Report No. 84-148 L

MEDICARE/MEDICAID REIMBURSEMENT: SELECTED REFERENCES

by
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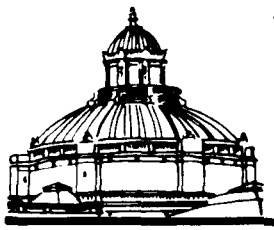
Library Services Division



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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.

Thanks and appreciation are extended to Subject Specialization Section Head Richard Gigax and colleague Marsha Cerny for their review of the manuscript and ongoing support and patience; the Health Section of the Education and Public Welfare Division for their review and especially to Jennifer O'Sullivan for her invaluable advice and provision of materials; also to Walter Albano of the Congressional Reference Division for his review. A special note of thanks goes to bibliographic assistant John M. White for his patience and conscientious typing of this bibliography.

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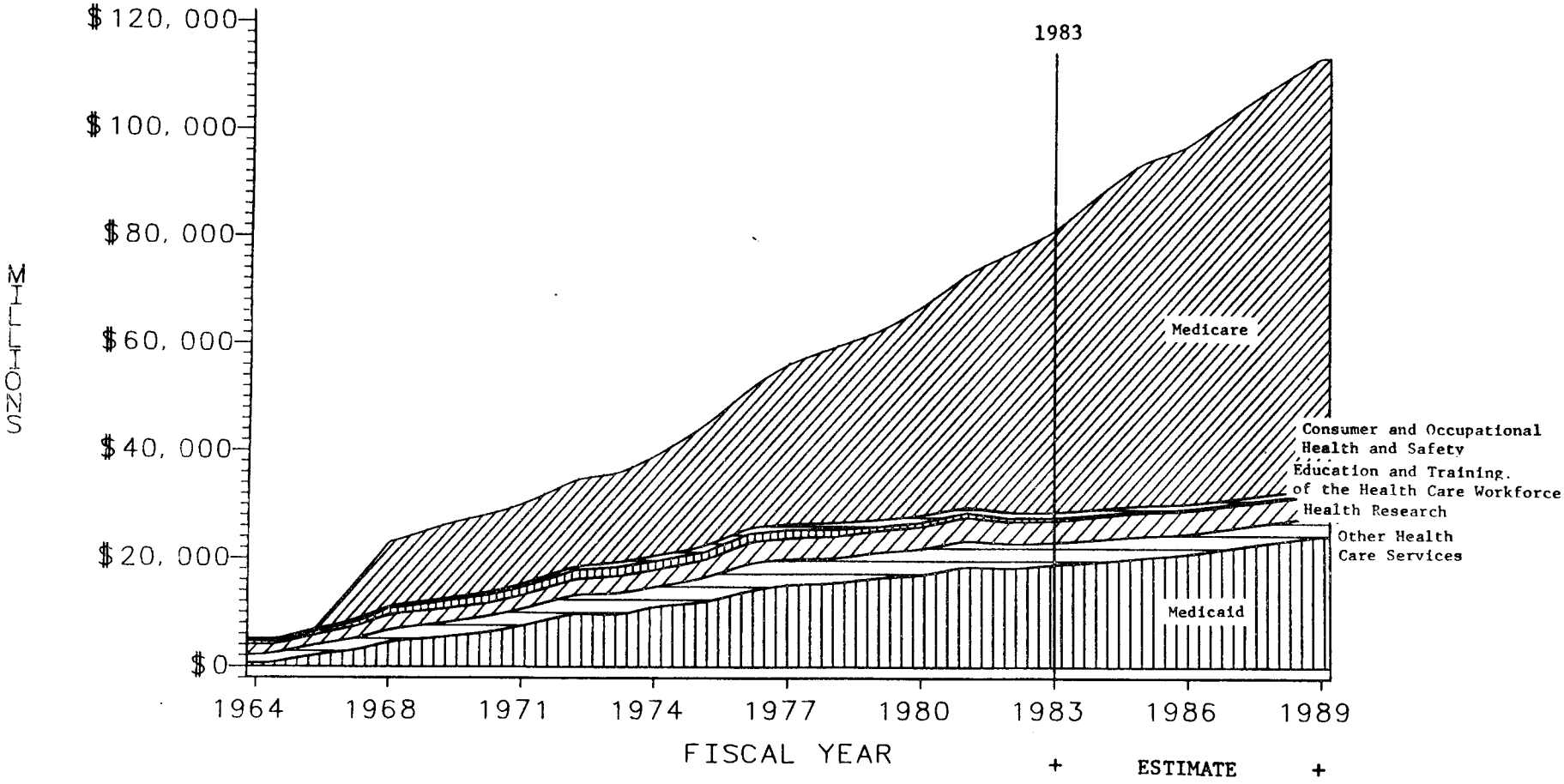
INTRODUCTION

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 Richard Rimkunas and Gene Falk. [Washington] Congressional Research Service, 1984. p. 70 (Report no. 84-35 EPW)

I. REIMBURSEMENT: GENERAL POLICIES AND ISSUES

A. Historical Perspectives (1965-1975)

Cooper, Barbara S., and Nancy L. Worthington. National health expenditures, 1929-72. Social security bulletin, v. 36, Jan. 1973: 3-19, 40.
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.

