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# Research Brief

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*Transforming American Health Care*

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## Study Reveals NAPH Members are ‘Providers of Choice’ for All Patients

*A new study reveals recent trends at NAPH members and outlines challenges and opportunities for safety net hospitals as health reform is implemented.*

### INTRODUCTION

For more than twenty-five years the National Association of Public Hospitals and Health Systems (NAPH) has collected data from its members as part of its Annual Hospital Characteristics Survey. This unique data source is the only comprehensive collection of detailed utilization and financial information for safety net hospitals. A new study, presented in this brief, analyzed the ten-year period from 2000 to 2009 to reveal the trends that have affected safety net hospitals and what insight these trends can offer as safety net hospitals move forward under health reform. This brief also explores how the role

of safety net hospitals is enhanced by the unique position they hold as integral parts of the nation’s health care safety net, and how this role may change as health reform is implemented.

For the study, a matched set of 58 NAPH member hospitals was examined. These hospitals had either completed surveys for all ten years or responded for most of the ten-year period so any missing data could reasonably be extrapolated. When we refer to NAPH members in this brief, we are referring only to member hospitals that were part of this study. Comparison data from other hospitals nationally was obtained by analyzing the American Hospital Association (AHA) Annual Survey Database for the same ten-year period. This research brief will detail the key findings from the analysis and discuss their implications.

### KEY FINDINGS

#### GROWING DEMAND RESULTS IN GREATER EFFICIENCY

The study shows that demand for services at NAPH members has increased steadily over the ten-year period. Inpatient discharges increased by 14 percent, from just under 18,000 per hospital in 2000 to over 20,000 in 2009 (see Figure 1). This increase in demand was significantly higher than the 9 percent increase seen at all U.S. acute care hospitals. However, the patient capacity of NAPH member hospitals grew at a slower rate than this demand for inpatient care. During the study period, the number of staffed beds at NAPH member hospitals increased by 7 percent, from an average of 389 staffed beds in 2000 to an average of 419 in 2009. Thus, NAPH members had to be more efficient in the care of admitted patients. As a result, the average length of stay at member hospitals dropped from 6.1 days in 2000 to 5.6 days in 2009.

NAPH member hospitals also saw a 16 percent growth in emergency department visits from 2000 to 2009, from an average of just over 71,000 visits annually to more than 82,000

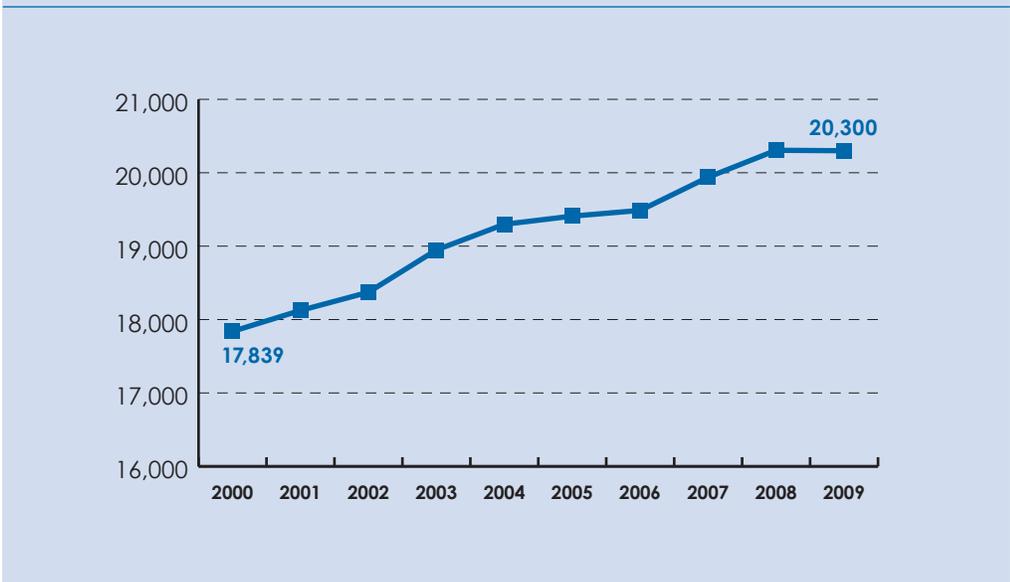
(see Figure 2). Similarly, the number of outpatient clinic visits at NAPH hospitals grew by 11 percent, from 321,000 on average in 2000 to over 355,000 in 2009 (see Figure 3). These increases in emergency department visits and outpatient clinic visits were similar to the growth rates seen among other U.S. hospitals.

