Comment on "Hospital Reimbursement under Medicare"

BRUCE C. VLADECK

United Hospital Fund of New York

MEDICARE HAS JUST EMBARKED ON THE MOST far-reaching changes since its inception, in the implementation of the new prospective payment system based on diagnosis-related groups (DRGs), and the principal point in Dr. Lave's excellent and thoughtful paper on "Hospital Reimbursement under Medicare" is that it would probably be prudent to wait a little while to see what happens before contemplating major changes in that system. I heartily agree. I also concur in her tacit scepticism about the $68 billion in savings projected over the next three years under the new system already in place (U.S. Senate 1983). While that may only postpone the insolvency of the trust fund by one year, $68 billion is still a substantial piece of change, and one wonders how much more savings can reasonably be expected from changes in payment methods for one class of providers.

Nonetheless, as Dr. Lave points out, there are some relatively short-term concerns about the new system which need to be addressed sooner rather than later. Further, there are some more basic underlying conceptual and economic issues that can appropriately be addressed at this point. These comments will touch on a number of these issues, beginning first with those that are most immediate and most technical, moving through what might be called an intermediate level, and concluding with some broader conceptual discussion.

Milbank Memorial Fund Quarterly/*Health and Society*. Vol. 62, No. 2, 1984

Technical Issues

National Rates

The plan to establish uniform national DRG prices by 1986 strikes me as a triumph of conceptual neatness over sound policy. Dr. Lave's technical objections to uniform national rates are all compelling and on point, but she slights an at least equally telling criticism: movement to uniform national rates produces no net savings to the trust fund whatsoever. For every hospital or group of hospitals that is severely and unfairly penalized by the inherent arbitrariness of a single national standard, there is a symmetrical hospital or group of hospitals that receives an unmerited windfall. A uniform national standard of efficient and effective production of care is certainly needed in the determination of Medicare payment rates, but to make that standard the sole basis for the rates, in light of the enormous variations in cost patterns from one part of the country to another, reflects a preference for abstract principle over simple equity or even common sense.

Dr. Lave recommends that the movement toward uniform national rates be delayed until substantially better data is available on actual input cost variations from one region to another. I would go a step further. Since no system of price-setting can ever be perfect, the prudent and equitable thing to do is always to continue to base at least a reasonable portion of any hospital's payment rates on its historic cost patterns. In New Jersey, a relatively complex formula has produced a pattern in which each hospital's rate for any given DRG is based roughly 50 percent on a uniform standard, and roughly 50 percent on the hospital's own historical cost experience, and that seems to be a reasonable approach.

Volume Variability

Dr. Lave legitimately raises a number of questions about the incentives in DRG-based payment systems to encourage marginally necessary or unnecessary admissions and readmissions. In addition to raising questions about the integrity of the system, those incentives also threaten the expected savings. Rather than establishing low length-of-stay outliers as a partial solution to this problem, or devolving all of the responsibility

to professional review organizations (PROs), it would make much more sense, I think, to develop an explicit volume variability adjustment in the Medicare prospective payment system.

All forms of hospital payment suffer from the significant discrepancy between average and marginal cost in hospital services, but the greater the level of aggregation in the payment unit, the more pronounced that effect becomes. Paying by the case can create substantial windfalls to institutions with marginal increases in the volume of admissions, while similarly creating excessive revenue losses for those with relatively small admissions declines. The application of appropriate volume adjustments in prospective payment systems is technically straightforward and relatively simple, supported by sound precedent from state rate-setting systems, and rooted directly in the economics of the problem to which it responds.

Technology

The rate of adoption of new technologies in hospital services is obviously a central concern, but there is very little empirical evidence on which to base any substantial faith in either formal technology assessment procedures or the ability of organizations like the PROs to adequately address this concern. One partial solution, but a very effective one, is to include the portion of hospital capital costs related to moveable equipment (which automatically encompasses most new diagnostic technologies as well as many new therapeutic technologies) in per case DRG rates. As has been the experience in New Jersey, hospitals under such a system have an automatic incentive to adopt those new technologies that increase productivity, in the sense of reducing total costs, in caring for patients within a specific DRG. The problem of technologies that produce a qualitatively superior outcome while increasing the costs of care remains, but that is a smaller problem than trying to address all new technologies.

