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MEDICARE PROSPECTIVE PAYMENT:
A QUIET REVOLUTION†

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DON E. WINEBERG**

I. INTRODUCTION

The Social Security Amendments of 1983¹ were enacted amidst a vast amount of publicity and media attention. A bipartisan commission² had recommended most of the changes in the Old Age and Survivors Insurance portions of the law which were ultimately enacted;³ the recommended changes had also been the subject of considerable congressional discussion. Almost unnoticed by the news media and apparently lost in the glare of the unrelenting publicity afforded the amendments to the Old Age and Survivors Insurance provisions was a sweeping change in the way the federal government would compensate hospitals for inpatient services.⁴ These provisions were enacted, after minimal hearings, in response to a directive in the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA had directed the Secretary of Health and Human Services to report to Congress by the end of 1982 on a new method of reimbursing hospitals for Medicare on a “prospective basis.”⁵ These changes probably deserved more attention than they received, since they signalled a change of fundamental magnitude in this country’s system of paying for health care costs.

Although the present law provides for payment on a prospective basis for Medicare hospital inpatients only, there is likely to be considerable pressure to ex-

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⁴ 1983 SSA, Title VI, 97 Stat. 149.

⁵ Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248 § 101(a)(3), 96 Stat. 324, 335 (codified as amended in scattered sections of 26 U.S.C., 42 U.S.C) [hereinafter cited as TEFRA]. Payment to hospitals on a “prospective basis” refers to a system of payment under which “rates are set prior to the period during which they apply and where the hospital incurs at least some financial risk” that its costs will be higher than the prospectively determined payment. OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, DIAGNOSIS RELATED GROUPS (DRGs) AND THE MEDICARE PROGRAM: IMPLICATIONS FOR MEDICAL TECHNOLOGY (Technical Memo No. OTA-TM-H-17, 1983) [hereinafter cited as IMPLICATIONS FOR MEDICAL TECHNOLOGY].
pand the system to cover more services such as physician's fees and outpatient services. There is also likely to be pressure for application of prospective payment systems (PPS) to payers for medical services other than Medicare, such as Blue Cross/Blue Shield and private insurers. In short, these changes in Medicare payments may well be a preview of changes in the total system of paying for health care which may become pervasive in the future. Although the news media has lately given some increased attention to these changes, it is unlikely that the general public, or indeed much of the legal community, is aware of the quiet revolution that is now taking place in the health care system.

This Article first discusses the economic background leading to enactment of PPS for Medicare. It then describes the new Medicare system of prospective payment based on classification of illness by diagnosis related groups (DRGs). Next, it discusses the effects which the enactment of PPS is likely to have on the various participants in the health care system. Finally, it makes some predictions about future developments in Medicare and in the total health care system.

II. ECONOMIC BACKGROUND

This portion of the Article first discusses the rapidly rising costs of the total health care system in this country and of the Medicare system in particular. It then enumerates the separate components of this phenomenon and explores the reasons for the existence of these components.

A. The High Cost of Health Care

If there is one thing that everyone even remotely familiar with the health care system in the United States agrees on, it is that health care is extremely expensive and becoming more so. Costs of health care have risen rapidly in the past several years and are projected to continue to do so.

1. National Health Care Expenditures

In 1950, national health care expenditures totaled $12.7 billion and amounted to $82 per capita. Health care expenditures constituted 4.4 percent of the gross national product. In 1970, total expenditures were $74.7 billion, or $358 per capita, which constituted 7.5 percent of the gross national product. In 1982, total national health care expenditures were $322.4 billion amounting to $1,365 per capita and 10.5 percent of the gross national product. Health care expenditures are projected

* See e.g., Stavro, Omnicare's Aches and Pains, FORBES, June 18, 1984, at 74-75; Teitelman, Taking the Cure, FORBES, June 4, 1984, at 82-91; Phillips, Medicare's New Limits on Hospital Payments Force Wide Cost Cuts, WALL ST. J., May 2, 1984, at 1, col. 6.
to rise further by 1990 to $690.4 billion, amounting to $2,724 per capita and constituting 12.3 percent of the gross national product. 7

Costs of hospital care have been a significant part of this increase in total health care costs. Expense per inpatient day rose from $41 per day in 1965 to $96 in 1972 and to $348 in 1982. These costs are projected to rise further to $432 in 1984; $584 in 1987; and $771 in 1990. 8 In aggregate amounts, total expenditures for hospital care in 1950 were $3.9 billion; in 1965 they were $13.9 billion; in 1972 they were $34.9 billion; and in 1982 they were $135.5 billion. Total expenditures are projected to rise further to $349.4 billion in 1984; $471.3 billion in 1987; and $619 billion in 1990. 9

Total national health expenditures increased at an annual rate of 7 to 8 percent in the 1950s, increasing to approximately 12 percent in the late 1960s, and to around 13 percent in the late 1970s. The percentage change peaked in the period of 1979 to 1982 at 14.5 percent. The Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) projects that the rate of increase will decrease to 9 to 10 percent for the period of 1984 to 1990. 10 Expenditures for hospital care follow a similar pattern, peaking at an annual percentage increase of 14.9 percent in the period of 1979 to 1982 and are projected to level off at 9 to 10 percent in the period of 1984 to 1990. 11 Health care expenditures have been increasing rapidly; in fact, they have been increasing at a substantially greater rate than the general rate of inflation. 12

While expenditures for health care have been increasing rapidly in the United States, this country is not alone in that regard. Rising health care costs have occurred in other industrialized countries as well. A study of the rising costs of health care among nine industrialized countries for 1969 to 1976 showed that all nine countries experienced increases in national health expenditures as a percentage of gross national product. 13 The United States was high on the list, but it was not highest. The Federal Republic of Germany had health care expenditures amounting to nearly 10 percent of gross national product for 1975, the last year for which data was available in the study. 14

Increases in percentage of gross national product spent on health care appear to be related to increases in national income, regardless of whether the health care

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7 Freeland & Schendler, Health Spending in the 1980's; Integration of Clinical Practice Patterns with Management, HEALTH CARE FINANCING REV., Spring 1984, at 1, 7.
8 Id. at 32.
9 Id. at 52.
10 Id. at 53.
11 Id.
12 See generally id. at 9.
14 Freeland & Schendler, supra note 7, at 14.
It appears that people in industrialized nations demand more health care as personal income rises, and all of the major nations' systems have responded to that demand by increasing the percentage of the gross national product spent on health care.

The problem is thus not unique to the United States, although a reading of the extant literature and news media coverage on the subject of health care expenditures would not make that readily apparent. Discussion in this country has generally concentrated on the increases in the total health care bill in the United States with little or no allusion to the fact that this is a phenomenon which is common to many countries. This is not to say that it is not a serious problem in this country, only that the siege mentality which is sometimes evident in discussions of the costs of the health care system may be overdrawn when the United States experience is compared with that of other industrialized nations.

2. Medicare Expenditures

Federal expenditures for Medicare have increased even more drastically than have expenditures for the rest of the health care system. In 1967, the first full year after the initial adoption of the Medicare system,16 total federal expenditures for Medicare were $4.5 billion. By 1975 the figure had risen to $15.6 billion and by 1982 to $50.9 billion. These amounts are projected to increase to $66.5 billion in 1984, $94.7 billion in 1987 and $131.5 billion in 1990.17 Medicare outlays increased at an average annual rate of 17 percent between 1967 and 1982, while the average annual increase in total national health expenditures was 13 percent.18 The projected Medicare increase for 1982 is 12 to 13 percent while gross national product is projected to rise at an annual rate of about 8 percent.19 Medicare costs are, therefore, projected to rise at a faster rate than the gross national product, thereby increasing the proportionate share of national wealth devoted to Medicare, even taking into account the recent legislation designed to contain costs.

The reasons for the high rate of increase for Medicare expenditures are partly attributable to the fact that hospital and physician services are a very high proportion of Medicare expense.20 The costs of these services are expected to rise more quickly than the costs of other kinds of services in the general economy. Moreover, the aged population eligible for Medicare is rising more rapidly than the rest of

15 Id.; Klein, supra note 13, at 188-89.
17 Freeland & Schendler, supra note 7, at 11.
18 Id. at 10.
19 Id.
20 See supra text accompanying notes 98-186.
21 In 1982, hospital care accounted for 74.4% of Medicare outlays and physician expense for 22.4%. Freeland & Schendler, supra note 7, at 11.
the population.\textsuperscript{22} For the period of 1982 to 1990, the population under age 65 is projected to increase at a rate of about .7 percent per year while the 65-and-over population is projected to increase at 2.8 percent.\textsuperscript{23} Medicare, therefore, has and will probably continue to lead the inflation in national health care costs.

B. Causes of Health Care Inflation

No one knows precisely what has caused these large increases in the cost of health care. Nevertheless, certain factors, having to do with the nature of health care generally and the United States health care system specifically, can be identified. One way to conceptualize these factors is to consider them as consisting of two distinct aspects. The first aspect consists of the components of the rise in total health care costs. These include inflation in the general economy, increased intensity of health care services and price inflation specific to the health care sector. The second aspect consists of the reasons why these components are present.\textsuperscript{24}

1. Components of Health Care Cost Increases

The component aspect is relatively noncontroversial. Several components of the increase can be readily identified. First, inflation in the general economy is a major factor in rises in health care cost. The persistent general inflation of the past several years, only recently abated, has been responsible for about 58 percent of the growth in total national health expenditures and 52 percent of the growth in expenditures for community hospital inpatient care during the period of 1972 to 1982.\textsuperscript{25} In addition, population growth has accounted for a small but steady increase in expenditures. Population growth accounted for about 8 percent of the growth in national personal health care expenditures and about 7 percent of the growth in expenditures for community hospital inpatient care during the period of 1972 to 1982.\textsuperscript{26} These factors are, of course, controllable, if at all, only in the context of the general economy.

In addition to these general factors, however, there are factors specific to the health care sector. On one side are factors categorized under the rubric of increased

\textsuperscript{22} Id. at 10; Ginsburg & Moon, \textit{An Introduction to the Medicare Financing Problem}, 4 as printed in \textit{Staff of House Comm. on Ways and Means}, 98th Cong., 2d Sess., \textit{Proceedings of the Conference on the Future of Medicare}, WMCP No. 23 (Comm. Print 1984) [hereinafter cited as \textit{Ways and Means Conference}].

\textsuperscript{23} Freeland & Schendler, \textit{supra} note 7, at 51 (Table 3). The increase in elderly population is due not only to the fact that proportionately more persons are reaching age 65 but also because of a decline in mortality rates among the over-65 population. See \textit{National Center For Health Statistics, Public Health Service, U.S. Dept. of Health and Human Services, Health, United States, 1982} at 34-35 (DHHS Pub. No. (PHS) 83-1232) (1982) [hereinafter cited as \textit{Health-1982}].

\textsuperscript{24} See generally, M. S. Feldstein, \textit{The Rising Cost of Hospital Care} (1971).

\textsuperscript{25} Freeland & Schendler, \textit{supra} note 7, at 18-19.
services. These include increases in patient visits to physicians and number of patient
days in hospitals. They also include increases in intensity of health care services,
such as improvements in the nature of services and supplies provided patients.27
Typical examples are improved diagnostic procedures such as CAT (computerized-
axial tomography) scans and improved therapies such as new drugs. Furthermore,
a pure inflation factor for medical care exists over and above the general rate of
inflation. Prices for health care, unaccounted for by real increases in volume and
intensity of services, have risen by an amount in excess of the general rate of infla-
tion. This health care price inflation factor accounted for about 10 percent of the
increase in national personal health care costs and about 13 percent of the increase
in expenditures for community hospital inpatient care in the period of 1972 to 1982.28
In 1981 the Consumer Price Index for all items (1967 = 100) was 272.3 while the
price index for all items of medical care was 295.1.29

2. Why the Components are Present

While there is little difference of opinion with respect to identification of the
components of health care cost increases,30 there is less agreement with respect to
the underlying reasons why these components have come to be present. Nevertheless,
several features of the health care system can be identified as contributing to the
situation, even if their exact interrelationships are incapable of determination.

