ALLIANCE FOR HEALTH REFORM

The Health of Safety-Net Hospitals: How are They Faring? What's the Outlook?
Alliance for Health Reform
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ED HOWARD: My name's Ed Howard with the Alliance for Health Reform. Thank you for you joining us on behalf of Senator Rockefeller and our board of directors. I want to welcome you to this program. The focus is on part of our changing healthcare system, on which our most vulnerable health populations depend, and that is safety-net hospitals.

These hospitals are one of the most important, but certainly not the only part, of the safety-net and I just should say as a footnote we're gonna be looking at community health centers and the rest of the safety-net institutions later this summer in another briefing.

Safety-net hospitals provide care to those most in need of it at a time when employer-sponsored coverage is declining and the demand for safety-net services in light of our economic situation has gone up dramatically, which of course means states are facing severe fiscal pressures. They're having to squeeze Medicaid spending overall.

We know that the patient protection and Affordable Care Act is going to offer some opportunities for safety-net providers, assuming it survives its many challenges, but it would also present some significant challenges as well. Under that reform law, about 16 million additional people are anticipated to enroll in the Medicaid program, which, of

course, is the single largest revenue source for most of these safety-net hospitals.

Also, under the law, beginning in 2014, there is scheduled to be a phased reduction in disproportionate shared hospital funds, DSH payments, which is another stream of funding on which these hospitals rely greatly.

Now we're pleased to have as a partner in today's program, the Commonwealth Fund, which has, particularly through its commission on high performance system, done a great deal of work how to help safety-net hospitals cope with their short-term and their longer term challenges and we're very pleased to have, as a co-moderator and an active participant in today's discussion, Dr. Pamela Riley, who's a pediatrician-in-training and a program officer in the Fund's vulnerable populations program. Pam, thanks for being here and let me turn it over to you.

PAMELA RILEY, M.D.: Great, thank you, Ed. So we're here today to really consider the importance of safety-net hospitals, both to the patients that they serve and also to their communities is a whole. Now, we'll hear today about many of the financial pressures that safety-net hospitals face, both that threaten their current operations and which could potentially be made worse by changes that are coming under the Affordable Care Act.

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We'll further score some of these issues and consider some of these policy options for perhaps using these limited funds that are available to safety-net hospitals a little bit differently, a little bit more wisely, to sustain the operations of safety-net hospitals, but also to encourage them to improve the way that they deliver care so that these hospitals will be around both now and after the Affordable Care Act is implemented to provide care to their patients and communities.

I'll start by just giving a high level overview for what the safety-net is. There is generally no one accepted definition of what safety-net providers are, but there are common traits that they have. It's basically a patchwork of healthcare providers that deliver a significant level of care to Medicaid uninsured and other vulnerable patients.

And there's a wide variety of providers that meet these criteria, however there's a subset of core safety-net providers, which provide a disproportionate share of care to these patients, and which are also required by admission or legal mandate to provide care to all patients regardless of their ability to pay. These core providers include public hospitals and health systems.

They also include community health centers including federally qualified health centers and local health departments

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and in many areas it also includes academic medical centers, other community hospitals and even private physicians. The focus of this briefing is on safety-net hospitals in particular just because the way in which they're funded and how they're funding strings will change under the Affordable Care Act really creates a set of unique financial pressures that are different from those faced by community health centers and other safety-net providers.

It's important to recognize the role that safety-net hospitals play, not just in terms of serving patients, but also for their communities as a whole. They are a source of direct patient care, both inpatient care and primary care for these vulnerable populations that they serve. The primary care issues are particularly important given the shortage of providers that are willing to see Medicaid patients and safety-net hospitals are also frequently the only source of specialty care for Medicaid and uninsured patients in a particular area.

They do provide other critical services to communities, for example, in many cases, safety-net hospitals have the only trauma centers in their local areas. And they also provide other services like burn centers and patient psychiatric units that are traditionally unprofitable and frequently not provided by other hospitals. Safety-net hospitals are also responsible

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for training the next generation of physicians and other healthcare providers.

In 2009, nearly a quarter of doctors who received training at acute care facilities nationwide were trained at safety-net hospitals. And finally, it's important to remember that safety-net hospitals are tremendous economic engines in their communities and they make major contributions to both state and local economies and are frequently the largest employers in their regions.

In terms of populations that safety-net hospitals serve, as we know they serve a disproportionate share of Medicaid and uninsured patients, as you can see from the data here, from the National Association of Public Hospitals and health systems, Medicaid and uninsured represented over half of the discharges from safety-net hospitals in 2009 as compared to over just a quarter of hospitals nationally.

The economic downturn has had a tremendous impact of the number of people who rely on safety-net hospital services, as people have lost jobs, they've also lost their insurance coverage. Many of these patients are working for, whose employers either don't offer employer-sponsored insurance or who they can't afford the insurance coverage that they employers are offering and many are under insured, meaning they

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actually have health insurance, but cannot afford their medical expenses or their benefits are not comprehensive enough.

The population served by the safety-net also includes people who have lost jobs or are in-between jobs and have temporary gaps in their coverage. A recent Commonwealth study found that nearly 1 in 4 working age adults experienced gaps in health insurance coverage ranging two months from over two years primarily because they changed or lost their job.

So it's important to remember that safety-net serves these populations as well. Finally, safety-net hospitals are an important source of care to immigrants, both legal and undocumented, who rely on the safety-net. Legal immigrants are temporarily ineligible for Medicaid and must wait five years until they are able to enroll if they are eligible and so they must rely on safety-net hospitals for their care and safety-net hospitals also provide to undocumented immigrants, although the proportion provided to undocumented varies quite considerably depending on the geographic location of the hospital.

This is a little bit difficult to read, but I'll just refer you to your handouts. This is just a chart that sort of describes the disproportionate needs that this population experiences. They tend to be very high need, high cost populations. They have higher incidences of poorly controlled chronic diseases, behavioral health issues, as well as personal

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and social and financial factors that can cause problems and has caused health problems and also impede access to care.

And safety-net hospitals in particular must be equipped to deal with these problems by providing services, such as social services, other support services, like transportation, translation, financial or housing assistance, and these services tend to not be very profitable, but they're just as essential to providing care for these populations as is providing healthcare.

The Affordable Care Act is expected to have a variety of implications for safety-net hospitals, but today we'll focus on how it will change the way that safety-net hospitals are funded. As we know safety-net hospitals are under current financial pressures imposed by the increased demand for their services, combined with their shrinking budgets.

And with a estimate 16 million people who are on Medicaid, under Affordable Care Act, there's a potential for hospitals to gain more revenue by seeing more uninsured patients, however there are many factors in play which will affect whether or not that actually translates into actual gains, including factors affecting which populations actually enroll in Medicaid and how this enrollment will affect the hospitals, pay or mix.

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The Affordable Care Act also includes cuts in disproportionate share hospital payments which are Medicaid supplemental payments which help cover the added costs of caring for Medicaid and uninsured patients and hospitals rely heavily on these DSH payments to cover the cost of uncompensated care.

There's a concern amount many safety-net hospitals that these potential increased gains from Medicaid will not be enough to offset the losses that they'll experience with the cuts in DSH payments. And this, you know, is a situation that could really threaten the care that they're able to provide to the patients that need it the most. It's also important to remember that even though the Affordable Care Act will expanded coverage for many, there will still be an estimated 26 million people who remain uninsured.

So safety-net hospitals will still very much be needed after health reform is implemented to take care of the remaining uninsured, but also be able to service a willing provider for this expanded Medicaid population and also to really best meet the help of health and social needs facing this particular population, so we really need to be concerned about what happens if safety-net hospitals collapse, or as many of them have folded.

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These patients who are extremely vulnerable would be left more vulnerable to poor health and poor healthcare access. And we also have to think about the burden on other providers, non safety-net hospitals, who if safety-net hospitals fold, would be faced with the burden of caring for these very high need, high cost patients and may not be as well equipped to do so.

So our panelists today will help us to further explore a lot of these issues. They're complete files are in your packets. I encourage you to read them, but I'll briefly introduce them. Our first speaker is Deborah Bachrach. She is special counsel for healthcare transactions policy for Manatt, Phelps and Phillips in New York City and she is actually the author of the recent report of the Commonwealth commission of high performance health report focused on sustainable funding for safety-net hospitals.

You do have the executive summary of the report in your packets and the full report is available on the Commonwealth Fund website. So she will discuss some of the policy recommendations from this report on how to better target these limited existing funds to hospitals serving populations with the greatest levels of need.

Deborah will be followed by Billy Millweed, who is the Medicaid director for the state of Texas, and he will give us

some more insight as to how he is approaching these changes from a Medicaid perspective.