DeLesseps, Suzanne. Medicare and Medicaid after ten years. [Washington, Editorial Research Reports] 1975. 525-542 p. (Editorial research reports, 1975, v. 2, no. 3)
Partial contents.--Evaluation of the programs.--History of Medicare in Congress.--Prospects for national health care.

Falk, I. S. Medical care in the USA--1932-1972. Problems, proposals and programs from the Committee on the Costs of Medical Care to the Committee for National Health Insurance. Milbank Memorial Fund quarterly, v. 51, winter 1973: 1-39.
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.

Hess, Arthur E. A ten-year perspective on Medicare. Public health reports, v. 91, July-Aug. 1976: 299-302.
"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."

Myers, Robert J. Medicare: the first six years. Pension & welfare news, v. 9, Apr. 1973: 32, 41-42, 44, 75.
Analyzes the impact of the Medicare program on hospitals, on other institutional providers of health services, and on physicians.

----- Significant events in the first decade of Medicare. Employee benefits journal, v. 1, fall 1975: 36-39.
Discusses several significant features of the Medicare program that occurred during this first decade of its existence, including cost reimbursement developments.

U.S. Congress. House. Select Committee on Aging. Medicare: a fifteen-year perspective. Hearing, 96th Congress, 2nd session. July 30, 1980. Washington, G.P.O., 1980. 65 p.
"Comm. pub. no. 96-258"

U.S. General Accounting Office. History of the rising costs of the Medicare and Medicaid programs and attempts to control these costs, 1966-1975, Department of Health, Education, and Welfare. Report to the Human Resources Task Force, House Committee on the Budget, by the Comptroller General of the United States. [Washington, G.A.O., 1976] 126 p.
HD7106.U5U63 1976a

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)

American Bar Association. Committee on Public Health Care. Legislative control of Federal health care costs. Urban lawyer, v. 15, fall 1983: 947-971.

"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."

Analysis of State Medicaid program characteristics 1983; prepared for the Health Care Financing Administration, U.S. Dept. of Health and Human Services. [Rockville, Md.] LaJolla Management Corporation, 1983. 196 p.

Barnard, Cynthia, and Truman Esmond. DRG-based reimbursement: the use of concurrent and retrospective clinical data. Medical care, v. 19, Nov. 1981: 1071-1082.

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."

Can incentives put brake on Federal health costs? Hospital practice, v. 11, June 1976: 122, 124, 129-130.

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.

Conference on the Future of Medicare (1983: Washington, D.C.) Proceedings. Washington, G.P.O., 1984. 362 p.
At head of title: 98th Congress, 2nd session. [House] Committee [on Ways and Means. Subcommittee on Health] Print, no. WMCP: 98-23.
"Organized by the staff of the Committee on Ways and Means in conjunction 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 Nation; conference proceedings. [Baltimore, G.P.O., 1984] 225 p. (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, American Enterprise Institute, 1984. 83 p. HD7102.U4F68 1984

Grimaldi, Paul L. Calculating reimbursement rates for Medicaid patients. American Health Care Association journal, v. 6, July 1980: 24-28.
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 and Julia A. Micheletti. Chicago, Pluribus Press, 1983. 106 p. 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 "I9" 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 economics, v. 60, Sept. 5, 1983: 262-266, 269, 272.
"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 economics, v. 61, Apr. 2, 1984: 145-152, 154, 157, 160.
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."

Kotelchuck, Ronda. Baring costs: how the DRG system works. Health/PAC bulletin, v. 15, Mar.-Apr. 1984: 7-12.
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.

Lesparre, Michael. Senator Talmadge (D-Ga.) talks about his Medicare reform bill. Hospitals, v. 50, June 16, 1976: 49-50, 54-55.
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."

Lundy, Janet. Health care cost containment. [Washington] Congressional Research Service, 1983. 16 p. (Issue brief ib83172)
Regularly updated.

Medicare. In U.S. Congress. House. Committee on Ways and Means. Background material and data on programs within the jurisdiction of the Committee on Ways and Means. Feb. 21, 1984. Committee Print, WMCP: 98-22. Washington, G.P.O., 1984. p. 106-188.

