AAMC

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AMERICAN
MEDICAL COLLEGES

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COTH REPORT

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Special Report: Teaching Hospitals and Uncompensated Care

COTH Line: Bad Debt and Charity Care

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COTH Holds Session at AAMC Annual Meeting

On October 30, the Council of Teaching Hospitals held a business meeting and program session during the AAMC's 100th annual meeting. At the business meeting, new COTH board officers were elected (entire board listing follows).

The program session, "The Canadian Healthcare System: Implications for COTH Hospitals," featured two speakers well-versed on the topic. Leading off was W. Vickery Stoughton, an American who, after working for a number of years in various Boston hospitals, is now CEO of the Toronto Hospital in Ontario. He presented an overview of the Canadian system, noting that universal access to healthcare, government financing, and lower costs distinguish it from the U.S. system. He then went on to discuss some of the main hospital-related differences between the two systems. For example, Canadian hospitals are administered by global budgeting—the provincial health minister approves annual inflation-adjusted budgets for each year (base year 1969) and the CEO must accept and work within this budget. Capital expenditures are not included in the budget but are individually approved—and financed—by the provincial health minister. Consequently, capital improvements are tightly controlled and advances in technology are limited to a few facilities. While this is a major cost control strategy, it has also meant that some technologies are not spread quickly and that patients must wait to obtain services. Nevertheless, according to Stoughton, Canadians live longer than their U.S. counterparts, have lower fetal death rates, and have better health status.

In Canada, unlike the U.S., Stoughton stated, hospitals do not close. The scope of Canadian hospitals is restricted and limited, and hospitals do not compete for patients. In addition, the capital payment policy has encouraged Canadian hospitals to add ambulatory services, in contrast to the U.S. where these services are now largely offered in non-hospital settings such as surgi-centers and imaging centers. Canadians view providing ambulatory services in a controlled environment as the best way to control quality and costs and to impose accountability. However, Stoughton indicated that despite the growth of ambulatory services, overuse of hospitals exists. Patients are hospitalized to obtain access to technology and physicians are paid faster if their patients are hospitals.

Stoughton concluded that in order for the U.S. to reform its health care system, it must decide on an objective—cost control, access, or competition—development of a system to meet that objective would then follow. He doesn't necessarily suggest that the U.S. adopt the Canadian system. Although Canada has shown that it can provide universal access at lower costs, there are trade-offs—limited access to technology, occasional rationing, and inappropriate waiting times. Nevertheless, he believes that despite its flaws, the Canadian system outshines all others.

Gerard Burrow, MD, now Dean of the Medical School at the University of California in San Francisco, spent 12 years as the Chairman of Internal Medicine at the University of Toronto and the Toronto Hospital. He discussed some of the pressures and difficulties he encountered in that role. For example, because of global budgeting, resources are concentrated in the CEO's office. In

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order to develop new programs, a chairman has to work closely with the CEO which necessitates having a good relationship with the CEO. However, the CEO and chairman frequently have different objectives—for instance, while the CEO feels pressure not to admit sick patients because they use up the global budget, the chairman and other physicians earn their income by admitting patients—and this causes tension.

Another pressure Burrow encountered related to residents who, in Canada, are financed by the government. To reduce the healthcare budget, the provincial health minister can reduce the number of residency slots. This means fewer physicians than a chairman had anticipated. Burrows stated that in 1987, he lost 60 internal medicine residency positions.

While Dr. Burrow felt that Canadians received better health care and at a lower cost than in the U.S., he also felt there were a number of problems, and in particular, that there needs to be some way to put the physician provider at risk. Currently, although physician fees are set by the government, there is no way to regulate volume. As long as volume can be driven by physicians, they have no motivation to control costs. Also, while free access to care is a cornerstone of the system, he felt the process would work better with some minimal deterrent fee. Some recognition of physician quality is also needed. He concluded by stating that in the U.S., teaching hospitals should take an active role in educating the public as to the dimensions of the health care crisis and develop some solutions.

The 1990 AAMC annual meeting will be October 19-25 at the San Francisco Hilton Hotel.

