MEDICARE/MEDICAID REIMBURSEMENT: SELECTED REFERENCES

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ABSTRACT

This bibliography is a compilation of selected articles, books, and executive agency and congressional publications on Medicare and Medicaid reimbursement, primarily to health facilities and physicians. Materials included focus on the years 1965 to 1984, and are arranged into four sections: general policies and issues; health facilities; physicians; and effects of reimbursement policies.

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INTRODUCTION

This bibliography is a compilation of selected articles, books, and executive agency and congressional publications on Medicare and Medicaid reimbursement, mainly to health facilities and physicians. Materials included focus on the years 1965 to 1984; and are arranged into four sections: general policies and issues; health facilities; physicians; and effects of reimbursement policies. To give some perspective on the size and growth of Medicare and Medicaid since inception, the graph on the next page shows expenditures from 1964 to 1983 and projections to 1989.

References for this bibliography were selected primarily from the bibliographic data base created and maintained by the Library Services Division of the Congressional Research Service, and from the computerized catalog of the Library of Congress. Most of the articles, books, and some of the executive agency publications have been annotated. Books from the Library of Congress' collections are listed with the Library's call number. The congressional user may request a book either by calling the Loan Division on 287-5441 (provide call number as well as author and title) or by placing a request through the CRS Inquiry Unit.

This bibliography has been compiled for the use of congressional offices in the Washington metropolitan area. Users of this bibliography in other parts of the United States may want to contact a nearby public, research or depository library for assistance in locating these materials.
HEALTH: MEDICARE AND THE HEALTH FUNCTION
FISCAL YEAR 1964 – FISCAL YEAR 1989
IN MILLIONS OF CONSTANT 1983 DOLLARS

SOURCE: 1985 Budget Perspectives: Federal Spending for the Human Resource Programs, by
1984. p. 70 (Report no. 84-35 EPW)
I. REIMBURSEMENT: GENERAL POLICIES AND ISSUES

A. Historical Perspectives (1965-1975)


Analyzes health expenditures data for a variety of factors, including type of expenditure, source of funds, historical trends, and the effect of the economic stabilization program. Growth rates and trends for Medicare and Medicaid are also discussed.


Partial contents.--Evaluation of the programs.--History of Medicare in Congress.--Prospects for national health care.


Reviews the major events and lessons from the Final Report of the Committee on Costs of Medical Care (1932) to Medicare and Medicaid (1965) and their early operational years through 1972.


"From the viewpoint of dollars expended, the decade of Medicare experience suggests that the population has expansive needs for service and that ... providers of care have an insatiable capacity to absorb reimbursement."


Analyzes the impact of the Medicare program on hospitals, on other institutional providers of health services, and on physicians.


Discusses several significant features of the Medicare program that occurred during this first decade of its existence, including cost reimbursement developments.


"Comm. pub. no. 96-258"

On cover: "MWD-76-93" "B-164031(3)" Publication date stamped on cover: Feb. 11, 1976.

"This report discusses the cost increases that have occurred in the Medicare and Medicaid programs since their inception and the reasons for these increases. Information on [H.E.W.] implementation of the Medicare and Medicaid cost control provisions of 1967 and 1972 . . . and of GAO's recommendations to control unnecessary costs is also included."

-----

Performance of the Social Security Administration compared with that of private fiscal intermediaries in dealing with institutional providers of Medicare services; report to the House Committee on Ways and Means by the Comptroller General of the United States. [Washington] 1975. 40 p.

"MWD-76-7, Sept. 30, 1975"

B. Current Outlook (1976-1984)


"This report presents an analysis of California's earliest experience with selective contracting. It reports findings in five areas: history and early expectations, implementation of Medi-Cal contracting for inpatient hospital services in the first year, impact of contracting on the hospital sector, impact on the health insurance marketplace, and impact on the statewide health delivery system."


The billing data from a large teaching hospital "are evaluated, based on the diagnosis and procedure codes and on the groupings (DRGs) [Diagnosis Related Groups] presently being used by HCFA [Health Care Financing Administration]; concurrent and retrospective data are found to be widely divergent on both measures. An apparent difference in complexity or extent of resource use is noted, suggesting that the data being used in HCFA's development effort may not fully represent the level of complexity of cases being treated and that reimbursement based on this data may be incorrect."


