Medicare’s Prospective Payment System

Health Care Community Reaction and Perceptions

Elizabeth Rolph, Phoebe Lindsey
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Elizabeth Rolph, Phoebe Lindsey

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U.S. Department of Health and Human Services
PREFACE

This report describes reactions in the health care community to the introduction of prospective reimbursement for inpatient Medicare coverage. It provides a comprehensive accounting of the range of issues associated with prospective reimbursement and describes the political environment in which those issues will be resolved.

This report examines a broad range of issues associated with the new prospective payment system, but it does not treat each in much depth. Therefore, it will be of use to researchers and policymakers who are reasonably new to the field and need a comprehensive picture of the policymaking environment before they specialize their efforts. It may not give the specialist already engaged in some facet of prospective payment additional information. However, it will provide a context for in-depth research and a useful perspective on current policymaking.

This research was conducted by the Rand/UCLA Center for Health Care Financing Policy Research, which is supported by the Health Care Financing Administration through a Cooperative Research Agreement.
SUMMARY

Faced with mounting federal deficits, increasing expenditures in the health care sector that have averaged about 6 percent per year in constant dollars over the past 20 years, and the threat of a bankrupt Medicare Hospital Trust Fund, policymakers have turned their attention, in recent years, to containing medical costs.\(^1\) Their principal concern has been Medicare's policy of cost-based reimbursement, which gave providers no incentive to contain services and costs. Indeed, it provided the opposite incentive. By the early 1980s, policymakers found themselves in general agreement that a new and more economy-oriented reimbursement policy must be found. After a series of quick, incremental moves, Congress abandoned cost-based reimbursement for hospitals in 1983 with the passage of the Social Security Amendments. The 1983 Amendments replaced cost-based reimbursement with a prospectively determined pricing schedule for most inpatient care.

The revolutionary shift from cost-based to prospective reimbursement occurred rapidly, and participants in the health care field had little time to prepare for its effects. Therefore, the current “start-up years” are particularly important in setting the future policy agenda for health care financing. Experience with the distributional consequences and implementation patterns of prospective payment will shape the attitudes and political positions of members of the health care community, determining the success of the current program and its future directions.

The objective of this research is to identify and understand in some depth the emerging perceptions and positions of members of the health care community toward prospective reimbursement, as well as other changes that might be occurring in the policymaking environment. Our analysis is based upon a comprehensive reading of the recent literature, both academic and trade publications, and upon interviews with representatives of most important national health care groups.

Both our review of the literature and our interviews indicate that members of the health care community support the policy of prospective payment, at least in principle. Although they vehemently argue what they believe are the faults of the new system, they appreciate the fiscal and political realities and do not expect to return to the former cost-based system. More positively, they continue to approve of the

\(^1\) Health care expenditures based on information in Table 1.
concept of prospective payment and, more broadly, competition in the delivery system.

This is not to say that their support can be taken for granted. The passage of time plays two roles. Participants in the delivery system adapt their behavior and restructure their organizations to accommodate the new system, which becomes the status quo; and movement to a different system then becomes more difficult. However, prospective payment was adopted, perhaps of necessity, in an information vacuum. As these same participants now gain experience and information regarding the effects of the system, they are coming to appreciate the problems it holds for them. If their frustrations continue to grow, the policy environment will become less and less stable.

As the structure of this report suggests, concerns with the new program fall into a few main categories, with a few items that cut across these categories. Most attention has been directed toward the prospective payment formula. The formula creates losers within the provider community. Moreover, its effects can be predicted and are being felt most immediately. These characteristics contribute to giving the formula political dominance.

Although the formula has raised a broad array of concerns, no one or few of them dominate the debate. The various constituencies have each chosen to concentrate on the concerns that they believe affect them the most. Thus attention is spread more or less evenly across the range of problems. Attention also shifts evenly from one issue to another as the issue moves onto a position of priority on the policy-making agenda.

Quality of care has the potential of being a very important issue. Thus far, attention to the issue has been modest, because quality is very difficult to define and to document. More important, most participants agree that there has been no decline in quality that could be documented save through occasional anecdotal evidence. However, most observers believe that the current prospective payment system invites underservice and that some decline in quality is likely.

In that eventuality, quality of care will almost certainly become a major political issue. The quality of care offered by Medicare is of concern to a very large and increasingly well-organized constituency, the elderly. Moreover, although our national sense of what constitutes an acceptable level of quality in health care may be in transition, there is no consensus yet on an alternative to our present standard of “the best available in care and technology.” Recognizing that it had no other basis for policymaking, Congress enacted the prospective payment system with the implicit promise that the quality of care provided under Medicare would not be reduced. If anything, it would be improved. Reaching accord on some alternative cannot be expected to be easy.
Although implementation concerns can be important to individual providers and to the overall attitude of providers to the program, such problems have not commanded much attention. Rather, providers and others expect to be able to resolve them in due course. Two types of problems seem to present the most serious obstacles to the smooth running of the program: cash flow burdens that claims processing delays impose on providers, and the unstable regulatory environment produced by delaying and changing regulations.

Instability warrants further mention as a cross-cutting issue. In 1983, Congress adopted a skeletal program with the intention that it would be modified and fleshed out as experience could be gained and analysis conducted. Although perhaps a necessary characteristic of a major shift in policy, this “fix as you go” approach to reimbursement policymaking imposes extreme costs on the health care community whose members must be continually reacting and revising their strategies to accommodate changes.

Health care groups are developing a profound ambivalence. On the one hand, the prospective payment program has imperfections that none want to see imposed. Therefore, groups will espouse changes in those provisions that they find most onerous. On the other hand, most groups are coming to understand the hardships imposed by instability in program provisions and plead for a cessation in additions to and revisions of the rules.

A second cross-cutting concern is the absence of information. The dearth of information on the effects of the current reimbursement mechanism creates further instability for the policy arena. For example, Medicare beneficiaries support prospective payment in principle, but cannot take stable positions on elements of the program unless they have a way of assessing their effects on the quality of care. Each new piece of information on the distributive consequences of prospective payment is likely to prompt shifts in positions.

The level of concern over the political instability and the unknown effects that the prospective payment program may impose suggests that there is a strong market for analysis of those effects. As the administration and Congress continue to flesh out the program, both lawmakers and affected interest groups want to understand the consequence of alternative policy options.

In recent years, the health policymaking arena has become choked with the players. In earlier years, a few powerful provider groups participated actively in policymaking. Since the mid-1970s, more and more groups find they have a stake in policy outcomes. The new participants include representatives of the business community, manufacturers of related products, beneficiaries, and the commercial insurers, to name only the most obvious.
Further complicating the policymaking environment is that one major participant, the American Hospital Association, is showing signs of splintering under the divisive pressure of the prospective payment formula; and hospitals are now reorganizing themselves along more particularistic lines that reflect their positions on the rate formula.

In sum, the current health policymaking environment can best be characterized as extremely uncertain. The configuration of current participants is unstable. They are adversary as much as ally in their competition for a larger share of the fixed Medicare budget. Reimbursement policy and goals are, likewise, not firmly rooted. It is a situation that stands in stark contrast to the predictable relationships and policies of decades past.
ACKNOWLEDGMENTS

In the course of this study, we benefited greatly from the expertise and encouragement of a number of our Rand colleagues. Richard Retting, Joseph Newhouse, and Dennis Pointer all provided valuable insights and critical advice as reviewers. Shan Cretin gave continuous support and encouragement throughout the project, without which it is unlikely that the research would have been completed. Paul Ginsburg generously shared his experience in the policymaking arena as well as his reactions to various drafts dealing with passage of the prospective payment legislation. Helen Turin edited the report with her usual competence and dispatch. Jeanne Shultz ably undertook the typing and other necessary support functions for our work.

In addition, we received invaluable help from the many persons we interviewed in the process of the research. Without their cooperation, this undertaking would not have been possible.

Any sins of omission or commission that remain are, of course, our own.
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I. INTRODUCTION

The last two decades have produced some extraordinary shifts in health care financing. Before 1965, financing of health care was a matter left largely to individuals and the medical community. Increasingly, people came to rely on insurance, but the federal government played no part in providing the insurance or supervising the care. In June of 1965, President Johnson departed dramatically from this tradition when he signed the Medicare and Medicaid programs into law. These two programs established the federal government as a major financer of health care services, and as a consequence of its changing role, the federal government has spent the last 20 years trying to balance the competing and often shifting demands for improved access, quality of care, and cost containment.

Faced with health care expenditures that were increasing at an annual average rate of 6 percent in constant dollars between 1965 and 1980, health policy analysts and policymakers alike spent the 1970s searching for ways to contain medical costs. Their principal concern was Medicare's policy of cost-based reimbursement. With some modifications, Medicare had been purchasing services from providers by paying "reasonable and customary" charges or service costs. Rather than giving providers an incentive to contain services and costs, this policy held out the opposite incentive.

During these years, analysts turned almost uniformly against retrospective, cost-based reimbursement; and a small literature was developing that supported the concept of a fixed price, prospective payment system. But policy change required some consensus among politically powerful groups regarding an alternative direction. That consensus did not exist, and the issue of cost control was not yet powerful enough to demand that the groups reach some compromise.

During the first years of the 1980s, the political environment changed markedly. The deficit burgeoned, giving the containment of all budget outlays a high priority on the policy agenda. At the same time, a new administration philosophically predisposed to support cost containment policies that relied on market forces rather than direct regulation was elected by a landslide. Thus, the setting and the direction for change were established.

After a series of quick, incremental moves, Congress abandoned cost-based reimbursement for hospitals in 1983 with the passage of the Social Security Amendments, which provided a prospectively deter-
mined pricing schedule for most inpatient care. Under the new legislation, Medicare pays hospitals a fixed amount for each Medicare discharge, based upon which of 470 Diagnosis-Related Groups (DRGs) the patient falls into, with some further adjustments for the location of the hospital and its labor costs. With Medicare's fixed fee schedule, hospitals now bear the risk of treating Medicare patients. If they can do it for less than the scheduled price, they may keep the difference. If it costs them more than the scheduled price, they must absorb the loss.

Adoption of the new prospective reimbursement system occurred quickly, with little warning, and of necessity in something of an information vacuum. The only DRG-based prospective reimbursement program that had actually been implemented was the Health Care Financing Administration's (HCFA) experimental program in New Jersey. In preparing its legislative proposal for Congress, HCFA had also conducted some analyses of the distributional consequences of alternative reimbursement formulas.

But providers, beneficiaries, and other payers came to the bargaining table with no information that would describe how HCFA's prospective reimbursement program might affect them. Moreover, they had little understanding of how the administration would choose to implement the skeletal legislation.

These "start-up years" should therefore be particularly crucial in setting the future policy agenda for health care financing. It is during these years that unexpected problems will emerge, and participants can be expected to gain a more complete understanding of the distributional consequences of applying HCFA's reimbursement formula. As those affected by the program get this experience and information, they will certainly return to the political bargaining table to redress any grievances. Their experience and perceptions with both implementation and distributional consequences will largely determine their positions on key issues and affect the success of the current program and its future directions.

PURPOSE OF THE STUDY

When we undertook this study, we expected that any new program with this scope was bound to experience troublesome implementation problems. We believed that a systematic description and ordering of these problems would be helpful to both the policymaking and the research communities and give them some basis for focusing their attention. However, as we gathered information, we came to realize that because adoption of prospective reimbursement proceeded so
rapidly, a study of the experiences and attitudes of actors in the health care field would uncover much more than implementation concerns. Thus, we expanded our scope to include a broader range of concerns with the current prospective reimbursement program and of attitudes toward alternative policies.

Our objectives in this report are to:

- Identify significant program implementation problems.
- Characterize in general terms the attitudes of major participants (hospitals, other providers, beneficiaries, and other payers) to the current program and to alternative reimbursement options.
- Identify and explore longer range issues that are likely to prompt increasing support or opposition to the current prospective reimbursement program.
- Provide an overview of program development and implementation, as we accomplish the above.

Given the broader scope of our research and the current instability in the political environment, we continue to expect members of the policy and research communities to find such a descriptive analysis useful in focusing their efforts.

**METHODOLOGY**

Our analysis rests on two sources of information. First, we conducted a complete literature search of trade publications, health-related journals, and major news magazines and newspapers for information that might contribute to our perceptions of and reactions to the new prospective reimbursement program. The literature is replete with articles on the new reimbursement plan, but it is worth noting some limitations in their content. The program is still reasonably new. Some hospitals have had it in place little more than a year and have only a vague sense of what distributional consequences it holds for them; therefore, reactions may still be somewhat poorly defined. The long publication lead time required by several journals makes it even more difficult to gather informed, timely information on constituency reactions.

With the literature review in hand, we conducted extensive, structured, but open-ended personal interviews with representatives of 16 major trade associations representing constituencies in the health care field. (For a complete list, see the appendix.) We had a set of points that we covered with each type of interviewee. However, there was no
standard interview form or format. Typically, we spoke with the head of the organization, the head of the governmental affairs department, or the head of the office of research. Material from these interviews provides the foundation for our analysis. We were also able to use this material to test how current and representative were the views we drew from the literature review.

Although a formal survey of the various constituencies would certainly have provided a more empirically defensible set of conclusions, such a methodology seemed inappropriate to our task. The foremost argument against such a course was that any research on current perceptions is akin to shooting at a moving target. Thus, for timely results, the research must be conducted rapidly, and even then, significant changes may have occurred. Given our objectives, the more formal methodology seemed certain to hamper the research as well as increase our costs considerably.

ORGANIZATION

Section II introduces our exploration of reactions to the current prospective payment system with a description of the historical context in which current policymaking is taking place. This background analysis is essential to understanding the roots of current conflicts and the constraints on policy options.

In Sec. III we describe the payment formula and examine reactions to the way in which its various components allocate revenues, focusing on the redistributive consequences of the new payment policy among hospital providers. Next, Sec. IV examines the growing tensions between the competing goals of cost containment and the maintenance of quality of care. We focus on reactions to the redistributive properties of the policy as it affects beneficiaries and taxpayers. In particular, this section addresses concerns about the quality of care being delivered under the new prospective payment system. Section V describes implementation problems that members of the health care community report they face under the rules of the new program. In Sec. VI we briefly report the effect that the new payment system seems to be having on the policymaking environment and summarize the issues that are central to the future acceptability of the prospective program.

This presentational structure is useful not only as a vehicle for placing the broad range of issues before the reader, but, by organizing the concerns and reactions of the various health care constituencies around central distributive issues, it gives the reader a better appreciation of
the political underpinnings of the policy process. The sequence also suggests the order in which the issues have and can be expected to emerge.
II. THE POLITICAL CONTEXT

In an effort to contain spiraling health costs, Congress has dramatically revised the way in which the federal government reimburses most hospitals for their care of Medicare beneficiaries. This new payment reimbursement policy contrasts with the first policy that Congress adopted in 1965 as part of the first Medicare legislation and, for the most part, left intact for almost two decades.

Under the old system, Congress mandated the Department of Health, Education and Welfare to reimburse hospitals for all reasonable costs associated with the care of Medicare patients. As the price or the volume of services increased or decreased, so would Medicare outlays for hospitalization. The government bore the entire risk for escalating costs, and hospitals, it is often argued, had little or no incentive to constrain costs. On the contrary, they had considerable incentive to increase them.

In 1983, Congress enacted legislation that many view as a watershed in modern health care financing. The Social Security Amendments passed that year included provisions requiring the Department of Health and Human Services to reimburse most hospitals for their care of Medicare patients on the basis of a fixed price schedule that varies according to the patient’s diagnosis. Under these provisions, the hospitals have been forced to assume much of the financial risk for managing Medicare patients. If they can provide care at less than the government price, they can turn a profit. If not, they stand to lose money.

Unlike the original Medicare reimbursement provisions, the 1983 Amendments were not born of consensus. Rather, they were launched in the absence of opposition. Those that might normally have opposed such a departure from past policy found themselves in a changed political environment and uncharacteristically ill-prepared for the swift legislative move, as well as uninformed of what its consequences might be. Only now, as the new reimbursement program takes hold, are the constituencies that the policy affects slowly shaping reactions to it. Their reactions are still ill-defined and sometimes contradictory; and therefore, the political context for the development of prospective payment can best be described as unstable.¹ Perhaps developing opposition will dissipate with more experience. Perhaps it will simply be overwhelmed

¹For a full discussion of the political stability surrounding current Medicare reimbursement policy, see Morone and Dunham, 1985.
by support for the program that grows in other quarters. Perhaps opposition will force the planned implementation of prospective payment to a standstill. Or perhaps it will not provide a sufficient obstacle to halt the program but will force unexpected changes upon policymakers.

Strongly held views of key constituencies often define the area policymakers have for maneuver. Understanding the historical roots of the views as well as the views themselves gives a sharper sense of where these boundaries lie.

Perhaps more important, how a group responds to a new policy or proposal depends upon how it affects the group relative to the old policy, not relative to a theoretical norm. Thus farmers will oppose reductions in grain price supports because benefits are reduced relative to the existing policy, although the proposed change may still offer them greater benefits than a free market would. Because the status quo will determine political reactions, understanding those reactions requires understanding existing policy. In our case, “existing policy” is the one that preceded the new prospective payment policy.

To provide the necessary background for understanding present attitudes and constituency configurations, we trace the evolution of major trends in health care financing since World War II. We do not attempt to treat the subject in depth. Rather, we provide a brief summary of the factors that appear to be significant determinants of current policy and perceptions.

