effects of the recession and preparations for health reform. Key organizational changes include changing the hospitals' leadership and management structure, as well as, aligning physician and hospital priorities.

In three out of the four study hospitals, changes in the hospitals' leadership and management structure have been key to responding to the rapidly changing health care landscapes. Prior work has highlighted the important role that strong leadership plays in the ability of safety-net hospitals to respond to rapidly changing circumstances. The importance of leadership was echoed in the experiences of the four study hospitals. Three of the hospitals—Cook County HHS, SCVMC, and UMC – have had significant changes in management within the last few years, while leadership at Harris Health has remained relatively stable.

Perhaps most striking has been the leadership shift at Cook County HHS, which introduced a wholesale reorganization of the hospital's management structure, from one that was very hierarchical to one that is flat, which is intended to facilitate more rapid decision-making. This leadership change took place at the system-level, affecting not only Cook County HHS, but also the system's extensive ambulatory care network. Respondents from both inside and outside of Cook County HHS also noted an important move away from the hospital's traditional crisis management model to one of a shared vision for system change. These changes were seen as key factors in securing Illinois's 2012 Medicaid Section 1115 waiver, that is playing a critical role in the transformation occurring at Cook County HHS.

In 2012, UMC also had a noteworthy management change, bringing on chief officers for finance, medicine, and operations, positions that had been vacant for several years. Prior leadership turmoil and serious financial problems, however, have compromised the new leadership's ability to make significant preparations for reform. UMC instead remains very much in a crisis management model, with hospital leadership struggling to address day-to-day financial and operational challenges. The hospital's prior governance structure, which required the hospital CEO to report directly to the Clark County Commission, further thwarted its efforts for change. However, in 2013 UMC received approval from the commission to move its governance from the county to an independent board. The expectation both inside and outside of UMC is that the new governance structure will support the hospital's ability to make more effective and timely decisions. This change in governance for UMC also holds the promise of being the starting point for the hospital to institute fundamental organizational reforms.

Finally, related to management structure, one Cook County HHS executive observed that hospitals that operate in less unionized environments enjoy a higher level of "nimbleness" in staffing than their heavily unionized counterparts, which can allow for a quicker adaptation to new initiatives and demands.

To remain competitive as more residents gain coverage, study hospitals were working on strategies to change the culture of patient care. While the four study hospitals have extensive experience in providing core safety-net services to their communities, each hospital is preparing for increased competition from private hospitals for newly-insured patients under the ACA. To prevent losing insured patients to other providers, each hospital is implementing initiatives to change the culture of patient care within their system. This is a seismic shift in the way the hospitals have traditionally done business. Historically, these hospitals have served the patients who "have nowhere else to go". Across the board, hospital management conceded that changing the culture of patient care and how they are perceived in the community is a heavy lift. One SCVMC executive observed that improving the patient experience is among the biggest organizational challenges that SCVMC faces. Despite the challenges, these hospitals have strong foundations to build off of because they already provide quality care and critical community health care services, have loyal patient bases, and have strong track records of providing health care services that are culturally and linguistically sensitive.

Initiatives to improve the patient experience include altering patient processes to reduce wait times and educating staff about having positive interactions with patients. The hospitals are also pushing to have a cleaner and more attractive physical environment. SCVMC, for example, is altering inpatient rooms by increasing the number of private rooms and Harris Health is moving from four-bed rooms to semi-private rooms. UMC, on the other hand, lacks the resources for such improvements and is the only hospital in Las Vegas without private rooms. However, UMC is also the only hospital in Nevada ranked by US News and World Report.[7]

The hospitals are also conducting outreach and education targeted to staff, patients, and the broader community. A major objective of these campaigns is to emphasize that the hospitals are providers to the entire community and not just standalone sources of care for the uninsured. These efforts were viewed as more important in Cook County HHS, SCVMC, and UMC, where significant shares of the uninsured are expected to gain coverage under the Medicaid expansion, than in Harris Health, where little change in insurance coverage is expected, given Texas's decision not to expand Medicaid. While the hospitals plan to staff about their mission to serve the uninsured, it is also important that they understand that if insured patients go elsewhere, the hospital will cease to exist.

Study hospitals have sought to better align the incentives of their physicians with the hospital's needs and goals to support more efficient care delivery. This has been less of an issue in SCVMC and Cook County HHS, where the hospitals' physicians are county employees (Table 1). One Cook County HHS leader observed that having employed physicians "is a gigantic strength of our organization because we attract people who want to work here. They didn't just get assigned here."

