THE
CHANGING
HOSPITAL
SECTOR IN
WASHINGTON, D.C.
Implications for the Poor

BARBARA A. ORMOND AND RANDALL R. BOVBJERG
Hospitals in the District of Columbia

Neighborhood Race, Ethnicity, and Poverty
1990

- Predominantly Black - Low Poverty
- Black-White Mixed - Low Poverty
- Completely Mixed - Low Poverty
- Hispanic-White - Low Poverty
- Predominantly White - Low Poverty
- Predominantly Black - Moderate Poverty
- Black-White Mixed - Moderate Poverty
- Completely Mixed - Moderate Poverty
- Hispanic-White - Moderate Poverty
- Predominantly White - Moderate Poverty
- Predominantly Black - High Poverty
- Mixed - High Poverty
- Non-residential

District of Columbia Hospitals

Tertiary Care Centers
1) George Washington (for-profit, 277 beds)
2) Georgetown University (not-for-profit, 359 beds)
3) Howard University (not-for-profit, 309 beds)
4) Washington Hospital Center (not-for-profit, 775 beds)

Public Hospital
5) DC General (public, 265 beds)

Community Hospitals
6) Hadley (for-profit, 71 beds)
7) Greater Southeast (not-for-profit, 296 beds)
8) Providence (not-for-profit, 316 beds)
9) Sibley (not-for-profit, 235 beds)

Speciality Hospitals
10) Children's (not-for-profit, 188 beds)
11) Columbia Women's (not-for-profit, 75 beds)
The Changing Hospital Sector in Washington, D.C.: Implications for the Poor

Barbara A. Ormond
Randall R. Bovbjerg

THE URBAN INSTITUTE
Support for this paper was provided by the Robert Wood Johnson Foundation. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. The authors gratefully acknowledge Peggy Sulvetta and John Holahan, who initiated the project and supported it in all phases. We would also like to thank Judith Feder, Joan Lewis, and Virginia Fleming for their helpful guidance and useful comments; Susan Wallin for her timely contributions to the research; Chris Hayes, Brian Bruen, and Suresh Rangarajan for assistance in mapping; Niall Brennan for data analysis; and Matthew Schirmer for research assistance. The research could not have been accomplished without the cooperation of Washington hospital officials, community providers, and health care observers too numerous to mention, and we greatly appreciate their having taken the time to meet with us.
Contents

Executive Summary .............................................1
Introduction .....................................................5
Context ..........................................................7
  Socioeconomic and Demographic Characteristics ..........7
  Health Status ................................................7
  Health Insurance and Supply of Providers ..................9
The Hospitals ..................................................10
  Hospital-Specific Utilization ................................12
  Payer Mix ....................................................12
The Hospital Market ..........................................18
  The Market for Insurance ....................................18
  The Maryland and Virginia Hospital Markets ..........19
  The D.C. Hospital Market ................................20
  Suburban and Regional Competition ......................21
Pressure for Change ...........................................22
  Pressure from Private Insurers ............................23
  Pressure from Public Payers ...............................24
  Hospital-Specific Pressures ...............................25
Strategies ......................................................26
  Cost Reduction .............................................28
  Patient Volume .............................................32
The Future ......................................................37
  Community Hospitals ......................................37
  Tertiary Care Hospitals—District Options ...............38
  Tertiary Care Hospitals—Regional Options ..........40
  Tertiary Care Hospitals—Regional Service Competition .42
  Summary ....................................................43
Discussion ......................................................44
About the Authors ............................................51
Tables
  1: Health and Demographic Data ...........................8
  2: D.C. Health Care Resources ............................9
  3: D.C. Hospitals: Acute Care, Short-Term, Nonmilitary ....11
  4: Hospital Utilization ....................................13
  5: Hospital Financial Data ................................14
  6: Market Share ............................................16
The Changing Hospital Sector in Washington, D.C.: Implications for the Poor

Executive Summary

The Washington, D.C., hospital sector has an excess of hospital beds and a concentration of services at the high end. Four community hospitals; three academic medical centers; a large, nonacademic tertiary care hospital; five specialty hospitals; and a public general hospital all compete to serve a city with a population of only 500,000. In addition, there are two military facilities. Forty percent of patients in this market are drawn from the adjacent Maryland and Virginia suburbs. The market is poised for change, driven by insurance market trends.

The insurance market in the District is bimodal. At one end, coverage is generous, strongly influenced by the federal employees’ plan, which offers both fee-for-service and managed care and has historically subsidized the high end of the market. To compete for professional workers, private firms attempt to match the federal plan. At the other end, nearly one-fifth of the city’s population is on Medicaid and another fifth is uninsured. Hospital overcapacity has given insurance plans the advantage in rate negotiations, and the consolidation among the plans that has begun in the past year threatens to further increase the bargaining power of the plans. In the public sector, the D.C. employees’ plan has recently moved to managed care for new hires, and mandatory enrollment of Medicaid recipients in managed care has just begun.

Hospital payer mix is determined in large measure by geographic location. While Medicare patients are fairly evenly distributed across the city, Medicaid patients are concentrated in certain geographic areas. Uncompensated care is
also concentrated, largely by geography, but hospital mission is also a determinant. The city’s public hospital provides the bulk of the uncompensated care, but there are other important providers as well. Total uncompensated care provision in the city declined during the 1990s, and its distribution became even more uneven, with the city’s public hospital picking up more of the burden. Unlike many other cities, Washington has only one academic medical center that is a major provider of uncompensated care. Even unburdened by uncompensated care, the academic medical centers are financially insecure, suggesting that uncompensated care is not a driving force behind their poor financial performance.

The community hospitals are widely distributed geographically. They are niche players, serving their neighborhoods and other chosen target populations, and are generally more stable financially than the academic medical centers. Two important factors influence their financial health. First, they have greater flexibility than the larger facilities to identify and institute cost-reduction measures. The institutions that have combined this flexibility with foresight are much closer to achieving the level of efficiency demanded in the current highly competitive market. Second, community hospital missions do not require them to maintain as broad a range of services as specialization in tertiary care. The community hospitals have, therefore, been able to concentrate on excelling in a narrower range of services.

With increasing pressure from payers, rising competition from both District and suburban hospitals, and changes in public policy regarding Medicaid and Medicare, many District hospitals are struggling financially. They also face a growing for-profit presence, from a small community hospital that converted in 1992 and, since last year, from a major medical center. These changes affect different hospitals in different ways, depending on their patient base and payer mix. Hospital survival strategies are, nonetheless, fairly consistent across institutions and typically old-fashioned, concentrating on cutting costs and filling beds. Vertical integration of services is also being tried as a way to position the hospital as a unit of a continuum of care rather than as the central provider. Hospital mergers might seem a logical strategy as well, but to date hospitals within the city have shown little propensity to affiliate with one another. More frequently, D.C. hospitals look to hospitals in the adjacent states, particularly Maryland, for partners, reflecting the fact that the market for tertiary care services is becoming increasingly regional. The
tertiary care centers are especially eager to expand their patient bases through affiliation with physician practices and hospitals in the Baltimore-Washington corridor, where the population is relatively affluent and population growth is relatively rapid. While some efficiencies might be expected from these affiliations, the dominant motivation appears to be to increase bargaining leverage with health plans and decrease competition for patients among the affiliated partners.

Most observers believe that the hospital sector will look very different in the not-too-distant future, but there is little consensus on what it will look like. It has long been expected that at least one hospital will close, and many hospital managers seem to expect the closure to relieve market pressure and reduce the bargaining power of insurers. From a policy perspective, what is important as the sector restructures is that the surviving hospitals offer an appropriate mix of services at locations that are geographically accessible to all, including the publicly insured and the uninsured, and at a price that reflects a balance of efficiency, quality, and access. It is the need to ensure accessibility and affordability that justifies public policy intervention in the hospital market.

The imminence of change argues strongly for intervention soon. The city needs to quickly end the near vacuum of policy brought about by its recent financial troubles and the leadership ambiguities created when Congress imposed Control Board authority over most city services. As the city regains financial stability and a measure of local control over its services, it will need to make key decisions about health care, especially about hospitals that provide a large measure of the available indigent care. Market forces are currently being allowed to shape the hospital sector with little local public intervention. The interplay of market forces should lead to a more efficient provision of services, a favorable outcome for those whose insurance makes them participants in the market. However, for a large number of poor D.C. citizens, the only voice available to them in the market is government policy on Medicaid and on care for the uninsured.

The District has no formal policy on hospital care for the uninsured, implicitly relying on the goodwill of individual hospitals for charity and other uncompensated care. When hospital finances were more secure and competition among hospitals was minimal, this policy might have been effective. In the current climate,
however, the uneven distribution of uncompensated care represents a competitive disadvantage for those hospitals that choose to care for the poor. City inaction by default favors hospitals that, by chance or design, provide little uncompensated care.

Other jurisdictions have used charity care pools, hospital rate-setting, or expansion of publicly sponsored or subsidized insurance programs to reduce uncompensated hospital care or to spread its burden equitably across hospitals. Current D.C. regulations require a minimum level of charity care by private hospitals, but the total amount required is insufficient to meet demand. The city’s quasi-public hospital, D.C. General, and its associated clinics serve as providers of last resort for all, without regard to ability to pay. Once again, however, demand exceeds capacity, and the incentives in place do not promote the most efficient provision of care.

Currently under discussion are proposals to expand health insurance coverage for children and their parents, childless couples, and single adults under the federal Child Health Insurance Program and through Medicaid waiver programs. Expanding insurance coverage would directly reduce uncompensated hospital care. In addition, it should encourage greater use of primary and preventive care so that, in the long run, as new patterns of utilization are established, inappropriate emergency room use might be curtailed and the number of preventable hospitalizations might decline.

Expansion of coverage should be encouraged, but uncompensated care will always remain. The District should analyze the pattern of uncompensated hospital care, looking at who is receiving care, what types of care are being received, and who is providing it. It should then articulate a citywide policy on uncompensated hospital care so that the restructuring hospital sector will serve all D.C. residents.

Instituted in response to market developments that reduce overall uncompensated care provision, policy could mitigate the worst effects of the new hospital market on the poor. Instituted before such a crisis, policy could influence which hospitals survive. Policies on uncompensated care do not represent simply protection for the safety net institutions. Rather, by spreading the social burden of caring for the disadvantaged, policies can level the playing field and allow the safety net institutions to compete on more nearly equal terms with the hospitals that provide little uncompensated care.
Washington’s hospital sector is poised for change, and the change is being driven chiefly by market forces. Overcapacity, resulting from declining lengths of stay and the trend toward substituting outpatient care for inpatient care, has created strong competition among hospitals for patients. Implementation of mandatory managed care for Medicaid recipients has begun; hospitals anticipate that Medicare will move that way soon as well. Price pressure from purchasers is already strong, and health plans have begun to consolidate, bringing the threat of even greater pressure. The current period is one of great stress for hospitals. Although it has long been expected that at least one District hospital would close, it is not clear which it might be, if any. All of the local hospitals have developed plans to get through this difficult period, positioning themselves not just for survival but also for success in the new medical marketplace.

The city has an interest in the outcome of this transition and should, therefore, articulate a policy to protect its interests in this sector. Its interests lie in two areas. First, when the market works well, the interplay of market forces should lead to a more efficient provision of services. As a purchaser of hospital services and an advocate for its citizens, the city has a financial interest in having as efficient an outcome as possible from the process. Second, the market will only yield an efficient outcome for those who are participants in the market. For a large number of D.C. citizens, the only voice available to them in the market is government policy on Medicaid and on care for the uninsured.

