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## ARTICLES

### **BALANCING EFFICIENCY AND QUALITY — TOWARD MARKET-BASED HEALTH CARE**

WILLIAM R. ROPER, M.D.\*

#### INTRODUCTION

Like some stubborn malady, health care cost inflation in recent years has resisted all economic and regulatory remedies. The Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS) has estimated that, in 1987, the nation spent nearly \$2,000 for every man, woman and child to pay for health care. This includes the costs of hospital stays, physician visits, and other personal health care, as well as funding for health insurance, public health services, and health-related research and construction activities.<sup>1</sup>

While official cost estimates will not be available until June 1988, total national health care expenditures in 1987 probably reached \$497 billion, or 11 percent of the Gross National Product. Spending on hospital care, which accounts for approximately 40 percent of national health expenditures, rose an estimated 7.3 percent. Spending on physician services, which accounts for another 20 percent of the national health-care budget, rose 10 percent in 1987. These cost increases were significant factors contributing to an overall rise of 8.4 percent in national health care expenditures.

The increase in spending between 1986 and 1987 was no higher than the increase in health care spending between 1985 and 1986, the year of the second-lowest increase in spending within the last two decades. The projected annual rate of increase in national health expenditures from 1986 to

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1. All health-care cost data and demographic projections in this report are from the DIVISION OF NATIONAL COST ESTIMATES, OFFICE OF THE ACTUARY, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

2000 is 9.0 percent, compared to an annual rate of 12.1 percent between 1965 and 1986. Nonetheless, medical costs will continue to outpace the rate of economic growth and may account for 15 percent of the GNP by the year 2000.

Physician costs especially must be addressed. Physician costs were a major factor in producing a 38.5 percent increase in the 1988 premium for Medicare's optional Part B, which covers physician and outpatient care, as well as premium increases for private health insurance ranging from 10 to 70 percent.<sup>2</sup>

A portion of the spiralling cost of medical care is justifiable and even inevitable. To begin with, America is aging. The aged population is expected to grow rapidly until the mid-1990's. After a temporary slowdown, this growth will resume again, peaking by the year 2035. Increased costs are also a function of the increased use of more sophisticated medical technology. Some increase in costs should be expected, for it indicates the health care system is improving and functioning well for patients. Few would be so hard-hearted as to fault services that save and prolong lives by enhancing medical efficiency merely because such services also increase costs.

Nonetheless, the continued high rate of health-care spending growth can and must be addressed, as part of the "morning after" of fiscal reckoning. Many financial experts, including former U.S. Commerce Secretary Peter Peterson, have stated this day of reckoning is inevitable because of years of improvident fiscal practices. Mr. Peterson's prescription for health-care spending constraint is to replace what he terms the "horrendous, indeed perverse inefficiencies" of the current health care system with the discipline of market forces.<sup>3</sup> One of the primary virtues of the "market" is its potential to combine appropriate incentives with local decision-making. Government, and particularly the federal government, is not an appropriate mechanism for deciding whom to pay, or for what to pay. Local, private competing organizations should make these decisions. Government's proper role is to set broad guidelines for this activity. Yet such a revolution in health-care also poses a serious challenge: can we make our health-care system more decentralized, more af-

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2. Kramon, *Insurance Rates for Health Care Increase Sharply*, N.Y. Times, Jan. 12, 1988, at A1, col. 6.

3. Peterson, *The Morning After*, Atlantic Monthly, Oct., 1987, at 43, 62.

fordable and more efficient while maintaining high quality care? Physicians and patients, businesses and unions, and government and private insurers alike must band together to meet this challenge.

While payments from private health insurers and direct payments from patients account for over half of all health-care spending, the Federal Medicare program remains the largest single payer of hospital and medical bills, meeting about 20 percent of these costs. The experiences gained from Medicare are instructive to all efforts to control medical costs. Further, the fiscal decisions of Medicare manifestly influence the economics of health care. This article describes the steps Medicare has taken and will continue to take to fulfill the Reagan Administration's mandate to control health care costs and maintain quality care by increasing reliance on market forces and on appropriate incentives.

