Deconstructing The Columbia/HCA Investigation

The conflict between market-driven forces for reform and the government’s outmoded health system architecture is what prompted the investigation of this for-profit giant, says one analyst-observer.

by J.D. Kleinke

PROLOGUE: Until the federal government descended upon Columbia/HCA in the spring of 1997, the rapid rise of this corporation health giant was a saga of success for its hard-charging chief executive, its private investors, and those physicians who bought equity stakes in the enterprise. At the time, Columbia/HCA was acquiring hospitals at a rate of almost one a week, growing from two hospitals in 1988 to become the tenth-largest employer in the country, with some 380 hospitals, 200 home health agencies, and 130 surgery centers. Now, one year later, the dreams of Columbia/HCA’s founder, Richard Scott, lie in tatters. The company has become the focus of multiple federal investigations, Scott has long since been forced to resign by the board of directors of Columbia/HCA, and the whole health system is waiting for the government’s other prosecutorial shoe to drop. In this lead essay J.D. Kleinke sets out a rationale for the strategy that Columbia/HCA aggressively pursued, arguing that its market-driven reform plan and what he characterizes as Medicare’s antiquated payment policies put this for-profit company and the government on a “collision course.”

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ABSTRACT: Every issue raised by the current investigation into the business practices of Columbia/HCA serves as a signpost for the progress and problems inherent in market-driven health care reform. Actions against Columbia/HCA by regulators reveal deeply rooted resistance to the profit-motivated reforms embodied in the company’s philosophy: the public’s reluctance to accept necessary reductions in excess hospital capacity; the legal and cultural obstacles to the overdue alignment of physician and hospital economic interests; and the myriad reimbursement and accounting problems involved in the vertical integration of health care delivery. The investigation also underscores the antiquation of the reimbursement mechanisms and control systems in place for financing the delivery of care to Medicare beneficiaries.

What the federal government may lack in tact it more than compensates for with its knack for symbolism. In March 1997, when investigators from the U.S. Department of Health and Human Services (HHS) Office of Inspector General embarked on what would mushroom into a widespread investigation into the business practices of Columbia/HCA, they did so by raiding for evidence the once beleaguered hospitals in El Paso that marked the formation of what grew into the largest health care company in the United States.¹ This was followed by similar raids at Columbia/HCA facilities around the country, the indictment of executives, and accusations of systemic fraud and financial conflict of interest. The investigation has resulted in the ouster of the company’s founder, Richard Scott; the potential for record-breaking fines that observers expect to exceed one billion dollars; and a financial tailspin for the company that has gutted its stock price and forced it to auction off crucial pieces of what it had built in less than a decade. In the investigation, the federal government has broadly and publicly challenged the company’s core business philosophy and practices under Scott. The company has proved supremely successful at making money by consolidating facilities within local health care markets, developing vertical systems of care, and compelling the formation of similar systems throughout the country. Its methods have brought upon it the wrath of not-for-profit community hospitals, labor and local activists, and states’ attorneys general.

On its march to market dominance, Columbia/HCA introduced market-driven strategies designed specifically to capitalize upon, by resolving, a number of key health system problems set in motion long before they manifested themselves in the cost crises of the 1980s. These problems are rooted in policy decisions of the 1950s and 1960s, when government mandates to build more hospitals, train more physicians, and fund open-ended care for the poor and elderly unleashed forces that grossly distorted the relationship be-
“The federal government is attacking the market’s attempt to cure a disease that it has itself created.”

tween health care supply and demand. When the inevitable cost crises reached their apex in the late 1980s and 1990s, the government ceded control for their remediation to the private sector: to health maintenance organizations (HMOs), which had positioned themselves to reduce excessive capacity and utilization through market leverage, and in turn to their for-profit providers, which had positioned themselves to absorb these reductions through the discipline of capital market rather than government funding. The national will for such a “privatization of reform” was confirmed, if only by default, by Congress’s failure to pass any of the provisions of the Health Security Act of 1994.

A critical flaw in this consignment of responsibility to private market forces to correct systemic flaws—aside from the lack of private sector–based mechanisms for providing universal coverage—is the inevitable conflict between market-driven reform strategies and legacy government reimbursement architectures. This conflict is central to the Columbia/HCA investigation: The federal government continues to administer a Medicare system using tools that have quickly grown not only outdated alongside corporate-driven reforms but wholly incompatible with them. As the most aggressive embodiment of those reforms, it was inevitable that Columbia/HCA, still a provider of enormous volumes of services to Medicare and Medicaid beneficiaries, would clash with government regulators.

