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Age/Indigence Adjustment to Hospital Care: Lessons from USA?

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By adopting the Diagnostic Related Groups (DRGs) classification, the Prospective Payment System (PPS) has been used as a means for Medicare hospital reimbursement since October 1, 1983. Because PPS brought about certain negative impacts, it jeopardized the receipt of equivalent inpatient hospital care by indigent elderly Medicare recipients. The purpose of this paper is to examine how a partial change to Public Law 98-21, the Social Security Amendment of 1983, would provide the assurance for the indigent elderly Medicare beneficiaries to receive fair health treatment. Several alternative strategies are recommended for further improvement.

Introduction

On and after October 1, 1983, the Diagnostic Related Groups (DRGs) provided the basis for a classification system by which data on the cost of a patient's care was formulated and predetermined and became the establishment of a federally initiated Prospective Payment System (PPS) for Medicare hospital reimbursement. Since then, DRGs remained controversial; nearly all comments were negative. Those comments were:

(1) DRGs only limited the cost for each admission, but did not deal with the total medical cost;

(2) DRGs provided potential incentives for hospitals to shorten patients'length of stay and reduced the quality of services delivered to the indigent elderly patients for profit-making reasons;

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(3) DRGs ignored the difference in patients' severity of ills and other factors that could legitimately cause differences in cost per case;
(4) DRGs categories were not precise enough and excluded a due consideration of the psychological correlation of health and illness for elderly patients;
(5) the increased risk of elderly's dying within 60 days of discharge; and
(6) DRGs encouraged the use of post-hospital care.

Actually congressional awareness of potential problems with PPS had existed even as the law established the draft system. Congressmen admitted, "PPS is an imperfect system," however, in order to control the rapid increasing astronomical Medicare figures, PPS would not be nullified. The acting administrator of the Health Care Financial Administration (HCFA) claimed that the government never apologized for implementing PPS while maintaining that an acceptable level of quality and access to inpatient hospital care was expected.

Beyond these, there was a concern that the economic pressure of PPS might adversely affect quality of care, especially, for those who were age 65 or older, with no third party coverage, and who did not have enough money to pay for health care. With the exception that the increasing cost-shifting did embarrass those elderly people, all the related problems could be categorized as the following:
(1) a shift from inpatient care towards ambulatory care could result in refusal or abuse,
(2) severely ill patients could be transferred among hospitals,
(3) hospitals implemented premature discharge planning, and
(4) the premature discharge could cause more readmissions.

The Social Security Amendment of 1983, Public Law 98-21, regulates the prospective payment system for inpatient hospital Medicare reimbursement. The purpose of this amendment is to reduce Medicare's outlays for inpatient hospital care while maintaining an acceptable level of medical quality and access for beneficiaries through the DRG-classifications. It seems that PPS does not address these problems precautionarily; therefore, this paper will discuss Public Law 98-21 and propose the adequate changes to provide the assurance for poor/near poor elderly Medicare recipients in receiving the equivalent health care as compared to other Medicare recipients of the same services.

Target Population

U.S. census data indicated that one in four persons over age 65 were poor or near poor, with family income less than 125 percent of the poverty line. In other words, there were more than 6 million elderly who were poor or near poor. Those elderly who were near poverty might be driven into poverty by some of the devices that had been suggested as methods of dealing with their health care. Poor elderly, lacking primary and preventive care, were more likely to enter a hospital in a more advanced state of illness. Often they were admitted on an emergency basis when their illness was at a crisis stage, without the benefit of readmission diagnosis, testing, or records which could shorten their stay. They were also more likely to suffer from general poor health, malnutrition, and multiple, unrelated illnesses which prolonged the recovery time.

On an average, older persons saw physicians more often than people of other ages did; they usually needed to remain in the hospital longer than younger patients because of their slower recovery or having

one or more illnesses (also see note 1). In addition, the elderly were apt to experience chronic conditions, which accounted for most of their hospitalizations. It was difficult for poor/near poor to join supplementary medical insurance because of their limited income. Without the supplementary coverage, it was difficult to pay for medical care. Nevertheless, the increased use of service by older people was usually due to their increased burden of illness. Thus, the problem moved in a circle.

