



Sample Press Articles:

Safety Net Hospitals & the Economic Crisis



The Denver Post

Denver Health may cut service as its costs soar

By Christopher N. Osher
November 25, 2008

Denver Health Medical Center's costs to provide care for the uninsured next year are expected to come in \$75 million higher than they did in 2007, forcing the hospital to consider cutting services.

Any cutbacks would come at a difficult time for indigent patients, who are using hospital services at a higher rate because of the downturn in the economy, health care officials said.

"If the safety net deteriorates, they're not going to have anyplace to go," said Dr. Patricia Gabow, chief executive officer for Denver Health.

She has been briefing U.S. Rep. Diana DeGette, D-Colo., and House Speaker Nancy Pelosi, D-Calif., on the issue. DeGette is pushing for an overhaul of how the federal government helps hospitals that end up shouldering a disproportionate share of such uninsured costs.

"I've been in Congress 12 years, and it's been underfunded virtually that whole time," DeGette said.

During a meeting with the editorial board of The Denver Post, Gabow added that the hospital is grappling with other challenges that also could significantly affect how health care is delivered in Denver.

Cuts elsewhere

Other hospitals in the metro area have eliminated emergency beds for the mentally ill, leaving Denver Health as virtually the only provider of such services, Gabow said.

Recently, University of Colorado Hospital announced that it was closing its 18 beds for psychiatric patients at the Anschutz Medical Campus in Aurora. Hospital officials complained that there was a lack of support from insurers and the government for maintaining those services.

The decline in emergency care for the mentally ill has forced the criminal justice system to absorb the overflow. Recent studies show that up to 17 percent of the 2,400 inmates at the Denver jails at any given time have serious mental illnesses, Gabow said.

Resisting tighter rules

Gabow also signaled that Denver Health may resist efforts to bring the hospital into compliance with National Fire Protection Association standards for paramedic response times.

Katherine Archuleta, a senior aide for Denver Mayor John Hickenlooper, recently told the City Council that the mayor expects a new contract to embody those standards, at a minimum.

The NFPA requires 90 percent of all calls requiring advanced life support to have a response on scene within nine minutes after a dispatcher answers an emergency call. Denver Health uses a different standard: 85 percent within eight minutes and 59 seconds starting at the time an ambulance becomes available to respond to the call, which sometimes is delayed from when a dispatcher receives a call.

Forcing the paramedic division to comply with the NFPA standards would increase costs at a difficult time for the hospital, Gabow said. She added that response times may not be the best way to measure paramedic service and encouraged instead a system that would track patient outcomes.

Archuleta did not return telephone messages seeking comment.

Hoping for federal aid



Gabow said she hopes Congress early next year will come up with new aid and formulas for how uninsured costs are calculated to provide some relief.

She said the hospital's costs for treating the uninsured added up to about \$275 million last year. They are projected to jump to nearly \$350 million next year, up from about \$300 million this year.

The costs for treating the indigent and uninsured are also increasing at University Hospital, and officials there are still working on a plan to deal with the problem, said Jacque Montgomery, a hospital spokesman.

Early warning

"We're the canary in the mine shaft," Gabow said. "When something bad happens in the economy, we tend to see it on our doorstep."

Gabow said the actual numbers may even end up worse than projections. She said uninsured costs could jump even higher if Colorado sees as steep an economic downturn as other areas of the country are experiencing.

She added that she fears the possibility of further Medicaid cuts to hospitals, causing the hospital further financial pressure.

Gabow said that if Congress does not come up with the new formulas she is seeking, she will be forced to cut services to the uninsured. Federal programs help the hospital shoulder some of the costs of the uninsured, but there is an 18-month lag in when that money comes to the hospital, Gabow said.

Those federal formulas have not allowed for any inflationary cost increases since 1997. In past years, the hospital was able to have the federal government pay as much as 30 percent of the costs for the uninsured. In recent months, the costs have risen so much that the federal assistance is accounting for less than 20 percent of the cost these days, she said.

DeGette said she supports letting states like Colorado tap federal aid for the poor that goes unused in other states but would also like to see a new formula that would provide adjustments for inflation.

Lawmaker's plans

DeGette said Congress recently extended unemployment benefits to the jobless. Now, she said, it's time for Congress to start looking at finding a way to provide insurance for those who lose their jobs or for the uninsured working poor.

"It's a really serious problem," DeGette said. "I have hopes with the new administration and the increased (Democratic) majority in Congress that we will be able to do something to fix the problem."



The Denver Post

Editorial

November 25, 2008

Additional aid for safety nets

As Congress targets the health of the economy, it should give consideration to hospitals that serve the poorest patients.