He will be followed by Art Gianelli who is president of the NuHealth System, a major public hospital system in East Meadow, New York, and he'll shed light on how these current financial pressures facing these safety-net hospitals play on the ground and how this system is preparing for an already dealing with some of the effects of the Affordable Care Act.

And our final speaker will be Patrick Conway who is the chief medical officer with the Centers for Medicare and Medicaid Services and he will give us the perspective of the administration on some of the challenges of implementing some of these provisions expected to have an impact on how these safety-net systems are financed. So with that, I will turn it to Deborah.

ED HOWARD: No, you won't. Eventually, I just wanted to do a little housekeeping if I could. As Pam alluded to, you'll find not just the Commonwealth executive summary of the report, but also a number of other background pieces that you might find useful and a list of additional material that you can use to get the next steps in your education.

Tomorrow there will be a webcast available of this briefing, compliments of the Kaiser Family Foundation, available both through their website, kff.org and the

Alliance's at allhealth.org. There'll be a transcript that we will have on our website within a week or so.

At the appropriate time, I want you to feel free to fill out a question on the green question card, there are also microphones that you can use to ask a question orally and take note of the blue evaluation form in your packets because we'd very much appreciate your filling that out before you leave so that we can improve these briefings and target them to your needs. So, we're ready for a great discussion and with the clicker in Deborah's hands, we're ready for Deborah Bachrach.

DEBORAH BACHRACH: I'm going to race through the first few slides because they focus on the characteristics of safety-net hospitals and Pam has really done a great job of that. So, take aways, just safety-net hospitals serve especially large numbers of Medicaid and uninsured, relatively fewer privately insured patients.

An important factor as well, limited reserves, low operating margins and there's no bright line. It's not like at 25-percent Medicaid discharges or more, you're safety-net, and below 25-percent, you're not, it's a longer continuum, and that's another important point to bear in mind.

So the next three graphs make the following point, this one, if you can see it at all, says that it's as Medicaid revenue goes up, commercial and Medicare revenue go down, but

commercial revenue goes down more quickly. And I'm happy that Art's nodding his head in agreement and don't look at far to the right, because we don't have enough hospitals in our sample. This one says to you that there are a relatively small number of hospitals that are serving a relatively high number of Medicaid patients.

And this one says, while that is true, many Medicaid patients receive care at hospitals that do not have high Medicaid mix, so if you move on now to let's talk about the core revenue streams for safety-net hospitals. And I want to focus on two today: Medicaid and Medicaid disproportionate share hospital payments, DSH payments. And these two, if we're going to have high quality cost effective care provided by a safety-net hospitals, we have to take a hard look at our Medicaid and DSH payment policies.

Medicaid is the largest payer for safety-net hospitals. Medicaid rates tend to be low, lower than commercial payers, lower than Medicare, they're getting lower. Now, that's not every state and it's not every service, but it's a general proposition, that's true. And the incentives, and we'll come back to this, are often completely irrational; by that I mean, encouraging inpatient over outpatient and the like.

DSH payments, Medicaid DSH payments are intended to cover the uncompensated care burdens of disproportionate share

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hospitals, of your high volume Medicaid uninsured hospitals, but in many states, perhaps most, they're not particularly well targeted to safety-net hospitals and on top of that, as both Pam and Ed said, the ACA, starting in 2014 is going to reduce Medicaid DSH payments significantly based on the theory and hopefully the reality that many more people will be insured and we will have far fewer uninsured.

So, now let's look at Medicaid payment policies because quite frankly, if we don't get this right, we aren't going to have a sustainable safety-net delivery system. So when we think about how do we want to target Medicaid payment? Where do safety-net hospitals fit into Medicaid payment policies?

The report suggests, and this came about with a lot of discussion with the commissioners, but we laid out three goals. And it starts with, but it does not end with, sustaining safety-net hospitals, because we go on to say we want to support the delivery system reform at these hospitals in order to insure that Medicaid patients have access to high quality coordinated and efficient care. I'm gonna stop and tell you a little story about myself.

For many, many, many years, before I became New York's Medicaid director, I represented Medicaid dependant providers, including safety-net hospitals, and I would go to our state capital and I would lobby to get more money for safety

hospitals. Just give them more money. They need it. They're the good guys.

Over time, and partly why I became Medicaid director, I realized that just give safety-net hospitals more money was not the answer. And I am now big into transparency and accountability and sustaining safety-net hospitals, so hence the three overarching goals. So what's the landscape today? We've all told it to you. It's not like we needed to tell it to you.

Federal, state budget deficits are putting pressure on Medicaid payment rates. It makes it almost impossible talk about across the board increases to Medicaid even if you're in a state where we know Medicaid rates are too low and the answer is if they're too low, raise them? That is impossible. So that's what brings us to strategically investing in Medicaid rates. It also means that we can talk about what's the method of payment? Is it rational? Is it transparent? Is there a level of accountability?

And we should remember that just two weeks ago, CMCS came out with draft regulations on the primary care bump, which indirectly benefits hospitals by proving increased Medicaid payments to primary care physicians when they deliver primary care services. So, let's talk about strategic investment in Medicaid rates. First, and I've really talked about all of

this, what's our first challenge? And that's to identify the hospitals, the services, and the settings in which we want to invest.

What's the safety-net hospital? How do we want to invest? In what setting? Inpatient versus outpatient? Both? What about what services? Which are the services to that Medicaid patients need access? So it's not just, hand over the money, and then we want to think about it in terms transparency and accountability. How do we target to hospitals to higher Medicaid volume and lower commercial volume? How do we link the payment to performance, insuring transparency and accountability, the theme of the day, and avoiding lump sum payments?

And I keep thinking about what many states do and what New York did, which is we took our Medicaid increases and we simply said, it's a $1,000 a discharge, whether it's appendectomy, a heart transplant, you get a $1,000. Well, what's the incentive with that? There's one state, and we discuss it in, I'm not sure it's this paper, it's another paper I wrote, which says, it's $1,000 per discharge, actually it's $3,000 discharge and the hospital's entitled to it, even if it was a potentially preventable readmission for which the underlying Medicaid payment is not being made.

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That doesn't make a lot of sense. So hence the avoid the lump sum payments as we invest in Medicaid payment policies, so again, incentivized care in the right setting. My personal experience, we've had lots of add-ons to inpatient rates, so that it was far more lucrative to admit a patient than to treat them on the outpatient side because there were all those payments attached to that discharge. And then target-needed services with limited access.

Mississippi did this by increasing their inpatient rates for behavioral health. They simply needed more access to psych beds, and I bet Art will talk about this as well, but we need to think about where do Medicaid patients need access and not just increase payments and then finally, and I think Billy will come to this, when we think about our strategies, we need to cross walk from fee-for-service to managed care, as we started to see more and more states embracing an managed care delivery model, as well as an ACO delivery model.

So there's a lot of reason to start with fee for service and there's a lot of reason not to end with fee for service. I want to move now to Medicaid DSH payments. And this is my set up slide. Now I could easily do an entire deck on Medicaid DSH payments, so I tried to think through what are the few features that I wanted to call out that were most relevant to the next slide which is how do we better target

Medicaid DSH payments, so really, here's a flyover on some very complicated laws and policies.

So, since 1987, federal law requires states to make Medicaid DSH payments to hospitals with a high volume of Medicaid and uninsured discharges, but the state has complete digression on how to allocate those dollars and can allocate them to hospitals with very little Medicaid and uninsured volume, so long as it also embraces or includes in the allocation your high volume Medicaid hospital.

While the state has significant flexibility, there are two overarching change constraints. One is the state has a DSH cap, so the state may only receive federal matching dollars, because, remember it's Medicaid, for a certain amount of money. So that's the state DSH cap. And there's also a hospital specific DSH cap that is tied to that hospital's cost, uncompensated care costs, for serving Medicaid and uninsured patients.

Earlier this year, new guidance came out on calculating unincompensated care costs for hospitals specific DSH cap. An important clarification was uninsured means uninsured for the service that you need. So you could be insured, but you don't have coverage for behavioral health, so you are then uninsured and those costs can go into the hospital's calculation. So bad debt doesn't count.

If I don't pay my copays or deductibles, that is not uncompensated care. And this is all very important and I'm sure Art will talk more about it because this is the limit how much any one hospital can receive. Now it's not on my slide, but I can't help saying something about provider taxes because they're always in the news, including last week. So, my personal view is there's nothing wrong with provider taxes.

Provider taxes are used to pay, directly or indirectly, the state's share, the non-federal share of the DSH payment. So in theory there's nothing wrong with it. Here's what I hate about provider taxes. In order to get them through the legislature, you often to get the hospital's buy-in. And the only way to get the hospital's buy-in is if they get the money back, so to the extent Medicaid DSH is intended to go to safety-net hospitals for the cost of uncompensated care, and the quid pro quo for getting the tax was an allocation formula that sent it to hospitals that have relatively few Medicaid and uninsured that compensate them for the tax, that's the problem.