This paper analyzes the key elements of the investigation and consequent disassembling of Columbia/HCA in the context of the resulting collision course between the for-profit company and the government. Given that the company’s most critical corporate strategies are designed specifically to correct many of the flaws institutionalized through multiple generations of government legislation, reimbursement, and enforcement, it is easy to view the investigation as a public policy drama, a battle over the philosophy and pace of market-driven reform. Although I am recognized through my published work as an advocate of the privatization of public health care programs, I do not intend this paper as a defense of, or an apologia for, Columbia/HCA; rather, I intend to describe and analyze the company’s business strategies and why they have placed Columbia/HCA at odds with public health administrators. Nor do I attempt through this paper to analyze the veracity of any of the accusations against Columbia/HCA. If proved true, each specific
accusation must be fully addressed and remedied as an unacceptable ethical lapse rather than as a signifier of policy aberration. This paper does, however, proceed on the premise that much of the investigation constitutes many such signifiers and as such represents an act of de facto self-reproach by the government. Indeed, by calling Columbia/HCA to task for its business practices, the federal government is attacking the market’s attempt to cure a disease that it has itself created.

**Choking On The Bitter Pill Of Consolidation**

It has long since passed into conventional wisdom that excess hospital capacity results in excessive hospital utilization and costs. This phenomenon, unique to the health care industry and termed “Roemer's law” after the economist who first identified it in 1959, describes a dysfunctional market dynamic in which supply dictates demand, and the perverse clinical behavior that results in hospital beds’ “filling up to the extent that they are available; in effect, the supply of beds creates a demand for those beds.”

Roemer’s law applies with equal force to other spheres of medical resource use—particularly, advanced technologies such as magnetic resonance imaging (MRI) and cardiac catheterization. Despite the inroads of information technology to identify, and managed care organizations to reduce, the excessive use of medical resources, Roemer’s law is thriving in the 1990s. The most recent edition of the Dartmouth Atlas of Health Care found that, after adjusting for demographic and health risk factors, communities with the fewest hospital beds per census average 1.6 inpatient days per resident per year, whereas communities with the most beds average 2.6 inpatient days per resident per year. The data also show a positive correlation between hospital capacity and the likelihood of a Medicare patient’s dying in an acute care rather than an alternative, lower-cost setting.

Columbia/HCA recognized in this economic dysfunction a key market opportunity: One of its core strategies has been to consolidate local hospital markets by buying several facilities in a market, closing the weaker ones, and bolstering the stronger ones with rerouted admissions. Following Columbia/HCA’s entry into a market with this strategy, competing organizations such as Tenet Healthcare, the national Catholic health systems, and the local not-for-profits and academic medical centers all respond with the same strategy; the market evolves, seemingly overnight, from a dozen unrelated hospitals to two to four aligned hospital networks. Such strategies are driven by the hardheaded decisions commonly associated with putting significant capital at risk. They also bring a key corollary to the economics of consolidation—economies of scale—
to health care in terms of reduced financing costs. When any well-financed national system purchases a stand-alone hospital, it refinances its debt with cheaper capital, which generates an immediate improvement in cash flow. This improved access to capital further allows hospitals to upgrade aging facilities and equipment, thereby making the hospitals potentially better care providers and better competitors. Such access to capital will continue to grow more critical, not less, now that the historical source of working capital for health systems (namely, the government through Hill-Burton and Medicare cost-based reimbursement) has ceased to provide it.

The consolidation strategy pioneered by Columbia/HCA and competing national organizations provides a far more effective way to rationalize a local market’s aggregate hospital capacity than the torturous, politicized certificate-of-need (CON) approach used to regulate new construction during the era when overcapacity emerged as a problem. This strategy meshes with fundamental changes in hospital reimbursement by both private and public payers; as Robert Kuttner observed in his 1996 analysis of Columbia/HCA in the *New England Journal of Medicine*, when “hospitals are no longer paid predominantly on a fee-for-service basis, profits must be made by cutting costs and services, not by increasing them.” The consolidation strategy also seeks to redress the medical “arms race,” whereby each previously stand-alone hospital was forced to equip itself to be all things to all patients, to remain viable in an unconsolidated market.

These market-driven rationalization strategies have scarcely managed to offset the effects of the steady migration of surgeries and patients from inpatient to outpatient settings. The median occupancy rate for all U.S. acute care hospitals has been steadily declining for a decade, reaching an all-time low of 41.1 percent in 1996, the most recent year for which we have complete data. If more than half of the hospital beds in the typical U.S. hospital are empty, and no one local player is willing to exit the market to help match supply with demand (and thereby put itself out of business), then the catalyst for change must come from without. Columbia/HCA’s stated strategy has been to “rightsize” individual markets, unapologetically closing weaker hospitals to bolster the aggregate performance of all of its hospitals in the market. (There have been several paradoxical variations on this strategy; in a number of markets with hospital capacity that is not excessive but, because of capital mobilization problems, is chronically antiquated, Columbia/HCA has actually built hospitals after it was unable to acquire and retool large community hospitals.) The company thus is able to rightsize (that is, usually reduce) capacity market by market because it is beholden to
shareholders’ economic interests—an accountability that is wholly divergent from that of the political- and civic-minded persons who run not-for-profits.\(^9\)

