National Association of Public Hospitals and Health Systems

30 YEARS

Transforming American Health Care

Research Brief

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2009 Annual Survey: Safety Net Hospitals and Health Systems Fulfill Mission in Uncertain Times

Despite an economic downturn and political uncertainty about the future of the U.S. health care system, safety net hospitals continue to fulfill critical roles in their communities according to results from the National Association of Public Hospitals and Health Systems (NAPH) 2009 Annual Hospital Characteristics Survey.

Once again, NAPH members deliver the wide range of crucial community-wide services—including trauma care, emergency response, neonatal intensive care, and disease and injury prevention—that make these facilities a principal part of our nation's health care infrastructure.

A number of factors distinguish safety net providers from other hospital systems:

- They treat all patients regardless of ability to pay—offering millions of uninsured and underinsured individuals and families access to care.
- They provide services needed by the entire community, including trauma and burn care, neonatal intensive care, and psychiatric emergency care, to name a few.
- They serve as first receivers in times of crisis and disaster, both natural and man-made, and they coordinate services with first responders and public health departments in their communities.

Whether serving as a medical home for families, providing lifesaving trauma or burn care, managing chronic conditions or delivering babies, public hospitals maintained their mission to provide care to all in 2009. Even though America depends heavily on the special mission of its public hospitals and health systems, those same hospitals are facing important challenges:

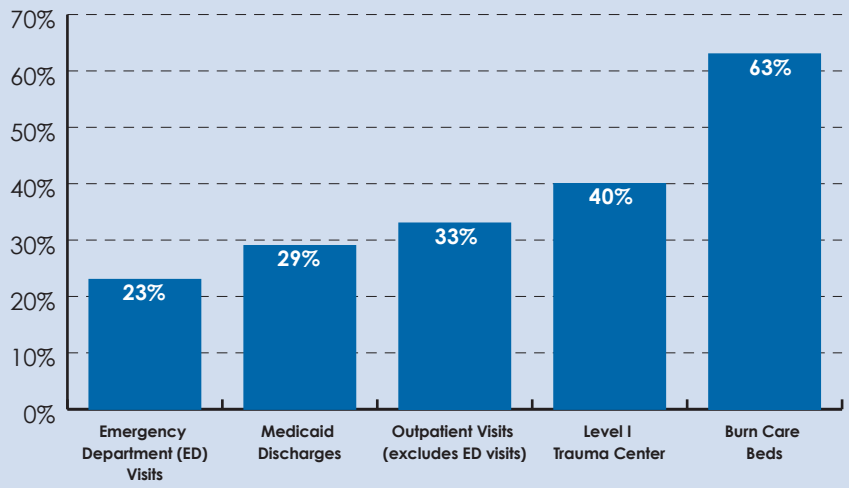
- High levels of unemployment nationally due to the economic slowdown have eroded employer-sponsored insurance coverage, leaving more than fifty million Americans without health insurance.[1] For many of the uninsured, public hospitals and health systems are their only option for essential medical care needs.
- New financial pressures loom due to potential cuts to critical sources of safety net financing such as Medicaid disproportionate share hospital (DSH) payments.

NAPH has published its 2009 Hospital Characteristics Survey results at www.naph.org, offering an in-depth analysis of the types of services member hospitals provide, the communities they serve, and the financial challenges they face. This research brief reports on key findings from the study.

Critical Roles of Public Hospitals

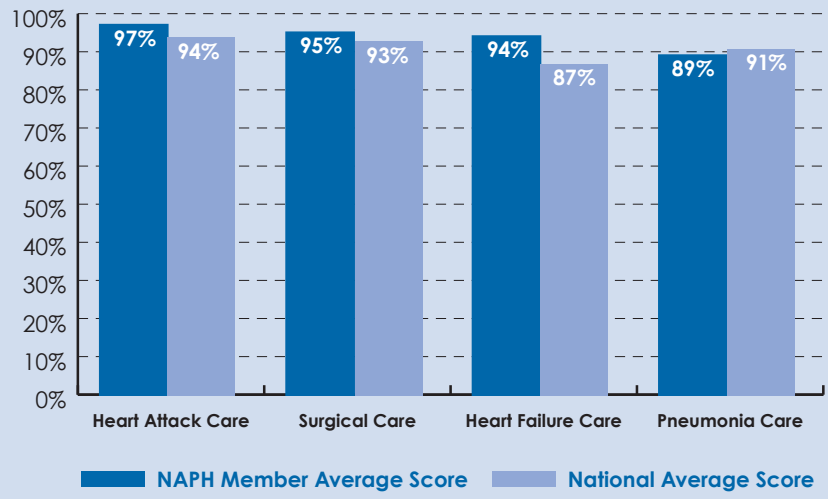
Public hospitals are a crucial component of the nation's safety net infrastructure. In 29 communities—

