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Caring for the Uninsured: Safety Net Hospitals and Health Systems

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Presentation Overview

1. Safety Net Hospitals & Health Systems – Basic Facts
2. Sources of Financing Care for the Uninsured
   - Current Threats
3. Innovative Models of Care for the Uninsured

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Safety Net Hospitals and Health Systems:

Basic Facts

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Key Roles of Safety Net Hospitals & Health Systems

- Care for the uninsured
- Emergency response
- Specialized services such as trauma, burn care, neonatal intensive care
- Train many of the nation's future health care professionals
- Community-based primary care
- Comprehensive, coordinated care
- Diverse patient population

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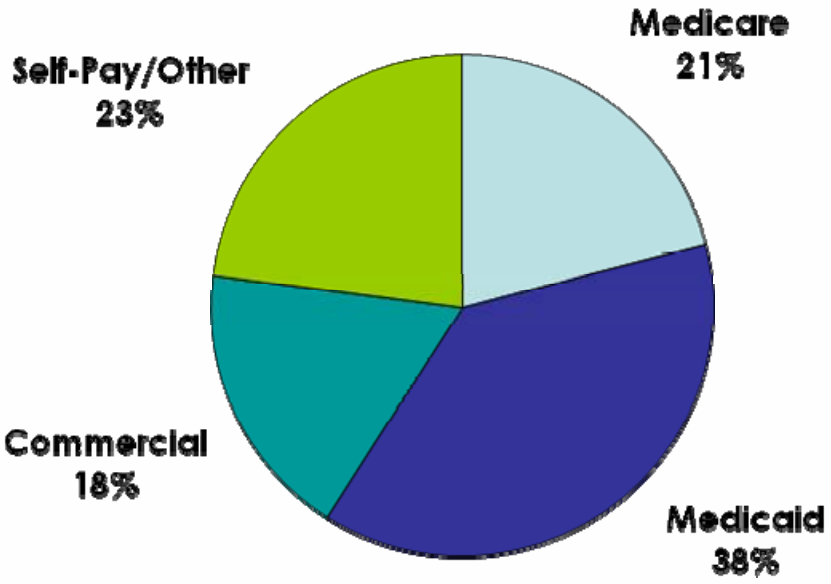
Discharges by Payer Source



Source: NAPH Hospital Characteristics Survey, 2004

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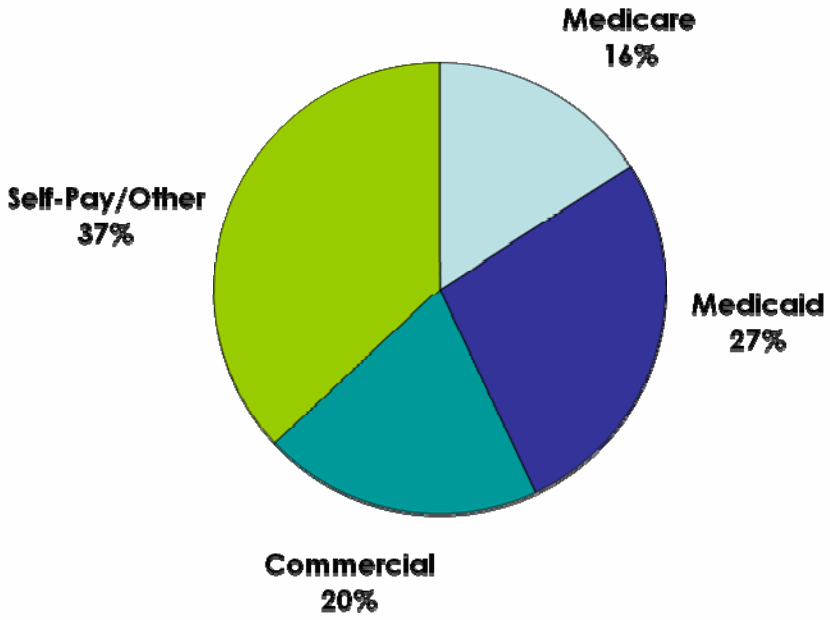
Outpatient Visits by Payer Source



Source: NAPH Hospital Characteristics Survey, 2004

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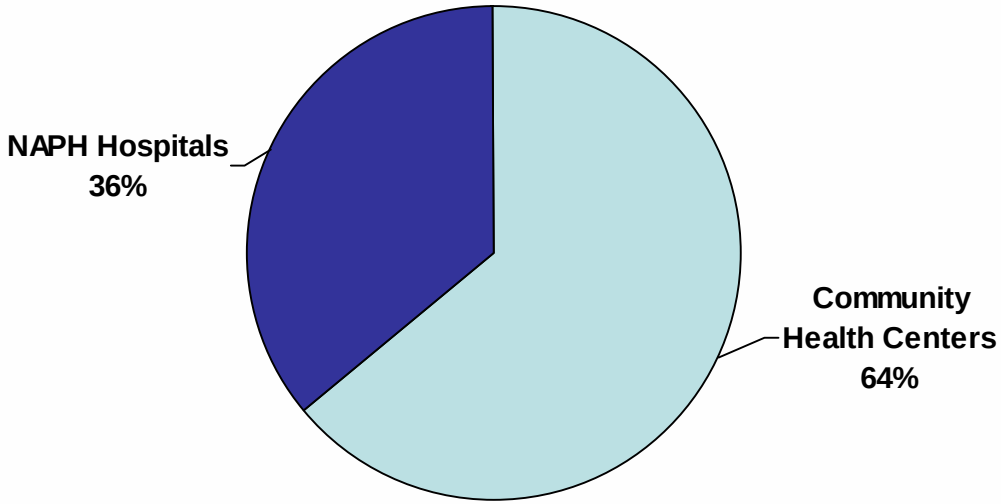
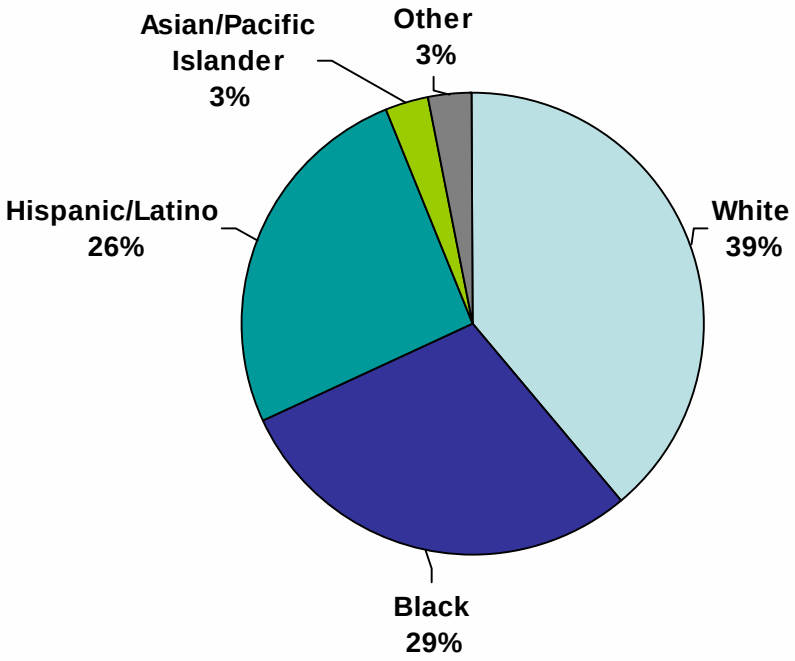
Outpatient Visits to Safety Net Providers (Excludes ED)



Note: This data from FY 2004 represents 914 community health centers that received HRSA Bureau of Primary Health Care grants and the 89 public hospitals and health systems that participated in the NAPH Hospital Characteristics Survey.

