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# *Many Massachusetts Hospitals Have Financial Problems, and These Must Be Addressed, but an Across-the-board Medicaid Rate Increase Is Not an Effective or Affordable Solution*

***A Brief Report***


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# *SUMMARY*

Prompt but targeted state aid is vital to stabilize those Massachusetts acute hospitals that are suffering financial distress.

The hospital industry has responded to declining average financial margins by seeking higher payments from Medicaid, HMOs, and others. The industry is asking the state for massive across-the-board increases in Medicaid payment rates.

This report assesses the need for across-the-board payment increases by Medicaid, and the fairness of such increases. We find that an across-the-board Medicaid increase is not appropriate because many hospitals are in much better financial shape than others, much of the aid would simply boost the surpluses of hospitals that already make money, and it would not do enough to help many financially distressed but needed hospitals.

Targeted financial relief is more fair, efficient, and affordable. Hospitals needed by their communities but at risk of closing should have first claim on scarce state dollars. The report offers six groups of steps for stabilizing needed hospitals, with immediate relief followed by payment reforms to make Massachusetts hospitals durably affordable.

## HOSPITAL FINANCES AND CAPACITY

Finances

Massachusetts hospitals are the most costly in the world, yet, we find, their financial margins have been below the national average for over 50 years.

Total margins rose slightly nationally but plummeted here from 1996 to 1999, we find.

- But this does not seem attributable to a revenue problem. Hospital revenue rose 13.6 percent here, versus 11.6 percent in the nation as a whole.
- Instead, falling margins here reflected a rapid growth in hospital costs, up 19.3 percent in Massachusetts versus 14.1 percent nationally.
- Thus, hospital revenue grew one-sixth faster here than nationally, but ***hospital costs here grew one-third faster than the national average.***
- In other words, Massachusetts hospitals' costs grew twice as fast as revenues, relative to the national experience.

***These findings argue strongly against claims that low revenue is the source of hospitals' financial problems here,*** and that more money is needed.

***Further, despite small overall losses in 1998 and 1999, Massachusetts hospitals' actual dollar surpluses statewide totaled $1.7 billion during the 1990s.***

With high costs the main problem, the main solution is improving clinical and administrative efficiency. We therefore argue that two things are needed to protect the finances of this state's hospitals—a focus on more effective cost control techniques, and targeted financial relief.

It is fortunate that hospitals overall don't need more money, because health spending in this state is the world's highest, premium increases are already high, and dental, nursing home, and home health care appear to have greater need of Medicaid rate increases.

Bed Capacity

The accelerating decline in Massachusetts hospital capacity reflects beliefs—embodied in state statute—that closing hospitals and beds would save money, and that a free market and price competition would close unneeded, inefficient hospitals and beds.

Reckless reliance on free market thinking—in the absence of anything close to a genuine free market for hospital care—has resulted in closings of too many Massachusetts hospitals and financial distress for many surviving hospitals that are needed to protect the health of the public. The report documents the failure of the hospital industry to satisfy any of the four requirements for genuine free market competition.

In a free market, profits signal efficiency and satisfaction of consumer wants. Without a free market, we often have profits without honor. That is, some hospitals garner profits not justified by genuine free market competition. On the other side of the ledger, we often see financial losses without blame—hospitals that are losing money even though they may be efficient and even though they may be needed by their communities.

The absence of a free market for hospital care, the loss of needed hospitals and emergency rooms, and the need to protect surviving hospitals (unless their closing can be shown to be safe) combine to warrant state intervention to identify and protect all hospitals needed to assure the health of the public. Without a functioning free market, the alternative to intelligent government intervention is hospital anarchy and a looming shortage of acute care beds and emergency rooms.

We have long warned that the actual pattern of hospital closings was likely not to save money but that it would harm access to care. We urged protecting all needed hospitals. But for most of the 1990s, the Massachusetts Hospital Association (MHA) willingly embraced the deregulation and price competition that have been forcing many hospitals to close. It stubbornly opposed state intervention to identify and stabilize needed hospitals.

Today, the MHA asserts that hospital closings and emergency room diversions warrant more money for all hospitals, through across-the-board Medicaid payment increases—and without any state oversight of hospitals' efficiency or need for the money.

As will be shown, this is rather like a person showing an empty pocket while asking for more money, without disclosing how much money might be in another pocket.

Hospitals' reported surpluses ignore the earnings of related corporations such as holding companies and therefore mask the true financial condition of wealthy hospitals that have substantial resources in related corporations. A full and fair examination of hospitals' financial problems should use consolidated hospital financial reporting, including all income in related corporations.

The 71 Massachusetts acute care hospitals reported a statewide 1999 surplus of revenues over expenses totaling $86.5 million. New data from hospitals show estimated

statewide surpluses of $192.3 million in 2000, a substantial improvement. Still, many needed hospitals are suffering grave financial distress. They need and deserve emergency financial relief. The question is how to provide that relief.

## *ONE PROPOSED REMEDY: ACROSS-THE-BOARD MEDICAID PAYMENT HIKES—* WHICH HOSPITALS WOULD GAIN?

This report's focus is on whether a 10 percent across-the-board Medicaid rate hike for each hospital, totaling about $60 million per year statewide, would

- do enough to help out the state's financially distressed hospitals, and
- be a good way for state government to target scarce financial resources.

We measured the effects of a 10 percent increase on hospitals grouped by their 1999 total financial margins, hospitals grouped by teaching status, and Greater Boston hospitals grouped by high versus low rates of emergency room diversion.

***Overall, we find that the proposed across-the-board Medicaid rate increase looks like an instance of "to those who have, shall be given."*** If its aim is to support financially distressed hospitals, an across-the-board increase fails spectacularly.

- Margins: The top 20 hospitals, which enjoyed 1999 *surplus* revenues of $207.2 million, would receive $30.2 million taken together, or just over half the statewide rise in Medicaid payments. The bottom 51 hospitals, with a 1999 *loss* of $120.7 million, would receive $30.1 million. ***Fully one-half of an across-the-board Medicaid rate increase would go to the least needy 20 hospitals in the state***, hospitals that are already making money, and whose surpluses would rise substantially.

- Teaching: Fully 63 percent of a ten percent across-the-board revenue hike would go to the state's 18 teaching hospitals even though, in the aggregate, they earned a surplus and their finances are improving. Money-losing teaching hospitals get too little from an across-the-board hike, and money-making teaching hospitals get too much. Two of the seven large academic medical centers lost money last year. The 10 percent rise in Medicaid payments would not have been remotely sufficient to offset their losses.

- ER diversions: The MHA's logic seems to run like this: tighter financial margins → service cutbacks → Emergency Room (ER) diversions. The MHA thus defines ER diversions as another justification for an across-the-board Medicaid hike. ***An across-the-board Medicaid rise is an improper response to ER diversions, as Boston-area hospitals with more diversions tend to be in better financial condition:***

    - The 12 ***hospitals that ran 1999 surpluses actually closed their ERs more often***, averaging 278 hours of ER diversion per hospital.
    - The nine hospitals that ran deficits averaged just 74 hours of ER diversion.

  Why is this occurring? Hospitals making money may have seen volume increases and become more crowded. Also, difficulty moving patients from the ER to ICU beds

or to ordinary nursing units may reflect poor scheduling of elective surgery, as Litvak and Long have argued.

In any case, it would be very hard to rely on higher Medicaid or free care pool payments to boost hospitals' margins across the board. That is because Medicaid provided only about 7.2 percent of hospitals' total revenue in HFY 1999 and the pool provided only about 2.9 percent, for a total of 10.1 percent.

## A BETTER SOLUTION: TARGETED FINANCIAL RELIEF

***Six specific steps must be taken to stabilize Massachusetts hospitals' finances with short-term emergency relief and durable financing reforms.*** The report details:

1. Regular monitoring of changes in hospital capacity.
2. Identification of the hospitals, beds, ERs, and other services needed to protect the health of the public.
3. Specification of efficiency standards—how much should it cost to run high-quality hospitals?
4. Identification of financially distressed hospitals with an early warning system.
5. Provision of emergency short-term revenue to needed (step 2) but financially distressed (step 4) hospitals to assure that each needed hospital obtains sufficient revenue to remain open and provide high-quality care, as long as it is operated efficiently (step 3). We suggest that some $90 – 100 million in emergency relief should be provided to distressed hospitals in the year to come. About half of this relief should be provided in each of two ways:
   - targeted increases in Medicaid payments or special grants and
   - a new hospital stabilization fund financed by assessments on those hospitals (and their related corporations) that can afford to pay them.
6. Durable long-term reform. This means negotiating a package deal to develop fair, comprehensive, straightforward, and durably affordable hospital payment methods.

If the public is to be responsible for paying enough to assure that all needed hospitals survive and provide high-quality care, it must set the rules for payment. The alternative is to throw money indiscriminately at all hospitals in hope that enough somehow finds its way to the hospitals that really need it.

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# I. INTRODUCTION: COMPETING REALITIES

Throughout the nation, headlines shout about rising health care premiums and rising health care spending. Even though spending is soaring again, HMOs, hospitals, physicians, nursing homes, home health agencies, and others complain that they don't have enough money. Some 45 million Americans lack health insurance, and their numbers rose during most of the 1990s. A decade of managed care, price competition, and hospital closings has not addressed the nation's cost, coverage, and quality problems. If all this has happened during the most prosperous decade in the nation's history, where will we be when our economy slows down or slides into a recession?

Throughout the nation, hospitals' financial margins have slipped since 1997. In Massachusetts, hospitals have responded by seeking higher payments from the state's Medicaid program, from HMOs, and from others. The Massachusetts Hospital Association is asking the legislature to approve massive increases in rates of Medicaid payment to acute care hospitals.

Different parties see different and competing realities when they consider the financial problems of Massachusetts hospitals. From one perspective, hospitals need and want higher revenue, which would require us to spend more money. From another perspective, employees, employers, and taxpayers don't want to or can't afford to provide more money. From one perspective, hospitals appear to have a revenue problem; from another perspective, they have a cost problem.

We wrote in 1989 that

> There are two conflicting truths about Massachusetts hospital financing in general. The first is that increasing numbers of our hospitals are experiencing financial distress. The second is that our hospitals are the most costly in the world. The second truth makes it more difficult to address the first by providing more money.[1]

There is a second pair of competing realities. In one view, Medicaid pays hospitals below their cost of caring for Medicaid patients, and that is unfair and should be remedied by an across-the-board hike in Medicaid rates paid to hospitals. In the other view, many hospitals that are needed to protect the health of the public face financial distress and are likely to close if they are not given targeted financial relief. We lean toward this second view of fairness, which we believe is closer to the public interest in protecting needed hospitals as fairly and efficiently as possible.

This report assesses the need for across-the-board payment increases by Medicaid, and the fairness of such increases. It concludes that some Massachusetts hospitals clearly need emergency short-term revenue infusions. But an across-the-board Medicaid increase is not desirable because too much of the money provided would go to hospitals that are in relatively good financial shape, and because an across-the-board increase would not do enough to help many financially distressed but needed hospitals. ***An alternative solution—targeted financial relief for needed hospitals—is more fair, efficient, and affordable***. Hospitals that are needed by their communities but are vulnerable to closing should have the first claim on scarce state dollars targeted to relieve hospital financial distress. In sum, state government should act, but it should act carefully and frugally to stabilize all of the hospitals that are needed to protect the health of the public.

## *II. BACKGROUND: HOSPITAL FINANCES AND HOSPITAL CAPACITY IN MASSACHUSETTS*

The Massachusetts Hospital Association now asserts that hospitals' financial condition is weak, that needed hospitals may be forced to close, and that hospitals therefore need more money from state government through an across-the-board Medicaid rate increase.[2]

- It is true that Massachusetts hospitals' financial conditions are not as good as those of hospitals nationally. But why is that the case?

- It is true that Massachusetts hospitals have been closing in places and at rates that are endangering the health of the public. But why has this been happening?

Before spending more money, we should assess whether an across-the-board increase in Medicaid payments is a reasonable response to the very real problems of weak hospital finances and dangerous rates of hospital closings. An examination of hospital finances and hospital capacity/closings in Massachusetts helps to answer this question.

