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PROSPECTIVE PAYMENT TO MEDICAL STAFFS: A PROPOSAL

by W. Pete Welch

Prologue: The issue that troubles analysts more than any other when the prospect of a Medicare physician fee schedule is discussed is its likely inability to control increases in the volume and intensity of Part B services. Over the past decade, increases in volume and intensity of services have accounted for about half of the rise in Medicare payments to physicians per beneficiary. Price increases have accounted for the other half. In this paper, economist Pete Welch proposes to moderate the growth of Part B physician spending by paying doctors prospectively through hospital medical staffs. As he points out, such an approach would deal with the volume and intensity issue in an explicit fashion. Welch holds a doctorate in economics from the University of Colorado. He served on the faculty of the University of Pittsburgh for seven years (1977–1984), at which point he joined the staff of the President’s Office of Management and Budget (OMB). While working in the OMB’s budget review division, Welch devoted his attention to Medicare, Medicaid, the veterans’ medical care program, and the Federal Employee Health Benefits Program. Welch joined the Urban Institute in 1987 as a senior research associate. At the institute, he has worked largely on projects funded by the Health Care Financing Administration, including capitation payment and adoption of a geographic price index that would lessen the wide variations in Medicare payments to physicians by relating payment to the cost of practice in the area.
Medicare physician spending per beneficiary grew at a compound annual rate of 15 percent between 1975 and 1987, and is expected to triple over the next decade.\(^1\) The crux of the spending problem is how to give physicians some incentives to contain costs, without jeopardizing quality of care and without placing physicians at unacceptable risk in a small risk pool. This article argues that a prospective payment system that defines the medical staff in a hospital as the risk pool solves all three aspects of this problem.

**Policy Context**

The Health Care Financing Administration (HCFA) introduced a prospective payment system (PPS) for hospital inpatient care in 1983. Under PPS, each patient is categorized into a diagnosis-related group (DRG), and payment reflects the average cost of the DRG. HCFA is now considering extending PPS to surgery performed in hospital outpatient departments and ambulatory surgical centers (ASCs). The next logical extension would seem to be DRG-based prospective payment for physician services in hospitals, both inpatient and outpatient. Under such a system Medicare would “bundle” all physician services associated with an episode of hospital care, and make a single payment for that bundle according to a formula analogous to that used for hospital PPS.

Congress, when enacting PPS in 1983, mandated a study of prospective payment for inpatient physician services, which was completed two years later\(^2\) By the end of 1985, however, Otis Bowen became secretary of health and human services (HHS), and soon thereafter William L. Roper became administrator of HCFA. Both are physicians; Bowen and Roper vigorously opposed prospective payment for physicians, as did organized medicine. Yet in 1987, the Reagan administration proposed prospective payment for hospital-based physicians (radiologists, anesthesiologists, and pathologists). With only nominal support from HHS and small budget savings, the proposal was not enacted. In the meantime, Congress established the Physician Payment Review Commission (PPRC).\(^3\)

The reform proposal for Medicare’s payment of physician services with the most political support at the moment is a fee schedule.\(^4\) However, a fee schedule provides no control over volume increases and could, in fact, aggravate the problem. Physicians sometimes respond to fee freezes or reductions by increasing volume to maintain their income.\(^5\) A fee schedule necessarily would increase the fees of some physicians and lower those of others; if the former maintained volume and the latter increased volume, total volume would increase.
Possible Risk Pools

The most fundamental question regarding prospective payment for physician services is whom to pay. In other words, which group or risk pool should share the risk of excessive costs? In the early discussion of prospective payment for physician services, there was no consensus on the risk pool. In the congressionally mandated study on prospective payment for inpatient physician expenditures, the foremost work on the topic, much of the analysis was relevant only to payment to the attending physician. Another work in the same year did not appear to favor one risk pool over another.

By 1986, however, analysts started to focus on the medical staff as the appropriate risk pool. By 1987, a consensus seemed to be emerging. Janet Mitchell and colleagues appeared to favor paying a hospital’s medical staff, organized as an individual practice association (IPA). The Department of Health and Human Services agreed. Needless to say, the HHS report to Congress reflected the political leadership’s rejection of any prospective payment. Thus, by the time analysts started to conclude that the medical staff was the logical recipient of a prospective payment, any such payment scheme had fallen off the political radar screen. The risk pool alternatives are discussed briefly below.

