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FEATURE STORY

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how long can hospitals survive with negative margins?

U.S. hospitals have for years offset negative margins on patient care with other sources of revenue, but it may be time for them to stop relying on these additional revenue sources.

AT A GLANCE

- A recent study has found that U.S. hospitals are apparently shifting the unreimbursed costs of caring for Medicare inpatients to other payers.
- So far, hospitals have found other sources of revenue to offset negative margins from patient care, but how much longer they can continue to do so is uncertain.
- The number of states in which hospitals were enjoying positive Medicare margins was found to have dropped from 44 to 13 during the study period.

A recent study using Medicare cost report data to analyze short-term acute care hospital margins has found that U.S. hospitals' margins from Medicare inpatient services declined steeply from federal fiscal years (FFYs) 2001 through 2008. Meanwhile, the study found, overall margins from patient care remained relatively stable, allowing hospitals to achieve positive net income from all sources during the same period.

In addition to examining these margins, the study analyzed the main components of Medicare payments and costs to assess the degree to which Medicare payment policies versus hospital operational efficiencies are contributing to the decline in Medicare margins.

Medicare inpatient margin percentages eroded from a healthy 11.0 percent in FFY01 to an unhealthy and worrisome –3.6 percent in FFY08. Yet during the same period, total patient service margin percentages improved from –2.7 percent in FFY01 to –1.3 percent in FFY08. These trends suggest several significant issues, discussed below.

Cost Shifting

For FFY05 through FFY08, the average annual increase in Medicare payments to hospitals under the inpatient prospective payment system (IPPS) declined to the point that the payments no longer cover the average annual increase in the costs of providing care to Medicare inpatients. During that same time, however, total patient service margin percentages remained relatively stable. These findings indicate that payers other than Medicare are subsidizing the unreimbursed costs of caring for Medicare inpatients. Although a certain degree of cost-shifting from Medicare to other payers has been suspected in the past, these trends indicate that the pattern has become more pronounced.

If these trends continue, the impetus to cost-shift will only increase. At the same time, hospitals will likely see their ability to cost-shift become more restricted as payers and policymakers react to the pressures of healthcare reform. Policymakers and working Americans do not seem to understand how the failure of federal programs to adequately compensate hospitals for treating a growing Medicare population has contributed to the escalating costs of commercial insurance and health care.

Maintaining Alternative Revenue Sources

Even though hospitals were able to shift some of their Medicare costs to other payers during the period studied, overall patient service margin percentages remained negative throughout the entire period. Thus, hospitals continued to lose money on their core activity of providing patient care. This trend could not have continued for so long had hospitals not been able to find ways to supplement operations through alternative sources.

For additional data from this study of the financial performance of U.S. hospitals, go to www.hfma.org/hfm.

Indeed, hospitals' apparent success in finding alternative sources of revenue is the one bright spot in this study. That negative margins from patient care activities were offset by revenue from other sources is supported by the total net income percentages during the study period, which remained positive and relatively stable, ranging from 4.6 percent in FFY01 to 5.3 percent in FFY08. Although this finding is reassuring, hospitals cannot depend on always having these other sources of revenue, and their reliance on such additional revenue sources could pose problems in the future.

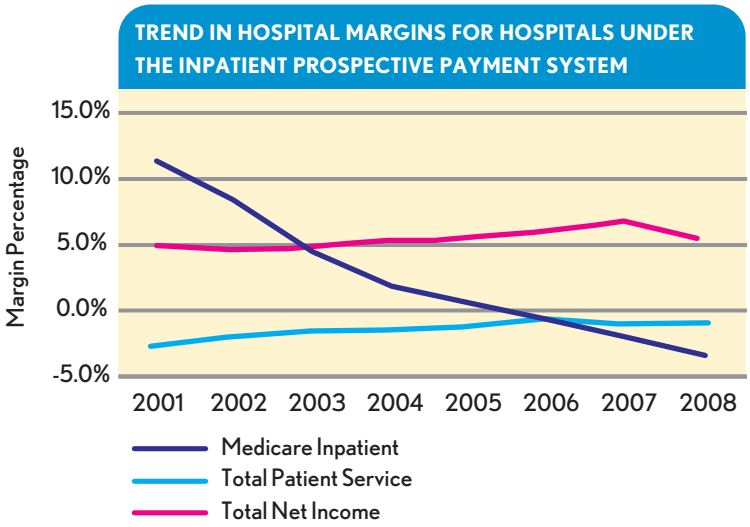
For example, many hospitals depend on donations and income from investments to help subsidize losses from patient care. Our current economic difficulties, however, are likely to hamper the general public's ability to continue making the same level of donations as in the past. Also, the bond and stock markets have significantly declined, placing further pressures on hospital income from sources such as investments and endowment funds. Both trends may interfere with hospital dependence on such alternative sources of revenue.

