Financial Crisis Threatens Future of Teaching Hospitals

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America's teaching hospitals are facing an unprecedented financial crisis that could leave more than one-third of the most respected institutions operating at a loss within the next five years, according to leaders in academic medicine. In addition to reducing their traditional educational programs, teaching hospitals may have to eliminate a wide variety of community health projects, poison control centers, safety programs and indigent care programs if budget cuts imposed by third-party payers are not reversed.

The twin culprits are the federal government and managed care organizations, which for different reasons and in different ways are reducing their financial support of traditional medical education. However, in spite of protests from academics, both the Health Care Financing Administration (HCFA), which administers Medicare and the budget cuts enacted by Congress, and the managed care industry deny that they have reduced support for medical education.

Across the country, teaching hospitals are being forced to cut back their training programs or reduce the amount of uncompensated care they provide to the community. For example, in Boston, Brigham and Women's Hospital has cut its planned expenditures for early-phase research to $2.7 million from its budgeted $6.6 million. Next year, that allocation will drop to $2 million from a planned $7.25 million.

Jeffrey Otten, president of Brigham and Women's, told reporters that the hospital previously had used money from clinical revenue and Medicare to subsidize training, indigent care and research. But the hospital's Medicare payments will fall from $120 million in 1997 to $103 million in 2001, while costs continue to rise. Partners HealthCare System, created by a merger of Brigham and Women's with Massachusetts General Hospital, reported that Medicare cuts for the two hospitals would total $340 million between 1998 and 2002.

In California, Loma Linda University Adventist Health Science Center said that Standard & Poor's had downgraded its credit rating because of a $6.9 million loss at the medical center in the first quarter of 1999. University President B. Lyn Behrens told employees in a letter:

Overall, U.S. teaching hospitals, including Loma Linda University Medical Center, have experienced significant decreases in funding as the result of the implementation of provisions of the Balanced Budget Act [of 1997]. In addition, our managed care business, representing 22 percent of our income, is providing inadequate margins and, in some instances, losses, to the institution's bottom line.

To the north, University of California at San Francisco Stanford Health Care, which combines the facilities of the UCSF and Stanford teaching hospitals, announced plans to reduce costs by 11% by August 2000, after it suffered a first quarter operating loss of $10.7 million. Officials said that as many as 800 layoffs will occur in the first round of budget-cutting, and an additional 725 positions will be identified for elimination later this year. This workforce reduction will save the institutions $112 million.

Miami's Mt. Sinai Medical Center has announced plans to lay off an undetermined number of employees in the wake of continuing losses. In 1997, the center lost $3.2 million. Last year, the red ink swelled to $13 million and, by the first quarter of 1999, Mt. Sinai had racked up another $1 million in losses.

Teaching hospitals in New York were facing the loss of $400 million in Medicare carveout funds that
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were being retained by health maintenance organizations before the intervention of U.S. Senator Daniel Patrick Moynihan (D-N.Y.). But Moynihan's colleague in the U.S. Senate, Charles Schumer (D-N.Y.), says the state's hospitals will lose $3.2 billion in funding under current federal law. "New York is hit especially hard because we are one of the world's leading medical centers," Schumer said. The latest financial woes for teaching hospitals come from the Balanced Budget Act of 1997 (BBA). BBA reduced the separate adjustments paid to teaching hospitals for indirect medical education (IME) and direct medical education (DME) under Medicare's Prospective Payment System (PPS) formula. BBA also placed a limit on the number of residents for which hospitals would be compensated. BBA also put a cap on the intern-and-resident-to-bed ratio (IRB), which is used in calculating the IME payments. Institutions will be restricted to the same IRB that they had on Dec. 31 of the preceding year. A reduction in beds would necessitate a corresponding reduction in interns and residents to stay within the cap. By 2001, the IME formula will be reduced from its 1996 level by almost 30%. Hospitals also will be offered incentive payments over five years to reduce the number of residents they train. In addition, so-called disproportionate share payments made to health plans for their services to Medicare managed care enrollees are doled out over a five-year period, reducing the current cash flow for teaching facilities. However, the government denies these provisions are hurting teaching hospitals. "According to current data, teaching hospitals are doing well," HCFA spokesperson Michelle Robinson said in an interview with Psychiatric Times. "MedPAC [the Medicare Payment Advisory Commission] projects that major teaching hospitals will have a 24.2% operating margin under the Prospective Payment System in fiscal 2002. Nonteaching hospitals will have a 12% operating margin under PPS. These projections are comparable to 1995 margins, which was before the BBA." Academic leaders disagree. "At a time when the health care marketplace is driven by the goal of cost containment, the BBA-imposed reductions that are making a tough financial situation even tougher for teaching hospitals," said Jordan J. Cohen, M.D., president of the Association of American Medical Colleges (AAMC), in a statement to the press. A study by the association's Council of Teaching Hospitals and Health Systems (COTH), which includes the largest and most comprehensive academic institutions, found the following:

- Medicare reductions resulting from BBA could result in the total margin for a typical COTH-member hospital falling by half or more, to about 1%, by 2002.
- 38% of COTH-member hospitals—roughly 100 institutions—could be losing money by 2002.
- Projected BBA Medicare payments amount to a loss of $45.8 million for a typical general, acute, nonfederal COTH hospital by 2002, compared with estimates of what Medicare payments would have been had BBA not been enacted.
- Cumulative losses for all COTH-member hospitals will be an estimated $14.7 billion.
- Margins for hospitals with an IRB of 0.25 or greater could fall from an average of 3% in 1996 to an average of 0.3% in 2002. At least 47 of these hospitals could face negative operating margins by 2002 or sooner.

