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Margins As Measures: Gauging Hospitals' Financial Health

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A discussion with

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Gauging Hospitals' Financial Health

The annual increase in payments to hospitals for providing inpatient services to Medicare beneficiaries has been a major policy issue for the administration, Congress, and acute-care hospitals since the implementation of the Medicare prospective payment system (PPS) in 1984. Generally included in an omnibus reconciliation bill, the increase is invariably linked to Medicare savings. It is a vulnerable target for policymakers seeking to offset the cost of a new benefit or to reduce overall cost inflation in the program. This year, the annual increase is even more vulnerable, because hospitals are perceived to be in particularly robust financial health, as indicated by both their Medicare inpatient and total operating margins. The Clinton administration and Congress are pursuing Medicare reforms—including enhancements of the program—and view a cut in next year's percentage increase (an increase already mandated by the Balanced Budget Act of 1997, or BBA) as a possible way to help finance the reforms.

Operating margins—"profits," in proprietary hospital terminology—are the traditional measures of hospitals' financial health. Reliance upon margins as principal measures of hospital profitability is raising questions in various quarters. The American Hospital Association (AHA) and other hospital organizations complain that Medicare inpatient margins—estimated to be 15.9 percent in 1998—mask hospitals' losses on outpatient services and disguise certain hospitals' financial struggles. Rather than reflecting a winning hand for hospitals, the percentage obscures the fact that some may be winners and some may be losers. A National Advisory Panel convened by the AHA and chaired by former Prospective Payment Assessment Commission (ProPAC) Chairman Stuart Altman indicates that margins are inadequate measures of hospital financial well-being when considered alone and should be supplemented by additional indicators.

Although the positions of the AHA and the National Advisory Panel may be seen as self-serving, their point of view is becoming more pervasive. Policy people who work on hospital finance issues see operating margins—tied to inpatient services—as holdovers from an era in which inpatient care under a fee-for-service medical model prevailed. As health care has reconfigured under PPS and moved relentlessly forward to

bundle outpatient and post-acute services under prospective rates, some contend that clinging to inpatient service operating margins makes no sense. Integrated health systems, for example, may have a number of hospitals, some acute-care and some specialty, along with outpatient clinics and surgery centers, home health agencies, hospices, and other units, with various payment systems and measures to indicate their financial health.

The Medicare Payment Advisory Commission (MedPAC), the agency responsible for reviewing and making recommendations to the secretary of health and human services and Congress on Medicare payment policy, has not gone that far. But, anticipating the president's call—in his fiscal year (FY) 2000 budget proposal, released February 1—for the annual increase to be frozen at its current level, it weighed in at the end of 1998 with a more generous policy. MedPAC (an amalgam of the disbanded ProPAC and Physician Payment Review Commission, or PPRC) recommended an increase of 0.7 percent, which is in line with the increase mandated for the year by the BBA.

This Forum session will examine the controversy over margins as measures of hospitals' financial viability. It will explore how the administration, Congress, and the hospital field got to the current stage of debate and what proposals are on the table for them to consider. Looking to the future, it also will raise some

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questions on the policy implications of hospital financial measures and Medicare's role in paying for inpatient and outpatient services.

BACKGROUND

The annual increase in Medicare payments to hospitals for inpatient services has a rather convoluted history that is now entwined with the similarly intricate saga of ways to measure hospitals' financial status. The Social Security Amendments of 1983, in establishing PPS for Medicare inpatient services based on diagnosis-related group (DRG) rates, prescribed that hospitals receive an amount equivalent to the growth in the "hospital market basket (an index of changes in the prices of resources, such as equipment, supplies, and labor, that are put into hospitals) plus two." The "plus two" percentage points, intended to reflect changes in technological and other improvements, were quickly cast aside, however, as the two houses of Congress and the executive branch sought savings to reduce the federal budget deficit or to fund other budget items. The hospital market basket became the unit of measure for negotiations each year among Congress, the White House, and hospital officials.