Examines S. 3205, the Medicare-Medicaid Administrative and Reimbursement Reform Act, which proposes a series of cost controls on Medicare/Medicaid reimbursement, fraud and abuse, and administration.
Proceedings. 

At head of title: 98th Congress, 2nd session. [House] Committee 
"Organized by the staff of the Committee on Ways and Means in con- 
junction with the Congressional Budget Office (CBO) and the Congressional 
Research Service (CRS)."

Cooper, Mary H., and Sandra Stencel. Rising cost of health care. Washington, 
Congressional Quarterly, 1983. 255-272 p. (Editorial research reports, 
1983, v. 1, no. 13)
Partial contents.--Reagan's proposal for controlling costs.--Factors 
behind health care inflation.--Prospective reimbursement for Medicare.--
Rise of third party payment mechanisms.

Diagnosis-related groups: the effect in New Jersey, the potential for the 
(HCFA Pub. no. 03170)
"A national conference cosponsored by the New Jersey Department of 
Health and the Health Care Financing Administration, U.S. Department of 
Health and Human Services."
"Held in Atlantic City, N.J., Nov. 30-Dec. 2, 1983"

Freud, Deborah A. Medicaid reform: four studies of case management, by 
Deborah A. Freund, with Polly Ehrenhaft and Marie Hackbarth. Washington, 

Grimaldi, Paul L. Calculating reimbursement rates for Medicaid patients. 
Provides "an overview of the crucial components of reimbursement 
methods such as the types of rates, peer groups, occupancy rates, screening 
processes, inflation factors and the appeal process."

----- DRG update, Medicare's prospective payment plan, by Paul L. Grimaldi 
HD7102.U4G73 1983

"Explains key features of Medicare's new payment plan and the 
implementing regulations." Discussion includes the DRG classification 
scheme and assignment process; the "19" coding scheme; calculation of 
DRG-specific prospective payment rates; and utilization and quality 
review.

Hunt, Karen. DRG--what it is, how it works, and why it will hurt. Medical 
"With Medicare providing about 40 percent of an average hospital's 
income, administrators are going to be looking over doctors' shoulders 
more than ever before. Admissions, lengths of stay, diagnostic tests, 
and requests for new equipment will be closely scrutinized with an eye 
toward eliminating everything that isn't absolutely necessary."

----- Do they finally have the guns to kill fee-for-service? Medical 
Examines the growth of diagnostic related groups, health maintenance 
orGANizations and other health insurance cost control mechanisms, 
especially in Medicare, as "the imminent threats to fee-for-service."
Describes the development of diagnosis related groups (DRG's). Looks at the consequences for hospital management of DRG's and their impact on the quality of care.

Sen. Talmadge answers questions about the proposed Medicare-Medicaid Administrative and Reimbursement Reform Act which "would streamline and improve HEW administration of Medicare/Medicaid, would attempt to contain program costs . . . and would establish a new reimbursement mechanism for provider institutions."

Regularly updated.


Partial contents.--The cost shift compared with the income and payroll taxes.--Other financing alternatives: a tax-subsidy cap and an excise tax.--Responses to the cost shift.--A blueprint for reform.

"This Note reviews arguments supporting and opposing reimbursement of costs that providers incur in the use of equity capital, acquisition of providers, and loan financing. The Note considers the Secretary [of Health and Human Services'] regulations in light of the congressional mandate to encourage efficient delivery of health care and concludes that current reimbursement policy promotes inefficiency."


Recommends that Medicare contracting be changed "from its current non-competitive, cost reimbursement basis to a competitive, fixed price basis."


"Management Office selected issues, volume IX."

Grace Commission report, building on the reports of its Task Forces on Health and Human Services--Department Management/Human Development Services/ACTION, Health and Human Services--Public Health Service/Health Care Financing Administration, and Federal Hospital Management, develops "recommendations that will generate savings from long-term reforms of Federal health care financing and reimbursement systems."


"Reports on ten "case studies of innovative state and local structural reforms in Medicaid and other programs for the indigent ... [which have the potential to] stimulate evaluation and dissemination of new models of health care cost containment."


"The National Study Group on State Medicaid Strategies formed in the fall of 1982 [and] composed of nine state Medicaid, Public Health and Human Service Administrators, reflects a growing concern about public support of health care for the poor. The Study Group's mission was to establish a new agenda for change that offers promise of controlling rapidly rising costs and improving access to and quality of needed health care services."


