URBAN Safety-Net Hospitals in the U.S. Today

Part One in a Series:

Financial Challenges to Urban Hospitals

The National Association of Urban Hospitals
January 2009

Introduction

The U.S. today has a vast, multi-part health care safety net. Among the major participants in this safety net are public hospitals and children's hospitals; federally qualified health centers and other government-sponsored clinics; sole-community, Medicare-dependent, and critical access hospitals; and others.

Urban safety-net hospitals, too, are a vital part of this health care safety net. These private, non-profit institutions are key providers – and often, the providers of last resort – for many uninsured, low-income, and Medicare- and Medicaid-dependent residents of urban areas throughout the country. Without urban safety-net hospitals, millions of Americans would have very limited access to quality health care.

In this brief paper, the National Association of Urban Hospitals (NAUH) reintroduces the concept of the urban safety-net hospital, describes why these hospitals are such a vital part of the American health care safety net, and presents some of the challenges these hospitals face in the current policy environment. NAUH also outlines the financial challenges that confront these hospitals because of the patients they serve and the manner in which they are paid to serve them.

Urban Safety-Net Hospitals Defined

NAUH classifies hospitals as "urban safety-net hospitals" based on five criteria:

1. Urban safety-net hospitals are *private* hospitals.

Public and private hospitals are different in very fundamental ways, and NAUH believes that the designation "urban safety-net hospital" must recognize and reflect these fundamental differences. Public hospitals are an important part of the health care safety net, but their situation differs significantly from that of private hospitals. Public hospitals typically receive considerable financial support from their state and/or local government; they exist primarily to provide free care to the uninsured, and the additional funding they receive to subsidize this work often has a statutory basis. Private hospitals, on the other hand, while often working side-by-side with public hospitals and serving the same communities, have no such statutory entitlement to supplemental state or local funds and therefore must be viewed separately from public hospitals.

2. Urban safety-net hospitals are *non-profit* hospitals.

The mission of urban safety-net hospitals is to serve their communities, not to make money for shareholders. Any surpluses they generate are reinvested in operations, improvements, their communities, and the subsidization of care for the poor rather than for the benefit of shareholders.

3. Urban safety-net hospitals are located in *urban areas as defined by Medicare.*

4. A *minimum of 15 percent* of urban safety-net hospitals' patients are insured by *Medicaid.*

NAUH believes that serving this level of Medicaid patients signifies that low-income patients constitute the heart of a hospital's service community and make it a safety-net provider.

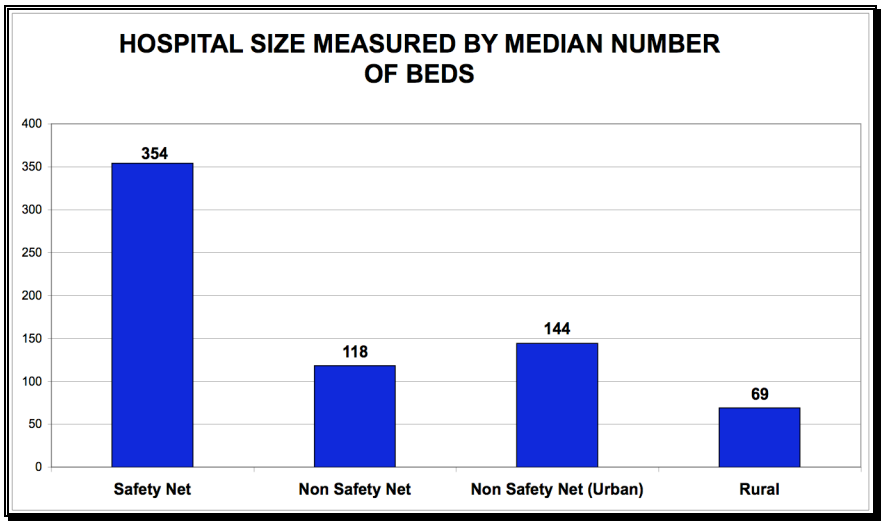
5. Urban safety-net hospitals have *more than 200 beds.*

Large hospitals have a much greater impact on their communities than small hospitals. Consequently, threats to the financial well-being of larger hospitals have more serious implications for the communities they serve.

