# TRENDS

## Caught In The Competitive Crossfire: Safety-Net Providers Balance Margin And Mission In A Profit-Driven Health Care Market

Safety-net providers' ability to stay viable may depend on strategies used in the private sector to direct capital toward renovation and expansion and to attract a more favorable payer mix.

**by Peter J. Cunningham, Gloria J. Bazzoli, and Aaron Katz**

**ABSTRACT:** This paper describes how intensifying competitive pressures in the health system are simultaneously driving increased demand for safety-net care and taxing safety-net providers' ability to maintain the mission of serving all, regardless of ability to pay. Although safety-net providers adapted to previous challenges arising from managed care, health system pressures have been more intense and more generalized across different sectors in recent years than in the past. Providers are adopting some of the same strategies being used in the private sector to attract higher-paying patients and changing their "image" as a safety-net provider. [*Health Affairs* 27, no. 5 (2008): w374–w382 (published online 12 August 2008; 10.1377/hlthaff.27.5.w374)]

For more than a decade, concern has been widespread about the financial viability of America's health care safety net—a patchwork of hospitals, community health centers (CHCs), and free clinics that either have an explicit mission to serve low-income, uninsured people or are widely recognized in the community as playing this role.[1] Although earlier fears of a total unraveling of the safety net did not materialize, safety-net providers operate in an increasingly competitive and profit-driven health care marketplace.[2] These market pressures are driven largely by financial concerns that are compelling many hospitals and physicians to focus intensively on activities that generate revenue, while dropping or limiting services for which reimbursements tend to not cover costs.[3]

This paper uses findings from the 2007 Community Tracking Study (CTS) site visits to describe how safety-net providers are affected by the growing trend among private physicians and hospitals to shed unprofitable patients and services. Our findings are similar to previous studies in that safety-net providers continue to experience financial pressures in part as a result of increasing numbers of unin-

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DOI 10.1377/hlthaff.27.5.w374 ©2008 Project HOPE–The People-to-People Health Foundation, Inc.

sured people. However, some providers are responding in ways that we have not observed previously. These responses include actions to limit their exposure to indigent care, as well as actions that often mimic non-safety-net providers' efforts to increase revenue and attract a more favorable patient mix.

## Study Data And Methods

The CTS is conducted by the Center for Studying Health System Change (HSC) and funded by the Robert Wood Johnson Foundation (RWJF). HSC has been conducting in-depth tracking of health system changes in twelve randomly selected metropolitan areas since 1996 through on-site and telephone interviews with leaders from the major health system sectors. The communities are Boston; Miami; Orange County (CA); northern New Jersey; Cleveland; Indianapolis; Phoenix; Seattle; Lansing; Syracuse; Greenville (SC); and Little Rock. The most recent site visits took place during February-June 2007, involving interviews with about 500 respondents.

Findings in this paper are based on interviews with health care providers and recognized local experts with broad knowledge of the health care system in their community. Providers interviewed include chief executive officers (CEOs) and chief financial officers (CFOs) of major hospitals and hospital systems, and CEOs and emergency department (ED) directors of safety-net hospitals, as described above. Interviews also were conducted with directors of CHCs (federally qualified health centers [FQHCs] and non-FQHCs), local medical societies, and large medical groups. In addition, group interviews of a cross-section of physicians in each community were conducted.

## The Medical Arms Race Intensifies

An important trend identified in prior CTS rounds was the buildup and renovation of capacity in highly profitable services, dubbed the "new medical arms race."[4] One feature that distinguishes the current medical arms race from the past is the extensive involvement of physicians in the competitive fray as they compete directly with hospitals for many services that can now be performed in outpatient settings. In virtually all of the CTS communities, we found that physicians are stepping up efforts to build their own diagnostic and ambulatory surgery centers and, therefore, are becoming less dependent on hospitals as their workshops. Likewise, many physicians have expanded capacity to provide ancillary services in their practices, which are then exempt from self-referral constraints. At the same time, the growth of single-specialty medical groups has allowed physician practices the scale needed to offer services that are more profitable.[5]

