The Impact of the American Health Care Act on Children's Hospitals: Preparing for the Road Ahead

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The first 105 days of the Trump Administration were an on-again off-again story of dismantling the Affordable Care Act (ACA).

While not a new challenge, the unaffordability of healthcare remains an important issue for consumers, employers and government at the federal and state levels alike. Throughout the campaign and early administration, Trump has promised to repeal “Obamacare” and he is now one step closer to dismantling the ACA after the recent passage of the American Health Care Act (AHCA) by the House. While there are still many unknowns and uncertainties of the next wave of healthcare reform, decreased funding for Medicaid will be a core component.

Throughout the debate these past few months, there has been little discussion about the impact of these potential spending cuts and programmatic changes on pediatric care. The underlying premise of the reductions would be to roll back Medicaid expansion and reduce spending on newly insured adults who previously did not have insurance — without any specific eligibility implications for children. However, the sheer magnitude of expected funding cuts, coupled with the shift in responsibility to states that will exhibit variability in how they respond, increase the likelihood of consequences for children who need care. For children's hospitals, which disproportionately serve these children, there are a handful of options for how to react to the likely changes ahead.

Children’s Hospitals’ Reliance on Medicaid

In March, the Congressional Budget Office (CBO) estimated that nearly 14 million Americans on Medicaid would lose their insurance by 2026 under the AHCA with the Federal Government reducing outlays to states for Medicaid by $880 billion over the next decade. Underlying this reduction in Medicaid spending are fundamental policy changes.
While Republicans revised the bill to ensure House passage on May 4 and revised estimates are not available from the CBO, the latest version still includes a significant overhaul of Medicaid, and industry estimates suggest that reductions in funding will be substantial. Medicaid is currently viewed as an entitlement with a minimum standard of benefits for poorer Americans to ensure they have access to a range of healthcare services. With the changes defined in the AHCA, the Federal Government would provide funding to states based on a per capita cap (or a state option to take a block grant for a period of 10 years), transforming the program and effectively limiting the federal exposure to spending growth. In addition, there would be an increased emphasis on the state’s role and authority on how funding should be spent for Medicaid.

Many states will need to reduce enrollment, benefits or reimbursement rates for children insured through Medicaid. States may or may not pursue explicit changes to children's eligibility criteria, but any changes in benefits coverage that have the impact of reducing enrollment would result in an immediate impact to children's health. With anticipated state budget pressures, states may also have to consider payment rate reductions. While a change in rates may maintain child enrollment, many physicians and other providers will limit access for lower paying patients or refuse to see them at all.

Finally, there may be other implications for children’s insurance coverage. It has been shown through several studies that children of uninsured parents often become uninsured themselves, even if they are eligible for coverage.

In 2017, there are two important realities to Medicaid and CHIP funding for children. First, while only approximately one-fifth of Medicaid spending is for children, about half of Medicaid and CHIP enrollees are children, even following Medicaid expansion for lower income adults in many states. In February 2017, 35.9% of the 74.5 million Medicaid and CHIP enrollees were children.

**Figure 1: Child Enrollment as a Percentage of Total Medicaid/CHIP Enrollment**

Medicaid and CHIP Cover Children More than Any Other Demographic

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35.9% of the 75.4 million Medicaid and CHIP enrollees were children.
Second, more than half of children’s hospitals’ patients are insured by Medicaid, and this figure has been increasing steadily for nearly a decade. Our nation’s children’s hospitals have become increasingly dependent on Medicaid as their primary payor. Given these realities, it is nearly certain that a meaningful reduction in Medicaid funding will reduce access, coverage and payments for children’s services.

Options for Children’s Hospitals in Response to the AHCA

Assuming there is a Federal reduction in funding for Medicaid and that states will not be able to compensate on their own, children’s hospitals will need to respond to anticipated Medicaid reimbursement constraints in one of two ways:

- Change Their Patients
- Change Their Care Delivery Model
Option 1: Change the Patients
Children's hospitals could respond to potential Medicaid funding cuts by seeking more volume — or revenue — from commercially insured children. However, growing commercial market share and reimbursement will be very difficult for many children's hospitals because they have already expanded their ambulatory and facility networks in their attractive nearby geographies. Many children's hospitals are already optimizing their commercial market share. Additionally, children's hospitals will be challenged to raise commercial rates to compensate for Medicaid reductions because many children's hospital and health plan leaders believe that reimbursement rates are already pushing up against a ceiling. If children's hospitals raise commercial rates further, it may result in other health systems expanding their pediatric programs to intensify competition with children's hospitals.

