

When the G.O.P. Medicaid Cuts Arrive, These Hospitals Will Be Hit Hardest

Republicans created a special \$50 billion fund to help rural hospitals stay afloat, but the biggest impacts may be in cities.

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In a typical year, more than 100,000 Medicaid patients depend on the emergency department at Martin Luther King Jr. Community Hospital in South Los Angeles, in a predominantly Hispanic and Black community where residents have high rates of diabetes, heart failure and pneumonia.

In a sense, the hospital depends on them, too, with its fragile finances resting on payments tied to Medicaid, the federal health insurance program for the poor.

In the coming years, steep cuts to the program, enacted by Republicans in their signature policy bill this year, will destabilize this precarious balance for M.L.K. and other urban safety-net hospitals across the country.

As Republican lawmakers debated the legislation, which cut more than \$1 trillion in federal health care spending to help offset large tax cuts, key senators worried the changes would shutter rural hospitals. But a new analysis led by Harvard researchers suggests that many of the hospitals most at risk of closing services — or even their doors — look more like M.L.K.

The analysis deemed 109 hospitals most exposed to the coming Medicaid cuts, because they share three risk factors: They serve vulnerable communities, their finances are already fragile, and more than a quarter of their patients rely on Medicaid. Of those hospitals, 85 percent were in urban areas.

“Urban” hospitals here include any in a metropolitan area, including inner suburbs. Those in large, central metropolitan areas are disproportionately vulnerable, according to the analysis. Hospitals in such places make up just 18 percent of all hospitals in the country, but they represent half of the most at-risk ones.

In interviews, officials at these urban hospitals described scrambling to plan service cuts and hiring freezes and to shelve capital projects and basic repairs, even with most of the law’s Medicaid cuts still a year or more away. Many will at minimum close departments, like obstetrics and behavioral health programs. Lurking behind the plans were the worst-case fears that hospitals could close.

At M.L.K., the hospital is preparing to lose 15 to 20 percent of its revenue. “There aren’t enough things for us to cut to make up for that loss,” said Dr. Elaine Batchlor, M.L.K.’s chief executive.

The most common surgical procedures performed at M.L.K. until recently were limb amputations — a reflection of the breadth and severity of diabetic wounds in the community. Then the hospital opened a wound care center to treat those patients, and the prevalence of amputations declined. That’s the kind of service the hospital might have to eliminate, Dr. Batchlor said.

Scripps Mercy Hospital in San Diego won’t be able to make renovations to meet a coming state deadline for hospitals to be able to remain fully operational after an earthquake. UMass Memorial Medical Center in Worcester, Mass., has already closed the state’s only drug detox program for adolescents. Bergen New Bridge Medical Center in New Jersey has paused plans for a new ambulatory care center. University Hospital in Newark expects to divert scarce resources to hire more financial counselors to help patients navigate the coming changes to Medicaid.

To help offset tax cuts primarily for the rich, the Republican legislation cuts Medicaid funding in numerous ways. It establishes a strict work requirement that is expected to push millions of poor Americans out of the program, and reduces funding streams that have enabled states to make direct payments to hospitals.

The changes, Republicans said, would reduce waste and fraud in the program. The bill “strengthens Medicaid for the people who actually need it and deserve it,” House Speaker Mike Johnson said this summer.

The debate over how these changes would affect rural hospitals prompted the Senate to add a special \$50 billion fund to support rural health systems. State applications for the first round of Rural Health Transformation Grants were just submitted this month. There is no such cushion for urban hospitals.

The Harvard analysis doesn’t identify every hospital at risk from cuts, because the changes are far-reaching and will vary by state. Rural hospitals are still vulnerable, and their closures can have ripple effects on their remote communities. But many have also benefited from previous rounds of congressional concern that have resulted in extra federal funding.

And while some urban hospitals have thrived financially, those hospitals tend to treat more affluent communities, can charge high prices, and can focus on the most profitable types of care, like orthopedic surgery and cancer treatment. The hospitals identified in the Harvard analysis are different — their deep exposure to Medicaid means their businesses have been built around serving poor populations on thinner

margins. These hospitals also frequently serve patients who are Black, Hispanic or immigrants.

“It’s going to be profound,” said Thomas Tsai, a surgeon at Brigham and Women’s Hospital in Boston and an associate professor of health policy at Harvard, who led the analysis. “There will be an acceleration of hospital closures, or at least acquisitions with hospitals changing hands. And the worry I have is that patients are sort of left in the middle.”

Closure is not just a hypothetical scenario for M.L.K. The hospital reopened in 2015 as a public-private partnership after a struggling county hospital at the site closed in 2007. In the intervening years without a hospital, studies documented that residents of South Los Angeles experienced longer delays in care and more challenges seeing a specialist. Nearby hospitals saw more trauma admissions and uninsured patients. And the chance of death for victims of gunshot wounds increased.