Discusses some of the proposals being considered by the Health Care Financing Administration for changing the Medicare and Medicaid reimbursement system.


   "Also appears in Part II of the Congressional Record of June 27, 1984 (v. 130, no. 87, Part II)"


   "Serial 98-42"

   At head of title: Committee print.

   At head of title: 96th Congress, 1st session. Committee print CP 96-6.


   At head of title: Committee print.
----- [Medicare/Medicaid] In its Deficit Reduction Act of 1984. Explanation
of the provisions approved by the Committee on Mar. 21, 1984. Apr. 2,

----- Medicare-Medicaid Administrative and Reimbursement Reform Act; report
to accompany H.R. 5285. Washington, G.P.O., 1978. 95 p. (95th Congress,
2nd session. Senate. Report no. 95-1111)

----- Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979;
1st session. Senate. Report no. 96-471)

----- Proposals for Medicare-Medicaid reform and overall hospital revenues
At head of title: Committee print CP 96-10.

Medicare-Medicaid administrative and reimbursement reform. Hearings,

----- Medicare-Medicaid Administrative and Reimbursement Reform Act. Hearings,
95th Congress, 1st session, on S. 1470. June 7-10, 1977. Washington,

U.S. Congress. Senate. Committee on the Budget. [Medicare/Medicaid] In its
Omnibus Reconciliation Act of 1983; report to accompany S. 2062. Nov. 4,

U.S. Congress. Senate. Special Committee on Aging. The crisis in Medicare:
proposals for reform. Hearing, 98th Congress, 1st session. Washington,
G.P.O., 1984. 120 p. (Hearing, Senate, 98th Congress, 1st session, S.
Hrg. 98-695)

U.S. President (1981- : Reagan) Health incentives reform program; message
from the President of the United States transmitting legislative proposals
to restructure the Medicare Hospital Insurance Program; to amend the
Internal Revenue Code of 1954 to provide for the inclusion of certain
employer contributions to health plans in an employee's gross income; to
provide for voluntary private alternative coverage for Medicare bene-
ficiaries, and for other purposes; to make improvements in the Medicare
and Medicaid programs, and for other purposes; and to provide for pro-
spective payment rates under Medicare for inpatient hospital services,
and for other purposes. Washington, G.P.O., 1983. 149 p. (Document,
House, 98th Congress, 1st session, no. 98-24)
Referred to the Committees on Ways and Means and Energy and Commerce.
II. HEALTH FACILITIES AND REIMBURSEMENT


Argues that "as Medicaid programs across the states are cut, resulting in fewer benefits and more restricted physician payments, beneficiaries may have greater incentives to enroll in organized systems. Private physicians may also face greater incentives to develop HMOs [Health Maintenance Organizations] to serve Medicaid beneficiaries. If that happens, however, a twoclass system—one for the poor and one for others—will be institutionalized; and to assure minimum standards of care for the poor, more, not less, regulation will be required."


Analyzes how university hospitals have fared in New Jersey since the introduction of a prospective payment system.


Discusses a study which analyzed the impact of prospective, as compared to retrospective, rate setting by state programs on Medicaid payment and utilization rates for nursing home care. Recommends prospective rate setting as a means of cost containment because it "does not adversely affect access of Medicaid patients to care." Also suggests linkage of payment rate to a "quality-of-care index" to minimize the dangers of lower quality care for Medicaid patients.


Describes the legislative package that has been enacted in California to control hospital costs. This package requires negotiated contracts with hospitals on a prepaid basis for inpatient services to Medicaid patients.


Reports on a "study of Medicare experience with seven selected group-practice prepayment plans [which] compares utilization and reimbursement for members with comparable control groups of beneficiaries who received services in the fee-for-service delivery system."

"The study findings reveal that many characteristics of hospital inflation in the pre-Medicare period continued with greater intensity in the first 2 years of Medicare. The findings tend to support the demand-pull view of hospital inflation and the views that emphasize changes in technology and expansion of the hospital's role."


Looks at the provisions of the New Jersey diagnosis-related group plan since the Medicare reimbursement plan is based on this State's regulatory plan. Also, analyzes the effect of this plan on the hospital industry in the State.


"Congress plans to limit Medicare reimbursements for spending on new plant and equipment. But hospitals fear the move might jeopardize their credit on Wall Street."