## I. MEDICARE: A CASE IN POINT

A "Great Society" program established in 1965, Medicare today insures some 32 million elderly and disabled Americans at a total estimated cost in 1987 of \$80 billion, approximately 8 percent of the federal budget. Spending for Medicare has increased each year during the Reagan Administration. The average increase in spending from Fiscal Year 1981 to Fiscal Year 1986 was 11.7 percent per year.

Medicare is divided into two parts. The Hospital Insurance Program (Part A) is funded through mandatory payroll deductions collected in the Hospital Insurance (HI) trust fund. Part A covers acute-care hospital stays, skilled-nursing care, and hospice and home-health care at an estimated 1987 cost of \$49.1 billion. The Supplementary Medical Insurance Program (Part B) is optional and covers physician and outpatient care, as well as medical equipment and supplies. Premiums charged to enrolled beneficiaries pay for 25 percent of Part B, with general federal revenues making up the difference. In 1987, Part B grew 16 percent over 1986 costs, for a total of about \$31.7 billion.

Between 1980 and 1987, Congress enacted more than 30 laws governing Medicare. In attempts to achieve savings, the Congressional budget process was often used to engineer major legislative changes in the program. Many of these changes have made the Medicare program difficult to understand, let alone to administer. The many changes affecting Medicare have produced three major reforms:

- The Prospective Payment System (PPS) for inpatient services by hospitals participating in the Medicare program;
- The Participating Physician Program, which permits beneficiaries to choose doctors who accept the Medicare rate for various services as payment in full; and
- The Private Health Plan Option (PHPO), which gives Medicare beneficiaries the option to enroll in private health plans such as health maintenance organizations and competitive medical plans.

## II. THE PROSPECTIVE PAYMENT SYSTEM

### A. *Payments to Hospitals*

During its first 15 years Medicare paid hospitals under a fee-for-service system. Under this system a hospital billed for each service rendered and the government reimbursed reasonable costs, the costs actually incurred in delivering efficient care for necessary services. This system drove Medicare hospital costs beyond even the wildest estimates of the program's architects. Medicare Part A (the Hospital Insurance Program) benefits grew an average of 18.5 percent per year between fiscal years 1967 and 1983. In 1983 the Reagan administration and Congress inaugurated a major change in hospital reimbursement known as the Prospective Payment System (PPS).

PPS was enacted to stem the growth of hospital costs while ensuring continued access to high-quality care. PPS establishes advance payment rates and pays this amount for each discharge, regardless of the costs actually incurred. Payments are calculated on the basis of the average cost of treating a patient with a particular condition, as organized by 473 categories known as diagnosis-related groups (DRGs). If the hospital can treat the patient for less, it keeps the balance; if it cannot, the hospital absorbs the loss.

PPS makes one fixed payment for a cluster of services associated with a hospital stay. This payment method eliminates needless services and promotes the most cost-effective ways of diagnosing and treating illnesses. Short-stay acute care hospitals are now included under PPS, and studies are underway to develop a DRG-type system for psychiatric, rehabilitation children's and long-term care hospitals.

It will be several years before the full impact of PPS can be measured, largely because of "cushions" built into the legislation to ease the transition to payments based on national

rates. During the first four years of PPS, the payment rate for a hospital was calculated on a combination of its historical costs and a federal rate based on national and regional costs. The relative weight of each factor has changed annually to shift gradually to the federal rate. In addition, certain types of hospitals are accorded special treatment, including teaching hospitals, sole community providers, regional referral centers and cancer hospitals. Despite these transitional rates, some conclusions can be drawn. In the five years prior to the passage of the Social Security Reform Act of 1983, which created PPS, Part A expenditures were growing at an average annual rate of 17 percent. In the five years since PPS was first enacted, this rate of growth has been reduced to 6 percent.<sup>4</sup> Because PPS pays per case rather than per service, it was anticipated that the new system would foster admissions as a way to generate more hospital revenue. Contrary to expectations, however, hospital admissions declined 9 percent during the first three years of PPS.