The District of Columbia does not lack prescriptions for the reform of its health care system. For over a decade, numerous commissions have offered the city well-researched and thoughtful plans. Last year, in particular, was a time of great activity in health care policymaking. A public-private Health Policy Council has been convened at the highest level of city government to direct policy in several critical areas. The membership is broad, meetings are regular, and enthusiasm is high. Reports are beginning to be developed and implementation of prior recommendations is being overseen.
In one area, however, there is little activity. While specific plans have been made and are being implemented for the city’s public hospital and its affiliated clinics, the Health Policy Council does not have a working group dedicated to setting policy for the overall hospital sector. Beyond setting up the public system as a model for the provision of health care services, the city has no overall policy to guide its private hospitals through the changes that are taking place in the sector. It is widely recognized that the city has more hospital beds than it needs, with estimates of the excess ranging from 25 percent to over 200 percent. There is duplication of services in areas such as heart surgery and organ transplantation, and fragmentation in areas such as emergency care and trauma. The result is that average hospital costs in the city exceed such costs in other comparably sized urban areas even while basic needs go unmet in certain areas of the city.

Effective policymaking requires a clear understanding of how the system currently functions. This paper examines how the 11 nonfederal acute care hospitals in the District of Columbia are responding to changes in the health care delivery environment and how the evolving health care system is affecting these institutions and the people they serve. Information comes from hospital statistics, newspaper and journal accounts of current sector activities, and personal interviews. Research for the paper covers the history of the hospitals and their activities recorded in secondary sources during 1997–98. Interviews of hospital officials, government and association representatives, ambulatory care providers, insurance plans, health advocates, and others knowledgeable about the Washington hospital market, conducted in late 1997 and early 1998, were also included in the data. Using the information gained in these interviews, we can provide a description of the market in which these hospitals are operating, the changes occurring in the system, and hospitals’ responses to these changes. This description pays particular attention to the effects the changes are having on different types of hospitals. The report looks at the likely consequences of various possible outcomes for the hospital sector from the perspectives of the hospitals and of the people of the city, especially those who are publicly insured and those without insurance.
Washington, D.C., is a city of about half a million people, with a close-in metropolitan area population of about 2.5 million. It is a city of contrasts—it has a much higher per capita income than the national average, ranking third compared with all 50 states, but it also has a higher rate of poverty and a higher unemployment rate. Despite its high average income, D.C. ranks only 28th among the states in median income, revealing its highly skewed distribution of income.

Washington has a majority black population, a large white minority, and a smaller Hispanic minority. As in many cities, Washington’s neighborhoods have distinctive ethnic and socioeconomic characteristics. (See map inside cover.) The northwestern section, separated from the rest of the city by a large urban park that stretches from the northern District line to the downtown business district, is largely white, professional, affluent, and well insured. The southeastern quarter, separated from the rest of the city by the Anacostia River, is largely black, has much higher rates of unemployment and uninsurance, and has other problems typical of urban inner cities. The area between the Anacostia River and the park is more racially and economically diverse, with areas of both affluence and poverty. Washington has a high percentage of undocumented immigrants, mostly from Latin America, and it is in this central area that most of the city’s immigrant neighborhoods are found. The population of the District is slightly older than the U.S. population generally, with fewer residents under age 18 and over age 65. (See table 1.) The large undocumented immigrant population means that a relatively high proportion of the city’s population is ineligible for public insurance programs.

Health indicators reflect the demographic and socioeconomic profile of the city. While most of the rates compare unfavorably with state or national averages, it should be kept in mind that D.C. is entirely urban, and its health status is typical of large urban areas in the United States. Among the states, D.C. has the highest, or nearly the highest, rates of tuberculosis infection, HIV/AIDS infection, incidence of certain cancers, syphilis infection, and admissions for
**TABLE 1  Health and Demographic Data**

<table>
<thead>
<tr>
<th></th>
<th>D.C.</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sociodemographic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population (1994–95)</td>
<td>573</td>
<td>260,202</td>
</tr>
<tr>
<td>Percent under 18</td>
<td>24.4%</td>
<td>26.8%</td>
</tr>
<tr>
<td>Percent 65 and over</td>
<td>11.2%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Percent Hispanic</td>
<td>4.5%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Black</td>
<td>69.6%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Percent Non-Hispanic White</td>
<td>23.9%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Percent Non-Hispanic Other</td>
<td>2.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Percent Noncitizen Immigrant</td>
<td>7.9%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Population Growth (1992–97)</td>
<td>–9.5%</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Economic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Capita Income</td>
<td>$35,852</td>
<td>$25,598</td>
</tr>
<tr>
<td>Unemployment Rate</td>
<td>7.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Percent below Poverty</td>
<td>24.1%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Percent Children below Poverty</td>
<td>41.2%</td>
<td>21.7%</td>
</tr>
<tr>
<td><strong>Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent Uninsured</td>
<td>18.7%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Percent Medicaid</td>
<td>18.9%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Percent Employer Sponsored</td>
<td>57.8%</td>
<td>66.1%</td>
</tr>
<tr>
<td>Low Birth-Weight Births (&lt;2,500 g)</td>
<td>14.2%</td>
<td>7.4%</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>12.1</td>
<td>7.1</td>
</tr>
<tr>
<td>AIDS Cases Reported</td>
<td>2,469.8</td>
<td>634.1</td>
</tr>
</tbody>
</table>

---


d. Preliminary data.


f. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute’s TRIM2 microsimulation model.


drug or alcohol abuse. Rates for teen pregnancy, infant mortality, and low birth-weight births are much higher than the national average. The morbidity patterns also differ by neighborhood. The rates in the affluent northwest section of the city are lower than national averages, while across the Anacostia River to the southeast, the rates exceed national averages.

Health insurance coverage is also skewed. The federal government employs 31 percent of the local workforce and offers a wide range of insurance options under the Federal Employees Health Benefits Plan (FEHBP). The results of a recent study by the Centers for Disease Control show that D.C. ranks second highest among the states (after Hawaii, where employer provision of insurance is mandatory) in the percentage of employers offering health insurance to at least some of their employees. Private employers that offer health insurance are often in competition with the government for employees and so must match its insurance offerings. Estimates of the number of uninsured range from 98,000 to 112,000, or nearly one-fifth of the population, with another fifth covered by Medicaid. D.C. ranks second highest among the states in the number of Medicaid beneficiaries as a percentage of state population and twelfth highest in the number of uninsured.

Belying the poor outcome measures, Washington is among the richest areas in the country in health care resources, especially tertiary resources. (See table 2.) Its rates of physicians, hospital beds, and registered nurses per thousand population all far exceed national averages. Some of this capacity exists to serve the many nonresidents—local, national, and international—who use the District’s health care system; 40 to 45 percent of inpatient days are attributable to nonresidents. Although border-crossing has diminished somewhat in recent years

<table>
<thead>
<tr>
<th>Resource</th>
<th>D.C.</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians per 100,000 Population</td>
<td>189</td>
<td>81</td>
</tr>
<tr>
<td>Generalists</td>
<td>342</td>
<td>128</td>
</tr>
<tr>
<td>Specialists</td>
<td>1,384</td>
<td>793</td>
</tr>
<tr>
<td>RNs per 100,000 Residents</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Nurse Practitioners per 100,000 Residents</td>
<td>31.5</td>
<td>9.8</td>
</tr>
<tr>
<td>Hospital Beds per 100,000 Residents</td>
<td>1,183.8</td>
<td>432.7</td>
</tr>
<tr>
<td>Population Underserved by Primary Care Physicians</td>
<td>25.4%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Dentists</td>
<td>2.4%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>12.1%</td>
<td>12.3%</td>
</tr>
</tbody>
</table>
In a city with such rich medical resources, it is clear that the geographic distribution of providers does not match the distribution of the population or of health care need.

as insurers have sought to reduce costs by steering patients to lower-cost suburban providers, suburban patients are still important for the city’s providers.

Despite the high provider per capita statistics, 71 of the District’s 192 census tracts have been designated as health professional shortage areas (HPSAs) and 36 as medically underserved areas (MUAs), implying that nearly 13.7 percent of the city’s population is without adequate access to primary care. In a city with such rich medical resources, it is clear that the geographic distribution of providers does not match the distribution of the population or of health care need. D.C. ranks highest among the states in the number of emergency room visits per thousand population. The lack of adequate primary care has been cited as a contributing factor in the high uncompensated care burden faced by District hospitals.

The Hospitals

The 11 study hospitals fall into four categories (table 3). Four tertiary care hospitals have 54 percent of the city’s beds: three academic medical centers—George Washington University Hospital (GW), Georgetown University Hospital, and Howard University Hospital—and the Washington Hospital Center (WHC), a major teaching hospital. WHC is the largest hospital in the city and the flagship of the city’s largest hospital system, Medlantic. Control of GW’s medical center was transferred in July 1997 to a for-profit partnership owned jointly (20%–80%) by the university and a national for-profit hospital system, Universal Health Services (UHS). The other tertiary care facilities are not-for-profit. There are four community hospitals: three medium-size, not-for-profit facilities—Greater Southeast Community Hospital, Providence Hospital, and Sibley Memorial Hospital—and one smaller, for-profit facility—Hadley Memorial Hospital. Two specialty hospitals were included in the study: Children’s National Medical Center, a major tertiary pediatric center, and Columbia Hospital for Women, both not-for-profit. There is one publicly supported hospital, D.C. General Hospital, which the city operated until October 1997, when it came under the authority of the independent, quasipublic Public Benefit Corporation (PBC).
The geographic distribution of the hospitals is important. Four of the hospitals, including two of the academic medical centers, are located west or just east of the park in northwestern D.C., where about a quarter of the city’s population lives (see map). These four hold about 30 percent of the city’s beds. Of these, GW and Columbia Women’s are close to downtown and accessible by subway; Georgetown and Sibley are located farther northwest and are less accessible by public transportation beyond their immediate neighborhood. Greater Southeast and Hadley, with 12 percent of the city’s beds, are located near the District boundary, across the Anacostia River in the southeastern portion of the city, where slightly more than a quarter of the city’s population lives. Both are community hospitals, originally founded with a mission to serve the poor of their neighborhoods, although Hadley converted to for-profit status in 1993. Both are easily accessible by bus within their neighborhoods but less accessible to those coming from across the river. D.C. General is located on a subway line just west of the Anacostia River and serves populations on both sides of the river. Children’s, Howard, and WHC are clustered together in the central part of the city, with Providence just to the northeast. All are relatively accessible by bus and are either near a subway line (Howard) or have regular shuttle bus service to the nearest subway station (Children’s and WHC).
The hospitals’ current positions can be seen in recent trends in occupancy rates, the number of staffed beds, and inpatient admissions and days (table 4). All of the city’s hospitals are currently operating with fewer than their licensed number of beds. Like most hospitals in the nation, most have cut the number of staffed beds within the past two years, some drastically. On the other hand, two—both in the central part of town—report that they could fill more beds if they had them; one is planning to reopen a closed unit.

Occupancy rates have been falling throughout the 1990s, despite the large decline in the number of beds. The falling occupancy rates are the result of declining admissions and decreasing average length of stay (ALOS). The citywide decline in ALOS from 7.5 to 6.0 days mirrors the nationwide decline from 6.4 to 6.0 days, although ALOS at most D.C. hospitals remains above the national average. The local decline in inpatient admissions (1991–96) has been 12.9 percent. The 30.6 percent decline in inpatient days over the same period has not been matched by the decrease in staffed beds, which have declined only 26 percent.

As shown in table 5, both Medicaid and Medicare are becoming increasingly important contributors to hospital utilization. By 1995, city hospitals attributed, on average, 23.4 percent of their inpatient days to Medicaid patients and 40.7 percent to Medicare. These figures exceed the national averages of 14.6 percent and 30.0 percent, respectively, reflecting the age structure and morbidity profile of the city, and its poverty. Hospitals between the park and the Anacostia River have the highest Medicaid percentages. At both Children’s and D.C. General, over 40 percent of inpatient days are attributable to Medicaid. Children’s high Medicaid share reflects not only its location but also the fact that over 50 percent of the city’s children are covered by Medicaid.