Although DRGs rates were adjusted for the urban/rural settings and wage levels in each area, it seemed that the DRGs/PPS system suggested Medicare beneficiaries use out-of-pocket expenses by supplementing their Medicare coverage with public or private insurance. According to Marc L. Berk and Gail R. Wilensky's survey, published in 1985, their findings suggested that the increasing cost-sharing could raise serios problems for the low income elderly in spite of the fact that they already appeared to be facing considerable hardship with respect to health care. One thing that could be certain is that low income elderly accounted for the comparatively lower levels of health service utilization.

Existing Facts

In 1985, statistical data showed that there were more than 7,500 hospitals across the U. S. A. following the DRGs system to pursue the Medicare inpatient hospital reimbursement, except for those hospitals in the state of New Jersey and Maryland. As hospitals sought ways of surviving under PPS, the possibility of increased-shifting and/or cuts in services to the seriously ill poor/near poor elderly patients was real.

The implementation of DRGs simply exemplified the inherent confict that exists between efficiency and equity goals in the delivery of health care in the USA, especially to the poor/near poor elderly. Thus , the rational for DRGs payment, as the U.S. General Accounting Office said,"everything that happens to a patient in a hospital can be attributed, directly or indirectly, to medical diagnosis and treatment " was doubtful. Quality of health care was hard to define, in fact, it would be much easier to define quality by what it was not than by what it was. Here, some of the existing evidence warned us that the poor/near poor elderly did receive nonequivalent health care as compared to other Medicare patients gave the same services:

(1) In the Los Angeles area, some community hospitals refused to accpt serious/complicated elderly cases and/or transferred them to teaching or public hospitals.

(2) Some surveys showed that poor/near poor elderly used health care more often than those who had higher incomes; however, poor/near poor elderly received fewer services than those who had third party coverage.

(3) In 1978, the discharge rate was 297/1,000 for poor elderly, 239/1,000 for non-poor elderly; in 1973, the discharge rate was 248/1,000 for poor elderly, 234/1,000 for non-poor elderly. Although the latest statistical data could not be found, it implied that the discharge rate for poor elderly was possibly constantly higher than that for non-poor elderly.

(4) Right after implementing DRGs/PPS, during 1983, there was an unexpected slip in the increased rate of hospital admissions for those aged 65 or over. This implied that the elderly hesitated to accept health care under the new reimbursement system if they had

no money to pay the health care costs and were with no third party coverage. Moreover, the median age of aged enrollees was 73.2 years old, 60 percent of those aged enrollees were women. At that high age, we could not expect them to work and make money to pay for these health care costs.

(5) Medical Intensive Care Unit (MICU) claimed that most patients in the national samples, including poor/near poor elderly patients, did not receive intensive care. This implied that mostly adequate health services were not provided. Moreover, over 30 percent of Medicare expenditures paid for patients who were dead within 12 months after being discharged; thus, the health care was questionable because it was the dying care for patients who had no real prospect of improving.

Hospitals usually used DRGs classification as an excuse to discharge elderly patients; but, DRGs did not restrict the length of stay ,only the amount of reimbursement payment was prefixed. The State of Texas had passed a law to protect poor/near poor older patients from being rejected by hospitals. From all these facts, it is understandable and reasonable that to show more concern/protection to indigent elderly Medicare patients is necessary.

Section 1886(c)(5)(C), Public Law 98-21

Other than regulating DRGs for PPS, section 1886 (c)(5)(C) of Public Law 98-21 left an incomplete ingredient for insuring the quality of health care provided:

"Section 1886(c)(5)(C): the State has provided the Secretary with satisfactory assurance that operation of the system will not re-

sult in any change in hospital admission practices which result in ------

(i) a significant reduction in the proportion of patients (receiving hospital services covered under the system) who have third party coverage and who are unable to pay for hospital services,

(ii) a significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such service,

(iii) the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital."

All indications here only pointed out that hospitals could not reduce the proportion for poor/near poor patients in hospital admissions , it did not provide the assurance that the poor/near poor elderly patients would receive the equivalent health care as compared to the other Medicare recipients of the same services. It could not see that the law tried to prohibit the possibility for elderly patients from being inter-hospital transferred, prematurely discharged, and rejected or abused.

Until now, most of studies have not examined how DRGs/PPS affected the elderly who really needed medical services. All examinations ignored how the poor/near poor elderly were suffering their hardship in pursuing the high cost of needed inpatient hospital services. Therefore, the looseness and ambiguity of the law would facilitate the unfair health treatment to those low income elderly. Besides, it had

become increasingly evident that most of the elderly Medicare recipients did not know how to use the Medicare system so as to ensure their own best interests for health care. Thus, it was not expected that Medicare, as it was, would cover a medical service, it would do so only if it was deemed medically necessary.