PPS offers dramatic new incentives for efficiency. PPS has been successful in holding down costs because it encourages more appropriate use of intensive hospital services and directs Medicare beneficiaries to more appropriate and less costly types of treatment. For example, the use of home health care services has escalated rapidly. These services are defined as part-time skilled health care and other therapeutic care provided in the patient's home by a Medicare-approved agency. Medicare home-health payments increased from \$1.3 billion in 1982 to \$2.7 billion in 1986, while the number of certified home health agencies rose during the same period from 3,600 to about 6,000. These services, having benefited from new medical technology, respond to an increased cost consciousness among hospitals and insurers.

### B. *The Problem of Profitability*

One common way to review the financial impact of PPS on hospitals is to examine profits, or "operating margins." This figure shows the percentage of revenues from Medicare payments that remain after deducting the expenses incurred in treating Medicare beneficiaries.

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4. All PPS hospital data is taken from a report by Stuart Guterman and Allen Dobson, "Impact of the Medicare Prospective Payment System for hospitals," 7 Health Care Fin. Rev. 97, (1986), published by HCFA's Office of Research and Demonstrations, as well as updates from HCFA's Bureau of Data Management and Strategy.

DRG rates are updated annually by the Congress. The HCFA now has three years of data for hospital performance under PPS rates and updates. This data shows that hospitals in general did quite well during the first two years of PPS, with operating margins averaging 14 percent each year. The high Medicare margins were partially a result of rates being set too high, for they were based on unaudited cost data from 1981. It also reflected the success of PPS in encouraging hospitals to change their practices, particularly in reducing length of stay and furnishing certain services in less costly settings.

These profit margins prompted many to suggest ways to recoup excessive hospital profits. HCFA has maintained, however, that the prudent means to control excessive profits was gradually to give hospitals smaller updates that would make up for the initial overstatement of hospital costs. As a result of this policy, the data from the third year of PPS show that Medicare margins for fiscal year 1986 were reduced to almost 9 percent on average.

As the size of the PPS update declined, there was also a corresponding increase in the cost per case. Falling admissions have made it difficult for hospitals to control this increase because costs are spread over fewer cases. As a result of these and other factors, including the increase in severity of illness of hospital patients, costs-per-case have increased an average of 10 percent annually between the first and third years of PPS. The decline in hospital operating margins can best be envisioned as a graph on which two lines intersect: a declining line which denotes the declining increases in the hospital payments rates, and a rising line indicating rising costs-per-case.

The problem is that PPS is a centrally administered price payment system and does not produce competition. Hospitals compete only to maintain or increase patient volume. Despite recent success in holding down the rate of growth, costs continue to rise and the rate of increase is again accelerating. HCFA has focused increasing attention on some of the reasons for the continuing increase in the cost per case of PPS. We could conclude the Medicare system has not been applying sufficiently firm pressure to hospitals to control costs. Alternatively, the current system may have given hospitals a difficult, if not impossible, task. It is open to question whether hospitals can control their costs further. A central issue is the degree to which hospitals truly can control physician deci-

sions, for these decisions predominantly drive health spending.

Given the declining hospital occupancy rates in many parts of the country, a major step to hold down Medicare hospital spending is to close some hospitals. As PPS has pinched more tightly in rural America, Congress has responded with special rules and higher payment updates for rural hospitals. Some changes were warranted and even advocated by HCFA as sound policy. Although observers recognize that some rural hospitals should change or even close, other proposed changes are designed to protect these hospitals. Unfortunately, it now appears the process will become increasingly politicized, to the point where local issues receive greater emphasis than national policy.

Payment at rural hospitals is particularly problematic under PPS, as it relies on national economic forecasting tools to deal with varying local markets. Adornment of a national program with local "fixes" underscores fundamental problems with such a nationally-administered price system. Consequently, it is doubtful that hospital spending under Medicare can be restrained further using PPS alone. While this system has faults, PPS is *far* superior to cost-reimbursement programs. For example, PPS is unable to reduce excessive utilization by physicians.

