

January 1986

Meeting the Goals of Medicare Prospective Payments

J. Timothy Philipps

Washington & Lee University

Don E. Wineberg

Adler, Pollock & Sheehan

Adam D. Elfenbein

Francis Lewis Law Center

Follow this and additional works at: <https://researchrepository.wvu.edu/wvlr>



Part of the [Government Contracts Commons](#), and the [Medical Jurisprudence Commons](#)

Recommended Citation

J. T. Philipps, Don E. Wineberg & Adam D. Elfenbein, *Meeting the Goals of Medicare Prospective Payments*, 88 W. Va. L. Rev. (1986).

Available at: <https://researchrepository.wvu.edu/wvlr/vol88/iss2/6>

This Article is brought to you for free and open access by the WVU College of Law at The Research Repository @ WVU. It has been accepted for inclusion in West Virginia Law Review by an authorized editor of The Research Repository @ WVU. For more information, please contact ian.harmon@mail.wvu.edu.

MEETING THE GOALS OF MEDICARE PROSPECTIVE PAYMENTS†

J. TIMOTHY PHILIPPS*
DON E. WINEBERG**
ADAM D. ELFENBEIN***

I. INTRODUCTION

A previous article in this law review explained the rationale and structure of the Medicare prospective payment system (PPS) based on diagnosis related groups (DRGs).¹ That article made some predictions concerning likely effects of the system and possible future developments. This article, written a little under two years after first implementation of PPS/DRG in October 1983, assesses the system in terms of the stated goals for the program and offers possible remedies for some of the problems which have arisen.

PPS/DRG has only recently been implemented for all the hospitals it was originally intended to cover,² and the system will not be fully operational until completion of a phase-in period.³ Moreover, empirical data on the impact of PPS/DRG is still sparse at best, and much of the evidence is anecdotal and informal in nature. Consequently, many of the conclusions and opinions expressed in this article are necessarily tentative. Nevertheless, some basic themes and issues

† This article was funded by a grant from the Frances Lewis Law Center.

* Professor of Law, Washington & Lee University; B.S., Wheeling College, 1962; J.D., Georgetown University, 1965; LL.M., Harvard University, 1966.

** Associate, Adler, Pollock & Sheehan, Providence, R.I.; A.B., Brown University, 1980; J.D., Washington & Lee University, 1985.

*** Research Assistant, Frances Lewis Law Center; B.A., State University of New York at Albany, 1983; J.D. (candidate), Washington & Lee University, 1986.

¹ Philipps & Wineberg, *Medicare Prospective Payment: A Quiet Revolution*, 87 W. VA. L. REV. 13 (1984). 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.

² PPS/DRG first became effective on Oct. 1, 1983, Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 149, 153 (1983), *codified* at 42 USC § 1395ww (1983). See note 3 *infra* for a description of PPS/DRG's phase-in.

³ Medicare is gradually phasing in PPS/DRG over three years. This transition is in two parts. The first part is a progressive realignment away from a price based upon the hospital's individual history, the hospital-specific portion, to a price based upon a national standard (federal portion). For hospital fiscal years ending between September 30, 1984 and September 29, 1985, the payment is 75% hospital-specific portion and 25% federal portion. For hospital fiscal years ending between September 30, 1985 and September 29, 1986, the payment is 50% hospital-specific portion and 50% federal portion. For hospital fiscal years ending between September 30, 1986 and September 29, 1987, the payment is 25% hospital specific portion and 75% federal portion. Beginning with hospital fiscal years ending after September 30, 1987 the payments will be 100% federal portion. See 42 U.S.C. 1395ww(d) (1983); the following table from PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, TECHNICAL APPENDIXES TO THE REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 7 (April 1, 1985) [hereinafter cited as PROPAC APPEND.] illustrates the phase-in of the federal portion:

are emerging in the non-legal literature, and it appears useful to air them in a general legal journal at this time as a basis for further evaluation by the larger legal community.

II. EFFECTS AND ISSUES

In its 1982 report to Congress on PPS/DRG the Department of Health and Human Services (HHS) predicted that the new payment system "will provide hospitals an incentive to improve efficiency, will establish Medicare as a prudent

	Hospital-Fiscal Year Ending	Federal Portion	Hospital Specific Portion
1	9/30/84 to 9/29/85	25%	75%
2	9/30/85 to 9/29/86	50%	50%
3	9/30/86 to 9/29/87	75%	25%
4	9/30/87 to 9/29/88	100%	—

The second part of the transition is a shift from a regional adjusted DRG prospective payment rate to a national adjusted prospective payment rate. For hospital discharges from October 1, 1983 through September 30, 1984 the rate is 100% regional. For discharges from October 1, 1985 through September 30, 1986, the rate is 50% regional and 50% national. Discharges after September 30, 1986 are, at the time this is written, scheduled to be 100% federal. *See* 42 U.S.C. 1395 ww(d) (1983). However, proposals currently being considered would freeze the rate blend at 50% regional and 50% national. *See, e.g.,* S. 1400, 99th Cong., 1st Sess. (1985), *reprinted in* 131 CONG. REC. S9096 (July 9, 1985) (Sen. Proxmire). The following table from ProPAC Append., at 7 illustrates the transition to the national rate:

	Federal Fiscal Year	Regional Rate	National Rate
1	Discharges during Oct. 1, 1983-Sept. 30, 1984. . . .	100%	—
2	Discharges during Oct. 1, 1984-Sept. 30, 1985. . . .	75%	25%
3	Discharges during Oct. 1, 1985-Sept. 30, 1986. . . .	50%	50%
4	Discharges after Sept. 30, 1986.	—	100%

The Prospective Payment Assessment Commission (ProPAC), upon whose report the above data is based, was created by the PPS/DRG legislation. Pub. No. 98-21, § 601(e), 97 Stat. 159, codified at 42 U.S.C. 1395 ww(e)(2) (1983). Every April 1, ProPAC must present a written recommendation concerning the annual increase in DRG prices. Moreover, in 1986, and at least every four years thereafter, the April 1 report must also review the individual DRGs' weights and categories. *See* 97 Stat. 157; OFFICE OF TECHNOLOGY ASSESSMENT, *First Report on the Prospective Payment Assessment Commission*, at 3 (1985). [hereinafter cited as OTA REPORT].

buyer of hospital services, will reduce the administrative burden on hospitals, and will assure beneficiary access to quality health care.”⁴ Of these goals it appears that PPS/DRG has indeed provided hospitals with an incentive to improve efficiency and made Medicare a more prudent buyer of hospital services, if by that is meant a buyer of less at lower prices. That PPS/DRG has accomplished the other two goals—reducing the administrative burden on hospitals and assuring access to quality health care—is considerably more controversial.

A. *Efficiency Incentive and Prudent Buyer of Hospital Services*

The first two stated goals will be treated together, since they are closely inter-related. Both aim toward the ultimate goal of Medicare cost containment. There can be little doubt that PPS/DRG has been largely successful in attaining its goal of Medicare cost containment. Moreover, PPS/DRG has probably contributed to a slowing down of cost rises in the medical care system as a whole. This is not surprising when one considers that the incentives in PPS/DRG are basically in the direction of cost cutting. Medicare pays the hospital a prospectively determined price per discharge based on the diagnosis classified according to DRG. If costs exceed that price, the hospital loses money; if costs are less than that price, the hospital makes money. Since the price is fixed, the way to turn a profit, or at least break even, is to cut costs.

1. Reduction in Hospital Utilization

The available statistics indicate that hospitals have been cutting costs since the inception of PPS/DRG. How much of this phenomenon is attributable to PPS/DRG and how much to other factors such as a slowing in the rate of general inflation is not known. However, a substantial part is undoubtedly due to PPS/DRG, since it is consistent with the cost cutting incentives of PPS/DRG.⁵

One solid indicator of hospital costs is the average length of stay (LOS) per hospital discharge. This is because LOS is closely related to hospital costs—the longer the stay, the higher the cost of that stay is likely to be.⁶ On this basis costs have been cut drastically. The average LOS per Medicare discharge in pre-PPS/DRG fiscal year 1983 was 9.5 days. The average LOS per PPS/DRG discharge in fiscal year 1984 was 7.5 days, a decrease of 21 percent.⁷ It, therefore, appears that medical

⁴ UNITED STATES DEP'T OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS: HOSPITAL PROSPECTIVE PAYMENT FOR MEDICARE (1982) at 1 [hereinafter cited as PPS REPORT].

⁵ See ProPAC APPEND., *supra* note 3, at 52.

⁶ *Id.* at 52.

⁷ U.S. GENERAL ACCOUNTING OFFICE: INFORMATION REQUIREMENTS FOR EVALUATING THE IMPACTS OF MEDICARE PROSPECTIVE PAYMENT ON POST-HOSPITAL LONG-TERM CARE SERVICES: PRELIMINARY REPORT (GAO/PEMQ-85-8 at 4 (Feb. 21, 1985)) [hereinafter cited as GAO PPS/DRG REPORT]; *reprinted in*

care providers have reacted sharply to PPS/DRG by reducing average LOS substantially.

This, of course, is precisely what PPS/DRG was expected to accomplish. More surprising, however, is that admissions to hospitals have also declined.⁸ At the inception of PPS/DRG, fears were expressed that the system might result in an increase in admissions as physicians and hospitals attempted to compensate for a decline in LOS by increasing the volume of patients.⁹ This seemed especially likely in view of the fact that physicians are still paid on a fee-for-service basis for inpatient hospital care while hospitals are paid under PPS/DRG. Physicians, who do the admitting, would have a real incentive to increase the volume of admissions and in the process increase their fees.¹⁰ In fact, however, both overall admissions, and admissions of patients over 65 years of age have declined since the advent of PPS/DRG.¹¹ Moreover, the trend appears to have accelerated as more hospitals came under PPS/DRG in 1984.¹²

The reasons for the decrease in admissions patterns are speculative. However, several reasons have been put forth. First, a general cost consciousness among all payors for medical services has resulted in attempts to restrict admissions to those where inpatient treatment is truly necessary. For example, many corporate health plans now either require or pay higher reimbursement for out-patient performance

Sustaining Quality Health Care Under Cost Containment: Joint Hearing before the House Select Committee on Aging and the Task Force on the Rural Elderly of the Select Committee on Aging, at 101, 99th Cong., 1st Sess. (1985). The average LOS per PPS/DRG discharge was up slightly to 7.6 days for the first five months of fiscal year 1985. DEP'T. OF HEALTH AND HUMAN SERVICES, HCFA BACKGROUND PAPER at 2 (June 1985).

⁸ PROPAC APPEND., *supra* note 3, at 53-54.

⁹ See, e.g., Wennberg, McPherson, and Caper, *Will Payment Based on Diagnosis-Related Groups Control Hospital Costs?*, 311 NEW ENG. J. MED. 295 (1984). These concerns were supported by the New Jersey experience with its PPS/DRG system. See Stern & Epstein, *Institutional Responses to Prospective Payment Based on Diagnosis-Related Groups: Implications for Cost, Quality, and Access*, 312 NEW ENG. J. MED. 621, 625 (1985).

¹⁰ Physicians, on the average, generate more revenue per hour by dispensing care to hospital inpatients than by office visits. STAFF OF SPECIAL SENATE COMM. ON AGING, 98TH CONG. 2D SESS., MEDICARE: PAYING THE PHYSICIAN-HISTORY, ISSUES & OPTIONS, at 22 (Comm. Print 1984).

¹¹ PROPAC APPEND., *supra* note 3, at 53-54.

¹² *Id.* The following table illustrates the long-term trends in admissions.

of certain surgical procedures such as tonsillectomies and cataract removal,¹³ and most provide for second opinions in the case of many surgical procedures.¹⁴ In addition, many more health plans are requiring payment of at least a part of the cost of health care (co-payment) by the recipient in the form of a deductible, coinsurance, or both.¹⁵

With respect to Medicare at least two additional elements appear to be related to the decline in admissions. First, the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS) administers the Admissions Pattern Monitoring System designed to review discharges for every hospital to determine if there has been a substantial increase in number of hospital discharges as compared to a previous period.¹⁶ Second, contracts with Utilization

Trends in Utilization

Percent Change in Admissions

Year	All Admissions	Admissions Per 1000 Pop.	Age 65 + Admissions	Age 65 + Admissions Per 1000 Pop.
1970	6.26%	5.93%	2.61%	0.43%
1971	0.04	-1.26	3.40	1.11
1972	2.56	1.36	6.15	3.83
1973	3.50	2.48	5.72	3.24
1974	3.70	2.73	6.01	3.43
1975	0.30	-0.69	4.50	1.59
1976	3.36	2.36	7.02	4.35
1977	2.52	1.50	4.38	1.69
1978	0.45	-0.61	4.88	2.26
1979	2.66	1.08	5.28	2.63
1980	2.89	2.44	6.70	4.32
1981	0.85	-0.45	3.03	0.90
1982	0.05	-0.93	4.08	1.87
1983	-0.55	1.50	4.74	2.60
1984 (9 mos)	-3.90	-4.89	-2.70	-5.40

Id. at 54.

¹³ See THE BUSINESS ROUNDTABLE TASK FORCE ON HEALTH, CORPORATE HEALTH CARE COST MANAGEMENT AND PRIVATE SECTOR INITIATIVE, 18-20 (1984) [hereinafter cited as BUSINESS ROUNDTABLE]; Colburn, *Hospital Use Drops Sharply*, Wash. Post, May 24, 1985, at 7, col. 1.

¹⁴ BUSINESS ROUNDTABLE, *supra* note 13, at 18-20. See generally, Herzlinger and Schwartz, *How Companies Tackle Health Care Costs: Part I*, HARV. BUS. REV., July-Aug. 1985, at 69; Herzlinger and Schwartz, *How Companies Tackle Health Care Costs: Part II*, HARV. BUS. REV., Sept.-Oct. 1985, at 108.

¹⁵ *Id.* at 24-28. A deductible requires that the recipient pay all of some floor amount of the cost of care, such as the first \$300. Coinsurance requires that the recipient pay a given percentage of the cost of care after the deductible amount has been reached. The standard percentage is set by many plans at 20%. *Id.* at 26.

¹⁶ 42 C.F.R. § 412.45 (1985). For the first three quarters this system was in effect 1,446 hospitals came under review. Of these 54% required no action, 31% required corrective action and 15% were still under review. REPORT OF THE AMERICAN MEDICAL ASSOCIATION BOARD OF TRUSTEES, AMA'S DRG MONITORING PROJECT AND THE PROSPECTIVE PAYMENT SYSTEM at 2 (Dec. 1984) [hereinafter cited as

and Quality Peer Review Organizations (PROs) have been entered into by HCFA under statutory authorization¹⁷ to monitor utilization and quality practices of Medicare providers. HCFA has placed emphasis on controlling admissions in formulating requirements for these PRO contracts.¹⁸ Both of these mechanisms have apparently caused physicians and hospitals to be cautious about making what might be deemed "unnecessary" or "inappropriate" admissions.¹⁹

Shorter LOS and decreased admissions have obviously resulted in lower costs for health care in general²⁰ and Medicare in particular.²¹ Although some of the

AMA MONITORING PROJECT]. HCFA is currently proposing to replace the system set out in 42 C.F.R. § 412.45 (1985) with more efficient simplified procedures. 50 Fed. Reg. 24,379 (June 10, 1985).

