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COMMENTARY

A Physician's Perspective

by D. Joshua Cutler

Years ago, the notion of screening for medical conditions in large populations was seen as wasteful, and some screenings still are. Many felt that information without knowledge of how to respond to it was useless and expensive. But as the value of early intervention in preventing or postponing the development of disease becomes clear, the value of screening has become demonstrable. Examples include cholesterol measurement, blood pressure measurement, and colonoscopy. So, too, the results of rigorous analysis of hospital financial performance should yield information that may facilitate interventions through policymaking, legislation, or collaboration, resulting in an overall improvement in Maine's medical care system and better accountability to the public. Such accountability is crucial, because it is the public—through taxes, insurance premiums, and the granting of nonprofit status to all of our acute care hospitals—that is ultimately footing the healthcare bill. Nancy Kane's analysis provides us with a rigorous examination of hospital financial performance in Maine. Here, I would like to comment on some of the criticisms raised not only in response to Kane's findings, but also to the underlying concept of developing agreement on reporting elements and standards.

One of many criticisms leveled at the draft report of the Commission to Study Maine's Hospitals, a group convened by the legislature to review hospital care and its funding, was that the statistics and financial data it relied on were flawed. This observation appeared to be most valid when referring to hospital costs (the current calculus for inpatient care cost is far more dependable than that for outpatient care costs) and to descriptions of hospital financial performance. Although not designed to be so, Maine hospitals' financial statements are methodologically different enough that drawing fair comparisons between hospitals based on their financial performance has not been possible. For example, some hospitals treat subsidies to physician practices differently than others. For another example, the necessity of estimating financial liabilities to payers prior to final settlement, which might take years, affects the calculation of operating margin. In the meantime, there is variation among hospitals in how large the estimate of these liabilities ought to be.

Agreement on reporting elements and standards, as suggested by Nancy Kane in this issue of *Maine Policy Review,* and applying this reporting and measuring methodology to hospital economic entities, is a critical step in developing the public's capability to reliably discern differences in financial performance among Maine's hospitals. Standardized financial reporting for hospitals will be a strong recommendation in the commission's final report, and should form a robust analytical instrument for policymakers intent on containing costs in Maine's hospital system without sacrificing accessibility or quality of care.

There is still considerable debate over the appropriate use of the results of such a standardized financial analysis. Some argue that the results should be used to apply limits on cost increases and operating margins of hospitals and of hospital systems. Others view this application of the results of standardized financial analysis as stifling to prudent management or to charitable giving. In reality, there is some truth in both sets of viewpoints. The value of the results of this and future analyses of hospital financial performance lies in the questions generated by the results and in their answers.

A major handicap facing hospital finances is the enormous Medicaid (MaineCare) payment shortfall. Estimates of the amount owed to Maine's hospitals by MaineCare range from $120-200 million for care already provided to enrollees. It is surprising, then, to note that Kane's analysis found that the hospitals in most financial difficulty are not ones providing more Medicaid-funded (or unfunded) care. Similarly, a disproportionate share of bad debt and free care provision falls to hospitals in the higher financial performance groups. In this context, the favorable performance of the hospitals in the high-performing groups is even more remarkable.

Nancy Kane also discusses other significant differences between the three hospital groups. Some, such as having a large proportion of uninsured patients, are the cause of financial performance differences. Others, such as the age of the plant, may be the result of financial performance differences (lower margins result in less investment in infrastructure). Still others may be both the cause and the effect of financial performance differences. For example, the trend toward fewer rather than more total discharges over a period of years may reflect a tendency of physicians to send patients to hospitals with younger plants or with newer, more advanced equipment.

Other hospital characteristics, such as lower average case weight or the higher prevalence of ambulatory-sensitive

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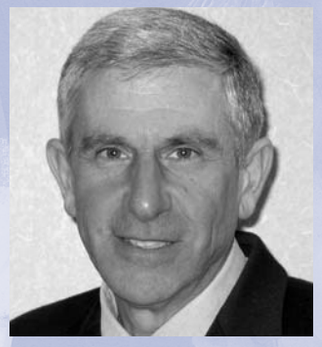
conditions in the lowest-performing group, may reflect access issues. If hospitals with these characteristics are located primarily in the less densely populated areas of eastern and northern Maine, providers may, over time, adopt a lower threshold for recommending inpatient care—especially given the impediments to follow-up imposed by long distances. The lower bed-to-population ratio in these areas makes it unlikely that this different pattern of utilization is driven by bed availability.

A statewide discussion of these and other data will advance our understanding of where problems lie, what they are, and how best to cope with them as a community. The migration of now 11 acute-care hospitals to critical access designation is evidence of one rational response already occurring. More dialogue should occur around the rational distribution of high-cost services and advanced technologies, and around the logical location of inpatient and outpatient facilities. The financial analysis of hospital performance is an important objective element in this discussion.



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