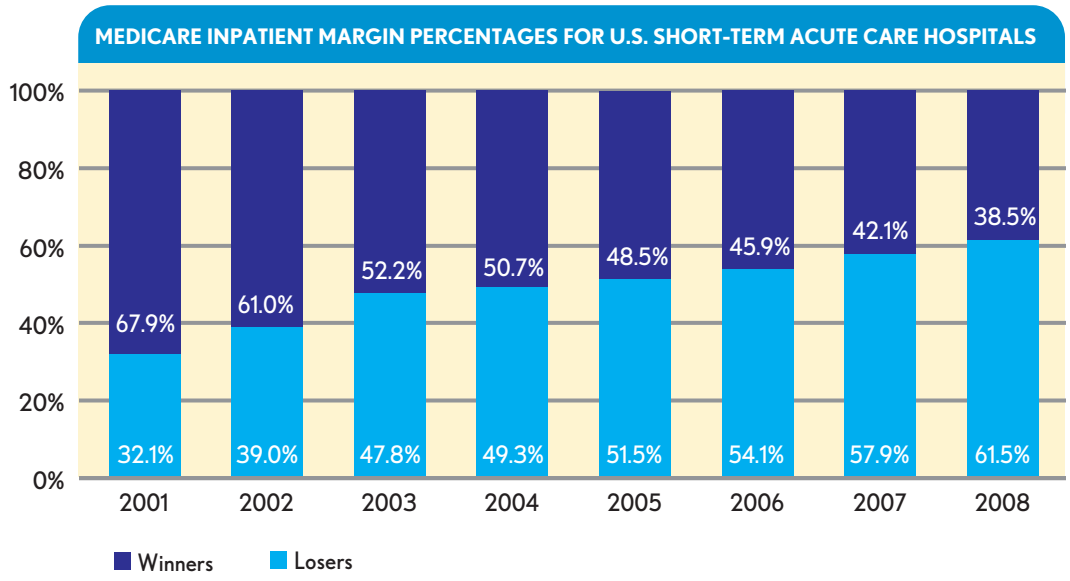
In the meantime, the struggling economy has also increased the number of unemployed and working poor who do not have health insurance. This trend will lead inevitably to an increase in hospitals' cost of uncompensated care and will put further pressure on access to alternative sources of revenue.

If hospitals are not able to find and maintain sufficient sources of revenue to offset the losses from providing patient care, all patients—not just Medicare patients—may find that they do not have access to the levels of care we currently enjoy.

Medicare Margin Dynamics

Medicare inpatient margin percentages declined precipitously over the period studied, dropping from 11.0 percent in FFY01 to –3.6 percent in FFY08. As a result, the percentage of hospitals