THE EVOLUTION OF POLITICAL CONSENSUS

Although the seeds of change may already have been sown, health care financing immediately after World War II did not differ markedly from the financing of most other services offered in the economy. The traditional buyer-provider relationship governed the delivery of services, for the most part. Although various forms of health insurance were available, few people had coverage. Medical care was forced to compete with other necessities for a share of the household budget. By and large, society afforded it no special rank through government subsidies.

To the degree that access to medical care was accorded special consideration, it was generally done through the private sector. Although major urban areas had tax-supported hospitals for charity cases, private philanthropy also supported an appreciable number of charity

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2For a full treatment, see Starr, 1983.
beds in private hospitals. At the same time, physicians generally
scaled their fees on the basis of a patient’s ability to pay, thereby shifting
the cost of service to those more able to pay.

Access for the Middle Class

Following World War II, improved access to medical care emerged
as an important societal concern. During the war, soldiers and their
families had enjoyed full access to military medical care on a routine
basis. They came to appreciate the benefits of such access and hoped
not to lose them as civilians. In the affluent environment of the
postwar period, broader access to medical care seemed a legitimate and
reasonable demand. Moreover, modern medicine was offering dramati-
cally improved outcomes. New drugs and procedures could be used
effectively against a broad range of diseases and disabilities. Access to
care was making a more obvious difference in the quality and length of
life. So, not surprisingly, access to care became more important to
people.

Improved access required two changes. A larger share of the popula-
tion had to find physicians’ services and hospitalization affordable. At
the same time, there had to be sufficient doctors and hospital facilities
to service a larger number of users.

During the postwar years, the private sector undertook the job of
making health care affordable to the growing ranks of the middle class.
Unions, which had fought for some form of government health
insurance in the 1930s, now negotiated more successfully with
employers for private coverage as part of wage packages. Following the
lead of the union shop, other employers also began offering health
insurance as part of their compensation packages. The number of
people covered and the extent of their coverage expanded rapidly. By
1954, unions were purchasing 25 percent of all the insurance in the
country, and 60 percent of the population had some form of coverage.

At the same time, government undertook responsibility for expand-
ing the infrastructure to permit care of those who now had the means.
In the immediate postwar period, the federal government invested
heavily in the expansion of the veterans’ hospital system. Also, in
1946 Congress enacted a program under the Hill-Burton legislation to
subsidize the construction of community hospitals around the country.
For some years, the American Medical Association successfully blocked
government efforts to extend support to physician training. But in

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3For an interesting description of the evolving effectiveness of medical science, see
Thomas, 1983.
1963, Congress also passed the first in a series of measures to expand health manpower.

Access Beyond the Middle Class

The robust economy of the early 1960s offered people a context in which it seemed reasonable to expand one's definition of well-being. In those years, the economy was growing at a rate of somewhat over 5 percent annually in real terms, and voters could begin to think of extending the benefits of that growth. Public debate over government programs began to examine determination of need. The job of policymakers came to be determining and meeting needs rather than choosing among competing needs.

It was in this environment that society's view of what constituted equitable access to health care expanded. The preceding decade had emphasized bringing care firmly within reach of the working middle class. Once accomplished, that goal became simply a way-station in the journey to make quality care available to all people. Nowhere was the change in the public attitude more apparent than in the legislative agenda of the 1960s, when Congress enacted several programs that extended health care access to those who might not qualify for or be able to afford the protection of full insurance coverage. Because access was to be accorded a group that had no connection to the private sector, government had to step in as a major provider. Most notable of the efforts to expand access to care were the Medicare and Medicaid programs, signed into law in June of 1965.

In essence, the Medicare program provided all persons 65 years and older with hospitalization insurance and allowed them to purchase supplemental coverage for physician fees at a subsidized rate. The program provided the coverage without imposing any significant restraint upon use of services or provider fees. Physicians were compensated on the basis of "reasonable and customary" charges and hospitals were reimbursed on the basis of costs. For reimbursement under Part A, the hospitalization coverage, hospitals submitted annual cost reports and apportioned the total, including operating costs, capital costs, and the costs of medical education, between Medicare and non-Medicare patients. Fiscal intermediaries reviewed the cost reports, disallowing unacceptable charges, and the federal government then reimbursed hospitals for their net approved Medicare costs.

The Medicare program, like the other federal programs adopted during the 1960s, had several design characteristics that proved to have a very strong effect on health care delivery and on costs in future years. Of perhaps greatest consequence was the fact that the increased access
to health care offered by Medicare was never paired with any restrictions on the quantity or the quality of service to be provided. To the contrary, the express philosophy underlying the legislation of those years was to finance care comparable to that provided through insurers in the private sector. Proponents of the programs argued that it was only equitable that all in need should be supplied with the most effective treatment available. In adopting this position, government implicitly agreed not to cap the revenues available to the health care sector of the economy.

At the same time, the program gave individual providers no incentive to contain costs. To the contrary, they each had every incentive to provide an increasing array of services in increasing volume. Because the program was adopted in a period of extremely rapid growth in medical technology, they had both the incentive and every opportunity to increase the services delivered.

Medicare was designed so that it could offer an increasing share of public resources to the providers of health care, so increasing costs imposed no losses on any of the political constituencies directly concerned with health care. Hospitals and physicians maintained and increased their income. At the same time, because insurers now had contracts as fiscal intermediaries and did not have to subsidize the care of uninsured elderly, they also benefited. Medicare beneficiaries also enjoyed access to their choice of medical providers and to a complete range of available services. At that point, the taxpayer, the only loser under the new program, found the burden still acceptable. Thus, the Medicare program was launched from a very stable political platform.

A Shifting Consensus

Stable though political consensus may be at any given moment, changing events often have a way of eroding it. Within a few years of the inauguration of the Medicare program, change began to overtake it.

Health care costs, driven by the introduction of new technologies and the inflationary reimbursement structure of first private and then public insurers, had been rising rapidly for some time. As Table 1 indicates, the trend in health care costs was striking. A small share of the cost increase could be attributed to population growth, but increases in input costs and in the use of services accounted for most of it.4

Increasing costs seemed acceptable in the context of a healthy and expanding economy. By the early 1970s, however, the economy, which many had believed capable of providing abundantly enough to make

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4Prospective Payment Assessment Commission, 1985a, p. 13.
Table 1
TRENDS IN HEALTH CARE COSTS IN CONSTANT DOLLARS
(Amounts corrected to 1982 dollars using GNP deflator)

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<tr>
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<tbody>
<tr>
<td>Total ($ billions)</td>
<td>87.1</td>
<td>124.0</td>
<td>223.8</td>
<td>354.1</td>
</tr>
<tr>
<td>Per capita expenditures (dollars)</td>
<td>517.8</td>
<td>612.4</td>
<td>994.9</td>
<td>1453.5</td>
</tr>
<tr>
<td>Percent of GNP</td>
<td>5.3</td>
<td>6.1</td>
<td>8.6</td>
<td>10.8</td>
</tr>
<tr>
<td>Paid by government ($ billions)</td>
<td>18.1</td>
<td>26.3</td>
<td>86.5</td>
<td>135.2</td>
</tr>
<tr>
<td>Medicare payments ($ billions)</td>
<td>—</td>
<td>—</td>
<td>27.5</td>
<td>55.6</td>
</tr>
</tbody>
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— Not applicable.

hard policy choices unnecessary, began to soften markedly. So, too, did business and the public’s attitude toward unfettered health care reimbursement policies.

As early as 1972, Congress recognized that Medicare’s cost-based reimbursement formula might hold the seeds for future fiscal problems and took some steps to constrain Medicare costs in the Social Security Amendments passed that year. Congress directed the Department of Health, Education and Welfare to limit Medicare reimbursement to costs required by the efficient provision of services. On the basis of this authority, the department developed the Section 223 limits, capping reimbursable inpatient routine operating expenses at 120 percent of the average of such costs for similar types of hospitals. Over the next eight years, this cap was gradually reduced to 108 percent. At the same time, Congress instructed the Department of Health, Education and Welfare to develop and demonstrate some alternative options for prospective reimbursement. Under this mandate, the department began developing classification techniques that eventually made the current prospective payment system possible.

In a further effort to contain spiraling health care costs, Congress passed the National Health Planning and Resources Development Act in 1974. The legislation mandated the existing network of health planning agencies to certify a need for beds and new facilities before such facilities could be constructed. Congress had turned to planning in hopes that reducing capacity would reduce use.5

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Late in the decade, President Carter returned to the strategy of capping hospital rate increases. However, after a lengthy debate, his proposed legislative package ultimately suffered defeat in the face of strong opposition from the American Hospital Association. Adopted as part of its strategy to defeat Carter's proposal, the Association's own voluntary cost containment program was also held to be a failure.

None of the several governmental initiatives deflected the strong inflationary trend in health care costs. As the nation moved through a severe recession and into a period of general inflation, health care costs shot up at a rate greatly exceeding that of other goods and services. Reimbursement caps, service reviews, and health planning all seemed unable to alter the basic trend.

In the face of the obvious failure of traditional regulatory techniques to curb health care costs, intellectual and experimental efforts were being made in other directions. Proponents of economic competition as a vehicle for cost containment began to gain credence. Alain Enthoven and others began arguing the merits of using market competition rather than regulation to contain costs. Their views were incorporated into several pieces of legislation in 1979 and 1980, and although these early legislative efforts proved unsuccessful, the notion that the market might accomplish what regulation could not began to acquire its own following.

Several states, including New Jersey, New York, and Maryland, were exploring the application of administered prices (rate-setting) to correct for what was described as the "market failure" caused by the presence of insurance coverage. Supporters of rate-setting reasoned that with insurance coverage, patients were not price sensitive, and therefore the market for medical services could not function properly. If an outside party set rates, then market forces would function to relieve government of its other regulatory functions, such as planning and perhaps quality control. Thus, rate-setting, although fundamentally a regulatory approach to cost containment, reflected a stronger pro-market orientation than is normally associated with regulatory solutions.

By the turn of the decade, policymakers and interest groups alike were generally agreed that the federal government would no longer be able to meet its Medicare commitments without some major reform of the system. The major health care constituencies, even the hospitals, were forced to acknowledge that tinkering with the cost-based reimbursement system would not yield the necessary change. Cost-based reimbursement itself would probably have to be replaced with some new form of reimbursement, although no one had yet decided exactly what new form that should be. Change was very much in the wind,
strongly affecting proposals that would be forthcoming from the various constituencies and positions they would take in the debates of the 1980s.

Ultimately, the new economic policies of the Reagan administration galvanized a coalition that supported immediate and dramatic change in Medicare reimbursement policy. In 1981, the new administration pushed through a series of measures that markedly reduced taxes and increased defense spending without reducing domestic spending commensurately. The resulting deficit was unprecedented. Both Congress and the administration were prompted to reexamine the bigger domestic budget items in their effort to reduce the growing gap between income and expenditures.

THE BIRTH OF PROSPECTIVE PAYMENT

The Political Climate

The political environment of the 1980s, then, offered great opportunity for change in Medicare financing. Even the powerful provider lobbies had come to accept change as inevitable. The 1980 election gave a new administration a mandate to radically reduce both the level of government spending and government regulation of the private sector. It was a political situation ripe for change.

Providers, particularly hospitals, grew fearful of what they perceived as alternatives to the status quo. The prospect of a heavily regulatory national rate-setting policy loomed ominously on the horizon. Hospitals were united in their opposition to this solution. As an alternative, they generally agreed they wanted a reimbursement formula based upon a schedule of fixed prices per admission. Other providers had not yet agreed formally on even the rudiments of a reimbursement system that might replace cost-based reimbursement.

The TEFRA Provisions

Congress took up the question of Medicare reimbursement once again in 1982. In the Tax Equity and Fiscal Responsibility Act (TEFRA), it imposed a series of new constraints on reimbursement. Although reimbursement remained cost based, several new elements could serve equally well as the basis for a prospective formula. In fact, many argue that it is the TEFRA provisions and not the 1983 Social Security Amendments that actually mark the watershed in Medicare reimbursement policy.
TEFRA imposed a hospital-specific cap on the amount of total inpatient operation costs that Medicare could reimburse. Thus, ancillary departments and special care units were drawn into the circle of controlled services. Hospitals were grouped according to their size, their location (urban or rural), and their case mix (a proxy for how seriously ill their patients tended to be). Their reimbursement was capped at 120 percent of the average cost per case for similar types of hospitals. The 120 percent ceiling was to be reduced to 110 percent over the following three years.

At the same time, the TEFRA legislation set cost growth rate targets on the basis of a weighted average of hospital input costs plus 1 percent. If hospitals exceeded the cost growth target, they were to be reimbursed a fraction of their costs; if they held costs below the target, they could keep a fraction of the cost savings. This provision was Congress's first real bow in the direction of market incentives. Finally, the costs of capital, medical education, and outpatient services continued to be paid on a "reasonable cost" basis.

TEFRA contained the clear outlines of our present prospective payment system. It capped reimbursement, something midway between pure cost-based reimbursement and prospective payment. It applied a system of diagnosis-related groups, a patient classification system designed to capture cases of similar resource consumption, to adjust each hospital's reimbursement limit. It established the case or discharge as the unit of payment. It permitted hospitals to keep some small share of the difference between their costs and Medicare's limit.

The policy direction set by the TEFRA provisions mirrored the course several states had already chosen as they adopted rate-setting statutes. Although the prospective payment mechanism was widely acclaimed and is still often described as a "pro-competitive" or "market" solution, it is in fact a clear case of administered pricing on a prospective basis. Under this policy, governments establish prices for a service or set of services. The policy flows from the regulatory tradition of administered prices and not from the pro-competitive rationale.

TEFRA's reimbursement changes met with little opposition from the active participants in health policymaking. Everyone accepted the need for cost containment of some sort. The TEFRA provisions offered a way of perhaps containing costs without resorting to rate review, a feature that many found encouraging. Furthermore, the TEFRA provisions did not appear to redistribute income among the providers in any serious way. TEFRA did not place a ceiling on the number of dollars available for payment, nor did it permit hospitals to keep much in the way of surplus. No one expected the new policy to create a set of big winners or big losers.
Full Prospective Payment

Even as these provisions were adopted, key lawmakers saw them as only a first unrefined step in the march toward full prospective payment. The law stipulated that the provisions “sunset” three years from the time of passage, and it directed the Department of Health and Human Services to prepare a fully developed proposal for presentation by the end of 1982 that described a workable reimbursement program based on the principle of prospective payment.

Much to the surprise of everyone, particularly the health care interest groups, the department was able to craft such a proposal in spite of the very short lead time it was given. Unbeknownst to most, a small group within the department had devoted several years to developing the structure for a national prospective reimbursement plan for Medicare beneficiaries. The department was also already funding an experimental prospective payment program in New Jersey from which they were getting implementation information. On the basis of these efforts, it formulated a workable proposal and presented it to Congress for placement on the 1983 legislative agenda in late December of 1982.

Although the new proposal was revolutionary in that it boldly espoused the principle of prospective payment, in many respects it simply amplified the changes introduced in the TEFRA provisions. In its broad outline, the plan required the department to establish a schedule of firm prices that would determine reimbursement to hospitals for each Medicare discharge. Hospitals received a fixed amount rather than a fixed maximum for each discharge. The amount to be paid for a discharge was based upon the diagnosis-related group (DRG) to which the patient was assigned and upon a further adjustment for area wage rates. Because payment was a fixed price, hospitals could keep the entire difference between their costs and the price paid. Hospitals with higher than average costs would have to bring their costs into line or face bankruptcy. Hospitals with lower than average costs could reap the reward of their presumed efficient performance.

The speed with which a prospective payment plan appeared on the congressional calendar caught most political interests totally unprepared. Few seemed to have had any idea of the specific form the proposal might take before it was introduced. Once it had been introduced, many groups found themselves without the data to analyze its

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6Based on interview information.

7The outstanding exception appears to have been the Federation of American Hospitals, the association representing the proprietary hospitals. The federation not only supported the legislative proposal but was firmly behind the strategy of quick passage.
effects, particularly its distributional consequences. For example, hospital associations did not have data on their membership broken down in such a way that they could determine the effects of the formula on inner-city or rural hospitals. Moreover, in the brief four months between introduction and passage of the proposal, they were unable to construct such data or do any analysis.

In the absence of hard information that proved the proposed plan would do serious harm to their constituencies, the major interest groups, particularly the hospitals, had every reason to let the proposed legislation go through. They agreed that Medicare financing demanded early reform, and they hoped to avoid any moves toward a rate-setting solution. Moreover, the hospitals found the TEFRA solution to be a harshly lopsided incentive structure. If they did a bad job, they lost money; if they did a good job, they did not gain much. The prospective payment proposal was viewed as a distinct improvement.

High-level supporters of the proposal adopted the strategy of moving quickly and providing as little information as possible. They believed that the lengthy debate accompanying President Carter’s cost containment proposal was largely responsible for its failure, and they were determined to avoid the same mistake.

The Department of Health and Human Services was studiously silent on the subject of distributional consequences, especially on how the prospective payment proposal might affect various providers. Although the department had the data and did some analyses that described the financial effects of alternative reimbursement formulas on hospitals by type and by location, this information was shared with only a limited number of people on the Hill. They understood that because their proposed price schedule would ultimately be based on average national costs, their proposal could potentially redistribute large sums of money among hospitals. They also understood that even the possibility of substantial distributional consequences would arouse strong opposition to the proposal from the hospitals.

