

**Stresses to the Safety Net:
The Public Hospital Perspective**

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Marsha Regenstein, Ph.D.

and

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The National Public Health and Hospital Institute

June 2005

kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.

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Dr. Regenstein is Director at the National Public Health and Hospital Institute (NPHHI), and Jennifer Huang is a senior research analyst at NPHHI. NPHHI is a private, nonprofit organization established in 1988 to address the major issues facing public hospitals, safety net institutions, underserved communities and related health policy issues of national priority. The Institute's membership includes the 127 institutions that comprise the National Association of Public Hospitals & Health Systems (NAPH). The board includes public and nonprofit sector leaders in health policy and service delivery. The authors would like to thank Diane Rowland, Barbara Lyons, and David Rousseau of the Kaiser Commission on Medicaid and the Uninsured for their many helpful comments. This paper was prepared for the Kaiser Commission on Medicaid and the Uninsured. The views represented here are those of the authors and do not necessarily represent the views of the Kaiser Commission on Medicaid and the Uninsured.

Introduction

Every year, more than 10 million people receive care from public hospitals and health systems – a complex and diverse set of providers that share a mission to deliver health services to individuals, regardless of insurance coverage or ability to pay. Together with federally funded health centers, free clinics, public health departments and scores of individual physicians and other health practitioners, public hospitals provide critical access points for the nation's uninsured population and form a vast patchwork of providers that is commonly referred to as the health care safety net.

Despite their importance, there is no single or stable source of financial support for public hospitals' service to their communities. Safety net financing is fragmented; consequently, providers must knit together resources from many different funding sources to create a stream of revenue to cover the costs of providing a very broad range of services. Part 1 of this report describes those sources of revenue, demonstrating the significant role Medicaid plays in supporting the current public hospital safety net, documenting that nearly 40% of all safety net revenues are from Medicaid. It also highlights trends affecting the health of the safety net over the past decade. Part 2 describes particular challenges that safety net hospitals and health systems are experiencing as they attempt to rebound from the economic downturn of the early 2000s.

Part 1 – A Profile of Public Hospitals and Health Systems

Public hospitals have a long history of service to the community.¹ The first public hospital, Philadelphia General, opened originally as an almshouse in 1731 and continued operating until 1977. Early public hospitals combined traditional almshouse activities on behalf of the poor with efforts to provide health services to patients and medical education for the nation's health care workforce.

Today, there are over 1,100 public, non-federal acute care hospitals in the country, most of which are owned by county governments.² Nearly three-quarters (73 percent) of these hospitals are located in rural settings and most are relatively small – 69 percent of acute care public hospitals have fewer than 100 beds and 85 percent have fewer than 200 beds.

The term “safety net hospital” refers to a subset of public and not-for-profit hospitals that provides disproportionate amounts of care to low-income and uninsured patients.³ Many of these hospitals belong to the National Association of Public Hospitals and Health Systems (NAPH), and NAPH's membership has collectively come to represent the majority of traditional safety net hospitals in the country. Currently, 61 hospital systems are included in NAPH's membership, representing approximately 120 individual hospitals and more than 700 affiliated community clinics. Most of the hospital systems are located in metropolitan areas although, in many cities, their service areas extend well beyond urban boundaries.

While safety net hospitals provide a broad range of services, they tend to be associated with two principal types of care – traditional health care services that are provided to low-income, uninsured, immigrant, or otherwise vulnerable individuals; and highly specialized trauma services, burn care, and general emergency services that are essential to the health of the entire community. Both of these impressions are correct and are indicative of the broad mission under which these hospitals operate.

Public Hospital Characteristics

Safety net hospitals tend to be large organizations located in metropolitan areas of the country. Nearly three-quarters of NAPH hospitals have 200 or more staffed beds and most have very large outpatient and emergency departments as well (see Table 1). In 2002, NAPH hospitals had an average of about 17,000 admissions⁴ – more than double the average rate of all acute care hospitals in the country. Collectively, these hospitals account for about 1.5 million inpatient admissions, or about 4.3 percent of acute care admissions nationwide.⁵

Table 1: Volume of Services at NAPH and Acute Care Hospitals in U.S., 2002*

Service	Average Volumes at NAPH Hospital	Total Service Volumes at NAPH Hospitals	Average Volumes at Acute Care Hospitals in the U.S.	Total Service Volumes at Acute Hospitals in the U.S.
Inpatient Admissions	17,000	1.5 million	7,000	34.8 million
Outpatient Visits	368,000	30 million	102,000	496 million
Emergency Department Visits	71,000	6 million	23,000	112 million
Diagnostic Services	NA	100+ million	NA	NA

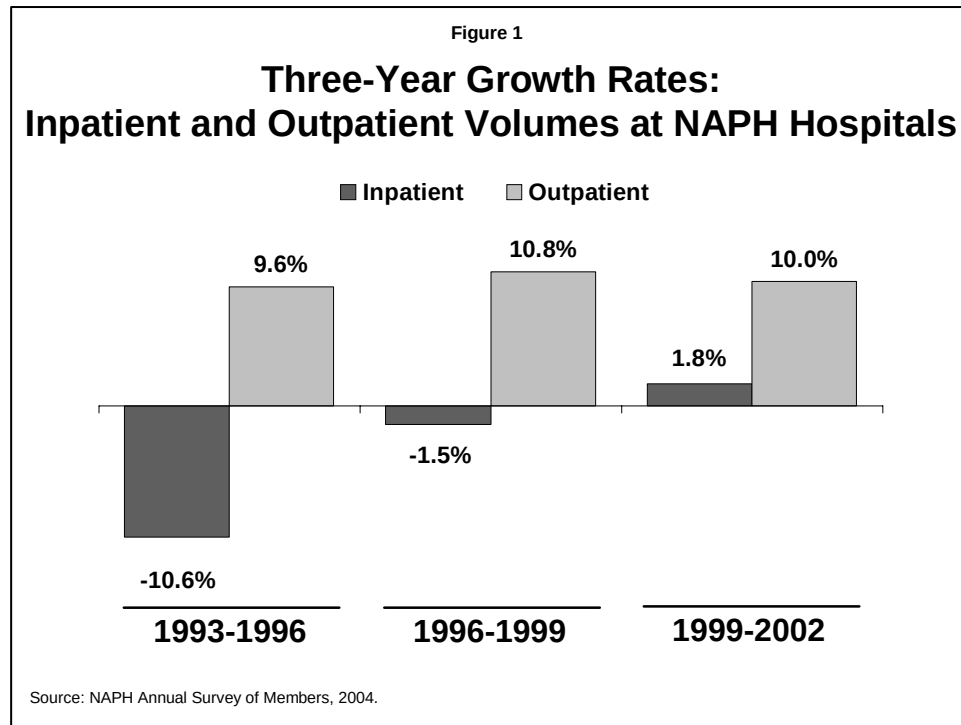
*Estimates of average volumes rounded to nearest thousand; estimates of total inpatient admissions rounded to nearest hundred thousand; estimates of other service totals rounded to nearest million.

NA = Not available.

Sources: NAPH Annual Member Survey, 2004. Data are for 2002. AHA Annual Survey Database, FY2002.

Inpatient volumes have stayed relatively flat in safety net hospitals over the past decade, after an abrupt drop in 1995-1996, mostly associated with a loss of Medicaid-covered births as Medicaid managed care began to take hold in many U.S. markets.⁶ The picture is quite different for outpatient services, which have seen steady increases in volume nearly every year for the past decade and show no signs of abating. Figure 1 compares growth across these two dimensions of care for the periods 1993-1996, 1996-1999, and 1999-2002 (the latest year for which data are available). In each of the three-year periods, outpatient care has grown about 10 percent; in 1993, the average NAPH hospital had about 276,000 outpatient visits and by 2002 that number had increased to over 368,000 – more

than three times the number for average acute care hospitals in the country. Several of these individual hospitals had volumes in excess of 1 million visits. And, as Figure 1 indicates, after two periods of negative growth, inpatient services are beginning to increase slightly, with many hospitals experiencing significant shortages of beds for acute care patients.