A hypothetical case can best illustrate these features. Pat Patient works for
Paternal Corporation which, for the benefit of its employees, pays the full premium
on a collectively bargained group health care insurance policy issued by Green Check
Health Plan. The policy pays all the patients' medical costs after a $100 deductible.
Paternal Corporation is quite willing to pay for the policy, since it can deduct the
amount of the premiums for federal income tax purposes as compensation expense,31
and the payment is not includable in the taxable gross income of its employees on
behalf of whom the premiums are paid.32 This allows Paternal to provide its
employees with this benefit on a tax free basis. Furthermore, any benefits paid
out under the policy are tax free to the employees to the extent these benefits are
reimbursement for medical expenses.33

Pat becomes ill one day with a sore throat, coughing, sneezing, and slight
dizziness. He is unsure whether to visit Doctor Cautious, his personal physician,
but decides to do so, since he has already used up his deductible for the year and the visit will not cost him any money. Doctor Cautious examines Pat and thinks he has an upper respiratory infection which will go away of its own accord. However, he also thinks there is a small chance it might be more serious. Doctor Cautious does not have the equipment in his office to perform the kind of diagnostic tests he would like to do, but they are available at Techtige Hospital which has just acquired the necessary equipment in response to requests from its prized medical staff.

Doctor Cautious suggests that Pat be admitted to Techtige Hospital for treatment of his condition and further testing. Pat is not enthusiastic about the idea, but he believes that “doctor knows best.” He knows that the company-paid health plan will pay the tab and that his sick leave will pay for his days missed from work. Furthermore, he values his health highly; his family depends on him being fit; and he needs a rest.

Doctor Cautious knows hospitalization will work no financial hardship on Pat, so he does not worry about the cost. He also prides himself on thoroughness and quality of care, and he truly believes there is a chance, albeit small, that Pat’s condition may be more serious. Besides, he gets paid on a fee-for-service basis and the more services he performs the more he gets paid. He is also aware of the fact that Pat can be a bit contrary at times, even to the point of instituting a lawsuit when he is upset with someone. He wants to be absolutely certain he has taken all possible steps in treating Pat adequately.

Techtige’s administrators are happy to admit Pat. They know that Green Check Health Plan pays well and promptly under an arrangement to cover Techtige’s costs of caring for Green Check’s enrollees. They are also happy to accommodate Doctor Cautious’ wish to admit Pat, since Doctor Cautious is a valuable member of the hospital’s medical staff who provides a steady supply of well-insured patients.

Techtige is under pressure to keep Doctor Cautious, whose services it values, on its staff. One way to compete for physician staff is to provide the best quality in technological and other facilities. Physicians derive prestige and status from being associated with modern, technologically advanced hospitals. Techtige, in addition to its revenues from Green Check, has considerable income from Medicare and Medicaid which until recently have reimbursed Techtige on the basis of the reasonable cost of providing its services. This, of course, meant that whatever Techtige spent it could ultimately expect to recoup, so the cost of new equipment has never been an overriding concern. Techtige has a substantial incentive to satisfy the desires of Doctor Cautious and, under a system of reimbursement by charge or reasonable cost, there is little countervailing incentive.

Doctor Cautious orders a series of diagnostic tests along with a regimen of drug therapy for Pat. The test results come out negative. After four days, Pat’s condition begins to clear up. Doctor Cautious arranges Pat’s discharge and writes him a drug prescription (covered by the Green Check plan) which Pat fills at the
Techtige pharmacy. Pat goes back to work healthy and happy, and everyone gets paid.

Is there really a free lunch and are all the players winners? The players in this system are patients (Pat) who receive health care services, providers—physicians (Doctor Cautious), hospitals (Techtige), and others who provide health care, and third party payers who compensate the providers—insurance companies (Green Check), Blue Cross/Blue Shield, and Medicare-Medicaid. In addition, there are suppliers to the providers, for example drug and medical equipment companies, and the real payers—employers, purchasers of health insurance, and taxpayers—who pay the third party payers. These players are affected by certain features of the health care system which for analytical purposes can be conceived as being either intrinsic to the nature of health care or as extrinsic to it.4

a. Features Intrinsic to Health Care. Certain features of the system seem to be derived from the nature of health care itself, at least as it is conceived in Western industrial cultures. Psychological and cultural attitudes of patients toward health care, the patient-doctor relationship, and physician-hospital relationships cause health care to be a good which does not lend itself to classical economic analysis. For example, studies have indicated that, contrary to what one might expect, increases in the number of physicians in an area do not necessarily bring about a reduction in physicians’ fees.3

Most people do not think of health care services in the same way as they think of other goods. Good health is necessary for a good life. Without it other things lose their capacity to give satisfaction.6 This leads to much greater willingness to make expenditures for health care. Furthermore, emotional factors related to illness, such as pain and guilt and the general subjectivity of the concept of health, lead many to be willing to spend more for health care than a strictly economic cost-benefit analysis would justify.7 As income rises, people in Western cultures are willing to put greater proportions of their discretionary income into health care. This phenomenon has been observed to some degree in all advanced industrialized countries.38

Finally, the relationship between patients and providers of medical services is normally considerably different than that between a usual customer and a supplier.

4 This dichotomy is not absolute and there is overlap between the features termed intrinsic and extrinsic. Nevertheless, the distinction is useful in analyzing the features contributing to increasing health care costs.

3 See S.R. Eastaugh, Medical Economics and Health Finances 29 (1981); Comment, Reagan Administration Health Legislation: The Emergence of a Hidden Agenda, 20 Harv. J. on Legis. 575, 578 (1983). There have been alternative explanations advanced for this phenomenon. The first contends that the increased supply of physicians simply meets health needs which were previously unmet. The second argues that physicians set income goals and then generate revenue to meet those goals. Eastaugh, supra, at 29-30.

37 Id.

38 See Klein, supra note 13, at 188.
in the general economy. For example, the physician and patient are in a relationship of superior to subordinate. The patient comes to a physician, often in pain or discomfort, and asks for help. At that point the patient is in a poor position to bargain about cost or medical procedures. The physician, on the other hand, is a professional person, normally a respected and prominent member of the community—an authority figure. It takes more than a little chutzpah for a patient to bargain about price or much of anything else in such a context. Consequently, Pat is typical in his reluctance to question Doctor Cautious about his medical decisions.

The physician, therefore, possesses and wields considerable authority by virtue of his position. Although physician reimbursement amounts to only about 20 percent of total health care expenditures, physicians are responsible for and control about 70 percent of such expenditures. In 1980 the average clinician generated approximately $500,000 in total health care revenue. Through their control over hospital admission and patient care decisions, physicians are the gatekeepers of the health care system. Physicians need to and largely do control decisions about patient hospital admission, diagnostic tests, course of therapy, and patient discharge. Neither the patient nor the hospital is in a position to exercise much control over these decisions. In this game Doctor Cautious calls the plays; Pat and Techtige carry them out.

The physician, through his special position as healer, in effect, controls both supply and demand for medical services. He acts as an agent for the patient in prescribing and seeking out the services of the hospital (along with his own services), and he acts as agent of the hospital in providing the hospital’s services (as well as his own services). Up to now hospitals have had little control over these decisions and little incentive to attempt to establish such control. On the one hand, hospitals are in competition for doctors who are the source of their admissions, and consequently have wanted to keep them happy. On the other hand, the system

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39 Illustrative of this is that in normal parlance one seldom speaks of “doctor’s advice,” but rather of “doctor’s orders.”
46 Redisch, *supra* note 44, at 220.
47 Boubjerg, *supra* note 40, at 982.
of reimbursement to hospitals has not provided an incentive for them to exert pressure on physicians to be cost-conscious in their decisions.\footnote{See supra text accompanying notes 98-186.}

Hence, Techtige is willing, even anxious, to placate Doctor Cautious’ desires for the most advanced technological equipment and services. Techtige depends on Doctor Cautious for a steady supply of patients. Moreover, it has little say in whether to admit Pat. That is a decision which must be left to Doctor Cautious who, because of his professionalism and adherence to the ethical standards of the medical profession, and also because of the possibility of a malpractice suit if something goes wrong, wants to be certain that the care Pat receives is of the highest quality. The net effect has been that hospitals have ridden the coattails of the special relationship of patient and physician on an upward spiral of health care cost increases.\footnote{In fact, the cost of hospital care has been rising at a faster rate than physician fees. As shown in the following table, in every period since 1959 the consumer price index for a hospital room has increased more rapidly than the consumer price index for physician fees:}

b. \textit{Features Extrinsic to Health Care}. The second aspect of health care cost increases involves factors that are not intrinsic to the nature of health care, but rather extrinsic economic factors that are part of the system of delivery and payment for health care that is unique to the United States. Because of these factors there have been few compelling economic incentives for any of the participants in the system to contain cost increases.

i. \textit{The Private Third Party Payer System}. By far the largest part of the costs of physician and hospital services is paid for by third party payers. In 1982 third party payers accounted for about 88 percent of expenditures for hospital care,\footnote{Gibson, Waldo & Levit, supra note 41, at 9.} and about 63 percent of expenditures for physician services.\footnote{Id. at 10.} The typical patient,
Pat, therefore pays directly only a fraction of hospital and doctor bills and has little incentive to worry about the cost of a prescribed medical procedure. Moreover, since many employers foot the entire bill for the cost of health insurance premiums or at least a sizeable portion, employees do not experience directly the effect of high medical costs on the premiums charged by the health insurance plan. Pat is unlikely even to know how much Paternal is paying Green Check for his health benefits.

The private third party payer system has largely been a post World War II phenomenon. Although Blue Cross/Blue Shield plans had begun to emerge as a mode of payment for health care costs as early as 1929, prior to World War II third party payers had not assumed a predominant role in the health care payment system. A significant enrollment increase in group hospital plans from about ten million to twenty-six million subscribers occurred during World War II as a result of a decision by the War Labor Board that fringe benefits up to 5 percent of wages would not be inflationary. As a result, employers sought to sidestep wartime wage controls by offering health insurance as a fringe benefit. After the war, labor unions made a decision to make welfare programs, including health insurance, a high priority in their bargaining even though at that time it was uncertain whether these were legally subject to collective bargaining. Then in 1949 the Supreme Court granted certiorari on other issues to review a circuit court decision holding, inter alia, that employee welfare plans were subject to collective bargaining, but did not grant certiorari to review the welfare plan issue. This was interpreted by employers as approval of the circuit court’s welfare plan holding.

This development, along with a provision in the Internal Revenue Code making employer contributions to health insurance plans nontaxable to the employee, although still deductible by the employer, brought on a movement by employers to adopt such plans. Employers, employees, and unions therefore have created,
in response to powerful incentives created by federal laws, a system of private quasi-national health insurance financed in large part by exclusion and deduction provisions in the federal income tax laws.

Although individual features of these arrangements vary,² they all have the common characteristic that a third party, not the patient, pays the provider of health care services. Under this arrangement, neither Doctor Cautious, Techtige Hospital, nor Pat Patient has a direct economic stake commensurate with the actual costs of providing health care. The economic burden falls on Paternal Corporation, the employer, who pays the Green Check health plan premiums and the federal government which foregoes tax revenues with respect to those premium payments.

ii. The Medicare Third Party Payment System. Since 1965, the third party payment system has been greatly expanded by increases in public sector spending. Public sector spending on personal health care has increased from $7.7 billion in 1965 to $115.7 billion in 1982.³ It is projected to rise to $141.5 billion in 1984 and $255.0 billion by 1990.⁴ On a percentage basis, the public sector accounted for 21.6 percent of personal health care expenditures in 1965 and 40.3 percent in 1982.⁵ It is expected to remain at about that level for the rest of the decade.⁶ With this expansion, caused in large part by Medicare, has come an exaggeration of the perverse economic incentives of the third party payer system. Pat Patient knows that when his employment days are over Medicare will be available to replace his employee health insurance plan. He also knows his aged parents are covered by Medicare, and he wants them to have the best of treatment in their old age. Moreover, Medicare Part B pays Doctor Cautious on the basis of customary or reasonable charges.⁷ Doctor Cautious is able to charge his Medicare patients the same employee a dollar cash plus enough additional cash to pay the employee’s income tax on the payment to provide that employee with a dollar’s worth of economic benefit after taxes. The employer, therefore, can provide the employee with a dollar’s worth of economic benefit through a health plan much more cheaply than the employer could provide a dollar’s worth of cash benefit.