**"One feature that distinguishes the current medical arms race from the past is the involvement of physicians in the competitive fray."**

Hospitals have responded to this competitive threat in a variety of ways. Some enter joint ventures with physicians to build facilities, allowing hospitals to retain at least part of the revenue stream. In addition, hospitals have renovated and built new facilities to house specialty services to attract or, at a minimum, not lose market share in selected services. Hospitals also are continuing to build new capacity or relocate existing capacity in suburban markets to attract high-income and well-insured patients who are moving out of the central city. Exhibit 1 summarizes the major types of construction activity reported by private hospitals in each of the CTS markets.[6]

Another aspect of the current medical arms race that differs from the past is that providers are less able to pass along cost increases from increased capital investments. In the current environment, public payers set rates, and consolidation among private health plans has increased their leverage in provider rate negotiations in some markets. Thus, hospitals' actions to stave off potential losses of business might not lead to increases in providers' prices or stability in their bottom lines. In addition, these

**EXHIBIT 1**
**Hospital Construction Activity Reported In Community Tracking Study (CTS) Markets, 2007**

| Type of construction activity | CTS markets in which activity was reported |
|---|---|
| Building new full-service hospitals or expanding existing general hospital capacity | Cleveland, Greenville, Indianapolis, Little Rock, Miami, Phoenix |
| Building new or expanding existing capacity in specialty service areas | Boston, Cleveland, Greenville, Indianapolis, Lansing, Little Rock, northern New Jersey, Orange County, Phoenix, Seattle |
| Replacing aged facilities, including conversion to private patient rooms | Boston, Cleveland, Greenville, Indianapolis, Lansing, Little Rock, northern New Jersey, Orange County, Seattle |
| Expanding capacity in selected service areas (ED, diagnostic services, cardiac cath labs) | Boston, Cleveland, Greenville, Indianapolis, Little Rock, Miami, northern New Jersey, Orange County, Phoenix, Seattle |

**SOURCE:** Authors' analysis of Community Tracking Study interview data, 2007.
**NOTE:** ED is emergency department.

actions may require some hospitals—especially multihospital systems and freestanding hospitals located in the central city—to allocate greater portions of their current and future profits to service growing debt, which in turn means that fewer funds are available to support indigent care.

## Effects On Uncompensated Care Provision

Does the recent intensification of competitive pressures reduce providers' willingness to provide uncompensated care? Observers in most CTS communities report that the costs of hospital uncompensated care continue to rise, largely as a result of continued growth in the number of people who are uninsured (which increased nationally by 13 percent between 1996 and 2005; see Exhibit 2). However, although longer-term national data from the American Hospital Association (AHA) show uncompensated care costs increasing 28 percent over the past decade (after adjusting for inflation), uncompensated care costs as a percentage of total hospital expenses decreased nearly 7 percent.[7] Hospitals' efforts to limit growth in uncompensated care may be occurring indirectly, by concentrating their expansion activities in more-affluent communities and by downsizing or eliminating certain unprofitable services, such as inpatient psychiatric units, as observed in Little Rock and Orange County.

It is more evident that private-practice physicians are decreasing the amount of charity care they provide. Data from the CTS Physician Survey show that the percentage of physicians providing any charity care declined more than 10 percent over the past decade, which is consistent with respondents' reports in most communities that private physicians are becoming less available to uninsured and Medicaid patients (Exhibit 2).[8] Contributing to this decline is the finding that physicians have recently grown less dependent on hospitals and are less willing to cover hospital EDs without compensation.

Also, the recent growth of large single-specialty groups that dominate a market might also contribute to decreased charity care. In Seattle, for example, access to orthopedic surgeons is virtually nonexistent for uninsured people and Medicaid enrollees, because a single group of orthopedic surgeons has a virtual monopoly in the community and does not accept Medicaid or uninsured patients.