"Data from the MEDPAR file, the original medical record discharge order, and a reabstracted record are compared and analyzed for their effect upon DRG classification and the resultant Medicare reimbursement ceiling for one large teaching hospital. The study results show widely divergent diagnostic and surgical data that results in a significant variation in DRG classification and reimbursement ceilings."


"Analyzes the politics of hospital payment over the last decade. [Also] explain[s] . . . how provider interests and judgments became a standard for appropriate hospital payment; the impact of that standard on hospital costs; and the political obstacles to imposing an alternative standard and controlling hospital costs." Discussion focuses on Medicare, Medicaid, and private sector reimbursement.


"Explores what states are doing or can do to implement cost-constraining ratesetting systems, given recent significant legislative changes."


"State governments, with federal subsidies under the Medicaid program, are the source of the largest share of expenditures to support patients in the long-term institutional nursing care. A major state policy tool that has been evolving is the authority to approve or deny expansions in bed capacity. This paper is an analysis of how the behavior of physicians and nursing home operators, given present reimbursement policies, could determine the allocation of beds among patients."
"Examines issues associated with revising the manner in which Medicare pays hospitals. [Reviews] the present reimbursement system, the general advantages and disadvantages of a prospective payment system for Medicare, [and] discusses the most controversial issues surrounding its design."

Partial contents.--Overview of the nursing-home industry.--Cost concepts and Medicaid reimbursement.--Computation of Medicaid reimbursement rates.--Economic models of nursing homes.--The question of profits.--Issues in cost containment.

"Focuses on relationships between profit and the provision of nursing home care to Medicare/Medicaid patients. It emphasizes that profits must be competitive if the supply of nursing home beds is to be sufficient to meet demand."

"Describes current Medicaid policies regarding the reimbursement of residents' stipends, salaries received by physicians for educational activities, and services provided by residents or teaching physicians to Medicaid recipients. Also describes the importance of Medicaid revenues to teaching hospitals; [and] discusses some of the potential consequences of Medicaid cuts for teaching hospitals, and some of the effects on Medicaid services that would result in turn."

"Analyzes the hospital cost-shift issue in the context of a theoretical economic model of hospital behavior. It shows that, under plausible assumptions, the Medicare/Medicaid reimbursement policy does lead to higher private-sector hospital charges, even when the government pays the full (average or marginal) cost of hospital services. It also demonstrates that, in contrast to the common view that cost-based reimbursement policy is inefficient, the current Medicare/Medicaid reimbursement policy provides certain static optimality characteristics, so long as hospitals provide at least some services to the private market."

"Determine[s] whether hospitals set their charges for laboratory, radiology and operating room services in order to maximize their Medicare reimbursement."

Article warns that "as Federal and state budgets become more constrained, the reimbursement of teaching physicians on a reasonable charge basis by Medicare and the state Medicaid programs will be targeted for future change. In addition, an increased emphasis on a more competitive system of financing the cost of health care is likely to mean more trouble for the nation's teaching hospitals and teaching physicians."


"Summarizes the major features of the prospective-payment legislation. . . . Also notes that looming ahead for Medicare, despite the savings projected from prospective payment, are massive long-range financial problems, indeed bankruptcy, unless the program's income and its expenses can be brought more nearly in balance before the end of the decade."


Focuses on Federal and State changes to force hospitals to become better managers of the resources they expend. These changes include an interim program of tighter Medicare controls on hospitals, and a Health and Human Services Department directive to develop a prospective payment system that would impose a ceiling on Medicare payments to hospitals.


"Explores the issues of capital cost reimbursement under Medicare and Medicaid and some of the ways current policies could be changed."


Regularly updated.


Regularly updated.


Comment "reviews the development and changing definition of the health-care crisis and of the government's response to that crisis. . . . Identifies and discusses the ways in which the provisions of TEFRA operate to impose limits on hospital reimbursement under Medicare, summarizes and analyzes in detail the report on prospective reimbursement under Medicare for hospitals. . . . Concludes that the Reagan [Health Care Incentives Reform Package] initiatives may begin to reduce the growth of federal health-care expenditures, but suggests changes to reinforce their strengths and to mitigate their weaknesses."
Discusses the problems of the Medicaid program and examines some proposals for addressing the problems of the health care industry. These include "using lower cost alternatives to hospital and nursing home care, paying providers according to care given, reforming long term care, and introducing price competition."

Comments on the effectiveness of the introduction of competition into the health care industry through the use of Medicaid contracts.

