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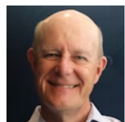
Revitalizing Safety Net Hospitals: Protecting Low-Income Americans from Losing Access to Care



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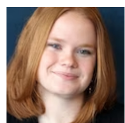

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Takeaways

Hundreds of hospitals throughout the country provide essential care to America's most vulnerable. These safety net hospitals play a vital role in our health care system–they make up about 5% of all US hospitals but provide more than 25% of the nation's charity care. But currently, they are fighting for survival because of numerous financing and staffing challenges. Below, we explain the basics of safety net hospitals, challenges they face, and a three-step plan to ensure their ability to provide care to all in need.

In September 2019, Hahnemann University Hospital in Philadelphia shut its doors after a storied past that began in 1848. [1] The hospital had nearly 500 beds, employed almost 600 medical professionals, and provided high quality, essential care for Philadelphia's poorest residents. It was victim of neglect by laws that are supposed to protect hospitals that serve low-income Americans.

Hundreds of hospitals throughout the country provide essential care to America's vulnerable populations by scraping together resources from a variety of public programs. While hospitals across the country are seeing record revenues, these "safety net" hospitals that provide care for the poor are struggling financially and may have to limit services or close their doors—like Hahnemann University Hospital. [2] Overall, safety net hospitals face three financial headwinds: low-reimbursement rates from Medicaid, unpaid care due to coverage gaps, and high labor costs from worker shortages. Each of these problems exacerbate the inequities in health care by preventing safety net hospitals from doing their job.

This report explains the basics of safety net hospitals and their challenges. It then proposes three ways to improve the ability for safety net hospitals to

provide care to all in need:

1. Fill the funding gaps for safety net hospitals in Medicaid.
2. Close gaps in coverage that contribute to uncompensated care for safety net hospitals and other providers.
3. Lower costs for safety net hospitals with a bigger, more diverse workforce.

This report is part of a series called Fixing America's Broken Hospitals, which seeks to explore and modernize a foundation of our health care system. A raft of structural issues, including lack of competition, misaligned incentives, and outdated safety net policies, have led to unsustainable practices. The result is too many instances of hospitals charging unchecked prices, using questionable billing and aggressive debt collection practices, abusing public programs, and failing to identify and serve community needs. Our work will shed light on issues facing hospitals and advance proposals so they can have a financially and socially sustainable future.

What are Safety Net Hospitals?

Fast Facts:

- Safety net hospitals provide medical care to patients regardless of their insurance coverage, ability to pay, or immigration status.
- They can be for-profit, non-profit, or public hospitals, though most are non-profit or public. [3]
- Safety net hospitals are usually located in low-income communities and rural areas that more profitable hospital systems have historically overlooked.
- A disproportionate share of their patients are uninsured or on Medicaid, meaning safety net hospitals see lower reimbursement rates for the care they provide.

- Safety net hospitals are also more likely to offer care that's expensive but not profitable–like emergency, maternity, and psychiatric care. [4] This leaves many hospitals dependent on public funding and operating on thin profit margins. [5]

Safety net hospitals play a vital role in our health care system–they make up about 5% of all US hospitals but provide more than 25% of the nation's charity care. [6] Their patients are disproportionately Black and Hispanic and experience inequities in our health care system. People of color are more likely to be uninsured or underinsured, leaving them susceptible to high out-of-pocket costs. [7] The high cost of care can be a big deterrent to seeking out medical care—nearly one-in-four Americans said they've avoided medical care due to the price. [8] Safety net hospitals help address this problem by providing free or discounted medical care to their communities.

While communities of color are less likely to seek health care, they're more likely to need it. Due to socioeconomic factors like poverty, people of color are more likely to suffer from chronic illnesses like diabetes or heart disease, and avoiding care only exacerbates this gap. [9] Safety net hospitals provide communities with the medical care they need to live a healthy life, and they present a great opportunity for addressing health disparities. They provide services that others don't, like community-health programs that target food insecurity and homelessness, some of the root causes of health issues. [10] And safety net hospitals often employ members of the communities they serve, which improves workforce diversity and cultural competence in care. [11]

