Overview

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The Medicare prospective payment system (PPS) for hospitals, implemented in 1983, has motivated major changes in the hospital industry and the way hospital services are used by physicians and their patients. By paying hospitals a fixed rate for each inpatient stay based on the patient's diagnosis-related group (DRG) classification, PPS gave hospitals new incentives to provide services economically.

Because Medicare's PPS concentrated on inpatient services provided in acute hospital settings, this system did not apply to all hospitals and all services. Certain specialized facilities—psychiatric, rehabilitation, long-term care, and children's hospitals—were excluded from PPS. These types of facilities were excluded because DRGs did not readily apply to the types of care provided by these facilities, or the settings for this care were otherwise unsuited to the PPS. These hospitals have remained under the payment system established by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Medicare payments to TEFRA facilities are related to the hospitals' actual allowable costs, limited by a facility-specific cost-based target amount.

As a group, the number of Medicare cases treated at excluded hospitals and units grew from 439,454 in fiscal year (FY) 1989 to 570,694 in FY 1991, a 30-percent increase. Children's hospitals treated the fewest cases (2,671 in FY 1991), with little change from year to year. Rehabilitation facilities experienced the greatest percentage increase in the number of cases during this period, rising from 144,252 in FY 1989 to 204,213 in FY 1991, a 42-percent increase. Psychiatric facilities treated the most cases in FY 1991, 343,912, up from 276,209 in FY 1989. Payments to excluded facilities grew by 39 percent during this period, from $2.8 billion in FY 1989 to $3.9 billion in FY 1991.

Classification schemes such as the DRG system, which describe case mix and form the basis for payments to health care providers, are often a key to the development of new payment policies. Systems with greater precision can ultimately play an important role in measuring utilization and costs and in resource management. More precise systems will be increasingly important whether the country moves toward a more competitive managed care environment or toward increased constraints on health care budgets, as providers and payers need to project future costs and negotiate contracts based on patient needs and characteristics and manage utilization and costs. The theme of this issue of the *Review* is "Hospital Payment: Beyond the Prospective Payment System." Three articles present authors' ideas on how current payment methods for excluded hospitals might be modified in the future.

Schneider, Cromwell, and McGuire examine trends in the financial performance of excluded facilities. They report that the number of TEFRA facilities and discharges has been increasing while their average profit rates from Medicare cases have been steadily decreasing. Modifying

TEFRA would require either rebasing the target amount or adjusting cost sharing for facilities exceeding their cost target. Based on simulations of alternative payment systems, the authors recommend rebasing facilities' target amounts using a 50/50 percent blend of a facility's costs and national average costs.

Fries, Durance, Nerenz, and Ashcraft propose a payment system for inpatient psychiatric care that would apply to both acute and chronic-stay psychiatric care. The payments are based on two new psychiatric patient classification systems. Shorter-stay patients would be paid on an episode basis, while the longest-staying patients are paid on a per diem basis. For short-stay patients, the model employs a new patient classification system, Psychiatric Patient Classifications, which was found to be superior to DRGs in explaining episode costs for psychiatric diagnoses. For long-stay patients, the payment scheme relies upon a second new classification system, the Long-Stay Psychiatric Patient Categories, that predicts per diem resource use. These two classification systems are combined in a prototype payment that seems to provide incentives for discharge of acute care patients yet finances chronic care appropriately as well. Use of a "transition pricing" method is proposed to provide a balance between the incentives of an episode-based system and the necessity of per diem long-term payments.

Payne and Schwartz report on a classification scheme—pediatric-modified DRGs (PM-DRGs)—developed to describe more accurately than DRGs the differences in severity of illness and costs across pediatric hospitals and patients. The authors report on a comparison of PM-DRGs and DRGs for use in a PPS. PM-DRGs performed markedly better than DRGs at explaining variations in length of stay (LOS) and charges. They improve the classification of neonatal discharges by concentrating them into fewer categories and measuring birth weight more accurately. The authors conclude that the improved performance of PM-DRGs in explaining variations in resource use suggests that the new system is preferable for use by hospitals for internal management and control and by researchers for controlling for factors influencing resource use. They suggest that the improvements at the hospital level also are preferable for payers, because they would improve the credibility of the payment system and its acceptance by hospitals. The authors note that under a fixed budget, PM-DRGs would shift payments from community and minor teaching hospitals to major teaching and children's hospitals. Furthermore, if this system were adopted, quality assurance and outcomes assessment would become even more important for protecting quality of care and preserving regionalized systems of perinatal care.

Three articles in this issue examine resource use and cost patterns for specific hospital patients or settings with atypical hospital costs. Buczko examines transfer episodes for aged Medicare beneficiaries hospitalized during 1987. His analysis indicates that these transfer patients have comparable initial stays to non-transfers in terms of LOS, case-mix intensity, and total charges, but during the final part of the episode, these transfers are clearly more intense cases than non-transfers. The data suggest that Medicare transfers involve cases that frequently require specialized treatment, and that the transfers appear to be motivated by primarily clini-

cal concerns related to appropriateness and quality of care rather than economic concerns. Small and rural hospitals were disproportionate senders of transfers and tended to receive relatively few transfers, while large urban hospitals received an exceptionally large percentage of transfer cases, suggesting that some "regionalization" of conditions requiring specialized care already exists.