³² For example, some employers purchase group health insurance, some finance their own self-insured plans, and others contribute to union welfare funds such as that of the United Mine Workers. See generally id.

³³ Gibson, Waldo & Levit, supra note 41, at 8.
³⁴ Freeland & Schendler, supra note 7, at 55-56.
³⁵ Gibson, Waldo & Levit, supra note 41, at 8.
³⁶ Freeland & Schendler, supra note 7, at 55-56.
customary price for similar services in his area and be reimbursed for this amount, less a deductible paid by the patient. 68

Until recently, Medicare paid hospitals under Part A on the basis of "reasonable cost." 69 Whatever Techtige spent, as long as it was "reasonable," was reimbursed by Medicare. This left little incentive to restrain costs. Medicare, therefore, simply exaggerated the tendencies of the private system to inflate costs.

When Medicare was enacted in 1965, little emphasis was placed on restraining costs. Its main initial goal was to increase access to health care for the elderly. 70 The American Medical Association had opposed enactment of Medicare, 71 and there was a willingness to placate providers by assuring adequacy of Medicare payments. 72 Therefore, a second goal was to maintain good relations between the program and health care providers. 73 This was accomplished through a variety of policies including payment of 2 percent more than costs, payment of accelerated depreciation, and prompt payment. 74 Physician charges were considered reasonable at virtually any level charged. 75 Moreover, the traditional medical care models of fee-for-service and free choice of provider were built into the program. 76 In short, Medicare was a generous replica of the private third party payer system. Far from being a bane to the health care industry, it at least started out as a bonanza.

Unfortunately, the bonanza was short-lived because the program was underfinanced from the beginning. 77 In 1967 the Trustees of the Federal Hospital Insurance Trust Fund estimated that costs of the program were .28 percent of payroll higher for 1965 than originally estimated. 78 Congress responded initially by raising payroll taxes in 1967. 79 These increases were inadequate, and in the 1972 Social Security Act Amendments, Congress, in response to predictions of bankruptcy, enacted further payroll tax increases. 80 At the same time, Congress expanded coverage to include the disabled and persons with end-stage renal disease, the only major expan-
sion in the program’s history. In this same legislation Congress also took the first major step toward cost containment by enacting the so-called section 223 cost limits. This legislation authorized the Secretary of Health, Education, and Welfare (now HHS) to set limits on costs that are reimbursed under Medicare. Under this authority, HHS has established limits for reimbursement annually since 1974. In addition, Congress took another step toward cost control at this time by enacting a Professional Standards Review Organization program designed to control costs by monitoring volume of service.

These efforts to control costs were not successful in achieving the goal of putting Medicare on a sound financial basis. Every report by the Trustees of the Hospital Insurance Trust Fund has concluded that the fund is being exhausted on an actuarial basis. The 1983 report by the Trustees predicted, using intermediate economic assumptions which took into account savings from the newly enacted prospective payment system, that the Fund would be exhausted by 1990 or 1991. Even under the most optimistic economic assumptions, the Trustees predict the Fund will be depleted in 1996. Under the most pessimistic economic assumptions, the Trustees predict the Fund will be depleted in 1988. The Supplementary Insurance Trust Fund, however, will not be depleted, since it is financed largely from general federal revenues which supplement enrollees’ premiums. Increases in Part B expenditures will, however, require larger federal contributions to the Fund and larger premium payments.

The same factors contributing to the general increase in health care expenditures have caused expenditures from the Medicare hospital insurance fund to escalate at a pace outstripping the ability of the fund, under present payroll tax rates, to cover payment over even the intermediate haul. Expenditures under Part A for inpatient hospitalization increased at an average annual rate of about 20 percent from 1972 to 1982. Expenditures for Part B physicians’ services have grown at a similar rate. For every future year the Trustees of the Hospital Insurance Trust

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81 Id. at § 299I(c)(3), 86 Stat. 1463-64.
82 Id. at § 223, 86 Stat. 1393.
83 Id.
84 See Lundy, supra note 30, at CRS-4 to CRS-5.
86 Wolkstein, supra note 70, at 15.
88 Id.
Fund predict that expenditures will exceed revenue, under present tax rates.\textsuperscript{92}

It was in an atmosphere of impending disaster, therefore, that Congress, in TEFRA, enacted new, more stringent cost controls and directed the Secretary of HHS to devise a new system of hospital reimbursement based on prospective rates.\textsuperscript{93}

In doing so, Congress zeroed in on only one factor of the many contributing to Medicare inpatient hospital care increases—the system of retrospective hospital cost reimbursement. Some of the reasons for the increase in Medicare costs are not in any realistic sense controllable. For example, the proportion of the population over sixty-five is increasing; elderly life expectancy is lengthening,\textsuperscript{94} and a degree of new, more expensive technological innovation is inevitable. Other cost factors, however, are at least theoretically controllable. The one factor about which almost everyone connected with the health care system agreed, in the period following enactment of the TEFRA cost limits, was the system of payment for Medicare.

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\textit{Wide Physician Incentives 108, as printed in Ways and Means Conference, supra note 22; Staff of Senate Special Committee on Aging, 98th Cong., 2d Sess., Medicare; Paying the Physician—History, Issues and Options 5 (Comm. Print 1984) [hereinafter cited as Paying the Physician].}

\textsuperscript{92} The following table from the 1983 Hospital Trustees Report contains their predictions of the shortfall expressed as a percentage of payroll:

<table>
<thead>
<tr>
<th>Calendar Year</th>
<th>Expenditures Under the Program</th>
<th>Tax Rate Scheduled in the Law</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>2.77%</td>
<td>2.60%</td>
<td>-0.17%</td>
</tr>
<tr>
<td>1985</td>
<td>2.88</td>
<td>2.70</td>
<td>-0.18</td>
</tr>
<tr>
<td>1990</td>
<td>3.46</td>
<td>2.90</td>
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</tr>
<tr>
<td>1995</td>
<td>4.05</td>
<td>2.90</td>
<td>-1.15</td>
</tr>
<tr>
<td>2000</td>
<td>4.58</td>
<td>2.90</td>
<td>-1.68</td>
</tr>
<tr>
<td>2005</td>
<td>5.13</td>
<td>2.90</td>
<td>-2.23</td>
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<tr>
<td>2010</td>
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<tr>
<td>2020</td>
<td>7.00</td>
<td>2.90</td>
<td>-4.10</td>
</tr>
<tr>
<td>2025</td>
<td>7.89</td>
<td>2.90</td>
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</tr>
<tr>
<td>2055</td>
<td>9.37</td>
<td>2.90</td>
<td>-6.47</td>
</tr>
</tbody>
</table>

\textit{Hospital Trustees Report, supra note 87, at 69, Table B1.}

\textsuperscript{93} TEFRA § 101, 96 Stat. 324, 331-336.

\textsuperscript{94} Freeland & Schendler, supra note 7, at 50. When Medicare began in 1966, 9.4% of the population was 65 years of age or older. By 1982 the Census Bureau estimated that 11.6% were 65 or older.

Gibson, Waldo & Levit, supra note 41, at 25.
hospital inpatient costs. This system, termed "retrospective cost reimbursement," paid hospitals for services to Medicare patients on the basis of reimbursement of "reasonable costs." Medicare in effect agreed to underwrite that portion of each participating hospital's costs determined under standard accounting procedures to be attributable to Medicare inpatients.

This system provided little incentive for a hospital to control costs since the more it spent, the more revenue it would receive from Medicare. High cost operations were in effect rewarded for being high cost. Low cost operations were in effect penalized for having lower costs. The system of prospective payment, using illness classifications based on DRGs, which was proposed by the administration in late 1982 and ultimately enacted in the Social Security Amendments of 1983, attempts to reverse these incentives by rewarding low cost providers and penalizing high cost providers. The following parts of this article describe this system, discuss the probable effects of its enactment, and venture some predictions about future developments in this country's health care system.

III. DESCRIPTION OF PROSPECTIVE PAYMENT SYSTEM

Although Congress enacted the Prospective Payment System (PPS) as a reaction to rapid inflation in the health care industry, it was equally concerned with maintaining quality health care. Detailed description of PPS reveals that each aspect of the system has been carefully crafted to encourage economically efficient behavior without impairing the quality of care.

A. History

The history of PPS begins with demonstration projects funded pursuant to section 222 of the Social Security Amendments of 1972. These projects were mandated to develop methods of determining and paying health care costs on a prospective basis. Foremost among these experiments was the New Jersey project limiting reimbursement for all hospital inpatient costs to prospectively determined

95 See PPS Hearings, Part 2, supra note 44; Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means, 98th Cong., 1st Sess. (1983) [hereinafter cited as Ways and Means Hearings].
96 U.S. DEP'T OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE (1982) [hereinafter cited as PPS REPORT].
97 Hereinafter the prospective payment aspect of the system will be referred to as PPS. The diagnosis related group aspect will be referred to as DRG. The combined system will be referred to as PPS/DRG.
98 1983 SSA, Title VI, 97 Stat. 149; see generally PPS Report.
99 See generally PPS Report, supra note 98.
rates. The prospective rates limited hospital payments to specific amounts based on a patient’s diagnosis at discharge. The classification of diagnoses was a system of “Diagnosis Related Groups” (DRGs) developed at Yale University.

The New Jersey experiment was thought to be so successful that Congress mandated the Secretary of HHS to develop a legislative proposal for a prospective payment system for Medicare. The Secretary developed and reported to Congress on a proposed prospective payment plan in 1983. After subsequent hearings on the proposal, Congress enacted a Prospective Payment System (PPS) in Title VI of the Social Security Amendments of 1983. As with any regulatory mechanism, the operational parameters of PPS are most completely described in rules and regulations. The Department of Health and Human Services published interim rules on September 1, 1983. Final rules were published on January 3, 1984.

The PPS enacted by Congress has a narrower scope than the experimental New Jersey program. PPS only applies to Medicare Part A hospital expenses and does not apply to Medicare Part B physician services or to psychiatric, rehabilitation, children’s, or long-term care hospitals. Other hospitals are exempt if they are participating in a qualified demonstration project. Under current law, Part B physician services will continue to be paid, as before, at the same “reasonable cost” rates. Other medical costs such as capital and medical education expenses are treated separately and are discussed herein.

B. Services and Providers Included in PPS

PPS changes Medicare reimbursement for Part A hospital services from a retrospective, per diem rate to a prospectively determined per discharge rate. The basis of this revision is the Diagnosis Related Group. DRGs are a detailed way of classifying cases. A DRG has been defined as “a class of patients defined by medical characteristics, such as primary diagnosis, secondary diagnosis, age, and

102 See generally J. FINLEY, supra note 101.
103 Id. at 39.
104 Id. at 1.
105 TEFRA at § 101(b)(3), 86 Stat. 333.
106 PPS Report, supra note 98.
108 1983 SSA Title VI, 97 Stat. 149.
111 1983 SSA § 601(e), 97 Stat. 152.
112 1983 SSA § 601(c), 97 Stat. 150.
113 See generally 1983 SSA § 601(e), 97 Stat. 152.
surgical procedure; representing a consistent amount of resource consumption as measured by some unit (patient days, dollars, etc.)." ¹¹⁴ In effect, DRGs are an empirically derived series of categories of diagnosis. Examples of DRGs are "renal failure, no dialysis prescribed" (DRG No. 316) and "renal failure, dialysis prescribed" (DRG No. 317).¹¹⁵ The common factor among patients with the same DRG at different hospitals is theoretically that treatment of individuals with the same DRG would tend to consume similar amounts of resources. Currently, there are 468 DRGs plus two DRGs that apply when the hospital makes coding errors.¹¹⁶

Under PPS, HHS has developed a fixed weight factor for each DRG.¹¹⁷ This factor limits the amount Medicare will pay for each patient discharged with the same DRG. This constancy permits hospitals to know in advance exactly how much money the hospital will receive for each patient discharged with a particular DRG.

