Analysis of Proposed Contract between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation

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A. INTRODUCTION

The mayor of the District of Columbia, the health commissioner of the District of Columbia[1], and the District of Columbia Financial Responsibility and Management Assistance Authority[2] (the Authority) have all criticized the city's past pattern of paying for health care. Pointing to the District's dismal health statistics, they have asserted that poor outcomes have been caused in part by devoting too great a share of the District's dollars to maintaining D.C. General Hospital, leaving too little money for primary care and prevention.

It is usually easy to criticize, but often hard to improve. That seems to be particularly true in this instance, where the mayor and the health commissioner seem to have been guided by a view that "anything has to be better than current arrangements." Those who take such a view may well find ways to make things worse.

The proposed contract between the Authority and Greater Southeast Community Hospital (Greater Southeast) illustrates this phenomenon. ***It increases cost, apparently without providing benefits commensurate with the greater cost.*** It runs a great risk of relocating the problem rather than solving it. That is no substitute for fixing the problem. The proposed contract may be more of a politically-driven solution than a substantive public health solution.

While the claims about prevention and primary care may have had the effect of helping to delegitimize D.C. General, a review of the proposed contract reveals that it would devote relatively little money to financing that care. ***The promises of prevention and primary care contrast starkly with the realities of the contract's focus on inpatient, surgical, and emergency services—and of its substantial administrative waste.***

B. GENERAL CONCERNS

Ceasing to provide acute inpatient care at D.C. General raises a number of general public health concerns. Most of these are addressed in my 5 October report.[3]

1. D.C. General is now available to and obliged serve all uninsured residents of the District. It has been providing very substantial total amounts of care (over 50,000 emergency room visits and over 10,000 hospital admissions in 1999), and other hospitals would find it difficult to pick up these obligations.

2. ***Closing D.C. General would leave the eastern part of the District (which has already lost 5 hospitals with 1,100 beds) excessively dependent on only one hospital***, Greater Southeast. That hospital has been in financial trouble recently. And given the stresses afflicting many U.S. hospitals in recent years, Greater Southeast could well face another episode of financial distress, resulting in its closure. The consequence of losing both D.C. General and Greater Southeast would be to create a complete hospital wasteland in an enormous share of the District.

3. There is reason for concern that, if D.C. General were to close, the surviving hospitals would lack the financial capacity and the emergency room capacity to serve the District's uninsured and other patients.

4. Hospitals are not inter-changeable parts. Patients who are displaced from one system of care—from doctors and hospitals—will likely experience considerable difficulty in making the transition to another system of care. Shepard has found, for example, that almost one-third of a hospital's patients cease to seek inpatient care for some time after their hospital is closed.[4] For those D.C. General patients who rely on the hospital to provide ambulatory physician care, the dislocation would be even greater—as they would have to seek both physician and hospital care elsewhere.

5. Those anxious to close D.C. General have not always behaved in ways that should enhance the public's trust in them. The Community Access Hospital (CAH) alternative that was pushed aggressively by the health commissioner last fall was falsely presented as well-tested elsewhere. The CAH proposal claimed that:

> Careful research was conducted to determine the feasibility of offering a freestanding emergency room with primary care and resources services together on one campus. The research revealed that there are freestanding emergency facilities currently operating in urban metropolitan areas and in dense suburban areas including Philadelphia, Fairfax, and a statewide system in Illinois.[5]

This language is confusing at best and positively misleading at worst. The research is called "careful" in the first sentence. And it is true that the Fairfax, Philadelphia, and Illinois examples involve freestanding emergency rooms, as stated in

the second sentence. But no research was able to demonstrate the feasibility of a freestanding emergency room like the CAH proposal envisaged. That is because the ***Philadelphia, Fairfax, and Illinois cases bear virtually no important resemblance to what was proposed for the CAH***.[6]

Therefore, while each of the two sentences may be true, individually, they are simply not connected, either logically or substantively. Joining them in the same paragraph leaves the false impression that research into the Philadelphia, Fairfax, and Illinois cases support the feasibility of a freestanding ER.

