

# Hospital Reimbursement under Medicare

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CHANGES PROPOSED TO ASSURE THE SOLVENCY OF the Medicare program are as often global as they are segmented; some offer untried fiscal panaceas and others mete out small doses of bitter medicine. Paradoxically, options for reforming hospital reimbursement—the largest expenditure under the Medicare program—should be discussed within more explicit limits. Two major legislative changes affecting hospital reimbursement policy have only recently been enacted: the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the 1983 Social Security amendments, establishing a prospective payment system. It seems prudent to gauge the adaptation of the health care system to these profound initiatives before advocating still further radical departures.

Hospital reimbursement under Medicare will be discussed in four parts, beginning with a synoptic history. Next, certain features of the current system are examined and proposals made for minor changes in current law—some designed to save money and others to increase the equity of the system. I then go on to discuss some of the likely effects of the Medicare Prospective Payment System by examining the nature of the incentives built into the program. Finally, I make some recommendations for changes in the administration and structure of the program.

## Overview of Hospital Reimbursement under Medicare

In 1965 Congress enacted the Medicare program, the goal of which was to provide federal health insurance for the elderly in order to improve their access to mainstream medical care and to decrease the financial burden of paying for medical services.

The Medicare legislation mandated that institutional providers be reimbursed for the reasonable costs of providing services to beneficiaries. In 1965 this cost-based reimbursement principle was already the predominant practice; having been endorsed by the American Hospital Association as early as 1953, it was also the basis of hospital payment for most Blue Cross plans, the largest private third-party payers (Somers and Somers 1967; Myers 1970). Between 1966 and 1982, however, there was considerable tightening of the definition of "reasonable costs," both through legislation and through regulation.

Over this period the costs of the Medicare program exploded, i.e., they grew at an unprecedented and unpredicted rate. Hospital reimbursements, which represent about 95 percent of Part A expenditures and 71 percent of total Medicare expenditures, increased at an annual rate of about 20 percent. The increase was attributed to several factors: a growth of the categories of beneficiaries (an expansion of entitlement to the disabled and to people with end-stage renal disease); an expansion of the numbers of the previously entitled over-65 population; and some to an increase in utilization. But most of the increase was due to increases in the unit cost of care—the cost of a hospital day. Retrospective cost-based third-party reimbursement, in a world with little patient cost-sharing and an open-ended entitlement, is now considered to have been the major factor contributing to the explosion in hospital costs. The increase in costs, accompanied by the reciprocal increase in hospital revenues, facilitated the expansion and upgrading of hospital facilities and services (in 1965 some were quite poor). The open-endedness of the system demonstrably improved access to hospitals by the elderly in general and the disadvantaged elderly in particular (Ruther and Dobson 1981; Link, Long, and Settle 1982) representing the achievement of an avowed goal of the Medicare program. However, if in 1965 improving access to the health care system was the major concern of public policy makers, by the mid-1970s cost-containment had become the overriding concern.

In 1982 the Congress passed TEFRA, which profoundly changed Medicare's hospital reimbursement methods in a number of ways. First, the basis of reimbursement was shifted from an implicit *per diem* system to an explicit *per case* system; second, case-mix was incorporated into the payment system; and third, a limit was placed on the rate of allowable increase in costs per case. Although the language of the statute continued to use the term "reasonable costs," the concept was radically changed. Costs per case higher than 120 percent of the average (adjusted for wage and case-mix) for comparable hospitals, or which increased more than the target rate over the base year, were no longer considered reasonable. TEFRA also required that the secretary of the Department of Health and Human Services develop a prospective payment system. The secretary reported to the Congress in December 1982, and by April 1983 prospective payment was embedded in law.