**EXHIBIT 2**
**Trends In Hospital Uncompensated Care And Physician Charity Care, Selected Years 1996–97 To 2004–05**

| | 1996–97 | 2000–01 | 2004–05 | Percent change, 96–97 to 04–05 | Percent change, 00–01 to 04–05 |
|---|---|---|---|---|---|
| Number of uninsured people (millions)[a] | 38.6 | 38.9 | 43.7 | 13.2 | 12.3 |
| Hospital uncompensated care[b] | | | | | |
| Total uncompensated care costs (in billions, inflated to reflect 2005 dollars) | 22.5 | 24.1 | 28.3 | 25.8 | 17.4 |
| Percent of total expenses | 6.0 | 5.8 | 5.6 | -6.7 | -3.4 |
| Percent of physicians providing any charity care[c] | 76.3 | 71.5 | 68.2 | -10.6 | -4.6 |

**SOURCES:** See below.
**NOTE:** Date ranges correspond with various rounds of the Community Tracking Study (CTS).
[a] P. Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," EBRI Issue Brief no. 310 (Washington: Employee Benefit Research Institute, October 2007).
[b] Computed from American Hospital Association, "Uncompensated Hospital Care Cost Fact Sheet" (Chicago: AHA, October 2006).
[c] P.J. Cunningham and J.H. May, "A Growing Hole in the Safety Net: Physician Charity Care Declines Again," Tracking Report no. 13 (Washington: Center for Studying Health System Change, March 2006).

## Effects On Safety-Net Providers

■ **Increased demand.** Most safety-net providers report increased demand for services, particularly among the the uninsured and Medicaid enrollees. Reasons for the increased demand varied, including rapid population growth (Phoenix and Miami), facility closures in other parts of the community (Cleveland and northern New Jersey), increases in health care costs, and local economic factors that were increasing the number and proportion of uninsured people. However, safety-net providers in most of the communities also reported increased demand because fewer providers accepted uninsured and Medicaid patients, consistent with the trends reported earlier. Some safety-net providers—for example, CHCs in Little Rock and Orange County—also reported that uninsured patients were showing up with more serious health problems than in the past, which they interpreted as another indication of worsening access in the community.

Access to specialty care continues to be the most serious and growing problem in most communities, with mental health, surgical, dental, and vision care frequently cited as the most difficult to obtain. Because the focus of CHCs and other free clinics is primary care, most of the "excess demand" for specialty care ends up at safety-net hospitals. These hospitals are sometimes the only source of specialty care in their communities for low-income uninsured people and Medicaid enrollees, especially if other institutions and specialists limit care to these patients.

As a result of increased demand by the uninsured, most safety-net providers reported an increase in the overall amount of uncompensated care they provide. Although they report that these increases are putting pressure on their margins, most still report balanced budgets or positive margins. For example, our analysis of 2005 hospital cost report data (the most recent year available) indicates that safety-net hospitals in the CTS communities had operating expenses for patient care services that exceeded revenues on average by 8.5 percent, but their total margins, which accounted for all patient revenues, subsidies, and

other sources of income, were 0.5 percent, on average. Similarly, total margins for National Association of Public Hospitals and Health Systems (NAPH) members had increased slightly—from 0.7 percent in 2001 to 1.2 percent in 2004, despite increases in utilization among uninsured patients.[9] Nevertheless, CTS safety-net hospital margins are well below the average for hospitals in general—4.9 percent in 2005—and around one-third of the CTS safety-net hospitals had negative total margins in 2005.[10]

