Tenet Medi-Cal Disproportionate Share Hospitals: High on Profits, Low on Patient Care Benchmarks

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September 2003

I. Introduction

California is Tenet Healthcare Corporation's largest market, with more than one-third of its hospitals (41 out of 117) located in the state.[1] Numerous reports have documented that Tenet's business strategy in California and nationwide has relied on increases in Medicare outliers and health plan stop-loss payments, which Tenet achieved by rapidly raising its gross charges, to dramatically increase profits. This report documents the parallel – but until now little-noted – manner in which California's Medi-Cal Disproportionate Share Hospital (DSH) program has contributed to Tenet's financial success.

In 1991, the California legislature created the Medi-Cal DSH program to shore up safety net hospitals in danger of closing because of their high proportion of low-income patients. While California's current fiscal crisis is forcing major cuts in the healthcare safety net, Tenet received in 2001 $119.4 million in DSH funds, far more money than it would receive if its DSH payments were proportionate to its provision of hospital services in low-income communities. More than 60% ($74.4 million) of these Tenet DSH funds came from financially troubled Los Angeles County alone.

This report describes how Tenet has turned the Medi-Cal DSH program, which was created to keep safety net hospitals alive, into a corporate profit center. First, it explains how Tenet grew its Medi-Cal DSH hospital business and how much it earns from this program. Next, it examines the patients in Tenet DSH hospitals and the care they receive. Finally, it suggests questions that merit further inquiry from California lawmakers and health advocates.

II. How Tenet Grew Its Medi-Cal DSH Business in California

In 1994, after a series of scandals related to questionable admissions of adolescent psychiatric patients, senior executives of National Medical Enterprise (NME) re-named and re-invented the company to emerge as Tenet Healthcare Corporation. The renamed Tenet rapidly began to increase its Medi-Cal DSH revenue in California.

[1] http://www.etenet.com/Apps/HospitalFinder/default.asp?Page=GeneralInfo, as of February 11, 2003. In Fiscal 2001, the last year covered by this study, Tenet operated 39 California hospitals.

During fiscal year 1995,[2] Tenet operated 5 DSH hospitals that received $24.7 million from the DSH program. Since then, Tenet's DSH Payments increased almost five fold.

This growth can be divided into two phases:

- In fiscal years 1995-98, the number of DSH-eligible Tenet hospitals in California grew from 5 to 15, and Tenet's DSH payments more than doubled to $60.6 million.
- In fiscal years 1998-01, the number of DSH-eligible Tenet hospitals declined from 15 to 12, yet DSH payments nearly doubled again, to $119.4 million.[3]

Tenet's portfolio of DSH hospitals changed over time as a result of corporate decisions to buy, sell, or close hospitals and as a result of declines in the volume of service to low-income patients Tenet hospitals serve.

In total, between 1995 and 2001, Tenet received DSH payments in at least one year at a total of 25 hospitals.[4]

The company acquired 11 DSH-eligible hospitals during the period covered by this study, all but one of them before the end of fiscal year 1998. It also closed three DSH hospitals, ended in-patient services at a fourth, and sold a fifth. In addition, eight Tenet hospitals that had qualified in previous years were not eligible for DSH payments in fiscal year 2001 because they no longer provided a sufficient proportion of their services to low-income patients.

In fiscal 2002, Tenet acquired another DSH hospital – Daniel Freeman Memorial in Inglewood. Because full financial data is not yet available for FY 2002, Daniel Freeman's performance will not be considered in this report.

[2] Data on DSH program expenditures is collected according to the federal fiscal year, which begins on October 1st. For example, fiscal year 2003 began on October 1, 2002.

[3] Years are the federal fiscal years in which hospitals received DSH payments. Data on DSH eligible hospitals and the amount of their DSH disbursements for federal fiscal years 1998 to 2001 was obtained from the California Department of Health Services (DHS), Disproportionate Share Hospital Unit on 7/24/02. The Office of Statewide Health Planning and Development (OSHPD) also provides hospital-reported lists of DSH eligible hospitals and DSH disbursements, but these data do not agree with data provided by DHS because OSHPD reports data according to the hospital's fiscal year rather than the federal fiscal year. Because DHS does not have DSH data for federal fiscal years 1995 to 1997, we used OSHPD data, which covers the individual facilities' own fiscal years for this period. However, no attempt was made to reconcile the hospital fiscal years reported to OSHPD with the federal fiscal years.

[4] Some of these hospitals did not qualify consecutively for every year. To be consistent with data presented later in this report, dates given here are the OSHPD reporting years (which are the individual facility's fiscal years) in which hospitals changed hands, not the calendar year.