Source: NAPH Hospital Characteristics Survey, 2004. U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Uniform Data Set (UDS), 2004.

Discharges by Race/Ethnicity at NAPH Members



Source: NAPH Hospital Characteristics Survey, 2004

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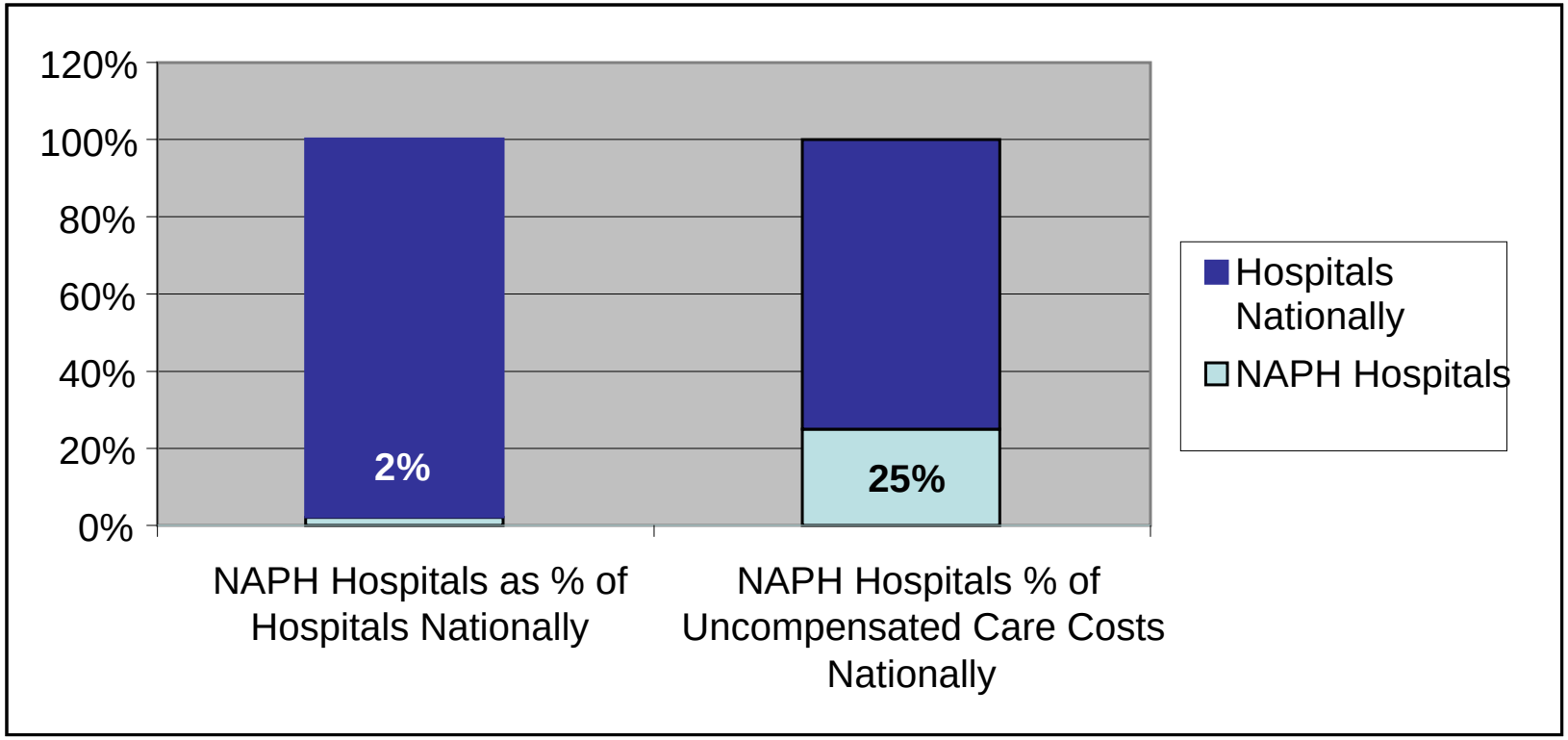
Disproportionate Share of Care to the Uninsured

NAPH hospitals represent only 2 percent of the acute care hospitals in the nation but provide 25% of the uncompensated care.



Source: NAPH Hospital Characteristics Survey, 2004

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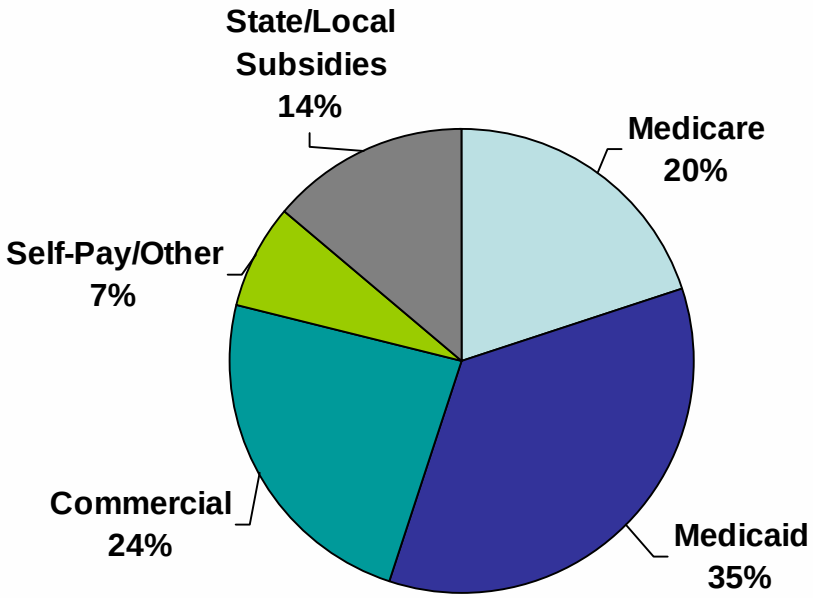
Net Revenues by Payer Source



Source: NAPH Hospital Characteristics Survey, 2004

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Sources of Financing Care for the Uninsured