The basic features of the Medicare prospective payment system are: (1) all patients will be classified into one of 468 diagnosis-related groups (DRGs); (2) with the exception of a limited number of "outlier" patients, the hospital will receive a fixed payment per DRG to cover operating costs (initially capital costs and direct education costs will be passed through); (3) the payment per DRG received by a hospital will be a function of area wages, whether it is in an urban or a rural location, and the number of full-time interns and residents on its staff, and (4) capital costs and direct education are to be passed through but the secretary is to report to Congress on methods of including these costs in the prospective rates. There is a three-year phase-in period during which the payment rates shift from being essentially based on the hospital's own "reasonable" costs, to being set on a national basis (with the adjustments noted above). Thus, by 1987 payments to an individual hospital to pay for the operating costs of providing services to Medicare beneficiaries will not be based on the hospital's costs.

The 1983 law contains a number of provisions requiring studies and reports that will help guide the evolution of the prospective payment system. For example, a commission is to be established to conduct studies and to advise the secretary on changes in both the DRG categories and the payment rates for each category. Also, the secretary is to monitor the progress of prospective payment and to report on such factors as the feasibility of adjusting DRGs for severity, and whether or not preadmission certification should be required.

## Options for Change in the Current System

The Medicare prospective payment system (PPS) represents a fundamental change in the way hospitals are to be paid. In order for hospitals to survive under the system, administrators must make basic changes in the way they collect and use information and how they interact with the medical staff. Professional associations and consulting organizations, through conferences, workshops, and journals are providing hospitals with advice on how to prepare for PPS. While these structural changes are taking place, it does not seem wise to propose yet another approach to hospital reimbursement. In this section, therefore, certain features of the current system are examined and options proposed to improve the system. Two features, the national rates and adjustments for teaching, are discussed in considerable detail because I believe they need to be changed immediately. (The issue of payment for capital is not discussed and the reader is referred elsewhere [Anderson and Ginsburg 1983] for a review of the issues and options.)

### *The Payment Rate*

Under current law, the payment level for each DRG is to be established on a national basis by 1987 but will vary by hospital location (urban/rural), by area wage levels, and by teaching levels. The effect of a national rate is to reallocate Medicare payments from hospitals that have relatively high costs to those that are relatively low cost. The majority of the savings from prospective payment come from the overall limit on the rate of growth of the average payment rate, not from the establishment of a national rate. The concept of a national rate and the speed with which it is to be fully implemented should be reevaluated.

Hospital care like all services is locally produced and consumed. Even after controlling for wage differences, teaching, and location (urban/rural), there remain significant differences in the cost per case by region. Some of this difference is due to regional patterns in length of stay, some is due to differences in the prices which hospitals have to pay for factors of production such as food and electricity, and the rest to less quantifiable variables including physician and consumer tastes. Factor price information is consistently available at the local

level only for wages. However, other prices also vary. For example, the "household" cost of food and electricity in Dallas are respectively 95 percent and 86 percent of the national average, whereas in Philadelphia they are each 112 percent of the national average.

These large regional differences in hospital costs are apparent both from data published by the Health Care Financing Administration (HCFA) and from an early Congressional Budget Office analysis of the regional effects of PPS. After controlling for wages, case-mix, and teaching, the Medicare cost per case of urban hospitals is approximately 20 percent higher in the East North Central Region than it is in the East South Central Region (*Federal Register* 1983). Additionally, under a system with national rates, 62 percent of the hospitals in the East North Central Region would receive an average 13 percent reduction in their payments. These large reductions in some regions would be occurring at the same time hospitals would be experiencing considerable pressure because of the overall limit imposed on how much the rates, on average, can increase.

If these reductions were being experienced by a small percentage of hospitals within a market area, there would be no particular reason for concern. However, we have no evidence either from the state rate-setting programs or from the experience of hospitals which were adversely affected by the old Medicare reimbursement rule (that did not pay routine per diem costs that were deemed to be excessively high—the hospitals affected by the Section 223 limits) that relatively high-cost hospitals have reduced their costs (Anderson and Lave 1984). Thus, given the magnitude of the necessary adjustments suggested by the above numbers, the number of hospitals affected, and their geographic concentration there is, I believe, significant reason for concern. In addition, we have no evidence that the regions of the country such as the East South Central or the West South Central, that would benefit from the establishment of national rates, need an infusion of funds either because their hospital industry is underfunded or because they produce lower quality of care.

