S. HRG. 100-263

MEDICARE HOSPITAL PAYMENT RATES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

APRIL 7, 1987

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

76-658 WASHINGTON : 1987

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

SPARK M. MATSUNAGA, Hawaii	BOB PACKWOOD, Oregon
DANIEL PATRICK MOYNIHAN, New York	BOB DOLE, Kansas
MAX BAUCUS, Montana	WILLIAM V. ROTH, JR., Delaware
DAVID L. BOREN, Oklahoma	JOHN C. DANFORTH, Missouri
BILL BRADLEY, New Jersey	JOHN H. CHAFEE, Rhode Island
GEORGE J. MITCHELL, Maine	JOHN HEINZ, Pennsylvania
DAVID PRYOR, Arkansas	MALCOLM WALLOP, Wyoming
DONALD W. RIEGLE, JR., Michigan	DAVID DURENBERGER, Minnesota
JOHN D. ROCKEFELLER IV, West Virginia	WILLIAM L. ARMSTRONG, Colorado
TOM DASCHLE, South Dakota	

WILLIAM J. WILKINS, *Staff Director and Chief Counsel*
MARY MCAULIFFE, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

GEORGE J. MITCHELL, Maine, *Chairman*

LLOYD BENTSEN, Texas	DAVID DURENBERGER, Minnesota
MAX BAUCUS, Montana	BOB PACKWOOD, Oregon
BILL BRADLEY, New Jersey	BOB DOLE, Kansas
DAVID PRYOR, Arkansas	JOHN H. CHAFEE, Rhode Island
DONALD W. RIEGLE, JR., Michigan	JOHN HEINZ, Pennsylvania
JOHN D. ROCKEFELLER IV, West Virginia	

CONTENTS

ADMINISTRATION WITNESSES

PUBLIC WITNESSES

ADDITIONAL INFORMATION

COMMUNICATIONS

MEDICARE HOSPITAL PAYMENT RATES

TUESDAY, APRIL 7, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 2:30 p.m. in room SD-215, Dirksen Senate Office Building, Hon. George Mitchell (chairman) presiding.

Present: Senators Mitchell, Baucus, Rockefeller, Heinz, and Durenberger.

[The prepared written statements of Senators Rockefeller, Durenberger, and Heinz, and the press release announcing the hearing follow:]

[Press Release]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON MEDICARE HOSPITAL PAYMENT RATES

Washington, DC—Senator George J. Mitchell (D., Maine), Chairman, announced Monday that the Subcommittee on Health of the Senate Finance Committee will hold a hearing to examine hospital payment rates under the Medicare program.

Senator Mitchell stated that the purpose of the hearings is to examine whether the payment rates under Medicare's propsective payment system (PPS) are set at appropriate levels, taking into account more recent data than was used to initially set the rates, and taking into account hospitals' Medicare and overall profit margins.

Senator Mitchell stated that the Subcommittee would receive testimony from the Congressional Budget Office, the Department of Health and Human Services, the Prospective Payment Assessment Commission and the American Hospital Association.

The hearing will be held on Tuesday, April 7, 1987 at 2:30 P.M. in Room SD-215 of the Dirksen Senate Office Building.

OPENING REMARKS
SENATOR JOHN D. ROCKEFELLER IV
FINANCE SUBCOMITTEE HEARING ON MEDICARE HOSPITAL PAYMENTS
April 7, 1987

Mr. Chairman, in all honesty, I approach this subject of Medicare's hospital payments for hospitals with a great deal of trepidation. Like you, I have read the news reports and material from CBO, ProPAC, and HHS's Inspector General which portray Medicare-related profits of up to 16%. In general, the impression given seems to be one of a healthy, profitable hospital industry that has been given a rather good "deal" in agreeing to Medicare's prospective payment system.

But because I represent a state with mostly rural and many small hospitals, my perpective is not nearly as positive. In 1985, over half of the 30 small and rural hospitals in West Virginia lost money -- their average loss that year was about $262,000. And last year, 44% of our hospitals suffered operating losses.

The figures I have on Medicare-related "profits" are unsettling as well. In a computer print-out prepared for me by the state's "Health Care Cost Review Authority" for today's hearing, the revenue gains stemming from Medicare payments are presented for 34 of West Virginia's 67 hospitals. Their Medicare-related "profit" has dropped from about 4.8% in 1985, to 2.7% in 1986, to 0.9% projected for this year -- needless to say, this is no where near the 12 to 16 percent profits that are getting all of the national attention.

This is not a comforting trend. And I would think these numbers indicate why I am concerned about proposed reductions in Medicare payments. I want to make absolutely sure that Congress doesn't further harm those hospitals which have <u>not</u> "profitted" from Medicare revenue, or which have been actually <u>losing</u> money by receiving inadequate payments for their Medicare patient load -- I'm opposed to setting rates below what they need in 1988 and the years thereafter to provide quality, reliable medical care to the elderly and to even survive institutionally.

I recognize that the reasons for the financial problems afflicting West Virginia's hospitals don't entirely rest with Medicare. Our hospitals' uncompensated care represents almost 8% of their patient bases, in contrast to the national average of 5.8%. We have an unusually high Medicaid population to serve. And weak local economies in many West Virginia communities take their toll in numerous ways on the hospitals.

Mr. Chairman, I also share with you and other members of this subcommittee a strong desire to eliminate the discriminatory nature of Medicare's payment rates for rural hospitals. I appreciate the growing sensitivity on the part of today's witnesses, the organizations they represent, and other health

care experts towards the financial plight of small and rural hospitals. A consensus is clearly emerging around the need to narrowing the disparity between urban and rural PPS rates.

I am immensely interested in hearing the testimony this afternoon, and I have a number of questions for our witnesses. I want to be open to the facts, to arguments, and to proposals which present ways to improve Medicare's payment system -- and to achieve savings where possible and justifiable. But at the same time, my position will be that Medicare's payment system should not take something away from hospitals which have nothing to give.

STATEMENT

SENATOR DAVE DURENBERGER

APRIL 7, 1987

MR. CHAIRMAN, I WANT TO COMMEND YOU FOR HOLDING THIS IMPORTANT HEARING ON HOSPITAL RATES UNDER MEDICARE. AS YOU KNOW, THESE ISSUES HAVE BECOME HIGHLY CONTROVERSIAL IN THE LAST FEW WEEKS AS EARLIER REPORTS OF HOSPITAL PROFITS UNDER MEDICARE BY THE INSPECTOR GENERAL WERE CONFIRMED BY PROPAC AND CBO. SUCH REPORTS, BALANCED BY OPPOSITE CLAIMS BY THE HOSPITAL INDUSTRY, MAKE IT ESSENTIAL THAT WE FIND OUT:

1) WHAT'S GOING ON IN THE COUNTRY
2) WHETHER "PROFITS" UNDER MEDICARE ARE EXCESSIVE AND CONTINUING
3) OR, WHETHER THEY ARE THE SHORT TERM EFFECTS OF CONGRESS'S EARLY FEAR OF HARMING HOSPITALS AT A TIME WHEN CONGRESS WAS INTRODUCING A RADICALLY NEW SYSTEM.

UNDER PRESSURES FROM BENEFICIARIES AND THE INDUSTRY AND IN THE ABSENCE OF CURRENT DATA, THERE IS NO DOUBT THAT CONGRESS ERRED ON THE SIDE OF PROTECTING THE BENEFICIARY AND THE HOSPITALS, RATHER THAN PUT THE ELDERLY AND DISABLED AT RISK BY ANY MORE DRACONIAN MEASURES. I BELIEVE THAT CONGRESS WOULD DO SO AGAIN IF THE SAME AMBIGUITIES EXISTED. ACCORDING TO MY MAIL, THERE ARE STILL MANY PROBLEMS IN THE COUNTRY. IF WE FIND THAT HOSPITALS ARE BETTER OFF FROM MEDICARE PAYMENTS, I HOPE WE WILL FIND THE MONEY TO MOUNT A PUBLIC, PROVIDER AND BENEFICIARY EDUCATION CAMPAIGN SO THAT THERE CAN BE MORE UNDERSTANDING ABOUT THE PROGRAM.

IF IN THIS HEARING WE ARE GIVEN CONSISTENT EVIDENCE THAT ON AVERAGE HOSPITALS ARE DOING BETTER THAN BEFORE, THEN WE NEEED TO KNOW WHY WE HEAR ABOUT SO MANY PROBLEMS IN THE COUNTRY. I CERTAINLY HEAR IN PERSON THROUGHOUT MINNESOTA AND THROUGH LOTS OF MAIL THAT MEDICARE CUTS ARE RESPONSIBLE FOR ALL SORTS OF PROBLEMS. IF HOSPITAL PAYMENTS ARE NOT BEING REDUCED, ESPECIALLY WHEN ADJUSTED FOR INFLATION AND EVERYTHING THAT WE NEED TO ADJUST FOR, THEN WE NEED TO KNOW HOW HOSPITALS ARE REACTING TO CHANGES AND WHY THE BENEFICIARIES AND THE PROVIDERS VIEW WHAT'S HAPPENING IN SUCH NEGATIVE TERMS. I RECEIVE LETTERS EVERY DAY EXPRESSING ANGER HURT, AND OUTRAGE AT THE FEDERAL GOVERNMENT'S FAILURE TO FULFILL ITS CONTRACT. MAYBE WE SHOULD ASK NOT HOW MANY EMPLOYEES PER ADMISSION THERE ARE (ACTUALLY A FIGURE THAT HAS STILL GROWN AS SHOWN IN THE ATTACHED TABLE,) RATHER, WE SHOULD ASK HOW MANY DIRECT PATIENT CARE EMPLOYEES PER ADMISSION THERE ARE, IF WE WANT TO FIGURE OUT WHY SO MANY PEOPLE FEEL THAT THEY ARE GETTING A LOT LESS HEALTH CARE AND CARING THAN THEY USED TO GET. THIS IS A MANAGEMENT PROBLEM, NOT A HEALTH EXPENDITURE PROBLEM. BOTH A HOSPITAL MANAGEMENT PROBLEM AND A MEDICARE PROGRAM PROBLEM.

ANOTHER IMPORTANT FIGURE TO LOOK AT IF WE ARE CONCERNED ABOUT HOSPITALS FISCAL HEALTH ARE TOTAL MARGINS AND OVERALL PATIENT MARGIN. THE LATTER FIGURE ILLUSTRATES HOW MUCH HOSPITALS' DEPEND ON OTHER (I.E. NONPATIENT) REVENUES TO MAINTAIN STRENGTH. FOR EXAMPLE RURAL HOSPITALS WITH LESS THAN 50 BEDS HAVE A PPS MARGIN OF 7.0%, TOTAL MARGIN OF 3.3%, AND A PATIENT MARGIN OF -3.7%. THE ATTACHED TABLE SHOWS SIMILAR DIFFERENTIALS.

THESE DATA CERTAINLY SHOW THAT MEDICARE IS CONTRIBUTING MORE THAN THE NARROWEST INTERPRETATION OF ITS FAIR SHARE AND THAT THE MIXED MESSAGES WE'RE GETTING REFLECT REALITY. HOSPITALS DID HAVE "HIGH PROFITS" IN 1984 AND THEY ARE ALSO STRUGGLING IN SOME PLACES WITH THEIR DECLINING ADMISSIONS. TO BE FAIR, WE MUST UNDERSTAND THE COMPLEXITIES.

FOR UNDERSTANDABLE REASONS, WE LOOK AT AND MAKE POLICY ON AGGREGATE STATISTICS , BUT WE ALL KNOW THEY ARE VERY MISLEADING AS A BASIS FOR INDIVIDUAL CASES, RARELY HAS THIS BEEN AS TRUE AS IT IS FOR SMALL RURAL HOSPITALS. PROPAC'S OWN REPORT NOTES THE PROBLEMS FOR SMALL RURAL HOSPITALS. SOME ARE IN GREAT DISTRESS THROUGH NO FAULT OF THEIR OWN. AS WE EXAMINE THESE PAYMENT ISSUES, WE MUST BE PARTICULARLY SENSITIVE TO THE ECONOMIC STRESSES AND PAYMENT HANDICAPS FACED BY RURAL HOSPITALS. I INTEND TO INTRODUCE MY OWN RURAL HOSPITAL PAYMENT EQUITY ACT

THIS WEEK TO REDUCE THE GAP BETWEEN RURAL AND URBAN HOSPITALS PAYMENT RATES, ALONG THE LINES RECOMMENDED BY THE PROSPECTIVE PAYMENT COMMISSION.

THERE ARE OTHER PROBLEMS IN THE PAYMENT SYSTEM, ALTHOUGH ON BALANCE IT STILL HAS MANY ADVANTAGES. I HOPE THAT WE WILL NOT LET OUR GENUINE AND SERIOUS NEEDS FOR DEFICIT REDUCTION, COMBINED WITH A CONFUSING AND CERTAINLY COMPLEX REPORT ON HOSPITALS OVERALL OPERATING SURPLUS IN 1984, LEAD US TO THINK THAT WE DON'T NEED TO MAKE OTHER CHANGES TO HELP HOSPITALS THAT HAVE PROBLEMS OR THAT THE GOOD REPORT FOR 1984 CAN NECESSARILY BE CONTINUED UNDER CURRENT POLICIES. WE HAVE MADE A DEAL WITH THE PROVIDERS OF THE NATION IN ORDER TO PROTECT MEDICARE BENEFICIARIES ACCESS TO HEALTH CARE. THERE IS SOME GOOD NEWS IN THE REPORTS ON HOSPITALS, THERE ARE ALSO SOME VERY WORRISOME PROBLEMS OUT THERE. WE MUST BALANCE OUR RESPONSIBILITIES TO PROTECT BENEFICIARIES, ENSURE THAT THE MEDICARE PROGRAM IS A CAREFUL AND WISE BUYER AND THAT THE TAXPAYERS AND ENROLLEES WHO PAY FOR THE PROGRAM KNOW THAT THEIR MONEY IS WELL SPENT. WHERE THERE ARE HIGH PAYMENTS, WHATEVER THE CAUSE, TO HOSPITALS, WE SHOULD DECREASE PAYMENTS AND MAKE OTHER MID-COURSE CORRECTIONS. WHERE THERE ARE <u>UNFAIRLY</u> LOW PAYMENTS, WE SHOULD INCREASE THESE. IN ALL INSTANCES WE SHOULD NOT FORGET OUR AIM: <u>GOOD QUALITY, APPROPRIATE, EFFECTIVE HEALTH SERVICES, AT A REASONABLE PRICE</u>. WE OWE THE BENEFICIARIES AND THE TAXPAYERS NO LESS! THANK YOU.

DAVE DURENBERGER
MINNESOTA

United States Senate
WASHINGTON, DC 20510

Table 15. Change in Hospital Employment, 1976-1986 (In Percent)

Year	Total Hospital Full-Time Equivalents	Inpatient Full-Time Equivalents	Inpatient Full-Time Equivalents per Admission
1976	6.1%	5.8%	2.3%
1977	5.1	4.6	2.1
1978	3.7	3.2	2.8
1979	3.5	3.3	0.7
1980	4.7	4.5	1.6
1981	5.4	5.1	4.3
1982	3.7	3.4	3.4
Average Increase 1976-1982	4.6	4.3	2.5
1983	1.4	0.8	1.4
1984	-2.3	-3.5	0.2
1985	-2.3	-4.3	0.6
1986*	0.4	-1.5	1.1
Average Increase 1983-1986	-0.7	-2.1	0.8

* Estimate based on January through August 1985 compared with January through August 1986.

SOURCE: American Hospital Association National Panel Survey.

Table 16. Change in Health Services Employment and Hospital Employment, 1976-1986 (In Percent)

Year	Health Services Employees	Hospital Employees	Hospital Employees: Proportion of Health Services Employees
1976	5.2%	3.9%	.54
1977	5.4	4.3	.54
1978	4.5	3.0	.53
1979	4.2	2.8	.52
1980	5.7	5.4	.52
1981	5.4	5.6	.52
1982	4.5	3.8	.52
Average Increase 1976-1982	5.0	4.1	—
1983	3.0	0.7	.51
1984	2.2	-1.1	.49
1985	3.1	-0.2	.48
1986*	4.3	1.2	.46
Average Increase 1983-1986	3.2	0.2	—

* Estimate based on January to September.

SOURCE: U.S. Department of Labor, Bureau of Labor Statistics.

DAVE DURENBERGER
MINNESOTA

United States Senate
WASHINGTON, DC 20510

Table 27. Comparison of Median PPS, Total, and Patient Margins in the First Year of PPS*

Hospital Type	Median PPS Margin	Median Total Margin	Median Patient Margin
All hospitals	11.6	6.7	2.5
Urban	14.1	7.6	4.0
Rural referral centers	8.0	7.9	3.4
Other rural	8.6	5.0	0.2
Major teaching	18.8	4.9	-4.3
Other teaching	15.2	7.8	3.8
Non-teaching	10.5	6.6	2.3
Disproportionate share	13.8	6.3	2.3
Non-disproportionate share	11.1	6.9	2.7
New England	10.7	7.2	2.0
Middle Atlantic	15.1	9.1	5.1
South Atlantic	10.4	7.9	3.8
East North Central	12.2	5.3	1.6
East South Central	9.0	7.5	4.2
West North Central	11.1	8.5	3.5
West South Central	11.8	6.3	1.4
Mountain	10.5	5.2	0.3
Pacific	13.3	6.4	2.8
Urban < 100 beds	12.4	5.1	1.4
Urban 100-249 beds	13.3	7.8	4.7
Urban 250-404 beds	15.0	8.0	4.6
Urban 405-684 beds	15.5	9.1	4.5
Urban 685 + beds	18.9	7.8	3.4
Rural < 50 beds	7.0	3.3	-3.7
Rural 50-99 beds	9.3	5.7	1.6
Rural 100-169 beds	8.7	6.4	2.9
Rural 170 + beds	7.9	7.7	3.6

* PPS margins = PPS revenue minus Medicare operating costs divided by PPS revenue. Excludes pass-through costs and payments. Total margin = total revenue minus total operating expenses divided by total revenue. Patient margin = net patient revenue minus total operating expenses divided by net patient revenue. Excludes hospitals in Maryland, Massachusetts, New Jersey, and New York, which were not on PPS during this period.

SOURCE: ProPAC estimates based on first-year PPS Medicare Cost Report data.

SENATOR JOHN HEINZ
SUBCOMMITTEE ON HEALTH
HEARING ON HOSPITAL PAYMENT RATES
APRIL 7, 1987

MR. CHAIRMAN: I COMMEND YOU FOR FOCUSING THE SUBCOMMITTEE'S ATTENTION ON THE ISSUES THAT WILL SHAPE OUR ACTIONS ON MEDICARE HOSPITAL PAYMENTS: PROFITABILITY, REBASING AND THE UPDATE FACTOR. WHAT WE HEAR TODAY -- FROM THE ADMINISTRATION, THE EXPERTS AND THE HOSPITAL INDUSTRY -- WILL GO A LONG WAY TOWARDS INFORMING THIS COMMITTEE'S DECISIONS ON THE MEDICARE BUDGET FOR FISCAL YEAR 1988.

OVER THE LAST TWO YEARS, THERE HAS BEEN A LOT OF PRESS GIVEN TO THE ECONOMIC STATUS OF OUR NATION'S HOSPITALS. THE RESULT HAS BEEN A MUDDLED MESSAGE: HOSPITALS ARE AT ONCE PROFITING AND FAILING. THEY ARE REAPING THE EXCESSES OF OVER COMPENSATION AND BUCKLING UNDER FROM TOO MANY YEARS OF INADEQUATE FEDERAL PAYMENTS. I SUSPECT THE TRUTH LIES SOMEWHERE INBETWEEN. MOST HOSPITALS ARE DOING WELL UNDER PPS; SOME -- ESPECIALLY SMALL RURAL HOSPITALS AND THOSE SHOULDERING LARGE NUMBERS OF UNINSURED PATIENTS -- ARE BARELY MAKING IT.

IF WE DECIDE TO REBASE THE DRGS OR LOWER THE UPDATE FROM THAT MANDATED BY OBRA, I HOPE THAT WE GIVE VERY CAREFUL CONSIDERATION TO THE DISTRIBUTIONAL EFFECTS OF SUCH CHANGES. I AM VERY CONCERNED THAT OUR EFFORTS TO MAKE MID-COURSE CORRECTIONS IN THE PPS PAYMENT METHODOLOGY MAY BACKFIRE: JUSTIFIED OR NOT, REDUCTIONS IN THE RATE OF INCREASE TO

HOSPITALS WILL LEAD SOME HOSPITALS TO REDUCE QUALITY OF AND ACCESS TO CARE. AND SOME HOSPITALS WILL SIMPLY GO UNDER. I KNOW THAT THERE ARE SOME HOSPITALS IN PENNSYLVANIA, BOTH RURAL AND URBAN, THAT CANNOT ABSORB TOO MANY MORE WAVES OF MEDICARE PAYMENT REDUCTIONS.

FOR THE MAJORITY OF HOSPITALS THAT ARE FARING WELL UNDER PPS, I HAVE TO WONDER WHETHER THEY ARE DOING ALL THEY CAN BE DOING TO ENSURE THAT THEIR MEDICARE PATIENTS ARE BEING WELL SERVED. WE KNOW THAT PPS AND INCREASING COMPETITION HAVE RESULTED IN NEW PROBLEMS FOR PATIENTS. MOVED OUT OF THE HOSPITAL SOONER AND SICKER THAN EVER BEFORE, MEDICARE BENEFICIARIES HAVE A MUCH GREATER NEED FOR TRANSITIONAL AND LONG TERM CARE SERVICES. HOSPITALS ARE IN A GOOD POSITION TO FOLLOW THROUGH WITH IMPROVED DISCHARGE PLANNING, HOME CARE SERVICES AND RESPITE CARE -- SERVICES WHICH WILL IMPROVE QUALITY OF CARE AND MAKE THESE FACILITIES MORE ATTRACTIVE IN AN INCREASINGLY COMPETITIVE ENVIRONMENT. I DO NOT BEGRUDGE HOSPITALS THEIR PROFITS, IF THOSE PROFITS ARE NOT AT THE EXPENSE OF PATIENT CARE.

MR. CHAIRMAN, I LOOK FORWARD TO HEARING TODAY'S TESTIMONY.

Senator MITCHELL. Good afternoon, ladies and gentlemen. Welcome to this hearing to examine the issue of Medicare hospital payment rates under the Prospective Payment System.

We will hear today from a number of witnesses, including representatives of the Administration, the American Hospital Association, and the Congressional Budget Office, in an effort to determine how different groups of hospitals have fared under the Prospective Payment System and what changes in payment rates, if any, should be made to enhance fairness in that system.

The committee is concerned about whether the payment rates are appropriately set, given recent suggestions by the General Accounting Office, the Inspector General of the Department of Health and Human Services, and ProPAC that the data used to initially set the rates may have been inaccurate.

The issue, at least here today, is not primarily the budget or the level of hospital profits under the Prospective Payment System, but rather whether the current rates are equitable for hospitals, Medicare beneficiaries and taxpayers.

While much of the attention of the media has been on so-called excessive profits of hospitals in 1984 and 1985, the real issue is whether some hospitals are receiving payments that are too high because of a problem in the way the rates were originally set.

Further, limits in the PPS update factor in past years, the transition to national rates, and dramatic changes in the competitive nature of the health care marketplace over the past two years, may have had a significant impact on hospital margins, which Fiscal Year 1985 data do not accurately reflect.

Many of us on this committee, because of the states we represent, are primarily concerned about the fairness of payments to rural hospitals under the Prospective Payment System. There is some evidence that rural hospitals have been especially hard hit by the constraints in the rate of increase, because of payment inequities that were inherent in the way the payment rate for the system was originally determined. This problem affects some inner city hospitals as well.

While changes enacted by Congress in the past two years may have corrected some of the reimbursement problems of rural hospitals, there is continuing concern that the payment system is still not equitable for such hospitals. The smallest rural hospitals face additional problems as inpatient care in the hospital is increasingly oriented toward the care of critically ill persons and the use of high technology.

The Administration's Fiscal Year 1988 budget proposes to return to the Secretary the authority to set the rates for hospitals under the Prospective Payment System, and to limit the increase to 1.5 percent, regardless of the market basket rate of increase.

While in recent public statements HCFA officials have revised the increase upward, the Administration's focus still seems driven by the desire to cut spending for domestic programs to the exclusion of other factors. Accordingly, I cannot support the suggestion that Congress return the authority to set the update determination to the Secretary. I believe Congress must continue to play a vital role in setting the rate, as we did last year.

As Congress attempts to set a rate which accurately reflects a fair reimbursement to hospitals that treat Medicare patients, we also have to consider a number of related issues: whether capital costs should be included in the DRG payment; whether there is a need to clarify the definition of the sole community hospital; and the need for more timely acquisition of data on the functioning of the Prospective Payment System.

Our major focus in all these determinations must be a bipartisan effort to ensure that the Medicare program can, both now and in the future, provide its participants with cost-effective care of high quality. I hope that this is the goal we all share, despite any disagreements we may have on how best to achieve it.

I look forward to the testimony today and hope that this subcommittee will be able to work effectively with the Administration and the organizations represented here, and other organizations, to develop an equitable reimbursement rate during our budget deliberations this year.

Our first witness is Dr. Nancy Gordon, Assistant Director, Human Resources and Community Development Division of the Congressional Budget Office.

Dr. Gordon, welcome. We look forward to hearing from you. For you and all other witnesses, you are aware of the committee's rules—your written statement will be inserted in the record in full. We ask you to limit your oral remarks to a 5-minute summary of the high points of that statement.

STATEMENT OF NANCY M. GORDON, PH.D., ASSISTANT DIRECTOR, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY, DR. STEPHEN LONG, DEPUTY ASSISTANT DIRECTOR, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT, CONGRESSIONAL BUDGET OFFICE, AND DR. STEVEN SHEINGOLD, PRINCIPAL ANALYST FOR HOSPITAL REIMBURSEMENT, CONGRESSIONAL BUDGET OFFICE

Dr. GORDON. Thank you very much, Mr. Chairman. I would like to introduce Stephen Long, my Deputy, who is seated to my right; and Steven Sheingold, Congressional Budget Office, Principal Analyst for Hospital Reimbursement, who is seated to my left.

Based on the recently available 1984 data, the CBO found that operating margins on Medicare PPS revenues were about 12 percent in 1984, which corresponds to profits of about 14 percent. Margins are projected to be 14 percent to 21 percent in each of the next three years, for an industry total of at least $20 billion over the four-year period. Although no particular average operating margin was specified as a target when the original PPS rates were set, such high ones are in stark contrast to the zero margins that prevailed under cost reimbursement.

Today, my statement will describe one method for adjusting the PPS rates to reflect these newer data, often called rebasing, and the implications of these data for updating the PPS rates for the next year.

The illustration of rebasing involves three steps:

First, the 1984 PPS rates are recalculated by substituting the new data for the original data, which would lead to about a 16 percent drop in the rates. These estimates convey essentially the same information as the operating margins for 1984.

Second, the update factors for 1985 to 1987 are recalculated using current information about inflation, growth in the average case mix of hospitals, and so on. They are structured so that they do not reflect influences that have already been accounted for by using the 1984 data. Over the three-year period, the cumulative effect of the recalculated update factors would differ from that of the actual ones by less than 1 percent.

Third, the new update factors are applied to the recalculated 1984 rates to produce the rebased 1987 rates.

Figure 2 on page 16 of my statement shows the effects on payment rates of both the actual and the recalculated update factors. The top line shows the actual rates and the bottom line shows the recalculated ones. Although the paths generated by the two update factors would differ, the actual payment rates would remain roughly 15 percent higher than hospitals' costs in 1987, as they were in 1984.

These calculations suggest that the Congress may want to modify the system. In considering various approaches, however, it is important to remember that the goals of the PPS cannot necessarily be achieved by targeting a particular average operating margin. Many different payment rates and adjustments could be set that would achieve a specified margin, but only one of them would also reflect the legitimate costs of providing care in efficiently run hospitals that have varying characteristics.

The decision about setting the rates for 1988 and beyond has two basic components: how should the gains in efficiency be shared between the hospital industry and the government, which acts on behalf of taxpayers and beneficiaries; and, should adjustments be made retroactively as new data permit correcting technical errors in setting the payment rates, or should corrections be applied only to rates for future years?

There are many arguments on both sides of these issues that are discussed in the written statement. But in the interest of time, I will examine specific alternatives that reflect a range of positions.

The CBO has analyzed three ways of sharing the efficiency gains: one approach would let hospitals keep all of them; another would share them evenly between the parties; and the third would give them to the government. Combining these alternatives with the illustration of rebasing would lead to downward adjustments in the PPS rates of 5.3 percent, 10.9 percent, and 16.5 percent respectively.

To avoid difficult adjustments that might be associated with an immediate reduction, the adjustments could be phased in—for example, over three years. One of our illustrations of phasing-in the adjustments is front loaded, while the other would occur evenly.

Turning to figure 3 on page 22 of the statement, each panel represents one of the alternatives for sharing the efficiency gains. The top line shows payment rates relative to their 1984 levels under current law, and the bottom line shows the recalculated ones. The

intermediate line shows the payment rates that would result for immediate implementation and for the two phase-in alternatives.

Comparing the three panels shows that the higher the proportion of the efficiency gains kept by the government, the lower the payment rates would be. In some cases, the 1988 payment rates would rise, but in others they would be below their 1987 levels.