The Medicare and Medicaid data book, 1983, prepared by Darwin Sawyer and others. Baltimore, Md., U.S. Dept. of Health and Human Services, 1983. 161 p. (HFCA publication no. 03156; Health care financing program statistics.)

Meyer, Jack A. Passing the health care buck: who pays the hidden cost? Washington, American Enterprise Institute for Public Policy Research, 1983. 49 p. (AEI studies, 386)
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.

Morrison, Kenneth P. Medicare reimbursement of financial transactions: do present policies promote efficiency? American journal of law & medicine, v. 9, spring 1983: 45-82.
"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."

O'Sullivan, Jennifer. Medicare and Medicaid provisions of the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). [Washington] Congressional Research Service, 1981. 55 p. (Report no. 81-210 EPW)

----- Medicare and Medicaid provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), by Jennifer O'Sullivan and Glenn Markus. [Washington] Congressional Research Service, 1982. 66 p. (Report no. 82-173 EPW)

President's Management Improvement Council. Report on Medicare contracting. [Washington] 1980. 1 v. (various pagings)

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

President's Private Sector Survey on Cost Control (U.S.) Federal health care costs. Submitted to the subcommittee for consideration at its meeting on January 15, 1984. [Washington] The Survey [1984] 65 p.

"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."

Restructuring Medicaid: a survey of State and local initiatives. Edited by Sean Sullivan and Rosemary Gibson. Washington, American Enterprise Institute Center for Health Policy Research, 1983. 80 p.

HD7102.U4R47 1983

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."

Restructuring Medicaid: an agenda for change: summary report of the National Study Group on State Medicaid Strategies. Washington, Center for the Study of Social Policy, 1983. 58 p.

"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."

Rosenberg, Charlotte L. Fee controls: what Uncle Sam is cooking up now. Medical economics, v. 57, Aug. 18, 1980: 27-28, 32, 34, 39-40, 42, 47.

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

Title III of the Bill. Description of Medicare Prospective Payment Provision. In U.S. Congress. Senate. Committee on Finance. Social Security Act Amendments of 1983; report to accompany S. 1. Mar. 11, 1983. Washington, G.P.O., 1983. (Report, Senate, 98th Congress, 1st session, no. 98-23) p. 47-59.

U.S. Congress. Conference Committees, 1983. [Medicare/Medicaid] In their Social Security Amendments of 1983; conference report to accompany H.R. 1900. Mar. 24, 1983. Washington, G.P.O., 1983. (Report, House, 98th Congress, 1st session, no. 98-47) p. 90-114, 179-207.

U.S. Congress. Conference Committees, 1984. [Medicare/Medicaid] In their Deficit Reduction Act of 1984; conference report to accompany H.R. 4170. June 23, 1984. Washington, G.P.O., 1984. (Report, House, 98th Congress, 2nd session, no. 98-861) p. 594-648, 1290-1371.
"Also appears in Part II of the Congressional Record of June 27, 1984 (v. 130, no. 87, Part II)"

U.S. Congress. House. Committee on Energy and Commerce. Medicare and Medicaid Budget Reconciliation Amendments of 1983; report to accompany H.R. 4136. Oct. 26, 1983. Washington, G.P.O., 1983. 133 p. (Report, House, 98th Congress, 1st session, no. 98-442, part 1)

U.S. Congress. House. Committee on Ways and Means. [Medicare/Medicaid] In its Social Security Act Amendments of 1983; report to accompany H.R. 1900. Mar. 4, 1983. Washington, G.P.O., 1983. (Report, House, 98th Congress, 1st session, no. 98-25, part 1) p. 132-160, 271-305.

----- [Medicare/Medicaid] In its Tax Reform Act of 1983; report to accompany H.R. 4170. Oct. 21, 1983. Washington, G.P.O., 1983. (Report, House, 98th Congress, 1st session, no. 98-432) p. 444-466.

----- [Medicare/Medicaid] In its Tax Reform Act of 1984; supplemental report to accompany H.R. 4170. Washington, G.P.O., 1984. (Report, House, 98th Congress, 2nd session, no. 98-432, part 2) p. 835-850, 982-1013, 1661-1663, 1791-1811.

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Administration's proposed elimination of the Office of Direct Reimbursement at the Health Care Financing Administration. Hearing, 98th Congress, 1st session. Sept. 14, 1983. Washington, G.P.O., 1984. 106 p.
"Serial 98-42"

U.S. Congress. House. Select Committee on Aging. Subcommittee on Health and Long-Term Care. Briefing on President Reagan's proposed changes in the Medicare program: Boston, Mass. Washington, G.P.O., 1984. 37 p.
At head of title: Committee print.