Denver Health executives are worried about how the worsening economy will leave the safety net hospital with more uncompensated care than ever — potentially \$75 million more this year over last.

We share their concern.

The institution has, with vision and smart management, earned a national reputation for delivering top-notch health care to a disproportionately poor clientele while staying within a budget that has remained in the black.

Given what has happened with health care during the last couple of decades, that's an accomplishment that deserves not only recognition but also a public commitment to protect it.

That's why we hope that hints coming out of Washington about additional health care funding are ideas that actually make it into any future economic stimulus package.

Dr. Patricia Gabow, Denver Health's chief executive officer, told us the hospital is the "canary in the mine shaft." When the economy gets bad, more people lose health care coverage and turn to Denver Health.

The institution expected to finish 2008 with about \$75 million more in uncompensated care than the prior year. It's still early, but indications are that 2009 will be worse.

Safety net hospitals like Denver Health get what is called "disproportionate share hospital funds" through Medicaid. These payments, based on the proportion of uninsured patients served, help keep these hospitals afloat and able to provide quality care.

As the economy worsens and need rises, increasing disproportionate share funding is a wise move.

Higher amounts of uncompensated care not only strain an institution, perhaps forcing service and staff cuts, but they also add up to a hidden tax on those who still have health insurance.

Typically, the cost of uncompensated care is calculated in the rates a hospital charges, which inevitably increases the cost of health insurance.

In essence, you can pay me now or you can pay me later.

On Monday, House Speaker Nancy Pelosi, D-Calif., said she hoped other lawmakers would support an economic stimulus plan to, in part, "help states avoid deep cuts to health care and other essential services."

Gabow said that on a recent trip to Washington she met with some Pelosi staffers as well as Congresswoman Diana DeGette of Denver, to talk about potential congressional fixes for health care.

We hope that as Congress targets ways to get this country back on its feet economically, there is strong consideration given to increasing funding that enables hospitals like Denver Health to provide quality health care to struggling people who have nowhere else to turn.



The Salt Lake Tribune

Unpaid bills mounting at Utah hospitals

Uncovered expenses » Bad debt, demand for charity care skyrocketing

By Lisa Rosetta and Heather May
November 28, 2008

With the state's housing market in peril, bankrupt builders were not paying what they owed Codee and Jim Marshall's heating and air conditioning business. When the business failed earlier this year, the Marshalls lost their South Jordan home, two rental properties and their health insurance.

So the family had no coverage in August - when their 3-year-old daughter's skull was crushed by a startled colt on the family's Lehi farm. Ali was flown by Life Flight to Primary Children's Medical Center in Salt Lake City, where she spent a month undergoing surgeries and recovering.

The Marshalls joined the growing number of Utahns who can't afford to pay their medical bills. They applied for charity care to forgive their debt, which Codee Marshall estimates is between \$200,000 and \$300,000.

As the ranks of the uninsured and underinsured swell, the state's four major health systems report they have seen their charity care grow in the past five years by 148 percent. Intermountain Healthcare alone, which includes Primary Children's, saw the charity care it grants nearly double between 2003 and 2007, from \$53.7 million to \$101.2 million.

More often, hospitals are left with unpaid bills. Patients owed Intermountain \$153.7 million last year, a 106 percent increase from 2003.

Hospital officials say those who are insured can't afford to pay ever higher deductibles passed on by their employers. Some of the uninsured refuse to pay. Others don't have the money.

"In the end, the responsibility or burden falls to the hospital," said Steve Bateman, chief executive officer of St. Mark's Hospital.

Hospital administrators expect to provide even more uncompensated care -- charity care plus unpaid bills -- this year, especially in emergencies for those who couldn't afford preventive care.

"Absolutely we're worried because the economy, potentially for a long period of time, is moving in the wrong direction," said Gordon Crabtree, chief financial officer for University of Utah's hospitals and clinics. "We only have so many beds. Some of those beds have to be filled with patients who have insurance."

Making matters worse, the investments hospitals also rely on as a source of revenue have been pounded this year by a volatile stock market. "This year hasn't been that good," said John Pingree, Intermountain Healthcare's vice president of community benefits.

While the hospitals remain committed to providing charity care, they also are making changes to ensure they get paid when possible -- deploying financial counselors to work with patients and requiring down payments for planned procedures. "It really goes to the notion of patients helping heal themselves," Bateman said. "We feel a measure of accountability is an important part of the overall fabric of health care delivery."

Patients who can't pay - and don't qualify for charity care or other programs -- are sometimes being turned away.