"Comment addresses the propriety of reimbursement under Medicare principles. The two theories of reimbursement--as an interest expense on construction loans or as an indirect cost of service--are examined. The conflict between these theories of reimbursement and the current regulations, the statutory provisions, and the basic cost principles and overall purposes of Medicare are discussed."


"Serial no. 95-45"

At head of title: 94th Congress, 2nd session. Committee print.

"Serial 97-40"

"Serial 98-6"


   At head of title: 96th Congress, 1st session. Committee print CP 96-9.


"HRD-77-128, July 27, 1977"


"B-164031(4), Aug. 16, 1974"


"B-164031(4), Aug. 3, 1972"


Partial contents.--Teaching cost containment to medical students: the University of Oregon experience.--The Iowa experiment: capitation reimbursement of pharmacists.--Supplementary insurance to Medicare--two viewpoints.--An analysis of Medicare reimbursement policy for provider based physicians.


Analyzes how "a dominant function of medical inflation, Medicaid reimbursement costs reflect the systems failure to create a cost-effective balance between supply and demand, government and the private sector, quality and price, flexibility and control. Also describes CAREPLAN which combines 'a cost control mechanism with a centralized service delivery system while providing for consumer choice.'"


"Examines variations in hospital expenditures and reimbursements under the Medicare and Blue Cross programs . . . The question of fairness that arises when public regulation imposes limits on market growth but does not take local health resources or expenditures into account is illustrated by examining the numbers of hospital beds and the rates of expenditure and Medicare reimbursement in two adjacent market areas in Rhode Island--a state where the hospital industry is regulated by strong certificate-of-need and prospective-reimbursement programs. The article also considers some of the economic implications of the voluntary voucher plan, which has been proposed as one approach for introducing competition into health-care markets"
III. PHYSICIANS AND REIMBURSEMENT


Burney, Ira L., and others. Geographic variation in physicians' fees: payments to physicians under Medicare and Medicaid. JAMA [Journal of the American Medical Association] v. 240, Sept. 22, 1978: 1368-1371. Analyzes physician reimbursement in the Medicaid and Medicare programs at the national, regional, State, and county levels during fiscal year 1975. Results show a wide range in fees and "indicate that under national health insurance, fees set at national or statewide levels could have notable effects on physician remuneration in some localities."

Cantwell, James R. Implications of reimbursement policies for the location of physicians. Agricultural economics research, v. 31, Apr. 1979: 25-35. "A simple model of physician migration predicts a positive relationship between physician fees and the number of physicians in an area and a negative relationship between physician fees and area population-physician ratios. The strong empirical support for this model suggests that Government health insurance programs could be used to encourage physicians to locate in scarcity areas."

Cassidy, Robert. A court takes a hand in fee-setting. Medical economics, v. 58, Mar. 2, 1981: 25, 28, 32, 34, 36, 41. "Setting Medicare reimbursement according to specialty is illegal, a federal judge in one state has declared."

----- These doctors forced Medicaid to shape up. Medical economics, v. 57, Aug. 4, 1980: 23, 26, 28, 30, 32. "Missouri's Medicaid bureaucracy had to be turned upside down before doctors' reimbursement rates were raised to acceptable levels."

Dalessio, Donald J. The hospital bill that Medicare won't pay. JAMA [Journal of the American Medical Association] v. 233, July 14, 1975: 179-187. Contends that "denial of payment for hospital service [provided by physicians] for Medicare patients is retrospective and arbitrary ... [and] could be ameliorated if fiscal intermediaries for the Medicare program would accept the decisions of the local Utilization Review Committees regarding the necessity for the admission of the patient."

Demkovich, Linda E. Congress eyes limits on doctors' fees to remedy runaway Medicare costs. National journal, v. 16, Apr. 7, 1984: 652-656. Explains why "a move by Congress to rescue the Medicare program that helps the elderly defray doctor bills would mean a showdown with the American Medical Association."


States that "side effects triggered by the latest Federal curb on doctors' earnings will victimize patients and dim any chance for rational improvement of the health-care system."


"Under Medicare's Part B program, the physician decides whether to accept assignment of claims. . . . Physicians' acceptance of assignment is of considerable importance in relieving the beneficiaries of the burden of the costs of medical care services. This factor and the beneficiaries' liabilities for premiums, the annual deductible, and coinsurance are analyzed in considerable detail in this report."