**GROWTH IN UTILIZATION VARIES BY INSURANCE TYPE**

NAPH member hospitals saw patient discharges increase for all but one insurance type over the period of this study (see Figure 4). Medicare discharges increased 31 percent between 2000 and 2009, while commercially-insured patients increased 11 percent. Medicaid discharges increased 22 percent but discharges for the uninsured decreased by 10 percent.

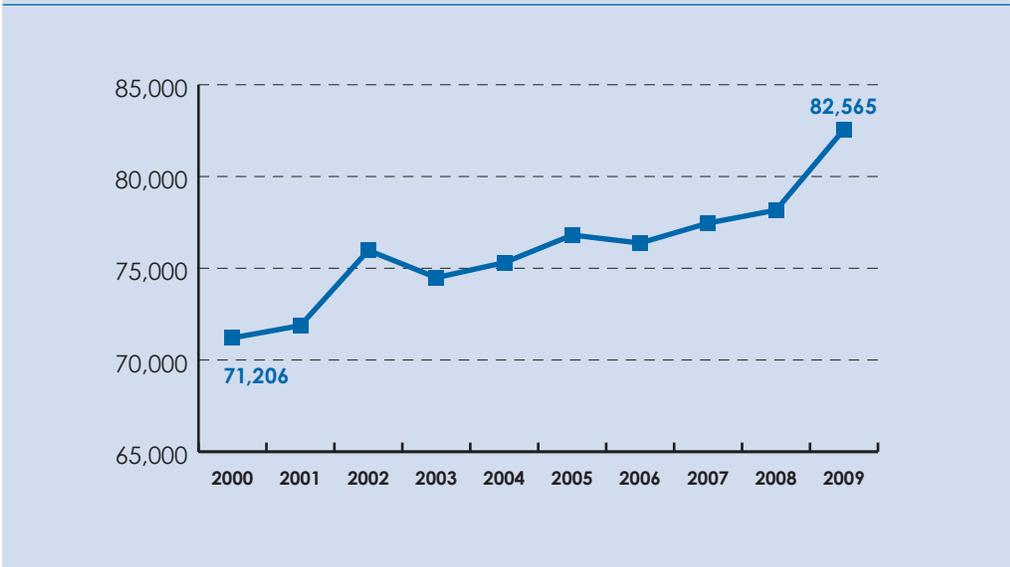
The decrease in uninsured discharges may be attributed to several factors. One factor is that as the U.S. economy has experienced recession and periods of slow economic growth over the past decade, the number of people eligible for and enrolled in Medicaid has increased.<sup>1</sup> Another factor to consider is that a number of NAPH members have implemented better systems to screen patients for eligibility and enroll them in Medicaid. For example, Memorial Health Care System in Florida has instituted outreach efforts that include door-to-door visits in the community to help patients apply for Medicaid.

**FIGURE 1** Average Number of Discharges at NAPH Member Hospitals, 2000–2009



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

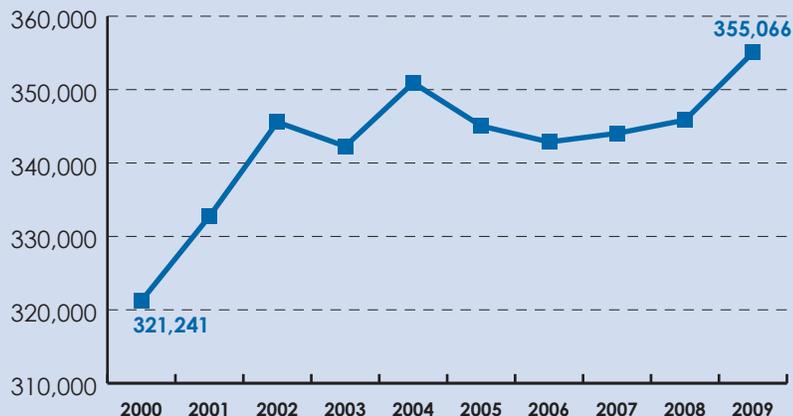
**FIGURE 2** Average Number of Emergency Department Visits at NAPH Member Hospitals, 2000–2009