Prospectively determined reimbursement amounts are the heart of the prospective payment system. Since Medicare will pay the hospital only the predetermined DRG rate for each patient’s diagnosis, if a hospital’s actual cost in treating a patient is less than the DRG rate, the hospital may pocket the difference; if the hospital’s actual cost is greater than the DRG rate, the hospital must bear the loss,¹¹⁸ since it is not entitled to bill the patient personally for the difference. It is the risk of loss that creates incentives for efficiency which were heretofore lacking. PPS thus changes the way hospitals are paid from a per-day basis, which encouraged resource utilization, to a prospectively determined fee per case, which places the hospital at risk of loss for any given patient and thereby stimulates efficient economic behavior.

This part of the Article will first analyze how the payment rates are calculated and will subsequently describe the procedures the hospital must go through to obtain payment. An explanation of these procedures will reveal that much of the informal criticism leveled at PPS is unfounded.

When the system is fully implemented in 1987, the amount of a hospital’s payment for a given case will be a standardized national rate per discharge multiplied by an assigned "DRG weight factor."¹¹⁹ The standardized rate is calculated by HHS and applies to each Medicare discharge from all Medicare participating hospitals for an entire fiscal year.¹²⁰ The standardized rate is determined by a series of somewhat complicated calculations. Specific rate calculation occurs by first determining the total national operating costs of Medicare for the most recent year.
available. This data comes from discharge reports routinely submitted to Medicare. The total national operating cost is then divided by the total number of national Medicare discharges. This quotient roughly approximates the average cost of treating a Medicare patient.

The average cost per patient is then updated for inflation in a two-step process. The first inflation updating process adds to the average cost per patient the annual rate of increase for hospital inpatient operating costs nationwide through the latest year available. The second step inflates the price to the current period by increasing the so-called hospital "market basket" by a statutorily prescribed percentage for each fiscal year. The rate of increase was originally set at the market basket plus one percentage point. The rate of increase for fiscal years 1985 and 1986 is limited to the market basket plus one quarter of one percentage point. The "market basket" is defined as the increased cost of goods and services purchased by hospitals for inpatient services and is weighted by category "to reflect the estimated proportion of hospital operating expenses attributable to each category." The categories used to calculate the market basket include wages and salaries, employee benefits, professional fees, business services, malpractice insurance, food, fuel, drugs, chemicals and cleaning products, surgical supplies, rubber and plastics, business travel, apparel, and miscellaneous expenses.

The updated average cost per Medicare discharge is then standardized to account for variations in the types of cases seen at one hospital versus another. Such variation is called a hospital's "case-mix." Case-mix refers only to the relative costliness of treating one type of diagnosis (such as burns) versus treating another type of diagnosis (such as diabetes). Case-mix is not a measure of severity. Severity varies when, for example, one hospital treats more severe burns than another hospital. An example of a variation in case-mix would be the difference between a large, regional hospital which possesses and uses a CAT scanner versus a small, community hospital which routinely transfers any patients needing a CAT scan to the larger, regional hospital. Clearly, the capital intensive regional hospital is generally going to have higher costs of providing care. Case-mix costs are not, however, reflected in the national standardized rates.

Eliminating the cost effects of variations in case-mix from the national, standardized rate is necessary because case-mix costs are reflected in the DRG weight

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122 E.g., PPS Report, supra note 98, at 76.
125 Id.
130 Id. at 39,764.
factors. Failure to eliminate case-mix costs from the standardized rates would result in double compensation for case-mix costs. The calculation which eliminates variation for case-mix equals the national, updated, average cost per discharge divided by a hospital's "case-mix index." The case-mix index equals the weight factor for each DRG times the hospital's total number of cases in that DRG. This product is then divided by the hospital's total number of discharges for the data set. The result of the case-mix index is an approximation of the relative frequency with which particular hospitals treat resource intensive diagnoses. When the national average cost per discharge is divided by a specific hospital's case-mix index, the resulting figure represents the hospital's average cost per discharge devoid of compensation for case-mix. The hospital's entitlement to greater reimbursement for systematically treating more resource intensive diagnoses will be realized in the systematically higher payments received for treating patients whose DRGs carry relatively high weight factors.

During the phase-in period from 1984 to 1987, Congress has mandated that the national rates be broken down into urban/rural distinctions for each of the nine United States census regions. It is these rates which are ultimately multiplied by the DRG weight factor to determine the amount of a hospital's payment.

In sum, the ultimate national, standardized rate is the mean of all the individual discharge rates devoid of case-mix costs for each hospital in the appropriate region. The result is a uniform base rate for all the hospitals in the data set.

Teaching hospitals tend to have more staff and treat more severely ill patients in a more costly manner. As discussed herein, direct medical education costs, such as additional salaries, and indirect medical costs, such as the severity of cases treated, are the subject of additional payment mechanisms to the DRG rate. Consequently, the standardized per hospital rate removes the element of indirect medical education costs because these costs are directly compensated in an annual lump sum payment in addition to any payments received through the prospective payment system.

Pursuant to statutory mandate, the standardized rate must also compensate for regional wage levels. The current wage standardization calculation is made by taking the specific hospital's average cost per Medicare discharge and multiplying that by the percentage of the market basket deemed to represent labor-related costs (presently 79.15 percent). This yields the amount of the hospital's average cost per Medicare discharge which is related to labor costs. This number is divided by the

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135 1983 SSA § 601(e), 97 Stat. 152.
wage index for the area in which the hospital is located, thereby preventing hospitals with higher labor costs from creating a regional windfall by using their own high costs to increase the standardized per discharge rate. The labor cost standardization, therefore, penalizes hospitals with high labor costs and rewards hospitals with labor costs lower than the regional average, because their standardized rates are increased to the regional average.

The net result of the standardization calculations is a fixed amount for hospitals treating Medicare patients in the appropriate region. This rate is updated for inflation, reduced for later compensated, indirect medical education costs, and standardized for case-mix and area wage levels.

A final adjustment is made for "outliers." "Outliers" are those cases "that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG."36 The Social Security Amendments of 1983 require that hospitals be compensated for outliers.137

PPS is further required to be "budget neutral."138 Budget neutrality essentially means that PPS may not cost the government any more money than financing under the previous system. As a result of this requirement, the ultimate standardized hospital rate must be reduced by a constant factor to permit HHS to compensate for outliers. In fiscal year 1984 this adjustment is .943.139 The standardized amount ultimately results in a constant dollar amount per region, per fiscal year which will be multiplied by a DRG weight factor to determine the ultimate payment received by a hospital for each patient.140

The weight factor represents the relative costliness of a diagnosis across all hospitals.141 For example DRG 457, extensive burns, on the average consumes 6.8631

The formulas for determining PPS payments can be summarized as follows:

Hospital Payments = (Standardized Amount x DRG Weight Factor + Addition Amounts)

Standardized Amount = \left( \frac{\text{National Average of Base Year Costs}}{\text{Case-Mix Index}} \right) x \text{Outlier Adjustment x Update Factor x Transition %}

DRG Weight Factor = Empirically Derived Constant Reflecting the Average Relative Costliness of a Diagnosis (e.g. 1.2345)

Additional Amounts when applicable = Capital Costs + Indirect Medical Education + Outliers + Other Costs

138 The formulas for determining PPS payments can be summarized as follows:
139 1983 SSA § 601(e), 97 Stat. 152, 158.
140 48 Fed. Reg. 39,767. The outlier adjustment for Fy 1985 was recently changed to .950. This increases the amount each hospital receives for treating patients who are not outliers. 49 Fed. Reg. 34,768.
141 Id. at 39,768.
142 Id. All weight factors have recently been reduced by 1.05 percent. This change reflects better
times more resources than the average national Medicare discharge diagnosis.\textsuperscript{142} Consequently a hospital with a standardized amount for fiscal year 1984 of $1,000 per discharge would receive $6,863.10 for each patient discharged under DRG 457.

Congress has built a phase-in period into PPS.\textsuperscript{143} The need for a phase-in period arises because when PPS is fully implemented, the standardized amount a hospital will receive will in no way be related to that hospital’s historical treatment costs. The standardized amount is related only to aggregate Medicare costs. The phase-in period softens this change by injecting a “hospital specific portion” into the calculation of Medicare payments. The hospital specific portion adjusts Medicare payments to a hospital’s own historic costs of treating patients. This adjustment softens the blow for hospitals whose costs are so high that immediate implementation of national costs standards would force them to close.\textsuperscript{144}

The phase-in period operates by breaking down the standardized amounts into a “federal portion” and a “hospital specific portion.”\textsuperscript{145} The federal portion is based in varying percentages on the standardized amount computed for the region in which the hospital operates and a separate percentage of the national standardized amounts. It is the federal portion that is likely to place hospitals at financial risk. Hospitals would be at risk of losing money under the federal portion when the hospital’s average costs are greater than other hospitals in their own region or throughout the nation.

The hospital specific portion is an attempt to mitigate the effect of the regional and national standardized amounts. The hospital specific portion is calculated first by dividing the particular hospital’s base year costs by that particular hospital’s case-mix index.\textsuperscript{146} This adjustment is the equivalent of the first step in the calculation of the national standardized amounts. Next, this quotient is multiplied by the national outlier adjustment and by an updating factor to account for inflation.\textsuperscript{147} The applicable phase-in percentages\textsuperscript{148} during 1984 were: 25 percent federal portion and 75 percent hospital specific portion. In 1984, the federal portion was calculated to be 100 percent of the regional standardized amounts. Thus the 1984 rates were entirely regional and hospital specific. For fiscal year 1985, the federal percentage is 50 percent and the hospital specific portion is 50 percent. The federal portion for fiscal year 1985 is 75 percent of the regional standardized amounts and 25 percent of the national standardized amounts. Fiscal year 1986 will be 75 percent federal portion and 25 percent hospital specific portion with the federal portion defined as 50 percent of the regional standardized amounts and 50 percent of the national

\textsuperscript{143} Id. at 39,886.
\textsuperscript{144} Id.
\textsuperscript{145} See, e.g., J. Finley, supra note 101, at 84.
\textsuperscript{146} 48 Fed. Reg. 39,772.
\textsuperscript{147} Id.
\textsuperscript{148} 48 Fed. Reg. 39,774.
\textsuperscript{149} 42 C.F.R. § 405.474 (1983).
standardized amounts. For fiscal year 1987 and thereafter, the program will be 100 percent federal portion, and the federal portion will be defined as 100 percent of the national standardized amounts.\textsuperscript{49}

The varying percentages place increasing reliance upon national amounts. National rates pressure the most expensive hospitals to streamline their medical procedures because reimbursement rates assume that each hospital's costs approximate the national average. Reliance on the federal portion is essential to the ultimate success of PPS; if a hospital’s reimbursement remains linked to its own economic performance, there is no incentive for the hospital to economize because its payments are always inflated by its own high costs. As noted earlier, rate updating is limited in fiscal years 1984 and 1985 to market basket plus one-quarter of one percentage point.\textsuperscript{150}

C. Exclusions From PPS

PPS does not apply either to all hospital costs or all health care providers. Certain costs and providers are excluded from the system. Excluded costs include capital costs, direct medical education costs, indirect medical education costs, and outliers.\textsuperscript{45} Specially treated providers include health maintenance organizations and specialty, sole community, and demonstration project hospitals.\textsuperscript{152}

Capital costs currently account for only 7 percent of Medicare expenditures.\textsuperscript{153}

\textit{Nevertheless, the influence of capital reimbursement on total Medicare outlays is much greater than the small percentage would indicate. Investment in new plant and equipment, often embodying new technology is closely related to the increase over time in the average number of diagnostic and therapeutic services provided during a hospital stay.}\textsuperscript{154}

Since capital costs lead to increasing service volume and, as discussed previously, thereby to inflation, controlling such costs is of great concern to PPS planners and hospital administrators.