Attending physician. Under this arrangement, other physicians would be subcontractors to the attending physician, who would receive the lump-sum payment, pay the other physicians for their services, and keep whatever was left. He or she would have the strongest possible incentive to be a prudent buyer of the services of other physicians.

Paying the attending physician, however, has two serious problems. First, the attending physician would be exposed to considerable financial risk. Second, and perhaps even more important from a policy point of view, is that the strength of the incentives to cut costs under such a system would threaten quality of care. Congress apparently agrees; in 1986 it prohibited hospitals from using physician-specific financial incentives to cut costs.

Payers’ inability to distinguish between medically appropriate expenses and inappropriate ones is inherent in any payment system. The best that can be done is to give physicians the appropriate incentives to control costs without compromising quality of care. The present system, under which they retain none of any cost savings, is one extreme. A fixed payment, which would allow the attending physician to retain all of any savings, is the other. The incentives to cut costs under the current system are zero. The incentives under a fixed payment to a single physician are enough to threaten quality of care.
**Hospital.** The problems outlined above largely disappear if risks are shared by all the physicians in a hospital, whether this involves a payment to the medical staff or the hospital. The risk to the individual physician is greatly reduced by the large number of physicians involved. DRGs explain a greater proportion of the variance of physician expenditures than hospital expenditures, so the risk would be lower. Experience has demonstrated that risk to the hospital under PPS is acceptable.

A hospitalwide risk pool could take the form of payment either to the medical staff (that is, the physicians with privileges at a particular hospital) or to the hospital as the legal unit. Under the latter, the hospital would receive two checks from Medicare, one from Part A (as it does now) and one from Part B for physician services. The hospital then would be responsible for paying physicians for their treatment of Medicare patients in the hospital. Paying the hospital as a unit has the theoretical advantage over separate payments to the hospital and the medical staff in that a single entity would, in principle, be responsible for a patient’s treatment and would be able to use hospital and physician inputs in the most efficient combination.

Although theoretically attractive, this combined payment ignores the reality of physicians’ strong preference for professional autonomy, which hospital administrators do not challenge. Decisions about physician inputs rest mainly with physicians anyway. Paying the hospital would increase physicians’ resistance without necessarily improving the hospital’s efficiency. Further evidence is that even in health maintenance organizations (HMOs)—perhaps the most radical alternative to fee-for-service payment—physicians are rarely on salary (that is, hired as employees). Only staff-model HMOs, with 11 percent of HMO enrollment, actually hire physicians as employees.

**Geographic area.** Another option is to constitute all physicians in a geographic area as the risk pool. There is serious interest among policy makers for this alternative, called “expenditure caps.” Its fundamental problem, however, is its lack of a mechanism to translate areawide incentives into incentives for individual physicians. Unlike medical staffs, which can refuse to grant admitting privileges, physicians in a metropolitan area cannot deny new physicians the opportunity to practice there. Also, peer pressure is unlikely to influence behavior at the area level as well as it does among medical staffs, which practice in the same building. Paying by geographic area and paying by medical staff, however, are not mutually exclusive; an area’s risk for some of its expenditures could be transferred to medical staffs. This is the most promising variant of the expenditure cap approach.

**Medical staff.** The medical staff of a hospital, as noted, consists of all
physicians with privileges at that hospital. I contend that paying the medical staff would avoid most of the problems with the other options. Unlike paying the attending physician, paying the medical staff spreads the risk in a way that does not threaten quality of care. Unlike paying the hospital, paying the medical staff does not threaten professional autonomy. Unlike paying the metropolitan area, paying the medical staff uses mechanisms that encourage its member physicians to control costs.

### Payment Mechanisms, Billing Limits, And Ambulatory Surgery

The reimbursement system proposed here is prospective payment for physician services associated with a hospital admission or outpatient department surgery, with the hospital’s medical staff as the risk pool. The amount of the payment would be determined, as is now the case for Medicare payments to hospitals, by the patient’s DRG. The two major dimensions of such a system are the payment mechanism and the kind of billing limits that will be imposed (mandatory assignment versus balance billing, for example).