Based on the most recent data available, more than 400 hospitals in the U.S. today meet these five criteria and are true urban safety-net hospitals.

A Closer Look at Hospital Size

While NAUH defines urban safety-net hospitals as those that meet its other criteria and have at least 200 beds, the median size of urban safety-net hospitals is 354 beds.



As this graph shows[1], urban safety-net hospitals are, as a group, much larger than other types of private hospitals.

With a median size of 354 beds, urban safety-net hospitals are:

- **more than twice as large** as private urban hospitals that are not safety-net hospitals;
- **three times as large** as the median private non-safety-net hospital; and
- **more than five times larger** than the median private rural hospital.

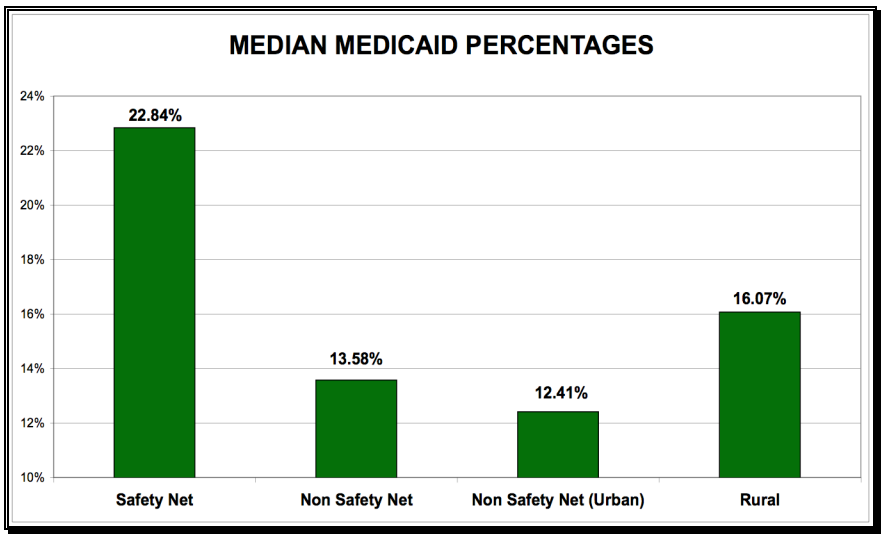
In fact, the smallest urban safety-net hospitals are larger than the median-sized hospital in all three other groups.

[1] The three graphs in this study were developed using four data sources: Medicare cost reports for the FY 2006 cost reporting period; the Medicare September 2008 Impact File; the Medicare October 2008 Provider Specific File; and the Medicare December 2008 Hospital Provider ID Information File. All are produced by, and available from, the Centers for Medicare & Medicaid Services (CMS) on the CMS web site (www.cms.hhs.gov).

NAUH views this as an important distinction. Except in the case of rural hospitals, NAUH believes that larger hospitals are, in general, more important to the lives of their communities than smaller hospitals. They serve more patients; because of their size, they often offer a wider array of services than smaller hospitals – including services that frequently are in greater demand among patients in vulnerable populations, such as neonatal intensive care, trauma care, pediatric intensive care, HIV/AIDS services, psychiatric care, and substance abuse services; and if they were to fail, their closure would leave a much larger void in their community. Most urban safety-net hospitals are tertiary-care hospitals as well – hospitals to which smaller providers frequently send their more complex cases for a higher level of care than is typically available in a smaller community hospital. Also, in an era of constant hospital consolidations, larger hospitals are more likely to survive such consolidations and continue offering acute-care services whereas smaller hospitals are more likely to be absorbed by larger institutions and converted to other uses that result in a loss of access to acute hospital care in the communities in which they are located.

Service to Medicaid Patients

As noted previously, more than 15 percent of a hospital's patients must be insured by Medicaid for that hospital to qualify for urban safety-net hospital status.



As this graph illustrates, urban safety-net hospitals serve a higher proportion of Medicaid patients than any other group of private hospitals in the U.S. today. In fact, the median Medicaid patient load of safety-net hospitals is almost twice that of non-safety-net hospitals.