Some information on the redistributive consequences of the formula did finally emerge, but not until the February hearings on the proposal. In those hearings, the Congressional Budget Office (CBO) documented the fact that the very elementary formula then before Congress would create great shifts in income among various types of hospitals. CBO went on to suggest that it was unlikely these changes in reimbursement simply reflected variations in efficiency among the groups of hospitals.

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8Based on interview information.
analyzed. Rather, CBO argued, the formula probably did not reflect true costs.9

Those managing the legislation, anxious to avoid much debate or delay, moved to moderate some of CBO's predicted shifts. They accommodated the teaching hospitals with a large bonus in the form of the indirect teaching subsidy (see Sec. III).10 They incorporated an urban/rural adjustment factor into the formula and provided that movement to the national rate should occur slowly over a three year period. In short, they were willing to pay a substantial price to move the proposal along without obvious controversy.

The strategy of "quickly and quietly" proved to be very effective. The major health care interest groups, already predisposed to favor a prospective payment system, did not oppose the plan, although they knew they had little information about its exact effects. They did not expect major problems, and they assumed that if any of them suffered unduly at the hands of the new system, appropriate adjustments would be made in future years by the health policy committees. In the past, the health care groups had worked reasonably harmoniously with these committees and had found them generally understanding.11

Prospective payment for Medicare beneficiaries became the law of the land when President Reagan signed the Social Security Amendments of 1983 (P.L. 98-21) into law in April of 1983. But it is well to remember that those who guided the proposal to its successful adoption did not owe their victory to a strong consensus they forged in support of the plan. Rather, they owed it to the absence of information and therefore the absence of opposition.

The policymaking process underlying the passage of the prospective payment system is characteristic of that underlying most significant shifts in policy. The new legislation was the product of a confluence of factors, intellectual and political as well as, to some lesser degree, individual and circumstantial. It was also based upon only the broadest and most general understanding of what its effects might actually be, because to gather more complete information about a major shift in policy, the details of which remain to be worked out in the early years of implementation, would have been impossible.12

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9Statement of Nancy M. Gordon, Assistant Director for Human Resources and Community Development to the Subcommittee on Health, Committee on Ways and Means, February 14, 1983.
10The teaching hospitals were the one type of hospital able to understand from the CBO data that they would experience severe losses under the proposed formula.
11Based on interview information.
12For a full description of what types of information accompany what types of decisionmaking, see Braybrooke and Lindblom, 1963.
The absence of information at the time of a major policy change leads to instability during the early years of implementation. Design and implementation details are hammered out during this period, creating continuing shifts in effects. At the same time, the various constituencies governed by the new policy both confront the reality of operating under it and have their first opportunity to assess its effects. It is a period of political and policy evolution.

REALITIES OF THE NEW PROSPECTIVE PAYMENT SYSTEM

As could be expected, their early experience with prospective payment presented the Medicare constituencies with several surprises.

Size of the Reimbursement Budget

At the time of its passage, prospective payment was seen as a way to control costs in the health care sector. All agreed that cost containment was a reasonable objective. Because it was price-based, however, the program adopted by Congress provided the mechanism not only to reduce the rate of inflation in Medicare costs, but to reduce costs absolutely. By adjusting the standardized amount per case that it would pay, the federal government now exercised absolute control over Medicare outlays. In an environment of growing hostility toward “inefficient” providers and increasing concern over a mounting deficit, policy decisions began to reflect a governmental effort to do more than simply contain inflation.

Both Congress and the administration made several moves within the first two years that were perceived to actually shrink the size of the Medicare pie. The original 1983 legislation required that the DRG prices be increased annually to reflect true inflation in input costs, with an additional 1 percent increase to account for changes in technology and productivity. In the 1984 Deficit Reduction Act, Congress reduced the 1 percent adjustment to .025 percent for FY85. At the same time, the department made two different downward adjustments in the DRG weights to compensate for the fact that doctors and hospitals seemed to be reporting patients into increasingly expensive DRG groups, a phenomenon commonly called “DRG creep.” The following year, in its most forthright effort to contain costs, the administration announced its intention to place a total freeze on all upward price adjustments for the following fiscal year. In the summer of 1984,
Congress also froze physician reimbursement rates for payments made under Part B of the Medicare program.

**Redistributive Consequences**

The current prospective reimbursement program can make significant redistributions along two key dimensions. First and most obviously, the formula that governs what the government will pay for hospital care may have built-in biases that unintentionally discriminate against some types of hospitals (for example teaching hospitals) or some types of caseloads (for example more severely ill caseloads). Thus reimbursement money will shift from one class of hospitals to another, independent of their relative efficiencies. Second, changes in the level or quality of care that come to be offered under the new system could potentially redistribute benefits. In that case, beneficiaries may suffer a reduced level of service and perhaps ultimately health, given the new spending constraints. But employees should suffer fewer payroll tax hikes than if reimbursement had continued to be cost based.

**Redistributions Among Hospitals.** Department and congressional supporters of the prospective payment package adopted in 1983 chose a design that had considerable redistributive consequences. Others had proposed alternative designs that rested more heavily upon rates derived from hospital-specific costs and less on average national costs. But supporters of the administration’s proposal believed that after years of feeding at the trough of cost-based reimbursement, hospitals had grown unduly fat and inefficient and needed strong incentives to mend their ways. Supporters saw nationally based rates as a way of forcing at least the many hospitals operating at above the national average cost to improve their performance. They wanted more than cost containment. They wanted change in health care delivery.

Once the reimbursement formula was made public with the introduction of the legislation, several groups undertook analyses of its financial effects on various types of hospitals. Because those doing the work lacked good data and the time to apply analytical sophistication, their findings could only be rough indicators of those effects. Since the results of these first studies made their way through the hospital community, concerns have mounted.

The CBO's preliminary analysis so alarmed the hospitals that the California Hospital Association, at the request of several other hospital associations, undertook a follow-on analysis. That study, conducted

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14 Based on interview information.
state by state, reached the same conclusion; once prospective payment moves to a payment schedule based upon average national costs, large sums of money will be shifted from hospitals in, for example, the midwest and east coast to hospitals in the south. Some states stand to lose hundreds of millions of dollars.

Hospitals particularly fear the effects of redistributive consequences, because it has become very apparent that they will have to survive these effects while the overall Medicare budget is contracting. Rather than have Medicare increase outlays to make up the losses, a hospital or group of hospitals will simply have to live with the revenue loss.

**Redistribution Between Beneficiaries and Taxpayers.** Although the redistributions that the new prospective payment rules may force on the hospital community have received reasonably prompt attention, for several reasons the same has not been true of possible shifts in benefits from the beneficiary to the taxpayer. Beneficiaries and providers are both concerned that the quality of care will suffer under prospective payment, but they have a much more difficult case to make. There is no agreed upon definition of appropriate or quality care. If anything, our societal sense of what constitutes appropriate care is less firm than it was even a decade ago. Moreover, the data that would support any debate on quality of care are not comprehensive, even if there were agreement on what constituted quality. Finally, deterioration in the quality of care may take some years to become fully obvious. Today's economies may not be reflected in declining quality for some years.

The debate on quality is further clouded by the fact that most commentators on the subject do not see it as a distributive issue. They report that Medicare patients now receive a reduced level of service without linking that phenomenon to the need to constrain costs or to the tradeoffs inherent in providing the higher level of service.

The quality issue may also be slower in coming to the surface, because the group most affected by reduced quality is a large but not well-organized group. The hospitals, through their trade associations, can identify the effects of new statutory provisions and mount rapid opposition; but the beneficiaries will be much slower to object, although when they do, they are a formidable force.

**The Policymaking Process**

While providers and beneficiaries were coming to understand how the new legislation would affect the size of the reimbursement budget and its distribution, they met with a third surprise as prospective payment took hold. Traditionally, the various health-related interest
groups had been able to get adjustments in new programs that gave them particular difficulty, and they expected such an option with the new prospective payment system. However, the locus of decisionmaking appears to be changing. The growing federal deficit and continuing pressure for its reduction have led to an increasing concentration of decisionmaking authority in the Office of Management and Budget and in the congressional budget committees. This shift has occurred at the expense of the departments and the congressional policy committees. Consistent with the change, trade association representatives, who normally do the negotiating, now report that health policy decisions are increasingly made in budget committees, where their ties are weaker and there is less understanding of their situation. Or worse, major decisions are made in conference on the budget, permitting the trade association representatives no opportunity to voice their concerns. In short, reimbursement policymaking had been caught up in the budget process, and old points of political access are no longer useful.
III. THE PROSPECTIVE PAYMENT FORMULA AND ITS DISTRIBUTIVE CONSEQUENCES

Although the Social Security Amendments of 1983 (P.L. 98-21) will certainly affect both providers and beneficiaries in ways we cannot yet know, providers have turned their attention to the payment formula for Medicare's new reimbursement policy. This formula is the heart of the program, defining its objectives in operational terms and determining who many of the winners and losers will be. The provider group is the group most affected by the payment formula, and it is also the best organized and most capable of voicing concerns. Thus, the problems faced by providers are the problems most likely to find first political expression.

Congress and the administration turned to the new payment mechanism with the clear and explicit intention of holding in check aggregate federal outlays. The old reimbursement rules had made the government financially responsible for bills that it could not control. The incentives inherent in cost-based reimbursement, according to most analysts, were largely responsible for the exceptional inflation in health care. Under the new rules, the government hoped to limit its expenditures by establishing the price it was willing to pay for each class of diagnosis. If admissions and the mix of diagnoses remained stable, then so too should government Medicare outlays.

Policymakers who supported the current reimbursement formula also had a second and less obvious objective. They wanted a set of rules that would do more than simply contain costs. They wanted to force hospitals to initiate major reforms in health care delivery. They argued that during almost two decades of cost-based reimbursement, providers had developed very inefficient and perhaps even harmful patterns of care. They believed that providers, responding to the incentives offered by cost-based reimbursement, tended to do too much to the patient and to do it in unnecessarily expensive ways. Therefore, in an effort to reverse this trend rather than simply halt it, policymakers settled on a formula specifically intended to force a large number of hospitals to reduce the number and complexity of the tests and procedures administered to their patients. They expected that hospitals would be encouraged to reduce costs and to maintain if not improve quality of care under the incentives of the new prospective payment formula.
We have structured our exploration of the reactions of members of the health care community to the current payment formula along the lines of the framework suggested above. We examine their reactions to aggregate cost containment and improved efficiency. For each of these policy objectives, we explore their attitudes toward its reasonableness, how effectively they believe the policy is accomplishing the objective, and how equitable the policy is. Table 2 characterizes the structure of our analysis.

THE PAYMENT FORMULA

Under the rules of the prospective payment program, hospitals treating Medicare patients will be reimbursed a predetermined amount upon discharge of the Medicare patient.\(^1\) The predetermined fee is intended to compensate the hospital for all in-patient operating costs including ancillary and special care services and malpractice costs. At least for the initial years of the program, hospitals continue to be reimbursed separately, on a cost basis, for capital costs, direct medical education, and Medicare bad debt costs, because no acceptable mechanism has been developed to include these items in the payment formula.

The payment formula is a mechanism for determining, on the basis of a few rules, the amount of money a hospital should be paid for treating any Medicare patient for almost any medical problem. Conceptually, the linchpin of the formula is the national standardized rate payable for each Medicare discharge. This rate is then adjusted in each

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\(^1\) For a complete description of the reimbursement rules and methodology, see the Final Regulations issued January 3, 1984 in the Federal Register, 42 CFR, Parts 405, 409 and 489.
case according to rules set forth in the Social Security Amendments of 1983 and Federal Regulations to reflect a few case characteristics that designers of the program believe either drive costs themselves or are proxies for characteristics that drive costs. The standardized price per case is thus adjusted to reflect the type of case being reimbursed for— that is, the DRG the case falls into. It is also adjusted to reflect whether the hospital treating the patient is located in an urban or a rural area and to reflect regional variations in wages. Finally, the formula adjusts for additional indirect costs incurred by teaching hospitals in the course of treating sicker patients and in the less efficient manner necessitated by their teaching obligations. In sum, then, hospitals are reimbursed on the basis of a uniform, fixed amount adjusted to reflect four factors that appear to drive costs; two location characteristics, one hospital characteristic, and the type of case being treated.2

The Health Care Finance Administration (HCFA) used 1981 Medicare cost report data, adjusted to reflect inflation, to determine the standardized rates to be paid per case. From these data, HCFA developed a standardized national urban and a standardized national rural rate. Congress stipulated that HCFA should update these standardized rates annually to reflect changes in both the prices hospitals must pay for the goods and services they use to deliver care (the hospital market basket) and in productivity and technology (the discretionary adjustment factor).

Those portions of the urban and rural rates that are wage related (approximately 80 percent) are then adjusted to reflect area wage differences.3 The rules of the reimbursement formula require that the standardized amount be multiplied by appropriate wage indexes derived from Bureau of Labor Statistics data. Each Metropolitan Statistical Area has its own wage index; the rural hospitals of each state are grouped, each group having its own index.

The adjusted standardized amount is finally multiplied by a weight representing the diagnostic category to which the discharged patient is assigned. Using the 1981 Medicare Cost Reports, 1981 MEDPAR data, and DRGs, HCFA developed a set of weights for the 469 diagnostic groups that reflect the relative resource consumption of each group.4 On the basis of information in his or her medical record, each patient is assigned to one of the DRGs. The weight given that group is used to

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2For a detailed description, see Prospective Payment Assessment Commission, 1985b.
3Ibid., p. 7.
4The MEDPAR data described Medicare use patterns based on a 20 percent sample of beneficiaries drawn from the 1981 Medicare enrollment.
convert a hospital’s adjusted standardized price into payments for individual Medicare discharges.

The formula makes one further adjustment to reflect the indirect costs of teaching in a teaching hospital. This item was and remains a highly political and very poorly defined concept; consequently, it is without any direct measure. As a proxy, the reimbursement formula specifies that the number of full-time teaching staff per hospital bed times a somewhat arbitrarily determined adjustment factor (11.5 percent) be used to increase the payment to teaching hospitals for each Medicare discharge.

The above adjustments do not reflect additional money being paid out by HCFA. Rather, they reflect transfers of revenues received by one hospital but taken from another. In determining the national standardized rate, HCFA corrected its cost data to remove differences in production costs, teaching status, and case mix. The “removed” revenues are then reallocated to hospitals according to the requirements of the formula. Thus, HCFA’s Medicare budget is no larger, but individual hospitals and various categories of hospitals can expect to experience substantial shifts in revenue depending upon how the formula matches their historical cost patterns.

The formula is the primary focus of provider attention precisely because there are big dollars at stake. Providers expect it to be responsible for large shifts in revenue. Moreover, any changes a group of providers can wring out of HCFA are certain to be of substantial benefit. Small adjustments in the wage index or in the DRG weights could easily result in the movement of millions of dollars to or from a particular hospital and to or from a given area, region, or class of hospitals.

In addition to the fixed price per discharge, the rules governing prospective payment also provide that HCFA will reimburse hospitals for capital costs, direct teaching costs, and kidney acquisition costs. These costs are determined from information reported in current Medicare cost reports and are paid as “direct pass-throughs.”

Figure 1 presents an overview of the prospective payment system’s price-setting process.

Because application of the prospective payment formula was expected to cause a major redistribution of hospital revenue, Congress provided that hospitals should move to the national reimbursement schedule over a three-year transition period. In the first year of the transition, Congress mandated that the adjusted standardized rate be based 75 percent upon the hospitals’ historical costs and 25 percent upon average regional costs. In the second year, historical costs account for 50 percent of the standardized rates, and a blend of regional and national average costs account for the other 50 percent.
Fig. 1—Overview of PPS price and revenue setting process
In the third year, the balance was to reverse itself, with hospital historical costs accounting for only 25 percent of the rate and a blend of average regional and national costs accounting for the other 75 percent. In the fourth year, the rate was to be based entirely on average national costs. The three-year transition period was intended to give hospitals whose costs have historically been above the national average an opportunity to initiate changes that would bring their costs into line with the revenues they could expect to receive under the new program.5

A TOOL TO CONTROL AGGREGATE COSTS

The Policy Objective

As we discussed in Sec. II, by the time Congress enacted the Social Security Amendments of 1983, there was a consensus in the health care arena that some cost containment measures should be adopted. Testament to the strength of the consensus was the fact that during the many days of committee hearings held on that legislation, no one spoke against the policy objective of cost containment nor, indeed, against the mechanism of prospective payment. The major beneficiary representatives and provider groups, with the possible exception of the Council of Teaching Hospitals, actively supported the package.

Effectiveness

Four characteristics of the formula relate directly to its ability to contain aggregate Medicare outlays: the standardized rate, the updating mechanism for the standardized rate, and the fact that payments are made on the bases of volume and of diagnosis. The standardized rate and the updating factor together with the DRG classification determine the price per case. The volume of discharges and the case mix, for the most part, translate these characteristics into HCFA’s total payout.