### *A. Hospital Financial Condition*

This section shows that

- ***Massachusetts acute hospitals' financial margins have been consistently below the national average as long as these have been measured and compared.***

- ***High costs—not low revenue—are the main reason for low financial margins here.***

- ***Massachusetts hospitals need lower costs, but some do need targeted revenue increases in order to survive.***

- ***Despite relatively low margins, Massachusetts hospitals garnered total surpluses of $1.7 billion during the decade of the 1990s.***

<u>Massachusetts hospitals' historically low margins.</u> Massachusetts hospitals' total margins[3] have consistently been below those of hospitals nationally, as shown in Exhibit 1.[4] Thus, low margins are not attributable to government regulation, as is sometimes imagined. Rather, the low margins antedate

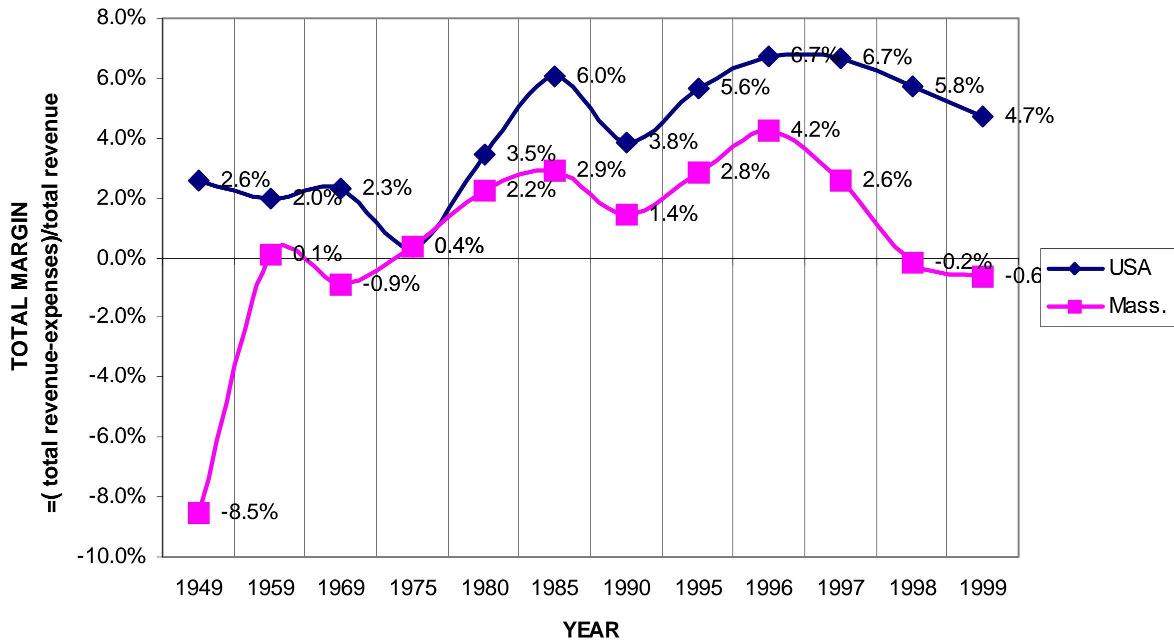
- Medicare and Medicaid (passed in 1965 and implemented in 1966),
- weak regulation of hospital charges by state government (which began in 1975), and
- the state's all-payor and multi-payor rate regulation (which prevailed in steadily weaker forms between 1983 and 1991).

Instead, lower total margins in Massachusetts are apparently attributable to the state's hospitals' tendencies to spend the dollars they have. That is probably associated with:

- a desire to do as much good as possible,
- pressure from communities and physicians to provide more equipment and staff, and
- fewer for-profit hospitals anxious to squeeze out dollars for owners.

The power of these different factors varies over time. But the pattern of lower total margins is consistent.

***Exhibit 1***




Source: Calculated by the authors from *Hospitals, J.A.H.A., Guide Issue* and American Hospital Association, *Hospital Statistics,* various years.

Notes: The 1949 data are for New England as a whole as state-wide financial data were not published. Massachusetts is reasonably representative of the region as it provided 52.0% of the region's inpatient days and 66.7 percent of the region's outpatient visits.

Data are reported at ten-year intervals until 1969, at roughly five-year intervals to 1995, and then annually.

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Massachusetts hospital finances recently ceased to track changes in hospital finances nationally. Generally, Massachusetts hospitals' total margins closely tracked the national pattern from 1975 to 1995, as shown in Exhibit 1. Massachusetts and U.S. margins rose and fell together.

But this changed visibly after 1996, when hospital total margins began to drop slowly in the nation as a whole but plummeted in Massachusetts between 1996 and 1998, before slowing their rate of decline substantially in 1999.[5]

Why did this state's hospitals' total margins cease to track the national pattern?

- This does not seem to have been caused by a revenue problem. Massachusetts hospitals' saw a substantially greater revenue growth from 1996 to 1999 than did the U.S., with total revenue rising here by 13.6 percent versus 11.6 percent in the nation as a whole.

- Instead, the cause of our falling total margins between 1996 and 1999 was a rapid growth in Massachusetts hospital costs, up 19.3 percent in this state versus 14.1 percent nationally.

Thus, our hospitals' revenue grew one-sixth faster than did that of the nation's hospitals, but ***our hospitals' costs grew more than one-third faster than did those of the nation's hospitals. Costs here grew twice as fast as revenue, relative to the national average.*** These data are summarized in Exhibit 2-A.

These data argue strongly against the Massachusetts Hospital Association's claims that low revenue—not high cost—is the source of hospitals' financial problems in this state. ***Even if costs here were justified before 1996, as the Association has long insisted, what could justify the extraordinary cost increase since 1996?***

***Exhibit 2-A***

***Changes in Acute Hospital Expenses and Total Revenue, United States versus Massachusetts, 1996 - 1999***

| | percentage change in expenses | percentage change in total revenue |
|---|---|---|
| USA | 14.1% | 11.6% |
| | | |
| Mass. | 19.3% | 13.6% |
| | | |
| Mass. rise as % of U.S. | +36.9% | +17.2% |

Over the years, we have compiled evidence showing that the weak financial status of many Massachusetts hospitals is attributable mainly to high costs. Costs have remained high after allowing for research, teaching, a slightly older-than-average population, service to patients from out-of-state, a reasonable level of reliance on hospitals for outpatient care, case mix, wage rates, and the like.[6] American Hospital Association data show that 1999 Massachusetts hospitals' costs per person were 38.5 percent above the national average. (The American Hospital Association reported 1999 hospital expenses per capita of $1,703 for Massachusetts and $1,229 for the U.S.) [7] This translates into a $2.9 billion excess. That is, our state would have saved $2.9 billion out of its actual 1999 hospital expenditures of $10.5 billion if we had spent on hospital care at the national average.

We have argued that excessive hospital costs in our state have been attributable in great part to a combination of an elaborate and expensive pattern of care, to over-reliance on teaching hospitals and under-reliance on community hospitals for inpatient acute care, to inefficiency associated with research and teaching, and to over-reliance on hospitals for provision of outpatient or ambulatory care (visits to physicians).

The Massachusetts Hospital Association has argued that inadequate revenue is the main cause of hospitals' financial problems—and that costs here are not unusually high. Various consultant reports prepared for the Association have been used to support this position.[8]

Some of the disagreement about the cost of hospital care in our state rests on the question of what should be the right measure.

- We argue that the best measure of the cost of hospital care is hospital expenditure per person. That is because this is the burden that hospital care imposes on everyone who lives, works, or does business in the Commonwealth.[9]

- The Hospital Association, however, argues that the best measure is hospital cost per unit of service. But that measure ignores the level of use of services. It simply assumes that the present level of use of services is appropriate and worth the money.

- We question whether current use rates are appropriate. They may reflect waste and over-service in some respects, and under-service in others. They also reflect excessive overall reliance on teaching hospitals for inpatient care, and on hospitals generally for outpatient care.

If low revenue were the problem, the main solution would be to provide more money.[10] Hospitals have recently tried aggressively to make a case for revenue hikes. They have won support in some quarters, including editorial support for higher Medicaid payments.[11]

If, as we firmly believe, high costs are the main problem, the main solution will be for hospitals to become more efficient, both clinically and administratively.

Massachusetts Hospitals' Surpluses Total $1.7 billion from 1990 - 1999

It is useful to appreciate that ***Massachusetts hospitals' actual dollar surpluses have been very substantial*** for almost all recent years even though Massachusetts hospitals' *total financial margins* have been below the national average historically, according to data reported by hospitals to the American Hospital Association. Actual surpluses have averaged $166 million annually. Exhibit 2-B displays Massachusetts hospitals' total revenues, total expenses, and surpluses from 1990 to 1999. (See also the chart in Appendix A on p. 33.)

It is worth noting that other data, reported by hospitals, to the Massachusetts Division of Health Care Finance and Policy, show no deficits for 1998 and 1999. They show state-wide surpluses of some $225 million in HFY 1998 and of $82.6 million in HFY 1999.[12]

***Exhibit 2-B***

***Massachusetts Hospitals' Total Expenses, Total Revenues, and Total Surpluses, 1990 –1999***
***(in thousands of dollars)***

| Year | Total Expenses | Total Revenue | Surplus/deficit |
|---:|---:|---:|---:|
| | | | |
| 1990 | $6,543,022 | $6,637,560 | $94,538 |
| 1991 | 7,284,846 | 7,450,070 | 165,224 |
| 1992 | 7,845,886 | 8,086,314 | 240,428 |
| 1993 | 8,507,912 | 8,656,653 | 148,741 |
| 1994 | 8,672,792 | 8,863,599 | 190,807 |
| 1995 | 8,823,926 | 9,082,514 | 258,588 |
| 1996 | 8,819,046 | 9,207,590 | 388,544 |
| 1997 | 9,539,109 | 9,792,878 | 253,769 |
| 1998 | 10,315,438 | 10,296,056 | -19,382 |
| 1999 | 10,518,161 | 10,459,829 | -58,332 |
| | | | |
| 1990 - 1999 | | | ***$1,662,925*** |

Source: American Hospital Association, *Hospital Statistics,* Chicago: The Association, various years.

Note: The dollars are nominal, not constant, so early years' surpluses are under-valued in today's dollars.

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Further, the latest new evidence indicates that ***Massachusetts hospitals are beginning to recover financially in hospital fiscal year 2000***.

- According a Massachusetts Hospital Association survey of 58 of the state's 71 hospitals, total margins rose from 0.5 percent in the first three quarters of HFY 1999 to 1.4 percent in the first three quarters of HFY 2000.[13]

- For these 58 hospitals, annualized surpluses rose from $46.3 million in HFY 1999 to $141.6 million in HFY 2000. Extrapolating to all hospitals statewide, the HFY 2000 surplus is estimated to be $192.3 million—a substantial improvement over the $82.6 million actually reported statewide for all of HFY 1999.[14]

- This was achieved by winning revenue growth of 6.1 percent, visibly above the growth in expenses of 5.3 percent. Remarkably, this one-year rise in revenue of 6.1 percent is nearly half of the total percentage rise for the previous three years.

Still, ***this good news for hospitals overall should not be allowed to obscure the financial problems faced by many needed hospitals.*** Those hospitals must be provided with targeted emergency financial relief.

***Rapid revenue hikes are not a durable solution to hospitals' financial problems. Two things are needed to protect the finances of Massachusetts hospitals:***

First, a focus on more effective cost control techniques.

- cutting administrative waste; we estimate that $1.9 billion yearly would be saved statewide on administration of hospital services under simplified financing and universal coverage[15]

- cutting unnecessary services—diagnostic activities such as unnecessary lab work and radiology, and therapeutic services such as unnecessary surgery

- avoiding duplicative and unnecessary new capital spending, such as that required to replace lost emergency room care—lost when some hospitals close, for example—with new construction at surviving hospitals[16]

- avoiding duplicative and unnecessary construction of sub-acute units or free-standing ambulatory surgical facilities that simply substitute for existing capacity already built and available at acute care hospitals

- improving the efficiency of scheduling elective surgery, and similar managerial improvements; Litvak and Long argue that improved scheduling for elective surgery would greatly reduce the variability in use of operating rooms;[17] this should lower both fixed and variable costs per unit of care in the OR and on inpatient floors as well

Second, targeted financial relief. Fortunately for the people of our state, hospitals overall should not need more money, we believe, though some hospitals do need special and targeted revenue increases. (In the concluding section of this report, we identify specific techniques for targeting financial relief to hospitals in need.)

It is fortunate that hospitals overall don't need more money because health spending in this state is highest in the world, because premium increases are already very high, and because other sectors of health care appear to be in greater need of additional resources overall.

- We estimate that total health spending in Massachusetts will be $37.8 billion this year. That translates into spending of $6,154 for the average person, 30 percent greater than the national average of $4,734 per person. ***If health spending per person in our state equaled the national average, we would save $8.8 billion this year alone. (And the national average is double that of any other wealthy nation.)***[18]

- In eastern Massachusetts, we estimate that health insurance premiums rose by 10 to 15 percent this year for family coverage. That translates into a rise of roughly $1,000 per family. Similar increases have been projected for next year and for the year after. If this materializes, that will mean a rise in the already high cost of family health insurance of fully 50 percent in only three years. This appears likely even with significant increases in out-of-pocket payments by insured patients. And insurance hikes could be greater than estimated here.[19]

- Although the Massachusetts Hospital Association has been seeking an across-the-board Medicaid rate hike, other health care sectors appear to be in greater need of Medicaid payment increases than are hospitals. Priorities must be set.

  - Dental care for Medicaid patients is inadequate, in large part owing to low rates of payment. This is a national problem, and it is very severe in Massachusetts.[20]

  - Many Massachusetts nursing homes are experiencing serious financial problems. Some 25 percent of Massachusetts nursing homes are in bankruptcy. This is attributable in part to risky investments. But it does seem that the Massachusetts Medicaid program's level of payment to a substantial share of nursing homes may not be sufficient to finance appropriate levels of care.[21]

  - Massachusetts home health agencies have seen their total visits per quarter drop by over 35 percent since 1997. They claim that Medicaid pays them "35% below the cost of providing a home nursing visit."[22]

  - With national prescription drug spending rising by 18 percent annually, the state's Medicaid program will be forced to pay more for prescription drugs unless positive and comprehensive steps are taken to hold down the prices that drug manufacturers are able to charge.[23]

### *B. Hospital Capacity*

The number of Massachusetts acute care hospitals has fallen from 140 in 1950, to 127 in 1970, to 110 in 1980, to 97 in 1990, and to 74 today. The number of acute care beds has fallen from 23,000 in 1970, to 21,000 in 1990, and to an estimated 14,000 today.[24]

The pace of the decline has accelerated sharply in the past decade. This is owing mainly to the beliefs—embodied in state statute—that closing hospitals and beds would save money, and that price competition would be the most efficient method of closing hospitals and beds.

We have long warned that the actual pattern of hospital closings, as distinguished from some theoretical pattern of hospital closings was not likely to save money but was likely

to harm access to care—both nationally and in Massachusetts.[25] We urged protecting all needed hospitals.