**Payment mechanism.** Medicare could pay each physician directly or make the payment to the medical staff as a legal entity. From Medicare’s point of view, it is preferable that physicians be paid explicitly as a group, because the ability to control the utilization of individual physicians would be strengthened. Since most medical staffs are not currently organized as legal entities that are able to accept and disburse funds—except for medical staffs in medical school hospitals—I discuss payment to individual physicians first. It seems preferable to implement a new system with minimal dependence on new institutional forms. At first, Medicare would only have to change the way its carriers pay physicians.

**Initial arrangement.** Under this arrangement, Medicare would continue to pay physicians directly for hospital services, but would withhold, say, 10 percent of its payment to physicians pending evidence on their cost-containment success. At the end of a year, Medicare would perform the following calculations for each staff: Budget equals the sum of DRG-based payments for physician services; expenses equal the sum of allowable charges for physician services; and surplus (deficit) equals budget minus expenses.

The medical staff’s surplus (or deficit) would then be prorated and paid to the individual physicians according to their charges. For a staff with a surplus of 6 percent, for example, physicians would be allocated 6 percent more for each Medicare charge than what they are receiving under the current system. At the end of the year, these physicians would receive 16 percent—the 10 percent withheld plus the 6 percent surplus.
For a staff with a deficit of 3 percent, for example, physicians would receive 7 percent—the 10 percent withheld minus the 3 percent deficit. A medical staff would gain or lose to the extent its member physicians controlled costs. This financial arrangement is similar to that of many IPAs, which now have a majority of the enrollment of all HMOs. IPAs create risk pools of physicians in several ways, one of which is a pool of physicians who practice in the same hospital. Thus, a medical-staff-level risk pool is a concept that can be borrowed from the private sector.

Converting to a practice plan. As noted, it is in Medicare’s interest to encourage each medical staff to create an organization that would receive the payments and disburse them to individual physicians, because this would strengthen the group’s ability to control the utilization of its members. A staff could request that the Medicare payment be made to itself as a legal entity instead of to each physician. The total payment amount would be the same, but the organization would be responsible for paying each physician.

Such arrangements are common in medical schools, where they are called practice plans. In 93 percent of medical schools, payment for physician services is made to a faculty practice plan, not the individual physician. In a few medical schools, the dean disburses these funds. More commonly, the dean’s office receives a fraction that rarely exceeds 10 percent, with the remainder going to the clinical department. These funds usually are given to faculty members according to a predetermined formula that rewards clinical productivity. Were medical staffs paid prospectively, such formulas could easily be changed to reward the practice of cost-effective medicine, as they are when hospitals are capitated as part of HMOs. (for example, University of California at San Diego Medical School).

One incentive to encourage such organization would be quicker payment by not withholding an initial amount. Another might be to set less restrictive balance billing limits for practice plans than for individual physicians (subject to congressional decisions, as discussed further below). This would also facilitate competition among medical staffs, because a single figure would be associated with each group, and information on it would be available to potential patients.

Mandatory assignment or balance billing. Perhaps the most important political issue involved in the prospective payment debate is mandatory assignment, under which physicians would have to accept Medicare’s specified payment level (including copayments by the beneficiary) as payment in full. At the other extreme, physicians could refuse assignment, in which case they charge whatever they wish, and the beneficiary is liable for any increment over what Medicare pays.
The argument for mandatory assignment is best seen in a prospective payment system with the attending physician as the risk pool. Medicare’s payment would reflect the average cost per case. Without mandatory assignment, for cases below average cost, physicians presumably would accept the prospective payment. For cases above average cost, physicians presumably would bill the beneficiary for the additional cost. Thus, without billing limits, prospective payment could easily increase payments to physicians in comparison to the current system instead of decreasing them. A danger of cost shifting to beneficiaries would exist for a medical staff system as well.