"Presents some evidence that physicians respond both to changes in relative prices and to absolute controls on their fees."


Examines the experience with constraints on physicians' private charges and public payments in California under the Economic Stabilization Program. Concludes "that controls over both public and private fees are needed in order to simultaneously contain costs of and maintain access to physicians' services by Medicare and Medicaid beneficiaries."


States that there is no possibility that the Federal Government will dictate how much a doctor can earn from private practice.


Identifies factors which influence physician participation in Medicare and Medicaid programs.


"Reports the results of research on Medicare and Medicaid reimbursement for physicians' services in California [which investigated] the relationships between physicians' behavior and two critical health policy goals: controlling the rate of increase in the costs of physicians' services; and assuring an adequate supply of care to beneficiaries of publicly financed health programs."

"The primary focus has been on the determinants of the level and rate of change in physicians' charges and Medicare and Medicaid reimbursement rates. . . . Also analyzes changes in the quantities of services supplied to inpatients in response to variations in private and program reimbursement levels."


"This study shows that the stringency with which Medicare carriers screen 'customary, prevailing, and reasonable charges' (C.P.R.) inhibits significantly the inflation of Medicare physicians' fees."


"Congress is looking to save Medicare money any way it can and as soon as it can. Not surprisingly, doctors' fees are a prime target."


"Looks at actions that might be taken by Congress to reform physician payments. "The options include freezing Medicare fee reimbursements, shifting physician payment to the same diagnosis-related system imposed on hospitals since last October, denying hospital privileges to physicians who don't accept Medicare assignment, and offering no-fault malpractice insurance coverage to induce those physicians to take assignment."


At head of title: 94th Congress, 2nd session. House Committee on Ways and Means print.


"Findings emphasize that "state Medicaid programs that streamline the billing and collection process or employ liberal eligibility criteria reap the rewards in terms of higher participation levels [of physicians]. If Federal policy in the future will allow states even greater discretion in setting reimbursement limits and in denying payment, then two unambiguous outcomes will be reduced physician participation in Medicaid and restricted access to specialist services for the poor."


"Reviews preliminary findings from a study which examines carrier differences in discretionary practices as to specialties, localities and other claims data that may be merged or compared with Medicare data in determining customary and prevailing prices used to set limits on Medicare payments, and other practices reported in an official questionnaire to carriers."

"Presents background material on the economics of aging and the Medicare market, including a review of literature and a summary of Medicare regulations; reports on national findings about Medicare practices and fees; describes a two-county micro study of carrier practices and experience of providers and beneficiaries under Medicare as well as a comparison with Medicaid in one of the counties; discusses methodological problems, summarizes findings, and presents a consideration of policy implications and recommendations for research."


"Describing past Medicare cutbacks in physician reimbursement as 'contrary to both the letter of the law and its intent,' an insider says the latest changes open the door to uniform payment schedules."


"Examines the effect of changes in Medicare reimbursement on the assignment rates of physicians. . . . Also predicts Medicare assignment rates under a policy option which would increase Medicare reasonable fees to the level of prevailing fees."


"National health insurance has been delayed again. But physicians now face a threat of Federally imposed Mediplan fee schedules."


Partial contents.--How DRGs are supposed to work.--Doctors and hospitals--a new era of cooperation.--Financial considerations that won't go away.--The New Jersey experience.--Using DRG data.

Reynolds, James A. The new index they'll use to hold down Medicare fees. Medical economics, v. 50, May 14, 1973: 35, 39, 43-44.

"Contends that the index developed by Congress to control medical fees "could lead to further erosion of the doctrine of usual-and-customary fees, if not an outright curb on the doctor's right to charge what he pleases."


"The results show that declining medical reimbursement rates result in increase in the intensity of medical services provided, and that declining surgical reimbursement rates result in increases in the intensity of surgical services provided."

With new payment schemes with built-in incentives to deliver health care at lower cost, hospitals will not only be pressing physicians to be more cost-effective but will also be competing for patients. Looks at the new payment schemes that might be used to do this.


This survey indicates that "most doctors still accept Medicare patients, but many say they'd stop if the Government imposed a fee schedule or made assignments mandatory."


Concludes that "with the exception of tonsillectomies/adenoidectomies, a very large reduction in the reimbursement fee for Medicaid surgery had only a small impact on the rate at which elective surgical procedures were performed."


