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Maine Community Hospitals: Providing High-Quality, Affordable Care

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Maine Community Hospitals: Providing High-Quality, Affordable Care

by Mary C. Mayhew

A sick child at 2 a.m. Abdominal surgery at 8 a.m. A breast biopsy in the afternoon. Chest pains at 6 p.m. A car wreck at midnight. Just an average day at local hospitals all across the state. But in addition to the emergency departments, intensive care units, operating rooms and other core services, Maine hospitals support doctors' offices, nursing homes, visiting nurse organizations, community wellness programs, disease prevention, rehabilitation, mental health and other services that reach beyond the hospital walls and do as much to prevent disease and injury as treat them.

In short, Maine's hospitals are on the front lines, providing quality healthcare 24 hours a day, seven days a week, 365 days a year to all patients, regardless of their ability to pay. The Maine Hospital Association and its 39 community hospital members have supported—and continue to support—efforts to ensure vital access to high-quality healthcare services throughout Maine and efforts to improve the affordability of healthcare and health insurance. And, although we support the goals of the Commission to Study Maine's Hospitals, we have several serious concerns with Nancy Kane's financial analysis of hospitals.

First, the labeling of hospitals as high, medium and low "performers" suggests a focus on management ability and cost effectiveness, as opposed to variability in profit margins. Maine's hospitals are governed by community boards of trustees that have a fiduciary responsibility to ensure that the missions of these organizations are met and that they are managed cost effectively. According to figures from the American Hospital Association (2004), in 2001 Maine's per patient hospital costs were $7,047, a figure that includes both inpatient discharges and outpatient visits. This was more than 10% lower than the New England average of $7,772 per patient, and only slightly above the national average of $6,976. Other financial benchmarks show Maine well within national norms. The most recent comparative data show Maine hospitals' debt service coverage is slightly below the U.S. average, and hospitals' days cash on hand is better than the national average, as is the equity financing ratio (Healthcare Financial Management Association 1999, 2004).

There is no doubt that Maine hospitals are committed to operating efficiently, and hospitals are working closely with the state to comply with voluntary cost targets to continue to hold down cost increases. Moreover, 11 Maine hospitals have now converted to critical access hospital status (up from eight such hospitals at the time of Kane's analysis). These hospitals have agreed to limit their number of beds to 25 and to limit the average length of stay for patients in exchange for cost-based reimbursement of allowable costs by Medicare and MaineCare. This improved reimbursement creates added financial stability for these hospitals and enables them to maintain vital access to critical acute-care hospital services and to support primary care and other community health programs in their communities.

The state health plan's goal is to make Maine the healthiest state in the nation. Maine hospitals support that goal every day with their preventive and acute-care services. But we can offer these services and fulfill our mission of improving community health only if our hospitals are financially healthy. In 2002, the most recent year for which we have comparative data, the median operating margin in Maine's hospital systems was just under 1%, which is below the national average, below the Dirigo target of 3%, and below what most experts would define as a credit-worthy nonprofit. Although one year does not represent a trend, margins this low cannot be sustained without serious consequences for the health of Maine's hospitals and healthcare system.

As Nancy Kane states in her article, "[Nonprofit hospitals] need to make profits in order to maintain their property, plant and equipment, to finance working capital, and to finance other strategic initiatives such as expansions of service." In the nonprofit sector, those "profits" are called margins and are measured as a percentage of a hospital's operating budget. With no margin there is no mission. Without margins, hospitals would be unable to financially support physician practices, nursing homes, home health agencies, public health initiatives, and numerous other healthcare services that routinely lose money. Thus, our second serious concern is that Nancy Kane's methodology examines only the cost data for services and care provided within hospital walls. By doing so, she fails to take into account the breadth of commu-

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nity-based services and care that hospitals provide. We believe this is inappropriate, and that her resulting analysis fails to truly capture hospital costs.