There is both political and analytical opposition to mandatory assignment. The political opposition comes from physicians. The analytical opposition comes from some economists, who argue that Medicare’s geographic adjustment may not reflect regional variation well enough to ensure equal access—an argument that is applicable to fee schedules as well as to prospective payment. Wherever Medicare sets payment too low relative to the local market, perhaps because other payers are especially generous, physicians may be able to avoid treating Medicare patients. Beneficiaries’ access to physicians thus could suffer.

Between the extremes of mandatory assignment and unlimited billing by physicians lie limits on billing. Billing limits were imposed in 1987, when Medicare established maximum allowable actual charges (MAACs) as the maximum fees physicians can charge Medicare and the beneficiary in total. Under MAACs set at, say, 115 percent of prevailing charges, Medicare would pay 80 percent of the prevailing charge, and the beneficiary would pay 20 percent of the prevailing charge plus the increment over the prevailing charge up to 15 percent. The MAACs, except for cataract surgery, originally applied to a physician’s charge for a given procedure averaged over all beneficiaries. As of April 1, 1988, the MAACs apply to each charge. Because MAACs protect beneficiaries from cost shifting, mandatory assignment is not necessary for prospective payment to the medical staff.

Ambulatory surgery. Surgery can be performed in outpatient departments and ambulatory surgical centers as well as inpatient settings. If hospital PPS is extended to surgery performed in outpatient departments and ASCs, the payment units will be aggregates of CPT4 codes instead of DRGs. The same payment units should be used as for physician PPS.

An ASC’s physicians are the analog to a medical staff and could serve as the risk pool. Because global billing is common for surgery, this would be an incremental change. Unlike paying the attending physician (discussed above), the financial risk might be acceptable because the costs of surgical cases vary over a much narrower range than the costs of medical cases.
However, the incentive to cut quality might be excessive. Thus, ASCs with few physicians should receive half prospective and half fee-for-service payments.

How The Proposal Would Work

This proposal hinges on how physicians respond to their staffs’ incentives (internal incentives) and how physicians select staffs and vice-versa (external incentives). Because medical staffs do not now constitute risk pools, they do not use internal mechanisms that control cost. Such mechanisms are available, however. Thus, a major impact of prospective payment for medical staffs over time would be institution building in ways that effectively control costs.

Internal incentives. To understand the incentives that this proposal would give physicians, consider a medical staff with 100 physicians, each of whom admits 1 percent of the patients. One attending physician might have to decide whether to use a surgical assistant costing $100. This cost would be shared equally by all members of the staff, such that the surgical assistant would cost the decision-making physician only one dollar. Because of the small incentive to the actual decisionmaker, this proposal can contain costs only if the medical staff develops mechanisms to police its members. Several possible mechanisms are available.

Selection. To admit patients to a hospital, a physician must first be on the medical staff. At the moment, selection of physicians may not be a very effective mechanism for quality (or cost) control. In 1985, only 38 percent of hospitals used references regarding an applicant’s clinical competence, only 16 percent inspected patient records, and only 7 percent required evidence of cost-effective provision of care. However, privileges are typically renewed annually; therefore, the process of obtaining credentials has the potential of weeding out physicians who do not practice cost-effective medicine.

Mandatory protocols. This mechanism specifies the standard set of services for a given procedure. If certain procedures do not normally require a surgical assistant, for example, a possible mechanism for cost control would be to make the medical director responsible for approving any exception. Almost half (49 percent) of physicians admitted most of their patients to a hospital that had a full-time medical director in 1982, and this percentage appears to be growing rapidly.

Hospital- or staff-level decisions. Decisions, particularly on capital for laboratory tests and radiology, that affect physician time are other mechanisms. Although capital decisions are nominally made by hospital administrators, physicians play a major role. New equipment might
increase physician expenditures and hence decrease the physician surplus. Under a risk pool, the staff would be more inclined to support cost-reducing technology instead of quality-enhancing, cost-increasing technology.

**Exclusive contracts.** Exclusive contracts with hospital-based physicians give a physician or a group of physicians the exclusive right to practice their specialty in a hospital, and ensure the hospital of continuous availability of the service. In 1984, the proportion of hospitals having exclusive contracts was 60 percent for radiologists, 30 percent for anesthesiologists, and 62 percent for pathologists. Hospitals have had little reason to negotiate payment rates under exclusive contracts, such that the financial return on training costs is higher for these three specialties than for most. This scheme would give hospitals and their medical staffs an incentive to bargain fees down.

