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Larry A. Oday

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Larry A. Oday†
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In 1983, Congress enacted as part of the Social Security Amendments of 1983 (SSA), major Medicare reforms designed to ensure the solvency of Social Security into the 21st Century.[1] The enactment and implementation of a "prospective payment system" (PPS) for hospitals under Medicare constituted one of the most significant, and perhaps enduring, innovations of the Reagan Administration.[2] The Prospective Payment System, which replaced the retrospective, cost-based reimbursement system, fundamentally altered the payment of hospital care for the elderly and disabled, and played an integral part in the revolution of health care delivery in America.[3] The Reagan Administration's goal was to create incentives for hospitals to operate more efficiently in order to curb rising government expenditures on health care. The underlying agenda, however, was to reduce the federal deficit, a political issue that related only tangentially to health care but that has driven the operation of PPS during the past seven years.[4]

In her probing article, Professor Judith Lave contributes significantly to the debate surrounding PPS by surveying the

† A.B., Case Western Reserve University, 1969; J.D., IIT/Chicago-Kent College of Law, 1973; Partner, Wood, Lucksinger & Epstein, Washington, D.C. The author served as Director of the Bureau of Eligibility, Reimbursement and Coverage within the Health Care Financing Administration where he had lead responsibility for the design, enactment, and implementation of the Prospective Payment System.

†† B.A., University of Washingon, 1965; Ph.D., Economics, Washington University, 1970; Vice-President, Lewin/ICF, Washington, D.C. The author served as Director of Research for the Health Care Financing Administration, where he was a key figure in the design of Medicare's DRG System.

1. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65 (1983) (codified as amended in scattered sections of 42 U.S.C.).

2. Social Security Amendments, 97 Stat. 65, 149-72 (1983) (codified as amended at 42 U.S.C. § 1395ww (Supp. V 1987)).

3. Under PPS, hospitals are reimbursed for each patient discharge based on diagnosis related groups, or DRGs.

4. *See Medicare Cuts Inevitable Until the Federal Budget is Balanced: Rostenkowski*, AM. HOSPITAL ASS'N NEWS, Apr. 2, 1990, at 3, col. 3; *See also* U.S. DEP'T OF HEALTH & HUMAN SERVS., THE FISCAL YEAR 1991 BUDGET 2 (1990).

PPS/DRG system and assessing its impact on quality of care.[5] She explains briefly the development and function of the system, compares the expected consequences of PPS with the actual impact, and concludes that, while PPS has undoubtedly changed the delivery of health care in America, its impact on the quality of care cannot yet be conclusively determined. She suggests that the evidence, although mixed, supports the conclusion that quality of care has not been significantly affected except insofar as the diffusion of new, more expensive technologies has been slowed. She does, however, point out that hospitals under increasing financial pressure may be forced to economize still further, resulting in a more noticeable impact on quality of care. Finally, she recommends three adjustments to the current Prospective Payment System, which she argues will make the system more sensitive to unavoidable costs incurred by individual institutions. Her suggestions would move PPS back to hospital-specific reimbursement, a formula that deters the effort to create uniform pricing incentives for hospitals. She also seemingly does not specifically address the central issue facing the system: chronic underpayment by Congress.

Professor Lave's article reflects a thorough and thoughtful understanding of the issues involved, but by failing to explicitly address revenue shortfalls, her analysis and recommendations do not reach the heart of the problems facing PPS.[6] The most critical impact of PPS has been financial, threatening the economic welfare of the hospital industry. The incentives created by PPS have forced efficiency and innovation in the hospital industry: more outpatient care is being provided and the average length of stay has been reduced.[7] Since the implementation of PPS, however, the hospital industry has suffered a steady decline in average operating margins; currently, a projected 63.2 percent of all hospitals show a negative operating margin.[8] This deficit has been caused by Congress' low increases in the rate of payment for hospital care under Medicare, decisions which are fundamentally political in nature and have been driven by the need to reduce the federal deficit. The critical concern for PPS right now is therefore increased reimbursements for all

5. Lave, *The Impact of the Medicare Prospective Payment System and Recommendations for Change*, 7 YALE J. ON REG. 499 (1990).

6. The editorial staff at the *Yale Journal on Regulation* requested that Professor Lave focus her article on the issue of the impact of PPS on Medicare beneficiaries.

7. Lave, *supra* note 5, at 513-20.

8. *See infra* Table 3.