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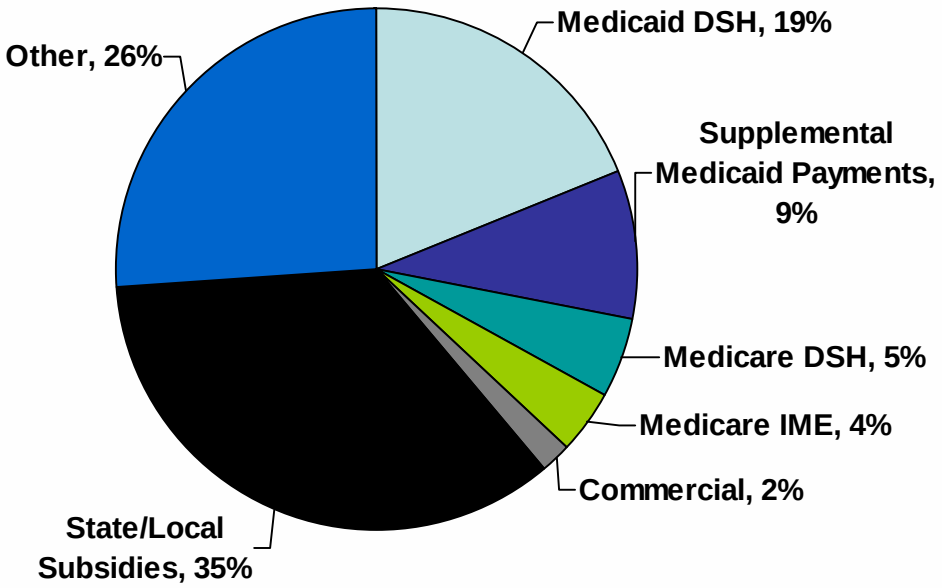
Sources of Financing for Unreimbursed Care



Source: NAPH Hospital Characteristics Survey, 2004

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Disproportionate Share Hospital Payments

- Only Explicit Medicaid Payment for the Uninsured
- Total $17 Billion ($9.6B Federal) in FFY 2005
- Hospital-Specific DSH Limits
  - No More than Unreimbursed Costs for Medicaid and Uninsured Patients
- State DSH Allotments Set in Statute
  - Based on Historical Spending

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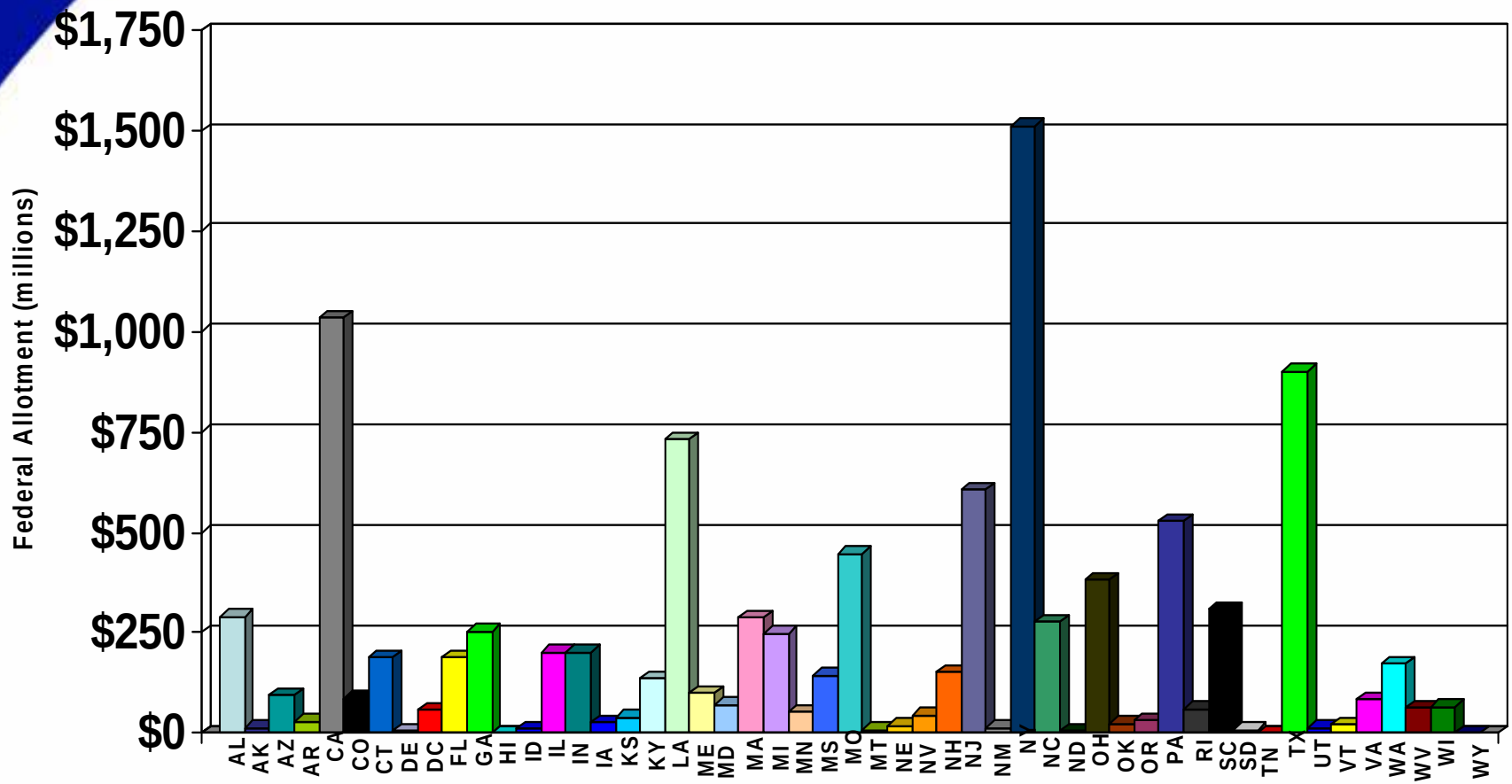
State DSH Allotments (FFY 06)



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Upper Payment Limits (UPLs)

- UPL is Limit on Non-DSH Medicaid Payments to Institutional Providers
- Supplemental Payments Outside of DSH May Not Exceed the UPL
- "UPL Payments" Are for Medicaid Patients Only
- Limit = Rates Based on Medicare Payment Principles
  - Calculated on an Aggregate Basis

