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RESTRICTED FUNDING OF U.S. BASED HOSPITALS TRANSLATES INTO A FINANCIAL CRISIS FOR THE WORKERS AND THE PATIENTS

PART A

Contrary to popular belief, U.S. based hospitals are not separate entities that always run smoothly based on their independent guidelines for management and delivery of care. Infact, they are deeply controlled by the decisions made by the trustee board, state and federal governments concerning their budget, staffing and quality of care. Due to the board of trustee and government deciding the amount of state and federal budget that is allotted to each hospital, most hospitals face rampant funding shortages that translates into limited availability of supplies, reduced hospital staffing, substandard quality of care and decreased patient intake. Problems with financing a hospital's day to day procedures has become so rampant that in a survey of 1,037 hospital CEO's conducted in 2014, a whopping "37% of them listed financing as the number one challenge for hospitals" (Healthcare Executive, Oct 2014).

The financial crisis afflicting U.S. hospitals can further be attributed to problems with Medicare reimbursement (4.93%), increased patient volume (5.40%), bad debt (6.30%), increasing cost for staff and supplies (6.46%) and Medicaid disbursement (5.40%) (Healthcare Executive, Oct 2014). In other words, the number of people receiving Medicaid and Medicare is increasing. However, these two government based programs are funding less and less procedures so when a patient undergoes an emergency procedure that is uncovered by his/her

insurance, the hospital receives the short end of it and has to make up the costs by either buying less supplies or reducing the intake of patients for future procedures. Similarly, as wages for hospital staff are increasing ever so rapidly, the hospital is unable to keep up with the demands and must shortlist their staff and cut their hours, which in turn results in less efficacy overall.

An extreme example of a hospital that suffered shutdown due to limited budgeting was the 200 bed Waltham hospital in Massachusetts. Although the hospital was serving 10 different communities, it was not as well funded as the teaching hospitals of Boston. Because of their higher prestige and reputation, teaching hospitals "snag most of Boston's endowment income, federal research dollars and financial resources" (Hayden, 2005, pg 5). . The second class status of the state's community hospitals is further deepened by the fact that they cater to populations on Medicaid and Medicare. Medicaid only "reimburses an average of 70 cents for each dollar's worth of inpatient and outpatient care; this is one of the lowest Medicare reimbursement rates in the nation" (Hayden, 2005, pg 4). Due to Medicaid eligibility cutbacks and small volume of privately owned hospitals, such non for profit hospitals as Waltham have no choice but to carry the burden of their uninsured patients on their shoulders. As a result, many cannot keep up with the costs and end up shutting down.

The situation is not much different in the state of New York where the Dept. of Human Health and Services recently planned to cut Medicare and Medicaid reimbursements by 28.5 percent. Such cuts will lead to "hospitals being stripped of their ability to provide critical services, and could even lead to the layoff of hospital staff" (Wham, Oct 2018). In total, New York State will lose about $1.8 billion in funding due to the cuts by next decade and amongst the hospitals affected will be Highland Hospital, Strong Memorial Hospital, unity Hospital, Clifton

Springs Hospital and United Memorial Medical Center. With a shortage of rural hospitals in NY, the population most affected will be the poor and the lower economic classes of the region.

While some states are undergoing recent changes to Medicare/Medicaid reimbursement, other parts of the country, mainly the Southern and Southeastern states as well as California are already suffering a huge blow. More than 120 rural hospitals have gone out of business since 2005…and the hotspot for closures and financial distress continues to be the South-particularly Florida, Alabama, Tennessee, Arkansas, Virginia-as well as Texas (Health Resources and Services Administration, Oct 2017). The percentage of uninsured people has risen from 45.8 million to 49.9 million in Texas within the past 4 years (lee, pg 1). These uninsured rely heavily on healthcare providers to give healthcare services at free or reduced fees. Therefore, non for profit hospitals such as Methodist Dallas Medical Center in Texas and Cedars Sinai in Beverly Hills, California are forced to provide a wide array of community benefits such as charity care, in exchange of tax exemptions each year. Charity care results in total uncompensated healthcare costs worth billions of dollars (Kim et. Al, pg 3).

To make matters worse, these non-profit community hospitals do not have an extended amount of cash flow and they are often suffering from bad debt. The hospitals, financially burdened beyond recovery, have no choice but to either limit services, cut staff or ultimately shut down. In fact when asked about how they attempt to reduce financial stress and recover from debt, “49% of [not-for profit hospitals] end up reducing staff” (Healthcare Executive, 2014, p 1). Meanwhile, “23% of the institutions reduce services and eliminate service lines, 15% cut wages and nearly 10% close sites” when they can no longer deal with increasing hospital expenses without revenues to match (Healthcare Executive, 2014, p 1). What it ultimately translates into is

less staff, supplies and procedures providing a lesser quality of care to compensate for uncompensated charity care mandated by the law.