When we raised these concerns three years ago, in a *Wall Street Journal* interview, one health care financial consultant responded by asking, "Do you build hospitals for the once-in-five-years flu epidemic?"[26] But it is being increasingly acknowledged that Massachusetts is facing shortages of hospital capacity far more often than that.

Our position has been consistent in opposing the extreme fashions of over-building and over-closing hospitals.

We have argued strongly against wasteful and unnecessary over-building by hospitals in Boston and Worcester.[27]

At the same time, we have argued for conserving needed hospitals for the long haul once they are built. There are four reasons.

- First, little money is saved by closing hospitals, particularly the smaller and less costly institutions that are typically more likely to close. Fixed costs persist because bonds must still be paid off, and variable costs follow patients to other hospitals where they obtain substitute care—if they are able to do so.

- Second, patients often do not obtain substitute care. They may fall through the cracks, deprived of care.[28] Shepard has found that as many as 30 percent of a closed hospital's patients fail to obtain care at surviving hospitals.[29]

- Third, hospitals tend to close disproportionately in minority and low-income areas, thereby harming access to care by residents of those areas.[30] And when hospitals close, other caregivers—particularly physicians in private practice—may be forced to move nearer to surviving hospitals in order to reduce time traveling back and forth to the hospital. As a result, communities that already suffer substantial unmet health care needs may be increasingly under-served in the future.

- Fourth, hospitals or parts of hospitals that may look unnecessary today—to some observers—are likely to be needed down the road as today's baby boomers age. We have estimated that, if present trends persist, this state will face a shortage of 1,650 acute hospital beds as soon as the year 2005, and a shortage of some 4,000 beds in 2025.[31]

State government has maintained an official policy since 1988 of encouraging hospital closings and bed reductions as a method of saving money. This approach was embodied in chapter 23 of the Acts of 1988 (the Massachusetts universal health care law), and in chapter 495 of the Acts of 1991.[32] This policy of state government has been consistently supported by the Massachusetts Hospital Association.

At one time, it was widely believed that an excess of hospitals and an excess of beds largely explained high Massachusetts hospital costs. If this was ever true, it is simply not true today.

- In 1984[33]
  - Massachusetts had 4.5 acute care hospital beds per 1,000 people, or 4.7 percent above the national average of 4.3 beds per 1,000.
  - Our state's hospital costs per person then were 38.2 percent above the national average.

- In 1999
  - Massachusetts had only 2.6 acute care beds per 1,000 people, or 13.3 percent ***below*** the national average. Our 2.6 beds per 1,000 were down by more than two-fifths from the 4.5 beds per 1,000 people that we had in 1984.[34]
  - But hospital closings and bed reductions apparently have not saved money. In 1999, according to American Hospital Association data, Massachusetts hospitals' costs per person were still 38.5 above the national average. [35]

***Exhibit 3***

***Hospital Beds per 1,000 People and Hospital Costs per Person, Massachusetts and U.S.A., 1984 and 1999***

| | Massachusetts | U.S.A. | Mass. % of U.S.A. |
|---|---|---|---|
| Beds/1000 people, | | | |
| 1984 | 4.5 | 4.3 | +4.7% |
| 1999 | 2.6 | 3.0 | -13.3% |
| Costs/person | | | |
| 1984 | $715 | $517 | +38.2% |
| 1999 | $1,703 | $1,229 | +38.5% |

Source: Authors' calculations from American Hospital Association, *Hospital Statistics,* Chicago: The Association, 1985 and 2000, and from U.S. Bureau of the Census data.

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In 1999, the Massachusetts excess hospital cost per citizen was $474, as calculated from the data in Exhibit 3. This $474 per person, multiplied by an estimated state population of 6,175,000, yields a Massachusetts hospital cost excess of $2.9 billion—the extra amount spent on hospital care in this state—above what our costs would have been had we spent at the national average.

Deregulation and competition were once widely sold as methods of lowering our state's high hospital costs. Different groups sought different things from rate deregulation and price competition. Some in the state administration and legislature apparently believed that if hospitals had to compete for HMO contracts and patients by price and quality, they would become more efficient. Some hospital executives apparently believed that their hospitals would fare better under competition than they had under rate regulation.[36]

During most of the 1990s, the prevailing view from the state administration, from HMOs, and even from the Massachusetts Hospital Association was that the state had too many hospitals and beds, that excess beds were an important reason why hospital costs were too high, and that unleashing price competition on hospitals would force them to become more efficient. Hospitals that were not needed, that were too costly, that were badly managed, or that delivered low-quality care would be forced to close.

For example, a high former official in the Weld administration urged the view that if hospitals made bad investments or bad business decisions, they deserved to close. Even the Massachusetts Hospital Association (MHA), which now calls for across-the-board increases in Medicaid payments to hospitals, opposed state intervention to identify and stabilize needed hospitals for most of the 1990s.[37] For years, when large and powerful hospitals that pay substantial dues to the MHA expected that they would fare well under competition and deregulation, the MHA favored competition and deregulation. The MHA did little to protect the financial interests of smaller hospitals with less bargaining power in the marketplace, and hospitals with smaller financial reserves.

It is frustrating that free market approaches to hospital competition have been endorsed without investigating the extent to which the hospital market satisfies the requirements of a free market. Unfortunately, nothing close to free market competition exists in the hospital field. This can be seen by considering the requirements for a genuine free market. Those requirements include:

1. Many small buyers and sellers, so each party takes the price that the market makes; no party is powerful enough to influence price.

2. There are no artificial restrictions on supply, demand, or price.

3. There is easy entry and exit to and from the market, so no party can build monopoly or oligopoly power.

4. There is good information about price and quality.

In the hospital market, each of these requirements is violated in profoundly important ways:

1. Increasingly, owing to hospital closings and mergers, there are fewer and fewer hospitals—sellers of hospital care—in each region of the state. Consider the mergers in Fall River – New Bedford, mergers and closings in the Springfield and Worcester areas, and three large sets of teaching hospital mergers in Boston.

2. There are many artificial restrictions on demand. Patients do not act as sovereign consumers. Instead, their doctors make or strongly influence almost all important decisions about hospital care. Patients are seldom obliged to consider price when they seek a doctor or choose a hospital. HMOs merge to bargain over price with hospitals. (It is no accident that the merger between Harvard Community Health Plan and Pilgrim Health Care was announced seven months after the merger between Massachusetts General and Brigham and Women's hospitals was announced.) There are many artificial restrictions on supply. Hospitals must satisfy licensing requirements.

3. Entry into the hospital marketplace is very hard. Once one hospital establishes a monopoly position, or once a few hospitals establish oligopoly positions, it is very hard for other hospitals to enter the market. Huge sums would have to be invested. Doctors would have to be lured to admit their patients to the new hospital. That reality makes inter-hospital competition a one-way street, pointing toward ever-growing control of markets by fewer and larger hospitals or chains of hospitals.

4. Competition by price and quality is very difficult. Most employers buy health insurance overwhelmingly by price. Quality is very difficult to gauge. Further, patients are not anxious to heed the law of the market—*caveat emptor*—let the buyer beware! Patients are interested in getting well. Patients are more likely to get well when they trust their physician and their hospital, other things equal. ***The market demands mistrust if it is to work, but patients' health demands trust that is built on a foundation of competence and caring.***

   Additionally, in health care, prices are set for many services at a level far from their cost. For example, a flat daily rate of $1,200 for an inpatient bed greatly exceeds the cost of recuperative inpatient days but under-prices the cost of a day of surgery. Similarly, a flat basic charge of $150 for an ER visit greatly exceeds the cost of seeing a patient with an ear infection but under-prices the cost of a severe trauma case. The result throughout is that prices often fail to track costs.

   This market failure means that when buyers purchase by price, they are not necessarily buying the lowest-cost care, holding quality constant. Therefore, cutting hospital length-of-stay, performing more same-day surgery, diverting patients from the emergency room, and transferring patients from ordinary inpatient services to sub-acute or observation beds can actually increase total spending on health care.[38] When price does not consistently track cost, blind anti-hospital sentiment can lead to prejudiced decisions to move care from hospitals without careful financial analysis.

Without a free market, for all these reasons, it is not surprising that a free market's benefits have not materialized in the hospital field. Indeed, a study of hospital closings in 52 cities found that, in the 1990s, larger hospitals were more likely to survive. As in earlier decades, hospital efficiency had no value in predicting which hospitals would survive. For the first time, hospitals with more money in the bank were more likely to survive.[39]

In a free market, profits signal efficiency and satisfaction of consumer wants. Without a free market, we have profits without honor. That is, some hospitals garner profits not justified by genuine free market competition. On the other side of the ledger, we often see financial losses without blame—hospitals that are losing money even though they may be efficient and even though they may be needed by their communities.

The absence of a free market for hospital care, the loss of needed hospitals and emergency rooms, and the need to protect surviving hospitals (unless their closing can be shown to be safe) combine to warrant state intervention to identify and protect all hospitals needed to assure the health of the public.

Today, the Massachusetts Hospital Association points to hospital closings and emergency room diversions as evidence that hospitals need across-the-board payment increases. The Association's logic seems to run like this: Hospitals suffer weak

finances and some close.  Fewer beds and ERs are available.  Closings and bed reductions therefore result in more ER diversions.  The solution:  more money for all hospitals, through across-the-board rate increases.[40]

Given the hospital industry's stance over the past decade on hospital financing and closings, this is a little like a person killing his/her parents and then begging for aid by claiming to be an orphan.

And, as will be shown, it is also like a person showing an empty pocket while asking for more money, without disclosing how much money might be in another pocket.

Over the past decade, the vocal segments of the hospital industry have willingly embraced methods of payment—deregulation and price competition—that have forced hospitals to close in large numbers—and that continue to deprive needed hospitals of the financial oxygen they require to survive.

Today, the Massachusetts Hospital Association simply wants more Medicaid money for all hospitals.  It does not want any state oversight.  It does not want the state to assess which hospitals are actually needed.  It does not want a state inquiry into which hospitals actually require more money. It does not want the state to measure and set standards for hospital efficiency that must be met before payment increases are granted.  It does not want the state to intervene to reverse or reform the deregulation and price competition that have helped to create today's hospital closings crisis.

## *III. ONE PROPOSED REMEDY: ACROSS-THE-BOARD PAYMENT INCREASES*

Some parties have argued that an important cause of hospital financial distress is that the Massachusetts Medicaid program pays hospitals at too low a rate. They say that hospitals are paid by Medicaid at a rate below hospitals' costs.[41]

The *Boston Globe* recently editorialized in favor of higher Medicaid payments to all hospitals, urging that "Using state revenues to help the most beleaguered hospitals makes sense…." [42] ***Unfortunately, reality does not correspond to the assumptions of the editorial.*** As will be shown shortly, boosting Medicaid payments to all hospitals does much more to help the hospitals in better financial condition than it does to help hospitals that are vulnerable to closing. That is why we have urged targeted financial relief through Medicaid and from other sources.

### *A. The Proposal*

Some parties have repeatedly proposed an across-the-board hike in Medicaid payments to all hospitals. In April of 2000, the Massachusetts Hospital Association requested Medicaid payment increases of between $100 million and $200 million for state fiscal year (SFY) 2001.[43] The Massachusetts Hospital Association is reported to be seeking increases of $100 – 150 million for SFY 2002, on top of the $25 million in higher Medicaid rates actually appropriated for SFY 2001.[44]

A $100 million increase would amount to a 16.6 percent rise from HFY 1999 actual Medicaid hospital payments of $603.3 million.[45] A $150 million increase would amount to a 24.9 percent rise from Medicaid's HFY 1999 actual payments to hospitals.[46]

The real cost of the Massachusetts Hospital Association's request for SFY 2002 is somewhat difficult to gauge. One *Boston Herald* report mentioned that it was estimated to be as low as $75 million, or about 10 percent above SFY 2002 payments without the rise.[47] But at least one preliminary analysis of the various provisions that make up the Association's proposal, prepared at the Division of Medical Assistance, apparently suggests that the proposal may actually be substantially more costly than this.

This report examines the impacts of an across-the-board hike in Medicaid payments. For convenience, we consider the effects of a ten percent increase in Medicaid payments to each hospital. That would amount to about $60 million in 1999, the year modeled in this report. (Increases of 16.6 to 24.9 percent, as sought by the Massachusetts Hospital Association, would flow to hospitals in the same proportions as those reported below.) Where would the money go?

The present report does not consider the overall question of what would constitute fair levels of Medicaid payment to hospitals. Instead, its focus is on

- whether an across-the-board hike would do enough to help out the state's financially distressed hospitals, and on

- whether an across-the-board hike would constitute a good way for Massachusetts state government to target scarce financial resources.

Similarly, the report does not distinguish the effects of separate Medicaid rate increases that are targeted at outpatient care or inpatient care. Because hospitals differ considerably in their provision of outpatient care to Medicaid patients, with teaching hospitals typically believed to provide more services, an increase in outpatient rates would help these hospitals the most.

The final section of this report will describe a set of six steps that should be taken to identify and then financially stabilize all hospitals needed to protect the health of the public.

### *B. Medicaid Payments and Hospital Finances*

To evaluate this proposal, two pieces of background data are needed:

First, in hospital fiscal year (HFY) 1999, direct Medicaid payments to 71 Massachusetts acute care hospitals totaled some $603.3 million.[48] Of this, an estimated $282.1 million (46.8 percent) was paid for outpatient care and $321.2 million (53.2 percent) paid for inpatient care.[49] Statewide, Medicaid directly provided hospitals with 6.7 percent of their patient revenue in HFY 1999, and with 5.5 percent of their total revenue.[50]

When HMO payments to hospitals for Medicaid-financed patients are included, Medicaid provided 8.8 percent of hospital patient revenue in HFY 1999 and 7.2 percent of total revenue.