¹⁷ See 42 U.S.C. § 1320c-1320c-12j; 42 C.F.R. § 462.100-107 (1984). Congress established the Utilization and Quality Control Peer Review (PRO) Program by amending Part B of Title XI of the Social Security Act. The PRO Program replaced the Professional Standards Review Organization (PSRO) program. Both programs concern local peer review and standard setting. Under the PSRO program each PSRO had to be nonprofit and have at least 25% of the area physicians as members. A PRO may operate for profit and need have only 10% (in some cases less) of the area physicians as members. PSROs received annual grants. PRO contracts with the Secretary of HHS are biennial. Each PRO must state goals to be accomplished over the two year contract. PSROs were not required to do this. A PRO sanction against an unsatisfactory provider becomes valid unless the HHS Secretary orders to the contrary within 120 days of the report's submission. A PSRO sanction had to be validated by the Secretary. PRO contracts were first awarded in the third quarter of 1984. HHS unified groups of PSRO areas into larger PRO areas. Each state will be a separate PRO area. Each PRO will develop its own rules and regulations. HHS's only interest is the quality of the review. HHS expects PROs to be more cost effective than PSROs. See 48 Fed. Reg. 36,970 (1983). See generally, Dans Weiner and Otter, *Peer Review Organizations*, 313 NEW ENG. J. MED. 1131 (1985).

¹⁸ See *Sustaining Quality Health Care Under Cost Containment: Joint Hearing before the House Select Committee on Aging and the Task Force on the Rural Elderly of the Select Committee on Aging 88-94*, 99th Cong., 1st Sess. (1985) [hereinafter cited as *Sustaining Quality Health Care*]; text accompanying notes 185 to 200 *infra*.

¹⁹ See *Sustaining Quality Health Care*, *supra* note 18, at 23: "Where a PRO designates a particular procedure as more appropriately performed on an outpatient basis, any attempt to hospitalize a patient for that procedure must be clearly documented or payment will be denied." (Statement of Louis Krieger, Chairman of New York State Legislative Committee of American Association of Retired persons.) Cf. 42 U.S.C. § 1395ww(f) (1983), (when HCFA or PRO determine hospital admission is unacceptable payment will be denied).

²⁰ The following table illustrates the trend in Medical Care Prices during the 1980s:

Percent Change in Selected Components of
Consumer Price Index, 1980-1984 Annual Averages

	CPI all items	CPI, all items less medical care	Medical care total	Hospital room	Physicians' services
1980	13.5	13.6	10.9	13.1	10.6
1981	10.4	10.3	10.8	14.8	11.0
1982	6.1	5.9	11.6	15.7	9.4
1983	3.2	2.9	8.7	11.3	7.7
1984	4.3	4.1	6.2	8.3	7.0

J. REUTER, *Health Care Expenditures and Prices*, Cong. Research Service Issue Brief IB77066 at CRS-5 (updated 3/1/85).

diminished pressure on health care prices can be attributed to a slowing in the general rate of inflation in the past few years, a substantial part of the decrease is the result of measures in the health care sector itself, leading to lower rates of hospital utilization and concomitant lower costs.²²

2. Reduction in Employment by Hospitals

Declines in hospital utilization have led to reduced employment by hospitals. The number of full-time equivalent of persons (FTE) employed by hospitals had historically grown at a rate of about four percent per year.²³ Growth in FTE began to slow down in 1982 and became negative in 1984.²⁴ The decline in FTE was not as rapid, however, as the decline in LOS and admissions, probably because of a normal lag time between hospital census declines and employment reductions.²⁵ This suggests that FTE will decline even further in the future.

A recent survey by the American Nurses Association indicates that the decline in FTE has affected various classes of hospital employees differently. Most respondents to the survey believed that a shift toward greater use of registered nurses as opposed to other nursing staff has been occurring.²⁶ The shift toward greater reliance on registered nurses has resulted mainly from attrition of other categories of employees such as licensed practical nurses and nurses' aides.²⁷ In addition, forty percent of the respondents reported a reduction in hours and budgeted positions.²⁸ The survey's summary indicates that, "These developments are almost certainly a consequence of the decline in census reported by 82% of respondents, 40% of whom identify reduced census as being 'primarily due to Medicare' changes involving prospective pricing and DRGs."²⁹

It is well documented, therefore, that PPS/DRG has at least helped to bring about a situation in which physicians and hospitals are acting to reduce the costs of inpatient hospital care. This is reflected in new optimism (or at least diminished pessimism) over the state of the Hospital Insurance Trust Fund through which Medicare Part A³⁰ is financed. Prior projections indicated that the fund could be

99TH CONG., 1ST SESS., MEDICARE, HEALTH CARE EXPENDITURES, AND THE ELDERLY 17-19 (Comm. Print 1985) [hereinafter cited as MEDICARE, HEALTH CARE EXPENDITURES].

²² See Virts & Wilson, *Inflation and the Behavior of Sectoral Prices*, Bus. Econ., May 1983, at 45.

²³ PROFAC APPEND., *supra* note 3, at 53.

²⁴ *Id.*

²⁵ *Id.*

²⁶ CENTER FOR RESEARCH, AMERICAN NURSES' ASSOCIATION, SUMMARY OF RESULTS OF SURVEY TO ASSESS THE IMPACT OF MEDICARE PROSPECTIVE PRICING SYSTEM, at 1 (January, 1985) [hereinafter cited as ANA SURVEY]. The survey was sent to 384 members of the American Nurses' Association Council on Nursing Administration. Fifty percent or 193 of those surveyed returned the questionnaire. Of these, 118 were included in the analysis. Those responses not included were from respondents who work in institutions not under PPS/DRG such as psychiatric hospitals, children's hospitals, and nursing homes. *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ 42 U.S.C.A. § 13951 (West 1983). Medicare consists of two programs: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part A basically covers inpatient hospital services,

depleted as early as 1988.³¹ Now the Congressional Budget Office predicts that exhaustion of the trust fund may be postponed until the mid-1990s,³² and some knowledgeable officials believe the date of exhaustion may be pushed back as far as the end of the century.³³

All the foregoing developments indicate that PPS/DRG has had a substantial effect in lowering Medicare inpatient hospital costs by providing hospitals with incentives to become more efficient and thereby making Medicare a "more prudent purchaser" of hospital inpatient services. Undoubtedly, in this respect, PPS/DRG has so far proven to be a marked improvement over the old system of retrospective cost reimbursement. Nevertheless, PPS/DRG is still new and to a degree experimental. As might have been expected, complaints have arisen about the system. These largely involve problems concerning PPS/DRG's two other stated goals—reducing the administrative burden on hospitals and assuring access to quality health care. In addition, the system's failure to provide a mechanism for appeal of the DRG rates set by HHS has caused concern to some. The validity of these complaints is difficult to assess at this stage. However, they are of sufficient gravity that those concerned with health care should give them serious consideration and act to remedy those that are valid where that is possible.

B. *Reducing the Administrative Burden on Hospitals*

The publicly available evidence of the extent to which PPS/DRG has accomplished this goal is sparse. Administration of Medicare (and other third party payment mechanisms) has always presented an administrative problem for hospitals, and the degree to which PPS/DRG has either increased or lightened that burden is unclear.

1. Record-Keeping and Discharge Planning

Some administrative functions almost certainly require increased input under PPS/DRG. For example, medical records must have a high degree of accuracy

skilled nursing facility services, and certain home health services. 42 U.S.C.A. § 1395a (West 1983). Part A is financed by compulsory payroll taxes earmarked for the Federal Hospital Insurance Trust Fund. 42 U.S.C.A. § 1395g (West 1983). Medicare Part B is a voluntary insurance plan designed to cover the cost of independent practitioners (primarily physicians), outpatient hospital services, laboratory services, and other medical and related services. 42 U.S.C.A. § 1395k (West 1983). It is financed partly by general federal revenues and partly by premiums paid by enrollees. 42 U.S.C.A. § 1395t (West 1983). Almost all persons enrolled under Part A are also enrolled under Part B. K. Davis & D. Rowland, *Reforming Medicare: A New Approach to Financing* 121, 122 (1983); reprinted in STAFF OF HOUSE COMM. ON WAYS AND MEANS, 98TH CONG., 1ST SESS., PROCEEDINGS AND PRELIMINARY PAPERS OF THE CONFERENCE ON THE FUTURE OF MEDICARE (Comm. Print. 1983).

³¹ BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND, 1983 ANNUAL REPORT: FEDERAL HOSPITAL INSURANCE TRUST FUND at 43.

³² MEDICARE, HEALTH CARE EXPENDITURES, *supra* note 21, at 23.

³³ *The Bipartisan Budget Control Act of 2011*, H.R. REP. NO. 111-175, 111th CONG. 1ST SESS. (2009), at 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

if the hospital is to receive proper reimbursement under PPS/DRG. This requires increased and more skilled personnel in the medical records department.³⁴ In addition, it appears that many hospitals have found it necessary to upgrade their data processing equipment in order to monitor physician admission and discharge practices, and profitable and unprofitable DRGs. Some hospitals have gone so far as to appoint a "DRG Coordinator" to monitor compliance with the system.³⁵

Another area of increased need is discharge planning. If patients are in fact being discharged earlier than in the past, as lower LOS indicates, it becomes more important that they be properly prepared and placed in appropriate settings upon their discharge.³⁶

New Jersey's PPS/DRG system has been in place longer than Medicare's. A survey of that state's hospitals on the impact of its PPS/DRG system (a prototype for Medicare PPS/DRG) found a consensus that the system had increased administrative costs.³⁷ At least some of this increase might be explained, however, by the fact that New Jersey's system applies to all payors, resulting in greater complexity in administering that system.

None of these results is unexpected, given the nature of PPS/DRG and its inherent incentives. Moreover, implementation of any new system is bound to result in new costs as the system starts up. The real question is whether these costs will be counterbalanced over time by increased efficiencies that the new procedures bring about and by elimination of costs associated with the old system. For example, it may be possible to eliminate some detailed cost accounting and audit procedures required by the old cost reimbursement system as PPS/DRG moves toward standardized nationally established DRG prices.³⁸

³⁴ In the ANA survey 87% of the respondents reported increased emphasis on medical records at their hospitals and 65% attributed this increased emphasis to PPS/DRG. ANA SURVEY, *supra* note 26, Table 4.

³⁵ See *Sustaining Quality Health Care*, *supra* note 18, at 26 (Testimony of Pat Hanson, Hospital DRG Coordinator); Stern & Epstein, *supra* note 9, at 624.

³⁶ See text accompanying notes 56 to 79 *infra*. In the ANS Survey 91% of the respondents reported increased emphasis on discharge planning at their hospitals and 68% attributed that increased emphasis to PPS/DRG. ANA SURVEY, *supra* note 26, Table 4.

³⁷ *New Jersey's Hospital Reimbursement System, Hearing before the House Select Committee on Aging*, 98th Cong., 1st Sess., 1983 [hereinafter cited as *New Jersey's Hospital Reimbursement System*] (statement of Dr. Alfred Alessi, Past President Medical Society of New Jersey and Cochairman, Medical Society DRG Evaluation Committee):

A broad consensus exists that the system has increased management, and cost due to management, data processing, medical records, fiscal and patient billing costs, and a need for additional staff at each hospital certainly has occurred.

Id. at 18.

It is reported that in New Jersey the personnel required in medical records departments has increased by an average of 3.3 FTE. Stern & Epstein, *supra* note 9, at 624.

³⁸ See *Sustaining Quality Health Care* *supra* note 18, at 65 (Statement of Ben White, Hospital Administrator). It may also be possible to replace the current overly cumbersome system for establishing the right to cost outlier (a hospital stay that is atypical because of unusually high costs) payments. *Id.*

2. Physician-Hospital Relationship

Another administrative problem facing hospitals under PPS/DRG is the changing relationships between hospitals and their physician staff. Hospital administrators have traditionally deferred to physician staff on medical decisions and also other decisions that involve hospital management.³⁹ The onset of PPS/DRG, among other things, has forced hospital administrators to rework this relationship and assume a more assertive role.⁴⁰ As PPS/DRG has made hospital administrators more cost conscious by putting financial pressure on them, they have responded by assuming a more active role in monitoring physician practices. A physician whose patients regularly have LOS beyond the DRG average is likely to be informed by the hospital administration that this is occurring. If his practices persist, there may be attempts at moral suasion and, in egregious cases, threat of loss of privileges.⁴¹

Many physicians are understandably unhappy about such developments. In a recent survey by the American Medical Association (AMA), forty-one percent of respondents reported a deterioration in relations between physicians and hospital management, thirty-one percent reported no change, and twenty-eight percent reported an improvement in relations.⁴² Hospital administrators have taken action to ease the strain in relations brought on by PPS/DRG. Among the steps reported are: providing individual physicians with profiles of their costs of treating patients; seeking suggestions from physicians on ways to control costs; developing a DRG committee comprised of physicians, administrators, nurses, and other personnel to identify cost-saving measures; investigating practice patterns of physicians deemed "DRG winners" to understand better the reasons for their positive financial impact; and providing extensive medical staff education in implementation of PPS/DRG.⁴³ Such measures have been viewed favorably by physicians and should help considerably in making the transition to the new system.⁴⁴

C. Assure Beneficiary Access to Quality Health Care

Whether PPS/DRG is achieving the goal of assuring beneficiary access to quality health care is a controversial issue. This involves providing Medicare patients with

³⁹ See Havighurst, *Doctors and Hospitals: An Anti-Trust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1084-1092. See generally, Angell, *Cost Containment and the Physician*, 254 J. AM. MED. A. 1203 (1985).

⁴⁰ *Id.* at 1077-1078. Other factors are an increased physician supply, resulting in increased hospital bargaining power in acquiring physician staff, and the threat of malpractice liability on the part of hospitals for actions of physician staff. *Id.* at 1077-78.

⁴¹ See, e.g., *Sustaining Quality Health Care supra* note 18 at 36 (testimony of Pat Hanson, Hospital DRG Coordinator).

⁴² AMA MONITORING PROJECT, *supra* note 16, at 10. Physicians have, in general, been more critical of PPS/DRG than other groups involved in health care. See, e.g., *New Jersey's Hospital Reimbursement System, supra* note 37, at 17-19 (statement of Dr. Alfred Alessi); *Sustaining Quality Health Care passim*. See generally, Rogers, *Weathering the Storm*, 254 J. AM. MED. A. 1461 (1985).

⁴³ AMA MONITORING PROJECT, *supra* note 16, at 10-11.

⁴⁴ See *id.* at 10.

treatment appropriate to their illnesses, neither overtreating nor undertreating them, and compensating hospitals equitably in an amount commensurate with the services provided.

1. Appropriate Treatment

The principal questions raised so far concerning the appropriateness of treatment under PPS/DRG involve allegations that patients are being discharged too early from the hospital, that there is insufficient provision for care after hospitalization, and that ancillary services to hospital inpatients may be reduced excessively. In addition, there have been indications of physician dissatisfaction with PPS/DRG.

a. *Early Discharge.* A common criticism of PPS/DRG to date has been the charge that it has resulted in undertreatment of patients, primarily through discharging them from the hospital before they are ready to go home.⁴⁵ This criticism, however, may be due more to misapplication of the system and lack of adequate arrangements for care following hospitalization than to defects inherent in PPS/DRG itself.