So I'm hoping we don't throw out the baby with the bathwater. And then finally as we've all said, the ACA reduces Medicaid DSH and that's a big issue that I'm gonna come back to. In fact, I want to do it on this slide. So let's talk a little bit about the ACA says. The ACA says to the secretary — I'm almost done, I'm almost done, I promise you — You have to

reduce your DSH, you have to reduce it to states, your largest DSH reduction goes to the lowest uninsured, the lowest levels of uncompensated care and those that don't target Medicaid and uninsured patients which is an incentive to start targeting now.

Okay, last one, and I'm gonna do this in a minute, I promise, Ed, is, okay, if we want to talk about better targeting Medicaid DSH payments? Here's what the report says and here's what I want to throw out to you for consideration. First and foremost, it ought to be targets to the hospitals that are still seeing those 26 million people that will remain uninsured.

And over 20, so now Commonwealth has updated to 26, and I would argue that it should go out based on services rendered to a particular uninsured patient. I know, and I'm looking at Layton [misspelled?] who will tell me it's hard for hospitals to get that data, but for Gods sakes, I'm on United, let's figure out who's uninsured, let's pay it out based on a unit that is service rendered to an uninsured patient and let's base it on some small discount off of the Medicaid rate because you took my first recommendation of the Medicaid rate has gone up. That should be the first priority.

Second priority, the under insured, I raised the question, who do we consider the under insured post 2014? And

the third priority, which is how DSH payments are used now, which I would suggest we ought to be rethinking is to cover the distance between Medicaid costs and a particular Medicaid revenue.

Hospital specific cost, we're moving away from that. Hospital revenue, is that really a criteria? And finally, I want to say, that as we cut Medicaid DSH payments, let's think about using the state dollars and reinvesting in the Medicaid rates of safety-net hospitals. Thank you.

BILLY MILLWEER: Good afternoon, it's a pleasure to be with you today. And thank you to the Alliance and the Commonwealth for hosting the discussion today. I'm Bill Millwee. I'm with the Texas Medicaid program. I want to talk to you today about the Texas healthcare transformation and quality improvement program waiver, but before I get into that, let's talk about the upper payment limit or UPL. UPL goes hand in hand with DSH in providing supplemental payments for the safety-net hospitals. UPL was actually the catalyst for our waiver.

Let me define UPL. UPL at its very simplistic level is this; it allows the hospital to claim the difference between what Medicaid paid and what Medicare would have paid. And it is an important funding stream for safety-net hospitals. In

Texas, that accounts for about 2.8 billion dollars every year in payments to our safety-net and other hospitals.

This slide kind of represents the hospitals in Texas, of which we have 531, the majority of which participate in the Medicaid program and provide services to our 3.5 million Medicaid recipients. Of that number, 122 are public hospitals, 154 are not-for-profits and 255 are for-profits and as Pamela and Deborah pointed out, it's hard to tell which one is really a safety-net, you really have to dive into what services they provide and who they serve.

Largely the publics and not-for-profits are, but we also have the for-profits that provide services to our safety-net programs. There are some problems with UPL and here are the problems. UPL inhibits efficiency in the delivery system. There are prohibitions on states implementing managed care because you take a decrease in your UPL to this very important source of funds for the safety-net. Managed care days can't count toward that managed care population.

So it creates some disincentives. For example, 2005, we expanded managed care, our initial early on expansion and the model that we expanded, we refer to it as Star Plus. Star Plus provides, it's an integrated acute care and long-term care model that serves the aged, blind and disabled. We actually carved inpatient services out of managed care in order to

preserve UPL. Now that wasn't done to make the system more efficient, it wasn't done because it was a really good idea, it was done because we had to, to preserve UPL.

Fast forward to 2011, we are facing some budget pressures and we need to expand to managed care yet again, this time to South Texas and to the rural areas of the state and also again, Star Plus, so we can care for the aged, blind and disabled in a more efficient way.

Well, that would've not only improved the delivery services to that population, but save the state $395 million in general revenue, save the federal government about $500 million in funds, but that expansion with UPL would have cost the hospitals and our communities $2.8 billion, so that was the catalyst for the federal funding stream because of the safety-net's reliance upon it.

There were some other issues around UPL. That was associated with not a payment for a service, it's a payment, and I cannot tell you what that $2.8 billion that we spend every year is really purchasing because it's a matter of providing the match to draw down those dollars, not really a level of quality or anything else that I can really attach to and tell you that that was a value purchase.

So that was context for the waiver. The waiver at high level was based upon three primary components. Regional health

partnerships, funding pools and regional partnership plans, the regional partnerships are locally developed, I call them confederations, because it's a group of people who come together who are not mandated by law, they come together to develop these regional health plans.

The plans identify strategies to address uncompensated care and delivery system reform. The participants in the partnership include county medical associations, community health centers, public and private hospitals, other local partners, academics health site centers, our public health directors and consumers and advocates.

In the past when you've talked about UPL, it was usually a conversation between the Medicaid program and the CFO hospital. Now you have a community of people who come together to talk about how they're going to use this partnership to leverage funding. The plan's developed by the regional health partnerships address payment for uncompensated care and identify delivery system reform projects.

For each delivery system reform project, methods are established that later drive payments. We formed our partnerships and this map kind of identifies our partnerships, we formed 20. Any one of these partnerships is rather large. Some of them large as, as large as the state either in geography or in population size. There are funding pools,

those funding pools are formed by savings for managed care expansion and also the previous UPL program. UPL no longer exists in Texas today, but rather we have the funding pools.

There are two funding pools available within the waiver, uncompensated care and these delivery system reform incentive payments. I'll refer to them as DSRIP. The public entities within the partnership provide the same match for either uncompensated care, district projects, and payments associated with uncompensated care limited to actual costs. That's important because in the old UPL days, a hospital could claim cost up to charges.

So UPL, in many ways, puts inflationary pressure on our whole healthcare economy. Each of these regional health plans. The regional health partnership then develops their plan and the plan identifies all those payments and the source of state match, the district projects are selected from a menu, that we have developed with partnerships, with academic health science center and also a consumer input.

There are also some components of the menu that we mandate that each partnership address. For instance, diabetes, infant mortality and access to mental health services, each of these twenty partnerships must address. For others, there's a local option. It becomes very much a community driven experience in participating in these partnerships. And

actually what's happening as we develop these regional partnerships, you're seeing these community systems of care develop.

Conversations are happening now that have not happened in the past when you have actually competing hospitals sitting down at the same table to talk to maybe a public health director that none of them really knew or talking to the community mental health center that previously was not engaged in any of their business.

It provides some real opportunities to provide integrated care and collaboration. From the menu, they select, we have four categories, category 1 is infrastructure development that may be expanding access to primary care or expanding access to mental health services. Program innovation and redesign. We've tried to frame those around potentially preventable events, primary care preventable admissions, preventable use of the emergency department.

And quality improvements. These are chronicle considerations. Things like prevention of central line infections, reducing hospitalization for a number of causes and then population based improvements. Something else that we have done is taken these items of these regional health partnerships that we're working on and we've baked them into our HMO rates. And here's what I mean by that.

We have 18 HMOs within the state operating in our managed care expansion. 5-percent of the HMO premium is at risk. And that risk is tied to performance on those same things that the regional health partnerships are working on. And what we're trying to do is create the synergy between our Medicaid HMOs and what our hospitals and safety-nets are working on to drive the performance improvement.

We're at implantation. We have formed our partnerships. May 25th we had our final hearing. We formed our partnerships and now we're negotiating our final district menu and the funding program protocol and those kind of things with CMS and we'll be standing up the program the 1st of September. Thank you very much.

ARTHUR GIANELLI: Well, good afternoon. My name is Arthur Gianelli. I'm the president and CEO of the NuHealth System, the public benefit corporation that runs public hospital, public nursing home, and co-operates a federally qualified health center.

Before I start I just want to thank Ed Howard from the Alliance and Pam Riley from the Commonwealth Fund for the invitation and to acknowledge the other panelists here today as well for the really striking and very, very interesting contributions. And I want to thank all of you for taking time out of your busy day for coming.

I'm going to give you a ground floor perspective. We've had sort of the upper floors talk, and I'm going to talk a little bit about what's going on the ground. The first thing that I think is important to say is that though there is a larger discussion that's going on about what's going to happen to the Affordable Care Act if the supreme court rules that the individual mandate is unconstitutional, the reality is that at least on the innovation side, at least on the side where we're talking about how to reform and change the delivery system from one that pays for volume to one that pays for an incentivized value, that train has left the station, alright?