The AAMC says COTH hospitals provide a wide range of services that are not reflected in the direct or indirect costs of medical education. For example, they say COTH hospitals provide 44% of all indigent care in the country while training 75% of all residents and hosting a majority of all clinical research.

"How do we provide the Poison Control Center for the state of Tennessee, fund our school-based health care services, or teach kids to wear helmets and bring reality to risks of drinking and driving through our school trauma education program—all services no one pays us to provide—if we have to struggle to make ends meet?" Harry Jacobson, M.D., asked rhetorically in a press statement. Jacobson is vice chancellor for health at Vanderbilt Medical Center in Nashville, Tenn. "Over the past few years, Medicare payments were rising faster than costs, so the teaching hospitals were able to use Medicare to subsidize managed care's demands for discounted services," HCFA's Robinson told PT. "Now Medicare payments are rising more slowly so the pressure is on because managed care is continuing to demand discounts and hospitals are having a more difficult time meeting those demands. What the COTH hospitals do is include all sources of payments. You have to compare apples and apples. That's what Medicare pays teaching hospitals under the PPS."

"The financial trouble teaching hospitals are in comes from two sources," counters Clyde H. Evans, Ph.D., vice president of the Association of Academic Health Centers, "both the BBA of 1997 and managed care in general." Evans went on to tell PT, "It's a double whammy. Managed care is
squeezing down our reimbursement. Even though many of our hospitals are at 100% occupancy, they are still losing money. The rate at which they are getting reimbursed still puts them in fiscal trouble. The impact of BBA has just added fuel to fire."

Managed care industry leaders deny that they are shortchanging medical education. Karen Ignagni, president of the American Association of Health Plans (AAHP), released study results from the Medstat Group, "HMOs admitted a slightly larger share of their patients to major teaching hospitals than fee-for-service plans. In addition, the analysis found that HMOs pay major teaching hospitals about 12% more than they pay nonteaching hospitals."

But Don White, a spokesman for AAHP, told PT that HMOs prefer to support teaching programs directed at training physicians for practicing in a managed care environment. "What those traditional medical educational centers teach is not the right way from the viewpoint of most HMOs," he said. "They [HMOs] support joint programs such as the department of ambulatory medicine and prevention at Harvard Community Health Plan and Harvard Medical School."

A study by the federal Health Resources and Services Administration found, "Half of all HMOs feel that residency programs have poorly prepared family and general practitioners for practice in HMOs. Over 60% feel that pediatricians are poorly prepared, and 75% feel that general internists and primary care obstetrician/gynecologists are poorly prepared."

Both the BBA and the managed care industry are implicitly using reimbursement to teaching facilities as a way to control the next generation's physician distribution and types. By capping resident programs, for example, Congress has taken the first steps toward limiting the number of practitioners in specific specialties. And AAHP points out that only 70% of medical school graduates in a 1995 survey were able to find employment in the clinical practice of their specialty.

"Advances in medical technology have shifted the locus of much of modern medicine from the hospital setting (the traditional site of medical training) to the outpatient setting or physician office," AAHP says in a fact sheet available on its Web site <www.aahp.org>. "Preventive medicine and health promotion, two major emphases of health plans, are also generally provided in these types of settings. Health plan involvement in GME [graduate medical education] provides opportunities for physicians to receive training in these types of ambulatory care environments. Physicians trained in these settings will be uniquely prepared for practice in the health care plan environment."

"I'm a firm believer in the market driving changes," Charlie Cosovich told PT. Cosovich is an academic consultant with Hamilton-HMC which specializes in health care. "I have a problem with defining the appropriate market to drive the changes as the payers. The market should be something more than the payers. It should include the students, as well as the larger health care system that is drawing those students out of their education and using them."

Cosovich suggested the need for some recognition within the marketplace for the training a physician receives. "For example, if Kaiser hires a doctor who went to medical school at the University of Washington and did a residency at UCLA [University of California, Los Angeles], there should be some way that Kaiser could pay a one-time fee to schools so that the market is giving something back to the educational system."

"This market-based stuff is imperfect and dangerous in some cases," he added. "If the market messes up for a year or decade, it will have dramatic implications for the lives of people. But how else are we going to restructure this monster [health care system]? Short of somehow helping the market to do a more sensible job of rationalizing the system, I don't know how to do it."