**■ Competition with non-safety-net providers.** Although safety-net providers are not typically viewed as major "competitors" by other providers in a market, some of these providers' more lucrative and prestigious activities may be increasingly at risk as opportunities to expand services in profitable areas—particularly specialty services—are pursued. For example, many medical schools have traditionally affiliated with safety-net hospitals because of their large and varied patient mix and access to public funding. Such arrangements also provide a boost to the resources and prestige of the safety-net hospitals. However, in competing to become the primary partner for a new medical school in Phoenix, the main safety-net hospital may lose out to a well-funded private hospital system (although a final decision had not been made as of this writing), despite the fact that many respondents viewed the safety-net hospital as a more natural and logical fit because it was a full-service facility. The leaders of the medical school initiative reportedly are attracted by the more specialized services being offered by the other system, its stronger financial position, and what they perceived as greater potential for state-of-the-art research and educational support. Not only would losing out on this affiliation be a blow to the prestige of the safety-net provider, but it also could result in a serious setback for its plans to build a new hospital.

**"Most safety-net providers attempt to balance increases in uncompensated care costs by also increasing care delivered to insured patients."**

CHCs also have found themselves in the midst of new competition. For example, some community clinics in Orange County reported growing competition with private providers over obstetric patients. Because these patients are nearly all insured—and reasonably paid for—through Medicaid or private insurance, this is a critical patient base to keep and expand if safety-net clinics are to strengthen their payer mix and bottom line.

Most safety-net hospitals also are acutely aware that private-sector providers' expansion activities in affluent suburban areas are making it more difficult to attract higher-income privately insured patients. Patients now can stay in the suburbs for their hospital care instead of traveling longer distances to downtown areas. In addition, the substantial investments in new buildings and new technology in suburban facilities, plus amenities such as private patient rooms, may create the impression that the suburban facilities have higher quality of care than the relatively aged facilities of many safety-net hospitals.

## Responses By Safety-Net Providers

Safety-net providers in many communities have been able to manage increased uncompensated care costs through both defensive actions to manage safety-net demands and offensive strategies to attract a better payer mix (see Exhibit 3 for summary).

**■ Limiting exposure to uncompensated care.** In three of the CTS communities (Seattle, Orange County, and Lansing), the major safety-net hospitals have restricted nonemergency care for uninsured people from outside the local area.[11] Because, as noted above, safety-net providers are often the only source of specialty care for low-income patients, taking such exposure-limiting actions may be effectively closing off the last remaining options for indigent specialty care for some communities. Queuing for appointments based on insurance

**EXHIBIT 3**
**Safety-Net Providers' Responses To Competitive Pressures And Increased Demand For Care From The Uninsured, 2007**

| Provider response | CTS markets in which response was reported |
|---|---|
| Defensive actions to limit indigent care exposure | |
| Restricting nonemergent patients | Seattle, Orange County, Lansing |
| Developing referral agreements | Boston, Cleveland, Greenville, Indianapolis, Little Rock, Miami, Orange County, Seattle |
| Enforcing financial policies | Cleveland, Miami |
| Offensive actions to attract better payer mix | |
| Marketing to insured patients | Northern New Jersey, Miami |
| Leveraging competitive advantages | Seattle, Cleveland, Orange County |
| Upgrading facilities | Cleveland, Seattle, northern New Jersey, Little Rock, Indianapolis |
| Expanding into new services | Miami, Cleveland, Indianapolis |
| Changing "safety-net" image | Miami, Boston |

**SOURCE:** Authors' analysis of Community Tracking Study (CTS) interview data, 2007.

coverage was another tactic being used by the safety-net hospital in Little Rock, with privately insured patients waiting the least amount of time for an appointment and uninsured patients waiting the longest.

EDs at some safety-net hospitals have been able to reduce overcrowding and prevent further increases in volume by shifting some care to other hospitals, outpatient clinics, or CHCs. This latter strategy appears, in some cases, to be part of an explicit effort to better coordinate care for low-income patients. Respondents in Boston, Cleveland, Greenville, Indianapolis, Little Rock, Miami, Orange County, and Seattle noted agreements between hospitals and community clinics to facilitate the referral of nonemergent patients to clinics for more appropriate care and to establish "medical homes."