**Peer pressure.** Although clearly insufficient by itself, this informal mechanism may be effective in conjunction with other mechanisms because members of the staff who work in the same building have face-to-face contact. It is unlikely to affect a group of physicians spread over a large area.

**Department-level risk pools.** This mechanism can be used by medical staffs that become practice plans. Large hospital size offers both problems and opportunities regarding risk sharing. On one hand, the larger the hospital, the smaller each physician’s share of the total cost, the more impersonal the staff, and presumably the less peer pressure to behave in the interest of the entire staff. On the other hand, the larger the hospital, the larger the typical department, and the less risk were it to serve as a risk pool. Department-level risk pools are too small to be adequate spreaders of risk in small hospitals but may be large enough in large hospitals. In most medical schools, departments already receive physician reimbursement (usually through the medical school) and have discretion over payment of their physicians. Johns Hopkins Hospital has taken this a step further by making each department financially responsible for the costs of physicians, nursing, and services ordered from other departments (for example, radiology) but not for overhead such as accounting costs.

There are two things that Medicare should do to help medical staffs contain costs. First, it should direct carriers to give staffs data on their DRG-adjusted utilization rates by service and by physician. Second, Medicare should empower medical staff utilization review (UR) committees to recommend denial of payment of specific charges, subject to approval by peer review committees. Since its establishment, Medicare has required each hospital to have a UR committee, so that the infrastructure already exists. Giving an arm of the medical staff a mechanism
to deny payment would strengthen mandatory protocols.

If prospective payment pertains to only a small proportion of a hospital’s patients, it may stimulate little cost containment. However, in 1988, the elderly accounted for 33 percent of hospital admissions and 43 percent of hospital days. Since these admissions are covered by Medicare, physicians are likely to respond to the incentives under Medicare.

**External incentives.** Physicians who admit to only one hospital are likely to be more committed to working on cost-containment measures there than physicians whose admissions are spread over several hospitals. Up to this point I have assumed that each physician has admitting privileges in only one hospital and has little opportunity to switch hospitals. I now examine the plausibility of these assumptions.

Physicians had privileges at an average of 2.1 hospitals in 1982. In 1978 (the latest pertinent data), 89 percent of a physician’s admissions were to his or her primary hospital. The number of hospitals at which the average physician has privileges has been dropping, however, suggesting that the concentration of admissions at the primary hospital has increased. Thus, physicians whose admissions are primarily at a single hospital are the norm.

Because hospitals are in greater proximity in large urban areas, physicians have privileges at more hospitals in those areas. In 1978, physicians had privileges at 2.7 hospitals in large metropolitan areas (versus 2.4 hospitals for all physicians in 1978); however, 87.5 percent of their admissions were at their primary hospital.

Were a medical staff to penalize a physician for costly practice, it would have to consider the possibility that he or she would shift patients to another hospital. This threat could lessen the staff’s ability to police the behavior of its members. The danger is more apparent than real, however, for several reasons: (1) patients prefer hospitals close to their homes; (2) physicians prefer hospitals that are close to their offices; (3) physicians also prefer hospitals with which they are familiar; (4) applying for staff privileges is not costless for the physician, reviewing such applications is not costless for the staff, and the outcome of a particular application may not be clear in advance; and (5) hospital privileges carry with them certain administrative responsibilities.

Needless to say, a physician who is a financial burden to one staff would probably burden another staff also. Hence, medical staffs may not be receptive to physicians who are high-cost at their present hospitals. One exception might be physicians whose patients are primarily non-Medicare.

Any opportunity for physicians to shift hospitals can strengthen cost containment. If cost-effective physicians move from staffs that do not
contain costs to staffs that do, the hospitals that they leave will lose
patients, and their staffs will experience additional increases in average
cost. Hospital administrators presumably will encourage their staffs to
to control costs.