For hospitals with a high level of charity care, such as D.C. General and Howard, expressing Medicaid as a share of inpatient days rather than as a share of revenue understates the importance of Medicaid for the hospital’s financial position. Medicaid patients represent a relatively larger share of paying patients for D.C. General and Howard than for hospitals with a smaller load of charity care. D.C. General’s Medicaid (42.4 percent) and Medicare (17.3 percent) percentages are roughly comparable to those of.
### TABLE 4  Hospital Utilization

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Operating Beds</th>
<th>Occupancy (%)</th>
<th>Inpatient Admissions</th>
<th>Inpatient Days</th>
<th>Length of Stay (days)</th>
<th>ER Visits</th>
<th>Outpatient Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Care Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Washington NW</td>
<td>NW</td>
<td>392</td>
<td>277</td>
<td>90.41</td>
<td>18,706</td>
<td>199,360</td>
<td>50,512</td>
<td>6,142</td>
</tr>
<tr>
<td>Georgetown NW</td>
<td>NW</td>
<td>500</td>
<td>359</td>
<td>78.37</td>
<td>10,050</td>
<td>143,028</td>
<td>23,179</td>
<td>5,975</td>
</tr>
<tr>
<td>Howard NW</td>
<td>Center</td>
<td>489</td>
<td>309</td>
<td>71.09</td>
<td>12,946</td>
<td>111,104</td>
<td>37,517</td>
<td>3,660</td>
</tr>
<tr>
<td>Washington Hospital Center NW</td>
<td>Center</td>
<td>874</td>
<td>775</td>
<td>76.78</td>
<td>30,307</td>
<td>9,113</td>
<td>3,967</td>
<td>3,219</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.C. General Center</td>
<td>Center</td>
<td>486</td>
<td>265</td>
<td>78.53</td>
<td>9,428</td>
<td>10,051</td>
<td>37,656</td>
<td>4,205</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hadley SE</td>
<td>SE</td>
<td>61</td>
<td>71</td>
<td>78.03</td>
<td>12,753</td>
<td>9,113</td>
<td>60,917</td>
<td>3,448</td>
</tr>
<tr>
<td>Greater Southeast SE</td>
<td>SE</td>
<td>470</td>
<td>196</td>
<td>73.01</td>
<td>15,537</td>
<td>105,241</td>
<td>37,056</td>
<td>4,932</td>
</tr>
<tr>
<td>Providence Center SE</td>
<td>Center</td>
<td>342</td>
<td>316</td>
<td>80.52</td>
<td>12,676</td>
<td>100,510</td>
<td>9,705</td>
<td>6,913</td>
</tr>
<tr>
<td>Sibley NW</td>
<td>NW</td>
<td>362</td>
<td>235</td>
<td>69.22</td>
<td>13,956</td>
<td>9,196</td>
<td>20,956</td>
<td>5,416</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's Center ROSE NW</td>
<td>Center</td>
<td>279</td>
<td>188</td>
<td>76.86</td>
<td>11,844</td>
<td>59,252</td>
<td>38,899</td>
<td>3,818</td>
</tr>
<tr>
<td>Columbia SE</td>
<td>NW</td>
<td>163</td>
<td>75</td>
<td>63.99</td>
<td>9,943</td>
<td>21,166</td>
<td>58,999</td>
<td>3,726</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NW</td>
<td></td>
<td>1,417</td>
<td>946</td>
<td>77.71</td>
<td>61,670</td>
<td>401,923</td>
<td>95,987</td>
<td>92,496</td>
</tr>
<tr>
<td>Center</td>
<td></td>
<td>2,350</td>
<td>1,853</td>
<td>76.61</td>
<td>81,966</td>
<td>657,145</td>
<td>992,871</td>
<td>210,928</td>
</tr>
<tr>
<td>SE</td>
<td></td>
<td>531</td>
<td>367</td>
<td>73.58</td>
<td>17,990</td>
<td>149,615</td>
<td>48,167</td>
<td>53,553</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Hospitals</td>
<td></td>
<td>4,298</td>
<td>3,166</td>
<td>76.60</td>
<td>139,648</td>
<td>1,201,683</td>
<td>834,209</td>
<td>61,251</td>
</tr>
</tbody>
</table>

TABLE 5  Hospital Financial Data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Care Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George Washington</td>
<td>NW</td>
<td>7.47</td>
<td>13.79</td>
<td>28.43</td>
<td>31.56</td>
<td>10,726,108</td>
<td>-6.09</td>
<td>-5.70</td>
</tr>
<tr>
<td>Georgetown</td>
<td>NW</td>
<td>9.07</td>
<td>10.95</td>
<td>31.55</td>
<td>27.38</td>
<td>9,207,795</td>
<td>2.08</td>
<td>-2.35</td>
</tr>
<tr>
<td>Howard</td>
<td>Center</td>
<td>99.73</td>
<td>22.64</td>
<td>30.82</td>
<td>33.02</td>
<td>38,799,919</td>
<td>-6.20</td>
<td>-6.58</td>
</tr>
<tr>
<td>Washington Hospital Center</td>
<td>Center</td>
<td>13.03</td>
<td>18.45</td>
<td>39.75</td>
<td>43.59</td>
<td>37,171,015</td>
<td>0.68</td>
<td>4.60</td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.C. General</td>
<td>Center</td>
<td>31.23</td>
<td>42.45</td>
<td>11.07</td>
<td>17.33</td>
<td>76,889,064</td>
<td>-7.36</td>
<td>5.57</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hadley</td>
<td>SE</td>
<td>23.96</td>
<td>15.53</td>
<td>51.85</td>
<td>52.71</td>
<td>1,397,355</td>
<td>-7.26</td>
<td>-2.66</td>
</tr>
<tr>
<td>Greater Southeast</td>
<td>SE</td>
<td>24.99</td>
<td>19.26</td>
<td>44.33</td>
<td>41.91</td>
<td>10,523,359</td>
<td>3.37</td>
<td>7.02</td>
</tr>
<tr>
<td>Providence</td>
<td>Center</td>
<td>14.91</td>
<td>19.68</td>
<td>52.71</td>
<td>53.19</td>
<td>9,299,954</td>
<td>1.42</td>
<td>5.93</td>
</tr>
<tr>
<td>Sibley</td>
<td>NW</td>
<td>1.22</td>
<td>1.42</td>
<td>54.10</td>
<td>67.16</td>
<td>3,394,892</td>
<td>5.97</td>
<td>10.23</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's</td>
<td>Center</td>
<td>45.48</td>
<td>40.32</td>
<td>0.56</td>
<td>0.65</td>
<td>34,009,976</td>
<td>3.09</td>
<td>-0.64</td>
</tr>
<tr>
<td>Columbia</td>
<td>NW</td>
<td>10.18</td>
<td>20.50</td>
<td>1.51</td>
<td>1.66</td>
<td>4,518,075</td>
<td>0.76</td>
<td>n/a</td>
</tr>
<tr>
<td>Subtotal (weighted average)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NW</td>
<td></td>
<td>6.74</td>
<td>10.17</td>
<td>39.99</td>
<td>36.45</td>
<td>27,846,870</td>
<td>0.82</td>
<td>-0.02</td>
</tr>
<tr>
<td>Center</td>
<td></td>
<td>21.20</td>
<td>25.01</td>
<td>30.15</td>
<td>35.35</td>
<td>196,169,927</td>
<td>-1.64</td>
<td>2.57</td>
</tr>
<tr>
<td>SE</td>
<td></td>
<td>24.87</td>
<td>18.54</td>
<td>45.19</td>
<td>44.00</td>
<td>11,920,714</td>
<td>2.15</td>
<td>5.15</td>
</tr>
<tr>
<td>All Hospitals</td>
<td></td>
<td>18.04</td>
<td>23.43</td>
<td>32.88</td>
<td>40.73</td>
<td>235,937,511</td>
<td>-0.36</td>
<td>1.78</td>
</tr>
</tbody>
</table>


a. Columbia Hospital for Women did not report uncompensated care or operating margin data to the District of Columbia Hospital Association for 1996. However, local newspaper accounts have reported large negative margins for both 1996 and 1997.
other public hospitals in large urban areas, which are 45 percent and 20 percent, respectively. Hadley Hospital serves a predominantly Medicare inpatient population. Its outpatient service, however, is nearly three-quarters Medicaid.

Geographic location greatly influences the payer mix of the hospitals. The hospitals west of the park have not only the relatively well-insured northwest D.C. neighborhoods from which to draw but also the similar Maryland neighborhoods just over the northwest District line. Their payer mix is more heavily weighted toward private insurance. Hospitals in the center and southeast sections have a higher percentage of Medicaid days. Some hospitals could be described as Medicare-dependent, in that more than 50 percent of their patient days are for Medicare patients. In general, the community hospitals are more dependent on Medicare in their patient mix than are the tertiary care facilities. Medicare is currently recognized as the best payer, which partly accounts for the relatively strong financial positions of the community hospitals. All but one of the community hospitals have operating margins far above the citywide average.

Similar patterns for Medicaid and Medicare shares are seen in patient stay data in table 6. Hospitals in the northwest hold 29.9 percent of total hospital beds and provide 30.5 percent of the total inpatient days, while hospitals in the center hold 58.5 percent of beds and 57.1 percent of days. Although the number of days is fairly equally distributed, inpatient days in the northwest are more likely to be Medicare or private pay, while in the center they are more likely to be Medicaid or self-pay. Medicare shares are seen to be slightly skewed toward the northwest hospitals, where the population is both older and more affluent. Medicaid shares, on the other hand, are disproportionately high in the hospitals in the center.

Uncompensated care provision is particularly skewed, determined primarily by geography and the historical mission of particular providers. The bulk of the city’s uncompensated hospital care (36 percent) is provided at D.C. General. Part of the city’s annual $80 million allotment to the hospital is intended to pay for this care. After D.C. General, WHC is the city’s second-largest provider of uncompensated care, with 8.6 percent of its total care provided as uncompensated care (measured at cost of uncompensated care as a percentage of total net patient revenue). It provides 16.8 percent of the city’s uncompensated care, or over one-quarter of such care
TABLE 6  Market Share (by percent)

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Operating Beds</th>
<th>Inpatient Days</th>
<th>Medicaid Days</th>
<th>Medicare Days</th>
<th>Uncompensated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary Care Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgetown NW</td>
<td>11.63</td>
<td>11.34</td>
<td>11.90</td>
<td>11.18</td>
<td>5.98</td>
<td>6.48</td>
</tr>
<tr>
<td>Washington Hospital</td>
<td>20.34</td>
<td>24.48</td>
<td>20.38</td>
<td>23.03</td>
<td>14.72</td>
<td>19.34</td>
</tr>
<tr>
<td>Center</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D.C. General Center</td>
<td>9.91</td>
<td>8.37</td>
<td>10.16</td>
<td>7.68</td>
<td>17.59</td>
<td>17.83</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hadley SE</td>
<td>1.42</td>
<td>2.94</td>
<td>1.45</td>
<td>2.06</td>
<td>1.92</td>
<td>1.45</td>
</tr>
<tr>
<td>Greater Southeast* SE</td>
<td>10.94</td>
<td>9.35</td>
<td>10.42</td>
<td>10.33</td>
<td>14.43</td>
<td>9.71</td>
</tr>
<tr>
<td>Providence* Center</td>
<td>7.96</td>
<td>9.98</td>
<td>8.36</td>
<td>10.19</td>
<td>6.91</td>
<td>8.89</td>
</tr>
<tr>
<td>Sibley NW</td>
<td>8.42</td>
<td>7.42</td>
<td>7.61</td>
<td>7.63</td>
<td>0.52</td>
<td>0.49</td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s* Center</td>
<td>6.49</td>
<td>5.94</td>
<td>6.51</td>
<td>7.10</td>
<td>16.42</td>
<td>15.64</td>
</tr>
<tr>
<td>Columbia NW</td>
<td>3.79</td>
<td>2.37</td>
<td>3.17</td>
<td>2.54</td>
<td>1.79</td>
<td>2.58</td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NW</td>
<td>32.97</td>
<td>29.88</td>
<td>33.45</td>
<td>30.50</td>
<td>12.74</td>
<td>16.22</td>
</tr>
<tr>
<td>Center</td>
<td>54.68</td>
<td>58.53</td>
<td>54.69</td>
<td>57.11</td>
<td>70.91</td>
<td>72.62</td>
</tr>
</tbody>
</table>


a. Hospital members of Capital Community Health Plan, a Medicaid managed care consortium.
provided by private hospitals. Despite the large dollar amount of care provided, its share of charity care is less than its share of the city’s hospital beds, where the number of beds is a proxy for overall hospital capacity. Of the other city hospitals, only Howard and Children’s provide a share of charity care that equals or exceeds their share of capacity. Howard provides 17.2 percent of the total (27 percent of the care provided at private hospitals) and Children’s provides 10.8 percent (17 percent of the privately provided care), despite their much smaller shares of the city’s beds. They provide 19.9 percent and 13.9 percent of their total care, respectively, as uncompensated care.14