The Marshalls first applied for coverage from Medicaid and the Children's Health Insurance Program for Ali. But on paper, the Marshalls and their four children still had too many assets, and were rejected.

Primary Children's was generous: It gave the family a \$25,970 uninsured discount and wrote off \$146,800,



covering all of Ali's hospital bills, according to hospital spokeswoman Bonnie Midget.

"It was for sure just a blessing," Codee Marshall said.

Paying off the doctors, however, will be another matter. While doctors on staff at Primary Children's are expected to honor the hospital's charity care policy, other doctors Ali has seen throughout the Intermountain Healthcare system are not.

Care in an emergency

Under federal law, hospitals must treat emergency room patients in a crisis, regardless of ability to pay.

They don't, however, have to treat an underlying illness. And once a patient is stabilized, financial advisors in many hospitals descend to see if the patient has insurance or if his care could be covered by any number of programs, from worker's compensation to the crime victim's reparation fund. The hospital also determines if the patient qualifies for federal programs such as Medicaid and CHIP.

Charity is the last option, and each hospital has its own system for deciding who qualifies. Nonprofit hospitals, which typically receive donations and other support to serve the poor and uninsured, tend to have more liberal policies. Intermountain Healthcare, for instance, offers at least partial charity care to patients making up to 500 percent of the federal poverty level.

"I think this it's pretty generous compared to a lot of policies out there," Pingree said. At the same time however, "we also feel strongly that ... people who can pay, should pay."

St. Mark's and other hospitals track local demographic trends and try to predict - based on the historical utilization of health care by certain groups - what its charity care and bad debt will be.

But it's not always right. And that can lead to financial juggling, Bateman said, because hospital owner Hospital Corporation of America is locked into multiyear contracts with insurance companies and can't easily change its cost structure.

Charity care, however, is "both a cost of doing business, as well as a responsibility we have as a good corporate citizen in the community," he said.

Still, Judi Hilman, executive director of the Utah Health Policy Project, which is pushing for health care coverage for everyone, said she worries that Utahns don't know about the charity policies, or don't fight when they are turned down.

Planned surgery? Pay up front

When patients have a planned procedure, from chemotherapy to the birth of a baby, hospitals are growing more insistent about getting paid. Many require down payments before they'll schedule care -- even nonprofits, which are expected to provide free treatment to the poor.

Hospitals often pursue patients' deductibles and their co-insurance, or the percentage the patient owes.

"We try to collect up front, there's no question about it," said Bryanie Swilley, CEO of Iasis' Pioneer Valley and Jordan Valley hospitals in West Valley City and West Jordan. "It's kind of hard to unfix an appendix or put back a gallbladder. You have to pay for a plane ticket before you fly."

The for-profit Iasis created a "stork program" for patients to pre-pay before delivery. It also offers uninsured patients up to a 50 percent discount if they pay within six months. And it's considering extending its no-interest payment plans from about six months to 18 months.

But sometimes payment arrangements aren't enough. Swilley recalls a patient who was scheduled for a surgery but backed out after learning he needed to pay \$1,800. The CEO expects such patients to later arrive in the emergency room, when the condition worsens -- and the hospital must provide care.



"It is a balance. [Refusing to provide care] is probably the most emotional and difficult thing you can do," he said, adding that sometimes patients who can't pay are referred to nonprofit hospitals.

"We'll let you be the one to tell the mom of the 2-year-old that has an ear infection that we're not going to treat the child without [her] paying for it," he said, offering an example. "But at the same time, medicine is a business."

The U. began requiring uninsured patients to pay a 50 percent deposit for scheduled procedures eight years ago when Sherrie Woodmancy started as director of patient access services.

"We were just an open door to all of the unfunded [patients]," she said. "It's taken me a long time to change that culture."

Doing out care

When patients at the U. can't pay the deposit, medical director Tom Miller steps in. If the attending doctor says a procedure is medically necessary, Miller must decide whether to proceed, and then seek payment later.

He said he gives preference to Utah citizens. He might make a patient with a hernia wait until money is raised but gives the OK for someone who would go blind without surgery to repair retinal detachment.

Because of the expense, the U. won't list unfunded patients for organ transplants. Miller also says "no" to heart assist devices, bone marrow transplants and foreign nationals who need kidney dialysis.

Depending on the economy, Miller said the U. may have to cut back, such as being more strict about the deposit and rejecting uninsured residents of other states, who come to the U. seeking a higher level of care. The problem is not only the growth in uninsured patients -- up 48 percent at the U. since 2002, to 88,000 last year -- but a jump in Medicaid patients as the economy falters.