U.S. Congress. Senate. Committee on Finance. Background materials relating to S. 505 and other health care cost containment proposals. Washington, G.P.O., 1979. 34 p.
At head of title: 96th Congress, 1st session. Committee print CP 96-6.

----- Background material related to Medicare financing issues. Apr. 1984. Washington, G.P.O., 1984. 366 p. (Print, Senate, 98th Congress, 1st session, committee print, S. Prt. 98-172)

----- Explanation of the Administration's Medicare hospital prospective payment proposal as compared to current law. Washington, G.P.O., 1983. 21 p.
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, 1984. Washington, G.P.O., 1984. (Report, Senate, 98th Congress, 2nd session, no. 98-169) vol. 1, p. 938-979; vol. 2, p. 1196-1286.

----- 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; report on H.R. 934. Washington, G.P.O., 1979. 172 p. (96th Congress, 1st session. Senate. Report no. 96-471)

----- Proposals for Medicare-Medicaid reform and overall hospital revenues limitation. Washington, G.P.O., 1979. 34 p.
At head of title: Committee print CP 96-10.

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health. Medicare-Medicaid administrative and reimbursement reform. Hearings, 94th Congress, 2nd session, on S. 3205. July 26-30, 1976. Washington, G.P.O., 1976. 604 p.

----- Medicare-Medicaid Administrative and Reimbursement Reform Act. Hearings, 95th Congress, 1st session, on S. 1470. June 7-10, 1977. Washington, G.P.O., 1977. 638 p.

U.S. Congress. Senate. Committee on the Budget. [Medicare/Medicaid] In its Omnibus Reconciliation Act of 1983; report to accompany S. 2062. Nov. 4, 1983. Washington, G.P.O., 1983. (Report, Senate, 98th Congress, 1st session, no. 98-300) p. 133-164, 178-180.

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)
Hearing held Dec. 13, 1983, Sioux City, Iowa.

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 beneficiaries, and for other purposes; to make improvements in the Medicare and Medicaid programs, and for other purposes; and to provide for prospective 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

Ashcraft, Marie L. F., and S. E. Berki. Health maintenance organizations as Medicaid providers. In Health care policy in America. Philadelphia, American Academy of Political and Social Science, 1983. (Annals, v. 468, July 1983) p. 122-131.

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."

Bergen, Stanley S., and Amy Conford Roth. Prospective payment and the university hospital. New England journal of medicine, v. 310, Feb. 2, 1984: 316-318.

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

Buchanan, Robert J. Medicaid cost containment: prospective reimbursement for long-term care. Inquiry (Chicago), v. 20, winter 1983: 334-342.

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.

Competition in the health-care marketplace: a beginning in California. New England journal of medicine, v. 308, Mar. 31, 1983: 788-792.

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.

Corbin, Mildred, and Aaron Krute. Some aspects of Medicare experience with group-practice prepayments plans. Social security bulletin, v. 38, Mar. 1975: 3-11.

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."

Davis, Karen. Hospital costs and the Medicare program. Social security bulletin, v. 36, Aug. 1973: 18-36.
"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."

Demkovich, Linda E. Verdict is still out on prototype of new hospital cost-cutting plan. National journal, v. 15, Dec. 10, 1983: 2573-2576.
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.

----- When Medicare tears up the blank check, who will lend hospitals capital? National journal, v. 16, Jan. 21, 1984: 113-116.
"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."

Doremus, Harvey D., and Elena M. Michenzi. Data quality: an illustration of its potential impact upon a diagnosis-related group's case mix index and reimbursement. Medical care, v. 21, Oct. 1983: 1001-1011.
"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."

Feder, Judith, and Bruce Spitz. The politics of hospital payment. Journal of health politics, policy and law, v. 4, fall 1979: 435-463.
"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.

Feuerherd, Kathy M. New strategies for containing hospital costs under Medicaid. Forum/Health Care Financing Administration, v. 5, Oct. 1981: 18-21.
"Explores what states are doing or can do to implement cost-constraining ratesetting systems, given recent significant legislative changes."

Friedman, Bernard. Economic aspects of the rationing of nursing home beds. Journal of human resources, v. 17, winter 1982: 59-71.
"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."

Ginsburg, Paul B. Issues in Medicare hospital reimbursement. National journal, v. 14, May 22, 1982: 934-937.

"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."

Grimaldi, Paul L. Medicaid reimbursement of nursing-home care. Washington, American Enterprise Institute for Public Policy Research [1982] 194 p. (AEI studies, 333) RA997.G74 1982

Studies in health policy.

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.

----- The role of profit in a reimbursement plan. American Health Care Association journal, v. 7, July 1981: 2-6, 8.