In passing, while on the subject of capital, I need to register personal alarm at the notion of any sort of formula add-on for capital, even if only plant capital. Dr. Lave's suggestions that states be permitted to pool such funds, and that costs incurred prior to the development of new capital reimbursement mechanisms be "grandfathered," do not completely allay those concerns. A full consideration of this issue is

outside the scope of this discussion, but the flat add-on strikes me as a simple solution to a very complicated problem, and thus probably an inadequate one (Anderson and Ginsburg 1983).

Professional Review Organizations

Dr. Lave is absolutely correct in emphasizing the critically important role of PROs in quality assurance under a DRG-based prospective payment system. The incentives to underprovide services are indeed much stronger in a DRG-based system than in cost-based reimbursement. The quality of services being rendered to Medicare beneficiaries has, however, always been a legitimate concern of the program. DRGs, in other words, do not create the problem of a need for quality assurance; they only put it in somewhat different forms.

In this regard, the track record of a professional peer review is less than entirely encouraging. On the other hand, it was the explicit objective of many of those who were involved in the early development of DRG-based reimbursement systems to develop a methodology and a "common language" which would permit more sophisticated and effective focusing of quality assurance activities on important issues. There are a number of ways in which DRGs are inherently useful for quality assurance purposes—in some sense, after all, that's what they were created for.

Rate of Increase

The greatest policy breakthrough, it seems to me, in the last years' evolution of Medicare prospective payment is not so much the adoption of DRGs as it is the notion of "budget neutrality." For the first time, there exists the statutory authority, as well as the necessary technical tools, for the secretary of Health and Human Services to establish, at the beginning of the year, within reasonable bounds of estimation (especially if a volume variability adjustment is added to the system), the total Medicare liability for inpatient hospital services for the coming year. In order to do so, the secretary need only determine one number—the allowable inflation rate for the Medicare average cost per case.

Dr. Lave quite correctly points out that the real savings from prospective payment systems arise not from the reallocation of revenues

among hospitals, but from reductions in rate of growth of overall hospital inflation. She is also correct in noting that an inflation rate of input prices plus one is substantially more stringent than anything within memory that the hospital industry has been forced to encounter. It is, as she also notes, a substantially lower rate of inflation than even the most optimistic private payers might hope to achieve.

At the same time, however, the pattern Dr. Lave notes—in which the medical market basket has increased faster than general inflation—suggests that the absence of price constraints has obviated, in the hospital industry, the incentives other industries have long had to change their input factor mix in response to differential price increases across types of inputs. More important, there is at least some precedent for the legislative enactment of a lower rate of increase. The Massachusetts rate-setting law is predicated on a growth rate over a three-year period of input prices *less* 1.5 percent per year. The notion there, which is clearly defensible conceptually, is that we should be able to expect productivity improvements in the hospital industry.

It is also important to note that the Congressional Budget Office (CBO) estimates that a rate of increase in hospital prices of input price minus 1.6 percent per year would keep the trust fund solvent indefinitely, without any further changes in the program (U.S. Senate. Special Committee on Aging 1983). We undoubtedly should wait and see what happens over the first three years of Medicare DRGs in terms of the effects of input prices plus one, but there is no need to be wedded to that target forever.

Intermediate Issues

State Systems

Dr. Lave takes two positions that are logically consistent but not, I believe, practicably compatible. She contends that the federal government should remain neutral toward alternative state systems, and should not encourage the development of all-payer systems. But she expresses concern about the problem of uncompensated care, suggesting that perhaps Medicare should begin to recognize an explicit subsidy for part of the burden incurred by hospitals treating uninsured and indigent patients. However, for the near future, the only proven method that

appears to be both politically and practically feasible to address the problems of uncompensated care, and the needs of the hospitals that serve substantial numbers of indigents, is the implementation of all-payer state rate-setting systems with explicit uncompensated care subsidies. Such subsidies are obviously imperfect, applying as they do only to hospital-based services. Broader insurance entitlements would be preferable from the standpoint both of economic theory and sound policy. But it is very unlikely that we will have either such expanded entitlements or explicit Medicare subsidies for uncompensated care in the near future.