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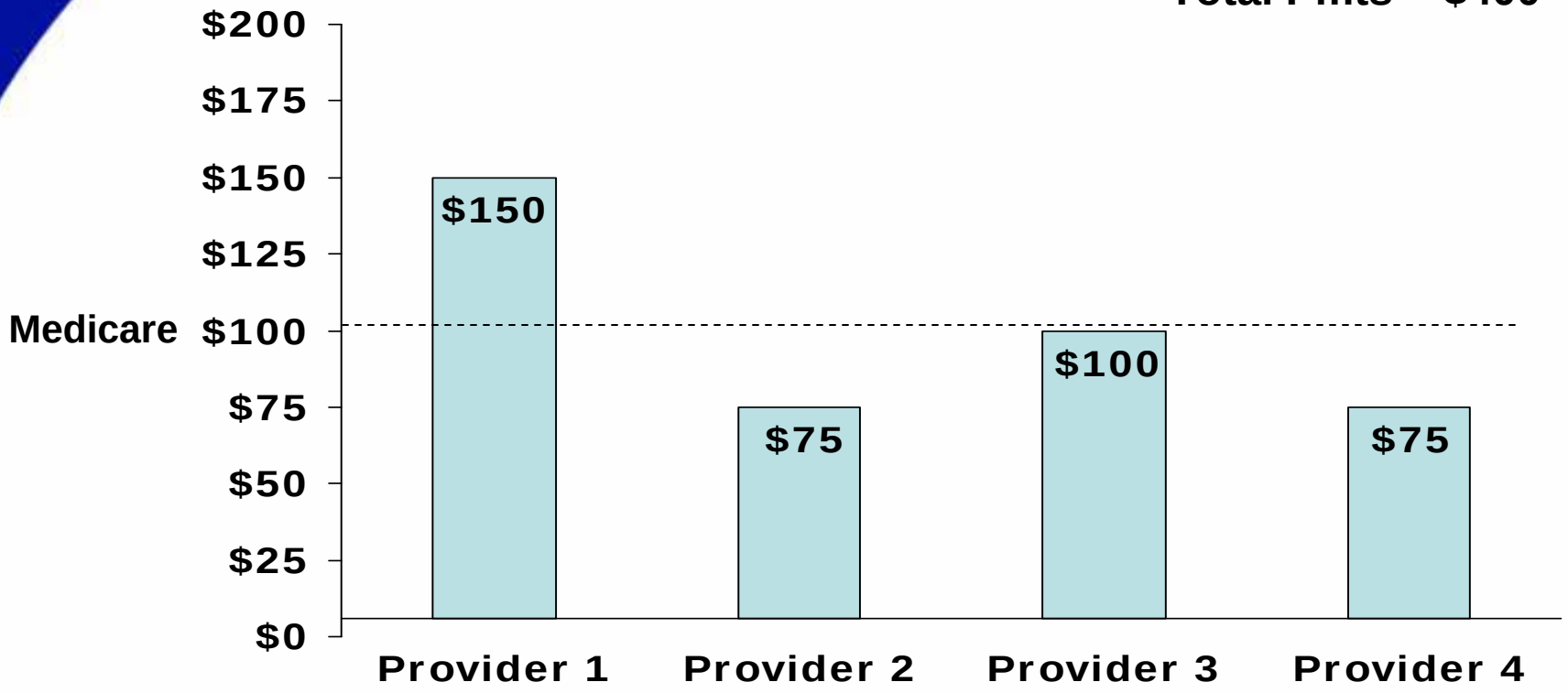
Aggregate UPL

UPL = $400
Total Pmts = $400



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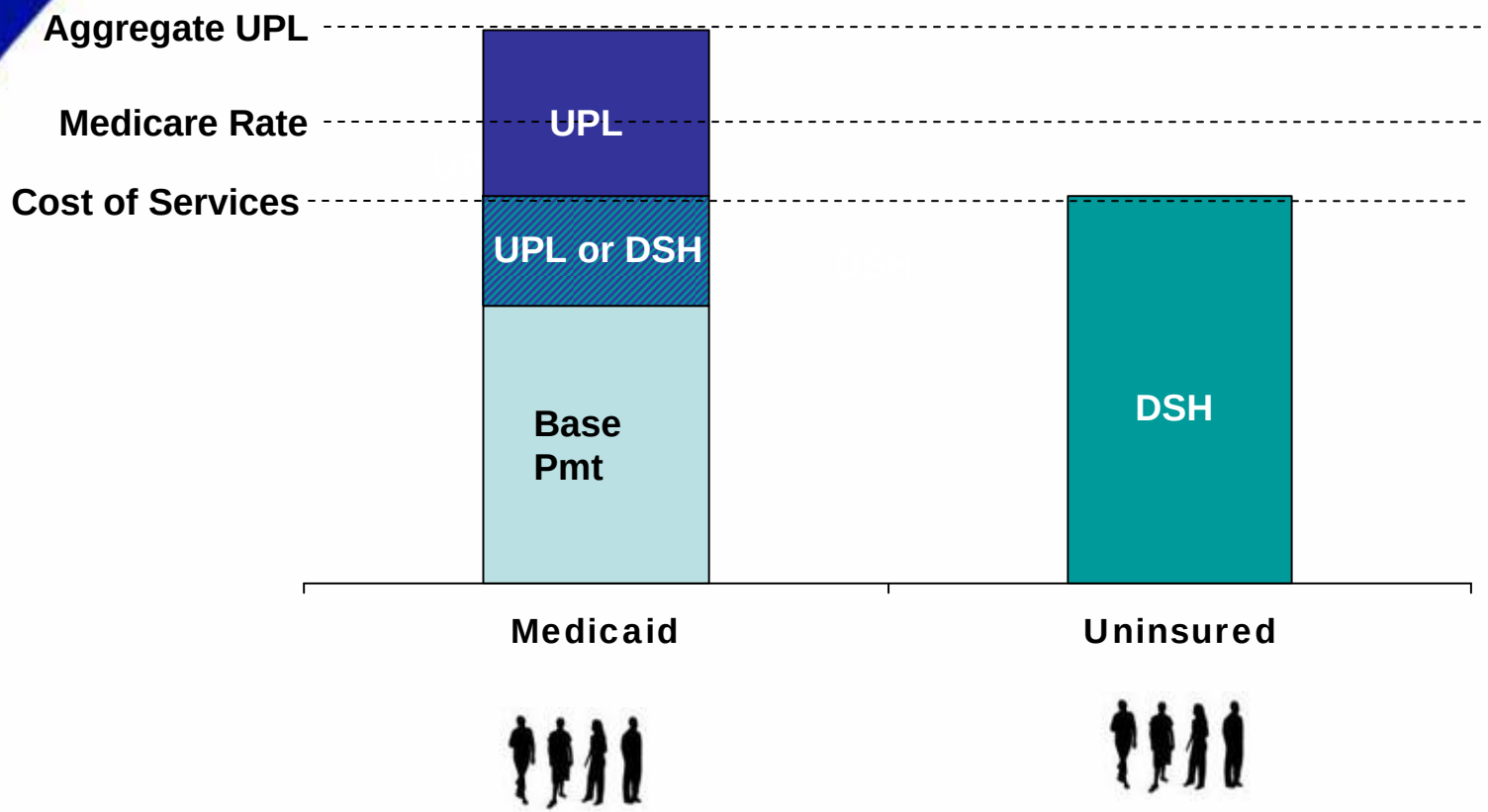
Medicaid Payments for Low Income and Uninsured Patients



