National Association *of* Public Hospitals *and* Health Systems

ResearchBrief

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1301 Pennsylvania Avenue, NW, Suite 950
Washington, DC 20004

202 585 0100 tel / 202 585 0101 fax
www.naph.org

Larry S. Gage / PRESIDENT
Christine Capito Burch / EXECUTIVE DIRECTOR

2007 Annual Survey Results Highlight the Importance of the Nation's Safety Net Hospitals and Health Systems

Results from the National Association of Public Hospitals and Health Systems (NAPH) annual membership survey indicate that safety net hospitals continue to fulfill critical roles in their communities. Public hospitals carried out their mission to provide high quality health care services to the uninsured and the underserved, ensuring these individuals' access to the medical services so important for lifelong health and well-being. NAPH hospital systems deliver a 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.

Safety net hospital systems distinguish themselves from other hospital systems in many ways, but primarily because:

- They treat all patients regardless of ability to pay—meaning that millions of uninsured and underinsured individuals and families have access to care.
- They treat large numbers of those considered to be among the most medically vulnerable, including the elderly, low-income children and families, and those with chronic illnesses such HIV/AIDS, mental illness, diabetes, and asthma.
- They provide services needed by the entire community, including trauma and burn care, neonatal intensive care, and psychiatric emergency care, among others.
- Public hospitals serve primary roles 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 life-saving trauma or burn care, managing chronic conditions or delivering babies, public hospitals maintained their mission to provide care to all in 2007. Even though America depends heavily on the special mission of its public hospitals and health systems, those same hospitals are facing a number of challenges, putting that mission at risk. Here are a few of the issue NAPH members face:

- Economic factors and shrinking coverage under employer-sponsored health plans leave more than 45 million Americans without health insurance. For many of these uninsured, public hospitals and health systems are their only option for their essential medical care needs.
- Federal and state budget pressures threaten funding for public health care programs.
- Bioterrorism and other public health threats have required public hospitals to make investments in emergency response and preparedness. Many public hospitals have had to make capital investments to comply with regulatory requirements. Safety net hospitals have had to respond to new privacy, patient safety, and quality reporting regulations that

require significant investments in systems and other equipment.

A recent study published by NAPH[1] documents, in detail, the challenges facing the nation's safety net hospitals. This *Research Brief* reports on the key findings from the annual NAPH hospital characteristics survey. The full report is available for download from the NAPH website (www.naph.org).

1. NAPH members continue to fulfill their safety net mission by providing high levels of uncompensated care.

As providers of high volumes of care to low-income patients, NAPH members have had historically high levels of uncompensated care as a percent of total costs. NAPH hospitals represent only two percent of the acute care hospitals in the country but provide 21 percent of the uncompensated hospital care provided across the nation (see Figure 1). Seventeen percent of NAPH member hospital costs are uncompensated, almost three times the national average of 5.8 percent for all other types of hospitals.

2. Government support is critical to the financial viability of public hospitals.

Because of the level of unreimbursed care they provide, NAPH members rely on government funding sources in ways that other hospitals do not: 67 percent of net revenues for NAPH member hospitals comes from Medicaid, Medicare, and state and local governments (see Figure 2).

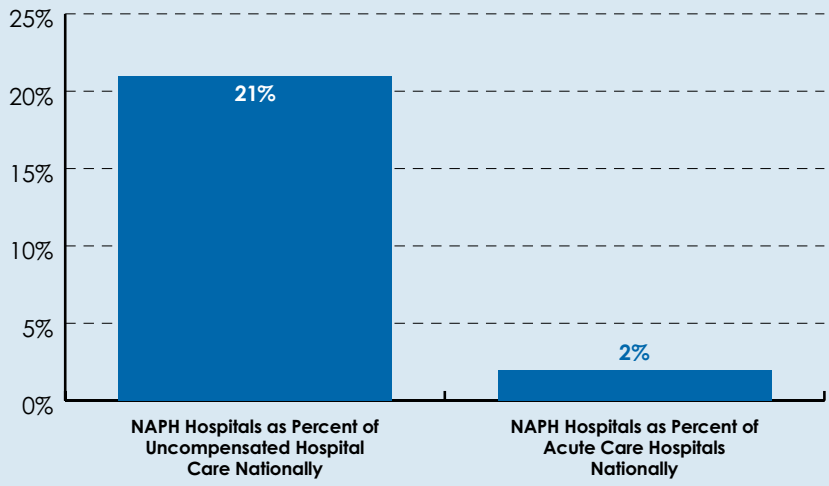
Medicaid and Medicare have historically been significant sources of revenue for public hospitals and health systems. As an example, in 2007:

- Medicaid remains the single most important source of financing for NAPH members; in 2007, it accounted for 33 percent of total net revenues. Critical components of Medicaid revenues were Medicaid disproportionate share hospital (DSH) payments and other supplemental Medicaid payments, which are intended to reduce the shortfalls accrued by treating Medicaid patients and to partially subsidize care for the uninsured. Without DSH and supplemental payments, NAPH members would have lost $2.8 billion on the care of Medicaid patients in 2007.
- Medicare revenues are supplemented by Medicare DSH payments, which also target hospitals that serve low-income and uninsured patients, and indirect medical education (IME) payments, which subsidize the higher costs incurred by teaching hospitals.

3. Public hospitals play a unique role in their communities by providing high volumes of low-income care.

The majority of patients served by NAPH members in 2007 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 (see Figure 3). Furthermore, 28 percent of ambulatory care services—compared to 19 percent of inpatient services—were provided to uninsured patients.

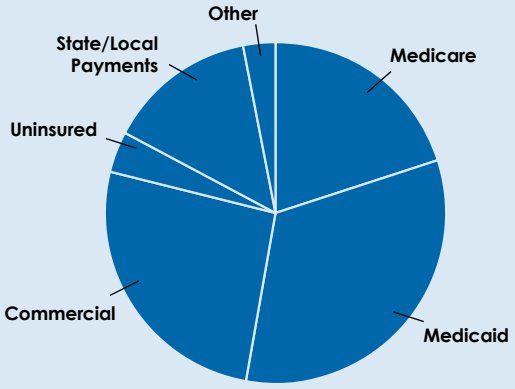
FIGURE 1 NAPH Hospitals' Share of Uncompensated Care Costs Nationally



SOURCES NAPH Hospital Characteristics Survey, 2007 and AHA Annual Survey of Hospitals, 2007 and AHA Uncompensated Care Cost Fact Sheet, November 2008

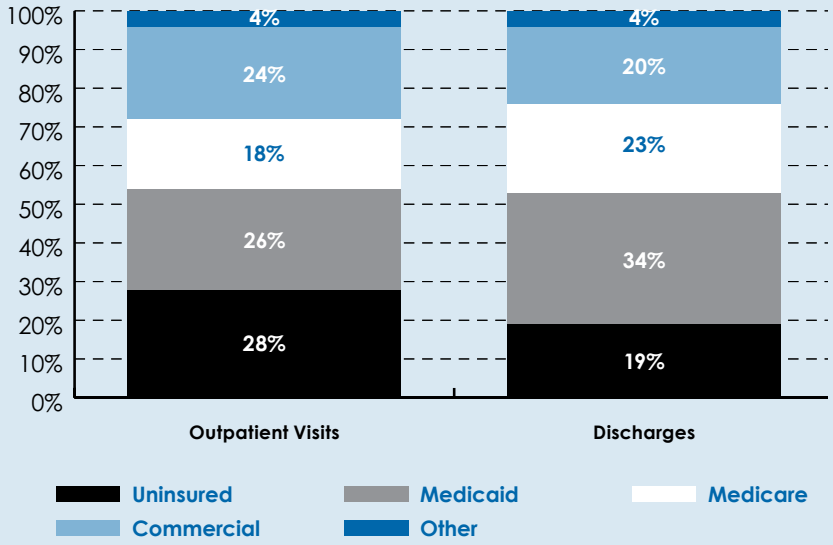
FIGURE 2 Net Revenues by Payer Source at NAPH Members, 2007

Medicare	20%
Medicaid	33%
Commercial	26%
Uninsured	4%
State/Local Payments	14%
Other	3%



SOURCE NAPH Hospital Characteristics Survey, 2007

FIGURE 3 Outpatient Visits and Discharges at NAPH Member Hospitals and Health Systems, by Payer Source, 2007

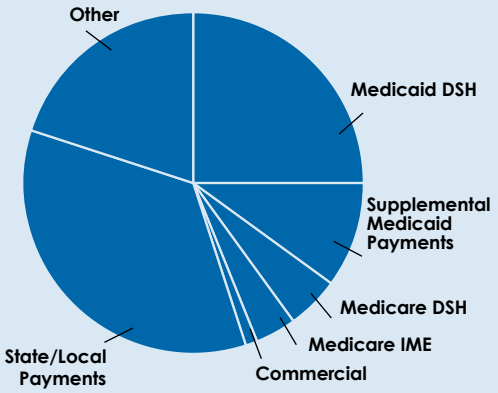


SOURCE NAPH Hospital Characteristics Survey, 2007

The extraordinary amount of ambulatory care NAPH members provide is poorly reimbursed, if it is reimbursed at all. This is due to reimbursement rates for outpatient services generally being lower than reimbursement rates for inpatient services, as well as a substantial amount of this care being provided to the uninsured. These factors contribute to the financial challenges NAPH members face.