A report from the General Accounting Office (GAO) to Senator John Heinz, Chairman of the Senate Special Committee on Aging, expressed concern that "some discharges from the hospital may be premature."⁴⁶ Senator Heinz concluded from this report that Medicare patients are being discharged "quicker and sicker."⁴⁷ An informal non-scientific survey of State Long-Term Care Ombudsmen by Representative Mike Synar, Chairman of the Task Force on the Rural Elderly of the House Select Committee on Aging, reached conclusions similar to those of the GAO. Seventy-five percent of those responding to Representative Synar's survey said patients are being discharged "sicker" or "much sicker" than before PPS/DRG.⁴⁸ The AMA survey, discussed above, reported that sixty-three percent of the respondents stated that quality of care had deteriorated or that it would deteriorate over time if PPS/DRG remained in effect.⁴⁹ Pressure on physicians by hospital ad-

⁴⁵ See e.g., *Sustaining Quality Health Care* *supra* note 18, at 119 (Letter from Lynn K. Klobuchar, attorney for the Senior Citizens Law Project of Legal Aid Service of North Eastern Minn.); 135 (Statement by James Roosevelt, National Committee to Preserve Social Security and Medicare); 139 (Statement by Sally Hart Wilson, staff attorney for National Senior Citizen's Law Center); *Medicare DRGs: Challenges For Quality Care, Hearing before the Senate Special Committee on Aging, passim*, 99th Cong., 1st. Sess. (1985); Hull, *Medicare Payment Plan is Blamed for Hasty Release of Aged Patients*, Wall St. J., June 26, 1985, at 35, col. 4.

⁴⁶ *Sustaining Quality Health Care*, *supra* note 18, at 102. The study was based on interviews with representatives of health care providers (representing hospitals, home health agencies, and skilled nursing facilities), advocate groups, health planning agencies, and PROs in six communities: Adrian, Michigan; Corpus Christi, Texas; Orlando, Florida; Pittsburgh, Pennsylvania; Richmond, Virginia; and Seattle, Washington. *Id.* at 103.

⁴⁷ Press release from Sen. John Heinz, February 26, 1985.

⁴⁸ *Sustaining Quality Health Care* *supra* note 18, at 4 (Survey submitted by Rep. Mike Synar, Chairman of House Select Comm. on Aging Task Force on Rural Elderly).

⁴⁹ AMA MONITORING PROJECT, *supra* note 16, at 7.

ministrators to make early discharges was cited as one of the principal concerns by those giving negative responses on quality of care.⁵⁰ These surveys are preliminary and do not purport to be scientific. Furthermore, the physicians responding to the AMA survey can hardly be characterized as disinterested observers. Nevertheless, this preliminary information is sufficient to cause concern, and it is obvious that some premature discharges have occurred.

At least part of the problem appears to stem from simple ignorance. When the DRGs and their respective weights were first published, the average LOS for each DRG was also published.⁵¹ Some hospital administrators have taken this average figure as a maximum.⁵² When the patient's LOS reaches the DRG's average LOS, they assume that the hospital is thereafter losing money and pressures to discharge the patient increase markedly.⁵³ It has been reported that in some instances when the average DRG days are up, patients have been told they must leave the hospital because "their Medicare coverage has run out."⁵⁴

These are obviously abuses of the system, but they are not the result of defects inherent to PPS/DRG itself. Rather, they are the result of misinformation and misapplication of PPS/DRG. The remedy is not to change the system; it is to better inform the system's participants about how it works.⁵⁵

⁵⁰ *Id.* The other principal concerns were complicated hospital stays, readmissions, and limitations on testing. With respect to complicated hospital stays, the main concern was that when a second condition requiring treatment is diagnosed some hospitals have encouraged the physician to discharge the patient and readmit the patient at a later date for treatment of the second condition. *Id.* at 7-8.

⁵¹ 48 Fed. Reg. 39, 876 (Sept. 1, 1983).

⁵² AMA MONITORING PROJECT, *supra* note 16, at 9; *Sustaining Quality Health Care*, *supra* note 18, at 25 (statement of Pat Hanson, hospital DRG coordinator); *Id.* at 120 (letter from Lynn K. Klobuchar, attorney for the Senior Citizens Law Project of Legal Aid Service of Northeastern Minnesota).

⁵³ *See e.g.*, *Sustaining Quality Health Care*, *supra* note 18, at 120, (letter from Lynn K. Klobuchar, attorney for the Senior Citizens Law Project of Legal Aid Service of Northeastern Minnesota):

A common comment made to me by Medicare recipients is that hospital staff people inform them from day one of hospitalization when their DRG days are up. Many hospital staff appear to feel that the average days computed for amount of payment purposes, contemplated for any given DRG is "check out time" for every patient.

Id. at 120.

⁵⁴ GAO PPS/DRG REPORT, *supra* note 7, at 7.

⁵⁵ *See* AMA MONITORING PROJECT, *supra* note 16, at 9:

It is important to clarify that the mean LOS . . . is not meant to be the absolute maximum number of available days to treat a patient in a given DRG; rather it is a reflection of the average number of days required for treating a patient. It is possible for a patient to be treated and discharged in less than the mean LOS and still incur costs higher than the DRG rate of reimbursement. It is hoped, therefore, that hospitals will analyze both LOS and utilization of hospital resources before developing hospital policies on early discharges.

Id. at 9. The spectre of medical malpractice suits should help deter the premature discharge of hospital patients. Physicians and hospitals who abuse the system by premature discharge of patients may receive a painful lesson in court for patient abandonment. *See* Marsh, *Health Care Cost Containment and the Duty to Treat*, 6 J. LEGAL MED. 157, 178-185 (1985); Note, *Rethinking Medical Malpractice in Light of Medicare Cost Cutting*, 98 HARV. L. REV. 1004 (1985).

b. *Need for Aftercare.* A second aspect of the early discharge problem is less tractable. Average LOS of Medicare patients is indisputably down substantially.⁵⁶ The necessary corollary to this is that patients are in fact being discharged earlier than they were prior to PPS/DRG. It may, therefore, be true that “patients are being discharged from hospitals after shorter lengths of stay and in a poorer state of health than prior to” PPS/DRG.⁵⁷ If that is so, the questions remain: Does this represent poorer medical practice than existed prior to PPS/DRG? Are patients being adversely affected? If so, what remedies are available?

The philosophy of the current system appears to be that a patient should be hospitalized only when hospitalization is necessary. The basic goal is to eliminate unnecessary utilization by monitoring admissions through PROs and HCFA’s Admissions Pattern Monitoring System and by providing financial incentives for earlier discharge through the PPS/DRG mechanism.⁵⁸ However, there are patients who, while not sick enough to require hospitalization, are also not well enough to be at home without some form of care. If they cannot be kept in the hospital, some form of care after hospitalization should be provided. It is here that the Medicare system (in contrast to Medicare’s PPS/DRG aspect) seems to be experiencing difficulty.

Demand for health care following hospitalization (aftercare) appears to be on the increase following implementation of PPS/DRG. A preliminary survey of Area Agencies on Aging by the Southwest Long Term Care Gerontology Center of the University of Texas Health Science Center indicated increased demand for skilled home health care (HHC) services and support services such as home delivered meals and housekeeping services in the post-PPS/DRG period.⁵⁹ The study also found that persons needed skilled care at home for an increased length of time.⁶⁰ These findings support the thesis that earlier hospital discharges of hospital patients is resulting in sicker patients demanding increased provision of aftercare services. To the extent that Medicare patients are discharged from hospitals sooner and with greater need for care, the demand for nursing and home health services covered by Medicare will increase.⁶¹

Unfortunately, no truly effective policy for addressing Medicare patients’ aftercare needs presently exists.⁶² Medicare’s coverage of skilled nursing facility (SNF)⁶³

⁵⁶ See *supra* text accompanying notes 5 to 7.

⁵⁷ GAO PPS/DRG REPORT, *supra* note 7, at 4.

⁵⁸ See *supra* text accompanying notes 5 to 22.

⁵⁹ SOUTHWEST LONG TERM CARE GERONTOLOGY CENTER, IMPLEMENTATION OF DRGs AND CHANGES IN SERVICE DELIVERY 6 (1985).

⁶⁰ *Id.*

⁶¹ GAO PPS/DRG REPORT, *supra* note 7, at 4.

⁶² GENERAL ACCOUNTING OFFICE, MEDICAID AND NURSING HOME CARE: COST INCREASES AND THE NEED FOR SERVICES ARE CREATING PROBLEMS FOR THE STATES AND THE ELDERLY at 1 (GAO/IFE 84-1, October, 1983) [hereinafter cited as GAO NURSING HOME REPORT].

⁶³ The term skilled nursing facility (SNF) refers to two distinct types of convalescent facilities which must follow the same admission rules: the “Swing-bed Hospital” and the Skilled Nursing Facility. Disseminated by The Research Repository at WVU, 1986

services is limited to short-term care for patients who require daily delivery of skilled nursing or rehabilitative services.⁶⁴ Additionally, the patient must have been hospitalized for at least three consecutive days prior to entering the SNF.⁶⁵ If a patient meets the eligibility requirements for SNF care, Medicare will pay for all approved expenses only for the first twenty days. There is a fifty dollar co-payment per day for the following eighty days, and then no payment after that for a single "spell of illness."⁶⁶ The average length of stay in an SNF for Medicare patients was about twenty-eight days in 1983.⁶⁷ Only a small percentage of total Medicare expenditures is spent for SNF care.⁶⁸ Medicaid has become the predominant payor for nursing home care.⁶⁹

SNFs do not appear to be filling the gap created by the earlier discharges encountered under PPS/DRG. HHS's own analysis indicates that a significant increase in use of SNFs may be precluded by such factors as shortage of SNF beds and reluctance of SNFs to accept Medicare patients who may become eligible for Medicaid (at low Medicaid payment rates) when their Medicare eligibility expires.⁷⁰

The situation with respect to HHC is similar. There is an acceleration of a trend started prior to PPS/DRG toward greater utilization of HHC,⁷¹ but stringent eligibility requirements and lack of availability militate against its use as a substitute for hospitalization.⁷²

42 U.S.C. § 1395tt(b) (1984). The SNF is distinct from the rest of the hospital, although not necessarily a separate edifice. 42 U.S.C. 1395x(j) (1984). A "Swing-bed Hospital" is a small facility, usually rural with fifty or fewer beds. The facility must, among other things, be a qualified Medicare hospital and substantially fulfill the requirements to be a SNF. 42 U.S.C. 1395tt(a)(1), (b)(1).

⁶⁴ 42 U.S.C. 1395d(b)(2); 42 C.F.R. § 409.31(b) (1984).

⁶⁵ 42 U.S.C. § 1395x(1); 42 C.F.R. § 409.30(a)(1) (1984). The day of discharge does not count toward the three days.

⁶⁶ 42 U.S.C. § 1395d(a)(2) (1984). A spell of illness begins upon the first day that the patient receives qualified Medicare Inpatient Hospital/SNF treatment, if the patient is eligible for Medicare coverage that month. 42 U.S.C. § 1395x(a)1 (1984). A "Spell of Illness" ends when the patient has been in neither a hospital nor an SNF for the previous sixty days. 42 U.S.C. § 1395x(a)(2). The day of discharge counts as a day out. RIA SOCIAL SECURITY COORDINATOR ¶ 60,433, *citing* SKILLED NURSING FACILITY MANUAL § 240 (1984).

⁶⁷ GAO NURSING HOME REPORT, *supra* note 64.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Sustaining Quality Health Care*, *supra* note 18, at 104. See *Generally*, Harrington and Swan, *Medicaid Nursing Home Reimbursement Policies, Rates, and Expenditures* 6 HEALTH CARE FIN. REV. 39 (1984).

⁷¹ *Sustaining Quality Health Care*, *supra* note 18, at 104.

⁷² *Sustaining Quality Health Care*, *supra* note 18, at 13-14 (statement of Pat Hanson, Hospital DRG coordinator). See *Generally*, H.A. PALLEY & J.S. OKTAY, *THE CHRONICALLY LIMITED ELDERLY: THE CASE FOR A NATIONAL POLICY FOR IN-HOME HEALTH AND SUPPORTIVE COMMUNITY BASED SERVICES* (1983); FELDBLUM, *Home Health Care for the Elderly: Programs, Problems, and Potentials*, 22 HARV. J. LEGIS. 193 (1985).

Several requirements must be satisfied before Medicare Hospital Insurance will pay for any care

Clearly, provision for SNF and HHC services needs to be upgraded and liberalized under Medicare. Otherwise, the result will be a reduction in the quality of medical services available to Medicare recipients and also a shift in the costs of care for early-discharged patients to Medicaid or to "informal care providers" in the home upon whom the burden for such care falls by default.⁷³

Congress has mandated that HCFA study and report to it on the feasibility of extending prospective payment to SNFs.⁷⁴ The whole subject of aftercare following hospitalization of Medicare patients should be studied. This study should include the possibility of covering intermediate nursing facilities as well as SNFs and HHC. Many Medicare patients being discharged earlier under PPS/DRG are likely not to be ready to go home in the absence of some kind of professional care without adverse effects on their health. Provision would have to be made to assure that Medicare is in fact paying for health care services and not merely custodial care. But that could be done without the present stringent restrictions on eligibility, benefits, and services.⁷⁵ For example, the three day hospitalization requirement for eligibility for SNF benefits could be eliminated,⁷⁶ and the definition of "home-

provided through Home Health Care (HHC). The patient must be confined somewhere other than a hospital or SNF; under a physician's care; in need of intermittent nursing care; or of physical or speech therapy. The HHC must be based upon a plan of treatment created and periodically reviewed by a physician. 42 U.S.C. 1395f(a)2(D) (1984). The HHC must be provided or arranged by a participating Home Health Agency (public or private). There is, currently, no prior hospitalization requirement. 42 C.F.R. § 409.42(g) (1984). At least one of the services must be furnished directly by the home health agency. 42 C.F.R. § 405.1221(a) (1984). A home health agency must, among other things, meet HCFA standards; comply with state regulations; maintain clinical records; be primarily involved in providing therapy and skilled nursing; and meet administrative standards. 42 U.S.C. § 1395x(0) (1984). Each service is a visit even if two or more of the visits are simultaneous. 42 C.F.R. § 409.43(a) (1984). Qualified patients are entitled to an unlimited number of fully covered visits. 42 CFR § 409.61(d) (1984).

The early discharge phenomenon is leading to some probably unanticipated results. For example, one company is setting up and running psychiatric units (not under PPS/DRG, 42 U.S.C. 1395ww(d)-(f) (1983) in hospitals. These units presumably are fulfilling some of the need for aftercare. See *We're Filling Beds*, FORBES, June 17, 1985, at 91. There is also a trend toward vertical integration of hospitals and SNFs, either by hospitals' setting up their own SNFs or entering into contracts with SNFs to take their discharged patients. See Nemore, *Medicare Prospective Payment for Hospitals: Implications for Nursing Home Residents*, 17 Clearinghouse Review 1309 (1984).