Table 1. Tenet's DSH Hospitals, 1998 – 2001	
Hospital	**Fiscal Year Acquired or DSH Qualified[5]**
Garfield Medical Center	pre-1995
Garden Grove Hospital and Medical Center	1997
Monterey Park Hospital	1997
Coastal Communities Hospital	1998
Community and Mission Hospitals Of Huntington Park	1998
Doctor's Medical Center—San Pablo Campus (formerly Brookside Hospital)*	1998
Fountain Valley Regional Hospital and Medical Center	1998
Greater El Monte Community Hospital	1998
John F. Kennedy Memorial Hospital	1998
Santa Ana Hospital Medical Center	1998
South Bay Medical Center*	1998
Suburban Medical Center	1998
Western Medical Center of Anaheim*	1998
Western Medical Center of Santa Ana	1998
Woodruff Community Hospital*	1998
Queen Of Angels—Hollywood Presbyterian Medical Center	1999

**Doctors Medical Center—San Pablo Campus (formerly Brookside Hospital, serving a high proportion of low income patients) ended inpatient services and Western Medical Center of Anaheim was no longer DSH eligible in 2001. South Bay Medical Center and Woodruff Community Hospital were closed.*

III. Tenet's DSH Payments Have Grown Rapidly While Other Hospitals' Payments Stagnated

A review of key financial indicators for Tenet DSH hospitals and their competitors tells a surprising story. Tenet's success at growing its DSH revenue and DSH hospital profitability – which began during its mid-1990s wave of hospital acquisitions – continued as the company moved to close DSH hospitals and reduce the number of DSH beds. Indeed, from 1998-2001, Tenet's DSH revenue almost doubled while the company slashed DSH hospital beds by 15%. For public hospitals and non-Tenet DSH private hospitals, which make up the healthcare safety net, neither DSH payments nor the number of DSH hospital beds changed dramatically in this period. (See Table 3.)

[5] Here and in subsequent sections of this report, the list of DSH eligible hospitals, and the amount of their DSH disbursements, are from data provided by DHS on 7/24/02. This and all other data for other financial figures and staffed beds are taken from OSHPD HAFD 1995 - 2001.

Viewed another way, Tenet's increase in DSH funds accounted for almost the entire increase in total DSH payments statewide during the period from 1998-2001 ($58.8 out of $60.9 million) while eliminating DSH hospital beds (Tenet eliminated 425 beds; all other DSH hospitals increased the number of beds by 9.)

This section will show just how much more successful Tenet has been than its competitors at increasing its DSH payments and maximizing their contribution to revenue and profits.

Table 2 summarizes the key indicators discussed in this section.

Table 2. Tenet DSH Hospitals vs. Other Private Sector and Public DSH Hospitals: Financial Performance 2001[6]

	Staffed beds	DSH payments	DSH payments per staffed bed	Operating Revenue	Operating Expense	Net Operating Profit	Operating Margin
Tenet DSH hospitals	2,384	$119 million	$50,084	$927 million	$783 million	$144 million	15.5%
Other private sector DSH hospitals	11,552	$367 million	$31,778	$5,684 million	$5,772 million	$(89) million	-1.6%
Public sector DSH hospitals	8,354	$504 million	$60,365	$5,290 million	$6,066 million	$(776) million	-14.7%

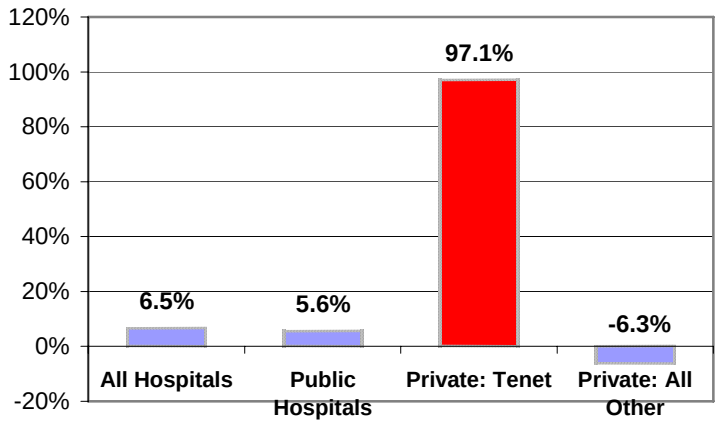
As shown in Tables 3 and 4 and Figure 1, between 1998 and 2001 DSH payments to public hospitals increased by just 5.6%, from $478 to $504 million, proportionate to the 7.9% increase in beds in those hospitals over that period. Payments to non-Tenet private DSH hospitals declined by 6.3%, from $392 to $367 million, proportionate to the 4.9% decline in non-Tenet private DSH beds in those four years. Tenet's DSH payment fortunes stand in marked contrast to these trends; while its staffed DSH beds fell 15.1%, its DSH payments nearly doubled, from $61 million to $119 million.