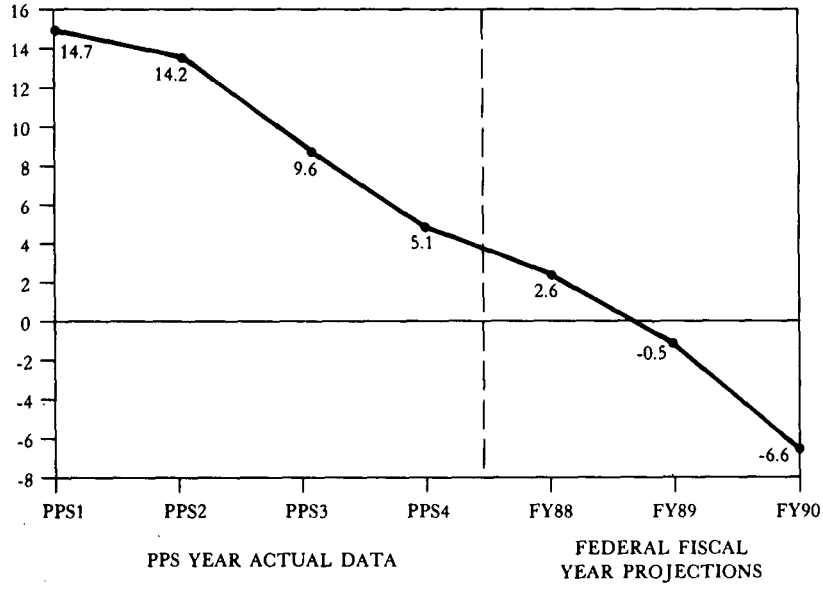
hospitals, not modifications in the way those inadequate payments are distributed.

I. Analysis of the PPS Program Impact

The Medicare system faces a financial crisis, not a crisis in the quality of care. Since the implementation of PPS in 1983, quality of care has shown no measurable deterioration, but hospital operating margins for Medicare patients have declined steadily, dropping from 14.7 percent in 1983 to a predicted -6.6 percent in 1990 (See Figure 1).[9] In other words, hospitals are continuing to provide high-quality

Figure 1

TREND IN CASE-WEIGHTED MEDICARE PPS OPERATING MARGIN (ACTUAL & PROJECTED)



SOURCE: LEWIN/ICF PAYMENT SIMULATION MODEL (1990)

treatment for Medicare patients, but in doing so they are running large and growing deficits. The operating deficits are a systemic

9. More recent simulation results suggest that the forecasts in Figure 1 are too low. The new evidence indicates that margins in PPS Year 7 (FY 1990) will be -2.4%. By PPS Year 9 (FY 1992), if PPS revenue rates of increase rise with the hospital market basket, PPS margins will be around -7%. If the Bush budget were implemented in FY 1991, and its payment rules extended to FY 1992, hospital margins for PPS Year 9 could be as low as -13%. Thus, the downward trend depicted in Figure 1 still holds and is predicted to continue at least through FY 1992.

feature of the Medicare payment system, not an isolated problem confined to a few hospitals or regions. A large and increasing percentage of every type of hospital in virtually every region of the country now experience negative operating margins for their Medicare patients. Moreover, the average deficits have been growing steadily in the past three years and most signs indicate that the trend will continue.

Data from Table 1 indicate that in almost every region of the country, the projected average operating margin for hospitals will be negative in 1990. Only in the mid-Atlantic region are projected operating margins still positive, but even there they have fallen from 16.5 percent in 1984 to an expected 3 percent in 1990. Furthermore, the data show that the projected average operating margins will be negative for rural as well as urban hospitals and proprietary as well as non-proprietary hospitals. The same will be true for teaching as well as non-teaching hospitals. Although major teaching facilities are expected to have a positive operating margin for 1990, the margins will be slight and will be significantly reduced from previous years.

Data from Table 2 reveal that all hospitals, regardless of financial strength, have suffered significant declines in their operating margins since 1984. Between 1984 and 1990, the median operating margin for all hospitals has dropped from 11.15 percent to a projected deficit of -6.63 percent. Over the same period, the 25th percentile margin fell from 2.77 percent to a predicted -21.61 percent, which means that 25 percent of all hospitals fare worse than this margin. Even among the financially strongest hospitals, those above the 75th percentile, the operating margin has fallen from 17.69 percent to a predicted 7.01 percent.[10]

Finally, data from Table 3 indicate a consistent increase in the number of hospitals operating with PPS deficits. Since 1988, when the deficits first became widespread, the proportion of hospitals with negative operating margins has increased from 46.1 percent to a projected 63.2 percent. The problem is most widespread in the New England region where currently an anticipated 78.2 percent of all hospitals are running deficits in their Medicare programs. Even in the West North Central region, where the problem is least severe, more than half of all hospitals are predicted to have negative operating margins.