Any investigations in these three jurisdictions should have revealed that they were strikingly different from what was proposed for D.C. General Hospital. These differences are so striking that the Fairfax, Philadelphia, and Illinois examples should not have been considered by a fair-minded individual to offer relevant evidence regarding the medical safety, financial feasibility, or managerial feasibility of the CAH plan for D.C. General Hospital.

Perhaps most important, the Philadelphia and Fairfax emergency rooms, and the two Illinois emergency rooms, while physically freestanding, are actually ***owned by and fully integrated with large and financially strong hospital systems***. They are not organizationally freestanding, as the CAH would have been. Further, three of the four facilities are located in relatively affluent suburban areas, while the fourth serves a wide cross-section of an urban community.

6. Closing D.C. General without assuring availability of a superior and durable substitute violates the medical injunction to "First, do no harm."

C. SPECIFIC CONCERNS

In reviewing the proposed contract between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital Corporation, I have identified several serious problems which could cause irreparable harm to the provision of health care services to District residents if this proposed contract were to go forward. These are my specific concerns:

1. The proposed contract may ultimately result in the provision of less care to fewer people at greater cost.

2. ***A very substantial share of the funds paid under the proposed contract will go to administration, not to delivery of care.*** Consider these calculations:

a. For each $10 million in health services delivery, the proposed contract will pay an additional 12 percent for administration, or $1.2 million.

b. Further, Greater Southeast would be obliged to pay at least 90 percent of its Health Care Services Amount to "the licensed health care facilities and/or health

care professionals who provide Health Care Services pursuant to this Agreement." The upper limit of ten percent for administration is the likely figure. That would be an additional $1.0 million for administration.

c. With $2.2 million earmarked for administration and $9.0 million for patient care, administration dollars are fully 24.4 percent as great as dollars for patient care.

d. Further, it is necessary to account for costs within hospitals and within health centers or physician groups. This cost is not explicitly referenced within the proposed contract, but it is a real cost nonetheless and therefore must be considered. Administrative costs appear to be roughly 26 percent of the cost of physician care and 30 percent of the cost of hospital care.[7] Applying the lower figure of 26 percent to the $9.0 million yields an additional $2.3 million for administration.

Consequently, administration costs now total $4.5 million while only $6.7 million goes to paying for health services for patients, so ***the cost of administration equals almost two-thirds (67.2 percent) of the cost of clinical services under the proposed contract.***

The complexity of the contemplated arrangements for organizing care, paying for services, coordinating all delivery and finance arrangements, and monitoring contract compliance will probably make the private and public costs of administration even higher than that calculated here.

3. With respect to the number of uninsured people who would be covered under this proposed contract, the proposed contract's Statement of Work (Exhibit A) specifies that Greater Southeast "shall enroll eligible individuals . . . in the program."[8] Under the terms of the proposed contract, District residents who lack health insurance and whose family incomes are at or below 200 percent of the federal poverty level would be eligible.

The proposed contract does not appear to require that all such individuals will be enrolled—or 1,000 individuals, or 5,000 individuals, or 10,000 such individuals, or any specified number—only that "eligible individuals" shall be enrolled.

For illustrative purposes, it would be useful to calculate the maximum number of such eligible individuals. In 1999, an estimated 80.0 thousand D.C. residents lacked health insurance. A 1997 Urban Institute study found that 66.4 percent of uninsured Americans had incomes of 200 percent of the federal poverty level or below.[9] If this proportion prevails in the District, that would mean that there were 53.1 thousand uninsured District residents with incomes below 200 percent of poverty. For convenience, we will use this figure as the ***maximum estimate*** of the number of eligible individuals who might be enrolled.