The effects of the phase-in alternatives would be small if the hospitals retained all the efficiency gains, because the total reduction in the rates would be relatively modest. The effects would be substantial, however, in the other two cases.

Figure 4 on page 24 shows another approach that would have the government recapture the portion of the 1984–1987 payments that resulted from the technical difficulties in setting the rates. This would lower rates by an additional 2.8 percent in 1988, if these overpayments were recaptured over 10 years.

Table 3 on page 25 shows the potential federal budgetary savings from these policy alternatives. They would range up to $20 billion over three years, but the savings could be substantially less depending on decisions about phasing them in.

Table 4 on page 27 shows that these options would differentially affect various groups of hospitals. Rates for urban hospitals would be reduced by more than those for rural hospitals, but rates for hospitals not receiving the indirect teaching or the disproportionate share adjustments would be reduced by less than average.

Thank you, Mr. Chairman. We would be pleased to answer any questions.

Senator MITCHELL. Pretty good timing, Dr. Gordon. [Laughter.]

Dr. GORDON. I didn't know I could talk quite that quickly, Mr. Chairman.

Senator MITCHELL. I guess you have done this before.

Let me just ask a couple of questions. As you know hospitals have asserted and will no doubt assert further, that it is unfair to rebase the standardized payment amount using data from 1984, because it would be—at least in some sense—a return to a cost-base plan of reimbursement and would remove the reward for efficiency implicit in the 1983 law. How would you respond to that assertion?

Dr. GORDON. One observation is that none of the options that have been analyzed in this statement would, in fact, violate the principles that PPS established back in 1983. It was agreed that hospitals could keep the difference in payments relative to cost as they became more efficient in that year.

But there was no notion that those rates that were initially set, and any surpluses that resulted from them, would remain part of the system forever. There was general recognition that the original rates reflected the inefficiencies that had developed under the cost reimbursement system, and that Medicare had no intention of continuing to pay for them forever. In fact, the mandate for the Prospective Payment Assessment Commission (ProPAC) precisely states that it should consider efficiency gains in setting its recommendations for the annual update factor each year.

Senator MITCHELL. Do you have any data that suggests whether the high Medicare profit margin in 1984 and 1985 was due more to the hospital specific portion than to the national rate?

Dr. GORDON. It seems to me that the high margins that we saw then were in part the result of the hospitals becoming more efficient, whereas and we had set the payment rates as best we could to reflect their actual costs. Also, the forecast about case mix turned out to be an error, so that actually we paid them more than we had intended to.

Senator MITCHELL. How did you separate the problem of the so-called "code creep" from true increases in the complexity of care?

Dr. GORDON. We used a combination of assumptions that we had to develop, and work that had been done by the Prospective Payment Assessment Commission. If you are interested in the details of the assumptions we made, they are shown in Appendix Table 2, which is on page 31 of the statement.

Senator MITCHELL. All right.

Dr. GORDON. Also, for 1984, we now have the actual cost data.

Senator MITCHELL. Thank you, Dr. Gordon. I see Senator Rockefeller has joined us. Senator, do you have an opening statement or questions of Dr. Gordon, or both?

Senator ROCKEFELLER. Mr. Chairman, I do have an opening statement. Why don't I just wait a bit. Go ahead.

Senator MITCHELL. All right. Thank you. Do you have any questions of Dr. Gordon?

Senator ROCKEFELLER. I do not for the moment.

Senator MITCHELL. All right. Dr. Gordon, thank you very much for your testimony.

Dr. GORDON. You are very welcome.

Senator MITCHELL. We appreciate it.

The next witness is Dr. William Roper, the Administrator of the Health Care Financing Administration. Is Dr. Roper present?

[No response.]

Senator ROCKEFELLER. Mr. Chairman?

Senator MITCHELL. Yes, Senator Rockefeller.

Senator ROCKEFELLER. May I make a comment or two at this time?

This question of Medicare hospital payments puts some fear into me. And I recognize that various reports talk about past hospital Medicare-related profits of up to 16 percent. That is not our situation, I have to tell you, in West Virginia.

My perspective obviously is more rural than urban. In 1985, over half of the 30 small and rural hospitals in West Virginia lost money. Their average loss that year was $262,000 per hospital. Last year, 44 percent of our hospitals throughout the state suffered operating losses.

The figures that I have on Medicare-related profits are very unsettling as well. I asked for a computer printout, Mr. Chairman, of a group that I started when I was Governor of West Virginia—the Health Care Cost Review Authority—for today's hearing. Their material shows the revenue gains stemming from Medicare payments for 35 of the state's 67 hospitals. These hospitals' so-called profits on Medicare-related payments have dropped from 4.8 percent in 1985 to 2.7 percent in 1986 to a projected less than 1 percent for this year, which are not exactly in the 12-16 percent range of profits that are getting all the national attention.

It is not a very comforting trend to this Senator from West Virginia. I am very much concerned about proposed reductions in Medicare payments that would entail providing my state's hospitals less than their current payments.

I recognize that the reasons for the financial problems that affect West Virginia's hospitals don't entirely rest with Medicare. Our hospitals' uncompensated care represents almost 8 percent of their patient base, in contrast to the national average of less than 6 percent. We have an unusually high Medicaid population to serve in West Virginia. We have very weak local economies. Our unemployment rate, Mr. Chairman, is now at 13 percent—it has been higher.

I share with you, Mr. Chairman, a very strong desire to eliminate the discriminatory nature of Medicare's payments for rural hospitals. And I appreciate the growing sensitivity on the part of today's witnesses, the organizations they represent, and other health care experts towards the financial plight of small rural hospitals.

Having said all of that, Mr. Chairman, I continue to be very nervous about this subject. Insofar as I see our hospitals in West Virginia, 50 percent of them are on very, very shaky ground. I want to see efficiency improved. 96 percent of West Virginia is mountains, and only 4 percent is flat—and that means that people are very tied to their local communities. Hospitals are an essential part of their communities and a lot of those hospitals are in trouble.

So, I am looking forward to what is said here, Mr. Chairman. I thank you for your indulgence.

Senator MITCHELL. Thank you, Senator Rockefeller.

We are pleased to be joined by Senator Durenberger, who so ably served as chairman of this subcommittee for six years. Senator, do you have a statement you would care to make?

Senator DURENBERGER. Mr. Chairman, I have a statement that I would ask be made part of the record.

I just make the comment that while we were all in on—with West Virginia, probably—in on the original urban-rural split and the DRGs, I think we find now that we have perhaps been maybe overcompensated a little bit—the hospitals of this country—for the transition into a fully prospective system.

The unfortunate part is that some people have been overcompensated and others not. I guess the purpose of this hearing is to see if we can find out who's who. I certainly have the same experiences in the State of Minnesota that you have had in Maine, and Senator Baucus has had in Montana, and Senator Rockefeller has had in West Virginia, to find—particularly in small places, rural areas principally—that the urban-rural differential works to the disadvantage of those hospitals that have very large Medicare and populations.

And I hope that during the course of this year and as a result of this hearing we might learn some things that will be helpful to us so that legislatively we might be able to overcome some of these problems.

Senator MITCHELL. Thank you very much, Senator. Senator Baucus, do you have a statement you would care to make?

Senator BAUCUS. Yes, Mr. Chairman. Thank you for the opportunity and I commend you for holding these hearings. I think the basic question is whether, in fact, there is overcompensation because of the profits of hospitals have risen; second, if, in fact, there is overcompensation, which hospitals?

And particularly in that respect, if there is a solution then, you have to be sure that—a solution to overcompensation, that the solution does not come at the expense of, again, of rural hospitals.

I want to, Mr. Chairman, thank Dr. Roper for paying attention to rural hospitals. He has taken steps to address that situation, and I notice it, others notice it. Mr. Chairman, I want you to know that I appreciate it. And I think we are making progress.

Thank you.

Senator MITCHELL. Dr. Roper, welcome. We look forward, as always, to your testimony. We have had the 5-minute rule, but inasmuch as you represent the Administration and are responsible for administering this program, I think you should be able to take as much time as you want on this. So, why don't you go ahead.

[The prepared written statement of Dr. Nancy M. Gordon follows:]

Statement of
Nancy M. Gordon
Assistant Director
Human Resources and Community Development Division
Congressional Budget Office

before the
Subcommittee on Health
Committee on Finance
United States Senate

April 7, 1987

From the inception of Medicare's Prospective Payment System (PPS), there has been concern about its effects on the financial condition of hospitals. Early studies suggested that the PPS might be making substantial contributions to the profits of hospitals. Because new data on hospitals' costs are now available, the Congressional Budget Office (CBO) and others were recently asked to analyze this issue. Their studies have found that operating margins on PPS revenues were about 12 percent in 1984, which corresponds to profits of about 14 percent. Although no particular average operating or profit margin was specified as a target when the original PPS rates were set, such high ones are in stark contrast to the margins and profits of zero that prevailed under the previous cost reimbursement system.

While these large profits represent a signal for concern, they do not necessarily imply a problem with the PPS. For example, they might simply reflect falling costs as a result of hospitals' response to the system's strong incentives for greater efficiency. On the other hand, they might also reflect payment rates that, for a variety of reasons, had been set higher than intended. At your request, the CBO is examining these possibilities.

Following a brief description of the PPS, my testimony will address three topics:

- A review of CBO's estimates of operating margins on PPS payments in federal fiscal year 1984, and projections of these margins for 1985 through 1987;

- An illustration of one method for adjusting the PPS rates to reflect newer data; and
- The implications of the new data for updating the PPS rates to fiscal year 1988 and beyond.

BACKGROUND

In passing the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), the Congress laid the groundwork for the PPS, which was enacted as part of the Social Security Amendments of 1983. Both actions were prompted by an unacceptably high growth rate in Medicare's outlays for hospital costs, which averaged 18 percent a year between 1975 and 1982, or 8 percent a year above general price inflation. Moreover, concern was widespread that the previous cost-based reimbursement system did not encourage the efficient provision of care, and that it was not improving the health of beneficiaries in relation to federal spending. In particular, cost reimbursement encouraged hospitals to provide all services that had any benefit at all--not just those that were worth more than they cost.

The main objectives of the PPS are to lower the growth rate of Medicare's payments to hospitals and encourage efficiency in the provision of hospital care, while not adversely affecting its quality. It attempts to do so by specifying payment rates in advance and requiring hospitals to bear the loss if their costs are higher. In exchange, hospitals are allowed to keep the difference if their costs are lower than the payments. Thus, hospitals face strong financial incentives to provide care as efficiently as possible. Peer review organizations monitor the quality of care.

In principle, the fully implemented PPS promises to pay hospitals an amount for each patient, or case, equal to the cost of treatment in an efficiently run hospital. 1/ Because costs vary among equally efficient hospitals for several legitimate reasons, the system also includes numerous adjustments according to various characteristics of hospitals. As a result, Medicare's payments for the same type of case differ considerably among hospitals.

Specifically, the PPS sets fixed payment rates in advance for each of 471 categories known as diagnosis-related groups (DRGs) that were designed to reflect the value of resources used to treat different types of conditions. During the four-year transition from 1984 to 1987, the prospective amounts have been based on a combination of hospital-specific, regional, and national PPS rates, with the hospital-specific portion reflecting each hospital's own pre-PPS costs. Starting with hospitals' fiscal years that begin in federal fiscal year 1988, however, payments will be based on national rates only. These rates will continue to be calculated separately for urban and rural areas and adjusted for differences in wage levels among geographic areas. They will also be adjusted for the size of an institution's in-hospital training program for physicians, and if a disproportionately large share of the hospital's patients have low incomes.

---

1. Some costs and some institutions are exempt from the PPS. Capital-related costs, such as depreciation and interest payments, and the direct costs of graduate medical education programs continue to be reimbursed separately. Moreover, children's hospitals, rehabilitation centers, and psychiatric hospitals are exempt from the PPS.

The national rates are based on the average cost per case in 1981, inflated to represent later years. As a result, when they were initially set, a number of assumptions had to be made about changes that would take place between 1981 and 1984. 2/ For example, how much hospitals' input prices would rise in 1983 and 1984 was not known. In addition, the new system was required to pay hospitals the same amount, in aggregate, as they would have received under TEFRA for 1984 and 1985. Because total PPS outlays are determined primarily by two factors--payment rates, which are subject to federal control, and hospitals' case mixes, which are not--this budget-neutrality requirement necessitated making an assumption about the increases in the case mix of hospitals that would occur as a result of improved coding practices. 3/ Even if all these assumptions had been correct, however, it was recognized that the PPS rates would still reflect the inefficiencies that had developed under the previous retrospective cost reimbursement system.

A process for updating the payment rates in subsequent years was also established. For 1985, Medicare's PPS rates were increased by the amount

---

2. The same 1981 data, which had not been audited, were used to set the regional rates. Audited data on hospital costs in 1982-1983 were used to set the hospital-specific amounts.

3. Improved coding generally has meant that the same patients were coded into DRGs with higher payment rates, causing total payments to rise. These increases were accounted for in the budget neutrality calculations, because it was assumed that they would not have occurred under TEFRA, which did not base payments to hospitals on case mix classifications. While the number of cases also affects total outlays, the PPS has apparently had little effect on this factor.

thought necessary to meet the budget-neutrality requirement. For fiscal year 1986 and beyond, however, the Secretary of Health and Human Services (HHS) was given discretion over the percentage change in the payment rates--often referred to as the "update factor." In addition, an independent Commission--the Prospective Payment Assessment Commission (ProPAC)--was established to make recommendations about the PPS, including each year's update factor. The Secretary must consider these recommendations in making final decisions.

To determine their update factors for 1986 and beyond, both the Administration and ProPAC established methodologies that have two basic components. One is a measure of change in the prices of goods and services purchased by hospitals--often called the hospital's market basket. The second is a composite factor (called the policy target adjustment factor by the Administration and the discretionary adjustment factor by ProPAC). This composite factor is based on changes in technology and efficiency, as well as on forecasting errors embodied in the payment rates for previous years. While the inflation or market-basket portion of the update factor is generally expected to be positive, the composite factor can be either positive or negative. In addition, the Administration and ProPAC recommended different ways to adjust the 1986 and 1987 payment rates to reflect improved coding of patients into DRGs by physicians and hospitals. In the end, the Congress enacted a 0.5 percent increase for 1986 and a 1.15 percent increase for 1987.

OPERATING MARGINS ON HOSPITALS' PPS PAYMENTS

Because hospitals' PPS payments and costs for treating Medicare beneficiaries are now available for 1984, the first year of the system, operating margins can be calculated directly. Cost data for 1985 through 1987 are not yet available, however, so projections must be made to calculate margins for these years.

Margins in 1984

Hospitals' 1984 operating margins, defined as:

$$\frac{\text{revenues - costs}}{\text{revenues}},$$

were determined by several factors. 4/ Because aggregate PPS payments were intended to match the outlays that would have occurred under TEFRA, payments were expected to be lower than the operating costs that hospitals as a group were experiencing when the system first went into effect. It was expected that some hospitals would have been penalized by the reimbursement limits set by TEFRA, and hence not have been paid for all the costs they incurred in treating Medicare patients. On the other hand, policymakers hoped that hospitals would respond to the new incentives, at least by enough to lower aggregate costs to the TEFRA limits, and possibly by more. In the former case, the average 1984 operating margin would have been zero; in the latter case, it would have been positive.

---

4. A hospital's margin is not the same as its profit rate, which is the difference between revenues and costs divided by costs. For example, a margin of 10 percent is equivalent to a profit of 11.1 percent, while a margin of 15 percent is equivalent to a profit of 17.6 percent.

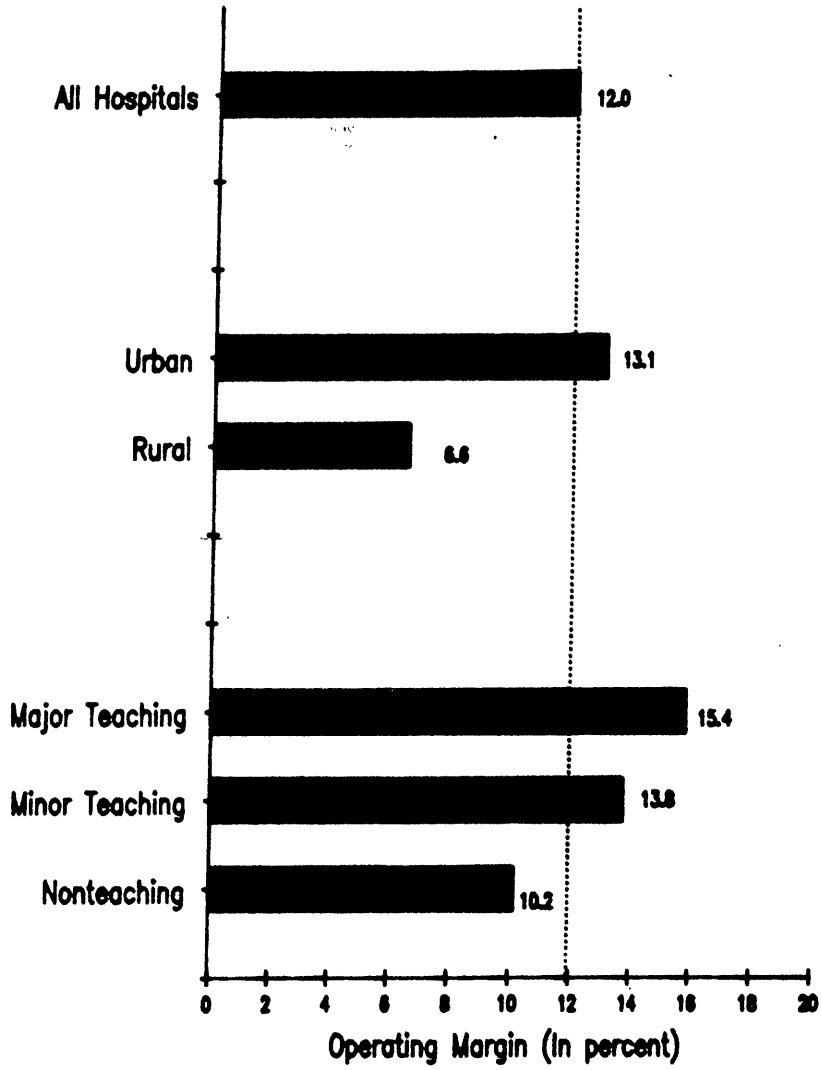
As noted earlier, CBO estimates that the average operating margin on Medicare's PPS payments during federal fiscal year 1984 was actually 12.0 percent. 5/ In other words, on average, the cost of treating each Medicare case was 88 percent of the PPS payment. Therefore, hospitals received, in aggregate, $2.2 billion more in PPS payments than the costs they incurred. About half of the margins resulted from more efficient provision of hospital services and about half from payment rates that had been set too high because they were based on unaudited data and assumptions that proved to be incorrect.

The average margins for certain groups of hospitals differed considerably, however, from the overall average of 12 percent, as shown in Figure 1. Urban hospitals--which represent about 50 percent of hospitals, but account for over 80 percent of PPS payments--had an average operating margin of 13.1 percent. In sharp contrast, the average margin for rural hospitals was 6.6 percent, or about one-half that of urban hospitals. In addition, the operating margins of teaching hospitals were noticeably higher than those of nonteaching hospitals--15.4 percent for major teaching hospitals and 13.8 percent for minor teaching hospitals, compared with 10.2 percent for nonteaching ones. These differences resulted from cost reductions occurring at different rates in the various groups and from differing impacts of the forecasting errors made when initial payment rates were set.

---

5. Maryland, Massachusetts, New Jersey, and New York hospitals are omitted from these calculations, because they were exempted from the PPS by waiver in 1984. The average margin is calculated by weighting hospitals according to their PPS payments.

FIGURE 1. HOSPITALS' OPERATING MARGINS ON PPS PAYMENTS BY SELECTED CHARACTERISTICS, 1984



SOURCE: Preliminary Congressional Budget Office estimates.

Projected Operating Margins for Fiscal Years 1985 Through 1987

Although it is not yet possible to estimate precisely the operating margins of hospitals on PPS payments after 1984, CBO has prepared some illustrative projections of these margins. These projections make several assumptions about the behavior of costs and payments after 1984--concerning efficiency, scientific and technological advance, and changes in hospitals' average case mix, for example. 6/

Under this range of assumptions, projected average margins for fiscal years 1985 through 1987 are higher than those calculated for fiscal year 1984. As illustrated in Table 1, the estimated margins rose substantially in 1985--from 12 percent in 1984 to approximately 18 percent to 19 percent in 1985. For 1986 and 1987, the estimated margins move downward in two cases. This reduction takes place largely because the legislated updates in payment rates were below the increase in the cost of the market basket by 2.6 percentage points in 1986 and 2.4 percentage points in 1987. The margins remain between about 14 percent and 20 percent in 1987, however. Consequently, hospitals as a group received substantially more in PPS payments than they spent to treat beneficiaries. The lowest estimates of the industrywide PPS surplus from these illustrations are $5.9 billion in 1985, $6.8 billion in 1986, and $5.7 billion in 1987.

---

6. For a more detailed description of these assumptions see Statement of Nancy M. Gordon, Congressional Budget Office before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, February 26, 1987.

If the only additional factor affecting operating margins were the legislated increase in payment rates that is set at 2 percent less than the rise in the cost of the market basket, operating margins for 1988 would be 2 percent lower than the illustrations for 1987. But other factors such as higher or lower costs will also affect the margins. Moreover, their pattern among various types of hospitals will not be the same in 1988 as the pattern shown for 1984 in Figure 1. One reason is that payments will be based entirely on national rates, so they will be redistributed among hospitals with different characteristics. In addition, little is known about how costs may have continued to change differentially among various types of hospitals.

TABLE 1. ILLUSTRATIVE PROJECTIONS OF HOSPITALS' SURPLUSES AND OPERATING MARGINS ON PPS PAYMENTS PER CASE, FEDERAL FISCAL YEARS 1985-1987 a/

Assumptions	Actual 1984 b/	Projections 1985	1986	1987
	Operating Margin (in percent)			
High	12.0	19.4	21.4	19.8
Intermediate	12.0	18.8	18.5	17.3
Low	12.0	17.6	17.2	13.8
	Surplus (in billions of dollars)			
Low b/	2.2 c/	5.9	6.8	5.7

SOURCE: Preliminary Congressional Budget Office estimates.

a. See Appendix Table 1 for details.
b. Comparable estimates for the high and intermediate cases are shown in Appendix Table 1.
c. The amounts for fiscal year 1984 reflect the phase-in of the PPS in that year.

AN ILLUSTRATION OF ADJUSTING PPS RATES TO ACCOUNT FOR NEW DATA

The new data also show that the forecasts of 1984 costs, on which payments have been based between 1984 and 1987, were too high. As a result, hospitals were paid more than was intended. 7/ Hence, there is considerable interest in adjusting the PPS rates to take the newly available data into account--a procedure that is being termed "rebasing."

The Congressional Budget Office is presently examining options for rebasing the PPS rates, but our analysis of this complex subject is incomplete. To respond to your request for information today, however, we have prepared an illustration of one way in which PPS rebasing could be implemented. We will provide the complete analysis as soon as it is available.

The following illustration of rebasing involves two technical steps. In the first step, the 1984 PPS rates are recalculated by substituting data from the 1984 cost reports for the 1981 data that had been projected to 1984. The second step recalculates the 1985-1987 update factors, using current information about conditions in those years, and applies them to the recalculated 1984 rates to produce the rebased 1987 rates.

---

7. Some of the cost reductions that occurred by 1984 probably represent an additional response to PPS incentives, over and above those under TEFRA, but the amount is unknown.

Recalculating the 1984 Rates

Using data for 1984 to recalculate the PPS rates would lead to about a 16 percent drop in them (see Table 2). The recalculated rates for urban hospitals would be 17 percent lower, and those for rural hospitals 11 percent lower. Of the 16 percent aggregate difference, about 10 percentage points would result from using the 1984 cost data and 6 percentage points would result from using the 1984 case mix data. 8/ Reductions would also take place in both the indirect teaching adjustment, which has been part of the system from the beginning, and the disproportionate share adjustment, which was enacted in 1986. While these adjustments reallocate payments toward the hospitals qualifying for them, they do not affect the overall urban and rural rates.

These estimates convey essentially the same information as the operating margins for 1984 presented in the previous section. In fact, they vary primarily because the difference between the recalculated and the actual PPS rates corresponds to a profit rate, rather than an operating margin, and because the two calculations were based on data from slightly different sets of hospitals. 9/

---

8. The original 1984 rates were reduced by 3.1 percent in an attempt to constrain PPS outlays to be the same as they would have been under TEFRA. This adjustment was not applied to the recalculated rates, since they reflect costs that were probably reduced to a greater extent than they would have been under TEFRA.

9. The PPS rates are based on data from 5,501 hospitals, including those in states with Medicare waivers in 1984--New York, New Jersey, Maryland, and Massachusetts. The operating margins for 1984 are based on data that do not include hospitals from these states.

Updating to Fiscal Year 1987

The second step is to inflate the recalculated 1984 rates using new update factors for fiscal years 1985 through 1987. This step serves two purposes.

First, the new update factors incorporate more recent data concerning both inflation and growth in the average case mix of hospitals. More specifically, these update factors are calculated with actual, rather than projected, growth in the cost of the market basket for fiscal years 1985 and

TABLE 2. DIFFERENCE BETWEEN THE RECALCULATED AND THE ACTUAL PPS PAYMENT RATES, 1984 (In percent) a/

	All Hospitals	Urban Hospitals	Rural Hospitals
Overall Difference	-15.9	-17.0	-11.0
Difference attributable to using 1984 cost data	-10.1	-10.6	-7.7
Difference attributable to using 1984 case mix	-5.8	-6.4	-3.3

SOURCE: Preliminary Congressional Budget Office estimates.

a. The current rates are adjusted to reflect a discharge-weighted rather than a hospital-weighted average in order to be consistent with the requirement in the Omnibus Reconciliation Act of 1986 for fiscal year 1988 and beyond.

The overall difference was calculated by substituting both cost data and case-mix data from 1984 for their 1981 counterparts. The portion of this difference change stemming from the 1984 cost data was estimated by substituting only the former. The portion stemming from the 1984 case mix data was estimated by calculating the difference between the two and, therefore, includes a small interaction effect.

1986. Moreover, the new update factor for 1985 reflects the actual increase in case mix for that year--5.7 percent--rather than the projected 2.4 percent used in the original update factor.

Second, the new update factors are structured so that they do not reflect influences that have already been accounted for by using the 1984 data. In contrast, the actual update factors for the 1985-1987 period were reduced in an attempt to reflect both efficiency and case-mix changes that occurred between 1981 and 1984, as data about them became available. Because the new update factors only reflect events in the post-1984 period, the recalculated rates for 1987 do not "double count" efficiency and case-mix changes that occurred in the earlier period.

Even though more information is available about 1985 and 1986, recalculating the update factors for the 1985-1987 period still requires some assumptions. One of them is a method for allocating the gains from greater efficiency between hospitals and the federal government, which acts on behalf of taxpayers and beneficiaries. The specific calculations are shown in Appendix Table 2. This table which also details the implications for the values of the update factors of three possible assumptions about dividing the efficiency gains.

Using the intermediate assumption--that hospitals and the government would share these gains equally--the recalculated update factors would be 4.1 percent lower in 1985, 2.2 percent higher in 1986, and 2.7 percent higher

in 1987, than the actual values. In other words, over the three-year period, the cumulative difference would be less than 1 percent.

Figure 2 shows the effects on PPS payment rates of both the actual and the recalculated update factors. The top line shows actual rates from 1984 through 1987. The bottom line shows the recalculated 1984 rates and their growth through 1987 using the recalculated update factors. Although the paths generated by the two update factors would differ, the relationship between actual and recalculated rates would be essentially the same in 1987 as in 1984. More specifically, the recalculated payment rates for 1987 would be 84.7 percent of their actual levels, compared with 84.1 percent for 1984. In other words, the actual payment rates would remain roughly 15 percent higher than hospitals' costs in 1987. 10/

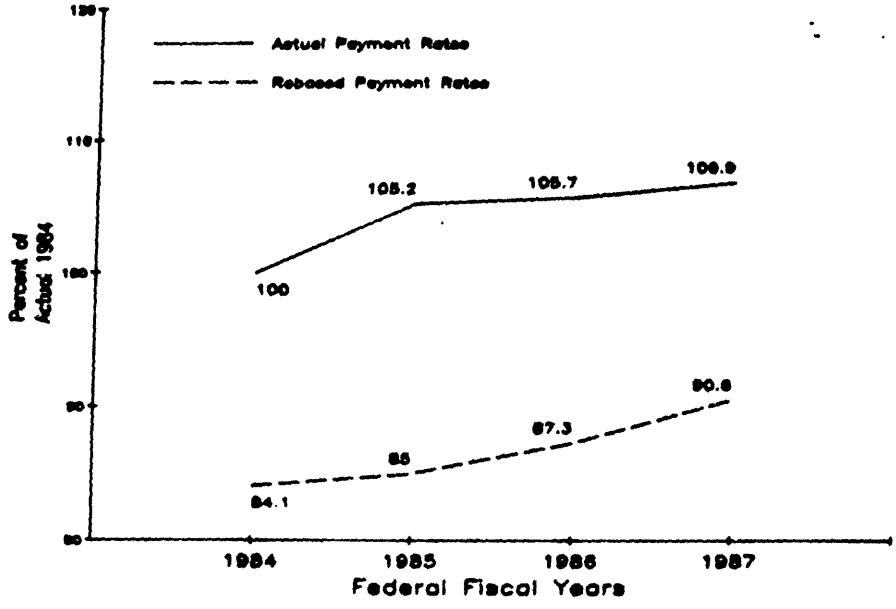
In effect, the recalculated update factors for 1986 and 1987--which are higher because they do not include the legislated reductions that responded to information about the 1981-1984 period--would be offset by the lower one for 1985. Two factors largely explain the smaller update factor for 1985--the actual increase in the cost of the market basket was lower than projected, and the average case mix of hospitals rose by more than was expected.