In other communities, some safety-net providers manage their uncompensated care costs through processes for determining eligibility for charity care and cost-sharing requirements. This includes more rigorously applying a sliding fee schedule, becoming more aggressive in collecting out-of-pocket payments from uninsured patients, verifying income, and offering discounts to patients who pay up front.

■ **Managing payer mix.** Most safety-net providers attempt to balance increases in uncompensated care costs by also increasing care delivered to insured patients, including targeting privately insured and Medicare patients, and these efforts appear to have accelerated in recent years. Among NAPH member hospitals, the share of revenue from Medicare and private insurance increased from 38 percent in 2001 to 47 percent in 2005. Overall, revenue from commercial insurers increased 84 percent during this period, while Medicare revenue increased 62 percent.[12] A recent development not observed in earlier CTS site-visit interviews is that these increases are being accomplished by embracing many of the same strategies being used in the private sector to increase patient revenue.

■ **Leveraging competitive advantages.** Many safety-net providers are trying to expand their patient bases by focusing on core competencies and playing to their strengths in having broader specialty coverage compared to most other hospitals. For example, Harborview Medical Center in Seattle says that it competes effectively with other hospitals for privately insured patients in the neurosciences and trauma care, the latter of which attracts a strong payer mix through transfers

from other hospitals. Cleveland MetroHealth also attempts to use its perceived competitive advantages in the areas of trauma care, stroke, spinal cord and brain injuries, and community health. The University of California (UC), Irvine, in Orange County has one of the only Joint Commission–accredited stroke centers in the state, and the program has expanded rapidly.

CHCs have emerged as formidable competitors in some communities for primary care services, incorporating many of the elements of the "medical home" model, greater coordination of care, and, in some cases, more advanced health information technology (IT) systems than other primary care providers in the community. CHCs in Greenville, northern New Jersey, and Syracuse also reported more aggressive marketing efforts to draw privately insured patients, with a center in Syracuse focusing especially on its highly regarded diabetes program.

**"Expanding insurance coverage is the most direct way to relieve some of the financial pressure on safety-net providers."**

**■ Upgrading or expanding facilities.** Even with more limited access to capital, many safety-net providers are upgrading and expanding facilities to attract more privately insured patients; such facilities include inpatient beds, operating and patient exam rooms, dental clinics, and EDs. Replacement hospitals being constructed for safety-net providers in Little Rock, Orange County, and southern Dade County (Miami) are expected to be stronger competitors for privately insured patients because the facilities will be more modern and more accessible to privately insured patients.

**■ Expanding into more profitable service lines and areas.** Some safety-net providers are trying to go beyond playing to their strengths and are competing directly for the most profitable services and patients. Miami's major safety-net system has acquired a hospital in a more affluent part of town, as well as a cardiac practice, and these acquisitions were explicitly aimed at increasing privately insured patients. Other acquisitions or expansions by some safety-net providers include opening a new state-of-the-art geriatric center (Cleveland), a CHC network taking over an obstetrics residency program from an academic medical center (and negotiating to operate its pediatric residency program as well) (Indianapolis), and expanding primary care in suburban markets (Boston).

**■ Changing the safety-net "image."** Respondents in Boston, Miami, and Orange County discussed their desire to shed their image as a "safety-net provider" to appeal to a broader spectrum of patients. In Boston, safety-net hospitals sense that a change in strategic direction is needed, given that the Massachusetts health reform is using the state's uncompensated care pool to help pay for health insurance coverage for the uninsured and that in the future they will have to compete for their formerly uninsured patients, who will have more choices for care.

**■ Are safety-net providers' responses related to other market factors?** We examined whether actions by safety-net providers were related to certain market or policy factors, including the size of the uninsured population (which reflects the demand for safety-net services), the traditional "strength" of the local safety net, and the presence and scope of certificate-of-need (CON) regulation in a community. We did not observe any apparent differences in the type and number of safety-net responses between communities with high uninsurance rates and communities with low uninsurance rates.