State-run all-payer systems have demonstrated the ability to solve at least a piece of the uncompensated care problem while saving Medicare as much money as its prospective payment system will. The problems of financially distressed institutions, especially in our inner cities, cannot wait for long-term solutions, and thus it seems to me the state option needs to be much more aggressively promoted.

Teaching Costs

Indirect and hidden subsidies are never popular among economists or policy theorists, but they may not be such a bad way to do business. One can certainly make a practical, if not theoretical, case for the maintenance of some level of subsidization for graduate medical education in Medicare payment rates.

I agree with Dr. Lave that the subsidy now contained in the Medicare prospective payment system is almost certainly too large, but I fear the suggestion that it be reduced by eliminating the indirect teaching cost adjustment from routine cases would be counterproductive.

There is a rather subtle technical issue involved here. While teaching hospitals seem particularly concerned about the problem of "intensity" within DRGs, on the notion that within any given DRG they probably treat the sicker cases, in my own view that presents much less of a fiscal threat to teaching hospitals than what might be called the "rate compression problem." Essentially, the rate compression problem is that, because of the way costs—especially nursing and overhead costs in ancillary departments—are allocated in all existing payment systems, there is a systematic overpricing of routine cases and underpricing of complex ones. To put the same proposition another way, the range of relative case-mix rates contained in the Medicare DRG system is too narrow because of a series of accounting artifacts. As a result,

simple cases subsidize complex ones. To remove the indirect teaching adjustment from simple cases would be to remove that subsidy, and thus leave the adjustment only for underpriced complex cases. That would be likely to have a particularly baleful effect on major teaching institutions.

Consolidation of Medicare Parts A and B

There appears to be a growing consensus that merging Parts A and B of Medicare, certainly on the benefit side if not immediately on the financing side, makes both administrative and policy sense. Among other things, such a merger (preferably in conjunction with some benefit redesign) would remove existing incentives for the "unbundling" of what are now hospital-based services. We need to go one step further, however. As long as we are merging Parts A and B, we should address the fact that, contrary to the undoubtedly sincere public statements of its administrators, Medicare already is very much a long-term care program. It pays substantial costs for long-term care for patients: in acute hospitals awaiting nursing home placement; admitted to hospitals from nursing homes, or receiving physician or other services in the long-term care setting; as well as the explicitly recognized long-term care costs in skilled nursing facilities and home health agencies. Conversely, Medicaid has become the de facto catastrophic insurance arm of Medicare, at least for long-term care clients.

Dr. Lave is undoubtedly correct in predicting that DRG-based Medicare reimbursement will increase pressures to discharge relatively sicker patients from the acute setting to long-term care settings. What needs to be recognized, however, is that such patients and, in the long run, the Medicare system, financially as well as programmatically, are much better served by a further integration of the acute and long-term care sectors than by the maintenance of rigid, arbitrary boundaries between them. The details, again, are necessarily outside the scope of this discussion, but the issue cannot be wished away (Vladeck 1983).

Some Conceptual Concerns

When all is said and done, however much the Medicare prospective payment system meets its objectives, or can be improved to meet

them, it is unlikely by itself to save enough money to preserve the solvency of the trust fund. As Dr. Lave quite correctly notes, it is concerned only with the setting of prices, while the volume and mix of services remain relatively uncontrolled. Total outlays, of course, are the product of price times volume, and even if the technical correction of a volume variability factor is added to Medicare prospective payments, the problem of getting an appropriate handle on the volume of services rendered to Medicare beneficiaries remains.

Dr. Lave contends that there are essentially two possible approaches to the volume issue. One is increased cost-sharing. The second is development of more capitated or managed care systems. I believe she is correct in contending that increased cost-sharing is not politically feasible, although it must be recognized that it is not politically feasible precisely because it is punitive toward those who are sickest and most in need.

Conversely, there is no one who opposes in principle the greater extension of capitation-based or managed systems in Medicare. It is hard to be against them. But I would also suggest that there are only limited grounds for optimism about their ability ever to meet the needs of a significant proportion of Medicare beneficiaries.