In the study described by Cartwright and Ingster, Medicare hospital discharge records for 1987 were assembled into patient-based records that included alcohol, drug, and mental health diagnoses as well as measures of resource use. Their analyses found that there are substantially higher costs of health care incurred by the drug disorder diagnosed population. If drug diagnosed, the disabled and aged Medicare populations had longer LOSs, higher hospital charges, and more discharges. Cartwright and Ingster conclude that, although the elderly are not generally targeted as a population suffering a substantial amount of drug disorders, the growing size of this group and the demonstrated additional burden that drug disorders place on Medicare resource consumption warrants further investigation into the distribution and dynamics of drug disorders in this population. They suggest that the numbers of drug diagnosed Medicare admissions might be reduced through a variety of interventions. The study shows the value of examining data in a longitudinal framework where multiple discharges may be captured. Readmissions can be more easily examined as an outcome with a resulting greater potential for measuring cost savings to the health care system.

Moscovice, Wellever, Sales, Chen, and Christianson propose an alternative to an LOS limit for defining service limitations for limited-service rural hospitals such as the rural primary care hospital (RPCH). Their analysis indicates that small rural hospitals admit patients in a limited number of DRG categories, typically representing low-intensity medical admissions; they transfer relatively few cases to other hospitals; and patient LOSs frequently exceed 3 or 4 days. The authors suggest that using strict LOS limits to define service limitations could discourage potential candidates for limited-service facility status, because they would lose a substantial portion of their existing inpatient business. The authors' proposed alternative model builds upon existing features of PPS and the Essential Access Community Hospital (EACH) program. It incorporates the 72-hour LOS limit proposed for RPCHs in EACH legislation and regulations, uses DRGs as the method for describing patients who are appropriate to be treated in a RPCH, and uses peer review organizations as a quality assurance regulator. Because the proposal builds upon existing features of the Medicare program, it minimizes the need for elaborate new policies.

This issue also includes several articles related to more general topics on hospital and physician services. An article by Kominski and Witsberger examines trends in hospital LOS for Medicare patients from 1979 to 1987 for all cases combined, for medical and surgical cases separately, and for different geographic regions. The increase in LOS for surgical cases from 1985 to 1987 represented two offsetting trends: Continuing declines in LOS for most procedures were offset by an increased shift toward complex, long LOS procedures. Their overall conclusion is that PPS had a substantial and continu-

ing impact in reducing one important component of hospital services—inpatient days. However, this trend is partially offset by an increase in days in PPS-exempt units. The ongoing influence of PPS on LOS has been offset by shifts in case mix toward procedures that require longer LOSs, which is attributed to greater use of outpatient surgery and advances in medical technology. These factors, which tend to reduce short-stay admissions and increase long-stay admissions, may not be related to PPS; however, PPS accelerated the substitution of outpatient for inpatient surgery.

Recently, Federal courts have become increasingly involved in setting State inpatient ratesetting policies through the Boren Amendment, a provision of the Medicaid law requiring States to provide assurances that their inpatient rates must meet certain specified standards of reasonableness. Since a 1990 Supreme Court decision, Medicaid providers have challenged State inpatient ratesetting methodologies under this amendment. Batavia, Ozminkowski, Gaumer, and Gabay review recent court decisions and discuss their implications for States' procedures in establishing inpatient hospital payment rates. Procedurally, court decisions have tended to require that, to meet the amendment's requirements, payment rates must be supported by findings based on a "reasonably principled analysis." Substantively, rates may fall within a zone of reasonableness, but courts have differed in interpreting and applying the amendment's terms. While some courts have found special studies and written findings unnecessary, States that undertake economic analyses to support their findings are more likely to withstand judicial scrutiny. However, the case law does not indicate what kinds of standards of efficiency will be adequate. In addition, economic analysis cannot be used to identify absolute standards of efficiency. Consequently, the concept of relative efficiency is the only readily available option. This article identifies several factors that are important in establishing a case that a relative standard of efficiency is a defensible method of complying with the intent of Congress.

Two articles in this issue address topics other than hospital payment. Miller and Welch propose an alternative method of paying for Medicare inpatient physician services. These services account for a significant proportion of all physician services, and their volume and intensity growth has been rapid. To control Medicare physician payments, Congress established volume performance standards (VPS). The VPS risk-pool is nationwide; some observers believe that this is too large to affect individual physician behavior. Miller and Welch suggest that VPS could be modified by defining a separate risk-pool for inpatient physician services and placing each hospital medical staff at risk for those services. Using a national random sample of Medicare admissions, the authors analyze the determinants of medical staff charges per admission and comment on the policy implications.

An article by Manton, Newcomer, Lowrimore, Vertrees, and Harrington examines the health outcomes of beneficiaries enrolled in the social/health maintenance organizations (S/HMOs), exploring four demonstrations that go beyond the focus of traditional HMO risk plans to offer additional long-term care community benefits targeted to an impaired and frail elderly population. The study, while finding that the plans, as a group, did not improve out-

comes for the frail elderly relative to fee-for-service care, indicates that S/HMOs were successful in providing integrated care for certain types of clients. The authors discuss the findings in terms of the goals of the demonstrations and suggest design improvements for future managed care programs targeting the frail elderly.