But it should be noted that an across-the-board hike in Medicaid payments to hospitals would only affect payments made directly by Medicaid, not the payments that Medicaid makes indirectly through HMOs. That is because the HMOs determine those payment rates, and the HMOs would not be given more money under any provisions for an across-the-board payment hike. And if separate provisions were made to give HMOs greater revenue with which to care for Medicaid patients generally, there is no assurance that a share of those higher payments would find their ways to hospitals generally—or to financially distressed hospitals specifically. Hospitals' bargaining power would influence that allocation, and many of the hospitals that now lose money are doing so because they lack sufficient bargaining power today.

Second, the 71 Massachusetts acute care hospitals reported a statewide overall surplus of revenues over expenses totaling $86.5 million in hospital fiscal year 1999.[51] This surplus reflected patient care revenue, other operating revenue, and non-operating revenue (such as donations or interest on endowments).

Third, the hospitals' reported surpluses usually ignore the incomes earned by related corporations, such as holding companies. We last compiled data on income of hospital holding companies and other related corporations for HFY 1988. Then, we found that 13 of the state's 20 largest hospitals had holding companies and subsidiaries on which complete and comparable data could be obtained.[52]

The holding companies and other related corporations earned incomes of $53.2 million in 1988. If these incomes (measured very conservatively) increased only in proportion to the Boston area consumer price index through HFY 2000, that income would be some $78.5 million this year (and $73.9 million in 1998).[53] Viewed statewide, it is enough to substantially improve the overall margins of Massachusetts hospitals. In 1998, for example, hospitals' total statewide surpluses totaled only $86.5 million, as just noted. An addition of $73.9 million in hospital revenue from parent corporations in 1998 would constitute an increase of 85.4 percent in hospitals' total statewide surpluses.

It is important to note as well that income from these related corporations is not evenly distributed among hospitals. It is heavily concentrated in a few hospitals.

Still, unless this additional income is considered, hospitals' overall financial conditions—viewed statewide—appear substantially worse than they really are. Ignoring the additional income masks the true financial condition of the wealthier hospitals with substantial resources in related corporations, blurring the differences between their own financial margins and the financial margins of less wealthy hospitals.

A full and fair examination of the financial problems of different hospitals should consider all income earned by related corporations. In 1990, Sen. Albano and Rep. McDonough filed legislation to require consolidated hospital financial reporting. The Massachusetts Hospital Association opposed it. It failed.[54]

Consolidated financial reports for all non-profit hospitals are now filed with the Attorney-General's Office, but they are not regularly compiled into state-wide statistical summaries. The Division of Health Care Finance and Policy should do so annually.

Fourth, from a cash perspective, the hospital surpluses include depreciation as an expense even though it is not one. Amortization of capital is an expense which is not included, but depreciation often exceeds amortization, leading to positive cash flows that do not appear in the reported hospital surpluses. On the other hand, costs of purchasing new fixed assets are not included, either. This highlights the importance of examining hospitals' cash positions as part of any assessment of their financial conditions.[55]

## *IV. WHICH HOSPITALS WOULD GAIN FROM AN ACROSS-THE-BOARD MEDICAID HIKE?*

We have analyzed the effects of a 10 percent ($60 million) across-the-board hike in Medicaid payments to hospitals in three ways. We investigated the effects on

- hospitals grouped by their hospital fiscal year (HFY) 1999 surpluses or deficits.
- hospitals grouped by teaching status (large academic medical centers, other teaching hospitals, and non-teaching hospitals).
- Greater Boston hospitals grouped by high versus low rates of emergency room diversion in 1999 and 2000.

In each instance, we considered whether hospitals in need would be the more likely to benefit from an across-the-board hike in Medicaid payments to hospitals.

### *A. Hospitals Grouped by HFY 1999 Surplus*

We first divided the 71 hospitals into two groups, the 20 with the highest dollar surplus of total revenues over expenses, and the remaining 51 hospitals.[56] We totaled each group's extra Medicaid payments and compared them with total surplus revenues before and after the $60.3 million or 10 percent hike. The results are summarized in Exhibit 4.

***Exhibit 4***

***Effects of Higher Across-the-board Medicaid Payments to Massachusetts Hospitals , Grouped by HFY 1999 Surpluses***

| hospitals grouped by surplus revenue | rise in Medicaid $ | surplus revenues before Medicaid rise | surplus revenues after Medicaid rise |
|---|---|---|---|
| | | | |
| top 20 hospitals | $30.2 | $207.2 | $237.4 |
| bottom 51 hospitals | $30.1 | ($120.7) | ($90.5) |
| all 71 hospitals | $60.3 | $ 86.5 | $146.9 |

The top 20 hospitals, measured by surplus revenue before the Medicaid hike, enjoyed surplus revenues of $207.2 million in HFY 1999. These 20 hospitals would receive $30.2 million in higher Medicaid payments, or just over half of the rise in Medicaid payments (50.1 percent). After the hike, they would enjoy surplus revenues of $237.4 million.

The bottom 51 hospitals, by contrast, showed a loss of $120.7 million in hospital fiscal year 1999. These 51 hospitals would receive $30.1 million in higher Medicaid payments, which would reduce their loss to $90.5 million.

If the aim of the across-the-board hike of 10 percent in Medicaid payments is to support financially distressed hospitals, it fails spectacularly.

- ***Fully one-half of an across-the-board Medicaid rate increase would go to the least needy 20 hospitals in the state***, hospitals that are already making money, and whose surpluses would rise substantially. The 10 percent Medicaid hike that is modeled here would boost these 20 hospitals' surpluses by 12.7 percent ($30.2 million hike divided by the existing surplus of $237.4 million). Bigger across-the-board Medicaid payment hikes—of 16.6 to 24.9 percent—would do even more for the most profitable hospitals.

- By contrast, the remaining half of the increase would go to the needier 51 hospitals, but it overcomes only $30.1 million (or 24.9 percent) of their $120.7 million loss in hospital fiscal year 1999.

- This across-the-board hike looks like an instance of "to those who have, shall be given."

### *B. Hospitals Grouped by Teaching Status*

Second, we considered the effects of a 10 percent across-the-board rise in Medicaid payments on three types of hospitals—the state's seven academic medical centers, the eleven other teaching hospitals, and the 53 non-teaching hospitals.

The data are presented in Exhibit 5.

The seven major academic medical centers would have received $27.8 million from a 10 percent across-the-board increase in Medicaid payments, or 46.1 percent of the statewide total increase of $60.3 million. In the aggregate, this extra money would have overcome about three-fourths of the $36.0 million overall deficit suffered by this group of hospitals in HFY 1999. (The uneven distribution of these gains among the seven academic medical centers is discussed shortly.)

The eleven other teaching hospitals would have received $10.3 million from a 10 percent across-the-board increase in Medicaid payments, or 17.1 percent of the statewide total. This money would have boosted the eleven hospitals' HFY 1999 surplus by one-seventh, from $72.2 million to $82.5 million.

The state's 53 non-teaching hospitals' would have received $22.2 million (36.8 percent of the statewide total). This would have raised the hospitals' HFY 1999 surplus by almost one-half, from $50.4 million to $72.6 million.

The lion's share of a ten percent across-the-board revenue hike would go to the state's 18 teaching hospitals even though, in the aggregate, they earned a surplus. Money-losing teaching hospitals get too little from an across-the-board hike, and money-making teaching hospitals get too much.

- The state's 18 teaching hospitals would garner $38 million (63.2 percent) of the $60 million increase from a ten percent across-the-board hike in Medicaid revenue.

- Teaching hospitals would get more money even though their overall financial conditions are improving. Sixteen teaching hospitals' finances improved from a –0.3 percent total margin in the first three quarters of HFY 1999 to +1.3 percent in the first three quarters of HFY 2000. By contrast, 42 non-teaching hospitals' total margins fell from +1.9 percent in HFY 1999 in the first three quarters of HFY 1999 to +1.4 percent in the first three quarters of HFY 2000.[57] (These data concern 58 of 71 hospitals.)

In the first three quarters of 1999, teaching hospitals were worse off than non-teaching hospitals, these data show. But in the first three quarters of 2000, the two groups' overall financial margins were virtually identical.

This shows that across-the-board hikes in Medicaid payments are shooting at moving targets. Teaching and non-teaching hospitals' financial status varies over time. Statewide, hospitals' finances vary from year to year, as demonstrated earlier. And, at the individual hospital level, finances fluctuate even more from year to year. This makes an overall rate hike not only an inefficient shotgun approach, but a shotgun that would shoot in the same spot year after year.

These aggregate data tend to minimize the unfairness of an across-the-board Medicaid rate hike. In practice, when considered hospital-by-hospital, the across-the-board revenue hike would not substantially address problems of the money-losing hospitals. It would, however, add to the surpluses of the money-making hospitals. This is illustrated below in a separate examination of the state's seven academic medical centers (see Exhibit 6 and Exhibit 7).

***Exhibit 5***

***Effects of Higher Across-the-board Medicaid Payments to Massachusetts Hospitals, Grouped by Teaching Status, HFY 1999***

| hospitals grouped by teaching status | number of hospitals | 10 percent rise in Medicaid $ | surplus revenue before Medicaid rise | surplus revenue after Medicaid rise |
|---|---|---|---|---|
| Academic medical centers (AMC) | 7 | $27.8 | ($36.0) | ($8.2) |
| Other teaching hospitals (TCH) | 11 | $10.3 | $72.2 | $82.5 |
| *subtotal— AMC + TCH* | *7 + 11 = 18* | *$38.1* | *$36.2* | *$74.3* |
| Non-teaching hospitals | 53 | $22.2 | $50.4 | $72.6 |
| ***All hospitals (71)*** | ***71*** | ***$60.3*** | ***$86.5*** | ***$146.8*** |

Note: The academic medical centers are the seven largest teaching hospitals, those very closely associated with medical schools, and with the highest ratios of medical residents to patients. The other teaching hospitals have residency programs and medical school affiliations, but these are not as large or close as those of the academic medical centers. The non-teaching hospitals are those without residency programs.

Exhibit 6 and Exhibit 7 detail the effects of a ten percent across-the board rise in Medicaid payments in HFY 1999 on each of the state's seven academic medical centers (AMCs).

- Two of the seven AMCs—Beth Israel-Deaconess and Children's—lost money in HFY 1999. The 10 percent rise in Medicaid payments would not have been remotely sufficient to offset those losses. The two hospitals' losses totaled $83.6 million. They would have received only $6.3 million in additional Medicaid payments—only 7.5 percent of their combined *losses*.

- At the remaining five AMCs, the 10 percent rise in Medicaid payments increased the reported surpluses from $47.6 million to $75.4 million—a 58.4 percent rise in their combined *surpluses*.

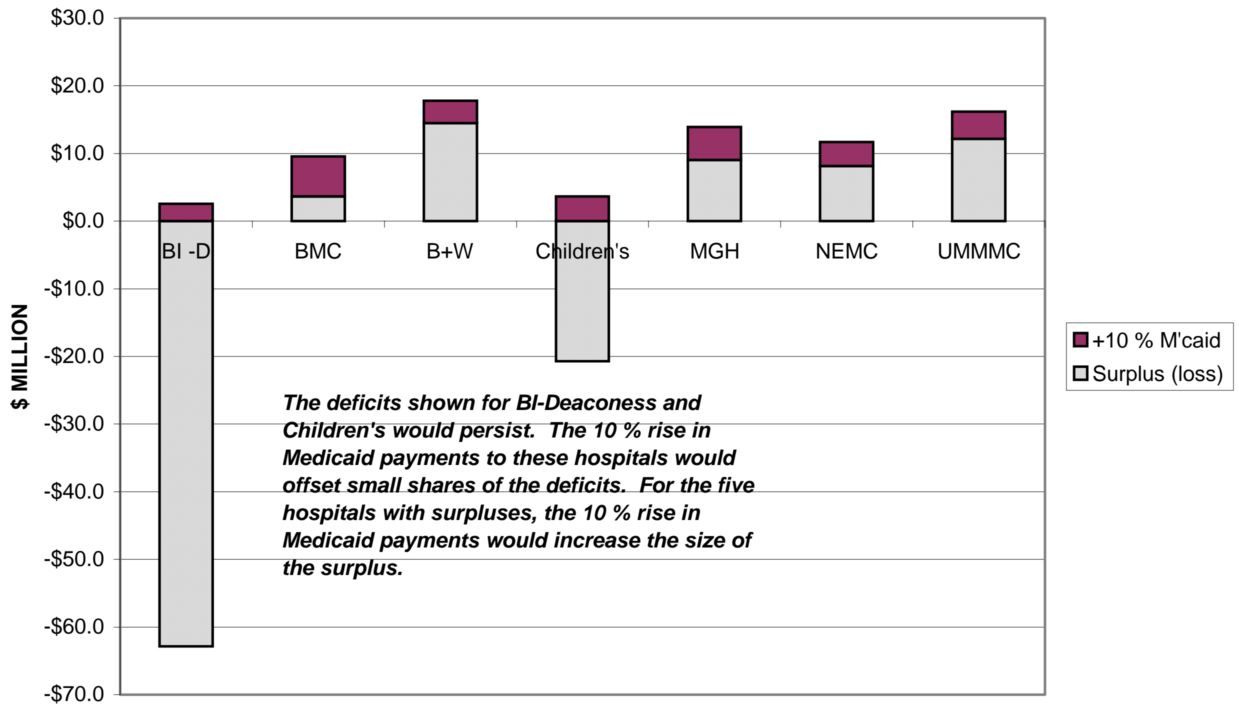
As before, these data include only hospitals themselves and do not reflect financial gains from related corporations.