On and after October 1, 1986, PPS would base 100 percent on the urban or rural national average DRGs price. Before implementing this, Congress should identify that the PPS did not simply offer a fixed dollar commitment. PPS had to encourage efficiency in health service delivery and induce cost consciousness by Medicare beneficiaries. As Public Law 98-21 requested: the Secretary of the Department of Health and Human Services (HHS) and the Prospective Payment Assessment Commission (ProPAC) had to collect the relevant PPS information and recommend necessary revisions to Congress before the end of 1986. Therefore, at least, there was one thing that could be done by all: to make pragmatic calibration and address considerations on those elderly whose incomes were under/close to the poverty lines.

Before proceeding with any changes, two premises which were specified in adjustments to the Medicare Prospective Payment System, published by the U.S. Government Printing Office in 1984 had to be recognized:Any proposed changes to Medicare should (1) contribute to restrain in escalating use in health care costs, and (2) avoid the cost-shifting to Medicare beneficiaries. Due to these restrictions, the basic assumptions for amendment would be: to provide the further assurance and protection for the target population to receive the equivalent health care as other Medicare reci pients did by utilizing the existing available monetary resources. It was expected that the proposed partial changes to Public Law 98-21 would reinforce hos-

pitals to provide equivalent services to the target population; if the proposed amendment could be billed, the premature discharge or abuse, inter-hospital transfers, and refusal in admissions would be eliminated. Hence, the anticipated effectiveness and efficiency of the changed policy would be judged by the declining rates for premature discharge, abuse, inter-hospital transfers, and refusal in admissions.

The Proposed Postulation

Although Public Law 98-21 requested the Secretary of HHS to provide additional payment for those who needed the intensive care or had to stay longer in hospitals as their health condition needed, it did not specify the requirement for hospitals to maintain the quality of care. For this reason, the proposed policy amendment had to demand hospitals to do so. It was urged that, if non-poor elderly patients could stay longer and receive the intensive care as their health condition warranted, poor/near poor elderly should have the equal right; meanwhile Medicare should have legal authority to request hospitals to provide health care on the equal basis.

The following statement was the proposed amendment, added language was underscored:

"Section 1886(c)(5)(C): The State has provided the Secretary with satisfactory assurance that operation of the system will not result in any change in hospital admission or discharge practices which result in--

(i) a significant reduction in admissions or length of stay, or increase in inter-hospital transfers in the proportion of patients (receiving hospital services covered under the system)

who are age 65 or over, who have no third party coverage and who are unable to pay for hospital services as compared to all recipients of these same services,

(ii) a significant reduction or refusal in the proportion of individuals (as defined in (i)) admitted to hospitals for inpatient hospital services for which payment is (or is likely to be) less than the anticipated charges for or costs of such service,

(iii) early discharge, inter-hospital transfers, or the refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those rea-lated to the appropriateness of the care available at the hos-pital."

Cost for the Proposed Postulation

As it was discussed, any change to increase Medicare outlays was not possible, however, the proposed amendment did not request any additional fund. The Public Law 98-21 did address efforts for those "outliers":

"Section 1886 (d)(5)(A)(i): The Secretary shall provide for an additional payment...for discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharge within that group by a fixed number of days,or exceeds such mean length of stay by some fixed number of standard devi-ations, whichever is the fewer number of days.

(iv) The total amount of the additional pay-ments made for ... discharges in a fiscal year may not be less than 5 percent no more than 6 percent of the total payments pro-

ojected or estimated to be made based on DRG prospective payment rates for discharges in that year."

It was obvious that the government had provided extra monetary resources for those people who needed the additional service; yet, hospitals might not follow the regulation. So, the law needed to be rewritten to protect the poor/near poor elderly from being discriminated against. In short, under the auspices of the DRGs/PPS system, hospitals were expected to serve poor/near poor elderly patients without increasing reimbursement outlays to government and cost-shifting to other beneficiaries.