Even when fixed in law, the annual adjustment has tended to be a moving target for budgeteers. For example, "the market basket is projected to increase by 3.0 percent in 1998 and by about 3.5 percent in each subsequent year [through 2002]," the Congressional Budget Office (CBO) declared in a 1997 BBA report. The BBA froze the basic PPS payment in FY 1998 and reduced the update by 1.9 percentage points in FY 1999. It provides for the update to be market basket minus "1.8 percentage points in 2000, and 1.1 percentage points in 2001 and 2002. . . . On balance, these provisions will save \$17.1 billion through 2002."¹

Since CBO issued its report, the market basket projection for FY 2000 has been revised downward to 2.5 percent, which, minus the BBA-provided adjustment, equals 0.7 percent. With the president having recommended a freeze for FY 2000, the committees of jurisdiction in Congress—the House Ways and Means and Senate Finance Committees—will be the next to decide. Their choices are to let the BBA increase of 0.7 percent automatically go forward, freeze the rates as the president proposes, or set the update at some other level.

The financial health of hospitals, as indicated by hospitals' average Medicare inpatient operating margin,

offers an appealing rationale for presidential and congressional payment reduction proposals. That is why the margin debate, which has waxed and waned since the inception of PPS, has become so heated. Faced with average PPS inpatient margins in the teens, the AHA and other hospital groups are challenging the usefulness of the measure. Some others in the health field are questioning the nature and use of the hospital cost reports from which the margins are calculated. They are expressing skepticism about the traditional links between the delivery and financing of inpatient and other levels of care. Not since former AHA President Carol McCarthy argued in the mid-1980s with then Ways and Means Committee Health Subcommittee Chairman Pete Stark (D-Calif.) about the counting of hospital revenues and expenditures has a hospital issue been joined on definition; now, as then, there is much at stake.

MARGINS AND MORE MARGINS

The Numbers—What to Count

When MedPAC met in December 1998, it indicated that hospitals' Medicare PPS inpatient margin of 16.1 percent in FY 1997 was the highest in history. It estimated that the margins for FY 1998 and FY 1999 would be 15.9 percent and 15.7 percent, respectively, despite BBA cuts. However, the commission said that nearly one-fourth of all hospitals had negative PPS inpatient margins in FY 1997, although that was much less than the 61.2 percent whose margins were in the red in 1991, the post-1984 peak.²

The commission also said that hospitals' overall total margin, which includes revenues from all payers, was 6.4 percent in 1997, the second highest since 1984. It compares with the following:

Percent Total Hospital Margin, 1984-1996³

FY 1996	6.1 percent
FY 1995	5.7 percent
FY 1994	5.0 percent
FY 1993	4.5 percent
FY 1992	4.4 percent
FY 1991	4.4 percent
FY 1990	3.6 percent
FY 1989	3.6 percent
FY 1988	3.5 percent
FY 1987	3.6 percent
FY 1986	4.3 percent
FY 1985	6.6 percent
FY 1984	7.3 percent

The AHA contends that cost control is the key to the trend toward higher margins. In January of this year, the AHA reported that hospital inpatient admissions increased by 1.5 percent in 1997 over 1996, but the length of stay decreased to 6.1 days from 6.2 days the previous year. On the outpatient side, visits went up by 2.3 percent over the previous year. The data are based on the AHA's annual surveys of acute-care hospitals—5,057 in 1997 and 5,134 in 1996.

Not only national but also state margin figures have made their way into the daily and trade press. New Jersey hospitals, for example, experienced a decline—an average margin of 0.8 percent in 1997, compared with 2.1 percent in 1996, according to an audit done for the New Jersey Hospital Association. The association attributes the decline to the amount of charity care provided by hospitals in the state and the impact of managed care contracts.⁴

On the other hand, New York hospitals, which had operated under a state waiver to PPS, had their “record surpluses for their first year operating under deregulation” published by the state’s Department of Health, which had conducted a study of the effects of deregulation using the hospitals’ own audit figures. According to the study, “New York’s 221 mostly not-for-profit hospital corporations rang up combined 1997 surpluses, or profits, of \$739 million, a 42 percent increase from the prior year.”⁵ The Healthcare Association of New York State countered that the “figures are misleading because they include unrealized gains on investments and donations earmarked for capital projects.” The association also contended that the data “fail to capture more recent pressures, including a problem with late payments and denials by managed-care plans, a rise in the number of uninsured in the state, and a \$3.9 billion reduction in Medicare payments that New York hospitals face” through 2002 as a result of the BBA. Saying that income from operations more accurately reflects hospitals’ 1997 performance, hospital spokespersons pointed to a drop of nearly 28 percent (to \$212.2 million) in operating profits. The state had used “unrestricted net assets,” rather than “net income or operating income,” to come up with its surplus figures.⁶