10. This data mean that the richest 25% of all hospitals are expected to have operating margins above 7.01 percent by 1990.

Table 1

ALL MEDICARE-ELIGIBLE HOSPITALS
MEDICARE ACTUAL AND PROJECTED CASE-WEIGHTED MEAN
MARGINS BY PPS YEAR AND BY HOSPITAL GROUP
AND OPERATING CHARACTERISTIC

GROUP	NUMBER OF HOSPITALS	PPS YEAR 1 MARGIN	PPS YEAR 2 MARGIN	PPS YEAR 3 MARGIN	PPS YEAR 4 MARGIN		PPS YEAR 5 MARGIN	PPS YEAR 6 MARGIN	PPS YEAR 7 MARGIN
ALL HOSPITALS	5078	14.7	14.2	9.6	5.1	:	2.6	-0.5	-6.6
URBAN	2669	16.1	15.4	10.5	6.0	:	2.7	-0.7	-6.9
URBAN BEDS < 100	700	17.2	15.5	10.9	2.8	:	3.1	0.0	-6.2
URBAN BEDS 100-404	1684	15.0	13.9	8.8	5.1	:	1.7	-1.8	-8.0
URBAN BEDS 405-685	248	16.9	18.3	13.3	8.3	:	5.0	1.9	-4.3
URBAN BEDS > 685	37	22.0	20.3	18.0	10.2	:	4.0	1.4	-5.6
RURAL	2409	8.2	8.1	3.8	-0.2	:	0.7	-1.2	-6.8
RURAL BEDS < 100	1938	7.5	5.7	0.2	-1.7	:	1.7	0.7	-4.9
RURAL BEDS 100-169	310	8.4	9.1	8.2	-0.1	:	-0.8	-3.1	-8.6
RURAL BEDS > 170	161	9.5	12.1	6.3	2.1	:	0.0	-3.2	-8.8
TEACHING - ALL	950	17.7	17.9	13.2	8.8	:	4.7	1.4	-4.9
TEACHING - MAJOR	169	21.2	21.7	16.3	13.7	:	11.4	8.3	3.2
TEACHING - MINOR	781	16.6	16.7	11.9	7.3	:	2.9	-0.4	-7.1
NON-TEACHING	4128	12.2	11.1	6.1	1.8	:		0.5	-2.5
NEW ENGLAND	224	12.8	13.2	8.7	3.8	:	-1.1	-4.8	-11.3
MID-ATLANTIC	429	16.5	15.8	12.4	9.8	:	10.9	7.6	3.0
SO. ATLANTIC	713	12.9	13.0	6.1	1.7	:	-1.6	-5.5	-11.3
E. N. CENTRAL	831	14.6	14.1	10.6	5.1	:	0.0	-3.1	-10.7
E. S. CENTRAL	430	10.6	12.1	5.9	3.0	:	4.2	1.5	-4.1
W. N. CENTRAL	730	16.0	16.1	12.8	6.6	:	4.2	1.7	-4.7
W. S. CENTRAL	747	15.5	13.5	8.4	2.9	:	0.8	-2.1	-9.2
MOUNTAIN	339	14.1	18.0	11.7	6.6	:	4.3	2.2	-2.8
PACIFIC	635	15.9	14.1	8.4	5.8	:	2.1	-0.9	-6.6
CHURCH	667	15.6	15.7	10.5	5.5	:		2.3	-0.7
VOLUNTARY	2176	15.1	14.4	10.0	5.8	:		3.0	-0.2
PROPRIETARY	991	13.8	12.5	6.8	2.1	:		0.3	-3.8
GOVERNMENT	1244	13.7	13.4	9.4	4.4	:		3.8	1.3
		ACTUAL CASES					PROJECTED CASES		

Source: Lewin/ICF Payment Simulation Model (1990)