The necessity of such a strategy is confirmed in its emulation by the not-for-profit chains. The second-largest Catholic hospital system, Daughters of Charity, routinely closes hospitals that are unable to compete in local markets; as a result of such closures, the number of hospitals managed by the system has decreased nearly 20 percent, while cash reserves and investments have swollen to $2 billion.\(^10\)

While Daughters of Charity and other nationally based consolidators in some markets have been able to match Columbia/HCA’s strategy, others have been unable to break the vicious cycle of overcapacity created when communities seek to protect jobs and fallow resources—a cycle that preserves the impact of Roemer’s law, ultimately increases aggregate costs, and thus acts as a drag on the larger local economy.

Much of the criticism aimed at Columbia/HCA, particularly at the local level, stems from an abhorrence of the realities of this rightsizing. There is a clear political sensibility driving this resistance, one that explains why Columbia/HCA has experienced its greatest difficulties entering markets with strong liberal traditions, particularly Rhode Island, Ohio, and Michigan, three states that moved aggressively to block its entry. Attorneys general in these and several other states have attempted to halt Columbia/HCA hospital purchases, citing below-market valuations, the secrecy of the transactions, and the alleged self-dealing of local hospital executives negotiating them. But much of the motivation behind this resistance is a bow to political pressure from competing hospitals, organized labor, local activists, and others positioned to lose from the streamlining that Columbia/HCA brings to a new market.

Several states have rightly sought to legislate a greater degree of fairness and openness in the way such transactions are conducted and the use of proceeds following the sale of a local not-for-profit to Columbia/HCA or another national organization. The experiences in Massachusetts, Nebraska, Ohio, California, and Texas are good examples and provide a variety of templates for preventing abuses within the for-profit conversion process.\(^11\) But this appeasement does not address the fundamental issue: Columbia/HCA is the impetus for a system seeking to correct a problem nearly half a century
in the making; it has provided much of the harsh medicine that the health care system has needed since the overbuilding of hospital capacity under the Hill-Burton program and the inadvertent, wasteful inducement of demand for inpatient services under Medicare reimbursement.\(^\text{12}\)

Unfortunately, these are abstract and difficult concepts to convey to people who stand to lose jobs and who view their local hospital as a community resource that should be immune to the cruelty of market forces and history. At the center of this emotional maelstrom, Columbia/HCA and its task-mastering corporate culture under founder Scott provide an easy target for demagoguery at the local level and regulatory fervor at the federal level.

**Is There A Doctor In The Corporation?**

Another of Columbia/HCA’s core strategies has been its attempt to resolve, for its own commercial benefit, the historical antagonism and conflicting economic interests of physicians and hospitals. One of the key themes of Paul Starr’s landmark *Social Transformation of American Medicine* is the perpetually unresolved struggle between these two constituencies for control over patients and dollars. With few exceptions (academic medical centers and the fully integrated model of Kaiser hospitals, medical groups, and the Kaiser Permanente health plan), this struggle has resulted in an uneasy truce, galvanized by the cumbersome bifurcation of Medicare funding and reimbursement into Parts A and B. It endures in the complex matrix of “admitting privileges” between physicians and hospitals.

The Medicare reimbursement bifurcation in particular, which complicates all efforts to coordinate patient care and information, was exacerbated by the advent of diagnosis-related groups (DRGs). Hospitals have been bearing financial risk for Medicare inpatients since 1985, but physicians have not. This creates a serious economic conflict of interest between physicians and hospitals with regard to inpatient resource consumption, especially among the high-cost specialists who treat complex cases in the hospital. Private payers began to address this problem in the early 1990s by introducing “package pricing” for physicians and hospitals, beginning with the delivery of newborns, major cardiac surgeries, and other high-cost or high-volume cases. Columbia/HCA also recognized the problem and sought to exploit, rather than attempting to manage through, the conflict. It sold equity stakes in its local hospital systems to physicians, seeking not only to capture referrals (the cause of much criticism of the strategy) but also to turn these adversaries into economic allies.\(^\text{13}\) Although Columbia/HCA has been singled out for the practice, it is a “common practice in competitive markets.”\(^\text{14}\)
Columbia/HCA and those who replicate this physician integration strategy recognize the tremendous financial leverage associated with such alliances, embodied in numerous studies of physician practice patterns under risk-bearing arrangements. A multitude of well-publicized studies indicate that hospitalization costs and lengths-of-stay decline significantly when physicians have economic incentives to manage both. The most widely noted of these, published in the *New England Journal of Medicine* in 1995, found that for every thousand non-Medicare HMO enrollees in California, those whose physicians were paid under capitation spent 120–149 days in the hospital, compared with 232 days for all non-Medicare HMO enrollees across California and 297 days across the United States in 1993. These reductions in costs and lengths-of-stay are critical for hospitals functioning under DRGs and may be the single most important competency for hospital-based health care systems seeking to bear even more risk in the form of global capitation.