The Numbers—What Types of Hospitals

The use of averages has also confounded the industry, which indicates that certain hospitals—or certain types of hospitals—are not doing well at all. Rural hospitals, public hospitals, teaching hospitals, and children’s hospitals have been singled out at various times as needing special subsidies. The AHA contends,

for example, that “19 percent of hospitals have negative total margins” and “9.9 percent have positive margins below 2 percent. The AHA considers positive margins under 2 percent as break-even and a sign of serious financial trouble.”⁷

The Department of Health and Human Services (DHHS) has been puzzled as well. The DHHS Secretary’s Task Force on the Future of Academic Health Centers (AHCs) last year explored the “financial paradox” of AHCs’ ability to stay solvent and fulfill their health service delivery, medical education, and biomedical research missions while incurring higher costs. Reporting on the task force’s findings in a *Health Affairs* article,⁸ Gerard Anderson, George Greenberg, and Craig Lisk looked at MedPAC operating margin and graduate medical education (GME) figures that suggest “that the Medicare program may be overpaying AHC [hospitals], at least as measured by PPS operating margins.” They also looked at Medicaid GME support and noted that it was declining as a result of states’ placing their programs under managed care.

Acknowledging that, according to MedPAC data for FY 1995, AHC hospitals had an average PPS inpatient margin of 21.4 percent, as compared to 10.5 percent for all hospitals, Anderson and Greenberg looked at categories within AHCs (in this case, total margins rather than PPS margins only).

Public AHCs had the lowest total margins in 1995, 3.2 percent. In 1995, AHCs located in markets with high managed care penetration had lower total margins than the overall average for all AHCs, 3.6 percent compared with 4.5 percent. However, other studies examining the relationship between margins and managed care penetration reach contrary conclusions.

The two researchers also looked at hospitals with operating losses. Again, they found that “public AHCs were more likely to have negative total margins than private AHCs” and that “AHCs in markets with high managed care penetration were more likely to have negative total margins.” But they concluded that no one class of hospitals dominated the group with negative margins. In addition, recognizing that “operating margins are only one measure of financial viability,” they examined other indicators. On most of them, the AHCs’ financial position improved to be generally comparable to the overall hospital average. The indicators were cash on hand, return on equity, long-term debt to equity, asset turnover ratio, and net assets per bed. Only on net assets per bed were AHC hospitals significantly different from other hospitals: \$252,000 in AHC hospitals compared to \$56,000 in nonteaching hospitals.

DHHS has also examined children's hospitals, with the result that the president included a legislative proposal for \$40 million in funds for children's teaching hospitals in his FY 2000 budget. Part of the rationale for providing the funds is that "many children's hospitals have negative operating margins, in part because they have unusually high proportions of Medicaid patients, and the lack of equitable support for GME compared with other teaching hospitals." The department is examining mechanisms for payment, such as a formula grant approach. In its budget documents, the White House indicated that payment would be "related to individual performance relative to the accomplishments of [the] hospitals as a group." The administration is considering various measures to gauge the effects of payments the hospitals receive. Possible indicators include their "financial status," in terms of operating margins; "percentage of residents' training that is supported in ambulatory settings; percentage of patients served living in poverty; percentage of uninsured patients"; and "shortages (if any) of pediatric health care providers in the area of the facility."⁹

In a 1998 survey of 5,190 acute hospitals across the country, the accounting firm of Deloitte & Touche LLP found that average profit margins—defined by the reporting hospitals, 12 percent of those surveyed—were averaging 6.5 percent. "Hospitals are projecting overall profit margins to decline to 5.5 percent over the next two years, and to 5.2 percent in five years." Of types of hospitals,

inner-city hospitals report the lowest average profit margins of 4.6 percent, while the highest margins are in the suburban hospital category at 7.6 percent, followed by rural hospitals at 6.4 percent and other urban hospitals at 5.8 percent. Investor-owned hospitals report the highest profits—an average of 11.1 percent—with government hospitals reporting an average of only 5.8 percent.

The Deloitte & Touche survey also indicated that "average profitability varies by region, with New England and Mid-Atlantic hospitals reporting the lowest average profits at 4.2 percent, while the West South Central region reports average profits of 8.2 percent."¹⁰

SOME OTHER APPROACHES

As PPS has expanded its inpatient focus to outpatient and sub-acute services and as hospital systems have brought together a broad continuum of services, from primary through long-term care, individuals and groups within the health arena have turned their atten-

tion to the best ways of measuring the economic and quality results. The recommendations tend to go way beyond margins.