These figures are significant for several reasons.

Medicaid Pays Less Than Cost

Medicaid generally pays poorly for the care its beneficiaries receive. In most states, Medicaid reimburses hospitals for less than the cost of the care they deliver. This means that the more Medicaid patients a hospital serves, the more money it loses – and as the graph above illustrates, urban safety-net hospitals care for more Medicaid patients than any other type of private hospital and therefore can be expected to lose more money doing so than those other hospitals.

The degree of Medicaid underpayment to hospitals can be striking. Because Medicaid is a state-federal partnership, states have considerable latitude to determine their own payment policies, so the adequacy of Medicaid payments – and the extent of Medicaid underpayments – varies from state to state. In Pennsylvania, for example, Medicaid payments are generally thought to cover about 80 percent of hospital costs[2]; in Wisconsin, less than 50 percent[3]; in Nevada, about 70 percent[4]; and in Minnesota, about 77 percent[5]. A December 2008 study commissioned by the American Hospital Association, the Blue Cross Blue Shield Association, and others concluded that in 2006, state Medicaid programs paid hospitals $10.7 billion less than the costs those hospitals incurred caring for their Medicaid patients.[6] It is reasonable to conclude that urban safety-net hospitals, because they care for more Medicaid patients than any other type of private hospital, shoulder much of this payment shortfall.

Caring For the Uninsured

It also seems reasonable to conclude that communities with large numbers and high proportions of Medicaid recipients also have large numbers and high proportions of uninsured residents. Consequently, NAUH believes that if urban safety-net hospitals serve more Medicaid patients than all other types of private hospitals, they also most likely serve more uninsured patients and provide far more uncompensated (charity) care than other private hospitals.

Medicare Beneficiaries and Bad Debt

Urban communities that have large numbers and high proportions of Medicaid recipients and uninsured residents also are highly likely to have large numbers and high proportions of low-income seniors who are Medicare beneficiaries. While Medicare provides extensive health care benefits to the nation's seniors, it also requires those seniors to make co-payments and reach deductibles for those services. Many low-income seniors cannot afford such payments, leaving hospitals with debts they cannot collect.

Historically, Medicare reimbursed hospitals for all of this bad debt, but since enactment of the Benefits Improvement and Protection Act of 2000, it reimburses hospitals for only 70 percent of their Medicare bad debt. Since then, hospitals have witnessed several attempts to reduce Medicare bad debt reimbursement even further – such as the Bush administration's FY 2007 proposal to phase out all Medicare bad debt reimbursement. In the meantime, the financial burden for the reduction in Medicare bad debt reimbursement enacted nine years ago has fallen most heavily on urban safety-net hospitals, leaving them with less – and in many cases, much less – Medicare revenue than Congress anticipated when it changed Medicare's bad debt reimbursement policy nearly nine years ago.

[2] The Lewin Group, "An Analysis of Pennsylvania Medical Assistance Payments as it Relates to the Financial Health of Pennsylvania Hospitals," prepared for the Pennsylvania Legislative Budget and Finance Committee, March 2001.

[3] Wisconsin Hospital Association, "Report Shows Cost-Shifting Major Component of Rising Health Care Costs," news release, June 30, 2008.

[4] Cy Ryan, "Medicaid reductions hit hospitals," *Las Vegas Sun*, September 5, 2008.

