Medicare and Hospitals

Mitchell T. Rabkin, M.D.

Before 1965, the American hospital labored under the historic burden of its essential mission being that of carrying out the work of God, a mission for which material reward was deemed unimportant. A second, and lower, minimum wage existed for employed hospital workers, and many institutions were peopled by nuns and others paid far less than the prevailing wage elsewhere. Juxtaposed with this otherworldly view, the hospital was also felt to be a refuge for the disabled, whom society deemed unemployable elsewhere and out of seeming kindness assigned more or less permanently to the entry-level positions in the hospital.

Medicare changed all that by providing funding to pay for the care of the population over 65 years of age and the disabled and by triggering reimbursement for the poor through Medicaid. Wage rates became normalized. Equally important was the concept of funding reasonable hospital costs, which allowed for the funding of depreciation, enabling hospitals to begin modernizing their physical plants, acquiring equipment of increasing sophistication, and of course, increasing costs.

The growth of the National Institutes of Health led to a burgeoning of biomedical research, and its technological development benefits were brought to the elderly's bedside in large part through the impact of Medicare. The earlier Hill-Burton legislation, which led to the emergence of new hospitals, helped facilitate Medicare's determination that the open ward should disappear and patients housing in a hospital setting should be semi-private at a minimum. Thus, Medicare made a new and important societal statement, with its commitment to equal treatment for the elderly and disabled and its thrust to improve their care, but it was inherently inflationary in and of itself.

For the teaching hospital, Medicare brought about a major change more powerful even than the capacity to acquire sophisticated diagnostic and therapeutic equipment. Medicare became a mainstay in financing graduate medical education through direct support of its proportionate share of the salaries of interns and residents and the faculty teaching them.

Medicare's support of medical education has also bolstered research, both clinical and laboratory research and, more recently, research on issues such as quality of care and assignment of risk. Although Medicare does not directly support research studies, it helps to secure and stabilize faculty salaries at academic medical centers through payments for teaching and related administrative activities, along with direct payment of care for beneficiaries.

Hospital operating margins have benefited from the relative generosity of Medicare payments in past years. As with other third-party payers, Medicare has trimmed that generosity considerably. The argument that hospital margins today fail to reflect the penury claimed of late by hospital administrators tends to ignore significant cost trimming by hospitals in recent years. In the not-for-profit sector, some margin is necessary for the unrecovered costs of the

Mitchell T. Rabkin, M.D. was with Beth Israel Hospitalwhen this article was written; he is now with Care Group, Inc.SM, the parent corporation of the now-merged Beth Israel Deaconess Medical Center. The opinions expressed are those of the author and do not necessarily reflect those of the Beth Israel Hospital or the Health CareFinancing Administration.

care of the poor, for community benefit activities not reimbursed as medical care, and for front-ending new clinical and academic activities as they are initiated to meet evolving needs. While Medicare operating margins of teaching hospitals have been somewhat greater of late than those of community hospitals, overall margins of the academic institutions have been lower in part, at least, from their performance of these activities. Serious questions are beginning to arise of late, in the midst of the resultant cost cutting, relating to possible inroads on the quality of care.

The growth in Medicare expenditures over the years, and increasing concern on Capitol Hill, at the White House, at HCFA, and among private employers has led to insights and actions that warrant mixed reviews. The cost of administering the program is exemplary, significantly lower than that spent through private insurers and thus highly supportive of the argument for simplicity and uniformity in the administrative aspects of all health insurance. By contrast, the growing numbers of hospital staff needed today to contend with the myriad of forms and formats of hundreds of insurers is in itself a compelling argument for administrative reform in the private health sector.

A more mixed blessing has been the concept of payment by diagnosis-related group (DRG). The idea of payment of a calculated average amount per case was accepted early as a useful methodology to counter the inflationary nature of reimbursement for "reasonable cost." One could argue that the categories of diagnostic groups remain less than perfect, but they are being improved year by year. The greatest challenges include the better characterization of medical, social, and economic factors impinging on the care of a patient that might warrant recognition of the greater resources necessary and appropriate to be applied—that is, a more sophisticated characterization of risk and intensity—and the dilemma that payment by episode carries inherent inflationary risk through growth in number of episodes—more so in outpatient than hospital admissions. The countervailing argument to concerns over "intensity" is that it all comes out on the average but, in any particular institution, its mix of Medicare patients can create a disproportionate burden where a more disadvantaged cohort of patients is served. This can be pointedly so in the public hospitals serving urban ghettos and in major academic medical centers.

A more pointed criticism of the DRG methodology is that its perpetuation of payment per episode is inherently less effective controlling aggregate costs than the concept of payment per capita per year. Payment per episode can lead to other kinds of inflationary creep; here patients may be seen more often in the clinic or office to bolster revenue. This has been illustrated in Medicare's payment history for home care, where some less responsible agencies have sometimes piled treatments and equipment onto patients and into Medicare's costs well beyond reason.

The inherent weakness of this payment methodology has led to a variety of efforts towards cost control. These range from pre-treatment documentation requirements and approvals to rules about the minimum acceptable timing of return to the hospital emergency unit following inpatient discharge. Such are imperfect controls at best, demanding a growing cohort of reporting, monitoring, and auditing staffs at hospitals and HCFA. These mechanisms offer but another challenge in the game of finding ways to bypass the newest restrictions—not necessarily civic participation at its finest.

Another problem in Medicare has to do with the health maintenance organization

(HMO) risk methodology and the Average Adjusted Per Capita Cost (AAPCC) payment calculation, a region-wide dollar figure designed to recognize actual cost of all Medicare patients in the county, from which the payments to HMOs may be more fairly calculated. For teaching hospitals, use of the AAPCC figure has created a major disservice, because that calculation includes the Medicare teaching and disproportionate share payments that today go directly to the appropriate hospitals. However, no mandate requires the HMO receiving this payment to hand over the dollars from those specific allocations to the area's teaching and disproportionate share hospitals (DSH). Recognition of this inappropriate shift of resources is growing at HCFA and on Capitol Hill, and we certainly hope a correction will emerge.

Such specific issues and their potential correction illustrate what may be most problematic not only about Medicare but also about the financing and delivery of health care in general. Tinkering with one specific aspect or another is not enough, nor will it foster prudent cost control while sustaining quality of care and the advancement of medical knowledge. Any action has its consequences and can lead to new problems. In so complex a system as health care, it is not easy to anticipate many of the actual consequences of well-intended perturbations; yet, we must continue to move forward. Whether it was thoughtful caution or reactionary intransigence that triggered the concerns voiced by physicians and hospital executives as Medicare emerged 30 years ago, the insight and concern of Lyndon B. Johnson and others who brought it forth must still be commended. Despite its imperfection, there is no doubt that overall Medicare has been and continues to be a source of good for the elderly, for all Americans, their physicians, their hospitals, and other providers of care, and a source of accomplishment and pride for this Nation.

Reprint Requests: Mitchell T. Rabkin, M.D., CEO, CareGroup, Inc.℠, 375 Longwood Avenue, Boston, Massachusetts 02215. E-mail: rabkin@east.bidmc.harvard.edu