National Advisory Panel

The National Advisory Panel, which convened health services researchers, accountants and other health finance experts, hospital chief executive officers, and trade association representatives in April 1998 to look at financial viability measures, concluded that "three categories of financial measures" are "critical to consider." The panel's report included (a) "net income (revenue minus expense)," because "persistent failure to earn a positive 'bottom line' can both signal and fuel a downward spiral for an organization"; (b) "liquidity and cash flow," because, "even with good margins, providers need enough liquid assets (increasingly cash) to meet near term obligations (to employees, vendors, and creditors) and to move on community needs and opportunities"; and (c) "debt burden," because if they are "too high, debt levels limit flexibility and pose undue risks of default or insolvency, if demand shifts or prices slump."¹¹

Panel members expressed concern about Medicare cost reports, particularly in terms of the reconfiguration of health care delivery, especially the growth of outpatient relative to inpatient services. Saying that "the Medicare cost report framework merits ongoing updating, validation, and refinement," they contended that the best sources of financial data are "certified financial statements, prepared annually for hospitals and health systems after an audit by CPA firms." They also felt that bond ratings can be valuable, particularly because independent analysts—counting financial and nonfinancial factors—produce and update them. They acknowledged that such ratings are limited because "not all providers have ratings and . . . the degree of 'risk aversion or preference' implicit in ratings is not easily quantified."

The panel also identified some nonfinancial factors for assessing providers. They include the

quality of strategy and management; market conditions (including managed care); strength of relationships with physicians, staff, communities, and partners; and investment in relationships, clinical and information technology, knowledge, and ongoing improvement.

MedPAC

Although the annual updates to the operating payment rate under the Medicare hospital inpatient PPS

already are set in law, MedPAC each year provides guidance to the Congress on the appropriate update for the upcoming fiscal year. MedPAC's recommendations are based on its ongoing analyses of the factors that determine year-to-year changes in hospital costs, including hospital input price inflation, changes in the care provided by hospitals and the way that care is provided, and the complexity of the patients they treat. Although MedPAC's recommendation for 2000 was to stick with the update enacted in the BBA, the commission's analysis indicated that an update anywhere between zero and 2.6 percent could be justified.

MedPAC's recommendation was made

in the context of evidence that the hospital industry has thus far successfully adapted to a more competitive market by changing its practice patterns and reducing its costs, but also out of concern that many of the major effects of the BBA are not yet fully evident. Therefore, reducing payment rates below the level prescribed in the BBA would not be prudent, at least for this year.¹²

Center for Healthcare Industry Performance Studies

The Center for Healthcare Industry Performance Studies (CHIPS), located in Columbus, Ohio, has extensive data files on U.S. hospitals. The files include audited financial statements from approximately 3,400 voluntary not-for-profit hospitals, operating performance data from about 1,800 of that group, and Medicare cost reports from approximately 6,000 for- and not-for-profit hospitals. From this database CHIPS draws "constant sample size" data, defined as data "that the same hospitals have reported . . . for each time period under study." It uses the data to generate 35 financial indicators and 43 operating indicators. The financial indicators can be grouped into five categories, expressed as ratios: profitability (including total margin), liquidity, capital structure, asset efficiency, and "other financial." The operating indicators, which sometimes are divided between inpatient and outpatient services, are in seven categories: profitability, price, volume, length of stay, intensity of service, efficiency, and unit cost of inputs.¹³

The median hospital total margin was 5.4 percent in FY 1997, compared to 4.4 percent in FY 1996, according to CHIPS data. CHIPS' financial flexibility index, which measures financial survivability on both a short- and an intermediate-term basis, showed improvement in FY 1997 over FY 1996. Medians for "high performance" and "low performance" showed an increasing

gap between hospitals with strong financial performance and those with weak financial performance. Small urban hospitals showed particular weakness. In an interview with *Modern Healthcare*, CHIPS President William O. Cleverley cited 1998-1999 almanac figures indicating that, after small increases, hospital costs per discharge rose 2.1 percent in FY 1997. "If cost control efforts have indeed peaked, future hospital profits could fall dramatically if pricing pressures resulting from the BBA materialize."