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

**FIGURE 3**

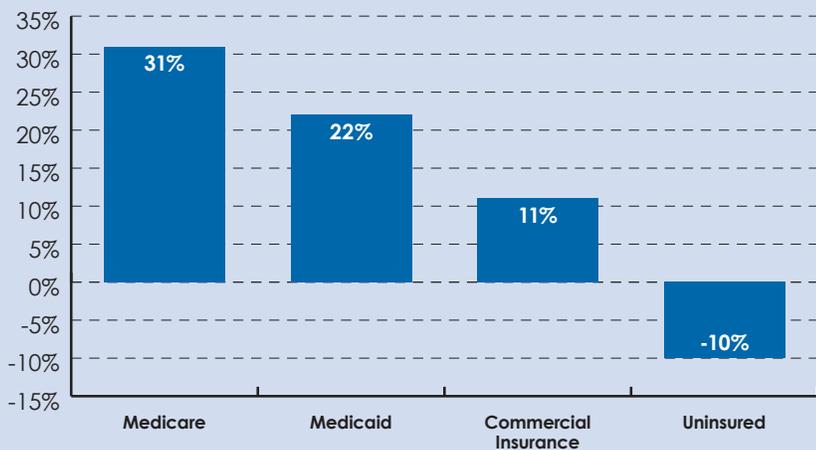
**Average Number of Outpatient Clinic Visits at NAPH Member Hospitals, 2000–2009**



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

**FIGURE 4**

**Growth in Discharges by Payer Type at NAPH Member Hospitals, 2000–2009**



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

The data from 2000 to 2009 suggest that over time, these hospitals have grown to be recognized as providers of choice — places where patients want to go for high quality care and specialized services, regardless of their income or insurance status.

On average, the typical NAPH member hospital saw the number of low-income patient discharges rise 11 percent from 2000 to 2009, from approximately 11,000 to 12,000 annually.

LSU Health Care Services Division hospitals in Louisiana have purchased laptops for their Medicaid Application Centers, enabling hospital staff to complete full Medicaid applications at the bedside and streamline enrollment.

This study also shows that NAPH members cared for increasing numbers of low-income patients, defined here as those covered by Medicaid and those without insurance (see Figure 5). On average, the typical NAPH member hospital saw the number of low-income patient discharges rise 11 percent from 2000 to 2009, from approximately 11,000 to 12,000 annually.<sup>2</sup> The study also reveals a shift in the insurance coverage of the low-income population whom NAPH members served. In 2000, 59 percent of low-income patients at NAPH hospitals were covered by Medicaid and 41 percent were uninsured. By 2009, that proportion had shifted significantly, with 66 percent of low-income patients covered by Medicaid and 34 percent classified as uninsured. NAPH hospitals saw similar increases in Medicaid percentages and decreases in uninsured percentages in emergency department and outpatient visits. These data provide further evidence that patients that had been uninsured in the early years of the study were increasingly enrolling in Medicaid by the end of this period.

#### **IMPORTANCE OF SAFETY NET FINANCING**

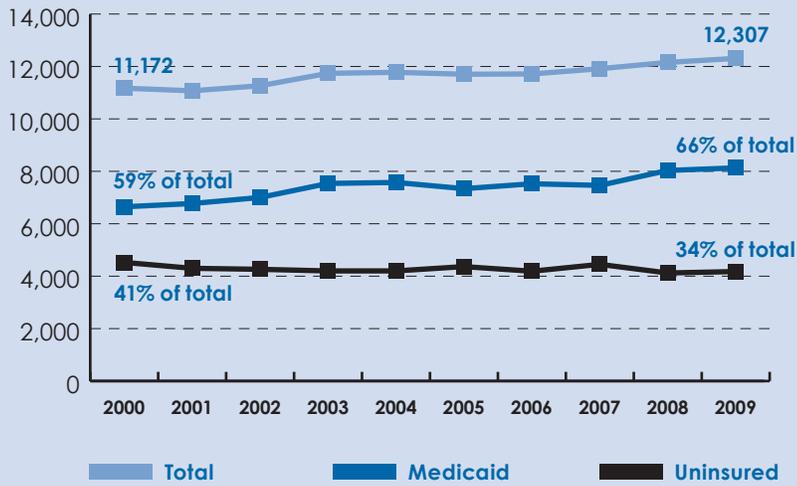
This study also illustrates the important role of supplemental payments like

