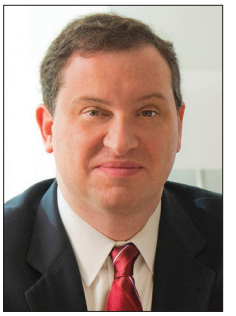
The Third Tier



I recently completed another two-week rotation on the lymphoma service at NewYork-Presbyterian Hospital/Weill Cornell Medicine, which always provides me with much food for thought. Many topics of interest arise while on service that cover a broad spectrum of issues. Over the next several editorials, I will address the topics of greatest interest to me. I want to start by discussing the viability of hospitals that are primarily responsible for the care of patients who are financially less well-off.

In my simplistic terms, the financial viability of a hospital is determined by the following factors: (1) philanthropic or government funding; (2) efficiency; and (3) reimbursement. Philanthropy applies mainly to academic medical centers that provide valued naming rights, whereas government funding is applied more broadly, but represents the necessary funding for those struggling nonacademic hospitals. Efficiency can be seen as a benefit that pays out in the long run, after a great deal of initial investment in infrastructure. This initial outlay tends to be something that at-risk hospitals cannot afford. This is exacerbated by less-resourced patients seeking a greater share of their care as inpatients, rather than in the less-costly outpatient arena. The third category, reimbursement, is a potential lifeline for these hospitals.

As luck would have it, *The New York Times* published an article on November 17 about saving "safety net" hospitals: "Hospitals both strained and essential." The article outlined three categories of hospitals: (1) big academic medical centers; (2) public hospitals; and (3) independent safety net hospitals. The academic medical centers, through adequate reimbursement rates and philanthropy, and the public hospitals, through city and state subsidies, can remain financially solvent. By contrast, the independent hospitals teeter on the verge of closing, and—possibly related—deliver care that is often substandard. The *Times* article focused on Wyckoff Heights Medical Center, which is in the predominantly Hispanic neighborhood of Bushwick in Brooklyn, New York. Wyckoff is anticipating a shortfall of approximately $135 million this fiscal year and is in the bottom 7% of US hospitals according to quality ratings by the Centers for Medicare & Medicaid Services.

How do we help this third group of hospitals improve their financial status, with the ultimate goal of improving the quality of care they deliver? According to the *Times* article, Medicaid patients make up slightly more than half of the patients at Wyckoff Hospital, compared with 18% at NYU Langone's main Manhattan campus. With Medicaid reimbursing hospitals as little as one-sixth the amount that a private health insurer does, a facility like Wyckoff is quickly left in a hole. These hospitals also bear a much greater burden of uninsured and undocumented patients. To add insult to injury, Wyckoff receives reimbursements from private insurance that are on average 52% lower than those commanded by Manhattan hospitals because of its inability to negotiate favorable rates.

I believe that access to quality health care should not depend on the ability to pay. I also know that the financial resources of a medical center undoubtedly affect outcomes. My ability to obtain a PET/CT scan for an inpatient (yes, I can), obtain a CT-guided biopsy the next day, and access excellent consultation services makes it possible for my patients to receive a higher quality of care. Thus, two patients who present to a specific hospital—safety net or Weill Cornell—will receive the same level of care (substandard or stellar), regardless of their finances.

The difference lies in location, with Weill Cornell situated in the pricey Upper East Side of Manhattan and safety net hospitals located in the outer boroughs. The less sophisticated or less resourced patient who is going to the nearest hospital is unlikely to wind up on the Upper East Side. Anyone can present to Weill Cornell for care, but only the savvy will understand the value of looking beyond their local facility.

These are just a few of the many factors that contribute to health care disparities. What steps can be taken to address these disparities? I do not advocate for government takeover of health care or of individual hospitals. I do, however, believe in creating parity regarding the amount that insurers pay to hospitals for equal care. How else can struggling hospitals invest in the equipment they need to provide optimal care? This would mean private insurers reimbursing equally across different sites, as well as Medicaid increasing their payments to levels similar to those of private insurers. Although this would certainly increase insurance and Medicaid costs, it would help ensure a quality of care for everyone. The current system uses increased reimbursement as a reward for better care, but financial reward should not drive the value of health care. I want the best for all my patients, regardless of where they come from and how well their insurance pays. I am sure you want the same for your patients.

Sincerely,

Richard R. Furman, MD