---

10. Using this methodology, the recalculated rates in 1987 would be 15.3 percent lower overall, 16.3 percent lower for urban hospitals, and 10.3 percent lower for rural ones. Alternatively, new update factors could be calculated separately for urban and rural hospitals, in order to reflect differential changes in efficiency, volume, site shifting, and average case mix in the two types of hospitals.

Figure 2.

Medicare Payment Rates, Actual and An Illustration of Rebased, 1984-1987



PPS Update Factors (In percent) a/

	1985	1986	1987	Cumulative Effect
Actual Update	5.2	0.5	1.15	6.9
Recalculated Update	1.1	2.7	3.8	7.7

SOURCE: Congressional Budget Office.

a. See Appendix Table 1 for details.

IMPLICATIONS FOR ADJUSTING PPS RATES FOR 1988 AND BEYOND

Both the estimated operating margins on PPS payments, and the difference between the recalculated PPS rates and those currently in effect, suggest that the Congress may want to modify the system. The 1984 data would allow technicians to enhance the accuracy of the PPS rates. It would also permit them to improve the adjustments that account for the additional costs of patient care incurred by hospitals with teaching programs and by hospitals that serve a disproportionately large share of low-income patients.

Nonetheless, policy decisions would also be necessary. Most important, the basic issue of how to share gains in efficiency between the government, which acts on behalf of taxpayers and beneficiaries, and the hospital industry cannot be resolved on technical grounds. In addition, we still lack complete information about past years, and setting rates prospectively will always require forecasts of several factors. The remainder of this statement addresses various policy alternatives for setting PPS rates for 1988 and beyond. In doing so, it uses the earlier illustration of rebasing.

In considering various approaches, however, it is important to remember that the goals of the PPS system cannot necessarily be achieved by targeting a particular average operating margin. Many different payment rates and adjustments could be set that would achieve a specified margin, but only one of them would also reflect the legitimate costs of providing care in efficiently run hospitals that have varying characteristics.

Policy Decisions

The decision about setting the rates for 1988 and beyond has two basic components:

- What proportion of the gains in efficiency should go to each party? and
- Should adjustments be made retroactively as new data permit correcting technical errors in setting the payment rates, or should corrections be applied only to rates for future years? 11/

Allocating Efficiency Gains. Representatives of the hospital industry argue that hospitals should retain most or all of the efficiency gains, since this is nothing more than the reward for taking the risk of losses under the PPS. Moreover, they contend that the industry should especially retain these gains in the future. Their reasoning is that the federal government has already claimed much of the efficiency gains achieved in 1984 by setting the update factors for 1986 and 1987 lower than the increase in hospitals' costs. In addition, they maintain that unless hospitals can keep most or all of the future gains, they will have no incentives for continued improvement. They also believe that hospitals need a "cushion" against being adversely affected by continuing deficiencies in the PPS rates. Finally, they argue that uncertainties about some aspects of rebasing--for example, the correct budget-neutrality factor for 1984--also justify hospitals retaining some of the efficiency gains.

---

11. Retroactive adjustments would only apply to technical errors, not efficiency gains. It would be inconsistent with the objectives of PPS to remove all previous efficiency gains, since doing so would remove the incentive for efficiency from the system.

Those who favor taxpayers or beneficiaries receiving most or all of the efficiency gains contest the allegation that the government has already claimed the 1984 gains. They argue that the legislative attempts had little or no such impact, as suggested by the illustrative update factors recalculated for 1985-1987. Similarly, the projected margins for those years suggest that the hospitals are retaining most of the efficiency gains. These people also note that the initial PPS rates reflected the inefficiencies that had been fostered under retrospective cost reimbursement and that Medicare should not have to pay for them. In addition, they point out that hospitals would always have incentives for greater efficiency because they would permanently retain part of the efficiency gains. Because of the lengthy delays in data becoming available, hospitals would retain these gains even if the PPS rates were always cut to absorb them as soon as they could be measured. Finally, these people argue that inflating the margins of all hospitals to "cushion" those that are harmed by technical deficiencies in the system is a costly and inefficient approach that should, at most, be done to a limited degree and as a temporary measure.

Making Retroactive Adjustments. Retroactive adjustments involve recapturing overpayments from hospitals or making up underpayments to them to compensate for technical errors in setting the payment rates. Proponents see them as a necessary response to the lengthy lags in the availability of data used in the system. Because the payments must embody many assumptions, they can be thought of as provisional ones, with "settling up" to occur as soon as possible. This approach would not represent a

return to cost reimbursement, because hospitals would remain at risk if they were not efficient and efficiency gains would not be recaptured. Moreover, neither hospitals nor taxpayers would bear the risks associated with the technical limitations in setting the rates--risks that can be substantial. For example, in a period of rapid and unexpected inflation, efficient hospitals would incur much greater costs treating beneficiaries than would be covered by the PPS payments.

Opponents counter that the PPS promised fixed advance payments and that, in the current situation, many hospitals would find it extremely difficult to "settle up" because they have already spent the extra revenues or used them to subsidize lower charges for their other payers. They also believe that the federal government is far more able to deal with unexpectedly high costs than hospitals are able to handle unexpectedly low payments. Therefore, they argue that the issue of retroactive adjustments should be resolved asymmetrically. In other words, they argue that there should be no recapturing of past overpayments, but that any future underpayments to hospitals resulting from technical difficulties should be made up by the federal government.

Specific Alternatives

This testimony analyzes three ways of splitting the efficiency gains between the hospital industry and the federal government--one would let hospitals keep all of these gains, another would split them evenly between the parties, and the third would take back the gains on behalf of taxpayers and bene-

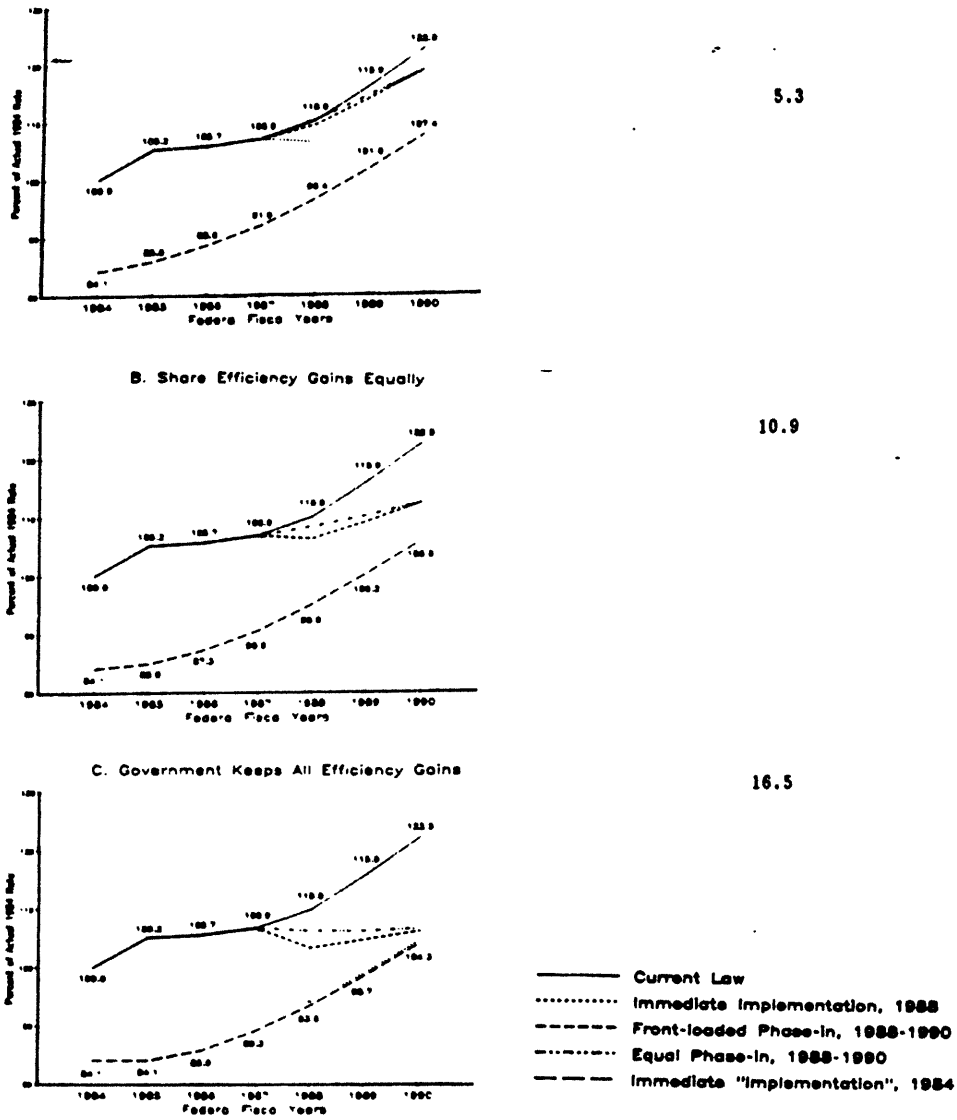
ficiaries. All three options assume that two-thirds of the observed cost reductions are the result of gains in efficiency, while the remainder is attributable to site shifting and other factors. (This assumption was employed by ProPAC in calculating its recommended update factor for 1988.) Combining these alternatives with the illustration of rebasing would lead to downward adjustments to the PPS rates totaling 5.3 percent, 10.9 percent, and 16.5 percent, respectively. (Appendix Table 3 shows their derivation.)

An immediate reduction by these amounts might present some hospitals with difficult adjustments, however, particularly if Medicare's payments represent a large proportion of their total receipts and if they have adjusted to the higher reimbursements. In response to this concern, the adjustments could be phased in over a number of years. Two possibilities are examined here: one is "front-loaded"--half the reduction would occur in the first year followed by one-quarter in each of the next two years; and the other would implement one-third of the reduction in each of three years.

The panels in Figure 3 represent the three specific alternatives for dividing the efficiency gains. In each case, the top line shows payment rates (relative to their 1984 levels) under current law and the bottom line shows the recalculated payment rates (again relative to the actual 1984 levels). The latter vary slightly from one panel to another, because each one is consistent with that panel's assumptions about dividing the gains. The intermediate lines show the relative payment rates that would result for

FIGURE 3. CHANGES IN PPS RATES UNDER REBASING AND SPECIFIC OPTIONS FOR SHARING EFFICIENCY GAINS, 1988-1990

Sharing Assumptions	Percent Reduction in Rates
A. Hospitals Keep All Efficiency Gains	5.3
B. Share Efficiency Gains Equally	10.9
C. Government Keeps All Efficiency Gains	16.5



SOURCE: Preliminary Congressional Budget Office estimates. See Appendix Table 2 for additional details.

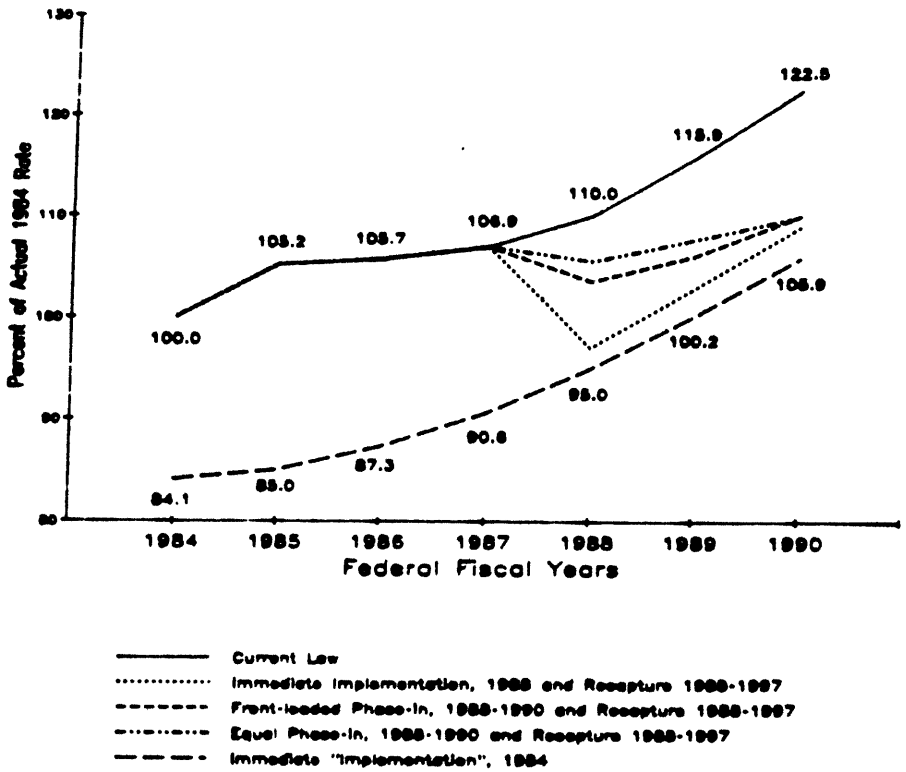
immediate implementation and for the two phase-in alternatives--if rebasing for 1988 were combined with the particular assumption about sharing the gains.

Comparing the three panels shows that the higher the proportion of the efficiency gains kept by the government, the lower the payment rates would be. In some cases, the 1988 payment rates would rise but in other cases, they would be below the 1987 levels. The effects of the phasing alternatives would be small if the hospitals are assumed to retain all the efficiency gains, because the total reduction would be relatively modest. The effects would be substantial, however, in the other two cases.

One final alternative would have the government recapture the portion of the 1984-1987 payments that resulted from technical difficulties in setting the rates, while allowing hospitals to keep all of the past efficiency gains and dividing the future gains evenly between the hospitals and the government. One version of this approach is shown on Figure 4. It would lower 1988 rates by an additional 2.8 percent, if the overpayments were recaptured over 10 years. After that time, the rates would return to the level they otherwise would have attained.

The potential federal budgetary savings of these policy alternatives are shown on Table 3; they would range from $2.5 billion to $20.3 billion for fiscal years 1988 through 1990. For any given percentage reduction in the PPS rates, the savings would be cut by the phase-in options, by as much as

FIGURE 4. CHANGES IN PPS RATES UNDER REBASING, SHARING EFFICIENCY GAINS EQUALLY, AND A RETROACTIVE ADJUSTMENT FOR TECHNICAL FACTORS, 1988-1990



SOURCE: Preliminary Congressional Budget Office estimates.

TABLE 3. REDUCTION IN OUTLAYS FROM ALTERNATIVE DECISIONS ABOUT REBASING AND SHARING EFFICIENCY GAINS, 1988-1990 (In billions of dollars)

Net Adjustment/ Timing of Adjustment	Fiscal Years			
	1988	1989	1990	1988-1990
5.3 Percent				
Immediate implementation	1.4	1.6	1.8	4.8
"Front-loaded" phase-in a/	0.3	0.9	1.7	2.9
Equal three-year phase-in	b/	0.8	1.8	2.5
10.9 Percent				
Immediate implementation	3.9	4.3	4.7	12.8
"Front-loaded" phase-in a/	1.5	2.9	4.6	9.0
Equal three-year phase-in	0.7	2.5	4.6	7.7
16.5 Percent				
Immediate implementation	6.1	6.7	7.5	20.3
"Front-loaded" phase-in a/	2.6	4.7	7.2	14.5
Equal three-year phase-in	1.5	4.1	7.1	12.7

SOURCE: Preliminary Congressional Budget Office estimates.

NOTE: All savings estimates are relative to a CBO baseline that uses the legislated update factor of the change in the cost of the market basket minus two percentage points for 1988. In examining these options, the two percentage point reduction under current law was assumed to recognize similar factors as would be corrected by rebasing. Thus, two percentage points were deducted from the alternative adjustments for the purposes of calculating savings for fiscal year 1988.

a. Assumes that 50 percent of the adjustment occurs in the first year and 25 percent in each of the next two years.

b. Less than $0.1 billion.

47 percent, compared with immediate implementation. 12/ Providing a phase-in period only for hospitals in special circumstances--such as those where Medicare represents an unusually high proportion of their total receipts--might be a way to balance the need for budgetary savings with a concern for effects on the financial health of hospitals. If the retroactive adjustment were also made, the budgetary savings would rise by about $1.2 billion in each of the next 10 years.

Combining the illustrative approach to rebasing with a policy decision about splitting the efficiency gains would differentially affect various groups of hospitals. Table 4 shows the percent change in PPS payments for some selected groups, relative to current law, that would occur if the efficiency gains were divided equally between hospitals and the federal government. While rates for urban hospitals would be reduced by 11.8 percent, those for rural hospitals would be cut by only 6.7 percent. Major teaching hospitals would face reductions of 16.7 percent under this option, compared with 11.8 percent for minor teaching hospitals and 9.2 percent for nonteaching hospitals. Finally, rates for hospitals receiving the "disproportionate share" adjustment would fall by 12.8 percent, compared with 9.9 percent for those hospitals not receiving the adjustment. The reductions for hospitals not receiving these adjustments would be smaller than the average, because the drop in indirect teaching and disproportionate share payments would be redistributed to all hospitals.

---

12. While the particular percentage reductions in the PPS rates used here are only illustrations, the budgetary effects of choosing any one of them are accurate.

TABLE 4. THE DISTRIBUTIONAL IMPACT OF A 10.9 PERCENT REDUCTION IN PPS RATES FROM THE REBASING ILLUSTRATION COMBINED WITH A DECISION TO SHARE EFFICIENCY GAINS EVENLY a/

	Percent of Current Law Payments	Percent of Illustrative Payments	Percent Change Relative to Current Law
All	100	100	-10.9
Urban	83.6	82.9	-11.8
Rural	16.4	17.1	-6.7
Major Teaching b/	10.6	9.9	-16.7
Minor Teaching c/	36.8	36.4	-11.8
Nonteaching	52.6	53.7	-9.2
Disproportionate Share d/	34.3	33.6	-12.8
Nondisproportionate Share	65.7	66.4	-9.9
Teaching			
Disproportionate share	20.5	19.7	-14.7
Nondisproportionate share	26.8	26.6	-11.7
Nonteaching			
Disproportionate share	10.8	10.7	-11.3
Nondisproportionate share	41.9	43.0	-8.6

SOURCE: Preliminary Congressional Budget Office estimates.

a. See text for details.

b. Hospitals that have a ratio of residents to beds exceeding 0.25.

c. Hospitals that have a ratio of residents to beds less than 0.25.

d. Disproportionate share hospitals are those that receive the adjustment designed to compensate for the increased costs of serving a high share of low-income patients.

CONCLUSION

In the last several years, the Congress has made many important decisions that have modified and updated the PPS. Yet the decisions that must be made this year on rebasing and updating are perhaps the most important for the system since it was enacted in 1983. They are critical because of the dollar magnitudes at issue and the precedents that may be set. While technicians can help to narrow the range of choices, some fundamental issues remain--most notably the choice of how efficiency gains are to be shared between the hospital industry and the federal government. The Congressional Budget Office will be pleased to assist you and your staff in analyzing options as they are developed.

APPENDIX

APPENDIX TABLE 1. ILLUSTRATIVE PROJECTIONS OF HOSPITALS' SURPLUSES ON PPS PAYMENTS, FEDERAL FISCAL YEARS 1985-1987 (In billions of dollars)

Assumptions	Actual 1984 a/	Projections 1985	1986	1987
High b/	2.2	6.6	8.4	8.2
Intermediate c/	2.2	6.4	7.3	7.2
Low d/	2.2	5.9	6.8	5.7

SOURCE: Preliminary Congressional Budget Office estimates.

a. The totals for 1984 reflect the phase-in of the PPS for that year.

b. Assumes that post-1984 costs reflect changing input prices and large net cost reductions, and that the average case mix rises by 1.5 percent for 1986 and 1.0 percent for 1987 in excess of case mix-induced cost increases.

c. Assumes that post-1984 costs reflect changing input prices and some net cost reductions, and that the post-1985 average case mix increases are accompanied by matching cost increases.

d. Assumes that post-1984 costs reflect changing input prices and small net cost increases, and that the average case mix rises by 1.5 percent for 1986 and 1.0 percent for 1987 in excess of case mix-induced cost increases.

APPENDIX TABLE 2. A COMPARISON OF ACTUAL AND RECALCULATED PPS UPDATE FACTORS, 1985-1987

	1985	1986	1987	Cumulative Effect
Actual Update	5.2[a/]	0.5	1.15	6.9
Recalculated Update				
Market Basket Increase	4.1	3.1	3.5	
Science and Technology	0.3	1.5	0.7	
Site Shifting [b/]	-0.5	-0.7	-0.6	
Within DRG Complexity [b/]	0.5	0.6	0.7	
Case Mix Change [c/]	-4.6[d/]	-2.6	-1.0	
Real Case Mix Change [e/]	2.3	1.3	0.5	
—Subtotal	2.1	3.2	3.8	
Efficiency A [f/]	0.0	0.0	0.0	
Efficiency B [f/]	-1.0	-0.5	0.0	
Efficiency C [f/]	-2.0	-1.0	0.0	
Recalculated Update A	2.1	3.2	3.8	9.3
Recalculated Update B	1.1	2.7	3.8	7.7
Recalculated Update C	0.1	2.2	3.8	6.1
Recalculated A - Actual	-3.1	2.7	2.7	2.4
Recalculated B - Actual	-4.1	2.2	2.7	0.8
Recalculated C - Actual	-5.1	1.7	2.7	-0.8

SOURCE: Congressional Budget Office calculations.

a. The DRG weights were uniformly reduced by 1.05 percent for fiscal year 1985 so the net update was 4.1 percent.

b. The 1987 components for site shifting and within DRG complexity are based on ProPAC's estimates for its recommended update factors in those years. The 1985 and 1986 components are CBO's assumptions.

c. The estimated case mix increase used for fiscal year 1986 is based on assumptions used by ProPAC in its update recommendations for that year. The 1987 increase is based on CBO's assumptions.

(Continued)

Appendix Table 2 (Continued)

d. CBO calculates that the actual increase in case mix from fiscal year 1984 to 1985 is 5.7 percent. Since the DRG weights were uniformly reduced by 1.05 percent in fiscal year 1985, the net change is 4.6 percent.

e. For fiscal year 1985, 40 percent of the 5.7 percent case mix increase (2.3 percentage points) is assumed to represent real increases in patient complexity and the remainder to represent improved coding. For 1986 and 1987, these two factors are each assumed to account for half of the projected change.

f. CBO assumed that efficiency gains were 2 percent in 1985 and 1 percent in 1986. Under the first alternative (labeled Efficiency A), hospitals would keep all of the gains so the update factors would not be affected. Under alternative B, the gains would be shared equally between the hospitals and the federal government so that the 1985 and 1986 updates would include reductions of 1.0 percent and 0.5 percent, respectively. Under alternative C, the federal government would keep all the efficiency gains, so the 1985 and 1986 updates would be reduced by 2.0 percent and 1.0 percent, respectively.

APPENDIX TABLE 3. ILLUSTRATIVE EXAMPLES OF ADJUSTMENTS TO 1987 PPS RATES BASED ON THE DIFFERENCE BETWEEN THE RECALCULATED AND THE ACTUAL PAYMENT RATES (In percent)

	Hospitals Keep All Productivity Gains	Productivity Gains Shared Equally by Hospitals and the Federal Government	Federal Government Keeps All Productivity Gains
Difference Between Recalculated and Actual Payment Rates a/	-14.0	-15.3	-16.5
Credit for Efficiency Gains b/	8.7	4.4	0.0
Net Adjustment	-5.3	-10.9	-16.5

SOURCE: Preliminary Congressional Budget Office estimates.

a. The difference between current and recalculated rates depends on which update factors were used to inflate the recalculated 1984 rates through 1987. The recalculated update factors differ by the assumptions used in sharing efficiency gains for the 1985-1987 period, which are consistent with the assumptions made about sharing the 1984 gains for the purposes of this table. For example, the update factors for the first column are calculated assuming that hospitals keep all gains; for the second column, the update factors are those detailed on Appendix Table 2, which are calculated under the assumption that gains are shared equally; and those for the third column assume the government receives all the gains.

b. The cost reductions used to calculate efficiency gains are those that result from substituting 1984 costs for 1981 costs in calculating the 1984 rates before applying budget neutrality factors. Therefore, the estimated aggregate cost reduction of 13.1 percent differs from the entry in the second row of Table 2 by the approximate amount of the 1984 budget neutrality factor--3.1 percent. Two-thirds of the total cost reductions are assumed to result from efficiency gains.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. ROPER. Thank you, sir. I will summarize my statement.

I appreciate the chance to appear before you today to talk about the applicable PPS percentage increase for Medicare hospital payments for the next fiscal year. As the Secretary indicated in his letter of last week to the Congress, we believe, based on data we now have, that the applicable percentage increase of 1.5 percent that the President's budget envisioned may be too low, and that the appropriate increase could range as high as 2 percent. We believe that a final recommendation should be deferred until nearer the beginning of the fiscal year, based on more recent data that we will be analyzing.

With regard to exempt hospitals and units, we currently believe that the appropriate update for the target rate of increase could range as high as 4 percent. Again, we will make a final recommendation later, based on later data.

Let me summarize the background for these recommendations. Every year since Fiscal Year 1985, the Secretary and his predecessors have been required to determine the annual rate of increase in payments to hospitals under PPS by taking into account various factors, including the recommendations of ProPAC. Under the first two years of PPS, the payments under the system had to be budget neutral to the TEFRA provisions.

Even in the face of budget neutrality requirements, hospitals appear to have generally fared quite well during the early years of PPS. Urban hospitals did particularly well, on average, experiencing operating margins about twice those of rural hospitals. This disparity between urban and rural hospitals is principally what led the Congress last year, in OBRA-86, to enact significant steps to increase payments for rural hospitals relative to urban hospitals.

Let me dwell a moment on what you did last year in OBRA. OBRA mandated separate outlier reductions to the PPS rates of urban and rural hospitals based on their differential outlier experience. Since rural hospitals typically experience fewer outlier cases than urban hospitals, the effect of this change is to increase rural rates relative to urban rates.

Second, last year OBRA provided, effective for discharges in the next fiscal year, that the PPS rates be computed on a discharge-weighted rather than hospital-weighted basis, thus giving greater weight to the cost experience of larger hospitals. Because large hospitals account for a larger proportion of all cases in rural areas than in urban areas, discharge-weighting increases payment to rural hospitals relative to urban hospitals.

The combined effects of these two changes in OBRA will be to increase the payment rates of rural hospitals by about 6 percent while reducing urban rates by slightly less than 1 percent. As a consequence, the discrepancy between rural and urban hospital operating margins will be almost eliminated.

Another recent change will enable an estimated 60 additional rural facilities to qualify as rural referral centers and be paid at the urban rate.

We are, of course, aware that ProPAC has proposed an adjustment to the PPS rates which favors rural hospitals relative to urban hospitals. We share their interest and yours in making sure that Medicare beneficiaries in rural areas receive access to quality health care services, and we have given consideration to such a differential update for rural hospitals. However, based on the actions that you took in OBRA-86 and the evidence that we have that this will substantially narrow the differential that has existed between urbans and rurals, we do not, at this time, recommend a higher applicable percentage increase for rural hospitals.

Although recent congressional action appears to have improved the equity in payments across hospitals, especially across urban and rural hospitals, the issue of overall profitability of hospitals under PPS remains. Our agency, the Inspector General, ProPAC, CBO, and others have all done analyses showing that Medicare payments exceeded hospital costs by 12-16 percent in the first year of PPS—Fiscal Year 1984. The Inspector General has found a similar pattern in Fiscal Year 1985—the second year of PPS.

The high operating margins observed in the first two years of PPS appear to be due, in part, to the rates in the first year being based on unaudited cost data. After audits were done, the data showed that these were overstated rates—the rates we paid were too high, given the better data.

Second, the success during PPS's first year in hospitals having large profit margins was also based on the fact that they were given incentives to economize—to be efficient, to do just what they were asked to do. And so, it is evidence of the adaptability of hospitals to the new incentives under PPS.

To some extent, though, the magnitude of the margins is a testimony to Congress awarding higher updates than we would have viewed as prudent. In Fiscal Year 1986, for example, we recommended a freeze as the most appropriate policy for PPS rates. Instead, hospitals were given an increase of one-half percent. Last year we recommended one-half of a percent, and Congress chose to provide an increase of 1.15 percent.

Since the start of PPS, we have seen Medicare's share of hospital revenues increase until in Fiscal Year 1985, for the first time, Medicare's share of hospital revenues exceeded its share of hospital days. During Fiscal Years 1984 to 1986, Medicare payments per admission increased more rapidly, after adjusting for inflation and hospital inputs, than they did in the period 1979 to 1983. My point is simple—it is that there should be no surprise that hospitals fared well, on average, during the early PPS years, because we paid them more than we should have because of unaudited data; second, we paid them more as far as year-to-year increases in that period than in the years before that; and finally, they were given incentives to manage efficiently, to develop profit margins, if you will.