Thus, I propose that the decision to move to a national rate for each DRG be reevaluated. Since the majority of the savings from the implementation of the prospective payment system comes from the limit on the increase in payment rates, this proposal would not increase the cost of the Medicare program. If the decision to move to national rates is sustained, then I recommend that the phase-in period be

extended. During the phase-in period, HCFA should work with the Bureau of Labor Statistics and the Bureau of Economic Analysis to collect better wage and other factor price data at the local level.

### *The Teaching Adjustment*

Under current law, the DRG payments to individual hospitals increase with the number of full-time equivalent interns and residents per bed (IR/B). The increment was determined by a statistical analysis of the relationship between the Medicare cost per case and IR/B (controlling for other factors), which indicated that costs rose 5.79 percent for every percentage point increase in the number of interns and residents per bed. The law mandates that this factor be doubled in setting the DRG rate for hospitals.

The "teaching factor" was originally doubled because the estimating equation contained variables (standard metropolitan statistical area [SMSA] size and bed complement) that are not considered in the setting of the payment rates but are positively correlated with IR/B. If this coefficient alone were used to adjust for the indirect costs of teaching, then the large teaching institutions, particularly those in large urban areas, would be relatively adversely affected. However, the doubling of the teaching factor means that the teaching institutions are at a strong advantage relative to other hospitals, and that the advantage increases with the size of the teaching programs. One option that would both save money and would treat all hospitals more comparably would be to reduce the size of the teaching factor. Thus, HCFA should be directed to reestimate the teaching factor, using as control variables only those that are actually taken into account in establishing the payment rates. Preliminary evidence suggests that the teaching coefficient would increase from 5.79 to about 9. Reducing the indirect teaching adjustment from 11.58 (which results from the doubling of 5.79) to 9 would save \$3 billion between 1985 and 1988.

### *The Teaching Hospital and Uncompensated Care*

For a given DRG, a teaching institution receives a higher reimbursement than a community hospital. This higher reimbursement compensates the institution both for the indirect costs associated with teaching

and for the increased severity and complexity of patients seen. The teaching adjustment also helps to moderate the effect of the slight underpricing of the more complex DRGs resulting from the way that the payment rates are calculated (Office of Technology Assessment 1983). The teaching adjustment is not designed to compensate these institutions for the relatively higher proportion of uncompensated care they provide.

A sizeable proportion (30.3 percent) of patients treated in large teaching hospitals are uninsured. This compares with 8.2 percent and 9.8 percent of admissions for nonteaching and small teaching hospitals respectively. As Medicare reduces its payments and as other payers (Medicaid and private) also become more restrictive, the ability of hospitals to cover the costs of providing uncompensated care will decrease. Given that it is likely that the uninsured are most likely to be "bad debts and charity cases," this means that hospitals which provide a considerable amount of care to the uninsured, i.e., large teaching hospitals, will be under considerable financial pressure.

I believe that the current financial environment is going to exacerbate the problem of some uncompensated care. It also seems unlikely that a new health insurance program to cover the costs of the currently uninsured will be implemented within the near future. Thus, I recommend that Medicare discontinue its policy of not sharing in the cost of general bad debts, and that it increase its DRG payment to a given hospital to pay for some share of the cost of uncompensated care delivered by that hospital. (Depending on their reimbursement policy, some private payers contribute toward the cost of bad debts.) This recommendation would not cost additional money if the amount Medicare contributed to covering the cost of uncompensated care were limited to the amount of savings generated by reducing the teaching adjustment.

### *Technology*

Under current law, the Prospective Payment Commission is to advise the secretary with respect to the general increase in rates to allow for technological changes as well as revisions in the definition of the DRGs and the prices paid for them. This continuous adaptation of the system is critical. The DRG system will stimulate the development and introduction of general or DRG-specific cost-reducing technologies.