⁷³ See Feldblum, *supra* note 72, at 213-15. A synonym for "informal care provider" is often adult daughter or daughter-in-law. *Id.* at 215 n.132.

⁷⁴ Pub. L. No. 98-21 § 605(a), 98 Stat. 169 as amended by Pub. L. No. 98-369, § 2319, 98 Stat. 1083 (1984). The report was originally due by December 31, 1983. That deadline was missed, reportedly because of negative reactions to a preliminary draft by some long-term health care industry officials. *Newswatch, Report on DRG System for SNFs Delayed*, Geriatric Nursing 76 (March/April 1984). The deadline was extended to December 1, 1984 by the Deficit Reduction Act of 1984, Pub. L. No. 98-369 § 2319, 98 Stat. 1083 (1984), but as of the time this is written had not yet been submitted.

⁷⁵ See Branch & Stuart, *A Five Year History of Targeting Home Care Services to prevent Institutionalization*, 24 The Gerontologist 387 (1984); Birnbaum, Burke, Swearingen, & Dunlop, *Implementing Community-Based Long-Term Care: Experience of New York's Long Term Home Health Care Program*, 24 The Gerontologist 380 (1984).

⁷⁶ See *Sustaining Quality Health Care*, *supra* note 18, at 14.

bound"⁷⁷ necessary for HHC eligibility could be broadened.⁷⁸ In addition, other measures should be considered. For example, it may be possible for many hospitals to convert empty beds to swing beds for the purpose of providing SNF services.⁷⁹

c. *Ancillary Services.* Another, albeit less strident, complaint voiced by some is that PPS/DRG has caused hospital administrators to pressure physicians to utilize fewer ancillary services such as testing.⁸⁰ The complaints, though, are mainly directed at a fear of curtailment in the future rather than belief that present practices are harmful to patients.⁸¹ Thus, even among some of PPS/DRG's severest critics, this is not perceived as a present problem, only a potential one. Nevertheless, it is a potential problem that bears watching with respect to both quality of care and cost. It is true that eliminating unnecessary tests, especially intrusive ones with a potential for iatrogenic effects, can actually enhance quality care while reducing costs. However, omitting tests where they are medically appropriate can increase costs. Such omissions do so by failing to detect medical conditions at an early stage when they can be effectively treated in a manner less costly than if the condition is allowed to progress.⁸²

d. *Physician Attitudes.* Overall, sixty-three percent of the respondents to the AMA survey reported that quality of care had deteriorated or that it would deteriorate under PPS/DRG, largely on account of the foregoing problems.⁸³ Some of this reaction may simply be attributable to resentment by physicians of the dislocations of a new system and intrusions of PPS/DRG into their traditional prerogatives.⁸⁴ It may, consequently, be a passing phase. However, any system of

⁷⁷ The "homebound" require health care to be brought to them because going to a health care facility is too straining. Two characteristics identify the homebound: functional immobility and actual immobility. Functionally, the individual must be genuinely impaired, (e.g., walk with a cane; have a restrictive heart condition; be blind; be senile), not merely be old. Also, the individual must actually be less mobile. Certainly, this is not synonymous with imprisonment. However, if Great Aunt Hannah can get to Wednesday night bingo, she probably does not need HHC. See RIA SOCIAL SECURITY COORDINATOR at § 62,011, citing HOME HEALTH AGENCY MANUAL § 208.4 (1984).

⁷⁸ *Sustaining Quality Health Care*, supra note 18, at 13-14 (statement of Pat Hanson, Hospital DRG coordinator).

⁷⁹ See Hochstein, *Treating Long-Stay Patients in Acute Hospital Beds: An Economic Diagnosis*, 25 *The Gerontologist* 161 (1985).

⁸⁰ See AMA MONITORING PROJECT, supra note 16: "There clearly seems to be a trend for hospitals to encourage limitations on services for patients." *Id.* at 8.

⁸¹ *Id.* For example, one respondent to the AMA Monitoring Project noted in a typical response: With the financial constraints placed upon us by the DRG system, tests will not be ordered as frequently for screening purposes. . . .one need not look too far down the road to see medical problems which will become more complicated and more difficult to manage by virtue of the fact that they were not diagnosed earlier.

Id.

⁸² *Id.*

⁸³ *Id.* at 7. A survey of physicians in New Jersey produced similar responses to that state's PPS/DRG system. *New Jersey's Hospital Reimbursement System*, supra note 37, at 56-58.

⁸⁴ A survey of New Jersey hospitals on the impact of PPS/DRG elicited a considerably more favorable response than did the physician survey. *New Jersey's Hospital Reimbursement System*, supra

payment which results in widespread and long-lasting physician dissatisfaction would obviously be in trouble. The long-term reaction of physicians to PPS/DRG is not yet clear but certainly deserves close monitoring.

2. Equitable Compensation to Hospitals

If a payment system is to assure access to quality health care over the long term, it must pay equitable compensation to the providers of health care commensurate with the services provided. Therefore, it is essential that PPS/DRG be as accurate as possible in paying compensation to hospitals that is neither excessive nor inadequate. In this regard, PPS/DRG has been subjected to the criticism that it has resulted in inappropriate compensation to hospitals in some instances.

a. *Severity of Illness.* One problem in providing equitable compensation under PPS/DRG is that there appears to be considerable variation in resource use within some DRGs. Even after adjustment for area wage levels, urban-rural location, and teaching activity are made, there is concern that costs vary considerably within given DRGs on account of factors beyond the hospital's control rather than due to the hospital's efficiency.⁸⁵ For example there may be a wide variation in costs within a single DRG depending on the severity of the illness, and some hospitals may tend to treat patients whose illnesses are more severe and whose costs of treatment are therefore higher.⁸⁶

Studies have indicated that costs within a DRG do vary with severity of illness.⁸⁷ While not fully accounting for cost variations within DRGs, introducing a measure of severity does substantially reduce this variation.⁸⁸ The question is whether there is any severity measure available which could be feasibly incorporated into the system.

⁸⁵ Memorandum, *An Analysis of the Impacts of a DRG-Specific Price Blending Option for Medicare's Prospective Payment System 2* (CBO Internal Document, Dec. 20, 1984) [hereinafter cited as *Price Blending Option*].

⁸⁶ *Price Blending Option at 2.*

⁸⁷ See Horn, Buckley, Sharkey, Chambers, Horn, & Schramm, *Interhospital Differences in Severity of Illness*, 313 NEW ENG. J. MED. 20 (1985); Gertman & Lowenstein, *Research Paradigm for Severity of Illness: Issues for the Diagnosis Related Group System*, HEALTH CARE FIN. REV. ANNUAL SUPP. 79, 85 (Nov. 1984). "Severity" has two applications for use in reference to a patient in a hospital. The first application is the severity of the damage, physical and psychological, inflicted by the patient's affliction. The second application is the affliction's material cost. Smits, Fetter & McMahon, *Variation in Resource Use Within Diagnosis-Related Groups: The Severity Issue*, HEALTH CARE FIN. REV. ANNUAL SUPP. 71-72 (Nov. 1984); [hereinafter cited as Smits] Obviously, the second application is exactly the form of severity data a case-mix system should produce. The first application, however, is the form of severity data that hospitals can best provide. Thus, the relationship between the two applications is pivotal.

⁸⁸ Horn, Horn & Sharkey, *The Severity of Illness Index as Severity Adjustment to Diagnostic Related Groups*, HEALTH CARE FIN. REV. ANNUAL SUPP. 33 (Nov. 1984) [hereinafter cited as Horn].

The following table is a study of 47 patients who were all classified within the same DRG (#75-Major Chest Procedures). The patients were rated on a severity scale of one to four: one is mild, four is catastrophic.

Five systems have been put forth as severity measures: Disease Staging (*Staging*); Severity of Illness Index (*Indexing*); Patient Management Categories (*Management*); Acute Physiology and Chronic Health Evaluation (*Apache II*); and Medical Illness Severity Grouping System (*MEDISGRPS*).⁸⁹ A case-mix system should have certain attributes. A system should accurately indicate the hospital resources each case will require.⁹⁰ A system should recognize clinical similarities in cases. This clinical perspective makes a system more adaptable to medical progress and more palatable to physicians and administrators.⁹¹ A system should not relapse into retrospective payment (fee-for-service).⁹² A system should be easy to implement.⁹³ A system should not be prone to "gaming."⁹⁴ A system should render consistent results at different hospitals.⁹⁵

Table E

Procedure type and severity level	Number of patients	Mean Charge	Coefficient of variation
Total	47	\$ 11,684	251
Moderate operating room procedure			
Severity level 1	6	2,650	43
Severity level 2	11	6,341	52
Severity level 3	3	14,789	8
Major operating room procedure			
Severity level 1	13	5,891	38
Severity level 2	13	10,523	55
Severity level 4	1	205,747	0

Id. at 38. See also Young, *Incorporating Severity of Illness and Comorbidity in Case-Mix Measurement*, HEALTH CARE FIN. REV. ANNUAL SUPP. 23 (Nov. 1984) [hereinafter cited as Young]. See generally Smits, *supra* note 87, at 7). See Horn, *supra* note 87 at 20.

⁸⁹ See generally, HEALTH CARE FIN. REV. ANNUAL SUPP. (Nov. 1984). (This issue is a collection of several important articles on case-mix systems.) HCFA has expressed interest in further research on such systems. See 50 Fed. Reg. 4483 (1985).

⁹⁰ Jencks, Dobson, Willis & Feinstein, *Evaluating and Improving the Measurement of Hospital Case-Mix*, HEALTH CARE FIN. REV. ANNUAL SUPP. 1, 5 (Nov. 1984) [hereinafter cited as Jencks]. Resource consumption includes diagnosis as well as treatment. *Id.*

⁹¹ *Id.*

⁹² *Id.* at 5. All five of these systems are prospective; therefore this will not be an issue in the analysis.

⁹³ *Id.* at 6.

⁹⁴ *Id.* "Gaming" refers to manipulation by the hospital of PPS/DRG to obtain more compensation without increasing efficiency. Gaming ranges from exaggerating complications to fabricating rendered services. *Id.*

⁹⁵ *Id.* at 6-7.

Staging, which began as a system to categorize cancer patients,⁹⁶ can now be applied to over 400 diseases.⁹⁷ *Staging* divides each disease⁹⁸ into four stages.⁹⁹ In the first stage there are no serious complications. In the second stage, although the disease is still confined to a single organ or organ system, there is a meaningful increase in the risk of complications. In stage three the disease is no longer confined. Stage four is death.¹⁰⁰

There is an abstract¹⁰¹ for each patient discharged from a hospital. *Staging's* software algorithm¹⁰² feeds on data directly from the abstract. The algorithm then determines the "underlying conditions of highest severity."¹⁰³ Complications are calculated as part of the development of the disease. The system also accounts for comorbidities (coincidental distinct diseases requiring additional resources).¹⁰⁴ *Staging's* utility in measuring resource consumption is dependent upon the nature of the disorder. President Reagan's cancer was archetypical of a disorder that *Staging* can measure quite well. His condition was comparable to countless other colorectal cancer patients past and present.¹⁰⁵

The *Staging* analysis of President Reagan's cancer would be simple; *Staging* would have done a poor job, however, with the 1981 assassination attempt. Bullets can be unique in their destructive paths. This lack of adaptability to trauma cases is *Staging's* weakness and indicates the advantage of a clinical perspective where

⁹⁶ Conklin, Lieberman, Barnes and Louis, *Disease Staging: Implications for Hospital Reimbursement and Management*, HEALTH CARE FIN. REV. ANNUAL SUPP. 13, 14 (Nov. 1984) [hereinafter cited as Conklin]. The National Cancer Institute conceived the staging classification system. The National Center for Health Services Research funded the cultivation of that system into a reimbursement system. *Id.*

⁹⁷ *Id.* at 15.

⁹⁸ The colloquial definition of "disease" is not synonymous with the medical definition. Most people do not consider a fractured rib a disease. However, the medical profession defines "disease" as "an interruption, cessation, or disorder of body functions, systems or organs." *STEDMAN'S MEDICAL DICTIONARY*, 403 (5th unabr. Law. ed. 1982). Therefore, laymen must be careful not to read unintended meanings into words such as "illness" or "disease." For example, Dr. William M. Chop of the University of Oklahoma at Tulsa Medical College, in a recent letter to the *Journal of the American Medical Association*, demonstrated the versatility of the word "disease" in one particular sentence: "any disease from Hemophilia to otitis media to hip fractures. . . ." *Letters*, 254 J.A.M.A., 503, 505 (1985).

⁹⁹ Conklin, *supra* note 96, at 14.

¹⁰⁰ *Id.* Generally each disease will have its own unique substages. Stage one, two, and three each represent progressive severity and therefore, presumably, progressive resource consumption. A stage 4 patient (expired before discharge) will generally consume less than a stage three patient. *Id.* at 14.

¹⁰¹ The abstract is the Uniform Hospital Discharge Data Set, (U.H.D.D.S.). The U.H.D.D.S. describes the patient, the patient's illness, the patient's condition upon discharge, and where the patient went when discharged, (home, SNF, etc.). Jencks *supra* note 90, at 1.

¹⁰² "Algorithm" is a term often used in computer science. An algorithm is a method for completing a task; often the blueprint for a computer program. *SEDEWICK, ALGORITHMS* (1985). For example, "a + b = c" would be an algorithm for adding two numbers.

¹⁰³ Conklin, *supra* note 96, at 15.

¹⁰⁴ *Id.* at 16.

¹⁰⁵ Stoler, *What the Diagnosis Means*, Time Mag., July 29, 1985, at 22-23.

patients are evaluated individually. *Staging's* strength is full automation. This deters gaming, facilitates implementation, and fosters uniformity in application and result.

Indexing calculates for each discharged patient a severity score based on seven factors: disease stage; complication of the primary condition; comorbidity; dependency upon the hospital staff; procedures performed outside the operating room (e.g., diagnostic tests, therapy); rate of recovery; and residual disability.¹⁰⁶ Each of the seven factors is rated on a scale of one to four with "one" being the most favorable score and "four" being the least favorable.¹⁰⁷ The scores are assigned by trained individuals (raters) who judge each patient's condition in each of the seven categories against definitions prepared by medical experts.¹⁰⁸ The scores are then fed into a computer.¹⁰⁹

Since *Indexing* considers other factors beyond disease stage, it provides more accurate analysis of trauma cases (such as gunshot wounds). However, in order to gain this flexibility, *Indexing* has sacrificed total automation. The devisers of *Indexing* are confident of the raters' consistency.¹¹⁰ Even if the raters would be reliable, however, they would still require training and a salary. Thus, implementation would likely be expensive and prolonged. Gaming would be a function of the raters' integrity. The clinical quality is apparently similar to *Staging*.

Management's basic concept is that in any given case resource needs are best indicated by clinical factors, severity, and comorbidity.¹¹¹ *Management's* software is a two part algorithm.¹¹² Part One is assignment to a "key diagnosis code,"¹¹³ such as acute myocardial infarction (AMI).¹¹⁴ A patient may be assigned up to five key diagnosis codes. These come directly from the patient's discharge abstract. In Part Two of the algorithm the patient is assigned a Patient Management Category (PMC) based upon *The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes.¹¹⁵ Each PMC designates a clinically defined type of case and has its own strategy. A PMC is determined by: the reason for admission; the diagnoses; and sometimes the medical procedures performed.¹¹⁶

¹⁰⁶ Horn, *supra* note 88, at 33-34.