[6] Data provided by DHS on 7/24/02. DHS reports DSH "base payments" for all hospitals, and "transfers" for public hospitals. DSH transfers represent the intergovernmental transfers made by public entities to draw the federal matching funds that fund the DSH program. These payments are returned to public hospitals, in addition to their share of the federal match, and the entire sum is reported as the hospital's DSH payment. OSHPD accounts for these payments by debiting the transfer amount from the total DSH payment to derive a net DSH figure for public hospitals. This report follows OSHPD's accounting conventions and debited a public hospital's transfer payment from the DSH disbursement it receives, producing a "net" DSH figure that represents the actual contribution of new funds to the public hospital. Public hospitals include hospitals licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state, as specified in the Welfare and Institutions Code 14105.98.

Table 3. Change in California Medi-Cal Net DSH Payments 1998-2001 (in $ millions)[7]				
	All Hospitals	**Public Hospitals**	**Private: Tenet**	**Private: All Other**
1998	$929.9	$477.7	$60.6	$391.5
2001	$990.8	$504.3	$119.4	$367.1
$ Change	$60.9	$26.6	$58.8	-$24.5
% Change	+6.5%	+5.6%	+97.1%	-6.3%

Table 4. Change in Number of Beds in California DSH Hospitals: 1998-2001[8]				
	All Hospitals	**Public Hospitals**	**Private: Tenet**	**Private: All Other**
1998	22,706	7,744	2,809	12,153
2001	22,290	8,354	2,384	11,552
% Change	-1.8%	+7.9%	-15.1%	-4.9%

Figure 1. Percent Change in Medi-Cal DSH Payments to California Hospitals, 1998-2001

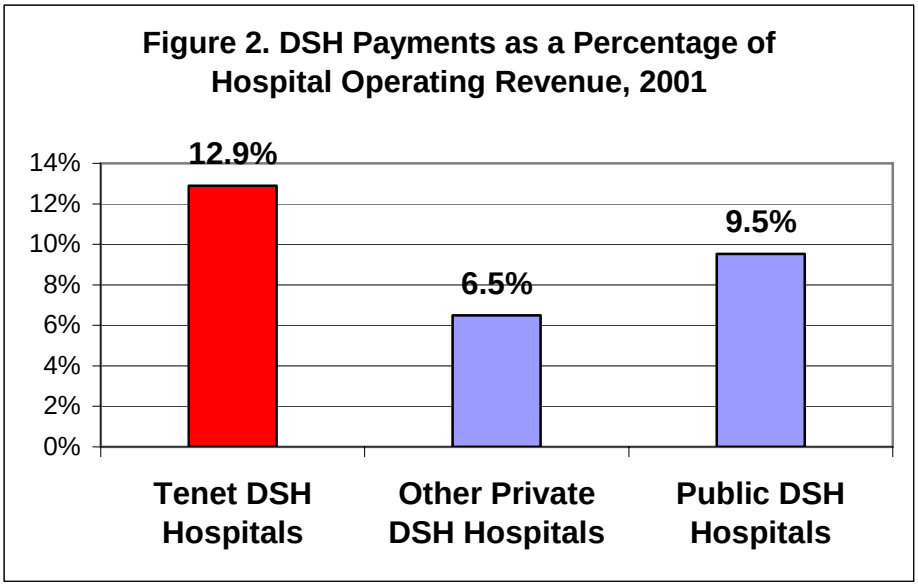


Tenet DSH hospitals received 25% of the private sector DSH pot in 2001—$119 million out of $486 million—although they owned only 17% of DSH hospital beds.

[7] DSH payments by hospital group were calculated from lists of DSH hospitals and disbursements provided by DHS on 7/24/02. This and all other data for other financial figures and staffed beds are taken from OSHPD HAFD 1995 - 2001.

[8] Staffed beds figures are from OSHPD HAFD 1998 - 2001.

The financial indicators illustrated above—Tenet's fast growing DSH payments, the larger amounts it receives from DSH relative to the size of its hospitals and relative to the cost of operating them—all contribute to the high profitability of Tenet's DSH hospitals. Tenet's DSH hospital growth resulted in substantial additional revenue, but fewer beds available in DSH hospitals. These trends suggest shrinking access for low income patients.



How Profitable is DSH for Tenet?

Tenet stands out as the largest financial beneficiary of the DSH program. As shown in Table 2 above, Tenet's 15.5% operating margin on its DSH hospitals in 2001 stands in sharp contrast to the –1.6% operating margin among other private DSH hospitals and the –14.7% operating margin among public hospitals. DSH payments represent a larger share of total operating revenue at Tenet DSH hospitals (12.9%) than in other private DSH hospitals (6.5%) or public DSH hospitals (9.5%) (Figure 2).

The combination of high profitability at Tenet's DSH hospitals and continuing operating losses at DSH hospitals not owned by Tenet, suggests that the current pattern runs contrary to the DSH program's goal of assuring financial stability for all hospitals serving low-income communities.

The pattern is even more dramatic when examining financial results on a hospital-by-hospital or county-by-county basis.