### III. BURGEONING PART B

The Part B program was designed to conform to practices in private health insurance existing at the time of its enactment. Medicare uses a system for calculating physician payments based on actual, customary and prevailing charges. Under this system, the Medicare payment is the lowest of three figures: the physician's actual billed charge, the physician's customary charge (the median actual charge during the previous year) or the prevailing charge (the 75th percentile of the customary charges of all physicians in a geographical area). The resulting part B payment is called "the reasonable charge." In 1972, Congress established a Medicare Economic Index (MEI) to limit annual growth in the prevailing charge. About 20 percent of Medicare Part B spending is attributable to hospital outpatient services. Another 10 percent is spent on medical equipment, ambulance services and laboratory costs. Physicians' services, however, make up 65 percent of Part B payments and effectively drive Part B spending.



Over the ten-year period ending in fiscal year 1983, Medicare spending for Part B physician care increased by an average annual rate of approximately 20 percent. The average annual growth of GNP for this period, however, was less than 10 percent. Two major weaknesses of the reasonable charge system contributed to these escalating costs. First, reasonable charges did not decline when improvements in technology or surgical techniques resulted in lower production costs. Second, reasonable charge payment offers no incentives for appropriate utilization of services. Indeed, about 42 percent of the increased costs during the last five years of this period was due to increased intensity of services, especially with more complex and expensive procedures.

In 1984 Congress sought to constrain Part B growth with the passage of the Deficit Reduction Act (DEFRA). A temporary freeze was placed on customary and prevailing charges. A Participating Physician Program was also established. A participating physician chooses to accept "assignment" in any given year. The physician agrees to accept the standard Medicare fee, together with Medicare's established deductible and beneficiary co-payments, without further charges billed to the patient. Two basic incentives are offered for joining the Participating Physician Program. First, participating physicians are listed in a directory made available to beneficiaries. Second, DEFRA allowed participating physicians to raise their actual charges when other physicians' charges were frozen, so that such increases could be reflected in the calculation of their customary charges for future years. The prevailing charges of non-participating physicians are set at 16 percent of those of participating physicians.

Beginning with the passage of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), attention was also focused on selected procedures which appeared to have inherently unreasonable prevailing charges. For example, technological improvements may have reduced the time and effort required for a procedure after the initial payment level was established. Under this "inherent unreasonableness" concept, payments for cataract surgery, including anesthesia, have already been lowered. Changes in the payment rates for other selected procedures were included in the Omnibus Budget Reconciliation Act of 1986.

The long-term growth trend in Medicare physician spending was cut roughly in half between fiscal years 1984 and 1986. Spending increased at a compound annual rate of 11.7 percent for this period, compared to an annual increase

of nearly 20 percent between 1975 and 1983. This slowdown can be attributed both to the hospital prospective payment system and to part B reforms, including the 22-month freeze on physician fees (which was extended to 30 months for non-participating physicians). Nonetheless, this rate of growth was still double the rate of growth in the GNP. Persistently high rates of increase in Medicare expenditures continue to pose a problem for elderly beneficiaries. Since enrollee premiums must cover 25 percent of Part B costs, these added physician charges helped contribute to the \$6.90 increase in the monthly Part B premium of \$24.80 for 1988. In fact, \$2.40 of this increase reflects new, higher estimates of Part B spending during 1987, and another \$3.00 reflects projected increases in 1988.

HCFA has concluded that the most significant overlooked contributor to rising Part B costs is not price increases per unit of service, but "net residual factors," as termed by the Board of Trustees of the Supplementary Medical Insurance Trust Fund.<sup>5</sup> These factors include costs from additional physician services per enrollee, use of more expensive techniques, and increased reliance on specialists rather than on primary care physicians.

Yet it remains unclear that increases in utilization have improved the quality of medical care. Research on practice patterns conducted by Dr. John Wennberg of the Dartmouth Medical Center and Dr. Philip Caper of the Codman Research Group indicates that wide variations in practice patterns exist without producing clinically meaningful differences in outcome.<sup>6</sup> Indeed, now is the logical time to question what has long been a fundamental premise of the American health care system: "More is better." More is not necessarily better. We seriously need to examine practice patterns and the effectiveness of different medical interventions to reach consensus about what care is appropriate and actually needed.

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5. STAFF OF HOUSE COMM. ON WAYS AND MEANS, 100TH CONG., 1ST. SESS., BACKGROUND REPORT ON THE INCREASE IN THE SMI ENROLLEE PREMIUM FOR 1988 19 (Comm. Print 1987). See also statement by William L. Roper, M.D., Administrator, Health Care Financing Administration before the [House] Comm. on Ways and Means, September 30, 1987.