¹⁰⁷ *Id.* A score of four in *Indexing* is different from the fourth stage in *Staging* because in the former a score of four means "catastrophic illness", *id.*, while the fourth stage in *Staging* means death. See note 100 *supra*.

¹⁰⁸ Horn *supra* note 88, at 33-34.

¹⁰⁹ *Id.* at 34.

¹¹⁰ *Id.* at 33. The devisers of *Indexing*, Dr. Susan Horn and her associates at Johns Hopkins University, conducted tests on the raters and the raters demonstrated remarkable accuracy. *Id.*

¹¹¹ Young, *supra* note 88, at 23. The Health Care Research Department of Blue Cross of Western Pennsylvania developed *Management* under a grant from HCFA. *Id.*

¹¹² *Id.* at 25.

¹¹³ *Id.*

¹¹⁴ *Id.* at 26. Acute Myocardial Infarction (AMI) is the sudden destruction of an area of heart muscle due to an insufficient blood flow. *STEDMAN'S MEDICAL DICTIONARY* at 21, 706-707. This is obviously a broad term considering the range of possible damage. See *infra*, notes 117 to 121 and accompanying text.

¹¹⁵ Young, *supra* note 88, at 23, 25. More than one code must apply for certain PMCs to be assigned.

Each PMC has a cost-weight (CW).¹¹⁷ For example, the AMI Code has 8 PMCs ranging from congestive heart failure¹¹⁸ (CW = 41.44)¹¹⁹ to “uncomplicated” (CW = 13.71).¹²⁰ The cost-weight often, but not always, parallels the death rate (severity). *Management*, by concentrating on resource consumption, observes both the cost-severity parallel and its exceptions.¹²¹

A PMC is also assigned to each comorbid condition. The system is alert for apparently distinct comorbid conditions that are actually the same disease. Often treatment of a more serious disorder subsumes the cost of a less serious disorder.¹²²

Management is the only system of the five to focus directly on cost rather than focusing indirectly on cost through severity. This system is inherently clinically sensitive. Since *Management* is totally automated, it is consistent, safe from gaming, and relatively easy to implement.¹²³

The *Apache II* algorithm is $A + B + C = \text{Total Apache II score}$, where $A = \text{Acute Physiology Score (APS)}$; $B = \text{Chronic Health Points}$; and $C = \text{Age Points}$.¹²⁴ APS measures severity of illness based on twelve physiological functions: temperature; blood pressure; heart rate; respiratory rate; arterial pH; serum¹²⁵ sodium; serum potassium; serum creatinine;¹²⁶ hematocrit;¹²⁷ white blood count; and Glasgow coma score. Each function is scored. A normal function scores a zero. A function that is too high or too low is given a score from one to four based upon absolute distance from normal.¹²⁸ The sum of the scores of all twelve functions is the APS.¹²⁹

Chronic health points are given to patients who, prior to hospitalization, are immunocompromised¹³⁰ or suffer a severe organ insufficiency.¹³¹ Five points are

¹¹⁷ *Id.* at 26.

¹¹⁸ Congestive heart failure is when the heart circulates the blood so poorly that watery fluid accumulates in the heart tissue. *STEDMAN'S MEDICAL DICTIONARY* at 443-44, 511-12.

¹¹⁹ Young, *supra* note 88, at 26.

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² *Id.* at 29.

¹²³ *Id.* The devisers of *Management* do point out that flaws in *ICD-9-CM* restrain the effectiveness of the system. They believe, however, that these problems can be solved. *Id.* at 31. See Smits, *supra* note 87, at 71, 74-77.

¹²⁴ Wagner & Draper, *Acute Physiology and Chronic Health Evaluation (Apache II) and Medicare Reimbursement*, HEALTH CARE FIN. REV. ANNOT. SUPP. at 91, 94 (1984) [hereinafter cited as Wagner and Draper]. *Apache II* is a revision of the more complicated *Apache I*. *Id.* at 91.

¹²⁵ Serum is the liquid left when the fibrin clot and blood cells are removed from the blood. *STEDMAN'S MEDICAL DICTIONARY* at 1278.

¹²⁶ Creatinine is an element in urine. *Id.* 334.

¹²⁷ Hematocrit is the percentage by volume of blood cells in the blood. *Id.* at 627.

¹²⁸ Wagner & Draper, *supra* note 124, at 93-94. For example, a respiratory rate of 12 to 24 (per minute) is a zero; 25 to 34 or 10 to 11 is a one; greater than 50 or less than 5 is a four. *Id.* at 93.

¹²⁹ *Id.*

¹³⁰ Immuno-compromised means the patient's immune system has been affected seriously either by treatment (e.g., chemotherapy) or by disease (e.g., AIDS, Leukemia). *Id.* at 94.

¹³¹ Examples of patients with severe organ insufficiency are those requiring renal dialysis or having serious cardiac impairment. *Id.*

given to nonoperative or emergency patients and two points are given to elective postoperative patients.¹³² Age point assignments range from zero (patients under forty-five) to six (patients over seventy-four).¹³³ The Total Apache II score is an indicator of severity of illness and, therefore, resource cost.¹³⁴

Apache II has been used only on intensive care patients.¹³⁵ With further testing, however, this system could be highly successful. Since *Apache II* is fully automated it is consistent and safe from gaming.¹³⁶ Hospital abstracts do not provide all the information required for *Apache II*.¹³⁷ Beyond this added expense, (and it would mean some otherwise unnecessary testing), the algorithm could be easily implemented. *Apache II* is not as clinical as PMC, but it details a patient's condition better than DRG.

MEDISGRPS employs a two step process.¹³⁸ First, upon admission, each patient undergoes clinical laboratory, radiological, pathological, and physical examinations.¹³⁹ The result of these examinations are called Key Clinical Findings (KCFs). Each KCF is rated and assigned to one of five groups numbered from zero through four. Group zero is for normal test results. Groups one to four are for varying degrees of gravity in abnormal test results and/or increased risk of organ failure. Group one is the least grave; group four is the most grave.¹⁴⁰

The second step is the repetition of the first step several days later.¹⁴¹ If any of the patient's second KCFs are placed in group two, three or four, then the patient is labeled "Morbid."¹⁴² Thus *MEDISGRPS* evaluates a case for both severity and rate of recovery.¹⁴³ Research indicates that for both rate of recovery and severity there is a parallel increase in cost.¹⁴⁴

¹³² *Id.*

¹³³ This is the complete Apache II age score table:

≤	44	0
	45-54	2
	55-64	3
	65-74	5
≥	75	6

Id. Numbers one and four are not assigned. *Id.*

¹³⁴ Jencks, *supra* note 90, at 2-3.

¹³⁵ *Id.*

¹³⁶ *Id.* at 3.

¹³⁷ *Id.*

¹³⁸ Brewster, Jacobs & Bradbury, *Classifying Severity of Illness by Using Clinical Findings*, HEALTH CARE FIN. REV. ANNOT. SUPP. 107 (Nov. 1984) [hereinafter cited as Brewster].

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Id.*

¹⁴² *Id.* Since a morbid patient must be in the second, third or fourth KCF group, the term "morbid" is more selective than LOS. "Morbid" should not be confused with "comorbidity."

¹⁴³ Brewster, *supra* note 138, at 107.

¹⁴⁴ *Id.* at 107-108.

Further analysis of *MEDISGRPS* will have to wait until the specifics of the KCF clinical standards are released.¹⁴⁵ The system will rely upon technicians similar to the *Index's* raters.¹⁴⁶ This will make the system more difficult to implement, more prone to gaming, and will raise questions as to the system's reliability.

In summary there is as yet no completely satisfactory severity measure for PPS/DRG. However, significant progress is being made and several systems show promise.

b. *Nursing Cost Measure.* A second problem, distinct from but related to the severity issue in setting equitable compensation for hospitals, is that DRGs currently make no special allocation for nursing costs. In constructing DRGs an artificial assumption was made that each DRG required the same amount of nursing care per day.¹⁴⁷ Obviously, though, this assumption cannot be true. Some DRGs are bound to incur more nursing costs per day than others. A patient with a broken leg may require minimal care, while a severe heart attack victim may require constant monitoring, even if not in an intensive care unit. Nursing costs comprise a large part of a hospital's budget, so failing to account accurately for such costs introduces a substantial element of error.¹⁴⁸

It may be feasible in the future to introduce nursing costs as a discrete element in constructing DRG weights. There are currently many nursing-patient classification systems currently in use by hospitals. These attempt to assess nursing time expended on patients for each day of their hospitalization. This time is estimated from factors such as patient characteristics, the nurse's perception of the patient's need for care, services the patients receive, or a combination of the foregoing.¹⁴⁹

Although there is not yet any completely satisfactory method for accurately incorporating nursing costs into PPS/DRG, some starts have been made.¹⁵⁰ For example New Jersey has experimented with a system using "relative intensity measures" of nursing care, but the usefulness of this system for Medicare has not been established.¹⁵¹ A system to incorporate nursing costs into PPS/DRG accurately

¹⁴⁵ *Id.* at 107.

¹⁴⁶ *Id.*

¹⁴⁷ See PRO-PAC. APPEND; *supra* note 3, at 86; Smits, *supra* Note 87, at 71.

¹⁴⁸ It has been estimated that nursing expenses account for up to 35% of direct patient care costs and about 50% of a hospital's non-physician personnel budget. PRO-PAC APPEND., *supra* note 3, at 87.

¹⁴⁹ *Id.* at 88. Hospital accreditation standards require that "The nursing department shall define, implement, and maintain a system for determining patient requirements for nursing care on the basis of demonstrated patient need, appropriate intervention, and priority for care." PRO-PAC APPEND., *supra* note 3, at 88, quoting, JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS, NURSING SERVICE STANDARD 3 (1985).

¹⁵⁰ See Thompson, *The Measurement of Nursing Intensity*, HEALTH CARE FIN. REV. ANNUAL SUPP. 47, 50 (1984); Caterinicchio, *Relative Intensity Measures: Pricing of Inpatient Nursing Services Under Diagnosis Related Group Prospective Hospital Payment*, 6 HEALTH CARE FIN. REV. 61 (1984).

¹⁵¹ See Thompson, *supra* note 150, at 50.

might well serve as an adequate substitute for a measure of severity, since for the most part, the more severely ill a patient is the more nursing care that patient is likely to require.¹⁵²

A measure of nursing care would also ameliorate another possible flaw in the DRG structure: DRG compression. Because nursing costs were allocated to DRGs on a per diem basis, it is likely that such costs are over-allocated to low cost DRGs and under-allocated to high cost DRGs. Therefore, the payment for truly high cost DRGs may be understated and the payment for low cost DRGs may be overstated.¹⁵³ If this is true, hospitals that treat the most complex cases are being undercompensated and hospitals treating simpler cases are being overcompensated relative to one another.¹⁵⁴ This would present hospitals with the incentive to limit admissions of higher cost DRG patients or at least limit services to them.¹⁵⁵ More precise allocation of nursing costs to DRGs would alleviate this problem.

c. *Disproportionate Share Hospitals.* Failure of PPS/DRG to account adequately for severity of illness and for nursing costs, with resultant DRG compression, may present a special difficulty in receiving equitable payment for "disproportionate share hospitals." A disproportionate share hospital is one serving a higher than normal percentage of low income or Medicare patients.¹⁵⁶ The Medicare statute makes special provision for these hospitals by providing:

The Secretary shall provide for such exceptions and adjustments to the payment amounts . . . as the Secretary deems appropriate to take into account the special needs . . . of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title.¹⁵⁷

The rationale for this provision is the belief that costs in disproportionate share hospitals are unavoidably higher than for other hospitals.¹⁵⁸ Many argue that low income patients tend to have more severe illnesses and require more care than other patients in a given DRG because they wait longer to seek care and are more likely to have secondary diagnoses and complications.¹⁵⁹

HCFA failed to respond to the statutory mandate to make special provision for disproportionate share hospitals until July of 1985 when it grudgingly pub-

¹⁵² See PROPAC APPEND., *supra* note 3, at 89-90.

¹⁵³ See *id.* at 89, citing Lave, *Note on the Compression in the HCFA DRG Prices* (unpublished paper, University of Pittsburgh 1984).

¹⁵⁴ See PROPAC APPEND. at 89.

¹⁵⁵ *Id.*

¹⁵⁶ 42 U.S.C.A. § 1395ww(d)(5)(C)(i). (West Supp. 1984).

¹⁵⁷ *Id.*

¹⁵⁸ See PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, REPORT AND RECOMMENDATIONS TO THE SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 37 (April 1, 1985) [hereinafter cited as PROPAC REPORT]; OTA REPORT, *supra* note 3, at 16.

¹⁵⁹ *Price Blending Option*, *supra* note 85, at 3.

lished regulations in the Federal Register¹⁶⁰ on order of a United States District Court.¹⁶¹ Justice Rehnquist, acting as Circuit Justice for the Ninth Circuit subsequently stayed the District Court's order to publish the regulations.¹⁶² HCFA, having published the regulations only on account of the District Court order, accordingly notified the public that the regulations were revoked before they ever became effective.¹⁶³ Thus, disproportionate share hospitals remain without the relief contemplated in the statute. This is a flaw in the system that can and should be remedied through the issuance of reasonable regulations. HCFA's reluctance to issue such regulations is regrettable.

d. *Price Blending*. The American Hospital Association has proposed a DRG-specific price blending approach as at least a partial remedy for the payment inequities associated with the foregoing problems.¹⁶⁴ Under this approach each DRG payment rate would be either the national average rate, a hospital specific rate, or some blend of the two.¹⁶⁵ The exact blend would depend on how widely the actual costs per discharge vary within each DRG. If the variation within a given DRG is narrow the blended payment would be weighted more heavily toward the national rate. If the variation is wide the payment would be weighted more heavily toward the hospital-specific rate.¹⁶⁶ The rationale is that a national average rate is more appropriate for some DRGs than for others.

Where the distribution of costs within a DRG does not vary by much, a national average rate is appropriate. If, however, the variation within a DRG is great, the variation may be caused by factors beyond the hospitals' control.¹⁶⁷ In that case a uniform national rate may result in undeserved overpayments for some hospitals and underpayments for other hospitals, depending on the relative cost variations in the DRGs they treat.¹⁶⁸ Hospitals whose case-mix shows a high percentage of wide variation DRGs would suffer under a uniform average rate. Preliminary studies by the Congressional Budget Office indicate that a price blending mechanism would, on the average, result in higher reimbursement for rural hospitals and for disproportionate share hospitals than those hospitals would receive under the fully implemented PPS/DRG system being phased in under current law.¹⁶⁹

¹⁶⁰ 50 Fed. Reg. 27,208 (1985) (to be codified at 42 C.F.R. pt. 412) (1985).