It is easy to predict, however, that there will be strong pressures on the commission to expand the number of DRGs to adjust for different ways of treating similar patients, and to increase the relative price of each DRG as new, but more expensive, diagnostic and treatment procedures become available.

The revised payment system offers an opportunity to moderate the flow of new technology into the health care sector. Good information should be required before either payment rates or DRGs are revised. The Congress might consider providing guidelines to the commission and the secretary for use in revising DRGs; for example, expensive technologies could be required to meet standards of effectiveness to be measured in terms of their effect on both the extension and the quality of life.

### *Rate of Increase Limits*

The current law gives explicit direction on how payment rates should be increased, at least in the near future. In essence, payment rates, on average, are to increase by "market basket plus one." The market basket is a measure of the rate of increase in the prices that hospitals have to pay for their inputs, and the additional one percentage point (the intensity factor) is to provide some room for "technological" change. As the market basket price index has consistently increased more than the price index of goods and services in general, the new law guarantees that the costs of a Medicare case will continue to increase at a faster rate than that of goods and services in general.

To reduce the increase in costs of the Medicare program, either of these two factors (the market basket price index or the intensity factor) must be reduced. The market basket price index, for example, could be reduced by substituting the increase in general area wages for the increase in hospital workers' wages or by replacing it with the consumer or producer price index.

However, the current allowed rate of increase is very tight compared to historical experience and it seems prudent to determine whether it can be achieved before recommending it be lowered. In addition, it must be recognized that the rate paid by Medicare should be influenced by what is happening in the private sector. If the private sector does not follow Medicare by implementing complementary cost-containing efforts, then the gap between the public and private payment



rates may become quite wide. In this case, it is unlikely that Medicare payment rates could be reduced further unless a general hospital cost-control program were implemented or unless the Congress were willing to accept the possibility of a two-class medical care system. I also believe that it is unrealistic to consider reducing the allowed rate of increase unless the policy of moving to national rates within a three-year period is reversed.

### *State Rate-setting*

The current law gives some encouragement to states to implement all-payer hospital state rate-setting programs—that is, programs whereby a state regulatory agency establishes mechanisms for setting hospital rates which are then paid by all payers of hospital services (individuals, Blue Cross, Medicare, commercial insurance companies, etc.). It seems likely that the new Medicare law will stimulate interest in such programs for a number of reasons. Some private insurers, for example, are concerned that the effect of the new Medicare law will be to shift costs to them and they, therefore, would like to limit the hospitals' ability to do so (Morefield 1983). In addition, hospitals, particularly those in the most negatively affected regions, may believe that they will have more control over their individual fates under a state rate-setting system than under the Medicare DRG system. A state rate-setting system, with its built-in appeals process, is likely to be more responsive to the needs of individual hospitals. The distribution of winners and losers is likely to be much different under the two systems. In addition, given that hospitals are important parts of the fabric of a community, many communities may want control over the structure of the hospital sector. Finally, as state rate-setting systems are all-payer systems, they provide a social mechanism for dealing with the problem of uncompensated care and can moderate a trend toward a "two class medical system" for publicly financed and indigent patients.

Many policy analysts argue that state rate-setting programs should be discouraged because they will stifle innovation and limit competition (Sloan 1983; Meyer 1983). They believe that the disadvantages of rate-setting outweigh their advantages and that policy makers should seek other mechanisms for dealing with rising costs and bad debts. However, I do not believe that innovation at the state level should be discouraged. Rather the mandate of Public Law 98-21 should stand:

The federal government should support state rate-setting activity if it meets the federal guidelines.

### *Cost-containment*

Can the Medicare prospective system be effective, if it is the only third-party payer that is limiting its reimbursements? Will the final result be a two-class system, in which public and private patients are separated either by facility or by treatment? Should the federal government once again try to implement general hospital cost-containment legislation?