HCFA has the authority to set both the standardized rate and the updating factor, giving it an extremely powerful policy lever to control government costs. We have found no one who questions the effectiveness of these two components of the formula. In fact, the administration has used its authority to set the updating factor as a lid for containing aggregate costs (see below). Instead, analysts have directed

5Under considerable pressure from the health care community as well as health policy analysts, Congress has temporarily frozen the transition at the 50-50 mark. It remains uncertain if or how the transition will continue to be carried out. (See below.)
their concern toward potential problems inherent in the choice of admissions as the payment unit and upon HCFA's ability to control treatment patterns and thus DRG assignment.

Although data now show a declining rate of Medicare admissions, early in the program, analysts raised the problem of controlling the admission rate. They argued that hospitals will have an irresistible incentive to increase admissions, particularly because they are reimbursed on the basis of average costs per case; but they will be incurring only marginal costs for the additional cases they admit. To support their contention, they cited data indicating that between 1979 and 1982, when its prospective payment system was in place, New Jersey's admissions increased at four times the national rate.\(^7\)

Wennberg et al. have offered the most influential description of the extent of the potential problem for the Medicare program. (More than half of our respondents referred to their study as evidence that the program has a large design problem.) Their study of the variability of practice patterns in Maine found substantial variation in admissions rates between one locale and another for identical illnesses.\(^8\) Their conclusions suggest that although physicians still hew to acceptable standards of practice, they have considerable latitude in which to increase admissions without risking penalty from the peer review process. Much discussion of the problem has generated few remedies.

Conversely, the provider community evinces little concern that physicians might push their patients into diagnostic categories with higher reimbursement rates. Although many of those we interviewed acknowledged that there appeared to be some "DRG creep," none believed it should be attributed to a conscious "gaming" of the new system. Rather, they thought it simply the result of the increased care with which hospitals and physicians are now maintaining their medical records. However, a recent study indicates 6.2 percent of the increase in the case mix index can be attributed to changes in coding practices and seems certain to draw more attention to the issue.\(^9\)

**Equity**

Although none of the elements of the formula that determine Medicare's aggregate payout has been described as inequitable in concept, two have been characterized as inequitable in practice. Both

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\(^7\)Stern and Epstein, 1985, p. 625.

\(^8\)Wennberg et al., 1984, p. 295.

\(^9\)Carter and Ginsburg, 1985, p. 28.
interest groups and analysts of health care policy have been carefully watching administration decisions on what rate increases to allow to accommodate cost increases. It is fair to characterize their reaction to date as one of uniform and pervasive dissatisfaction with what they perceive as government’s use of the Medicare budget as a deficit reduction tool.\textsuperscript{10} At the time of the program’s adoption, the cost update factor was set at the hospital market basket inflation rate plus a 1 percent increase to cover improvements in technology, productivity, and other such items. This was identical to the update factor built into the 1982 TEFRA legislation. Clearly, participants in the program came to expect “market basket plus 1 percent” to become institutionalized as the annual update in future years. They were, however, quickly disappointed as the Medicare budget got caught up in the effort to reduce the deficit.

The pattern over the past several years has been clear. In the Deficit Reduction Act of 1984, Congress reduced the discretionary adjustment factor, one element determining the standardized rate, from 1 percent to 0.25 percent for fiscal year 1985 and set that number as a ceiling for FY 1986. Then, in the face of a counter-recommendation by ProPAC to increase standardized rates by 1 to 3 percent, HCFA is freezing the rates at the 1985 level.\textsuperscript{11} While Congress and the administration have blocked hospital rate increases, they have also frozen physician payments under Part B of Medicare and increased the beneficiary’s share of the bill.

Although the administration maintains that its cost containment measures reflect steps to bring payments into conformity with costs, providers, beneficiaries, and commentators seem less persuaded. They believe the Medicare budget has become, as one observer says, “the domestic target in the administration’s war against spending,” and many argue that it is unfair to force one constituency to bear such a large share of the burden. Several Congressional health policymakers agree with this position and support modest rate increases.\textsuperscript{12}

The hospital associations also argue such policies jeopardize their ability to operate under the new program. High-cost hospitals will find it particularly difficult to weather the transition to prospective payment, because they will be losing any small margin of surplus revenue they may have. Furthermore, the associations maintain that hospitals cannot plan and make sensible management decisions when

\textsuperscript{10}See particularly, Iglehart, 1985a, pp. 525–528.

\textsuperscript{11}ProPAC recommends that rates be increased as follows: FY86 Update Factor = 4–5 percent (market basket) – 1 percent (DAF) – 1–2 percent (real increase in case mix complexity). If taken, these recommendations would result in a 1–3 percent increase in the Medicare rates for 1986. Prospective Payment Assessment Commission, 1985a, p. 30.

\textsuperscript{12}See Iglehart, 1985a.
reimbursement rules continue to fluctuate. The American Hospital Association and the Federation of American Hospitals are currently appealing to Congress to enact a payment floor that would prevent the administration from actually reducing the rates.\textsuperscript{13}

Most other members of the health care community have joined the hospitals in opposing the rate freeze. The American Association of Retired Persons, the chief representative of the Medicare beneficiary, has spoken out against the freeze, giving the same reasons as the hospitals. The American Medical Association, whose members are suffering from the existing freeze of Part B payments, opposes a freeze of hospital rates. But because it is not a policy that directly affects its members, the American Medical Association has chosen to be softspoken.\textsuperscript{14}

Most other trade associations, although they have not adopted a formal position, also oppose freezing the payment rates. Several researchers in health policy support this position, arguing that prospective payment is too new and revenue is already too tight for anyone to predict what unwanted results might follow.\textsuperscript{15}

Although there appears to be considerable opposition to making further cuts in the Medicare payments, the health care community has resigned itself to that eventuality. Group representatives described themselves as powerless to affect the outcomes of questions that have been caught up in the budget negotiation. By mid-1985, they were already exploring what accommodations they might extract on other issues, in return for acquiescence on the rate freeze.

A second and minor concern regarding the rate structure has been raised by the Prospective Payment Assessment Commission, which has some misgivings about the derivation of the standardized amount upon which payment is based. Almost as an afterthought, the Commission notes that the information used to determine the amount may have some serious flaws. It also suggests that the standardization process itself may result in some observable biases in payment and says it intends to examine both of these issues in future studies.\textsuperscript{16} We have not encountered this concern elsewhere.

\textsuperscript{13}Demkovich, 1985b.
\textsuperscript{14}Ibid.
\textsuperscript{15}Lave, 1984, p. 258.
\textsuperscript{16}Prospective Payment Assessment Commission, 1985a, p. 54.
A TOOL TO PROMOTE EFFICIENCY

In 1983, health care groups concentrated upon the question of cost containment. Since then, attention has shifted to elements of the payment formula that were adopted to encourage provider efficiency. Providers have come to understand that these elements are and will increasingly be responsible for the movement of large sums of money among hospitals and, because the Medicare budget is frozen, winners will be balanced by losers.

The fact that Medicare financing had become a zero-sum game has changed interest group alignments in the health care policy debate. The competition for limited resources has shattered the traditional unity of provider groups, who can no longer agree on unified positions, as they have so often in the past. And of perhaps more importance, the large trade associations are also losing some ground to smaller associations with more homogeneous interests.

Policy Objective

A review of the legislative debate over the Social Security Amendments of 1983 suggests that no member of the health care community opposed the goal of improving the efficiency with which services were delivered. Only a few representatives made any comment on the subject of efficiency, and they chose not to take issue with the objective itself. Rather they challenged the ability of the formula to accomplish its objective. The absence of opposition, however, did not necessarily reflect any measure of genuine support for the objective within the provider community.

During the legislative debates, cost containment was the primary issue and captured most of the attention. The efficiency issue raised a host of more controversial questions, so supporters of this objective preferred to keep attention focused on cost containment. Moreover, many interested parties did not seem to grasp the importance of the efficiency provisions during the brief period of legislative debate. No doubt it was difficult for a provider to disagree openly with the objective of improving efficiency in the delivery of health care.

Providers agree that there are substantial inefficiencies in health care delivery and that they were brought about, in large part, by cost-

based reimbursement. They also appear to agree that there is a legitimate role for public policy in reducing the inefficiencies. Their growing opposition takes a different form. Rather than quarreling with the underlying assumptions, many providers argue that the present formula (and perhaps any formula) cannot fairly and effectively accomplish the objective.

**Effectiveness and Equity: Production Costs**

Designers of the prospective payment formula hoped to encourage efficiency through two provisions. First, reimbursement rates would be based upon average national costs. Hospitals spending more than the national average would have to improve their efficiency to stay in business. Second, hospitals could keep any surplus. Hospitals already spending less than the national average would have no incentive to increase their costs.

To promote efficiency effectively, the formula must satisfy a second, competing objective. The dictates of both effectiveness and equity require that the formula be sufficiently fine tuned to reimburse providers for certain differences in costs. If the reimbursement formula does not accurately account for such factors as local wages and differences in patients' medical needs, then it will stimulate perverse behavior rather than efficiency. If the formula does not mirror costs, it will give some hospitals an unwarranted competitive advantage and force others under in spite of efficient management.

When they constructed the formula and provided for supplemental pass-throughs, designers of the prospective payment program tried to balance the demands of a powerful, workable incentive and accurately mirror legitimate costs. As noted above, the formula adjusts compensation to account for local wages, the hospital’s location (urban or rural), the type of illness being treated, and indirect costs associated with medical education. The program also reimburses hospitals directly for their capital and direct teaching costs until an acceptable way can be found to incorporate these costs into the prospective payment formula. The challenges raised by the health care community center on whether these adjustments accurately mirror cost variations that cannot be attributed to inefficiencies. Is the formula effective? Is it equitable?

As they move through the transition phase, providers and others seem increasingly persuaded that the reimbursement formula is flawed, perhaps beyond remedy. However, the specific concerns of each group are quite varied, reflecting its interests, organizational structure, and analytical capacity. A particular group of providers is likely to be especially affected by one element in the formula and therefore
concentrate its attention on the problems inherent in that element. For example, the American Association of Medical Colleges directs much of its attention toward the fate of the indirect teaching subsidy and pays less heed to problems with the wage index.

The organizational structure of the interest group is likely to determine the way it defines and pursues its concerns. For example, as hospitals realize that the prospective payment program causes major shifts in revenues, their organization into state associations prompts them to examine the shifts by comparing the effects of the program by state, not by type of hospital, geographical setting, or other more defensible unit of observation. Hospital lobbying postures are increasingly determined at the state level and thus reflect only majority interests in each state, not the more homogeneous breakdown of interests that might emerge from a different organizational base. Finally, the lack of good analytical capability also constrains the ability of many providers to effectively oppose and even to identify problem elements in the formula.

Many groups competing for a limited resource means that the long-standing unity of several provider groups may be breaking down. As early reports of the prospective payment program's distributional consequences became available, hospitals observed that it would prompt shifts in the flow of Medicare revenues from northeast, north central, and some western states to southern and some other western states. This information turned hospital against hospital and state association against state association. Hospitals perceiving themselves to be losers under the new program organized through their state associations to urge modification of the payment formula, particularly of the wage indexes. Conversely, hospitals perceiving themselves to be winners have also organized through their state hospital associations to oppose any changes in the formula or in the transition period. Some winner states and some loser states have now formed loose associations to better represent their common positions. The American Hospital Association now finds it difficult to agree upon common positions for representing its diverse membership as various of its constituencies begin battling each other for a larger share of the limited Medicare revenues. Policymakers might well anticipate similar fragmentation and realliances among other groups as the program continues.

**Transition to National Rates.** Initial opposition to the formula grew out of early analyses indicating that some states and perhaps some types of hospitals would be big winners and some big losers under the new prospective payment system. Early estimates revealed that the shift in revenues would be large and that it would affect many hospitals concentrated in particular regions of the country. State hospital
associations in those states expecting to be adversely affected responded quickly, arguing that such redistributions could not be explained simply in terms of regional differences in the efficiency with which hospitals delivered health care. They were joined both by other associations and by outside analysts in concluding that the formula must not be accounting adequately for acceptable variations in treatment costs.\textsuperscript{19}

Most provider groups have only limited analytical capabilities, and they have not been able to identify elements in the formula that pose a problem. Thus, their opposition has remained general, and they have concentrated on halting further movement toward national rates on the grounds that it is both unfair and counterproductive to move away from hospital-specific rates until the formula reflects appropriate costs, whatever those might be. With the exception of the Federation of American Hospitals, the national and state associations that we interviewed firmly support halting the transition to national rates at the present mix of 50 percent hospital-specific and 50 percent nationally based rates. Hospital associations representing states that are, on average, winner states remain the only outspoken supporters of moving on schedule to national rates.

The Wage Index. Of the formula’s several controversial elements, the wage index has commanded by far the most attention. Other issues may come to dominate the debate, but the wage index gained early attention because the analyses mentioned above gave hospitals information showing large and immediate changes in the flow of revenues. Although they had no clear evidence directly linking the indexes with the revenue shifts, several hospital associations quickly identified the indexes as the culprit, because they are seen as the adjuster for geographic differences. Fueling their sense that something was wrong, the associations also observed anomalies: For example, some suburban indexes are higher than the index for New York City. Because much of the criticism directed at the wage index is based upon an ill-defined sense that such major redistributions of revenue cannot be right, it is difficult either to rebut or to remedy.

The hospital associations in California, Ohio, and Illinois have been particularly concerned about the wage indexes. Although such national associations as the American Hospital Association acknowledge that the indexes may present a problem, they have been less outspoken, probably because their membership, with both winner states and loser states, has mixed views.

\textsuperscript{19}See the positions taken by the major provider organizations and Lave, 1984 and Vladeck, 1984.
Some groups have identified two types of failings inherent in the wage indexes. They argue that the indexes have been poorly constructed and therefore lead to undercompensation in particular locales. Rural hospitals, for instance, assert that they are penalized by the way in which their more abundant use of part-time employees was factored into the indexes and by the use of a single rural index for each state. Other groups argue that the way the indexes are applied can create serious boundary problems. Inner-city hospitals, supported by several state hospital associations, hold that the formula is insensitive to large swings in labor costs within the statistical metropolitan areas and therefore penalizes hospitals in the high cost, poorer sections of cities, while favoring hospitals located in the lower cost suburbs.

Congress was sufficiently concerned about the criticisms being raised to order HCFA, in the Deficit Reduction Act of 1984, to revise the wage indexes. When no revisions were forthcoming, Congress again ordered HCFA to issue a report and, at the same time, made the expected revisions retroactive. HCFA’s report was issued in March of 1985, and the proposed revisions came as a surprise to many.21

The revised index did not substantially lessen the redistributitional effect of the prospective payment formula. Although some rural areas fare better, others fare worse, and the revenues flowing to and from various states remain more or less the same.21 Given the outcome, HCFA’s revisions are unlikely to quiet critics of the wage index. Instead, Congress’s retroactivity requirement may simply stimulate more opposition.

**Urban and Rural Rates.** Congress sought to account for cost differences that were not related to wage differences by creating two standardized amounts for use in calculating reimbursements: one for higher cost urban areas and one for lower cost rural areas. This second adjuster for variations in the cost of providing service has attracted very little attention. In the few comments directed at this element of the formula, our respondents mentioned only that it, too, creates boundary problems. That is, hospitals on the urban fringe have the benefit of lower cost but get reimbursed at full urban rates. Two hospitals at the fringe can be within blocks of one another yet be paid at very different rates. Some also question whether the urban differential adequately accounts for higher urban costs.

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20See Fackelmann, 1985, p. 33.
21Ibid., p. 34.
Effectiveness and Equity: Level of Service

An efficient and equitable formula should adjust for variations not only in the cost of providing a given level of service, but in the level of service or treatment that different patients might require. If the formula fails in this dimension, it then gives hospitals a strong incentive to “skim” the less costly patients and to “dump” the more costly patients on other facilities. The DRG weighting schedule is the only element in the prospective payment formula that adjusts for variations in the level of treatment, and several provider groups and analysts are concluding that it is not sufficiently accurate or sensitive.

Those most keenly aware of the problems posed by the DRG weights fall into two groups: hospitals that believe their patients require more care than the “average patient” and researchers who believe that subgroups of patients within existing DRGs can be identified who have systematically higher or lower than average costs. Most state and nationally based hospital associations do not have a preponderance of members who believe they are being penalized by the DRG schedule, and these associations have given their attention to the problems of variations in input costs. However, the memberships of the AAMC and the Association of Public Hospitals both have a sufficient concentration of hospitals who believe they are being penalized to examine the problems raised by the formula’s poor ability to adjust for varying levels of service. American Hospital Association staff have also expressed concern over the issue.

Construction of the DRG Groups and Weights. Several sources believe the DRG weights inaccurately reflect the resource consumption of the patients that fall into each group. There is a consensus that the weights were constructed from poor, outdated data, the 1981 MEDPAR files, and therefore both the diagnosis classifications and the weights pose problems. Some also note that the weights favor surgical rather than medical treatment and simple rather than complex procedures. Moreover, they favor DRGs requiring little rather than intense nursing care, because the weights were constructed on the assumption that nursing requirements were equal across groups.

These problems appear to be viewed as short term. Those who raise them seem to believe that they will be resolved when the weights are recalibrated in 1986 (and every four years thereafter) on the basis of more current and accurate data. However, no sooner will the providers begin to respond to the incentives that these weights provide than recalibration will change those incentives. Winners under the old

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23 Prospective Payment Assessment Commission, 1985b, p. 86.
weights will certainly oppose the changes, while planning and decision-making will become more difficult for all providers as they face instability in the reimbursement rules.