Table 2

PPS MARGIN BY PERCENTILE (PPS-1 TO PPS-7) BY URBAN/RURAL AND TEACHING STATUS

		NUMBER OF HOSPITALS	10TH	25TH	MEDIAN	75TH	90TH
ACTUAL DATA							
PPS-1	TOTAL	5214	-7.81	2.77	11.15	17.69	23.42
	URBAN	2527	1.23	8.04	14.17	20.03	25.69
	RURAL	2687	-14.04	-2.03	7.41	14.69	20.92
	TEACHING	886	3.47	10.45	15.76	21.22	26.70
	NON-TEACHING	4328	-9.34	1.34	10.04	16.69	22.34
PPS-2	TOTAL	5038	-11.57	1.36	10.44	17.97	25.10
	URBAN	2490	-2.99	6.20	13.68	20.51	26.79
	RURAL	2548	-20.32	-3.62	6.40	14.71	22.38
	TEACHING	862	0.77	8.33	15.75	22.77	28.72
	NON-TEACHING	4176	-14.19	-0.07	9.26	16.84	23.86
PPS-3	TOTAL	4977	-20.97	-5.45	5.06	13.43	20.31
	URBAN	2575	-9.50	0.02	8.37	15.70	22.66
	RURAL	2402	-32.05	-11.31	0.39	9.66	17.51
	TEACHING	913	-6.11	3.25	10.90	17.99	24.25
	NON-TEACHING	4064	-24.48	-7.13	3.51	12.03	19.06
PPS-4	TOTAL	5078	-24.04	-8.86	2.07	10.84	18.61
	URBAN	2669	-16.04	-4.86	4.61	12.78	20.14
	RURAL	2409	-32.80	-13.53	-1.41	8.11	15.99
	TEACHING	950	-10.91	-1.47	7.64	15.67	21.67
	NON-TEACHING	4128	-27.02	-10.52	0.68	9.64	17.55
PROJECTED DATA							
PPS-5	TOTAL	5070	-26.27	-11.02	1.79	13.37	24.01
	URBAN	2661	-23.12	-9.62	2.03	13.15	23.57
	RURAL	2409	-29.47	-12.90	1.60	13.57	24.39
	TEACHING	946	-19.16	-8.05	2.75	13.22	23.56
	NON-TEACHING	4124	-28.26	-12.00	1.62	13.43	24.07
PPS-6	TOTAL	5070	-31.27	-14.36	-0.56	11.90	23.05
	URBAN	2661	-29.96	-14.05	-1.30	10.76	22.00
	RURAL	2409	-32.66	-14.82	0.29	13.35	24.50
	TEACHING	946	-24.53	-12.26	-0.84	11.12	21.41
	NON-TEACHING	4124	-32.44	-15.02	-0.45	12.19	23.40
PPS-7	TOTAL	5070	-39.93	-21.61	-6.63	7.01	18.98
	URBAN	2661	-37.52	-21.94	-7.35	5.20	17.60
	RURAL	2409	-42.57	-21.19	-5.36	8.76	20.74
	TEACHING	946	-34.44	-20.14	-7.17	5.20	18.06
	NON-TEACHING	4124	-41.69	-22.03	-6.43	7.41	19.30

Source: Lewin/ICF Payment Simulation Model (1990)

Table 3

PROJECTED PERCENTAGE HOSPITALS WITH NEGATIVE PPS OPERATING MARGINS

	PPS YEAR 5	PPS YEAR 6	PPS YEAR 7
ALL HOSPITALS	46.1%	51.1%	63.2%
URBAN	45.3	53.0	65.7
URBAN BEDS < 100	41.9	46.2	57.0
URBAN BEDS 100-404	47.7	56.6	69.9
URBAN BEDS 405-685	38.5	48.2	63.2
URBAN BEDS > 685	45.9	51.4	56.8
RURAL	46.9	49.0	60.5
RURAL BEDS < 100	45.0	46.5	57.7
RURAL BEDS 100-169	54.7	58.6	73.0
RURAL BEDS > 170	54.0	60.9	71.4
TEACHING - ALL	43.5	52.1	65.7
TEACHING - MAJOR	25.6	31.1	44.5
TEACHING - MINOR	47.3	56.5	70.1
NON-TEACHING	46.6	50.9	62.7
NEW ENDLAND	61.4	68.2	78.2
MID-ATLANTIC	33.7	38.0	53.5
SO. ATLANTIC	55.4	61.3	71.3
E. N. CENTRAL	49.6	56.5	73.5
E. S. CENTRAL	38.5	43.6	53.8
W. N. CENTRAL	37.7	39.7	52.5
W. S. CENTRAL	50.3	55.6	66.8
MOUNTAIN	45.2	48.2	59.8
PACIFIC	44.1	50.1	58.6
CHURCH	44.9	51.7	65.3
VOLUNTARY	45.2	50.1	63.6
PROPRIETARY	48.9	55.3	63.7
GOVERNMENT	45.8	49.3	61.1

Source: Lewin/ICF Payment Simulation Model (1990)

The falling average PPS operating margins are, of course, explained by the fact that PPS case revenues are rising less rapidly than PPS case costs. For instance, during the first six years of PPS, case revenues rose by about 35 percent while PPS case costs rose by about 60 percent.[11] The ultimate cause of the operating deficits, however, lies in Congressional unwillingness to provide adequate funding to the Medicare system. Rather than rising each year to reflect increases in inflation or in hospitals' average costs, reimbursement levels have been determined by political considerations—mainly by Congress' desire to reduce the budget deficit.[12] As a result, annual increases in reimbursement levels have lagged behind increases in hospitals' cost of treating patients.