In Fiscal Year 1987, the current fiscal year, however, we are modestly increasing Medicare payments per admission, in sharp contrast to the rapid growth in Fiscal Years 1984 and 1985. As I will explain shortly, Medicare payments per admission, after adjusting for inflation, may decline in Fiscal Year 1987. We believe that we are just now starting to tighten the system. If maintained,

this trend will ultimately begin to reduce the high margins of the early PPS years.

Let me discuss our rationale in more specifics.

Based on the most recently available data, we believe that we ought to continue on the same course for Fiscal Year 1988, as in the last two years. That is, the PPS rates should be increased modestly, but the increase should be substantially less than the forecasted increase in the hospital market basket. In this way, financial dislocation in the hospital industry is avoided, while at the same time the Medicare program will continue to benefit from the changes in the hospital behavior that have resulted from PPS.

The most important change since the President's budget was announced in February has been that the predicted increase in reported case mix has stopped, at least temporarily. Data from early 1986 to the present show no increase in case mix. This is a surprising development and we will continue to monitor it carefully. Increase in case mix was one of the ways in which hospitals maximized their return, and the fact that case mix increase has stopped is an important change in the ability of hospitals to profit from PPS.

If hospitals are, at least temporarily, no longer benefiting from changes in coding practices, the PPS system is becoming more stringent in Fiscal Year 1987 than in the system's early years, especially since we have begun significant changes in Medicare payments for medical education and capital. Consequently, we estimate that inflation-adjusted payments per case will fall more than 3.5 percent in 1987 compared to 1986.

We believe that reductions in payments per case adjusted for inflation are appropriate, based on the reports of hospital profits in the early years of PPS, but we favor a policy of gradually tightening the rates rather than making dramatic reductions. Hospitals may be losing some, though by no means all, of their ability to respond to low update factors by cutting their costs. For example, under Medicare, the decline in the average length of stay has stopped, and hospitals will be adjusting this year to reductions in payment for medical education and capital.

In addition, beyond the Medicare program, hospitals face difficulties attracting and keeping qualified nurses, and they face a burden of uncompensated care that is a growing problem for them in doing business generally.

Finally, let me just say again, we believe that the appropriate increase in PPS standardized amounts is between 1.5 percent and 2 percent. We will continue to analyze this and report to you. As conditions change, our recommendations may change.

In closing, let me say that I would urge you to reexamine the issue of the Secretary's authority over the PPS update factor and return to the Secretary his discretion to set the rates of increase for hospital payments. In past years, you have decided that the Secretary has not set rates as you would have them and have chosen, occasionally, to overrule that. That is certainly within the purview of the Congress. We would urge you, though, as a matter of policy, to allow the Secretary to set the rates, as has been the case in all years except this one.

Thank you.

Senator MITCHELL. Thank you very much, Dr. Roper. We will now begin the questioning, and under the committee practice will limit the first round to five minutes per Senator, and Senators will question in the order in which they appeared at the hearing.

You suggested that the inequities in reimbursement between rural and urban hospitals have been dealt with by the 1986 Omnibus Reconciliation Act. I gather that ProPAC will disagree with that analysis—the witnesses will be able to speak for themselves. My question is, in view of the precarious financial state of many rural hospitals, wouldn't it be more prudent, given the uncertainty implicit in rate setting, to make further changes as suggested by ProPAC?

Dr. ROPER. As you say, Mr. Chairman, ProPAC is best acquainted with the reasons for its recommendations. However, I just point out I learned this morning that, based on staff-to-staff discussions our agency had with ProPAC, it did not take into account the two factors I cited in my testimony for what happened in OBRA-86 and the likely impact that will have on hospital payments next fiscal year. I may be mistaken, and certainly would go back and correct the record, but our understanding was that they did not take at least one of those two factors into account in their analysis.

Senator MITCHELL. So your answer is that rather than you changing to conform to their recommendations, you think they should change to conform to your position.

Dr. ROPER. We urge everybody to look carefully at this issue. The simple message is we believe that Medicare beneficiaries in rural areas are owed access to quality health care services. I understand, and have heard from you and others, the plight of rural hospitals in America. We are anxious to be responsive to the needs for Medicare beneficiaries in rural areas, but we believe that OBRA-86 went a very long way toward satisfying that. And we would urge that you examine the data before letting the pendulum swing too far in the other direction.

Senator MITCHELL. Do you have any evidence that there is still significant inefficiencies in the hospital sector?

Dr. ROPER. Significant inefficiencies—not widespread inefficiencies. I think there are additional things the hospitals can do to improve productivity to some extent.

Senator MITCHELL. Even assuming that hospital profits were high in 1984 and 1985, there were some hospitals that had actual losses on Medicare patients. Do you have data concerning which hospitals had low margins or losses under the first year of the Prospective Payment System, and what effect further across-the-board cuts would have on them?

Dr. ROPER. We have data from the first two years of PPS about the profit margins of hospitals in various regions of the country. And, if I understand your question, what I would say is that, clearly, PPS's impact has been varied in different regions of the country. Averages explain a number of things, but they also conceal a number of things. In trying to portray average hospital profits, for example, they conceal as much as they reveal.

The impact of PPS has been widely varying, and our recommendation of a modest 1.5 to 2 percent increase is based on the view that hospital margins are tightening across the country. We are

seeing a change from large increases year to year in inflation-adjusted Medicare payments per case; and, to say it again, a predicted decrease in Medicare payments per case of 3.5 percent in Fiscal Year 1987, adjusted for inflation. We think that argues for caution in making decisions about how much of an increase to give across-the-board this year.

Senator MITCHELL. There is growing evidence of a shortage of registered nurses and some technical personnel—it is especially critical in rural areas. Does your update projection take into account the probable effect of this shortage on nursing and allied health labor cost?

Before you answer, let me recognize Senator Heinz, because we are all going to have to go vote in a minute, and he may want to make a statement.

Senator HEINZ. Mr. Chairman, I want to thank you for having a hearing on this matter. I have no opening comment, but I would appreciate it if you would hold the record open so that hopefully I can come back and ask some questions.

Senator MITCHELL. Just one moment, Dr. Roper.

Dr. ROPER. Certainly.

Senator MITCHELL. We don't know whether any Senator has voted it on the way back, so to enable Senator Rockefeller and I, and Senator Heinz to vote and return, I give you about 5 minutes to think about the answer to that question, Dr. Roper.

Dr. ROPER. Thank you, sir.

Senator MITCHELL. We will recess just briefly.

[Whereupon, at 3:10 p.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. For a change, I get to seize power.

Dr. ROPER. Go for it.

Senator DURENBERGER. George is now running back from the Capitol. He did say go ahead. I am informed that you are in the middle of answering a question.

Dr. ROPER. Yes, sir. Shall I answer his question?

Senator DURENBERGER. Pardon?

Dr. ROPER. Shall I answer his question?

Senator DURENBERGER. Yes. That would be helpful.

Dr. ROPER. All right. The question, if I remember it, is did we take into account the difficulties that hospitals are having attracting and retaining qualified nurses as a part of their offering quality health care services.

The answer is "yes". In my prepared statement, I made that specific point. Additionally, I would just note that that is in the statement because Secretary Bowen personally said we ought to say that. So, at the highest levels of the Department, we are concerned about that issue.

Senator DURENBERGER. I understood your testimony to say that there are good reasons why there may have been some overcompensation in the system in the first few years.

Dr. ROPER. Yes, sir. It should not be a surprise.

Senator DURENBERGER. Do you have a chart, or do you have any other—and I haven't read your statement—but, is there some way

that you can actually demonstrate that for us and then demonstrate the way in which it is leveling out or—is that sort of evidence available for the record?

Dr. ROPER. It sure is. I would be glad to provide it at length for the record, but let me try to summarize it for you.

Senator DURENBERGER. All right.

Dr. ROPER. I don't have a chart—at least a big one. I have a little one.

I'll just make again the key points.

First of all, the first year rates were based on unaudited data—the unaudited data were found to be inflated. So, we have known that for a couple of years now, that the first-year rates were overstated, because of the unaudited data.

Second, is the matter of hospital behavior. As you and others have said, we gave hospitals incentives to economize, to save money, to profit at the bottom line—and there should be no surprise that, in fact, they did that.

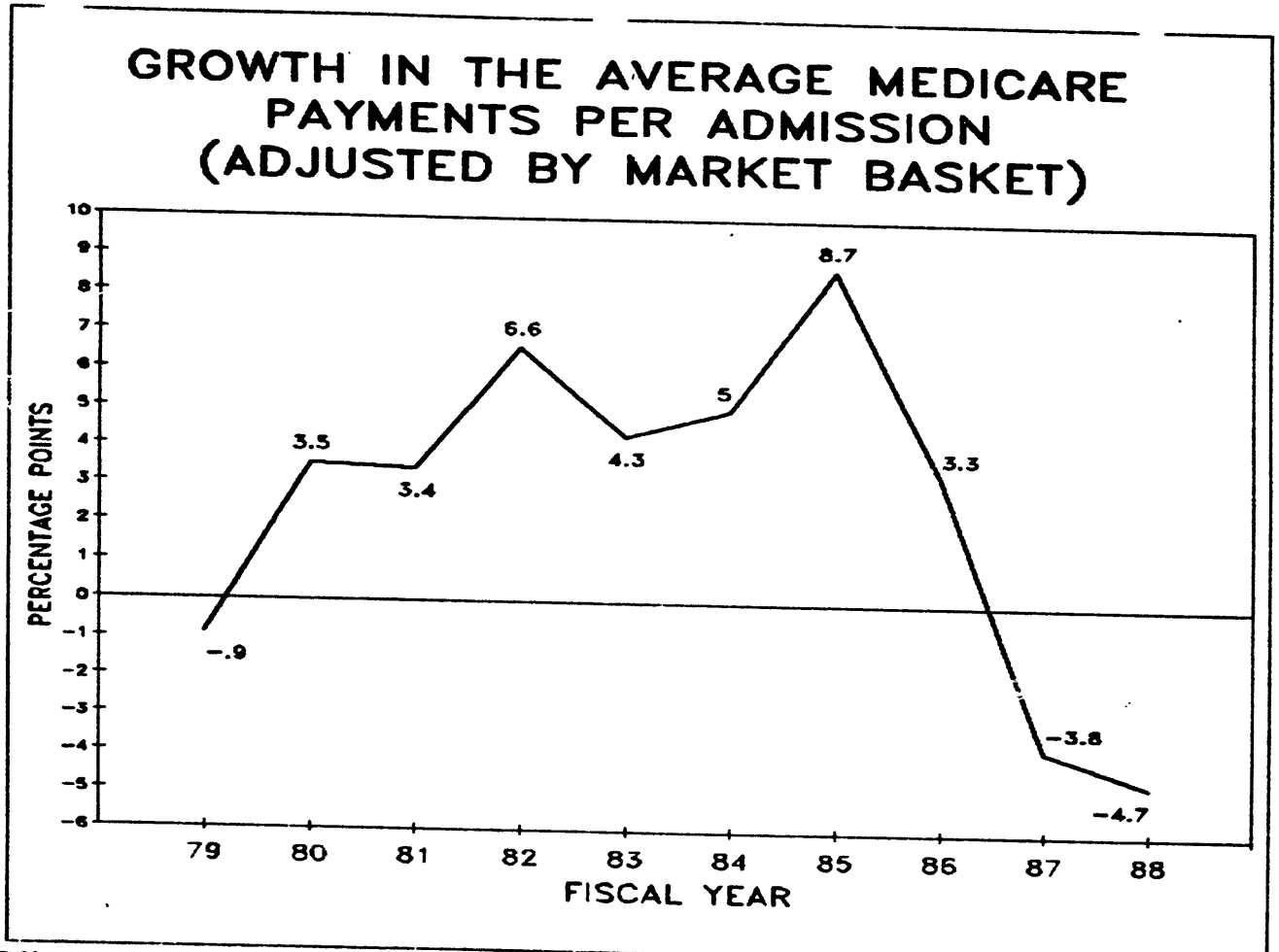
But the third point is that year-to-year increases in Medicare payments per case were at very, very high levels, when adjusted for inflation, in the early years, immediately after the implementation of PPS. Just to cite the numbers, Fiscal Year 1984, increased Medicare payments per case over Fiscal Year 1983 were 5 percent, when adjusted for inflation. The next year, Fiscal Year 1985, increased payments per case were 8.7 percent. So, in one year, the rates went up 8.7 percent.

In sharp contrast to that, Fiscal Year 1987 is a 3.5 percent decrease compared to Fiscal Year 1986, and our best judgment is that with a 2 percent increase, the upward bound of the Secretary's recommendation, there will in 1988 be a 4.5 percent decrease in inflation-adjusted Medicare payments per case.

If I may show you the chart, which demonstrates year to year the number of percentage points by which Medicare payments per case increased. And if you look at this year—this is 1983—they went up about 6 or 7 percent. For 1984, you see the tremendous increase in Medicare payments per case. The next year increased significantly as well.

But we are now down in 1986, will be further down in 1987 actually below zero, a cut in payments—and even further down in 1988. The message in all this is the early years were substantially different from the period we are now in and where we are going next year.

[The information follows:]



FY88 assume 2.0% update + enactment of all Admin. budget proposals. If only 2.0% update is enacted, FY88 = -2.3% growth.

Senator DURENBERGER. A related question. In the beginning, or in the first couple, three years of this transition, when we were trying to help hospitals, and having not chosen to go the hospitals' specific route—we sort of thought in terms of categories of hospitals and categories of clients or case mix and that sort of thing—do you have information that would indicate how what we have done in the indirect teaching adjustment and in the disproportionate share adjustment might work to increase the so-called profit level, beyond what they might appropriately be, or to work to the disadvantage of certain hospitals that don't have access to those two?

Dr. ROPER. The Inspector General has recently released a report, based on 1984 data, that looked at disproportionate share hospitals as a class, compared to non-disproportionate share hospitals—of course, that was before this add-on payment was added on. But, in that period, disproportionate share hospitals, as a class, did better, were better off financially than non-disproprotionate share hospitals.

And then the additional step was taken to add a further payment on top for them. And I think those points speak for themselves.

Senator DURENBERGER. There is a recommendation in the President's budget, again, that is fairly substantial in decreasing the indirect teaching adjustment.

Dr. ROPER. Yes, sir.

Senator DURENBERGER. Is that backed up by data?

Dr. ROPER. Yes, sir.

Senator DURENBERGER. And do you have that data?

Senator ROPER. I can supply it for the record, but we recommend lowering the amount by which hospitals are given a bonus for teaching costs.

[The data follows:]

The estimated payment adjustment of 4.05 percent to reflect the effect of medical education programs on hospital costs is a refinement of the earlier payment adjustment of 5.795 percent. This earlier adjustment factor was the basis for payments prior to the addition to the prospective payment system of disproportionate share payments. When the effect of disproportionate share status is taken into account, the effect of medical education on costs is reduced from approximately a 4 to a 6 percent increase in costs for every one percent increase in a hospital's resident-to-bed ratio. The specific estimate of 4.05 percent was made by the Congressional Budget Office (CBO) and forms the basis for the indirect medical education factor mandated by the Consolidated Omnibus Budget Reconciliation Act of 1985. The CBO estimate is consistent with our estimates of an appropriate payment adjustment factor.

Senator DURENBERGER. Just one last question.

Are you able, from sort of a non-statistical base—maybe, I think, suggesting a matter of observation, information, instinct, and so forth—to determine the impact which the urban-rural differential, together with the other adjustments, may have had on competition among hospitals which are located in sort of, what might be considered, a common service area? Have you undertaken—looked at the impact that the differential is actually having on the ability of certain hospitals, or the position that may be involved to direct patients away from one kind of hospital—it could be a rural hospital, for example, or those compensated at a rural basis—and in the di-

rection of more expensive hospitals compensated with the urban rate, and plus, perhaps, some disproportionate share indirectly?

Dr. ROPER. If I am following you, you are asking if we have studied the question of whether physicians have referred their patients to hospitals that get more money under the PPS system? I don't think we have studied that precise question. We do have a report due to the Congress on the question of rural and urban hospitals under PPS—and that report we will have up to you this summer. But whether it specifically looks at incentives for physican-patient referrals, I don't think so—but I will check that.

Senator DURENBERGER. Do you have—and Max complimented you earlier on the fact that you have spent a good deal of time looking at the rural hospital situation. In rural parts of America, we have some SMSAs in cities that are somewhat larger than your typical rural city. And around these these community hospitals have arisen kind of a powerful medical hospital economic force that is out getting business from rural hospitals.

And I take it, the way the differential works, costing Medicare a fair amount of money, if, in fact, they are taking patients away from a rural hospital and moving them into an urban rate hospital—costing Medicare trust funds some amount of funds. Have you looked at that situation?

Dr. ROPER. Again, I don't know whether we have looked at that specifically. I just cite anecdotal information—the conventional wisdom is that we do not have enough rural referral centers, for example, that we need to make more provision for these medium-sized hospitals in semi-rural areas, et cetera.

We continue to hear from rural hospitals that they are not at all anxious to have further competition from these medium-sized hospitals, because they are doing just the thing that you are describing—that is, drawing patients away. We are in the line drawing business—and what I mean is somebody who is just over a given size may well get a bonus payment because of one of the special provisions in the law, and the people down the street, who happen just to be slightly smaller than that line, don't like that at all.

Senator DURENBERGER. You are absolutely right. And we had this in OBRA the last time we got together for reconciliation. We have this little thing called the Fergus Fall Hospital Demonstration, which is supposed to take up on that thesis, and determine if, in fact, we aren't overspending on some of our regional referral centers for Medicare patients that could be as easily taken care of in some other hospitals. How is that demonstration coming?

Dr. ROPER. We will have to check, and I will provide you an answer very quickly.

[The answer follows:]

Under the Rural Secondary Specialty Center Demonstration, Lake Regional Hospital will be paid the same as a Medicare-qualified rural referral center. The Federal portion of the DRG payment will be established at the urban standardized rate instead of the rural rate, but adjusted by a rural wage index.

In a letter dated June 3, 1987, we notified Lake Region Hospital that its project had been approved retroactive to October 1, 1986 through September 30, 1989.

At the time of approval, the intermediary was instructed to immediately make the appropriate change in the PPS rate to refect the new project payment methodology and to make a retroactive adjustment for services provided from October 1, 1986.

A task order to complete the evaluation and assist in writing the report to Congress will be awarded shortly. The demonstration evaluation will include an assessment of the Medicare cost and and quality of health care provided to the Medicare population.

Senator MITCHELL. Thank you, Senator Durenberger. Dr. Roper, following up my question on the shortage of nurses and other technical personnel, if rural hospitals are forced to compete even more for nurses and other personnel, will the wage index differential that will apply next year take that into account?

Dr. ROPER. I believe, Senator, that the wage index is based on wages generally in the economy—not specifically nurses' wages. So it would not immediately take it into account.

Senator MITCHELL. All right. In view of the shortage, how can you propose deleting the cost of nursing and allied health training for the Medicare direct medical education payment?

Dr. ROPER. Because the shortage of nurses in America's hospitals is based on the fact that the payment is not enough to draw nurses already trained into the continued practice of nursing. We are not facing a shortage because of too few having been trained, but because hospitals as a group are not paying an amount that keeps nurses practicing nursing, instead of going onto other activities. We see it as basically an economic problem that hospitals are beginning to respond to by raising the amount that they pay nurses, providing more favorable working conditions for nurses, et cetera. Not a training issue.

Senator, I would just make the point I made while you were out. In my prepared statement, I noted the problem of hospitals' difficulty in attracting nurses. And I said that Secretary Bowen specifically asked me to say that. He is concerned about that problem as well.

Senator MITCHELL. Thank you very much, Dr. Roper. As always, we appreciate your cooperation. And there will be additional questions for you in writing, and I would ask that you respond to them at your earliest convenience.

Dr. ROPER. Certainly.

Senator MITCHELL. Thank you very much.

The next witness is Dr. Stuart Altman, Chairman of the Prospective Payment Assessment Commission.

Dr. Altman, welcome. We look forward to hearing from you again.

[The prepared written statement of Dr. William L. Roper and answers to questions from Senators Bentsen and Baucus follow:]

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

APRIL 7, 1987

I appreciate the opportunity to appear before you today to discuss the applicable PPS percentage increase in FY 1988 Medicare payments to hospitals. As Secretary Bowen indicated in his April 1 letter to the Congress, we believe, based on preliminary data and analysis available at this time, that the applicable percentage increase of 1.5 percent envisioned in the President's FY 1988 budget may be too low, and that the appropriate increase could range as high as 2.0 percent. However, we believe a final recommendation should be deferred until nearer the beginning of the fiscal year, when more recent data and complete analysis will be available to develop an equitable and realistic update.

In regard to exempt hospitals and units, we currently believe that the appropriate update for the target rate of increase could range as high as 4.0 percent. When we make our final recommendation for the PPS standardized amount, we will also update our estimates of the appropriate update for the target rate of increase based on more complete analysis.

I would briefly like to outline the reasons for the foregoing recommendation and to review the evolution of the program over the past few years.

BACKGROUND

For each year since FY 1985, the Secretary has been required to determine the annual rate of increase in payment rates to PPS hospitals by taking into account various factors affecting hospital costs, as well as the recommendations of the Prospective

Payment Assessment Commission (ProPAC). Under the first two years of PPS, payments under the new system had to be budget neutral relative to the Tax Equity and Fiscal Responsibility Act of 1982.

As you are aware, even in the face of the budget neutrality requirement, hospitals appear to have generally fared quite well during the early years of PPS. Urban hospitals did particularly well, on average, experiencing operating margins about twice those of rural hospitals. This disparity between urban and rural hospitals was the impetus for Congress to enact in the Omnibus Budget Reconciliation Act of 1986 (OBRA-86) significant steps to increase payments for rural hospitals relative to urban hospitals.

First, OBRA-86 mandated separate outlier reductions to the PPS rates of urban and rural hospitals based on their differential outlier experience. Since rural hospitals typically experience fewer outlier cases than urban hospitals, the effect of this change is to increase rural rates relative to urban rates.

Second, OBRA-86 provides, effective for discharges in FY 1988, that the PPS rates be computed on a discharge-weighted rather than a hospital-weighted basis, thus giving greater weight to the cost experience of larger hospitals. Because large hospitals account for a larger proportion of all cases in rural areas than in urban areas, discharge-weighting increases payment to rural hospitals relative to urban hospitals.

The combined effect of these two changes will be to increase the payment rate of rural hospitals by about six percent while reducing urban rates by less than one

percent. As a consequence, the discrepancy between rural and urban hospital operating margins will be almost eliminated.

Another recent change will enable an estimated 60 additional rural facilities to qualify as rural referral centers and be paid at the urban rate.

We are, of course, aware that the Prospective Payment Assessment Commission has proposed an adjustment in the PPS rates which favors rural hospitals relative to urban hospitals. We share their interest in preserving access to quality health care in rural America and have given consideration to such a step. Based on data and analysis available at this time -- and before we have completed a full analysis of ProPAC's recommendations -- the cumulative effect of changes enacted in OBRA-86 suggests that a higher applicable percentage increase for rural hospitals is not justified. While OBRA-86 changes will improve the equity of the system, our analyses indicate that their effect, in conjunction with a higher FY 1988 increase for rural hospitals than for urban hospitals, could be to produce a payment system which would over-compensate rural hospitals.

Although recent congressional action appears to have improved the equity in payments for urban and rural hospitals, the issue ofthe overall profitability of hospitals under PPS remains. HCFA, the HHS Inspector General, ProPAC and CBO all have done analyses showing that Medicare payments exceeded hospital costs by 12 - 16 percent in FY 1984. The Inspector General has found similar margins persisting into FY 1985 for at least a statistically representative sample of hospitals.

The high operating margins observed in the first two years of PPS appear to be due, in part, to prospective payment rates being set too high from the outset, based, as they were, on unaudited cost data. These high Medicare operating margins also stem from the success of PPS in getting hospitals to change their behavior, particularly with respect to reducing length of stay and furnishing certain services in less costly settings. That some 80 percent of hospitals experienced positive Medicare operating margins during the first two years of PPS is, in large measure, evidence of the adaptability of hospitals.

To some extent, though, the magnitude of the margins is a testimony to Congress awarding higher updates that we would have viewed as prudent. For FY 1986, for example, we recommended a freeze as the most reasonable policy. Instead, Congress chose to provide an applicable percentage increase of half a percent. Last year, in response to our recommendation of half a percent increase, Congress chose to provide an increase of 1.15 percent. Moreover, for FY 1988, Congress mandated an applicable increase equal to the market-basket rate of increase less two percentage points, or 2.9 percent. This is almost a full percentage point higher than what we now believe to be the upper limit for the applicable percentage increase.

Since the start of PPS, we have seen Medicare's share of hospital revenues increase until in FY 1985, for the first time, Medicare's share of hospital revenues exceeded its share of hospital days. During FY 1984 to 1986, Medicare payments per admission increased more rapidly, after adjusting for inflation and hospital inputs, than they did in the period from FY 1979 to 1983. It is, therefore, no surprise that hospitals fared well, on average, during the early PPS years.

In FY 1987, however, we are modestly increasing Medicare payments per admission, in sharp contrast to the rapid rates of growth in FY 1984 and FY 1985. As I will explain shortly, Medicare payments per admission, after adjusting for inflation in hospital inputs, may decline in FY 1987. We believe that we are now just starting to "tighten" the system. If maintained, this trend will ultimately begin to reduce the high margins of the early PPS years, assuming hospitals do not continue to adapt their practice patterns and improve their efficiency.

With this background, let me discuss our rationale for our FY 1988 recommendation.

UPDATE RECOMMENDATION

Based on the most recent available data, and currently available but preliminary analysis, we believe we should continue on the same general course for FY 1988 as over the last two years. That is, the PPS rates should be increased modestly, but the increase should be substantially less than the forecasted increase in the hospital market basket. In this way, financial dislocation in the hospital industry is avoided, while at the same time the Medicare program continues to benefit from the changes in hospital behavior that have resulted from PPS.

The most important change since the President's FY 1988 budget was prepared is the fact that the increase in reported case mix has stopped, at least temporarily. Data from early 1986 to the present show no increase in case mix. We will continue to monitor this surprising development. Casemix changes are comprised of two components, real casemix changes and coding creep. In the past, hospitals have benefitted from changes in their DRG coding practices -- coding cases into DRGs with higher payments without experiencing higher costs. If the trend of no observed

casemix change continues, it may mean hospitals are no longer benefitting financially from changes in DRG coding practices. On the other hand, no observed casemix increase may mean that hospitals have experienced a drop in real casemix (reducing their true costs) and at the same time are continuing to code cases as more complex, generating a financing "bonus" for themselves. We plan to further analyze the data and determine whether hospitals still reap a "bonus."

If hospitals are at least temporarily no longer benefitting from changes in coding practices, the PPS system is becoming more stringent in FY 1987 than in the system's early years, especially since there have been significant legislative changes in Medicare payments for medical education and capital. Consequently, we estimate that inflation-adjusted payments per case will fall more than 3.5 percent in FY 1987 compared to FY 1986.

We believe that the reductions in inflation-adjusted payments per case in FY 1987 and FY 1988 are justified based on the available evidence of hospital profits under PPS. However, we favor a policy of gradually tightening the PPS rates rather than dramatic reductions. Hospitals may be losing some, though by no means all, of their ability to respond to low update factors by cutting their costs.

Two factors seem particularly relevant to Medicare prospective payment;

- The decline in the average length of stay has stopped, at least temporarily. After declining about 18 percent in the early years of PPS, the average stay actually increased slightly in the most recent data.

- During fiscal years 1987 and 1988, hospitals will be adjusting to reductions in Medicare payments for medical education and slowed growth rates for capital payments.

In addition, hospitals face other financial pressures as a part of their cost of doing business more generally;

- There are increasing reports that hospitals are having difficulty attracting and keeping qualified nurses, an essential ingredient for high-quality care to all hospitalized patients, not just Medicare beneficiaries. Hospitals may have to pay nurses more and increase their nurse-to-patient ratios in order to make careers in hospital nursing more attractive.

- Uncompensated care for non-Medicare patients is a growing burden on hospitals. AIDS and other high cost illnesses contribute to this problem.

In assessing an appropriate update factor for FY 1988, Congress should consider the varying effects of PPS on different types of hospitals in different regions. We will soon be submitting a report to Congress documenting these variations. Although some of the variation is almost certainly due to differences in hospital efficiency, other factors may play a role -- for example, the inability of the DRG system to fully account for differences in patient severity of illness.

CONCLUSION

Based on the most recent available data, we believe that the 1.5 percent increase in the PPS standardized amounts envisioned in the President's budget may be too low.

Current data suggest that the appropriate increase in the standardized amounts could range as high as 2.0 percent.

This recommendation is contingent on current projections of relevant data. If current preliminary analysis were to change based on later data or more complete analysis, our recommendation for the applicable percentage increase would change correspondingly. We will make our final recommendation on the appropriate increase nearer the beginning of the new Federal fiscal year based on the latest estimates of all relevant factors, including ProPAC's recommendations.

In your consideration of the FY 1988 update over the coming months, I also ask that you reexamine the issue of the Secretary's authority over the PPS update factor and that you return to the Secretary the discretion to set the rates of increase for hospital payments. We are not, as some have alleged, interested in budget policy to the exclusion of health policy, but rather in the striking the proper balance between fiscal prudence and concern for the welfare of our beneficiaries.
Thank you. I would be happy to take your questions.