**Severity of Illness Adjusters.** Critics of the DRG element argue most strongly that DRG-based payments are ineffective and inequitable, because the payments do not account for variations in severity of illness. They cite studies that conclude hospitals systematically vary in the proportion of severely ill patients they treat and relate these variations to differences in costs within DRGs.\(^{24}\)

Public hospitals point out that in addition to simple differences in severity of illness, other characteristics may complicate a patient’s treatment, making the patient more expensive to treat. For example, patients from lower socioeconomic backgrounds tend to have additional, complicating illnesses and lack outside support networks. Certain types of hospitals may also carry a larger share of patients with these characteristics.

The above-mentioned studies notwithstanding, there is no agreement yet among analysts on how to identify the types of patients that lead to higher costs or the institutions that get these patients. Nonetheless, those hospitals, primarily those represented by the AAMC and the Association of Public Hospitals, believe themselves to be most seriously affected and have pressed very hard for some form of additional compensation. They have met with mixed success.

Using teaching hospitals as a proxy for those hospitals with more severely ill patients, Congress incorporated an additional subsidy into the payment formula in the form of an inflated allowance for the indirect costs of teaching. Somewhat arbitrarily, Congress doubled the allowance that was originally intended to cover the hard to define extra costs that teaching incurred: extra tests, greater intensity of care, supervision, etc. It did so with the clear understanding that the augmentation was to compensate those hospitals for the more expensive caseload they presumably carried.\(^{25}\) But the indirect teaching subsidy has proven somewhat problematic.

There is evidence that the measure of teaching status in the formula offers only the crudest proxy for those hospitals with more expensive caseloads. Even the Association of American Medical Colleges acknowledges that the subsidy, based upon the ratio of teaching staff to beds, has led to instances of serious overpayment. Recent research suggests there may be a systematic bias in the formula, with university

\(^{24}\)Coulton, 1985.

\(^{25}\)Demkovich, 1985a, p. 310.
hospitals being overpaid and nonteaching community hospitals being underpaid relative to the severity and complexity of their caseloads.\textsuperscript{26}

The size of the subsidy also is increasingly controversial. As efforts to cut next year's budget grow more serious, both the administration and some members of Congress now talk of halving the indirect allowance. Although the AAMC acknowledge that the original allowance was perhaps too generous, it and other provider associations argue that teaching hospitals still need and deserve some subsidy to compensate them for carrying a more severely ill and complex caseload.\textsuperscript{27} All the provider organizations we interviewed supported the continuation of the indirect subsidy, although that issue did not rank high on most political agendas.

Another technique for adjusting for more severely ill caseloads is the disproportionate share adjustment, but it has proved to be as problematic as the indirect teaching subsidy. In the 1983 legislation, Congress ordered the Secretary of Health and Human Services to adjust the rates paid to hospitals that carried a disproportionate share of Medicare or low income patients. This provision grew out of a concern that public and other hospitals might be serving a more severely ill and expensive caseload and have less opportunity to cross-subsidize that caseload from full paying patients.\textsuperscript{28} To forestall a deterioration in access and in quality of care in these hospitals, Congress provided for a special adjustment.

The American Public Hospital Association and, to the degree they are able, individual large community hospitals that are likely to benefit from the rate augmentations have pressed hard to get the adjustment. However, the Secretary has eschewed defining disproportionate share hospitals and subsidizing their rates on the grounds that such hospitals receive adequate reimbursement under the present program. Recently, the U.S. District Court of Northern California, in \textit{Rosebud Community Hospital District v. Heckler}, ordered the Secretary to comply with the provisions of the statute and provide for a disproportionate share adjustment, but the verdict will be appealed.

While Congress, the administration, and a few particularly interested provider associations struggle for a political solution, considerable research is under way to provide documentation and to develop an acceptable mechanism to adjust for severity of illness in the reimbursement formula. However, among those following the issue closely

\textsuperscript{26}Horn et al., 1985.
\textsuperscript{27}Demkovich, 1985a, p. 309.
\textsuperscript{28}Prospective Payment Assessment Commission, 1985b, p. 59.
the consensus is that, as yet, no methodology offers real hope of providing an accurate, easy to apply adjuster.29

In the absence of any good technique to identify acceptable variations in the costs of treating different patients in the same diagnostic group, providers and others again argue against moving to nationally based rates. A rate schedule based upon each hospital's historical costs will automatically account for systematic biases in caseload costs. At the same time, a formula based on hospital-specific costs will not provide hospitals with as strong or as immediate an incentive to improve the efficiency with which they deliver care. In an effort to better accommodate both objectives, the American Hospital Association renewed a proposal it made several years ago: a payment schedule drawn from a mixture of hospital-specific and average national costs.30 However, the proposal elicited little interest and was dropped.

PASS-THROUGH PAYMENTS

In its rush to construct and adopt a workable prospective payment system, Congress postponed several particularly thorny reimbursement questions. It continued to permit capital costs and the direct costs of medical education to be reimbursed on a cost basis. It also exempted several types of providers from the program entirely, because their costs could not be accurately enough captured by the DRG classification system. Now, health care groups, the administration, and Congress are struggling to find mutually acceptable rules by which to incorporate these costs and these providers into the prospective payment scheme.

Capital Reimbursement

In 1983, the subject of capital reimbursement was controversial and high on the political agenda. A decision on the subject was certain to affect the flow of revenue, and different hospitals saw advantages in having one or another mechanism adopted. In the intervening years, interest in capital reimbursement has waned. New information on the distributional consequences of other elements in the formula have prompted providers to shift their attention. Moreover, as the prospective payment program gets under way, a large proportion of hospitals

29 Those less familiar with the subject appear to assume that Susan Horn's highly visible Severity of Illness Index will eventually be woven into the formula (Horn et al., 1985).

find themselves unexpectedly comfortable with the current pass-
through system and less anxious than they were in 1983 to move on to
a new arrangement.

Current law provides that unless Congress adopts some alternative
mechanism for reimbursing hospitals for their capital outlays, they will
continue to be paid on a cost basis, and all new hospital outlays of
$600,000 or more will be subject to the capital expenditure review pro-
visions of Section 1122 of the Social Security Act. The administration
and most hospital associations oppose this alternative as overly regula-
tory. However, they have had difficulty finding an alternative upon
which they can jointly agree.

Several variants of both add-on and cost-based reimbursement alter-
natives have been under consideration. The simplest of the add-on
alternatives is a fixed add-on rolled into the basic DRG rates, similar
to the add-on for the indirect costs of medical education. Although
simple to administer, this technique results in distortions, because hos-
pitals would be paid on the basis of volume, not on the basis of the
resources each case would use. A second alternative, the variable add-
on, with reimbursement tied to the capital used in treating patients in
each DRG, would eliminate distortions but add complexity. A third
possibility, continuing with the present system of cost-based reimburse-
ment but under close regulatory control, offers providers continuity
and security but little flexibility and control. A fourth alternative, a
hybrid of the add-on and cost-based approaches, would reimburse
smaller expenditures on an add-on basis and major construction on the
basis of cost. Finally, there is an option with very little political sup-
port, that of giving block grants to state planning agencies for distribu-
tion.

The administration and most of the stronger provider groups support
the concept of add-on reimbursement in some form. The Federation of
American Hospitals has been the most outspoken supporter of this
solution, urging other associations to give it active and immediate sup-
sport. The proprietary hospitals believe their more competitive posture
will allow them to take better advantage of investment flexibility. Other
provider groups, including the AAMC and the American Hospi-
tal Association, favor add-ons if sufficient funds are guaranteed to
them. The administration favors the add-on reimbursement format as
a step toward deregulation and as a vehicle for reducing its reimburse-
ment costs. Thus, there is considerable tension between providers and
the administration over the size of the reimbursement. Negotiations currently hover around 7 percent of in-patient costs.\textsuperscript{31}

A few opponents are making the case against add-on reimbursement. The most outspoken of these, the Catholic Health Association, represents a hospital constituency that, on average, has a higher capital to cost ratio than do other hospital groups because of recent refinancing and construction trends. Therefore, it argues that Catholic hospitals would be penalized by the add-on approach, as they already are by the fact that the rate formula discriminates against large, inner-city hospitals.

The American Health Planning Association, another opponent of the add-on approach, fears the elimination of any planning control over investment decisions. The Association also notes that any add-on formula is very easy to cut and thus offers hospitals little prospect of financial stability or security. It also offers no mechanism to accumulate capital for major construction.

Although several studies of alternative capital reimbursement plans are either under way or have been completed, the current (albeit subdued) debate on the subject suggests that they will not provide the basis for building a consensual solution. Neither do they describe the long term effect of alternative policies on health care delivery. In the absence of better information, decisions will inevitably be made in the political arena according to short term distributional advantage.

\textbf{Medical Education}

Historically, insurers and the federal government accepted the principles that patients should bear the costs of medical education and that hospitals themselves should manage that education. They did this by explicitly agreeing to reimburse hospitals for education costs without demanding any control over education programs. In the current era of cost containment and physician surpluses, these principles are the object of increasing challenge.\textsuperscript{32}

Efforts to begin shifting the cost of medical education back onto the trainee have come from several quarters. In the private sector, insurers and employers are implicitly withdrawing their support of graduate teaching as they shift their business to alternative delivery systems in cheaper, nonteaching hospitals. In the public sector, the 1986 budget calls for a freeze in direct medical education payments and proposes to reduce the indirect subsidy by 50 percent. At the same time, a leader

\textsuperscript{31}\textit{Medicine and Health}, September 30, 1985, p. 2.

\textsuperscript{32}Iglehart, 1985b, p. 1402.
in health policymaking, Senator Durenberger, has proposed giving states block grants for medical education, thereby relieving the Medicare budget of the financial obligation.

The proposals to change Medicare's arrangement for financing graduate medical education have met with opposition from all the provider associations save the Federation of American Hospitals, which shows some interest in the block grant idea.\textsuperscript{53} But the growing pressure suggests that change may be inevitable. The fear is that it may occur without sufficient information identifying the long term effects on well-established educational training practices.\textsuperscript{54}

**Exempt Providers**

Although in principle prospective payment should apply to all providers, several of them are exempt because no acceptable way has yet been devised to estimate the costs for their patient populations. Most notable of the exceptions are physicians and all outpatient services. In addition, care rendered in pediatrics, rehabilitation, long term care, psychiatric, and substance abuse facilities continues to be paid on a cost basis. As many observers note, the existence of exempt providers over the long term will bias the availability and the delivery of services in their favor. Beds will be converted and patients will be admitted inappropriately to such facilities.

Currently, HCFA is making a major effort to develop patient classification systems that will reflect the costs of care rendered by the exempt providers. Such a system was expected to be ready for physicians within a few years of the adoption of prospective payment, with systems for covering care rendered in the exempt facilities following. However, the problem of developing a defensible system has proven greater than many imagined, and most believe HCFA is far from its goal. Exempt providers remain pleased with their status and clearly will do what they can to preserve it.

**THE FORMULA IN PERSPECTIVE**

The prospective payment formula has created a broad range of controversies that are best understood as two distinct classes of problems: those that relate to the size of the Medicare budget and those that relate to how that budget is divided among the providers. Conflict over the size of the budget is reasonably straightforward. Although health

\textsuperscript{53}Demkovich, 1985a, p. 311.

\textsuperscript{54}Iglehart, 1985b, p. 1402.
care representatives acknowledge that costs must be contained, they have come to agree that current administration constraints go too far. Alignments in the debate resemble traditional health policy alignments in that health care groups stand united in asking for a larger share of the federal budget.

Congress’s decision to design the formula to promote efficiency as well as to contain costs has clearly provoked most of the controversy and, at the same time, greatly altered interest group composition and alignments. The elements of the formula that purport to adjust for legitimate variations in the cost of delivering services have been the object of growing criticism. Although various groups have complained about the inaccuracies and inequities of different elements in the formula, their combined objections suggest that in its totality, the formula raises genuine questions of effectiveness and equity. Nothing indicates that current efforts to improve the formula will change their perceptions.

Those same elements of the formula have considerably altered the political configuration of provider groups and therefore the structure of Medicare policymaking. Because the formula redistributes a fixed amount of money among health care providers, a formerly cohesive group is now fragmented, with losers and winners pitted against one another on an array of issues. Because the formula has divided the providers, it has, perhaps, reduced their ability to lobby effectively for any major change in the program. The smaller coalitions neutralize one another, leaving federal policymakers with the strongest hand.

In its rush to adopt the new prospective payment system, Congress settled for an unrefined payment formula, expecting that imperfections and omissions would be dealt with later. This strategy implies considerable adjusting and tinkering, a situation that now presents policymakers with a serious dilemma. On the one hand, there is good reason to improve the formula as new information and techniques permit. The institutional mechanisms to conduct reviews and revisions exist, and political constituencies for change abound. On the other hand, health care groups agree that the continuing instability in the system is causing them difficulty. Their members find it impossible to plan or to make sensible management decisions in the face of constantly changing regulations, and frustration is acute.

Providers have found it very difficult to understand exactly how the complex payment formula works and, more important, how it affects them. Initially, supporters of the prospective payment relied on speed and secrecy to push the program through Congress. But even after the terms of the formula became clear, provider groups have had difficulty analyzing their effects. Most associations lack the analytical expertise
to explore the implications of so complex a mechanism. Furthermore, what research they conduct is generally structured to mirror the organizational lines of the associations rather than the appropriate analytical framework.

In the absence of good information, providers and their representatives find it difficult to be clear about what problems they have and what changes they want. Moreover, as the controversy over the wage index demonstrates, groups tend to direct their attention toward issues about which they have at least some information, even if those issues are not the most pressing.
IV. QUALITY OF CARE:
A SECOND DISTRIBUTIVE ISSUE

The policy goals of broad access to care, quality care, and reasonable cost appear to be held in mutual regard by the American people and their representatives. These are, however, competing goals and lawmakers have shown some ambivalence when they are forced to make tradeoffs among them.

When Congress enacted the Medicare program in 1965, expanding access to quality health care was uppermost in the minds of most supporters. Congress passed this legislation with little appreciation of how the new insurance system might affect use of health care services and, therefore, costs. By 1983, cost containment had become the predominant issue, and the prospective payment system was adopted to control unparalleled rises in health care costs. But Medicare continues to serve the same broad population, and if access is to be preserved, cost containment may come at the expense of quality of care.

Consistent with the widely held view that the physician, unconstrained by cost considerations, will provide the optimum kind and amount of care, Medicare initially reimbursed providers for their reasonable and customary costs. However, analysts quickly came to believe that cost-based reimbursement gave physicians and hospitals some very powerful incentives to provide unnecessary care. Not only was this level of service extremely expensive, it also came to be recognized as imposing additional risks on the patient. More was not better. By contrast, prospective payment offers an opposing set of incentives. Because providers receive a flat rate per diagnosis regardless of the costs of treatment, they have every incentive to provide a minimum rather than a maximum level of service.

If the new prospective payment program does, in fact, reduce the quality of care Medicare beneficiaries receive, either in the short or the long term, that reduction will be a redistributional consequence of the program, just as shifts in revenues among classes of hospitals is a redistributional consequence. In this case, the winners will be the payers of the social security tax that supports government Medicare payments. As prospective payment effectively contains Medicare outlays, they will be paying less than they would have paid under the old system. The losers, if there are to be losers, will be the Medicare beneficiaries, who will receive a lower standard of care.
The potential for redistribution becomes important because it identifies an area ripe for political conflict. Although Medicare and cost-based reimbursement once enjoyed broad political support from both the taxpayer and the beneficiary, today's cost containment movement reflects the taxpayer's growing unwillingness to foot increasing medical bills for the elderly and the disabled. At the same time, the Medicare beneficiary is not likely to relinquish without a contest what he has come to view as a right, and he belongs to a growing, increasingly well-organized, and effective political force. The elderly are well represented by several lobbying groups, including the American Association of Retired Persons (AARP), which has a membership of over 20 million. They constitute a major force in the policy area.

QUALITY OF CARE UNDER PROSPECTIVE PAYMENT

Defining Quality

The debate over how prospective payment has affected and will affect the quality of care is greatly handicapped because there is no broadly accepted definition of what constitutes quality care. Not only is there disagreement within, say, the medical community over appropriate patterns of diagnostic exploration and treatment, but the providers and payers and the beneficiaries disagree over what types of services and amenities should be available through a period of illness. The providers and payers limit their concern to those components of the care process that directly affect health outcomes, while the beneficiary wants to extend the definition to include his sense of well-being and comfort.

The effects of the new prospective payment system on the quality of care may manifest themselves only very slowly. For example, hospitals may shift to a pattern of underservice, but only gradually. The effects of prospective payment on research and development patterns might not be identified for years, if at all. Thus, discussion in these first few years centers on anecdotal evidence of poor care and surmises of what responses the changed incentives will elicit.

The Issue of Quality in 1983

The administration believed that the introduction of the prospective payment system would have no adverse effect on the quality of care received by the Medicare recipient. Administration officials argued that quality would improve, because hospitals and eventually
physicians would be stripped of the incentives to overserve patients. At the same time, competition, medical ethics, and the threat of legal liability would prevent underservice. Believing that the new system was, in effect, self-policing, the administration (particularly the Office of Management and Budget) made every effort to terminate all existing quality review functions and to kill any new congressional proposals.

