California Association of Public Hospitals and Health Systems

Measuring the Impact of the ACA on Safety Net Hospitals

December 11, 2012

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Overview

- Who are California's public hospital systems
- ACA changes that impact public hospital systems
- Hospital Groups
- Using data to monitor ACA impact
  - Utilization Data
  - Financial Data
- Caveats about comparing hospital groups
- Concluding thoughts

Public Hospital Systems

- 19 health *systems*; 6% of hospitals in CA
- Generally have Section 17000 responsibility
- 2.5 million Californians served each year
- 10 million outpatient visits provided every year
- Provide medical homes, chronic disease management, care coordination, and focus on population health, to our patients within our systems
- Serving nearly ¾ of the enrollees in the Low-Income Health Program – managing care, providing medical homes
- Operate more than half of the state's Level I trauma centers, almost half of the burn centers, and train 43% of new doctors in the state

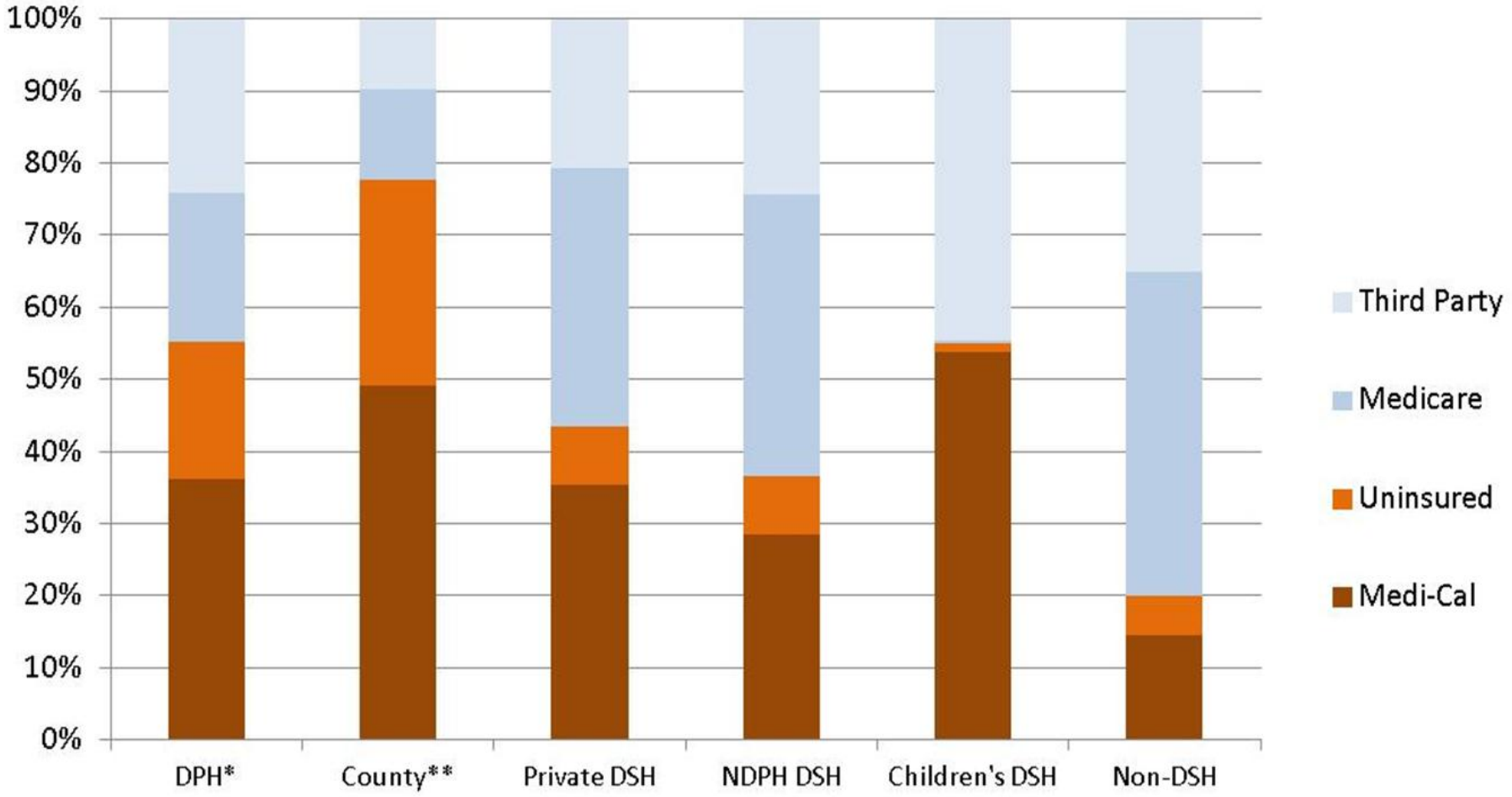
Terminology

DPH = Designated Public Hospital

DSH = Disproportionate Share Hospital

NDPH = Non-Designated Public Hospital

2010 CA Hospital Payer Mix



Source: OSHPD 2010 Hospital Annual Financial Data

*DPH= Designated Public Hospitals, as defined under the 2010 Section 1115 Medicaid Waiver, includes 21 county and UC DSH hospitals.

***County = CAPH members with Section 17000 responsibility.

Trauma and Burn Care

	# General Acute Care Hospitals	# All Facilities	# Level I Trauma Centers	# w/ Staffed Burn Beds
DPH	21	21	8	6
Private DSH	73	83	3	3
NDPH DSH	28	32	0	0
Children's DSH	7	7	2	0
Non-DSH	222	289	2	4
Grand Total	**352**	**433**	**15**	**13**

ACA Changes

- Medi-Cal: .6-1.2 million uninsured expected to enroll
- Exchange: 1.3-1.8 million uninsured expected to enroll
- Residual uninsured: 3-4 million
- Important question for public hospitals: will take-up within the county materialize within our health system?
  - 18% take-up rate among those <100% FPL
  - 31% take-up among all <200% FPL
- DPHs will look at impact of ACA changes from a systems of care perspective, not just within the hospital

Source: CalSIM v.1.8

Impact of ACA on Safety-Net

What can we measure with OSHPD?

- Changes in Payer Mix
- Changes in Volume
- Changes in County Subsidies

Which groups of hospitals should we look at when looking for these changes?

Groups of Hospitals

Important to know what you are comparing when you select comparison groups

- DPHs are funded in a unique way, including providing significant non-federal share contributions to Medi-Cal
- Public hospitals generally have Section 17000 responsibility
- DPHs provide community benefits like trauma, burn, and physician training

Groups of Hospitals – City/County