"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."

Hadley, Jack. Medicaid reimbursement of teaching hospitals. Journal of health politics, policy and law, v. 7, winter 1983: 911-926.

"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."

Hay, Joel W. The impact of public health care financing policies on private-sector hospital costs. Journal of health politics, policy and law, v. 7, winter 1983: 945-952.

"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."

Hellinger, Fred J. Hospital charges and Medicare reimbursement. Inquiry (Chicago) v. 2, Dec. 1975: 313-319.

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

Hitchner, Carl H. Medicare and Medicaid reimbursement of teaching hospitals and faculty physicians. Journal of college and university law, v. 10, 1983-1984: 79-91.

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."

Iglehart, John K. Medicare begins prospective payment of hospitals. New England journal of medicine, v. 308, June 9, 1983: 1428-1432.

"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."

----- The new era of prospective payment for hospitals. New England journal of medicine, v. 307, Nov. 11, 1982: 1288-1292.

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.

Kinney, Eleanor D., and Bonnie Lefkowitz. Capital cost reimbursement to community hospitals under Federal health insurance programs. Journal of health politics, policy and law, v. 7, fall 1982: 648-666.

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

Lundy, Janet. Hospital insurance under Medicare: the financing problem. [Washington] Congressional Research Service, 1983. 15 p. (Issue brief ib83019)

Regularly updated.

----- Prospective payments for Medicare inpatient hospital services. [Washington] Congressional Research Service, 1983. 16 p. (Issue brief ib83171)

Regularly updated.

Michaelson, Michael G. Reagan Administration health legislation: the emergence of a hidden agenda. Harvard journal on legislation, v. 20, summer 1983: 575-599.

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."

Passett, Barry A. Reform Medicaid? The view from a community hospital. Forum/Health Care Financing Administration, v. 5, Oct. 1981: 30-34.
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."

Petersdorf, Robert G. Progress report on hospital cost control in California: more regulation than competition. New England journal of medicine, v. 309, July 28, 1983: 254-256.
Comments on the effectiveness of the introduction of competition into the health care industry through the use of Medicaid contracts.

The Propriety of reimbursement by Medicare for Hill-Burton free care. University of Pennsylvania law review, v. 130, Apr. 1982: 892-918.
"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."

U.S. Congress. House. Committee on Energy and Commerce. Subcommittee on Health and the Environment. Prospective reimbursement for hospitals. Hearing, 97th Congress, 2nd session. Nov. 22, 1982. Washington, G.P.O., 1983. 324 p.

U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Health and the Environment. Reimbursement of rural clinics under Medicare and Medicaid. Hearing, 95th Congress, 1st session, on H.R. 8543, H.R. 791, H.R. 8459, H.R. 6259, H.R. 2504 and H.R. 8422. July 29, 1977. Washington, G.P.O., 1977. 147 p.
"Serial no. 95-45"

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Cost-based reimbursement of hospitals under Medicare; alternatives and issues. Washington, G.P.O., 1976. 8 p.
At head of title: 94th Congress, 2nd session. Committee print.

----- Medicare coverage and reimbursement of skilled nursing facility services. Hearing, 97th Congress, 2nd session. Feb. 2, 1982. Washington, G.P.O., 1982. 84 p.
"Serial 97-40"

----- Medicare hospital prospective payment system. Hearings, 98th Congress, 1st session. Feb. 14 and 15, 1983. Washington, G.P.O., 1983. 310 p.
"Serial 98-6"

----- Medicare reimbursement issues. Hearings, 94th Congress, 2nd session. Aug. 3 and Sept. 15-16, 1976. Washington, G.P.O., 1976. 610 p.

U.S. Congress. House. Select Committee on Aging. Administration's proposed payment system for hospice care. Hearing, 98th Congress, 1st session. May 25, 1983. Washington, G.P.O., 1983. 195 p.
"Comm. pub. no. 98-394"

U.S. Congress. Senate. Committee on Agriculture, Nutrition, and Forestry. Subcommittee on Rural Development. Medicare reimbursement for rural health care clinics. Hearing, 95th Congress, 1st session. Mar. 29, 1977. Washington, G.P.O., 1977. 429 p.

U.S. Congress. Senate. Committee on Finance. Materials relating to health care cost containment and other proposals. Washington, G.P.O., 1979. 37 p.
At head of title: 96th Congress, 1st session. Committee print CP 96-9.