As a group, these hospitals provided over 30 million outpatient visits⁷ in 2002, and reports are that the numbers for 2003 and 2004 will continue to show similar growth in outpatient volume.⁸ Much of this growth over the last decade was planned in direct response to community needs for more accessible and affordable primary care services. As a result, over the past decade, safety net hospitals have become major providers of hospital and community-based primary care services. Nearly half of all ambulatory care visits are now for primary care services; these visits take place on the hospital campus as well as in community clinics owned and operated by the hospital system.⁹ Outpatient specialty services commonly take place in clinics on the hospital campus.¹⁰

These trends in inpatient and outpatient utilization have important implications for financing and reimbursement. Traditionally, inpatient services are more adequately reimbursed than outpatient services, which are often very low relative to the cost of the service. This creates particular tensions or challenges for safety net hospitals and health systems that rely on Medicaid reimbursement and also have large outpatient volumes.

Public hospitals often serve as the only source of specialty care for uninsured and underserved residents in communities across the country. Previous research has described a growing shortage of specialty services that hit low-income and uninsured individuals particularly hard.¹¹ Health center patients, for example, have difficulty accessing specialty services, as do uninsured patients who may see community physicians and pay for primary care out-of-pocket. Safety net hospitals are under increasing pressure to support entire communities of low-income residents who have no other avenues to turn to for a broad range of specialty services.

Many safety net hospitals are able to respond to their community's need for specialty care because they operate large teaching programs that train a disproportionate number of the nation's medical and nursing workforce. About 80 percent of NAPH acute care hospitals are teaching institutions and half of these are classified as academic medical centers.¹² These teaching hospitals train about 15 percent of all medical and dental residents in any given year.

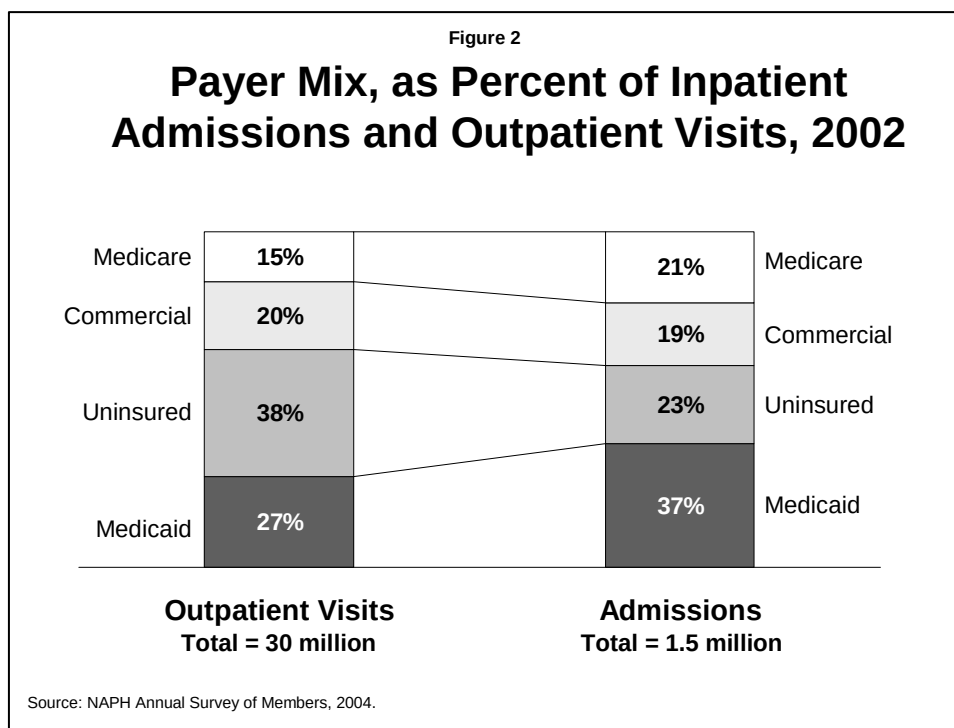
At least three important categories of outpatient services are not included as a component of the 30 million ambulatory visits: emergency department care, diagnostic services, and pharmacy services. Safety net hospitals are principal sources of emergent care for their communities and in 2002 logged nearly 6 million emergency department visits. More than a dozen NAPH members have well over 100,000 emergency department visits per year, and a majority of individuals receiving inpatient care at NAPH hospitals are admitted through the emergency department.

Safety net hospitals provide laboratory, x-ray, and other high-tech diagnostic services for patients who receive care within their systems and for many others in the community who access these services to supplement care at health centers and private physicians' offices. Given the volume of patients who receive outpatient care at these hospitals, we estimate that well over 100 million diagnostic services are performed at these hospitals each year.¹³

Safety net hospitals also operate extremely busy outpatient pharmacies that provide free or reduced-cost pharmaceuticals to their patients. Many also operate pharmacies at community clinics to facilitate patients' access to important medications and supplies. Previously available to anyone in the community, pharmacy services at safety net hospitals are now commonly limited to patients who receive health services from the hospital. Even with this restriction, safety net outpatient pharmacies are flooded with demand for low-cost pharmaceuticals.

Who are the Patients?

These huge volumes notwithstanding, what clearly sets safety net hospitals apart from other hospitals in their markets is the overall vulnerability of their patient populations. As can be seen in Figure 2, nearly two-thirds of patients who receive



care from safety net hospitals are either uninsured or covered by Medicaid,¹⁴ although the proportions differ quite a bit depending on whether the patient seeks inpatient or outpatient care. Individuals receiving outpatient care are much more likely to be uninsured (38 percent are uninsured) and much less likely to be covered by Medicaid (27 percent) than individuals receiving inpatient care, where 23 percent are uninsured and 37 percent are covered by Medicaid.¹⁵

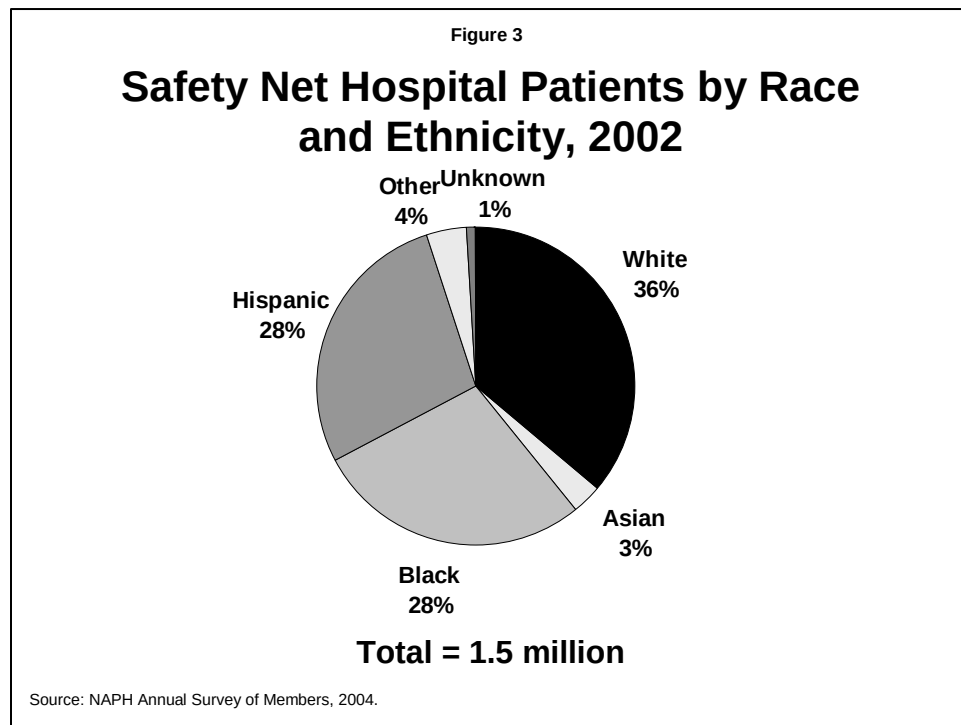
The differences in payer mix for individuals receiving inpatient care and individuals receiving outpatient care may be a reflection of several factors, including:

- difficulties enrolling individuals receiving outpatient care in Medicaid: prior studies have shown that safety net hospitals undertake more aggressive enrollment activities for individuals receiving inpatient care ;¹⁶
- availability of Medicaid for pregnant women: labor and delivery accounts for a sizeable percentage of inpatient visits and may increase Medicaid numbers for individuals receiving inpatient care ;
- utilization patterns for certain patients: adults with chronic conditions, for example, have relatively high rates of outpatient services – a pattern that has been associated with lower rates of hospitalization and emergency department services. Despite being low-income, many of these adults do not meet Medicaid categorical eligibility requirements and may therefore drive up uninsured utilization numbers on the outpatient side.

Regardless of the reasons for the differences across delivery sites, it is clear that the majority of patients are low-income, although the extent of poverty within the safety net hospital population is not known.¹⁷

About one-fifth of patients are covered by commercial insurance. Anecdotal evidence suggests that many of these patients are also low-income, choosing to come to safety net hospitals in part because of reduced fee schedules and the availability of lower-cost pharmaceuticals. Similarly, a significant portion of the 21 percent of inpatient admissions and 15 percent of outpatient visits covered by Medicare are likely to be for low-income, elderly patients. For these patients, access to pharmaceuticals may be an important factor in their health care choices.

In addition to being disproportionately low-income, safety net hospital patients tend to be members of racial and ethnic minorities. Two-thirds (65 percent) of individuals receiving inpatient care in 2002 were classified as Black, Hispanic, Asian/Pacific Islander, or other races (see Figure 3). These proportions mask an even greater amount of diversity, since there is also substantial within-category variation. For example, black patients at safety net hospitals represent African Americans as well as large numbers of individuals from African countries, Haiti and other Caribbean countries.



Given the racial and ethnic diversity of the populations, it is not surprising that individual safety net hospitals routinely see patients who speak literally dozens of different languages. While the majority of acute care hospitals in the U.S. may be confronted with the need for bilingual staff or interpreters for a small proportion of their patients, many safety net hospitals have put into place interpreter services

programs designed to provide in-person interpretation for upwards of 30 languages on a 24/7 basis.¹⁸

Safety Net Hospital Financing: Who Pays for the Care?

Increasingly, researchers and policymakers have underscored the role that Medicaid plays in financing care for low-income individuals. In a 2003 *Health Affairs* article, Alan Weil, then director of the Urban Institute's Assessing the New Federalism program, dubbed Medicaid "the workhorse of the U.S. healthcare system."¹⁹ Clearly, without Medicaid, the current public hospital safety net could not exist.

Medicaid has become the engine that fuels access to health services for individuals who rely on the safety net for their care. Medicaid funding is the single largest source of support for both public hospitals and community health centers.²⁰ It provides this funding through a combination of payment mechanisms for direct patient services and institutional supports.

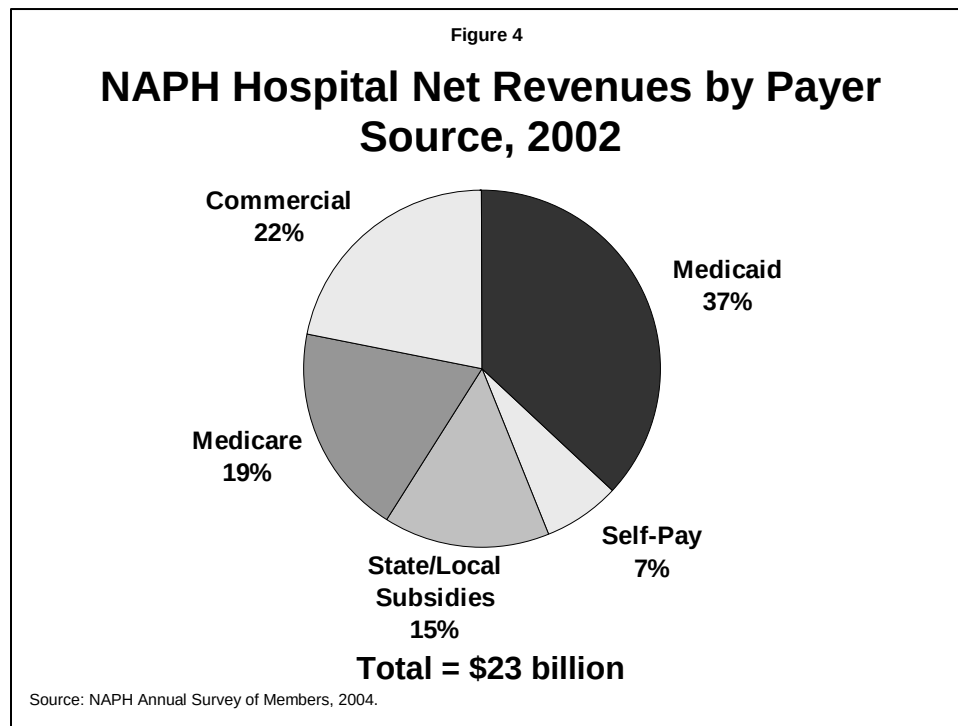
The Medicaid program is a federal-state partnership that provides health coverage to certain low-income and disabled individuals. All states opt to participate in the Medicaid program and must conform to federal regulations concerning mandatory populations, benefits and policies.²¹ States have considerable discretion, however, in terms of shaping their Medicaid programs and can create more or less generous programs that still meet federal requirements and restrictions. Patients qualifying for Medicaid in one state may be uninsured in another state with different eligibility requirements for Medicaid. Thus, large safety net hospitals and health systems are extremely sensitive to changes in both federal and state Medicaid policy.

Current Financing of Safety Net Hospitals

In national studies, the safety net has been described as being "intact but endangered"²² and "fragile yet resilient"²³ – terms that recognize the precarious state of safety net financing in this country. In 2002, while acute care hospitals had margins on average in the 4.5 percent range, more than half of NAPH members had negative margins and the average margin for all hospitals in the membership was -0.3 percent.²⁴ This is dangerously low for an industry that considers margins below the 2 percent level to be inadequate for financing working capital or reinvesting in infrastructure and technology.²⁵ Unfortunately, low margins are not unique to 2002; average margins at NAPH hospitals have been below the 2 percent point since 1998.²⁶ These low margins are evidence that safety net hospitals and health systems are incapable of shifting costs onto other payers, underscoring the importance of adequate reimbursement through Medicaid.