Despite the relationship of capital costs to inflation, PPS does not currently attempt to control capital expenditures. Capital costs under PPS are directly “passed through” to the hospital.\textsuperscript{155} As noted earlier, direct medical education costs, including

\textsuperscript{49} 48 Fed. Reg. 39,775.
\textsuperscript{150} 1984 Medicare and Medicaid Report Reconciliation Amendments, § 2310, at S-169.
\textsuperscript{152} Id. at 39,755, 39,758-59, 39,780.
\textsuperscript{154} Id.
\textsuperscript{155} 49 Fed. Reg. 39,777.
intern salaries, are also passed through to the hospital in a direct payment.\textsuperscript{156}

Indirect medical education costs are compensated under a lump sum payment. The amount of the payment is calculated by multiplying a hospital’s total DRG revenue times a factor representing increases in the ratio between the hospital’s full-time intern and resident staff and its total beds times an education adjustment factor. The education adjustment factor is twice the percentage “representing the [inflationary] effect of teaching activity on operating costs.”\textsuperscript{157}

The most significant feature of the indirect medical education reimbursement system is the calculation of the education adjustment factor at twice the empirically determined rate. This factor is important because teaching hospitals greatly fear that since they tend to treat more severely ill and more resource intensive patients, the average DRG payment would consistently leave teaching hospitals with less reimbursement than their costs of delivering care.\textsuperscript{158} Doubling the impact of indirect medical education costs for teaching hospitals is therefore an attempt to insure that they are not unduly prejudiced by PPS.\textsuperscript{159}

Possibly the most significant source of additional payments to hospitals, other than DRG based payments, is payment for “outliers.” As noted earlier, outliers are atypical cases that HHS recognizes as costing hospitals significantly more to treat than the ordinary DRG payment would provide. There are two types of PPS outliers. The first type is a length of stay outlier. A length of stay outlier is defined to exist when “the beneficiary’s length of stay . . . exceeds the mean length of stay of the applicable DRG” by the lesser of a fixed number of days or a fixed set of standard deviations.”\textsuperscript{160} The second type of outlier is a cost outlier. Cost outliers are defined to exist when a hospital’s charges for Medicare covered services exceed a fixed dollar amount or a fixed multiple of the federal prospective payment rate.\textsuperscript{161}

Section 405.475(c) of the Regulations\textsuperscript{162} states that length of stay outliers will automatically be recognized by the fiscal intermediary determining payment to the hospital, and consequently, “[a] special request or submission by the hospital is not necessary to initiate this payment.”\textsuperscript{163} The amount of payment for length of stay outliers is equivalent to 60 percent of the average per diem payment of the applicable DRG. The per diem rate for each DRG is calculated by dividing the federal prospective payment rate for that hospital by the mean length of stay for that DRG.\textsuperscript{164} Payment for cost outliers, however, does require a special request

\textsuperscript{156} 42 C.F.R. § 405.477(c)(2).
\textsuperscript{157} Id. § 405.477(d)(2).
\textsuperscript{158} PPS Hearings, Part 1, supra note 133, at 115 (testimony of Ass’n of Am. Medical Colleges).
\textsuperscript{159} Ways and Means Conference, supra note 22, at 91.
\textsuperscript{160} 42 C.F.R. § 405.475(a)(1).
\textsuperscript{161} Id. § 405.475(a)(2).
\textsuperscript{163} Id.
\textsuperscript{164} Id.
The amount paid for a cost outlier is the regular DRG rate to which the hospital is entitled plus 60 percent of the difference between the hospital’s adjusted cost for the discharge and a dollar amount or multiple of the federal prospective payment rate as fixed by HCFA. Informal discussions with hospital administrators have revealed that the administrative burden of pursuing cost outliers rarely justifies the amount of the payment. Consequently, cost outliers may be requested less frequently than their actual existence in the Medicare population.

PPS does not apply to certain providers. In particular, psychiatric, rehabilitation, children’s and long-term hospitals, along with similar specialty units of hospitals, are exempt. The rationale for excluding these hospitals is that “since the DRGs were developed for short-term general hospitals, their application to these hospitals would be inaccurate and unfair.”

Hospitals which are covered by experimental and demonstration project reimbursement control systems are also exempt from PPS. The rationale for this exemption is to encourage innovative methods of health care financing. The continuation of the exemption, however, is contingent on whether the demonstration project yields rates of inflation below the national rate of increase in Medicare hospital costs.

PPS also makes special payment provisions for hospitals which are “sole community hospitals.” Sole community hospitals are those which for various reasons are “the sole source of inpatient hospital services reasonably available in a geographic area to Medicare beneficiaries.” The payment rate for sole community providers “equals 75 percent of the hospital-specific base payment rate . . . plus 25 percent of the appropriate regional prospective payment.” The sole community hospital provisions effectively permit hospitals which meet the criteria to base their prospective payment rate on their own personal experience and less on aggregate data. The rationale for this treatment is that hospitals which are sole community providers often have a moral duty to maintain services which are only infrequently used. This duty conflicts with the economic tendency to eliminate inefficient services. The sole community hospital provisions permit, for example, rural community hospitals to maintain obstetrical facilities which are economically unjustified given the small population of the hospital service area.

Health maintenance organizations (HMOs) are funded by Medicare on a capitation basis or reasonable cost basis. The hospital costs of HMOs are not

165 Id.
166 Id.
167 PPS Report, supra note 98, at 50.
168 1983 SSA § 601(c), 97 Stat. 150.
169 Id.
170 42 C.F.R. § 405.476(a)(1).
171 Id. § 405.476(c).

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automatically subject to PPS levels. Qualifying HMOs can choose to have hospitals which deliver care to HMO members paid directly at the prospective payment rate, or if an HMO has negotiated its own hospital rate, the HMO can be paid by HCFA on a capitation basis with the HMO in turn paying the hospital. This arrangement permits HMOs which have negotiated hospital rates lower than PPS rates to continue to pay the cheaper rate.

PPS contains extensive quality review provisions which can be broken down into two categories: systemic review (hereinafter referred to as appeals) and review of particular cases. Systemic review is quite limited. In general, administrative or judicial review of the DRG classification system is prohibited. There may be some pressure to change this provision. The prospective payment system does permit a hospital which is dissatisfied with the coding of an individual patient’s case to take a series of appeals.

D. PPS Payment Process

Case-related review is conducted by HCFA, fiscal intermediaries, and Utilization and Quality Control Peer Review Organizations (PROs). PROs are independent quality review organizations which contract with hospitals. The function of these groups is to review a hospital’s “admission patterns, length of stays, transfers, services furnished in outlier cases, the validity of diagnostic information, and the quality of its services.”

The fiscal intermediary (also called a Medical Review Agent) then receives, reviews, and approves or rejects hospital bills. HCFA ultimately pays the bills only after intermediary approval.

Contrary to popular perception, DRG assignment and validation are conducted only after patients are discharged. The DRGs are finally assigned only by the fiscal intermediary. The process for a hospital’s billing begins with the attending physician attesting in writing, after the discharge of the patient, to the principal diagnosis, secondary diagnoses, and names of procedures performed for that patient. After the attending physician has attested to the record, an employee of the hospital will tentatively assign the appropriate DRG. Once the DRG is assigned, the hospital

174 Id.
175 Id.
176 1983 SSA § 601(e), 97 Stat. 152, 158.
177 Id.
178 Id.
183 Id.
184 Id.
185 Id.
submits the bill for payment to the fiscal intermediary who decides whether the bill should be paid.

The fact that DRGs are not assigned by physicians and that DRGs are not assigned until after a patient’s discharge deflates two standard misconceptions entertained by the medical community. Informal conversations with physicians and nurses have revealed the general, incorrect beliefs that physicians are responsible for assigning a specific DRG to a specific patient and that this assignment must occur upon admission of each individual patient. If such requirements were true, provider resistance to the system would be well founded. It is patently unfair to presume that any health care provider can recognize a given patient’s illness immediately upon admission to the hospital. It would also be a waste of physician time to require physicians to assign DRGs to patients. As the system currently operates, a particular patient’s ultimate principal and secondary diagnoses are not relevant to the payment process until the patient is discharged and the particular episode of illness has been resolved. At this stage, physicians should not find it too difficult to attest to the ultimate principal and secondary diagnoses of the patient. Indeed such documentation was a routine aspect of at least Medicare discharges prior to PPS. Furthermore, since assignment of the DRG is not the physician's responsibility, the payment system does not have a major effect on a physician’s administrative workload.

IV. ANTICIPATED IMPACTS AND FUTURE OF PPS

A. Impacts

Due to the nature of medical economics, PPS is likely to have a profound effect on providers, patients, insurers, and federal expenditures. The fundamental reason for the great impact of PPS is that PPS places hospitals “at risk” for losses and in a position to “profit” for efficiently delivered services. Although superficially hospitals under PPS only compete against the DRG rate, since the rates are adjusted national average costs, hospitals must effectively compete with each other to keep their individual costs lower than other hospitals treating patients with similar types of illnesses. This responsibility will increase as the prospective payment rate gradually incorporates greater and greater percentages of national cost data.

The PPS system has at least two characteristics which, taken together, profoundly influence hospital behavior. First, the rates are determined in advance and will not be changed in any given year. This makes hospitals aware in advance of their maximum payment for a given diagnosis and their likely yearly income from Medicare. Such notice can be a profit goal or a warning of loss depending on the hospital’s efficiency. Secondly, since DRG rates are calculated independently of
a given hospital’s past cost experience, administrators are forced to be vigilant regarding wasteful service use.

A preliminary question is why should “nonprofit” hospitals be interested in making a “profit”? In other words, does PPS give hospitals truly compelling incentives? It is hypothesized that “nonprofit” hospitals will indeed attempt to minimize costs. The reasons for this hypothesis include, first, the fact that all institutions, particularly nonprofit health corporations, gain institutional momentum for continued existence and growth. The at-risk nature of PPS, therefore, forces hospitals which desire continued existence to either become efficient or stop admitting Medicare patients. Since refusing Medicare patients would deprive the hospital of a major revenue source, any administrator or physician interested in continued viability of his or her hospital will most likely strive to control costs.

The second reason hospitals will alter their behavior to comport with PPS reimbursement rates is that hospitals will discover that some of the areas of their practice produce surpluses and some areas do not. PPS leaves hospitals completely free to subsidize the losses incurred by their costly services with the surpluses earned by their efficient services. Administrators and physicians will have wide latitude in the reallocation of funds to high cost departments which are particularly valued at a particular institution.

Determining the allocation of resources is thus the fundamental dynamic injected by PPS. Since administrators control unit service costs such as meals, but physicians control admissions and medical service utilization, PPS demands new levels of administrative collaboration. One of the most fundamental changes brought about by PPS will be the increased leverage of administrators in controlling service use in their institutions. The main challenge of PPS for administrators will thus be to encourage physicians to balance cost against medical necessity. Consequently, the ability of a hospital to respond to prospective payment incentives depends on the ability of the hospital administrator to transmit these incentives to the attending physician staff. Since the physician staff generally is not integrated into the administrative hierarchy of the organization, the administrator must exercise influence over the medical staff organization and the organization and management of the hospital’s clinical departments. . . .

One of the fundamental ways administrators may seek to enforce economizing incentives is through increasingly sophisticated data systems. The cost and apportionment incentives of PPS will almost certainly affect the quantity and quality of health services. One major effect of PPS will be to increase hospital specialization. Hospitals will most likely expand delivery of services in

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188 PPS Report, supra note 98, at 17.
189 See generally Implications for Medical Terminology, supra note 5.
190 PPS Report, supra note 98, at 102-104.
their most efficient areas while curtailing or eliminating services in their least efficient areas. Such specialization will probably increase the quality of patient care since it has been widely shown that hospitals which infrequently perform complex procedures have no economies of scale and experience higher levels of patient expense, morbidity, and mortality.\textsuperscript{191} Eliminating such services may reduce costs and increase quality of care by forcing patients to seek services at more efficient facilities.\textsuperscript{192} Economically inefficient services which nevertheless produce valuable health care results may always be subsidized through the profitable areas of any particular hospital.

Many witnesses at Senate hearings voiced concern that the economizing incentives in PPS will result in minimized and therefore low quality health care.\textsuperscript{193} HHS believes that the integrity of physicians, the continued use of review organizations, and the threat of malpractice suits will counterbalance any tendency to withhold treatment or discharge early.\textsuperscript{194} The HHS analysis seems appropriate since similar fears were voiced regarding similar incentives in HMOs, yet the empirical evidence indicates that HMOs deliver equivalent or higher quality care than fee-for-service providers.\textsuperscript{195}

Equipment manufacturers have noted that PPS will definitely affect technology use and may possibly affect technology development.