The level of uncompensated care provided in the District has been declining slowly over the decade, with declines reported in almost all of the city’s hospitals. The total constant dollar amount of charity care provided by city hospitals declined by 12.4 percent between 1991 and 1996. Accompanying the decline has been a shift in distribution, with D.C. General and Howard both seeing an increase in their shares of the city’s free care. Sibley Hospital, although a small total provider of uncompensated care, increased its charity care by over 40 percent during this period. This increase is discussed on page 30, under “Strategies.”

In many cities, academic medical centers are major providers of uncompensated care. In Washington, however, the direct provision of such care at the medical schools’ own hospitals, with the exception of Howard, is generally low. The implication of this distribution of care is that, in Washington, geographic location rather than academic mission is driving the provision of charity hospital care. Furthermore, while the academic medical centers are not the only District hospitals reporting negative operating margins, they are among the least financially secure hospitals in the city. As seen in table 5, operating margins for all three academic medical centers are negative. Among the largest providers of uncompensated care—WHC, Howard, and D.C. General—only Howard shows a negative margin.15 Clearly, uncompensated care provision is not a major factor in the poor financial health of the academic medical centers in the city.

The uneven distribution of uncompensated care means that some hospitals bear a cost that others do not. Other things being equal, this extra cost could differentially affect the ability of these
hospitals to compete in the market. In D.C., there are hospitals that are both financially strong institutions and large providers of uncompensated care, evidence that hospitals are capable of thriving even while they care for the uninsured. Hospitals with a high uncompensated care load are also those whose payer mix is dominated by Medicaid and Medicare. As cost-cutting measures are implemented in public insurance programs, these hospitals will likely see lower revenue from their most important payers. When these changes are implemented, there is a danger that the hospitals will be less able to strike the necessary balance between paying and nonpaying patients, and the poor may see their options under an already inadequate charity care system further constrained.

The Hospital Market

One interviewee said that two features of the Washington market make it different from anywhere else. The first is the dominant presence of the federal government and its health insurance plan, the Federal Employees Health Benefits Plan (FEHBP). The other is the presence of three academic medical centers in a metropolitan area as small as Washington, D.C. In addition, the market has been shaped over the years by the relationship between the District and its suburbs. Some observers argue that the market for hospital services, at least at the high end, is becoming regional, with the effective service area for the tertiary care providers stretching as far as Richmond, Virginia, to the south, and Baltimore, Maryland, to the north.

The Market for Insurance

Washington is, in a sense, a company town, with the federal government as the company. The FEHBP offers a wide variety of health insurance plans, both managed care and fee-for-service, and exerts a major influence on the health insurance climate of the city. Government workers in the city are covered under the FEHBP, as are all city workers hired before 1989. Federal government employees across the country are all covered by largely the same set of health insurance options. The FEHBP is, as a consequence, responsive not just to the concerns and conditions in the
Washington area but to concerns and conditions all over the country. Where other major employers nationally have been pushing cost-containment strategies vigorously in the 1990s, the FEHBP has historically subsidized the high end of the market. As a result, the demand for fee-for-service products and choice of providers is still high. There is no guarantee that the current range of choice in insurance products will continue under the FEHBP, but in the past, changes under the plan have come relatively slowly, giving insurers and providers time to adjust.

Other major employers include the many international representatives and organizations in the city, as well as trade associations from all over the country. Much of the city’s employed population is professional and mobile and, as such, is a demanding consumer of health insurance. Health maintenance organization (HMO) penetration is relatively low in Washington. Only 21 percent of hospital care is reimbursed under managed care (1996). Low HMO penetration reflects the strong preference of D.C. consumers for maintaining a choice of providers in their insurance coverage.

The two states bordering the District have very different hospital markets. Maryland has one of the most highly regulated hospital sectors in the country, with the only remaining all-payer rate system. The presence of for-profit hospitals is minimal, and no national hospital chain has yet entered the Maryland market. State-level hospital systems have developed, and in recent months, there has been considerable consolidation activity among the state’s independent hospitals. Virginia, on the other hand, has allowed market forces a much freer play. Not only have state-level systems developed, but Columbia/HCA has been actively seeking to consolidate its foothold in northern Virginia.

For many years, Washington served as the central tertiary care source for the entire metropolitan area. Its three prestigious medical schools attracted patients from all over the region. African-American patients, in particular, were attracted to Howard, one of only four historically black medical schools in the country. Hospitals in the nearby suburbs for the most part provided primary and secondary care only. As the population of the region grew and suburban population density rose, these community hospitals found that they could support more services and more sophisticated treatments.
There are currently two suburban hospital systems that have developed enough of a local reputation and presence to attract the suburban (and some District) patients who once were firmly within the market of the various D.C. hospitals. To the southwest, Inova Health System began as a small, not-for-profit community hospital built to serve the unmet needs of then-rural Fairfax County, Virginia. Inova Fairfax Hospital is now one of the largest hospitals in the region and has grown from a community hospital to a tertiary care hub of a not-for-profit health care system that provides services ranging from heart transplants to home health. Columbia/HCA is still only a secondary force in the northern Virginia market, with three facilities; reports are that it intends to maintain its presence there. To the north of the city in Maryland, the not-for-profit Adventist Health Care System owns two hospitals and several other health care ventures. Both the Inova system and, to a lesser extent, the Adventist system are competitive with the District’s hospitals, Inova for tertiary care and the Adventists for routine maternity and pediatric care. Both have signaled their intention to continue expanding in both hospital-based and non–hospital-based services. The area to the southeast of the city is served primarily by independent community hospitals. Johns Hopkins is an hour’s drive from downtown D.C. and clearly competes in high-tech elective services. It has been trying for years to increase its share in the Washington metropolitan market.

**The D.C. Hospital Market**

In D.C., the community and specialty hospitals are becoming niche players, with revenues dominated by Medicare in the community hospitals and by Medicaid in the women’s and children’s specialty hospitals. The community hospitals define their markets primarily as their neighborhoods. Sibley pulls patients from northwest D.C. and from the similarly white and affluent neighborhoods across the border in Montgomery County, Maryland. It relies generally on the Medicare and private-pay patients of its market area. Providence’s neighborhood is made up primarily of African Americans and Latin immigrants. Medicare is its most important payer, but its Medicaid share is also significant. Hadley’s patient mix is largely African-American and Medicare-eligible. Medicaid is slightly less important for Hadley than it is for Providence. The nearby Greater Southeast Community Hospital serves a similar clientele and payer mix but with a higher proportion of Medicaid patients than at Hadley. Greater Southeast also looks across the District line to the relatively underserved southern Maryland
neighborhoods in Prince George’s (PG) County. While PG County is not as affluent as Montgomery County to the north, it has in recent years become a mecca for upwardly mobile African Americans leaving the District, and it is seen as an area with potential for growth.

Georgetown shares Sibley’s affluent and well-insured market area in northwest D.C. and Montgomery County, but its technical reputation allows it to draw from beyond both neighborhood and District lines. It draws a large percentage (about one-third, according to hospital officials) from the northern Virginia suburbs. George Washington’s downtown location, easy accessibility, and—until the recent turmoil associated with its transfer of ownership—excellent reputation allow it to tap both the population of its neighborhood and the rest of the city. Howard’s history makes it the hospital of choice for many of the region’s African-American residents. Like Greater Southeast, it is looking outward toward the more affluent African-American population of PG County. Howard must compete, however, with its larger neighbor, WHC. WHC’s location in the central portion of the city, combined with its size and perceived preeminence in many service areas, notably trauma and cardiology, give it the ability to more easily transcend its geographic location and appeal to residents across the city and the region.

Within the metropolitan area, competition for patients is heating up and is generally taking the form of competition for profitable services and services around which patient loyalty can be built, such as pediatrics and obstetrics. While the community hospitals can rely on their neighborhood niches, the continued border-crossing by patients is particularly difficult for the specialty hospitals and the academic medical centers, which must maintain enough common diagnosis cases to support their unique capacity in specialty care. They must define their markets more broadly than just a neighborhood in order to ensure a large enough patient base needing specialty services. Columbia Women’s seeks to draw from the entire District population. Children’s sees the market for its specialty services as the entire metropolitan area. These services represent only about 10 percent of the care it provides, so it must also compete District-wide and in the suburbs for routine pediatric cases.

The four tertiary care centers must also define their market areas more broadly. The need for a broad geographic market area is the
major impetus toward the regionalization of the hospital market in the Richmond-Washington-Baltimore corridor. Baltimore is about 40 miles to the northeast and is connected to Washington by several direct highways. Population growth in the corridor has been strong over the past decade, and hospitals in both Washington and Baltimore would like to tap this market. While the near-in suburbs of each city are unlikely to be tempted to travel 40 miles except for very specialized care, the population centers in between represent a tempting market for hospitals in either city, as well as for hospitals in Annapolis, Maryland, a bit farther to the east. Competition has already begun among the tertiary care centers of the District and those of metropolitan Baltimore, particularly Johns Hopkins University Hospital. Strategies are being put in place by D.C.’s tertiary care facilities to address the growing competition from the north. In the first formal joining of the District and suburban hospital markets, a merger between a Baltimore hospital system (Helix) and a Washington hospital system (Medlantic, with WHC as its flagship), discussed below under “The Future,” was completed in July 1998. Competition is less intense between Washington and the Richmond market to the southwest, probably because of the presence of the Inova system in northern Virginia and the greater distance between Washington and Richmond.

Pressure for Change

Numerous changes are taking place in the Washington hospital sector, and the combination of the various changes has created a climate of gradually building pressure for change. Because of location, mission, payer mix, or past decisions or commitments, each hospital is affected differently by the mix of pressures. Hospitals with a high private-pay population are most affected by the rising strength of insurers relative to providers in the negotiations over hospital reimbursement. The arrival of managed care in the Medicaid market and the threat of managed care in the Medicare market, on the other hand, affect hospitals with a large publicly insured population. The growing integration of the Washington and Baltimore markets for hospital services, with the Richmond market as a lesser influence, currently affects hospitals that need a broad patient base more than it affects
the community hospitals. A projected cut in the District’s disproportionate share hospital (DSH) allotment and changes in its allocation among hospitals affect DSH recipients. The financial and administrative problems of the District government form a backdrop affecting all the hospitals.