(Audiocassette tapes of the COTH program session and many other annual meeting sessions are available by calling InfoMedix at 800-367-9286.) ■

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COTH Chair Final Address

Gary Gambuti, outgoing COTH Chair, completed his year in office by presenting the following address at the October 30 business meeting:

As I conclude my term as COTH Chair, I am delighted to have this opportunity to speak with you. The year has been a good one, marked internally by the adoption of a strategic plan for the AAMC and externally by our strong advocacy for and defense of Medicare's indirect medical education adjustment. Members of Congress have heard our concerns and responded. As a result, the adjustment is not the easy source of budget savings some observers had predicted. We will continue to defend your need for adequate payment and will continue to ask for your help with your Congressional delegation.

This afternoon, I wish to focus my comments on two topics: (1) the role of affiliated, community hospitals in the AAMC, and (2) the importance of taking significant positions in the difficult era before us. Last fall, a rumor began circulating among the affiliated hospital members of COTH: the CEO of an affiliated hospital had become

Teaching Hospitals and Uncompensated Care

On October 24, the U.S. Commission on Comprehensive Health Care (see *COTH Report*, vol. 23, no. 4, September/ October 1989) held a hearing in Washington and requested that the AAMC submit a statement regarding teaching hospitals and the provision of uncompensated care. The following report contains the essence of that testimony.

As major providers of health care services to the uninsured, the underinsured, and Medicaid recipients, teaching hospitals are acutely aware of the financial and other problems associated with the provision of uncompensated care. Teaching hospitals are increasingly concerned about their ability to finance the existing level of uncompensated care, let alone any increases that will be required in the future if the number of uninsured and underinsured individuals continues to grow. This report will focus on the costs and consequences of uncompensated care—the effects felt by teaching hospitals in caring for the medically indigent, both uninsured and underinsured.

Definitions

—Individuals who are **uninsured** have no health insurance at all, neither public nor private.

—Individuals who are **underinsured** have public and/or private health insurance that is inadequate in terms of depth or breadth: the insurance program may include uncovered services, service limitations, or heavy cost sharing, any or all of which result in individuals having out-of-pocket expenses which are too high in relations to their income.

—**Charity care** is care provided to individuals who are unable to pay.

—**Bad debt** results from providing services to patients from whom payment is possible but not made.

—**Uncompensated care** is the amount of free care provided by a hospital and is the total of bad debt and charity care.[1]

—**Unsponsored care** is uncompensated care minus any offsetting state or local tax appropriations.

Teaching Hospitals and the Provision of Uncompensated Care

Knowledgeable health care providers are aware that the problem of the uninsured is significant, but perhaps none are more aware than teaching hospitals. The number of uninsured individuals increased from 30 million in 1980 to 36.8 million in 1986, although recent statistics suggest this number is now closer to 31 million. Most have very modest incomes, but are in families exceeding the federal poverty threshold for their family size, thus not qualifying for Medicaid.[2] Moreover, the majority of the uninsured are employed, but work in jobs where health care coverage is not provided.

Major amounts of uncompensated care are provided by this nation's hospitals. In 1980, hospitals provided a total of $1.3 billion in charity care and deducted $3.3 billion in bad debt. This compared to $3.5 billion in charity care and $6.8 billion in bad debt in 1987. Of the 1987 amounts, the 309 non-federal members of the AAMC's Council of Teaching Hospitals that responded to the AHA Annual Survey[3]—and which account for 7.5% of all non-federal short-term hospitals in the United States that responded to the survey—provided 59% of all charity care, or $2.1 billion, an amount that has more than tripled since 1980. In 1987, these hospitals also deducted $2.3 billion in bad debt. These figures indicate that teaching hospitals, and particularly members of COTH, provide a very substantial portion of care provided to the uninsured and underinsured.

While the provision of some uncompensated care by teaching hospitals is nearly universal, the amount varies across hospitals. Higher levels of uncompensated care occur in areas with a poorer population and poorer economic conditions—usually large urban areas. It is in these areas—locations with over a million population—that about half of COTH members are located. In turn, some of these hospitals, along with urban public hospitals not belonging to COTH, provide a disproportionate share of uncompensated care. For example, in 1987, municipal COTH hospitals, a small group of hospitals numbering less than 40, accounted for 3% of total net patient revenues, but furnished 28% of all charity care provided by U.S. hospitals.