If children's hospitals have difficulty growing commercial business and income, perhaps they can decrease Medicaid exposure by reducing care for Medicaid insured children. While children's hospitals could limit Medicaid patients in their pediatrician or specialty physician panels and relocate their ambulatory services from lower to higher income geographic areas to ration Medicaid services, these efforts would defy their missions. Nearly all children's hospitals have a commitment to serve all children in their service areas, regardless of payor mix. Rationing care for Medicaid insured children might be considered if rate reductions are severe, but clearly it will be a last resort.

Option 2: Change the Care Model
Assuming they will not change their patient bases sufficiently to compensate for potential Medicaid reductions, children's hospitals will need to evolve their care models. There are three mutually reinforcing strategies children's hospitals should consider to meet the financial realities of the future.

Mutually Reinforcing Strategies
- Reduce the Cost Base
- Implement New Care Models
- Pursue Global Budget Payment Models

The particular focus and emphasis that children's hospitals place on each of these three strategies should depend on the unique set of circumstances they face in regard to competitive landscape, state economics, current cost position and the strategic direction of their organizations.
1. Reduce the Cost Base – Many children’s hospitals have and continue to focus on optimizing their cost base.

Using advanced provider profiling and business intelligence, children’s hospitals will need to further reduce costs by tackling the more challenging drivers of costs, such as:

- Reducing variability of care across their portfolio of providers;
- Eliminating unnecessary care and activities, such as less valuable or non-value added diagnostics;
- Ensuring care team members are operating at the top of their licenses; and
- Shifting care to lower cost settings in collaboration with partners (e.g., Federally Qualified Health Centers) and exploring new care modalities (e.g., virtual care) to offer convenient, accessible care at a lower cost.

2. Implement New Care Models – Many children’s hospitals have begun piloting new models of care oriented towards managing health.

Children’s hospitals will need to accelerate design of these interventions and rapidly implement them to address total cost of care for Medicaid patients. These new models have the potential to sustainably address costs by reducing unnecessary emergency department (ED) visits and patient days. Across the country, these interventions have been effective for:

- Highly prevalent chronic conditions (e.g., asthma and diabetes);
- Infants who spend significant time in the neonatal intensive care unit (NICU);
- “Medically complex” children living with multiple, severe health conditions; and
- Patients who are living with a combination of mental and physical health conditions.

Inherent in the success of these models is the ability to address the social determinants of health — which may account for as much as 80% of health outcomes. While most children’s hospitals are already very connected in the communities they serve, innovative care models must integrate non-clinical resources as key members of the care team. In some instances, new business models and formalization of partnerships may be helpful to provide the appropriately integrated care required to more effectively manage the health of these vulnerable populations.

For example, children that receive sufficient asthma education, have a second inhaler at school with a nurse that is knowledgeable about their condition, and live in houses where the vents are cleaned, mold is eliminated and pests are controlled, will routinely see fewer ED visits and hospital admissions. Achieving innovative care models requires more than the clinical care team. It requires partnership with schools and coordination with housing and other social services.
3. Pursue Global Budget Payment Models – Children’s hospitals will also need to evolve their reimbursement models, in parallel, towards global budget payment models.

If children’s hospitals are successful with their new population health models described in the previous section, they will significantly reduce their fee-for-service payments. Investing time, effort and resources to achieve population health goals under the current fee for service model would result in continued Medicaid losses, just with a lower cost base. To be successful, children’s hospitals will also have to transition to global budget payment models. This is the only way children’s hospitals will be rewarded for their population health achievements and ensure sufficient funding for preventive and ambulatory services. By assuming responsibility for the health and costs of children, children’s hospitals can better deploy available Medicaid funds to care for children in the ambulatory setting, addressing both clinical and social determinants of health before conditions are exacerbated and require acute care resources. In many markets, this transition will require children’s hospitals to pursue deliberate and concentrated efforts with payors to transition to new payment models.

As the debate on the next wave of healthcare legislation moves on from the House and into the Senate, significant uncertainty remains. Yet irrespective of the specific changes to come, children’s hospital reimbursement is at risk. Children’s hospitals will have to wrestle with and balance these strategies and interventions to sustain performance and uphold their commitments to serve all children — regardless of income.
Sources


3 The Chartis Group Research.


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