In contrast, the majority of UMC's physicians are based in the community and have limited ties to the hospital and Harris Health relies on contracts through two medical schools for its physicians. Respondents at both

UMC and Harris Health acknowledge that the interests and motivation of the physicians are not necessarily consistent with the needs of the hospital. To help mitigate this, UMC is working to build a stronger relationship with the University of Nevada's School of Medicine. Along the same lines, Harris Health is pushing against "fractionalization"—that is, where the medical schools fill a full-time position with multiple physicians rather than a single individual, compromising continuity of care. The goal of both UMC and Harris Health is to have a more limited group of physicians who have a stronger focus on prioritizing patient needs.

Infrastructure and Technology Investments

As the study hospitals prepare for the future, each has included infrastructure investments as part of their strategic plans. Improvements to their physical and information infrastructures, not only make the hospitals more attractive to consumers, including newly-insured consumers, but they also offer opportunities to improve efficiency, capacity, and can enable cost-savings over time to support the hospitals' on-going financial viability. While some of the study hospitals had infrastructure projects underway before reform passed, the ACA provided additional incentives to undertake these investments. Local revenue as well as the priorities of each hospital's governing boards also affected the hospitals' ability to pursue infrastructure improvement projects.

Hospital strategic plans and governing board priorities played an important role in determining new infrastructure projects. As part of its strategic plan, Harris Health designed a capital building program, supported by its governing board that designated $370 million for the effort, made possible by an increase in Houston property values and a bond issue. Harris Health began capital construction in 2008, which was still ongoing as of late 2013. Meanwhile, lack of capital and support from its county commissioners have prevented UMC from making any investment in facility renovation, which executives fear may negatively affect the hospital's competitiveness. UMC executives estimate that they would need an infusion of $50 million "to bring them up to where they should be" in terms of capital investment.

To better meet the needs of their patients and to control costs, both SCVMC and Harris Health have built new ambulatory care centers. Harris Health is also building nine new primary care and same-day clinic facilities, which are projected to enable an additional 30,000 primary care visits per year.

Health Information Technology (HIT) offers opportunity for increased efficiency, timelier patient information-sharing, and cost savings over time. The ACA has new billing collection and financial aid requirements that can be best met through the usage of EHRs, an area of significant infrastructure development for each of the hospitals. All four hospitals are working on modifying or improving their current HIT systems to better share patient health information among providers both within their own health system and throughout the community, as well as to enable patients to interact with doctors through the EHR.

Cook County HHS and Harris Health have had EHRs for several years, whereas UMC began installation of EHRs in late 2012 and SCVMC switched to EHRs at the beginning of 2013, with the goal of making the transition on an accelerated basis.

The new EHR frontier for the hospitals is improving communication among their hospitals, ambulatory, and urgent care centers, and with their partner clinics. Improving this type of communication was a priority for each of the study hospitals, but they were at different levels of integration. Cook County HHS, for example, uses

a single EHR throughout its inpatient, outpatient and correctional care settings but it still has a limited ability to communicate and share information with its partnership clinics, and instead uses a separate web-based system. In contrast, SCVMC's EHR linked the hospital and its associated ambulatory and specialty care centers, and plans to link to its community partners in the near future.

Looking Ahead

Leadership at the study hospitals thought the ACA provided them with opportunities and were optimistic that, in the long run, reform will have a positive impact on them. The opportunities for study hospitals were clearer at Cook County HHS, SCVMC, and UMC, because they operate in states that are moving forward with the Medicaid expansion, these hospitals have opportunities to reduce the number of uninsured patients and capture significant new Medicaid patient revenues. Some Harris Health hospital executives and local health care stakeholders believe that a "Texas Solution" for the ACA coverage expansion will eventually be executed, and that they could see an increase in Medicaid revenues for eligible but unenrolled individuals, in addition to those with new coverage purchased through the Health Insurance Marketplace.

At the same time hospital leaders were concerned about financial risks associated with the changes under the ACA. All were worried about the federal Medicare and Medicaid DSH cutbacks that have been key sources of financing for safety-net hospitals. This was a key issue in Texas where the numbers of uninsured are likely to remain significant despite reductions in DSH. Financial worries also stemmed from the potential decline in state or local funding. In California, for example, the governor has announced that because many individuals will gain Medicaid coverage with the ACA, the state is reducing funding that it had provided to counties to support health care services for the low-income. Similarly, UMC leadership noted that cutbacks in local indigent care funding will ensue once the ACA Medicaid expansion is implemented. While hospital leadership understand that new funds will be available to them under reform (particularly in states implementing the Medicaid expansion), given that each of the study hospitals is located in areas with high immigrant populations, many of whom will not qualify for coverage under the ACA, reductions in support for indigent care will be challenging.

For the three hospitals with 1115 waivers, management also expressed concern about the continued flow of revenue through this vehicle. While Harris Health hopes for another waiver, it acknowledges that the federal matching dollars provided through DSH, UPL payments, and the waiver are critical, they also need to consider strategies if the state cannot secure a second waiver.