Those changes are fundamental, they're absolute, they're occurring all across the United States. You just heard some very, very interesting examples from the state of Texas. Deborah who was the Medicaid Director several years ago was frankly ahead of the curve and really quite progressive on this front as well. It's happening all over the United States.

And the reality is that we as providers are having to adjust and change how we do business in order to accommodate these changes, what's going on. So reforms here, the reality is that the government at all levels is resource starved and there's pressure on the entire healthcare delivery system to reduce cost and simultaneously improve quality.

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So you've got payers at all levels that are pushing hospitals to bend the cost curve to improvements and driving care to ambulatory settings and these payers are incentivizing improvement efforts through a number of different strategies, accountable care organizations, bundle payments, health homes and other risk based strategies.

The bottom line is that, again, the payers are moving from simply paying for fee for service to paying for some kind of value delivered for the payments that they are providing. So, what are hospitals doing in response to these changes that are going on? Well, they're doing a number of different things.

Hospitals are actually engaging right now in reducing unnecessary admissions in a whole host of ways. Whether it's partnering for care management services, whether it's focusing on those patients with high probabilities of readmission, whatever it is. And what's very, very interesting and I'm borrowing a phrase from the advisory board, is that hospitals are in an economy where they are effectively being asked to do something that's against their nature which is to destroy their own demand.

Hospitals are being asked to play a critical role in the healthcare delivery system, precisely by preventing admissions that are preventable. You almost can't find another

example in any other sector of an economy where a major economic player is asked to do less of what they do, but that's precisely what's going on in healthcare and it's critically important, by the way, that hospitals succeed in doing this, for the healthcare system to be sustainable in the long-term. Hospitals are expanding their primary care and care management reach.

They're developing alignment strategies with physicians, they're integrating with other hospitals and with insurance plans. They're seeking capital where they can and in some sense in some very unusual places, including from for-profit investors and even private equity firms and they're entering into quality driven risk and shared savings contracts with payers.

Now, we talked about what a safety-net provider is, I don't need to get into that, but again, safety-net providers, high degree of Medicaid and uninsured and a special focus on taking care of the most vulnerable patients in a community and that vulnerability can be care independent. Vulnerability can be mental health, disease, vulnerability can be frail or elderly, etcetera.

But I'm going to speak as an executive from a public hospital and talk a little bit about what public hospitals do in the United States and again, I borrow this from the National

Associates of Public Hospitals and we have a few representative from the Association here today. National Associates of Public Hospital members provide 31-percent of their ambulatory and 18-percent of their inpatient services to uninsured patients. Uncompensated care represents of NAPH total member costs.

It's 6-percent for all other hospitals. And any NAPH member provide 20-percent total uncompensated acute care in the United Sates, but they represent 2-percent of acute care hospitals in the United States. NAPH member provide 45 million non-emergency outpatient visits and the average NAPH member provides more than 5 times the volume of non-emergency visits, outpatient visits are other acute care hospitals.

As Deborah indicated earlier, the paid makes us heavily weighted toward the other payers. The average NAPH hospital has 27-percent Medicaid and 26-percent Medicare, 24-percent commercial, 19-percent uninsured and 4-percent other, that's on the inpatient side.

On the outpatient side, you would likely see more uninsured and more Medicaid, you certainly would see that at our hospital. And the source of financing for uncompensated care is really reliant on heavily on two sources. State and local subsidization and really Medicaid and Medicare disproportionate share payments.

Now I use this chart, which is a chart that's provided by the American Hospital Association to really drive home the point that the more heavily weighted a hospital is toward governmental payers, Medicaid and Medicare payers, the tighter its margins are going to be.

Because the reality is, and most of you know this, but this chart emphasizes the point that hospitals have gone to the commercial payers in order to cross subsidize losses that they incur in taking care of Medicaid beneficiaries or those who are enrolled in Medicare. And as we progress into the Affordable Care Act, as more and more patients in some states are enrolled in Medicaid, and where there is downward pressure on the part of state departments of insurance, for example, in regulating increases in commercial premiums, you're going to see a true tightening of the resources that are available to hospitals and certainly a tightening of the resources that are going to be available to public hospitals and safety-net facilities.

It's also important to know that though it's pretty much an even split nationally between the projected increased in the commercial enrollment in the Affordable Care Act and Medicaid enrollment due to the Affordable Care Act, that differs state by state.

So, if you take a state like New York, because New York has expanded its Medicaid enrollment over the years, the

Affordable Care Act really will have an impact on the commercial side, not so much on the Medicaid side. Other states are differently positioned, but it's an important point to note that that slide is not uniform across each and every state.

Now what I thought I would do is try to give you a sense, you know, as folks working for policymakers, wanted to give you a sense of those strengths and weaknesses and opportunities and threats that characterize public hospitals as they are approaching reform. And it's important to know that there are certain strengths that public hospitals have.

Most public hospitals have a much higher degree of employed physicians than community hospitals or other sorts of hospitals. That's important for alignment purposes. That's important to ensure that hospitals and physicians are working in coordination in order to achieve quality and reduce unnecessary unitization.

Public hospitals have extensive primary care networks. Many are integrated care delivery systems and they have a lot of experience working on limited resources. So we know that game and we've been doing it a long time and we know we're going to continue to do it.

Now, weaknesses of course is there's flipside is that they have been working on thin or negative operating margins

for years and as a result, they're undercapitalized organizationally, and that makes it difficult to make investments that are necessary to make the transition from volume to value payments.

Governmentally appointed boards means you can have an interesting cast of characters on your board or you can have transitions in your board at particularly difficult or challenging times. Public hospitals have limited organizational flexibility, high cost structure and difficulty accessing capital.

But now there are opportunities and there are threads and I do want to focus on the opportunities and certainly one, which I didn't put here which I do want to note, is clear that the Affordable Care Act goes through and survives the Supreme Court challenge, the reality is that there will be more patients who will be insured and that will help across the board and will certainly help public hospitals.

But public hospitals will have the opportunity to expand the current outpatient and primary care capacity, leverage the certain alignment drive quality and utilization management. User integrated systems to participate in accountable payment opportunities. Partner with states to manage the dual eligible population.

I think this is a huge opportunity for public hospitals. These are high cost drivers, highly needy population, the public hospitals I think are uniquely situational to try and make improvements in. Obtain Section 1115 waivers geared toward delivery system redesign. California is an excellent example, the Bridge to Reform waiver.

And I would note as well, this is something we're doing in New York, is that states have the capacity to confer state action antitrust protection on a variety of unique collaborative relationships amongst providers if that they conclude that the collaboration, even though it's reducing competition, is for the public benefit. And that's a very, very powerful tool and I think it's a tool that could be used state by state, in order to help to protect important collaborative relationships amongst public providers and safety-net providers and maybe more financially well-endowed providers.

But there are threats. The Supreme Court, either way, you still have to deal with the exchanges of who's insured and who's not, the disproportionate share payment reductions and adverse selection to the extent that the Supreme Court selection is adverse in declares the mandate unconstitutional.

There's an incongruence between the integration imperatives and the law and the current stark antitrust and

anti-kickback laws. That has to be resolved and we have to make a choice at the policy level of which way that has to go, patients, actable chare and population management business models haven't been proven out yet and there's ongoing downward pressure on payers.

And let me just conclude here in terms of how policymakers can help, and just very quickly, and I think, you know, sort of echoing what Deborah indicated, but I would even broaden it, you've got limited Medicaid dollars and limited disproportionate and share dollars, so I think from a policy perspective, you've got to think about focus.

We've got to think about how o focus those dollars to do the maximum amount of good in terms of quality, in terms of access, in terms of accountability and in terms of transparency, and what's needed is for the public hospitals to step up and say, you know what? We'll take that tradeoff, we'll take the tradeoff of focus, of that focus, in exchange for our performance.

And I think that's something that public hospitals will be willing to do because the reality is we don't have a lot of Medicaid dollars to fool around with the system and heck of a lot more for the patients that are enrolled. The Section 1115 Waiver Program is a hugely important program to try to catalyze reform efforts at state level.

State and local governments can provide public hospitals with greater organizational flexibility to get disencumbered from the legacies that, frankly, are costly and don't add value. We need to clear up the antitrust concerns and again, the utilization of state acts and antitrust protection, and again, I think provides a unique and important opportunities for public hospitals and other providers to collaborate in a non-owned capacity.

And finally, I would encourage this amongst policymakers at all levels: let's not keep changing the rules. It's very, very challenging as a provider to have the rules constantly change for what you need to do. Let me leave quickly with this story. I was in a meeting the other day talking about the decline in our volume and in the discussion that we were having, it was clear that my emergency department was actually reducing admissions to the hospital based upon the tenor of discussions that I've had about unnecessary readmissions admissions.