“No one is shielded from this,” said Renee Hsia, a professor of emergency medicine and health policy at the University of California, San Francisco, who has studied M.L.K. and stresses on other hospitals. She’s also an emergency room doctor at San Francisco General Hospital — another urban safety-net hospital on Harvard’s list.

Researchers like Dr. Hsia have found patterns in the kinds of services that typically disappear when finances get tight. Hospitals tend to close departments that are expensive to run, even if they are critical to the communities they serve, like emergency departments, trauma services, obstetrics and behavioral health.

Those losses can affect whole communities, not just the particular patients who rely on Medicaid; patients with private insurance will also lose access to services that shut down. And the costs of health insurance could go up as hospitals try to squeeze more dollars from the patients who are still paying, hospital executives said.

“Anybody who thinks that they are not going to be impacted by this is crazy,” said Eric Dickson, the chief executive of UMass Memorial Health. “I don’t care who you are, your premiums are going to go up. And when you end up in an emergency department — and everyone’s going to end up in an emergency department eventually — they will wait longer.”

Safety-net hospitals also often specialize in services that other hospitals neglect. They are more likely to employ social workers to sign up patients for social welfare programs, to host food banks, and to arrange transportation to visits.

“There’s a value to keeping a vibrant safety-net system in place that sometimes serves communities in ways that communities can’t even imagine,” said Charlie Shields, the chief executive of University Health in Kansas City, Mo.

Diana Thomas, 57, has been a regular patient at University Health for more than 40 years. She has limited sight and relies on the hospital's transportation services and a social worker on staff to help her schedule appointments, make it to the hospital and access her medication.

Staffers help her in ways that would be hard to replace. "I have to trust other people with my vision," she said.

Safety-net hospitals also tend to have experts in medical services that richer populations need less often. Just as Los Angeles's other hospitals weren't as effective at saving gunshot victims when M.L.K. closed, richer hospitals are less likely to have experience treating diabetic wounds or abscesses among injection-drug users, or managing patients with H.I.V.

And safety-net hospitals frequently provide statewide services. More than half the doctors in Minnesota have trained at Hennepin County Medical Center in Minneapolis, and the hospital runs the state's poison-control services. In Newark, University Hospital provides the flight paramedics and nurses for the state emergency helicopter response program that covers all of New Jersey.

As the Republican bill was nearing its Senate vote in July, Senator Ed Markey, Democrat of Massachusetts, asked researchers at the University of North Carolina to prepare a list of rural hospitals at highest risk of closure.

"The rural hospital report was crucial to show Republicans they were hurting their own people," Mr. Markey said, "but we knew that rural hospitals were only the tip of the iceberg."

Some of the challenges faced by the two types of hospitals are similar, including health disparities their poorer patients experience.

"Our stories are the exact same," said Holly Mitchell, an L.A. County Supervisor who has been an advocate for M.L.K. "The difference in my humble opinion at the federal level is red state, blue state, and this notion of who goes to an urban hospital."

In California, M.L.K. is already on a state list of distressed hospitals, and it relies on infusions of support from state and local government to keep going. Its emergency room is so overburdened that providers now also see patients in tents outside its front door. Dr. Batchlor said the organization's financial planning is often made month to month. But, for now, Medicaid and state funds help keep it solvent.

When that money starts to dwindle, she will need to make harder choices.

"We know what's coming," she said. "We just don't know how fast."

Sources

The analysis identifying the characteristics of hospitals that are at the highest risk from Medicaid cuts comes from a team of researchers: Thomas C. Tsai, Brigham and Women's Hospital, Harvard T.H. Chan School of Public Health, and American College of Surgeons; Jessica Phelan, Harvard T.H. Chan School of Public Health; Samuel J. Enumah, University of Rochester Medical Center; and Jose F. Figueroa and E. John Orav, Brigham and Women's Hospital and Harvard T.H. Chan School of Public Health.

The researchers collected data on 4,412 general acute care hospitals for 2021-23 from the American Hospital Association Annual Survey, Medicare Healthcare Cost Report Information System, the Agency for Healthcare Research and Quality Compendium, and the Private Equity Stakeholder Project.

Definitions

Counties were considered rural or urban based on the U.S.D.A. Economic Research Service's Rural-Urban Commuting Area (RUCA) codes.

Safety-net hospitals are defined as those in the top quartile of the federal "disproportionate share" measure, which accounts for the number of poor and disabled patients it treats. Critical access hospitals represent a selection of rural hospitals that meet certain criteria by the Centers for Medicare and Medicaid Services.

Financial distress levels were calculated based on a modified version of the Altman-Z score, which combines measures of hospital liquidity, profitability, financial efficiency and solvency to identify hospitals at high risk for bankruptcy. Hospitals that scored less than 1.8 were considered financially distressed.

High Medicaid payer mix was defined as a hospital with more than 25 percent of admitted patients with Medicaid