All hospitals report considerable pressure from insurance plans for greater and greater concessions on payments. As a result, many hospitals find themselves struggling to identify ways to reduce costs and increase efficiency. Some observers say that, although much “fat” has been removed from the system, much remains that could yet be cut. These observers may get a chance to test that hypothesis. Consolidation has begun among regional insurance plans with the merger of the District and Maryland Blue Cross/Blue Shield chapters approved in late 1997 and the recently announced (March 1998) acquisition of NYLCare by Aetna, which makes Aetna the third-largest plan in the mid-Atlantic region. Both Blue Cross and NYLCare were already known as strong negotiators, and their increased size is likely to increase their bargaining position further.

Local hospitals report that payment rates under most contracts have at best stayed level and often have declined in recent years. Acceptance of very low, perhaps below cost, reimbursement rates by some hospitals, reportedly anxious to maintain or regain volume, has put downward pressure on the reimbursement rates that other institutions feel they must accept. Blue Cross has tied its rates to the lowest rate accepted by the hospital from any other plan in what is known as a “most favored nation” pricing policy. Although administrators report that they negotiate with all comers and try to get the best deal they can, most report that there are still a few payers with which they have been unable to reach mutually agreeable contract terms. Still, most hospitals deal with most plans.

Many hospitals find themselves struggling to identify ways to reduce costs and increase efficiency. Some observers say that, although much “fat” has been removed from the system, much remains that could yet be cut.

One hospital official described the frustration of negotiations in recent years. When managed care arrived, the insurance plans came to the hospital with requests for lower rates based on promises of channeling more patients to the hospitals with the lowest rates. As consumers have demanded more choice of providers, the channeling of patients by the insurers has gone by the wayside, but the discounted rates have stayed. In effect, hospitals bargained to increase patient volume and market share by accepting lower reimbursement, but what they received was lower reimbursement without
the increased volume to offset the lower rates. They now bargain to maintain rather than gain patient volume.

**Pressure from Public Payers**

Cuts in public programs have as yet been less severe but are intensifying. Voluntary managed care in Medicaid was instituted in 1994 in the District, and mandatory enrollment for beneficiaries of Aid to Families with Dependent Children (AFDC; now Temporary Assistance for Needy Families, or TANF) in April 1998. Seven managed care firms, one owned by a consortium of District hospitals, have been awarded contracts to enroll beneficiaries. While hospitals expect total revenues from Medicaid to fall, the timeliness of payment—a long-standing problem in the District—is expected to improve.

Across the District line, mandatory managed care for nearly all of Maryland’s Medicaid recipients is in the first year of implementation and may actually help D.C. hospitals. While D.C.’s Medicaid program prohibits hospitalization in non-District facilities, the Maryland program has no such restrictions. Maryland’s all-payer rate system precludes negotiation of hospital reimbursement rates by Maryland’s managed care plans, making the possibility of negotiating with District hospitals particularly attractive. Furthermore, hospital rates are public in Maryland, so D.C. hospitals know what they are bidding against.

The District’s Medicaid inpatient reimbursement has long been recognized as overly generous, but outpatient and physician reimbursement have been seen as inadequate. The rate structure is currently under revision for the portion of the population that will remain under the fee-for-service (FFS) plan. The District’s Medicaid program has serious problems that affect hospitals beyond the biased rate structure. The problems in the eligibility and enrollment system, for example, have been serious enough to warrant appointment by the courts of a monitor to oversee compliance in this area. The city’s failure to pursue enrollment of all eligibles in the program contributes to the hospitals’ charity care burden. Its failure to disenroll noneligibles contributes to the program’s constant financial problems. In addition, while the inpatient reimbursement rates have been generous, the timeliness of payments has been an issue for hospitals, with payment lags regularly running months or even years. The Medicaid administration has...
recently taken steps to remedy many of these problems, including purging the rolls of ineligibles and adding a line item to the budget to meet arrears in payments. The hospitals are guardedly optimistic about the sustainability of these improvements.

Major changes are being made in DSH payments in the District. The federal DSH allotment for the District has been reduced, as it has been for all states, beginning in fiscal year 1999, and the District is developing a new strategy for using its DSH allotment. Both the reduction, which amounts to nearly half of the old allotment, and the proposals for the new use are being examined by the D.C. Hospital Association (DCHA) on behalf of its members. One proposal calls for using DSH monies to expand Medicaid coverage and thereby reduce demand for uncompensated care. The effect of such a program would be different for each hospital, and DCHA members are divided in their response to both the general approach and the particular details of the proposal. For DSH recipients (Children’s, D.C. General, Greater Southeast, Hadley, Howard, and Providence), the potentially large reduction in this source of revenue is likely to pose a serious problem, especially when combined with the expected reduction in total Medicaid revenues due to the move to managed care and the likely reduction in inpatient FFS reimbursement rates.

The changes to the Medicare program outlined in the 1997 Balanced Budget Act are likely to affect all the hospitals but particularly those most dependent on Medicare revenues. While the hospitals had expected changes in the program, the legislation went beyond those expectations, forcing hospitals to raise their estimates of the likely reduction in their Medicare revenues. Hospitals that have diversified into on-site skilled nursing facilities were caught most off-guard by the proposed changes in reimbursement for such facilities. In addition, the threat of expansion of managed care for Medicare recipients has many hospitals worried. Smaller hospitals, in particular, are concerned about their ability to compete against more comprehensive facilities for Medicare managed care contracts.

Each of the hospitals is constrained in various ways by its physical facility, its historical mission, its access to capital, and its location. Georgetown and WHC both have excellent physical facilities. Howard has recently completed major renovation of its emergency
department. Other parts of its much-needed renovation are either in progress or in the planning stages. GW has recently announced (February 1998) its plan to replace its facility completely; construction is to begin in late 1998, pending regulatory approval. The community and specialty hospitals all have adequate facilities—both have been renovated recently. D.C. General has suffered from years of inadequate maintenance and capital investment and needs major renovation. In its strategic plan, renovation priority is given to its system of community clinics for capital financing; renovations at the hospital itself are being funded out of operational savings.

Mission constraints include a historical commitment to certain populations. Howard’s legacy as the “Freedmen’s Hospital,” established to treat ex-slaves coming to Washington during the Civil War, and as the first hospital to allow African-American physicians to admit and treat patients inhibits its enthusiasm for marketing directly to the white population of the city and its suburbs. White patients are perceived by hospital officials as reluctant to patronize what is seen as the city’s black hospital. Providence has a commitment to Latino immigrant populations. Columbia Women’s and Children’s are constrained by specialization to their respective populations. D.C. General would like to avoid, for political reasons, at least the appearance of directly competing with the city’s private hospitals for paying patients. Nonetheless, as it has moved away from its purely public character, it has reportedly become more active in its pursuit of insured patients, both privately insured and Medicaid and Medicare patients.

In many ways, Washington lags behind other large urban areas in the evolution of its health care market. Responses to the growing pressure have to date been modest, and decisions now need to be made quickly.

Strategies

In many ways, Washington lags behind other large urban areas in the evolution of its health care market. The District’s relatively late start on health market change represents both an advantage and a disadvantage for the hospitals. D.C. hospitals have the reported experience of hospitals in more advanced markets to consider when trying to decide which strategies to adopt. In areas of vertical and horizontal integration, risk management, and cost control, D.C. hospitals report researching and learning from the experiences of hospitals in other cities. The
disadvantage of late entry is that the change is now taking place very rapidly. Responses to the growing pressure have to date been modest, and decisions now need to be made quickly.

It is clear from the interviews that different hospitals have different options for cutting costs. Some hospitals are just now instituting cost-reduction measures, such as streamlined management structures, that others have had in place for years. Because of mission or location, some will likely never have the flexibility to institute some of the measures that other hospitals have used successfully. Two mission constraints stand out as limiting factors in hospital strategies: a commitment to teaching and a commitment to serve the uninsured. The hospitals with more foresight and fewer constraints are those that are now in the most favorable financial positions. Hospitals with leadership that early on recognized the opportunities and constraints of the new medical marketplace and acted on this strategic vision are now best placed to survive and thrive.

Good leadership is critical; access to adequate financing equally so. Hospitals that have access to outside capital from a for-profit partner or system affiliation, or that have reserves built up from the past, have a distinct advantage over those that must finance change through operating revenues or debt.

While in the past many hospitals had grander ideas of the role of the hospital in the life of the community, the dominant strategy now seems to be the almost old-fashioned one of cutting costs and filling beds, with an eye toward the continuing push away from inpatient care. Mergers and affiliations have not yet become a dominant part of hospital strategy, although in the broader regional market hospital consolidation is beginning to be apparent. As hospitals see their financial positions either weaken to the point that a stronger partner is needed or strengthen enough that the hospital is able to demand a dominant position in an alliance, affiliation becomes more attractive.

In semi-structured interviews conducted over a period of about three months, hospital officials discussed, under promise of confidentiality, the strategies they were using to cope with the changing environment. Specific strategies should not be attributed to specific hospitals. All hospital-specific information has been drawn from public sources.
Cost Reduction

Operations. As reimbursement rates fall, hospitals are all turning to cost-cutting as a first strategy to maintain profitability. All hospitals have reduced the number of beds; some have closed specific services. Others, particularly the community hospitals, report focusing on core competencies and not trying to compete in other areas, echoing what one administrator said: “We don’t do everything, but what we do, we do well.” The emphasis for all was on cutting costs while maintaining quality.

Almost all report group purchasing arrangements to decrease the cost of supplies. Although most of these arrangements are not new, some hospitals report increased use of existing arrangements. As the belt tightens, renegotiation of vendor contracts is a frequently mentioned place to look for savings. A closer scrutiny of insurance contracts, often on a diagnosis-by-diagnosis basis, was also reported. Hospitals with high debt loads report efforts to refinance bonds.

Other strategies include outsourcing certain functions—both nonmedical, such as housekeeping, and medical, such as laboratory work. Outsourcing of labor-intensive functions is particularly important for hospitals with high personnel overhead costs or where union agreements limit other options for reducing staff. In the case of the smaller hospitals, outsourcing of services such as laboratory work makes sense where the size of the hospital makes maintaining an in-house capacity uneconomical. More than one hospital reported outsourcing entire hospital services by hiring independent physician practices to run, for example, the outpatient department or the obstetrics service.

Notably, several hospitals mentioned the need to invest in new medical information systems to streamline ordering, charging, scheduling, and billing in order to decrease errors, reduce transaction times, monitor clinical practice, and schedule the vast array of treatments needed in current inpatient care. Ease of scheduling, in particular, is seen as a way to attract physicians to the hospital. Interestingly, one official reported that streamlining billing systems is relatively unimportant, because the bill rendered has little to do with what the hospital is paid. While a new information system requires a high initial investment, a commitment to staff training, and a long implementation period, respondents felt that it was a necessary investment and would pay for itself over time.
Labor. All hospitals have cut staff either at the management level or at the operational level or both. Administrative reorganization was a frequently cited source of savings. Some felt no need to reduce administration, pointing with pride to their historically lean management structures. At most, however, layers of management in either administration or governing boards or both have been eliminated, or such eliminations are under consideration. D.C. General’s administration has been completely reorganized. Following the recommendations of numerous commissions on the future of D.C. General, the hospital and its nine community health centers were, as of October 1997, given independence from the city under the quasi-public PBC, freeing it from the city’s contracting and procurement regulations and allowing it to act more nearly like a private institution in the market.

At the operational level, hospitals are using fewer workers and trying to get more from each worker. Cross-training of hospital staff to increase flexibility of employees was mentioned as a way to do more with less. The medical side of employment is also reportedly undergoing slimming at some hospitals, with house staff being asked to cover functions that were previously covered by other workers. Respondents mentioned the increasing use of “hospitalists,” physicians whose specialty is treating patients who are hospitalized.

