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Medicare and the Philadelphia Market: The Gathering Storm

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Medicare and the Philadelphia Market: The Gathering Storm

Perhaps no more definitive phrase defines the status of Medicare in our nation today than the subtitle of William L. Kissick, MD, DrPH's book, *Medicine's Dilemmas: Infinite needs versus finite resources*. While most of us are aware, at least in general terms, of the financial woes that face our government's program for the elderly and disabled, few practicing physicians in the metropolitan Philadelphia region understand the economic and clinical forces at play that have caused our region to be characterized as one of the most volatile Medicare markets in the country. The facts are so compelling that it behooves every physician, whether we treat a large percentage of Medicare patients or not, to understand the dynamic and to be prepared.

A overview of the principles involved in providing health care in our region lays the groundwork for understanding the Medicare dynamic. Our region has three large academically based hospital systems, and several smaller but aggressive community based systems, yet conservative estimates indicate that there is upwards of 40% excess in hospital beds throughout the region. A closer look indicates that Medicare revenues constitute large percentages of the operating budgets of these institutions.

What are some of the factors at work? Nothing has yet occurred in the reimbursement scheme of these institutions that creates anything but the desire to keep these beds filled. Most have discovered ways to continue Medicare reimbursement through the use of transitional care units. On the physician side, there are approximately 16,000 clinicians, the majority of whom are specialists. Within these practices, whether they are academically based, hospital owned, or privately held, private Medicare patients represent the last bastion of fee-for-service medicine. On the commercial side, the insurance market is dominated by two large insurers, with most of the business being directed by brokers who, over the years, have developed solid relationships with employers throughout the region. The Medicare patient is not, however, under the purview of either employers or brokers; several large, nationally-based insurers have staked their claims at becoming number three in the market and are demonstrating a long term commitment to the region. Finally, the fact that Medicare pays reasonably well and on time for services provided is another incentive to keep beds filled.

A review of the economics of Medicare is worthwhile in shedding light on Medicare's impact regionally. The Health Care Financing Administration (HCFA) defines for each county throughout the state (and the country) a dollar amount per Medicare recipient per month known as the Average Adjusted Per Capita Cost (AAPCC). As it is based on retrospective review of expenditures in a given county, the AAPCC is a reflection on utilization of resources on behalf of Medicare recipients on a county by county basis. Approximately 64% of these dollars are spent on the Part A side (acute hospital care, skilled nursing facilities, home care and blood transfusions), with the remainder going to all other providers. Nationally, numbers in excess of \$400 per member per month are considered generous. In Delaware County, the AAPCC is approximately \$602, in Montgomery County, \$526. In Philadelphia county, the AAPCC is \$718, the second highest in the country. With approximately 224,000 Medicare recipients, HCFA will spend approximately \$160 million per month in Philadelphia County alone. Monthly expenditures will approach \$60 million in Montgomery County and \$50 million in Delaware County. On average, each Medicare

recipient in our region spends 3.5 days in the hospital per year, nearly twice the national average in unmanaged markets, and over three times the average in highly managed care markets.

The federal government is responding to the "infinite needs, finite resources" reality by encouraging enrollment in Medicare Managed Care. To date, Medicare HMOs have struggled in our region despite receiving one of the richest per capita monthly capitation payments to be found anywhere, from any source. HCFA reimburses Medicare licensed HMOs in the following manner. Five percent of the AAPCC is retained by HCFA for administrative purposes. An age/sex/acuity adjustment factor follows that, on average, is around 13% of the adjusted rate. What remains is the global capitation paid to the HMO, which in Philadelphia would be \$594 per Medicare enrollee per month.

Why are Medicare HMOs struggling then? The enrollment in managed care products has preceded the maturation of the provider compensation and delivery model. Discount fee for service managed Medicare has resulted in hospitalization rates of 2,500 bed days per thousand in southeastern Pennsylvania still far above national rates for a population a little older than average, but with statistically no greater acuity requirements. What HMOs in other markets have demonstrated, and what will inevitably happen here, is that placing the providers (hospitals and/or doctors) at risk rapidly reverses utilization trends. Well-managed markets with providers at risk have demonstrated 800 to 1200 bed days per thousand for Medicare patients with little or no change in measurable health outcome parameters. The implications? Far fewer patients in acute care settings. Far fewer procedures. Enormous potential savings. At stake are hundreds of millions of dollars of risk revenues, the majority being spent currently on the Part A side. Hospitals, physicians and insurers are vying for their share of revenues critical to their financial future, all the while bound, either legally or by oath, to provide care of exceptional quality to the recipients of our government's most generous entitlement program.

About the Author

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