6. Wennberg, *Population Illness Rates Do Not Explain Population Hospitalization Rates*, 25 MED. CARE 354,359; Caper, *Outcome Assessment for the Purposes of Epidemiological Surveillance*, PROC. OF QUALITY OF CARE RESEARCH SYMPOSIUM (June 11, 1987).

In our search for ways to constrain Part B spending growth, using incentive payment systems like PPS for doctors will be difficult. There are far more Part B providers than hospitals, the volume for each Part B provider is much smaller, and there are vast differences among providers because of specialization. These factors produce significant pricing problems. Uniform fee schedules, such as a relative value scale to value individual services in relation to each other, could bring greater equity to discrepancies between procedural and cognitive services. Such fee schedules, however, would also fail to address utilization growth, a major component in rising Part B costs. The best cost-control mechanism for physician services is a competitive system that allows patients to choose among high-charging, over-utilizing physicians and those who practice more appropriately for more reasonable fees. This might occur through the creation of a preferred provider network.

The private sector increasingly uses preferred provider networks (PPOs) to direct beneficiaries to selected providers. Plan administrators enroll providers that offer high-quality care at favorable prices. Provider performance is assessed through utilization review, and poor performers are excluded from the network. Both volume and price limits are necessary if total costs are to be reduced. While there are no utilization controls under the Participating Physician Program, a preferred provider network would add them.

#### IV. THE PRIVATE HEALTH PLAN OPTION

The Private Health Plan Option is to tomorrow what the Prospective Payment System was three years ago — the next logical step. PHPO embodies the Reagan Administration's guiding principles for Medicare by: (1) reducing government's direct role in medical and pricing decisions; (2) increasing choices, both for beneficiaries and for providers of care; (3) promoting competition among private organizations that deliver health care; and (4) sharpening the industry's incentives for efficiency.

Under the Private Health Plan Option, each Medicare beneficiary is given the choice of remaining in the traditional Medicare program or participating in Medicare through enrollment in a private health plan. Once a beneficiary enrolls in a private health plan, Medicare pays the plan a monthly lump sum equal to 95 percent of Medicare's costs for the average beneficiary. This payment is adjusted according to certain characteristics such as age, sex, county of residence, and

other factors. In return, the plan assumes financial and medical responsibility for the beneficiary's total care. There are currently two enrollment options: Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).

Many HMOs and CMPs offer greater benefits than those provided under Medicare. Deductibles and copayments are often smaller or are nonexistent. One hundred and fifteen managed-care plans provide prescription drugs. Joining a private plan also reduces paperwork for older Americans, because the plan itself handles the claims. Since the government is no longer the primary insurer under PHPO, its regulatory burden is lessened. Doctors and hospitals are given a more direct role in deciding how to control the utilization of services, how to finance services, and how to control the quality of services.

The confusion surrounding appropriate payment rates for physicians and hospitals under PPS is also a powerful argument for the Private Health Plan Option. Government simply cannot develop fair payment rates as quickly as market forces. PHPO offers physicians the chance to participate in a variety of private organizations delivering health care at payment rates that are decided locally. This would eliminate the difficulties of setting national payment rates.

In the five years since the passage of the Tax Equity and Fiscal Responsibility Act of 1982, which gave Medicare beneficiaries the right to choose a managed-care alternative, about 1,000,000 elderly American people have chosen to leave traditional Medicare and join a private plan.<sup>7</sup> However, the success of PHPO cannot be measured simply in terms of the number of people who have joined such plans. The real criterion is choice. Currently, about one-half of America's Medicare beneficiaries live in areas where at least two competing private plans are available in addition to traditional Medicare. The HFCA is eager to offer even more Medicare beneficiaries this choice.