FIGURE 1 Percentage of Services Provided by NAPH Members in the 10 Largest U.S. Cities, 2009



SOURCE AHA Annual Survey of Hospitals, 2009.

FIGURE 2 NAPH Member Average & National Average Summary Performance Scores on *Hospital Compare* Core Measure Data, 2009



SOURCE Analysis of data downloaded from The Commonwealth Fund's Why Not The Best Website on November 8, 2010.

including Albuquerque, Las Vegas, Memphis, Richmond, and San Francisco—NAPH members are either the only Level I trauma center or the only trauma center of any level.

Most NAPH members maintain close ties with their local health departments, and a significant number are responsible for public health services in their communities. In several major cities across the country, including Cambridge, Denver, Los Angeles, and San Francisco, as well as in counties like Cook County in Illinois and Contra Costa County in California, the public hospital is integrated with the local public health department.

NAPH members play a leading role in efforts to improve the health status of the communities they serve. They have established programs to provide immunizations, address teen pregnancy and low birthweight, prevent violence and injury, and provide mammography and other cancer screenings. Within their communities, NAPH members perform a significant amount of adult and teen outreach, crisis prevention, reproductive health services and education, and dental care.

In an analysis of the ten largest U.S. cities, NAPH members represent only 12 percent of local acute care hospitals, but provide a disproportionate share of critical services (see Figure 1).[2] Specifically, NAPH member hospitals provide 23 percent of the emergency department visits and 33 percent of non-emergency outpatient visits. As major providers of trauma care, public hospitals represent 40

percent of Level I trauma providers and 63 percent of the burn care beds available to treat the critically injured in these cities. Moreover, illustrating their importance in providing care to low-income patients, NAPH members are responsible for 29 percent of Medicaid discharges in these major metropolitan areas.

Because of their leading role as providers of emergency, trauma and burn care services, public hospitals have long been first-receivers for catastrophes such as chemical spills, fires, disease outbreaks, and natural disasters. As an extension of these responsibilities for emergency preparedness, public hospitals now play an important role in ensuring homeland security. Their duties include working with local governments, health departments, and first responders like police, fire, and emergency services to coordinate communication and response in the event of a natural or man-made disaster. NAPH members also play a leading role in trauma research and education.

High Quality Care

While providing a wide scope of services to their communities, NAPH members maintain high standards in the delivery of key medical services. The result is care that is not only accessible but high quality.

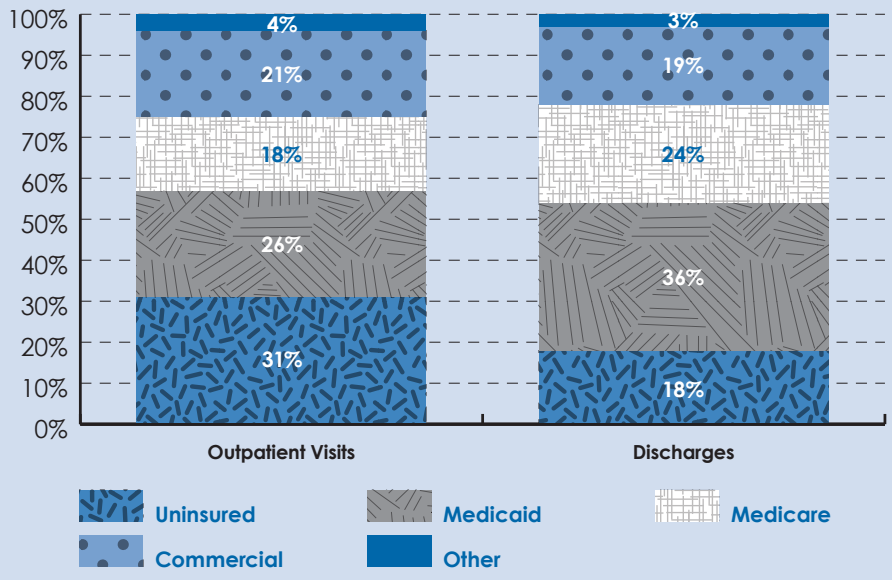
Data from The Commonwealth Fund indicate that public hospitals perform well when evaluated on measures of health care quality (see Figure 2). In an analysis of four clinical areas using summary performance scores, the average NAPH member provided appropriate care more often than other hospitals nationally for heart attack and heart failure patients, as well as for patients who had surgical procedures.[3] NAPH members performed slightly lower, on average, than other hospitals nationally on the measure for pneumonia care.