I told them, I said, look, the reality is that we live in a world right now, we're in two boats. We're still a little in that fee for service boat, but we're kind of lening into the accountable care and the value boat, but we're not quite there yet.

So the reality is that we as providers have to do everything right to prevent somebody from trying to come to the hospital. Primary care management, medicine reconciliation, everything we need to do, but as is still the case until the payment structure fully changes over, that we have to, when somebody comes to our hospital, if there's an argument to be made for their admission, we have to admit them because we have to get paid.

But what I would encourage though is that disconnect, that incongruity, we need to move sooner than later away from and we as a nation and as a state and as a provider, are then all moving in one direction, we're in one boat rowing together in order to be able to improve our delivery system and reduce our cost and ultimately save our healthcare system. Thank you.

ED HOWARD: Just don't do it and change the rules continuously, and that leads us to Dr. Patrick Conway.

PATRICK CONWAY, M.D.: Thank you for having me here today, so I'm Patrick Conway, chief medical officer at CMS, director of the office and clinical standards and quality. I want to thank the Alliance and the Commonwealth for having us. I should note I trained and practiced in a number of safety-net hospitals in Ben Taub in Texas at one point.

I currently work weekends as a pediatric hospital medical attending at an institution that serves a lot of

Medicaid and low income families. I am a chief medical officer for CMS, that is broader than just Medicare, so that includes Medicaid and CHIP and the exchanges now as well, and we work very closely with our Medicaid and Duals office colleagues and I'd be remiss if I didn't say how much this work I'm talking about is led by our Medicaid and Duals office and CMMI and others across CMS.

So I'm going to talk briefly today about some health transformation changes that we're making and then tie it back to the safety net as well, first on quality improvement, second on payment models, third on regulation and then four, as was alluded to, cut accessed insurance coverage. We have a common goal here: it's better health, better care, and lower costs. I've practiced in systems and led QI transformation of systems focused those three goals. It is achievable. You have tremendous safety-net hospital examples of achieving those three goals.

And the question now is how to we do foster that transition broadly across the safety-net. So in terms first of quality improvement funding, we have our quality improvement organization funding. We are now focused much more on learning and action networks, getting networks of collaborative QI across states and in localities and, I think, a much larger focus on population health, safety, readmissions and safety in

the hospital.

I should note that there's no corollary steady funding stream in Medicaid and CHIP like the QIO program. Second, in terms of partnership for patients, we're funding over $500 million through innovations that are focused on hospital safety and readmissions, have hospital engagement networks that literally cover the country engaging now with, I think, we have to check with our innovation colleagues, I think we're about up to 4,500 hospitals, so I think almost every hospital in America.

This is a very different paradigm for CMS to fund this kind of work. The third kind of program I'll mention is community care transition, so funding up to $500 million in communities across this country, focusing on readmissions and funding community based organizations, realizing that readmissions is complex phenomenon that really involves the whole community and is not just a hospital issue.

Next I want to talk about payment models. Some of this was alluded to already. With accountable care organizations, whether it's shared savings programs or a pioneering CEO program, I think this is an opportunity for safety-net hospitals and safety-net providers, and we've seen safety-net providers come to the table, safety-net providers have a history of thinking about population health.

You know, it also goes into some of our managed care work, which very much aligns with thinking about managing populations of patients. Second, I'll mention hospital value based purchasing. This program, we were given the flexibility by Congress to reward both improvement or attainment.

We have safety-net providers with very high performance and we're able to reward that and we also have safety-net providers that maybe have struggled on some measures and we can reward them on improvement, so that when we have that flexibility, it aides us in our programs. I mentioned the Medicaid medical home work and other primary care model work. I think a tremendous focus on safety-net providers and enabling you to be successful.

We do, in some programs, our readmissions program that was alluded to, there's less flexibility in the statute in NQF endorse measures, it's all payment adjustment negative, and we don't have an opportunity to reward improvement, however, I'd say that the overall focus is how do we decrease admissions and how do we think about population health is on target and now I think our challenge as an agency is to execute in a way that we don't create unintended negative consequences for safety-net providers and the patients that you serve.

Lastly, in CMMI, our innovation center, funding a number of programs, certainly they're focused on broad health

system transformation, but I know that we often have safety-net providers and hospitals that apply and are awarded grants. Denver Health is an example was just rewarded one of the Innovation Challenge awards.

Next I'll talk about regulations and some of the work we're doing to try to help safety-net hospitals. In May 2011, this also comes out of my office, we streamlined the credentialing process to enable telemedicine for rural health and critical access hospitals, this was critical, no pun intended in terms of enabling telemedicine in those areas and then just last month we released the largest overhaul of hospitals conditions of participation and agencies, so we removed over $1 billion of unnecessary regulations from hospital conditions participation.

Much of it focused on flexibility to different providers and this would include safety-net providers on how you would provide care and also removing things like a separate nursing care plan, for anyone who's worked in a hospital, it actually makes no sense when we're trying to integrate care to have regulations that actually disintegrate care.

So we're providing the flexibility so you can take care of the populations that you serve. I'm actually going to end up finishing early, so we'll kick back. And then the last area, which I won't spend a lot of time on because others

already have, you know, we, at the agency, view the Medicaid expansion and the healthcare exchange as an opportunity to increase access to health insurance in this country.

Accessed health insurance doesn't complete the transformation cycle of better health, better care and lower cost, but it's a critical step along that pathway. So we really view this as an opportunity to achieve that three part aim of better health, better care and lower cost to making sure that people have access to the insurance coverage that they need.

I think lastly I'll end where I started. Healthcare transformation is deeply personal to me. I am still practicing physician, as I mentioned in all my stops, I've actually practiced in safety-net providers as part of my work. I think the work that safety-net hospitals do is incredibly important.

I think you serve some of the most vulnerable populations of this country and I think CMS as an agency, we need to work with you to make sure they're able to serve those populations to achieve what we want for our nation, so to achieve better health, better care and lower cost for continuous improvement.

So thank you, those of you from the Hill and from safety net providers and others, thank you for being here and thank you for the work that you're doing.

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ED HOWARD: Thank you and the other panelists. Now we get your into this conversation, we offer you the opportunity to ask your question directly, as I've said, there are green cards in your packets that you can use to write the question down. If you do use the microphones, I would ask you to identify yourself and keep it as brief as you possibly can.

Pam, you should feel free to interrupt me at anytime as well. One of the questions that occurred to me as I heard a couple of the presentations was the emphasis on outpatient care, the need to reduce unnecessary readmissions and admissions. What does that do to the capital expansion plans that people have in mind? Arthur referred to that specifically.

ARTHUR GIANELLI: Well, that's such a great question and what I struggle with is the fact that if I look at my hospital in the cold objective reality, in the cold, objective light of reality, in five or ten years, the Affordable Care Act moves along the path that I think it's going to move, and the path that I think it's going to move, I will have a much smaller inpatient hospital in a 19 story building.

And I will need to have capital to make investment in primary care facilities, because I will need a lot more primary care capacity to do that's required and I'm going to need to figure out what to do with parts of the building that frankly

are no longer necessary because my primary care should not be in the hospital, it should be out in the community.

So these are significant capital challenges which is why I think one of the ways in which policymakers can help is to provide access to safety-net facilities to capital, but target the capital for these kind of transformation. This is something that New York state is doing and I think they're doing it quite smartly.

It sounds like Texas is doing that as well, California is doing that and I think it's a pattern that we'll see throughout the United States. The reality is that I could not affect that transformation without the access to capital to do it, but it's a necessary transformation to really accommodate the perils of reform.

STEPHANIE PINCUS: Stephanie Pincus, Institute of Medicine. Current with the changes in the Affordable Care Act, there are also changes in the graduate level education. Graduate medical education is intimately tied to the safety-net hospitals. In your slide shows about 4-percent of the funding comes from IME.

I would propose the IME be cut approximately 50-percent and the Institute of Medicine will be initiating a big study on GME and I'd be interested in the panelists comments about how they think these changes in graduate medical education are

going to influence these safety-net hospitals.

BILLY MILLWEER: Well, it will impact the safety-net hospitals. And we've run across that a great deal in Texas already and that's one of the reasons we chose to address the waiver. If we're going to build infrastructure, if we're going to build capacity, then redirecting those UPL dollars to something more transparent and being able to bring in additional providers that can share in that.

I did mention in the pool funds that we have available, we expanded over a five year period, had we just stayed with UPL, that would've been about a $15 billion pool. Through the waiver, we have access to $29 billion in the pools. So we're really looking at how we can leverage some of those residency programs to answer some of the underlying access to care issues that we have in the state to the waiver and funds some of those through that process.