Questions from Senator Lloyd Bentsen
April 7, 1987

1. Q. In your testimony you stated that changes in the prospective payment system enacted in the Omnibus Budget Reconciliation Act of 1986 will almost eliminate the discrepancy between rural and urban hospital operating margins, and you disagreed with the recommendation of the Prospective Payment Commission that rural hospitals be allowed a higher update percentage than urban hospitals.

Would you please elaborate on your disagreement with ProPAC and include any analyses you have used to reach this decision. Specifically, please provide the latest data on the projected differential between urban and rural rates and margins after the changes mandated in 1986 are taken into account.

A. ProPAC recommends separate urban and rural updates to the PPS standardized amount of 2.2 percent and 3.0 percent respectively for FY 1988. The difference of 0.8 percent would be continued with the updates for FY 1989 and FY 1990. It is ProPAC's belief that a separate adjustment for urban and rural hospitals is needed to account for different cost experiences reflected by the first-year PPS cost data.

Our findings indicate that the changes mandated by OBRA-86--specifically, separate urban and rural outlier reductions and the change to discharge-weighing of the standardized amount--will increase the payment rate for rural hospitals by about six percent while reducing urban rates by less than one percent. Other refinements to PPS have further benefitted rural hospitals. These include: an adjustment to the payments for hospitals serving a disproportionate share of low-income patients, an advantageous payment blend for sole community hospitals, a payment adjustment for sole community hospitals experiencing a significant decline in patient volume, and modified criteria for qualification of rural hospitals as regional referral centers.

We believe that the combined effects of these changes will put rural hospitals on a more equal footing with their urban counterparts. We anticipate an overall differential between urban and rural hospitals of 14 percent. We feel this differential fairly reflects the differing cost experiences of the two groups. Establishing separate updates on top of these changes would actually overcompensate rural hospitals.

Questions from Senator Max Baucus
April 7, 1987

1. Q. In their April 1, 1987 report, ProPAC recommends that HCFA issue clear instructions on how sole community hospitals can qualify under present law for increases in PPS payments if their patient volume declines by more than 5 percent. I am told people really do not know what information HCFA wants before you will grant an adjustment to their payments and that HCFA's criteria in this area are unclear. Regulations on the sole community hospital volume adjustment were issued in March 1985, but do not provide specific information on how HCFA will determine whether a sole community hospital is eligible for an adjustment to their payments.

   Does HCFA intend to issue clear implementing instructions to your regional offices and to program contractors related to the sole community hospital volume adjustment? What criteria are currently used to determine whether a sole community hospital qualifies for a volume adjustment?

   A. Preliminary instructions have been drafted and we are working toward publication by the Fall of this year.

   In response to ProPAC's recommendation, we have proposed revised regulations to clarify the sole community hospital volume adjustments in the proposed notice of FY 1988 PPS update, published June 10. This revision would provide more detail on our process and eliminate the current requirement that the volume decline be caused by extraordinary circumstances. However, a hospital will be eligible for a volume adjustment only if their prospective payments are <u>less than</u> their reported Medicare costs.

   The current regulations specify that a hospital must experience more than a 5 percent decline in its total number of discharges over those of the immediately preceding cost reporting period due to extraordinary circumstances beyond the hospital's control.

   An adjustment amount may be determined on the basis of the reasonable cost of maintaining the hospital's necessary core staff and services; the individual hospital's needs and circumstances; the hospital's fixed (and semi-fixed) costs, other than those reimbursed on a reasonable cost basis; and the length of time the hospital has experienced a decrease in utilization.

To date, we have received only 12 requests for additional payment due to volume declines. One-third of these has been denied because the hospital had already been fully compensated for its Medicare costs under the prospective payment system. Another third has been denied due to the fact that the submittal failed to demonstrate that an extraordinary circumstances caused the volume decline. These hospitals were invited to resubmit their request with additional justification. The final third has been approved.

2. Q. What is your response to ProPAC's recommendation to collect more information on hospital labor costs as well as information on the wages and hours of hospital employment by occupational categories?

What changes in hospital payment would you expect to find if the wage index used more recent information on hospital labor costs?

A. HCFA has collected more up-to-date wage data from 1984 to use in calculating a new wage index. In order to avoid large changes in payment to individual hospitals, we are proposing to use an index that blends 1982 and 1984 wage data. We believe that the use of such a blended index will result in an overall increase in payments of 0.1 percent nationally, with a slightly greater percentage gain to rural hospitals of 0.2 percent.

We are also collecting 1986 wage data that include information by occupational category. We will not know what changes to hospital payment would occur because of occupational mix until we complete our analysis of the 1986 data.

3. Q. What can be done to reduce the long delays that we now have in obtaining information on PPS payments and hospitals costs? Is it feasible in your opinion to develop a representative sample of hospital costs using more recent year data so that decisions in PPS could be made based on more current information than we now have? What do you see as the pros and cons of this approach?

   A. We are planning, in agreement with a recommendation by ProPAC, to use hospital cost report data collected in the first 4 months of the Federal fiscal year to extrapolate costs for the entire fiscal year. We have reviewed a study conducted by the RAND Corporation for ProPAC on the feasibility of this proposal, and we are prepared to work with ProPAC staff to implement such a system.

   Clearly, the advantage of this approach is that we we can develop, in a more timely fashion, estimates of hospital costs that can provide up-to-date information for decision making. However, in order to get cost reports in earlier, we may have to rely on unaudited data, and any late submission of reports could compromise the process of developing national cost estimates.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, PH.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Dr. ALTMAN. Thank you, Mr. Chairman. I have with me Donald Young, who is the Executive Director of the Prospective Payment Assessment Commission.

Perhaps, in the short period of time that is allotted to me, the best I could do would be, if you don't mind taking a look at the tables which are appended to my prepared testimony.

Senator MITCHELL. All right.

Dr. ALTMAN. And let me just focus on what we are all about here today, and see if I can take you through them as best I can.

First of all, you are correct that we, as others, have found that the so-called margins, revenues minus costs, in 1984 were much larger than anyone could have expected. We knew that they were going to be positive, but no one, at least I was not prepared, for the 14.8 percent mean increase and 11.6 median, and the fact that at the 90th percentile, these hospital rates were in excess of—margins in excess of 23 percent.

You are also correct in saying that rural hospitals did not do nearly as well as urban hospitals, where the median for urban was 14.1, for rural referral centers it was 8 percent, and other rural 8 percent.

We did not specifically use that information in our update factor, but it did influence us in understanding what was going on. Rather, we did something else. We looked at costs in 1984 versus what was expected when the system was put in place, using 1981.

As Dr. Roper has indicated, 1981 used unaudited costs—and I don't want to repeat what he said. I would just like to add one other factor that made those costs different, other than the fact that hospitals did were more efficient. Something had to do with the idea that much of the care that previously had been provided in hospitals was now provided in outpatient departments, home health agencies, and was not provided at all. That was a good thing by in large—hospitals did respond correctly.

However, the Medicare program wound up paying twice, because these costs were built into the base of part A, and was then being picked up in part B; or was being paid for by the beneficiary; or was not being provided. It seems to me and it seemed to ProPAC that without casting aspersion on the hospitals, that needs to be taken out of the base or you are going to wind up paying for it twice. So that was a significant percentage, about a third, of the 12 percent in costs.

Basically, ProPAC did a calculation, which appears in the last table, Table 5, where we attempted to find out what was a reasonable allocation of that 12 percent. And we rounded from the original 12.3 to make our point clearer. As I indicated, 4 percent of it was the so-called site substitution, which should not be shared with the hospitals. That left 8 percent. That 8 percent we said should be shared with the hospitals, because we do want to maintain the incentives for them to become more efficient. That left 4 percent out, and so you wind up again with 8 percent.

Now, we went back and tried to figure out what part of that 8 percent had already been paid for by the hospitals in accepting lower update factors, and came up with a number of 2.6. So when you subtract the 2.6 from the 8, you wind up with 5.4. That was our best shot at understanding what part of the update should be adjusted downward.

Now, again we made another decision. And that is, as you pointed out, we are dealing with a lot of institutions, and it didn't seem right to take it away all at once. So we recommended that the update factors, in the future, be reduced by 1.8 percentage points a year for three years.

As you pointed out, we made a differential payment reduction between urban and rural—not because of differences in profits, but because of the fact that the differences in the urban costs were higher than the rural. And, therefore, our recommendation was that the urban rate should be adjusted down by—as indicated in that table—5.7 for the three years, while the rural should be adjusted only 3.3.

We then used that information in coming up with a recommendation to you for 1988. And, basically, our recommendation is that when you go through inflation and do the other adjustments that you have asked us to do, giving hospitals more money for scientific advances, taking some away for productivity, trying to understand case mix, you wind up with a net figure, on average, of 2.3 percent.

But, because of the difference, we recommend that rural hospitals be given a larger increase of 3 percent, and urban hospitals be given 2.2. And that is our recommendation.

Senator MITCHELL. I don't understand that. You are suggesting that that takes into account the rebasing that you earlier described?

Dr. ALTMAN. Yes, that is right.

Senator MITCHELL. All right.

Dr. ALTMAN. It takes in the 1.9 reduction for urban hospitals, and the 1.1 percent in rural. And that is summarized in Table 4. I realize I am out of time, but I would like——

Senator MITCHELL. Take the time, because this is important.

Dr. ALTMAN. I would like to focus on two other aspects.

First, for exempt hospitals. We have looked at exempt hospitals and believe that you should not use a mechanical formula that is the same for the exempt hospitals as we use for the PPS hospitals. They are under a different set of incentives. And what we have recommended to you is that you take the inflation rate, which is roughly 4.9 percent, and you take out of it 0.5 percent, which takes account of productivity advances that are appropriate, and some adjustments for science and technology, and we recommend that exempt hospitals be given a 4.4 percent adjustment, which is pretty close to the Administration—I think Dr. Roper indicated around 4 percent.

Then, we moved into a whole series of recommendations to make the playing field, if you will, a little more level—make the system more equitable. I would like to focus particularly on our recommendations for rural hospitals. We continue to believe that rural hospitals need some special help to play more evenly. Now the kinds of recommendations we have put in our proposal we believe

should go forward, regardless of the modeling effort that HCFA has—I support what you said, Mr. Chairman.

The numbers have been too out-of-wack in the past. And the kinds of adjustments we are recommending seem to me, as an urban person, to make sense. And just let me quickly summarize them.

First, we believe some rural hospitals should be given a volume protection. They are the hospitals that are really effected by one physician moving out, a few patients moving to another—their swings in volume should be protected. So, that is the first adjustment I would recommend.

The second is that even though there is a provision out in the hinder land for sole community hospitals, the way the system is being implemented, even with the good offices of Dr. Roper, as Senator Baucus indicated, we understand hospitals are still having trouble getting that criteria established.

And, therefore, we have asked for substantial clarification, what the rules are, so those hospitals can respond.

We also believe that the wage adjustment should be changed. Right now, there is a wage adjustment for urban hospitals and for rural. And we are recommending that urban be split into two categories—a urban-urban or a core city, and suburban—because, quite frankly, the suburban hospitals often benefit from the higher wages that the urban hospitals, the core hospitals have to pay, and they get the same adjustments.

Rural hospitals—we have found that if you adjust rural areas for, if you will, urban-rural, as opposed to the real rural hospitals, that improves the predictive ability of the model to explain actual wage differences. Some rural areas have to pay more than their more urban colleagues—and they should be compensated. So, we have recommended a refinement. Wage adjustments, for some hospitals, account for as much as 30 percent of their total payment. So we are not talking about a trivial amount.

We also would recommend strongly that we have quicker, more timely data. The idea that I am sitting up here today, talking to you about 1988, and the best available data we have is 1984—something is wrong. And we have recommended a sampling technique be instituted, where whoever is interested in it will have available a sample of hospitals from the first quarter of each year. They will be unaudited, and obviously over time we would need to get more refined numbers. But, at least we would have an understanding of how well the system is operating.

If the hospitals are correct that in 1986 and 1987 they are in real serious shape, we will see that. Right now, the only information we know for sure is 1984. I don't think we should be sticking our finger quite up in the air so much. And we have recommended that.

In addition, we have a number of other recommendations dealing with new technologies, how to adjust for that, and I will be glad to talk about that, if you are interested. But, basically, our summary is that we recommend to you that the annual update for 1988 be on average 2.3—it should be 3 percent for rural hospitals, and 2.2 percent for urban.

Thank you for giving me the extra time.

Senator MITCHELL. Thank you, Dr. Altman, as always, for informed testimony.

One of the concerns raised by some hospital spokesmen is that use of the 1984 data to rebase payments is a one-way street. That, in other words, the cost data, actual costs will be used only to decrease payments, but not to increase them if costs exceed payments in the future. If reported Medicare costs do exceed payments at some time in the future, do you think that ProPAC should or would consider rebasing upward?

Dr. ALTMAN. If you don't mind, let me answer that in two ways. I and we oppose rebasing. We do not believe the system ought to automatically rebase, just because the numbers turn out. But, the cost information needs to be part of the decision-making process. You need to look at it and decide if the system is operating the way you want it. It seems to me that the people that put the system together used the best information they had. We are dealing with what—$45 billion.

So, it is not unreasonable to have a couple of corrections. And what we said was the base for the future. We are not taking any money away from hospitals in the past. We are talking about what the standardized amount should be in the future. It needs to be adjusted for the issues I said.

Now, the answer is, if in the future we tend to be collectively giving the hospitals much less than their costs are, then we have a serious problem—yes. I would not be opposed to coming before you and recommending that the payments are inadequate and were really effecting quality of care. I think it is a two-way street. But, it should not be mechanical—it should be part of any judicial decision.

IBM looks at its cost data when it decides how to price its computers. It is not un-American to look at costs when you set prices. And just because you do that does not mean you are going back to cost based reimbursement.

Senator MITCHELL. ProPAC has, again, recommended that capital payments be included in the Prospective Payment System.

Dr. ALTMAN. Yes sir.

Senator MITCHELL. How do you address the concerns of those hospitals with existing capital obligation that they will not be able to make obligated payments on bonds or loans if they are not grandfathered for existing obligations?

Dr. ALTMAN. It is very important that we adopt a system that, over time, has the same set of incentives for the operating side as the capital side. And we are going to see distortions take place over time that I don't think any of us are going to like. We have seen that in the past when we only adjust one part of the system.

So, we need to include it in some way. Now, we need to be mindful of these obligations. Grandfathering is a very bad way to do it, because it draws the line in the sand at some point, and it says if you are on one side of the line you get everything, and if you are on the other side you get what is left. So, hospitals that are just about to introduce capital expenditures are going to be really hurt by grandfathering.

So, what we decided, and I hope we have tried to be as equitable as we can, we have a 10-year phase-in, which allows hospitals, over

the next 3, 4, 5, 6, 7 years, to slowly adjust, and we make the adjustment based on their own costs. And we try to model, and most of the modeling efforts that we have looked at indicates that hospitals—provided they are having the patients—will do all right. They will get adequate amounts of money to pay off their bonded indebtedness.

Those hospitals that will have trouble are those that have volume reductions, because the big difference between PPS and the previous system is it does not reward hospitals, or it does not pay hospitals more, when their census goes down. The system is based on volume.

But, even after you come through with that, I have recommended, and the Commission has gone along with it, we need to establish a pool of dollars for an exceptions process. It is going to be tough, and there are a lot of people—there are several commissioners, particularly those who have had administrative responsibilities, that are very concerned about how you would operate that.

Well, regardless of how we do it, it seems to me that there are going to be those cases that you would want whoever is going to operate the system to give them more money. I think there ought to be a limited pool of money, and I think there ought to be very tight criteria, so you are not bailing out financially distressed hospitals for other reasons.

So, between the two—a good phase-in period plus an exceptions process—I would not expect to see significant numbers of hospitals in serious trouble, provided their volume is up. If their volume is not, then they could have a problem.

Senator MITCHELL. My time is about up on this round of questioning. Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Roper, on page 2 of his testimony, refers to the recent changes concerning outlier payments and "discharge weighting." He then concludes, Dr. Altman, that the combined effect of these two changes will be to increase Medicare payments to rural hospitals by about 6 percent, while reducing urban rates by under 1 percent; he also says the discrepancy between rural and urban hospitals' operating margins will be almost eliminated. Do you agree with that?

Dr. ALTMAN. Well, we have not seen their modeling. But, let me make a distinction between what they did and what we are recommending.

They were looking at margins, which is revenues minus costs. Even if that is the case, we still believe that the rural hospitals should not have their costs reduced as much as the urban hospitals for the 1984 overpayments. So, I don't know whether he is right. I don't see any reason why his modeling is in error. But, even if that is the case, our recommendations, both with respect to the differential update factor and the recommendations about giving sole community hospitals and isolated hospitals a better break, should, in my view, go forward.

Senator ROCKEFELLER. Let me ask you a broader philosophical question. I am not quite sure what is happening these days in terms of the population trend of rural America overall. But it probably is not increasing in rural America, at the very least. In West

Virginia, we are having some population loss—we didn't for awhile, now we are once again.

We get into this question of saving rural hospitals. And now I am stepping aside from my own hard-core position by trying to draw you out. In the desire to save and protect rural hospitals, I am sure these are examples of some rural hospitals clamoring for assistance, which may not, by virtue of internal problems or other reasons, deserve the help.

Two questions. One, should the formula of Medicare payments simply try to make up for all rural deficiencies, or is their some way to make qualitative judgments about which deserve the help?

Number two, in my opening statement I talked about the tremendous decline in the profits of my state's hospitals. In fact, some of our rural hospitals had, on the average, an operating deficit of $262,000 last year. That may be inevitable. I mean, it may be that our small, rural hospitals cannot be sustained in spite of our wishes.

Can you take a crack at each of those?

Dr. ALTMAN. I will try.

I understand the emotional and economic attachment of communities to their hospital. You don't have to be in a rural area. You can go into the heart of New York and Chicago and see the intensity with which local communities fight to hold onto their own institutions. But, there are some mitigating circumstances that would lead you to occasionally say that certain institutions should not be there.

I am not a physician, but I have spent much time with physicians and other health professionals to know that sometimes such institutions just don't provide good quality care, and the emotional attachment overrides good judgment, medical judgment. These people should be in other places.

And, therefore, just keeping an institution around because it is the closest and you have been on the Board and your father was on the Board, may make neither economic sense nor medical sense. And, so that is the first answer—that just because they are there, they should not be continued.

Senator ROCKEFELLER. Is there anything that can be built into the formula?

Dr. ALTMAN. Then we get to the second question. Well, I think this mechanism will take care of them, even to the point that you want to shut it off, because one of the big advantages—or disadvantages, depending on which way you are; the DRG system has posted the other one—is it pays on volume. If the patients don't go to that hospital, the hospital does not get reimbursed. In the old days, under cost base reimbursement, you wound up doubling the payment per patient if the census went in half. We had that system. And if there was one, literally, Medicare patient, that Medicare patient would pay the total bill, because you divided the cost by the patients.

Now, each patient brings the same dollar per DRG. So, to the extent that those individuals, for whatever reason, even in rural areas, are leaving their hospitals and going to either urban-rural or suburban or urban, wherever they go, they are voting with their feet and they are taking their payments with them.

Now, as Senator Durenberger said, that may have a negative impact on the trust fund, because when they wind up at the urban hospital it costs them more. But, they are saying, for whatever reason, we get better quality care. And, therefore, I think that is a good sign and you should listen to that.

Now, with that said, Senator, this system does penalize those institutions. And you might say it overpenalizes them. And that is what we were looking at. You are going to have random swings. We have hard examples—the sole surgeon in a community leaves, and all of a sudden the census falls, not because the hospital is bad, but there is nobody to do surgery. So, we have recommended a volume protection system. I have always been concerned about the lack of a volume adjuster in the DRG system. But, I have been persuaded that, on average, we don't need it. But, for rural hospitals you do.

To take account of that, I also think we can take hard looks and decide, as we have done, that sole community hospitals should receive special compensation, special arrangements. Now, we need to look at that—I think Senator Mitchell indicated before. We know that rural hospitals have not fared as well under this system. And, I think we ought to continue to titrate until we feel comfortable.

Now, we are never going to make it perfect for all of them—and I don't think we should. Because if you go down that slope, you are going to go back to cost base reimbursement so fast.

So, my recommendation is use the system, let it adjust, and adjust it for volume, but ultimately, be prepared to see some of those hospitals go under if the patients in their own areas don't go there. Because, maybe it is for the good of the quality of care in that area. And I think we have seen the same thing in urban areas.

Senator MITCHELL. Thank you very much, Dr. Altman. Thank you Senator Rockefeller.

I have some additional questions for you in writing.

Dr. ALTMAN. Thank you, sir.

Senator MITCHELL. We are going to proceed with our final witness now, who is Jack Owen, Executive Vice President and Director of Washington Office of the American Hospital Association.

Mr. Owen, welcome. We look forward to hearing from you.

[The prepared written statement of Dr. Stuart H. Altman and answers to questions from Senator Mitchell follow:]

STATEMENT OF

Stuart H. Altman, Ph.D.

Chairman

PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

I appreciate your invitation to appear before the Subcommittee today to discuss the work of the Prospective Payment Assessment Commission. I will describe some of our recent analytic studies of hospital payment rates under Medicare and our recommendations for changes in the Medicare prospective payment system for fiscal year 1988. I am accompanied today by Donald A. Young, M.D., Executive Director of the Commission.

One of the most important ways PPS influences the health care system -- the availability and quality of services -- is to effect the financial status of hospitals. As part of ProPAC's effort to assess the impact and functioning of PPS we have thus carefully reviewed hospital financial status. I am pleased to share with you today the information which we have developed on hospital operating margins, and on the cost differential between projected and actual costs under PPS. Then I will describe how the Commission used this and other information in our recommendations regarding updating the PPS payment amounts for fiscal year 1988.

Prior to PPS, hospitals were paid on the basis of their costs as defined by the Medicare program. This method of payment resulted by definition in Medicare margins which should have been zero. One of the basic tenets of PPS was to provide hospitals with financial incentives to improve efficiency and productivity in the delivery of services. It was intended that hospitals be placed at financial risk and that they share in financial gains. Therefore, some level of profit or surplus was a desired goal of PPS. But, as I will explain, the level of surplus in the first year of the program far exceeded our expectation.

PPS Margins from Medicare Cost Reports

ProPAC's analysis of hospital margins is based on information from the Medicare cost reports submitted for the first year of PPS and is comparable to analyses completed by other organizations. Our review of this data suggests that the first-year PPS margin for hospitals averaged 14.8 percent.

Our findings and those of others must be interpreted with caution for several reasons. First, PPS margins do not reflect the overall financial condition of hospitals. A hospital could, for example, have a relatively high Medicare margin, but have considerable uncompensated care, which would lower its total margin and impair its financial status. Second, the data are from the first year of PPS. During fiscal year 1987, hospitals entered the fourth year of PPS. The transition to fully Federal rates, policy adjustments, and other changes since PPS implementation will affect hospital financial performance. For

example, recent data on overall hospital margins show that total margins have declined from 6.7 percent in 1985 to 5.5 percent in 1986. In addition, the relative margins across groups of hospitals are affected by policy changes, such as the lowering of the indirect teaching adjustment and changes in the calculation of the outlier payment pool.

ProPAC conducted this analysis to determine distributional effects as well as the overall size of the PPS margins. We believe that although the level of margins is important, examining the differences in margins across hospitals can provide information about possible systematic problems in PPS payments to hospitals.

Distributional Differences in Margins Across Hospitals

Data from the first-year PPS Medicare Cost Reports suggest that there are significant differences, some systematic, in how well hospitals were succeeding financially in the first year of PPS. PPS revenue margins are calculated by subtracting Medicare operating costs from revenue and dividing by PPS revenues. As I indicated, the average first-year PPS margin for hospitals was 14.8 percent as shown in Table 1. Despite this high average margin, 10 percent of hospitals had PPS margins less than -5.0 percent. On the other hand, 10 percent of hospitals had margins greater than 23.4 percent. Costs and payments for capital and direct medical education, which are separate from PPS, are excluded from the margin calculations.

A number of factors are likely to contribute to the range of PPS margins. Some hospitals have low margins because they experience unusually high Medicare costs that are not fully paid by the PPS system. Other hospitals have been slower to reduce costs either prior to or during the first year of PPS. This may be particularly true of hospitals with relatively high volume declines, since the cost-cutting response to volume declines is not immediate. On the other hand, some hospitals generated relatively high margins by being quick to reduce costs. In addition, payments to many hospitals were higher than expected because of the PPS payment formula. Growth in the Medicare case-mix index, for instance, was the source of significant payment increases in the early years of PPS.

Urban and rural hospitals showed the most striking systematic difference in first-year PPS margins. As a group, rural hospitals had a first-year PPS margin averaging less than 9%, compared with 16 percent for urban hospitals. Margins for one-quarter of rural hospitals were less than -0.2 percent. In contrast, the 25th percentile for urban hospitals was 7.8 percent. The group of rural hospitals with fewer than 50 beds had particularly low margins--10 percent of these hospitals had margins of -18.4 percent or less.

Changes in payment policy since the first year of PPS may have reduced the disparity between the urban and rural margins. The large difference in margins between the urban and rural groups reflects more than PPS payment disparities, however. Bed size seems to be an important factor. First-year PPS margins for urban hospitals increase with bed size. As with rural hospitals, small urban hospitals were more likely to have negative margins than larger urban hospitals.

Major teaching hospitals had relatively high PPS margins -- 21.1 percent as a group, compared with 12.4 percent for nonteaching hospitals. The relatively generous indirect teaching allowance in the first year of PPS had some influence on these margins. This cannot be a full explanation, however, since in the first year of PPS the teaching allowance was applied to only the quarter of payments that were based on regional averages. The rest of the per-case payment rate was hospital-specific.

Both the level and distribution of current PPS margins may differ from those shown for the first year of PPS. Changes in costs and responses to PPS incentives are likely to have occurred since then. As mentioned previously, changes in payment policy have also affected the distribution of payments to hospitals. These include the transition to national rates, the reduction in additional payments to teaching hospitals, implementation of an adjustment to payments for hospitals serving a disproportionate share of low-income patients, and changes in payments to rural hospitals.

Comparison of PPS Margins with Total Margins and Patient Margins

PPS margins are not directly indicative of the overall financial condition of hospitals. Median first-year PPS margins were higher than median total and patient margins for the same reporting period (see the attached Table 2). Total margins are calculated by taking the difference between total revenue and total expenses as a percent of total revenue. Patient margins are the difference between net patient revenue and total operating expenses as a percent of net patient revenue. Unlike the PPS margins, total and patient margins reflect revenue and expenses for all payers, and include capital and direct medical education costs and revenues.

The median first-year PPS margin was 11.6 percent, compared with a 6.7 percent median total margin and a 2.5 percent median patient margin. By definition, half the hospitals have margins above the median and half below.

Overall margins were computed using financial information provided on the Medicare Cost Report from the first year of PPS. This section of the cost report is not audited and under PPS does

not affect Medicare payment for inpatient hospital operating costs. The overall medians presented here, however, are consistent with data from the American Hospital Association for the relevant time period.

Financial incentives included in TEFRA and the change to prospective payment resulted in cost reductions in the care of Medicare patients. These cost reductions contributed substantially to the relatively high margins we have observed. There is disagreement about the extent to which hospitals can continue to reduce costs. Overall patient margins reflect discounts and other competitive pressures from non-Medicare payers. Moreover, overall patient margins reflect hospitals' total admissions and all the services provided, including losses associated with patients who have no insurance coverage and cannot afford to pay their bills.

The distribution of median total and patient margins across hospital groups is generally similar to the pattern of first-year PPS margins. Rural hospitals had lower median total and patient margins, although the difference between rural and urban margins was much smaller than in the case of PPS margins. Median margins for hospitals in the larger bed size groups were higher than for their smaller counterparts.

Differentials Between Actual and Projected 1984 Costs

Our analysis of hospital profit margins, which I just described, used information available to us from the first-year PPS cost reports. This data became available late last year, and this was the first time that any of us had known what hospitals' actual experience looked like under the new system. This data was also used by ProPAC to develop another analysis -- this one comparing these newly available actual first-year PPS costs to the costs that were projected at the beginning of the PPS program. You will recall that when the PPS was begun in fiscal year 1984, we did not have current actual costs. Rather, actual costs for fiscal year 1981, the most recent data that were then available, were used in developing the PPS rates. Estimates of 1984 costs and payments were derived from the 1981 data, consistent with the Congressional mandate that the initial rates for FY 1984 and FY 1985 be "budget neutral" with respect to what would have been spent under the TEFRA limits. Since the first year of PPS, the amounts have been updated -- by 3.4 percent in FY 1985, by 0.5 percent in FY 1986, and by 1.15 percent in FY 1987.

If we replace the updated 1981 costs with these new actual first year PPS costs, the calculated standardized amounts are substantially lower. The amount of the difference -- which ProPAC has estimated to be about 13 percent for urban hospitals and 7.6 percent for rural hospitals -- is comparable to the margin figures which we are discussing today.

To some extent ProPAC anticipated that the actual cost data would be lower than the costs used to calculate the 1984 PPS rates and recommended that the standardized amounts should be recalculated when first year PPS cost data were available. This is not because we favor a return to a cost-based system. Rather, we believe that industry-wide cost information is an important part of informed decision-making about future payment rates for hospitals. We recognized, however, that there is no simple way that more current cost information could be used in setting payment rates, and that substantial judgment would be required.