The 1983 hearings indicate that quality of care was not a major concern of most members of the health care community. Hospitals, threatened by the major redistributions of income described above, gave little attention to the quality issue. Similarly, other groups concentrated on the specific issues that affected their constituencies. However, beneficiaries, represented by the American Association of Retired Persons and the Grey Panthers, did express concern that the incentives built into the prospective payment system might adversely affect the quality of care being delivered, and they supported a strong quality review process. The American Medical Association also expressed concerns about changes in quality.¹

In the face of stiff opposition from the administration, Congress met the demands of the beneficiaries. Although there was great dissatisfaction with the Professional Standards Review Organizations (PSROs), created in 1972 to monitor costs and quality, and considerable support for terminating the program when it came up for renewal in 1982, Congress refused to let the concept die. As PSROs were abandoned, the Peer Review Improvement Act of that year created a similar set of organizations in their stead. The new Peer Review Organizations (PROs), like their predecessor organizations, were designed to insure that Medicare hospital costs and quality of care would be monitored at the state level and that payment for inappropriate care would be denied. Congress obligated the PROs to continue these functions with the advent of prospective payment.

At no time did anyone, Congress or the administration, suggest cost containment was so important that it would be won through a reduction in quality of care. Rather, they promised that the prospective payment system would not redistribute benefits, that it would create no losers on the dimension of quality. Now, after two years of prospective payment, beneficiaries and observers increasingly question the reality of that early assurance.

The Issue of Quality Today

Quality of care is rapidly assuming a preeminent role on the political agenda. Beneficiaries, gaining direct experience with the new system, evidence increasing concern, which both feeds on and fuels congressional hearings and stories in the press. Since 1983, Congress has held more than 20 hearings on prospective payment, several of which were devoted entirely to the subject of quality of care. At the same time, virtually every national newspaper and news magazine has run at least one major story on the implications that prospective payment may have for the quality of health care.

Independent observers and analysts also indicate increasing concern with the issue of quality. The Prospective Payment Assessment Commission, charged with recommending appropriate charges in the standardized payment and the relative DRG weights, states in its April 1985 report that the maintenance of quality is a paramount concern of the Commission.\(^2\) Similarly, the Office of Technology Assessment devotes considerable attention to the topic in its recent report on evaluating the new system.\(^3\) Policy analysts in the health field are also turning to the subject in increasing numbers.

While interest in quality currently runs high, what effects prospective payment has had or will have on quality is less clear. Who should be responsible for quality and how quality should be monitored are questions that also remain unresolved, as our interviews with provider and beneficiary representatives demonstrate.

Both beneficiary and provider representatives are remarkably consistent in their belief that the health care delivery system contained enough fat to forestall any immediate deterioration in quality. They agree that there is as yet no evidence that quality has suffered.

Beneficiary representatives argue that quality need not suffer in the future either. They believe that the introduction of low cost technology coupled with greater standardization of practice patterns would permit the maintenance of quality while costs are cut. However, these same representatives fear that continuing Medicare budget cuts will lead to a deterioration in the quality of care available to beneficiaries.

Providers, however, believe that aggressive cost containment will inevitably lead to a reduction in quality. The Board of Trustees of the American Medical Association reported in December 1984 that physicians who responded to inquiries about the effect of Medicare’s PPS on quality of care had the following perceptions: 37 percent believed that quality had not yet deteriorated, and 63 percent stated that quality had

\(^2\)Prospective Payment Assessment Commission, 1985a, p. 21.
\(^3\)U.S. Congress, 1985.
deteriorated or that it would deteriorate over time if prospective payment continued. Similarly, a National Research Corporation survey of 450 hospital administrators\(^4\) reports that 8 percent of the administrators expect quality to improve as a result of Medicare’s Prospective Payment System and 54 percent expect quality to worsen; 38 percent believe that the introduction of a new payment system will have no effect on quality. A higher percentage of administrators (62 percent) of small hospitals (less than 100 beds) believe quality will worsen than do administrators of large hospitals (larger than 300 beds). Only 38 percent in this group believe quality will decline.

Although there is general agreement that the new prospective payment system has not yet adversely affected the quality of care delivered under Medicare, those who foresee a decline expect it to manifest itself in the following practices:

- Underserving patients.
- Premature discharge.
- Inappropriate transfer.
- The “dumping” of severely ill patients into public facilities.
- Excessive readmissions.

**Underserving Patients.** Hospitals underserve their patients when their staff is too small or contains the wrong mix of skills to provide adequate service. They also underserve their patients if they cannot or do not use appropriate diagnostic and therapeutic technologies or procedures in the course of treatment. Although providers do not believe patients are being underserved yet, they suggest that it is only a matter of time. Already, they note, hospitals are cutting their staffs dramatically, and at some point the cuts will begin to affect quality.

**Premature Discharge.** Because hospitals are now paid a predetermined rate for each Medicare patient, the hospital is strongly motivated to carefully monitor a patient’s resource consumption and to discharge the patient as soon as possible. If the patient has not fully recuperated, he may be discharged to a skilled or an intermediate nursing care facility or referred for home health care. Providers and beneficiaries alike agree that under cost-based reimbursement, patients were kept in hospitals longer than necessary. They also agree that, under prospective payment, patients are being discharged “quicker and sicker.” But they do not agree on whether these discharges tend to be premature. There is no definition of premature, and there are as yet no data on the characteristics or medical outcomes of the earlier discharges.

\(^4\)Jackson and Jensen, 1984, pp. 108, 110.
Anecdotal accounts of premature discharges provide grist for the popular press and are broadly circulated. One such typical article cites nine cases reported by family members wherein beneficiaries received poor quality care; in several of these cases, the families vividly describe what they judge to be premature discharge and its terrible consequences.\textsuperscript{5} Such accounts also crop up routinely in hearings on quality of care.

In a correlated problem, provider and beneficiary representatives fear that nursing homes are experiencing a flood of “quicker and sicker” patients that they are ill-equipped to handle. They have anecdotal information that many states already have a shortage of appropriate nursing home beds. Moreover, the homes are not staffed or equipped to handle the new type of patient. Again, there is little hard information, although some provider associations are beginning to collect such data.

**Inappropriate Patient Transfers.** Analysts examining the incentives of Medicare's prospective payment system believed that inappropriate transfers of patients from hospital to hospital could become a problem. Hospitals can reduce their financial risk by transferring a patient who has consumed resources equivalent to the payment for his diagnosis. Proposed legislation is currently pending that would impose fines of up to $25,000 on hospitals or physicians involved in inappropriate transfers. Hospitals could be dropped from the Medicare program or fined if they fail to stabilize patients in medical emergencies before transferring them to another institution, if the fiscal 1986 budget recommendations of the Senate Labor and Human Resources Committee prevail.\textsuperscript{6}

**Dumping Patients.** Because it is generally believed that hospitals are undercompensated for treating severely ill patients (see Sec. III), many observers expect to see them “dumping” such patients—refusing to admit them whenever possible. In most instances, dumping a patient means referring him to a public hospital, which is typically required by charter to accept all patients who seek admission. Not only does dumping imply that patients are suffering a reduction in quality of care, but it also means that public hospitals may be receiving a disproportionate share of expensive patients.

Like premature discharges, dumping has been of particular interest to the media. The *Los Angeles Times*, in an article characteristic of those commenting on the subject, notes:

\textsuperscript{5}\textit{Los Angeles Times}, April 14, 1985.

While the practice of shifting patients to public hospitals for strictly economic reasons—commonly called “dumping”—has long been thought to be widespread, experts now fear that economic pressures for better cost control and more stringent limitation of insurance benefits may be forcing an even greater burden on municipal facilities than ever before.7

But again, as with premature discharges, there is no systematically gathered evidence supporting the conclusion that the new reimbursement system is prompting an increase in dumping.

**Refusals to Admit Medicare Patients.** Beneficiary representatives also fear that under the new and rigorous admissions requirements, some patients might be denied needed hospitalization. They argue, for example, that patients who live alone or far from a treatment facility may need to be hospitalized overnight for treatments classified as outpatient procedures. The PROs, under tight admissions guidelines themselves, would in all likelihood disallow such hospitalization costs. Anticipating the PROs’ position, hospitals will be very conservative in admitting such patients, and the patients who need the extra care will suffer.

This concern perhaps best illustrates the increasing tension between the taxpayer and the beneficiary as the struggle continues to find an acceptable definition of quality. Historically, hospitals have been reimbursed for most medically associated services that might facilitate a patient’s treatment or speed his recovery, even tangentially. In today’s cost-conscious environment, both payers and providers increasingly view all services save those directly related to the immediate ailment as “fat” to be trimmed. Thus, what the beneficiary sees as his complement of Medicare benefits, the payer and provider are coming to view as nonessential or even nonmedical services.

**Excessive Readmissions.** Because prospective payment reimburses hospitals on the basis of their number of discharges, hospitals have a great incentive to readmit patients for a sequence of treatments. Such behavior will have adverse Medicare cost consequences, and beneficiaries also fear they will suffer concomitant reductions in convenience and quality of medical care. They will be subjected to repeated admissions workups, and their care will lack continuity.

Beneficiary fears notwithstanding, hospitals do not yet appear to be gaming the prospective payment system by unnecessarily discharging and readmitting patients. Current data indicate that admissions are declining. Moreover, the PROs have a mandate to monitor readmissions very carefully as part of their cost control mission. Therefore,

7See Parachini, 1985.
they are likely to quickly identify any significant changes in hospital admitting practices.

**Effects on Technology Development and Dissemination.** The debate over the long term effects of prospective payment on the quality of care suffers even more acutely from a lack of substantiating information than does the debate over the near term consequences. Analysts have suggested several possible effects, and members of the health care community evidence some concern over these possibilities. However, because they are distant and uncertain eventualities, they have not attracted either the public or interest group attention that the short term effects have.

By paying a flat rate per diagnosis rather than reimbursing for reasonable costs associated with the provision of comprehensive care, Medicare's prospective payment system alters a hospital's incentives to acquire new equipment and to offer costly specialized services.

The long term effect of the prospective payment system on medical technologies such as devices and medical and surgical procedures has been of concern to the developers of such technologies as well as to health care providers and consumers. Developers fear that given the current incentives of the prospective payment system, new technologies may not be disseminated as promptly or as pervasively as they were under cost-based reimbursement. Physicians are concerned that they may not be able to obtain the most advanced technologies, because a hospital or other care setting will not be able to afford them. Hospitals are concerned that they may no longer by able to offer a full range of services or attract prestigious specialists if the costs of the technologies are not fully reimbursed, thus jeopardizing their competitive status. Consumers are worried that they will be denied the best possible care, because the provider, now competing on price rather than on service, may not offer the most recent technological advances.

Enabling legislation established two methods of changing DRG prices to reflect changes in technology—updating and recalibration—and required the Prospective Payment Assessment Commission to recommend changes annually. The update factor is the percentage by which Medicare's payments to hospitals is to increase or decrease. Recalibration involves adjustments of DRG classifications and rates based on the previous year's experience.

Leaders in the health equipment manufacturing industry believe that the costs of developing a new technology or changing an existing technology will not be handled adequately by the recalibration process, necessitating reliance on the update factor. They recommend an alternative method to account for changes in quality and quantity of ser-
vices and technology based on an analysis of a representative sample of DRGs.\textsuperscript{8}

Prospective reimbursement does influence technology diffusion, according to a study of states with prospective reimbursement or rate setting.\textsuperscript{9} Although the multi-million dollar cost of a magnetic resonance imaging (MRI) machine is a type of technology often envisioned when the costs of new technologies are considered, authors of the study point out that small ticket (under $100,000) technologies may actually affect costs more than do the big ticket MRIs. This study’s results suggest that the technology adoption effects of restrictive prospective reimbursement programs such as that of New York are not necessarily harmful and may even be beneficial. They report a weak finding that the attractiveness of cost-saving technology can be enhanced by a strong prospective reimbursement program. They also conclude that prospective reimbursement as implemented in New York has a more powerful effect on the extent of adoption than on the initial decision to adopt. The study concludes that if a technology enhances surplus, it will be favored under prospective reimbursement; if it decreases surplus, it will be less favored. Some cost-saving mechanisms such as delayed maintenance or delayed salary increases may perversely affect the quality of care even in the short run.\textsuperscript{10}

The Market for Assessing Quality of Care

Perhaps the most outstanding characteristic of the quality debate is the absence of any empirical information. Groups have formed attitudes and taken positions on program issues solely on the basis of anecdotal evidence and speculation. As the debate intensifies and receives more attention from the press, reporters draw on much the same material.

Although the program’s success may ultimately depend upon defining its effect on quality, those we interviewed thought doing so would be very difficult. First, they believe that there are no agreed upon definitions of quality, and therefore evaluating the program’s effect may be impossible. Second, several respondents noted that we have no baseline data against which to measure change, a gap they expect to frustrate any future efforts to evaluate the program’s effect on quality.

Representatives of all the groups we interviewed supported doing more research on the effects of prospective payment on quality. They

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\textsuperscript{9}Romeo et al., 1984, pp. 1–24.

\textsuperscript{10}Gelman, 1982.
all urged that research be undertaken to establish a baseline to be used in future research. They also argued that HCFA and Congress should stop tinkering with the program if meaningful data are to be collected. The present instability not only creates problems for management, but also makes measurement difficult and unreliable.

The American Association of Retired Persons, the beneficiaries’ principal representative, gives research on quality of care issues a high priority in its 1985 Legislative Policy Statement. The Association maintains that “we must improve the methods of assessing quality of care by developing reasonable assessment standards.” To this end, it recommends:

- Research to develop quality assessment measurements;
- Development of early warning mechanisms to monitor outpatient as well as inpatient quality; and
- Longitudinal studies that focus on functional status at discharge, changes in patient status at discharge, effects of shorter lengths of stay on discharge destination, and post-discharge experience.\(^{11}\)

Several other associations and independent researchers have joined the American Association of Retired Persons in recommending specific research agendas or mechanisms such as the development of a patient grievance system to handle quality of care concerns.\(^{12}\)

A second characteristic of the quality debate is the absence of any discussion of tradeoffs. Articles in the press as well as program critics talk only in terms of a decline in the quality of health care. For the most part, they do not give their evaluations context by identifying the additional costs of maintaining the patterns of care that were established under cost-based reimbursement. Their evaluations rest on the premise, accepted in the 1960s and 1970s, that there can be no compromising the quality of health care. They seem to assume that by simply demonstrating a decline in quality, they have made a sufficient case for reform.

**Quality Control Under the PROs**

Beneficiaries and others fought hard for the continuation of a quality assurance function in the face of staunch administration opposition. These groups believed that, given the incentives of the new system,

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\(^{12}\)Vance-Bryan, 1984, p. 1447.
some review was essential to maintaining an acceptable level of service. After much legislative wrangling, Congress gave continuing life to the concept of quality assurance through peer review in the Peer Review Act of 1982.

The Peer Review Act required HCFA to contract with one PRO in each state to monitor the quality of care received by Medicare patients, to review the appropriateness of admissions, and to validate the information upon which DRG assignments are made. The PROs were, if possible, to be controlled by physicians. Their contracts were to be negotiated on the basis of well-defined objectives specified as numerical goals against which their performance could be measured. The quality objectives, to be accomplished by the end of the first two-year contract period, include:

- Reduce unnecessary hospital readmissions resulting from sub-standard care provided during the prior admission;
- Assure provision of medical services that, if not performed, have a "significant potential" for causing "serious patient complications";
- Reduce the risk of mortality;
- Lower unnecessary surgery or other invasive procedures; and
- Reduce avoidable post-operative or other complications.

**Physician Control of the PROs.** The AMA demanded that any quality control process be controlled by physicians. Only physicians, they argued, could judge the adequacy of the care rendered by other physicians. After the legislation gave physician-controlled organizations preference as PRO candidates, the AMA has worked successfully to develop acceptable, physician-sponsored organizations in all of the states save two: Idaho, where HCFA has contracted with a fiscal intermediary; and Florida, where the PRO uses but is not controlled by physicians.

**Clarity of Mandate.** Congress has assigned to the PROs the dual role of monitoring actions that relate to cost or admissions and to quality. The AARP, the AMA, and other provider organizations fear that the PROs, like their predecessors the PSROs, will increasingly concern themselves with their cost objectives at the expense of their quality related objectives. Cost objectives are more easily defined and measured, and beneficiary and provider associations believe that cost is also the dominant interest of the contracting agency, HCFA. The American Medical Peer Review Association, representing PROs, shares this fear and worries that if the PROs fail to give sufficient attention
to quality, they will lose essential support in the health care community and perhaps be eased out of their monitoring role.

**Performance Objectives or Quotas.** Providers, beneficiaries, and AMPRA share a second area of serious concern, the quality performance objectives, numerical goals to be achieved by the end of the two-year contract period. PRO boards establish the numerical goals they intend to achieve in each of the five areas and determine which types of procedures they will review most comprehensively. As of April 1985, some 35 PRO boards had selected cataracts as one of the procedures they would review.\(^{13}\)

Congress intended that these objectives serve as devices by which to measure the performance of the PROs. However, if they are to be used to judge the performance of the PROs, then the PROs will make every effort to realize their objectives and the objectives will become, for all intents and purposes, quotas. Most members of the health care community see the elevation of the numerical objectives to quotas as extremely problematic, because the lists of objectives were very hastily compiled and agreed to. They agree that lists do not reflect adequate research identifying problems or determining realistic targets for change. The AMA further argues that even with adequate research, a quota system will prompt review decisions that may be based on more than simply the best interest of each individual patient, and therefore it should be avoided.