We support [PPS] as manufacturers, recognizing that it is going to have an impact on our markets for our products in some cases and that impact will be negative. There will be a dampening of demand for certain medical products because the concept is one that is based on prospective reimbursement in which it behooves a hospital to use only those products which it absolutely has to in order to treat a patient.\textsuperscript{196}

In terms of technology development, PPS will stimulate development of cost-saving technology while discouraging cost raising technology.\textsuperscript{197} This analysis suggests a shift in focus from efficacy for the patient to efficiency for the institution. Nevertheless, the authors believe that if an adequate appeals process such as New Jersey's is developed the system need not discourage technological advances. PPS will discourage development of financially expensive technology which yields marginal administrative or clinical results, but, given an adequate appeals process, should not adversely affect truly useful technologies.

PPS will probably encourage the same selectivity in technology use (as opposed

\textsuperscript{191} Id. at 103.
\textsuperscript{192} Id.
\textsuperscript{193} See generally PPS Hearings, Part 2, supra note 49.
\textsuperscript{194} PPS Report, supra note 98.
\textsuperscript{196} PPS Hearings, Part 2, supra note 44, at 90-91 (statement of Harold Buzzell, President, Health Indus. Mfrs. Ass'n).
\textsuperscript{197} IMPLICATIONS FOR MEDICAL TECHNOLOGY, supra note 5.
to development) that PPS will stimulate in clinical practice; that is, only necessary technologies and clinical interventions will be employed. Furthermore, since capital costs are passed through, hospitals may economize in volume of procedures conducted rather than acquisition of equipment.

PPS should have minimal effect on medical and technological research. Drug and technology manufacturers will have the same incentives they have always had to create marketable products. PPS may however reorient the marketing priorities of manufacturers in favor of cost efficiency. Although less equipment will be purchased for convenience, under the aggressive purchasing stance hospitals will probably assume, the maker of the better medical mousetrap stands to make up in volume what is lost in unpurchased “luxury” equipment.

Hospitals may experience many changes in service utilization due to PPS. One of the likely effects will be a decrease in the length of stay per case. Hospitals will also probably conduct fewer tests and practice defensive medicine on a reduced basis. These procedures will be deemed superfluous in light of their heavy costs. It is also likely that community hospitals will attempt to skim the most severely ill patients out of their case load and transfer patients which appear to be losers in relation to the DRG rate for their diagnosis.

Forcing patients to make co-payments, shifting costs to non-Medicare patients, and increasing incentives to admit marginally ill (that is, easy to treat and, therefore, profitable) patients were concerns expressed by many witnesses in the PPS legislative hearings. The American Hospital Association testified that “trends make it inevitable that Medicare beneficiaries must accept more of the payment burdens for services that are more costly than the government is willing to finance.” As a policy matter, the authors believe such cost shifting to Medicare beneficiaries should not be allowed to occur because elderly people who do not have the technical knowledge to be prudent purchasers of health care, should not be burdened with effectively uncontrollable out-of-pocket costs. Keeping co-payments minimal is also desirable because this encourages patients to seek early diagnosis. Such diagnosis makes illness both easier to bear and less costly to treat. PPS properly places the incentive to economize in the hands of professionals who have the knowledge and skill to recognize what is necessary and what is not. Although the American Hospital Association testimony was prompted by sincere concern over their ability to both reduce costs and maintain quality of care, another industry spokesman noted, “people . . . who don’t believe they can reduce costs, won’t.”

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198 Phillips, supra note 5, at 1, col. 6.
199 Ways and Means Conference, supra note 22, at 96.
200 See generally PPS Hearings, Part 2, supra note 44.
202 PPS Hearings, Part 2, supra note 44, at 90 (testimony of H. Buzzell, President, Health Indus. Ass’n).
The PPS system addresses some concerns of those seeking to prevent cost shifting. Forcing payment by consumers is prohibited. Unnecessary admissions are prohibited as well. Cost shifting to retrospective payers such as private insurers will be discouraged because insurers will be aware of and refuse to pay increases in rates related to losses on Medicare patients. Although the aforementioned measures interdict some cost shifting efforts, other cases, however, are likely to remain undetectable. One partial solution, discussed herein, is to extend PPS to physicians’ fees, outpatient services, and all payers. The authors personally believe such change is desirable and inevitable. The problem of unnecessary admissions is a difficult one. Only peer pressure and utilization review can discourage admission of the marginally ill; no system is perfect. It remains likely that some unnecessary admissions will be an unavoidable aspect of PPS.

DRG “creep” is the expectation that as physicians learn which DRGs pay more money, physicians will tend to diagnose more patients with the more expensive DRGs. Such behavior is somewhat easy to detect if hospitals have computerized records. Sophisticated record systems will permit diagnosis patterns between physicians to be compared over time and anomalies identified. Since HHS will periodically revise the rates for each DRG, any systematic infusion of less resource intensive patients into a particular DRG will result in a decreased weight factor for that DRG. A reduced weight factor would reduce payments and ameliorate the benefits of the higher diagnosis. Similarly, diagnosing the most resource intensive patients into more high paying DRGs, will lower the rate for the accurate DRG. Only by accurately diagnosing patients will hospitals be adequately compensated for treatment of patients with particular DRGs.

Since PPS is a new administrative methodology and since outpatient services continue to be reimbursed on a reasonable cost basis, there is some speculation that hospital admission rates will be lowered. Informal conversations with various health care providers identified a low period of hospital occupancy in the spring of 1984. The cause of this decrease was said to be PPS; however, it is not yet certain that any census change which may have existed was exclusively attributable to PPS. Recent news reports do indicate, however, that PPS may well be having the effect of reducing patient census and length of stay.

The future treatment of capital expenses is essential to efficient public investment in health care. Although capital expenditures continue to be reimbursed as they were prior to PPS, hospitals are concerned that controls on capital expenses

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204 Id. at § 601(e), 97 Stat. 152.
205 PPS Hearings, Part 2, supra note 44, at 114.
206 PPS Report, supra note 98, at v.
207 Id.
208 Pear, Medicare’s Limits Making Hospitals Careful on Costs, N.Y. Times, Aug. 26, 1984 at 1, Col. 1.
will be imposed in the future. Therefore, prudent hospitals may restrict their capital
growth until an ultimate and predictable system is in place.209

Possible alternatives for capital treatment include direct factoring of all capital
costs into DRG rates; including reimbursement of equipment only in DRG rates;
and establishment of statewide capital spending limits. The advantages of reim-
bursing capital costs through DRGs include the fact that capital payments would
be predictable and “hospitals would have an incentive to reduce capital costs as
well as operating costs.”210 A major drawback of the system is that if capital rates
are constant, hospitals with old physical plants would be placed at a disadvantage.
Although older hospitals would need more capital to modernize than would newer
hospitals, both older and modern institutions would have access only to the same
amounts.211

Incorporating capital costs for the purchase of equipment in DRG rates is a
variant of the first option. Such a system would encourage efficiency in hospital
purchasing. The disadvantage of this system would be that hospitals would have
no incentive in the future to control nonequipment capital costs.212

An advantage of statewide capital spending limits would be to permit states
to aggregate and direct capital spending to areas of highest priority. One disad-
vantage noted is a somewhat disappointing prioritizing record in state health planning
agencies.213 The ultimate treatment of capital costs is an essential question that
will be the subject of continued debate in upcoming years.

Analysis of PPS reveals that hospitals which, for whatever reason, tend to treat
patients with less severe illnesses may do better under PPS than hospitals which
tend to treat the most severely ill. One phenomenon which may occur is that for-
profit hospitals and well managed community hospitals may transfer their most
severely ill patients and, therefore, make out best in the system. This concept is
closely related to skimming. Some commentators have suggested developing a severity
index to discourage such behavior.214

PPS promises to also significantly affect the practice of medicine. Among
changes physicians will have to make in their orientation towards patient care are:
increased emphasis on the balancing of cost versus necessity of care, a decrease
in the practice of defensive medicine, possible rejection of Medicare patients, and
increased incentive to admit marginally ill patients. Procedures which may be
increased include preadmission testing and outpatient treatment delivered by physi-
cians, since these are not currently covered by PPS.215

209 Health Planning 1983, supra note 153, at 8-18 (statement of Nancy M. Gordon, Assistant Director
for Human Resources and Community Dev., Cong. Budget Office).
210 Id. at 13.
211 Id. at 14.
212 Id. at 16-17.
213 Id. at 18.
214 The severity problem is discussed infra text accompanying note 236.
215 Ways and Means Conference, supra note 22, at 96.
The effect of PPS on physician behavior will be limited by the degree of leverage possessed by the hospital. This limitation occurs since under the current PPS, physician services, normally covered by Part B of the Medicare, remain based on a reasonable charge basis. Physicians, therefore, continue to have incentives for providing increased services.

Patients will detect very little change in the delivery of their health care. This is primarily true because patient responsibilities in terms of copayments and deductibles remain unchanged. Possible impacts might include changes in the quality of food service, staffing patterns, and distance travelled for advanced care.

Insurers will need to be vigilant to protect themselves against cost shifting. Furthermore, private insurers may ultimately be included in the prospective payment system.

B. Prospects for the Future

Some of the expected consequences of the Medicare prospective payment system have been discussed. Because the health care system is in flux, further changes appear likely if not inevitable. The final section of this Article presents the authors' views concerning future developments likely to result from enactment of prospective payment for Medicare.

With respect to Medicare itself, at least three developments appear on the horizon. First, the DRG classification system will be retained but will be changed to take into account factors such as severity of illness. Second, the appeals process will be liberalized to permit a broader range of hospital appeals. Third, the payment system will be expanded to cover physician fees for inpatient hospital service under the DRG rates. In addition, PPS/DRG may be extended beyond Medicare.

1. Refinement of the DRG System

The DRG classification system is still in the process of development. Other possible developments are incorporation of capital costs such as depreciation, interest, and loan repayments into PPS/DRG and inclusion of outpatient costs in the system. The statute requires the Secretary of HHS to submit a report on inclusion of capital costs in PPS/DRG within 18 months of the date of enactment of 1983 SSA, that is, in October 1984. The question of incorporating capital costs into the system is discussed supra, text accompanying notes 209-214.

Inclusion of costs of outpatient services would be a logical concomitant of incorporating physician fees for inpatient hospital services into PPS/DRG discussed infra. Inclusion of these services would prevent hospitals from shifting costs to outpatients. In addition, hospitals are more costly providers of outpatient care than are nonhospital providers of similar services. Inclusion of outpatient services would therefore serve to contain costs. See Ways and Means Hearings, supra note 95, at 89 (statement of Harold A. Cohen, Executive Director, Md. Health Servs. Cost Review Comm'n). No DRG type classification is presently available for outpatients. However, a research group at Yale University is developing ambulatory patient groups (APG's). J. Finley, supra note 101, at 43.

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1 J. Finley, supra note 101, at 54-60; PPS Hearings, Part 1, supra note 133, at 47 (testimony of Richard S. Schweiker, Secretary, U.S. Dep't of Health and Human Services).
classifications were revised recently from 383 DRGs to the present 468. The statute provides for a "Prospective Payment Assessment Commission" whose duties are, among other things, to monitor development in medical technology and knowledge, "giving special attention to the needs of updating existing diagnosis related groups [and] establishing new diagnosis related groups." Moreover, the statute mandates the Secretary of HHS, in consultation with the Commission, to adjust the DRG classifications and weighting factors in fiscal year 1986 and at least every four years thereafter. Clearly, Congress anticipated continuing improvements in the DRG classification system.

At least one serious deficiency in the DRGs, which improved knowledge and methodology should ameliorate, is that the DRGs do not adequately take into account the severity of a patient's illness. This is so even though it is likely that more severe illnesses require proportionately more hospital resources than less severe ones. Thus, there can be considerable cost variation within a given DRG simply on account of the severity of the illness. Several witnesses at congressional hearings, preceding enactment of the DRG system, expressed concern about this deficiency.