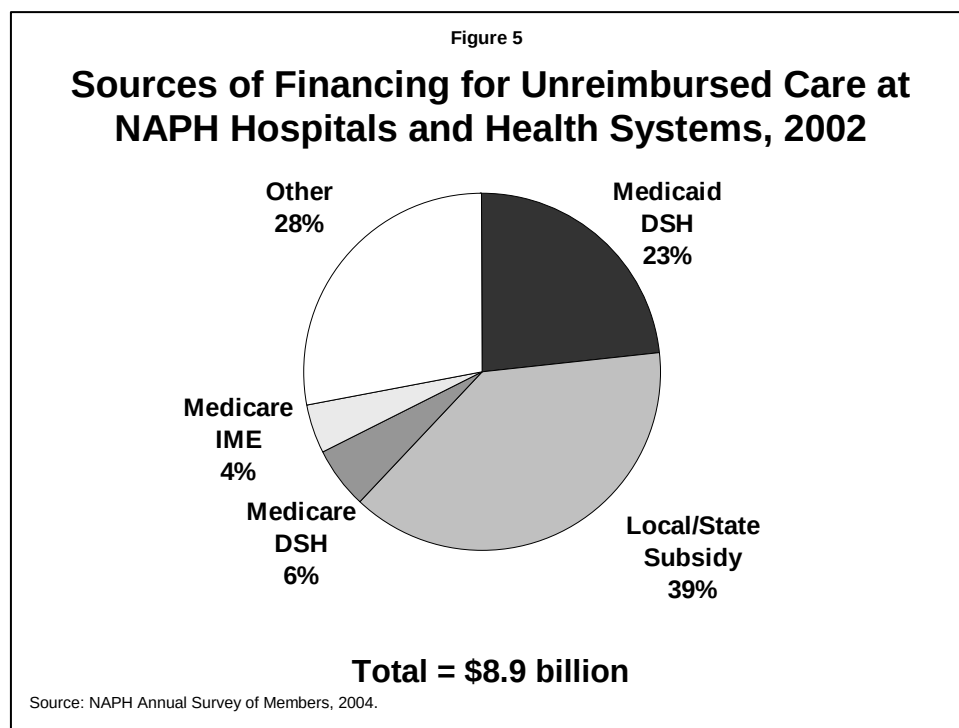
The Medicaid program constitutes a very large proportion of revenues for safety net hospitals and health systems. In 2002, the Medicaid program was responsible for over one-third (37 percent) of the nearly \$23 billion in net revenues collected by

NAPH hospitals (see Figure 4). This includes state and local subsidies to cover losses. When excluding state and local subsidies, the proportion covered by Medicaid is even greater – 49 percent of patient care revenues. Only 7 percent of revenues came from uninsured patients, most of whom are very low-income and therefore not required to cover the full costs of care out-of-pocket.²⁷



As part of their mission to serve large numbers of uninsured and low-income patients, safety net hospitals provide significant amounts of uncompensated care. While these hospitals provide only about 4.3 percent of admissions nationwide, they are responsible for 24 percent of uncompensated care provided by the hospital industry.²⁸

While uncompensated care represents 21 percent of the costs at NAPH member hospitals, an even greater percentage is *unreimbursed*, meaning the payments received for services provided do not cover the full costs of providing these services. Safety net hospitals often lose money on Medicare and Medicaid patients. These hospitals and health systems rely on a number of sources to support this unreimbursed care. As Figure 5 illustrates, state and local subsidies are important to safety net financing, providing 39 percent of the unreimbursed care. Despite the importance of this funding, state and local financing varies quite a bit across NAPH hospitals and is considerable in some communities and minimal in others. On average, state and local subsidies represent about 15 percent of net revenues at NAPH hospitals.²⁹ Still, over 15 percent of NAPH hospitals receive no state or local support and an additional third indicate that these subsidies represent less than 10 percent of net revenues.



State and local subsidies take many different forms and reflect the political, economic, cultural and historical realities of the community in which the hospital operates. Local support can provide direct payment for general health care services, or it can provide targeted subsidies, for example for specific services such as trauma services or capital expenditures.³⁰ Often, when local monies finance direct patient care, communities define populations who are eligible for free- or reduced cost services in terms of county or city residency requirements, income eligibility, or other criteria.

Another 28 percent of funding for unreimbursed care comes from revenues not associated with direct patient care, such as interest and investment income, cafeteria and parking revenues, medical record fees, rental fees, and sales taxes. Funding from tobacco settlements is included in this category.

Medicaid disproportionate share hospital (DSH) payments are also a significant source of funding for unreimbursed care, financing 23 percent of this care, while Medicare DSH finances about 6 percent of unreimbursed care. Medicaid DSH payments are determined by individual state Medicaid programs and are given to hospitals the state designates as serving a disproportionate share of low-income or uninsured patients.³¹ These payments are in addition to payments made to hospitals for direct patient services and are intended to offset losses hospitals experience treating Medicaid and uninsured patients. The payments are capped at the state level so that state contributions cannot exceed federally determined limits.

The Medicaid disproportionate share hospital payment was enacted as part of the Omnibus Budget Reconciliation Act of 1981. OBRA '81 severed the link between Medicare and Medicaid payment practices for hospitals. As states moved from cost-based reimbursement to a prospective payment methodology, they were required to “take into account” the situation of hospitals serving a disproportionate number of low-income patients with special needs.^{32,33} Although states were slow during the 1980s to set up DSH programs, changes in the program’s financing mechanisms during the 1990s facilitated rapid growth of the program, which by 2003 provided approximately \$8.6 billion in federal Medicaid funding to nearly all of the states and the District of Columbia.³⁴

Medicaid DSH is a central source of financing for safety net hospitals:

- According to NAPH, in the absence of Medicaid DSH, safety net hospitals’ payment-to-cost ratio would be 0.77 and they would have lost over \$1.8 billion on the care of Medicaid patients alone in 2002.³⁵
- A 2002 report prepared for the Office of the Assistant Secretary of Planning and Evaluation by Rand and the Urban Institute found that approximately 75 percent of net Medicaid DSH payments went to hospitals that had negative total margins before receiving these payments.³⁶
- An estimated 64 percent of net Medicaid DSH payments went to hospitals with at least 30 percent low-income patients while 80 percent of net payments went to hospitals with at least 20 percent low-income patients.³⁷ Also, 63 percent of Medicaid DSH payments go to hospitals with a Medicaid utilization rate, defined as Medicaid days divided by total days, that is above one standard deviation from the state average.

Despite its importance in financing care for the nation’s safety net hospitals, Medicaid DSH is especially vulnerable to budget cuts, in part because it is not tied to a particular set of services.³⁸ Several aspects of the program make it unpopular with at least some policymakers, and in the early 1990s, Congressional action was taken in the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and OBRA 93 to limit DSH spending.³⁹ Multiple payment methodologies and eligibility criteria can create, at least in some states, unique state DSH programs that are inequitable and poorly targeted.⁴⁰ Also, while Medicaid DSH funds are intended for hospital-based care related to Medicaid and uninsured individuals, states can determine how the funds are spent. The result has been that some states have used DSH funds to finance other health-related, and in some cases non-health-related, expenses rather than using these federal funds as Congress intended.⁴¹ Finally, many states finance the DSH program with intergovernmental transfers (IGTs) from public hospitals. While consistent with federal Medicaid provisions, this practice has been exploited in the past. As a result, appropriate and well-targeted IGTs operate under a cloud.⁴² Given the historical problems with the program, researchers and policymakers often point to

DSH funding as a source of financing for health insurance expansions, without fully considering the consequences associated with removing this source of financing from the safety net.⁴³

Medicaid supplemental payments using the Medicaid Upper Payment Limit (UPL) are another source of funding for public hospitals. Medicaid UPLs allow states to pay categories of providers as a group up to the “upper limit” of what Medicare would pay for similar services. Because base Medicaid reimbursement is typically so low, most states have a significant gap between actual Medicaid payments and the UPLs. Some states have narrowed or closed this payment gap by providing supplemental payments (UPLs) to providers, usually public providers. Although data are not available to quantify UPL payments to public hospitals,⁴⁴ anecdotal evidence suggests that these supplemental payments have become nearly as central a source of financing for unreimbursed care as Medicaid DSH payments.

UPL payments have come under much the same scrutiny as Medicaid DSH payments. Like DSH, many UPL payments are financed through IGTs. In addition, past flexibility in the UPL regulations enabled states to make nearly unlimited supplemental payments to providers. While many states used this flexibility to support safety net providers, other states took advantage of it to draw down excessive federal funding with no real non-federal contribution. Changes to the UPL law and regulation since 2001 have closed the loopholes that previously permitted state abuses.