If you look at all hospitals with City/County designation, you are mixing in DPHs with non-designated publics hospitals, the latter which do not have Section 17000 responsibility

City/County ≠ DPH

FAC_NAME	Hosp Type DSH	TYPE_CNTR	TYPE_HOSP	TYPE_CARE	TEACH_RUR
ALAMEDA COUNTY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
ARROWHEAD REGIONAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
COLORADO RIVER MEDICAL CENTER		City/County	Comparable	General Acute	Small/Rural
CONTRA COSTA REGIONAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A
EL CENTRO REGIONAL MEDICAL CENTER		City/County	Comparable	General Acute	N/A
KERN MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
LAC/HARBOR-UCLA MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
LAC/OLIVE VIEW-UCLA MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
LAC/RANCHO LOS AMIGOS NATIONAL REHABILITATION C	DPH	City/County	Comparable	General Acute	N/A
LAC/USC MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
MODOC MEDICAL CENTER		City/County	Comparable	General Acute	Small/Rural
NATIVIDAD MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
SAN JOAQUIN GENERAL HOSPITAL	DPH	City/County	Comparable	General Acute	N/A
SAN MATEO MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A
SANTA CLARA VALLEY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
VENTURA COUNTY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A

Groups of Hospitals - DPHs

If you want to look at DPHs, you would also need to include the UC hospitals, which are labeled as non-profits in OSHPD

DPH Hospitals

FAC_NAME	Hosp Type DS	TYPE_CNTR	TYPE_HOSP	TYPE_CARE	TEACH_RUR
ALAMEDA COUNTY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
ARROWHEAD REGIONAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
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RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
RONALD REAGAN UCLA MEDICAL CENTER	DPH	Non-Profit	Comparable	General Acute	Teaching
SAN FRANCISCO GENERAL HOSPITAL MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
SAN JOAQUIN GENERAL HOSPITAL	DPH	City/County	Comparable	General Acute	N/A
SAN MATEO MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A
SANTA CLARA VALLEY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	Teaching
SANTA MONICA-UCLA MEDICAL CENTER& ORTHOPAEDI	DPH	Non-Profit	Comparable	General Acute	N/A
UCSF MEDICAL CENTER	DPH	Non-Profit	Comparable	General Acute	Teaching
UNIVERSITY OF CALIF - SAN DIEGO MEDICAL CENTER	DPH	Non-Profit	Comparable	General Acute	Teaching
UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER	DPH	Non-Profit	Comparable	General Acute	Teaching
UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER	DPH	Non-Profit	Comparable	General Acute	Teaching
VENTURA COUNTY MEDICAL CENTER	DPH	City/County	Comparable	General Acute	N/A