This severe financial pressure shows no signs of abating. Hospitals, like all private institutions, cannot run financial deficits indefinitely: sooner or later, the financial pressure will force some hospitals to close and others to curtail dramatically their services to the public. The most important question the PPS program raises is how to reverse the trend in hospital finances and to restore positive operating margins.

In our view, the problem is primarily a political one, and therefore cannot be adequately addressed by making adjustments to the PPS regulations. The shortfall in hospital revenues can be explained by the severe budget constraints faced by the Congress due to the continuing federal budget deficit. As long as the deficit persists, and as long as Congress' spending priorities remain as they are, it is unlikely that Congress will be willing to provide an overall level of Medicare support that is adequate to meet the expenses generated by the PPS system.

11. These numbers are internal calculations based on information in the PROPAC Report to Congress (June 1989).

12. *See, e.g.*, The Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, § 9101, 100 Stat. 151 (1985) (codified as amended at 42 U.S.C. 1395ww (Supp. V 1987)). These Amendments froze the 1985 rates in place through April 30, 1986 and then granted only a one-half of one percent increase for the remainder of Federal FY 1986 (i.e., through October 1, 1986). This in turn was followed by the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9302(a), 100 Stat. 1874, 1982 (1986) (codified as amended at 42 U.S.C. § 1395ww (Supp. V 1987)), which granted a mere 1.15% increase for Federal FY 1987. Congress has imposed further limits in the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, Pub. L. No. 100-119, § 107, 1987 U.S.CODE CONG. & ADMIN. NEWS (101 Stat.) 754, 782 (imposing a temporary freeze); Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, §§ 4001-02, 101 Stat. 1330-42, 1330-42-1330-46 (codified as amended at 42 U.S.C. § 1395ww (Supp. V 1987)); and the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6003(a), 103 Stat. 2106, 2140 (1989) (to be codified at 42 U.S.C. § 1395ww).

II. Medicare Payment Systems: Another Perspective

Professor Lave correctly identifies the problem with PPS when she notes that the financial condition of *all* hospitals has deteriorated in recent years. From this finding, she makes three recommendations for change: 1) rates for PPS should be "rebased" using the most current data, 2) the rates should be reformulated to include a 25 percent hospital-specific component, and 3) the payment formula should also include a new index to adjust for non-labor costs across geographical areas.[13] When taken together, Lave's recommendations are actually intended to replace PPS' national standard with a hospital-specific rate of reimbursement. Such a proposal represents a return to cost-based reimbursement that runs counter to the price incentives put in place by PPS. If implemented on a budget-neutral basis, it will act merely as a device to redistribute current payments.

Lave's recommendations can best be understood in the context of the national debate over the implementation of PPS. The 1983 Social Security Amendments that authorized the prospective payment system anticipated that by the end of fiscal year (FY) 1986 there would be a national schedule of PPS/DRG rates.[14] Under the national standard, the only differences between the basic rate payments made by Medicare to various hospitals for a given diagnosis were to be determined by whether the hospital was urban or rural,[15] by the relative wage rate in its locality,[16] and by its status as a teaching hospital.[17] The basic PPS/DRG rates and these adjustment factors were to be revised periodically by the Department of Health and Human Services (DHHS) under the auspices of the Health Care Financing Administration (HCFA) after consultation with the newly created Prospective Payment Assessment Commission (PROPAC).[18]

Prior to the end of FY 1986, however, Congress extended the period of transition to the completely nationalized standard, preserving the temporary partial reimbursement based on actual historical costs.[19] In addition, the standardized "national" portion of

13. Lave, *supra* note 5, at 525-27.

14. *See* Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 152-153 (1983) (codified at 42 U.S.C. § 1395ww(d)(1)(A)(iii) (Supp. V 1987)). The Act anticipated a gradual phase-in of the national standard during which a portion of the hospitals' reimbursement would continue to be based on actual costs.

15. 42 U.S.C. § 1395ww(d)(3)(A) (Supp. V 1987).