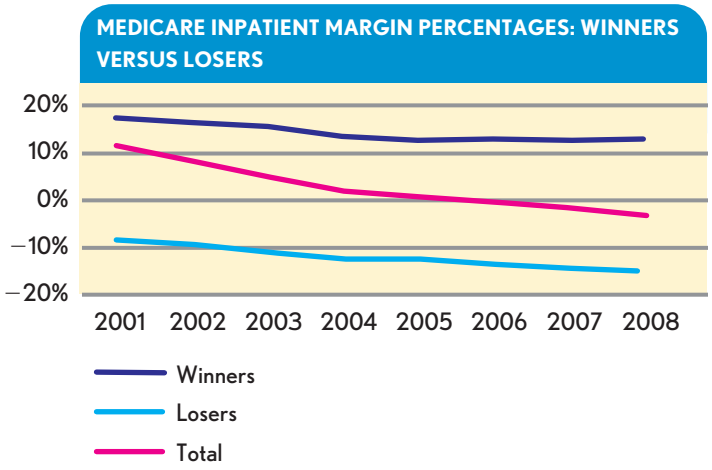


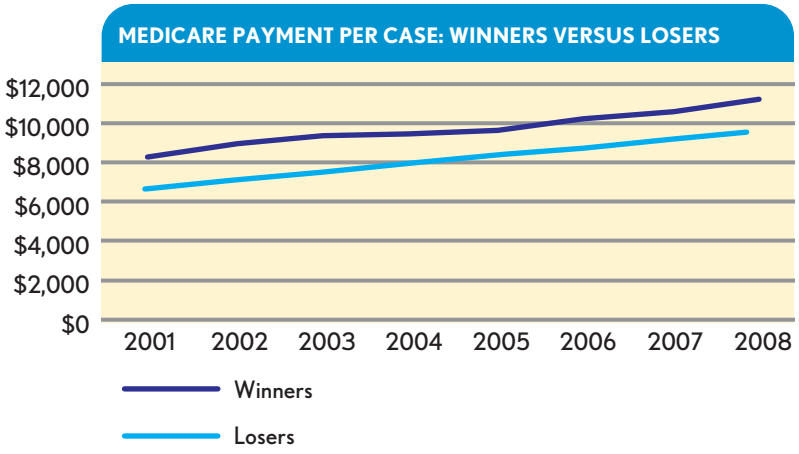
with negative Medicare margins (referred to as "losers" in this study) increased from 32.1 percent in FFY01 to 61.5 percent in FFY08.

Conversely, the percentage of hospitals with positive Medicare margins (referred to as "winners") declined from 67.9 percent to 38.5 percent during the same period.

Hospitals that were able to maintain positive Medicare margins (the "winners") enjoyed double-digit positive margins ranging from 16.7 percent in FFY01 to 12.5 percent in FFY08, while hospitals with negative Medicare margins (the "losers") experienced double digit negative margins for almost all of the period studied, ranging from –8.9 percent in FFY01 to –15.5 percent in FFY08.

That the number of states with positive Medicare margins declined dramatically during the period studied, from 44 winner states in FFY01 to only 13 in FFY07, suggests that payment policies may need to be adjusted for regional differences.





The study also examined some other differences between the winners and losers.

Medicare Payment Policies

On average, the Medicare payment per case for the winners (ranging from $8,235 in FFY01 to $11,053 in FFY08) was much higher than for the losers (ranging from $6,509 in FFY01 to $9,474 in FFY08). This difference was in part due to the fact that the winners had much higher disproportionate share hospital (DSH) and indirect medical education (IME) payments per case. The winners' higher average payments per case may also suggest that the winners are treating sicker patients or may be located in areas of the country with higher wage indexes.

DSH payments. DSH payments are intended to compensate qualifying hospitals for the higher costs of treating economically disadvantaged patients. Regulations are based on the premise that higher proportions of economically disadvantaged patients result in proportionately higher costs of providing care. Medicare DSH payment policy was designed to increase Medicare payments to cover those higher costs.

A review of Medicare DSH payment per case as a percentage of total Medicare payment per case by year for the period studied disclosed that the DSH percentage for the winners rose from 7.3 percent in FFY01 to a remarkable 12.7 percent in FFY08. The DSH percentage for the losers during this time was much lower than for the winners, rising only slightly from 3.2 percent in FFY01 to 6.2 percent in FFY08.

This finding suggests that hospitals receiving DSH payments are more likely to have positive Medicare margins, which could mean that the Medicare DSH payment policy overcompensates for the higher costs expected by qualifying hospitals.

IME payments. IME payments are intended to compensate hospitals for the higher costs associated with teaching programs. Historical experience suggests that residents in teaching programs are prone to overutilize services as part of the learning process. Based on this experience, the larger a teaching program, the more costly it can be for a hospital. The Medicare IME payment policy was designed to increase Medicare payments to cover these higher teaching costs.

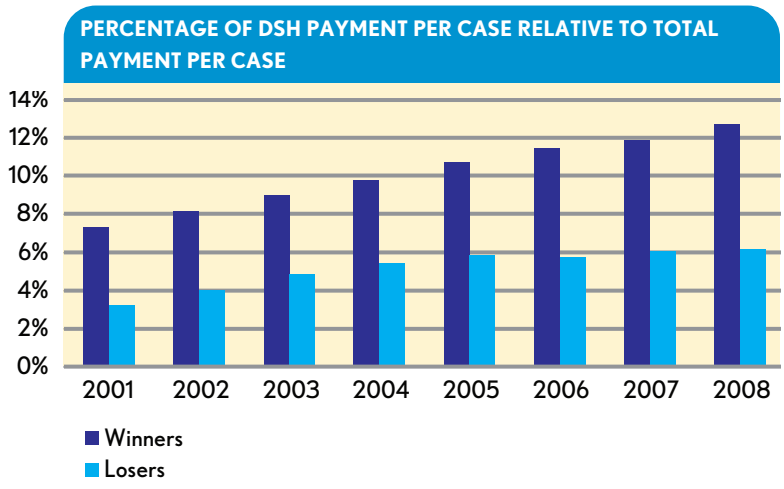
A look at the IME payment per case for winners and losers as a percentage of total Medicare payment per for the period studied disclosed that the IME percentage for the winners rose from 6.9 percent in FFY01 to 9.3 percent in FFY08, while the IME percentage for the losers was much lower, rising only slightly from 1.7 percent in FFY01 to 2.9 percent in FFY08.