FIGURE 4 Sources of Financing for Unreimbursed Care, 2007

Medicaid DSH	25%
Supplemental Medicaid Payments	10%
Medicare DSH	5%
Medicare IME	4%
Commercial	1%
State/Local Payments	35%
Other	20%



SOURCE NAPH Hospital Characteristics Survey, 2007

4. Safety net hospitals rely on federal and local payments to fund losses on patient care.

"Unreimbursed care" refers to losses on care provided to all patients, excluding "mission-related" supplemental funding such as DSH and IME payments and state or local government payments. In addition to the number of uninsured patients they care for, a large percentage of care provided by NAPH members is unreimbursed, meaning that base payments received for services provided do not cover the full costs of providing these services. As a result unreimbursed care costs present a significant burden to public hospitals. In 2007 (see Figure 4):

- State and local payments financed 35 percent of the unreimbursed care provided by NAPH members.
- Medicaid DSH was a critical funding source, financing 25 percent of the unreimbursed care provided.
- Medicare DSH and IME together represented nine percent of financing for unreimbursed care.
- NAPH members financed 1 percent of their unreimbursed care through cost shifting from commercial payers.
- 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 the remaining 20 percent of losses from patient care.

5. Sustaining investment in America's public hospitals and health systems is in the best interest of the nation and its communities.

NAPH members are a crucial component of the nation's safety net infrastructure. In 32 communities, 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.

In an analysis of the ten largest U.S. cities, NAPH member represent only 11 percent of local acute care hospitals, but provide a disproportionate share of critical services (see Figure 5).[2] Specifically, NAPH member hospitals provide 20 percent of the emergency department visits and 27 percent of non-emergency outpatient visits. As major providers of trauma care, public hospitals represent 32 percent of Level I trauma providers and 58 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 24 percent of Medicaid discharges in these major metropolitan areas.

Because of their leading role as providers of emergency department, trauma, and burn care services, NAPH members have long been first-receivers for catastrophes such as chemical spills, fires, disease outbreaks, and natural disasters. As an extension of this role, public hospitals now play a key role in ensuring homeland security. Their responsibilities 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

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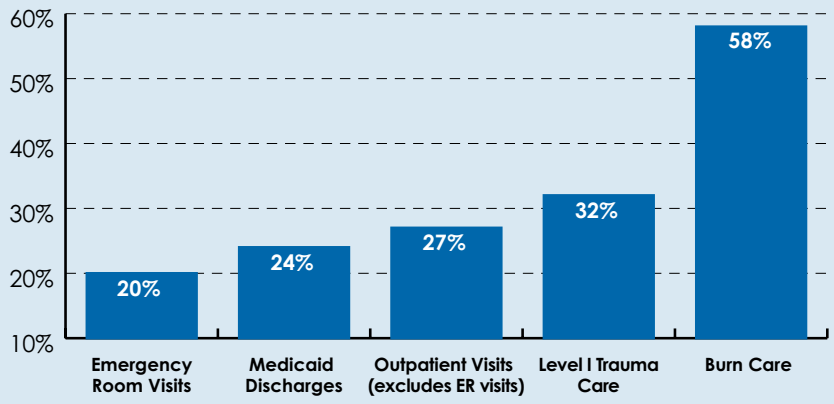
FIGURE 5 Percentage of Services Provided by NAPH Members in the 10 Largest U.S. Cities, 2007



SOURCE AHA Annual Survey of Hospitals, 2007

disaster. NAPH members also play a leading role in trauma research and education.

Given the important role public hospitals play in caring for the communities that they serve, federal, state, and local policy-makers must make a continued and sustained investment in strengthening our nation's public hospitals and health systems. ■

Notes

1. O. Zaman, L. Cummings, and S. Siegel Spieler, *America's Public Hospitals and Health Systems, 2007: Results of the NAPH Annual Hospital Characteristics Survey.* Washington, DC: National Association of Public Hospitals and Health Systems, 2009.

2. The analysis is based on the 10 largest cities, data presented in US Census Bureau: Table 1: Annual Estimates of the Population for Incorporated Places >100,000 (July 9, 2008). These cities include New York City, Los Angeles, Chicago, Houston, Phoenix, Philadelphia, San Antonio, San Diego, Dallas, and San Jose.