Hospital executives also worry about being able to compete in a post–ACA health care market. Hospital leaders recognize the amount of work ahead in having the right patient culture and up-to-date infrastructure in place to compete for the expanded pool of insured patients and to operate in health care systems that are moving toward increasing levels of integration and coordination.

Another concern expressed by hospital leadership is whether they will effectively be able to compete for newly-insured patients and the revenue associated with those patients. Leadership at each hospital acknowledged that there is excess capacity in their local health care system, which will drive competition for the newly insured. Even with their preparations, management worried that the attitude and culture of their hospitals had not

sufficiently shifted to keep their patients after they obtained insurance. As one Cook County HHS executive observed, when Medicaid shifted to managed care for pregnant women, the pregnant women often chose better facilities to get care. Now, Cook County HHS handles few deliveries. Harris Health's experience was similar when Texas introduced managed care for pregnant women and children.

The ability to effectively broaden their mission was another major concern for management. While acknowledging that they "will always be the safety-net hospital," they need to move beyond being "just" a safety-net provider and get their communities to view them differently. From their perspective, they need to be "a system of choice" or they will cease to exist. Making the transition from "the" safety-net hospital to the hospital for all of the community is a critical component of the hospitals' plans to survive and hopefully thrive under health reform.

Conclusion

This study has reviewed the major opportunities and challenges four safety-net hospitals were facing in adapting to changes under the ACA, as well as strategies to be better positioned to meet these challenges. Reflecting the diversity of safety-net hospitals' situations across the country, study hospitals varied in both the intensity of effort and their availability of resources to adapt for health reform. SCVMC has taken a robust approach to its ACA preparations, which have included employing financial strategies, undertaking significant organizational changes, forging new relationships with community-based providers, and moving ahead with infrastructure improvements. Leading up to ACA implementation, SCVMC, Cook County HHS, and Harris Health all benefit from Section 1115 waivers that are supporting system transformation. Constrained financial resources and a highly competitive market in Las Vegas that is resistant to collaborative efforts, have strained UMC's health reform preparations. However, the challenges are greater for Harris Health, given that Texas is not moving forward with the Medicaid expansion.

Even after full implementation of the ACA, the study hospitals, as well as other safety-net hospitals across the country, are expected to continue to serve a critical role in their communities in caring for uninsured and underinsured populations including undocumented immigrants who are not eligible for Medicaid and other coverage options in the ACA. Safety-net hospitals are also important as providers of core services for the entire community that are not available elsewhere (e.g., trauma and burn care services). So while these and other safety-net hospitals must adopt new strategies to thrive under reform, policy makers at the federal, state and local levels of government will need to monitor and evaluate how safety-net hospitals are faring as the ACA is implemented to ensure that the safety-net is sustainable for vulnerable populations and for broader community needs. We will also continue to track safety-net hospitals across the country as health reform is fully implemented to identify successful strategies hospitals are using to adapt to the changing health coverage environment and to better understand how they and the populations they serve are faring in the post-reform world.

Appendix

Table 1: Study Hospitals Overview

Hospital/ Health System Name	City, State	Associated Facilities	ACA Implementation		Physician Staffing Arrangement and Academic Affiliations	Preliminary DSH Allotment to State, FY 2012 (in millions) [2]
			Medicaid Expansion [1]	Marketplace Type [1]		
Cook County Health and Hospitals System	Chicago, IL	2 hospitals; 16 ambulatory care clinics; 1 managed care plan	Yes	Federal-state partnership	Physicians are employed by Cook County, academic relationships with Rush Medical College and University of Illinois at Chicago.	$225.9
Harris Health System	Houston, TX	2 acute-care hospitals; 1 specialty hospital; 16 community health centers; 6 school-based clinics; 1 dialysis center; 1 dental clinic; 1 managed care plan	No	Federally-facilitated	Physicians are employed by Baylor College of Medicine and The University of Texas Health Science Center at Houston (UTHealth).	$1,004.7
Santa Clara Valley Medical Center	San Jose, CA	1 hospital; 11 clinics, (including a homeless and a mobile dental clinic); public health department, custody department; 1 managed care plan	Yes	State-based	Most physicians are employed by the County of Santa Clara, academic relationship with Stanford School of Medicine.	$1,151.8
University Medical Center of Southern Nevada	Las Vegas, NV	1 hospital; 10 urgent and primary care clinics	Yes	State-based	Most physicians are community physicians, an academic relationship beginning with the University of Nevada School of Medicine.	$48.6

SOURCES: [1] State Health Facts, *Health Reform Indicators*, http://kff.org/state-category/health-reform/; [2] Centers for Medicare & Medicaid Services, "Medicaid Program: Disproportionate Share Hospital Allotments and Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY 2012, and Preliminary FY 2013 Disproportionate Share Hospital Allotments and Limits," 78 Federal Register 45217 (July 26, 2013).