If physicians’ clinical behavior is this malleable under capitation, Columbia’s strategy seems to reason, then economic incentive alignments of any variety—even in markets that have yet to introduce capitation as a reimbursement tool—will have a profound impact on hospitals’ profitability. While waiting for markets to evolve toward global capitation, Columbia/HCA’s strategy of physician integration via economic stakes in its hospitals is the most expedient path to reducing costs and increasing profits on Medicare; it makes the hospitals, because of reduced costs and lengths-of-stay, more economically attractive to private payers. However, it also exposes Columbia/HCA to accusations of “buying” physician referrals under the legacy fee-for-service system that characterizes the bulk of Medicare administration. In this, the company’s strategy—developed specifically for a long-anticipated future mode of reimbursement—conflicts directly with the antiquated present mode.

Various attempts at achieving this alignment of economic incentives are hampered by the legacy of laws at the state level against the “corporate practice of medicine,” which forces Columbia/HCA and other systems to add layers of corporate infrastructure. Such attempts are also greatly complicated by federal laws designed to protect consumers against channeling and inducement of referrals by physicians to facilities in which they have a financial stake. The new layers of corporate infrastructure seeking to align physicians and hospitals are forced to comply with “safe-harbor” provisions contained within the Medicare and Medicaid Patient and Program Protection Act of 1987. Compliance and enforcement are greatly complicated by the safe-harbor regulations published in 1991: These describe not what conduct would be considered illegal, but rather...
what conduct would be considered legal or “safe”; if a particular physician/hospital arrangement does not fall within a safe harbor per se, it does not necessarily mean the arrangement is illegal but rather that it must be scrutinized in context. As a result, specific safe-harbor rulings vary from judge to judge, federal district to federal district, and legislative season to legislative season.

As with the policing of Medicare fraud-and-abuse actions—now emerging as a growth industry in response to mounting political frustration over Medicare’s perennial financial problems, with expanded enforcement funding from the Kassebaum-Kennedy insurance portability law—there are no clear-cut interpretations of the laws governing physician self-referral. Enforcement is fraught with caprice, opening the door for accusations of conflicts of interest that imperil efforts at hospital/physician integration and, in the matter at hand, bringing down the wrath of the federal government on Columbia/HCA. Writing in the Wall Street Journal, business law expert James DeLong notes that “mistakes of fact, honest efforts to comply, and even misleading government interpretations are no defenses. Matters that should be hashed out as contract disputes are turned into criminal cases.”17

Against this complex backdrop, attempts by the Health Care Financing Administration (HCFA) to reform the reimbursement mechanisms foisted upon it by an increasingly politicized congressional process move forward with a suffocating slowness. After years of study, legal debate, and a disputed exemption granted by HHS Secretary Donna Shalala, HCFA was only recently able to initiate a program for “global package pricing,” whereby physicians and hospitals receive bundled reimbursements for care for Medicare inpatients, and only for five hospital/physician alliances around the country.18 The same struggles have characterized the long-anticipated Medicare “centers of excellence” demonstration project, which seeks to improve quality of care while reducing costs by allowing hospitals and physicians to “partner” in return for global fees and the ability of hospitals to market this designation. Years in the making, this project is only now moving through a lengthy site selection process and demonstration phase; it has endured several sessions of Congress in an attempt to win relief from the Stark laws governing physician self-referral and conflict of interest. A waiver of the rules for hospitals selected to participate in the project by Secretary Shalala promises to spawn litigation from hospitals excluded from the project.

This last point is important: One of the impediments to reimbursement reform is the provider industry itself, which actively complicates HCFA’s attempts at introducing innovations in Medicare reim-
bursement strategies. Such resistance is evidenced in the lobbying of congressional opponents of such reforms by the less ably positioned among the provider groups: those that stand to lose both market power and subsidized profits under the price competition and market innovations introduced by the better-performing providers. Both the global package pricing and centers of excellence programs represent HCFA’s frustrated desire to adopt strategies pioneered by HMOs and employers in direct contracts. Both require specific congressional actions to exempt HCFA from antiquated or ill-conceived laws designed, paradoxically, to protect it and its beneficiaries.

