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WHO SAYS TEACHING HOSPITALS ARE "THRIVING"?

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Gerard Anderson, et al., in a recent commentary published in *Health Affairs* (March/April 1999), concluded that "despite dire predictions, America's teaching hospitals appear to be thriving".[1] This outdated conclusion, based largely on data from 1995, is dangerously optimistic and belies mounting evidence that documents the significant financial stress now facing teaching hospitals around the country. An analysis of more current information by the Association of American Medical Colleges (AAMC) provides quite a different view of the financial health of major teaching hospitals.

Total margin is an important financial performance measure that reflects total hospital revenues and costs associated with all inpatient, outpatient and non-patient care activities. The Medicare Payment Advisory Commission (MedPAC), and its predecessor, has reported every year since at least 1984 that major teaching hospitals (defined as those that have 25 or more residents for every 100 beds) have had the lowest total margins. In 1996, the total margin for major teaching hospitals was approximately half that of non-teaching hospitals, 3.6 percent compared to 7.0 percent. In fact, major teaching hospital total margin performance in 1996 represents a decline from 1995, when the total margin was 4.0 percent. Even in 1995 -- the year studied by Anderson, et al. -- one-fifth of major teaching hospitals had *negative* total margins.

Preliminary MedPAC 1997 data for a small subset of major teaching hospitals suggest that total margins may have increased for these institutions between 1996 and 1997. One factor potentially contributing to this apparent improvement is an increase in investment income, a patently unreliable revenue source on which to base an institution's long-term financial stability. Another likely factor contributing to this apparent improvement is the success teaching hospitals have had in reducing costs in response to diminishing revenues. In the 1990s, major teaching hospitals, as was true of virtually all hospitals, achieved remarkable reductions in average Medicare inpatient operating costs per case.[2] Whether teaching hospitals can continue to reduce their costs, without endangering their critical societal missions, is a legitimate and worrisome question.

While in recent years teaching hospitals may have managed to maintain relatively stable, albeit low, margins this situation may be short lived. The disproportionately adverse impact of the Balanced Budget Act of 1997 (BBA) renders the already uncertain future of teaching hospitals even more problematic. The BBA reduces teaching hospital PPS standardized payment amount increases, capital payments, and the level of

[1] "Academic Health Centers: Exploring a Financial Paradox," *Health Affairs*, March/April 1999.

[2] According to a December 1998 MedPAC Commission presentation, annual changes in Medicare inpatient operating costs per case between 1993 and 1997 for major teaching hospitals averaged -0.7 percent; for other teaching hospitals, -0.4 percent; and for nonteaching hospitals, -0.5 percent.

disproportionate share payments. In addition, the BBA reduces indirect medical education payments by a whopping 28.6 percent between 1998 and 2001. The AAMC projects that Medicare reductions alone could result in the total margin for a typical member teaching hospital falling by as much as half or more by 2002, with one-third of AAMC-member hospitals facing negative total margins in three years. As disturbing as these projections are, an even bleaker picture emerges when one considers the likelihood that private payers and/or Medicaid will continue to reduce their payments as well.

Supporters of the BBA's Medicare reductions contend these funding cuts are warranted because of teaching hospitals' higher Medicare inpatient margins. Focusing on inpatient margins, of course, illuminates only one portion of a teaching hospital's total Medicare activity. Teaching hospitals, as well as other hospitals, provide services beyond inpatient care to Medicare beneficiaries, and when they do, they frequently lose money. For example, in 1996, Medicare payments covered only 84 percent of major teaching hospitals' outpatient service costs. To make matters worse, the discrepancy between costs and revenues for hospital outpatient services to Medicare beneficiaries is about to worsen with the scheduled implementation of the outpatient prospective payment system, yet another feature of the BBA. MedPAC estimates that outpatient payments for major teaching hospitals will fall to 70 percent of costs when this change goes into effect sometime next year.

Clearly, a hospital's financial performance under the Medicare program cannot be gauged adequately by focusing only on Medicare inpatient services; *all* services provided by the institution to Medicare beneficiaries must be considered. MedPAC's July 1998 Data Book includes overall Medicare hospital payment-to-cost ratios for 1996 based on data from the American Hospital Association. The data show that overall Medicare margins are substantially lower than the corresponding *inpatient margins* for these same hospitals.