Medicare DSH operates under a more uniform financing mechanism, but its impact on safety net financing is not as significant. Many more hospitals qualify for Medicare, rather than Medicaid, DSH; \$6.3 billion in funding came from Medicare DSH payments in 2002 – an amount stretched rather thinly across over 2,800 eligible hospitals.⁴⁵ Importantly, Medicare DSH does not compensate hospitals for costs of caring for uninsured patients; payments are based solely on utilization of Medicare patients who receive Supplemental Security Income (SSI) and Medicaid utilization. In addition, payments are tied to Medicare volume, which is generally lower at safety net hospitals than at other acute care hospitals in the country. Medicare also supports safety net hospitals through indirect medical education (IME) payments, which finance the additional costs associated with their teaching mission. In 2002, these payments supported 4 percent of unreimbursed care at NAPH hospitals. Even with these sources of financing, the majority of NAPH hospitals lost money on Medicare patients.⁴⁶

Part 2. The Experience of Public Hospitals during an Economic Downturn

Federal, state and local financing can have an enormous impact on safety net hospitals, but there are additional factors, some of which are related to the local economy and others related to state and federal fiscal conditions, that affect the viability of safety net providers. Researchers from the National Public Health and Hospital Institute (NPHHI) interviewed senior leaders from public hospitals in eight states to learn about pressures that their hospitals have faced over the past several years. We also asked about their priorities for the coming years. Respondents were asked about a variety of topics, including local economic conditions, changes in the demand for services from uninsured or underinsured residents; workforce issues; the availability of capital for investment in facilities and information technology; cost drivers; and efforts to improve efficiency and better coordinate services. We spoke to chief executive officers, chief financial officers, chief medical officers, directors of ambulatory care and emergency department heads.

The interviews took place from November 2004 through January 2005 and focused on issues in California, Florida, Georgia, Minnesota, New Mexico, New York, Ohio and Texas. We selected providers in these states to provide diversity in terms of regional variation, demographic characteristics of the populations, and state Medicaid program features.

The interviews portray an industry that is remarkably resilient, despite a combination of stresses that, if unabated, will certainly result in a net decrease in safety net services in the next several years. As the number of uninsured in the country climbs, our safety net hospitals and health systems will continue to be called on to fill the gaps, stretching resources and services that are already nearly stretched to the breaking point. Combined with higher costs of capital, this situation creates a vicious cycle for safety net hospitals, with increased demand for services on already stressed resources.

Changes to the Medicaid Programs in the Eight States

Over the past several years, states have contended with huge budget deficits and many have responded by searching for ways to reduce spending on public programs. Enrollment in Medicaid has grown by one-third since 2001, despite state budget crises, and while enrollment growth appears to have slowed, efforts to rein in state spending will continue to focus, in part, on cuts to Medicaid.⁴⁷

Significant changes to state Medicaid programs will have profound effects on safety net providers' financial viability. In October 2004, the Kaiser Commission on Medicaid and the Uninsured issued an updated survey of state Medicaid programs and their cost containment practices in fiscal years 2004-2005.⁴⁸ Key cost containment provisions are shown in Table 2 and illustrate the multiple challenges that providers face when trying to serve growing numbers of Medicaid and

uninsured patients. Not surprisingly, cuts to provider payments are the most common cost containment strategy, with providers in all eight states implementing cuts in both fiscal years. Because these cuts are generally not tied to specific services, they are less visible to community residents and policymakers alike.

Table 2: Key Changes to the Medicaid Program in Eight States in 2004 and/or 2005

	CA	FL	GA	MN	NM	NY	OH	TX
Cuts in provider payments	✓	✓	✓	✓	✓	✓	✓	✓
Benefit reductions	✓	✓	✓	✓	✓		✓	✓
Eligibility restrictions	✓		✓	✓	✓	✓	✓	✓

Source: Kaiser Commission on Medicaid and the Uninsured, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, October 2004. Information in this table also comes from conversations with senior leaders in safety net hospitals in these states.

Only one of the eight states, Florida, has not cut eligibility for certain categories of Medicaid patients; one other state, New York, has not reduced benefits in either fiscal year. Seven states are implementing a combination of benefit reductions and eligibility restrictions designed to slow growth in state Medicaid expenditures. While beneficial to state budgets, these changes do not result in effective cost containment at the safety net provider level.

The need for health services does not diminish as Medicaid eligibility or benefits contract. In practice, previously covered individuals or services are reclassified as “self pay” instead of “Medicaid,” and the burden of care – without the benefit of coverage – remains with the safety net provider.

In fact, this pattern was mentioned repeatedly in conversations with safety net leaders in the eight-state study. In Texas, a combination of provider cuts, benefit reductions, eligibility changes and cuts in DSH and medical education-related funding occurred simultaneously with an increase demand for safety net services. A Texas safety net hospital, for example, has been able to provide services to low-income uninsured residents – many of whom are immigrants – because of funding from Medicaid and Medicare DSH and supplemental payment streams, in addition to commercial insurance. After years of cuts to those payment streams, and with deeply discounted care through commercial managed care contracts, underpayment appears to be the biggest single threat to the organization’s stability. Similar sentiments were echoed by respondents in Georgia and Ohio.

Table 3 identifies common pressures facing safety net hospital systems. These include: growing demand from uninsured patients as well as demand for specific services such as emergency and trauma care and interpreter services; decreasing funding from traditional sources of financing; workforce issues such as rising labor costs, shortages of key health care professionals and cutbacks in staffing; difficulties related to investment in capital resources and information technology, and rising pharmaceutical costs.

Table 3: Stresses to Public Hospitals in Eight States

	CA	FL	GA	MN	NM	NY	OH	TX
Increased numbers of uninsured		✓		✓			✓	✓
Increased demand for emergency and trauma services	✓	✓			✓	✓	✓	✓
Increased demand for interpreter services	✓	✓	✓	✓	✓	✓	✓	✓
Decreases in funding from federal or state/local sources	✓	✓	✓	✓	✓	✓	✓	✓
Rapidly rising labor costs	✓	✓	✓	✓	✓	✓	✓	✓
Significant nursing shortages or difficulties recruiting nurses	✓	✓	✓	✓	✓	✓		✓
Significant specialist shortages	✓			✓	✓	✓	✓	✓
Layoffs over past three years		✓	✓	✓			✓	✓
Difficulties investing in current or new facilities and equipment (including IT)	✓	✓	✓	✓	✓	✓	✓	✓
Difficulties managing growth in pharmacy costs	✓	✓	✓	✓	✓	✓	✓	✓

Source: NPHHI interviews with senior leaders in safety net hospitals in eight states, November 2004 – January 2005.

Growing Numbers of Uninsured

Not all safety net hospitals are feeling the effects of growing demand for care from uninsured residents. Safety net providers in half of the states have experienced growth in their uninsured populations; in Florida and Texas, this growth commonly involves new immigrants. Respondents in California, Georgia, New Mexico and New York indicated that they are not seeing growing numbers of uninsured patients. Instead, they are feeling the effects of increasingly lower payments for underinsured patients or patients whose coverage provides underpayment for care. While some of the providers in the eight states are not experiencing increases in the number of uninsured patients, they all provide care to extremely large numbers of uninsured patients.

Several safety net providers noted changes in their local markets with hospitals and other ambulatory care providers completely moving out of their service area or cutting back on certain categories of care provided to lower-income patients. This was mentioned by respondents in Minnesota, New Mexico, Ohio, and Texas. Movements such as these tend to result in greater pressures on emergency department and trauma services and increased demand for outpatient services. Frequently, uninsured or low-income patients look to the safety net hospital for

care, while insured patients either set up alternative arrangements in the service area or maintain relationships with their providers and follow them to their new locations.