But the question now becomes: what is HCFA doing to offer the privately-managed care industry the opportunity to fulfill its role in the continuum of health care services in today's America? The Reagan Administration is now engaged in a market test of PHPO, for Medicare, to prove the program can operate in a fair and beneficial manner: fair to the

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7. Statistics on the Private Health Plan Option are from the DIVISION OF CONTRACT ADMINISTRATION, OFFICE OF QUALIFICATION, OFFICE OF PREPAID HEALTH CARE, HEALTH CARE FIN. ADMIN., OPERATIONAL REP. (Feb. 1, 1988).

private plans doing business with Medicare, so these plans can grow; and beneficial to the consumers served, so they can promote the concept to others. The PHPO test program operates under real market conditions. To that end, on September 9, 1987, HCFA announced an increase of 13.5 percent in the Adjusted Average Per Capita Cost (AAPCC) used to compute the payments to HMOs and CMPs for calendar year 1988. This compares to a 4.6 percent increase in 1987.

There are perceived flaws in the AAPCC, however. The HCFA plans to ask all managed-care plans with Medicare risk contracts if they would participate in a demonstration project. This project would test a payment method that better reflects the effect of an enrollee's health status on HMO costs. The current AAPCC uses only demographic information in setting payment rates. HCFA would like to add diagnostic information as well, based on information from the previous year's hospitalizations among current enrollees at an HMO. Many times knowing the reason for a hospital admission can greatly help in predicting the enrollee's future need for higher levels of care. This refined model is known as the Diagnostic Cost Grouping method (DCG). Under DCG, payment rates would depend on where the diagnosis fell within eight pre-defined risk categories known to be reliable predictors of future health care costs.

HCFA has also moved forward with additional demonstration projects testing the expansion of the private health plan option with employment-based groups. Such groups include Taft-Hartley trusts, unions, and self-insured employers. This concept, known as Medicare Insured Groups (MIGs), offers several distinct advantages. MIGs can provide a more accurate prediction of the future health care expenses of large groups, thus allowing for more accurate payment rates. Beneficiaries can stay in the same plan that provided coverage during their working years, rather than being forced to make an artificial switch at retirement. Through the unified administration of basic Medicare coverage and fund-provided supplemental plan benefits, the MIG may be more efficient and thereby provide additional benefits to retirees. A MIG can eliminate the need for retirees to file multiple claims. It can also help ensure continuity of care, just as managed-care itself gives more continuity to a patient's total care.

HCFA has already signed a tentative MIG agreement with the Amalgamated Life Insurance Company, which administers health insurance benefits for one-half million workers and their families. This includes some 130,000 retirees

and their spouses participating in certain Taft-Hartley trusts sponsored by the Amalgamated Clothing and Textile Workers Union. This agreement reflects HCFA's conviction that, while Medicare cannot and should not *set* the pace for the private sector, it can and must *keep* pace.

## V. QUESTIONS OF QUALITY

Senior-citizen advocacy groups have alleged in recent years that PPS has prompted hospitals to discharge Medicare patients "sicker and quicker." The Prospective Payment Assessment Commission compiled the results of reviews of hospital readmissions under PPS. This study found that only 1.6 percent of hospital readmissions within 15 days were the result of premature discharge. In February 1988, the Office of Inspector General of the Department of Health and Human Services released a study of the hospital records of 7,045 randomly selected Medicare patients discharged from October 1984 through March 1985. The sample indicated that only 0.8 percent of all Medicare discharges were premature. Yet everyone recognizes the importance of running the nation's Medicare program in a way that not only assures access and controls costs, but also sets a proper standard of quality care. HCFA's quality-assurance efforts are focused in three major areas: the dissemination of information on hospital mortality rates; the latest developments in peer review; and quality-assurance in the field of managed-care.

### A. *Measuring Hospital Mortality Rates*

In 1986 HCFA issued information on mortality rates at the nation's hospitals. This information was intended for use by hospital-care monitoring groups. It was disseminated to the public following a Freedom of Information Act request. HCFA clearly stated those lists did not necessarily indicate good or bad providers of care. Yet the HCFA did learn the public liked having this information, and this service will continue. To further a more competitive health care system, consumers must be given appropriate information on which to base choices.

The problem, however, is that mortality rates are just one piece of a large picture — these rates are important but incomplete. HCFA is also well aware of the effect the release of such information can have on physician behavior and on the hospital industry. For these reasons, in late 1986 and throughout 1987 HCFA consulted individuals with a wide

range of expertise in health policy, health services research, and statistics. These experts assisted HCFA in developing a policy for the public release of appropriate information on hospital mortality rates.