Third, the reality is that hospital budgets (and margins) are greatly affected by the broken payment systems created by state and federal government insurance programs (which fail to cover the costs of their beneficiaries), and the socio-economic status of the communities served by these hospitals, which dictates the types of healthcare services needed in a region. In Maine, 58% of hospital services are provided to Medicare and MaineCare patients (Figure 1A)—public payers that fail to fully reimburse hospitals for the costs of caring for these individuals (Figure 1B). Fully 14% of Maine's population is 65 or older (the national average is 12%), with our state having the seventh highest population of elderly. That 14% of Mainers aged 65 and over account for 45% of all hospital services (in- and outpatient) provided (Figure 1A). Medicare, which covers those 65 and older, pays hospitals only 88 cents for every $1 of cost for care provided. Its counterpart, MaineCare, the insurance program for the poor and disabled, pays hospitals only 75 cents for every $1 of cost for care provided to MaineCare patients.

In addition to these shortfalls in Medicare and MaineCare payments, Maine state government owes hospitals more than $120 million in payments for services to individuals treated and cared for during the past three years at Maine hospitals, which have not been paid for at all.[1] For state fiscal year 2005, projections are that the state will owe hospitals more than $75 million as the result of growing enrollment that has not been budgeted for by the state. We

FIGURE 1A: **Hospital Services Provided, by Patients' Payer Source**

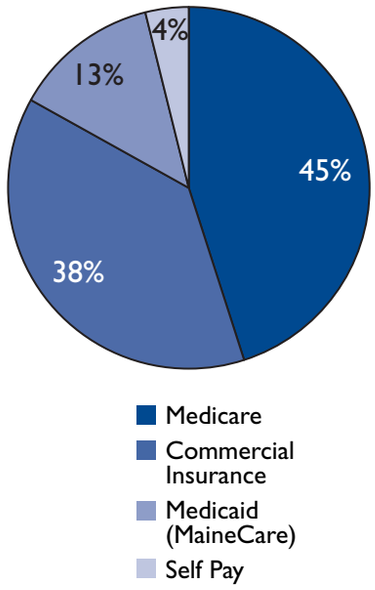
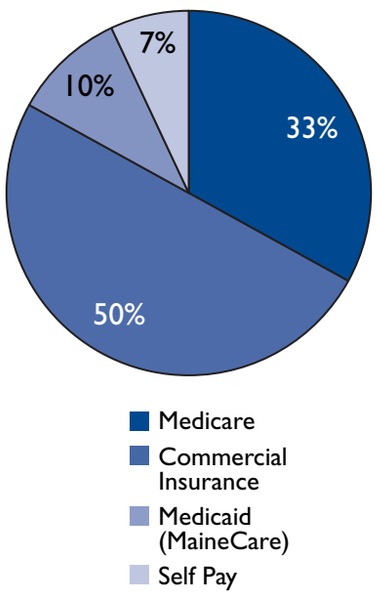


FIGURE 1B: **Hospital Services Payments, by Payment Source**



are deeply concerned that Nancy Kane's evaluation of the financial performance of hospitals does not include the significant debt owed to Maine hospitals by the state's MaineCare program. Additionally, Maine hospitals in 2003 also provided more than $170 million in uncompensated care.[2]

There is no doubt that the failure of these two large government payers to fairly reimburse the costs of caring for their beneficiaries is a significant contributor to the affordability problem in Maine. These losses cannot be sustained by hospitals and other healthcare providers. And they have led to an affordability crisis in commercial health insurance, because losses must be recovered through higher charges borne by commercial insurers and self-paying patients.

Poor reimbursement by federal and state government is forcing hospitals to hire more physicians in order to ensure critical access to primary care and other needed physician specialists who cannot financially support their practices independently. Nancy Kane suggests that the state should consider pressuring hospitals to stop using profits to subsidize physician practices, particularly in the central and southern regions of the state. However, we believe that removing hospital support in these regions would jeopardize access to family doctors, pediatricians, obstetricians, dermatologists and other physicians, and would only result in more pressure on hospitals to provide care that is best offered outside their walls.