The point here is that many people have the mistaken impression that the terms "teaching hospital" and "charity care hospital" are synonymous and that all teaching hospitals are in essence charity care hospitals. However, that is not the case—as indicated above, not every teaching hospital provides a vast amount of charity care. For example, a Florida study of teaching hospitals found that the charity care burden as a percent of gross revenues in these hospitals varied from 4.6% to 13.7%. One hospital, with 100 residents, had a 12.5% charity care burden, while another, with 126 residents, had a 4.6% burden. According to the study, the critical factors in determining the share of charity care were location and location-related factors such as wage mix and payer mix. As a general rule, however, a hospital with a large charity care load is likely to be a teaching hospital, but not all teaching hospitals have large charity care loads.

This is not to say that the existence of teaching programs—medical education—within a hospital is not an important factor in the provision of charity care. To the contrary, because of medical education programs, the hospital has salaried residents and in some cases supervising faculty able to provide medical services without fee-for-service payments. For poor patients, the resident becomes the primary source of physician services. However, this confounds the uncompensated care issue with respect to teaching

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hospitals in two ways. First, expenses for residents and supervising physicians are categorized as educational costs, even though they are also supporting physician services to poor patients. Second, while the hospital incurs these added costs, it is not credited with the savings that result from the absence of a fee-for-service physician. This is particularly important to remember when comparing teaching hospital and non-teaching hospital costs. The overlap of the educational and charity care issues is extensive because many teaching hospitals, located in urban centers, have established large clinics and primary care services to meet neighborhood needs. Their programs for burn, trauma, high risk maternity, substance abuse, and intensive psychiatric care, and the presence of advanced technology, attract patients having acute medical needs but unable to pay for their care.

Some critics assert that teaching hospitals **need** charity care patients in order to provide comprehensive medical education and that therefore the issues of charity care and medical education are inextricably linked. This view is true in part because of the number and variety of cases needed to carry out a broad educational curriculum, and because the poor often present cases in the more advanced stages of illness and with greater medical complexity. However, it is also true that this view reflects the historical fact that many early graduate medical education programs developed in municipal hospitals and in charity care wards of voluntary hospitals where the need by educational programs for patients complemented the need by hospitals for physicians. While today a number of educational programs are still located in hospitals and wards that serve a large number of charity care patients, many other programs are conducted in community hospitals that serve only a small number of these patients.

It should be noted that the VA health care system also serves an important role in the provision of uncompensated care by serving the health care needs of veterans who are uninsured and underinsured. Currently there are 172 VA medical centers—132 of which are affiliated with medical schools and are considered teaching hospitals. By law, 13 million veterans have categorical entitlement to VA hospital care.[1] A recent report indicated that about 12% of all veterans had no insurance at all, but even more importantly, 45% of veterans hospitalized in VA hospitals lacked insurance of any type. Another 21% of veterans hospitalized in VA hospitals have nonprivate insurance—Medicare, Medicaid, or military (CHAMPUS and CHAMPVA)—thus having the potential to be underinsured. Since significant numbers of veterans using VA hospitals are uninsured and underinsured, the role of the VA in providing uncompensated care—and in reducing the burden of providing uncompensated care on other hospitals—must also be understood and included when addressing the uncompensated care issue.

Medicaid

In addition to providing a substantial amount of charity care, teaching hospitals also provide care to many underinsured individuals, especially Medicaid recipients. Medicaid, enacted in 1965 to provide access to health care to the poor, is in 1989 utilized by only 40% of this country's poor, down from 53% 10 years ago. Cuts in the program over the past 8 years have totaled $4 billion, and while there have been some recent improvements in the program, they restored only 10% of what was cut. Benefits and eligibility vary from state to state, so that accessibility to health care for low-income individuals largely depends on state of residence. Moreover, because Medicaid is a means-tested program and eligibility is dependent on enrollment in either the Aid to Families with Dependent Children program or the Supplemental Security Income program, individuals may suddenly find themselves without Medicaid should they no longer qualify for either of these programs. States also vary in the extent to which they have implemented optional programs for the medically needy.

Teaching hospitals are acutely aware of the problems associated with Medicaid. In 1987, COTH members accounted for 23% of all patient discharges but 34% of all Medicaid discharges. In addition, in 1987, COTH hospitals reported $7.6 billion in Medicaid gross patient revenues or 45% of that reported by all hospitals; 14% of all COTH hospitals gross patient revenues came from Medicaid, compared to 7% of non-teaching hospital revenues.