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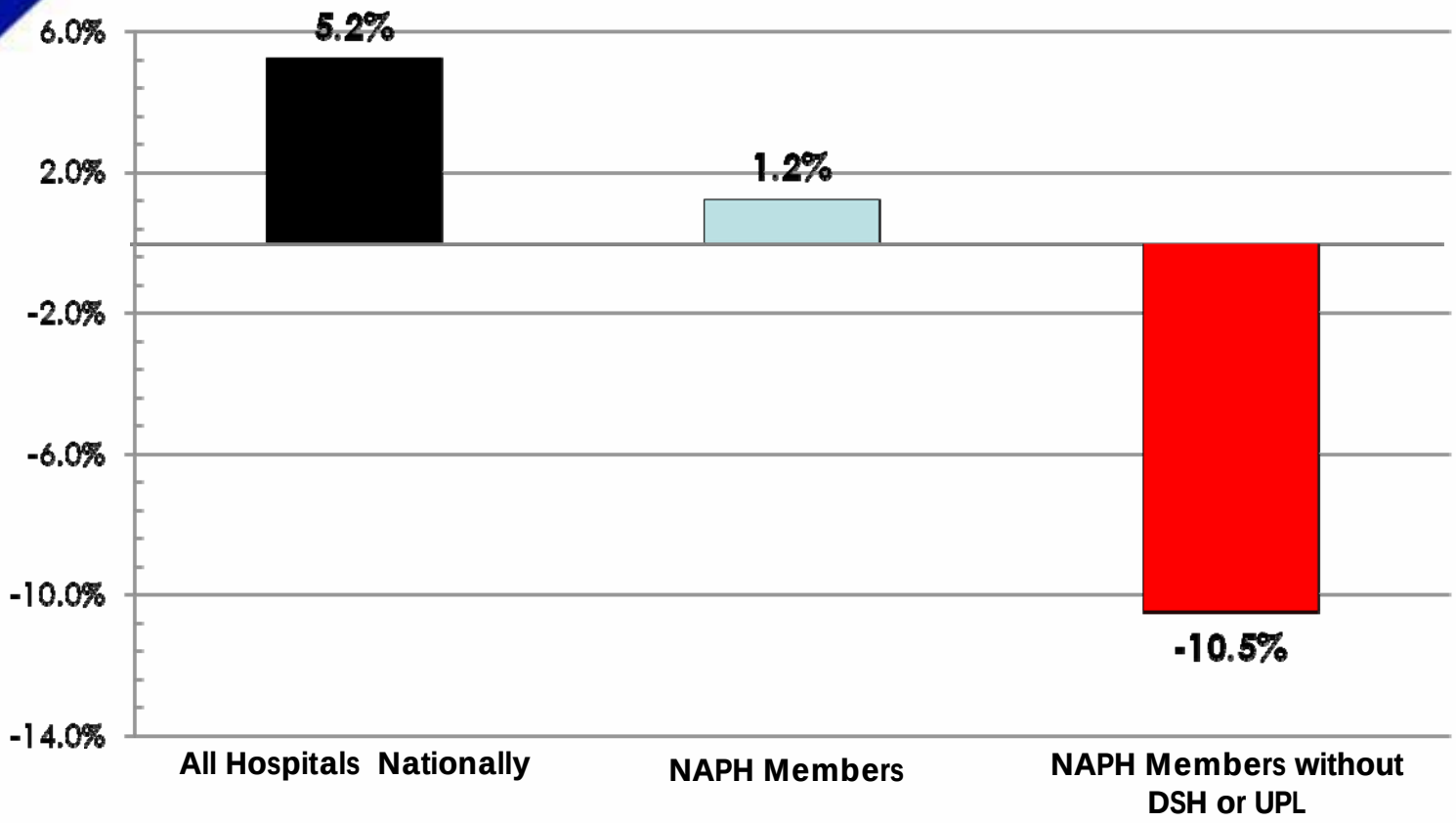
Importance of Supplemental Medicaid Payments



Source: AHA Annual Survey 2004; NAPH Hospital Characteristics Survey, 2004

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Funding Supplemental Medicaid Payments

- State General Revenues
- Intergovernmental Transfers (IGTs)
- Certifications of Public Expenditures (CPEs)
- Broad-Based, Uniform Provider Taxes

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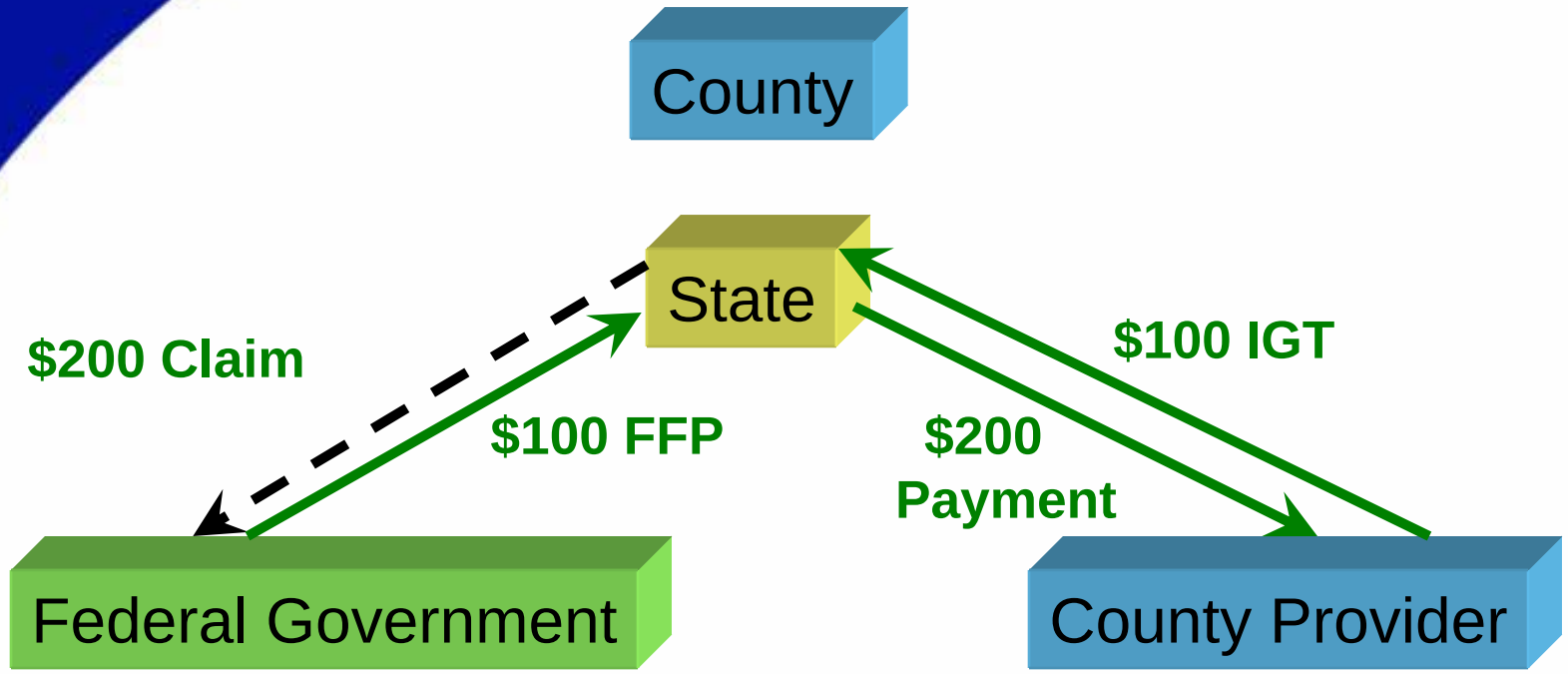
IGT Mechanics