----- Staff data and materials related to Medicaid and long-term care. Washington, G.P.O., 1984. 32 p. (Print, Senate, 98th Congress, 1st session, committee print, S. Prt. 98-112)

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health. Hospital prospective payment system. Hearing, 98th Congress, 1st session. Parts 1-2. Feb. 2 and 17, 1983. Washington, G.P.O., 1983. 2 v. (Hearings, Senate, 98th Congress, 1st session, S. Hrg. 98-60, parts 1-2)

----- Hospital reimbursement systems used by private third-party payors. Hearing, 97th Congress, 2nd session. Sept. 16, 1982. Washington, G.P.O., 1983. 291 p.

----- Medicare reimbursement of HMO's. Hearing, 97th Congress, 1st session. July 30, 1981. Washington, G.P.O., 1981. 256 p.

----- State hospital payment systems. Hearings, 97th Congress, 2nd session. June 23, 1982. Washington, G.P.O., 1982. 249 p.

U.S. Congress. Senate. Special Committee on Aging. Controlling health care costs: State, local, and private sector initiatives. Hearing, 98th Congress, 1st session. Oct. 26, 1983. Washington, G.P.O., 1984. 103 p. (Hearing, Senate, 98th Congress, 1st session, S. Hrg. 98-529)

----- Current developments in prospective reimbursement systems for financing hospital care; an information paper. Washington, G.P.O., 1983. 23 p. (Print, Senate, 98th Congress, 1st session, committee print, S. Prt. 98-108)

----- Medicare reimbursement to competitive medical plans. Hearing, 97th Congress, 1st session. July 29, 1981. Washington, G.P.O., 1981. 127 p.

----- Problems associated with the Medicare reimbursement system for hospitals. Hearing, 97th Congress, 2nd session. Mar. 10, 1982. Washington, G.P.O., 1982. 189 p.

U.S. General Accounting Office. Impact of Medicare reimbursement limits on small rural hospitals. Washington, 1982. 13, 9 p.
"GAO/HRD-82-109, Aug. 6, 1982"

----- Information on use of Medicare reimbursement method to determine hospital payments under the civilian health and medical program of the uniformed services, Department of Defense; report of the Comptroller General of the United States. [Washington] 1977. 17 p.
UB403.U55 1977

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

----- Need to more consistently reimburse health facilities under Medicare and Medicaid, Department of Health, Education, and Welfare; report to the Congress by the Comptroller General of the United States. [Washington] 1974. 50 p. HD7102.U4U55 1974

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

----- Problems associated with reimbursements to hospitals for services furnished under Medicare, Social Security Administration, Department of Health, Education, and Welfare; report to the Congress by the Comptroller General of the United States. [Washington] 1972. 65 p.
HD7102.U4U55 1972a

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

U.S. Health Care Financing Administration. Medicare program; changes to the inpatient hospital prospective payment system; proposed fiscal year 1985 rates; Final rule. Federal register, v. 49, Aug. 31, 1984: 34728-34797.

----- Perspectives on Medicaid and Medicare management. Baltimore, Md., U.S. Dept. of Health and Human Services [1980] 79 p. (U.S. Dept. of Health and Human Services. DHHS (HCFA) 80-20021) HD7102.U4P47

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.

Volk, Laura, Jeanne B. Hutchins, and Jean S. Doremus. A national cost-containment strategy for long-term care. Public administration review, v. 40, Sept.-Oct. 1980: 474-479.

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.'"

Wennberg, John E. Should the cost of insurance reflect the cost of use in local hospital markets? New England journal of medicine, v. 307, Nov. 25, 1982: 1374-1381.

"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

Boyles, William R. Why don't physicians like assignment? Forum/Health Care Financing Administration, v. 5, June 1981: 5-9.
Tries to "identify what factors increase physician acceptance of the Medicare payment over time."

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 renumeration 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."

Etheredge, Lynn. Medicare: paying the physican--history, issues, and options; an information paper prepared for use by the Special Committee on Aging, United States Senate. Washington, G.P.O., 1984. 37 p. (Print, Senate, 98th Congress, 2nd session, committee print, S. Prt. 98-153)

Felts, William R. The Medicare fee index--everyone loses. Medical economics, v. 52, Nov. 24, 1975: 86-88, 91, 93.
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."

Ferry, Thomas P., and others. Physicians' charges under Medicare: assignment rates and beneficiary liability. Health care financing review, v. 1, winter 1980: 49-73.
"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."

Hadley, Jack. Can fee-for-service reimbursement coexist with demand creation? By Jack Hadley, John Holahan, and William Scanlon. Inquiry (Chicago), v. 16, fall 1979: 247-258.
"Presents some evidence that physicians respond both to changes in relative prices and to absolute controls on their fees."

----- Toward a physician payment policy: evidence from the Economic Stabilization Program, by Jack Hadley and Robert Lee. Policy sciences, v. 10, Dec. 1978-1979: 105-120.
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."