A policy of making additional payment in cases classified as outliers because of an extremely long length of stay or extraordinarily high costs, indirectly takes severity of illness into account, because the more severe cases are likely to have longer lengths of stay. The present law and regulations do provide for outlier classification and additional payments for some long length of stay cases. The statute, however, limits the total amount that can be paid by Medicare for outlier cases to no "more than 6 percent of the total payments projected . . . to be made based on DRG prospective payment rates" in any given year. That amount may not be adequate in light of the experience in New Jersey which also uses the DRG classification system. New Jersey's DRG system classifies approximately 10 percent

218 J. FINLEY, supra note 101, at 54-60.
221 See, e.g., Ways and Means Hearings, supra note 95, at 237-244 (statement of Larry S. Gage, President, Nat'l Ass'n of Public Hosps.) (range of cost at one hospital within a single DRG was $400 to $59,000).
222 See, e.g., PPS Hearings, Part I, supra note 133, at 103, 105 (statement of Dr. Mitchell Rabkin, Past Chairman of the Council of Teaching Hosps.); Id. at 207 (testimony of Harold A. Cohen, Executive Director, Md. Health Servs. Cost Review Comm'n); Id. at 221, 237 (statement of Ron J. Anderson, M.D., Chief Executive Officer, Parkland Memorial Hosp.); Ways and Means Hearings, supra note 95, at 298-308 (statement of Stanley Brezenoff, President, N.Y. City Health and Hosps. Corp.); Id. at 310 (statement of Lawrence G. Crowley, M.D., President, Stanford Univ. Hosp.).
223 As used here, the term "outlier" refers to a case which is atypical for some reason, e.g., cases involving extremely long lengths of stay or extraordinarily high costs.
224 1983 SSA § 601(e), 97 Stat. 157. The payment amount for a long length of stay outlier is 60% of the average per diem payment for the applicable DRG. 42 C.F.R. § 405.475(c)(3) (1983).
of its cases as length-of-stay outliers. New Jersey also classifies cases in ninety-seven DRGs as "clinical outliers." These DRGs are considered to contain patients with such diverse medical problems that to lump them at one payment rate would be inequitable. These comprise about 6 percent of New Jersey outlier cases. The federal system does not recognize this outlier category, which is likely to contain some long length of stay or extraordinarily high cost cases.

Failure to take into account severity of illness is an especially acute problem for teaching hospitals and public hospitals serving a low income clientele whose cases tend to be more severe and require more complex procedures. DRGs are conceptually designed to accurately take into account the average cost of a hospital stay for a given classification of illness. It is a logical extension to include in the classification system characteristics which substantially affect the cost of treating the illness. Severity appears to be just such a characteristic. The awareness of this problem by Congress is evidenced by its enactment of a provision in the 1983 SSA requiring the Secretary of HHS to include studies taking into account illness severity under DRG in her annual report to Congress.

It is possible to devise at least rough measures of severity. Two methods in the process of development are "disease staging" and "severity of illness index." Disease staging consists of specifying by numerical index the progressive levels of a disease. For example, one system assigns values ranging from 0 (no disease present) to 4 (death). This index is directed to the stages of a particular disease rather than the overall condition of the patient. The severity of illness index, under development at Johns Hopkins University, classifies patients into four severity levels. It rates patients based on the overall condition of the patient rather than according to the stage of a specific illness. These measures are still in the early stages of development and far from perfect. However, continued progress in severity measurement should occur, and when it does, the logical step will be to build it into the DRG system.

See Ways and Means Hearings, supra note 95, at 105, 108 (statement of Charles F. Pierce, Jr., Deputy Comm'r, N.J. Dep't of Health).


See PPS Hearings, Part 1, supra note 133, at 105; id. at 221, 227-28; Ways and Means Hearings, supra note 95, at 298-308; Bergen & Roth, Prospective Payment and the University Hospital, 310 New Eng. J. Med. 317 (1984).

See Ways and Means Hearings, supra note 95, at 300-08.


Implications for Medical Technology, supra note 5, at 16-17.

Id. at 16.

Id.

Id. at 17.

Patients are classified according to a set of seven criteria: 1) stage of the principal diagnosis; 2) complications of the principal condition; 3) concurrent, interacting conditions that affect the course of hospital treatment; 4) dependency on the hospital staff; 5) extent of nonoperating room procedures; 6) rate of response to therapy, or rate of recovery; and 7) impairment remaining after therapy for
2. Appeals

Another area where change may occur is in the DRG appeals procedures. As the law currently stands, appeals by hospitals of DRG rates and DRG classifications are precluded. Hospitals thus have no administrative or judicial procedure available to question DRG rates or classifications. This is potentially unfair to hospitals developing improved technologies which may be more costly than old methods, since these hospitals have no recourse from the pre-set DRG rates. The only mechanism in present law for bringing about changes in DRG classification is through the periodic revisions required of the Secretary of HHS in consultation with the Prospective Payment Assessment Commission. There is at least a possibility that this situation may retard the development of new technology. A hospital experiencing additional costs in developing a new technology may be penalized by being paid a DRG rate appropriate to an older, less expensive technology, and there is presently no way to obtain an exception.

Granted, a very liberal policy with respect to appeals could undercut the basic concept of prospective rates by delaying the setting of the rates beyond their applicable time period. Nevertheless, there is room for an intermediate position between permitting unlimited appeals of DRG rates and classifications and completely precluding them. One model is the process used in New Jersey known as the “DRG appeal”; it permits a hospital to appeal a DRG rate or classification where it may significantly affect one or more hospitals. Such a provision enables a hospital to challenge a DRG classification or rate where it can show, for instance, that a new procedure is likely to be adopted by other hospitals and will bring about a significant change in treatment patterns within a given DRG. Several individual

the acute aspect of the hospitalization. A rater then indexes the patient’s overall condition based on the criteria. The index ranges from 1 (least severe) to 4 (most severe). Id. See also P. GRIMALDI AND J. MICHELETTI, DIAGNOSIS RELATED GROUPS, A PRACTITIONER’S GUIDE 41-48 (1983).

237 1983 SSA § 601(e), 97 Stat. 158 provides:
There shall be no administrative or judicial review . . . of

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to [the provision for setting DRG payment rates], and

(B) the establishment of diagnosis-related groups, of the methodology for the classification of discharges within such groups, and of the appropriate weighting factors. . . .

While this lack of review may raise constitutional issues, these issues are beyond the scope of this Article.


239 See IMPLICATIONS FOR MEDICAL TECHNOLOGY, supra note 5, at 42-45.

240 This may have happened initially in New Jersey, where it is reported that only 6 of an original 26 participating hospitals had their 1980 rates finally fixed by December 1982. PPS Hearings, Part 2, supra note 44, at 30 (testimony by Frank J. Primich, M.D., Medical Soc’y of N.J.); see also J. FINLEY, supra note 101, at 6. Testimony in the Congressional Hearings preceding enactment of 1983 SSA indicates that this problem has been ameliorated. Ways and Means Hearings, supra note 95, at 291 (statement of Louis P. Scibetta, Pres., N.J. Hosp. Ass’n).

241 N.J. STAT ANN. § 26:2H-18.1(c) (West Supp. 1983); J. FINLEY, supra note 101, at 51; IMPLICATIONS FOR MEDICAL TECHNOLOGY, supra note 5, at 43.
organizations voiced concern during congressional hearings on the DRG system that the appeals process was inadequate.\textsuperscript{242} In light of this it is likely that there will be continuing pressure to open up the appeals process at least to some type of review modeled on the New Jersey "DRG appeal."

3. Physician Fees for Inpatient Hospital Services.

A third area of anticipated change in the present DRG system is the method of billing physician fees for inpatient physician services. These are billed (with certain exceptions such as for residents and interns enrolled in accredited teaching programs) by the attending physician under Part B separately from the hospital’s bill.\textsuperscript{243} Moreover, physicians are not required to "accept assignment under Part B."\textsuperscript{244} A logical next step would be to include physician fees for services rendered to hospital inpatients in the DRG payment system.

As the system now stands, the hospital has a direct economic stake in minimizing the cost of a hospital inpatient stay. Unless the case falls within the outlier classification, the hospital will be paid the set DRG rate regardless of the costs actually incurred. The physician’s stake is indirect, however, because the physician is not limited by the DRG rate. The physician may be subject to moral persuasion from hospital administrators and peers to avoid over-utilization of his services, but the direct economic incentive is opposite. Being compensated on a fee-for-service basis, the physician can increase his income by increasing the volume of services provided.\textsuperscript{245} Furthermore, studies have indicated that on a unit of time basis,

\textsuperscript{242} See e.g., Ways and Means Hearings, supra note 95, at 23 (testimony of Jack W. Owen, Executive Vice President, Am. Hosp. Ass’n); id. at 36 (statement of Richard Knapp, Director, Dep’t of Teaching Hosps. Ass’n of Am. Med. Colleges); id. at 39 (testimony of M. Keith Weikel, President-Elect of Fed’n of Am. Hosp.); id. at 47 (testimony of John H. Stroger, Jr., Comm’r, Cook County, Ill., on behalf of the Nat'l Ass’n of Counties); id. at 291 (testimony of Louis P. Scibetta, President, N.J. Hosp. Ass’n).

\textsuperscript{243} See 42 U.S.C.A. §§ 1395k(a)(2)(B), 1395x(b)(4), (6); 42 C.F.R. §§ 405.231(a), 409.10(a)(7).

\textsuperscript{244} By "accepting assignment" a physician agrees to bill Medicare directly for services and further agrees not to charge patients for these services beyond the reasonable charge amount authorized by Medicare. Medicare pays this amount less a statutorily authorized deductible for which the patient is liable. If a physician does not "accept assignment" he bills the patient for his regular fee (which may be in excess of the Medicare authorized reasonable charge). Medicare pays for the authorized reasonable charge less deductible, and the patient is liable for any excess of the bill over the amount paid by Medicare. See 42 U.S.C.A. §§ 1395k(a(b), 1395u(b)(3)(B); 42 C.F.R. § 405.1675.

\textsuperscript{245} PAYING THE PHYSICIAN, supra note 91, at 3-4. Physicians accept assignment on only about 50% of Medicare claims, with many of these being for very elderly and poor patients, and there is a wide variation in assignment rates among geographic regions. Id. at 31-32; Fox, supra note 91, at 112 n.7. Only 41% of Medicare bills not involving Medicaid are assigned. Id. at 112.

From my own practical experiences, I know if I order large numbers of tests and procedures I will get paid and my patients will be reimbursed relatively more by Medicare, but if I spend more time with my patients questioning the need for each test and procedure, I will get paid less for this cognitive service and my patients will be reimbursed relatively less.
remuneration is greater for physicians when they render services in the hospital than when they do so in their offices. 246

Combining physician fees and hospital charges into one DRG payment would reverse this incentive. Excessive use of resources would result in a physician losing money. 247 Physicians would be under the same constraints as hospitals presently are. Moreover, a combined payment would offer an alternative to the prestige associated with advanced technology ("techtige") as a way for hospitals to compete for physician staff. Hospitals could compete on the basis of lower costs, which leave more funds for physician reimbursement out of the combined DRG rate. 248

This may be a feasible next step in expanding coverage of the PPS/DRG system for Medicare. Its chances of occurring are enhanced by the fact that the Chairman of the Senate Finance Committee’s Subcommittee on Health, which has jurisdiction over Medicare, views such a proposal favorably. 249 Moreover, the statute itself directs the Secretary of HHS to study and report back to Congress on the feasibility of including physician fees for services furnished to hospital inpatients within the system. 250

It is apparent that a sense of urgency with respect to physician fees exists on the part of Congress. It enacted several provisions directed toward physician fees in the Medicare and Medicaid Budget Reconciliation Amendments of 1984. 251 First, Congress changed the due date for the Secretary’s report on DRG payment for physician fees from “in 1985” to “July 1, 1985.” 252 Second, Congress imposed a freeze on physician fees under Medicare Part B for the fifteen month period of July 1, 1984 to September 30, 1985 at the same level as for the twelve month period beginning July 1, 1983. 253 Third, incentives for physicians to “accept assignment” for all medicare fees were enacted. These included use of directories and toll-free lines to identify physicians who have agreed to accept assignment (termed “participating physicians”). 254 More importantly, perhaps, participating physicians will have any normal increase in their actual billed charges, during the fifteen month freeze period, reflected in updating their usual, customary, and allowable charges for future periods, while this factor will be limited for “nonparticipating” physicians. 255

Finally, Congress directed the Congressional Office of Technology Assessment (OTA) to conduct a study of the Part B reimbursement system and report back.