- County provider contributes $100
- CMS provides $100 FFP
- County provider is reimbursed $200
- No state general revenues

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CMS IGT Cost Limit Rule

- Cost Limit for Governmental Providers
  - Significant Reduction in UPL
- Restrictive Definition of Governmental Providers
  - Limits Sources of Non-Federal Share Funding
- Threatens Viability of Supplemental Payments

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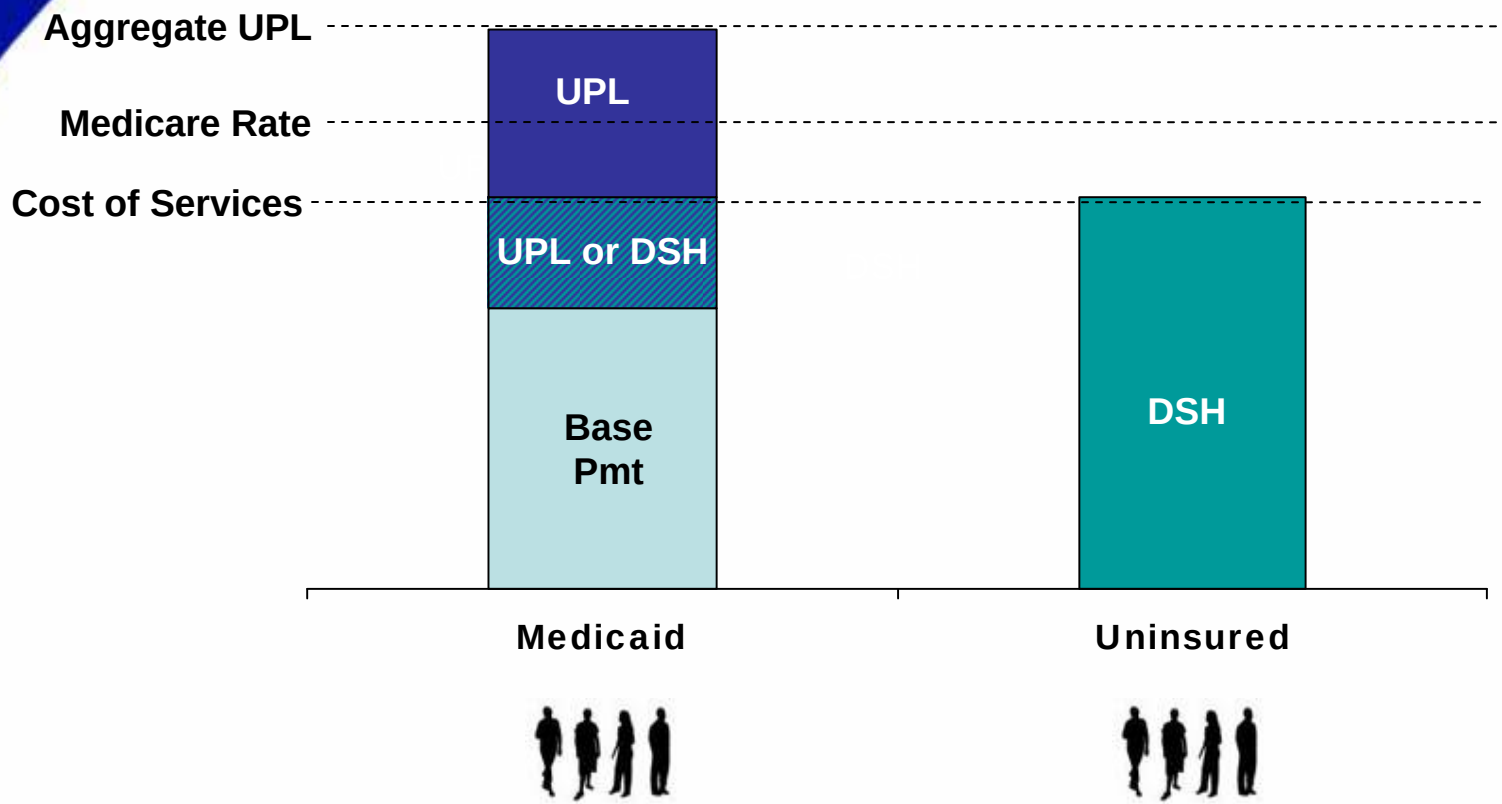
Medicaid Payments for Low Income and Uninsured Patients