¹⁶¹ *Redbud Hospital District v. Heckler*, No. C-84-4382-MHP, Slip. op. (N.D. Cal., filed July 30, 1984), *stay granted in part, denied in part*, *Heckler v. Redbud Hospital District*, 54 U.S.L.W. 3027, 3027-28 (U.S. July 24, 1985) (No. A-32).

¹⁶² *Heckler*, 54 U.S.L.W. 3027, 3027-28 (U.S. July 24, 1985) (No. A-32).

¹⁶³ 50 Fed. Reg. 30,944 (1985) (to be codified at 42 C.F.R. pt. 412) (1985).

¹⁶⁴ *Sustaining Quality Health Care*, *supra* note 18, at 59 (statement of James Mongan, M.D. on behalf of the American Hospital Association); *Price Blending Option*, *supra* note 85, at 3.

¹⁶⁵ *Price Blending Option*, *supra* note 85, at 3. There have also been proposals to blend regional and national rates rather than move to a uniform national rate. See e.g., S. 1400, 99th Cong., 1st Sess. (1985), *supra* note 3.

¹⁶⁶ *Price Blending Option*, *supra* note 85, at 3.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 13.

Price blending is a relatively new proposal and studies concerning its effects are preliminary and tentative. Nevertheless, if in fact some DRGs do not lend themselves as well as others to equitable payment under a national rate, it is an option which should be further explored. In this regard it is relevant to note that the New Jersey PPS/DRG system takes account of this problem by automatically classifying a large number of DRGs as outliers not subject to the prospective payment rates because of wide cost variations in these DRGs.¹⁷⁰ However, to the extent that a price blending option is adopted the prospective payment incentives of PPS/DRG will be pro tanto diminished.

e. *Area Wage Index.* Another aspect of PPS/DRG which has been subject to the criticism that it results in inequitable payment to hospitals is the area wage index. This index is used by HCFA to make adjustments to DRG payments reflecting geographic differences in hospitals' employment costs.¹⁷¹ The index, based on statistics from the Bureau of Statistics of the Department of Labor, has been criticized on the grounds that it does not take account of differences in wages within a given area, and does not account for variation among areas in utilization of part-time employees.¹⁷²

The first problem occurs because all hospitals in a given metropolitan statistical area (MSA) are lumped together for purposes of the wage adjustment. The wage statistics for an MSA may, however, contain data from the core city, suburban areas, and even rural areas whose wage levels differ considerably.¹⁷³ Hospitals in core city areas generally experience costs that are significantly greater than suburban hospitals within the same MSA.¹⁷⁴ For example, a recent study of five metropolitan areas found that core city hospitals had wage indexes up to twenty-nine percent higher than suburban hospitals in the same area.¹⁷⁵ Various reasons account for this differential. Core city hospitals may have to pay premium wages to attract skilled employees and also may have a higher skill level among their employees.¹⁷⁶ Undoubtedly, some of the differential is beyond the control of the core city hospitals, yet the present wage adjustment treats them the same as the lower wage suburban hospitals.

A similar problem exists for rural hospitals. A single index is used for all rural hospitals within a state.¹⁷⁷ However, not all rural hospitals within a state are likely

¹⁷⁰ See *Medicare Hospital Prospective Payment System: Hearings Before the Subcomm. on Health of the House Comm. on Ways and Means*, 98th Cong., 1st Sess. 105, 108 (Statement of Charles F. Pierce, Jr., Deputy Commissioner, New Jersey State Department of Health). An outlier case is one that is reimbursed outside of PPS because of extraordinarily high costs or extraordinarily long LOS. See OTA REPORT, *supra* note 3, at B-3.

¹⁷¹ 42 C.F.R. § 412.62(k) (1984).

¹⁷² See PROPAC APPEND., *supra* note 3, at 7, 66.

¹⁷³ *Id.* at 66.

¹⁷⁴ *Id.*

¹⁷⁵ *Id.* See 49 Fed. Reg. 257 (1984).

¹⁷⁶ PROPAC APPEND., *supra* note 3, at 66.

¹⁷⁷ *Id.* at 7; *Sustaining Quality Health Care*, *supra* note 18, at 59 (statement by John Mongan, Research Director of the American Hospital Association). See 49 Fed. Reg. 257 (1984).

to be facing the same labor costs. For example, a rural hospital adjacent to a metropolitan area may actually be competing for labor in the same market as hospitals within the metropolitan area.¹⁷⁸ Such a hospital would be inadequately compensated by the current wage adjustment.

A second problem with the wage index is that it does not take into account variation among areas in utilization of part-time employees.¹⁷⁹ Part-time employees weigh as heavily as full-time employees in constructing the index. An employee working on a half-time basis would simply be treated as a low compensated employee, even if the hourly wage were relatively high. The result of this is that the wage adjustment in areas that use part-time employees more extensively is artificially low.¹⁸⁰

HCFA has recognized that the current wage index does contain serious limitations,¹⁸¹ and Congress, in the Deficit Reduction Act of 1984, directed HCFA to conduct a study to develop an improved index.¹⁸² HCFA has responded by making its own hospital wage survey and proposes to use the results to revise its DRG payment rates. However, HCFA currently proposes to make adjustments only for the mix of full-time and part-time employees, and does not plan to make any changes with respect to the problem of defining hospital labor market areas.¹⁸³ The wage index deficiencies are a serious problem¹⁸⁴ that is amenable to technical improvement. HCFA has already taken a partial step in that direction by making adjustment for the mix of full-time and part-time employees. It should now go the rest of the way by addressing the definition of hospital labor markets.

3. Professional Review Organizations

An issue with implications both for access to quality health care and equitable treatment of hospitals concerns the operations of PROs.¹⁸⁵ The function of these

¹⁷⁸ See 49 Fed. Reg. 257 (1984).

¹⁷⁹ PROPAC APPEND., *supra* note 3, at 7.

¹⁸⁰ J. LUNDY, PROSPECTIVE-PAYMENT FOR INPATIENT HOSPITAL SERVICES, CONG. RES. SERV. ISSUE BRIEF IB83171 at CRS-19 (Updated March 3, 1985).

¹⁸¹ See 49 Fed. Reg. 257 (1984); 50 Fed. Reg. 24,375 (1985).

¹⁸² Pub. L. No. 98-369, § 2316(a), 98 Stat. 494 (1984). Congress also directed that any payment adjustments to reflect changes in the wage index should be made retroactive to the inception of PPS/DRG. *Id.* § 2316(b). This provision may cause unanticipated problems by requiring some hospitals to repay amounts that were overpaid during the retroactive period. See 50 Fed. Reg. 24,377 (1985). Legislation has been introduced to make the adjustments prospectively effective only. S. 1401, 99th Cong., 1st Sess. 1985 reprinted in 131 Cong. Rec. S9097 (July 9, 1985) (Sen. Proxmire).

¹⁸³ See 50 Fed. Reg. 24,375-77, 24,384 (1985).

¹⁸⁴ The wage index can have a significant effect on a hospital's payment. For example, the unadjusted federal portion of the payment for a hospital in the Pacific region for fiscal year 1985 is \$1524.56. But adjustment for the wage index would result in a federal portion of \$1983.09 in San Francisco, while a hospital in Salem, Oregon would be entitled to a federal portion of \$1589.52. PROPAC APPEND., *supra* note 3, at 7.

¹⁸⁵ See note 17, *supra* for an explanation of the structure of PROs.

organizations as set out in the statute is to serve as monitors of both hospital utilization and the quality of hospital care.¹⁸⁶ However, there are indications that the function of monitoring utilization may be taking precedence over the function of monitoring quality of care.¹⁸⁷

HCFA contracts with PROs are emphasizing performance objectives which lend themselves to quantitative analysis. A HCFA spokesman has stated that, "A major provision of the new PRO program is the use of *measurable* performance objectives."¹⁸⁸ For example, the contract with the Missouri PRO sets out as an objective to "[r]educe admissions Statewide by 65,328."¹⁸⁹ This would result in an admissions reduction of ten percent over the two year duration of the contract.¹⁹⁰ Other PRO areas also have overall admissions objectives.¹⁹¹ Moreover, there are PRO objectives for specific kinds of admission. For example, the Oklahoma PRO has among its objectives:

Admission Objective -1, 'Reduce by 77% or 24,881 the admission for surgical procedures which could safely and appropriately be performed as outpatient procedures.' 'Reduce by 100% or 17,748 admissions for one-to-three day stays where one or more outpatient procedures are performed.'

Admission Objective -2, 'Reduce by 50% or 6,728 the number of inappropriate Medicare admissions in 31 targeted DRGs.'¹⁹²

Objectives stated in such terms sound very much like quotas. They have raised serious questions in the medical community as to whether pursuit of such numerical objectives could result in patients needing hospitalization being refused admission,

¹⁸⁶ 42 U.S.C. § 1320c- 3(1) provides:

The organization shall review some or all of the professional activities in the area . . . for the purpose of determining whether:

(A) such services and items are or were reasonable and medically necessary or otherwise allowable . . . ;

(B) the quality of such services meets professionally recognized standards of care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or in an inpatient health care facility of a different type.

Id.

¹⁸⁷ See *Sustaining Quality Health Care*, *supra* note 18, at 39 (testimony of Pat Hanson, Hospital DRG coordinator; at 97 (testimony of American Hospital Association). See generally, *Dans*, *supra* note 17.

¹⁸⁸ *Id.* at 50 (statement of Martin Kappert, Acting Assoc. Administrator for Operations, HCFA) (emphasis added).

¹⁸⁹ HCFA Contract with Missouri Patient Care Foundation, Objective #3, *reprinted in Sustaining Quality Health Care*, *supra* note 18, at 89-90. This was later modified to read "Reduce unnecessary admissions Statewide by 65,324." *Id.* at 90 (emphasis added).

¹⁹⁰ *Sustaining Quality Health Care*, *supra* note 18, at 88 (letter from Rep. Ike Skelton, citing Missouri Hospital Association).

¹⁹¹ *Id.* at 90. These include at least Alabama, Arizona, Delaware, Nebraska, Iowa, Kentucky, Puerto Rico, South Dakota, Louisiana, Minnesota, Tennessee, and Wyoming, and there may be others.

or in hospitals not being paid if such patients are admitted, because the admission was not an approved one.¹⁹³

Spokesmen for HCFA contend that only unnecessary admissions are being targeted.¹⁹⁴ However, the utilization objectives lend themselves easily to quantification, thereby taking on an air of objectivity which quality objectives may not possess. Moreover, some of the "quality" objectives being included in PRO contracts are more readily characterized as utilization objectives. For example, among the "quality" objectives PRO contracts include are "reduction of unnecessary hospital readmissions resulting from substandard care" and "reduction of unnecessary surgery or other invasive procedures."¹⁹⁵

It is certainly true that "less" is sometimes better. Reducing unnecessary procedures may in fact improve quality of care by reducing patients' exposure to harm from them. Nevertheless, a monitoring program that concerns itself primarily with quantifiable measures of utilization is incomplete. HCFA and PROs need to develop procedures for quality review and then to implement these in addition to the quantitative utilization measures that now predominate.¹⁹⁶

PROs are subject to contract renewal periodically.¹⁹⁷ These renewals will be based on the PRO's performance of its contract. Given the nature of bureaucratic procedure, a PRO's performance is very likely to be evaluated on the basis of the degree to which the contracts' numerical goals are attained. Under present administration policy this evaluation will be based on a cost-benefit analysis.¹⁹⁸ If the PRO reports, for example, that it reduced Medicare admissions by 1,000 and the DRG payment is \$4,000, the PRO will have saved the government \$4,000,000. If the PRO contract fee is \$500,000 there will be a cost to benefit ratio of 1 to 8.¹⁹⁹ Obviously, on this basis the more that can be verified as having been saved, the better the PRO's performance will be evaluated. Performance which is not as easily measured in a quantitative manner (i.e., monitoring of quality of care) is likely to become obscured under this methodology.²⁰⁰

¹⁹³ Brinkley, *Experts Question Program to Cut Hospital Deaths*, N.Y. Times, Aug. 5, 1984, at 25, Col. 1.

¹⁹⁴ *Sustaining Quality Health Care*, *supra* note 18, at 50-51 (statement of Martin Kappert, Acting Associate Administrator for Operations, HCFA).

¹⁹⁵ *Id.* at 50.

¹⁹⁶ *See id.* at 98 (testimony of Andrew Webber, Executive Vice-President, American Medical Peer Review Association):

Unfortunately, much work needs to be done and research dollars devoted to developing the outcome instruments for quality review. This effort must include the development of generic quality screens; severity indices; clinical trials; and an integration of inpatient and outpatient data bases so patient encounters can be tracked over time.

Id. at 98.

¹⁹⁷ 50 Fed. Reg. 15,328 (1985) (to be codified at 42 C.F.R. § 462.107) (1984).

¹⁹⁸ *See* E.O. 12,291, Feb. 17, 1981; Schnitzer, *Physicians and Prospective Payment*, 6 WHITTIER L. REV. 863, 866 (1984).

¹⁹⁹ *See* Schnitzer, *supra* note 198, at 866.

4. Preclusion of Review

Another aspect of PPS/DRG with implications for both access to quality care and equitable payment to hospitals is the extent to which providers and beneficiaries can obtain administrative or judicial review of perceived inequities in the system. Review procedures may affect beneficiary access by permitting hospitals to force changes in Medicare reimbursement methodology. As shown previously, changes in reimbursement methodology directly affect the complement of services offered by hospitals and thereby modify access to those services by the relevant population. Judicial and administrative review are directly related to the goal of equitable payment to hospitals since such review is a vehicle for the correction of perceived inequities.

Although providing a judicial forum for the articulation of complaints sounds fair, Congress has a long history of limiting judicial review of Social Security and Medicare ratemaking methodology.²⁰¹ Providers and beneficiaries have been equally consistent in attacking these limitations in federal court.²⁰² The PPS provision limiting review, 42 U.S.C. § 1395ww(d)(7),²⁰³ adds a new dimension to the issue because rather than the usual statute ensuring exhaustion of administrative remedies, subsection (d)(7) appears to completely preclude both administrative and judicial review of DRG weights, rates, and methodology.

The following discussion explores the possibility of a judicial assault on subsection (d)(7) and assesses its likelihood of success. Since the United States Supreme Court has clearly permitted Congress to preclude review of rights derived from statutes,²⁰⁴ any attack on subsection (d)(7) would have to be based on denial of constitutional rights. The main issues in such a challenge would include: who are potential plaintiffs; whether Congress actually intended subsection (d)(7) to preclude all review, including review of constitutional claims; whether Congress has the authority to preclude review of constitutional questions; and the merits of a constitutional attack against DRGs.

a. *Plaintiffs and Intent to Preclude.* Although a constitutional challenge to subsection (d)(7) and DRGs has only a slight chance of success, there are at least three possible plaintiffs in such a suit. First, a hospital on the verge of bankruptcy

²⁰¹ See, e.g., 42 U.S.C. § 405(h), 1395ii, 1995oo, 1395ww(d)(7) (1983).

²⁰² E.g., *Johnson v. Robison*, 415 U.S. 361, (1974), *Weinburger v. Salfi*, 422 U.S. 749, (1975), *Hechler v. Ringer*, 466 U.S. 602 (1984), *Michigan Academy of Family Physicians v. Blue Cross and Blue Shield of Michigan*, 757 F.2d 91 (6th Cir. 1985).