Impact of ACA on Safety-Net

What can we measure with OSHPD?

- Changes in Payer Mix
- Changes in Volume
- Changes in County Subsidies

Utilization Data

- Data available through Hospital Annual Financial Data includes
  - IP discharges, days
  - OP hospital-based visits
  - ER visits
- Data does not include
  - Non-hospital outpatient visits
- Problematic because county clinics are providing a significant amount of coordinated care within our hospital systems

Utilization Data

Two examples:

- Current example - SPD transition to managed care
- Future implementation of the ACA - LIHP to Medi-Cal transition

Utilization Data

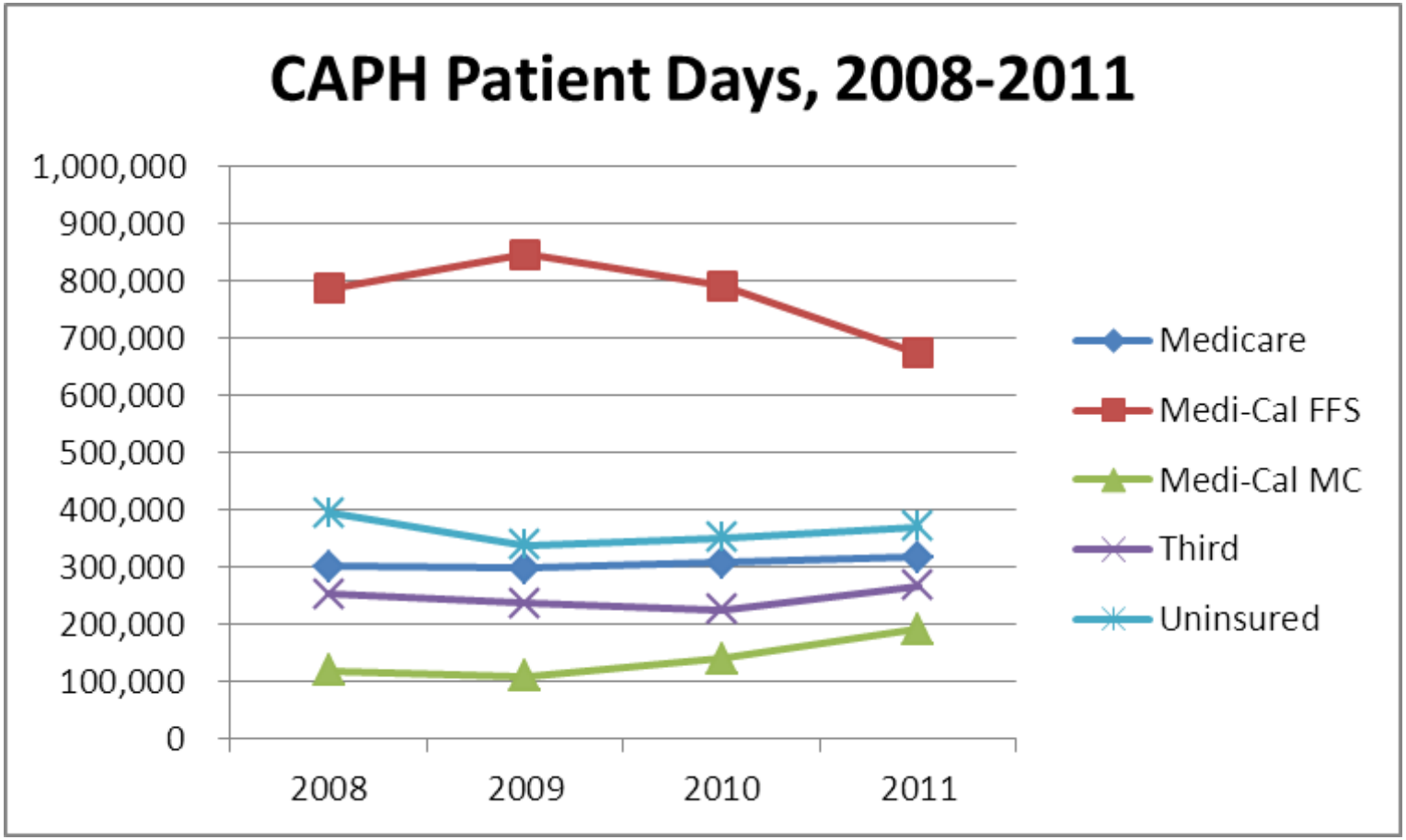
Example: SPD transition to managed care