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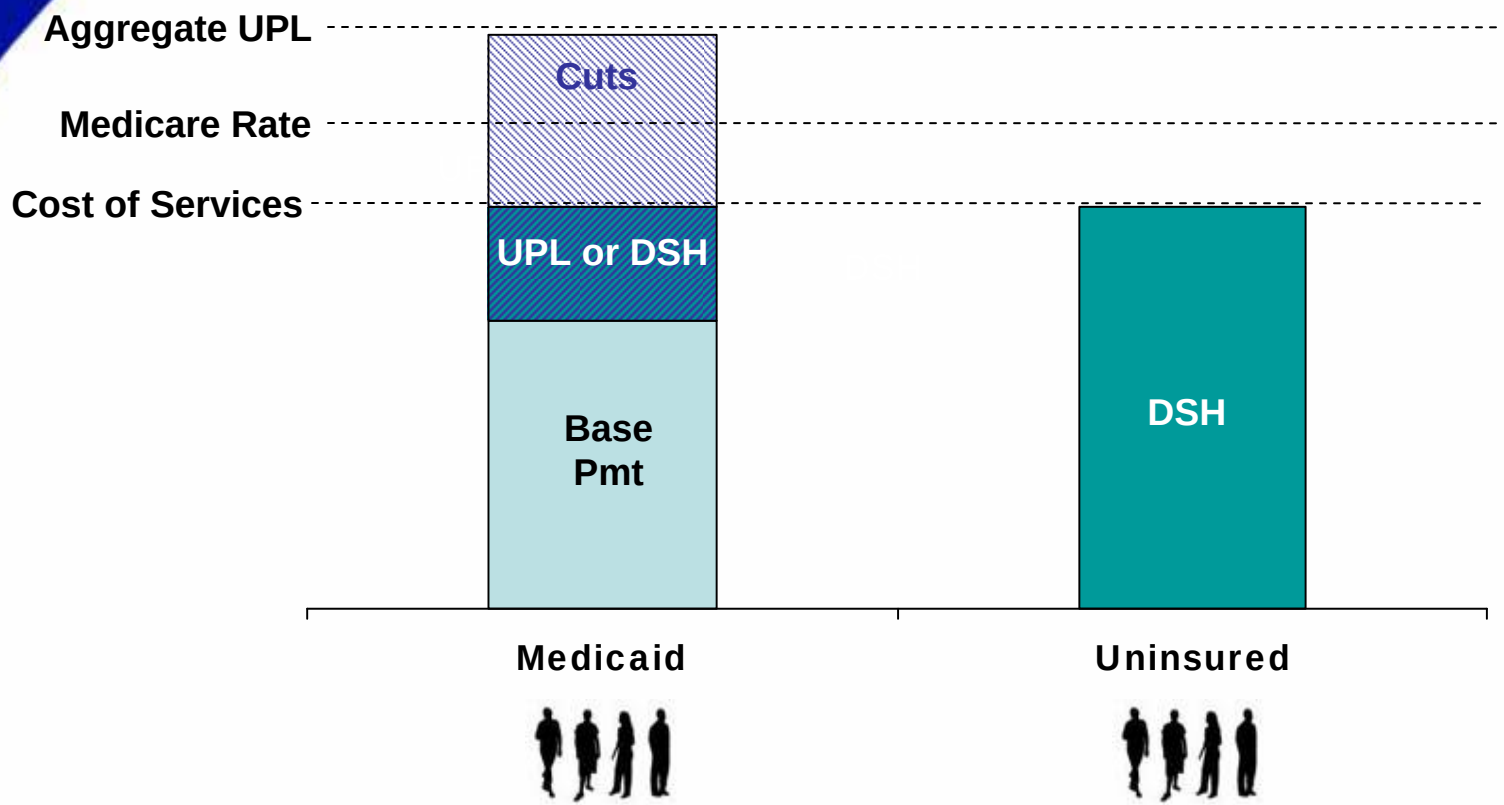

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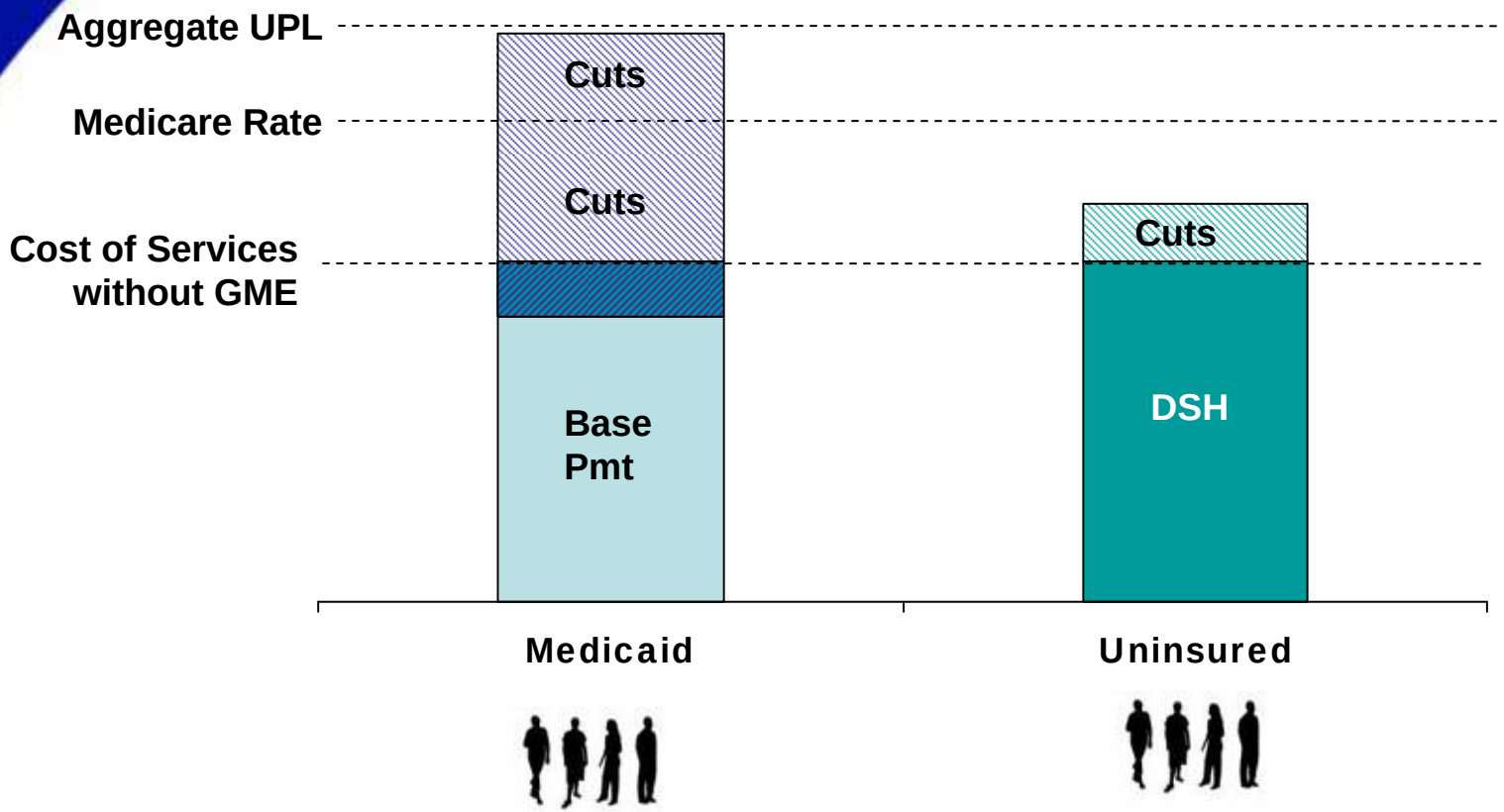

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Financial Impact

The regulation will have a significant financial impact on states, safety net providers and their communities.