Medicaid reimbursement rates for many providers are low. A 1985 survey by the American Hospital Association comparing Medicaid per diem payments with per diem expenses found that Medicaid as a percentage of actual expenses ranged from 46.1% to 127%, with 32 of 42 respondents below 100%. This underreimbursement often works as a disincentive for many providers to accept Medicaid recipients.

Consequences of Uncompensated Care

Both hospitals and patients suffer because of uncompensated care. Because of the lack of insurance or underinsurance, individuals either may fail to seek needed care or wait until a condition has progressed to an advanced and more serious state to seek care. These individuals rarely have a personal physician and there is no continuity of care, often no follow-up or aftercare. Moreover, most of the uninsured use hospitals as their regular source of care, relying on the hospital outpatient department or emergency room for treatment. A Fairfax County, Virginia study found that 21% of uninsured families used the hospital emergency room as their "normal site of care," compared to 3% of Medicaid and privately insured patients. That same report, in analyzing hospitalization rates for self-pay and privately insured patients for several conditions that should be preventable or controlled, found that the uninsured are three times as likely to be hospitalized for uncontrolled diabetes than the privately insured, and that they are more than two times as likely to be hospitalized for cervical cancer. An Indiana study of hospital charity care patients found preg-

nancy and childbirth, injury and poisonings, digestive system disorders, newborn aftercare, and mental disorders to be their primary diagnoses—a hospital emergency room is not the most appropriate site of treatment for the majority of these conditions and ailments. Finally, a recent article in the *Journal of the American Medical Association* indicated that in one California study, babies whose parents lacked health insurance were about 30% more likely to die at birth or be born seriously ill than insured babies. In sum, individuals' health and well-being suffer when they are not afforded regular and timely access to health care.

For teaching hospitals, uncompensated care losses are becoming a major component in the creation of financial distress—the combination of charity care and Medicaid "undercompensation" are having serious adverse effects on some teaching hospitals. In the past, teaching hospitals have generally provided care to all regardless of ability to pay. Uncompensated care was financed through "cost-shifting" (subsidizing charity care by increasing the prices charged to other patients), government subsidies, and philanthropy. However, changes in third-party reimbursement, reduced health care spending by federal, state, and local governments, and limits on health insurance coverage have combined to squeeze hospital revenues by increasing need for charity care but reducing the resources to finance it.

The increase in competition has also made it more difficult to shift costs. For example, hospitals may negotiate with insurers to provide "discounted rates," below standard charges, in order to be price-competitive and retain patients. This practice limits the hospitals' ability to generate extra revenue from paying patients. Moreover, teaching hospitals are already more expensive than non-teaching hospitals, putting them at a disadvantage before the burden of uncompensated care is even added. Financial losses from charity care and bad debt may be compounded if the hospital's Medicaid reimbursement is below actual care costs.

All these events—which are compounded by continuing federal efforts to reduce Medicare payments to teaching hospitals—have resulted in decreased revenues for teaching hospitals. According to an analysis done by the AAMC, 65 COTH academic medical center hospitals experienced a marked decline in their financial position in 1988, as measured by Medicare PPS margins[5] and total margins. In the early years of PPS, this group of hospitals experienced relatively high Medicare margins; however these dropped to 5.3 percent in 1988. While only two of the 55 reporting hospitals had negative margins in 1986, 19 of the 65 reporting 1988 data had margins of less than zero. The combination of a low update factor and a reduction in the indirect medical education adjustment from 8.1% to 7.7% will likely produce many more hospitals with Medicare margins near zero for 1989. Total margins for the 65 hospitals, which include revenues and costs from all patients and endowment and investment income, were in 1988 one-half of their 1986 level, falling from 6.2 percent in 1986 to 3.1 percent in 1988.