- Seniors and Persons with Disabilities transitioned from Medi-Cal FFS to Managed Care
- Year–long transition began in June 2011, and approximately 20,000 SPDs were transitioned each month through May 2012
- How did this transition impact public hospital systems?

SPD → Managed Care

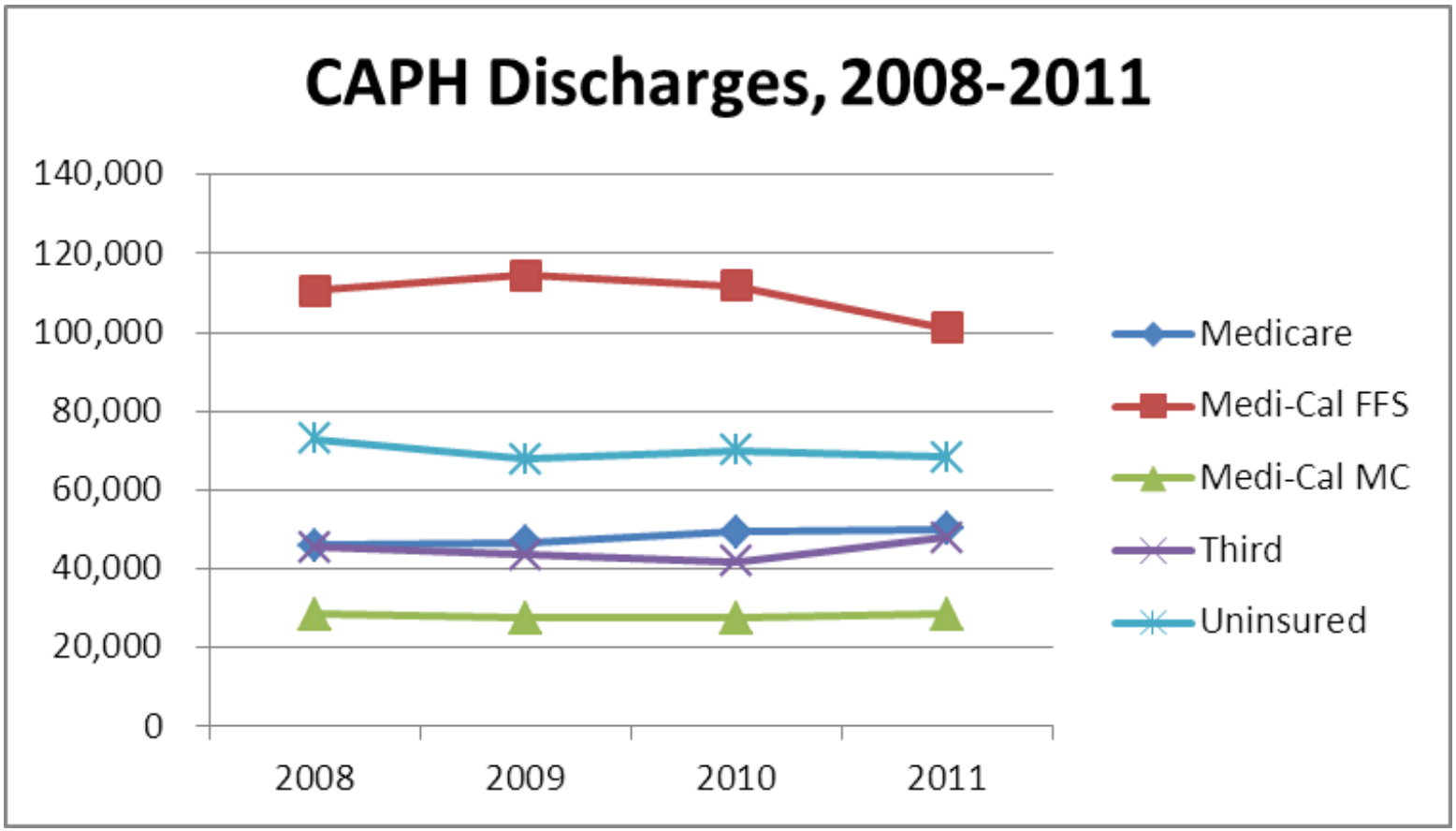
- Utilization data might be useful here to show shift in patient population, but may only scratch the surface from a systems of care perspective
- Financial data is also important, but extremely complex for SPDs; difficult to tease out in this dataset
- We need to know when the policy occurred, and what time period of data we are looking at
- Co-occurring trends could muddle the data
- We need to see multiple years of data before we can see a trend