16. 42 U.S.C. § 1395ww(d)(3)(E) (Supp. V 1987).

17. 42 U.S.C. § 1395ww(d)(5)(B) (Supp. V 1987).

18. 42 U.S.C. § 1395ww(e)(2) (Supp. V 1987).

19. Pub. L. No. 99-272, § 9102, 100 Stat. 151 (1986)(Supp. V 1987).

the rates used during this period was actually a blend of national rates and separately determined regional PPS/DRG rates, reflecting cost differentials in different parts of the country.[20] It was not until FY 1988 that the system finally phased out the use of historical costs as a portion of reimbursement.[21] The use of regional PPS/DRG rates remains in effect (at a 15 percent weighting factor) for some areas of the country.[22]

The delay in effectuating this transition was in part caused by the heated battles that have raged within the Congress, as well as between the Congress and the Administration since the implementation of the PPS/DRG scheme.[23] The battles have ranged from debates over the appropriateness of various DRG categories to arguments concerning the accuracy of various inflation and adjustment factors. At the center of the political debate has been controversy over whether or not the country should adopt a single national rate for Medicare reimbursement. In our opinion, this controversy has been fueled more by geographical considerations than by ideological fervor. Because of internal disagreement, the timetable for the phase-out of regional rates and hospital-specific costs and the complete adoption of a national PPS/DRG rate was repeatedly delayed and complicated.

This move to a national rate for PPS/DRG determinations is exactly what Lave contests in her article. In her conclusion, she explicitly states, "that the national rate now in effect under PPS does not adequately adjust for the factors that influence the level of costs in specific hospitals. . . ."[24] Her recommendations are thus designed to make the PPS reimbursement scheme "more sensitive to the costs of individual institutions."[25] Lave's first proposal for improving the system is to make the national PPS/DRG reimbursement rates more current. She suggests that data on actual costs per case for individual hospitals should be calculated for the most recent time period (presumably FY 1990) and established as the new basis for future payment schedules.

20. 42 U.S.C. § 1395ww(d)(1)(D) (Supp. V 1987).

21. Social Security Act, 42 U.S.C. § 1395ww (d)(1)(A)(iii) (Supp. V 1987), *amended by* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4002(d), 101 Stat. 1330, 1330-44 (1987).

22. This provision sunsets on September 30, 1990. *Id.*

23. *See* G. ANNAS, S. LAW, R. ROSENBLATT & K. WING, AMERICAN HEALTH LAW, 239-48 (1990).

24. Lave, *supra* note 5, at 528.

25. *Id.*

Perhaps the best way to understand this recommendation is by assessing its effects in a particular example.[26] For instance, in FY 1990 a payment to Memorial Hospital, a non-teaching, "large" urban institution (i.e., located in a Metropolitan Statistical Area [MSA] greater than 1 million in population), for DRG "X" with a weight of 1.0 would be computed in the following manner:

DRG standardized amount in round terms for FY 1990, for "large" urban hospitals:

1. labor component: $2508
2. non-labor component: $888
3. Memorial Hospital's area wage index: 1.100

The labor component of the DRG standardized amount is adjusted for the area wage index: $2508 x 1.1 = $2759. The total adjusted standardized amount is $2759 + $888 = $3647. The total adjusted standardized amount is multiplied by the DRG weighing factor for the particular diagnosis: $3647 x 1.000 = $ 3647. The hospital will receive $3647 as the PPS/DRG payment for the patient.[27]

As Lave notes, the first two factors of this formula (the labor and non-labor components) are currently based on actual cost data from 1981 which have been trended forward to 1984 and increased on an annual basis in the course of Congressional budget determinations. Lave calls for these figures to be recalculated for the most recent fiscal year so that they more accurately reflect a hospital's actual costs.[28] Clearly, she expects that the new figures will be higher than the ones presently reimbursed by Congress because she explains that the new rates will "accommodate" for the increase in hospital costs that has occurred in recent PPS years.

The problem with this recommendation is that Lave does not explicitly state that Congress would have to allow more funds than

26. For the purposes of this hypothetical, the labor component and the non-labor component are taken from the national adjusted standardized rates set by HCFA. *See Medicare Program: Legislative Changes Concerning Payment to Hospitals for Federal Fiscal Year 1990*, 54 Fed. Reg. 53,753 (1989). We assume for this example that Memorial Hospital is located in an area in which the area wage index is 1.1.

27. In addition, the hospital will be reimbursed for other expenditures, such as capital costs, "outliers", the direct costs of medical education, and service to a disproportionate number of low income patients. G. ANNAS, *supra* note 22, at 241, 245-46.