The Problem: Safety Net Hospitals Face Multiple Challenges

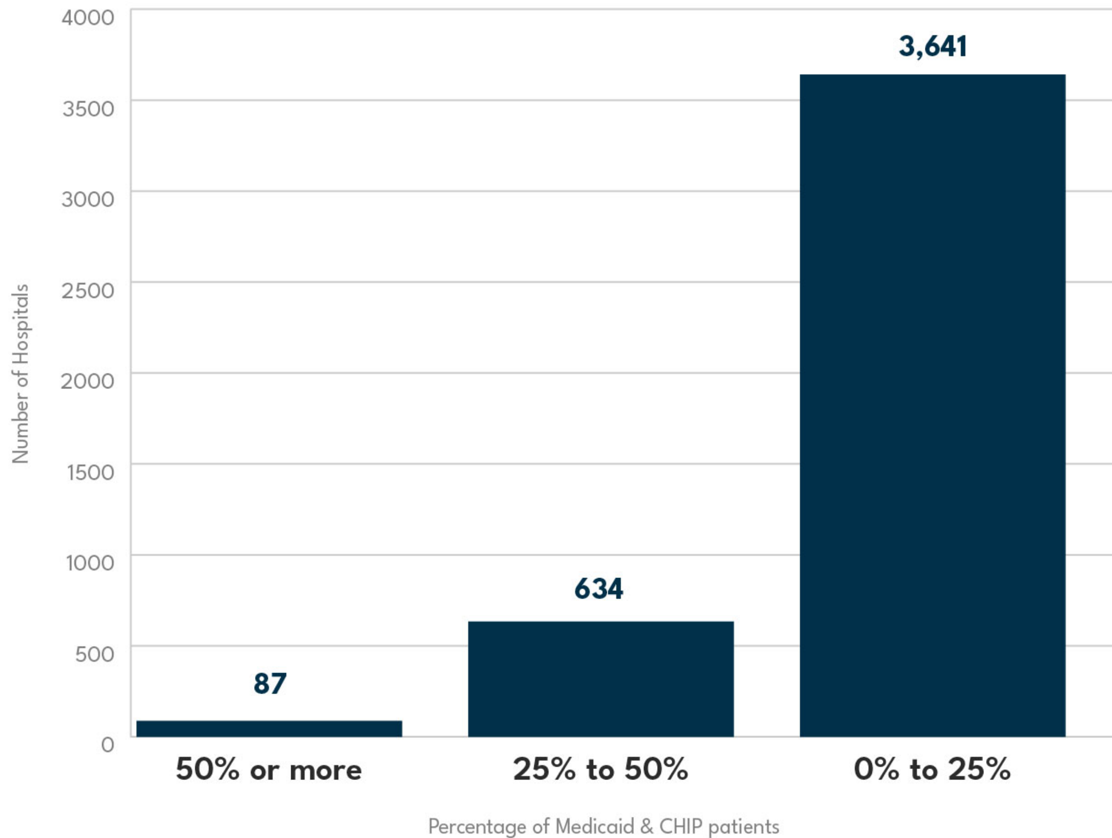
Safety net hospitals face challenges in three areas: 1) incomplete public financing; 2) gaps in coverage that leave patients without the ability to pay for care; and 3) high costs from workforce shortages and other factors. As Congress

looks to restrain costs across the hospital industry, it's critical to understand these three unique pressures.

Challenge #1: Incomplete Public Financing

Safety net hospitals would not survive without public support. But support for safety net hospitals is full of holes.

Medicaid has historically underfunded hospital care for its enrollees. Basic Medicaid reimbursement is 22% lower than Medicare's and much lower than private health plans. [12] That creates a huge challenge for the small number of hospitals that have a lot of Medicaid patients. In 2021, 7% of hospitals have one-third or more patients with Medicaid coverage. [13] This kind of uneven burden also affects hospitals who have a lot of patients who are unable to pay their bills, as shown in the chart below.



Source: National Academy for State Health Policy's Hospital Cost Tool.

States have worked to make up this deficit. Under a program called "upper payment limits," states add payments to Medicaid's base payments to bring them up to Medicare levels. [14] Because Medicaid is a federal-state partnership, states must pay a portion of any provider payments. States often finance these upper payment limit payments with a provider tax, which applies to the revenue of hospitals and other providers. Another example is Medicaid "disproportionate share payments," which are aimed at covering the costs of uninsured patients as well as a portion of low Medicaid payments. Under the Affordable Care Act, the disproportionate share payment program faces cuts over the next four years.

Congress originally intended those cuts to accompany coverage expansions through Medicaid, which has not happened in all states.