In considering charity care for planned procedures, Intermountain Healthcare generally uses standards similar to what an insurance policy would cover -- not some cosmetic surgeries, for instance, but those that are considered medically necessary or life-saving.

Hilman said her organization is hearing more often from patients who have been denied care, which she sees as a "tragic" consequence of a broken health care system.

Utah lawmakers are pondering reform that would allow businesses to give workers money to buy their own insurance, instead of providing a company plan. But Hilman predicts employees won't be able to afford coverage.

"If that's the direction we want to go in, we're talking about bankrupting our hospitals and making them less available to see everyone in the community," she said.

Hospital officials also say they may eventually need to cut back on capital and technology upgrades. And they acknowledge they pass on the costs of uncompensated care to insured patients. About 17 percent of private health care premiums go to pay for hospitals' uncompensated care, according to Hilman.

"That's one thing that helps us, every health care provider, from going bankrupt," said Kim Wirthlin, the U.'s associate vice president for health sciences public affairs and marketing. "It means all of us will pay more in the market for health insurance."



Las Vegas Sun

Medicaid cuts compound health, economic crises

But some see opportunity for universal coverage if things get bad enough

By Marshall Allen

Tue, Dec 2, 2008

There wasn't broad consensus for decreasing gas consumption until we started paying \$4 a gallon.

Could there be a parallel with a call for universal health care, as the cost of health care grows out of the reach of many who need it?

The problem is compounding: The faltering economy is increasing the number of poor and uninsured Nevadans at the same time that the state is drastically reducing their health care coverage.

In September, Medicaid, the state's health insurance for the poor, cut hospital reimbursement rates across the board by 5 percent. That led University Medical Center, Clark County's only public hospital, to ditch its cancer program — and hundreds of patients who depended on it for treatment.

Some pediatric specialists suffered cuts of as much as 41 percent, causing them to stop accepting new Medicaid patients. That means low-income children with bone and spine problems, for instance, may now need to leave Las Vegas for treatment.

The situation may soon become even worse.

Medicaid's proposed budget for the 2010-2011 biennium includes an additional 5 percent cut to hospital reimbursements in July. In addition, the Medicaid eligibility of people who qualify for the Temporary Assistance for Needy Families program will be reduced from 24 months to 15 months. And the Nevada Check Up program, which provides low-cost health care coverage to children not covered by Medicaid, will be capped at 25,000 youngsters. The number of Nevada Check Up children may already have reached the cutoff level but it's not known because the staff hasn't kept up with the applications, officials say.

Chuck Duarte, administrator for the Medicaid and Check Up programs, says the situation could be even more dire if the economy continues to suffer. So far the 2010-2011 budget is based on a 14 percent overall reduction in expenses, but he has also been required to draw up scenarios for overall reductions of 24 or 34 percent. The hardest hit will be the poor, frail and elderly.



“This will affect people’s lives and livelihoods,” Duarte said.

The cutbacks to health coverage for the poor come at a time when the flagging economy causes more people to need the services. Duarte says if legislators don’t find a solution, and the situation worsens in 2010 and 2011, the state will have to eliminate almost all of its optional services and eligibility groups.

Pulling money from Medicaid takes revenue from health care providers who depend on it to run their businesses, Duarte says. In this way, the Medicaid cuts push the economy further into a downward spiral. In the long run, health care entrepreneurs will cut jobs and be “loath to reinvest” in Nevada, he worries. Other states are facing similar problems.

“You’re seeing a tipping point of a health care crisis that’s going to have an effect on the economy overall,” Duarte said.

When meeting the health care needs of the poor and uninsured is delayed, or chronic conditions go untreated, patients often require more expensive and protracted hospital stays. Thus, the cuts to health coverage for the poor will likely lead to higher long-term costs paid by everyone else, in the form of tax money spent and insurance premiums.

Nancy Menzel, an associate professor at UNLV and president-elect of the Nevada Public Health Association, says the health care crisis makes a case for universal health insurance coverage.

“It’s unprecedented because we have so many more poor people in need of health care and the so-called safety net has vanished,” Menzel said.

Moral arguments for insuring the poor may fall on deaf ears, Menzel says, but once the wealthy and insured understand how the uninsured population affects their lives, they might be more motivated to work toward universal health care.

If the homeless can’t be treated for communicable diseases, and their children go to school and infect the children of insured residents, people will pay attention, she says. And when more people who are employed become uninsured because of rising health care costs, others will take notice.

“When many people see the negative effect, that’s going to make a difference,” Menzel says.