Funding Decreases

All respondents reported that their organizations are experiencing decreases in one or more sources of revenue. In Minnesota, for example, Medicaid cost containment strategies are coupled with cutbacks in state and county general assistance programs; and in Georgia, changes to Medicaid managed care are expected to result in multi-million dollar losses in revenue. These Medicaid cost containment strategies are all on top of current Medicaid payment policies that often pay rates below the cost of providing care.

Safety net hospitals in California are extremely concerned about state-wide plans to restructure the state Medicaid program, Medi-Cal. As part of that restructuring, preliminary reports suggest that the state will require that financing for many payments used to support safety net hospitals through Medi-Cal will shift from IGTs to a cost-based reimbursement methodology based on certified public expenditures (CPEs).⁴⁹ Ohio will also move from IGTs to CPEs beginning with 2004 expenditures. The implications of this change are not yet fully understood, although safety net hospitals are concerned that reimbursement levels will drop. Safety net hospitals in California have voiced their opposition to the switch from IGTs to CPEs.⁵⁰ On top of these changes, the state's proposed Medi-Cal plan also shifts the aged, blind and disabled population from fee-for-service to managed care – a move that would result in annual decreases of hundreds of millions of dollars in supplemental federal funding.⁵¹

In the meantime, safety net providers in other states are experiencing difficulties securing supplemental payments, in part because of the Administration's increased scrutiny of these arrangements. For example, in Ohio, requests for additional DSH and UPL funding have been held up, despite legislation allowing such expenditures. According to the 2004 state survey compiled for the Kaiser Commission on Medicaid and the Uninsured by Smith and colleagues, the Centers for Medicare and Medicaid Services (CMS) has slowed the Medicaid State Plan Amendment approval process most notably in states that rely heavily on special financing arrangements such as IGTs and UPL, regardless of whether the state plan amendment is related to IGT funding.⁵²

Increased Demand for Emergency Department, Trauma, and Interpreter Services

Providers in six of the states indicated that they were experiencing growing demand for emergency and trauma services, with several saying that emergency departments and trauma units were overwhelmed with patients in need of care. Respondents in Georgia and Minnesota have high emergency department and

trauma volumes that have held steady over the past several years. Both experience significant problems with long wait times and crowded facilities.

Respondents at a Florida safety net hospital indicated that nearby counties frequently refer indigent patients to the emergency department.⁵³ In California, safety net hospitals are reportedly experiencing large increases in the numbers of patients requiring psych-ED care. Fortunately, additional funding may be available through a new state tax on income over \$1 million that is expected to generate \$700-\$800 million per year, all of which will be dedicated to expanding capacity for mental health services. Safety net emergency departments in the state will receive at least some portion of this funding.

Public hospitals in New York have also seen significant increases in emergency department volume over the past several years, in part because of poorly coordinated mental health care and inadequate referral arrangements between emergency departments and primary care sites. One Texas safety net hospital reported that trauma visits have been increasing at about 1,000 additional visits per year for the past few years. Trauma services are growing at such a rapid pace that they are crowding out elective and non-trauma related surgeries, many of which are for insured patients. This results in a double hit to the bottom line – rising costs of expensive trauma patients (many of whom are uninsured) and decreased payments from insured non-trauma patients who are “crowded out” (many of whom are insured).

Along with a surge in ED and trauma volume has come sustained growth in terms of patients with limited English proficiency and demand for interpreter services. While this is true for providers in seven of the states, the challenge is especially great in states with large linguistically diverse patient populations (such as California, Florida, New York, and Texas), and states with small but rapidly growing groups of patients who have limited English proficiency (such as Georgia). Despite the need for interpreters, few state Medicaid programs explicitly cover interpreter services. Thus, safety net providers must address these growing needs out of general operating revenues.

Workforce Issues

Safety net hospitals are major employers and are extremely dependent on the supply of labor to provide a full complement of health care services. They must compete with non-safety net hospitals and health systems and other employers in their markets and offer competitive compensation packages to recruit and retain a talented and highly skilled workforce.

The largest single category of expenses is the cost of labor, and with thousands of employees, safety net hospital budgets are influenced largely by both market conditions and contractual obligations to employees. In New York, for example, the Health and Hospitals Corporation is facing a \$150 million increase in pension

costs in 2005; this increase is part of a contractual obligation between the Corporation and its employees and is independent of any salary increases or other growth in expenditures. While the scale of this expense is greater for the New York hospital system (because it the largest public system in the country with more than 30,000 employees), similar types of challenges are occurring in safety net hospitals in the other states.

As total labor costs rise, safety net hospitals must either cut costs through efficiencies or service reductions; or increase revenues, either through enhanced subsidies or expanded or new lines of business. Many of the respondents in the eight states indicated that they are “hitting the wall” in terms of options to absorb these growing costs.

The U.S. health care system is experiencing a shortage of nurses, with over one in 10 nursing positions estimated to be unfilled.⁵⁴ Providers also have difficulties recruiting pharmacists and pharmacy technicians, certain specialty physicians, dental and mental health providers, and many other clinic and hospital-based health professionals.

Although providers in six of the states indicated that there were difficulties recruiting nurses, with some experiencing very severe shortages, the more common response from safety net providers was that nursing was relatively stable in their organizations due to their additional efforts to recruit and retain nurses. Safety net facilities were able to attract and retain high-quality nursing staff, primarily because they offered a mission-driven environment dedicated to providing outstanding care to patients in need. Several respondents spoke about efforts necessary to recruit and retain nurses in a competitive labor market, including encouraging significant clinical and career development opportunities for nurses, creating supportive and pleasant work environments, and integrating nurses into patient care teams.

Even with these additional efforts to recruit nurses, respondents indicated that the widespread nursing shortage is a constant threat, and requires vigilance and ongoing monitoring to ensure adequate nurse staffing in their hospitals. Some safety net hospitals are working very hard just to keep afloat in terms of nursing supply. California hospitals have an explicit mandate to conform with nursing staff ratios;⁵⁵ several hospitals, for example in California and New Mexico, can meet these or other staffing needs only through costly and inefficient arrangements with contract nurses.

Safety net hospitals in six of the states also reported shortages of specialist physicians and other providers, although the nature of the shortage varies from state to state. Dermatologists, neurosurgeons, ophthalmologists, orthopedists, and radiologist positions are difficult to fill for providers in some of the states. Pharmacists with advanced clinical training were also in very short supply. Even with these specialists on staff, however, safety net hospitals are not equipped to

meet the enormous demand for specialty services from residents in their communities. Virtually all of the respondents indicated long waits for access to specialty care. These waits are one reason why patients turn to emergency departments for care they could receive in other ambulatory settings.

Investment in Facilities and Equipment

Perhaps the most visible sign of financial pressure is the condition of many safety net hospitals in the eight states profiled in this report. While most respondents generally indicated that they could access capital, they often were unable to invest in capital improvements because of more critical needs for direct patient care. As a consequence, safety net hospital facilities tend to be older than average acute care hospitals in the country,⁵⁶ and are much less likely to have fully developed state-of-the-art information technology such as electronic medical records than other not-for-profit academic health centers.⁵⁷

Respondents in the eight states were acutely aware of the hazards associated with neglecting physical plants and infrastructure. All of the safety net hospitals in these eight states exist within markets that can boast newer and more attractive hospital and health system facilities – a condition that lowers workforce morale and serves as a disincentive for individuals who can choose to seek care from other providers in the community.

Aside from the aesthetic issues, lack of investment in infrastructure puts safety net hospitals at a disadvantage in terms of their ability to compete for patients who require sophisticated surgical, diagnostic and therapeutic services, many of which are revenue enhancers. While all of the respondents indicated that they have made significant investments in IT, they recognize that much more is necessary to bring systems in line to advance safety and quality improvement initiatives.