On December 17, 1987, HCFA released its Medicare Hospital Mortality Information, which documents mortality rates at nearly 6,000 short-term acute care hospitals nationwide that treated Medicare beneficiaries in 1986. The seven volume report contains figures reflecting the overall mortality rate for Medicare patients at each hospital, as well as the mortality rates in each of 16 diagnostic categories, such as cancer, kidney disease, and stroke. Each hospital's actual mortality rates were compared with HCFA's calculation of the mortality rate that could have been expected for the hospital, given the characteristics of patients it treated. A range rather than a point estimate was used to avoid implying that the predicted mortality was more precise than it actually is. In addition, each hospital was given the opportunity to comment on its own statistics. These written comments were published in the report.

Admittedly, this information would be more accurate if more precise methodologies were available, allowing for full adjustment for the severity of illness and other factors. Nevertheless, the information does contribute to our overall knowledge about hospital performance. If interpreted properly, this information can benefit physicians, hospital administrators and peer review organizations.

### B. *Peer Review*

The Peer Review (PRO) program is HCFA's primary tool for assessing quality health care. The PRO program, first enacted into law in 1982, has developed rapidly. As indicated by its legal title, "Utilization and Quality Control Peer Review Organizations," PRO review activities first focused on utilization control. HCFA sought to avert potential "gaming" of the new prospective payment system through improper or unnecessary admissions or frequent readmissions. Once it had been established that admissions had actually decreased under PPS, HCFA re-oriented the scope of PRO work in 1986 to emphasize quality of care. The PROs review approximately 25 percent of all hospital admissions, or 2.5 million cases annually. Every reviewed case is examined to determine if the care provided meets professionally-recognized standards of quality.

Each reviewed case is compared to a set of generic quality screens which focus on: discharge planning, medical stability at discharge, unexpected deaths, unscheduled return to the operating room and trauma suffered in the hospital. These screenings ensure an extremely broad quality review. PROs also review all readmissions occurring within 15 days of discharge, if the readmission is thought to be related to that discharge. Hospital transfers are also reviewed. PROs soon will be phasing in review of hospital readmissions occurring within 31 days of discharge. Payments for readmission will be denied if the PRO finds a premature discharge caused the readmission.

Recent Congressional actions have assigned HCFA new tasks that significantly broadened the duties of the PROs in assuring quality. They also raised some sensitive and complex issues. For instance, Congress has authorized PROs to deny payment for substandard care. The idea of classifying care as "substandard," however, raises many questions. Questions concerning mandatory review of elective surgical procedures and the requirement of a second surgical opinion in certain cases are also raised, and the HCFA is proceeding carefully in these matters, encouraging input, and will issue proposed rules for public comment. The HCFA already has issued instructions to require PROs to review the use of assistants during cataract surgery.

As a result of another congressional mandate, hospitals are now prohibited from turning away or transporting to another facility any patient who is in immediate need of services. Since August 1, 1986, all Medicare-participating hospitals providing emergency services have been required to meet new requirements for emergency medical screening, stabilizing, treatment and transfer of patients. As part of their provider agreement, these hospitals must also provide medical screening examinations and stabilizing treatment for individuals with emergency medical conditions and women in active labor. The penalty for knowingly, willingly, or negligently failing to meet these requirements for ANY of these individuals, not just for Medicare beneficiaries, is termination or suspension of the hospital's Medicare provider agreement. HCFA has terminated two hospitals and has issued 29 termination notices. These notices were rescinded only after the hospitals had fully corrected the problems causing the inappropriate transfer of patients. This swift response to allegations of "patient dumping" demonstrates to the hospital community that this behavior will not be tolerated.



Indeed, whenever PROs find quality problems they take appropriate action. The enforcement philosophy emphasizes rational action based on facts and seeks to identify problems, to educate, and to correct practice patterns where necessary. But if the circumstances merit, HCFA will not hesitate to invoke the most severe penalties available, from payment denials to exclusion from the Medicare program. The decision to impose such drastic sanctions should not be made lightly. Physicians and providers are given several opportunities to refute or correct any identified deficiencies. For peer review to work, the reviewer must be a true peer and knowledgeable about the standards of medical practice in the area of concern. HCFA has issued a reminder, for instance, that rural practice must be reviewed by PRO physicians who practice in a similar setting. Only this can ensure genuine peer review.