28. It should be noted that the DRG weighting factors and the regional wage indices are updated periodically. 42 U.S.C. § 1395ww (d)(4)(C) (Supp. V 1987) (DRG weighting factors updated at least annually); 42 U.S.C. § 1395 (d)(3)(E) (Supp. V 1987) (regional wage indices updated at least every 36 months).

it has historically provided to Medicare in order to cover these newly calculated costs. In fact, Lave makes no mention whatsoever of infusing more dollars, in the aggregate, into the system. If she does not intend this and instead expects the system to operate on a "budget neutral" basis, with no new dollars to Medicare, then the purpose of her rebasing is a mystery. While it would create a more accurate pool of cost figures, the rebasing effort will be futile if the calculated amounts are then trended forward based on policy determinations, as has been the practice in the past, rather than the inflation rate.

Lave's most significant proposal for change lies in her recommendation to include a hospital-specific component in the PPS rate. She suggests devising a rate that gives 75 percent weight to the national rate and 25 percent weight to the hospital's specific costs.[29] Ostensibly, this new rate would account for "those unmeasured factors that influence hospitals' costs."[30] Lave's lack of specificity about these factors makes it difficult to assess whether or not the system should consider reimbursing them. It may be that some of the factors that cause one hospital to have higher costs than another are precisely those efficiency-related ones within a hospital's control. For example, in another of Lave's articles criticizing the national rate, she states that institutional expenses may vary based on such factors as "regional patterns in length of stay" and "less quantifiable variables including physician and consumer tastes."[31] This kind of variation across the country is exactly what implementation of a national standard aims to reduce. As such, Lave's recommendations to reimburse partly on a hospital's actual historical costs would create the very kinds of incentives for inefficiency that the PPS/DRG system was designed to overcome.

Referring again to the example above, the implementation of Lave's proposal would mean that each hospital would be reimbursed based on a factor that was 75 percent determined by the national average and 25 percent determined by its incurred costs in a recent period. Even partial reimbursement on a hospital-specific basis would result in a highly redistributional payment scheme. Those hospitals that have been successful in holding down costs would be locked into a reduced payment. Conversely, those hospitals whose costs have increased at a rate greater than the year-to-year increases in

29. Lave, *supra* note 5, at 526.

30. *Id.*

31. Lave, *Hospital Reimbursement Under Medicare*, 62 MILBANK MEM. FUND Q. 251, 254 (1984).

payment would be awarded a more generous payment based on their recent operating expenses.

The same dynamic would occur in relation to hospitals differentiated by volume of patients. Those hospitals which have experienced constant or increased inpatient utilization might be penalized, while hospitals whose occupancy has decreased would be rewarded in the future due to their present high costs per case. Such a reversal of financial incentives would send a very ambiguous signal to the hospital industry.

Finally, Lave proposes to increase the number of adjustment factors that PPS figures into its payment formula. Lave notes that PPS currently recognizes geographical differences in labor costs. In the above example, the area wage index factor adjusts the standard labor component to account for regional variations. What Lave presumably calls for is a new non-labor index, covering such costs as food, gas, electricity, and oil, to be calculated for similar geographical regions and figured into the standardized PPS/DRG payment. This adjustment factor would be multiplied by the non-labor component (element #2) in the example.

As with Lave's hospital-specific rate, implementation of this proposal would be explicitly redistributional. For example, if the system adjusted for national variation in gas prices, hospitals in those areas where gas is relatively expensive, such as the industrial Northeast, would be allotted increased federal funds while other hospitals, such as those in Texas, would be penalized simply because they are located in areas where gas is relatively inexpensive.

Lave's proposal is also problematic because it unreasonably assumes that there is not a national market for any item purchased by hospitals. To justify this, Lave should at minimum offer evidence that substantial geographical variation exists for items such as supplies, food, and drugs. Moreover, Lave fails to note that the vast majority of hospitals now belong to huge cooperatives called group purchasing organizations [GPOs] that negotiate national or super-regional contracts for such items from the large corporate vendors who sell them.[32]

Finally, any proposal to increase the number of adjustment factors will necessarily be a proxy. The unhappy history of the wage index adjustor calls into question the efficacy of a proxy. First, the creation of the data base will be suspect, even if it is hospital data. Second,

32. *See* Healthweek, Apr. 4, 1990, at 27, for a list of the fourteen largest hospital alliances.

the weighting of data such as the costs of heating versus air conditioning is problematic. Third, arithmetic errors are highly likely.