Despite these limitations, safety net hospitals may be ahead of the curve in terms of their ability to access and analyze clinical information by the race and ethnicity of patients – a field that is of great interest to policymakers and one that is of critical importance on a variety of quality dimensions. Most of the safety net hospitals in the eight states collect information on patients' race and ethnicity and have the IT capacity to link this information with patient clinical data – producing empirical data on quality of care across racial groups within safety net hospital systems. Many of these hospitals are actively engaging in chronic care management programs that rely heavily on information technology to track and monitor patient outcomes.⁵⁸

Finally, some safety net hospitals systems have been able to construct new facilities or add new components to their systems. For example, within the New York City Health and Hospitals Corporation, new hospital facilities recently opened at Kings County Hospital and Queens Hospital Center. Significant modernization projects are also underway at Bellevue Hospital Center, Coney Island Hospital,

Harlem Hospital Center and Jacobi Medical Center, while additional improvements are being implemented at other facilities. Also, after years of struggling to approve new construction, the University of New Mexico Health Sciences Center expects to break ground on a new hospital facility later this year. Over the past five years, the Santa Clara Valley Health and Hospital System, located in San Jose, CA, has seen the construction of a new hospital and a subsequent hospital addition, six new federally qualified health centers that are part of the hospital system, and is beginning construction on a major new outpatient center. Even with new construction at several facilities, many safety net hospitals and health systems still lag behind industry standards in terms of plant years.

Rising Pharmacy Costs

After several years of rapid increases in the costs of pharmaceuticals, safety net hospitals are beginning to see the effects of targeted efforts to hold down the growth of spending on pharmacy. Providers in four of the eight states indicated that a combination of efforts, most notably use of 340 B pricing,⁵⁹ use of formularies, and effective medical management, have contributed to more modest growth (in the 2-4 percent range) in the coming year. Providers in the other four states are continuing to absorb increases in pharmacy costs that, while not as dramatic as the past two or three years, are still in the double-digit range. Leaders in safety net hospitals reported using aggressive strategies to mitigate the effects of rising costs of pharmaceuticals, including efforts to obtain drugs that are free or at reduced-costs for patients. Because of the importance of outpatient pharmaceuticals to safety net populations – and the understanding that poorly managed individuals receiving outpatient care quickly become avoidable emergency department and inpatient visits – all of the respondents indicated reluctance to increase co-payments from currently modest levels in order to offset or reduce costs because they might serve as a barrier or disincentive to utilization.

Stresses to Safety Net Hospitals: Discussion and Policy Implications

In light of these challenges, what are the prospects for safety net hospitals in the next several years? What lessons can we take from the difficulties of the past few years and how can safety net hospitals become stronger and more stable organizations to serve the needs of millions of uninsured, underinsured, and otherwise vulnerable residents in their communities?

Our review of safety net hospital characteristics and trends over the past several years illuminates several realities that will make the continued viability even more challenging for safety net hospitals in the years to come. Among these:

- Federal sources of financing have become a critical source of revenue for safety net hospitals. Because of this, safety net hospitals are more sensitive to policy changes that have a direct or indirect impact on federal sources of financing than they are to local market conditions or other economic factors.

Safety net hospitals rely on multiple funding streams, but state and local payments have remained relatively flat, as have payments from public and private insurers for direct services. As was stated before, respondents all reported that provider payments have been cut year after year in the Medicaid program, affecting patient revenues from Medicaid; one respondent indicated that Medicaid reimbursement rates at a California safety net hospital had not been increased in 13 years.

- Shortfalls in financing are increasingly being addressed through DSH and other supplemental payments that bring additional federal resources into a safety net system. Without these federal supports, which can vary widely because of each state's role in setting DSH allocations, safety net hospital systems will be unable to continue operating at current levels. At the same time, there are no comprehensive health insurance expansions under serious consideration. Safety net hospital systems and advocates fear the worst of both worlds – deep cuts to or elimination of supplemental payments without broad increases in coverage for the uninsured. Such actions would effectively eviscerate the nation's hospital-based safety net.
- The growth in services within safety net hospital systems is on the outpatient side, and not on the more lucrative inpatient side. As a leading growth area, this does not bode well for the financial health of safety net hospitals in the next several years. Outpatient service volumes are enormous in safety net hospitals and are growing each year, yet these visits are characterized by lower rates of insurance coverage and lower per patient revenue due in part to Medicaid reimbursement that is often even lower for outpatient than inpatient care. Reimbursements for outpatient services are generally extremely low, since most safety net hospital outpatient clinics, which are usually publicly owned, do not qualify for the cost-based payments that federally funded health centers receive to assure that federal grants for care of the uninsured are not shifted to offset losses on Medicaid patients. In practice, Medicaid reimbursements from outpatient services are between one-fifth and one-tenth the amount that are paid to federally funded health centers. To add further stress to the public hospital safety net, outpatient services are often not factored into DSH calculations; the end result is that providing more uncompensated outpatient care may not translate into additional DSH funding, and may actually reduce DSH funding if uncompensated inpatient care drops.
- Despite the lack of a “business case” for high-quality outpatient care, safety net hospitals actively promote effective chronic care management, with the goal of improving health and keeping patients out of emergency departments and hospital beds. This strategy also involves more aggressive use of pharmaceuticals to better manage chronic conditions. Unfortunately, what's good for the patient is not always good for the health care organization's bottom line, especially in an environment where providers are poorly reimbursed for outpatient care compared to inpatient services.

- Even in times of economic stress, safety net hospitals generally do not respond by eliminating services. Very few respondents indicated that services had even been curtailed, although all pointed to more subtle retrenchments that effectively lengthened patients' waits for care. Leaders at safety net hospitals have reported using a variety of strategies to tighten their budgets including delaying capital improvements, eliminating or scaling back social services that are not reimbursed, eliminating emergency room stations, and shortening clinic hours. These strategies have potential implications on quality of care provided to patients, but have become necessary given the financial stresses to safety net hospitals. These strategies could also result in adverse selection, however. As patients wait longer for necessary services, individuals with the means to choose other health care options will do so, leaving safety net hospitals with a greater proportion of patients unable to obtain care elsewhere. These patients are likely to be uninsured or underinsured and may actually contribute to increasing levels of uncompensated care.

Safety net hospitals are large complex organizations that operate budgets in excess of hundreds of millions of dollars and offer an extremely broad array of services. At the community level, local residents and policymakers may assume that organizations such as these can absorb cuts year after year, with little or no effect on quality or access. Community expectations surrounding quality and service availability have not changed over the past several years, despite extremely dire shortfalls in state and county budgets across the country. And, from a national perspective, large supplemental payment programs may produce the impression among policymakers that these organizations can weather the storm, year after year, with no discrete discontinuation of services.

Once organizations that reflected home-grown responses to health care for uninsured and low-income residents, today's safety net hospitals increasingly are part of a national network of health care providers that serve as the hub of the safety net in their communities. Their survival is inextricably tied to federal sources of support – a situation that is only likely to continue in the years ahead. Direct subsidies may be inadequate; a federal-state partnership, with incentives for reasonable Medicaid payment rates, may be key to the survival of the safety net. The time has come for national policy to recognize this network of providers and solidify financing to support and maintain their critical missions.