Hendricks, James D. How much you can charge. Medical economics, v. 52, Sept. 29, 1975: 10-18.
States that there is no possibility that the Federal Government will dictate how much a doctor can earn from private practice.

Hill, David B. Physician participation in health care programs: bibliographic essay. Policy studies journal, v. 9, summer 1981: 1092-1096.
Identifies factors which influence physician participation in Medicare and Medicaid programs.

Holahan, John, and others. Paying for physician services under Medicare and Medicaid. Milbank Memorial Fund quarterly, v. 57, no. 2, 1979: 183-211.
"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."

----- Physician pricing in California: executive summary. [Washington, U.S. Health Care Financing Administration, 1979] 41 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (HCFA) 03005 9-79)

"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."

Huang, Lien-Fu. Controlling inflation of Medicare physicians' fees. Policy analysis, v. 3, summer 1977: 325-339.

"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."

Hunt, Karen. Congress draws a fresh bead on your fees. Medical economics, v. 60, July 11, 1983: 43, 47, 51.

"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."

----- Washington's 1984 game plan for physicians. Medical economics, v. 61, Jan. 9, 1984: 35, 38, 42, 47, 49, 52, 54, 57.

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."

Institute of Medicine. Medicare-Medicaid reimbursement policies; social security studies final report. Washington, G.P.O., 1976. 382 p.

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

Mitchell, Janet B. Medicaid participation by medical and surgical specialists. Medical care, v. 21, Sept. 1983: 929-938.

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."

Muller, Charlotte, and Jonah Otelsberg. Carrier discretionary practices and physician payment under Medicare Part B: a preliminary report. Medical care, v. 17, June 1979: 650-666.

"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."

----- Study of physician reimbursement under Medicare and Medicaid. [Washington, U.S. Health Care Financing Administration, 1979] 2 v. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (HCFA) 03008 9-79) R728.5.M84

"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."

Myers, Robert J. How they've perverted the Medicare payment system. Medical economics, v. 50, Feb. 19, 1973: 229, 233, 235, 239-240.

"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."

O'Sullivan, Jennifer, and Glenn Markus. How Medicare pays doctors. Washington, Congressional Research Service, 1984. 34 p. (Report no. 84-41 EPW)

Paringer, Lynn. Medicare assignment rates of physicians: their responses to changes in reimbursement policy. Health care financing review, v. 1, winter 1980: 75-89.

"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."

Peck, Richard L. H.E.W. launches a new move to control doctors' fees. Medical economics, v. 55, Sept. 18, 1978: 35, 38, 42, 46, 50, 55.

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

Physician's guide to DRGs, edited by Robert J. Shakno. Chicago, Ill., Pluribus Press, 1984. 232 p. HD7102.U4P492 1984

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."

Rice, Thomas H. The impact of changing Medicare reimbursement rates on physician-induced demand. Medical care, v. 21, Aug. 1983: 803-815.

"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."

Rosenberg, Charlotte L. As their problems spread, so will yours. Medical economics, v. 60, Oct. 3, 1983: 112, 114-115, 118, 121, 124, 129, 133, 136, 141.

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.

----- Will doctors tolerate another Medicare squeeze? Medical economics, v. 54, Oct. 17, 1977: 113, 117, 121-122, 124, 129.

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."

Shwartz, Michael, and others. The effect of a thirty per cent reduction in physician fees on Medicaid surgery rates in Massachusetts. American journal of public health, v. 71, Apr. 1981: 370-375.

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 eight elective surgical procedures were performed."

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Physician reimbursement under Medicare: current policy, trends, and issues. Washington, G.P.O., 1980. 58 p.

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, 98th Congress, 1st session, joint committee print, S. Prt. 98-106)

"WMCP: 98-16"

"Serial no. 98-P"

U.S. General Accounting Office. Study of the application of reasonable charge provisions for paying physicians' fees under Medicare, Social Security Administration, Department of Health, Education, and Welfare; report to the Special Committee on Aging, United States Senate by the Comptroller General of the United States. [Washington] 1973. 56 p.

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

Warner, Judith S. Trends in the Federal regulation of physicians' fees. Inquiry (Chicago), v. 13, Dec. 1976: 364-370.

"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

Exotech Research & Analysis, inc. Reimbursement for durable medical equipment; volume I (final report). [Baltimore] Health Care Financing Administration, 1980. 210 p. (U.S. Dept. of Health, Education, and Welfare. DHEW publication no. (HCFA) 03018)

"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."

Lee, A. James, Dennis Hefner, and Ralph Hardy, Jr. Evaluation of the maximum allowable cost (MAC) for drugs program: phase I report: final design report and report of pilot study analysis. [Baltimore] Health Care Financing Administration, 1980. 239, 20, 45 p.