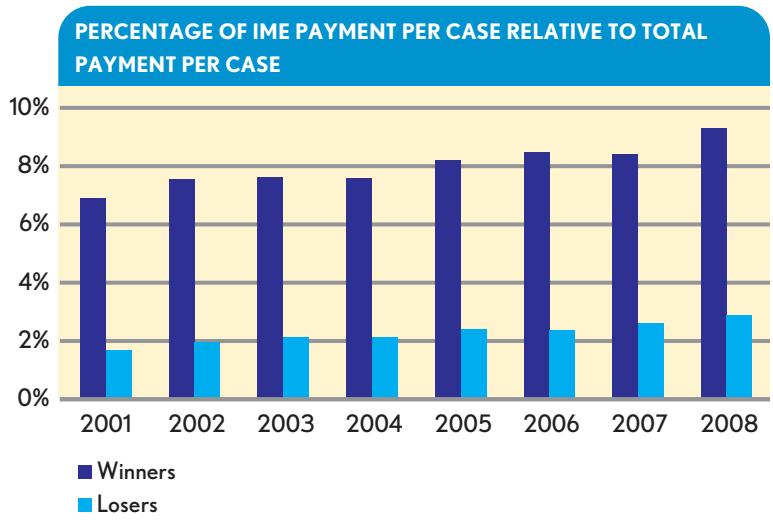
This finding suggests that hospitals receiving IME payments to compensate for the higher costs of teaching programs are more likely to have positive Medicare margins. It further suggests that the Medicare IME payment policy does more than cover the perceived higher costs of many of the qualifying hospitals, thereby allowing them to maintain positive Medicare margins.

Controlling Costs

A comparison of the average Medicare cost per case for winners and losers found that the losers had a higher Medicare cost per case (ranging from $7,087 in FFY01 to $10,946 in FFY08) than did the winners (ranging from $6,863 in FFY01 to $9,669 in FFY08). One might expect that the losers would have higher costs than the winners, and, indeed, the winners have apparently done a much better job at controlling their costs per case while maintaining much higher Medicare payments per case than the losers as discussed above.

Nonetheless, recalling the fact that the Medicare inpatient margin percentages for winners decreased from 67.9 percent in FFY01 to 38.5 percent in FFY08, it is apparent that hospitals are having more trouble than ever in managing their Medicare costs relative to their Medicare payments.





Regional Differences

In addition to examining differences in the payment and cost components of Medicare inpatient margins, the study examined the margins by geographical regions of the country and measured the number of state winners versus losers. Even though all regions enjoyed positive Medicare inpatient margins in FFY01, only two regions remained positive by FFY08: East South Central and Middle Atlantic. The four regions that declined the most during the period studied were New England, Mountain, West North Central, and Pacific.

The study also found that the number of states with positive Medicare margins declined dramatically during the period studied, from 44 winner states in FFY01 to only 13 in FFY07. This finding suggests that payment policies may need to be adjusted for regional differences or hospitals may need to find more ways of controlling regional differences in costs.

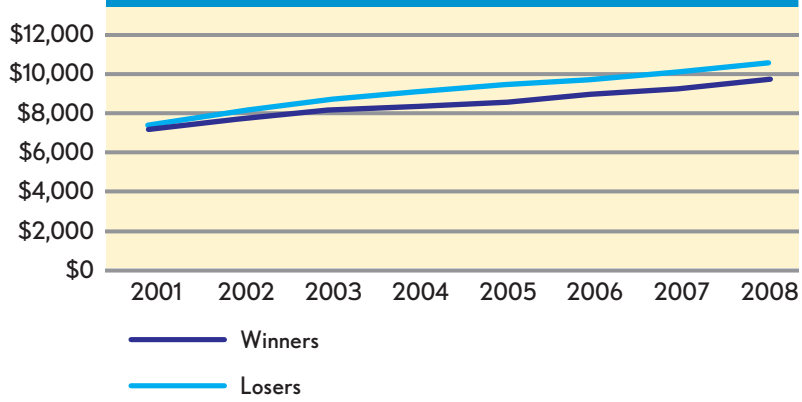
> Hospitals should refuse to be victims of healthcare reform efforts based heavily on reimbursement cuts.