Reduced revenues produce financial stress on teaching hospitals, which must then find ways to ease the burden of uncompensated care. One way is to limit the amount of uncompensated care provided. Hospitals could achieve this by, for example, not accepting non-paying patients for non-emergency care, setting a fixed annual budget for uncompensated care, developing a priority system for nonemergency care, requiring a downpayment for elective admissions, or reducing hours or staffing for outpatient and emergency care. Teaching hospitals could also discontinue or reduce programs that traditionally draw a high volume of uncompensated care patients, such as substance abuse and social service programs. Teaching hospitals, however, because of their historic commitment to provide care to all, are reluctant to take any of these actions, but may be forced to in the near future. For example, on August 28, West Virginia University Hospitals in Morgantown began to ration care to the poor by setting a monthly quota for admissions of non-emergency charity care patients. By doing this, the hospital hopes to reduce its uncompensated care burden by $5 million. However, it means that 500 poor people will be turned away by the hospital each year.

Recommendations

Positive steps must be taken to increase the number of insured individuals. Two general approaches to help resolve the situation deserve attention. the *first* is the expansion of the Medicaid program to provide more services to a broader scope of individuals. For example, the Ad Hoc Committee on Medicaid of the Health Policy Agenda of the American People has developed recommendations to expand Medicaid that include a uniform national income eligibility standard and a standard benefit package. The *second* is mandated employer-provided insurance. Since most uninsured individuals are employed, mandated employment-based insurance would significantly decrease the problem of the insured. ■

—*Joanna Chusid*

NOTES

[1] Because hospitals vary substantially in how they classify patients as either bad debt or charity, the two measures have traditionally been combined into a single uncompensated care measure.

[2] Individuals are considered to be poor when their family's annual pretax cash income is below a federally predetermined poverty threshold. In 1988, for the 48 continental states and the District of Columbia, an individual with income below $5770 and a family of three with income below $9690 were considered poor.

[3] Except where otherwise noted, statistics in this report regarding COTH members are for non-federal members of COTH only.

[4] Category A includes veterans having a service-connected disability, regardless of age, as well as those meeting a strict income or means test. Category B veterans, whose income is above the Category A cut-off but falls below a second income standard, are eligible for care on the basis of available space.

[5] PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, and outlier payment) less Medicare inpatient operating costs, divided by PPS revenue.

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COTH Line —*Linda E. Fishman*

Bad Debt and Charity Deductions for Short-Term, Non-Federal Hospitals by Membership in the Council of Teaching Hospitals 1987

(Dollars in Billions)

	COTH Members		Non-COTH		Total	
	Number	Percent	Number	Percent	Number	Percent
Number of Hospitals*	309	7.5	3,788	92.5	4,097	100.0
Deductions for Charity Care	$ 2.1	58.7	$ 1.5	41.3	$ 3.5+	100.0
Deductions for Bad Debts	2.3	33.4	4.5	66.6	6.8	100.0
Total Net Patient Revenue	36.6	31.4	79.9	68.6	116.5	100.0
Charity Care and Bad Debt as a Percentage of Net Patient Revenue	4.3	11.9	6	7.5	10.3	8.9

* Based on 4,097 of 5,610 short-term, non-federal hospitals responding to the 1987 AHA Annual Survey. Approximately 73 percent of the respondents (N = 4,097) reported confidential financial data on charity and bad debt deductions. Net patient revenue data were adjusted to match the number of hospitals reporting charity and bad debt deductions.

+ Numbers may not add due to rounding.

SOURCE: AAMC calculations of data from the American Hospital Association, Annual Survey of Hospitals, 1987. (Support for data collection provided by The Commonwealth Fund of New York City.)

Major amounts of uncompensated care are provided by U.S. hospitals, but the uncompensated care burden of non-federal COTH members is disproportionately large. Based on 1987 data provided by 4097 short-term, non-federal U.S. hospitals (73 percent of all U.S. hospitals), COTH members (representing 7.5 percent of the respondents) incurred over $2 billion (59 percent) of the $3.5 billion charity care charges. COTH hospitals also accounted for $2.3 billion (33 percent) of the $6.8 billion total bad debt deductions. The average COTH member deducted 11.9 percent of revenues for uncompensated care; by comparison, the average community hospitals deduction was 7.5 percent. (It should be noted that the former figure was obtained by averaging a small number of COTH hospitals that provide a disproportionate share of charity care with a much larger number of COTH hospitals that provide charity care at levels similar to that provided by community hospitals.) ■

COTH chair. While this was not unprecedented — Stuart Marylander from Cedars-Sinai and Sid Lewine from Sinai of Cleveland had already been COTH chairs — it flew in the face of a common misconception. Namely, that the AAMC is primarily interested in the university-type hospital. This perception continues to exist in some quarters despite

- the fact that the current COTH Administrative Board includes three community hospital CEOs, a VA CEO, and a children's hospital CEO;
- the fact that the COTH delegation to the AAMC Assembly is almost evenly divided between CEOs from community, VA, and university hospitals; and
- the fact that COTH members on AAMC committees consistently include representatives of community and VA members.