Tenet operates the six most profitable DSH hospitals in California. Garfield Medical Center in Los Angeles County, with a 2001 operating margin of 31.8%, heads this list. Among California's more than 400 general acute care hospitals, only two non-DSH hospitals, both owned by Tenet—Doctors Medical Center in Stanislaus County and Redding Medical Center in Shasta County—reported higher profits than Garfield in 2001.

All but one of Tenet's 12 California DSH hospitals is located in Orange or Los Angeles Counties. These two counties accounted more than 95% of the company's DSH revenue in 2001. The following sections illustrate how Tenet's DSH hospitals fare in the two counties where they play the largest role.

Tenet's DSH Hospitals in Los Angeles and Orange County

In Orange County, Tenet dominates DSH funding. In 2001, it received more than $40 million in DSH payments. In contrast, non-Tenet private hospitals received $12 million and UC Irvine received $24 million.

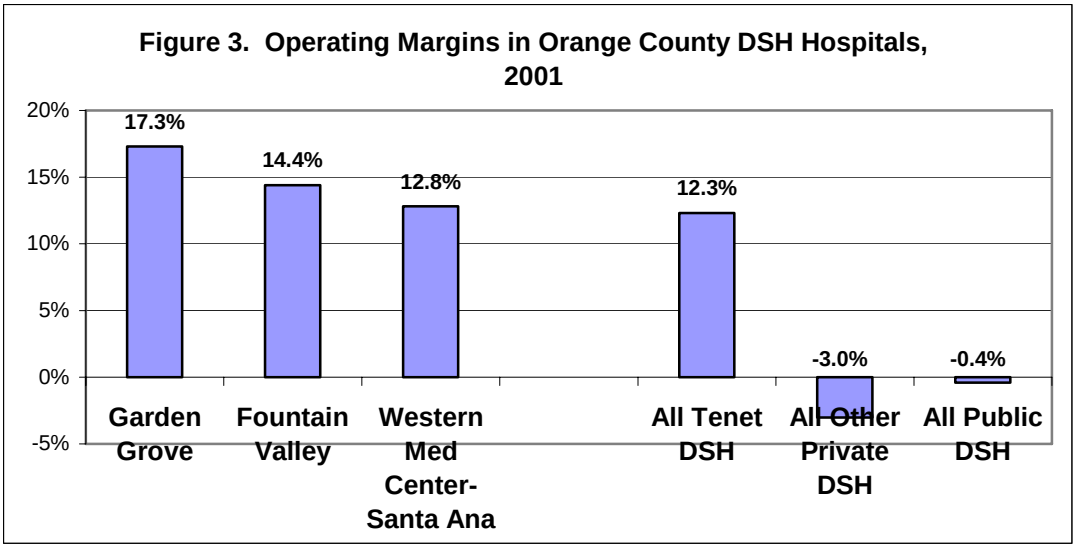
The number of staffed beds in Tenet's Orange County DSH hospitals declined by 20% in 1998-2001. Yet:

Tenet's Orange County DSH payments more than doubled in this period, from $19.5 million to $40.5 million, while DSH payments to other private DSH hospitals declined by 5% and payments to UC Irvine increased by only 5%.

Table 5. Change in Orange County Medi-Cal Net DSH Payments, 1998-2001 (in $ millions)

	All Hospitals	Public Hospitals	Private: Tenet	Private: All Other
1998	$54.8	$22.8	$19.5	$12.5
2001	$76.4	$23.9	$40.5	$11.9
$ Change	$21.6	$1.2	$21.0	-$.6
% Change	39.4%	5.1%	107.8%	-4.8%

Tenet owned Orange County's three most profitable DSH hospitals in 2001. They were Garden Grove Hospital and Medical Center (operating margin 17.3%), Fountain Valley Regional Medical Center (14.4%), and Western Medical Center–Santa Ana (12.8%) (Figure 3). All three rank among the most profitable 10% of California hospitals.



In Los Angeles County, Tenet's DSH funding soared during 1998-2001, a period in which the company closed three unprofitable DSH hospitals. Between 1997 and 1998, Tenet closed two hospitals – Woodruff Community and South Bay – that received DSH funds in 1998, and a third hospital – North Hollywood Medical Center – that received DSH funds in 1997.[9]

Tenet's Los Angeles DSH payments more than doubled, from $35.2 million to $74.4 million. DSH payments to other private sector hospitals in the county remained virtually unchanged at about $183.6 million. DSH payments to LA County hospitals actually declined, dropping from $209.0 million to $206.8 million.