²⁰³ 42 U.S.C. § 1395ww(d)(7) (1983) provides:

(7) There shall be no administrative or judicial review under section 1878 [42 U.S.C.S. § 1395oo] or otherwise of—

(A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1), 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 thereof under paragraph (4).

might blame DRG rates for its financial plight and allege that DRGs as implemented violate some constitutional right of the hospital. Second, an individual beneficiary who deems himself wronged as a result of DRG implementation could seek damages or equitable relief. Third, a hospital accused of malpractice by a private plaintiff might implead HHS and allege that the extreme pressure of DRGs, not the hospital itself, caused the plaintiff's injury. Any or all of these plaintiffs would still be required to show clear and convincing evidence of congressional intent to preclude review, lack of congressional authority to preclude, a substantive violation of a constitutional right by DRGs, and relevant damages.

Although there are not many cases addressing Congressional authority to preclude judicial review, there is a line of cases construing the limited judicial review provisions of social welfare programs.²⁰⁵ These cases establish that courts will construe limited review statutes narrowly in order to avoid reaching the question of Congressional authority to preclude review. The standard is whether the legislative history contains "clear and convincing" evidence of Congressional intent to preclude review.²⁰⁶ Consequently, the first thing a court would do in a case brought against DRGs and defended on the ground of lack of jurisdiction as a result of subsection (d)(7), would be to analyze the legislative history of subsection (d)(7) for clear and convincing evidence of intent to remove jurisdiction.

The express terms of subsection (d)(7) suggest a clear intent to preclude review. The statute unequivocally states that: "[t]here shall be no . . . review. . . ." Although the simplicity of this language does not immediately suggest any ambiguity, it could be argued that the absence of a clear statement extending preclusion to constitutional claims is sufficiently vague to justify jurisdiction. Though this argument seems strained, it conceivably could be acceptable to a court which is narrowly construing a statute in order to preserve a right to review. Intention to preclude is further supported by the fact that the prohibition on review extends to both "administrative or judicial" remedies. Prohibition of both avenues of relief implies that subsection (d)(7) is more than an exhaustion of remedies statute. The section also appears to cover both provider and beneficiary claims due to its preclusion of review under "§ 13950o of this title or otherwise. . . ." The inclusion of "or otherwise" suggests that all other bases of review are as precluded as 13950o remedies.

As to the subject areas precluded, subsection (d)(7)(A), limits review of section 1395ww(e)(1) issues. Section 1395ww(e)(1) requires the Secretary of HHS, *inter alia*, to limit annual adjustments in PPS rates to maintain budget neutrality. Subsection (d)(7)(B) appears to preclude challenges to the decision to use DRGs ("[t]he establishment of diagnosis-related groups"), the methodology for using DRGs as a basis for prospective payment, and the accuracy of any weighting factor assigned to any DRG. Consequently subsection (d)(7)(B) appears to preclude any attack on DRGs at all. Viewed in totality, the express terms of the statute do appear to intend preclu-

²⁰⁵ See *supra* note 202.

²⁰⁶ *Michigan Academy of Family Physicians*, 757 F.2d 91; *National Ass'n of Home Health Agencies v. Schweiker*, 690 F.2d 932 (D.C. Cir. 1983), cert. denied, 459 U.S. 1205 (1983).
Disseminated by The Research Repository @ WVU, 1986

sion. The best argument a plaintiff could make to deny such intent is the absence of an express prohibition on constitutional claims.

Analysis of the legislative history of PPS/DRG corroborates the conclusion that subsection (d)(7) is a conscious executive and legislative effort to preclude administrative and judicial review of any challenge to using DRGs as a method for paying hospitals. The first explanation of the intent and scope of what was to become subsection (d)(7) was given by Secretary Schweiker.

Retroactive adjustment of the payment rates, as might result from judicial review, is inimical to the basic purpose of a prospective system. Moreover, the delays inherent in the judicial process, when coupled with the likelihood of annual revisions in the rates of payment, could lead to chaotic results, in which rates for a previous period may be overturned by a court, or remanded to the Department for further consideration, even though different rates had superseded the contested rates.²⁰⁷

As for Congress, the only reference to judicial review in the House Report states that "Paragraph (7) of that subsection prohibits administrative review (including review by the Provider Reimbursement Review Board) and any form of judicial review of the Secretary's establishment (including classification methods and weighting factors) of diagnosis-related groups (DRGs)."²⁰⁸

The Senate Report similarly states that

With respect to administrative and judicial review, your Committee's bill would permit review except in the narrow cases necessary to maintain budget neutrality and avoid adversely affecting the establishment of the diagnosis related groups, the methodology for the classification of discharges within such groups, and the appropriate weighting of such groups. . . .

Thus, it is your Committee's intent that a hospital would not be permitted to argue that the level of the payment which it receives under the system is inadequate to cover its costs. . . .

Your Committee bill precludes review of the establishment, methodology and weighting of diagnosis related groups because of the complexity of such action and the necessity of maintaining a workable payment system. Thus, neither the definition of the different diagnosis related groups, their weights in relation to each other, nor the method used to assign discharges to one of the groups would be reviewable.²⁰⁹

The Conference Report also affirms preclusion by stating that the bill "permits administrative and judicial review in all cases except the narrow items necessary to maintain budget neutrality: (1) the level of the payment amount, and (2) the establishment of the DRG classifications."²¹⁰ Research has indicated no floor debate on the issue of judicial review.

²⁰⁷ PPS REPORT *supra* note 4, at 41.

²⁰⁸ H. Rep. No. 25, 98th Cong., 1st Sess. *reprinted in* 1983 U.S. Code Cong. & Ad. News 219.

²⁰⁹ S. Rep. No. 23, 98th Cong., 1st Sess. *reprinted in* 1983 U.S. Code Cong. & Ad. News 143.

²¹⁰ Conf. Rpt. No. 47, 98th Cong., 1st Sess. *reprinted in* 1983 U.S. Code Cong. & Ad. News 404. <https://researchrepository.wvu.edu/wvlr/vol88/iss2/6> 32

Since the express terms and legislative history of subsection (d)(7) contain strong evidence of intent to preclude and since no countervailing theory appears credible, it appears that reviewing courts would likely find clear and convincing evidence of intent to preclude review.

b. *Constitutionality of Preclusion.* Assuming there were clear and convincing evidence of Congress' intent to preclude all administrative and judicial review of DRG methodology and rates, the next question a plaintiff would face is whether Congress can constitutionally preclude such review. Arguments about the authority to preclude review are based, not on the due process clause, but on Article III, Section 2, the "exceptions clause." The exceptions clause gives the Supreme Court appellate jurisdiction in all cases "both as to Law and Fact, with such Exceptions, and under such regulations as the Congress shall make." Although the United States Supreme Court has never directly construed the extent of the exceptions power, courts and eminent commentators have been discussing the issue for many years.²¹¹ Indeed there seems little one can add to the literature concerning preclusion and this article makes no attempt to do so. Suffice it to say that reasonable persons differ on whether the breadth of the Congressional exceptions power permits complete preclusion of administrative and judicial review.

Since such preclusion is arguably beyond the scope of the exceptions power and since courts will narrowly construe the terms of any preclusion statute, it is not beyond the pale of reason to assume, at least for academic purposes, that a suit challenging PPS/DRG and subsection (d)(7) may survive a motion to dismiss. Such a suit's chances for survival, however, depend on the existence of an underlying constitutional violation independent of the constitutionality of subsection (d)(7). The following discussion explores some arguments institutional and individual plain-

²¹¹ See *Constitutional Restraints Upon the Judiciary: Hearings Before the Subcomm. on the Constitution of the Senate Comm. on the Judiciary*, 97th Cong., 1st Sess. (1981) [hereinafter cited as *Judiciary Hearings*]; Gunther & Berger, *Congressional Contraction of Federal Jurisdiction*, 33 OR. L. REV. 1 (1973); Ely, *Legislative and Administrative Motivation in Constitutional Law*, 79 YALE L.J. 1205 (1970); Forkosch, *The Exceptions & Regulations Clause of Article III and A Person's Constitutional Rights: Can the Latter be Limited by Congressional Power Under the Former?*, 72 W. VA. L. REV. 238 (1970); Hart, *The Power of Congress to Limit the Jurisdiction of Federal Courts: An Exercise in Dialectic*, 66 HARV. L. REV. 1362 (1953); Ratner, *Majoritarian Constraints on Judicial Review: Congressional Control of Supreme Court Jurisdiction*, 27 VILL. L. REV. 929 (1981-82); Ratner, *Congressional Power Over the Appellate Jurisdiction of the Supreme Court*, 109 U. PA. L. REV. 157 (1960); Redish, *Constitutional Limitations on Congressional Power to Control Federal Jurisdiction: A Reaction to Professor Sager*, 77 NW. L. REV. 143 (1982); Redish, *Congressional Power to Regulate Supreme Court Appellate Jurisdiction Under the Exceptions Clause: An Internal and External Examination*, 27 VILL. L. REV. 900, 911 (1981-82); Sager, *Foreword: Constitutional Limitations on Congress' Authority to Regulate the Jurisdiction of the Federal Courts*, 95 HARV. L. REV. 17 (1981); *symposium: Congressional Limits on Federal Court Jurisdiction*, 27 VILL. L. REV. 893 (1982) (contributions by Bator, Ratner, Redish, Rice, Baucus & Kay, and McClellan); Tribe, *Jurisdictional Gerrymandering: Zoning Disfavored Rights Out of the Federal Courts*, 16 HARV. C.R.-C.L. L. REV. 129 (1981); Van Alstyne, *A Critical Guide to Ex Parte McCordle*, 15 ARIZ. L. REV. 229 (1973); Wechsler, *The Courts and the Constitution*, 65 COLUM. L. REV. 1001 (1965).

tiffs might make in attempts to overturn PPS/DRG on its merits and return to the retrospective payment of Medicare costs.

c. *Constitutionality of DRGs.* Even if a plaintiff demonstrates that subsection (d)(7) is clear and convincing evidence of Congressional intent to preclude any review and even if the plaintiff proves that Congress lacks the power to preclude review, the plaintiff would not have been damaged unless he could prove that DRGs violate a constitutional right. Although a number of arguments present themselves, none is compelling. Institutional plaintiffs can argue violations of substantive due process, equal protection, and confiscation while individuals may argue loss of due process rights to life.

Any attack on PPS must be on constitutional grounds because *Weinberger v. Salfi* establishes Congressional power to preclude review of mere statutory rights.²¹² This line of cases does not, however, extend to preclude review of constitutional claims. Therefore, a DRG plaintiff must prove violation of an underlying constitutional right in order to get a remedy. This violation must stem from the DRG methodology itself; merely showing that preclusion is invalid will be insufficient to overturn DRGs as a basis for payment.

The first argument an institutional plaintiff could make is that the use of DRGs, as opposed to the preclusion of review, violates equal protection. This argument is the modern reincarnation of the moribund doctrine of substantive due process. Substantive due process is moribund because it has been relegated to the "hell" of the rational relation test. Substantive due process arguments are based on the premise that regulation unreasonably deprives the regulated of liberty or property interests.²¹³ The demise of substantive due process occurred as the Supreme Court gradually decided that economic regulation which is rationally related to a legitimate government interest is constitutionally permissible.²¹⁴ Thus federal courts employ essentially the same test for substantive due process claims as they do for many equal protection claims.

The modern Supreme Court has not retreated from the rational relation test. Indeed only one recent case in the Supreme Court has been able to strike down an economic regulation, *Morey v. Doud*.²¹⁵ The *Morey* Court invalidated a grandfather clause as "irrational." Nineteen years later, *Morey* was overruled by *City of New Orleans v. Dukes*.²¹⁶ *Dukes* also considered the validity of a seemingly arbitrary grandfather clause. The Supreme Court held "that the equal protection analysis employed in [the *Morey* opinion] should no longer be followed. *Morey* was the only case in the last half century to invalidate a wholly economic regula-

²¹² *Weinburger*, 422 U.S. 749.

²¹³ *See, e.g., Chicago, Milw. & St. P. Ry. v. Minnesota*, 134 U.S. 418 (1890).

²¹⁴ *See, e.g., Munn v. Illinois*, 94 U.S. 113 (1876); *Lochner v. New York*, 198 U.S. 45 (1905).

²¹⁵ 354 U.S. 457 (1957).

²¹⁶ 427 U.S. 297 (1976).

tion solely on equal protection grounds, and we are now satisfied that the decision was erroneous."²¹⁷

Possibly the closest case to a PPS case is *In re Permian Basin Area Rate Cases*.²¹⁸ In *Permian* the federal government had imposed maximum price levels for different types of natural gas. High cost producers complained about the rates. The *Permian* Court held that the rates were not arbitrary and discriminatory and abridged no constitutional right.

No constitutional objection arises from the imposition of maximum prices merely because "high cost operators may be more seriously affected than others" . . . or because the value of regulated property is reduced as a consequence of regulation. . . . Regulation may, consistently with the Constitution, limit stringently the return recovered on investment, for investors' interests provide only one of the variables in the constitutional calculus of reasonableness.²¹⁹

The *Permian* price structure is analogous to the mandatory maximum prices imposed by PPS/DRG. As in *Permian* a PPS/DRG plaintiff is also likely to be a high cost provider unable to keep his costs within DRG rates.

PPS/DRG plaintiffs arguing equal protection or substantive due process would need to marshal facts to show a lack of rational relation. Possible facts to emphasize would be hospital closures as indicative of reduced quality of service, the fact that past government policies, i.e. retrospective payment, created an economic addiction that could not be rationally removed cold turkey, and reference to any negative epidemiological effects incurred under PPS/DRG. However in light of *Dukes*, even proof of these facts would probably be insufficient to overturn PPS/DRG.²²⁰

A second argument that a plaintiff could make is that DRG payment rates are confiscatory in violation of the fifth amendment guarantee of just compensation. The analysis to assess whether a publicly imposed rate is confiscatory is set forth in *Bowles v. Willingham*.²²¹ *Bowles* upheld a wartime rent regulation as the rational exercise of government emergency powers. The *Bowles* scheme was deemed not confiscatory in part because participation in the program was not mandatory and in part because procedural devices for individualized relief were available. The *Bowles* standard was clarified in *Permian*. The *Permian* Court held that rates are not confiscatory if the rate-makers apply the standards mandated in the appropriate legislation.²²² In *Permian*, for example, the rates had to be "just and reasonable."²²³

PPS/DRG plaintiffs will have to distinguish their case from *Bowles* and *Permian*. Although participation in Medicare is voluntary, plaintiffs can distinguish

²¹⁷ *Id.* at 306.

²¹⁸ *In re Permian Basin Area Rate Cases*, 390 U.S. 747 (1968) [hereinafter cited as *Permian*].

²¹⁹ *Id.* at 769 (quoting *Bowles v. Willingham*, 321 U.S. 503 (1944)).

²²⁰ *Dukes*, 427 U.S. 297.

²²¹ *Bowles*, 321 U.S. 503.

²²² *Permian*, 390 U.S. at 770.