However, using an earlier classification of the "strength" of local safety nets in CTS communities, we found that providers in communities with traditionally strong safety nets (Boston, Indianapolis, Miami, Seattle) had a greater number of reported actions (both offensive and defensive) compared to communities with traditionally weak safety nets (Phoenix, Orange County, northern New Jersey, Greenville).[13] Strong safety-net providers may

be more proactive in trying to maintain and strengthen their financial viability, because they often have greater organizational capacity to do so.

In addition, CTS communities located in states with more comprehensive CON regulation in 2007—namely, states with CON covering a broader range of health services (Greenville, northern New Jersey, Seattle, Syracuse, and Lansing)—had fewer reported offensive and defensive actions relative to those in states with no or limited-scope CON.[14] Thus, while CON laws attempt to control health care costs by regulating the expansion of health care services, more comprehensive CON laws may also inhibit some safety-net providers' efforts to maintain their viability by expanding into new areas.

Although these results suggest certain patterns in safety-net responses by market characteristics, they are not conclusive and should be viewed with caution because of the relatively small number of sites and the nature of the qualitative data.

## How Can Public Policy Offset Market Pressures?

Expanding insurance coverage is the most direct way to relieve some of the financial pressure on safety-net providers. Some states that provide subsidies for uncompensated care propose using these subsidies to pay for insurance coverage expansions. Such an approach may be a double-edged sword for many safety-net providers if some uninsured people remain uncovered, because they may lose both their newly insured patients as well as public subsidies for those who remain uninsured. Even in Massachusetts, which is using the state's uncompensated care pool to help pay for universal coverage, transitional support for safety-net providers was required when it became evident that achieving 100 percent coverage would take longer than expected.

Policymakers can also increase subsidies to safety-net providers, which have been critical to their survival. Federal Medicaid disproportionate-share hospital (DSH) payments have essentially been flat since 1998 as a result of federal efforts to contain these costs and regulate states' use of provider donations and taxes, and intergovernmental transfers to increase their DSH allotments.[15] Also, revenue from state and local subsidies for NAPH member hospitals declined between 2001 and 2005, after general inflation is adjusted for, and has also decreased as a share of total revenue.[16]

Despite these national trends, state and local support for safety-net providers had increased in several communities at the time of the site visit. These include increased funding for indigent care services in Orange County; a new uncompensated care pool in Florida funded by the state's Medicaid waiver; and the extension of state uncompensated care pool funding to community health clinics in New Jersey.

Regulation can also help offset certain incentives to reduce uncompensated care. For example, heightened public concern about the community benefit activities of tax-exempt hospitals has prompted some states to enact laws that require minimum standards of charity-care provision by hospitals. Elsewhere, state hospital associations are trying to preempt more-aggressive legislative action by getting member hospitals to voluntarily adopt higher standards. It is unknown whether such measures have increased hospitals' provision of care to the uninsured, but hospitals have become more sensitive to community perceptions of their charitable activities.

SAFETY-NET PROVIDERS have largely weathered the threats of the past decade, and some have even thrived. In the past, they were able to adapt by maintaining or increasing public subsidies, using creative strategies to adapt to a changing marketplace and to gain recognition in the community as high-quality providers of specialty care (hospitals) and primary care (CHCs). With financial and competitive pressures in the health system increasing, safety-net providers' ability to maintain viability may depend on the same strategies being used in the private sector to direct available capital toward facility renovation and expansion and to attract a

more favorable payer mix among both services and patients. Maintaining the balance between their mission and the requirements for financial viability has been tenuous for some time, but is becoming even more so in a marketplace that is becoming more competitive and profit-driven.

*This research was supported by the Robert Wood Johnson Foundation. The authors thank Nicole Kemper and Johanna Lauer for their assistance. Paul Ginsburg, Debra Draper, Laurie Felland, Bob Hurley, Alwyn Cassil, and two anonymous reviewers provided helpful comments on an earlier draft.*

## NOTES

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