Employee layoffs have not been conducted lightly. More than one hospital stressed the importance of loyalty to employees as a way of keeping their employees’ loyalty to the institution, particularly in difficult or uncertain times. Employees, on the other hand, are not always cooperative in the effort to do more with less or may feel that they are being pushed too hard. In one case, the efforts to reduce staff and increase task flexibility have led to union organizing activities at the hospital. Despite the high level of unemployment in the District, highly skilled labor, such as tertiary care nurses, is in relatively short supply in the area. The threatened return of the nursing shortage is likely to hit Washington hospitals particularly hard since the high cost of living in D.C. has led to increased outmigration to the suburbs, where the cost of living is lower. It reportedly can be difficult to entice workers who live in the suburbs to come into the District to work in D.C. hospitals. In addition, D.C.’s administrative problems have recently meant that licensing of professionals, including nurses, can take many times longer than in the adjacent suburbs, although this situation is improving.
UNCOMPENSATED CARE. Most hospitals also reported improved management of uninsured patients as a way to trim costs. Not surprisingly, no hospital reported turning away uninsured patients. Most did report, however, that they had taken steps to decrease the level of uncompensated care, and uncompensated care levels have declined in almost all the city’s private hospitals. All aggressively seek Medicaid enrollment for their indigent patients, and most have an on-site enrollment facilitator on contract. As one administrator put it, “Uncompensated care is just sloppiness in getting people onto Medicaid.” A recent DCHA study shows a high percentage (10 percent to 17 percent) of uncompensated care discharges attributable to maternity and neonatal care, suggesting that better enrollment outreach could reduce uncompensated care.

More effective Medicaid enrollment will not, however, solve the problem of uncompensated care for single adults, undocumented immigrants, or the working poor. As discussed earlier, the city’s eligibility and enrollment system has historically had serious shortcomings. District personnel ceilings have thwarted efforts by hospitals and patient advocates to get city eligibility workers stationed at the city’s hospitals, even at the public hospital.

More direct methods were also reported to decrease uncompensated care levels. Some hospitals encourage their indigent patients to go to D.C. General or, for nonresidents, to their own county hospitals, even providing taxi vouchers when needed. In response, D.C. General has also had to get tough. The administration at D.C. General has instituted a strict anti-dumping policy, letting other hospitals know that they will be reported to the Health Care Financing Administration for violating patient transfer standards. Transfers of stabilized, uninsured emergency patients to D.C. General are not uncommon.

Part of D.C. General’s strategy to cut the cost of uncompensated care is to invest in its network of community-based primary care clinics in an effort to reduce routine traffic in its emergency room and decrease the number of hospital admissions that could have been prevented through the timely provision of primary care services. Capital for clinic renovation is provided through the PBC budget. Measures have been taken to improve services at clinics, to increase care coordination between the clinics and the hospital, and to offer extended hours on weekdays and service on weekends. Inappropriate emergency room use, the result in part of inadequate primary care resources in the community, has been cited as a major
factor in the high level of uncompensated care at the D.C. General emergency room. To discourage inappropriate use of the emergency room, D.C. General has instituted a $20 payment for all patients seeking nonurgent care at the emergency room.

Hospitals west of the park were frank in their appraisal of the uncompensated care situation. No active measures are needed to avoid uninsured patients because the hospitals’ location makes high levels of uncompensated care unlikely. When queried about what effect the hypothetical closure of one of the major free care providers (which are all east of the park) might have on their hospital, each of these hospitals suggested that the burden would then fall on some other hospital east of the park. Hospitals east of the park tended to agree with this assessment. The converse is also true: The closure of a hospital west of the park would have little effect on access to care by the uninsured. The distribution of the charity care burden is in large measure a function of geography.

Some hospitals have found that charity care, well managed, can be used to a hospital’s advantage. As mentioned earlier, Sibley has nearly doubled, albeit from a small base, its market share of uncompensated care in recent years. Early in the decade, Sibley was faced with two problems: an inability to meet its legal requirement regarding minimum uncompensated care levels and a badly faltering maternity service. It solved both by instituting a cooperative program with one of the city’s not-for-profit free clinics to handle deliveries for its indigent patients. The program has been successful in contributing to the hospital’s free care obligation and has allowed an increase in the number of obstetrics residents training at the hospital. These residents develop a loyalty to Sibley that they carry into private practice when their training is completed. Under the program, not only did charity care deliveries increase, deliveries by insured patients also increased, and an obstetrics service that was on the verge of closure is thriving. By affiliating with a free clinic whose prenatal procedures have been carefully screened, Sibley is able to ensure that the patients it gets have had adequate prenatal care, thereby minimizing the risk to the hospital. The program’s administrator called it a “win, win, win” situation.

Columbia Women’s established its teen health clinic in an underserved area of the city out of civic responsibility. When Medicaid coverage for pregnant women was expanded, the clinic became a source of Medicaid revenue for the hospital, although
reportedly not enough to offset the cost of the clinic. The clinic has, however, been successfully used as part of the hospital’s fundraising campaign.

**Patient Volume**

Maintaining or increasing patient volume is critical. Hospitals are marketing both to physicians and to potential patients. Given the importance of consumer choice in the local insurance market, if physicians and patients demand a certain hospital in a network, the hospital’s bargaining position will be strengthened vis-à-vis the insurance plans. Hospitals are therefore seeking patient and physician allegiance not only to fill beds but also, potentially, to influence payment rates.

The view of the hospital as having the central role in health care is being replaced by one of the hospital as just part of a continuum of care that runs from maternity services to hospice care, with all levels of outpatient, inpatient, and home health in between. The hospital’s aim is to create a system of care through vertical integration of various health care services and to attract patients into that system as loyal, lifetime customers.

**Approach to Patients.** The approach to potential patients is twofold. Increased advertising of hospital services on radio and television as well as in the print media is combined with internal programs to increase patient satisfaction through such activities as staff training to “put the patient first,” increased solicitation of and attention to patient comments about their treatment while at the hospital, and added patient amenities. It was also reported that greater attention is being paid to the appearance of the facility, from the uniforms that the staff wear to the landscaping of the grounds. Some respondents noted that patient expectations are higher now, forcing them to invest in amenities even while trying to restrain costs in other areas.

Hospitals are also seeking patients and investing in services that are reliably and well reimbursed. Medicare is seen as a good and reliable payer, and all types of hospitals are investing in services for this population, such as cardiac care or skilled nursing facilities and nursing homes. Payer and patient preferences for outpatient services have led many hospitals to invest in new or renovated emergency rooms or on-site ambulatory care clinics. Investment and advertising for maternity services is also an area of strong competition. GW’s new facility design has maternity suites with private baths and
room for overnight stays by the mother’s partner. This move is seen as a direct challenge to neighboring Columbia Women’s.

As competition for patients has increased, the tertiary care centers have started to look toward the populations historically served by the community hospitals. WHC has recently (March 1998) launched a major campaign to attract the region’s Hispanic population by advertising in the local Spanish-language media and emphasizing its bilingual and cultural competencies. Neighboring Providence may soon see its dominance in this population threatened.

Outreach to potential patients also takes the form of establishing off-site or mobile units that take the hospital to the patient in order to get the patient to the hospital. GW sponsors a Mammo-Van for outreach to women for its breast care services. Columbia has its teen health clinic, and Providence is building a neighborhood primary care clinic to be staffed partly by Georgetown family practice residents. Georgetown sends a pediatric van to the Anacostia neighborhood. Both Greater Southeast and Children’s have established hospital services in Maryland to extend their markets, Greater Southeast through its satellite hospital and Children’s through its collaboration with a Maryland hospital that wanted to expand its pediatric service. Children’s is using this joint venture both to expand its market area and to reduce competition for its services.

**Approach to Physicians.** The approach to physicians follows a similar pattern. Internal measures are reported at several hospitals designed to make it easier and more attractive for physicians to practice at the facility. Installing information systems facilitates the scheduling of procedures by allowing physicians to schedule electronically. Another method is apportioning blocks of time—for example, cardiac catheterization unit or operating room time—to particular physician practices rather than scheduling procedures one at a time. Purchasing state-of-the-art technology for well-remunerated services such as cardiac procedures or diagnostic imaging draws physicians away from competing facilities. Finally, hospital officials stressed the importance of establishing and maintaining good working relations between the administration and the physicians.

The hospitals are generally well staffed with specialists but are seeking affiliations with primary care practices to generate more

---

The view of the hospital as having the central role in health care is being replaced by one of the hospital as just part of a continuum of care that runs from maternity services to hospice care, with all levels of outpatient, inpatient, and home health in between.
referrals and to provide the breadth of service attractive to managed care plans. Few hospitals report the purchase of physician practices. Most are using what they consider to be less risky measures to gain physician referrals. Most respondents cite the experience of hospitals in other cities to explain why purchasing physician practices is not a preferred method of affiliating with physicians. Georgetown includes the purchase of physician practices as part of its strategy, but it is structuring the purchase contracts to avoid problems that other hospitals have encountered. It is too early to gauge the success of these modifications. Georgetown still expects losses from the management of the practices but hopes to compensate for its losses through increased inpatient and specialty referrals.

Hospital location is again an important factor. Although a hospital located in downtown Washington, where many physicians already have their offices, can rely on the convenience of its location to attract physicians and patients, other hospitals, less well located, are investing in physician office buildings on campus and recruiting physicians to locate their practices in these facilities. Several hospitals in the District have also established ambulatory care clinics in both the Maryland and Virginia suburbs and reportedly have been successful in attracting new private-pay patients to their hospitals. In contrast, respondents report that clinics established in the District draw mostly charity care or Medicaid patients.

As another lure to patients, physicians, and plans, hospitals are making targeted investments on a service-by-service basis, in an attempt either to broaden the range of services they provide or to establish centers of excellence in particular services. Where hardware is a critical part of the service, such as cardiac catheterization or diagnostic imaging, hospitals are investing in state-of-the-art technology. Hospitals may also seek to partner with another provider with a complementary service. For example, Sibley had a growing obstetrics service but lacked a neonatal intensive care unit and so lost admissions on high-risk pregnancies. In response, it arranged to serve as a satellite unit for neonatal specialists from Georgetown. Such arrangements are under development at other hospitals. Taking another route to service excellence, some hospitals have decided not to provide certain services in order to concentrate their efforts on the services they provide well or on payers that are more suited to the hospital’s mission or market demographics. For example, more than half of Hadley’s business is Medicare-related, and it has no inpatient pediatrics service. This
option is only open to community hospitals; tertiary care centers have limited ability to eliminate services.

**MEDICAID.** The hospitals with a high volume of Medicaid patients have established a strategy to maintain their share of the Medicaid market as it moves to managed care. The five hospitals (Children’s, Howard, WHC, Providence, and Greater Southeast) that prior to mandatory managed care had about two-thirds of the Medicaid inpatient volume have joined together as a consortium to create an HMO specifically for the Medicaid managed care program, with the goal of maintaining their Medicaid shares and reducing competition for these patients among the consortium hospitals. Other hospitals considered membership but declined for various reasons. The consortium HMO contracts only with its five member hospitals and D.C. General for inpatient services. (All plans are required to contract with D.C. General.) In addition, the member hospitals have contracts with other Medicaid HMOs as inpatient providers. The consortium primarily uses office-based physicians for primary care. HMOs generally save money by reducing hospitalization; in this case, the savings from reduced hospital costs, after administrative costs, are returned to the hospitals as owners of the HMO. Overall Medicaid revenues to the hospitals are likely to be lower, but competition among the consortium owners will be diminished. Medicaid is a less important payer for the nonconsortium hospitals, which expect to maintain their current Medicaid volume. Each has a contract with at least one Medicaid HMO. GW has its own Medicaid HMO and expects to increase its share of Medicaid patients in this way.