²²³ *Id.* at 767.

themselves from other regulated industries by arguing that the size of Medicare makes participation a practical necessity and, therefore, constructively mandatory. A plaintiff would also have to argue that PPS/DRG provides only limited relief for individual cases. However HHS can rebut this claim by noting that 42 U.S.C. § 1395ww(b)(4)(A) provides the requisite emergency relief by permitting the Secretary of HHS to make exceptions to payment methods in extraordinary circumstances. If a plaintiff can convince a court that Medicare is mandatory and PPS/DRG precludes "special relief" from group rates, then PPS/DRG is distinguishable from *Bowles*.

There are two additional obstacles to the confiscation argument. First, there is a long line of cases holding government benefits not to be property rights entitling former beneficiaries to compensation for changes in benefits.²²⁴ Institutional plaintiffs can attempt to distinguish their case as a provider's receipt of contractual payments rather than a beneficiary's receipt of benefits.²²⁵ The second obstacle is that DRG rates will be upheld as long as they conform to the "reasonable cost" or "customary charges" standards imposed by 42 U.S.C. § 1395f(b)(1). Since DRG rates are by definition aggregates of actual costs, it will be difficult to prove that a specific rate is unreasonable. Even a successful condemnation of a single rate would be a pyrrhic victory. This is because the damages from condemning one rate would probably be insufficient to alleviate the severe financial problems which would have prompted a plaintiff to pursue adjudicatory rather than legislative remedies in the first place. The difficulties in proving one rate unreasonable would be exponentially increased in any attempt to show that the entire DRG methodology is unreasonable. Consequently, the confiscation argument is unlikely to be successful.

Individual plaintiffs may make equal protection and due process arguments in attempts to obtain damages for a death or injury perceived as attributable to PPS/DRG. Even assuming that subsection (d)(7) is unconstitutional, an individual making a constitutional claim against DRGs would probably be required to exhaust administrative remedies before seeking judicial review. This exhaustion of administrative remedies would even apply to constitutional claims, because the remedy requested indicates that the claim arose out of Medicare and such claims have been held subject to 42 U.S.C. § 405(g) review under the case of *Heckler v. Ringer*.²²⁶

The necessary precursor to any individual claim against DRGs would be some aggregate evidence tending to show that the method of payment is causing injury as opposed to the method of treatment. One would have to show, for example, increases in morbidity or mortality occurring in conjunction with PPS/DRG's implementation.²²⁷ The following discussion therefore assumes the availability of negative empirical data.

²²⁴ See, e.g., *Jones v. Reagan*, 748 F.2d 1331 (9th Cir. 1984); *Flemming v. Nestor*, 363 U.S. 603 (1960).

²²⁵ *Federal Power Comm'n. v. Hope Natural Gas*, 320 U.S. 591 (1943).

²²⁶ 466 U.S. 602 (1984).

²²⁷ As of the time this is written there is no statistically significant evidence of impaired health status
<https://researchrepository.wvu.edu/wvllr/vol88/iss2/6>

Individual plaintiffs can try to argue deprivation of equal protection and loss of the due process right to life. The only difference between the institutional and individual equal protection arguments is that the individuals have at least a chance to obtain elevated scrutiny. Under normal circumstances individual plaintiffs are not members of a suspect class and will consequently fall into the rational relation abyss.²²⁸ The fact that Medicare is primarily a program for the aged will not help individual plaintiffs because the Supreme Court has held that the aged are not a suspect class.²²⁹ The poor have also been denied suspect classification.²³⁰

Women could attempt to obtain scrutiny of PPS rates under the substantial relation test.²³¹ It could be argued that since the vast majority of Medicare beneficiaries are women,²³² any decline in quality of care for the aged will disproportionately affect women. The government can defend against allegations of discrimination by emphasizing the fact that PPS/DRG benefits are identical for men and women with the same DRG. Although no equal protection case has required that discrimination be overt, the equality of PPS rates regardless of gender will probably be persuasive on any question of substantial relation. In summary, despite the fact that many parties are concerned that PPS/DRG will overburden public hospitals and impair the quality of care delivered to poor people,²³³ courts will analyze individual complaints under the rational relation test.

The final argument an individual plaintiff can make is that the health care provided by Medicare is a fundamental right derived from the due process right to life. A plaintiff making this argument would need to show first, that PPS/DRG was responsible for the injury, and second, that personal health is contained in the right to life. The Ninth Circuit case of *Jones v. Reagan*²³⁴ has recently circumvented the question of whether medical care is a fundamental right. *Jones* involved the elimination of free medical care provided to seamen at United States Public Health Service hospitals. The seamen argued that medical care is a fundamental right subjecting the removal of benefits to the compelling state interest test. The Court avoided ruling on whether medical care is a fundamental right by holding that nothing in the removal of benefits impaired the plaintiffs' right to access to private medical care and that, as long as the seamen's access rights to health care were the same as other private citizens, no discrimination existed to submit to strict scrutiny even if medical care were a fundamental right.

[T]he seamen are in no different position with regard to access to medical care than many other American citizens. Because the seamen have not been denied equal

²²⁸ See generally, Sager, *supra* note 211, at 78-79.

²²⁹ *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307 (1976).

²³⁰ *Dandridge v. Williams*, 397 U.S. 471 (1970).

²³¹ *Kahn v. Shevin*, 416 U.S. 351 (1974); *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975) (invalidating gender based social security classification).

²³² Waldo and Lazenby, *Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States; 1977-84*, 6 HEALTH CARE FIN. REV. 1, 15 (1984).

²³³ See *supra* notes 156-163 and text accompanying.

access to medical care, we need not decide whether equal access to medical care is a fundamental right subject to strict scrutiny for purposes of constitutional review.²³⁵

Medicare beneficiaries could easily distinguish the *Jones* reasoning from their own circumstances. First, since the entire discussion of this issue is predicated on the existence of negative health effects associated with PPS/DRG, plaintiffs can use this evidence to show collective decreased access to the quality health care they were receiving before PPS/DRG was implemented. Second, as long as the private insurance industry continues to pay retrospective benefits, medicare recipients will not have equal access with the privately insured. Third, plaintiffs can argue that their right is to health, not medical care, and that any public program which knowingly decreases health status violates that right.

HHS will probably defend against individual claims by entering a numbers battle and by arguing that elderly access to medical care is comparatively greater than the rest of the population so that no discrimination exists. Another defense would be that in an era of finite resources, public decisions to apportion benefits are per se reasonable. This defense was successful in *Dandridge v. Williams*²³⁶ and would probably prevail in these circumstances as well.

It therefore appears that there are no compelling constitutional arguments against PPS/DRG. Consequently it appears that obtaining adjudicatory solutions to current hospital financial pressure will be difficult: PPS/DRG appears to be immunized by subsection (d)(7).

This immunity fits precisely into the scheme of PPS/DRG. Prospective rates which can be retroactively adjusted by a court can never be relied on by hospitals to constitute complete payment. As long as the possibility for supplemental payment to hospitals exists, the economizing incentives implicit in PPS/DRG are diluted. Consequently, although the provisions of subsection (d)(7) may be harsh, they are a necessary component of a prospectively based health care financing system.

III. CONCLUSION—A BROADER ISSUE

All of the foregoing suggests a broader issue, namely the permeation of economic and business concepts such as cost-benefit analysis into the health care field.²³⁷

²³⁵ *Id.* at 1337.

²³⁶ *Dandridge*, 397 U.S. 471.

²³⁷ See Avorn, *Benefit and Cost Analysis in Geriatric Care*, 310 NEW ENG. J. MED. 1294 (1984); Levey & Hesse, *Bottom Line Health Care* 312 NEW ENG. J. MED. 644 (1985); Relman, *Economic Considerations in Emergency Care*, 312 NEW ENG. J. MED. 372 (1985); Wrenn, *No Insurance, No Admission* 312 NEW ENG. J. MED. 373 (1985); Freedman, *Megacorporate Health Care*, 312 NEW ENG. J. MED. 579 (1985); Stone, *Law's Influence on Medicare and Medical Ethics*, 312 NEW ENG. J. MED. 309 (1985). See generally, S. WOHL, THE MEDICAL-INDUSTRIAL COMPLEX (1984); THE HEALTH CARE SYSTEM IN THE MID-1990s (study conducted by Arthur D. Little, Inc. for the Health Insurance Association of America,

This development has been both rapid and far-reaching. For example, the *Hospital Literature Index* did not even include the subject "Marketing of Health Services" until 1979, and "Economic Competition" made its first appearance in 1982.²³⁸ By that time the language of business had begun to displace that of medicine. Patients became "customers" and physicians were "members of the hospital sales force."²³⁹ Today the "monetarization"²⁴⁰ of health care proceeds apace and the jargon of business and economics has become commonplace.²⁴¹

Certainly, the increased cost consciousness on the part of those involved in health care that is among the prime contributors to this rapid change in perspective was long overdue.²⁴² It undeniably has produced many beneficial results. For too long the aspect of cost had been virtually ignored by those involved with health care. However, when it became a matter of public concern, at the onset of the 1980s, that health care was consuming an ever-increasing share of the gross national product,²⁴³ the philosophical emphasis began to shift dramatically toward cost containment away from assuring widespread access to quality care.²⁴⁴ Medical care costs have slackened in recent years.²⁴⁵ But the question remains whether the shift to an economic model may be carried too far.

There is a tendency among at least some economists to emphasize maximization of production to the detriment of other non-quantifiable values such as equitable distribution of goods.²⁴⁶ However, the question of who is to receive what health care is a moral as well as an economic issue.²⁴⁷ Precisely because this is a difficult moral issue, there is a dangerous tendency to finesse it by retreating to the safety of the hard science of economics, especially when a questioning of economic analyses

1985); HEALTH CARE IN THE 1990S: TRENDS AND STRATEGIES (study conducted by Arthur Anderson & Co. for American College of Hospital Administrators, 1985); Thurow, *Medicine versus Economics*, 313 NEW ENG. J. MED. 611 (1985).

²³⁸ Levey & Hesse, *supra* note 237, at 644.

²³⁹ *Id.*

²⁴⁰ See Ginzberg, *The Monetarization of Medical Care*, 310 NEW ENG. J. MED. 1162 (1984). "Monetarization" refers to the rapid penetration of the money economy into all facets of the health care system. A striking illustration of this phenomenon is a marked decline in hospital philanthropy over the years. In 1940, philanthropy constituted 24% of a non-profit hospital's budget; today philanthropy accounts for 1% of those budgets. *Id.*

²⁴¹ See, e.g., Christianson, *Competitive Bidding: The Challenge for Health Care Managers*, 1985 HCM Review 39.

²⁴² Levey & Hesse, *supra* note 237, at 644.

²⁴³ See Philipps & Wineberg, *supra* note 1, at 13.

²⁴⁴ See Dunmeyer & Herda, *Implications of Hospital Cost Control for Administration*, 1985 HCM Review 29, 31-33. Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 1984 Law, Medicine and Health Care 245; Malloy and Skinner, *Medicare on the Critical List*, HARV. BUS. REV. 122 (1984) (brief history of developments leading to increased cost consciousness).

²⁴⁵ See *supra* notes 5-22 and accompanying text. See generally, Balfe, Boyle, Brocki and Lane, *A Health Policy Agenda for the American People*, 254 J. AM. MED. A. 2440 (1985).

²⁴⁶ See, e.g., R. RICARDO-CAMPBELL, *THE ECONOMICS AND POLITICS OF HEALTH CARE* 29-35 (1982).

²⁴⁷ See Dunmeyer & Herda, *supra* note 244, at 33-34.

is considered by some a sign of ignorance.²⁴⁸ As has been pointed out there is "something very seductive about quantification."²⁴⁹

Health care managers want to be viewed as effective in their tasks. The quantified bottom line provides a tangible means of evaluating their performance.²⁵⁰ Likewise, placing the onus for controlling costs on the health care profession itself permits public policy-makers to shift some of the burden of making the hard moral choices away from themselves.²⁵¹

Even where changes directed toward cost control, such as PPS/DRG, are effective in attaining that goal, they may present a danger of "diffusing ethical responsibility," and adversely "affecting the doctor-patient relationship."²⁵² These are not necessary results of attention to cost containment, but to avoid them we must remember always that "we live in a society not an economy."²⁵³

This is not to disparage health care cost control in general nor PPS/DRG in particular. Rather, it is a warning against an over-emphasis on cost control to the detriment of other values in health care and a caution against stressing cost control under PPS/DRG to the neglect of access to quality care. Proposals to freeze the DRG rates²⁵⁴ are a signal that cost control may be predominating to a detrimental extreme. This harsh, stingy approach could doom PPS/DRG before it has ever had a chance to prove itself. Payment rates under PPS/DRG must be adequate if its beneficial aspects are to be fully achieved. PPS/DRG can be administered either to provide an adequate amount of money for hospitals to operate efficiently, or it can be administered to squeeze them dry, with consequent detrimental effects on access to quality health care.²⁵⁵ It is to be hoped that the former course is chosen.

²⁴⁸ Levey & Hesse, *supra* note 237, at 645.

²⁴⁹ Fein, *Social and Economic Attitudes: Shaping American Health Policy*, 58 MILBANK MEM. FUND Q. 349, 370 (1980). This issue of quantification has been recognized beyond the health care industry. The Wall St. J. Editorial page quoted Norman Lear, speaking at a Security Industry Association meeting in 1984, ". . . this stunted number based mentality impoverished our understanding of the world because non-quantifiable facts of life are screened out." Wall St. J., August 1, 1985, at 16.

²⁵⁰ Levey & Hesse, *supra* note 237, at 644.

²⁵¹ See Mariner, *Diagnosis Related Groups: Evading Social Responsibility?* 1984 Law Medicine and Health Care 243; Stone, *supra* note 237, at 310. In this regard it is significant that while Congress has consistently passed laws stressing cost-containment such as the TEFRA limits on Medicare reimbursement, see 42 U.S.C.A. § 1395ww, (West Supp. 1984), when the bureaucrats at HCFA have responded in kind with an equally tightfisted attitude toward administration, Congressmen have decried HCFA's actions. See, e.g., *Sustaining Quality Health Care*, *Supra* note 18, at 1-2 (statement by Edward R. Roybal, Chairman, House Select Committee on Aging); *Id.* at 2-3 (statement by Mike Synar, Chairman of House Select Committee on Aging Task Force on the Rural Elderly).

²⁵² Stone, *supra* note 237, at 310.

²⁵³ Avorn, *supra* note 237, at 1297, quoting R. FEIN, ON MEASURING ECONOMIC BENEFITS OF HEALTH PROGRAMS IN MEDICAL HISTORY AND MEDICAL CARE: A SYMPOSIUM OF PERSPECTIVES 179-220, (1971).

²⁵⁴ See, e.g., 50 Fed. Reg. 24,392-98 (June 10, 1985); J. O'SULLIVAN, MEDICARE—FY 1986 BUDGET, CONG. RESEARCH SERV. ISSUE BRIEF IB85047 at CRS-9 (updated Mar. 3, 1985).

²⁵⁵ Thompson, Book Review, 9 J. HEALTH, POLITICS, POLICY, AND LAW 717, 719 (1985). (Reviewing [THE POLITICS OF REGULATION: THE EVOLUTION OF DRG RATE REGULATION IN NEW JERSEY]).