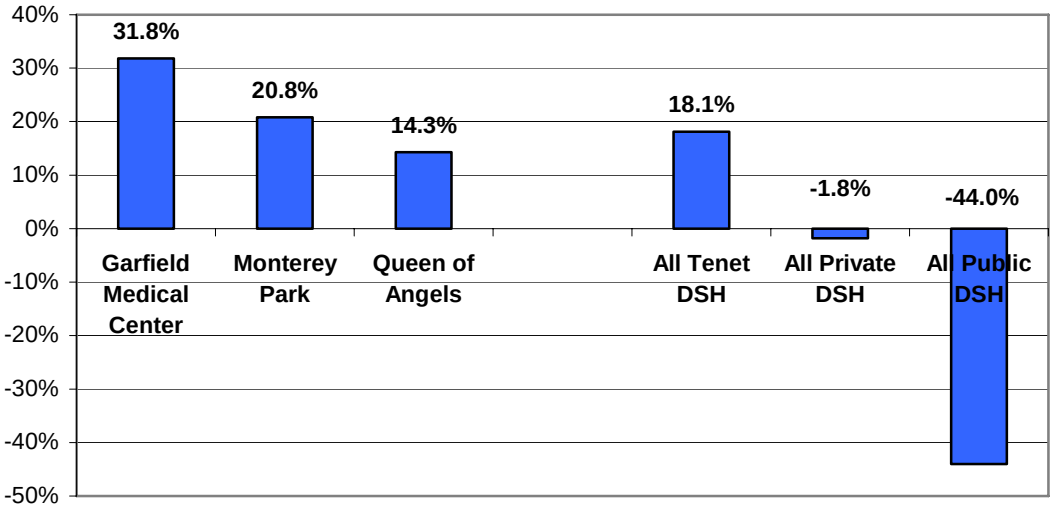
Table 6. Change in Los Angeles County Medi-Cal Net DSH Payments, 1998-2001 (in $ millions).

	All Hospitals	Public Hospitals	Private: Tenet	Private: All Other
1998	$427.4	$209.0	$35.2	$183.2
2001	$464.8	$206.8	$74.4	$183.6
$ Change	$37.4	-$2.2	$39.2	$.4
% Change	8.8%	-1.1%	111.5%	0.2%

[9] Hospital closure years are given as calendar years; see *California's Closed Hospitals, 1995-2000*, Nicholas C. Petris Center, April 2001, p.7. DSH eligibility years are taken from DHS data provided 7/24/02, except for 1997 DSH data for North Hollywood Medical Center, which is taken from OSHPD (no DHS data is available for this year). Tenet closed Woodruff Community Hospital in 1997, although the hospital received DSH funds in 1998; this discrepancy results from differences between the hospital's fiscal year and the federal fiscal years used to administer the DSH program. North Hollywood Medical Center is not included in Table 1, "Tenet's DSH Hospitals: 1998 – 2001" because the hospital was not DSH eligible in 1998.

Tenet owned LA County's three most profitable DSH hospitals in 2001. They were Garfield Medical Center (operating margin 31.8%), Monterey Park (20.8%) and Queen of Angels—Hollywood Presbyterian (14.3%) (Figure 4). All three ranked among the most profitable 10% of all California hospitals.

Figure 4. Operating Margins for Los Angeles County DSH Hospitals, 2001



IV. Tenet DSH Hospitals: Patient Characteristics and Patient Care Benchmarks

DSH payments make a considerable contribution to the bottom line at Tenet's DSH hospitals. This section examines two other key components of Tenet's DSH business pattern: (1) the characteristics of the patients they treat; and, (2) the expenditures spent caring for those patients.

Patient Characteristics

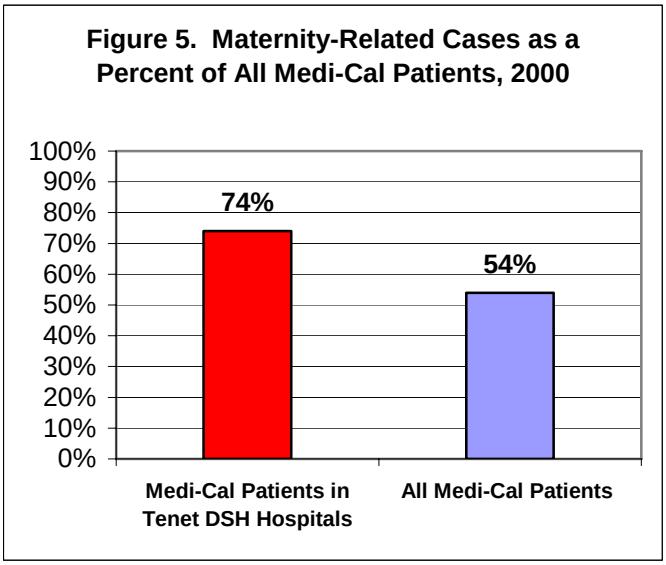
Pregnant women and their newborn babies make up three-quarters of Tenet's Medi-Cal patients.[10] This patient group tends to be much less costly to care for than other categories of hospital patients for several reasons.