**Affiliation and Consolidation.** With the Medicaid alliance as a notable exception, it is apparent from the strategies described above that, to date, the hospitals in Washington have developed individual rather than collective strategies for survival. The strategies are aimed primarily at attracting individual physicians and their patients through quality and location and at keeping costs low enough to meet the rates offered by the insurance plans. The drive toward consolidation among hospitals that has occurred in other comparably sized markets has not yet appeared in Washington, although the Medlantic-Helix merger may be a sign that it is about to begin. Hospitals have tried temporary partnerships at times—for example, Columbia Women’s and WHC worked together for several years before agreeing to split—but no permanent alliances have been formed, nor do any appear on the horizon within the District.
Some alliances of District hospitals with non-District hospitals, however, are in various stages of development, as will be discussed below under “Tertiary Care Hospitals—Regional Options.” There are also affiliations between different hospitals on a service-specific basis or between hospitals and providers of other levels of care to further the aim of developing a continuum of care.

There are several possible explanations for the apparent independence of Washington hospitals. Within the District, constraints of geography and institutional culture appear to inhibit hospital consolidation. Hospitals can see the up-front costs of mergers and affiliations, which can be considerable, but the benefits down the road are uncertain. One hospital official openly questioned the benefits of mergers and talked about the desirability of a “virtual merger,” which would bring the benefits of close affiliation without the costs of actual consolidation.

Perhaps the most important factor in the sustainability of the hospitals’ independence is the peculiar nature of the Washington market for health insurance. Managed care penetration is lower than in similar cities, and no large employer is pushing for more managed care. The lack of a dominant employer putting its money behind a few plans means that there is a lot of competition among the plans and that, for the most part, individual consumers still have the power to demand a choice of provider. Plans can negotiate lower hospital prices (or dictate them, in the case of the largest plan), but most cannot channel a high volume of patients to any particular facility or lock any facility out of the market. If consumers demand choice within their plan, and if no employer is pushing for limiting that choice in order to drive down premiums, it will be physicians and their patients who make the choice of which hospital to use. Plans must continue to compete on the breadth of their networks rather than on price alone, so they must try to contract with as many providers as possible. Without the threat of being locked out of a plan’s network, hospitals have very little incentive to undergo the cost and dislocations of mergers as long as they can keep their costs low enough to meet the stagnant or declining reimbursements offered by the plans. Growing consolidation among the plans may change this aspect of the market.

The presence of four tertiary care hospitals affects the independence of all the hospitals. Each has its strengths, but none is indispensable in the city, so none has been able to attract the more
flexible and financially stable community hospitals into a strong alliance or merger, unlike leading hospitals in other markets. Finally, because Medlantic has a new partner in Baltimore, it may not feel the need for a local partner in the city, at least currently. The community hospitals also frequently cite irreconcilable differences in organizational culture as a major factor in not wanting to consolidate with the tertiary care centers. Consolidation among the community hospitals themselves seems equally unlikely, given their geographic dispersion across the city and the strong financial position of most of them.

Among the academic medical centers, institutional pride as well as geographic dispersion have thus far prevented consolidation. In the short run, each is likely to continue alone and, while some are in precarious financial positions, none is likely to close in the near future. GW has its for-profit partner, Howard has its legacy, and Georgetown may give its new and highly regarded management team time to make its financial position as strong as its technical reputation. Given the widespread reports of severe financial pressures at Georgetown, however, the development of a strategic alliance with a financially stronger partner is more likely there than at the other academic facilities.

The Future

For the time being, D.C.’s community hospitals seem secure in their service and geographic niches. Sibley and Providence, in particular, have been successful at developing and strengthening their vertically integrated systems. Only two, Greater Southeast and Hadley, are located close enough to each other to compete for the same patients, and those are in the southeast section of the city, where the payer mix is less favorable. Competition could increase between the two, prompting consolidation or closure. On the other hand, the nearby southern Maryland market, south of PG County, is less well served and could provide an expansion area for either or both of them. They are less financially stable than the other two community hospitals. In addition, Greater Southeast has had labor problems over the past year and recently (June 1998) replaced its longtime CEO and system
president. Officials there have expressed a desire to form an affiliation at some level with a larger partner. For years Greater Southeast has been advocating, unsuccessfully, a trilateral union of itself, Howard, and D.C. General. Hadley is already part of a national for-profit system, Doctors Community Healthcare Corporation, which has reportedly offered itself as a solution to Greater Southeast’s financial problems. GW’s for-profit partner has also reportedly expressed interest, as has an independent hospital system in Maryland. Which, if any, of these affiliations Greater Southeast will choose and how well it maintains its historically strong community identity in the transition will be important factors for access to health care in one of the District’s poorest neighborhoods.

The independence and relative security of the community hospitals could be threatened if managed care becomes stronger in Washington. All the community hospitals have strong Medicare inpatient percentages. As Medicare moves more toward managed care, more of these hospitals might have to expand the range of services they can offer by forming affiliations either among themselves or with outside, probably larger, institutions. Their response to the coming of managed care to Medicaid is an example of what the future might hold.

Tertiary Care Hospitals—District Options

The tertiary care market is less secure or predictable, and several scenarios are possible. First, one or two medical centers might simply close. Some of the hospital interviewees seemed to want such a resolution, in the hope that it would lessen price pressure on the survivors. All expected their institution to survive and were planning for an immediate future in which insurers would continue to dominate price negotiations. Until it was essentially acquired by an out-of-state for-profit system, most observers expected GW to close.23 Now GW’s deeper pockets and administrative resurgence threaten Columbia Women’s. Columbia Women’s is reorganizing under Chapter 11 (as of February 1998) to forestall a takeover by its major creditor but contends that this financial crisis does not imply long-term instability. Today, many see Georgetown as vulnerable. Howard, too, faces considerable pressure, but its legacy argues against its closure.

Consolidation of two or more hospitals would have the same effect on the market as would closure. Competition for tertiary services would be reduced. Operating efficiencies might also result,
particularly if redundant services could be eliminated. WHC pro-
posed joining with GW in early 1997—to pay for the hospital, but
then to convert it to an ambulatory care clinic, and to consolidate
inpatient services into its own facility. Since competition would
have been reduced for all District hospitals, this move was applau-
ded by other hospitals in town, but it was rejected by GW
University, which wanted to maintain its own teaching site. GW, in
turn, offered to consolidate its women’s services at nearby
Columbia Women’s, only to be rejected by that hospital’s board,
despite Columbia’s severe financial difficulties. A similar arrange-
ment is frequently proposed for Howard and D.C. General; D.C.
General would become an ambulatory care clinic and trauma cen-
ter, and Howard would assume its other services.

Many interviewees spoke of cultural differences among institu-
tions or personalities that have impeded these and other attempted
realignments. It is unclear whether these are any greater in D.C.
than in other market areas, where consolidation is nonetheless pro-
ceeding apace. Partnerships have been achieved in the D.C. area
among other former competitors, such as Children’s and
Maryland’s Shady Grove Hospital. Further financial pressure may
show that the D.C. medical-institutional culture is more malleable
than now supposed.

Closure or merger of a hospital does not necessarily mean that
the associated medical school must close. Historically, medical
schools have nearly always been synonymous with their flagship
hospitals, but it is possible that could change under competitive
pressure. Logical partnerships for either of the two remaining inde-
pendent medical schools exist in the city or near suburbs. The tra-
ditional association of a medical school with a public hospital could
be an option for either Howard or Georgetown, which have resi-
dency programs at D.C. General, or for GW, whose medical school
was not part of the partnership with Universal Health System.
More than one observer noted that, given the two cultures
involved (academic versus public) and the historical unreliability of
the District government as a payer or partner, an outside interme-
diary would be required to arrange any partnership and guarantee
the terms should such an affiliation take place. One observer has
suggested that the three medical schools might logically establish a
joint medical program in which each institution would specialize in
one part of the curriculum while maintaining its own identity and
granting its own degrees.
All of the tertiary care hospitals might conceivably survive if each downsized substantially, either through cuts across the board or by a departure from maintaining comprehensive capabilities in favor of emphasizing particular specialties—much as one would expect if two hospitals merged. There are several potential drawbacks. Small size could bring diseconomies of scale in operations and reduced clout in negotiations with insurers. Moreover, small volume in any specialty or subspecialty could threaten to erode the skills of practitioners, making it difficult to attract and keep good faculty or practitioners and to attract referrals. Quality might suffer visibly. Low volume or less-than-comprehensive capabilities might also simply fail to meet the mission of a medical school and hence undermine its other sources of support—from universities, from research grant makers, and from alumni donors. Finally, it is not clear how a downsizing could be brought about without cooperation among the entities involved. Were one facility to unilaterally downsize, it is not at all certain that it could maintain a competitive position with respect to the insurance plans or in the market for physicians and patients. The tertiary care facilities vary in the strength of their current financial positions. All have strong leadership but differ considerably in underlying mission and in the strategies chosen for the near future. Cooperation might be difficult to achieve without an external impetus, and antitrust issues might arise as well.

While intra-District mergers seem unlikely in the current atmosphere, the tertiary care hospitals might form networks beyond the District borders, in response to the increasingly regional character of the market. This course currently appears most probable for D.C. hospitals. Two of the four tertiary care hospitals, WHC and Georgetown, have adopted strategies that would position them to become the dominant player in a regional market. WHC is negotiating from a position of both financial strength and technical expertise; Georgetown has only its technical reputation.

Both are pursuing regional strategies, both allying themselves with physicians and hospitals in the Richmond-Washington-Baltimore corridor, but with a difference in emphasis. Georgetown is apparently concentrating on developing a physician network, but unlike GW it is purchasing physician practices, using carefully structured contracts, as discussed above. GW’s strategy is location-based, emphasizing physicians in its downtown neighborhood.
Georgetown, on the other hand, would like to continue its expansion in the suburbs in a bid to be a player in the regional market, but lack of investment capital apparently constrains it. With the expressed aim of drawing in more managed care business, it has established outpatient clinics or bought primary care practices in both the Virginia and the Maryland suburbs. It has had reported success with its clinics but less with the physician practices. It has also signed an agreement with the region’s largest physician practice firm, Doctors Health, which is based outside Baltimore and has a network that stretches as far south as Richmond. Under this agreement, Georgetown’s hospital-based physician practice becomes part of this regional network and its hospital becomes a primary referral center. If managed care becomes more important in the local market, this arrangement could begin to yield more positive benefits than it apparently has to date. Georgetown’s strategy is not entirely physician-based; the hospital has also been mentioned in local business reporting as an interested party in the purchase of at least two southern Maryland hospitals, competing with other regional players such as WHC and Johns Hopkins. Again, capital is a constraint, given Georgetown’s financial woes and reportedly waning support from its university community, and affiliation with another financially stronger hospital would be a logical strategic move.

WHC’s strategy also includes physicians and hospitals, but it appears more active in the hospital sector, and, unlike Georgetown, it is concentrating nearly exclusively on Maryland. It is currently the strongest of the city’s four tertiary care hospitals, and it alone has a positive operating margin as well as rising inpatient admissions and emergency room visits. It does, however, carry significant long-term debt. WHC’s parent company, Medlantic, recently finalized its merger with the Baltimore-based Helix Healthcare System, the largest hospital group in Baltimore. The Helix system is composed of five community hospitals, so the two systems are complementary, and the transition could be eased by the reportedly good relations between top officials of the two firms. By merging with the Helix system, WHC not only defuses a competitor but also gains a collaborator in the Baltimore-Washington corridor, where both Georgetown and Johns Hopkins have been seeking to extend their reach.

The Medlantic-Helix merger is advantageous for both, as both are competitors with Johns Hopkins—Helix in the local Baltimore
market and Medlantic in the Baltimore-Washington market for high-end services. Both Helix and Johns Hopkins own HMOs that were developed specifically for the Maryland Medicaid market and that serve the entire state. The alliance between Helix and Medlantic is likely to channel Maryland Medicaid patients who need tertiary services preferentially to WHC. Both Helix and Johns Hopkins have been named among the bidders for various community hospitals in Maryland that are seeking the security of affiliation with a hospital system.