What Can Hospitals Do?

For years, policymakers and payers have maligned hospitals as being inefficient and overpaid. Yet for at least the past eight years, it is apparent that hospitals have struggled against negative margins from patient care services as a result of being systematically underpaid by all payers.

Even U.S. hospitals' largest payer, Medicare, has begun to underpay, resulting in negative Medicare margins since FFY06. Moreover, negative Medicare margins are expected to worsen, as Medicare payment updates continue to restrict

MEDICARE COST PER CASE: WINNERS VERSUS LOSERS



MEDICARE INPATIENT MARGIN PERCENTAGES BY GEOGRAPHICAL REGION

Fiscal Year	2001	2002	2003	2004	2005	2006	2007	2008
East North Central	7.1%	4.4%	0.7%	−1.3%	−2.4%	−3.5%	−4.9%	−6.5%
East South Central	9.5%	7.0%	2.9%	3.5%	3.8%	4.0%	2.3%	3.9%
Middle Atlantic	20.7%	20.0%	17.0%	11.5%	7.6%	7.5%	7.1%	6.0%
Mountain	6.7%	3.8%	−0.7%	−2.4%	−3.4%	−8.2%	−7.4%	−10.4%
New England	14.5%	12.2%	6.4%	4.9%	3.5%	0.1%	−0.3%	−11.0%
Pacific	14.2%	10.9%	5.2%	−1.3%	−4.0%	−4.7%	−7.9%	−9.4%
South Atlantic	7.3%	3.1%	0.1%	−1.9%	−2.6%	−4.1%	−5.4%	−5.1%
West North Central	6.0%	2.3%	−1.9%	−2.8%	−3.6%	−5.0%	−7.8%	−9.7%
West South Central	10.3%	6.0%	3.2%	2.5%	2.1%	1.7%	1.0%	−3.4%
Total All Hospitals	**11.0%**	**8.2%**	**4.4%**	**1.7%**	**0.2%**	**−0.9%**	**−2.3%**	**−3.6%**

About the Study

The study of Medicare margins cited in this article was based on available cost report data for short-term acute care hospitals paid under the inpatient prospective payment system (IPPS). Hospital cost reporting periods ending in federal fiscal years (FFYs) 2001 through 2008 were analyzed. Critical access, rehabilitation, long-term, and other IPPS-exempt hospitals were not included.

Margins Studied

Various types of hospital margins are used to examine relationships among Medicare inpatient and total margins for hospitals. Margins indicate the difference between revenue and costs, expressed as a percentage of revenue. For purposes of this study, the following margins were examined.

Medicare inpatient margin percentage. IPPS revenue was determined from Worksheet E, Part A, Line 8 (total payment for inpatient operating costs) + Line 9 (payment for inpatient program capital) + Line 10 (exception payment for inpatient program capital). IPPS program inpatient costs were from Worksheet D-1, Part II, Line 53 (operating) and Line 52 (capital) and Line 49 (total).

Total operating margin percentage. The total operating margin percentage includes only a hospital's total revenues and costs related to direct patient care. Revenues include all payer sources (e.g., Medicare, Medicaid, other government, and private payers). Total patient care revenues and total operating expenses were determined from Worksheet G-3, Lines 3 and 4, respectively.

Total net income percentage. The total net income percentage includes a hospital's total revenues and costs for all activities from all sources. For example, revenues include other income such as contributions, income from investments, and rental income. Total net income was determined from Worksheet G-3, Line 31, and was expressed as a percentage of the total patient care revenues used in the computation of the total operating margin percentage above.

Payment and Cost Components Studied

The study also examined the main components of Medicare payments and costs. The payment components indicate the impact of Medicare payment policies on various types of hospitals, while the cost components indicate hospital operational efficiencies in response to payment policies. For purposes of this study, the following components were examined on a per case (or per discharge) basis. (Medicare discharges were determined from Worksheet S-3, Part I, Line 12, Column 13.)