Considering Margins and Actual 1984 Costs in Updating the Rates

In making its recent recommendations concerning the update factor for hospital payments for fiscal year 1988, the Commission considered the analyses of the margins and the cost differential between actual and projected first year PPS costs I have just described. The range of figures which represent the "bottom line" in each analysis are similar -- the margins in our analysis average around 14%; the differential between projected and actual costs averages 12%.

The Commission's approach was to use this information to complement and inform our decision-making process. We did not view this problem as a simple arithmetic exercise. Viewing 14 percent margins or a 12 percent difference between actual and projected costs should not lead to the conclusion that PPS rates can or should be decreased on this order of magnitude. Several factors are important in arriving at an appropriate adjustment.

Basic Concerns in Using Margins and Cost Data

One basic concern is that the prospective payment system was designed to encourage maximum efficiency on the part of hospitals. This means that savings realized from the PPS program due to efficiency gains should be shared with the hospitals. This has been an integral part of ProPAC's approach to each year's update factor, and we strongly believe that this concern should be reflected in whatever actions are considered for this year's update factor. If you design an incentive-based system and then take away all of the gains resulting from actions taken to respond to the incentives, you have undermined those very incentives which you so carefully designed in the first place.

Another problem is that hospitals are having different financial experiences under PPS. Even if the hospital industry as a whole has received payments which are greater than anticipated, individual hospitals could suffer dramatically if we cut the system in an indiscriminate way.

Other concerns relate to the problems associated with moving to large cutbacks without warning. Hospitals are complex institutions and need time to adjust to new payment policies. Thus, it is appropriate to consider some phasing of any sizeable reduction in the level of payments.

Finally, we need to take into account what has happened since the first year of PPS. Update factors for FY 1985, FY 1986, and FY 1987, for example, were considerably below the inflation level in hospital costs of doing business in those years. Nevertheless, the total increases in Medicare per case payment levels under PPS were far higher than the update factors or these inflation rates, as you can see in Table 3.

Recent ProPAC Recommendations

Based on these and other considerations, the Commission developed its recommendations for updating the hospital payment rates for fiscal year 1988. In addition to describing our recent formal recommendations in this area, I would also like to submit for the hearing record a copy of the executive summary of the Commission's April 1, 1987 report. This report contains a number of recommendations which we feel are important to consider in improving the distributional equity of PPS and assuring all Medicare beneficiaries access to high quality hospital care. Today, however, I will focus my comments on our recommendations regarding the update factor.

Updating the PPS Payment--Overview

For fiscal year 1988 payments, the Commission recommended an increase in the level of prices of 2.2% for urban hospitals and 3.0% for rural hospitals. These update factors are derived by combining several components.

The first component is a 5.4% average reduction in the standardized amounts, to be phased in over the next three years. This reflects that the Commission's best estimate of that portion of the 12.3% first year cost difference (previously discussed) which should be taken out of future standardized amounts. The result is a decrease of 1.9% for urban hospitals and 1.1% for rural hospitals for fiscal year 1988.

The other components are: increases of 4.9% for inflation in the hospital market basket, 0.5% for scientific and technological advances, and 1.3% for real case-mix change; and decreases of 1.0% for improvements in hospital productivity, 0.3% for shifts in the site of service, and 1.3% for expected changes in the case-mix index. These components are summarized in Table 4.

Let me now address each of the update factor components in some detail, and describe the reasoning behind our recommendations.

Adjustment to the Level of Standardized Amounts

Table 5 summarizes the judgments made by the Commission in deciding to recommend a 5.4% average cumulative adjustment. In its deliberations, the Commission reviewed a variety of approaches, and considered reductions ranging from 3.4% to 8.0%.

The Commission began with a rounded estimate of 12.0% of the average cost differential. The Commission's rural and urban reductions are in the same proportions as the rural and urban standardized amount differentials (7.6% and 13.0%).

The Commission then considered several factors to determine the ultimate recommendation. First was the extent to which hospitals should share in the gains from PPS. It is primarily because of the importance we place on sharing gains with hospitals that the Commission opposes a strict rebasing of the standardized amounts -- that is, adjusting the standardized amounts for the entire 12 percent differential. We believe this would be inconsistent with the basic incentives of PPS.

In ProPAC's judgment, 4.0% of the 12.0% cost differential should not be shared with the hospital industry. This portion takes into account our estimate of the amount of costs included in the original figures that were shifted to other sites of care and paid for by either the Medicare program or the beneficiary. In addition to efficiency gains and site substitution, part of the 12% difference may have arisen from errors in projecting costs and changes in hospital accounting practices. Small auditing effects might also be reflected in the 12 percent cost differential.

The Commission's recommendation apportions the remaining 8% of the cost differential equally between Medicare and the hospital industry. The total reduction we consider appropriate is therefore 8%: 4% that is not to be shared with the industry, and 4% that is Medicare's half of the efficiency gains.

We also considered the extent to which PPS payments have already been reduced as a result of hospitals' early PPS experience. That is, although first-year cost report data were not available until recently, decision-makers were generally aware that the hospital industry was responding to PPS incentives, and that hospitals were doing well financially. ProPAC believes that this general assessment was reflected in the relatively low update factors allowed in fiscal years 1986 and 1987.

The extent to which prior year update amounts have already been partially adjusted is shown by the fact that hospitals received a cumulative increase in the standardized amount of 5.1% over the last five years. The Commission estimates that the amount would

have been 7.7% if the update factors consisted of the market basket, adjusted only for coding improvement and site substitution. Therefore, when this 2.6% difference is subtracted from the 8.0% Medicare portion of the differential, the recommended reduction in future standardized amounts is 5.4%. We recommended this be phased in over three years.

To summarize:

- o We started with a difference of 12% between projected and actual costs.
- o We agreed that 4% of the difference should not be shared with hospitals and that half of the remaining 8% should be shared equally between hospitals and Medicare (beneficiaries and the government).
- o At that point, the reduction would be 8%. We concluded, however, that 2.6% of the difference had already been reflected in relatively low update factors.
- o We, therefore, subtracted the 2.6% and arrived at the recommended reduction of 5.4%.
- o We recommended the phase-in of the adjustment over three years, or 1.8% per year.

Some have charged that this recommendation to reduce standardized amounts based on first year PPS cost data breaches the basic principles of PPS. They have suggested that it is an attempt to regulate hospital revenue margins. It is neither.

The recommended reduction applies only to future PPS prices -- not to gains previously earned by the hospital industry. A fundamental principle of PPS is that if a hospital's costs for treating Medicare patients is less than its PPS payment, the hospital keeps the entire difference. This principle is not violated by our use of cost information as one factor in recommending the level of future prices.

While the Commission considered data on hospital revenue margins, we did not directly incorporate this information into the 5.4% figure that I have been discussing. The Commission does not believe that PPS prices should be set to achieve a particular average revenue margin. If all other factors were unchanged, the adjustment to the standardized amounts would lower PPS margins. But hospitals would still have an opportunity to increase revenue margins by further reducing costs.

Other Update Factor Allowances

After accounting for changes in the standardized amounts which I just described, the Commission recommends that the update factor next consider: changes in the hospital market basket; a discretionary adjustment factor (which we often refer to as DAF);

and, adjustments related to increases in the average DRG weight, or case-mix index, during fiscal year 1987.

The hospital market basket -- the measure of the price of goods and services purchased by hospitals -- is currently estimated at 4.9%. Turning to Table 4 you will see that we have added this projection to our update factor for fiscal year 1988.

The discretionary adjustment factor, or DAF, is calculated by continuing allowances for scientific and technological advancement, productivity change, site-of-care substitution, and real case-mix change. In the table, you will see that the Commission recommends a 0.8% net reduction to recognize scientific and technological advancement, productivity and site-of-care substitution. This 0.8% reduction includes: a positive 0.5% adjustment for scientific and technological advancement, reflecting the need to adjust payment levels upward to account for new advancements in medical practice; a negative 1% adjustment to reflect our belief that hospitals should continue to strive for additional efficiency in producing hospital services; and, a negative 0.3% adjustment for changes in the site of care from the inpatient to the outpatient setting.

Following these factors, we assess changes in real case-mix, or change in the complexity of Medicare patients treated in the hospital. We estimate that a positive 1.3% should be added to the update factor to take into account these real case-mix changes.

These adjustments result in a total discretionary adjustment factor of 0.5%. To complete the update computation, we subtract our estimate of total change in the case-mix index for fiscal year 1987, or 1.3%, which should occur as part of the process of recalibrating the DRG weights. The result is an update and case-mix adjustment of 4.1%.

I would like to point out that the matter of distinguishing between real case-mix change and coding improvements has been an especially difficult component of our update factor recommendation for several years. Based on preliminary evidence, however, the Commission believes that these components approximately offset one another and that the case mix change phenomenon is diminishing in its importance to calculating the appropriate update of PPS prices. Nevertheless, the Commission also believes that this phenomenon bears watching carefully in the future and that it is appropriate to devote substantial resources to understanding case-mix change better than we currently do.

After applying the average adjustment to the standardized amounts which I described as our first step, we reach the Commission's

recommendation of an average total change in PPS prices of 2.3%: 2.2% for urban hospitals and 3.0% for rural hospitals.

While we stand firmly behind this recommendation, I want to remind you that we continue to be concerned about the distributional consequences of our actions in updating and changing the prospective payment system. Thus, I want to stress that the Congress and the Secretary should seriously consider our other recommendations, listed in the Executive Summary of our April 1st report. I or the ProPAC staff would be pleased to discuss these issues with the committee.

Earlier Availability of Cost Data

I do want to highlight one additional recommendation. The Commission strongly urges the adoption of the sampling strategy we have developed to speed up the availability of Medicare Cost Report data. We believe there is a critical need for more timely information for decision-making. This need is clearly demonstrated by the debate and discussions today concerning the differential between actual and projected first-year PPS costs, and hospital operating margins. The Medicare Cost Reports provide important information for developing the annual update factor, for assessing the relationship between PPS payments and costs, and for analyzing the costs of individual DRGs.

Our proposal calls for the routine collection of Medicare cost data from a sample of PPS hospitals whose accounting years begin in the first four months of the Federal fiscal year. The current delay of about two years in obtaining complete cost reports results in part because most hospitals have accounting years that begin after the start of the Federal fiscal year. Because hospitals have 3 months after the end of their (not the Federal) accounting year to submit cost reports, long delays are encountered in developing a complete set of cost report data. We believe a sampling scheme could reduce this delay by at least eight months.

The full text of this recommendation is included in our report. More details about the analysis upon which it is based are found in the Technical Appendixes to the report.

Summary

Mr. Chairman, I am pleased to provide you with this information about our analyses and judgments concerning hospital payment amounts under PPS. I would be pleased to answer any questions you or members of the Subcommittee may have at this time.

Table 1: First Year PPS Margins, Means, and Percentiles*

Hospital Type	Mean	Percentiles 10	25	Median	75	90
All hospitals	14.8	-5.0	3.8	11.6	17.9	23.4
Urban	16.0	1.0	7.8	14.1	19.8	25.3
Rural referral centers	8.5	-3.5	2.5	8.0	13.8	18.0
Other rural	8.8	-10.6	-0.2	8.6	15.1	21.4
Major teaching	21.1	8.1	14.3	18.8	24.2	29.7
Other teaching	16.7	4.3	10.0	15.2	20.2	25.7
Non-teaching	12.4	-6.7	2.6	10.5	16.9	22.4
Disproportionate share	16.2	-2.1	6.8	13.8	20.5	26.2
Non-disproportionate share	14.2	-5.4	3.3	11.1	17.2	22.5
New England	12.8	-1.8	6.4	10.7	15.7	19.6
Middle Atlantic	16.1	2.5	10.3	15.1	20.0	24.5
South Atlantic	12.7	-3.3	3.9	10.4	16.4	21.4
East North Central	15.5	-2.3	5.1	12.2	17.3	22.1
East South Central	10.2	-7.5	1.2	9.0	14.9	21.4
West North Central	17.0	-5.2	3.0	11.1	17.8	24.6
West South Central	16.2	-8.8	2.8	11.8	19.4	25.3
Mountain	14.4	-14.9	0.3	10.5	18.5	24.5
Pacific	15.6	-3.9	5.0	13.3	19.8	26.4
Urban < 100 beds	13.9	-6.0	4.6	12.4	19.5	26.7
Urban 100-249 beds	13.9	-0.4	7.3	13.3	19.2	23.6
Urban 250-404 beds	15.1	3.5	9.4	15.0	19.6	24.1
Urban 405-684 beds	16.3	4.7	9.7	15.5	21.1	26.3
Urban 685+ beds	21.6	10.1	14.9	18.9	25.0	28.0
Rural < 50 beds	7.3	-18.4	-3.4	7.0	15.2	22.7
Rural 50-99 beds	9.0	-7.2	1.2	9.3	15.8	21.1
Rural 100-169 beds	9.4	-4.8	1.7	8.7	14.1	19.7
Rural 170+ beds	8.4	-4.3	1.9	7.9	13.4	18.1

* PPS margins = PPS revenue minus Medicare operating costs divided by PPS revenue. Excludes pass-through costs and payments. Excludes hospitals in Maryland, Massachusetts, New Jersey, and New York, which were not on PPS during this period.

SOURCE: ProPAC estimates based on first-year PPS Medicare Cost Report data.

Table 2: Comparison of Median PPS, Total, and Patient Margins in the First Year of PPS*

Hospital Type	Median PPS Margin	Median Total Margin	Median Patient Margin
All hospitals	11.6	6.7	2.5
Urban	14.1	7.6	4.0
Rural referral centers	8.0	7.9	3.4
Other rural	8.6	5.0	0.2
Major teaching	18.8	4.9	-4.3
Other teaching	15.2	7.8	3.8
Non-teaching	10.5	6.6	2.3
Disproportionate share	13.8	6.3	2.3
Non-disproportionate share	11.1	6.9	2.7
New England	10.7	7.2	2.0
Middle Atlantic	15.1	9.1	5.1
South Atlantic	10.4	7.9	3.8
East North Central	12.2	5.3	1.6
East South Central	9.0	7.5	4.2
West North Central	11.1	8.5	3.5
West South Central	11.8	6.3	1.4
Mountain	10.5	5.2	0.3
Pacific	13.3	6.4	2.8
Urban < 100 beds	12.4	5.1	1.4
Urban 100-249 beds	13.3	7.8	4.7
Urban 250-404 beds	15.0	8.0	4.6
Urban 405-684 beds	15.5	9.1	4.5
Urban 685 + beds	18.9	7.8	3.4
Rural < 50 beds	7.0	3.3	-3.7
Rural 50-99 beds	9.3	5.7	1.6
Rural 100-169 beds	8.7	6.4	2.9
Rural 170 + beds	7.9	7.7	3.6

* PPS margins = PPS revenue minus Medicare operating costs divided by PPS revenue. Excludes pass-through costs and payments. Total margin = total revenue minus total operating expenses divided by total revenue. Patient margin = net patient revenue minus total operating expenses divided by net patient revenue. Excludes hospitals in Maryland, Massachusetts, New Jersey, and New York, which were not on PPS during this period.

SOURCE: ProPAC estimates based on first-year PPS Medicare Cost Report data.

Table 3: Changes in Hospital Operating Payments Per Case, Hospital Market Basket, and PPS Update Factor, 1985-1987

(In Percent)

Fiscal Year	Per-Case Payment	Market Basket	Update Factor
1985	10.2	4.1	3.40
1986	5.7	3.1	.50
1987	NA	3.5	1.15

Source: Health Care Financing Administration

Table 4: Estimated Increase in PPS Prices for Fiscal Year 1988 Under Commission Recommendations

Adjustment to level of standardized amounts*	
Urban	1.9
Rural	1.1
Average adjustment to standardized amounts	**-1.8**
Fiscal Year 1988 Update Factor	
Fiscal year 1988 market basket forecast	4.9
Correction for fiscal year 1987 forecast error	0.0
Components of discretionary adjustment factor	
Scientific and technological advancement	0.5
Productivity	-1.0
Site substitution	-0.3
Real case-mix change in fiscal year 1987	
DRG case-mix index	0.8
Within DRG patient complexity	0.5
Total discretionary adjustment factor	0.5
Estimated total change in case-mix index for fiscal year 1987 (DRG weights adjusted after recalibration)	-1.3
Subtotal: Update and case-mix adjustment	**4.1**
Total change in PPS prices	
Urban	2.2
Rural	3.0
Average total change in PPS prices	**2.3**

* A total adjustment averaging 5.4 percent to be made in three equal increments through fiscal year 1990.

Table 5: ProPAC Treatment of First-Year PPS Cost Differential

Total cost differential	12.0%[a]
"Non-shareable" portion[b]	4.0
"Shareable" portion[c]	8.0
Medicare Proportion of Total Difference:	
"Non-shareable" portion of cost differential	4.0%
Medicare's half of "shareable" cost reductions	4.0
Subtotal appropriate average reduction	8.0
Reductions accounted for in previous updates[d]	-2.6
Total recommended average adjustment[e]	5.4
Urban adjustment	5.7
Rural adjustment	3.3

a For purposes of these calculations, the estimated cost difference of 12.3% was rounded to 12.0%.

b The portion of the differential attributed to shifts in site of care, errors in projecting costs, changes in hospital accounting practices, and auditing of cost reports.

c Cost reductions attributed to increased hospital efficiency.

d Estimated difference between actual updates for fiscal years 1985 through 1987 and what updates would have been if applied to a lower base.

e Reduction to be phased in equally over three years.

Questions for the Record
Stuart H. Altman, Ph.D.
Chairman, Prospective Payment Assessment Commission
April 7, 1987
Subcommittee on Health
Senate Finance Committee

Senator Mitchell: In public testimony the American Hospital Association has stated that using historical data to predict productivity and so-called code creep is inappropriate in view of the evidence of a trend towards little or no change in these parameters in the most recent data that is available. Given the lack of timely data, do you feel your estimates for productivity and case-mix are fair?

Dr. Altman: Yes, we do believe that those portions of our update factor recommendation which deal with productivity and case-mix change are fair. These components of the update are considered using different data and approached in different ways, so I will address each separately.

The productivity allowance contained in our update factor recommendations is a goal or target. We use several types of data to inform our decision making, most of it historical. This information includes past productivity trends and various indicators of productivity change. We believe that reviewing this historical data as a basis for making judgments about reasonable targets for future productivity is entirely appropriate and fair. The prospective payment system, after all, was established to encourage efficiency. We think it is entirely appropriate to continue to push hospitals toward greater productivity gains, if the evidence we have reviewed shows that such gains are achievable. The data we reviewed, which is described in detail in our report and the Technical Appendixes to the report, indicated that such productivity gains are achievable goals.

ProPAC has adopted the position that it is both desirable and appropriate to translate productivity gains into price reductions. These price reductions, we believe, should be shared by the Medicare program, the Medicare beneficiaries, and the hospital industry. Thus, this year, the Commission recommended a minus 1.0 percent productivity allowance for fiscal year 1988. This reflects a productivity goal of 2.0 percent that would be shared equally between the Medicare program and the hospital industry.

In contrast to our approach to productivity, our recommendation regarding case-mix coding is an explicit adjustment to remove case mix increases due to upcoding over the past year. While some judgement is called for in estimating the portion of case-mix increase due to upcoding, or "coding creep," we have balanced our decision-making by also allowing for real case mix change. That is, when increases in inpatient complexity occur, we believe it is appropriate for hospital payments to

increase. But upcoding does not reflect greater resource requirements for patient care and should not be allowed to systematically increase payments. Here again, we believe that our estimates are fair and appropriate given the data available.

It is true that recent evidence indicates that both upcoding and real case-mix change are tapering off. In the Commission's Recommendation for fiscal year 1988, they are estimated to offset one another. Because of this offset case-mix change, in net, is not an important part of our fiscal year 1988 recommendation.

Senator Mitchell: Although this hearing focused on hospital payment rates, the Commission has also made recommendations for refinements of the PPS system. On which of those proposals do you think it is particularly important for Congress to focus, and would your recommendations for the update factor change depending on which of these proposals are enacted?

Dr. Altman: Our update factor recommendations would not change in the face of adoption or rejection of other recommendations. Each of our recommendations is important, and each is carefully considered before adoption. We have not formally prioritized or ranked recommendations in order of importance. My own view is that in addition to our update factor recommendations, others of particular significance include those recommendations related to inclusion of capital in the system; recommendations related to rural hospitals; and our recommendation for a sampling system to facilitate more timely availability of Medicare cost report data.

Senator Bentsen: At the hearing, Dr. Roper stated that he disagreed with the Commission's recommendation that rural hospitals be allowed a greater update percentage than urban hospitals, and stated that the Commission's analysis did not take into account the changes made in the Omnibus Budget Reconciliation Act of 1986.

Would you please elaborate on your recommendation in light of Dr. Roper's comments, and include any analyses you used in arriving at your recommendation, including any projections of the differential between urban and rural rates and margins after the changes mandated in 1986 are taken into account.

Dr. Altman: Our decision to recommend a separate and higher update factor for rural hospitals was based on our analysis comparing projected and actual first year PPS costs. We found that there were major differences between the costs used to set the original first-year PPS rates and the actual first year PPS costs. Our study found that there was a 12.3 percent difference between the projected and the actual costs -- a 7.6 percent difference for rural hospitals and a 13 percent difference for urban hospitals. That means that urban hospitals "benefited" proportionately more than rural hospitals.

When we reviewed the update factor, we determined that it was appropriate to lower the standardized amounts to take these projected and actual costs into account. In doing this, we

lowered the rural rates less than we lowered the urban rates. Our recommendations to recalculate these standardized amounts were not based on revenue margin data. Nor were they intended to be based on future projections but rather on past inequities.

The Commission is well aware of the OBRA changes, but they are not germane to the reasons why the Commission recommends a differentiated update for urban and rural hospitals.

It is my understanding that HCFA has developed a payment model which suggests that rural hospitals will be adequately compensated in the future. I believe that Dr. Roper was referring to this model in his comments about the adequacy of rural hospital reimbursement. ProPAC has not reviewed this model or its findings, so I cannot comment formally on this analysis.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT AND DIRECTOR OF WASHINGTON OFFICE, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Senator. It is a pleasure to be here. You have a copy of my statement, so I am just going to comment briefly on some of the high points contained in the statement.

The Prospective Pricing System was adopted by Congress, as you know, as part of the Social Security Amendments of 1983. Its purpose was to save the Medicare trust fund, number one; reduce hospital costs to beneficiaries; and provide predictability to the Federal Government and to hospitals. It was not enacted as a part of a budget bill.

While the trust fund is not only in a surplus position, it is adding to that surplus every year. It is now anticipated that the surplus will not start to decrease until 1993, when the number of elderly has increased dramatically.

The government has gotten its predictability from the program. But what about the hospitals? And that is what I am concerned about. The hospitals went into this program on the basis that we were going to have a market basket increase, plus 1 percent for technology. In 1983, before we even had a chance to finish our first year, it was market basket plus .25 percent, and then the Administration stepped in, re-rated the weights on the DRGs, and we ended up with about a 4 percent increase. Last year, we went through a freeze. We received 1.15 increase this year. And, next year, the most we can hope for is market basket minus 2 percent. The base line has already built in a reduction of about $1.2 billion.

And if you are a hospital administrator sitting now, thinking about what kind of programs you are going to have for next year and how you are going to budget for them, it would be nice to know what that increase is going to be, or if there is going to be any at all.

And that is one of the big concerns. We have got the predictability now for the government—we need to get the predictability for the hospitals so that we know each year what we can do and how we can do it.

Let me just comment on a couple of things that came up—the profits that you talked about, which have been a concern, I know here on the Hill, and concern in the newspapers and other areas as well. As long as we are going to pay on an average rate—and that is what we are paying on, a national average, as we move more and more to that—we are going to have those hospitals who are getting underpaid and those hospitals who are going to get overpaid. That is what an average is all about. So we cannot eliminate the so-called profits from those who are overpaid, no more than we are ever going to eliminate all the losses on the underpaid, unless we look at some fashion of getting rid of a strictly average rate.

The total revenue and cost, which we have been watching very closely, because it is much more important than just what the profit is on Medicare alone, showed that in 1983 we had a 1.6 percent differential between revenue and expense. And that jumped in 1984 to 2.2 percent—and there was a big jump. In 1985, things

dropped down to 2.1 percent, and our preliminary data indicate that it is only going to be 1 percent in 1986.

So, we have already seen the so-called bulge or the profit that happened in 1984 and 1985 start to dissipate.

I came from New Jersey and we started the DRG program, as a pilot program in New Jersey, back in 1978. And if the Administration or anybody else would care to look and see what happened to the DRG in New Jersey, you could almost anticipate what was going to happen nationally.

The first thing that occurred was that there was a so-called high profit margin in the first year, and it is because hospitals had an opportunity to get rid of some one-time costs—to lower their personnel ratio, do things that could be done within that price and still remain profitable. That profit dissipated in New Jersey the same way that it is dissipating nationally.

We invented some of the words—like outliers and DRG creep—in New Jersey. And DRG creep, which was a big concern to most of the state health people in New Jersey, was that hospitals were cheating, they were upgrading their records to show that patients had a higher and more severe rate of illness than was necessary, so that they got a higher rate.

We found that what really happened was that because, for the first time, hospitals were paid on the basis of a diagnosis, not on the basis of cost or length of stay, that it became very important that you have the proper diagnosis. And that has been true nationally, and we have seen that happen. And today, I heard Dr. Roper testify that that so-called creep or that so-called severity-of-illness ratio has started to change—and that happened as well.

The biggest problem that we had in New Jersey, and we are going to have nationally, is the rate lag. And that is what we have been talking about—the update factor, and how do you bring it closer to 1988, not 1984. And I think Dr. Altman stressed a need for up-to-date data, and I think he is absolutely on the mark.

Now let me just make a couple of comments quickly. We do support the ProPAC approach to getting more funds to the rural hospitals, by taking the update factor and allowing a larger increase to the rural hospitals and less of an increase to the urban hospitals.

There is no perfect way to do that, but our statistics indicate that a 3 percent increase could allow the rural hospitals almost a 6 percent increase, and the urban hospitals about a 2.3 out of that 3 percent increase. And that would bring that differential very, very close.

We are opposed to rebasing. We are opposed to rebasing for just a couple of reasons, and I will be very quick.

First, we don't think it is consistent with the intent of the program—it was not what prospective payment was all about. It is going to destroy the incentive system that we do have. And we think there is a way to solve the problem, and you have been solving it, by reducing the price, rather than going back and looking at the cost.

In conclusion, I would just say that the Prospective Payment System has been working. The trust fund is solvent. There are inequities that exist—it is not perfect. And what we need now is to

get predictability so that the small rural and all hospitals know what is going to happen a year in advance.

And I would finish by saying that we would be happy to work with you, Senator, as you look at this problem in your role as the chairman of the Subcommittee on Health, and look forward to working with you. Thank you.

[The prepared written statement of Mr. Jack W. Owen and answer to Senator Mitchell's question follow:]

STATEMENT OF THE
AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman, I am Jack W. Owen, Executive Vice President of the American Hospital Association (AHA) and director of its Washington Office. I am pleased to be here today, representing AHA's 5,600 institutional members, to discuss the issue of hospital payment rates under the Medicare program.

MEDICARE AND THE FEDERAL BUDGET DEFICIT

The prospective pricing system (PPS) was adopted by Congress as part of the Social Security Amendments of 1983 in an effort to ensure the long-term solvency of Medicare. The purpose of the new payment system was to establish positive incentives that would reward hospitals for reducing the rate of increase in hospital costs. The opportunity to earn a surplus was the positive incentive. In return, hospital managers accepted the risk of incurring sizeable deficits if costs exceeded the prospectively determined prices.

The system was not enacted as part of a budget bill. The original legislation explicitly directed the Secretary of Health and Human Services to set prices that were neither greater nor less than amounts that would have been paid for services if the new payment system had not been adopted. In short, the new payment system was to be used to promote the "efficient provision of quality care," and not as a means of reducing the growing federal deficit. Since passage of the Social Security Amendments of 1983, prospective pricing has, despite its auspicious beginnings, been used repeatedly as a primary instrument of deficit reduction. In Fiscal Years (FYs) 1986 and 1987, the Reagan Administration proposed legislative or regulatory initiatives that would have reduced DRG payments by $1.8 billion in FY 1986 and $455 million in FY 1987. In addition, substantial cuts in both direct and indirect graduate medical education allowances were proposed. These proposals were intended to reduce expenditures from the level that would have resulted from setting prices as directed by the original prospective pricing amendments. That is, they reduced payments below the "current services" budget, which presumably reflected a level of spending consistent with the original legislation. Although Congress subsequently intervened and increased payments by more than was proposed by the Administration, its action still yielded substantial budget "savings," and so was less than originally called for. The end result has been that Medicare has contributed disproportionately to the federal deficit reduction effort--even though Medicare Part A is funded entirely through the payroll tax system.

That prospective pricing has achieved its original goal is unarguable. In the first year, the Health and Human Services Secretary announced that the rate of increase in program outlays had fallen to the lowest level since Medicare was created. And recent reports from the trustees of Medicare's Hospital Insurance trust fund have announced a substantial improvement in the solvency of the program. Despite this success, policies have been dictated by considerations other than the viability and funding requirements of Medicare. The adoption of prospective pricing, combined with continuing concern about rising federal deficits, increases the urgency of finding a way of ensuring adequate funding for benefits promised current and future Medicare beneficiaries.