In the first place, most pregnant women and their newborn babies are healthy – their stay in the hospital is usually brief and predictable. Unless the hospital serves an area with a

[10] "Maternity Related Cases" are defined as Major Diagnostic Categories (MDCs) 14 (Pregnancy, Childbirth, and the Puerperium) and 15 (Newborns and other Neonates with Conditions Originating in the Perinatal Period). MDCs 14 and 15 cover Diagnostic Related Groups (DRGs) 370 through 391, inclusive. This and all subsequent patient level data is taken from OSHPD Patient Discharge Data, 2000 (Calendar Year).

disproportionate number of very high-risk mothers, only a small number of these patients will develop costly complications.[11] For newborns with complications, California Children's Service (CCS) provides extra payments to subsidize their care in the Neonatal Intensive Care Unit (NICU).

Second, the DSH program provides the same credit for a healthy pregnant mother as it does for a very sick cancer patient. In fact, for each pregnancy it provides twice as many credits, because the baby counts as a separate patient, so Tenet's patient population is unusually lucrative. For the Medi-Cal program as a whole, just over half of patients are pregnant women and their babies, compared to 74% for Tenet (Figure 5).



Race/Ethnicity

Tenet's DSH hospitals care for a particularly high share of Latina and Asian mothers and babies compared to other hospitals in the same Southern California counties. In Tenet DSH hospitals, 75% of all mothers and babies are Latino, 15% are Asian, 7% are White, and 1% are African American. For all hospitals in Los Angeles, Orange, and Riverside counties, pregnant women and babies are 53% Latino, 8% Asian, 28% White, and 7% African American.

[11] Marquis MS, Long SH. The role of public insurance and the public delivery system in improving birth outcomes for low-income pregnant women. *Medical Care* 2002;40(11):1048-1059.

Table 7. Race/Ethnicity of Maternity Related Cases in Southern California Hospitals Tenet DSH vs. All Hospitals[12]		
Race/Ethnic Group	**Tenet DSH Hospitals: LA, Orange, and Riverside Counties**	**All Hospitals: LA, Orange, and Riverside Counties**
Latina	75%	53%
Asian	15%	8%
White	7%	28%
African American	1%	7%
Total (includes Native American, Other, and Unknown race categories)	100%	100%

As Table 7 illustrates, Tenet's DSH hospitals have a one-third higher proportion of Latina and almost twice as many Asian mothers and newborns as the average hospital in the same geographic areas of Southern California. These facts make the findings presented in the next section on Tenet's patient care in these hospitals of particular concern to the Latino and Asian communities where Tenet appears to have targeted its growth.

Patient Care Benchmarks in Tenet DSH Hospitals

A key issue in Tenet's DSH hospitals is the impact of corporate cost-cutting practices on patient care. This study reviewed two key benchmarks of good patient care for Tenet's DSH hospitals in California. On both, Tenet's DSH hospitals scored considerably worse than the most appropriate control group, non-Tenet DSH hospitals.

The first benchmark measures the number of productive hours of direct care per adjusted patient day. (See Table 8.) Since a number of studies have shown that the amount of nursing care hospital patients receive correlates directly and positively with good patient outcomes, Tenet's DSH hospitals' poor performance on this benchmark raises troubling questions.[13]

[12] Ibid. OSHPD codes patient records for both Ethnicity (Hispanic, Non-Hispanic, or Unknown) and Race (White, Black, Native American/Eskimo/Aleut, Asian/Pacific Islander, Other, and Unknown), which are both self-reported by the patient. To avoid double counting, we have counted all patients who have identified themselves as Hispanic as Hispanic, regardless of their reported Race. We have used the term "Latino" interchangeably with "Hispanic" in this report.

[13] Recent studies pointing to a strong and significant link between nurses, nurse staffing levels, and patient outcomes include Needleman J et al., Nurse staffing and patient outcomes in hospitals, *NEJM* 2002;346(22):1715-22; and Aiken LH et al., Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction, *JAMA* 2002;288(16)1987-93. The Joint Commission on Accreditation of Healthcare Organizations recently released a report, *Health Care at a Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, August 2002, identifying the role of inadequate staffing levels in "sentinel events." An expert panel convened by the California Department of Health Services in 2001 did an extensive literature review of 37 studies and concluded that nurse staffing is related to patient in-hospital morality rates and several patient complications (http://www.applications.dhs.ca.gov/regulations/store/Regulations/Section%201%20Literature%20Review.pdf, 12/02). For a discussion of the role of staffing issues in medication errors, see the United States Pharmacopeia's Center for the Advancement of Patient Safety report, *Improper Administration Technique Harmful to Patients; Costly to Health Systems and Insurers*

As shown in Table 8, Tenet DSH hospitals provide patients far fewer hours of direct patient care than Medi-Cal DSH hospitals that are not owned by Tenet. The finding holds true whether Tenet DSH hospitals are compared to other DSH hospitals that are in their same geographic region or to other DSH hospitals statewide. The care deficit is most acute in Los Angeles County, where Tenet obtains more than 60% of its DSH funds. In Los Angeles County, Tenet DSH hospitals provide 25% fewer patient care hours.