***Exhibit 6***

***Effects of a Ten Percent Rise in Medicaid Payments on Seven Massachusetts Academic Medical Centers, HFY 1999***

| | Estimated FY 1999 Medicaid Payments | Total Unrestricted Revenue and Gains[58] | Medicaid % of Total Unrestricted Revenue and Gains | Excess of Total Revenue over Total Expenses | Total Margin | Additional Revenue from 10 % rise in Medicaid |
|---|---|---|---|---|---|---|
| Beth Israel Deaconess | $25.6 | $714.4 | 3.6% | -$62.9 | -8.8% | $2.6 |
| Boston Medical Center | $58.9 | $563.6 | 10.5% | $3.6 | 0.6% | $5.9 |
| Brigham and Women's | $33.0 | $884.4 | 3.7% | $14.5 | 1.6% | $3.3 |
| Children's | $36.7 | $460.6 | 8.0% | -$20.7 | -4.5% | $3.7 |
| Massachusetts General | $48.5 | $1,050.9 | 4.6% | $9.1 | 0.9% | $4.9 |
| New England Med. Ctr. | $35.3 | $404.9 | 8.7% | $8.1 | 2.0% | $3.5 |
| U.Mass. – Memorial | $40.2 | $611.5 | 6.6% | $12.2 | 2.0% | $4.0 |
| | | | | | | |
| AMC subtotal (7) | $278.3 | $4,690.4 | 5.9% | -$36.0 | -0.8% | $27.8 |

*Exhibit 7*




### *C. Hospitals Grouped by Hours of Emergency Room Diversion*

Eastern Massachusetts hospitals have recently been closing their emergency rooms more frequently than in the past.

The Massachusetts Hospital Association asserts that hospitals have “cut services, reduced community benefits programs, eliminated jobs and decreased the number of beds they have open” in the face of tighter financial margins.[59] “As a result, emergency rooms are backed up more often.” [60]

The Hospital Association's logic, then, seems to run like this:

- tighter financial margins →
- service cutbacks →
- ER diversions

In this way, the Hospital Association seeks to present emergency room diversions as another justification for an across-the-board hike in Medicaid payments.

But there is a problem. Examination of the data on ER diversions shows that:

- ***The hospitals that close their emergency rooms more often are typically in better financial condition.***

- And hospitals that close their emergency rooms less often are typically in inferior financial condition.

We have analyzed the data on emergency room diversions reported by 21 greater Boston hospitals to the Metropolitan Boston EMS Council, Inc. We considered the months of January through October 2000.[61] We compared each hospital's total hours on diversion during these ten months with the hospital's HFY 1999 financial condition, the most recent available.[62] Exhibit 8 displays the main findings.

- Twelve of the 21 hospitals garnered surpluses during HFY 1999 totaling $64.0 million. Yet these hospitals totaled 3,334 hours on ER diversion, an average of 278 per hospital.

- The remaining nine hospitals suffered deficits totaling $106.0 million. Yet these hospitals totaled only 670 hours on ER diversion, an average of 74 hours per hospital.

***Exhibit 8***

***Surpluses versus ER Diversion Hours,***
***21 Greater Boston Hospitals, 1999 - 2000***

| | total for all hospitals | | average per hospital | |
|---|---|---|---|---|
| | surplus/deficit | ER diversion hours | surplus/deficit | ER diversion hours |
| 12 hospitals with surpluses | $64.0 million | 3,334 | $5.3 million | 278 |
| 9 hospitals with deficits | ($106.0 million) | 670 | ($11.8 million) | 74 |
| 21 hospitals | ($42.0 million) | 4,004 | ($2.0 million) | 191 |

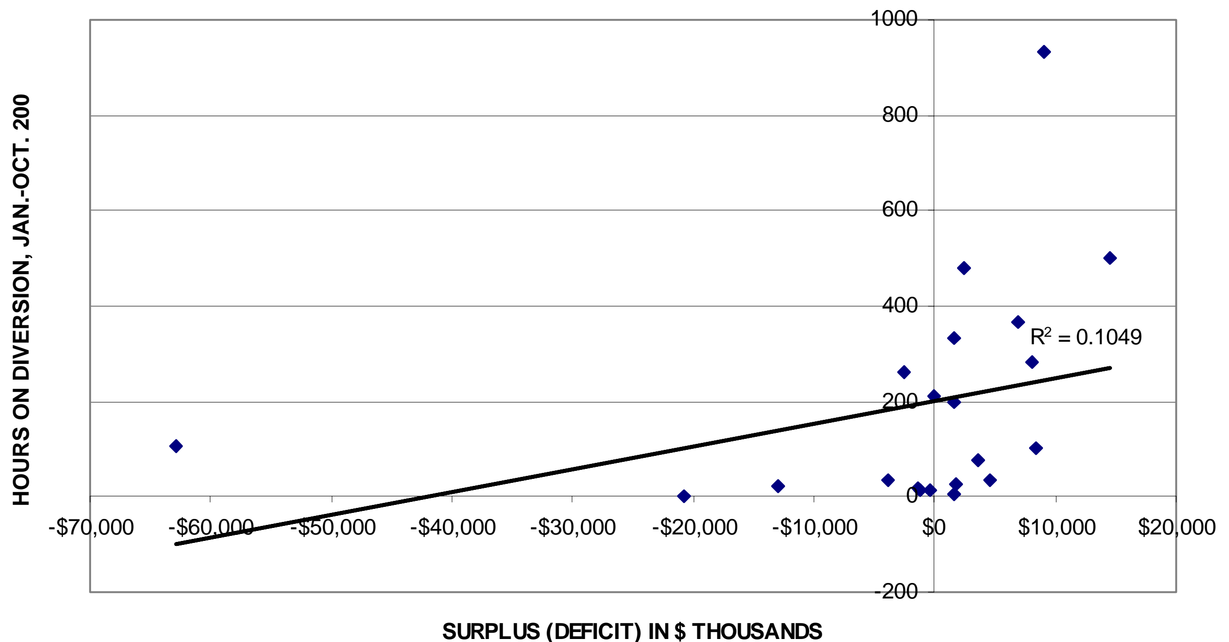
Source: Hospital reports of hours on ER diversion to the Metropolitan Boston EMS Council, Inc. for January – October 2000, and hospital financial reports to the Massachusetts Division of Health Care Finance and Policy for HFY 1999.

We also correlated each of the 21 hospitals' surplus/deficit with its hours on diversion. As shown in Exhibit 9, the two are positively correlated. In other words, ***hospitals with higher surpluses generally had ERs that were on diversion for greater numbers of hours***. (The Pearson correlation between surplus/deficit and hours on ER diversion is $r_p = 33.0$; the $R^2 = 10.5$ %; and the relationship is significant at 0.144.)

This suggests that financial distress is not typically the reason why some hospitals divert ambulances from their emergency rooms more frequently.

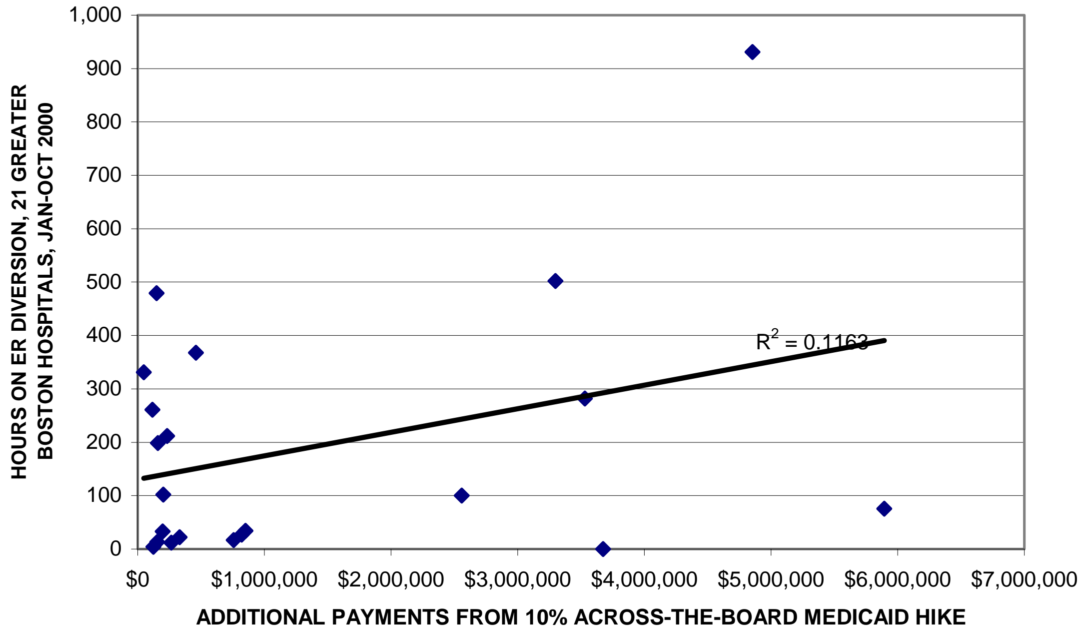
We expect that this relation between ER diversions and hospital financial condition would be even stronger if income from hospitals' parent corporations or holding companies were consistently incorporated into measures of hospital financial condition.

***Exhibit 9***




Hospitals whose ERs are on diversion more often would be slightly more likely to receive more money from a ten percent across-the-board hike in Medicaid, as shown in Exhibit 10. But the across-the-board hike is an inappropriate response to the problem of ER diversions because hospitals with higher ER diversions tend to be in better financial condition, as just shown in Exhibit 9.

*Exhibit 10*




These analyses indicates that greater ER diversions are found in hospitals with greater financial resources. ***Therefore, an across-the-board hike in Medicaid payments would constitute a foolish response to the problem of ER crowding and resulting diversions.***

Some might speculate that some hospitals deliberately close their ERs more often in order to keep out patients on whom they might lose money, thereby improving their financial margins. We do not credit such speculation. Rather, it may be that hospitals that are making money have seen volume increases and are more often crowded, while hospitals that are losing money are less crowded and are reluctant to close their ERs for fear of seeing their revenues and volumes of care drop still further.

It is possible, though, that bad management is part of the explanation for ER crowding. Often, ERs are placed on diversion because they are unable to move patients from the ER to an ICU bed or to an ordinary hospital bed. In turn, ordinary beds and ICU beds can be crowded owing to improper scheduling of elective surgery, as Litvak and Long have argued.[63] In that case, "reducing variability in elective case volume in operating rooms as a 'side effect' has a great potential to improve the access to hospitals, particularly to emergency rooms and ICUs." [64]

In sum, an across-the-board Medicaid increase would be very badly targeted:

- It would do too little to help hospitals that are losing money while rewarding hospitals that are already enjoying surpluses.
- It would go disproportionately to the hospitals that already have high levels of ER diversions even though those are also the hospitals that enjoy substantial surpluses.

Further, an across-the-board hike in Medicaid rates for hospitals would be undesirable public policy because:

It would be inappropriate to try to remedy overall hospital financing problems with higher revenue—because revenue shortfalls do not seem to be at the heart of our hospitals' financial problems.

Similarly, even if it were desired to boost hospitals' revenues across the board, it would be extremely difficult to rely on increases in total Medicaid payments financed with state and federal dollars to do the job. That is because, as noted earlier, Medicaid provided only about 7.2 percent of hospitals' total revenue in HFY 1999.[65]

Relying on changes in the financing of the state's uncompensated care pool to protect financially distressed hospitals shares the problems of relying on Medicaid. The pool provided only about 2.9 percent of hospitals' total revenue in HFY 1999. (Medicaid and the pool together provided only about one dollar in every ten.) Even more important, reducing the financial obligations of hospitals to the pool might well disproportionately benefit the hospitals that typically make money today. That investigation is beyond the scope of this report.

Finally, Medicaid spending has been rising rapidly for many reasons, and may be in danger of breaching the revenue neutrality ceiling imposed by federal law and waiver. Looking forward, dentists', nursing homes', home health agencies', and (probably) many physicians' claims on state dollars for across-the-board Medicaid increases are probably more pressing than are the claims of the hospital industry for an across-the-board rate increase.

## V. A BETTER SOLUTION: TARGETED FINANCIAL RELIEF

State action is vital to preserve all needed Massachusetts hospitals endangered by unsafe and unfree competition and other forces. But throwing money indiscriminately at all Massachusetts hospitals through an across-the-board hike in Medicaid payment rates

- does much too little to help most of the hospitals that now face serious financial distress,
- relies excessively on Medicaid, which provides a very small share of hospitals' total revenue,
- provides windfall payments to hospitals that are doing well financially today,
- does not address the causes of the problem of ER diversions, and
- is very costly, wasting scarce state dollars that are probably more needed elsewhere.

Further, a big Medicaid payment hike for hospitals inevitably means that less money is available for all other public purposes. Inside health care, these could include higher Medicaid payments to dentists, physicians, nursing homes, and home health agencies—all of which might be in greater need of the funds than is the hospital industry state-wide.

***We therefore recommend targeted financial relief for needed Massachusetts hospitals experiencing financial distress.*** The money to relieve hospitals should be drawn from two sources—Medicaid payments and a hospital stabilization fund drawn from hospitals that can afford to pay it.

If possible, the Medicaid portion of this relief should be crafted as part of Medicaid's overall payments to hospitals so that it appropriately qualifies for the federal government's 50 percent financing match. Some assert that this is difficult to do; others insist that it is possible if done right. This avenue must be explored carefully and it should be explored quickly.

State government must, in cooperation with other parties, act to identify and protect all needed hospitals, as we have argued since 1991.[66] Now that there is growing public concern that some needed hospitals have closed and others are in danger of closing, targeted financial relief must be planned carefully and quickly.