PROSPECTIVE PRICING: PRINCIPLES AND PROFITS

Prospective pricing was intended, by Congress, to create positive incentives to restrain the rate of increase in hospital costs by putting hospitals "at risk" for the difference between a fixed price and costs. Hospitals that increase their efficiency earn a surplus. Hospitals unable to keep costs within the price incur deficits. That is the theory. In practice, it is important to recognize that, under prospective pricing, hospitals are "at risk" for more than their own efficiency. They also bear the risk of admitting patients who require extraordinary treatment and incur extraordinary costs. For this reason, hospitals need to earn a surplus on Medicare payments. The only alternative is to shift a part of the cost of treating Medicare patients to private patients--an increasingly difficult task in today's competitive health care system.

The "savings" that are discussed each year during the debate over the federal budget are above and beyond those that the prospective pricing system was intended to produce. Those savings were never intended to be produced by arbitrary "ratcheting" of prices. Instead, savings were to be produced by holding the annual rate of increase in prices to a level closer to the rate of increase in the hospital marketbasket. Throughout the 1970s, hospital costs rose on a per case basis substantially more than the marketbasket. Holding the rate of increase in prices to the hospital marketbasket would have produced substantial savings for the Medicare program; limiting prices to less-than-marketbasket increases have produced even greater savings. More important, holding the annual rate of increase in costs to the rate of inflation is a challenging goal for hospital managers. To insist on more than this, year after year, jeopardizes the ability of hospitals to provide access to high quality care without depending on subsidies from privately insured or self-paying patients.

Recently, the General Accounting Office (GAO), the Congressional Budget Office (CBO), and the Prospective Payment Assessment Commission (ProPAC) have called attention to "profits" earned by hospitals during the first year under prospective pricing. These reports are troublesome for several reasons.

First, the data on "profits" under PPS that are being discussed by CBO, ProPAC, and others, and that have attracted public notice, are from 1984--the first year of operation under the system. These "profits" were earned more than three years ago. No data have been presented or are available on the adequacy of current prices, let alone the adequacy of prices in FY 1988. Subsequent updates since the first year of PPS have fallen behind hospital inflation by approximately 50 percent. For FY 1988, Congress has directed that prices rise only by marketbasket minus 2 percent; in dollar terms this reduction will reduce any surplus--or increase any deficit--by approximately $800 million in FY 1988.

Thus any surplus earned in the first year will have been cut by more than half by subsequent below-marketbasket increases in prices. The data that have been presented also focus on overall or average operating margins. These averages conceal tremendous variations in individual hospital financial performance. Even in the first year of prospective pricing, significant numbers of hospitals--particularly rural hospitals--experienced Medicare operating deficits, and recent projections by AHA indicate that the number of hospitals

operating at a deficit has risen significantly. AHA projections for FY 1988 indicate that approximately 33 percent of all hospitals will experience an operating deficit, and 15 percent will experience a deficit of greater than 10 percent.

Although CBO, ProPAC, and others have attempted to estimate Medicare operating margins for more recent years, no one can do more than project first year margins. No actual data on later years have been presented. AHA has attempted to collect actual data on Medicare costs for later years, but finds that changes in the Medicare cost report effectively preclude the development of reliable data on costs--at least in the near term and without substantial additional effort. Our efforts to project costs based on historical data, and based on the assumption that hospitals have been able to hold the annual increase in costs to the hospital marketbasket, indicate that Medicare operating margins have fallen substantially since the first year of payment under PPS, until by FY 1988, operating margins--if present at all--would at best be less than half those reported in the first year. Estimates prepared by other organizations will differ from those prepared by the AHA, but differences will represent variations in the assumptions employed--not any hard evidence of actual changes in Medicare costs.

The only hard evidence that the reported 1984 Medicare operating margin is overstated is provided by changes in overall operating margins computed by comparing revenues received from patient care to total costs. It is true that operating margins rose from 1.6 percent in FY 1983 to 2.2 percent in FY 1984, and then declined to 2.1 percent in FY 1985. It is also true that since that time operating margins have been declining sharply: in FY 1986, operating margins were only 1.0 percent.

Medicare may have contributed to the increase in operating margins between 1983 and 1985, but it is unlikely that Medicare accounted for all of the increase. In late 1984, the overall net patient revenue margin reached approximately 2 percent. To have earned a 2 percent margin if operating margins on Medicare patients were actually 12 to 15 percent as reported on cost-reports submitted in 1984, hospitals would have had to have experienced a loss on non-Medicare patients of between 5 and 7 percent. For this to have occurred--given that hospital charges continued to rise between 1982 and 1984 and have continued to rise since then, and that total per case costs rose by nearly 9.7 percent over the same period--the cost of treating non-Medicare patients would have had to increase by more than 15 percent. None of these assumptions is reasonable, suggesting that the "profits" earned by hospitals on Medicare patients are an accounting artifact and not an economic reality.

A third source of skepticism concerning reported "Medicare operating margins" is the questionable validity of the Medicare cost-finding process used to estimate 1984 Medicare inpatient operating costs. Data collected from hospitals even in the first PPS year are likely to understate costs for several reasons. First, to determine Medicare's share of "routine" costs, the cost-finding method used in the cost report assumes that Medicare and non-Medicare patients use the same services and incur the same costs. At one time this may have been true, but the recent changes in utilization patterns by Medicare and non-Medicare patients render the assumption questionable today. The days of inpatient care that have been eliminated tend to be the lower-cost days at the end of a hospital stay. The Medicare patients who are now admitted to hospitals are more seriously ill and require more intensive

care than Medicare patients admitted a few years ago or than non-Medicare patients admitted today.

In addition, between 1982 and 1985, the relationship between Medicare and non-Medicare utilization changed dramatically. Most important was a significant and unprecedented 16.5 percent decline in the number of over-65 patient days caused by a 2.9 percent decline in the number of over-65 admissions and a reduction of 14.1 percent in the average length of stay of patients aged 65 or older. During the same period, the number of admissions and length of stay of patients under the age of 65 declined 19.1 percent and 6.5 percent, respectively. Looking at Medicare patients, it appears that Medicare patient days now account for a smaller percentage of total patient days than was the case a few years ago. The downward shift in the percentage of inpatient days accounted for by Medicare patients may simply shift the percentage of routine and overhead costs assigned to Medicare. The actual cost of treating a Medicare patient really changed by more than suggested by Medicare cost report data. If a more accurate method of determining the cost of treating Medicare patients were used, a more accurate--and probably lower --estimate of operating margins would be available.

Some evidence supporting this argument is provided by trends in total per diem costs. Although per case and total costs experienced a sharp reduction in 1984 and 1985, per diem costs continued to rise at a rate well above the hospital marketbasket. Given the fact that a significant percentage of the reduction in total patient days was accounted for by Medicare patients, this pattern is consistent with the previously outlined argument. A much smaller increase in the average per diem costs of hospitals would have been observed during the period from 1984 through 1986 either if Medicare patients incurred the same costs as non-Medicare patients or if shorter lengths of stay have been achieved by eliminating the lower-cost days at the end of a patient's stay. This pattern is reassuring on another count as well: it suggests that patients who need the intensive services available in hospitals are kept in the hospital and that the reduction in the average length of stay of Medicare patients has been achieved while protecting quality.

FY 1988 UPDATE FACTOR

Since 1984 the increase in prices paid to hospitals under PPS has fallen far behind inflation. By 1987, the hospital marketbasket--which measures the prices paid by hospitals for the resouces consumed in providing care to patients--is expected to be 13 percent higher than in 1984, the first year of prospective pricing, yet prices will have increased by only 5.6 percent. And in FY 1988, Congress already has directed the Secretary to limit the DRG update factor to the rate of increase in the hospital marketbasket minus 2 percent. Repeatedly limiting hospital updates to significantly below the marketbasket has produced substantial savings for Medicare while challenging hospital managers to continue to provide access to high quality care for beneficiaries.

In principle, the AHA believes that limiting increases in prices to the rate of increase in the hospital marketbasket is a reasonable goal and responsible public policy. In addition, to address the problem of differences in urban and rural rates of payment, we recommend that the rate of increase be slightly higher for rural than for urban hospitals.

Finally, PPS-exempt hospitals should be granted a separate update for FY 1988 of no less than the marketbasket.

REBASING

Recent reports by the CBO and GAO have suggested that additional budget "savings" can be achieved by reducing payments to hospitals under PPS. Proponents of cuts in payment point to the "profits" discussed in the previous section to justify "rebasing" the system. Such proposals would be a fundamental break with the original design of PPS. Inherent in that design was the idea that hospitals should hold the annual increase in their costs to a reasonable level, representing inflation and a very modest allowance for technological advances during the first two years of the new system's existence.

In setting prices for subsequent years, the Secretary was granted broad authority to set a ". . . percentage increase [in prices] . . . which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." (Sec. 1886(e)(4) of the Social Security Act) Nowhere in this directive is any comparison of payments to costs as determined on the Medicare cost report even mentioned as a factor to consider in setting prices. The emphasis is on establishing a reasonable rate of increase within which hospital managers should strive to hold costs.

Hospitals have worked hard to respond appropriately and effectively to the new incentives--and the risks imposed on them--by the prospective pricing system. Hospitals are and should be proud of their achievement. Their pride is not in the fact that they have "earned a profit." Many hospitals, despite their best efforts, have actually experienced losses. Even these hospitals, however, can take pride in the fact that generally they have been able to respond to the incentives of a radically different payment system and manage the risks to which they have been exposed. Hospitals that have experienced losses believe that, given a fair chance, they will be able to manage those risks implicit in the new system. Operating margins, or "profits," or surpluses, are an essential element of this system. The possibility of incurring losses for reasons that have nothing to do with hospital efficiency requires hospitals to develop surpluses that can be used to offset losses during periods when an extraordinarily large number of high-cost patients are admitted. These risks are not trivial. For example, between the base year and the first PPS year, many hospitals were successful in holding down the rate of increase in their costs. Yet, a significant percentage of hospitals experienced increases in costs substantially more quickly than the average. In fact, many of the hospitals that had costs below the median in the base year ended up with costs above the median in the first PPS year. This pattern indicates that many of the hospitals experiencing a surplus of revenues over expenses in the first year will experience losses in the second year. It is to protect against such unpredictable swings, and to prevent them from jeopardizing the ability of a hospital to continue providing high quality care to all of its patients, that hospitals overall need to earn a margin or surplus under PPS.

The AHA supported the approach to setting prices reflected in the original statute, and opposes any effort to rebase the system for several reasons:

- As noted above, rebasing--setting prices based on Medicare cost reports submitted after the implementation of prospective pricing--is inconsistent with the original concept supported by the hospital industry. It is reasonable to expect hospitals to hold cost increases within the rate of increase in inflation as measured by the hospital marketbasket. Ideally, adjustments could be made for productivity, technology and other factors, but the necessary measures are not currently available. Until they are, AHA believes that limiting increases in prices to the rate of increase in the marketbasket is a reasonable goal and responsible public policy. AHA will, of course, continue to work to develop better methods of measuring other factors affecting costs, such as productivity, clinical practices and technology.

- Rebasing the system would largely destroy incentives that are essential to the continued effectiveness of the system. To give such incentives, and to provide hospitals with the reserves they need to bear the substantial risks implicit in prospective pricing, hospitals need operating margins. If an adequate operating margin is provided, it is likely that little change in the level of prices will result from rebasing--unless the rebasing is manipulated to produce artifical "savings."

- Using 1984 data to rebase prices that will be used to pay for services in 1988 makes little sense. Much of the reported first year margin will have been eliminated by the 0.2 percent increase in prices during FY 1986, the 1.15 percent increase in prices for FY 1987, and the scheduled increase of marketbasket minus 2 percent for FY 1988. Without knowing what costs actually are in a more recent period, there is no way of knowing whether rebasing the system will result in prices that are substantially less than costs. Under rebasing, AHA's projections indicate that the number of hospitals operating at a deficit would rise to 43 percent and the number of hospitals experiencing a deficit of 10 percent or greater would rise to 22 percent.

- Even in 1984, available data indicate that cost report data are giving an increasingly inaccurate picture of what it actually costs hospitals to produce the services provided to Medicare patients. This problem is particularly acute as neither hospitals nor the Medicare program anticipated using cost reports to rebase the system. To ensure Medicare was not arbitrarily shifting additional costs to the private sector, an intensive effort to resubmit and re-audit cost reports would be required.

- Rebasing the system will also exacerbate inequities that arise from the limited ability of DRGs to accurately reflect the types of patients admitted to different hospitals and the methods used to set prices. Until the adequacy of these methods has been assured and the principal deficiencies in the DRG system corrected, hospitals are at risk for far more than their efficiency. A reduction of 5 to 10 percent in prices will have a significant detrimental impact on hospital financial performance, particularly on those hospitals adversely affected by inequities that continue to exist, four years after enactment of amendments that created the system. Such

hospitals would have to either make significant changes in services, significantly increase charges to non-Medicare patients, or face a precipitous decline in their financial health.

- As noted in the previous paragraph, one additional effect of rebasing the system will be a substantial increase in the prices charged to non-Medicare patients.

CAPITAL

The Administration, in its proposed FY 1988 budget, has recommended that capital payments be folded into PPS over a total of 10 years. The April 1 ProPAC recommendation differs marginally from a similar recommendation in last year's report, and differs slightly from the current thinking of the Health Care Financing Administration. The key features of the Administration's proposal:

- A three-year phase-in of capital payments for moveable equipment;
- A 10-year phase-in of capital payments for fixed equipment; and
- An overall limitation on the level of the capital add-on based on recently enacted limits on cost-based reimbursements of capital-related costs.

Capital expenditures are of several types. Many of these types have significant implications for operating costs. Many capital expenditures, particularly those that expand capacity or involve addition of services, result in new operating expenses, which must be paid for using revenues received under PPS. Limitations on operating revenues created by PPS create a strong incentive that discourages unnecessary capital spending, even though capital costs continue to be paid on the basis of reasonable costs. In addition, it should be noted that recent reductions in the cost-based payment formula create a strong disincentive to undertake marginal capital projects, particularly in the increasingly competitive medical care system.

Our analysis of approaches similar to those proposed by both the Administration and ProPAC indicates that incorporation will sharply increase the number of hospitals experiencing substantial shortfalls between their capital payments and capital requirements. Very little information is available describing the methods used by ProPAC in its analysis. The AHA analysis, in contrast, is based on a direct comparison of hospital capital costs to the amounts they would receive after capital is fully incorporated in PPS and at various points during the transition. This preliminary analysis indicates that even with the split transition for fixed and moveable equipment:

- Nearly 30 percent of small hospitals (fewer than 1,000 admissions annually) and more than 30 percent of large hospitals (8,000 or more admissions annually) would experience a capital shortfall of 10 percent or more;
- Nearly 20 percent of small hospitals (fewer than 1,000 admissions annually) and more than 15 percent of large hospitals (8,000 or more admissions annually) would experience a shortfall of 30 percent or more;

- Approximately 40 percent of mid-sized hospitals would experience losses of 10 percent or more, and approximately 30 percent of these hospitals would experience losses of 20 percent or more;

- Nearly one-fourth of all rural hospitals and almost 35 percent of all urban hospitals would experience a loss of 20 percent or more; and

- More than one-fifth of all non-teaching and more than one-fourth of all teaching hospitals would experience a shortfall of 30 percent or more.

AHA has devoted and will continue to devote significant resources to development of a fair and adequate method of paying for capital by the Medicare program. But, on the basis of all currently available information, AHA has concluded that the only method of paying for capital that provides reasonable assurances of adequacy and equity is a continuation of the cost past-through. This position has the broad support of the hospital field and reflects a strong consensus among hospitals in all parts of the nation that none of the methods of paying for capital that has been proposed would result in either adequate or equitable payment.

AHA has attempted to evaluate comprehensively the impact of ProPAC's and the Administration's proposals on hospitals but lacks the information needed to perform the definitive evaluation. The data presented above, based on the information available, do strongly suggest that until the data needed for a more thorough evaluation are available, no change in capital payment policies should be enacted.

Therefore, AHA recommends that any action to incorporate capital into PPS be delayed until at least October 1, 1989, to provide additional time for development, evaluation, and refinement of an adequate and equitable method of paying for capital-related costs.

CONCLUSION

Prospective pricing was a bold step to reform the system of hospital payment in an effort to create positive incentives to control costs. As originally designed it won the broad support of the hospital industry. An essential feature of that design was the opportunity for hospitals to earn a surplus in exchange for their willingness to bear the risks inherent in a prospective pricing system, surpluses that could be used to improve services to Medicare and non-Medicare patients alike.

If some hospitals have been able to earn a surplus under the system, the system is working as it should. It has enabled hospitals to continue providing high quality care to Medicare beneficiaries at the same time that the Medicare program has experienced the lowest rates of increase in expenditures since it was created. To rebase the system--or to ratchet down the prices because hospitals reported surpluses in the first year of the program--would fundamentally change the original design, violate the basic trust of providers in the good faith of the federal government, and threaten the future delivery of high quality health services to beneficiaries.

Much of the discussion of surpluses also misses a fundamental point. The most recent complete data on Medicare costs are from 1984. Enormous changes have occurred in utilization since then, and Medicare costs in 1988 are likely to bear little relationship to costs in 1984. Moreover, since 1984, prices have been rolled back substantially by Congress, leaving a 10 percentage point gap between the rate of increase in prices and the rate of increase in the hospital marketbasket. Any surpluses that may have been earned in 1984 have probably been eliminated. There are no actual Medicare data available for more recent periods, and data for all patients indicate that costs have continued to increase and operating margins have declined sharply.

Finally, in the discussion of Medicare "profits" there has been little attention given to the need of hospitals to earn a surplus, given the risks they are carrying under PPS. Specifically, each DRG includes a significant number of high-cost patients who can completely wipe out the "profit" earned on large numbers of low-cost patients, and a hospital that earned a surplus one year may well incur a sizeable deficit the next. As originally set, the prices made no allowance for these risks. Hospitals have had to create this surplus by increasing their efficiency. It should not be taken away if their ability to continue providing high quality services to Medicare patients without relying on private-sector subsidies is to be preserved. An increasingly competitive private sector cannot and should not be expected to subsidize Medicare. Our common goal should be the development of a payment system that is fair, adequate and predictable, and that promotes the efficient delivery of high quality hospital care to the nation's elderly.

American Hospital Association

AHA

Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
Cable Address: Amerhosp

Jack W. Owen
Executive Vice-President

April 22, 1987

Honorable George J. Mitchell
Chairman, Subcommittee on Health
Committee on Finance
United States Senate
176 SROB
Washington, D.C. 20510

Dear Senator Mitchell

During the presentation of my testimony on Hospital Profits under the Prospective Payment System at the April 7 hearing, you asked me whether the American Hospital Association could provide your office with evidence that the increase in case mix severity within DRGs is due to increases in severity and not to code creep. I hope you will find the following analysis useful.

Because hospitals are being paid on the basis of a diagnosis, there have been substantial improvements in accurately coding the diagnosis. As you know, case mix changes are comprised of two components, real case mix changes and coding creep. As Mr. Roper's testimony indicates, if the trend of no observed case mix change continues, it suggests that hospitals are no longer unnecessarily benefitting from changes in DRG coding practices.

Price-level adjusted revenues (i.e., changes in patient revenues adjusted for changes in hospital charge levels) are an indication of the number and complexity of services received by patients over their stay. Overall, this indicator suggests that intensity of treatment received by hospital patients has increased for both Medicare and non-Medicare patients.

Between 1977 and 1982, using the hospital room component of the Consumer Price Index to correct for inflation, the number or intensity of services consumed by the average inpatient rose approximately 0.7 percent annually. Between 1984 and 1986, the post-PPS period, the annual rate of growth in the number of services or intensity of treatment received by the average patient rose to 2.6 percent--nearly four times the pre-PPS rate. If these figures are corrected for changes in case mix, the rate of change in intensity of treatment in the pre-PPS period falls to - 0.4 and +0.6 percent in the post-PPS period.

It is possible to distinguish between Medicare and non-Medicare patients for the period from 1983 to 1985, and these data indicate that the intensity of treatment of Medicare patients may have declined in 1984 and 1985, but that the trend is toward greater intensity. For example, in 1984, the hospital room component rose 8.8 percent, compared to an increase in Medicare gross inpatient revenue per case of 6.1 percent, suggesting a reduction in use of services by Medicare patients of 2.7 percent. Similarly in 1985, the hospital room component rose 6.7 percent, while Medicare gross inpatient revenue per case rose 6.9 percent, suggesting a 0.2 percent increase in use of services by Medicare patients. Because changes in room rate reflect rising intensity and changing case mix, and because much of the reduction in charges probably was the result of changes in average length of stay of Medicare patients, these figures are likely to understate the increase in intensity.

Should you have further questions please feel free to contact me.

Sincerely

Jack W. Owen
Executive Vice President

Senator MITCHELL. Thank you, Mr. Owen. On the question of rebasing, do you agree that the unaudited 1981 data used to set the rates contained significant costs that were later excluded on audit?

Mr. OWEN. Yes, they were. And that was an agreement that we made, really, with HCFA. Carolyn Davis was director at the time. The question was, how do you get started in a program like this? What data do you use?

And there was agreement that we would use the 1981 data; and in so using it, we would, as an industry, would not come back and say you used it all wrong, we are going to sue you, or do something like that. And they were willing to take a look at it and see how it was going to develop.

At the same time, the adjustment that would take place could really take place on the price, which they have. The market basket prices have gone up about 13.6 percent in those last four years, where the actual price to the hospitals only went up about 5 percent. So, there has been a readjustment of that price, so that you don't have to really look at the base, per se, because you have done it at the top side. And that is what Congress has been doing in setting the price. And that way, you have eliminated the need to tackle the base.

Senator MITCHELL. Let me ask it another way.

Mr. OWEN. All right.

Senator MITCHELL. If an employer makes a mistake and overpays his employee, the employee wouldn't be surprised if the employer later decides to correct the error. In this case, you are not even being asked to pay back what may have been overpayments—just to start from a different and correct base. It is hard for me to comprehend how you can acknowledge that there were significant costs in the 1981 data that were excluded on the later audit, and still say that there shouldn't be any rebasing.

Mr. OWEN. Okay. First of all, the question is whether they were really overpaid or not. I mean, it was agreed that there would be a price set for a DRG diagnosis, and that the price was established by the federal government—it was not established by the hospitals. In other words, the hospitals did not come out and say, this is our price on the basis of all the information. The government said, this looks like what your costs are. We said, yes, that looks like what your costs are. You have got to remember that the costs were there. The difference between the 1981 audited costs and unaudited costs were what Medicare allowed—it didn't mean that the costs were not there.

In other words, if the cost was $100, and after it was audited Medicare said, well, $10 of those $100 we won't pay for, because they are not part of our program, or that we don't consider them part of our program. But, the costs were still there. It is not a question of the hospital had put costs in that were not there, so that they were paid on the $90, let's say. Now, they said, okay, we are going to reduce your——

Senator MITCHELL. On that point, surely you don't suggest that the government should be responsible for all costs, regardless of their relationship, or lack thereof, to the program.

Mr. OWEN. No, and I wouldn't suggest that. Not at all, you are absolutely right, Senator. But, I am saying that if you give me the

right to set the price, if I realize that, okay, I have probably paid you too much in the first year and I said I am going to pay you market basket; now, I have cut that back each year by not paying what would be considered the price to move forward on.

You are correcting as you go along. You don't have to go back and say, now, well back in 1984, we overpaid you. And then the question is, well in 1986, did you underpay us? Will you come back and give us money in 1986 if we have been underpaid? The price was struck and we lived with it, one way or the other. That was the issue.

Senator MITCHELL. Do you think the 1984 data is as flawed as the 1981 data used to set up the payment system in the first place?

Mr. OWEN. Yes, I do. And the reason why, is because hospitals were not asked to keep cost data the same way they used to. They used to keep cost data just the way they were paid. The idea was to get rid of all cost reporting systems to go on a pricing mechanism.

If you said to me—and if I were running a hospital—and you said to me that, I am going to now pay you on the basis of cost. I am going to rebase those costs every year. I would make very sure that my costs were high enough to make sure that I got a good price.

That was the problem with the old system. We paid whatever those costs were, with the exception of those things that were not covered by the program—private rooms, television, whatever the case might have been.

And what we are doing is we are moving back to a system where you are going to have to keep accurate costs, and if you want to get a good price, you better keep your costs up. I think we run the risk of destroying the incentive of what the Prospective Payment System is all about.

Senator MITCHELL. Your Association has said that most of the apparent increase in case mix severity within the DRGs is due to true increases in severity and not to so-called co-creep. Could you provide the committee with any evidence you have to support that assertion? You don't have to do it now. Give me a letter on it.

Mr. OWEN. I would be happy to do that. I think that Dr. Roper's statement[1] also is proving that out.

[The information follows:]

Senator MITCHELL. All right. And I will have some other questions for you in writing that I ask you to respond to at your earliest convenience.

Mr. OWEN. All right. Thank you very much.

Senator MITCHELL. Thank you very much, Mr. Owen. We look forward to working with you and the others on this matter.

The hearing is now concluded.

[Whereupon, at 4:07 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

---

[1] See p. 62.

Statement for the Record
by
Richard P. Kusserow
Inspector General

Department of Health and Human Services
Before

The Subcommittee on Health of the
Senate Committee on Finance
on

Causes of Profits Earned by Hospitals Subject
to the Prospective Payment System

Richard P. Kusserow, Inspector General of the Department of Health and Human Services, wishes to enter this written statement into the record for consideration by the Senate Subcommittee on Health on the subject of profits earned by hospitals under the Medicare prospective payment system.

In an effort to control the growth of Medicare expenditures, Congress enacted a prospective payment system (PPS) for certain inpatient hospital services rendered during hospital cost reporting periods beginning on or after October 1, 1983. Under this system, Medicare payments would be based on fixed predetermined rates that represented the average nationwide operating costs of treating a patient for a particular illness (Federal rate). During a 4-year transition period, however, Congress provided that the PPS payments would be based on a blending of the Federal rate with a rate based on hospitals' historical reasonable costs. By FY 1988, hospital payments under PPS will be based entirely on the national average cost, or Federal rate, of treating a patient.

In addition to the predetermined payment rate for each allowable discharge, certain hospital inpatient costs, such as capital, direct medical education and bad debts, are excluded from the prospective payment system and continue to be paid to hospitals on a reasonable cost basis. Placing hospitals under a prospective payment system not only limits the growth of future Medicare expenditures but also gives hospitals an incentive to control their costs and either profit or lose from Medicare work, depending on their ability to keep costs below the predetermined PPS rates.

Although Medicare reimbursement for most hospitals is now based upon PPS, hospitals can exclude certain distinct units from PPS. The Social Security Act specified that PPS did not apply to psychiatric or rehabilitation distinct units meeting certain requirements or to alcohol/detox units. Hospital units qualifying for these exemptions continue to be paid on a reasonable cost basis.

Since inception of PPS, the HHS Office of Inspector General (OIG) and other government agencies have conducted a number of studies on the effects of PPS on the delivery of health services to Medicare beneficiaries and the financial implications for participating hospitals. These studies have shown that PPS hospitals, in general, have earned substantial profits by treating Medicare inpatients. Specifically, the studies show that:

- 1985 hospital profit rates from PPS averaged 15.27 percent, up from 14.18 percent in 1984.
- 1985 PPS hospital profit amounts averaged $1,037,314, up from $939,207 in 1984, about 10.44 percent improvement.

- Projected total net PPS 1985 profits for all hospitals increased by about $500 million, from $4.6 billion for 1984 to $5.1 billion in 1985.

- 1985 Medicare inpatient discharges decreased by 5.63 percent at surveyed hospitals.

- 80 percent of surveyed hospitals earned PPS profits in 1985 and 20 percent incurred a PPS loss, the same result in 1984.

These profits have been partially the result of overstated initial (1984) PPS rates that were improperly based on inflated hospital inpatient operating costs for the 1981 base year used by HCFA for setting the Federal portion of the PPS rates. The attached OIG report summarizes the OIG and General Accounting Office (GAO) reviews that have identified base year errors contributing to the overstated PPS rates and makes recommendations for correcting these errors through alternative forms and levels of rate rebasing.

Five OIG and GAO reviews conducted from January 1985 through April 1987 have pointed out flaws in the base year (1981) hospital inpatient operating cost data used by HCFA for initial PPS rate setting. These flaws caused an identified overstatement of at least 6.84 percent in the standardized average Medicare cost per discharge used to derive the Federal portion of the PPS rates for 1984, the first PPS year. This overstatement was the result of the unintentional inclusion in the baseline hospital cost data used for PPS rate setting of the following types of costs which should have been eliminated or excluded from the total allowable hospital inpatient operating costs from which PPS rates were computed:

Item	Percentage of Overstatement of Baseline Costs
Capital costs paid as a pass-through	2.70%
Exempt unit costs reimbursed separately from PPS	.96%
Education costs paid as a pass-through	.20%
Unallowable costs due to use of unaudited data	2.98%
Total Overstatement	6.84%

For the initial PPS year, therefore, the Federal portion of the PPS rates was set about 6.84 percent too high because of the errors in the base data. Since these errors have not been corrected in the annual PPS rate updates since 1984, future PPS rates should be reduced by at least this level to deflate the PPS rates to their proper initial values.

All of these studies concluded that initial PPS rates were overstated because of HCFA's unintended use of inflated hospital inpatient costs reported for the base year period, 1981. Since hospitals earned profits from PPS averaging 14.18 percent in 1984 and 15.27 percent in 1985, the 6.84 percent of overstated costs incorporated into the initial rates were a major cause of the average hospital profit levels. However, all of a hospital's profits cannot be ascribed to the incorporation of unallowable costs in the data. In response to the implementation of PPS in 1983, studies show that hospitals also significantly reduced their cost of operations.