246 PAYING THE PHYSICIAN, supra note 91, at 21-22.
247 Id. at 29.
248 Id.
252 Id. § 2317, at S-170.
253 Id. § 2306(a), at S-167.
254 Id. § 2306(c), at S-167.
255 Id. § 2306(e), at S-167.
to Congress by December 31, 1985 on ways in which the system can be modified.\textsuperscript{256} OTA is required to include in this report "information on methodologies which could be applied in the development of fee schedules on a national or regional basis for payments under Part B."\textsuperscript{257,258} The Act also directs the Secretary of HHS to compile a centralized Part B charge data base, including information on utilization, assignment rates, actual customary and prevailing charges, and differences in charges by physician specialty and locality.\textsuperscript{258} This kind of data, of course, would be necessary in any effort to include physician fees in the PPS/DRG system. The legislation further directs the Secretary of HHS to review OTA's report and thereafter make legislative recommendations to Congress.\textsuperscript{259}

These legislative actions indicate an intent on the part of Congress to take additional action in the area of physician fee cost containment. Making physician services for inpatient hospital care subject to the DRG system would be a feasible next step from both a technical and political standpoint. From the technical standpoint it is easier to allocate services from the beginning to ending of a given hospital stay than to do so for a particular episode of illness. It is difficult to determine just when a given episode of illness begins and ends.\textsuperscript{260} From a political standpoint, legislation attempting to include a portion of physician fees under PPS/DRG would undoubtedly meet with strong opposition from physicians' organizations, but would be more likely of enactment than an attempt to include all physician fees under a DRG-based prospective payment system.\textsuperscript{261}

Including these physician fees in the DRG system would substantially improve Medicare's fiscal situation, since physician fees for inpatient hospital services constitute 60 percent of Medicare physician reimbursements.\textsuperscript{262} In summary, Congress seems willing; the machinery is in place to acquire the necessary technical expertise; expansion of the DRG system to include physician fees for inpatient hospital ser-

\textsuperscript{256} Id. § 2309(a)(1), at S-168.
\textsuperscript{257} Id. § 2309(a)(3), at S-168.
\textsuperscript{258} Id. § 2309(b), at S-168.
\textsuperscript{259} Id. § 2309(c), at S-168.
\textsuperscript{260} Fox, supra note 91, at 108. There is some experience, however, under Part A with delineating a particular "spell of illness." See 42 U.S.C.A. § 1395x(a) (West 1983).
\textsuperscript{261} News stories reporting a June, 1984 meeting of the American Medical Association (AMA) House of Delegates give an indication of the organized medical profession's reaction to any proposal to include physician fees in the DRG system. A story in the June 19, 1984, Washington Post headlined "Right to Die' and Cost Controls Peril Quality Care, Doctors Say," described the contentions of several attendees that the PPS/DRG system was threatening quality health care and could prevent physicians from doing all they can to save lives. Wash. Post, June 19, 1984, at A2, col. 4. An earlier story described physicians' perceptions that they were being squeezed by the PPS/DRG system and quoted the AMA Executive Vice President, Dr. James Sammons as saying that "This is the toughest time for doctors since the end of World War II." Wash. Post, June 18, 1984, at A3, col. 3. In the Congressional hearings preceding enactment of the PPS/DRG system, a representative of the AMA termed the proposal "radical." Ways and Means Hearings, supra note 95, at 184 (statement of Jerald R. Schenken, Vice Chairman of AMA Council on Legis.).
\textsuperscript{262} PAYING THE PHYSICIAN, supra note 91, at 28.
vices is a logical extension; and the organized medical profession is on the defensive. It therefore appears that the system may well be expanded to cover physician fees for Medicare inpatient hospital services. Moreover, it is not out of the question that eventually most, if not all, physician fees will be covered.

4. Extending PPS/DRG Beyond Medicare

In addition to the more likely future changes in the Medicare system, there looms a truly revolutionary possibility: the extension of the PPS/DRG system to include most, or all, third party payers (known as the all-payer system). This could come about either by voluntary action of private organizations, such as Blue Cross/Blue Shield and commercial insurers, or by governmental action.

As to voluntary action, the DRG classification system has now developed to the point where it has already been implemented and is being refined and tested by experience. The system could be used as a ready made model for any third party payer to adopt as its own. It is possible that some Blue Cross/Blue Shield payers and commercial insurers might do just that, but it does not seem likely. It is still too early to tell whether any significant movement by Blue Cross/Blue Shield or commercial insurers to PPS/DRG will develop, but as yet there has been no significant indication of their doing so. Furthermore, it may be that, lacking concerted action by a sizeable number of third party payers, no single organization has the market power to do so. For example, Prudential Insurance Company, which is the largest commercial insurer in the country, has only about 4 percent of the market. To adopt PPS/DRG voluntarily, private third party payers would have to band together and adopt the system collectively, a very difficult if not insuperable task. Therefore, a purely voluntary movement to PPS/DRG is unlikely, although not impossible.

A more likely occurrence is adoption of an all-payer system through governmental action. A recurring theme at the Congressional hearings prior to enactment of the PPS/DRG system was the need for an all-payer plan to make the system work. A wide array of organizations testified in favor of an all-payer system.

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263 Some physicians apparently find the situation threatening. For example, in a recent news story Dr. Robert Wilbur of the Council of Medical Specialty Societies, was quoted as saying: "With the passage of the Medicare legislation,... organized medicine's defense system was smashed." Wash. Post, June 18, 1984, at A3, col. 4.

264 See PPS Hearings, Part 2, supra note 44, at 245 (testimony of John K. Kittredge, Executive Vice-President, Prudential Ins. Co. of Am., on behalf of the Health Ins. Ass'n of Am.).

265 That it is unlikely is not, however, a universally held view. See, e.g., PPS Hearings, Part 2, supra note 44, at 100 (testimony of Harold O. Buzell, President, Health Indus. Manufrs. Ass'n): "[I]f you launch a prospective system based on DRG's for the Medicare population, the rest of us will follow suit very quickly."

266 See, e.g., Ways and Means Hearings, supra note 95, at 56 (statement of Bert Seidman, Executive Director, Dept. of Social Sec., AFL-CIO); Id. at 77 (statement of James M. Hacking, Ass't Legislative Counsel, Ass'n of Retired People); Id. at 102 (statement of Robert M. Crane, Director...
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These organizations based their support of an all-payer system largely on the phenomenon of "cost shifting." They argued that the effect of limiting the PPS/DRG system, with its cost containment features, to Medicare payments would be to cause hospitals to shift uncompensated Medicare costs to other payers. If Medicare payments were limited by the Medicare system of payment, then hospitals would make up for any shortfall by extracting more from other payers who would bear the ultimate economic burden of any Medicare cost savings resulting from PPS/DRG. Those to whom costs would be shifted consist of employers and others who pay health insurance premiums, patients who make direct payments on their hospital bills, and state and local taxpayers who contribute to the support of public hospitals. A PPS/DRG system restricted to Medicare, the all-payer proponents argued, might reduce Medicare's own costs, but would not result in cost reduction for the health care system as a whole.

There is some dispute as to whether such cost shifting actually occurs. Some have argued that, because Medicare represents such a large proportion of hospital revenues it would be difficult for hospitals to shift all of the Medicare cost savings to other payers. Moreover, private payers can hardly be expected to stand idly by while major cost shifting takes place. Nevertheless, there is some evidence that cost shifting has occurred. In New York, prior to institution of an all-payer system, the difference between charges to private insurers and their allocated cost of treatment grew to as much as 80 percent in some cases. The Florida Hospital Cost Containment Board estimated that in 1982 (prior to PPS/DRG) about $65 per patient-day extra costs were shifted to non-Medicare patients to make up for shortfalls in Medicare cost reimbursement.

Although the conclusion that cost shifting constitutes a major problem is subject to question, there is no doubt that many believe it does. Moreover, a study of the DRG system in New Jersey concluded that because of cost shifting an all-payer system was essential for success. Pressure is therefore likely to build for a move to an all-payer system, and indeed it has already been heeded in some
quarters. For example, legislation recently introduced by Senator Kennedy provides for an all-payer system. 272

Moreover, Congress in the PPS/DRG legislation enacted two provisions which portend a future move to an all-payer system. The first of these requires the Secretary of HHS in her 1985 annual report to Congress to include the results of studies on the "feasibility and desirability of applying [the PPS/DRG] payment methodology . . . to payment by all payers for inpatient hospital services," 273 and to include in that report consideration of the effect of cost shifting to nonfederal payers and on employers and employees. 274 The second provision is perhaps more significant but has not received much attention. Congress enacted a provision requiring the Secretary of HHS to grant to individual states waivers from compliance with the national Medicare reimbursement system and permit them to implement their own payment systems under certain conditions. 275 Prior to this legislation, granting such a waiver was an exercise of discretion by the Secretary. 276

By this provision, the Secretary must grant the waiver if the conditions are fulfilled, and the conditions are such that any state seeking a waiver must submit a state hospital payment plan which goes a long way toward an all-payer prospective payment system, albeit not necessarily one based on the DRG classification system. Among other conditions the state plan must apply to substantially all "non-federal acute-care hospitals . . . in the state" and to "at least 75 percent of all revenues or expenses in the state for inpatient hospital services." 277 Moreover, the state plan must utilize a prospective payment methodology. 278

The provision, requiring HHS approval of a waiver under these conditions, amounts to a standing invitation by Congress to the states to set up their own systems of payment covering a substantial portion of payments (and, concomitantly, payers). In order to do so the state must use some form of prospective payment methodology, but does not have to use a DRG system, although not precluded from doing so either. A few states now have HHS waivers granted under the prior discretionary waiver provision. 279 Some, such as Maryland and New Jersey, have

274 Id. § 603(a)(2)(C), 97 Stat. 166, 167.
275 1983 SSA § 601(c)(4), 97 Stat. 151 provides: "The Secretary shall approve the request of a state with respect to a hospital reimbursement control system if [these conditions are fulfilled]." (emphasis added).
276 See 42 U.S.C.A. § 1395ww(c)(1): "The Secretary may provide in his discretion. . . ." (emphasis added).
claimed a significant degree of success in holding down increases in hospital costs, while compensating hospitals adequately. \(^{281}\) If other states accept the invitation Congress has extended through this waiver requirement, the result will be a state-by-state evolution toward an all-payer prospective payment system. State-by-state adoption of such plans is likely to raise less well-organized opposition than proposal of a national federally-enacted plan. States receiving waivers will have a strong incentive to adopt the DRG system since it is readily available and is further developed than any other system. \(^{282}\) If physician fees are ultimately incorporated into the DRG system, as previously discussed, the net effect of all these developments could be a subtle movement toward a nationwide all-payer prospective payment system based on the DRG classifications.

V. CONCLUSION

From what originated as an almost unnoticed amendment to the Old Age and Survivor's Insurance provisions instituting PPS based on DRG classifications for Medicare hospital inpatients alone, a possibly far-reaching transformation in the total system of paying for health care may ensue. In an effort to contain rapidly rising Medicare costs by creating incentives for efficient economic behavior, Congress enacted PPS/DRG and, thus, set the course for future change and development in this country's health care system. PPS/DRG will have a profound effect on providers, patients, insurers and federal programs. Hospital specialization, selectivity in technology use, changes in service utilization, as well as cost-shifting DRG "creep," fewer hospital admissions, and increased preadmission testing and outpatient treatment are just some of the possible effects of PPS/DRG. As the effects and impacts of PPS/DRG come to fruition, and the inevitable refinements, revisions and outgrowths of the system are made, it will become apparent that Medicare prospective payment has begun a quiet revolution in the health care field.

\(^{281}\) See Ways and Means Hearings, supra note 95, at 86-90 (testimony of Harold Cohen, Executive Director, Md. Health Servs. Cost Review Comm'n); PPS Hearings, Part 1, supra note 133, at 159-87 (testimony of Charles F. Pierce, Jr., N.J. Dep't of Health). It should be noted, however, that New Jersey has recently experienced new cost control problems, and the Health Care Financing Administration is threatening not to renew its Medicare waiver on that account. Spencer, U.S. Warns New Jersey on Health-Care Plan's Cost, Wash. Post, June 19, 1984, at A2, col. 1.

\(^{282}\) See PPS Hearings, Part 1, supra note 133, at 32 (testimony of HHS Secretary Richard S. Schweiker): "The Department has concluded that the DRG system is the only currently available methodology which can be easily used for prospective payment..." Id. at 41.