Other Necessary Improvements

After adopting "providing assurance to the poor/near poor elderly for the inpatient hospital care" as the first step, many things still remained to be improved. Actually, it was the responsibility for all the related persons, organizations, or legal authorities, especially for Congress, to consider all possible alternative strategies for the improvement in providing health care based on DRGs/PPS. These new strategies included:

(1) Deciding another rational DRGs formula. The new formula should:

a. increase the reimbursement rate for financially distressed hospitals which served a large number of poor/near poor elderly Medicare patients,

b. redistribute Medicare hospital reimbursement to those hospitals which could maintain (or provide) equivalent (or better) quality of health care to the poor/near poor elderly patients,

c. distinguish the differences in the severity of illness within

the same diagnosis category and reweigh the cost for the future development of appropriate equivalent reimbursement , cost cotainment, and quality assurance strategies.

(2) Reforming DRGs and allowing extra additional payment for patients who needed more care because of extreme age or other complicating factors, if 5 to 6 % additional payment was not enough.

(3) Sustaining the existing DRGs/PPS, another system for monitoring physicians/hospital administrators to accept the Medicare assignment needed to be established.

(4) State governments should change the subsidy system. Other than subsidizing the teaching or public hospitals, state governments should also subsidize private hospitals for taking over the larger number of the poor/near poor elderly Medicare patients.

(5) Passing the other bill, as Senator John Heinz (R., PA.) suggested, to offer the full responsibility for Peer Review Organizations (PROs) (also see note 2) to monitor what happened to patients, to check for abuse, refusal, premature discharge, and inter-hospital transfers.

(6) Upgrading DRGs reimbursement pertinent to the provision of care and central to maintaining and improving quality of health care, recognizing fully variations in the intensity of illness and the impact of complications.

(7) Developing better evaluating/reporting systems containing both clinical and financial "makers" to assure the medical appropriatness, fair treatment of inpatient hospital service, as well as, ambulatory services offered under PPS.

Conclusions

As hoped, there must be an adequate safeguard in the law for

DRGs/PPS so that hospitals do not mistreat indigent older patients in order to squeeze greater profits. As the proposed amendment indicated, the new amended policy would meet special needs of those exceptions and take into account special hospitals who served a disproportionate share of the indigent elderly patients. For enforcing the new amended policy, the federal government left the full responsibility to each individual state, the regional HCFA units, local Social Security offices, and PROs.

PROs have the responsibilities of reviewing diagnoses, quality of care provided, the appropriateness of admissions and discharges, and the nature and handling of unusual cases. The federal government could not be expected to find out the level and quality of health care in relationship to local resources. These estimations must be made locally in order to coordinate available resources with patient's needs. To date, the Secretary of HHS has failed to do so despite the recent court decision in "Redbud Hospital vs. the Secretary" case in which the court directed the Secretary to take the necessary steps to develop on adjustment methodology.

Contemporarily, Medicare was making an implicit promise to mill ions of beneficiaries. The promise was that in return for the taxes these workers were paying into the system, government would pay medical expenses during their retirement years. But, it was not at all that this promise could ever be met individually or completely. However, the poor/near poor elderly were more likely to be dependent on the government health program; if they were deprived of this only opportunity for the health care, undoubtedly they would be drawn to die.

Essentially, Medicare protection was threatened by Congress' failure to enact needed reform in the health system and policy. Senior citizens were far more aware of the crises in health care costs and Medicare inpatient hospital care than any other people; they always experienced these problems firsthand. The Congress, budget and health policy experts, and related interest groups were certainly aware of the problems and the threats the poor/near poor elderly faced. Why not work together to make the appropriate changes for necessity while there was still time?

Notes

1. People over 65 used hospitals at 2.8 times the rate of those aged under 65, and their average length of stay was 1.75 times as long (US Senate, Select Committee on Aging, 1983).

2. PRO was composed of local practicing physicians organized for the purpose of conducting peer reviews. PRO was responsible for assuring that the care provided to Medicare beneficiaries was medically necessary and reasonable, that the care was provided in the appropriate setting, and that the care met professionally accepted standards. Each hospital must have an agreement with a PRO to receive Medicare payment.

References

Adjustments in Medicare's Prospective Payment Systems.
1985 Washington, DC: U.S. Government Printing Office.

Begley, C. E.
1985 "Are DRGs Fair?"Journal of Health and Human Resources Administration 8 (Summer).

Berk, Marc L. & Wilensky, Gail R.
1985 "Health Care of the Poor Elderly:Supplementing Medicare." The Gerontologist Gerontologist Medicare." The Gerontologist 25 (June).

Caputi, Marie A. & Heiss, William A.
1984 "The DRG Revolution." Health and Social Work 9 (Winter).

