THE DOUBLE BIND: CHALLENGES TO SAFETY NET AND TEACHING HOSPITALS

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The major transformation now under way in American health care financing poses challenges for the nation's safety net and teaching hospitals. The growth of managed care and the spread of competition among providers may ultimately deprive safety net and teaching institutions of the support that has traditionally allowed them to provide health care to the uninsured. An analysis of current circumstances and trends can move the understanding of the situation beyond anecdotes and allegations.

Two strong trends are shaping the future of indigent care provision by safety net and teaching hospitals. First, the movement of Medicaid patients into managed care seems to be accompanied by a tendency among plans to shift patients and revenues away from traditional safety net hospitals, especially those with substantial academic missions. Second, uncompensated care is increasingly becoming concentrated in public hospitals. Under pressure from managed-care plans to reduce their charges, many hospitals have scaled back their commitment to uncompensated care, leaving public hospitals to treat patients with more-complex illnesses. For hospitals that serve both safety net and teaching functions, this creates an agonizing double bind: forced to assume greater responsibility for uncompensated care, these same institutions face the loss of a significant portion of their paying Medicaid patients.

Major safety net hospitals serve a higher percentage of uncompensated care and Medicaid patients than other hospitals. (Uncompensated care includes both charity care to the uninsured and "bad debt" care for patients who are underinsured or who for some reason do not pay for all their care.) Although major safety net hospitals comprise only 5% of all hospitals, more than half of their patients are either uncompensated care patients or Medicaid beneficiaries (Fig.

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FIG. 1 Share of hospitals' discharges that are uncompensated care and Medicaid, by safety net role, 1994. Source: Gaskin D, Hadley J. Georgetown University analysis using 1994 hospital discharge data from 8 states.

1). This is more than 2½ times the total share for hospitals with a minor safety net role. Medicaid revenues are especially important to major safety net institutions, accounting for an average of 41% of patients.

Major safety net hospitals are also teaching hospitals. Of hospitals with a major safety net role, 82% are teaching hospitals, compared to only 21% of facilities having a minor safety net role (Fig. 2). Targeted Medicare payments show the overlap between safety net and teaching hospitals (Fig. 3). Hospitals that treat a relatively large volume of low-income patients are paid under Medicare's Prospective Payment System (PPS) and Medicaid with a special disproportionate share adjustment (DSH). Sixty-four percent of all DSH payments go to teaching hospitals, indicating that a large proportion of safety net institutions train medical

FIG. 2 Distribution of hospitals by teaching status, 1994. Source: Gaskin D, Hadley J. Georgetown University analysis using 1994 hospital discharge data from 8 states.

FIG. 3 Distribution of Medicare targeted operating payments, by hospital type, 1996. Source: Prospective Payment Assessment Commission. *Medicare and the American Health Care System: a Report to Congress*. Washington, DC: General Services Administration; June 1996.

residents. PPS also pays teaching hospitals a special adjustment for the indirect costs associated with graduate medical education (IME). Seventy-five percent of IME payments go to hospitals that receive DSH, illustrating that most teaching hospitals also treat the nation's poor.

The role of teaching hospitals in providing indigent care is even more pronounced when academic health centers (AHCs) are examined separately. Academic health centers are inter-related entities consisting of a medical school, an affiliated hospital and outpatient centers, and a faculty practice plan.¹ Eighty-two percent of major safety net institutions are AHC hospitals. Although AHC hospitals constitute only 2% of US hospitals, they provide 23% of the total of \$28.1 billion in uncompensated care.² Further, AHC hospitals provide at least twice as much uncompensated care as other teaching or nonteaching hospitals (Fig. 4).

The expense of providing uncompensated care contributes to the higher costs of operating an academic health center. As institutions, AHCs perform missions that provide benefits for the society at large. AHCs bear the primary responsibility for training the next generation of health professionals, for conducting biomedical research to improve the quality and effectiveness of medical care, and for providing highly specialized health care services. Carrying out these missions is costly—an estimated \$18 billion in 1997. The cost per case for mission-related activities averaged \$2,681 in 1993, or 28% of the total cost per case in AHCs. The higher prices AHCs charge are a disincentive for managed-care organizations to use them.³

With the growth of Medicaid managed care, many safety net and teaching hospitals stand to lose profitable patients and critical revenues. Between 1990–1996, the number of Medicaid managed-care patients increased dramatically, from 2.3 million to 13.3 million, accounting for more than 40% of all beneficiaries.³

FIG. 4 Level of uncompensated care, by hospital type and ownership, 1994. *Source:* Reuter J, Gaskin D. The role of academic health centers in providing care to the poor. In: Altman SH, Reinhardt UE, Shields AE, eds. *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* Chicago: Health Administration Press; 1998.

AHCs are concerned that managed-care plans are steering Medicaid patients toward other hospitals with lower costs, leaving AHCs to care for patients with more-complex problems. In Tennessee, for example, the number of annual births in one prominent AHC fell from 8,000 to 4,000 after the implementation of the statewide Medicaid managed-care initiative.⁴ As a result, this AHC was left to treat the predominantly high-risk (and more expensive) births. In addition, the loss of Medicaid patients means a decline in hospitals' DSH subsidy, further reducing their ability to use public money to pay for uncompensated care.

Provision of uncompensated care appears to be associated with the hospital's ownership status: 44% of urban AHC hospitals are publicly owned. Across the board, public hospitals provide more uncompensated care than their privately owned counterparts (Fig. 4). Among non-AHC teaching hospitals (teaching hospitals without an affiliated medical school), public hospitals treat four times as many uncompensated care patients as private institutions. Academic health centers, regardless of ownership status, provide a greater proportion of uncompensated care. This leaves public AHCs with the responsibility of treating the lion's share of uncompensated care patients, averaging 20% of their gross patient revenues.⁵

Compounding the loss of Medicaid revenues, uncompensated care has become increasingly concentrated in public teaching hospitals. From 1989 to 1994, uncompensated care grew by 33% in public AHC hospitals, 37% in other public teaching hospitals, and 12% in public nonteaching hospitals. During this period, uncompensated care provided by private hospitals either remained constant or declined (Fig 5).

The increased concentration of uncompensated care exacerbates the existing fiscal challenges facing safety net and teaching hospitals, many of which also

FIG. 5. Trends in uncompensated care provided by teaching hospitals, 1989–1994. *Source:* Reuter J, Gaskin D. The role of academic health centers in providing care to the poor. In: Altman SH, Reinhardt UE, Shields AE, eds. *The Future U.S. Health Care System: Who Will Care for the Poor and Uninsured?* Chicago: Health Administration Press; 1998.

have higher costs due to their academic missions. These high costs place safety net and teaching hospitals at a competitive disadvantage: managed-care plans are unlikely to compensate AHCs for their higher costs and, in their search for discounted rates, are inclined to avoid AHCs altogether.

The combination of increasing costs and shrinking revenues endangers the ability of safety net and teaching hospitals to sustain their academic mission and their traditional role in providing indigent care. Public teaching hospitals, and particularly public academic health centers, confront an even greater challenge. Future discussion about preserving the health care safety net must recognize the double bind facing public teaching hospitals as they struggle to maintain their social and academic missions in an era of managed care.

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