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

Partial contents.--Background on the MAC/EAC [Estimated Acquisition Cost] program.--An overview of the pharmaceutical marketplace.--A review of literature relevant to MAC-EAC evaluation.--The hypotheses and conceptual perspective for MAC evaluation.--Survey of Medicaid drug programs. --Econometric analysis--a cross section/time series model of Medicaid drug reimbursement experience in the States.

Lowrie, Edmund G., and C. L. Hampers. The success of Medicare's end-stage renal-disease program: the case for profits and the private marketplace. New England journal of medicine, v. 305, Aug. 20, 1981: 434-438.

"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."

Moon, Marilyn. Changing the structure of Medicare benefits: issues and options. Washington, U.S. Congressional Budget Office, 1983. 82 p.
HD7102.U4M665 1983

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."

Sawyer, Darwin O. Pharmaceutical reimbursement and drug cost control: the MAC experience in Maryland. Inquiry (Chicago), v. 20, spring 1983: 76-87.

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

Smith, Michael Ira, and Albert I. Wertheimer. Maximum allowable cost: can the Government control drug costs? Journal of health politics, policy and law, v. 5, summer 1979: 155-175.

"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."

U.S. Bureau of Health Insurance. Review of Medicare payments to renal physicians under the alternative method of reimbursement. Washington, G.P.O., 1977. 20 p.

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.

U.S. Bureau of Health Manpower. Division of Associated Health Professions. Report to the Congress: reimbursement under part B of Medicare for certain services provided by optometrists; as required by title I, section 109, of P.L. 94-182. [Washington] U.S. Bureau of Health Manpower, 1976. 132 p.
RE959.3.U54 1976

"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."

U.S. Congress. House. Committee on Ways and Means. Subcommittee on Health. Medicare coverage of emergency response systems and direct reimbursement of mental health specialists. Hearing, 97th Congress, 2nd session, on H.R. 3921 and H.R. 6092. Dec. 14, 1982. Washington, G.P.O., 1983. 297 p.

"Serial 97-87"

----- Medicare reimbursement for physician extenders practicing in rural health clinics. Hearing, 95th Congress, 1st session, on H.R. 2504. Feb. 28, 1977. Washington, G.P.O., 1977. 203 p.

"Serial no. 95-8"

U.S. Congress. Senate. Committee on Finance. Proposed prospective reimbursement rates for the end-stage renal disease (ESRD) program under Medicare. Washington, G.P.O., 1982. 62 p.

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

U.S. Congress. Senate. Committee on Finance. Subcommittee on Health. Proposed prospective reimbursement rates for the end-stage renal disease program. Hearing, 97th Congress, 2nd session. Mar. 15, 1982. Washington, G.P.O., 1982. 406 p.

U.S. General Accounting Office. Home health care services--tighter fiscal controls needed; report to the Congress by the Comptroller General of the United States. [Washington] 1979. 48 p.
"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."

----- Programs to control prescription drug costs under Medicaid and Medicare could be strengthened; report by the Comptroller General of the United States. [Washington] 1980. 55 p.
"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."

Wriston, Sara. Nurse practitioner reimbursement. Journal of health politics, policy and law, v. 6, fall 1981: 444-462.
"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

Demkovich, Linda E. Technological medical breakthroughs may collide with new cost controls. National journal, v. 15, Apr. 30, 1983: 892-893.
"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."

Greenberg, Barbara, and Robert A. Derzon. Determining health insurance coverage of technology: problems and options. Medical care, v. 19, Oct. 1981: 967-978.

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."

Medical technology and costs of the Medicare program. Washington, Congress of the U.S. Office of Technology Assessment, for sale by the Supt. of Docs., G.P.O., 1984. 2 v.

"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.

Potter, Dave. Health care: the high price of technology. Denver magazine, v. 12, Oct. 1982: 26-31.

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

Stein, Jane. Keeping an eye on the medical technology store. National journal, v. 11, June 9, 1979: 958-961.

"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

Altman, Drew. Health care for the poor. In Health care policy in America. Philadelphia, American Academy of Political and Social Science, 1983. (Annals, v. 468, July 1983) p. 103-121.

"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."

Feder, Judith, and John Holahan. Financing health care for the elderly: Medicare, Medicaid, and private health insurance. Washington, Urban Institute, 1979. 106 p. RA413.7.A4F42

"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."

Link, Charles R., Stephen H. Long, and Russell F. Settle. Cost sharing, supplementary insurance, and health services utilization among the Medicare elderly. Health care financing review, v. 2, fall 1980: 25-31.

"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."

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