The competition for hospital services in the Baltimore-Washington corridor is not being left solely to the Baltimore and Washington hospitals. Two hospitals in the Annapolis, Maryland, area recently merged with the stated intention of dominating the central Maryland market. Merger talks are under way among hospitals in the greater Baltimore area, particularly to the north and west of the city; Johns Hopkins is a potential partner in at least two of these new systems. Some foresee a Maryland hospital market in the near future composed of only three or four systems.

In contrast to Georgetown and WHC, the other two tertiary care hospitals in D.C. appear to be targeting specific physician or patient populations in D.C. and its near suburbs. Howard, as discussed above, is building on its legacy and concentrating on the large African-American population in D.C. and adjacent PG County. GW appears to be banking on its downtown location to attract a network of physicians and patients. Now that the hospital is independent from the medical school and has a for-profit backer, it has the flexibility to pursue a growth strategy. Its first step, however, must be to rebuild the physician and patient loyalty that it lost in the years of uncertainty that surrounded its search for a partner.

**Tertiary Care Hospitals—Regional Service Competition**

The competition among the high-end hospitals is not based on facilities and market area alone; there is also service-specific competition. For example, while WHC is highly rated in most high-end services, it is seen as second to Georgetown in the local market for oncology services. Both Georgetown and WHC compete with Johns Hopkins in oncology. Possibly in an effort to compete in this area, WHC, through Medlantic, has developed Oncoplex, a comprehensive cancer care treatment program, in collaboration with a
Florida-based physician practice management firm that has an extensive oncologist network in the Baltimore-Washington corridor. Helix, Medlantic’s new partner, has a partnership with a radiation oncology services provider as part of its strategy to compete with Johns Hopkins in oncology. WHC’s position in oncology vis-à-vis Georgetown’s will clearly be affected by these affiliations.

WHC is also trying to challenge Johns Hopkins for the international market. Foreign patients often come to the United States for specialized treatment. WHC recently announced an international service that includes pickup at the airport, hotel reservations, translation services, and billing facilitation and coordination. This new WHC initiative matches a similar two-year-old program at Johns Hopkins.

The community hospitals are seeking to maintain their community and Medicare niches and strengthen their patient bases through vertical integration of programs. Those in the northwest and center of the city are currently fairly secure in their positions. In the southeast, where the payer mix is less favorable, the community hospitals are trying to reach out to other markets. One already has a partner; the other is actively seeking one. The specialty hospitals are seeking to maintain their patient bases in the face of competition from the general hospitals both in the District and in the suburbs by emphasizing their specialty expertise. D.C. General, now technically independent of the city, is reorganizing under the PBC, investing in primary care through its network of neighborhood health centers and asserting the responsibility of other hospitals to provide for the uninsured in their neighborhoods. The tertiary care hospitals have further goals: to regain a lost market, in the case of GW; to expand a traditional market, in the case of Howard; or to extend their geographic coverage area through affiliations with physicians or other hospitals or both. WHC/Medlantic seems to be concentrating on the Baltimore-Washington corridor, while Georgetown is looking at the whole Richmond-Washington-Baltimore corridor. Both the Washington and the Baltimore hospitals are looking at southern Maryland. All are cutting costs and emphasizing the quality of their relationships with both physicians and patients. None currently will publicly recognize closure as an option.
While most observers felt that the health care sector in Washington, D.C., would look very different in the not-too-distant future, there was little consensus on what it would look like. Change is imminent. For the time being, hospitals are acting on the old-fashioned strategy of cutting costs and filling beds, some apparently betting on Washington’s distinctive health insurance market to allow them to coast into the new medical marketplace. It may take a precipitating event to make hospitals change their long-term perspectives. The recently announced merger between Medlantic and Helix, quickly followed by GW’s announcement of plans to build a new hospital to replace its old one, may be that event. Georgetown’s and Columbia Women’s financial problems and Greater Southeast’s change in leadership add to the sense that Washington’s hospital market may follow Maryland’s in coalescing into a small number of large hospital systems.

This period of change is being driven primarily by market forces. The uninsured lack a voice in the market and so may bear much of the cost of the change unless there is specific intervention to protect them and the providers that serve them. The examples of WHC and Providence show that a well-run hospital can maintain high-quality, competitively priced care and still devote a significant proportion of its revenues to uncompensated care.

Some benefits could come from the recent changes in the hospital market. First, hospitals have been forced to cut costs while maintaining quality to attract patients. If the cuts represent real sav-
ings in the system and not simply a shift of revenues from the providers to the insurers, the result may be quality care at a lower price. Second, with declining private-sector reimbursement, Medicaid patients have become more desirable, and their access to quality care could improve. Medicaid managed care could theoretically bring more attention, in particular, to the primary care needs of this population. Lower prices, constant or higher quality, and better access for publicly insured populations are potential benefits from the current market transformation. How the system evolves will determine whether these potential gains are realized.

Continuing cuts in public and private payer rates, plus potential increases in channeling of patients, are likely to force yet stronger responses. In the face of increasing pressure and declining patient choice, several scenarios are possible. In one scenario, the D.C. hospitals will choose to remain independent, facing continuing pressure to downsize or make cuts, including cuts in their share of uncompensated care. Alternatively, some hospital or hospitals could be forced to close. The optimal result would be that the least efficient hospital would close. Surviving hospitals could then earn higher net revenues at the same price by increasing occupancy, and pressure to cut free care would be eased. Reduction in competition might also raise prices.

The role of hospital sponsorship cannot be ignored in these scenarios. It may be that a less efficient hospital can survive if it has outside financing to support it through the period of greatest price pressure. If so, then the end result might be fewer hospitals but not necessarily more efficient hospitals. Furthermore, sponsorship and uncompensated care provision are not correlated in the D.C. market. Outside support of one or more local hospitals could further tilt the advantage away from the greatest providers of uncompensated care.

Which hospital or hospitals closed would influence the level of uncompensated care that is maintained. One result might be that the hospitals that have been unable or unwilling to sacrifice care for the uninsured would find themselves at such a disadvantage in the market that they would be the ones most at risk of closing. The closure of a large provider of uncompensated care could precipitate a crisis for uninsured access. Other hospitals would face the dilemma of how to meet the inevitable increase in demand for free care at

Some benefits could come from the recent changes in the hospital market. How the system evolves will determine whether these potential gains are realized.
their hospitals. Hospitals unaccustomed to providing uncompensated services or those that already provide a large proportion of their care uncompensated might suddenly find themselves with an unacceptably high level of demand for free care. Public intervention would be needed to protect access to care by the uninsured.

Under another scenario, one or more mergers could take place among the city’s or the region’s hospitals. If the new entities maintain the current configuration of their components, efficiencies would not necessarily be achieved, though larger systems could probably boost prices as competition was lowered. Uncompensated care could be supported at current levels through cost-shifting, although missions that motivated uncompensated care provision might be altered by consolidation. Alternatively, the new systems could choose to close or to convert one or more of the merged facilities, resulting in lower capacity and a more efficient sector. Given the correlation between geographic location and uncompensated care provision, the effect on the uninsured would depend on which facilities chose to merge and which were closed.

While the mayor has standing committees to enunciate policy for health care reform for the city, the recent financial difficulties of the District of Columbia, combined with severe administrative and managerial weakness in many city departments, have focused departmental leadership attention on the process of service delivery rather than on underlying policies. While such inward attention may be appropriate under the circumstances, the result is that the transformation of the hospital sector and, more broadly, the health care sector in the city is taking place with little policy direction. By operating on automatic pilot in the policy arena at this critical juncture, the city runs the risk that those with no market power—that is, the uninsured—will be left out of the transformation altogether.

The imminence of change argues strongly for intervention soon. The city needs promptly to end the near vacuum of policy brought about by its recent financial troubles and the leadership ambiguities created when Congress imposed Control Board authority over most city services. As the city regains both financial stability and a measure of local control over its services, it will need to make key decisions about health care, especially about hospitals that provide a large measure of the available indigent care. Market forces are currently being allowed to shape the hospital sector with
little local public intervention. The interplay of market forces should lead to a more efficient provision of services, a favorable outcome for those whose insurance makes them participants in the market. However, for a large number of poor D.C. citizens, the only voice available to them in the market is government policy on Medicaid and on care for the uninsured.

The District has no formal policy on hospital care for the uninsured, implicitly relying on the goodwill of individual hospitals for charity and other uncompensated care. When hospital finances were more secure and competition among hospitals was minimal, this might have been effective. In the current climate, however, the uneven distribution of uncompensated care represents a competitive disadvantage for hospitals that choose to care for the poor. City inaction by default favors hospitals that, by chance or design, provide little uncompensated care.

Other jurisdictions have used charity care pools, hospital rate-setting, or expansion of publicly sponsored or subsidized insurance programs to reduce uncompensated hospital care or to spread its burden equitably across hospitals. Current D.C. regulations require a minimum level of charity care by private hospitals, but the total amount required is insufficient to meet demand. The city’s quasi-public hospital, D.C. General, and its associated clinics serve as providers of last resort for all, without regard to ability to pay. Once again, however, demand exceeds capacity, and the incentives in place do not promote the most efficient provision of care.

Currently under discussion are proposals to expand health insurance coverage for children and their parents, childless couples, and single adults under the federal Child Health Insurance Program and through Medicaid waiver programs. Expanding insurance coverage would directly reduce uncompensated hospital care. In addition, it should encourage greater use of primary and preventive care so that, in the long run, as new patterns of utilization are established, inappropriate emergency room use might be curtailed, and the number of preventable hospitalizations might decline.

Expansions of coverage should be encouraged, but uncompensated care will always remain. The District should analyze the current pattern of uncompensated hospital care, looking at who is receiving care, what types of care are being received, and who is
providing it. It should then articulate a citywide policy on uncompensated hospital care so that the restructuring hospital sector will serve all D.C. residents.

Instituted in response to market developments that reduce overall uncompensated care provisions, policy could mitigate the worst effects of the new hospital market on the poor. Instituted before such a crisis, policy could influence which hospitals survive. Policies on uncompensated care do not represent simply protection for the safety net institutions. Rather, by spreading the social burden of caring for the disadvantaged, policies can level the playing field and allow the safety net institutions to compete on more nearly equal terms with the hospitals that provide little uncompensated care.

Notes
4. Ibid.
11. There are also military hospitals, public and private inpatient psychiatric facilities, rehabilitation hospitals, and long-term chronic care facilities. These are not included in the current analysis. The PBC will be described in greater detail below.
14. Ibid.
15. Operating margin is an imperfect measure of hospital financial status, as it does not reflect the total operation of the hospital. In some cases—for example, Greater Southeast—a strongly positive operating margin can obscure a financial position that is widely considered to be weak.

16. City workers hired after 1989 participate in a city-only plan, which has been run under a managed care contract since 1996.


19. Three inpatient psychiatric hospitals also receive DSH payments.


BARBARA A. ORMOND is a research associate with the Health Policy Center of the Urban Institute. Her work there has focused on the impact of health system change on uninsured and publicly insured populations. Prior to coming to the Urban Institute, she conducted research on hospital provision of uncompensated care in the United States and on the demand for curative care in rural Indonesia. She spent several years working at the U.S. Agency for International Development, with a focus on rural health systems.

RANDALL R. BOVBJERG is a principal research associate in the Health Policy Center of the Urban Institute. His main research interests are health coverage and financing; regulation, competition, and the appropriate role for government action; and the working of law in action, including the influence of legal culture upon policy. Earlier work on changing state policy led him to co-author one book on Medicaid and another on block grants, both from the Urban Institute Press.