Another Look at Hospital Finances

Is Medical Assistance Really the Villain?

PHC4 recently issued *Financial Analysis 2000, Volume 1*. This in-depth report covered the financial health of Pennsylvania's general acute care hospitals, on a hospital-by-hospital basis, using hospital-provided data, and was made available for public review. The report notes that hospital income statewide has increased for the first time since 1995. In the report, and in comments to the media, PHC4 indicated that while this finding was good news for hospitals overall, "*a significant number of individual hospitals continue to struggle*."

There have been a number of salient responses to this report from interested parties. In the context of these responses, we offer the following observations:

- The hospital industry is not yet financially healthy, and the statewide hospital operating margin is still too low.
- The cost of uncompensated care continues to grow.
- More hospitals had negative three-year average total margins for the fiscal years 1998-2000, than for the fiscal years 1997-1999.

Noting these concerns about the hospital industry, we observe that media reports have pointed out that managed care systems are struggling while hospital finances are improving. For example, a *New York Times* article headlined "Medical Costs Surge..." (May 25, 2001) contains this opening sentence: "Many hospitals are winning higher payments from insurers..." This sets the tone for an article that clearly suggests that nationally hospital finances are improving.

One commenter indicated that three out of four PA hospitals (75 percent) lost money in FY 2000 on patient care. PHC4 data, from our FY 2000 *Hospital Financial Analysis* (pages 34-47) shows that operating margins (OM) were negative for 84 of 190 reporting hospitals (44 percent). Admittedly, gain or loss on "patient care" is not precisely synonymous with operating margin, but most observers suggest that OM is a good reflection of income derived from patient care. Because the data comes directly from audited hospital financial reports, we are confident it is a reliable indicator of hospital margins. *While we think 75 percent overstates the problem, 44 percent of hospitals with negative operating margins is still a troubling figure*.

We have heard one viewpoint that part of the improvement in hospital income is attributable to increased Medicare payments passed by Congress in 1999. Others suggest there are other reasons for gains in hospital income, such as improvements in income from investments and other non-operating income, as well as the documented increase in commercial reimbursements. In fact, hospital data shows that Medicare reimbursements remained relatively constant during FY 2000; the small decline in Medicare hospital revenue for FY 2000 was due to a decrease in utilization not a change in Medicare reimbursement rates. Many aspects of the Congressionally approved Balanced Budget Act could still have a negative impact on the financial picture of acute care hospitals during the next several years.

Medical Assistance

Because we received some questions about Medical Assistance (MA) reimbursements to hospitals, we have looked to see if our data might illuminate some of the MA issues.

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This paper is provided as a public service by the Pennsylvania Health Care Cost Containment Council. PHC4 is an independent agency of state government, which offers data and information to health care purchasers and consumers. Using our data, purchasers can make better-informed decisions on health care.

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First, as we noted in our Hospital Financial Analysis Preview (chart - page 3), 67 percent of the "change in statewide net patient revenue" came from commercial insurers – using "purchaser" (business and labor) dollars. These payments by purchasers to hospitals are increasing. Only 8.9 percent of the change in net patient revenue came from MA payments.

A study performed by Lewin Associates concludes that MA reimbursements in Pennsylvania are inadequate. The Lewin study appears to assume that costs per patient are the same for all payors. While some of the methodologies of the Lewin study are documented, the Lewin study apparently did not investigate whether the cost to treat MA patients is different from the average cost for all patients treated in PA hospitals. As a result it is difficult to draw conclusions about the adequacy of MA reimbursement levels in PA from this data.

The Lewin study also appears to assign to the MA program hospital expenses for activities not associated with patient care and expenses for care not covered by the MA program. For example, in a March 12, 2001 letter to the Legislative Budget and Finance Committee, Welfare Secretary Feather Houstoun said her department's discussions with Lewin revealed that Lewin "considers it is possible that up to 10 percent of the total hospital costs in the American Hospital Association database (used by Lewin) are related to items that MA considers unallowable for reimbursement purposes." Examples of these "unallowable costs used in the (MA) Payment Analysis," her letter said, would be "costs for lobbying, fundraising, patient telephone and television expenses, gift shops, public cafeterias, and corporate advertising." If accurate, this observation might "have a material effect on the calculated 'coverage of costs' by MA," her letter said.

MA and disproportionate share payments

Hospitals receive additional Commonwealth funds when a disproportionate share of their patient population consists of low-income individuals, typically MA patients. For example, PHC4 data shows that the 20 hospitals which treat the largest percentage of MA patients received an additional $103 million in special grants and allowances from the Department of Public Welfare in fiscal year 1999-2000.

Interestingly, 12 of the 20 hospitals with the largest percentage of MA Outpatient visits in the Commonwealth had positive total margins in 2001, and 13 of the 20 hospitals with the largest percentage of MA inpatient discharges had positive total margins. These numbers indicate to us that treating large MA populations at current MA reimbursement levels does not, in and of itself, lead a hospital to negative operating or total margins.

Hospital efficiency is independent of MA funding adequacy

Hospitals have an obligation to deliver quality care in the most effective, efficient manner possible and many hospital administrators excel at this. Sometimes this will mean making hard choices about how to manage non-performing resources. Those who manage hospitals that struggle financially might benefit from a hard look at how others provide quality care while still minimizing expenses. The Lewin Group's report cited Pennsylvania as having the second most efficient group of hospitals in the country. While that may be true, it is important to note that the study included only Medicare (over 65 years of age) data and does not relate well to the issue of whether the state's Medical Assistance program is adequately reimbursing Pennsylvania hospitals.

PHC4 looks forward to an ongoing dialogue about the cost and quality of hospital care in Pennsylvania. These are important issues. Hospitals need adequate reimbursement. Purchasers and consumers of health care deserve nothing less than the best quality treatment available, and at a cost that is reasonable and affordable. In this dramatically shifting health care marketplace, as health insurance costs begin to escalate in a manner reminiscent of the early 1980s, we urge hospital management to continue with us as partners in an effort to fully identify, analyze and report hospital costs, revenues and treatment results.

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