**Confidentiality Issues.** A review of a medical record, whether on a prospective, concurrent, or retrospective basis, always raises concerns about maintaining the confidentiality of the information. In developing provider profiles, PSROs had to build in safeguards against the inadvertent disclosure of data leading to the identification of individual patients, providers, or facilities that might then be used in an inappropriate or misrepresentative manner. Privacy must be a major concern behind any medical data disclosure policy.\(^{14}\) All parties to the PSRO data disclosure issue supported that position; the controversy centered on access to data about identified institutions and practitioners that could result in retribution, embarrassment, and exposure to malpractice litigation.\(^{15}\)

PROs face similar problems as they work with hospitals to develop the most efficient and protective way to request records for review. PROs may use the UB-82 billing form, which has a six space field for patient name and a single field for numeric patient identification to

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\(^{13}\)Based on interview information.

\(^{14}\)Institute of Medicine, 1981.

\(^{15}\)Ibid., pp. 7–8, 99.
identify cases for review. Some PROs prefer that this numeric field be used for the medical record number for ease in access to records and in tracking a patient, but hospitals are wary that patient confidentiality may thus be jeopardized.

Regulations regarding confidentiality of data in the review process appeared in the April 17, 1985 Federal Register. Access to aggregate statistical information by institution is provided under these regulations, but practitioner data will be held confidential unless a PRO chooses to release selected data. Data will not be disclosed to health researchers, thereby eliminating one potential data source for evaluating quality of care.

**Protocols.** The AMA, representing physicians, strongly opposes the PROs' development and use of protocols or acceptable practice patterns for screening admissions and treatment. They fear these protocols will soon become standards of practice that will constrain the creative or innovative practice of medicine. They also believe protocols will almost certainly come to define nonnegligent care.

**Scope of Review Authority.** Providers, beneficiaries, and others also indicate some dissatisfaction with the scope of the PRO review authority. PROs currently monitor only the care rendered to hospitalized patients. Services formerly offered on an inpatient basis are now available on an outpatient basis. Patients who in the past remained in the hospital now get early discharges to other care settings. Thus, an increasing pool of patients will be treated without benefit of any quality control. HMOs also treat a substantial number of Medicare patients. These patients all fall beyond the current purview of the review process, yet they offer an excellent opportunity for the PROs to identify deterioration in the quality of care induced by the new payment system.

**Start-Up Problems**

Those interviewed identified a number of PRO start-up problems that could affect quality assessment. Problems such as delayed regulations, lack of clarity on legal liability for the review process, difficulties in evaluating PROs, and PRO dependence on other data sources are discussed in Sec. V.

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16 Each hospital elects whether to use this field for a financial account number, the medical record number, or some other identification.

17 Arstein-Kerslake, 1985, p. 4.

18 Based on interview information.
THE CONTINUING DEBATE OVER QUALITY

The quality of care received by the Medicare patient has recently begun to receive widespread attention stemming from the payment incentives inherent in the prospective payment system, which foster underservice rather than overservice. Even though the dangers of overservice were recognized under the cost-based system, concerns about quality were often overshadowed by concerns about cost. With the cost containment provisions of prospective payment, health care providers and consumers are expressing fears about the potential problems of underservice: the danger that patients may be discharged too soon, excessively readmitted, transferred inappropriately or dumped on the provider of last resort, the public hospital.

At the moment, there is little substantive data to support or refute intuitive and anecdotal descriptions of a deterioration in quality caused by the change in how providers are paid for Medicare patients.

In the short term, analysts will be able to measure what care is rendered and use this information to describe how prospective payment has affected the process of care. However, measuring the long term effects of the program will require information on the outcomes of care to the patient, an often time-consuming and expensive determination. Measuring changes attributable to the institution of Medicare’s prospective payment system will be particularly difficult because no baseline was established before the program began. Program instability will further increase the difficulty in measuring changes in quality.

The absence of data is related not only to the newness of the program and difficulty in gathering it, but to the difficulty in defining what we as a society mean by “equality” or “an acceptable level of quality.” As policies to contain costs threaten to affect the delivery of health care, disagreements over what constitutes appropriate or “quality” care grow. In fact, quality appears to be a subjective assessment that defines that level of care the individual or the society is willing to support. As the electorate’s willingness to support health care changes, so does the definition of quality. Currently our willingness to pay and our definition of quality are very much in transition.
V. IMPLEMENTATION PROBLEMS

The new prospective payment system is often characterized as a revolutionary approach to health care financing; and the system is indeed a departure from old practices. We undertook this research with the view that such a dramatic change in policy would create serious implementation problems and that these problems needed definition as a first step to resolving them. We discovered, however, that although implementation problems do exist, they certainly are not the object of attention. The redistributive consequences of the new payment system and not implementation problems preoccupy members of the health care community. Members are aware of the implementation problems, they are working hard to resolve them, and they do not view them as insurmountable. Thus, they are not high on the political agenda. Nonetheless, resolving implementation problems is important to the success of the prospective payment program.

The larger the number of participants in a new system, the greater is the variety of perceptions about implementation. Figure 2 shows the major actors involved in carrying out Medicare's prospective payment system and the relationships between and among these actors. Congress, which designed the legislation, is not shown, nor is the beneficiary, who is most directly affected by the legislation. However, these additional perspectives will be incorporated in our discussion.

We organized the implementation problems we identified into two major categories: those associated with the preparedness or readiness of the health care delivery system to respond to a new financing mode and those tied to the actual payment mechanisms. Each category affects major participants to a different degree: System readiness issues affected every actor, whereas payment problems most directly affected hospitals.

IMPLEMENTATION ISSUES THAT RELATE TO SYSTEM PREPAREDNESS

Many of the prospective payment system implementation problems can be traced back to the speed with which the new system was legislatively enacted. The 1982 TEFRA amendments required the Secretary of the Department of Health and Human Services to propose a prospective payment system that would replace the retrospective cost-based system. The health care community was taken by surprise when
the Secretary’s plan, submitted to Congress in December of 1982, was signed into law in April of 1983 with a start-up date of October 1, 1983.

Implementing a financing system that affects a major portion of the budget of all general short term hospitals in the country requires lead time to design the system, to set up monitoring capabilities, to notify hospitals of how the system will work, and to issue the governing regulations for all parties—hospitals, fiscal intermediaries, and peer review organizations. Although HCFA had been working on the system design and had as a model the New Jersey system, translating a single state system into one that would blanket the country required considerable effort.
Hospital Readiness: Accounting and Data Management

Hospitals, the group most affected by the new policy, must adapt many important procedures to the new prospective payment system. Among these, accounting practices and data management are perhaps the most critical.

An assumption underlying the adoption of the prospective payment system was that hospitals could cost out their product lines reasonably accurately and on that basis make fairly efficient decisions. But many hospitals do not have sophisticated cost accounting systems, because the cost-based reimbursement system did not require this level of information. According to one hospital representative, hospital cost accounting has traditionally been done on the basis of average costs, and as yet no good ways of establishing the true costs of a service have been developed. Although the trade journals have reported the availability of new accounting systems, hospital representatives describe them as seriously flawed.1

Closely related to the accounting system problems is the need for data management systems. Again, hospitals vary in their ability to handle and process patient data in a new way. HCFA introduced a new billing form (UB-82) to allow greater efficiency in bill processing, and hospitals and payers had to quickly become familiar with the use of this form. If hospitals are to provide care consistent with the payments they receive, they must have systems that provide quick and accurate information for decisionmaking. To develop the necessary capability, hospitals must either adapt existing systems or design and install new systems. Identifying data collection points, becoming familiar with new billing (and other) forms, and working the bugs out of new data management systems pose additional challenges to hospitals.

The medical record suddenly has become very important, because information contained in it determines the discharge diagnosis and thus the amount of payment the hospital will receive. Also, for the first time, medical information must be correlated with financial data from the cost accounting system and made part of the medical record. Accuracy therefore becomes extremely important. Traditionally, physicians have not always been prompt in fully reporting all the information they had on diagnosis and treatment. Hospitals must persuade physicians that immediate action on the medical record is essential. At the same time, hospitals must adjust to providing more time and manpower for coding the records, because these are now longer and must be coded accurately and promptly for reimbursement. All these adjustments take time.

1Based on interview information.
Other Provider Readiness: Physicians, Nursing Homes, and Home Health Agencies

The physician staffs in most hospitals are not salaried hospital employees but have privileges to admit their patients to the hospital for care. The physician controls the ordering of tests, procedures, surgery, and other care for the patient and ultimately controls the costs of care for any Medicare patient, but the hospital has to live with the financial consequences of physicians’ decisions. Hospitals are developing strategies to familiarize physicians with the cost consequences of their decisions, but these take time to put in place. Moreover, the incentives inherent in prospective payment do not apply directly to the physicians, leaving them perhaps less interested in modifying their practice patterns. Lohr et al. point out the potential for conflict if administrators dictate patterns of practice formerly thought to be the exclusive domain of the physician.2

Medicare’s prospective payment system clearly provides an incentive for the hospital to discharge a patient earlier than was the case under the retrospective reimbursement system. Although a patient may no longer need the intensive care provided by an acute care facility, he still may require some additional care. In such cases, the patient ought to be discharged to a skilled nursing facility or to the supervised care of a home health agency. Beneficiary representatives, some hospitals, and articles in the press report that nursing home beds are not always immediately available when they are needed. Nursing home occupancy rates average nearly 90–95 percent nationally,3 and many homes have waiting lists for beds. Not all nursing homes have designated beds for Medicare patients, because Medicare is actually a low volume payer for skilled nursing care. (Medicaid pays for a much higher proportion, approximately 48 percent of its overall resources for nursing home care, than does Medicare, which expends 2 percent of its resources for nursing home care.)4 Exacerbating the shortage, some respondents report that nursing homes have also been refusing to admit the patients that hospitals are seeking to discharge, prematurely in the nursing home’s view, to their care.

The construction of additional nursing home beds is one possible solution to the shortage. Many states control the expansion of nursing home beds through the certificate of need or the 1122 capital expenditure review processes, both of which require approval for the

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2Lohr et al., 1985.
3Kosterlitz, 1985a, pp. 798–801.
4Vladeck, 1985. See also Lawrence and Gaus, 1983.
construction or expansion of nursing home capacity. Utah, which has removed such controls, has already approved 1200 new nursing home beds for construction. But even if the beds receive prompt approval, the design, financing, and construction of additional capacity takes several years. Thus, the shortage should be with us for some time.

Particularly in light of declining hospital admissions and lengths of stay, which result in lower occupancy rates, another solution to the shortage might be to approve the use of hospital beds as “swing beds.” Swing beds are certified for acute hospital care when that capacity is needed but are also certified for skilled and/or intermediate nursing care if a lower level of care is required. However, the nursing home industry has opposed this solution, because it could infringe upon its market. The American Association of Homes for the Aging and other representatives of nursing homes are sponsoring legislation to make the approval of swing beds more difficult. State nursing home lobbies also oppose the conversion of hospital beds to long term care beds or to swing beds. In California, for example, only 56 of the state’s 600 hospitals are licensed to provide long term care even though occupancy in the nonpublic hospitals is running 50–60 percent.

The availability of home health agencies may also pose problems to the hospital seeking to discharge a Medicare patient. Although recent Medicare amendments appear to have stimulated the development of home health agencies, these agencies are not uniformly distributed among hospital market areas. The establishment and licensing of home health agencies may come under state control, which could also influence the availability of such systems.

These gaps in the delivery system have concerned both beneficiary and provider groups.

**Peer Review Organization Readiness**

The 1983 Medicare Amendments assigned the PROs specific responsibilities for Medicare cost containment and quality review. However, assumption of these responsibilities has not been smooth. The TEFRA amendments, which established PROs, specified structural, organization, and operational requirements that differed from those of the predecessor PSROs, necessitating in many cases the development of new organizations. Medicare’s new payment system was implemented rapidly, adding the burdens of a rapid start-up to the pressures of

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5Based on interview information.
6Based on interview information.
7Lohr and Brook, 1984.
establishing a new organization. Perhaps of greatest consequence, the administration and Congress continued through the start-up phase to differ markedly on what role they wanted the PROs to play. Many observers argue that the administration, unhappy that the PROs had been created, consciously obstructed their development. Congress, in turn, used hearings and threats of more directive legislation to press the administration into a more supportive posture.

The PROs have found themselves hampered in assuming and conducting their responsibilities because regulations governing their activities have faced frequent delays. Regulations defining eligible contract applicants, areas to be served, and the scope of work were still not available in February 1984, even though hospitals were to have an effective agreement with a PRO by October 1, 1984. (The date was later extended to November 15, 1984.) By August of 1984, HCFA had contracted with only 28 PROs as the debate continued over what constituted adequate performance goals and whether PROs could subcontract to local organizations. At the time of our interviews, in the spring of 1985, final regulations on memoranda of understanding between the PROs and the hospitals as well as regulations governing PRO sanctions against hospitals and confidentiality of data (including public access to and PRO disclosure of data) were just being issued.

The legal liability of a PRO in review decisions is as yet unclear, posing additional potential roadblocks to PRO establishment. Even though no PSRO was ever held liable for an adverse action to an individual patient,\(^8\) the issue of shared liability for the PROs has not yet been resolved. Based on the final regulations regarding confidentiality of data in the April 17, 1985 Federal Register, the most protected PRO data involve the actual quality assurance discussions. Because protecting peer review is an overriding concern, the prevailing view is that peer review is not discoverable or admissible in malpractice court proceedings.\(^9\)

Evaluating PROs may eventually pose an additional problem. The PROs were unsuccessful in negotiating an opportunity to survey quality of care in their states and develop a baseline of information from which they could develop an informed set of quality improvement goals.\(^10\) This lack of a baseline, coupled with provider and beneficiary uneasiness that PRO targets will become quotas, suggests that it may be difficult to achieve consensus on how to use the target objectives

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\(^8\) Based on interview information.


\(^10\) Based on interview information.
that were originally intended to be performance measures for evaluating the PROs.

The lag in the availability of regulations as well as what some PRO representatives believe to be a too prescriptive scope of work have resulted in slow progress. PROs are required to review all readmissions occurring within seven days, every transfer from acute to acute and acute to rehabilitation facilities, every pacemaker implant, all diagnoses assigned to DRG 468, preadmission review on five medical and surgical procedures, sampling on DRG validation, a retroactive look at a 5 percent sample of all cases to determine appropriateness of admission, and a 100 percent review of all outliers. The slow review of outliers is linked with the slow receipt of data from the fiscal intermediary, according to PRO representatives.

The dependence on the fiscal intermediary for data poses another problem in PRO implementation. Instead of receiving abstracted data directly from the hospital, the PRO will get aggregate data from the fiscal intermediary based on the uniform hospital discharge data summary (UHDDS). Peer review organizations question the accuracy and timeliness of these data.

PROs also depend on the availability of the uniform billing form, UB-82, to do their data profiling. Medical records personnel are concerned that PRO staff be certified in ICD-9-CM coding because they will be checking diagnosis codes. The PRO’s latitude in coding has prompted some records administrators to suggest that there be an appeals mechanism for PRO coding decisions.

**Fiscal Intermediary Readiness**

Like the PROs, fiscal intermediaries have experienced their own share of start-up problems. Since Medicare’s inception, the fiscal intermediaries have validated and paid claims and sent the bill record to HCFA.

The introduction of the new uniform billing form has required a period of adjustment on the parts of the hospitals as well as the fiscal intermediary. Delays in establishing PROs have also slowed fiscal intermediary reimbursement, because the PROs are responsible for reviewing all outliers before payment can be made. Although the phasing in of direct data entry by hospitals to the intermediaries is more efficient in the long run, it has slowed immediate intermediary response with the usual start-up and learning curve problems.

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11 Based on interview information.
The paperwork chain has a domino effect: Hospitals claim that fiscal intermediaries are slow in advising of the Medicare patient's eligibility for care, and fiscal intermediaries state that HCFA is slow in returning data to them, which slows peer review and hospital payment.12

The adequacy of HCFA's direction to the fiscal intermediaries is an issue raised by several of those interviewed. For example, intermediaries are to determine the number of residents in each teaching facility in order to calculate the indirect medical education subsidy. In some cases, such as nephrology and gastroenterology fellows, the definition of a resident may not fit. The potential result is that each intermediary will individually interpret and apply the formula.13

The intermediary-hospital relationship has the potential for becoming adversarial, according to some hospital representatives, because fiscal intermediaries are now being judged by HCFA on their performance and may be expected to apply HCFA's payment criteria very stringently. Even the potential for such conflict could further increase the tension and uncertainty in the delivery system.

**Extending PPS to Other Providers:**

**Delivery System Readiness**

In establishing the prospective payment system for hospitals, Congress mandated a series of reports from the administration on how the system could be extended to nursing homes, physicians, and specialized hospitals (long term, psychiatric, rehabilitation, and pediatric), which are currently exempt.

