Microscope on Washington

Hospitals and Physicians To Bear Brunt of Medicare Cuts

The House and Senate Budget Committees have approved separate fiscal year 1988 budget resolutions that set targets for spending or, as in recent years, savings for congressional authorizing committees. Savings targets in the House and Senate Budget Resolutions for the Medicare program were $1.5 and $3.3 billion, respectively, compared with the nearly $5 billion in Medicare cuts proposed by the Reagan administration. The Medicare targets have significant implications for laboratory concerns, such as RAP DRGs and the clinical laboratory fee schedule. While the House and Senate have yet to come to a compromise on their budget targets, the outlook for Medicare cuts appears to be better than expected. Congress has made it clear, however, that Medicare savings are not to come from beneficiaries, leaving laboratories, hospitals, and physicians at risk.

Over the past five years, nearly $30 billion has been cut from the Medicare program. Since hospitals have borne the brunt of those savings, some Congress watchers felt that FY '88 would be the year of the physician. An RAP DRG savings proposal initiated by this administration was one indication that physicians were being targeted. Recent developments, however, appear to have returned the target to hospitals. Pressures to find savings from the Medicare clinical laboratory fee schedule and RAP DRGs appear to be lessened by this turn of events.

Rebasing of Hospital Rates Gains Momentum

The timing of two reports on hospital data could not be worse for hospitals and the congressional budget process. Actual 1984 cost data for hospitals under the Prospective Payment System (PPS) are now available. The Congressional Budget Office (CBO), in its annual report on budget options, stated that Medicare could save $27.2 billion over five years if actual 1984 cost data were used to calculate Medicare reimbursement to hospitals. Payments to hospitals have previously been based on 1981 cost data inflated to reflect 1984 costs. CBO reports that rebasing the system might be justified since "hospitals have reduced their costs substantially both before and after the implementation of the PPS." In addition, some services presently being reimbursed under PPS are in fact being performed and reimbursed on a reasonable cost basis in other settings. "[T]he lower rebased rates would avoid what is, in effect, double payment for these services."

The Hospital Response

Hospitals have responded quickly to this proposal, making the case for leaving the surplus in the system that resulted from using the early cost data. The surplus acts as a cushion against current inadequacies in the PPS rates—particularly severity of illness and wage differences—that adversely affect particular hospitals in an unfair and unintended manner. The American Hospital Association unconditionally opposes rebasing of the prospective pricing system because it represents a fundamental departure from the original design of PPS and because adequate factual basis for making rebasing judgments does not exist.

The other major report that sets the stage for substantial cuts in hospital payments is by the Inspector General (IG), the "policeman of the Department of Health and Human Services." The IG reports that hospitals earned large profits in 1985—about 15%—on services to Medicare patients. This report is particularly damaging because it implies a trend. The IG's earlier report showed profits of about $5.5 billion (14%) during the first year of PPS. Hospitals, in response to the IG's first report, claimed the profits were the result of one-time changes. Continued substantial profits in the second year of PPS (1985) has removed much of the sympathy hospitals were beginning to enjoy after so many cuts.

Hospital Update Factor Affected

The change in the outlook for hospitals is evident in the current discussion on the update in Medicare payments to hospitals. Congress is considering an update of approximately 1.5% for FY '88 in spite of strong sentiment last year that hospital payments needed protection. The (Sixth) Omnibus Budget Reconciliation Act of 1986 (OBRA) required the Department of Health and Human Services (DHHS) to boost rates by the rise in the marketbasket minus 2% and...
removed the Secretary's discretion to set hospital payment rates. The administration was accused of viewing hospital rate setting authority purely as a means to achieve budget savings. Current estimates indicate that hospital payments would rise by 2.9% under that formula.

In the face of recommendations by the IG, the CBO, and the Prospective Payment Assessment Commission (PROPAC), Congress now appears to be receptive to achieving significant savings from hospitals. Even the administration appears to be more generous to hospitals. In a March 31, 1987, letter to Congress, DHHS Secretary, Otis Bowen, MD, stated that "based on preliminary data and analysis... the applicable percentage increase of 1.5% envisioned in the President's FY '88 budget may be too low, and that the appropriate increase could range as high as 2.0%.”

**PROPAC's Input**

PROPAC, an independent advisory group established by Congress, will have a significant say in the debate over hospital payments under Medicare. In its April 1987 report to Congress, PROPAC recommended a 2.2% increase in Medicare DRG rates for urban hospitals for FY '88. This figure represents a 1.9% reduction from PROPAC's initial update estimate of 4.1% and is based on the 1984 data, which more accurately reflects current hospital costs for Medicare services. A 3.0% increase is recommended for rural hospitals. PROPAC arrived at its initial update estimate based on the following components: increases of 4.9% for inflation in the hospital marketbasket, 0.5% for scientific and technological advances, and 1.3% for real casemix 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 casemix index.

The 1.9% reduction for FY '88 is the first installment of the total 5.4% reduction PROPAC proposes over a three-year period. While PROPAC uses the term "recalculation of Medicare DRG rates" rather than rebasing, the result is essentially an adjustment in the rates based on more current data—an evaluation tool that PROPAC has always supported.

**RAP DRGs**

The budget situation (ie, the lower Medicare savings target and the significant savings to be achieved from hospitals) is only one factor in the environment for congressional consideration of RAP DRGs. Politics is another important factor, and the overwhelming response in the House of Representatives to the AMA-initiated House Concurrent Resolution that Congress is against RAP DRGs and mandatory assignment for physicians is a result of medicine's significant political power. Truly a grass roots effort, thousands of letters and personal meetings have been generated by physicians directed at defeating the concept of an RAP DRG. Representative Pete Stark (D-CA), Chairman of the Ways and Means Health Subcommittee, appears to be the lone congressional champion of an RAP DRG payment system. The delay in the administration's RAP DRG legislative proposal has not assisted Stark in garnering the interest of his colleagues. The House Appropriations Committee recently rejected the administration's request for $10 million in FY '87 supplemental funds to enable the Health Care Financing Administration (HCFA) to carry on initial research needed prior to implementing changes in RAP reimbursement. While the committee recognized that the administration proposes a reimbursement change for RAPs, it decided against increased resources until congress acts on the issue.

Representative Stark is looking to two advisory groups to breathe some life into an RAP DRG proposal. The General Accounting Office (GAO) is conducting a study for the committee on the medical practice of RAPs and will testify before the Committee in May during a hearing on the RAP DRG proposal. The study is expected to be published in June. The Physician Payment Review Commission is also expected to make a recommendation on RAP DRGs in June. At the April meeting of this independent advisory commission established by Congress, HCFA staff made a presentation on the development of their RAP DRG reimbursement system expected in May. The severe complexities of a RAP/DRG reimbursement system were described, leaving commission members to question the wisdom of the department's decision to propose such a system.

It now appears that the real debate on RAP DRGs will be starting late in the congressional session—May/June—but still in time for consideration in the budget reconciliation process. At press time, however, no specific legislation had been submitted by either the administration or the Ways and Means Subcommittee chairman who had initially showed interest.