At head of title: 96th Congress, 2nd session. Committee print WMCP: 96-77.

Prepared with the assistance of the Congressional Research Service.

U.S. Congress. Senate. Committee on Finance. Background data on physician reimbursement under Medicare; prepared by the staffs for the use of the Committee on Finance, United States Senate, Robert J. Dole, Chairman, and the Committee on Ways and Means, Dan Rostenkowski, Chairman, and Committee on Energy and Commerce, John D. Dingell, Chairman, House of Representatives. Washington, G.P.O., 1983. 109 p. (Print, Senate, 96th Congress, 1st session, joint committee print, S. Prt. 98-106)

"WMCP: 98-16"

"Serial no. 98-P"


"B-164031(4), Dec. 20, 1973"


"Traces the development in the Federal regulation of physicians' fees over the past 10 years." Emphasis is on the impact of Medicare and Medicaid reimbursement and the control mechanisms of the Economic Stabilization Program.
IV. IMPACT/EFFECTS OF REIMBURSEMENT POLICIES

A. Coverage: Services and Programs


"This document is the Final Report of a research and demonstration project entitled 'An Experiment in Alternative Methods of Reimbursing for Durable Medical Equipment (DME) Acquired by Medicare Beneficiaries.' This report describes the implementation, operation and results of the experiment; and [the] tabulation and interpretation of a large database of DME claims is presented."


At head of title: Health care financing grants and contracts report.


"The success of the ESRD [End Stage Renal Disease Program] program in expanding services to meet demand while controlling costs and maintaining quality has been due primarily to the combined effect of setting a price and creating a system of incentives that involves physicians in the medical marketplace."


Report "explores potential changes in Medicare's benefit structure. It examines options for increasing the share of medical care costs paid by beneficiaries and changes that would improve the protection of the elderly and disabled against catastrophic medical expenditures. In addition to calculating the federal savings from each options, the paper estimates the impact of such changes on individual enrollees."


Focuses "on economic benefits to the government resulting from reduced levels of Medicaid spending for outpatient drugs" in Maryland.

"In 1973 the federal government moved to limit drug reimbursement to providers in federally sponsored or supported programs, to the lowest cost at which the drug is generally and consistently available unless a difference in therapeutic effect can be demonstrated between the brand name and generic drug. This paper examines the political evolution and rationale for this program and explores the issues surrounding the ongoing controversy regarding publicly financed programs offering drug benefits."


At head of title: 95th Congress, 1st session. Committee print WMCP: 95-5.

Printed for the use of the Subcommittee on Oversight and Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives.


"Expert consultants to the study concluded that steps should be taken immediately to extend reimbursement under Part B for services provided by optometrists to both aphakic and cataract patients. It was their collective judgement that referral delivery patterns, costs, and administrative features of the program, would not be significantly affected if reimbursement of optometrists were extended to cataract, as well as aphakic patients."


"Serial 97-87"


"Serial no. 95-8"


At head of title: 97th Congress, 2nd session. Committee print CP 97-12.

 "HRD-79-17, May 15, 1979"
 "Discusses the need for improvements in Medicare's cost reimbursement procedures for home health care services and makes recommendations for such improvements."

----- Medicare's reimbursement policies for durable medical equipment should be modified and made more consistent; report to the Honorable Russell B. Long, United States Senate. [Washington] 1981. 32 p.
 "HRD-81-140, Sept. 10, 1981"
 "Evaluates allegations to the effect that suppliers of durable medical equipment to Medicare beneficiaries in certain southeastern States were being subjected to discriminatory reimbursement and coverage requirements."

 "HRD-81-36, Dec. 31, 1980"
 "Concludes that MAC has resulted in savings under the State-operated Medicaid outpatient drug programs. This savings could have been greater, however, if States had implemented the limits in a more timely manner, HHS had systematically updated the limits, and HHS had encouraged States to implement or expand their own MAC programs."

 "Addresses problems related to nurse practitioner reimbursement and the Rural Health Clinic Services Act of 1977. An overview of payor policies prior to the passage of P.L. 95-210 is presented, followed by a discussion of some of the difficulties in implementing the statute."

B. Medical Technology and Devices

 "Medicare's new payment system will force hospitals to be conscious of costs, but it may also discourage their investing in important medical advances."