This explains why Columbia/HCA’s business strategies, devised in anticipation of these and other innovations in Medicare reimbursement, were running a collision course with the status quo that HCFA is, for the most part, forced to maintain and police. In its quest to gain market share from private payers and among Medicare beneficiaries, Columbia/HCA under Richard Scott anticipated the eventual widespread adoption of programs such as global package pricing and centers of excellence. This strategy has proved to be wholly premature, or so it now appears, at least in the case of HCFA’s adoption of these programs: It built economic alliances between hospitals and physicians that would allow it to prosper under these reforms, long before HCFA was ready or able to effect them. Columbia/HCA built the car, is happily driving it on the highways of the private-payer market, but is still impatiently waiting for Congress to build the road for HCFA. Columbia/HCA’s efforts have been matched, but with far less formality and therefore workability, by the second-largest hospital company, Tenet: In early 1997 Tenet announced a major “strategic partnership” with MedPartners, the nation’s second-largest physician practice management company.

It does not take a conspiracy theorist to sense that a certain impatience with progress by the federal government implied by Columbia/HCA’s physician integration strategy is the source of much of the government’s displeasure with the company. Because it represents a reversal of the perverse incentives that traditionally have set the motives of physicians and hospitals at odds, the very implementation of Columbia/HCA’s physician integration strategy is rife with the potential for violating rules that govern a legacy reimbursement and regulatory framework. In hindsight, such a strategy almost certainly would expose the company to accusations of conflict of interest.

Continuum Conundrum

Another of Columbia/HCA’s core strategies has been to develop vertically integrated systems of care in local markets. It has assembled
these systems by acquiring and nurturing networks of outpatient surgery centers, home health care agencies, and a health benefits management company. Linking these components of the continuum of care under one corporate roof allows Columbia/HCA to offer “one-stop shopping” for third-party payers; it provides convenience and continuity of care for patients; and it allows the company to offer a global capitation product directly to private payers and governments, cutting out the third-party payer. Columbia/HCA’s assemblage of this continuum is consistent with other national health care companies—in particular, HealthSouth and Integrated Health Services—that have woven together a variety of related clinical services, including subacute facilities, outpatient “surgicenters,” rehab centers, nursing homes, assisted living centers, and home health agencies. Unlike many of the window-dressing-only integrated systems strung together by not-for-profits, Columbia/HCA has sought to operate these as truly integrated systems by introducing financial incentives for executives based on market rather than site-specific performance.

Columbia/HCA and the other national health care companies have sought to integrate care vertically because they spotted a market opportunity. As with the integration of physicians, the operation of the full continuum of care addresses another structural flaw that has plagued the U.S. health care system from the start: the balkanization of care settings and fragmentation of medical delivery. Among the many problems mentioned in one of the American Hospital Association’s surveys of hospital patients, the most frequently cited was “continuity and transition”—with an astounding 28.7 percent of hospital patients reporting difficulties. One of the best ways to resolve this enormous “continuity and transition” problem—one that would be intolerable in any other industry from the consumer’s standpoint—is the vertical integration of medical care. Control of the continuum allows for the coordination, timing, and management of postdischarge care, rehabilitation, drug compliance, and other services. This is particularly important for clinical cases that involve more complex, longitudinal medicine, particularly cancer and cardiovascular disease.

Control of the continuum also enables the fluid exchange of patient information; the monitoring of patients’ disease states, health status, and risk; and management of all of the other facets of care that need to be managed across an archipelago of sites. The theoretical advantages of this concept are embodied in the business model developed by Salick Health Care for coordinated cancer care. This once entrepreneurial start-up (it has since been acquired by Zeneca Pharmaceuticals) argues that it can greatly improve the treatment of cancer patients simply by locating all of that treatment in the same
facility: the inpatient surgeries, outpatient radiotherapy, chemotherapy, and so on. The Salick approach is based on the belief that it is easier to centralize treatment than it is to attempt to coordinate its many elements across settings. A supreme irony accompanies the way in which this belief was put into practice: Salick successfully launched its system in Los Angeles, a locality least likely to reward the centralization of anything. Like Columbia/HCA, Salick is an aggressive, profit-motivated company with a culture driven more by market needs than by medical traditions; like Columbia/HCA, it has borne its share of wrath from the provider community with a vested interest in maintaining the balkanization of care delivery.23

When viewed historically, the development of the treatment continuum is less a radical vertical integration of health care than it is a correction of its traditional “dis-integration.” As with its cultivation of physician partnerships, Columbia/HCA’s business strategies purport to address where the market needs to go, not where HCFA’s administration of the large Medicare portion of that market is functioning today. Excluding inpatient care, HCFA is still forced by legislative rules to reimburse providers and facilities in all care sites on a fee-for-service basis; treating Medicare patients in an integrated system thus opens up Columbia/HCA to potential violations of self-referral laws and accounting rules. In a recent study HHS found—to its indignation—that 62 percent of Medicare patients discharged to home health care from a hospital that owns a home health agency were treated by that hospital’s agency.24 Despite the fact that home health self-referrals achieve a needed “continuity and transition” for patients—and thus make perfect clinical and operational sense—this is considered scandalous by regulators. And indeed it is potentially abusive, but only because HCFA still pays for home health on a fee-for-service basis. (Such a legacy reimbursement method guarantees induced utilization by all home health providers, regardless of whether they are owned by the referring hospital or not.)