This means that some 26.9 thousand uninsured individuals would not be eligible and therefore would remain uninsured. Today, they have access to D.C. General's inpatient, emergency, and outpatient services because of the hospital's open door policy. Under the proposed contract, the District would apparently not continue to finance their care. (And many—or most—will not be able to afford needed health care,

as 200 percent of the federal poverty level is not a great deal of money, particularly given the cost of living and of medical services in the District.) ***In addition to the 26.9 thousand***, ***unenrolled persons with incomes below 200 percent of poverty would also apparently not be eligible for service under the contract. Together, these two problems could lead to dangerous denials of needed services.***

Further, the proposed contract rests in part on an expectation that "All other providers in the District of Columbia" will "continue to provide at least their historical level of charity care."[10] It is hard to imagine how this could possibly be enforceable on entities that are not parties to the proposed contract. If so, this is rhetoric that has no practical meaning.

This is consequential because it is possible that some other hospitals in the District may choose to seize on the proposed contract as a reason to cut their own provision of uncompensated care to uninsured patients. Those hospitals could seek to justify that action by arguing that the District is now causing uninsured people to be enrolled in an alternative system of care (and also by arguing that their own difficult or desperate financial conditions oblige them to cut back on uncompensated care).

4. Despite all the primary care and prevention rhetoric of past months, the proposed contract is, in practice, heavily skewed toward financing acute inpatient services.

After months of talk from the health commissioner and others about the dismal health outcomes of District residents and about the purported value of primary care and prevention in improving those outcomes, the proposed contract's actual dollar allocations reveal a very different financial plan. ***The proposed contract's health services financing is heavily skewed toward acute and inpatient services.*** Of the grand total of $4,286,680 monthly (or $51,440,157 annually), fully 72.5 percent would be used to pay for in-hospital, surgical, and emergency room care. (See the following table, abstracted from Exhibit E of the proposed contract.) That would be $3,108,015 monthly (or $37,296,186 annually).[11] ***Thus, the very rhetoric used to support dismantling D.C. General has apparently been replaced by a proposed contract for financing alternative inpatient, surgical, and emergency services at Greater Southeast and other sites.***

Health Care Services Amount (from Exhibit E of proposed contract)

	$/unit	units/mo.	$/mo.
Inpatient hospital services	$6,479.27	316.67	$2,051,790
ER services (excl. MD fees)	$295.02	2,797.25	$825,245
Ambulatory surgery (excl. MD fees)	$617.50	148.92	$91,958
Other hospital outpatient visits (excl. MD fees)	$130.15	3,195.50	$415,894
Community clinic services (including MD fees)	$156.75	2,721.67	$426,622
MD services			
primary care	$40.00	2,008.00	$80,320
specialty care	$39.39	6,494.75	$255,828
inpatient surgery	$400.00	82.58	$33,032
ambulatory surgery	$200.00	148.92	$29,784
hospital-based	$25.00	3,048.25	$76,206
GRAND TOTAL, HEALTH SERVICES			$4,286,680

5. The proposed contract appears very costly, in comparison to costs of existing PBC services, and it raises certain quality and safety problems. Some of the proposed contract's costs would be reduced if volumes of care were less than those projected in the proposed contract, but some of the District's financial obligations under the proposed contract do not depend on volume of care. The District would be obligated to make these payments even if Greater Southeast and its sub-contractors chose to enroll fewer people than those projected in the proposed contract, were unable to enroll as many people as projected, or provided fewer services than projected to people who were enrolled.

Capital improvement payments and loans (which could be forgiven) are one example of such payments. The proposed contract would make available $11.8 million in payments and loans to finance improvements at D.C. General, PBC clinics, and Greater Southeast. It is not clear what sum would be a payment and what sum would be a loan. The loans would be forgiven if Greater Southeast complies with the proposed contract. This is additional money that would not be devoted to primary care or prevention.

The proposed contract manifestly excludes some costs that are currently borne by District government, such as those for mental health and substance abuse services.

Worse, the proposed contract does not explicitly allow for other costs, such as those for ambulance transfers, that would very probably increase under the proposed contract.