Diagnosis related groups (DRGs) and the Medicare program: implications for medical technology. Washington, Congress of the U.S., Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1983. 82 p.
 RA971.3.D5 1983

 Reviews the use of Diagnosis Related Groups (DRGs) to measure hospital care mix. "Beginning in October 1983, Medicare will phase in a per-case payment system using DRGs as the case-mix measure."

Examines the coverage process of Medicare and Blue Cross-Blue Shield and the policy changes that both programs are considering. In addition, it discusses the strengths and drawbacks of four coverage policy options: restricting insurance coverage of unproven procedures, introducing cost-effectiveness criteria, educating physicians and educating consumers."


"OTA-H-227 and 228, July 1984"

"Reviews specific Medicare policies that have had an influence on the adoption and use of medical technology and also analyzes the contribution of medical technologies to increases in Medicare costs. The report identifies several possible changes in Medicare coverage, payment, and other policies that could be used to influence medical technology adoption and use and to restrain Medicare program costs." Volume two is a summary of the report.


"Inflationary pressures have taken their toll, but the major factor behind spiraling costs is technology: who uses it and who pays for it."


"Congress established the National Center for Health Care Technology to help determine which of the bewildering array of medical equipment and techniques should be paid for by medicare. So far, the new center has had to operate with only $175,000—not even enough to set up shop. But it has already begun to consider whether medicare should pay the bills when the elderly receive such new-fangled services as electromagnetic treatment of fractures and electric pain-relieving techniques."

C. Beneficiaries


"Government has been rethinking its capacity to finance health services for the poor, and new and sometimes controversial arrangements for delivering these services are being developed. The dilemma government officials face now is how to cut costs while still assuring that quality medical services are available. This article focuses on what these new policy developments and arrangements are and whether the significant gains in access and in health achieved over the past 20 years will be sustained."

"Identifies current gaps in Medicare coverage and attempts to determine the extent to which continued liability for medical expenses creates a burden for elderly citizens." Describes "expenses for medical care that are explicitly excluded from Medicare coverage, notably custodial care in a nursing home or a place of residence, out-of-hospital prescription drugs, nonprescription drugs, dental care, eyeglasses, and hearing aids." Also provides a "detailed examination of private health insurance policies for the elderly."


"Investigates the extent to which private supplementary insurance and Medicaid, which vitiate the effect of Medicare cost-sharing, encourage elderly beneficiaries to seek additional medical care."


Contends that "Congress set up the [Medicare] plan to pay only a severely restricted portion of medical expenses. Many of the most common health needs of the elderly--routine checkups, false teeth, eyeglasses, drugs, private nurses, long-term custodial care in nursing homes--are excluded."


Article examines the impact of eye care benefit exclusions and restrictions and their effect upon the use of ophthalmological and optometric services by the elderly."


"Comm. pub. no. 98-427"


D. Quality Control and Utilization

"Documentary history of Medicare reveals serious flaws in regard to cost and quality control."

Comment "analyzes the possible policy objections to concurrent review [of Professional Standards Review Organizations or PSROs]; the statutory objection that utilization review . . . [interferes] with the physician's practice of medicine and mandates a treatment process not in the patient's best interest; [and] the argument that concurrent review . . . intrudes upon a constitutionally protected right to privacy [in the doctor-patient relationship]."

"Nobody argues that the eight-year-old Professional Standards Review Organizations (PSROs) have not reduced the federal government's expenditures for medicare--and probably for medicaid as well. But critics say that the savings have been outpaced by the costs of the physicians' peer review program and that some savings have been accomplished by shifting the costs to privately insured patients."

Article contends "that regardless of the cost or quality results achieved by PSROs [Professional Standards Review Organizations], the PSRO law provides the opportunity to expand the availability of medical care to the populations affected by it."

Case note written by a physician examines three methods provided by PSRO legislation to eliminate unnecessary services and enhance the quality of care: "review with denial of payment; review with sanctions against the physician or provider; and malpractice immunity for the physician relying on PSRO standards."


"This report contains information on the use of reimbursed services by Medicare beneficiaries. It profiles amounts reimbursed, services paid for, variations in utilization and reimbursement by age, race, and sex of the beneficiaries, and beneficiary place of residence in 1975."


Describes physicians' fee patterns by analyzing physician reimbursement rates according to local Medicare reimbursement areas. "The results indicate that the maximum prevailing charge ... generally ranged from three to ten times the minimum charge ... [but] clustered around the mean" in most cases.