As Medicaid has shifted to providing coverage through private managed care health plans, the Obama Administration allowed states to direct managed care organizations to pay providers using specific rates or methodologies. These state-directed payments are now larger than the other types of add-on payments. [15] While critical, the Biden Administration has raised concerns that some of the funding goes to hospitals that don't need them. [16] Moreover, the Administration cannot fully account for the funding because provider taxes sometimes involve private pooling of funds, which are not disclosed publicly. [17] For example, the California Hospital Association runs a charity that redistributes provider taxes that nets a profit for one of the nation's wealthiest hospitals, Cedars-Sinai in Los Angeles. [18]

While public accounting is incomplete, the available data show that Medicaid rates are comparable to Medicare after accounting for all kinds of state payments including upper payment limits and disproportionate share, but not everywhere in the country. On average, state Medicaid programs pay about 6% more for key procedures than Medicare after accounting for add-on payments. [19] But 22 states still pay less than Medicare, which creates a barrier to care for Medicaid patients.

People of color account for 42% of the non-elderly US population, but they account for over 60% of the non-elderly with Medicaid and those without insurance. [20] Safety net hospitals are a vital resource in low-income communities, and underfunding them only exacerbates racial health disparities, like gaps in health outcomes.

Challenge #2: Gaps in Coverage

Federal programs through Medicare and Medicaid help hospitals with high levels of uncompensated care. However, these programs don't reimburse the full amount of uncompensated care, with the rest being a loss to the hospitals. But most uncompensated care comes from uninsured patients, with the biggest source of uninsured individuals being in the Medicaid coverage gap.

To date, 10 states have not expanded Medicaid to the working poor as the Affordable Care Act intended. Medicaid expansion allowed low-income adults who were under 138% of the federal poverty line to enroll in Medicaid. Failure by states to expand coverage has led to 2.1 million Americans within incomes between 100% and 138% of poverty, without access to Medicaid and subsidies to purchase insurance for themselves. Most of the states that have failed to expand Medicaid are in the South—Tennessee, Mississippi, Alabama, Georgia, South Carolina, Florida, and Texas—and have large Black and Hispanic populations. Over 60% of people who fall in this coverage gap are people of color, leaving many without access to affordable health care and hurting the safety net hospitals serving these patients. [21] Uninsured rates are about twice as high among most racial groups in non-expansion states versus in expansion states. [22]

This significant gap in coverage results in more uncompensated care for hospitals. Hospitals in states that have not expanded Medicaid are seeing a total of $11.9 billion in lost margins. According to the Brookings Institution, uncompensated care costs as a share of hospital expenses in non-expansion states are about triple the amount as expansion states. [23]

While Congress has failed to cover these 2.1 million Americans, it did recently expand Medicaid in another way. Through the American Rescue Plan Act, the federal government gave states enhanced federal matching funds for expanding postpartum coverage to a full year from the previous 60 days of coverage. To date, 38 states and Washington, DC have implemented this expansion, with eight states currently in the planning stage, two states proposing limited coverage,

and three with no action. [24] This expansion of postpartum coverage will ensure safety net hospitals can get some reimbursement for the maternity care they provide to Medicaid recipients.

Challenge #3: A Shortage of Health Care Professionals

The demand for health care services from an aging population is increasing the need for more health care professionals. According to the Association of American Medical Colleges, the United States is projected to have a shortage of up to 124,000 physicians over the next decade. [25] Additionally, there is an increasing shortage of nurses following an exit of 100,000 from the profession, with over 600,000 intending to leave in the next four years. [26]

The shortage of health care professionals is compounded by another issue: lack of workforce diversity. According to 2019 data, only 5.2% of physicians were Black and only 6.9% were Hispanic. [27] Some lower-paying health care professions were a bit more diverse—11.3% of registered nurses were Black and 7.8% were Hispanic—but diversity is lacking throughout the sector.

Lack of workforce diversity has consequences for patients of color. Seventy percent of Black Americans have reported being treated unfairly by the health care system, often building mistrust of doctors and discouraging patients from seeking care in the first place. It also creates language and cultural barriers for patients. All of this culminates in an inaccessible health care system and, as a result, worse health outcomes for patients of color.

There is no single reason for the shortage and lack of diversity. As previously noted, an aging population increases demand for health care services. Also, the COVID-19 pandemic increased burnout amongst providers. Between 2019 and

2021, the percentage of clinicians feeling burnout rose from 45% to 60%. [28] Specifically for physicians, the federal government funds most of residencies in the United States, and that number is capped under law. On the nursing front, there is also a shortage of nursing faculty to teach new nurses entering the field. This leads to a lack of capacity for nursing students, in which schools of nursing turned away 66,000 applicants in 2022. [29]

Because most health care professionals work in hospitals, these shortages have a significant financial impact on the hospital industry, particularly on safety net hospitals experiencing thin margins and serving vulnerable communities with health care that is less profitable. Staffing shortages are especially problematic in rural areas. With 15% of Americans living in rural areas, less than 10% of doctors practice in those areas. [30] This lack of access makes it more difficult for rural hospitals and clinics to provide care to patients and keep their doors open.

