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PRESS RELEASE

April 14, 2010, Braintree, MA - Massachusetts Council of Community Hospitals releases "A Comparative Analysis of Costs, Revenues, & Profits," by Dr. Edward Moscovitch, Cape Ann Economics

Dr. Edward Moscovitch, a well respected local economist, periodically examines the economic condition of our community hospital sector.

His key finding is that unit costs and revenues at Massachusetts community hospitals, adjusted for differences in patient severity and area wage rates, are actually lower than for community hospitals in other states. Moscovitch observes that this is paradoxical - overall spending on hospitals in Massachusetts, adjusted for population, is higher than in other states. His study finds that this is attributable not to high prices at community hospitals, but to the very high usage of hospital outpatient services in Massachusetts and to Massachusetts' unusually high reliance on high-cost teaching hospitals.

Key findings:

- Community hospital unit costs (adjusted for patient severity and wage differences) are 8% lower in Massachusetts than in other states
- At 2.6%, community hospital operating margins in 2007 were well below the 3.8% margin in other states. (More recent data show no significant improvement.)
- Plant and equipment at Massachusetts community hospitals, in relation to patient volume, is some 34% less than what's available to patients at community hospitals in other states.
- Hospital outpatient utilization in Massachusetts, relative to population, is some 52% higher than elsewhere.
- Unit revenues at Massachusetts teaching hospitals – the prices they charge Massachusetts payers – adjusted for differences in patient severity and for the funds the teaching hospitals receive for research and medical education average some 38% more than what community hospitals charge for treating patients with comparable illnesses.

Moscovitch concludes, "Because their operating margins and available capital are so much lower than at teaching hospitals, any effort to restrict further the already squeezed unit revenues of community hospitals could cause some to close and weaken the competitive position of others, forcing still more patients to the downtown teaching hospitals and, in the long run, increasing the overall cost of hospital care in Massachusetts."

As noted above, Dr. Moscovitch's report determined that community hospital unit costs are less than the national average. "This is an important finding," says Donald Thieme, executive director of MCCH, "coupled with historical and recent reports on the high quality of care in our community hospitals, it says that the sector has been a responsible steward of the funds that have been allocated to them."

Non-Medicare payers, apparently recognizing the value of community-based medicine, began increasing rates of payment to community hospitals beginning in 2004, reversing a situation where hospitals lost money on Non-Medicare patients. Unfortunately, beginning in 2003, significant cutbacks in Medicare began and where in earlier years hospitals made money on Medicare patients they now lost money. The result was only very modest profitability overall.

Historical losses from operations in the early part of the decade, and only modest profitability toward the end of the decade, shows that Massachusetts community hospitals are poorly capitalized as compared to national counterparts.

"This is a worrisome condition", according to Thieme, "without a reasonable profit, our hospitals either cannot go to the debt market for financing or if they are able to go it is likely to be relatively expensive. One way the Commonwealth can help avoid incurring excessive cost and provide access to capital is to allow HEFA to implement a moral obligation bond program for community hospitals and community health centers."

Dr. Moscovitch's analysis went on to note the unusual reliance of Massachusetts patients for care in teaching hospitals. Nationally, 20% of all admissions are seen in a teaching hospital, in Massachusetts it is 45%. "Thousands of admissions, that in other states would be handled by community hospitals, are going to Massachusetts teaching hospitals –at substantially higher cost," according to Moscovitch. "His estimate of approximately $2B in cost associated with this abnormality in the market points to an opportunity," according to Thieme, "that maybe through the artful design and acceptance of new insurance products and implementation of ACOs, some of this cost could be reduced. We shouldn't be increasing this cost."

"We hope the report adds to the discussion and complements other recent reports prepared by the Attorney General and DHCF&P," says Thieme. He continues, "In the effort to solve immediate and real economic problems, whether that be through rate controls or Accountable Care Organizations, our high performing community hospital system could suffer further collateral damage. We will compromise our mission of delivering the right care, at the right time, in the right place if haste is substituted for a thoughtful application of scarce resources to cure historical inequities in payments and prepare us for the future."

Massachusetts has fifty-one (51) acute care community hospitals and fourteen (14) acute care hospitals classified as teaching hospitals. In conducting his study, Dr. Moscovitch utilized the only consistent cost and revenue data set across over 4,000 hospitals nationwide-the Medicare Cost Report. His findings are important in the context of growing concern over the rate of health insurance premium increase, especially to small business, concern over the sustainability of almost universal insurance coverage achieved under Chapter 58, and the continued upward pressure of health costs on the state budget as well as the health care budgets for employees of cities and towns.