If a 62 percent self-referral rate constitutes a scandal, then Columbia/HCA’s stated goal of sending 85 percent of its postdischarge home health referrals to its own agencies would constitute a major subversion of the public trust.25 In addition to publicly criticizing Columbia/HCA for this goal, regulators also have claimed that the company shifts costs to its home health business, which is still reimbursed on a cost basis.26 Both accusations point to a fundamental flaw—not with the regulation of Columbia/HCA, but with the entire way that HCFA is forced to reimburse for home health care. If Congress wanted to resolve the self-referral and cost-shifting problems, it would actually encourage hospitals to discharge patients to
“As long as it competes against systems that have yet to achieve this level of integration, Columbia/HCA’s strategy remains suspect.”

their own facilities and include the reimbursement for these services as part of an expanded DRG payment. But rather than seeking to develop a solution that encourages the coordination of medical care, HCFA is forced to address the inducement problem—which has been plaguing it since the early 1990s—by finally introducing standalone prospective payment for home health care. This is still an interim solution to the problem, one which merely guarantees the migration of the inpatient “upcoding” problem to a new setting.

Columbia/HCA also has been accused of shifting revenues and costs to its various other outpatient businesses, to maximize Medicare reimbursements across the continuum. In this, the company has proved a master at a shell game that Congress created, one enabled by Columbia/HCA’s purchase, sale, and leaseback of various health care businesses. Among the various accounting tricks the government is reportedly investigating at Columbia/HCA is its alleged practice of buying home health care businesses from home health care companies at a reduced price, then paying the same companies an inflated management fee to run them. This tactic increases reimbursement to Columbia/HCA because Medicare pays for operating costs but does not subsidize the amortization of capital expenditures for home health.

Such accounting shenanigans confirm once again that money is fungible. They remind us that the historical basis for much of the economic dysfunction of health care stems from a legacy of cost-based reimbursement, a legacy from which HCFA still has a long struggle to break free. Most importantly, they teach the difficult lesson that integrated care requires integrated reimbursement and accounting.

Waiting For Godot’s Capitation Payment

The integration of cost accounting across a continuum of care sites should be Columbia/HCA’s problem to manage, not the federal government’s to police. Columbia/HCA’s strategies for consolidating local markets, aligning its economic incentives with those of physicians, and developing vertically integrated systems of care were not established specifically to defraud the federal government. They were established to position the company competitively, in anticipation of private-sector reimbursement innovations and public-sector adoption of them. Columbia/HCA probably overestimated the speed of
such an adoption, based on inflated expectations that privatization would proceed rapidly after rejection of the Clinton health care reform plan; the emergence in Congress of a Republican majority that was vocally critical of the status quo in Medicare; and the conventional wisdom throughout the industry (pre–managed care backlash) that the movement of Medicare beneficiaries into managed care plans would accelerate exponentially. Positioning aggressively for a future that has yet to be realized would increase Columbia/HCA’s market share and earn more money for its shareholders.

All three of these business strategies (consolidation, integration, and physician risk alignment) are essential to the assumption of full medical/financial risk for covered members under global capitation arrangements. Such risk assumption is designed to allow Columbia/HCA to eliminate the third-party payer altogether and contract directly with employers and the government; this is a clear goal of every major health care system in the country, as evidenced by the hospital industry’s intensive lobbying for favorable “provider-sponsored organization” legislation in the past three annual Medicare budget bills. When accepting global capitation and delivering services through a fully integrated system of care, Columbia/HCA and its competing systems would be equipped to direct patients toward the lowest-cost treatment settings, thereby improving its profitability on such contracts. This is the operating principle behind system integration for all providers, be they for-profit companies, local not-for-profit systems, or networks assembled around flagship academic medical centers.

Unfortunately for Columbia/HCA, it built a system positioned to work so ably under capitation—that is, to compete in the next century’s health care system—that this system cannot but conflict with the perverse economics of an antiquated public reimbursement system that is still struggling to reform itself. This may be the single greatest source of ire for the federal government: As described by Bradford Gray in a recent Health Affairs analysis of for-profit conversions of hospitals and HMOs, patients admitted by a group of physicians to one Columbia/HCA hospital had an average length-of-stay of 8.5 days, versus 13.5 days for patients admitted by the same physicians to a competing hospital. Gray aptly points out that this could be the result either of steering the healthier patients to Columbia/HCA facilities or of better management of those patients’ care at the Columbia/HCA hospitals. Although closer study of the patient data would reveal the source of the disparity, there is a more important theme to these findings, one that Columbia/HCA has done a poor job of articulating in defense of its own strategy: If all systems in the studied market were sufficiently integrated with
their physicians, there would be no possibility of cream-skimming. Potential divergences in clinical behavior from hospital to hospital would be neutralized, and the issue would be moot. As long as it competes against systems that have yet to achieve this level of integration, Columbia/HCA’s strategy remains suspect, by default.