Speaking of the law, both federal and state legislature has compelled public hospitals to take in the uninsured and those below the poverty line, extending the financial burden across the institutions. In fact, the Commonwealth Care Program created in Massachusetts, in 2006, required all Massachusetts residents earning below 300% of the Federal Poverty line to obtain Medicare and as a result, the load on public hospitals to take in these new cases had increased their expenditures substantially. Another common law created back in 2009 by President Obama , known as the Congressional Budget Office or CBO law, requires hospitals to bundle all their hospital and physician expenses initiated within a period of 30 days into one. As a result, it has become substantially more difficult for limited funding programs such as Medicare to approve bundled expenditures over individually packaged ones. Consequently, recent years have seen many acute hospital procedures being turned down by Medicare and Medicaid, which has translated into the individual community hospitals owning upto and paying the patient's uncompensated expenses.

The latest federal law that attempts to reduce healthcare funding on Medicaid by $834 billion over the next 10 years is part of the American Healthcare Act (AHCA). In addition to revoking Medicaid expansion, the bills place limits "on the federal dollars that state hospitals receive to provide health insurance to millions of low income Americans, including the elderly, disabled and people with opioid addiction" (Haught, 2017). Due to this most recent legislation, hospitals in Medicaid expansion states will experience a further 14 percent drop in revenues from year 2017-2026. On average, rural hospitals will see even more of a decline, a whopping 20% or

more, in the states of Michigan, New Mexico, Kentucky and Nevada (Haught, 2017). Decreased hospital revenues and inadequate Medicaid reimbursements will compound the financial crisis for community based and rural hospitals, resulting in more staff being laid off and medical care being further compromised.

Different states have devised different solutions to deal with the bad debt, restricted cash flow and Medicare cuts that is ailing not for profit hospitals. About 32 percent of such institutions are planning to merge with another provider, out of which 25% will acquire another payer through the merge. Meanwhile, another 46% are considering entering a joint venture (Healthcare Executive, Oct 2014). An example of this was in 2010 when Massachusetts' second largest healthcare system, Caritas Christi Health care, was acquired by Cerebrus Capital Management. With the merger, Caritas was able to resolve its bad debt, acquire its hospitals' physical plants and provide additional healthcare services to the hospital community (Hayden 2005, pg 4).. In New York, meanwhile, the state legislature has increased public hospital funding to include $50 million extra to compensate for the money such hospitals did not receive from Medicare and Medicaid reimbursement. From 2018-2019, the Enacted budget will allot this money to hospitals receiving a high percentage of Medicare and medically uninsured cases. Another $50 million will be awarded to federally designed critical access hospitals (CAH) and federally designed sole community hospitals (SCH) (Rubin 2018).

Yet another solution to ending the debt and increasing the revenue for not for profit hospitals is to convert them into physician based hospitals. In such a venture, physicians own 30-40% stakes and provide financing to get the institution out of debt caused by charity care. The advantage of a hospital to align with a physician is that physicians have an interest in the

facility's financial success and clinical success. As a result, they will balance the amount of Medicare/Medicaid patients seen with those that are privately insured, so that no one is medically neglected, but the hospital also does not end up recurring avoidable debt. The physicians sometimes bail the hospital out during times of debt so they can continue funding their necessary staff and services to keep the institution running. The Texas Institute of Surgery at the Presbyterian Hospital in Dallas, is one of many hospitals owned by multiple physicians who help finance and operate the facility after it had initially fallen into bad debt (Zigmond, pg 4).

PART B

The challenge highlighted above regarding insufficient budgeting and reimbursement difficulties afflicts no other hospital more than Flushing Hospital in Queens, NY. Because the neighborhood of Flushing is home to many immigrant populations and low income minorities, much of the influx of the hospital is either uninsured patients or those on Medicare or Medicaid (Flushing Hospital, Billing Information, 2018).. Because many of the high cost dental procedures conducted at the hospital are not covered by insurance, they are executed on an emergency basis and the patient is billed later. Although the patient signs a binding contract saying they owe the hospital for the services provided, such as an endodontic root canal or a composite filling, very few end up keeping their word and paying it. As a result, the emergency dental service turns into a case of uncompensated charity care that eats away at the overall hospital budget.