Medicaid Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments for NAPH members (see Figure 6). NAPH members have faced fluctuations in these payments over the period of the study. In 2000, NAPH members in this study received \$1.6 billion in Medicaid DSH and UPL payments, which represented 11 percent of their total operating revenue. When the Balanced Budget Amendment of 1997 and other federal actions reduced Medicaid DSH and UPL funding, NAPH members saw supplemental payments level off for several years.<sup>3</sup> Then in 2004, as policies regarding Medicaid DSH and UPL payments changed, states were able to use these programs to increase their support to safety net hospitals.<sup>4</sup> By 2007, Medicaid DSH and UPL payments to NAPH members had grown to \$4.3 billion, or 17 percent of these hospitals' total operating revenue. In 2008, however, as several states saw reductions in supplemental payments, Medicaid DSH and UPL payments to NAPH members fell to \$3.6 billion, or 13 percent of total operating revenue.

The study shows how levels of supplemental payments under Medicaid affect the operating margins of NAPH member hospitals. As Figure 6 shows, from 2000 through 2003, as Medicaid supplemental payments remained relatively unchanged as a percentage of hospital operating revenues, NAPH members

FIGURE 5

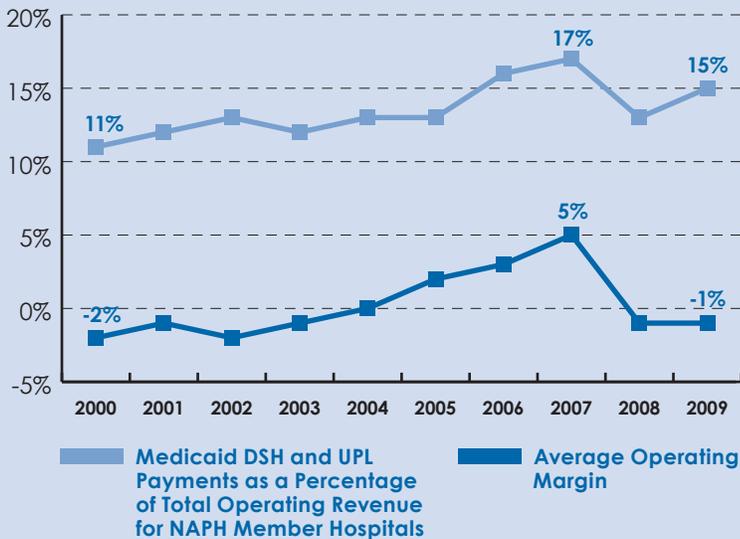
Average Number of Low Income (Medicaid and Uninsured) Discharges at NAPH Member Hospitals, 2000–2009



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

FIGURE 6

Medicaid DSH and UPL Payments as a Percentage of Total Operating Revenue and Average Operating Margins for NAPH Member Hospitals, 2000–2009



SOURCE Analysis of NAPH Hospital Characteristics Survey, FY 2000–2009.

In comparison, the average NAPH member handled more than five times as many non-emergency outpatient visits as other acute care hospitals in the U.S., and almost three times as many as other acute care hospitals in NAPH members’ markets.

It is critical that policymakers pay careful attention to the adequacy of payments to safety net providers, in 2014 and beyond, either through supplements or increased Medicaid reimbursement, so providers who continue to ensure access to care will be there for patients who need it.

struggled with negative operating margins between -2 and -1 percent, on average. In 2004, when supplemental payments for Medicaid began to increase, member hospitals experienced increasingly positive operating margins, reaching as high as 5 percent on average in 2007. When Medicaid DSH and UPL funding was again reduced, starting in 2008, NAPH members saw their average operating margins fall back below zero.

## DISCUSSION

The findings from this study have immediate implications for NAPH members under health reform. The findings also demonstrate important points for policymakers to keep in mind as reform implementation proceeds.