Table 8. Average Direct Care Productive Hours Per Adjusted Patient Day, Tenet DSH vs. non-Tenet DSH Hospitals, 2001[14]

Geographic Area	Tenet DSH Hospitals	Non-Tenet DSH Hospitals	Tenet Shortfall
Los Angeles County	10.57	14.53	27%
Orange County	14.46	17.70	18%
Riverside County	13.24	15.55	15%
California statewide	***12.36***	***14.85***	***17%***

The second patient-care benchmark measures the hospitals' average labor cost per adjusted patient day across all employee classifications including both caregivers and other staff. This is a further indication that Tenet DSH hospitals invest less than their competitors in providing the staff who perform the full range of services that directly or indirectly support a hospital's delivery of high quality patient care.

Because hospital labor costs translate directly into patient care, this benchmark also measures the adequacy of Tenet's DSH hospitals compared to the peer group of non-Tenet DSH. As shown in Table 9, Tenet spends one-third less on labor costs than non-Tenet DSH hospitals, in the same geographic area and on a statewide basis as well. The disparity is even more pronounced in LA County, where Tenet DSH hospitals on average spent 44% less than non-Tenet DSH hospitals.

Table 9. Average Total Labor Costs Per Adjusted Patient Day, Tenet DSH vs. non-Tenet DSH Hospitals, 2001[15]

Geographic Area	Tenet DSH Hospitals	Non-Tenet DSH Hospitals	Tenet Shortfall
Los Angeles County	$505	$896	44%

(http://vocuspr.vocus.com/vocuspr30/xsl/uspharm/Profile.asp?Entity=PRAsset&EntityID=37659&XSL=PressRelease, 12/4/02). For the role of nurse staffing levels in various hospital quality indicators, see Kane NM, Siegrist RB, *Understanding Rising Hospital Inpatient Costs: Key Components of Cost and The Impact of Poor Quality*, August 12, 2002, Blue Cross Blue Shield Association (http://bcbshealthissues.com/costpressconf/materials.vtml).

[14] OSHPD HAFD 2001. "Direct Care Productive Hours" is the sum of the OSHPD Labor Productivity by Employee Classification categories for Technical and Specialists, Registered Nurses, Licensed Vocational Nurses, and Aides and Orderlies. OSHPD calculates "Adjusted Patient Days" to adjust patient days to include outpatient services, according to the formula: [(Total Gross Patient Revenue / Inpatient Gross Revenue) X Patient Days].

[15] "Labor Costs" is the sum of the OSHPD expense categories for "Salaries and Wages" and "Employee Benefits." These figures do not include the expenses for registry staff or for staff whose departments have been contracted out. OSHPD does not report either of these figures.

Orange County	$655	$912	28%
Riverside County	$619	$669	7%
California statewide	***$574***	***$876***	***34%***

V. Is Tenet Manipulating Medi-Cal DSH Payments? Questions for Further Investigation

The facts detailed in this report raise serious questions about the Medi-Cal DSH payments received by Tenet hospitals in California. They show that Tenet was successful both in rapidly increasing its revenue from DSH and in attracting the type of Medi-Cal patients who would maximize DSH payments while minimizing the cost of providing services.

This report does not, however, explain what financial factors, and what actions or decisions by Tenet, contributed to this result. Precise and careful examination of those factors is especially important in the light of recent revelations about the company's strategies for manipulating other payment sources to maximize revenue.

The rapid growth in Tenet's Medi-Cal DSH revenue in a period when payments to other hospital companies stagnated bears striking resemblance to the similarly rapid rise in Tenet's Medicare outlier and private insurance stop-loss payments. The sophisticated financial manipulations Tenet used to inflate payments from these sources provoked numerous federal and state investigations as well as private law suits. The company has itself acknowledged and renounced as inappropriate the mechanisms it used to maximize Medicare payments.

A public inquiry into the methods which Tenet has used to maximize DSH payments and DSH hospital operating margins will be especially valuable given the need to focus the state's limited Medi-Cal and DSH dollars on financially troubled essential community hospitals.

Questions to be considered in such an inquiry include:

1. Why does Tenet receive such a high share of California's DSH funds in comparison with other hospital companies, while focusing the operations of its DSH-eligible hospitals on the patients who are least costly to treat?
2. Should this high share of DSH funding go to a company that spends less on providing patient care and provides lower levels of patient care staffing than its competitors?
3. What exactly has Tenet done to attract rapidly rising DSH payments to a shrinking group of DSH hospitals that spend less than the average DSH hospital on patient care during a period when other providers received little or no increase?

Utilization and Patient Selection

The amount of Medi-Cal DSH money a hospital receives in California is based partly on its Low Income Utilization Rate (LIUR). LIUR is a measure of the hospital's services to Medi-Cal, charity care and County Indigent fund patients, calculated as a percentage of total revenue.