Due to these financial challenges, Flushing Hospital has acquired a bit of bad debt and has been forced to compensate for it by buying cheaper supplies, cutting back hospital staff,

reducing their hours and increasing daily patient intake. Because the hospital can simply not afford to pay all 5 dental assistants on any given day, one of them is always given a one day leave to make up for expenses. This increases the burden on the remaining 4 assistants to cover the 5 dental chairs, sterilization room and supply unit that they are assigned to cover during the day.

Likewise, the supplies bought are of cheaper quality in the not for profit institution. For example, rather than using blue tape to cover the cavitron handpieces, curing lights and polishing agents, cheaper plastic covers are used instead. Because they are not adhesive, they keep slipping off the handpiece and lead to increased risk of injury and hospital liability if they accidentally slip and fall into the patient's mouth. Similarly, due to decreased funding and uncompensated care adding to expenses, the hospital has yet to buy new dental chairs or dental lights. In fact, some of the chairs are so outdated that they do not move back and forth and when the dental light does not turn on, we are left to our own devices, which means either turning on our loupes or performing prophylaxis on a patient in the dark. What's even worse, the hospital is unable to afford digital x-ray machines in all the rooms. So we all have to make use of the film based radiographs and process them in the same dark room using one processing machine, which often leads to long wait times for patients, lost radiographs, and increased length of appointments.

Although these restraints in budgeting have all had some effect on our working experience at the hospital, nothing has affected the staff at the dental clinic including myself more than the constant pressure we face to see more and more patients each day. Because administration is always forcing more patients on us in an attempt to increase the amount of daily revenue raised by the hospital to offset the debts, the residents, assistants and interns are unable

to provide the quality of care that each individual patient deserves. Endodontic root canals take a minimum of 2 visits at the hospital because there is simply not enough time to seat a patient for 2 hours straight to finish the process in one visit; there's always 5 more waiting to be seen in the waiting room. As a result, root canals are often finished in one month and by that time, the infected tooth has broken up in several places and now requires an extraction instead. Due to the overbooking of patients to meet hospital revenue quotas, most patients receive only a supragingival prophylaxis procedure by the interns even though they qualify for subgingival root planning and scaling. There is simply not enough time to give them what they deserve or enough money to buy the local anesthesia required during an SRP, so consequently, patients walk away with loads of plaque and calculus beneath the gingival margin that continues to cause them gingival irritation, inflammation and bleeding. The standard of care and dental ethics are compromised in order to keep the hospital running.

Because the residents are under constant pressure to see more and more patients each day, this translates into them doing most of the procedures themselves rather than sharing the work with the somewhat slower interns. The work driven, stress induced atmosphere of the clinic just doesn't allow for enough breathing room to teach newbies like us the proper techniques to take an FMS or perform a deeply subgingival scaling and root planing. It's a "do or die" situation where you either know the procedure and perform it properly within the time limits or you don't know the work and you are no longer included in the competent work pool. Although there have been many times in the past where the residents have refused to give me work and have rather taken over an FMS for me when I was not up to their speed, this, in the long run, has polished me into a much faster, more competent and efficient hygienist that can take FMS within 15 minutes

and perform prophylaxis of the whole mouth in under 20 minutes. Therefore, in an attempt to maximize revenues and increase patient intake, Flushing hospital has inadvertently made all staff and interns into more proficient and accomplished workers, whose skills will be recognized wherever they go.

Regardless of the positive impact it has had on the workers, however, the majority do not appreciate being held over after work hours to care for more patients than what was initially planned for. Likewise, patients are delivered a substandard quality of care when they are squeezed into short appointment times, given a reduced staff to work with and not provided the necessary set of supplies to carry out the procedure.

The staff shortages, supply limits and time constraints afflicting Flushing Hospital mirror the budgeting setbacks many of the not for profit hospitals all across the nation are experiencing. Such setbacks all stem from the same source: cutbacks in Medicare and Medicaid reimbursement combined with bad debt and restricted cash flow creating a deficit in the hospital's budget pool. The best way to combat and solve all these funding based problems would be for Flushing hospital to merge with another larger teaching hospital such as New York Presbyterian Queens on Booth memorial Ave. With this merger, not only can Flushing Hospital receive a better cash flow and overcome its debt, it can direct some of its Medicaid based population towards the larger hospital which is better funded. Dividing the patient population across a bigger base will allow both hospitals to have the proper amount of staffing, supplies and time to carry out emergency and routine dental procedures in a safer and more efficient manner.

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