Examples of State Impacts

State	Annual Impact (in millions)
Florida	$930
Georgia	$253
New York	$350
Texas	$294

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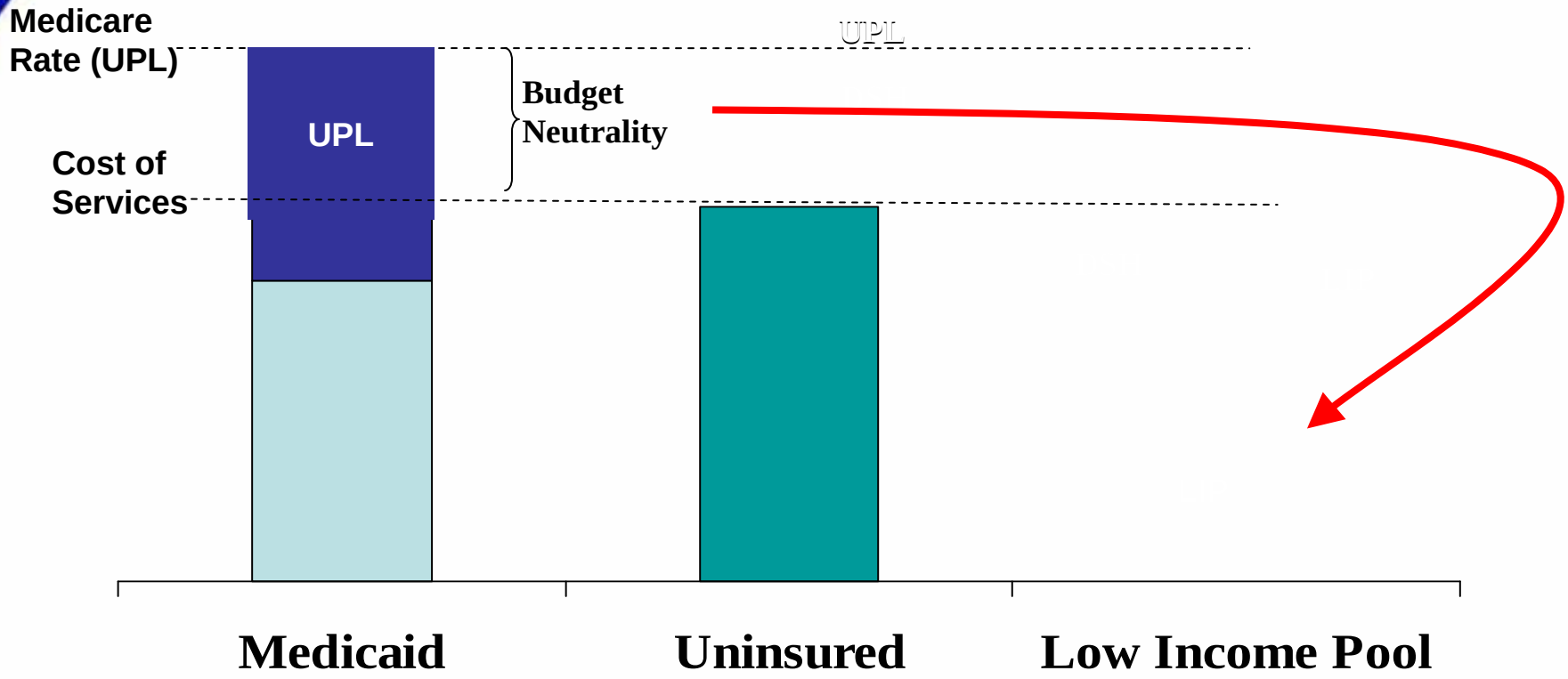
Waiver-Based Implementation of Cost Limit



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Current Status

- CMS Issues Final Rule 5/25 – AM
- President Signs War Funding Bill with One-Year Moratorium on Rulemaking 5/25 – PM
  - Halts Implementation of Final Cost Limit/IGT Rule
  - Halts Finalization of GME Rule

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Innovative Models of Care for the Uninsured

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Safety Net Provider-Based Health Plans

- Developed as a Means to Participate in Medicaid Managed Care
- Infrastructure Used for "Lookalike" Plan for the Uninsured
- Plans Participate in Coverage Expansion Initiatives

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Virginia Coordinated Care (VCC)

- Developed by VCU Health System, Richmond, VA
  - Health Plan for the Uninsured
  - Comprehensive Benefits Package
  - Provides Medical Homes
  - Network of VCU and Community Providers
  - Sliding Scale Co-pays

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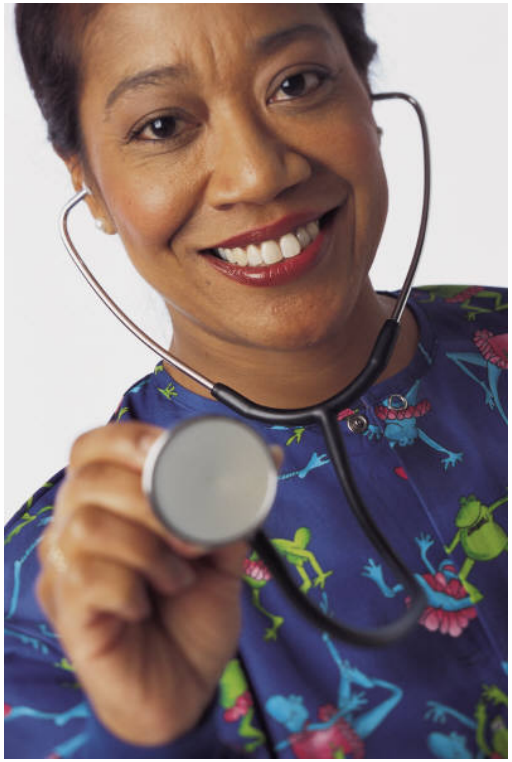
Virginia Coordinated Care (VCC)

- **VCC Goals:**
  - **Manage care for the uninsured**
  - **Reduce cost of care**
  - **Improve quality**
  - **Reduce inappropriate ED utilization**
  - **Establish community-specialist relationships**



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Chronic Care Management

- **Chronic Disease a Major Challenge for Safety Net Hospitals**
  - **Low Income Populations at High Risk**
  - **High Rate of Co-morbidities**
  - **Prevalent Psycho-Social Issues**
  - **Few Resources to Provide Care**

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Denver Health

- Initiatives for:
  - Asthma
  - Diabetes
  - HIV
  - Depression
  - Cancer Prevention
  - Prenatal Care

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Denver Health

- **Combines:**
  - **Primary Care Teams**
  - **Frequent User Progr**
  - **Advanced Access**
  - **Patient Self-Management**
  - **Clinical Information Systems (e.g. Diabetes Registry)**

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Language Access

- Over 100 Languages Spoken at NAPH Member Hospitals
- 20-30 Languages at the Typical Safety Net Hospital
- Longstanding Efforts to Improve Language Access
  - Employed Interpreters
  - Volunteers
  - Telephone Interpretation

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Alameda County Medical Center

- Video-Conferenced Interpretation
  - Reduced Wait Times
    - From 30-45 Minutes to 5 Minutes
  - Improved Communication
    - Visual Cues Are Key
  - Wider Range of Languages Available
  - Increase Provider Efficiency
    - Visits Decreased from 32 to 18 Minutes

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