One aspect of the proposed contract is both costly and potentially risky to patients. This pertains to plans for emergency care. The proposed contract seems to envision operation of a freestanding emergency room at the D.C. General site. That tends to be a costly enterprise because an emergency room requires certain support services, such as laboratories, diagnostic radiology, coronary care, surgery, and a unit for providing intensive stabilization and life-saving services. Specialized physicians and nurses are also required. All of these services and individuals are costly. When an emergency room is part of a full-service acute care hospital, these costs can be shared with those of the acute inpatient services. A freestanding emergency room has no such opportunities. It must bear those fixed costs alone, meaning higher costs per emergency room visit.

If the services are not provided, then the emergency room is not a full-service emergency room and more patients will probably have to be transferred to other hospitals—and patients in less stable condition will probably have to be transferred. This increases both risk to patients and dollar costs.

Because intensive care unit beds are said to be in tight supply in the District, and because the proposed contract apparently entails a substantial net reduction in intensive care unit beds, the proposed contract poses a potential threat to the health of public. Lack of intensive care unit beds harms the individuals who need them but can't be served in them. It also can be one of the main causes of emergency room diversions, which can harm additional individuals—those who need emergency room care but whose care is delayed by ambulance diversions owing to emergency room closings.

6. Delivering the volumes of care indicated in Exhibit E of the proposed contract will depend greatly on the adequacy of staffing at hospital clinics, health centers, and other facilities. It is not clear from the proposed contract that the needed capacity will be available.

7. ***The proposed contract's payment provisions may offer inappropriate financial incentives.*** In most arrangements to serve a group of patients, payor and caregiver (often a managed care organization) negotiate a monthly fee per person or per family. That has not been done here. Instead, specified sums would be paid for providing given volumes of health services. But this arrangement could well contain undesirable incentives and disincentives. For example, and hypothetically, if Greater Southeast made money providing inpatient services under the proposed contract but lost money providing primary care services, it could be tempted to do more of the former and less of the latter. But the District would still be obliged to pay the full annual Health Care Services Amount to Greater Southeast.

8. Another contractual provision may provide financial incentives that are even less desirable. If the cost of health care services exceeds the budgeted level, Greater Southeast would be paid at 50 percent of average cost for the first 20 percent overage. This assumes an overall marginal cost equal to one-half of the average cost. But the marginal or incremental cost of physicians' services is probably higher than that. (The 50 percent figure is probably adequate for most hospital care, with its higher share of fixed costs.) If this is so, the result is that ***Greater Southeast would suffer a financial penalty if it goes over budget by providing more primary care and other basic physician services.*** That is because its costs would increase faster than its revenues. The remedy for this would be to calculate distinct and separate payment and volume corridors for inpatient care, emergency room care, office-based primary care, and the like.

NOTES

[1] Ivan Walks, testimony before the D.C. City Council, 18 September 2000.

[2] See the Authority's "Health Services Reform Initiative," 11 April 2001.

[3] Alan Sager, *Saving D.C. General Hospital: Why and How,* Boston: Boston University School of Public Health, 5 October 2000.

[4] Donald S. Shepard, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs: A Preliminary Model and Application," *Health Services Research*, Vol. 18, No. 4 (Winter 1983), pp. 513-549.

[5] Public Benefit Corporation, District of Columbia, "Community Access Hospital," Draft, 11 September 2000, p. 2.

[6] I was not able to contact anyone in Illinois to verify claims regarding freestanding emergency rooms in that state.

[7] Access and Affordability Monitoring Project and Solutions for Progress, Inc., *Massachusetts Can Afford Health Care for All: Covering Everyone Comprehensively Without Spending More,* Boston: The Project, 2 November 2000.

[8] Agreement between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital, dated 12 April 2001, Statement of Work (Exhibit A), p. 1.

[9] Urban Institute, *Health Insurance Access and Use in the United States: Tabulations from the 1997 National Survey of American Families,* Washington: The Institute, 2000, http://newfederalism.urban.org/pdf/discussion00-14.pdf.

[10] Agreement between the District of Columbia Financial Responsibility and Management Assistance Authority and Greater Southeast Community Hospital, dated 12 April 2001.

[11] This is the sum of inpatient hospital services, ER services (excl. MD fees), ambulatory surgery (excl. MD fees), inpatient surgery, ambulatory surgery, and hospital-based physician services.