ARTHUR GIANELLI: Just a response to that, I think it's an excellent question. I think for a couple observations from my hospital. Number one, we recognize that we're going to need to shift our residency programs to emphasize more the kinds of physicians that we need to be training in the future.

So we're actually initiating this July 1st, an FQHC family based residency program, which is a first that we've done and I think that's critically important. That's number

one. Number two, many of the residency programs, though from an ACGME standpoint, need to catch up.

So in our particular case for example, the requirements for pediatrics are so overwhelmingly specialist and inpatient based, and I can't really provide the necessary clinical experiences for my residents because the reality is my inpatient service and pediatrics has diminished significantly, because, A, children don't get as sick anymore and, B, there's a major children's hospital in the area.

And most pediatricians are not going to be inpatient pediatricians. They're going to practice in the community. So most residency programs need to catch up how we need to train doctors and where we need doctors to be going forward. And I think the last point that I would make, I'm relatively new to healthcare, so I just find some of the history of this interesting.

I get paid probably half of what my competitor hospitals get paid in the area to train my residents because of the byzantine formula that's used to allocated GME dollars. If we're going to be talking about transparency in DSH and transparency in other payments, we need to be talking about transparency in GME funding as well. There's no reason why I get paid $77,000 a resident and my competitor gets paid $150,000 a resident, when I do the same exact teaching as my

competitor hospitals do because that does not permit me to fund the educational experience the way that I would need to.

ED HOWARD: Do any of the other pediatrician people up here have anything to add?

PATRICK CONWAY: I thought about writing this before. I mean, I agree we need to shift the way we train physicians, not just pediatricians, but broadly, I think system redesign, quality improvement, etcetera. I think team-based practice that are critical for sort of health transformation that has historically we haven't gotten as well through medical school and the residency process.

SHAWN GREMMINGER: I'm the main lobbyist. I'm the person who gets to come up here and ask for money. And I will assure you asking for money with nothing in exchange is just as effective in Washington as it is in Albany. To that end though, we remain deeply concerned about the level of DSH cuts included in the Affordable Care Act.

Particularly, I mean, they start literally next fiscal year, in 2014, but they get very, very large as you go into the out years and we are very concerned that they'll be far too little DSH, even if it's better targets to fund everything that we have to do.

Do you think that there is a deal that can be made when we talk about greater transparency in DSH, linking DSH money to

quality outcomes and you know, effectively be able to get some of that money back, understanding the deep fiscal pressures that we have here it's something that we're toying with, saying look, we know that Medicaid DSH has a very strange formula and one that's not well understood and one that frankly is probably irrational in some ways, you know, can we make a more efficient DSH program with better accountability and actually be able to hold onto some of that money?

ED HOWARD: Can I just ask, that same connection, could someone in the course of responding to your question, put the cuts in a context? We have the numbers of what the cuts are, off what kind of a base? Is this 20-percent cut over ten years? 2-percent cut —

PAMELA RILEY, M.D.: 15-percent cut over ten years. I can't speak to whether or not there's a deal to be cut, I think many of you around the room are better positioned to indicate whether there's a deal to be struck. I think the issue though is the DSH cut is premised on the success of the ACA.

If the ACA is successful, completely successful and we only have 22 or 26 million uninsured, and we agree that we would like to see the DSH dollars subsidize the least cost of the uninsured, and at least at something approaching the Medicaid rate, that would be my premise.

I'm not sure that you would agree with me, then that's

the question. Can we reduce the uninsured sufficiently so that the remaining DSH dollars can in fact cover the cost of the uninsured or most of the cost of the uninsured? Where does Medicaid DSH fit into that is an open question as well?

But I think we have to acknowledge that there will be remaining uninsured and that through our DSH mechanisms and it is important that, particularly the safety-net hospitals, they're serving the largest numbers, if you have five uninsured patients, it's a lot different than if they are 10 or 20-percent of your patient population, that those dollars need to flow to those hospitals. So there's not a perfect answer but that's how I look at it.

ARTHUR GIANELLI: I think for the sense of the rest of the room, just to get a sense of the importance of this, to a public hospital. My hospital specific disproportionate share payment last year was something in the order of $85 million. My hospital is a $440 million hospital. So you know, 50-percent reductions in disproportionate share payments have a massive impact to a hospital like mine unless there are the common adjustments that we're talking about, but it's not benign.

And I know there's a history, a somewhat sordid history relative to how the disproportionate share funds are being used, so much by the providers but at the state levels for

example, but I think that that's frankly been cleaned up in most instances.

And so I would urge policy makers to understand the critical nature of this funding and that the kinds of cuts that we are talking about, the latter part of this decade, if the Affordable Care Act is sustained, if the individual mandate is sustained and if we proceed along the path that we're currently proceeding, they are large and they have the potential to be radically dislocating unless the insurance levels are commonly increased.

So careful attention needs to be paid to that and I would obviously I would be supportive of where NPH stands that the reality is that we, if you're taking care of a lot of Medicaid folks, you're undercompensated relative to the cost of care that you deliver, and I know no one wants to talk about it, but the reality is that places like mine for example, we're not going to see much of an impact in increase in Medicaid enrollment because most of the folks that we see are undocumented and this is just a fact of life. And the reality is that someone has to pay for that.

JOHN CUSTER: My name is John Custer, I'm with Mintz, Levin and ML Strategies. My question was for Dr. Conway. It's a little more specific. You mentioned the community care transition grants. I was just curious as to what type of

groups are actually applying for these and are actually getting accepted.

Community care transition can be pretty wide ranging from everyone who provides out of pocket, you know, home health aids and companions, to shorten long-term rehabilitations, you know, like nursing facilities and things like that, so I was just kind of curious about the transparency of where some of that money was going.

PATRICK CONWAY, M.D.: Let me give you a general answer and then afterwards I'm happy to follow up with more specifics. So, there are given out to community based organizations which was defined reasonably broadly in the RFP related to this funding.

It's been an array of organizations that apply. I think, to be fair, in the beginning parts of the program, there were some challenges for the RPF in the funding dollars to the organizations and so we've actually done some work working with organizations to try to understand, you know, even having our QIOs works with organizations in their state to help understand the program better, help understand the application process.

Help understand that you're partnering with groups in your communities, which is really what we're looking for, so you have sort of coalitions within your community. But happy to talk after if you want more specifics, we can get you in touch with the right folks about who all's been awarded, etcetera.

ED HOWARD: The next question is for Billy and Dr. Conway and I think we first want to acknowledge, I think I read that Billy's supposed to retire at the end of the month and I think we all want to acknowledge the leadership role that he's taken on Medicaid issues.

I think we're all going to miss him, but I suspect we'll still see him around D.C. One of the examples of that leadership is what you discussed how you're dealing with the supplemental payment limits, and I was wondering, Billy, how difficult it was to get that waiver approved, and perhaps Dr. Conway would want to speak on that as well, and to Dr. Conway, are there other way, Billy pretty much had to take a roundabout way of dealing with the issue, it's a fairly convoluted approach, is it within CMMI's authority to avoid the waiver and grand states permission to do this directly?

BILLY MILLWEER: Thank you for your kind words, but it's actually the end of August, but within this month. It was a difficult process, no doubt, proving up the need for the waiver with CMS. And probably rightfully so because they have to be judicious stewards of the program they're charged to manage and then proving up the need for the OMB. It was an arduous process.

I think there were some things that probably the federal government would do to streamline this process, for once we had done this, maybe make it easier for other states that follow. We spent a

lot of time on standard terms and conditions. I have 85 pages of standard terms and conditions, which I think I probably could have gelled this down to 20 or 25. Much easier said.

So I think there's, CMS has been more than helpful, but I think there's some other things that we can do to administratively simplify this waiver process when you look at what states are trying to do, the objectives you're trying to achieve but still build in that accountability.

But again, going back to it was a partnership working with CMS and what we're trying to achieve and in that whole negotiation process, we started, we submitted our waiver in July and negotiated through until it was finally approved on December 12, 2011. So it was a quick process, but it was time intensive involving many trips to Washington, D.C. from my home in Austin, Texas.

PATRICK CONWAY, M.D.: I'll be brief, I have Medicaid colleagues in the room who want more detail on the way it was processed. I think certainly like all our processes, we want to look at ways to streamline to make it still an effective process but as an efficient a process as possible. We also from our quality office we're detailing some folks to help with the 1115 waiver process to make sure we have both our quality and payment, we have a good cohort of people to review.

We've always had a good cohort of people, but to make sure we have the right skills at all times to review the waivers and then

I think lastly in terms of CMMI, I don't want to get ahead of Rick Gilfillen and their group, but I think they're certainly thinking about, and I've talked about this publicly, about sort of state-based innovation as well.