***Six specific steps must be taken to stabilize Massachusetts hospitals' finances through short-term emergency relief and durable financing reforms:***

1. Monitoring of changes in hospital capacity.
2. Identification of hospitals, beds, ERs, and other specific hospital services needed to protect the health of the public.
3. Specification of efficiency standards.
4. Identification of financially distressed hospitals.
5. Provision of emergency short-term revenue to needed but financially distressed hospitals to assure that each needed hospital obtains sufficient revenue to remain open and provide high-quality care, as long as it is operated efficiently.
6. Durable long-term financing reform.

1. Monitoring of changes in hospital capacity. State government, through the Department of Public Health and the Division of Health Care Finance and Policy, must obtain weekly reports from each Massachusetts hospital on

- acute care beds actually set up and staffed—and ready to serve patients,
- intensive care unit beds actually set up and staffed
- emergency room beds actually set up and staffed
- hours that the hospital's emergency room is on diversion (daily report)
- average daily census and occupancy rate for each unit
- beds of each type that can be brought into service and staffed appropriately on 24 and on 48 hours' notice

These are things that each well-managed hospital should know for itself, so reporting regularly to the state should not be burdensome. And the data are vital, especially as hospitals increasingly assert that they must divert patients from their emergency rooms.

We noted in public testimony in 1999 that no one in state government—or in the hospital sector—maintains real-time and consistent information on actual hospital beds set up, staffed, and ready to serve patients. No one tracks changes over time, except years after the fact when data are compiled from hospital reports. But those reports are themselves unreliable as different hospitals apparently use very different definitions and some apparently count licensed beds rather than beds actually available. We urged that accurate information be compiled as a foundation for early identification of bed shortages that could endanger the health of the public. The members of the Health Care Committee agreed verbally at the time, but the necessary action has not been taken.[67]

2. Identification of hospitals, beds, ERs, and other specific hospital services needed to protect the health of the public. State government, through the Department of Public Health and the Division of Health Care Finance and Policy, must identify the number of hospitals (and in which locations), the numbers and types of acute care beds, and the number and location of emergency rooms (and associated intensive care unit capacity) that are required to protect the health of the public. The need for other vital hospital services should also be assessed.

This has not been done—or even attempted—for many years. As a result, there is no agreement on needed hospital capacity. Yet without this agreement, the state has no foundation for intervening carefully to protect needed hospitals.

Chapter 141 of the Acts of 2000 does require the Massachusetts Department of Public Health to define essential health services. But that statute lacks any way to prevent needed services from closing. It provides no money. It provides no enforcement teeth.

Some argue that state government should not or can not identify needed hospital capacity. The objections fall into three main areas.

First, some say that prevention and outpatient care are making hospitals obsolete, that hospitals are costly, and that non-hospital care saves money. But important evidence contradicts these positions.

- As noted earlier, in 1998, Massachusetts had only 2.7 acute care beds per 1,000 people, down by fully two-fifths from the 4.5 beds per 1,000 people that we had in 1984. The decline was faster here than nationally. The 2.7 beds per 1,000 people in Massachusetts in 1998 was 12.9 percent below the national average.[68] There is ample reason for concern that, with an aging population, Massachusetts faces a shortage of acute hospital beds not to many years down the road.

- Further, hospital closings and bed reductions apparently have not saved money. According to American Hospital Association data, Massachusetts hospitals' costs per person in 1998 were 42.3 above the national average, as also noted earlier.[69]

Second, some argue that this state should rely on a free market to decide how many hospitals are needed, with what ER and bed capacity, and where they should be located. Again, the evidence indicates that this approach is not safe or feasible.

- Reliance on the market has helped to cause a rapid increase in the rate of hospital closings and bed reductions. In 52 cities nationally, and in a three-state southern New England study, hospitals have closed more often in lower-income and minority areas.[70] This suggests that the market is closing hospitals that are needed by patients, contrary to the expectations of market proponents.

- Less efficient hospitals have been more likely to survive, again contrary to the expectations of market proponents.

- All this is a particularly serious problem as hospitals merge and close, leaving survivors with regional monopolies or oligopolies. These are already realities or closely looming threats in Bristol County, Berkshire County, the Springfield area, Cape Cod, Worcester County, Essex County, and elsewhere. Without competitors, there is no competition.

- This evidence suggests the possibility that the rhetoric of free market competition has in reality functioned as a smokescreen behind which the smaller hospitals have been forced to close or merge, and the more powerful and the better bankrolled hospitals have been able to enjoy reduced competition—reductions that will allow them, in time, to obtain higher prices from HMOs and other private payors.

- In seeking an across-the-board Medicaid hike, the Massachusetts Hospital Association is demanding, in effect, that "heads, we win; tails, you lose." That is, under market competition—however flawed—hospitals get to keep surpluses, but when they fall into financial trouble, regardless of the reason (high cost or low revenue), they may turn to government for higher payments. Hospitals are demanding higher payments without accepting greater public accountability or state oversight in return.

Third, some say that it is simply too hard for state government to identify which hospitals, in which locations, should provide which services, and that political considerations would make it impossible for government to allow hospitals to close. Identifying which hospitals are needed would be a hard job. Politics would indeed enter.

- But what is the alternative? While price competition—even in a market that is not remotely free and efficient—may be good at closing hospitals, it is very bad at saving them. Indeed, the market is likely to close many of the wrong hospitals, and too many overall.

- Given that nothing close to a free market is present here, the alternative to government action may well be hospital anarchy. Further, the policy of closing hospitals to save money has failed. A bed shortage looms.

- Government may be bad at closing hospitals, but it may be very good at saving them. And that is what is needed today.

Moreover, in the face of the growing realization that some needed hospitals have already been forced to close and others are at risk of closing, Massachusetts state government is learning how to target financial relief to distressed hospitals. Some $10 million of the $25 million in higher Medicaid payments to hospitals was targeted specifically to help financially distressed hospitals in SFY 2001.[71] The legislature and the Division of Medical Assistance (DMA—the state's Medicaid agency) have established criteria for awarding these funds. And now, DMA is getting practice in assessing different hospitals' needs and giving out money in accord with the criteria.[72]

This legislation may be viewed, in part, as a response to the perception that another recent statute, one that provided emergency financial relief for Quincy Hospital, was politically motivated. Similar concerns have been raised about legislatively-directed aid to the Carney Hospital. But it seems clear that the legislature and DMA are moving toward regularizing the process and toward devising fair ways to target needed dollars.

The state Department of Public Health, Division of Medical Assistance, and Division of Health Care Finance and Policy should continue to work to identify needed but distressed hospitals. They will be spurred on by the very real financial needs of these hospitals and by the growing public realization that across-the-board payment increases to all hospitals are unaffordable.

The Massachusetts Hospital Association decries targeted aid for distressed hospitals. According to the Association, only "very, very limited money should be targeted for distressed hospitals—" and only in "clear public health emergencies." [73] It finds four advantages for across-the-board hikes in Medicaid payments:

- There would be fewer distressed hospitals, reducing the need for a special fund.
- Ordinary Medicaid payments qualify for the 50 percent federal match.
- Higher payments across-the-board could provide preventive help to hospitals, preventing aid to financially distressed hospitals from becoming a "'revolving door.'"
- A "myriad of complicated questions about definitions and qualifications for 'distressed' relief" are avoided. [74]

For the reasons noted earlier in this report, we find the Association's insistence on across-the-board payment hikes to be unfair, wasteful, and inefficient. Even if the federal government paid one-half of the cost of such hikes, the state's half would still be substantially greater than would the cost of more modest and targeted aid to hospitals in

genuine need. And aid may not need to be uniform to receive a federal match. It is possible that the state's Medicaid plan could be amended, so as to provide higher Medicaid payments to hospitals in special need, in ways that appropriately qualified those payments for federal matching funds.

The Association is plainly wrong in complaining about the problem of "definitions and qualifications" for aid. It is the Association that for years successfully opposed legislation that would have required the Department of Public Health to identify needed hospitals and financially distressed hospitals. Therefore, the Association should not complain that the job remains complicated today. It is a job that has to be done and, as just noted, state government is beginning to learn how to do it.

The Association raises important concerns, however, when it points to the benefits of prevention and the risks of a revolving door. This signals a more positive attitude on this issue than we have seen from the Association in at least a decade. For it is price competition that helps to create financial winners and losers. And many of the financial losers might lack the money to give high-quality care. Further, undue reliance on targeted relief to distressed hospitals and excessive financing for such relief might lead some hospitals to try to game the system by incurring avoidable costs—typically with good intentions—or managing carelessly, because they know a bailout is available.

That is why we propose expanded *targeted and short-term relief* for financially distressed hospitals as one of two financial elements of a hospital stabilization plan. Step 5, described below, would provide this emergency relief. Step 6 would provide durably affordable reform in payment to Massachusetts hospitals.

3. Specification of efficiency standards. If hospitals want to turn to government for more of their revenue, they need to be able to demonstrate that they are efficient, that they are not wasting money. This requires that government, other payors, hospitals, and other parties work together to devise reasonable and robust standards of hospital efficiency. The state of Maryland has acquired considerable experience in doing this in recent decades. In any case, it is clear that each individual hospital's claimed historic cost is not an appropriate standard.

4. Identification of financially distressed hospitals. Government must monitor the finances of each hospital and identify, in advance, hospitals that are at risk of closings. Reasonably accurate long-distance and medium-distance monitoring and warning techniques are already available.[75]

5. Provision of emergency short-term revenue to needed but financially distressed hospitals to assure that each needed hospital obtains sufficient revenue to remain open and provide high-quality care, as long as it is operated efficiently.

For the next few years, we propose that up to $90 to $100 million in targeted short-term emergency financial relief should be provided annually, if necessary, to all needed but financially distressed hospitals. About half of the money should come from Medicaid and about half from a new hospital stabilization trust fund. If a hospital is financially

distressed but is not currently operated efficiently, relief should be contingent on moving to more efficient operation. This relief should be financed through a combination of:

- Targeted increases in Medicaid payments. A substantial share—$10 million—of the $25 million in increased Medicaid payments to hospitals that was appropriated by the legislature for state fiscal year 2001 is being spent in this targeted fashion. This is a useful precedent. More money is needed. For the next year, we propose that some ***$50 million*** be made available to finance targeted emergency relief. If possible and appropriate, this money should be paid as part of the state's Medicaid plan so that it qualifies for federal matching funds. Therefore, the first choice should be to make this money available to hospitals in a deliberate manner as one element in the method of hospital payment. Were this to prove impossible, the second choice should be to target this money by the same methods as those employed by the hospital stabilization fund.

- A new hospital stabilization trust fund. This should be financed by assessments levied on the incomes—operating and non-operating—of those hospitals (and their related corporations). Trust fund revenues should be drawn from hospitals that can afford to pay them and paid to hospitals that need them the most.

  The trust fund should be financed by an average one-quarter of one percent assessment on each hospital's actual patient service revenue plus a five percent assessment on each hospital's non-operating revenue, including non-operating revenue from its parent corporation, if any. (Hospitals with negative total margins or with total margins that would go negative through payment of these special assessments would be exempted fully or partly. Assessment rates would be raised commensurately on profitable hospitals in order to generate the target trust fund revenues.)

  In HFY 1998, these assessments would have produced some ***$43.6 million***—$21.4 million from the one-quarter of one percent assessment on operating revenue, $18.5 million from the five percent assessment on hospitals' non-operating revenue, and $3.7 million from the five percent assessment on parent corporations' non-operating revenue (estimated very conservatively at $74.9 million in total).[76]

The hospital stabilization fund should be prepared to finance managerial and technical assistance to needed but distressed hospitals. It should also provide short-term emergency financial relief in the form of cash grants. These would help stabilize a needed but distressed hospital until the long-term financing reforms take hold. The experience now being gained by the Division of Medical Assistance, as it administers the state's $10 million pool of fund for financially distressed hospitals, should inform the procedures by which hospitals request aid, the priorities for allocating it, and the methods of insuring accountability and careful spending.

Short-term financing to relieve needed but distressed hospitals must be accompanied by a state hospital receivership statute. To provide organizational stability for needed but financially distressed hospitals, Massachusetts needs a hospital receivership law. This has been proposed for many years, but has been stubbornly opposed by the Massachusetts Hospital Association. But consider how state government—particularly the Attorney-General and the Commissioner of Insurance—could have coped with the Harvard Pilgrim crisis in January of 2000 if the legislature had not finally passed an HMO

receivership statute in the fall of 1999. ***Massachusetts hospitals need the same protection and shelter and time that the state was able to offer Harvard Pilgrim in the winter and spring of 2000.***

6. Durable long-term reform. This means negotiating a package deal to develop comprehensive, fair, straightforward, and durable methods of hospital payment. Today, facing tight financial circumstances, Massachusetts hospitals are calling for more money from all possible sources:

- In-state, they ask for across-the-board hikes in Medicaid, increased payments from the state's uncompensated care pool, higher payments from HMOs.
- They are also asking Congress for higher Medicare payments.

Revenues provided from all of these payment sources must be coordinated. Otherwise, some hospitals will get more money than they need and others will get less. Public dollars will be spent unfairly and inefficiently.

As noted earlier, it now appears that it would be inappropriate to remedy overall hospital financing problems with higher revenue. That is because overall revenue shortfalls do not seem to be at the heart of our state's hospitals' financial problems. Similarly, even if it were desired to boost hospitals' revenues across the board, it would be extremely difficult to rely on increases in total Medicaid payments financed with state and federal dollars—or increases in state payments for the free care pool—to do the job. That is because, as noted earlier, Medicaid provided only about 7.2 percent of hospitals' total revenue in HFY 1999 and the pool provided only about 2.9 percent, for a total of 10.1 percent.