### C. *Quality and Managed Care*

The quality of care received by Medicare beneficiaries enrolled in private health plans has been criticized in recent months. In April 1987, for instance, a Senate committee released a preliminary report about the Medicare HMO/CMP program. Unfortunately, HCFA was not given an opportunity to review the report, nor was it made clear to the public that its findings could not be generalized in a scientific way to all Medicare HMOs. Rather, the report was based on anecdotal information — and not even much of that. The so-called “evidence” cited in the report consists of 37 anecdotes ranging back to 1983. It is entirely misleading to base conclusions on such skimpy evidence.

Nevertheless, HCFA believes that even one quality-of-care problem is one too many. HCFA also recognizes problems in marketing practices and in enrollment and disenrollment procedures. At HCFA's request, legislation has been passed to impose civil monetary penalties whenever medically necessary services are denied or inappropriate marketing procedures practiced.<sup>8</sup>

In order to contract with the Medicare program, HMOs and CMPs must first undergo a rigorous eligibility process to review their fiscal solvency, health service delivery system, internal quality-assurance program, and marketing practices.

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8. OMNIBUS BUDGET RECONCILIATION ACT OF 1986, Pub. L. No. 99-509, 100 Stat. 1874; OMNIBUS BUDGET RECONCILIATION ACT OF 1987, Pub. L. No. 100-203, 101 Stat. 1330.

Once a contract is signed, HCFA continually monitors the plans to assure their compliance with eligibility requirements. Medicare's quality review of managed-care plans considers the appropriateness of medical treatment and the setting in which care is delivered. The review focuses on several areas in which concerns about private plans have been expressed, such as the potential for underutilization of medical services in a private plan, the ease of access to medical services, and the timeliness of the services provided. There are three levels of review — "limited," "basic," and "intensified." The reviewing organization will analyze the private plan's internal quality-assurance process before determining the intensity of review. Thus private plans have incentives to strengthen their own quality-assurance systems. Not only will they receive a less intensive level of outside quality review, but they will also benefit by attracting consumers with a tough quality-assurance system. Quality review is necessary to ensure the long-term future of Medicare's private health-plan option. This option will not succeed unless the American people are convinced that managed-care in the Medicare program is care of high quality.

### CONCLUSION

In seeking to compare the effects of a regulatory system with a free market approach in containing health care costs, the course of public policy toward health care since 1965 should be considered. The regulatory approach has been tried with some effect, but overall without much success. Regulation stifles initiative and interferes with the ability of doctors and hospitals to practice medicine as they see fit. For this reason President Reagan sought to introduce more competition into the health care system. This effort is not yet complete. But the HCFA believes that competition will ultimately have two beneficial effects on American health care. First, competition will constrain costs more efficiently than regulation could. Second, and more importantly, it will help the Medicare system to preserve and enhance quality in health care.

Although it may appear to be a major departure from past policies in Medicare financing, the Private Health Plan Option is not a radical program. On the contrary, it reflects mainstream American values. PHPO relies on market incentives rather than on government regulation to keep costs rea-

sonable, while it respects the independent professional judgment of physicians.

In the 62nd Essay of the *Federalist Papers*, James Madison wrote:

It will be of little avail to the people that the laws are made by men of their own choice if the laws are so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow.<sup>9</sup>

Madison's observations are certainly as cogent as ever, and they apply with equal force to the Medicare system. In health care, long-term solutions need to focus on decentralization, competitive forces, and incentives for the appropriate use of medical services. We must resist telling ourselves that old ways are the best ways and commit ourselves to the enterprise ahead.

We believe our policy is one of vision tempered by pragmatism. We believe that a more competitive, decentralized system of private providers and of educated consumers will ensure a bright future for health care in America, at a price affordable to all.

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9. THE FEDERALIST No. 62, at 381 (J. Madison) (C. Rossiter ed. 1961).