Clearly, there are many ways to measure hospitals' financial health, some of which focus only on acute-care hospitals and others of which take outpatient and other services into account. This year, because of controversy over the PPS update, the measures are attracting attention not only from the usual policy analysts who are used to comparing Indicator A and Indicator B but also from the policy community at large. Moreover, as the community focuses on managed care options, especially the federal government's new multi-choice Medicare+Choice initiative, it is gaining a greater appreciation of the links between delivery and financing. For example, with some plans having dropped out of or reduced their service areas in Medicare+Choice because of its payment levels (detailed in NHPF Issue Brief No. 730, *Medicare HMO Pullouts: What Do They Portend for the Future of Medicare+Choice?*), discussions of plans' financial health and the effects of payment rates on them are extending to that program as well. So what began as a lobbying effort on the part of hospitals seems to be having ripple effects.

SOME KEY QUESTIONS

Using margins as measures to gauge hospitals' financial health raises a number of questions. The following will guide the Forum session:

- Why were operating and total margins—whether for Medicare or for other programs—chosen as measures in the first place?
- What impact has case mix had on Medicare PPS and total margins since PPS was implemented?
- Is the current debate over operating and total margins—in its linkage to the Medicare PPS hospital update—a smoke screen for hospitals' lobbying on the PPS update?
- Has the health care sector evolved to the point that hospital inpatient service indicators are useful only for measuring acute-care and for nothing else?

- What is the status of outpatient service indicators?
- As services are bundled and coordinated under PPS, what sorts of measures should be used to assess hospitals' financial performance? Medicare beneficiaries' access to services?
- What effects is the BBA expected to have on hospitals' financial health? How can researchers tell?
- Should the financial status of certain types of hospitals—say, teaching hospitals or children's hospitals—be assessed separately? Differently?
- What would be better indicators than operating and total margins? The National Advisory Panel's recommendations? Those of the Center for Healthcare Industry Performance Studies?
- How would the selection of new measures affect MedPAC's role?
- How should margins and other financial performance indicators be used by policymakers?
- From a health systems point of view, what is the significance of the margins debate?

THE FORUM SESSION

This Forum meeting will examine indicators of hospitals' financial status, focus on the major issues the indicators raise, and highlight recommendations of different ways of assessing hospitals' financial health. It also will explore the implications of the update for FY 2000, in terms of the BBA provision, president's proposal, and MedPAC and other organizations' perspectives.

Four panelists will examine the topic. Following their brief comments, there will be a roundtable discussion with meeting participants.

Lawrence S. Goldberg, director of national affairs for health care in Deloitte & Touche's Washington office, will provide an overview of hospital financial indicators and the ways in which they have been used in the policy environment, leading to the current PPS update debate. Prior to joining Deloitte in the mid-1980s, he spent 11 years with the AHA, working on Medicare prospective payment legislation and implementation and chairing the UB-82 national claim form committee, among other activities.

William O. Cleverley, Ph.D., C.P.A., is co-founder and president of the Center for Healthcare Industry Performance Studies and a faculty member in Ohio State University's Graduate Program in Hospital and Health

Services Administration and its Department of Accounting. He has been a health care educator, consultant, researcher, and author for 25 years. He will look at hospital financial status in terms of the CHIPS database and the implications of the data for policymakers.

Stuart Guterman became a principal research associate in the Health Policy Center of the Urban Institute in March, after having been deputy director of MedPAC. He joined MedPAC as a result of the amalgam of ProPAC and PPRC in 1997. He had been with ProPAC since 1988, as its deputy director since 1990. Previously, he was chief of institutional studies in the Health Care Financing Administration's Office of Research. He served on the National Advisory Panel that developed *Financial Viability Measures for Hospitals and Health Systems* in 1998. He will explore the policy aspects of ProPAC's and MedPAC's work on hospital financial indicators, including derivation of recommendations for the PPS update.

Terence M. Mieling, C.P.A., is director of Merrill Lynch's Health Care Finance Group. Located in Chicago, he was also a member of the National Advisory Panel. During his 18 years at Merrill Lynch, he has provided investment banking services to hospital, physician, managed care, and long-term-care clients. Prior to that, he was a senior manager with Ernst & Young in Chicago. Earlier, he served as the chief financial officer of Hospital Sisters Health System in Illinois. He will share a Wall Street view of hospital financial indicators. In his investment perspective, he will explore bond ratings, liquidity and cash flow, debt burden, and other factors.

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