Although there is no doubt that it is more efficient to manage a DRG system in the context of an all-payer system, my recommendation is to adopt once again a wait-and-see strategy. Public expenditures represent approximately 53 percent of overall hospital revenues. The private sector is also trying to control its expenditures on health care services, and it is highly unlikely that it will idly sit by and let the hospitals "cost shift." It, too, is searching for innovative methods of controlling costs, and although one option is clearly to follow the federal lead and base payments to the extent possible on DRGs, other outcomes are possible. Although there may be some institutions that will not accept public pay patients and some cases where treatment patterns will vary by patient payment source, this is unlikely to be widespread. However, if the rate of increase in hospital costs is not moderated or if a distinct two-class system emerges, then I would recommend that a general hospital cost-containment plan be implemented.

### The Likely Effects of the Medicare Prospective Payment System

Prospective payment represents a fundamental change in the method of paying for hospital care—a method with which we have limited experience. As noted above, for a hospital administrator to be able to respond effectively to the system, changes will have to be made in the hospital's accounting and reporting systems, and the relationship between administration, trustees, and staff. The per case system should promote efficiency in the production of health care services and in

the development and adoption of cost-reducing technologies. It will have many other effects, possibly resulting in a decrease in inpatient hospital costs while increasing total health system costs, or it may even lead to increased hospital use. These effects will have the consequence of offsetting some of the expected savings from prospective payment.

The most significant of these responses are listed below:

1. There will be incentives to decrease the services provided to patients; it is easy to predict bitter disagreements about whether these reductions are a "rational" response to newly imposed constraints or represent a deterioration in the quality of care provided (Schwartz 1983). In addition, some hospitals will eliminate some services entirely and will stop treating certain conditions that require the curtailed services or are simply more costly to treat than are covered by payments.
2. Lengths of stay for particular diagnoses should decrease, but use of home health agencies, nursing home beds, and rehabilitation centers will increase. It is possible that patients seen in these other settings will be "sicker" (and thus more costly) on average than those treated before the implementation of PPS.
3. The number of admissions and readmissions will likely increase. Some patients who could be treated as outpatients may be treated as inpatients. In addition, there will be some incentive to space treatments or operations (if possible) rather than to do them during the same hospital episode. This incentive will be even stronger for those hospitals experiencing decreased occupancy rates—induced in part by the shorter lengths of stay encouraged by PPS.
4. Preadmission testing should increase, as it will occasionally be possible to charge for preadmission testing under Part B and collect the full DRG rate under Part A. (This is a form of "unbundling." The law makes it illegal to "unbundle" services while the patient is hospitalized. All services received must be covered by the DRG payment regardless of where that service was purchased—i. e., a hospital could use an outside laboratory.)
5. Some legitimate recoding of diagnoses may take place. For example, if "frequency of urination" is noted as the primary diagnosis rather than "hypertrophy of the prostate" for a patient who has a transurethral resection of the prostate gland, the patient will

be classified in DRG 306 rather than DRG 336. The payment for DRG 306 is about \$290 higher than that for 336. In addition, if the payment to marginal cost relationship varies across the alternative treatment modalities the treatment selected may be influenced by payment levels.

6. Since every DRG represents a collection of different diagnoses and conditions along with their associated treatments, it is possible that some providers may attempt to establish policies to “skim” patients within a given DRG; that is, they may try to select only the relatively inexpensive patients within a given DRG and transfer the sicker patients elsewhere. However, the extent to which such practices can be developed, and physicians induced to follow them, is questionable.
7. Services that have been cross-subsidized by other services are likely to be phased out. Some of these services—such as social services, nutritional counseling, health promotion, or prevention activities—may be services that contribute to a decrease in the cost of post-hospital care, but to an increase in inpatient costs.
8. The new financial arrangements will further stimulate the restructuring of the hospital sector. This restructuring of the hospital sector consists of the corporate restructuring of given hospitals, horizontal integration into hospital chains, and vertical integration as the corporate structure links ambulatory care centers, hospitals, nursing homes, etc. (Starr 1982).

Some of these possibilities are a likely response to the end of open-ended financing of hospital services: some may be a response to constraints being imposed on only one part of the system—the inpatient hospital sector. Other changes will be a response to the unit of payment (the “case” and not the “patient day”), and still others a response to the definition of the reimbursement unit (the DRG, with its imperfect patient classification and pricing system, although no case-mix system will be perfect).