Serving Vulnerable Populations

Safety net hospitals treat all patients regardless of ability to pay. As a result, NAPH member hospitals and health systems provide high volumes of care to low-income and uninsured individuals. Figure 3 shows that the majority of patients served by NAPH members in 2009 were uninsured or low-income; more than half of all discharges and outpatient visits were either for uninsured patients or for those covered by Medicaid. Furthermore, 31 percent of ambulatory care services—compared to 18 percent of inpatient services—were provided to patients who were uninsured.

In total, NAPH members reported more than 50 million outpatient visits in 2009, an average of more than 580,000 per member. This extraordinary amount of ambulatory care is poorly reimbursed because reimbursement rates for outpatient services tend to be lower than the actual cost of services delivered. Given that such a high percentage of the ambulatory care administered by member hospitals

FIGURE 3 **Outpatient Visits and Discharges at NAPH Member Hospitals and Health Systems, by Payer Source, 2009**



SOURCE NAPH Hospital Characteristics Survey, 2009.

are for the uninsured, little or no payment is received for a large portion of the outpatient services provided.

As a consequence of providing high volumes of inpatient and outpatient care to low-income patients, NAPH members historically have reported high levels of uncompensated care as a percent of total costs. Member hospitals represent only two percent of the acute care hospitals in the country but account for 20 percent of uncompensated hospital care costs nationally (see Figure 4). Sixteen percent of NAPH member hospital costs are uncompensated—almost three times the national average of six percent for all other types of hospitals.[4]

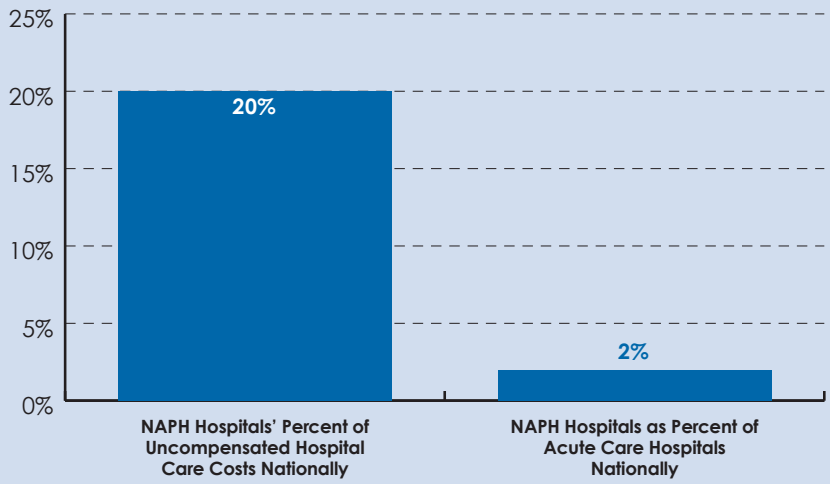
In addition to the uncompensated care for which no payment is received, NAPH members often find that base payments for services provided to many of those under Medicare and Medicaid do not cover the full costs of providing their services. Taken together, these total losses on patients are considered "unreimbursed care."