### CAPACITY CONSIDERATIONS WITH INCREASES IN COVERAGE

One important issue that will arise in 2014 as coverage expands, and in particular as Medicaid expands, is the need for adequate patient capacity. NAPH member hospitals already face special challenges in providing adequate capacity for inpatient care, as has been discussed earlier. But capacity is at a premium for outpatient services as well. NAPH members currently provide extraordinary levels of outpatient care — more than 52 million total outpatient visits in 2009, an average of about 511,000 per hospital. In comparison, the average NAPH

member handled more than five times as many non-emergency outpatient visits as other acute care hospitals in the U.S., and almost three times as many as other acute care hospitals in NAPH members' markets (see Figure 7).<sup>5</sup>

Furthermore, the majority of outpatient clinic visits at NAPH member hospitals are for specialty care services. Health reform legislation includes some provisions to improve primary care capacity, but there is evidence that these changes will not be sufficient to care for millions of the newly insured.<sup>6</sup> Reform also did not address demand for specialty care among low-income populations. NAPH members have found innovative ways to manage overcrowded emergency departments, bed shortages, and outpatient settings that are at capacity. Policymakers will need to take steps to ensure that safety net systems have adequate financing for the increased primary and specialty care demands created by expanded coverage.

### CONTINUING NEED FOR ADEQUATE FUNDING EVEN WITH INCREASED COVERAGE

Adequate funding will also be a central issue for NAPH members as health reform is implemented. This study has demonstrated how important supplemental payments are for safety net health systems — keeping them in business and adequately reimbursed. Over a seven-year period beginning in 2014, Medicaid DSH payments

are to be cut by \$18 billion. These planned reductions present challenges for NAPH hospitals, given the low reimbursement rates for Medicaid patients. As Medicaid DSH funding decreases under health reform, policymakers will need to ensure that payments from Medicaid and newly covered low-income patients are adequate to cover the costs of care provided by safety net hospitals.

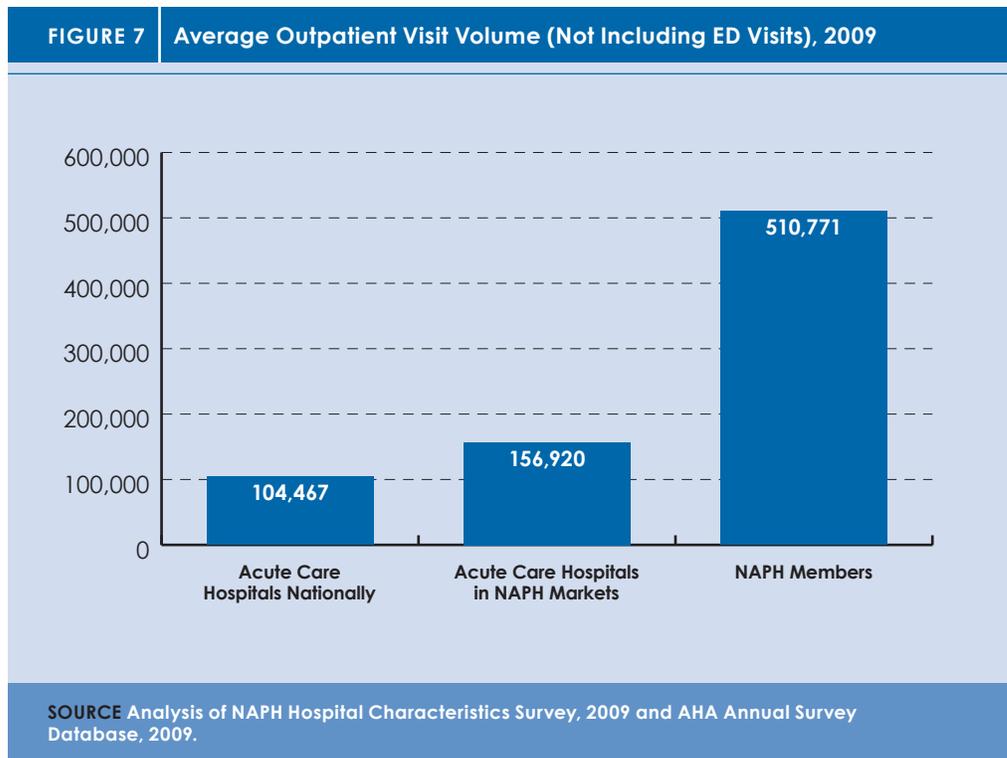
This study has shown that safety net hospitals cared for a growing number of low-income patients from 2000 to 2009, and these increases are likely to continue as health reform is implemented. Starting in 2014, health coverage is to be extended to 32 million currently uninsured Americans.<sup>7</sup> Half of these will be

covered by expansions to Medicaid. Other low-income populations will obtain coverage through new insurance exchanges.