David, Karen, Anderson, Gerard & Steinberg, Eerl
1984 "Diagnosis Related Group Prospective Payment: Implications for Health Care and Medical Technology." Health Policy 4.

David, Sheri I.
1984 "With Identity: The Search for Medicare and Medicaid." Westpoint, CT: Greenwood Press.

Frank, Richard G. & Lave, Judith R.
1985 "The Psychiatric DRGs: Are They Different?" Medical Care 23 (October).

Frick, Alexander P., Martin, Suzanne G. & Shwavtz, Michael
1985 "Case-Mix and Cost Differences between Teaching and Nonteaching Hospitals." Medical Care 23 (April).

Gaumer, G. L., Poggio, E. L., Coelen, C. G., Sennett, C. S. & Schmitz, R. J.
1989 "Effects of State Prospective Reimbursement Programs on Hospital Mortality." Medical Care 27:724-736.

Halloran, Edward & Halloran Diane C.
1985 "Exploring type DRG/Nursing Equation." American Journal of Nursing (October).

Harrington, Geri
1982 The Medicare Answer Book. New York: Harper and Row, Publishers.

Health Care for the Poor and Elderly: Meeting the Challenge. in
1984 Duncan Yaggy (ed). Durham, NC: Duke University Press.

Health Care
1985 Health Care Financing Review 7 (Fall).

Health PAC Bulletin
1984 March-April.

Hing, E.
1989 "Effects of the Prospective Payment System on Nursing Homes." Vital and Health Statistics. DHHS Publication No. [PHS]89-1759. Hyattsville , MD:National Center for Health Statistics.

Issues Relating to Medicare Hospital Payments
1985 Washington, DC: U.S. Government Printing Office.(May 14).

Leibson, Cynthia, Naessens, James M., Krishan, Iqbal, Campion,Mary E. & Ballard, David
1990 "Disposition at Discharge and 60-Day Mortality among Elderly People Following Shorter Hospital Stays: A Population-Based Comparison." The Gerontologist 30:316-322.

Lindberg, G. L., Lurie, N., Banaick-Mohrland, S., Sherman, R. E. & Farsetu, P. A.
1989 "Health Care Cost Containment Measures and Mortality in Hennepin County's Medicaid Elderly and All Elderly. " American Journal of Public Health 79:1481-1485.

Medicare, Health Care Expenditure, and the Elderly
1985 Washington, DC: U.S. Government Printing Office.(March).

Medicare and the Health Costs of Older American: The Extent and Effects of Cost Sharing
1984 Washington, DC: U.S. Government Printing Office.(April).

Rising Health Care Costs and the Elderly.
1984 Washington, DC: U.S. Government Printing Office.(January 20).

Rock, Robert C.
1985 "Assuring Quality of Care under DRG-Based Prospective Payment."Medical Decision Making 5 (Spring).

Sager, M. A., Easterling, D. V., Kindig, D. A. & Anderson, O. W.
1989 "Changes in the Location of Death after Passage of Medicare's prospective Payment System." The New England Journal of Medici.. 320: 433-439.

Swan, James H., Torre, Adela de la & Steinhart, Rachel
1990 "Ripple Effects ofPPS on Nursing Homes: Swimming or Drowning in the Funding Stream?" The Gerontologist 30:323-331.

The Crisis in Medicare: Exploring the Choices.
1984 Washington, DC: U.S. Government Printing Office.(August 20).

U.S. Congress Office of Technology Assessment, OTA-H-262
1985 Medicare's Prospective Payment System: Strategies for Evaluating Cost, Quality, and Medical Technology. Washington, DC: U.S. Printing Office. (June).

Wattenberg, Shirley H. & McGann, Leona M.
1984 "Medicare or 'Medigap'? : Dilemma for the Elderly." Health and Social Work 9 (Summer).

Wing, Kènneth R.
1985 "Public Health and the Law: Medicare and President Reagan's Second Term." American Journal of Public Health 75 (July).

「疾病診斷關係群」對低收入老人尋求住院醫療照顧之影響

蔡啟源

摘 要

為有效控制日益膨脹之醫療費用，自1983年起，美國採用DRGs（疾病診斷關係群）為醫療保險(Medicare)住院補助之標準。DRGs依各項疾病種類訂定補助款額，但實施後帶若干負面影響，尤其對尋求住院醫療之低收入老年病人尤甚。本文就美國之 Public Policy 98-21 (The Social Security Amendment of 1983) 提出修正建議，以確保低收入老者獲取公平之醫療照顧。