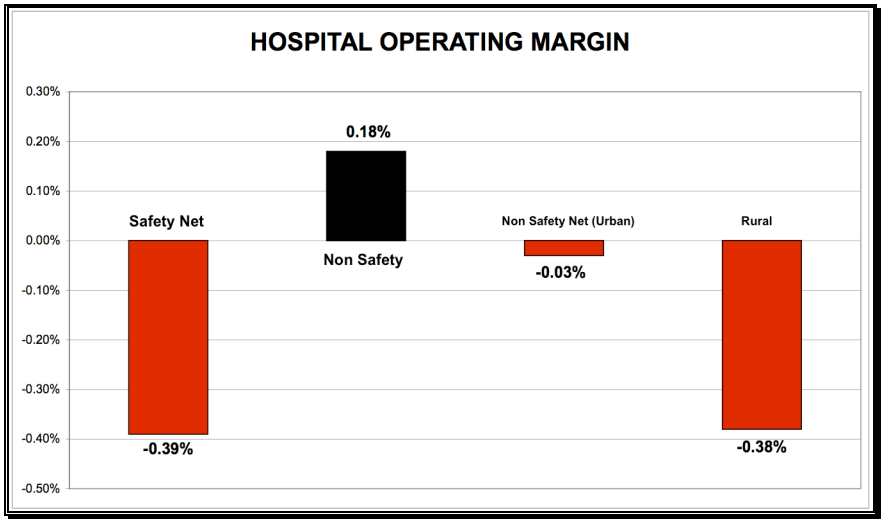
[5] "Fact Sheet: Medicare & Medicaid," Minnesota Hospital Association, 2008.

[6] Will Fox and John Pickering, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman, December 2008, p. 5.

How it All Affects the Bottom Line: Hospital Operating Margins

One of the most widely used measures of hospital financial performance is operating margin, which is the difference between a hospital's patient revenue and its operating expenses divided by its patient revenue. Caring for so many Medicaid, uninsured, and low-income Medicare patients takes an unmistakable financial toll on urban safety-net hospitals – a toll that can be seen on their bottom line: their operating margin.

The following graph shows the operating margins of all types of private hospitals in the U.S.



The median operating margin for urban safety-net hospitals is lower than that of any other group of private hospitals: -0.39 percent. In fairness, it must be noted that this median margin is lower than that of rural hospitals as a group by only the slimmest of amounts: rural hospitals have a median operating margin of -0.38 percent.

These figures compare unfavorably with those of other private hospital groups. Urban hospitals that are not safety-net hospitals have a median operating margin of -0.03 percent. Nationally, non-safety-net hospitals have a positive median operating margin: +0.18 percent.

Within the hospital industry, experts believe that hospitals need operating margins of at least +4.0 percent to operate effectively. Simply covering costs is not enough for hospitals because it does not provide resources to upgrade technology, replace outdated equipment, renovate aging facilities, invest in information technology, and remain competitive with nearby hospitals located in areas with fewer low-income patients. By this barometer, no group of private hospitals in the U.S. today is performing at a financially desirable level – but among such hospitals, urban safety-net hospitals, along with their rural counterparts, are clearly performing at the worst level.

It is clear, moreover, that government is a major cause of this problem. According to the December 2008 study commissioned by the American Hospital Association, the Blue Cross Blue Shield Association, and others, the collective margins of all hospitals for the care they provided to their

Medicare patients in 2006 was -9.4 percent and for their Medicaid patients was -14.7 percent.[7] Caring for more such patients than any other private hospitals, the figures for urban safety-net hospitals are undoubtedly even worse.

Conclusion

In recent years, the administration, Congress, and the Medicare Payment Advisory Commission (MedPAC) have all generally focused on revising federal health care reimbursement practices in ways that benefit rural hospitals. This effort appears to have been based, in large measure, on their belief that current reimbursement practices treat rural hospitals unfairly and jeopardize the ability of those hospitals to serve their communities. MedPAC also has suggested that some urban hospitals are overpaid for their efforts and has considered possible measures to reduce payments to those hospitals.

Rural hospitals do, in fact, face considerable challenges in their efforts to meet the needs of their communities. As the data and conclusions presented in this brief report suggest, however, urban safety-net hospitals face challenges that are just as great – and probably even greater. Their needs, too, merit more careful consideration by the new President, the new Congress, and MedPAC.

■ ■ ■

For further information about the data presented and views expressed in this paper, please contact Ellen Kugler, Esq., NAUH's executive director, at ellen@nauh.org or 703-444-0989.

[7] Fox and Pickering, "Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," p. 5.

National Association of Urban Hospitals
21351 Gentry Drive, Suite 210
Sterling, VA 20166
(703) 444-0989
(703) 444-3029 (fax)
www.nauh.org