Effective prepaid capitated systems, such as the best group-model HMOs, address both qualitative and financial concerns where they exist, when they work, and when you can get people to enroll in them. But it is awfully hard to effectively develop and operate a well-managed medical care system. Larry Brown (1983) has eloquently and exhaustively documented the effect of those difficulties on the impact of the federal HMO act. Moreover, it appears to be surprisingly difficult to get people who have decent insurance for fee-for-service care to enroll in prepaid systems. The only way to ensure that a large proportion of beneficiaries will enroll in such systems is to require them to do so, but the recent experience with Medicaid recipients in Massachusetts and New York suggests that that may not be very feasible politically either (Iglehart 1983). If governments in New York and Massachusetts are unwilling to accept mandatory enrollment for the welfare poor, just think how much harder it will be to achieve an analogous political decision for the empowered elderly.

We cannot, in short, put all our chips on prepaid systems as the approach to the problem of getting an adequate handle on the volume of services. It will be necessary to try many additional approaches as well. Let me suggest just a few among many.

Since we are going to need to find a way to make PROs work in terms of quality assurance, we might as well, in the process, see what they can do in terms of utilization review. From a narrow technical perspective, the technology is already well in hand. In the past, what has been lacking is the political and administrative will, but the balance of forces has certainly been changing, and here I would find some grounds for optimism.

There is also a need to play with more directly financial approaches other than capitation. There are promising experiments in regional or state-wide budget caps for inpatient services, and these need to be developed and explored further.

There is also increasing reason to believe that changes in the relative prices paid physicians for different sorts of services might have a beneficial effect on utilization patterns even in the absence of adequate administrative controls. Finally, the broader issue of the way in which physicians are paid, even in the absence of formal management systems, would seem to hold some significant promise relative to these utilization issues.

Again, this is not to say that we should not encourage as much enrollment in sound and well-managed capitated plans as is attainable. It is only to caution that there may not be that much that is in fact attainable, and that the utilization issue will need to be addressed on many fronts simultaneously.

Conclusion

Prospective payment of hospitals is the only demonstratedly successful and politically acceptable policy tool currently available for addressing the Medicare financing problem. That is undoubtedly why it is the only one that has so far been formally adopted as part of Medicare legislation. As a means of controlling expenditures, prospective payment can work. Just how well it works will depend on a number of relatively specific and often technically complex factors, which have been the primary focus of this discussion.

But even if prospective payment, in any of a number of forms, can achieve significant savings, the ultimate issue must always be not the economic side of the equation but the implications for what actually happens to actual Medicare beneficiaries in need of actual medical services. Here it is important to remember the aspirations, if not yet

the demonstrated performance, that lie at the root of the development of DRG-based payment. As opposed to any other currently available methods for prospective price-setting for hospitals, DRGs focus, at one and the same time, both on the specific issue of hospital productivity for clinically defined products, and on the identification and scrutiny of the patterns of care being rendered in individual institutions. In other words, what DRGs are all about is finding a mix of services that, in the inevitable statutory phraseology, are both efficient and effective. That is an aspiration that extends far beyond fiscal solvency. If it succeeds, then it will succeed at addressing some of the broadest and most basic concerns of Medicare, not just its potentially transient fiscal problems.

References

Anderson, G., and P.B. Ginsburg. 1983. Prospective Capital Payment to Hospitals. *Health Affairs* 2 (Fall):52–63.

Brown, L.D. 1983. *Politics and Health Care Organization: HMOs as Federal Policy.* Washington: Brookings Institution.

Iglehart, J. 1983. Medicaid in Transition. *New England Journal of Medicine* 309 (October 6):868–72.

U.S. Senate. Special Committee on Aging. 1983. *Prospects for Medicare's Hospital Insurance Trust Fund.* Washington.

Vladeck, B.C. 1983. Two Steps Forward, One Back: The Changing Agenda of Long-term Care Reform. *PRIDE Institute Journal of Long-term Home Health Care* 2 (Summer):1–7.

Acknowledgments: An earlier version of this paper was prepared for the Conference on the Future of Medicare sponsored by the U.S. House of Representatives, Committee on Ways and Means, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, Washington, November 29–30, 1983.

Address correspondence to: Bruce Vladeck, President, The United Hospital Fund of New York, 3 East 54th Street, New York, NY 10022.