Co-Occurring Trends



Source: OSHPD Hospital Annual Financial Data

Co-Occurring Trends



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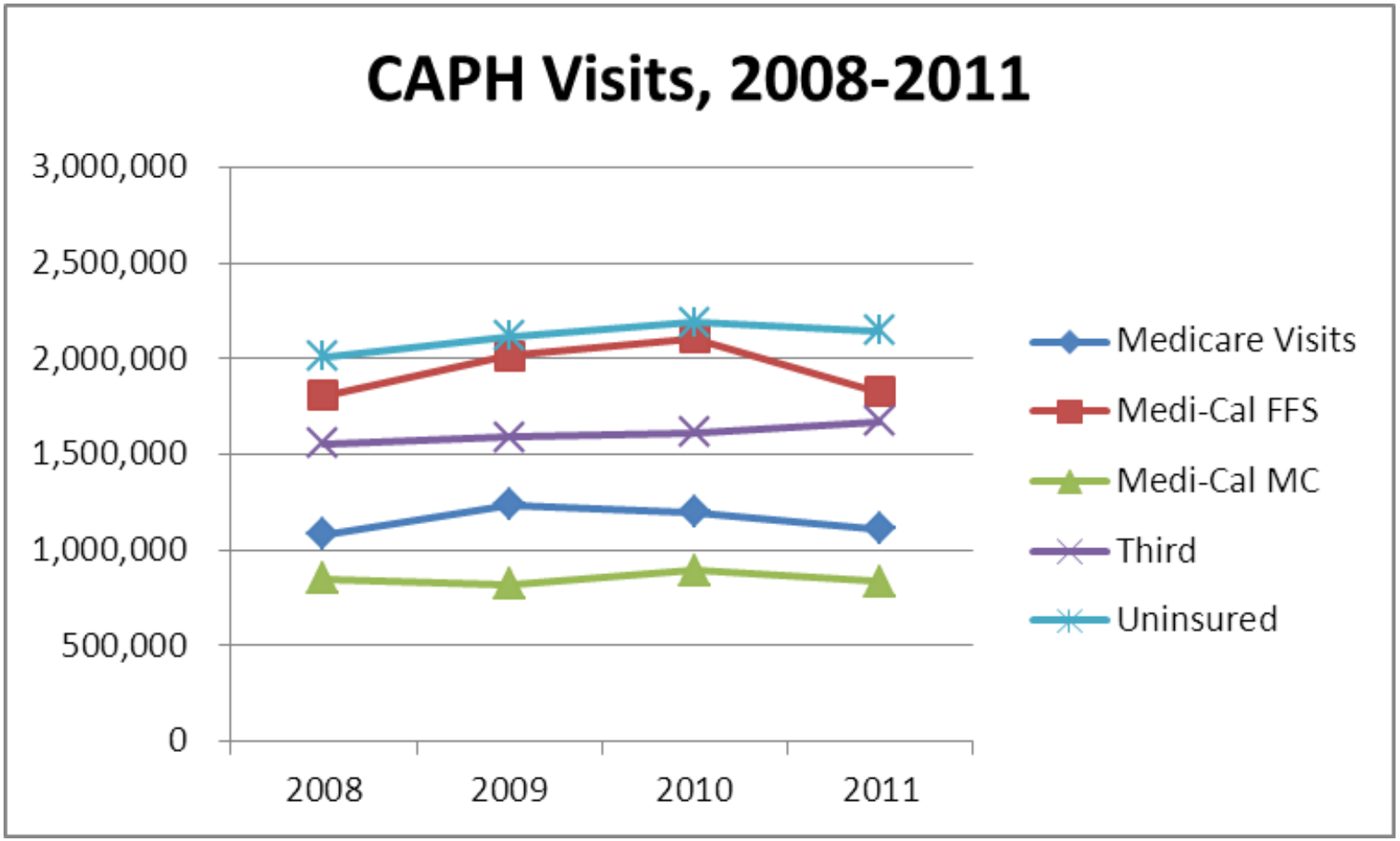
Co-Occurring Trends