JUDY CHESSER: My name's Judy Chesser and I'm with the New York City Health and Hospital System. We're the largest public hospital in the country and just to give you some numbers to try address this at some point. We serve 1.3 million people last year. 475,000 were uninsured. Given that New York is pretty progressive already, and has a very generous Medicaid program as far as eligibility, we don't see a lot of those people getting a lot of change in those numbers with the ACA.

We're thrilled that the ACA has passed, don't get me wrong, and we're working with people trying to come up with more and better and more efficient ways to deliver services, but one thing I would encourage is for CMS and the Innovation Center to focus some more on the Medicaid side of the house because there's been much more emphasis on Medicare and I sort of understand that Medicare is federally run and all the data is much more readily available and you don't have to deal with 50 different programs because every state has its own deal, but I would just encourage you, because when Medicaid gets expanded in 2014, it would be if you got your arms around it before the expansion. Thank you.

ED HOWARD: Advice taken, I guess. Let me just say as we turn to the next questioner, as we go through this Q&A section, I note with approval that a number of people have the blue evaluation forms and I would urge you all to do that to give us the feedback that we need to shape. I know it's hard to believe, but perhaps even better programs than this one in the future.

MARISSA WEISEL: Good afternoon, I'm Melissa Weisel [misspelled?] from the American Heart Association. Dr. Conway, you mentioned the bill, or the regulations that came out about a year ago about physicians and providers' ability to use telehealth and I was wondering if from the safety-net hospital standpoint, has that kind of been embraced? Have there been any improvements in using telehealth to improve access to world populations, and if not, what else is needed?

PATRICK CONWAY, M.D.: Yeah, I just have to say that we don't have a lot of farms. I will say this, that we have not to the level that I would like really integrated telehealth in to our programming. I think that has to come. It's going to come soon. And it's certainly going to be, we're discussing design of expansion sites for outpatient primary care and that's something that we particularly for psychiatric consultations, etcetera, and other specialty consultations.

It's definitely part of our plan. It's not something that we've really embraced at the level that I would like to have, but I'm not a representative. In other words, you're talking about other areas where we're getting into the specialist is a couple hundred mile trek. Here we have specialists falling all over one another in my neck of the woods, so I don't know if I'm the best person to address that, but it's definitely part of what every safety hospital strategy going forward. It's the future. I'm told there are rural areas in Texas.

BILLY MILLWEER: There are a few, there are a few. It was curious when we developed a delivery system reform, instead of payment menu, that wasn't an issue in Harris county where you have Houston and you have a wealth of resources, but it was in some of our rural areas. And that's why we allowed partnerships to address telehealth, and also this focus on primary patient centered medical home, where there may not be access to a specialist in the building capacity of the primary patient's centered medical home by having access to that specialist. So that's being addressed in our district menu, but again it came out of the rural areas, probably more so than the urban areas.

CAROL BACKSTROM: Hi, my name is Carol Backstrom and I'm a senior advisor in the Senate for Medicaid and CHIP services, so I'm with CMS. I just wanted to reemphasize about what Dr. Conway was talking about in terms of some of the pathways and work that we're

doing at the center for Medicaid and working with states, unlike the Affordable Care Act, where they really lay out sort of the parameters for a Medicare/ACO-like model, it's very much a reality that Medicaid, it can't be a one size fits all kind of approach because each state is different, but also it allows us, in other words, there are good sides and bad sides to that.

In the one sense, it'd be great to have more formal parameters, but on the other hand, we really need to take a state by state approach for the different populations within Medicaid and the uniqueness of the Medicaid populations.

To that end, we are aware we need to be a lot more proactive around guidance to these states to some of these issues and we're in the process of releasing some guidance in the form of state Medicaid director letters that will help define the different pathways that different states can take whether it's a state plan or waiver, highlighting the Texas waiver, as well as the California waiver, that's one example of a tool in the toolbox of doing something different under Medicaid reform and payment reform, but that's only one tool so there's a lot of other existing way s that we can thinking about this with our Medicaid populations, but stay tuned to hear more from CMS on that front.

ED HOWARD: Dr. Riley, you've been compiling questions here.

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PAMELA RILEY, M.D.: Yes. Okay. So, could the speakers comment on the potential role that private equity can play as a potential source of capital for safety-net hospitals? Is it currently being used? And if so, to what extent and what are some of the drawbacks of doing that?

ARTHUR GIANELLI: There are examples in the country where private equity has been tapped by safety-net facilities in order to enhance access to capital. Let me take a step back and say, particularly in New York, safety-net facilities, whether public or not-for-profit, you have an incredibly limited ability to access capital and so you have sort of a bimodal distribution where you have these facilities that have essentially limited or no access other than through the government to capital resources or then you have institutions that are running $1 billion multi- or capital campaigns.

And that creates a huge disconnect in the delivery system in New York really between the have's and the have-not's. And that actually led to an inclusion by a major figure in New York in a report of one of the hospitals in one of the boroughs in New York City.

I think he had one sentence where he talked about the possible reintroduction of for-profit healthcare in hospitals in New York, which is a major source of controversy because of the potential conflict between the need to maximize shareholder

value in a for-profit company and the mission that the not-for-profits and the public's have to serve the underserved.

So but that being said, we have to have a robust discussion about how we can connect up between private equity and safety-net facilities because the government just simply aren't going to have the capital resources to allow these types of facilities to make these types of improvements that are going to be necessary.

That's number one and number two, I would encourage safety-net facilities to be creative in how to tap private sources for capital. So, for example, my hospital has about 80 acres of developable real estate. I don't intend to spend a dime developing that real estate because I don't have a dime to spend developing that real estate, but what I am going to do is attempt to encourage private investment in ways that synergize and support what it is that we're doing.

So whether it's private investment in outpatient services or private investment in senior living and assisted care or private investment in academic facilities, that investment will ultimately enore to the benefit of the patients that I serve and it's a way of leveraging private dollars to help serve the public good and we have to be open to that and be creative in how we do that and still be true to our mission.

ED HOWARD: Deborah, have you run into that in other states?

DEBORAH BACHRACH: No, I actually, I haven't, and to the extent that we've discussed this a great deal in New York, I think the tension is what Art alluded to, which is private equity wants a return, so how do you balance their need for a return on the investment with the mission of a safety-net hospital?

And is there a way to do it outside of the creative notions that Art put forward, which are win-win. It's not that often that you can meet both of those needs; the need for a return and the need to maintain mission. And I think that's the challenge and that's part of the controversy in the one sentence of the report Art alluded to engendered in New York among our safety-net community hospitals.

PAMELA RILEY, M.D.: Could the panelists say a little bit more about the role of safety-net hospitals in caring for undocumented immigrants? Specifically what is the obligation to care for the undocumented population and how will the Affordable Care Act impact the ability of safety-net care providers to provide this care?

DEBORAH BACHRACH: Well, I think first of all, there's EMTALA. So when a patient comes into the emergency room, whether their documented or undocumented, the hospital has to

take care of them and stabilize them and that includes admitting them and taking care of them in the hospital until they're stabilized. And then the challenge is once they're stabilized, you can't discharge a patient to the street and if they're undocumented, no nursing home will take them, and if they can't go home, then there's a continuing problem. Everybody has alluded to this.

Undocumented immigrants will not have access to coverage under the ACA and then for hospitals in states like New York and, I suspect, states like Texas and California and several others, a large percentage of the uninsured are undocumented and the DSH dollars then are a critical revenue stream.

One thing that Medicaid does that's very important is that Medicaid will cover the emergency cost of undocumented immigrants up to the state's eligibility level, which in 2014 will be 133-percent of the federal poverty level. So Medicaid is an important revenue stream in two respects. One is it covers emergency costs of undocumented immigrants. And two, it provides for Medicaid DSH and that is absolutely critical because whether a patient's a citizen or undocumented, the hospital incurs costs of treating them.

PAMELA RILEY, M.D.: We have a couple of questions about the 340B program which is the federal program which

provides low cost medications to safety-net patients. Have states expanded the 340B program to safety-net hospitals in raising revenues or in containing their cost for medications?

ARTHUR GIANELLI: Well, again, I can speak to is at a hospital level. The 340B program is one of really four tools that we use to provide low cost medicine to our low income populations. So we use a 340B program, which is a Medicaid program. We have an indigent drug program where we partner with a number of the major pharmaceutical drug companies to provide us the low cost or free medicine in certain circumstances.

For example, if we're taking care of somebody's uninsured and who has cancer and need chemotherapy, we can oftentimes get those drugs donated or get it to us at a significant discount. We use a product called Sample M.D. Those of you who are familiar, in the old days, you used to go to a doctor's office, they had samples lying around, they give you samples for a week or whatever, then they take them away.