A HCFA study under way at Rensselaer Polytechnic Institute (New York) is addressing the extension of the prospective payment system to long term care facilities. Sources in the long term care industry state that the current system cannot be extended, inasmuch as long term care facilities do not diagnose and diagnosis has been a poor predictor for long term care costs.14

Extending the current system to physicians is also under study by several groups. Ginsburg et al. identify the issues essential to planning a demonstration that relied in part on per case reimbursement of physicians, including to whom payment is made, beneficiary cost sharing, assignment policy options, and defining an episode of care.15

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12Based on interview information.
13Based on interview information.
14Based on interview information.
15Ginsburg et al., 1986.
Medical association representatives are skeptical that an admissions-based prospective payment system would be imposed on physicians, because no methodology identifies homogeneous diagnosis sets with low variability, and no methodology spreads risk among an adequate group of physicians. The American Medical Association is designing and supporting the use of an alternative approach that would set out a fee schedule system based on relative values for various procedures.

Those interviewed shared no common view on how and when other providers should be incorporated under the new system. One hospital representative pointed out that the hospital prospective payment system is rapidly becoming a system of exceptions; when every issue can be justified as an exception, little remains of the intended system.

PAYMENT ISSUES

The second set of implementation problems, all of which particularly affect hospitals, relate to the way in which hospitals are paid under Medicare's prospective payment system. Some of the problems may be short term, such as cash flow problems, diminishing as participants gain experience with the system. Other problems relate to payment policies that have not yet been developed or promulgated, and hospitals are particularly uneasy that future payment policies could put them at even greater financial risk.

Cash Flow

Hospitals continue to experience cash flow problems as a result of the transition from retrospective to prospective payment. Smaller hospitals, particularly those not in multi-hospital chains, expect cash flow problems to seriously affect their ability to do business. The dilemma is related not only to the newness of the system, but also to the number and variety of actors, each of which has a different responsibility and a unique interface with the hospital.

Hospital representatives identify several sources of problems: slow notice of patient eligibility for care from the fiscal intermediary; very slow review of outlier cases, which can take up to 60 or more days; and the slowdown that occurs when the PRO reviews administrative errors, delaying payment even though the treatment may be correct, until the errors are corrected. Others note that the fiscal intermediaries differ in their sophistication in processing claims. Therefore, turnaround times

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16Based on interview information.
may differ considerably from place to place. Fiscal intermediaries may also be behind in their workloads because of the use of the new billing form, their need to establish effective working relationships with the PROs for outlier review, and the difficulties inherent in establishing the new direct data entry system.

**Proposed Changes in Periodic Interim Payment**

Medicare regulations permit hospitals to elect a periodic interim payment (PIP) to ease cash flow problems. Under PIP, the fiscal intermediary estimates total reimbursable costs for a year and makes periodic payments to hospitals based on that estimate. Adjustments are then made annually at the time of the cost report settlement. Hospital representatives expressed concern that HCFA may eliminate their PIP payment option, and that would, in their view, exacerbate their already very difficult cash flow situation.

**Waiver of Liability**

The Medicare program has traditionally had a waiver of liability provision whereby hospitals that perform services in good faith obtain a waiver holding them harmless if less than 2.5 percent of their claims are disallowed. This system protects the provider against loss if it mistakenly believes a service would be covered by Medicare but the service is later disallowed. Under the waiver, Medicare will still pay for the service. The PSROs had difficulty in denying payments, because they had to establish a clear pattern of inappropriate use before they could deny a claim. The PROs, however, can revoke a waiver and deny payment retroactively. Hospitals are seriously concerned about the PROs’ waiver powers and what it could mean to the availability of high risk services and their ability to recover costs that are denied by the PRO.\(^{17}\)

**Appeals Process**

Prospective payment regulations outline the appeals mechanisms available to two groups, the beneficiary and the hospital. Beneficiaries continue to be covered by the existing appeals process with respect to matters of entitlement to benefits or coverage of health care services under Parts A and B of the Medicare program. However, the regulations do not permit providers or beneficiaries to appeal the denial of

\(^{17}\)Demkovich, 1985c, pp. 9–12.
service (refusal of admission), nor is there a mechanism for appealing HCFA's rate-setting decisions.\textsuperscript{18}

Both beneficiaries and providers argue that the appeals process to challenge payment and other related issues is totally inadequate. Beneficiaries claim that their rights are jeopardized, because the present system provides them with no record or review and no right of appeal when their claims are denied. In response to beneficiary complaints, currently pending legislation (H.R. 2864) would grant them administrative hearings for disputes over $500 for their Part B coverage and the right to judicial review if the amount exceeds $1,000.\textsuperscript{19} Providers, too, oppose the absence of an effective appeals process through which to challenge PRO or HCFA decisions. They noted several areas of special concern including the following:

- The Administrative Procedures Act has no meaningful protections and the DHHS Secretary is not bound by the act for a benefit program such as Medicare.
- The Secretary has broad discretion to set conditions of participation and price.
- Access by hospitals to administrative and judicial review is closed off. Hospitals cannot appeal the DRG rates in court, for example.

**Difference Between Inpatient and Outpatient Payments**

Because Medicare's prospective payment system currently applies only to inpatient services, it provides clear incentives for the hospital to unbundle services and to treat as many patients as possible on an outpatient rather than an inpatient basis. Discrepancies have already appeared between what Medicare pays for a procedure on an inpatient basis and what it pays for the same procedure on an outpatient basis or in a free standing facility. The wide cost variation in intraocular lens implants is one diagnosis that is currently under scrutiny. Inpatient providers observe that such variations are not fair. Moreover, they worry that the skimming being done by facilities not subject to PPS provisions may undermine the hospital's ability to offer a full range of services.

\textsuperscript{18}42 CFR 412.42 provides for PRO review of a discharge decision when the hospital intends to begin charging a patient who remains beyond medical necessity. See American Association of Retired Persons, 1985.

\textsuperscript{19}Medicine and Health, July 1, 1985.
VI. CONCLUSIONS AND OBSERVATIONS

THE CONTEXT FOR INTRODUCING PROSPECTIVE PAYMENT

Although an examination of health financing in the Medicaid and the private sector is beyond the scope of our analysis, it is important to understand Medicare’s prospective payment policy as part of a broader array of policy changes. Viewing the policy as part of a changing landscape helps explain why there has been little opposition to painful policy changes.

The government-financed Medicaid programs and private payers have faced the same difficulties with cost containment as has the Medicare program. Their solutions, although varied, have been similar. They have turned to payment mechanisms that shift the financial risks of escalating costs to the provider, using HMOs, IPAs, and other variants on the theme of capitation payments. They have also turned to increasingly rigorous utilization review programs that often require providers to get permission from the review authority for hospital admissions and for many inpatient procedures.

The “costs,” both in dollars and in benefits or quality, that the prospective payment system may be imposing on providers and beneficiaries are not unique to the Medicare community. They are being borne, increasingly, by all insureds. The changes wrought by prospective payment therefore become more defensible on grounds of necessity and on grounds of equity. It can be argued persuasively that Medicare providers and beneficiaries are not being singled out for second class treatment.

PROSPECTIVE PAYMENT: AN ACCEPTABLE ALTERNATIVE?

It is important to recall there was a political consensus that supported cost containment measures, but not one that supported the efficiency objectives of prospective payment at the time Congress adopted the measure. Furthermore, the prospective payment system need not redistribute benefits among providers, if it is solely a vehicle for cost containment. A formula based upon historical costs could contain costs without creating winners and losers relative to the present system. The most onerous component of the formula, the redistribution
of large sums of money among providers, addresses the policy objective with the least amount of political support. The question then is, “Will that policy hold?”

Both our review of the literature and our interviews clearly show that members of the health care community do, in fact, support the policy of prospective payment, at least in principle. Although they argue the faults of the new system, they appreciate the fiscal and political realities and do not expect to return to the former cost-based system. But more positively, they continue to approve of the concept of prospective payment and competition in the delivery system.

Continuing support of the prospective payment system suggests that opposition to the redistributive properties of the formula will not be fatal to the program. Support for cost containment is too strong. Also, because the formula creates winners as well as losers, it has supporters as well as opponents. Divided, the hospitals cannot effectively determine policy. Their support, however, cannot be taken for granted. The passage of time plays two roles. Over time, participants in the delivery system adapt their behavior and restructure their organizations to accommodate the new system. The new situation becomes the status quo, and movement to a different system then becomes more difficult.

Prospective payment was adopted in something of an information vacuum. As these same participants now gain experience and information regarding the effects of the system, they are coming to appreciate the problems it holds for them. If their frustrations continue to grow, the policy environment will become less and less stable. In fact, instability is already mirrored in the growing support for a capitated program. Constituents are coming to view the current prospective payment system as simply an interim point. Increasingly, they appear to be eyeing the policy alternative of a fully capitated program as a vehicle for escaping the problems they now experience with prospective payment.

CHIEF CONCERNS

Redistributive Effects of the Payment Formula

Most attention has been directed toward elements of the prospective payment formula. The formula creates losers within the provider community. Moreover, its effects can be predicted and are being felt most immediately by that group.
Although the formula has raised a broad array of concerns, no single issue dominates the debate. The various constituencies have each chosen to concentrate on those concerns that they believe affect them the most. Thus attention is spread more or less evenly across the range of problems. Attention also shifts over time as issues rise and decline in importance.

Quality of Care Under Prospective Payment

Quality of care has the potential of being a very important issue. Thus far, attention to the issue has been modest, because quality is very difficult to define and to document. Most participants agree that there has been no decline in quality that could be documented save through sporadic anecdotal evidence. However, most observers believe that the current prospective payment system invites underservice and that some decline is likely.

In that eventuality, quality of care will almost certainly become a major political issue. The quality of care offered by Medicare is of concern to a very large and increasingly well-organized constituency, the elderly. Moreover, although our national sense of what constitutes an acceptable level of quality in health care may be in transition, there is no consensus yet on an alternative to our present standard of "the best available in care and technology." Recognizing that it had no other basis for policymaking, Congress enacted the prospective payment system with the implicit promise that the quality of care provided under Medicare would not be reduced. If anything, it would be improved. Reaching accord on some alternative cannot be expected to be easy.

Implementation Problems

Although implementation concerns can be important to individual providers and to the overall attitude of providers to the program, such problems have not commanded significant attention. Rather, providers and others expect to be able to resolve them in due course.

Two types of problems seem to present the most serious obstacles to the smooth running of the program: cash flow burdens that claims processing delays impose on providers and the unstable regulatory environment produced by delaying and changing regulations.
Instability

Instability warrants further mention as a cross-cutting issue. In 1983, Congress adopted a skeletal program with the intention that it would be modified and fleshed out as experience could be gained and analysis could be conducted. This "fix as you go" approach to reimbursement policymaking imposes predictable costs on the health care community, whose members must be continuously reacting and revising their strategies to accommodate changes.

The representatives we interviewed reflected the profound ambivalence of their constituencies regarding change. On the one hand, the prospective payment program has imperfections that all want to see corrected. Therefore, groups will espouse changes in those provisions they find most onerous. On the other hand, most groups are coming to understand the hardships imposed by instability in program provisions and plead for a cessation in additions to and revisions of the rules. The growing frustration with instability has clear implications for the care with which policymakers should take in making new changes.

The Absence of Information

Another concern is the absence of information describing the effects of the new policy. These information gaps create difficulties for all members of the health care community, particularly exacerbating the problems created by instability.

Governmental policymaking, both that of the administration and of Congress, suffer from poor information. The administration finds it difficult to issue program regulations in part because it cannot be reasonably certain of their effects. Similarly, it has trouble responding to Congressional mandates to extend the program either to costs that are currently paid on a pass-through basis or to currently exempted providers. Without a better grasp of the effects of the program, Congress also has some difficulty responding to constituent pressures on such subjects as altering the transition period or extending the purview of the program.

Since 1983, most members of the health care community have not been well enough equipped to gather their own information on as complex a topic as prospective payment. Therefore, they are forced to participate in the policymaking process with little understanding of the implications of alternative options, a situation they find frustrating and unfair.
The dearth of information on the effects of the current reimbursement mechanism creates further instability for the policy arena. For example, the beneficiaries' chief representative, AARP, supports prospective payment in principle but cannot take stable positions on elements of the program, unless it has a way of assessing their effect on the quality of care. Each new piece of information on the distributive consequences of prospective payment is likely to prompt shifts in positions, as did the first analysis of the effect of the rate formula on hospital revenues.

Many also argue that the program needs baseline information to conduct necessary evaluations of its effects on the spectrum of issues. In sum, the shift to prospective reimbursement has created a strong market for analysis of every type. The question is whether in these tight fiscal times the money will be made available for the types of analyses that can at least ground the debate over redistributive consequences in fact rather than speculation.

EFFECTS OF PROSPECTIVE PAYMENT ON ALLIANCES AND POLITICS

In recent years, the health policymaking arena has become choked with players. In earlier years, a few powerful provider groups participated actively in policymaking. Since the mid-1970s, the number of groups finding they have a stake in the policy outcomes has increased. The new participants include representatives of the business community, manufacturers of related products, beneficiaries, and the commercial insurers, to name only the most obvious.

Further complicating the policymaking environment is the fact that one major participant is showing signs of splintering under the divisive pressure of the prospective payment formula. The fundamental unity of the hospitals, reflected in the uncontested positions the American Hospital Association and the Federation of American Hospitals have enjoyed for years, has been shattered. Hospitals are now reorganizing themselves along lines that reflect their positions on the rate formula. State associations are banding together either to support or to oppose completing the transition to national rates. The Catholic Health Association, the American Association of Medical Colleges, and others have assumed more active representative roles, while the American Hospital Association has had increasing difficulty reaching internal agreement on positions it can support.

At the same time, radical organizational changes in the health care delivery system may lead some hospitals to find they have more in
common with other types of providers than with other hospitals. For example, proprietary systems may come to share more with health maintenance organizations than with the hospital membership that makes up the AHA or even the FAH. The organizational structure of the provider groups may begin to shift, changing power bases and influence.

In sum, the current health policymaking environment can best be characterized as extremely unstable. The configuration of current participants is uncertain. They are adversaries as much as allies in their competition for a larger share of the fixed Medicare budget. Reimbursement policy and goals are likewise not firmly rooted. It is a situation that stands in stark contrast to the predictable relationships and policies of decades past.
Appendix

ORGANIZATIONS AND INDIVIDUALS CONTACTED/INTERVIEWED IN THE PREPARATION OF THIS REPORT

ORGANIZATIONS

Organization: Association of American Medical Colleges/Council of Teaching Hospitals, Washington, D.C.
Constituency: Medical schools, societies, hospitals seeking the advancement of medical education, biomedical research and the nation's health
Membership: 430 members from medical schools, teaching/university hospitals, medical societies

Constituency: Retirees from all fields
Membership: 21,000,000 U.S. citizens

Constituency: State and local health planning agencies and other organizations involved in health planning
Membership: 1,500–1,600 agencies

Organization: American Hospital Association, Chicago, IL
Constituency: Hospital Administrators, personnel, trustees and board members, volunteers
Membership: 6,100 institutions and 25,000 individuals

Organization: American Medical Association, Chicago, IL
Constituency: U.S. medical profession with about 2,000 local and regional medical societies
Membership: 250,000 individuals

Organization: American Medical Peer Review Association, Washington, D.C.
Constituency: State level Peer Review Organizations and others
Membership: 147 organizations, 300 individuals
<table>
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<tr>
<th>Organization:</th>
<th>American Nurses Association, Kansas City, MO</th>
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<tr>
<td>Constituency:</td>
<td>National professional organization of registered nurses</td>
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<tr>
<td>Membership:</td>
<td>170–180,000 individuals</td>
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<td>Organization:</td>
<td>Blue Cross/Blue Shield Association, Chicago, IL</td>
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<td>Constituency:</td>
<td>Non-profit medical and hospitalization plans</td>
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<td>Membership:</td>
<td>95 associations</td>
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<tr>
<td>Organization:</td>
<td>California Hospital Association, Sacramento, CA</td>
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<tr>
<td>Constituency:</td>
<td>Public, voluntary and proprietary hospitals operating in California</td>
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<tr>
<td>Membership:</td>
<td>480 institutions</td>
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<tr>
<td>Organization:</td>
<td>Catholic Health Association, Washington, D.C.</td>
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<tr>
<td>Constituency:</td>
<td>Catholic hospitals and nursing homes</td>
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<td>Membership:</td>
<td>6–7,000 hospitals and 2–300 nursing homes</td>
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<td>Constituency:</td>
<td>Investor-owned hospital</td>
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<td>1000 hospitals</td>
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<td>Constituency:</td>
<td>Financial managers in hospitals and long term care facilities, CPA firms, payers, and others</td>
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<td>Membership:</td>
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<td>Constituency:</td>
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<td>Illinois Hospital Association</td>
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<td>Public Hospitals in U.S.</td>
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<td>Membership:</td>
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</table>
INDIVIDUALS

Linda Demkovich  
(formerly on the staff of the National Journal)

Staff of Senator David Durenberger  
Chairman, Subcommittee on Health of Senate Committee on Finance  
Staff members: Kerry Kilpatrick, Lynn Blewitt

Paul Ginsburg  
Senior Economist  
The Rand Corporation, Washington, D.C.  
(formerly on the staff of the Congressional Budget Office)

Marvis Oehm  
District Director  
California Medical Review, Inc.
Sacramento, CA

Karen Williams  
Health Insurance Association of America  
Washington, D.C.  
(formerly on staff of DHHS/HCFA)
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