Source: OSHPD Hospital Annual Financial Data

SPD → Medi-Cal: Lessons

- Look carefully for
  - Co-occurring trends
  - Implementation date of policy compared to data period in OSHPD
  - Group of hospitals
  - Multiple pieces of data
  - Data across time
- Utilization data still does not measure the number of *people* whose care DPHs are managing; it scratches the surface in terms of measuring impact throughout the system
- You will still need more research, like talking to hospital administrators, to understand the full picture

Example: LIHP → Medi-Cal

- The Low-Income Health Program is a significant source of coverage for the uninsured provide through public hospital systems
- They are currently reported in the County Indigent – Managed Care category
- Will be important to see how that category changes after 2014, especially relative to Medi-Cal
- Will need to monitor for multiple years after 2014

LIHP → Medi-Cal

Will want to compare the County Indigent category (especially managed care) to Medi-Cal managed care.

But, important to assess all three indigent categories to see impact of ACA on overall uninsured care at hospital

LIHP → Medi-Cal

Questions that remain:

- Did the LIHP patient's medical home stay with the hospital system?
- Did the hospital system gain other Medi-Cal managed care patients, more uninsured patients?
- Did the intensity of the remaining patients increase?

Financial Data

Some caveats about our financial data:

- Inconsistencies with reporting on DSH and county subsidy payments, in part due to reporting instructions or references that may create ambiguity: Many references to old programs like SB 855, the old DSH program, and AB 8 instead of realignment
- Some public hospitals systems employ physicians; their costs and revenues are included in the Medi-Cal data, making it hard to draw apples to apples comparisons with other hospitals that do not employ physicians

Financial Data

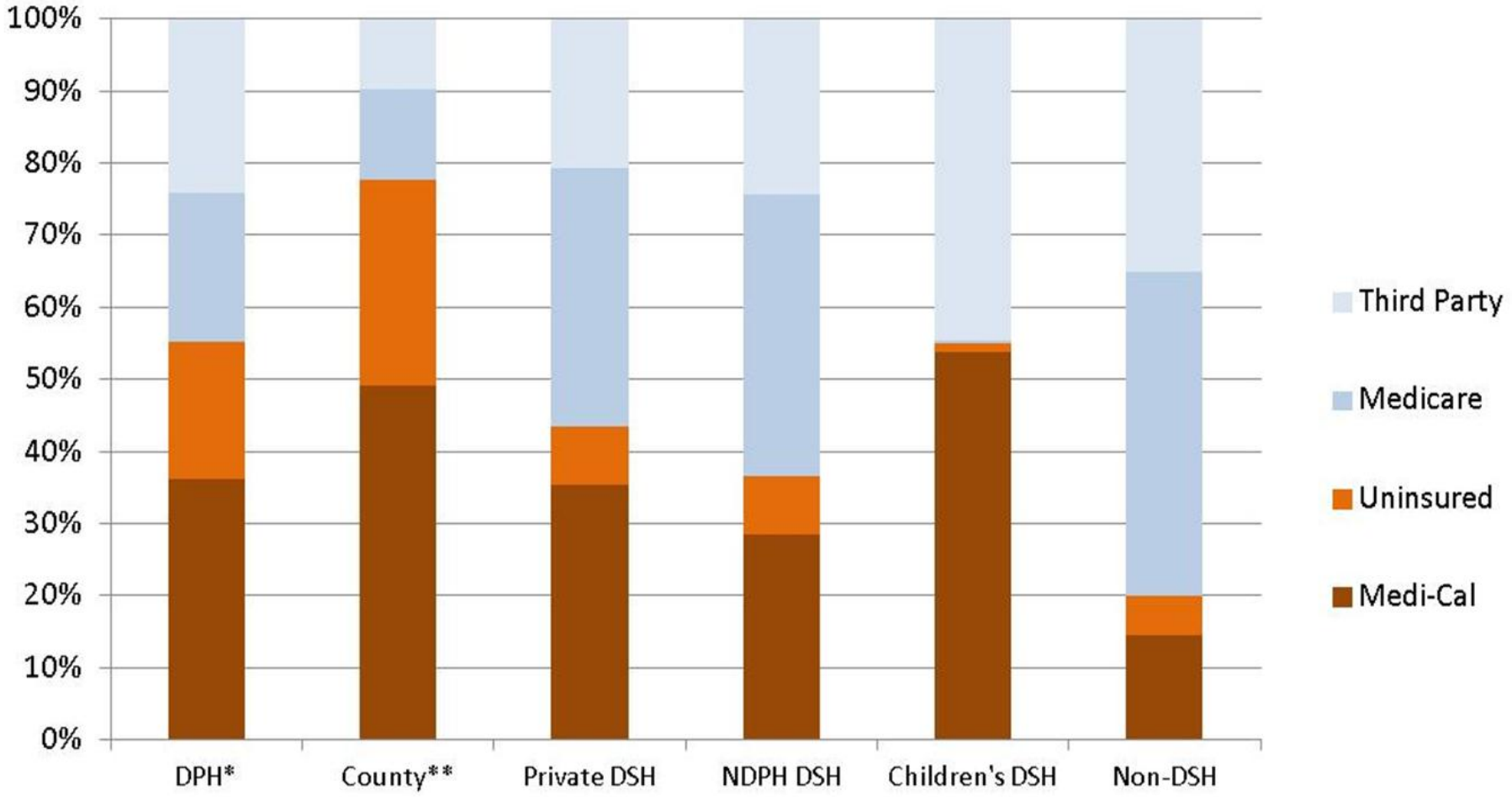
More caveats about the revenues:

- Certain supplemental streams of funding are technically Medi-Cal and are required to be reported as uninsured
- In the case of Safety Net Care Pool (SNCP), funding is for hospital and non-hospital costs, the latter of which is not in the dataset, but the entire SNCP reimbursement is, which would overstate our reimbursement relative to costs
- P14 cost reports are often filed much later than OSHPD data reporting is due

ACA Impact: Financial Data

Payer mix would be a good indicator, but based on costs not revenues

2010 CA Hospital Payer Mix



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Financial Data – Non-Operating Revenue

- Public hospitals self-finance a significant amount of Medi-Cal and uninsured care
- Medi-Cal reimbursement on average for public hospitals is $.50 on the dollar, which is inherent in the structure
- Financed with significant support from counties, reflected in the variable "non-operating revenue," or explicitly in the complete dataset in 3 separate County Appropriation categories, like AB 8 (for realignment)
- State will propose changes in realignment funding next year, so changes in the AB 8 variable may simply reflect a policy choice, not actual changes in financial need. Unclear if counties would backfill shortfalls, so hospitals may make other adjustments to compensate

Financial Data - Comparing Groups

Different hospitals are paid differently, especially by Medi-Cal

- Publics: largely self-financed, Section 17000, providing community services (trauma, burn, teaching)
- Districts: making change to payment structure starting in FY 2013
- Privates: paid through general fund; also receive hospital fee worth billions that might skew comparison data because of when checks actually arrive and instructions the period in which to report the data

Looking Ahead

Fiscal Cliff for Public Hospitals?

- High estimated number of residual uninsured, with public hospitals still paying non-federal share
  - 3-4 million still uninsured in 2019
  - Take-up among those <100% FPL as low as 18%
- Decline in DSH; SNCP and DSRIP only funded through Oct. 2015

Opportunities

- Becoming providers of choice through transformative Incentive Program work

On the Data

- It will take time to see the full impact of the ACA

True Impact of ACA

Measuring the ACA's impact on public hospital systems is a complex and multi-faceted task

- Focusing on patient outcomes, population health
- Transforming systems, care delivery
- Taking on more risk and providing coordinated care
- Moving away from face-to-face visits and toward managing health on an ongoing basis, e.g. via e-mail
- Shifting financing

Conclusion

Public hospitals' face enormous challenges and opportunities in the next 5 years. We want to continue fulfilling our multi-part mission:

- Providers of choice
- Core providers of care to residual uninsured
- Providers of critical community services like trauma, burn, and teaching programs

Challenge: to ensure a financial structure that appropriately supports this multi-part mission

Questions