As has been seen during state health reform in Massachusetts, many newly-insured people will continue to come to safety net systems for their care. After health reform was instituted in the state, safety net providers Cambridge Health Alliance and Boston Medical Center saw a higher number of low-income patients, including those covered by Medicaid, those insured through exchanges, and the uninsured. As national health reform is implemented, NAPH members will continue to treat large numbers of low-income patients, whatever their insurance status.

Under health reform, it will be important for NAPH member hospitals to care for the expanding Medicaid population. Member hospitals have indicated that a major factor in increasing their Medicaid patient numbers from 2000 to 2009 has been their increased emphasis on hospital-based eligibility screening. With these systems in place, NAPH members will be particularly well suited in the future for enrolling newly-eligible Medicaid patients. NAPH members also have the advantage of having services tailored to suit the particular needs of Medicaid patients, many of whom need accommodations such as language services to effectively meet their health care needs.<sup>8</sup>

Though NAPH members typically have built their reputation as safety net care providers, this study has shown significant increases in the numbers of Medicare and commercially-insured patients at NAPH hospitals. The data from 2000 to 2009 suggest that over time, these hospitals have grown to be recognized as providers of choice — places where patients want to go for high quality care and specialized services, regardless of their income or insurance status. Continuing to attract Medicare and commercially-insured patients could help NAPH hospitals make up for some losses resulting from caring for low-income patients. But it is critical that policymakers pay careful attention to the adequacy of payments to safety



In order to meet these challenges, safety net hospitals will need to continue to be innovative in their care delivery systems and accountable for high-quality care and value. But targeted support from federal, state, and local lawmakers will be essential to ensure that access to care, not just coverage, is realized under health care reform.

net providers in 2014 and beyond, either through supplements or increased Medicaid reimbursement, so providers who continue to ensure access to care will be there for patients who need it.

#### **NAPH MEMBER REPRESENTATION IN DEMONSTRATION PROJECTS**

Finally, under health reform, a number of demonstration projects will be established to encourage delivery system reform, including the Accountable Care Organization (ACO) model, Collaborative Care Networks (CCNs), and other projects. Many NAPH members are eager to participate in these demonstrations to help vulnerable populations enter a coordinated system of care focused on quality, value, and population health. Policymakers should ensure that safety net systems are part of these demonstration projects in order to provide low-income populations

with care delivery that meets the goals of health reform.

#### **CONCLUSION**

This latest study by NAPH examining data collected from member hospitals between 2000 and 2009 highlights the challenges they have faced in increased demand for services, limited capacity, high levels of low-income patients (including a growing Medicaid population), and uncertain safety net financing. These challenges will become even more significant for safety net hospitals as health reform proceeds. In order to meet these challenges, safety net hospitals will need to continue to be innovative in their care delivery systems and accountable for high quality care and value. But targeted support from federal, state, and local lawmakers will be essential to ensure that access to care, not just coverage, is realized under health care reform. ■

#### **Notes**

1. Kaiser Family Foundation, *Medicaid Enrollment: June 2009 Data Snapshot*, (Washington, DC: Kaiser Family Foundation, February 2010).

2. According to an NAPH analysis of data from the U.S. Census Bureau and information for the Kaiser Family Foundation, the number of individuals that were either uninsured or were enrolled in Medicaid has increased 40 percent between 2000 and 2009.

3. Jennifer Tolbert, ed., *Safety Net Financing: A Policy Source Book for Healthcare Executives*, (Washington, DC: National Association of Public Hospitals and Health Systems, June 2003).

4. Jim Frizzera, *History of Medicaid Disproportionate Share Hospital (DSH) Program, 1981-2009*, (Washington, DC: Health Management Associates, 2009).

5. Obaid S. Zaman, Linda C. Cummings, and Sari Siegel Spieler, *America's Public Hospitals and Health Systems, 2009: Results of the Annual NAPH Hospital Characteristics Survey*, (Washington, DC: National Association of Public Hospitals and Health Systems, February 2010).

6. Leighton Ku et al. "The States' Next Challenge — Securing Primary Care for Expanded Medicaid Populations," *New England Journal of Medicine*, 364, no. 6 (2011): 493-495.

7. The Commonwealth Fund, *What Will Happen Under Health Reform — and What's Next?* (New York: The Commonwealth Fund, May/June 2010).

8. Mitchell H. Katz, "Future of the Safety Net Under Health Reform", *JAMA*, 304, no. 6 (2010): 679-680.