There are all sorts of issues with doing that, regulatory issues with doing that, so there's a company that we work with position can literally, off his or her desktop, print out a coupon which you would then take to a drugstore and that would then provide you with the equivalent of a sample, so the

sample's not, it's a virtual sample, the sample's not in the office, you would go get the samples at the drugstore.

And the last thing I would say, one of the best programs that's out there is actually the Wal-Mart program, which is the $4 program, because oftentimes, even the 340B program can't beat that. And so what we've done is we've had our director of pharmacy services provide our physicians of inpatient and outpatient with a big chart and the chart talks to the most commonly prescribed drugs and then where to best direct the patient to get them most inexpensively, in order to try to improve medication compliance because ultimately that's going to go to the patient's benefit and the hospital's benefit in terms of quality improvement.

So that's what we've tried to do. It's our view is this is a critical piece. 340B and other programs are critical if you're really going to get at things like readmissions because the two drivers of the readmission are the failure of a patient after discharge to get follow-up care and the failure of a patient to take his or her drugs.

And that failure to take his or her drugs can be an affordability question or it can be a reconciliation question. This helps to focus on the affordability question, so those tools are necessary for us to be able really drive down readmissions in a safety-net context.

ED HOWARD: Could you explain to me what you mean by reconciliation question?

ARTHUR GIANELLI: In other words, you may have patients that are taking five, six, seven meds or taking meds from two or three prescribing physicians. They may or may not have disclosed that to the hospital. They may or may not have remembered this and as a result of the medicine that we prescribed may not have the desired effect and that's where the follow-up care and some sort of external care management is so critical for making sure that the patient is not only taking the medication and is taking the correct medication, given all the other medications that he or she is taking.

BOB RHODE: Hi, I'm Bob Rhode at BMJ. A number of hospitals have gone about the process of integration by purchasing medical practices, everything from specialty even down to general practices. What are safety-net hospitals doing in their version of this? Are they doing, I know they don't have the financial resources to go out and purchase things, but how are they preparing themselves to better provide a full spectrum of integrated care?

ARTHUR GIANELLI: Well, you know, some of our competitors last year, you know, their goal was to acquire 1,000 physician practices. We could not acquire 1,000

physician practices, we wouldn't have the wear-withal to do that.

However, I think, at least, I'll speak for my hospital, it's critically important, though we have an employed physician base and though the employed physician base has turned from a liability even five or six years ago, to now a significant asset to developing the kinds of alignment strategies to really the kinds you want to develop to provide a high quality, low cost care, we know we have to expand on our medical perimeter.

We know we have to expand beyond the walls of our hospital and our health caneters. So we have to have vehiciales to acquire strategically physician practices that would help the support our hospital and diversify the services that we offer and hopefully help to augment our payer mix.

So you know, we don't have a lot money to do that and we don't have a lot of money to initially make investments that will initially lose money until hopefully they make money, but the reality is that you have to compete in that world because otherwise what's going to happen, is that the hospitals that are better endowed financially will simply buy up all of the competitive physician practices in any kind of external based referral.

And so from a competitive positioning standpoint, that's just not something you can permit to happen. We are

going to be capital challenged in that regard, so we just have to smart in that resource. Again, I don't want to say guess that that's representative of every safety-net hospital. They're all going to approach this differently.

But I can say that in mine where I am competing against the inquisitive hospital systems, even if for district defensive purposes, I have no choice but to do that, but in reality, what I've tried to do is be smart and strategic about it in order to position.

So I'll give you an example. There are a number of mental health providers, outpatient mental health providers, in my county who, for a number of different reasons, just because of state funding issues, are going to have a real hard time surviving three to five years in the future. It's also the case in Nassau, in my county, you don't have much by way of collocation of primary car and mental health services.

So my strategy is that we should be looking at these marginal mental health outpatient services that are going to go in the next couple of years. Try to see if we can leverage what resources I do have, in this case it's my cooperated federally qualified health center, try to leverage that as a resource and essentially expand out further into the community and wrap these mental health providers in and collocate primary care with ese mental health providers.

I've expanded my medical perimeter, I've brought more patients in. There's clearly a vulnerable population and a collocated primary care and mental health, so to me it's all of my strategic points and it's something that I need to do.

Now, that's an unconventional strategy that my competing systems are going to be going after, it's a strategy we would pursue, but then I also have to pursue a more conventional strategy of identifying some practices in the area that would help the augment and support my hospital and my primary care region, but again, I have to be targeted and selective in how I do it.

DEBORAH BACHRACH: I just want to make a quick point and it's a little bit off point, but I think the Medicaid expansion is going to have a tremendous impact on the mental health system, or the mental health and substance abuse system because in the vast majority of states, there's only limited behavioral health services being provided today under Medicaid and with the expansion and with the application of Mental Health Parity to Medicaid, this will change dramatically how mental health is delivered and the demand for it among low income populations, which, building off of Art's point, which is it's both an opportunity and a challenge we'll need for the safety net delivery system and little bit off point, but I think it's something that we'll hear increasingly more about.

SAK KUMAL: Hi, my name is Sak Kumal [misspelled?], I'm a public policy analyst here. It's a follow-up to the antitrust question. What kind antitrust clarity are you looking for? This is specifically to Art, that can help with your strategy for safety net hospitals and the second part to that is how much of this consolidation is based on the fact that the Part A schedule under Medicare is more stable than Part B?

ARTHUR GIANELLI: In terms of clarity, I meant that as a general point, but I am going to make it a specific example. The general point that I was trying to make is that there seems to be an inherent tension between a progressive body of law and of opinions and approaches by regulatory bodies relative to enhancing and improving competiveness amongst providers and the imperatives that I think are implicit and sometimes explicit in the Affordable Care Act and a number of the payment and delivery system reforms that are in the Affordable Care Act and that is you've really got to be integrated and coordinated as providers to really make those things work.

So, I just think, and it's a recognize, I just think that over the next few years, that tension's gotta play itself out and we've gotta understand that the greater good here may be an intensive amount of collaboration which may not

necessarily mean increased in competitiveness, but it may actually mean better results for patients.

So I think that this tension has to play itself out amongst a body of laws and regulations that have existed and now the new laws and regulations that have been propagated under the Affordable Care Act.

The specific example I'll give you, is, and this will play out in the Supreme Court, it'll be interesting how it does, that's an 11th Circuit decision relative to the use of state action and antitrust protection, and this particular case, it was basically if I understood it, it was a public authority, and this was without any kind of state parameter, it was a state public authority, essentially acquired the only one other hospital in a particular region, and I believe it was the FTC that indicated that they were concerned the anticompetitive effects of this and the view of the 11th Circuit was, well, in the statute, it says that this public authority could acquire hospitals, it must've been understood that they could acquire hospitals whether the word dozen or only one, and so the argument that this was somehow violative was wrong and that somehow state action has to prevail.

Well, that's going to be tested, I mean, that's going to go up the chain, but the federal government is making a case here that that's a problem. And maybe it is a problem, alright,

when you get into the details, but I think it's very important that this gets clarified because I think what's important on the provider levels, providers and states, but really providers understand what tools are available. In my particular case, state action and antitrust protection, I think is going to be critical.

I'm public authority, my board is appointed by the government. I'm not a membership corporation and I'm not a for-profit corporation, so ownership becomes an issue, but because I'm essentially a standalone public hospital, my managed care rates are abysmal and I cannot cross subsidized losses that I incur from other payers, so I have to figure out a strategy that would allow me as a non-owned or sponsored entity to still be able to be paid and I'm not suggesting to be paid grossly, I'm saying, get paid fairly for the work that I'm doing.

And the strategy that we've identified and is the only strategy that I think is available is a combination of clinical integration which isn't an acknowledged safe harbor with an overlay of state action and antitrust protection which would essentially allow us, as a non-owned entity with a major system in the area to have protected collaboration on quality strategy and managed care. I think that's a good strategy.

It's an untested strategy, so we're going in way in uncharted waters on this, but I think it's necessary in order for facilities that can't access capital and can't get the kinds of managed care rates that are necessary to be paid appropriately for the services that we provide, to be able to position themselves to be able to do that, it's still a preserve the public entity and still preserve the public mission.

ED HOWARD: Okay, that actually is a pretty good place to bring this discussion to a close. And while you're filling out, those of your who haven't done it already, the evaluation forms, let me just say that the Commonwealth Fund and Dr. Pam Riley have made a substantial contribution to the success of this conversation.

I want to thank them I want to thank you for staying with a very complicated set of topics within the general topic and ask you to help me thank the panelists for grappling with and subduing for the most part a whole range of questions in this area. Thank you very much.

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