A Vital Need for Government Support

Unreimbursed care costs present a significant burden to public hospitals but local, state, and federal support helps ensure that these providers are able to fulfill their critical roles within their communities and the nation.

Figure 5 illustrates that the state and local payments NAPH members received in 2009 financed 32 percent of the unreimbursed care they provided. In addition, sources such as

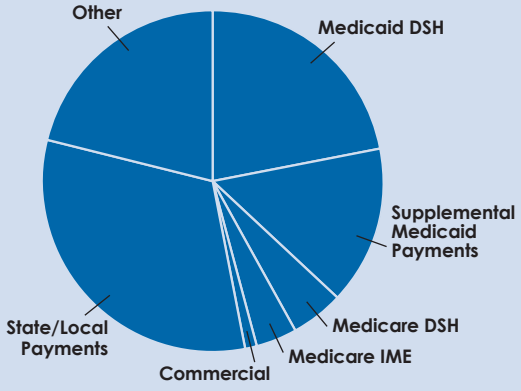
FIGURE 4 NAPH Hospitals' Share of Uncompensated Care Costs Nationally



SOURCES NAPH Hospital Characteristics Survey 2009, AHA Annual Survey of Hospitals 2009, and AHA Uncompensated Care Cost Fact Sheet, December 2010.

FIGURE 5 Sources of Financing for Unreimbursed Care, 2009

Medicaid DSH	22%
Supplemental Medicaid Payments	15%
Medicare DSH	5%
Medicare IME	4%
Commercial	1%
State/Local Payments	32%
Other	21%



SOURCE NAPH Hospital Characteristics Survey, 2009.

Medicaid disproportionate share hospital (DSH) payments and supplemental Medicaid payments (also referred to as "upper payment limit," or UPL, payments), which are intended to reduce the shortfalls accrued by treating Medicaid patients and to partially subsidize care for the uninsured, covered 22 and 15 percent of unreimbursed care respectively. Medicare DSH and IME (indirect medical education) payments combined to provide nine percent of financing for unreimbursed care. Revenues unrelated to patient care—which can include interest and investment income, cafeteria and parking revenues, medical record fees, sales tax, tobacco settlement monies, and rental income—covered 21 percent of losses from patient care. NAPH members financed the remaining one percent of their unreimbursed costs through cost shifting from commercial payers.

As with funding to offset unreimbursed care, government payments are primary contributors to the overall revenues of NAPH members: 68 percent of net revenues for NAPH member hospitals come from Medicaid, Medicare, and state and local governments (see Figure 6).

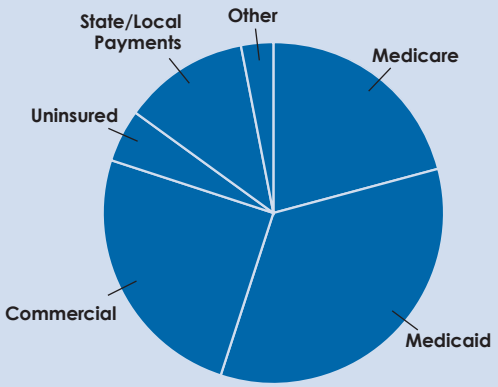
According to the data, Medicaid remained the single most important source of financing for NAPH members, accounting for 35 percent of total net revenues. Critical components of Medicaid revenues were Medicaid DSH and other supplemental Medicaid payments (UPL). Without Medicaid DSH and UPL payments, NAPH members would have lost $3.2 billion on the care of Medicaid patients in 2009.

Data on hospital margins further underscores the importance of government support for safety net hospitals. The average margin for NAPH members in 2009 was 2.5 percent—lower than the average margin of 5.0 percent for all U.S hospitals (see Figure 7). Without

In total, NAPH members reported more than 50 million outpatient visits in 2009, an average of more than 580,000 per member.