Table 2: Selected Hospital Utilization and Financial Characteristics, 2010								
Hospital/ Health System Name	Hospital Discharges			Net Revenues by Payer Source				
	Total	% Medicaid	% Uninsured/ Self-Pay/ Indigent Care	% Medicaid	% Medicare	% Commercial	% Uninsured/ Self-Pay/ Indigent Care	State/ Local Payments
Cook County Health and Hospitals System	23, 763	33%	52%	54%	7%	1%	1%	37%
Harris Health System	40,666	45%	40%	33%	7%	3%	2%	54%
Santa Clara Valley Medical Center	23,433	55%	21%	42%	13%	19%	3%	21%
University Medical Center of Southern Nevada	26,436	31%	32%	36%	13%	17%	17%	13%

SOURCE: Zaman, O.S., Cummings, L.C., Laycox, S., *America's Safety Net Hospitals and Health Systems, 2010: Results of the Annual NAPH Hospital Characteristic Survey* (Washington, DC: National Public Health and Hospital Institute, 2012).
NOTE: Revenues from others sources, such as worker's compensation, veterans' care, prisoner care, not shown.

Table 3: Selected Hospital Quality Indicators					
Hospital/ Health System Name	Outpatients who received correct antibiotic after surgery [1]	30-day mortality rates (from heart attack/heart failure/pneumonia) [2]	30-day readmission rates (hospital-wide) [2]	Average time spent in ED before admittance to hospital [1]	Percent of patients who would definitely recommend hospital [3]
Cook County Health and Hospitals System	97% vs. 97% statewide	No different from U.S. national rates	Higher than U.S. national rate	602 minutes vs. 261 minutes statewide	61% vs. 69% statewide
Harris Health System	97% vs. 98% statewide	No different from U.S. national rates	No different from U.S. national rate	803 minutes vs. 270 minutes statewide	70% vs. 73% statewide
Santa Clara Valley Medical Center	97% vs. 97% statewide	No different from U.S. national rates	No different from U.S. national rate	423 minutes vs. 323 minutes statewide	66% vs. 70% statewide
University Medical Center of Southern Nevada	97% vs. 98% statewide	No different from U.S. national rates	No different from U.S. national rate	476 minutes vs. 350 minutes statewide	49% vs. 68% statewide

SOURCE: Centers for Medicare & Medicaid Services, *Hospital Compare* (2014), http://www.medicare.gov/hospitalcompare/search.html?AspxAutoDetectCookieSupport=1.
NOTES: [1] IQR and OQR Measures for effective and timely care, based on audited data for all adult patients for whom the treatment would be appropriate; [2] 30-day readmission and mortality rates based on Medicare claims and eligibility data and include only Medicare beneficiaries. The measures are risk-adjusted for patient characteristics that may make death or readmission more likely including age, gender, comorbidities and past medical history. Performance categories are based on the U.S. national 30-day mortality and readmission rates. If the interval estimate includes and/or overlaps with the national observed mortality or readmission rate, the hospitals performance is "no different from U.S. national rate". If the entire interval estimate is above the national observed rate, it is "higher than U.S. national rate". [3] HCAHPS survey data, which is a survey administered to a random sample of adult patients across all medical conditions continuously throughout the year, between 48 hours and six weeks after discharge. Results are adjusted for patient mix.

Endnotes

[1] Theresa Coughlin, Sharon Long, Edward Sheen, and Jennifer Tolbert, "How Five Leading Safety-Net Hospitals Are Preparing for the Challenges and Opportunities of Health Reform," *Health Affairs* vol. 31, issue no. 8 (August 2012): 1690 – 1697, doi: 10.1377/hlthaff.2012.0258.

[2] Theresa Coughlin, et al. "How Five Leading Safety-Net Hospitals Are Preparing for the Challenges and Opportunities of Health Reform" (August 2012).

[3] Authors tabulations based on the 2010 NAPH Characteristics Report and the Healthcare Cost and Utilization Project [HCUP].

[4] Authors' tabulations based on the summary 2010 federal fiscal year Medicaid Statistical Information System data. Figures cited represent the number of nonelderly enrolled in a comprehensive managed care plan as a percentage of the number of total nonelderly Medicaid enrollees in the given county.

[5] U.S. News and World Report, *Best Hospitals* (2013) http://health.usnews.com/best-hospitals/area/nv/university-medical-center-6880071.

[6] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2012 and 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).

[7] U.S. News and World Report, *Best Hospitals* (2013).