The impact of these potential effects on the costs of the Medicare program and the quality of care provided are difficult to anticipate. They may be so small that there is no need to develop countervailing regulations, or they may be sufficiently extensive to overwhelm the system. Many of these problems, however, were identified by Congress which mandated that the secretary do a series of studies and make

recommendations to modify the system. It also mandated that the peer review organizations (PROs) focus on both quality of care and appropriateness of admissions.

Because of the possible effect on the costs of Medicare, the various incentives to increase admissions has been a major cause of concern. To dampen the incentive to increase admissions, some observers have argued that the payment rate should be reduced if the hospital experiences increased admissions. I would argue against this for two reasons: (1) Medicare admissions are only a fraction of total admissions and they can rise when total admissions fall; and (2) research indicates that if the increase in admissions is expected to be permanent then marginal cost is close to average cost (Friedman and Pauly 1983). The admission effect may be small; the evaluation of the state rate-setting programs has indicated that the utilization effects were small (Worthington and Piro 1982).

## Long-run Solutions

If the perverse incentives that are embedded in the prospective payment system prove to be large, then I do not believe that they will be solvable within the current structure of the Medicare system.

Medicare, along with most private insurance plans, makes coverage and reimbursement policies that vary according to the location of the service and the characteristics of the individual or group providing that service. As the number of alternative providers and sites increase, there is great pressure to extend Medicare reimbursement to them. It is a fee-for-service system where decisions must be made about what prices are to be paid for what services and in what location (Young 1983). It is essentially an open-ended system in which there are few limits placed on the number of units of service that will be paid for.

The current structure of the Medicare program does not lead to the most efficient mix of services (inpatient, physician, outpatient, etc.) or to the "ideal" number of services. The current financing mechanisms become more problematical as the number of services and providers (which are both complements to and substitutes for each other) increase. The problems multiply when there is considerable discretion as to whether, or how, to diagnose and treat particular conditions. Under

the fee-for-service system the need for and direction of regulation is clear: increased preadmission review; increased governmental determination of what and where care is delivered; and, increased control over the prices of the individual services. Most of the problems these regulations are designed to correct will exist regardless of the particular *structure* of a hospital prospective payment system.

There are two long-run alternatives to increased regulation: increased cost-sharing or increased use of competing capitated or managed health care delivery systems. The first alternative does not seem promising if past history is any guide. Many Medicare beneficiaries would purchase supplemental medical insurance; for others, welfare assistance programs would bear the cost. Thus, the incentive effects of increased cost-sharing would not be realized.

The second alternative would, in effect, turn the Medicare program from an open-ended system to a closed system by enrolling the Medicare beneficiaries in managed health delivery systems. Although the health maintenance organization (HMO) is the classic managed system, a number of other forms are emerging. This option would relieve the federal government from setting prices for individual services, would encourage the efficient *mix* of services and providers, would reduce the incentive to increase the volume of services, and would stimulate *effective* health education and promotion activities. It also would allow for regional variations in the practice of medicine. The drawbacks of capitated systems are equally well known. There is a need to adjust for the health status of enrollees in order to reduce—even to eliminate—the disincentive to enroll people with deteriorated health status who will be heavy users of services. There is also an incentive to underproduce services. In addition, it is unlikely that these systems would have the same ability to set prices as does the federal government, which is exerting more and more of its monopsonistic power.

While Medicare policy is undergoing change, there are also some changes taking place in the private sector. Private payers (employers) are becoming more actively involved in health care policy and in seeking mechanisms to control their health care liabilities. One result is the increased growth of HMOs and of other alternative delivery systems including preferred provider arrangements. While preferred provider arrangements are still evolving, they seem to have some basic characteristics, the most important of which are strong utilization review and controlled use of providers. (The enrollee choice of providers

can be restricted to a subset of providers, or they can use other providers only by paying an additional fee.)