**Upcoding Redux**

Columbia’s premature anticipation of reimbursement innovations by public payers is especially problematic because it guarantees continued exposure to accusations of upcoding, another alleged practice for which the company has been targeted by regulators. The perpetuation of fee-for-service reimbursement for Medicare beneficiaries means that the government will continue to face ever more insurmountable regulatory and enforcement challenges: Congress’s current strategy of attempting to manage Medicare inflation by freezing per service payment levels will serve only to aggravate the situation. The inevitable result of freezing prices will be pressure on providers to increase the provision of services to maximize total reimbursement for those services.

Central to any provider’s maximization strategy is the obsessive management of patient diagnosis and procedure codes. Overly aggressive management of these codes is the thrust of the case against Columbia/HCA; the government has accused the hospital company of routine “upcoding” of the clinical conditions of Medicare patients to maximize their revenue potential. Upcoding involves overly zealous recording (or outright falsification) of the principal diagnoses, complications, and comorbidities of patients for the purpose of assigning patients to DRGs with higher reimbursement rates. Upcoding also involves the computerized reordering or “optimization” of these codes for the same result. But as Joshua Nemzoff points out in a *Modern Healthcare* editorial, “proper upcoding is not illegal and is commonplace throughout the industry.” Indeed, the practices of upcoding, and optimization in particular, are so commonplace that they have spawned a cottage industry of software vendors and consulting firms that specialize in them. In fact, as a high-growth company preparing for its first issuance of stock to the public, my former health care information company, HCIA, chose to exit the optimization software business in 1993, specifically because we recognized it as a mature industry. Our market research revealed that the majority of hospitals had already purchased optimization software or consulting services, making optimization a low-growth replacement business that would have restrained our overall growth rate.

With the practice of optimization so widespread, its net result over the long run is a zero-sum game. Because of budget constraints
imposed by the perennially threatened Medicare Hospital Insurance trust fund (Part A), the aggregate funding available for inpatient reimbursement is fixed through the political process. With all hospitals engaged in optimization using the same tools, the fixed funding is ultimately distributed precisely as it would have been if no hospital engaged in optimization. A given inpatient may be recorded as marginally more acutely ill; however, in the aggregate, the collective marginal increase in illness severity for all inpatients averages out. The increasing sophistication of the practices of optimization helps to explain, to some degree but not entirely, why studies of the acuity of illness among the inpatient population in U.S. hospitals show increases every year. Such studies almost always rely on Medicare claims data and can be summarized by the increase in case-mix index for the median U.S. acute care hospital, which rose from 1.217 in 1989 to 1.258 in 1996.31 As a measure of total resource consumption by the portion of the U.S. health care economy dedicated to inpatient care, the five-point increase in this figure is enormously significant.

Although optimization is common throughout the industry, the government’s investigators may well find Columbia/HCA to be more effective at the practice than the typical hospital is and thus the beneficiary of a disproportionate share of the fixed funding available for Medicare inpatient reimbursement. If so, then Columbia/HCA will prove to be guilty of a greater level of competence, rather than a greater degree of corruption. And if so, then this is the government’s real issue with Columbia/HCA and the for-profit medicine it embodies: HCFA uses a reimbursement system that presumes a certain level of skill and sophistication on the part of hospitals, one that perhaps has been surpassed by the aggressive corporate culture of Columbia/HCA. While hardly an apologia for Columbia/HCA, it is important to point out that the company is guilty, then, of nothing more than achieving a degree of success deemed inappropriate for a Medicare provider. This is a strange way to make public policy, if not an unprecedented one.

**Public Flogging As Enforcement Strategy**

Public reproach of Columbia/HCA for its overly successful gaming of the Medicare reimbursement system is an admission that the system is wholly ill suited to cope with private-sector behavior. It also is a
highly efficient mechanism for signaling to the rest of the private sector that business practices such as those exemplified by Columbia/HCA require modification. Because Columbia/HCA is the largest, most visible health care company in the United States, the government’s actions against it have enjoyed high-profile, detailed coverage throughout the business and trade media. Well-publicized accusations of fraud at Columbia/HCA mirror the Internal Revenue Service’s (IRS’s) notorious practices of making audits as unpleasant as possible, imposing liens on taxpayers without due process, and other tactics that drew congressional attention in the fall of 1997. These methods, which make for lively conversation at office watercoolers and dinner parties, serve as object lessons for all taxpayers: Comply voluntarily, because you could be next.