Today, in seeking across-the-board payment increases, the Massachusetts Hospital Association is saying that past, current, and future hospital surpluses belong to them, but that hospital deficits belong to the public. ("Heads, we win; tails, you lose.") But if the public is to be responsible for paying enough to assure that all needed hospitals survive and provide high-quality care, it must set the rules for payment.

The aim, again, should be to assure that each needed hospital obtains enough total revenue to remain in business and provide high-quality services, as long as it is operated efficiently. Since no free market exists to make that level of revenue available, the state must assess proper revenue levels. The alternative is to throw money at all hospitals indiscriminately in hope that enough dollars somehow stick to the hospitals that really need it. We can do much better than that.

Once we recognize that nothing close to a free market exists to pay hospitals fair rates, ***the only alternative to hospital financial anarchy is public rate setting married to fair and adequate financing***. Massachusetts attempted this from 1983 to 1988. It had many problems, some of them—such as failure to set an equitable cost base—actually stemming from complexities and inequities demanded by hospitals. Maryland, on the other hand, has been making all payor rate setting work for a quarter of a century.

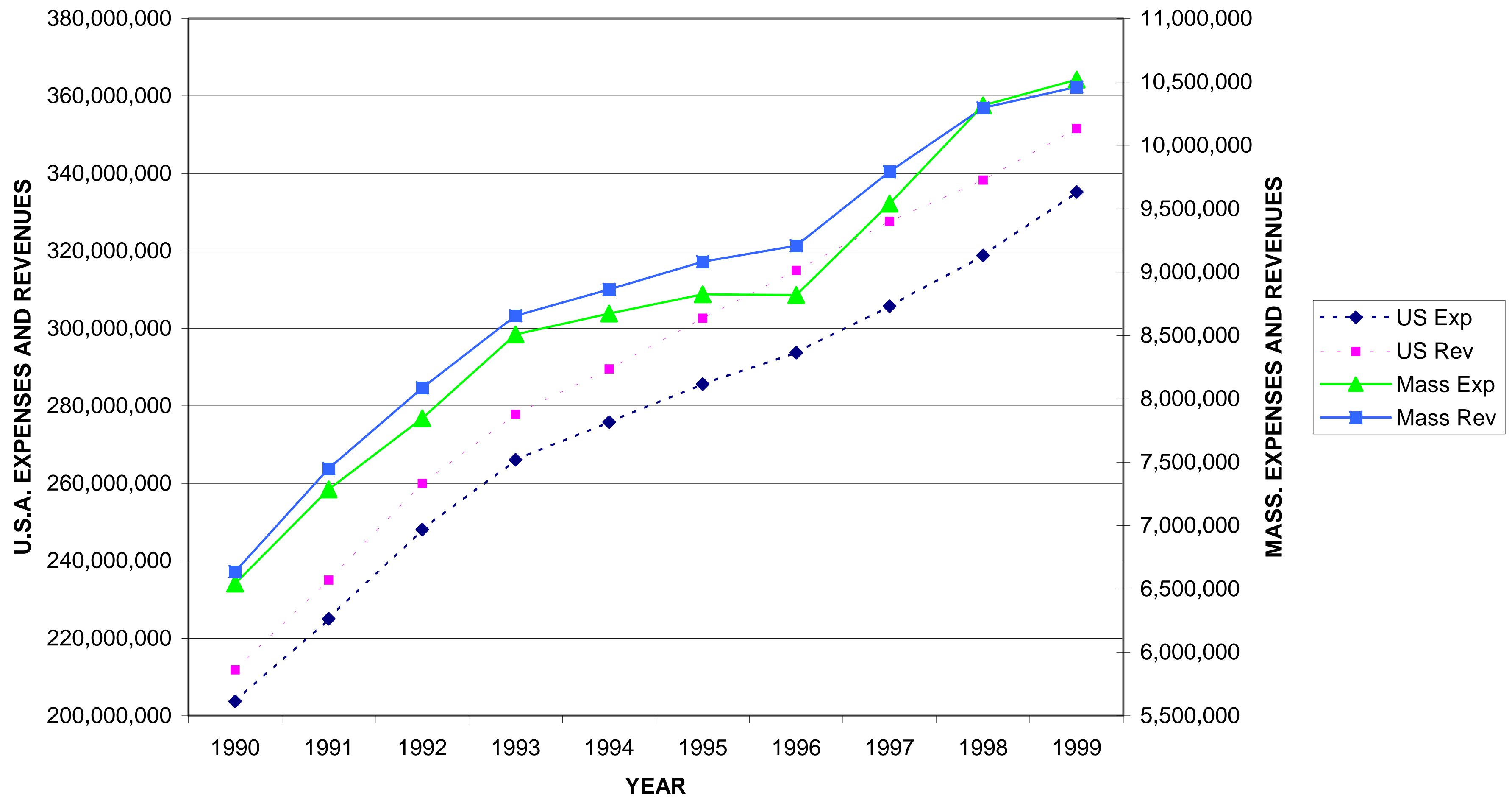
But recognizing the usefulness of all payor rate setting is not the same thing as winning the federal waivers needed to implement it. State government should therefore begin the job of constructing and testing "shadow" rate setting. This rate setting should identify the total revenue that needed hospitals require to remain open and provide high-quality care (if operated efficiently).

For now, state government should use this approach to compare needed revenue with actual revenue and seek to persuade industry, public, and private sources to make up any identified shortfalls—and to persuade hospitals to give back any identified overages. Looking ahead, state government should be prepared to implement all payor rate setting with force of law as soon as hospital financial realities oblige and political realities permit.

This job is not easy. But failing to tackle it would leave state government obliged to confront year after year of demands for higher payments from all hospitals without any reasonable standards for saying yes or no, without any confidence that its money was being well-spent, and without any hope of saving all of the hospitals that are needed to protect the health of the public.

*Appendix A*

# HOSPITAL EXPENSES AND REVENUES, U.S.A. AND MASS., 1990 - 1999



NOTES

[1] Alan Sager, Peter Hiam, and Deborah Socolar, *Promise and Performance: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing (Chapter 23 of the Acts of 1988),* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989.

[2] The MHA asserts "a rapid and unprecedented deterioration of hospitals' financial condition," Ronald M. Hollander, letter to Stuart Altman and Herbert Wilkins, 11 October 2000; "Survey: Widespread Hospital Financial Distress Continues," Massachusetts Hospital Association Press Release, 27 November 2000; and Eric Convey, "Hospitals: Hike Our Medicaid Payments," *Boston Herald,* 6 April 2000.

[3] Total margins equal the difference between total revenue and total expenses, divided by total revenue. Revenue from parent corporations or holding companies is typically not included.

[4] A hospital's total margin is defined as the difference between total revenue and total expenses, divided by total revenue. Revenue and expenses of related corporations, such as holding companies are excluded. The data used to prepare the exhibit are drawn from the American Hospital Association's annual Guide Issue (through 1969) and the Association's *Hospital Statistics* from 1979 through 1998.

It is not possible consistently to compare operating margins over time using the data provided by the American Hospital Association. That is because the Association provides data on patient revenue and total revenue, but does not provide a figure for operating revenue (one that includes patient revenue and "other operating revenue."

The Massachusetts figure for 1949 actually uses the figure for all of New England for that year.

[5] Financial margins of Massachusetts acute care hospitals first rose from 2.8 percent in 1995 to 4.2 percent in 1996 and then sank steadily for two years—to 2.6 percent in 1997 and then to –0.2 percent in 1998.

[6] Alan Sager, Deborah Socolar, and Peter Hiam, *The World's Most Expensive Hospitals: One-fifth of Massachusetts Hospital Costs Appear Unjustified,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 1 February 1991.

[7] See American Hospital Association, *Hospital Statistics, 2001,* Chicago: The Association, 2000, tables 3 and 6.

[8] See, for example, Codman Research Group, *Comparative Analysis of Inpatient Hospital Utilization and Charges in Massachusetts,* Lyme, New Hampshire: The Group, 21 February 1991; and The Lewin Group, *An Analysis of Massachusetts Hospitals'*

*Efficiency and Costs, Prepared for the Massachusetts Hospital Association,* Prepared for the Massachusetts Hospital Association, April 2000.

[9] Some observers suggest that hospital and overall health care spending in Massachusetts is elevated by patients from other states who obtain care here. They therefore suggest that dividing health care or hospital spending here by the state's population yields an over-estimate of Massachusetts spending relative to other states. But an analysis of such border-crossing found that health costs per capita for Massachusetts were highest among the states no matter whether one measured care provided in Massachusetts (that is, care provided by caregivers here) or care provided to this state's residents. (Joy Basu, "Border-Crossing Adjustment and Personal Health Care Spending by State," *Health Care Financing Revie*w, Vol. 18, No. 1 (Fall 1996), p. 226, Table 5.)

The inflow of out-of-state patients for hospital care here has been partially offset by an outflow of Massachusetts patients—for example, those from border communities who seek care in neighboring states. As we have documented, the *net* inflow has been modest. See Alan Sager, Deborah Socolar, and Peter Hiam, *Hospital Expenses: Massachusetts vs. the United States,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 11 September 1990; see also Alan Sager, Deborah Socolar, and Peter Hiam, *The World's Most Expensive Hospitals: One-fifth of Massachusetts Hospital Costs Appear Unjustified,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 1 February 1991, pp. 9-11.

[10] See, for example, Central Massachusetts Business Group on Health, "The Status of Massachusetts Hospitals: Two Views," *CMGBH News*, Vol. 2, No. 1 (March 1990), summary of remarks by Steve Hegarty, "Hospitals in Revenue Crisis" and Alan Sager, "Hospitals Have a Cost Crisis."

[11] "First Aid for Hospitals," editorial, *Boston Globe,* 20 October 2000.

[12] Calculated from Massachusetts Division of Health Care Finance and Policy, *The Financial Health of Massachusetts Hospitals,* Boston: The Division, August 2000, p. 10.

[13] Massachusetts Hospital Association, "Financial and Utilization Survey: Q3 FY 2000 Data," Burlington: The Association, 2000.

[14] We estimated HFY 2000 surplus for all hospitals statewide in proportion to the 58 hospitals' share of all hospitals' expenses statewide for HFY 1999. The HFY 1999 surplus is taken from 403 forms prepared by hospitals for the Massachusetts Division of Health Care Finance and Policy.

It is important to note that different sources of data indicate somewhat different hospital surpluses.

For example, Massachusetts hospital 403 reports to the Massachusetts Division of Health Care Finance and Policy indicated 1999 statewide surpluses of $82.6 million, as

mentioned in the text. But survey reforms completed by hospitals for the American Hospital Association indicated a 1999 loss of $58.3 million

[15] For estimates, see Alan Sager, Deborah Socolar, Robert Brand, and David Ford, *Massachusetts Can Afford Health Care for All: Covering Everyone Comprehensively without Spending More,* Boston: Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 November 2000, table 3, p. 21, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm. The estimate is for calendar year 1999.

[16] Caroline Louise Cole, "Two Hospitals Eye ER Growth, Raise Concerns," *Boston Globe,* Northwest Edition, 26 November 2000.

[17] See, for example, Eugene Litvak and Michael C. Long, "Cost and Quality under Managed Care: Irreconcilable Differences?" *American Journal of Managed Care, Vol. 6, No. 3 (March 2000), pp. 305-312.*

[18] Alan Sager and Deborah Socolar, *The World's Most Expensive Health Care: Massachusetts Health Care Costs, 1980 to 1998,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 October 2000, http://dcc2.bumc.bu.edu/lcmerr/aamp.htm.

[19] See, for example, Milt Freudenheim, "Consumers Facing Sharp Rise in Health Costs," *New York Times,* 10 December 2000; and Julie Appleby, "What Happens after the Band-Aids Run out? Medicare Costs Are Rising and Insurance Premiums Could Jump 20%--Signs that Managed Care Isn't Working," *USA Today*, 8 December 2000.

[20] "Overcoming Problems with Dental Care for Medicaid Beneficiaries," *States of Health,* Vol. 8, No. 2, April 1998; Sheryl Gay Stolberg, "'Epidemic of Oral Disease' Is Found in Poor," *New York Times,* 26 May 2000; and Richard Saltus, "Suit Seeks to Force Masshealth to Raise Dental Fee Rates," *Boston Globe*, 5 May 2000. More generally, see Massachusetts Oral Health Commission, *The Oral Health Crisis in Massachusetts,* Report of the Special Legislative Commission on Oral Health, Boston: The Commission, February 2000.

[21] Health Care Finance Working Group, "Proposed Findings on Nursing Homes," Report to Governor Cellucci's Health Care Task Force, Boston: Secretary William O'Leary's Health Care Finance Working Group, Draft of 24 July 2000; Jennifer Heldt Powell, "Report: Nursing Homes Ailing," *Boston Herald,* 25 July 2000.

[22] Home Health Care Association of Massachusetts, *Bridging the Growing Gap between Need and Coverage*, Boston: The Association, Fall 2000.

[23] Alan Sager and Deborah Socolar, *A Prescription Drug Peace Treaty: Cutting Prices to Make Prescription Drugs Affordable for All and to Protect Research,* State-by-state Savings, Boston: Health Reform Program, Boston University School of Public Health, 5 October 2000, http://dcc2.bumc.bu.edu/lcmerr/UShealthreform.htm.

[24] We count sites at which acute care is provided, not corporate entities. Thus, for example, we count Southcoast as three hospitals—in New Bedford, Fall River, and

Wareham—not as one. See data presented in Alan Sager and Deborah Socolar, *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution, 2nd edition,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 June 1997; and Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999, Table 3.

[25] Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Services Research*, Vol. 18, No. 3 (Fall 1983), pp. 45l-48l; Alan Sager, "Testimony on H. 2010, Hospital Receivership," before the Health Care Committee, Massachusetts General Court, 24 March 1993; Alan Sager and Deborah Socolar, *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution, 2nd edition,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 June 1997; and Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999, Table 3.