One way, however, for alternative delivery systems to reduce costs is to control directly where patients receive care. Thus, it is likely that they will promote the use of lower cost alternatives. One policy would be to limit the use of tertiary-care institutions to those patients needing tertiary-level care. This control over the site of patient hospitalization is likely to take place even in rate-setting states as long as there are significant differences among hospitals in the cost per payment unit (day, case, or DRG). Thus, it seems likely that the long-run effects of prospective payment systems, controlled patient choices, and the growth of alternative delivery systems will put significant pressure on our premiere health care institutions. Patient revenues will become a much less reliable source of funding for training and research. It is likely that these other issues will have to be explicitly addressed as options for change in the Medicare program are considered.

## Summary and Conclusions

With the implementation of the prospective payment system by Medicare, the nation has embarked on a national experiment in hospital reimbursement. In order for hospitals to survive, major changes will have to be made in the internal administrative systems, in the way decisions are made, and in the relationships among trustees, administrators, and physicians.

Since the system is new it is important to let it evolve. However, certain features of PPS should be modified in the short run in order to sustain it in the long run. The decision to move to national rates should be reconsidered. If the decision is sustained, then the phase-in period should be lengthened and better factor price information at the local level should be collected. The current adjustment for indirect teaching costs should be reduced but an adjustment for the level of uncovered care provided by a hospital added. Research on refining the basis of payment (the DRG) and the method for determining the payment rates should be encouraged and funded.

The health care system in general, and the hospital industry in particular, will respond to the PPS. As lengths of stay decrease and hospital occupancy rates fall, some hospitals will close wings and

others may close completely. It is easy to predict that there will be great outcries that the quality of care has diminished and that the practice of medicine is being interfered with. Therefore, it is important that the PROs monitor the quality of care even while recognizing that the system is designed to reduce inputs and to alter current practices that developed in response to open-ended systems. Outcome measures of quality, unrelated to treatment patterns, will have to be defined. Members of Congress will be under tremendous pressure to ameliorate the situation—a pressure that should be resisted.

Although I have argued that the DRG system should be allowed to evolve, it is possible that it will collapse. In that case two alternatives should be considered: (1) a simple payment rate per case, initially based on the hospital's own base costs and increased by the market basket with a gross case-mix adjustment at final settlement could be set, or, (2) preferred provider arrangements with certain hospitals to provide services to Medicare beneficiaries could be developed—a policy that would require modifying the freedom-of-choice provisions in the Medicare law.

As noted earlier, PPS is a pricing policy; it controls the price of only one input (acute hospital care) that goes into patient treatment. Given the increase in the cost of Medicare, pricing policies will no doubt be developed for all other services. Utilization-review activities will have to be strengthened in order to control the quantity of services used and their mix. However, as the number of alternative sites and providers multiply (as they seem to be doing), the decisions that HCFA will have to make will increase exponentially.

This dynamic leads me to conclude that the delivery of medical services to the Medicare beneficiaries will have to be managed. Federal regulations are one method of management, but they are likely to be rigid and not sensitive to regional or local concerns. They also promote the development of institutions that are responsive to reimbursement policies as opposed to real costs. In addition, prior experience suggests that such regulations have not been effective. Thus, it is important to promote the development of alternative systems of care in which organizations at risk are responsible for providing services for Medicare beneficiaries. With the exception of the price of acute hospital care, which may still have to be controlled, pricing policies with respect to other providers can be left to the private sector. The HMO strategy is one such strategy; preferred provider arrangements is another; the



gate keeper is a third; and putting areas up for bid for *management* by the contractor is yet another.

There are two implications of the recent changes that are taking place in the health care sector that will have to be addressed by the legislators. The first is the effect of the tightening of hospital payment levels on the hospital's ability to finance uncompensated care. The second is the likely effect of growth of alternative delivery systems and competition on the ability of teaching hospitals to continue to support the training of interns and residents and research out of patient revenues. As the future of hospital payment policy under Medicare is being debated, so too must the federal role in funding uncompensated care and research and training be discussed.

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