Instead, we advocate for changes in state and federal reimbursement policies. These policies are not only compounding the challenges of managing hospital budgets in Maine (and nationally), but further jeopardizing our collective ability to maintain an adequate healthcare

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delivery system that will advance the state health plan's goals of improving the health of all Mainers.

Today, as never before, there are enormous economic pressures on our hospitals. The key drivers of hospital and healthcare spending are complex and many. But without a doubt the leading driver of healthcare spending is the demand for services. The generational expectations for our healthcare system are significant and astounding in terms of their impact on overall growth in healthcare spending. Patients increasingly demand unfettered access to sophisticated medical technology and medical services. According to some health economists, new medical technologies—from CT scans and drug-coated stents to targeted chemotherapies—may be responsible for as much as half of the U.S. medical cost growth. Moreover, consumers, employers, payers and regulators continue to seek more detailed information regarding the quality of care and patients' satisfaction with their hospital experience. There is a push to embrace computerized pharmacy technology and electronic medical records—both of which will require enormous financial investments. Pressure to collect and report clinical quality data and to invest in expensive health information systems has a significant financial price tag that must be acknowledged in the overall debate in balancing cost, quality and access.

These drivers of healthcare spending are further compounded by an increasingly unhealthy population that suffers from a sedentary lifestyle and poor eating habits. Maine has the fourth highest rate of chronic disease in the country. Chronic diseases cause a third of all disabilities, and often require long hospital stays. Future insurance premium growth will have more to do with increases in healthcare spending as a result of higher utilization rates, increasing costs of medicines and new medical technologies, consumerism, and a rapidly aging population.

As we attempt to constrain costs in our healthcare system, we must not inappropriately reduce access to healthcare or jeopardize the quality of that care. In two recent studies conducted by the Centers for Medicare and Medicaid Services, Maine hospitals rated third best in the nation on 16 indicators of the quality of care given to Medicare patients (Jencks et al. 2000, 2003). These indicators measured delivery of services that evidence suggests will be effective in treating heart attack, heart failure, pneumonia, and stroke. Additionally, Maine hospitals voluntarily undertook projects to evaluate themselves in terms of clinical quality and patient satisfaction (Maine Hospital Association 2004). The clinical quality project found that in the areas of heart attack and heart failure treatments, Maine hospitals collectively scored better than 97% of the hospitals in a national database. In patient satisfaction, Maine hospitals collectively scored above the norm 175 times in 16 categories.

We are very disappointed with Nancy Kane's cursory analysis of hospital quality in Maine. For example, she examines admission rates for ambulatory care-sensitive conditions but, in our view, ignores the role of the hospital, which cares for patients admitted by physicians who are not necessarily hospital employees. She also does not take into account the socioeconomic status of the community served by the hospital, and the fact that smaller hospitals inevitably will have higher percentages of such admissions because of the numbers of services offered as compared to a tertiary hospital.

In conclusion, healthcare financing is stunningly complicated. One simply cannot compare the management of for-profit enterprises with the management of nonprofit charitable organizations. In few for-profit industries is a service provided, only to be paid for years later as happens with MaineCare patients. And few for-profit companies would continue to subsidize money-losing services the way that hospitals, as part of their charitable and benevolent missions, support emergency rooms, pediatric practices, nursing homes, home health agencies, public health initiatives, etc. But hospitals are different. Our mission isn't to make money—it's to save lives and improve health.

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ENDNOTES

1. Hospitals file annual Medicare Cost Reports with the Centers for Medicare and Medicaid Services and the state of Maine. The figure cited here is derived from the reports for state fiscal years 2003 and 2004.

2. Hospitals are legally required to file audited financial statements with the Maine Health Data Organization. Information here on uncompensated care is based on those statements.

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