Endnotes

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- ⁵ American Hospital Association, 2004. Statistics are for 2002.
- ⁶ For information on the decrease in Medicaid births in public hospitals as a result of managed care and competition for healthy Medicaid births, see: Gaskin DJ, Hadley J, Freeman VG. Are urban safety-net hospitals losing low-risk Medicaid maternity patients? *Health Serv Res*. 2001 Apr;36(1 Pt 1):25-51.
- ⁷ The vast majority of these visits are face-to-face encounters with physicians, physicians' assistants, and nurse practitioners. In most cases, laboratory and other diagnostic services are not included in visit numbers.
- ⁸ Personal communications with safety net hospital leadership, November 2004-January 2005.
- ⁹ A handful of public hospitals include federally funded health centers within their systems and the ownership arrangements can vary from system to system. The majority of the 700+ community clinics affiliated with safety net hospitals are owned and operated by the hospital system.
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- ¹¹ Regenstein M, Nolan L, Wilson M, Mead H, Siegel B. Walking a Tightrope: The State of the Safety Net in Ten U.S. Communities (Washington, DC: George Washington University Medical Center, May 2004). See also: Felt-Lisk S, McHugh M, Howell E. Monitoring local safety-net providers: do they have adequate capacity? *Health Affairs*, September/October 2002; 21(5): 277-283.
- ¹² American Hospital Association, 2004. Data are for 2002.
- ¹³ There are no reliable estimates of the volume of diagnostic services at acute care hospitals. AHA data appears to be unreliable in this area, with some hospitals including diagnostic services in their estimates of ambulatory care and others excluding them. We estimate them to be well over 100 million in this report to provide a sense of the demand for these types of safety net services. The real number may be much closer to 200 or 300 million.
- ¹⁴ Nearly two-thirds (63 percent) of patients at NAPH members that are also academic medical centers are either uninsured or covered by Medicaid.
- ¹⁵ The payer mix across inpatient and outpatient sites is nearly identical for NAPH members that are academic medical centers. For example, on the inpatient side, 25 percent of admissions are for uninsured patients; an additional 38 percent of admissions are covered by Medicaid. On the outpatient side, the respective percentages are 38 and 25.
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- ¹⁷ NAPH does not collect income information on member hospital patients. Nevertheless, with such a high proportion of patients covered by Medicaid or uninsured, even without precise estimates of poverty within this population, it is a safe assumption that the majority of patients are low income.
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- ¹⁹ Weil A. There's something about Medicaid. *Health Affairs*. 2003 22 (1): 13-30.

- ²⁰ For information on specific financing arrangements and local conditions of safety nets, see: Rosenbaum S, Shin P, Darnell J. "Economic Stress and the Safety Net: A Health Center Update," *Issue Paper* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2004); Regenstein M, Nolan L, Wilson W, Mead H, Siegel B. *Walking A Tightrope: The State of the Safety Net in Ten U.S. Communities* (Washington, DC: George Washington University Medical Center, May 2004).
- ²¹ The Bush Administration is currently looking into further changes to the program that would increase flexibility on the part of the states to determine benefits and optional populations.
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- ²³ Laurie E. Felland, Kyle Kinner, John F. Hoadley. *The Health Care Safety Net: Money Matters but Savvy Leadership Counts*. Center for Studying Health System Change. Issue Brief No. 66, August 2003.
- ²⁴ NAPH Annual Survey of Members, 2004. Data are for 2002.
- ²⁵ Ibid.
- ²⁶ Ibid. See also: Singer I, Kuzner J, Fagnani L. *America's Safety Net Hospitals and Health Systems, 2000: Results of the 2000 Annual NAPH Member Survey*. (Washington, DC: National Association of Public Hospitals and Health Systems, July 2002).
- ²⁷ Sources of revenue are nearly identical for NAPH members that are academic medical centers; at NAPH AMCs, the revenues are as follows: 17 percent from state and local sources, 34 percent from Medicaid, 18 percent from Medicare, 8 percent from self-pay patients, and 23 percent from commercial insurers.
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- ³⁰ Tolbert J, ed. *Safety Net Financing: A Policy Source Book for Healthcare Executives*. (Washington, DC: National Association of Public Hospitals and Health Systems, June 2003).
- ³¹ Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer*. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2001).
- ³² For a history of the Medicaid Disproportionate Share Hospital Program, see: Tolbert J, 2003.
- ³³ OBRA '81 also contained the requirement that Medicaid payments be reasonable and adequate, a provision that was referred to as the Boren Amendment. In response, HCFA issued a rule allowing states flexibility to set payment rates for inpatient hospital services that were, in the aggregate, no greater than the amount that would be paid for the same set of services under the Medicare principles of reimbursement. This rule became known as the upper payment limit – a limit that has facilitated a variety of targeted supplemental Medicaid payments to support safety net hospitals. The upper payment limit has been modified and curtailed over the years but that continues to allow for supplemental payments that are an important source of financing for safety net hospitals.
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- ³⁵ Singer, et al., 2004.
- ³⁶ Wynn B, Coughlin T, Bondarenko S, and Bruen B. *Analysis of the Joint Distribution of Disproportionate Share Hospital Payments*. Prepared for the Assistant Secretary of Planning and Evaluation U.S. Department of Health and Human Services by RAND under contract with the Urban Institute, September 2002, accessed 3/3/2005. <http://aspe.hhs.gov/health/reports/02/DSH/ch9.htm>. See also Mechanic R. *Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments*. National Health Policy Forum Background Paper, September 14, 2004. (Washington, DC: The George Washington University). Accessed 2/1/2004: http://www.nhpf.org/pdfs_bp/BP_MedicaidDSH_09-14-04.pdf.
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- ³⁸ Gage LS. "The Future of Safety Net Hospitals," in: *The Future U.S. Healthcare System: Who Will Care for the Poor and Uninsured?* Stuart H. Altman, Uwe E. Reinhardt, and Alexandra E. Shields, eds. (Chicago, IL: Health Administration Press, 1998).

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- ⁴¹ Coughlin TA, Bruen BK, King J. States' Use of Medicaid UPL and DSH Financing Mechanisms. *Health Affairs*. 2004, 23(2): 245-257. See also Coughlin TA, Ku L, Kim J. Reforming the Medicaid Disproportionate Share Hospital Program. *Health Care Financing Review*. 2000, 22(2): 137-157.
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- ⁴⁷ Smith V, Ramesh R, Gifford K, Ellis E, Rudowitz R, O'Malley M. The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey. (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2004).
- ⁴⁸ Smith, et al., 2004.
- ⁴⁹ BNA's Health Care Daily Report: *Changes in California Hospital Payment Said Key Component of Governor's Plan*. Volume 10, No. 5, January 7, 2005. In general, federal Medicaid law requires that the state share of Medicaid spending be public funds that are not federal funds. These public funds may be State funds, or they may be local government funds transferred to states (intergovernmental transfers (IGTs)). Public funds may also include certain Certified Public Expenditures (CPEs) which are funds certified by the State or by local units of government as the non-Federal share of Medicaid expenditures. 42 CFR 433.51(b). For example, if a county-run hospital incurs costs in delivering covered inpatient and outpatient services to eligible Medicaid patients, the county or its hospital could certify those costs, which it has met with local funds, as the non-Federal share of Medicaid expenditures, and the state could rely on this certified amount in drawing down federal Medicaid matching funds, subject to CMS approval.
- ⁵⁰ See: Proposed Restructuring of Safety Net Hospital Financing Update: A statement from the California Healthcare Association, the Private Essential Access Community Hospitals, and the California Association of Public Hospitals and Health Systems, December 8, 2004.
- ⁵¹ Certain supplemental Medicaid payments are based on Medicaid fee-for-service payments. Moving aged, blind and disabled patients into capitated managed care arrangements would effectively remove the costs of their care from the supplemental payment calculations.
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- ⁵³ The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that requires that all patients presenting to an emergency department be screened to determine whether their condition is emergent. The provision applies to all patients, regardless of coverage or ability to pay, and is in effect the only statutory guarantee of access to health services. If the patient's condition is emergent, EMTALA requires that the emergency department provide at least some level of appropriate treatment. The full text and regulations of EMTALA can be found at <http://www.emtala.com/#stat>

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