The AAMC believes that fully informed judgments about the financial performance of hospitals should rest on a foundation of ongoing, independent analyses (by MedPAC or other appropriate entity) of the institutional costs incurred in providing *all* Medicare services. Such analyses of financial performance should take into account all categories of payers and also assess financial variables beyond operating and total margins.

Is the academic medicine community crying wolf? Recent press reports heralding a worsening of financial stress at institutions around the country suggest not. Here is a sampling:

- Detroit Medical Center--1998 losses of $100 million with 2,000 full-time positions cut in January 1999 ("Medical Center Bond Rating Slips," *Detroit Free Press*, 2/12/99; "Wayne State's Links to DMC Examined," *Detroit Free Press*, 1/23/99).
- Georgetown University Hospital--1998 losses of $62.4 million ("GU Medical Center Loses $62.4 Million; Deficit Results in Lower Credit Rating," *Washington Post*, 1/7/99)
- UCSF-Stanford--1999 first quarter losses of $10.7 million ("UCSF-Stanford Announces $170 Million Budget Balancing Plan" UCSF-Stanford press release, 3/30/99).

- Henry Ford Health System (Detroit)--1998 losses of $43.8 million and plans to reduce workforce by 425 by May 1, 1999 ("Ford Health System Plans More Layoffs," *Detroit Free Press*, 3/24/99).
- Massachusetts General Hospital (Boston)--1999 first quarter losses of nearly $5 million with plans to eliminate 130 positions ("MGH Will Cut 130 Jobs, Raise Prices," *Boston Globe*, 3/20/99).
- Lifespan Hospital Network (Providence)--1998 losses of $50.2 million, with 506 positions eliminated in March 1999 ("Lifespan Slashes 506 Positions; Officials Blame Reduced Medicare and Private Insurance Payments," *Providence Journal*, 3/25/99).
- Mercy Health Services (Detroit)--Losses in the first eight months of fiscal year 1999 total $6.9 million, with plans to cut 1,350 full-time positions by July 1999 ("Mercy Health Services will Slash 1,350 Jobs by July," *Detroit Free Press*, 3/31/99).
- Beth Israel Deaconess Medical Center (Boston)--1999 first quarter losses of $16.7 million ("Medicare Cuts Blamed for Woes in First Quarter," *Boston Globe*, 3/19/99).
- Brigham and Women's Hospital (Boston)--1999 first quarter losses of $3.5 million ("Medicare Cuts Blamed for Woes in First Quarter," *Boston Globe*, 3/19/99).
- University of Massachusetts Medical Center (Worcester)--1999 first quarter losses of $6.6 million ("Medicare Cuts Blamed for Woes in First Quarter," *Boston Globe*, 3/19/99).
- University of Illinois at Chicago Medical Center--Losses of $8 million in the first half of fiscal year 1999, with plans to eliminate more than 250 positions by May 1999 (UIC Medical Center Eliminating 250 Jobs," *Chicago Tribune*, 3/9/99).

The AAMC believes that everyone, including Medicare beneficiaries, benefits from the invaluable societal contributions made by teaching hospitals. These contributions include the training of physicians and other health care professionals, sustaining the supportive environment essential for research advances, maintaining key standby and special services, and providing care for the uninsured. The BBA reductions, combined with decreasing payments from private payers and Medicaid programs, will surely make it more difficult for teaching hospitals to meet society's expectations for fulfilling these special missions. Unfortunately, Medicare is the only consistent, national payer that explicitly pays its share of these costs. The AAMC, and many others, have advocated that a funding mechanism be established whereby all other payers of heath care services would be required to follow Medicare's model and pay their fair share of the costs teaching hospitals incur in fulfilling their special societal missions.

All aspects of the health care industry are changing more rapidly than current methods of data collection and analysis can keep pace with. As emerging trends demonstrate, teaching hospitals have unique vulnerabilities in today's highly competitive environment and are increasingly sensitive to changes in Medicare's payment policies. The BBA is nearing the midway point of its implementation. Its early impact is no longer hypothetical; it is subject to analysis. The AAMC advocates that policymakers do such an analysis immediately, with special emphasis on the BBA's impact to date on teaching hospitals. We believe this analysis will reveal the need to make significant policy corrections *today* to ensure that the vital contributions provided by teaching hospitals will be there *tomorrow*.