The very protracted nature of the Columbia/HCA investigation, beginning in March 1997 and still gathering momentum as of this writing, confirms this theory: Columbia/HCA is undergoing a public, almost ritualistic rebuke, if only to frighten the rest of the industry into greater compliance. While typical of government enforcement strategies, this is a foolhardy way to manage a health care system in desperate need of the many market corrections that Columbia/HCA—through its unvarnished ambitions—has attempted to bring to the delivery of medical care. In this context, the Columbia/HCA investigation takes on much greater meaning than any of the individual accusations imply: It is a struggle between regulators and private enterprise over the pace of health system reform, a struggle to manage revolutionary change. As the medical director for a Columbia/HCA hospital told the Wall Street Journal, “If you’re with Columbia, you’re afraid you’ll suddenly be investigated. If you’re with the local not-for-profit, you’re afraid it’s so far behind the times it won’t make it.”

The Best Of All Possible Reform Strategies

The fear articulated by the Columbia/HCA physician-executive is driving the not-for-profits to emulate his company’s business practices. Such is the dynamic nature of truly market-driven reform. Even casual observers of the aggressive consolidation moves, integration strategies, and management styles of the Catholic hospital systems recognize, as did Kuttner writing in the New England Journal of Medicine, that “a market culture and market idiom are becoming pervasive, even among the not-for-profits.” A Wall Street Journal report on the Daughters of Charity found that this national system was aggressively managing hospitals based on bottom-line results, working Wall Street to protect its investment-grade debt rating, and managing its $2 billion in cash and investments with the same
savvy used by the best-managed corporations.\textsuperscript{34}

In a separate report on the most highly acquisitive and business-minded of the largest of these systems, Catholic Healthcare West, the \textit{Journal} pointed out that the “nuns can be just as aggressive as their for-profit rivals when fighting to gain market share.”\textsuperscript{35} Nor are the academic medical centers immune to the same forces. A good example is the 1996 merger between the venerable Brigham and Women’s Hospital and Massachusetts General Hospital in their bid to protect market share. As Jeffrey Otten, chief executive officer of Brigham and Women’s, commented to Kuttner in the same \textit{New England Journal of Medicine} report, the for-profit companies “exert competitive pressure on us to become more cost-effective. It makes us reexamine how we are providing care. Academic medical centers are very reluctant to close capacity. We haven’t been able to do it through planning; perhaps having an external force like Columbia might be the only way to do it.”\textsuperscript{36}

If this is the inevitable path toward correcting fundamental problems with the organization of the U.S. health care system—and the collapse of systemic reform at the national level in 1994 its most potent evidence—then the policy mandate is obvious: clear and consistent regulation of for-profit conversions and the resulting fallout of market consolidation. Over the past year state legislatures have begun in earnest with rudimentary regulatory responses to the myriad legal, political, and financial challenges associated with this process. These responses and the general framework they point to are well articulated in the March/April 1997 issue of \textit{Health Affairs} dedicated to exploring the regulation of conversions. These include the development of guidelines for disclosure, the mandated preservation of necessary but unprofitable medical services, and the just disposition of funds released during the conversion process.\textsuperscript{37} Such regulation should apply not only to purchases and conversions by the for-profit companies, but to the acquisition of hospitals by the national not-for-profit systems as well.

With these safeguards in place, the fully consummated, market-driven health care system destined to emerge will be the embodiment of a reigning pragmatism that Voltaire’s Pangloss found so at odds with his own idealism during the Age of Enlightenment: The world we make for ourselves, however imperfect, is indeed the best of all possible worlds. As a key chapter in this unfolding drama, the Columbia/HCA investigation may serve no greater purpose than to underscore the depth of the federal government’s uneasiness with the nation’s decision that markets are the best of all possible health system reformers.
The author acknowledges the insights and assistance of Kevin M. Metz and Kathleen A. Ford in the research and preparation of this paper.

NOTES
11. See the series of “Perspectives: States” in *Health Affairs* (March/April 1997).
13. Columbia/HCA’s strategy of physician integration has been criticized for violating the spirit, if not the letter, of 42 U.S.C. Section 1320a-7b(b), the Medicare and Medicaid antikickback statute prohibiting payments to physicians for patient referrals.

25. Corporate goals for self-referral to Columbia Home Care, discovered in internal Columbia documents by federal investigators and reported in the Wall Street Journal, Modern Healthcare, and other sources.


34. Langley, “Nuns’ Zeal for Profits Shapes Hospital Chain.”


37. See all of the papers in the “Conversions” sections of Health Affairs (March/April 1997).