My naiveté about the persistence of the inaccurate perception of university hospital dominance even led to a humorous event. Just after last year's Annual Meeting, a representative from a community hospital called to discuss his concern about an important issue facing academic medicine. As we were concluding the conversation, he asked how I was treated as the COTH CEO. Not appreciating the seriousness of his question I responded, "They make me sit outside the door and pass in notes." Unfortunately, the caller took my sarcastic comment at face value, and I quickly explained I was joking. Lest any of you share the caller's perception of COTH and the AAMC, I must report that the officers, staff, and Board members have considered the interests and problems of both university-type and community affiliated hospitals. As both a Board member and officer from a community hospital, my views have been actively sought and listened to on topics ranging from AIDS to accreditation and from physician supply to legislative strategy. Thus, I would advise anyone who holds the perception of bias to discard it and appreciate the community hospital's role as a full COTH member.

Earlier today in his plenary address, Spike Foreman observed that the community of academic medicine was concentrating on the micro issues and ignoring some of the macro issues. I share Spike's concern. Perhaps it is simply that we are both in New York State where new monies are scarce and regulatory intervention is plentiful. But I don't think we have a shared myopia. For forty years, the faculties, facilities, and finances of academic medicine, including teaching hospitals, have grown. In fact, we have become hooked on a growth psychology. That outlook doesn't fit the facts of unhappy payers and growing demands that accountability replace autonomy. Our roles in education, research, and charity and tertiary care depend on a public willingness to pay more than the minimum costs of their immediate care. The need for subsidies of our multiple missions is real.

To continue enjoying public support, we must be able to address difficult issues and take public positions on them. This can be difficult in a voluntary organization whose diverse governance of faculty, deans, and hospital CEOs works to attain consensus. Our discussions about a policy on resident hours revealed much anxiety, but our position helped many members reform their current practices and stave off burdensome regulation. Now, the GME accreditation community is following our lead. In the next few years, I believe the AAMC will have to make difficult decisions about policies concerning

- practice guidelines and standards;
- access to care and financing of the uninsured;
- the appropriate number and speciality mix of new physicians, especially the need for more primary care physicians;
- long-term financing for graduate medical education and high cost tertiary care services;
- the introduction and assessment of new technologies;,
- costly accreditation requirements of small educational value; and
- new tenure policies that reflect clinical and educational competence.

Some of these difficult issues are internal to academic medicine and its institutions; others involve interaction with the broader social and political environment. In both cases, the AAMC and COTH will have members with honestly held differences of view. But these differences must not paralyze the AAMC. The AAMC must protect and promote its member interests; but it also must protect and advance the societal functions of education, clinical research, and high quality patient care. If the AAMC successfully promotes these broad functions, there will be opportunities for members to prosper. To promote the broader functions, COTH must combine its present strength of consensus with a membership commitment to leadership positions, even if this temporarily disrupts the goal of consensus. To attain this leadership role, members must have loyalty and dedication to our common good rather than our individual advantage.

Thank you for your support during this past year. I have enjoyed the opportunity to serve you. ■

GME Update

At the fall interim meeting of the American Board of Medical Specialties, the following applications were approved:

—The American Board of Emergency Medicine to be a Primary Board;

—The American Board of Pathology to issue Special Qualifications in Pediatric Pathology;

—The American Board of Preventive Medicine to issue certificates of Added Qualifications in Underseas Medicine;

—The American Board of Family Medicine to issue certification of Added Qualifications in Sports Medicine; and

—The American Board of Psychiatry and Neurology to issue certificates of Added Qualifications in Geriatric Psychiatry. ■

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COGME Hears Report on Teaching Hospitals Financial Status

At a November 2 plenary session chaired by Neal A. Vanselow, MD, Chancellor of Tulane University, members of the Council on Graduate Medical Education (COGME) heard Robert A. Derzon of Lewin/ICF present findings of an analysis of teaching hospital financial status. The study was commissioned by COGME after its June meeting when Council members became concerned about the effect of federal and private payer reimbursement policies on teaching hospitals' willingness and ability to continue to participate in graduate medical education. One of COGME's Congressional charges is to make recommendations concerning changes in the financing of medical education programs.