All three of Lave's recommendations move the PPS/DRG system to a regime more sensitive to the specific costs of an individual hospital. Her departure from a national standard would be deleterious for the PPS/DRG system because it would reinstitute a highly confounding variable. Furthermore, her proposals do not sufficiently address the overarching financial crises that afflicts *most*, not just some hospitals. At best, what Lave proposes is a stop-gap measure to subsidize those institutions with the worst operating margins. Clearly, a greater level of reimbursement is required across the board.

Conclusion

The Prospective Payment System has been in place for almost seven years, yet it still generates considerable controversy and debate. The lessons of those seven years have been mixed, and in some respects difficult to decipher. Many of the actual consequences, particularly those financial in nature, have been unintended and unanticipated, running counter to the incentives built into PPS. Further, some of the most feared impacts, such as those affecting quality of care, have not resulted from the reforms. With costs continuing to climb in spite of intense financial pressure on hospitals to economize, many critics point to the failure of PPS to control inefficiencies. Others argue that additional factors unrelated to hospital efficiency have contributed to rising costs rather than an inherent defect in PPS. Despite the competing arguments and speculation, PPS has for the most part proved to be a success. The development of PPS as originally created, however, has been thwarted by Congressional manipulation and chronic underfunding of the program.

Although initial concerns about PPS focused on quality of care, as Lave's article points out, surprisingly few of those fears have been realized. The most significant impacts of the reforms have been financial in nature. As we have argued, PPS has succeeded in creating the incentives to reduce costs. In fact, PPS has saved the Medicare Hospital Insurance Trust Fund 18 billion in 1990 dollars in spite of rapidly rising costs.[33] The system, however, has been

33. L. Russell & C. Manning, *The Effect of Prospective Payment on Medicare Expenditures*, 320 NEW ENG. J. MED. 439, 441 (1989).

subjected to political pressures which are gradually undermining the carefully structured program. Responding to constituent special interests, Congress has made significant changes to PPS, particularly in budget reconciliation bills.[34] Because hospitals located within Metropolitan Statistical Areas (MSAs) receive more money on a per-case basis than do providers outside of MSAs, Congress has often chosen to change the boundaries of particular MSAs to provide for increased reimbursement for certain hospitals.[35] Responding to competing budgetary pressures, Congress has not increased PPS revenues commensurate with either the inflation rate or the rising costs of goods and services used by the hospital industry in the delivery of health care. The legislated increase in PPS revenues has fallen far short of the actual increases in costs of care; consequently, the entire hospital industry has shown a significant deficit in their operating margins during the last two years.

This problem is the most critical one facing PPS. Congress is essentially developing a piece-meal health care policy based upon yearly budgetary constraints by consistently creating budget shortfalls for the hospital industry. Hospitals cannot continue to operate at a loss; eventually they will be forced to limit services, close departments or wings, or maybe shut down altogether. As a consequence important policy decisions, such as those concerning access to care and development of new technologies, will be made not by Congress or DHHS, but rather by individual hospitals in response to continuing financial crisis. A rational long-term program for the provision of hospital care under Medicare requires consistent funding which represents, to some extent, the legitimate cost of care. As it now stands, PPS funding simply represents the priority of health care relative to Congress's other budgetary demands.

The answer to the problem at this point does not lie entirely in the redistribution of Congressional outlays, as Professor Lave recommends; rather, the solution lies in across-the-board increases

34. *See, e.g.*, Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061, 1061-1103 (1984) (codified as amended in scattered sections of 42 U.S.C. § 1395 (Supp. V 1987)); Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. No. 99-272, 100 Stat. 151, 151-201 (1986) (codified as amended in scattered sections of 42 U.S.C. § 1395 (Supp. V 1987)); Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. 1874, 1980-2049 (1986) (codified as amended in scattered sections of 42 U.S.C. § 1395 (Supp. V 1987)); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2137-2258 (1989) (to be codified as amended in scattered sections of 42 U.S.C. § 1395).

35. *See, e.g.*, Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4005, 101 Stat. 1330, 1330-47-1330-48 (1987) (codified as amended at 42 U.S.C. § 1395ww (Supp. V 1987)).

in payment to cover, at a minimum, yearly increases in the rate of inflation. Professor Lave's recommendations, without an aggregate increase in funding, provide a solution much like those already adopted by Congress. They will transfer an inadequate amount of money from one hospital to another and complicate the administration of PPS by making the reimbursement formulas more hospital specific. Moreover, her recommendations, unless very carefully designed and implemented, would reward hospitals for their inefficiency and recreate some of the incentives that PPS sought to abolish.