The Solution: Revitalize Safety Net Hospitals

Safety net hospitals need federal policy help to meet the challenges they face. Here are three steps Congress should take:

First, fill the funding gaps for safety net hospitals in Medicaid. Congress should end the discrimination against safety net hospitals in Medicaid and make them financially stable for the care they provide to vulnerable patients. It should require states (and the managed care plans they contract with) to pay fair rates to safety net hospitals by prioritizing hospitals with high percentages of Medicaid patients and uncompensated care. For example, prioritizing hospitals that have 25% or more of their patients with Medicaid coverage would help one of every six hospitals. Similarly, prioritizing hospitals with 10% or more their patients who cannot pay for their care would cover one of every nine hospitals.

In addition, any safety net hospital receiving these new, equitable Medicaid payments should follow three basic protections for low-income patients:

1. Hospitals should treat anyone regardless of the ability to pay for any type of care. (Current law stipulates that hospitals must offer only emergency care regardless of the ability to pay.)

2. Patient payments for services should be on a sliding scale as federal law requires federally qualified health clinics to use for people without coverage.

3. Hospitals should drop any aggressive debt collection practices like wage garnishment for all patients and debt collection of any kind on patients with incomes under twice the federal poverty level. [31]

As part of this reform, Congress should require states to publish all current payments to hospitals, including payments through private pooling arrangements like the California Hospital Associations charity. [32] While the Administration is pursuing this policy through regulation, Congress should act to avoid a legal battle over the administration's authority to act. [33] The Administration has raised the possibility of a cap on state-directed payments though managed care plans, which Congress could also enact. But before the implementation of any cap, the Administration and Congress should ensure targeted and transparent distribution of payments.

Second, close gaps in coverage in Medicaid that contribute to uncompensated care for safety net hospitals and other providers. Closing the Medicaid coverage gap would provide coverage to an additional 2.1 million Americans and ease the burden of uncompensated care costs for hospitals. The House of Representatives previously passed a way to close the gap as part of the Build Back Better Act. [34] That provision would have allowed low-income Americans in states that have not expanded Medicaid to get coverage through the Affordable Care Act's exchanges at no cost. Part of this federal expansion of coverage should include a delay in Affordable Care Act cuts to disproportionate share hospitals and an additional add-on payment to safety net hospitals until the expansion is fully phased in. Congress should also continue encouraging states to expand

Medicaid's postpartum coverage for up to one year by providing financial incentives through federal matching.

Third, lower costs for safety net hospitals with a bigger, more diverse workforce. While there is no silver bullet for addressing the shortages in the health care workforce, a combination of policies would alleviate the pressures for all hospitals, especially safety net hospitals that have smaller operating margins. [35]

1. *Expand residency slots in Medicare, especially in primary care.* This would increase the pipeline of physicians entering the workforce and should be targeted in a manner to address shortages in areas experiencing the most hardship. For example, the Resident Physician Shortage Reduction Act (HR 2389) would create an additional 2,000 residency positions, including for rural and shortage areas, and would require the Government Accountability Office to report strategies for increasing diversity in the workforce. [36]

2. *Expand the scope of practice for certain providers, such as nurse practitioners and physician assistants under Medicare*. Non-physician medical providers have limits on the type of care they can deliver without physician supervision, which is known as their scope of practice. Expanding their scope of practice can alleviate the workload of physicians in hospitals and other care settings. For example, the Improving Care and Access to Nurses Act, or the I CAN Act (S 2418), would expand the types of care non-physician health care professionals are able to provide. [37]

3. *Increase the number medical professionals from other countries*. A group of three bills introduced by Reps. Adam Smith (D-WA) and Lucille Roybal-Allard (D-CA) would reduce barriers to employment for foreign health care professionals. [38] These bills, the Immigrants in Nursing and Allied Health Act (HR 3731), the International Medical Graduate (IMG) Assistance Act (HR 3733), and the Professional's Access to Health (PATH) Workforce Integration Act (HR 3732), would open the National Health Service Corp to immigrants who are not citizens, increase international medical graduates assistance, and create counseling and training opportunities for international health professionals respectively. [39]

While many of these solutions would require significant federal funding, they should be fully offset by lowering the cost of hospital care system wide. [40]

Conclusion

Ultimately, no hospital or any other health care provider should face a financial obstacle to caring for Medicaid patients or those who cannot pay for coverage. But ending that obstacle for safety net hospitals is the critical first step.

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TOPICS

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