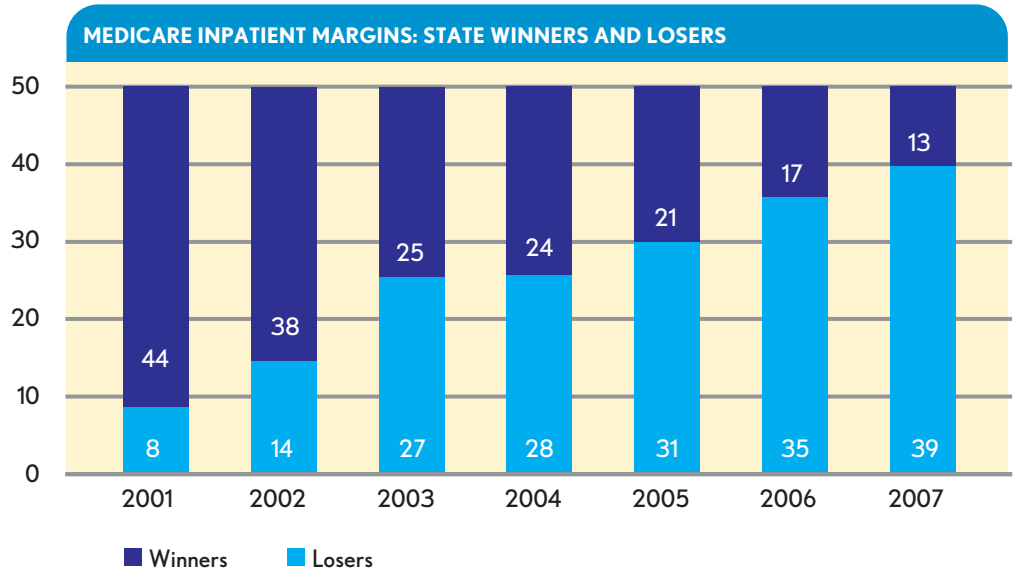
Disproportionate share hospital (DSH) payment per case. Total DSH payments were determined from Worksheet E, Part A, Line 4.04 divided by total Medicare discharges.

Indirect medical education (IME) payment per case. Total IME payments were determined from Worksheet E, Part A, Line 3.24 divided by total Medicare discharges.

Total payment per case. Total payment was determined as the total IPPS revenue, as defined above, divided by total Medicare discharges.

Total cost per case. Total costs were from Worksheet D-1, Part II, Line 49 divided by total Medicare discharges.

Finally, all margins and components of Medicare payments and costs were computed from Medicare cost report data obtained from the Centers for Medicare & Medicaid Services (CMS). The Healthcare Cost Report Information System (HCRIS) dataset contains the most recent version (i.e., as submitted, settled, or reopened) of each cost report filed with CMS since FFY96. The most recent HCRIS dataset available at the time of this study was for the cutoff at Dec. 31, 2008. All computations were assigned to each FFY based on the cost report end date. The study looked at approximately 26,000 Medicare IPPS cost reports from FFY01 to FFY08.



payment increases through low market-basket increases, negative coding adjustments, and other major policy changes—all occurring at a time when hospital costs continue to rise.

It is time for hospitals to become more vocal with their various publics and elected representatives. Hospitals should refuse to be victims of health-care reform efforts based heavily on reimbursement cuts. Hospitals should not wait for margin studies to be reported to Congress annually by the Medicare Payment Advisory Commission (MedPAC) and other organizations based on retrospective data. Individual hospitals should report current financial information to their U. S. House and Senate representatives and explain the importance of fair and equitable rate increases every year. They should specifically focus on concerns such as DSH, IME, wage index, case mix, transfer policies, and reimbursement tied to spurious quality measures.

Of course, hospitals should continue to seek to limit their rate of growth in spending to the extent possible. It is an open question, however, whether hospitals can do much more than they are already doing to control costs without compromising their commitment to quality.

Hospitals with negative overall margins from patient care should first seek to bring their costs in line with those of their peers and then seek higher reimbursement rates from the private insurers in their markets. Hospitals should use compelling data to support their demand that private insurance plans give fair and equitable reimbursement rate increases every year. The insurance companies should be made aware of the dire circumstances the provider community may face if hospitals are under-reimbursed so that insurance companies can keep from raising insurance premiums too rapidly.

If Medicare and other payers continue to set payment below hospital costs, the results could be disastrous. As a defense, hospitals will need to protect alternative sources of revenue and develop new ones, as they have done for years. Unfortunately, in the current economy and political climate, this response may prove to be increasingly difficult. ●

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