FIGURE 6 | **Net Revenues by Payer Source at NAPH Members, 2009**

Medicare	21%
Medicaid	35%
Commercial	25%
Uninsured	4%
State/Local Payments	12%
Other	3%



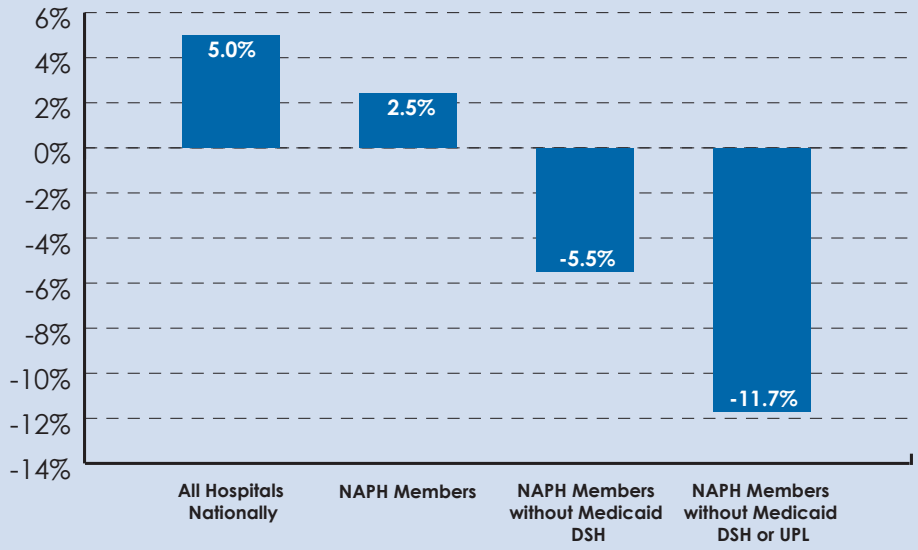
SOURCE NAPH Hospital Characteristics Survey, 2009.

the critical support of Medicaid DSH, the overall NAPH member margin would have dropped to -5.5 percent. Without UPL payments, the average margin would have dropped even further, to -11.7 percent.

An Investment in the Future

Given the vital mission of these institutions—the wide scope of services and high quality of care they provide, even while operating on small margins—investing in America's public hospitals and health systems is in the best interest of the nation and its communities. In fact, public hospitals are well equipped to succeed during this time of transition. As health reform moves from policy to implementation, health care providers nationwide will need to adapt to new conditions and requirements. Passage of the Patient Protection and Affordable Care Act has resulted in new requirements in areas such as delivery system improvement for health care providers including public hospitals.

FIGURE 7 Hospital Margins, 2009



SOURCE NAPH Hospital Characteristics Survey, 2009 and AHA Hospital Statistics, 2009.

With their extensive community networks and ambulatory care centers, however, many NAPH members have the capacity to improve the efficiency of their care delivery. In a number of cases, members have highly integrated systems already in place. True success, though, will entail all public hospitals progressing towards the transformation envisioned for hospital systems under reform. This means providing sufficient funding support to develop the essential infrastructure for efficient care delivery while maintaining the ability of public hospitals to provide critical services, such as trauma and burn care, upon which their communities depend. ■

Notes

1. U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009.* Data released September 2010. Table 8. People With or Without Health Insurance Coverage by Selected Characteristics: 2008 and 2009.

2. The analysis is based on the ten largest cities based on data presented in US Census Bureau: Table 1: Annual Estimates of the Population for Incorporated Places >100,000 (July 1, 2010). These cities include New York City, Los Angeles, Chicago, Houston, Phoenix, Philadelphia, San Antonio, San Diego, Dallas, and San Jose.

3. Using core measure data, summary performance scores are calculated for each hospital for each of the following four conditions: Heart Attack Summary Score—composite of seven process-of-care core measures for this condition; Surgical Care Improvement Summary Score—composite of seven care processes used to prevent surgical infections; Heart Failure Summary Score—composite of four process-of-care core measures for this condition; Pneumonia Summary Score—composite of six process-of-care core measures for this condition. The summary score is the number of times a hospital performed the appropriate action across all core measures for that condition, divided by the number of opportunities the hospital had to provide appropriate care for that condition. Scores are not weighted, except that measures with larger denominators contribute more weight to the calculation of the mean for that measure. Hospitals with fewer than thirty patients reported for a particular measure were excluded from the measure summary.

4. National figure is reported in AHA Uncompensated Hospital Care Cost Fact Sheet, December 2010.