[26] Carol Gentry, "Hospital Closings Prompt Alert: Stop the Bleeding," Economic Focus, *Wall Street Journal,* New England Edition, 11 February 1998.

[27] Alan Sager, Letter to David H. Mulligan, Commissioner of Public Health, Commonwealth of Massachusetts, 26 December 1990. This letter identified six capital projects—four in Boston and two in Worcester—with capital costs totaling $785 million that were considered unneeded and harmful to both access to care and to hospitals' financial security. For our opposition to the Worcester Medical City project, see "Testimony against Medical City," Worcester (Massachusetts) City Council, 27 October 1992; and a series of public reports published subsequently.

[28] See, for example, Caroline Louise Cole, "Two Hospitals Eye ER Growth, Raise Concerns," *Boston Globe,* Northwest Edition, 26 November 2000.

[29] Donald S. Shepard, "Estimating the Effect of Hospital Closure on Areawide Inpatient Hospital Costs: A Preliminary Model and Application," *Health Services Research, Vol. 18, No. 4 (Winter 1983), pp. 513-549.*

A recent closing which cut off care for many patients, even in the midst of treatment for kidney failure, cancer, and other life-threatening conditions, is described in Anita Lienert, "Mercy patients left adrift after closing," *The Detroit News*, 26 June 2000. http://www.detnews.com/specialreports/2000/health/monmain/monmain.htm.

[30] For Massachusetts and southern New England analyses, see Alan Sager, "Price Competition Closes Needed Hospitals: Threats and Responses," Plenary Address, Massachusetts and Rhode Island Nurses Association Joint Annual Meeting, Newport, 31 October 1997; and Alan Sager and Deborah Socolar, *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution, 2nd edition, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 June 1997.* For analyses from a study of 1,200 hospitals in 52 cities nationally, *see* Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Service Research*, Vol. 18, No. 3 (Fall

1983), pp. 45l-48l; more recent national evidence shows that this problem has persisted for the years 1980 to 1997.

[31] Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999, Table 5.

[32] See Alan Sager, Peter Hiam, and Deborah Socolar, *Promise and Performance*: First Monitoring Report on "An Act to Make Health Security Available to All Citizens of the Commonwealth and to Improve Hospital Financing" (Chapter 23 of the Acts of 1988), Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 9 April 1989; and Alan Sager, Deborah Socolar, and Peter Hiam, *A Reckless Miscalculation: Spending More to Serve Fewer People: Summary, Analysis, and Recommendations on the Weld Administration's Competitive Hospital Payment Plan*, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 16 September 1991.

[33] 1984 was chosen because Massachusetts hospital beds per 1,000 residents peaked in that year; 1998 is the most recent year for which data were available at the time of this writing.

[34] Data from American Hospital Association, *Hospital Statistics,* Chicago: The Association, various years, compiled in Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999, Table 3.

[35] Authors' calculations from American Hospital Association, *Hospital Statistics, 2001,* Chicago: The Association, 2000.

[36] And, indeed, regulation of Massachusetts hospitals' rates was never practiced here with the fairness and reasonableness that was attained in Maryland.

[37] See, for example, Ronald M. Hollander, "Mass. Hospital Consolidation: Story Proposed the Wrong Answers," Letter to the Editor, *Boston Globe,* 25 May 2000. See also Massachusetts Hospital Association testimony in opposition to legislation that would require state government to identify and stabilize all needed hospitals in 1995, 1997, and 1999.

[38] Alan Sager and Deborah Socolar, "Testimony on S. 1926, An Act Expanding Childbirth and Post Partum Care Benefits," Massachusetts General Court, 11 July 1995. See also Uwe E. Reinhardt, "Spending More Through `Cost Control:' Our Obsessive Quest to Gut the Hospital," *Health Affairs*, Vol. 15, No. 2 (Summer 1996), pp. 145-154; Robert M. Williams, "The Costs of Visits to Emergency Departments," *New England Journal of Medicine*, Vol. 334, No. 10 (7 March 1996), pp. 642-646; George Anders, "A Plan to Cut Back on Medical Expenses Goes Awry; Costs Soar," *Wall Street Journal*, 3 October 1996; and Adriana Jenkins, "`Observation Status' Has Area Hospitals Seeing Red," *Boston Business Journal*, 15 March 1996.

[39] Alan Sager, Hospital Closings in 52 Cities, 1980 – 1997, unpublished data.

[40] As noted earlier, the MHA asserts "a rapid and unprecedented deterioration of hospitals' financial condition," Ronald M. Hollander, letter to Stuart Altman and Herbert Wilkins, 11 October 2000; "Survey: Widespread Hospital Financial Distress Continues," Massachusetts Hospital Association Press Release, 27 November 2000; and Eric Convey, "Hospitals: Hike Our Medicaid Payments," *Boston Herald,* 6 April 2000.

[41] Ronald Hollander, president of the Massachusetts Hospital Association, points to "underpayments by Medicaid…." and other payors. See Jennifer Heldt Powell, "Mounting Losses Hit Hospitals," *Boston Herald*, 28 November 2000.

[42] "First Aid for Hospitals," Editorial, *Boston Globe,* 20 October 2000.

[43] Eric Convey, "Hospitals: Hike Our Medicaid Payments," *Boston Herald,* 6 April 2000.

[44] Liz Kowalczyk, "Deficits Widen at Most Mass. Hospitals, Group Says," *Boston Globe,* 28 November 2000.

[45] The Medicaid data were provided by the Massachusetts Division of Health Care Finance and Policy.

[46] The Massachusetts Hospital Association says that its request, to be embodied in legislation filed by 6 December 2000, is slightly lower. Telephone conversation, Judy Glasser, 4 December 2000.

[47] "Hospitals Seek Increase," Business Briefs, *Boston Herald,* 7 December 2000.

[48] These hospitals are the 71 corporate entities, not the 74 locations at which acute inpatient care is provided as of this writing. (Whidden Hospital is included among the hospitals still open.)

[49] The Medicaid data were provided by the Massachusetts Division of Health Care Finance and Policy. The inpatient payments are taken from Division of Medical Assistance claims. The outpatient payments are estimated by Medicaid outpatient department charges reported on hospitals' DHCFP-403 forms, reduced by 34.8 percent, the ratio of charges to actual payments estimated by the Division of Medical Assistance.

[50] Medicaid's 7.2 percent contribution to hospitals' total revenue includes payments made by HMOs on behalf of Medicaid-insured patients. The estimate of those payments was provided by the Massachusetts Division of Health Care Finance and Policy.

We calculated these percentages for HFY 1999 as follows:

| | dollars | % of TR | % of NPSR |
|---|---|---|---|
| Total hospital revenue | $11,012,031,981 | 100.0% | |
| Net patient service revenue (NPSR) | $8,997,463,207 | 81.7% | 100.0% |
| Medicaid payments | $603,262,609 | 5.5% | 6.7% |
| HMO payments for Medicaid patients | $188,489,935 | 1.7% | 2.1% |
| Free care pool payments | $315,000,000 | 2.9% | 3.5% |

Source: Data on hospital finances were provided by the Massachusetts Division of Health Care Finance and Policy, and were reported by hospitals on their DHCFP-403 forms.

[51] Hospital revenues from all sources statewide in HFY 1999 totaled $11,012,031,981 and expenses totaled $10,929,382,743. Data on hospital revenue, expenses, and surpluses were taken from hospital fiscal year 1999 DHCFP-403 reforms, Schedule 23, column 2, line 74 (standardized financial statements). Payments to and from the Hospital Uncompensated Care Pool are included.

[52] Alan Sager, "Testimony on S. 429, An Act to Establish Comprehensive Financial Reporting Procedures for Hospitals," Health Care Committee, Massachusetts General Court, 21 March 1990.

[53] We increased the value of the income in proportion to the rise the Boston area consumer price index for all urban consumers, for all items (not health care alone, which shows a substantially higher price increase). In April of 1988, the Boston CPI was 1.231; in April of 2000, it was 1.817. April is the data point closest to the middle of an October-September hospital fiscal year. See U.S. Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers, http://146.142.4.24/cgi-bin/surveymost.

[54] See S. 429 and H. 3517, Massachusetts General Court, 1990.

[55] Robert DeNoble has urged the importance of evaluating hospitals' cash positions.

[56] Data on hospital finances were provided by the Massachusetts Division of Health Care Finance and Policy, and were reported by hospitals on their DHCFP-403 forms.

[57] Summary hospital financial data provided by the Massachusetts Hospital Association to the Massachusetts Division of Health Care Finance and Policy.

[58] Total unrestricted revenue and gains equal the sum of patient care revenue, other operating revenue (such as research grants), and non-operating revenue (such as interest income).

[59] Ronald Hollander, President, Massachusetts Hospital Association, in Liz Kowalczyk, "Deficits Widen at Most Mass. Hospitals, Group Says," *Boston Globe,* 28 November 2000; and Jennifer Heldt Powell, "Mounting Losses Hit Hospitals," *Boston Herald*, 28 November 2000; .

[60] Ronald Hollander, President, Massachusetts Hospital Association, in Jennifer Heldt Powell, "Mounting Losses Hit Hospitals," *Boston Herald*, 28 November 2000.

[61] We also compared calendar year 1999 diversions by 9 greater Boston hospitals (all those for which data were available then) with those hospitals' HFY 1999 total financial margins; again, there was a mild tendency for hospitals in better financial condition to divert more often.

[62] Data on individual hospitals' HFY 1999 finances were provided by the Massachusetts Division of Health Care Finance and Policy, and were reported by hospitals on their DHCFP-403 forms. While we have reported summary data for the first three quarters of HFY 2000, financial data on most individual hospitals for HFY 2000 are not yet available, either for the first three quarters or the entire fiscal year.

[63] Eugene Litvak and Michael C. Long, "Cost and Quality under Managed Care: Irreconcilable Differences?" *American Journal of Managed Care, Vol. 6, No. 3 (March 2000), pp. 305-312.*

[64] Eugene Litvak and Michael C. Long, personal communication (by e-mail), 8 December 2000.

[65] As noted earlier, Medicaid's 7.2 percent contribution to hospitals' total revenue includes payments made by HMOs on behalf of Medicaid-insured patients. The estimate of those payments was provided by the Massachusetts Division of Health Care Finance and Policy.

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Source: Data on hospital finances were provided by the Massachusetts Division of Health Care Finance and Policy, and were reported by hospitals on their DHCFP-403 forms.

[66] Alan Sager, Deborah Socolar, and Peter Hiam, *Which Hospitals Are Vulnerable? Characteristics That Might Endanger Massachusetts Hospitals under a Competitive Payment Plan,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 28 October 1991; Alan Sager, "Testimony on H. 2010, Hospital Receivership Legislation," before the Health Care Committee, Massachusetts General Court, 24 March 1993; Alan Sager and Deborah Socolar, "Testimony on H. 4822, An Act to Stabilize and Preserve Essential Community Hospitals," before the Health Care Committee, Massachusetts General Court, 25 April 1995; Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999.

[67] Alan Sager and Deborah Socolar, "Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999.

[68] Data from American Hospital Association, *Hospital Statistics,* Chicago: The Association, various years, compiled in Alan Sager and Deborah Socolar,

"Massachusetts Should Identify and Stabilize All the Hospitals Needed to Protect the Health of the People," Testimony on H. 781 and H. 2698, Health Care Committee, Massachusetts General Court, 20 May 1999, Table 3.

[69] Alan Sager and Deborah Socolar, *Massachusetts Hospital Costs per Person Have Risen Much Faster that the National Average, 1997 – 1998,"* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 15 December 1999.

[70] For Massachusetts and southern New England analyses, see Alan Sager, "Price Competition Closes Needed Hospitals: Threats and Responses," Plenary Address, Massachusetts and Rhode Island Nurses Association Joint Annual Meeting, Newport, 31 October 1997; and Alan Sager and Deborah Socolar, *Before It's Too Late: Why Hospital Closings Are a Problem, Not a Solution, 2nd edition, Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 June 1997.* For analyses from a study of 1,200 hospitals in 52 cities nationally, *see* Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Service Research*, Vol. 18, No. 3 (Fall 1983), pp. 45l-48l; more recent national evidence shows that this problem has persisted for the years 1980 to 1997.

[71] Chapter 236 of the Acts of 2000, the state's final deficiency budget for SFY 2000, divided the $25 million between $10 million for distressed hospital grants and $15 million for rate increases for hospitals across-the-board. Additional payments were made to the Carney Hospital.

[72] See Liz Kowalczyk, "20 Hospitals Send Signals of Distress," *Boston Globe,* 13 December 2000.

[73] Andrew Dreyfus, Massachusetts Hospital Association presentation at meeting of Executive Office of Health and Human Services Secretary William O'Leary's Health Care Finance Working Group, 12 December 2000.

[74] Ronald M. Hollander, letter to Stuart Altman and Herbert Wilkins, 29 November 2000.

[75] See, for example, Alan Sager, "Why Urban Voluntary Hospitals Close," *Health Services Research*, Vol. 18, No. 3 (Fall 1983), pp. 45l-48l; Monty L. Lynn and Paul Wertheim, "Key Financial Ratios Can Foretell Hospital Closures," *Healthcare Financial Management, Vol. 47, No. 11 (November 1993), pp. 66-70; and William O. Cleverley and K. Nilsen, "Assessing Financial Position with 29 Key Ratios," Healthcare Financial Management, Vol. 34, No. 1 (January 1980), pp. 30-36.*

[76] Authors' calculations from American Hospital Association, *Hospital Statistics, 2000*, Chicago: The Association, 1999.