The draft report describes teaching hospitals' past and present financial position using five measures of hospital financial performance: three measures from the hospital's operating statement (PPS margin, patient margin, total margin) and two measures from the hospital's balance sheet (current ratio and fixed asset financing ratio).

The researchers used Medicare Cost Report data to calculate PPS margins for the first four years of prospective payment (PPS-1 through PPS-4) and then projected hospitals' PPS margins for 1988-1990 (PPS-5 through PPS-7). One of the key assumptions of the payment model was an indirect medical education (IME) adjustment of 7.65 percent. The data showed that major teaching hospitals had higher PPS margins than other types of hospitals in each year since the beginning of PPS, but like all hospitals, PPS margins had fallen since the first year. By federal FY 1990, however, the authors predicted that major teaching hospitals would continue to show positive PPS margins, unlike other types of hospitals. Table 1 presents actual and projected PPS margins by teaching status.

The authors found that while teaching hospitals generally had higher PPS margins, their *total* margins (the net income or loss from all patients and hospital activities) were *lower* in the fourth-year of PPS than any other group of hospitals. This was particularly true for major teaching hospitals, and reflected, in part, the relatively large proportion of uncompensated care delivered by these institutions. The payment model did not project hospitals' total margins for PPS-5 through PPS-7. Table 2 below shows the relationship between hospitals' PPS margins and total margins.

Table 1

Medicare Actual and Projected PPS Margins by PPS Year by Teaching Status

	Actual				Projected		
	PPS Year 1	PPS Year 2	PPS Year 3	PPS Year 4	PPS Year 5	PPS Year 6	PPS Year 7
All Hospitals	14.7%	14.2%	9.6%	5.1%	2.8%	−0.2%	−6.3%
All Teaching	17.7	17.9	13.2	8.8	5.0	2.1	−3.9
Major Teaching	21.2	21.7	16.3	13.7	11.2	10.4	5.5
Minor Teaching	16.6	16.7	7.3	3.2	−0.2	−6.5	
Nonteaching	12.2	11.1	6.1	0.7	−2.5	−8.6	

Source: Lewin/ICF Payment Simulation Model.

Table 2

PPS Margins and Total Margins by Hospital Teaching Status PPS Year 4

	PPS Margin (Medicare PPS Patients Only)	Total Margin (All Patients & Hospital Activities)
All Hospitals	5.1%	3.5%
All Teaching	8.8	3.2
Major Teaching	13.7	1.8
Minor Teaching	7.3	3.8
Nonteaching	1.8	3.8

Source: Lewin/ICF Payment Simulation Model.

Additional analysis by hospital group showed that urban hospitals had much higher PPS margins than rural hospitals, although there was little difference in urban and rural total margins. Both PPS and total margins varied markedly by region and hospital ownership, and margins were, in general, higher for hospitals receiving disproportionate share payments.

The authors concluded that although teaching hospitals are experiencing growing financial pressure, they have been able to control cost per case as well or better than nonteaching hospitals. At the same time, teaching hospitals' case mix grew more rapidly than other types of hospitals. Finally, although occupancy rates have declined for the industry in general, they have increased for teaching hospitals, and because PPS pays hospitals on a per case basis, increases in volume are rewarded.

COGME participants also heard from health care providers, payers, and educators, in addition to the views of an economist and the Prospective Payment Assessment Commission (ProPac). Among the respondents was James D. Bentley, AAMC Vice President for Clinical Services, who emphasized that hospitals' total margins, not just Medicare PPS margins, should be examined in assessing the financial status of teaching hospitals. Dr. Bentley explained why teaching hospitals had unexpectedly high PPS margins in the early years of the payment system and observed that the Lewin/ICF "projections" of declining PPS margins (for years 1988-90) are the current circumstances of teaching hospitals.

Council members have requested additional analysis from Lewin/ICF and are tentatively planning an interim report to Congress after further discussion of this topic at the January 1990 meeting. ■

—Linda E. Fishman

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