However, once a hospital qualifies for DSH payments based on its LIUR, the other half of the formula determining the actual amount actually paid to the hospital by the DSH program – the Medi-Cal Utilization Rate (MUR) – is based on the number of inpatient days covered by Medi-Cal, without regard for the cost or complexity of the care provided.

Admissions at Tenet DSH hospitals are substantially weighted toward one of the lowest cost categories of hospital service: maternity-related cases. This fact raises two critical questions:

1. What steps, if any, has Tenet taken to "cherry pick" the lowest cost and least complex Medi-Cal cases?
2. Is there evidence that Tenet avoids or discourages costly and complex Medi-Cal patients?

Charity Care

California laws and regulations give hospitals a great deal of flexibility in classifying non-paying accounts as either "charity care" or "bad debt." Charity care cases are included in a hospital's LIUR, and thus can have a direct effect on the size of its DSH payments. Hospitals must have an LIUR of at least 25% to qualify to receive Medi-Cal DSH payments. California hospitals are permitted to reclassify patient accounts between charity care and bad debt subsequent to the initial determination of a patient's status.

Tenet's practices on the classification of non-paying accounts between charity care and bad debt should be closely scrutinized and measured against hospital accounting standards and California legal and regulatory requirements. Questions that should be answered in this area include:

1. How much Tenet's practices regarding the categorization of non-paying accounts as "charity care" or "bad debt" vary between DSH and non-DSH hospitals?
2. What are Tenet's policies and practices regarding the reclassification of non-paying accounts? Do the company's practices vary depending on the DSH qualification status of its hospitals?
3. Is there any evidence, especially in DSH hospitals or hospitals on the margin with regard to qualifying for DSH, that patients who have been the subject of aggressive collection efforts are later reclassified as "charity care."

Other Issues

Tenet is the focus of federal investigations in two other key areas whose implications for the Medi-Cal DSH program merit careful scrutiny.

The company has publicly acknowledged that it inflated "outlier payments" from the Medicare program by rapidly increasing gross charges (i.e., list prices) at its hospitals without regard for the cost of providing services. What impact, if any, have Tenet's charging practices had on DSH payments?

Any review of the methods Tenet used to maximize Medi-Cal DSH payments should ask whether, or to what extent, inappropriate behavior by Tenet physicians or inappropriate incentives from Tenet to those physicians have contributed to Tenet's success in attracting DSH payments and in profitably shaping its mix of DSH patients.

Conclusion

This report has shown that at a time when Los Angeles County is cutting healthcare services to the poor for lack of funds, Tenet Healthcare has turned California's DSH program into a major profit center. Tenet's DSH hospitals receive a disproportionate share of DSH funds while spending less on patient care than other DSH hospitals. Tenet has thus turned a program created to ensure health access to low income patients, into a source of shareholder profits. In 2001, more than half of Tenet DSH hospitals (7 of 12) ranked among the most profitable ten percent among all California hospitals.[16]

Although Tenet appears to have turned the California DSH program into a corporate profit center, the company has not delivered a commensurate level of services to the state's low-income population. Even as Tenet grew its DSH funding, it reduced access for low-income patients by closing 3 DSH hospitals and ending inpatient services at a fourth. Tenet operated 15.1% fewer DSH hospital beds in 2001 than in 1998, while it doubled its DSH payments. An even larger decline in Tenet's DSH hospital beds was partially offset by Tenet's acquisition of the highly profitable Queen of Angels. This acquisition converted DSH beds from charitable to for-profit status but did not represent a net increase for the region.

Tenet's success in earning profits from the DSH program decreases the funds available to provide access for low-income patients in another significant way. Each year, California faces an aggregate cap, or "federal DSH allotment", that limits the total amount of federal funds it can spend on DSH payments to all hospitals in any fiscal year. In this respect, DSH is very much a "zero sum" game: hospitals serving large number of low-income patients compete for a fixed pot of DSH funds. Tenet's success in attracting DSH payments in excess of its level of services to low-income patients means that other hospitals that could serve more low-income patients receive less money. Nowhere is this issue more apparent than in financially troubled Los Angeles County, where Tenet DSH hospitals earn large profits while the public health system, which serves the greatest number of low income patients, eliminates beds and shutters entire facilities to deal with crippling budget deficits. This distribution of limited healthcare resources for low-income patients calls into question whether California's DSH funds are being allocated in the best possible way.

Acknowledgments

This study was supported in part by a grant from the UCLA Institute for Labor and Employment. Maura Kealey, Steve Askin, and Brian Olney of the Service Employees International Union in Los Angeles made valuable contributions to the data analysis and initial draft of this manuscript.

[16] OSHPD HAFD 2001. Analysis based upon all general acute care hospitals defined by OSHPD as comparable.