HCFA has two general options in adjusting PPS rates. Our most favored approach, called rebasing, would recompute baseline cost per discharge data using more recent audited cost data. This approach would eliminate the effect of overstated costs in the initial PPS rates. We have previously recommended that HCFA rebase the PPS rates using audited cost data to correct for deficiencies in the present data and to reflect recent hospital behavior under PPS incentives. Since HCFA has not acted on our prior recommendations, we again recommend that HCFA clarify the legal bases to rebase. And, after obtaining authority to rebase, HCFA should recompute PPS rates using the most current audited cost data and rebase the DRG rates again after the full transition has been made to a 100 percent Federal rate.

The second approach is to adjust PPS rates for overstated costs and hospital behavioral changes through an annual update factor. In this approach, the update factor would be set to both adjust for unallowable costs now reimbursed to hospitals under PPS and consider the cost implications of other changes in the delivery of inpatient care. Therefore, should Congress choose to defer rebasing at this time, it should take into consideration the inflated nature of the current system when determining the update factor.

I want to thank the members of the Subcommittee for giving us an opportunity to enter this material into the record. The OIG is available if members of the Subcommittee wish to discuss our findings and conclusions in greater depth.

HEALTHCARE
FINANCIAL
MANAGEMENT
ASSOCIATION

1050 17TH STREET NW
SUITE 510
WASHINGTON, DC 20036
TELEPHONE 202/296-2920

STATEMENT OF THE
HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

About HFMA

The Healthcare Financial Management Association (HFMA) is a professional membership association composed of over 25,000 individuals in 75 chapters who share an interest in financial management of hospitals and other healthcare institutions. These are the individuals with primary responsibility for the fiscal health of hospitals and other institutional healthcare providers across the country.

HFMA operates a Financial Analysis Service (FAS) which provides each subscriber hospital with an annual report of its financial performance compared to other providers in our database. Financial performance is measured in terms of 29 ratios in five major categories; profitability, liquidity, capital structure, activity, and other. Annually we publish the "Hospital Industry Analysis Report" based on our FAS data.

During late 1986, HFMA undertook a survey to collect current financial information including information about profits from patient care services and services to Medicare beneficiaries. The results of the study are referenced in this testimony and a copy of the report is attached.

The Change in Medicare Payment Arrangements

From its inception, until the introduction of prospective price setting (PPS), Medicare paid institutional healthcare providers on a cost basis. Over the years, Medicare's definition of "cost" became so distorted that the effect of the former system was the equivalent of Medicare saying, "Whatever you spend, Medicare will pay a portion of it. If you spend more, we'll pay more; if you spend less, we'll pay less -- but we'll never pay all the costs necessary to provide service to Medicare beneficiaries." This was a true "cost-minus" payment formula. No managerial initiative to save money could offset the effect of the formula and avoid a Medicare payment shortfall.

Under the former arrangement, there was no alternative but for hospitals to charge payers other than Medicare more than their prorata share of cost to make up for the unavoidable shortfall. This payment deficiency grew over the years.

The PPS system, on the other hand, allowed hospitals to institute operating economies to bring the cost of operations down to match the amounts that Medicare indicated it was willing to pay. In the first and second years of PPS, many hospitals found it unnecessary to make price increases to other payers because Medicare cost and revenue were in closer balance than had been

true in previous years. It was widely recognized in the first year of PPS that many hospitals were doing well financially. However, this is not necessarily evidence that PPS rates were too high since payments by payers other than Medicare did not yet fully reflect the operating economies achieved by hospitals.

Furthermore, it was quite apparent from the beginning of PPS that rates could be established arbitrarily and the incentives inherent in the initial program would probably be short lived. Congress made this apparent almost immediately be reducing the portion of the original formula that recognized technological improvements. Since then the Administration has been even more arbitrary in overriding the initial provisions for adjusting rates to reflect inflation. Thus, hospitals were quite prudent in their decisions to keep rates charged to other payers at a level which might again be able to subsidize deficiencies in Medicare payments and to restore the financial condition which was undermined by earlier Medicare payment arrangements.

Hospitals responded to new Medicare incentives very promptly; to the benefit of both the hospital and the Medicare program. The government has saved billions of dollars per year over what would have been spent under former arrangements. We see no sin in hospitals making a modest operating margin, or "profit," even

when dealing with the government as the purchaser. After the fact criticism of achieving the objectives that were established undermines the constructive relationship that must exist.

Profitability Levels and Trends

HFMA has been concerned that many important decisions about Medicare's PPS system are being made on the basis of dated information. Hospitals are in an environment of rapid change, and data from a few years ago is not valid for today's decisions. We are concerned that Congressional decisions about rates of payment for Medicare services are based only on data about hospitals' financial operations in the first or second year of prospective price setting. Accordingly, the effect of recent legislation on years three, four, or future years are not being adequately considered.

Because of this concern, we asked chief financial officer members of HFMA to provide current financial information about their organizations. About 950 responses were received. The results include data from 614 surveys that were received by the processing deadline and had fully useable data.

The survey asked for hospital data from four fiscal years -- two years ago, last year, the current and next year. Hospital fiscal

years end on various dates. For a hospital with a year end of December 31, the years reported would have ended December 31, 1985, 1986, 1987, and 1988. The survey's findings about overall patient care profit margins and Medicare profit margins follow.

Margin from Providing Patient Care Services

	Profit %	Annual Change	3-year Change
2 years ago	3.6		
last year	2.1	down 42%	
current year	1.2	down 43%	
next year	.9	down 25%	down 75%

Profit margins from patient care reflect profitability from all such services, not just Medicare. This decline since PPS began reflects increased discounting from established charges; increasing costs of services; shifts to outpatient; and, of course, reductions in Medicare payment and the move to national rates.

Margin from Serving Medicare Patients

	Profit %	Annual Change	3-year Change
2 years ago	5.3		
last year	4.5	down 15%	
current year	1.5	down 66%	
next year	loss 1.1	down 173%	down 121%

April 7, 1987

In the survey, we asked hospitals to report the cost of serving Medicare patients. This was not necessarily from the Medicare cost report. Since Medicare cost reporting defines what costs Medicare wishes to pay, rather than the true cost of treating patients, hospital-specific data represents the best indicator of actual costs.

The Inspector General's Profitability Data

The profit (or loss) on serving Medicare patients presented above is in sharp contrast to the HHS Inspector General's (IG) reports of profits as high as 14 percent or 15 percent on these activities. Several factors contribute to this difference, including:

1. The IG's report of high profit on Medicare is inconsistent with well-documented profitability from operations for the industry. HFMA's FAS, which has compiled audited financial report information from approximately 1,400 hospitals, shows overall profit in 1984 and 1985 of 3.9 percent. These years roughly coincide with the first and second years of PPS. Medicare comprises 34 percent of total net revenue, according

to HFMA's profitability survey. A loss on all of the 66 percent of non-Medicare activities is required to produce a Medicare profit of 15 percent. This result is clearly illogical.

2. The IGs profit percent calculation substantially overstates profitability because it excludes Medicare payments for capital-related cost, direct medical education, and bad debts. The following example illustrates how the exclusion of these factors inflates the percentage.

   If a hospital has a profit of $50 on Medicare payments of $1,000, it has a 5 percent profit. By excluding $200 in such costs as capital, direct medical education and bad debts, as the IG has done, the profit of $50 is divided by $800 yielding a 6.25 percent profit.

   Note that while the precentage increases the actual profit level in dollars remains unchanged. Accordingly, the calculation method selected by the IG artificially increases the profit percent.

April 7, 1987

3. The costs reported on the Medicare cost report do not accurately describe and in many cases understate Medicare costs. Examples of Medicare inaccuracies in calculating the cost of serving Medicare patients include:

   - o failure to correct PPS rates for court decisions,
   - o a formulae for allocating malpractice, bad debt, and home office cost that results in Medicare paying less than its proportionate share of these costs,
   - o using data about non-Medicare maternity services to dilute the calculation of the average daily cost of Medicare services,
   - o failure to pay any share of the cost of serving indigent patients or costs of ownership; and,
   - o failure to recognize the higher cost of serving elderly patients.

pril 7, 1987

4. The IG report fails to project the effect of existing rules and payment rates on future profitability. It is also appropriate to consider the artificial reductions in rates that have offset real increases in case complexity. HFMA's survey clearly shows the significant decline in profit resulting from these rules and payment rates.

Conclusion

Attention to the fiscal health of hospitals is timely. The first and second years of PPS demonstrated that with new incentives, hospitals could save money. Both hospitals and the government benefited. Industry data shows, as expected, improvements in profitability during those first years. The IG's methodology is flawed and brings unwarranted attention to the level of hospital profits. The fact is that Medicare profitability has never been high and is declining. It would be unfortunate if payment rates were reduced (via rebasing or artificial offsets to payment rates) because of a misperception about true profitability levels. Such adjustments would unnecessarily handicap providers attempting to respond to previously required but unimplemented payment restrictions. We conclude that rebasing is unwarranted and unnecessary and urge you to affirm your earlier decision to pay no less than the market basket minus 2 percent as an update factor for fiscal 1988 Medicare rates.

April 7, 1987

The National Association of Private
Psychiatric
Hospitals

1319 F Street, NW, Suite 1000, Washington, DC 20004 • 202-393-6700

April 2, 1987

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
SD-205 Dirksen Building
U.S. Senate
Washington, D.C. 20510

Dear Mr. Chairman:

On behalf of the National Association of Private Psychiatric Hospitals, the National Association of Children's Hospitals and Related Institutions, and the National Association of Rehabilitation Facilities, we respectfully request that this letter be included in the Committee on Finance, Subcommittee on Health hearing record of April 7, 1987 on the subject of the update factor for PPS and PPS-exempt hospitals.

Last year, Congress clarified in the Sixth Omnibus Budget Reconciliation Act that the statutory provision which authorizes annual hospital payment increases, allows for separate rates of increase for PPS and PPS-exempt facilities. In addition, the Senate Finance Committee stated in its report accompanying the reconciliation bill, that "It is the committee's view that the criteria utilized to develop the update factor for PPS-exempt hospitals should be specific to the operation of these facilities." This year, Congress will determine the update factors for PPS and PPS-exempt hospitals. We would urge you and the Committee to recommend a separate rate of increase for PPS-exempt hospitals.

Each year since the beginning of the PPS, the Prospective Payment Assessment Commission (ProPAC) has recommended a separate rate of increase for PPS-exempt hospitals. This year, ProPAC will recommend a 4.4% increase for PPS-exempt hospitals, while the recommendation for DRG hospitals will be 2.3%. These ProPAC recommendations are consistent with the congressional requirement that the increase in FY88 hospital payments --PPS and PPS-exempt -- do not exceed market basket minus 2%. The reasons for the higher recommendation for PPS-exempt facilities are straightforward and logical.

First, the argument about rebasing does not apply to PPS-exempt hospitals. Under the per case cost limit, PPS-exempt hospitals receive an incentive payment (above actual current costs) of no more than 5% of the per case target rate, while PPS hospitals retain the full difference between the DRG payment and their costs.

Second, PPS-exempt hospitals are not able to increase their revenue by upgrading the coding of cases (DRG Creep). In calculating an update factor for PPS-exempt facilities, there should be no adjustment for "DRG Creep" since excluded hospitals are not paid on a DRG basis. In past years, failure to establish a separate update factor has penalized PPS-exempt hospitals for a phenomenon that was not applicable to their payment system.

Third, the PPS hospital "site substitution" factor is inapplicable to PPS-exempt hospitals. The "site substitution" factor avoids double payment by reducing DRG payments where services originally included in the DRG fixed rate have been shifted to the outpatient sector. SiSince exempt hospitals are only paid for services actually provided there is no need for a "site substitution" adjustment.

Finally, both ProPAC and HCFA calculate separate market baskets for the different types of PPS-exempt hospitals because they recognize the different mix of inputs used in providing care in these specialized settings.

During the last few years, over 1700 hospitals have been negatively affected by the issuance of a single rate of increase for both PPS and PPS-exempt hospitals. Although the ProPAC recommendation moves toward a correction of this problem, it does not make up for the past shortfalls in the update factor for PPS-exempt hospitals. Therefore, it is imperative that Congress build upon its actions of last year and set a separate and adequate update factor for these hospitals. Although payments to PPS hospitals will increase in proportion to their update factor, the PPS-exempt hospitals' update factor affects only the target per case limits.

Your strong support and leadership in assuring fair and adequate payment for all hospitals is greatly appreciated. We look forward to working with you and the Committee in crafting a reconciliation bill that establishes a separate and fair Medicare payment increase for PPS-exempt hospitals.
On behalf of:

National Association of Private Psychiatric Hospitals,
Robert L. Thomas, Executive Director
National Association of Children's Hospitals and Related
Institutions, Robert H. Sweeney, President
National Association of Rehabilitation Facilities, Carolyn
Zollar, General Counsel and Associate Director for Medical
Rehabilitation

cc: Members, Senate Finance Committee

National Rural Health Association
301 East Armour Blvd., Suite 420, Kansas City, Missouri 64111, Telephone (816) 756-3140
Kevin Fickenscher, M.D., President Robert T. Van Hook, Executive Director

Statement of the
National Rural Health Association
to the Subcommittee on Health
Committee on Finance
United States Senate

April 7, 1987

The National Rural Health Association (NRHA) wishes to express its appreciation to the Chairman and members of the Subcommittee for holding this hearing on Medicare hospital payment rates. NRHA has been particularly pleased to note this subcommittee's sensitivity to and concern for the difficulties rural hospitals face under Medicare's Prospective Payment System (PPS).

It is important to keep in mind when considering PPS payments to rural hospitals that almost a quarter of the entire U. S. population, and about a third of our nation's elderly, live in rural communities.

Rural poor outnumber inner-city poor. A higher rate of our nation's uninsured and under-insured are rural Americans. Further exacerbating the situation of rural health care, according to data from the 1980 National Medical Care Utilization and Expenditure Survey and the 1982 HCFA-SRI study, the elderly who have lower incomes and greater health care needs are the most likely to rely solely on Medicare coverage.

There are higher concentrations of low-income elderly in rural America, and they rely on rural hospitals for their care. As you consider changes in PPS for Fiscal Year 1988, NRHA urges you to continue to pay special attention to rural hospitals, and the need to ensure the viability of rural hospitals in order to maintain the health care delivery system throughout rural America.

The recently released Prospective Payment Assessment Commission (ProPAC) report entitled, "Medicare Prospective Payment and the American Health Care System" presents some telling evidence about the effects of PPS on rural hospitals. ProPAC notes that there are significant differences, some systematic, in how well hospitals were succeeding financially in the first year of PPS.

Of the 5700 hospitals under PPS, about half of the hospitals are located in urban areas, and half in rural areas. Yet rural hospitals account for only about 16% of PPS payments. As a group, rural hospitals had a first-year PPS margin of less than 9 percent, compared with 16 percent for urban hospitals. And in the 25th percentile, margins for of rural hospitals were less than -0.2%, while first-year margins in the 25th percentile for urban hospitals were 7.8%. Across the board, small rural hospitals -- those with fewer than 50 beds -- had particularly low margins. Ten percent of these hospitals had margins of -18.4 % or less.

Being on the rural side of a Metropolitan Statistical Area (MSA) county line is costing most rural communities hundreds of thousands of dollars each year. About two-thirds of rural hospital patients are Medicare beneficiaries, compared to an average of one-third for urban hospitals. Rural hospitals, even though they treat higher proportions of Medicare beneficiaries, do not treat the large numbers of patients necessary to survive under a payment system based on averages. Their censuses and case mixes vary greatly, and they are falling uniformly at the low end of the scale.

The Prospective Payment System was intended to provide incentives to hospitals to increase efficiency in order to achieve savings. PPS was not intended to discriminate, but to provide adequate operating margins for all hospitals and thus assure availability of care to Medicare beneficiaries.

The ProPAC report has codified evidence many had considered anecdotal: rural hospitals' operating margins are half that of urban hospitals. Rural hospitals have had the highest rate of financial failure since the start of PPS. PPS was instituted with an urban/rural payment differential based on perceived differences in operating costs. But, clearly, the PPS concept of "separate but equal" is not working for rural hospitals.

Using geographic boundaries for payment differentials between urban and rural hospitals defies true market conditions, and places rural hospitals in a situation of untenable financial risk. NRHA believes that changes must be made to PPS to eliminate the inherent bias against rural hospitals. NRHA urges the Subcommittee to look behind the averages.

NRHA recommends several changes in PPS for the consideration of the Finance Committee.

Equity With National Rates

NRHA believes that DRG reimbursement for all hospitals, rural and urban, in each state should be based on one rate. Modification from a single rate should be permitted only as a result of variations in non-professional labor markets, hospital-specific variations in severity of illness, or cost-of-doing-business adjustments for inner-city hospitals with disproportionate share status. The single rate should be instituted as soon as possible to avoid further economic dislocations to rural hospitals as a result of the current discriminatory bias in PPS.

Area Wage Index

The area wage index is intended to adjust Medicare payments to reflect labor costs to hospitals in different geographic areas. However, it actually calculates wage variations among Metropolitan Statistical Areas (MSAs). All rural areas within a state are now assigned the same wage index, which does not accurately reflect wage costs in the non-metropolitan hospital labor market areas.

ProPAC has recognized the inequity of the present urban-rural division, and has recommended revising the area wage index to reflect more accurately local labor markets. NRHA supports a revision in the area wage index, but is concerned that implementing ProPAC's recommendation for a subdivision into "urban rural" and "rural rural" labor market areas might further endanger remote hospitals. The necessary protection for hospitals on the edge of MSAs must not come at the expense of more remote hospitals.

NRHA supports a redefinition of the area wage index into separate components to distinguish between the different types of hospital employees: e.g., health professionals and other employees, or skilled and unskilled employees.

Given that small rural hospitals attribute a greater proportion of their expenses to labor costs than other hospitals, NRHA supports a study to determine whether the current ratio of labor to non-labor costs of the standardized rates results in fair payments to small rural hospitals. It may be appropriate to use separate ratios by class of hospital of labor cost to total cost.

Outliers

Current outlier payments affect small and rural hospitals disproportionately; these hospitals' size puts them particularly at risk. Recognizing this, the Congress included a provision in the Sixth Omnibus Budget Reconciliation Act establishing separate outlier pools for urban and rural hospitals. NRHA supports further study of outlier expenditures, and recommends that HHS or an independent advisory council such as ProPAC be required to report to Congress on the impact of expenditures from the outlier pools. In addition, **NRHA recommends further study of the criteria used to determine eligibility for day and cost outliers, to determine whether current outlier policies are effective in preventing small and rural hospitals from suffering severe financial hardship due to outlier cases.**

Rural Referral Centers

Under current law, hospitals classified as Rural Referral Centers are paid at the urban rate. However, many rural hospitals act as referral centers for only some of their services. The current "all or nothing at all" system does not account for those hospitals. **NRHA believes the definition of rural referral center should be modified to include special payments to rural hospitals on a "service provided" basis for services in specific DRGs that are proportionately equal to or higher than the average for urban hospitals, determined by volume. Rural hospitals that qualify as Partial Rural Referral Centers should be paid the urban rate for those qualifying services.**

Sole Community Providers

ProPAC has recognized the need to clarify the qualifications for hospitals to be designated Sole Community Providers (SCPs), and to extend volume protection to SCPs. NRHA supports these recommendations.

NRHA would also urge the Subcommittee to consider further study of whether current geographical and mileage standards are appropriate. **NRHA believes SCP status should be granted to a hospital if no other hospitals are located within a 30-minute driving distance, or if it is the sole hospital in a county.** In addition, in order to preserve the infrastructure of health care providers in rural areas, **NRHA supports Medicare reimbursment for SCPs with negative operating margins at cost;**

i.e., Medicare income for SCPs with negative operating margins should equal Medicare costs, so that Medicare is not exacerbating those hospitals' financial hardships.

Quality of Care Review

Small rural hospitals have a number of concerns regarding quality review activities conducted by Peer Review Organizations (PROs). Currently, most reviews of small rural hospital cases occur off-site, away from the hospital setting. **NRHA recommends that a specific percentage of PRO reviews of rural hospitals should occur on-site.**

Criteria for quality review often vary among PROs, and hospitals and health professionals are not always able to determine the standards by which they are judged. **NRHA supports requiring that health care providers be informed in writing of the specific criteria used for judgment. In addition, NRHA supports an appeals process that includes either telephone or in-person contact between the PRO and the provider under review.**

As the Finance Committee heard recently in hearings, sanctions against health care providers have impacted rural areas disproportionately. Sanctions imposed on one or more providers in a rural community may leave beneficiaries with limited or no access to medical services. **NRHA believes that consideration should be given to the impact sactions will have on beneficiaries' access to medical services in the community.**

NRHA recognizes the Subcommittee's extremely difficult position vis a vis the budget situation. However, as the Chairman and members of the Subcommittee are well aware, rural hospitals are at a critical crossroads. Their survival is threatened, and the preservation of a network of rural hospitals is essential to the maintenance of a health care infrastructure that will serve the one-third of our elderly who are rural Americans. We therefore urge you to carefully consider the disproportionate impact of PPS on rural hospitals, and to make needed adjustments to the system to ensure the survival of rural hospitals.

Thank you.

ST. VINCENT MEDICAL CENTER

COMMENTS ON MEDICARE'S PAYMENTS TO HOSPITALS

St. Vincent Medical Center, is a not-for-profit, 646 bed, urban, tertiary care facility located in Toledo, Ohio. St. Vincent was established in 1855 by the Grey Nuns of Montreal, Canada as the first hospital in Toledo. In our fiscal year 1986, we generated gross revenues in excess of $149 million.

The mission of the Grey Nuns was, in 1855 and still is today, to provide health care to anyone regardless of the ability to pay. In keeping with this mission, St. Vincent provided uncompensated care to the community in 1986 valued in excess of six million dollars.

In addition to uncompensated care, St. Vincent is also one of the ten largest providers of services to Medicaid beneficiaries in the State of Ohio, as well as the largest provider of services to county welfare recipients in Lucas County.

St. Vincent entered the Medicare program in July of 1966. From then until 1983, we were reimbursed by Medicare for the "reasonable cost" of providing care to Medicare beneficiaries. Examples of costs that are not considered reasonable are such things as advertising intended to increase patient utilization, the cost of providing patients with a telephone, and the excess cost of providing meals to visitors and guests over the revenue collected for those meals.

In addition to costs not considered reasonable, most non-patient revenue generated by hospitals is used to reduce total costs. An example is income generated by investments.

All told, reasonable cost for Medicare reimbursement purposes in the case of St. Vincent was approximately 95% of total cost. The perception that hospitals broke even from Medicare was simply never true. Hospitals were reimbursed at less than total cost, therefore, they lost money.

Despite popular opinion, hospitals are cost conscious. Not all of our business is related to Medicare. Some third parties pay billed charges. In order to make modest profits under the cost reimbursement system where we recovered less than our cost, hospitals had to contain costs to maximize profits from these payors.

The public's perception of rising hospital costs is what they see on their hospital bill. What they don't understand is that hospitals do not, for the most part, collect this amount. Exhibit 1 attached, shows our last three years revenue billed and collected. It is apparent that our percentage of revenue collected is falling at an alarming rate.

What is the reason for this decline? The answer is the Medicare Prospective Payment System (PPS).

When Medicare introduced PPS in 1984, hospitals were promised a system that would afford them the opportunity to do something never before possible, make a profit from providing care to Medicare patients. By keeping costs less than the prospectively determined payment amount per DRG, hospitals could keep the difference. If costs exceeded the payment, it was up to the hospitals to take appropriate measures (i.e. reduce costs or close their doors). The system put all the pressure on the hospitals.

St. Vincent, for one, responded to the challenge. Our costs from Year End 1983 to 1984 increased only 2.8%. We discovered that Medicare was right. St. Vincent did indeed make a profit. Exhibit 2 shows our profit from Medicare on a per case basis for 1984. Remember, however, that the cost reimbursement per case is not full cost but Medicare's "reasonable " cost. Our actual profit is something less than what is shown.

In 1985, St. Vincent's costs increased 8.3%. Since Medicare increased their payment system by 6.003%, our profits decreased by just over 2% from the prior year.

Even though incentives inherent to a prospective payment system afford hospitals the opportunity to make a profit, HCFA has taken it upon themselves to determine how much profit is too much. After analyzing data from 1984, they concluded there were "flaws" in the system. They attempted to correct these flaws by not increasing the payment rates in 1986. As it turned out, hospital payment rates were increased by 1/2 of one percent for five months of 1986. This, coupled with seven months of a 1% Gramm/Rudman reduction, yielded a slight reduction in hospital payment rates.

St. Vincent's costs increased by 8% in 1986 over 1985. This, combined with reduced payment rates, decreased our Medicare profit just over 8% or our entire cost increase.

For Fiscal Year End 1987, our payment rates have been increased by 1.15%. We have budgeted a 5% cost increase for the same period, obviously, we will fall farther behind.

Exhibit 3 shows the decline of our Medicare profit from 1984 through projected 1987. If this decline in profitability was entirely the fault of St. Vincent being run inefficiently, there would be no need to take up your time.

Hospitals are not under a prospective system with Medicare. We are, in fact, in a <u>retrospectively adjusted</u> prospective system. The system is constantly being constricted to reduce federal outlays and hospitals are suffering.

To this point, I have not touched upon anything other than the actual DRG payment. There are other payments which are not affected by annual updates as they are still paid under cost reimbursement. These costs are associated with capital and medical education.

Capital costs have been under great scrutiny recently with HCFA trying to develop a way to blend these costs into the prospective payment rate. In the interim, St. Vincent's capital costs are being reduced by 4.375% in our Year End 1987, 7.75% in 1988 and 10% thereafter. The projected savings these arbitrary cutbacks yield will certainly be built into any system HCFA develops when they pay for capital prospectively.

The formula developed by HCFA to reimburse teaching hospitals for the indirect costs of Medical Education was altered in Fiscal Year 1986. This change cost St. Vincent over $500,000 in 1986 and will cost us in excess of $1,000,000 in 1987.

Today further cuts are being discussed. Things such as eliminating reimbursement for undergraduate nursing education, and cutting by 50% the already reduced indirect medical education payments have been proposed in the President's Fiscal Year 1988 budget for Health and Human Services. Referring back to Exhibit 3, St. Vincent in 1987 already will be receiving less than our reasonable cost reimbursement for covered services.

The continuous cutting of hospital payments must stop and stop quickly. During the period 1966-1983, St. Vincent was reimbursed less than full cost. Yes, we did profit from Medicare for three years, but it seems obvious those profits will be taken back, plus some, in as short a time.

In our discussion, we have yet to bring up the subject of quality of care suffering due to all that has been cut from the payments to hospitals, because it has not suffered at St. Vincent. The mission of the Grey Nuns will not allow that to happen. The point is quickly approaching, however, where hospitals simply will not be able to afford to care for the elderly. These people deserve better than to be treated as statistics in the Federal Budget.

To expect hospitals to accept less than cost for providing services is something no other industry is subjected to. Further, to expect other payors to make up for what Medicare has decided not to pay for via cost shifting is equally unfair.

If the prospective payment system cannot be made fair for everyone concerned, perhaps we should go back to reasonable cost reimbursement. At the very least, hospitals could predictably plan future payments expected for providing care. Under PPS, we cannot predict payments further than one year into the future. PPS has turned into nothing more than a means of reducing hospital payments and it must come to an end.

ST. VINCENT MEDICAL CENTER

EXHIBIT 1

GROSS REVENUE COLLECTION RATE

	1984	1985	1986
Gross Revenue	$ 129,623,009	$ 137,461,000	$ 149,015,000
Uncompensated Care	(5,896,000)	(6,167,000)	(6,004,000)
Medicare PPS	(2,468,000)	(4,788,000)	(9,121,000)
Contractual Adjustments	(8,122,000)	(7,605,000)	(8,319,000)
Collected Revenue	$ 113,137,000	$ 118,901,000	$ 125,571,000
% of Revenue Collected	87.3%	86.5%	84.3%

ST. VINCENT MEDICAL CENTER

EXHIBIT 2

PPS YEAR 1 PROFIT

Medicare Gross Revenue Per Case	$ 7,054.00
Collected Revenue Per Case (1)	$ 6,509.00
Cost Reimbursement Per Case (2)	(5,526.00)
Profit Per Case	$ 983.00

(1) Includes - DRG Payment and Passthroughs

(2) Cost reimbursement per case is calculated under the old Medicare cost reimbursement system.

ST. VINCENT MEDICAL CENTER

EXHIBIT 3

MEDICARE PROFIT

	1984 Actual	1985 Actual	1986 Actual	1987 Projected
Medicare Inpatient Revenue	$ 37,372,000	$ 37,818,000	$ 44,767,000	$ 45,828,000
Medicare Inpatient Pymts (1)	$ 34,483,000	$ 34,777,000	$ 36,880,000	$ 35,445,000
Medicare Reasonable Cost	29,277,000	30,544,000	35,813,000	36,051,000
Medicare Profit (Loss)	$ 5,206,000	$ 4,233,000	$ 1,067,000	$(606,000)
Medicare Discharges	5,298	5,020	5,135	5,075
Medicare Profit (Loss) Per Case	$ 983	$ 843	$ 208	$(119)

(1) Includes - DRG plus passthroughs

189/500 X