This scheme is predicated on a behavioral response of medical staffs. If
there is no behavioral response, there will be a decrease in Medicare
payments to physicians, be they cost-conscious or profligate. Physicians
may be less willing to accept Medicare patients, resulting in a decrease in
access. This is unlikely for several reasons. First, staffs possess a range of
formal ways to cut expenditures. If one mechanism does not work
because of technical weakness or excessive opposition from physicians,
another may work. Second, staffs need not make formal changes, much
less organize practice plans. For instance, the climate of opinion among
physicians may change, so that there is less support for cost-increasing
equipment and less prestige for high-utilizing physicians. Third, most
financial incentives elicit a behavioral response, sometimes surprising
noneconomists.42

Sources Of Savings

For prospective payment to medical staffs to yield budget savings
without decreasing physician fees or shifting costs to beneficiaries, it must
lead to cuts in medically unnecessary services. HHS argued that savings
would be small, an argument that was weak for two reasons.43 First, some
expenditures can be cut through prospective payment or some alterna-
tive policy. For instance, assistance at surgery could be decreased through
national administrative rules. If prospective payment were implemented
instead, such savings would be properly attributable to prospective
payment policy. The report attributed these savings to administrative
rules. Second, recognizing the link between prospective payment for
hospital services and for physician services in the hospital, the HHS
report argued that PPS could indirectly cut physician services; for in-
stance, shorter lengths-of-stay could decrease the number of physician
visits. The report, however, ignored the corollary: that cuts in physician
services could lead to savings in hospital services. For instance, fewer
pathological and radiological services could result in savings for both Part
A and Part B.

Prospective payment to medical staffs could lead to savings in areas of
surgical assistance, ancillary services for radiologic tests, and consultations
that are mislabeled or provided by nonspecialists. One should not assume
that savings are limited to those that can be identified at a national level.
The general argument for incentives, whether in the health sector or
elsewhere, is as follows: specific providers, such as a medical staff, can identify savings that cannot be identified at a national level, because the provider is better informed about the nature of the particular situation. Consider surgical assistance, for example; because of carriers’ and HCFA’s inherent lack of knowledge about specific cases, any guideline has less opportunity for savings than an incentive system has. This general argument for incentives is implicit in PPS.

The proposal I have described here would apply cost control to more than one-third of Part B expenditures. In conjunction with an extension of the hospital PPS to outpatient surgery, half of Part B expenditures would be controlled.\(^{44}\)

### Counter-Arguments

**Lowering quality of care.** In spite of the fact that physicians would not profit as individuals from cutting services, the issue of quality of care will be raised. Lower quality of care was also a concern when prospective payment for hospitals was established and when HMOs were new. There is little evidence to date that quality of care has suffered under PPS.\(^ {45}\) The medical staff risk pool would be similar to the group-model HMO, whose average quality is at least as high as the quality in the fee-for-service sector.\(^ {46}\) In view of this evidence, prospective payment to medical staffs is as likely to increase quality of care as it is to decrease it.\(^ {47}\)

**Upcoding case-mix.** Under hospital PPS, there have been increases in the average case-mix index. Hospitals may have undercoded prior to PPS because it made little difference. Or hospitals may be actively upcoding to obtain more revenue than they deserve. Either way, the policy response has been to correct the payment level for increases in case-mix. Should there be case-mix creep under prospective payment to medical staffs, the same solution could be applied.

**Unbundling.** Medical staffs might shift, or unbundle, services that are normally part of the hospitalization episode outside the hospital immediately prior to or following the hospitalization. Such shifting could be lessened by defining the episode to include “windows”\(^ {48}\) that is, periods immediately preceding or following hospitalization, when fee-for-service charges would not be reimbursed. In addition, the opportunity for unbundling is restricted because testing, at least in some cases, is less accurate when performed too early and more dangerous when performed outside the hospital. More research is needed here. There also are dangers of physicians splitting admissions or admitting patients unnecessarily. However, peer review organizations are set up to ensure against that.
Shifting the site of care. There are two potential site-of-care problems. First, if prospective payment for surgery is limited to inpatient surgery, this may encourage more surgery to be done outside the hospital. This is another reason to extend physician PPS to freestanding ASCs. The second problem is shifting surgery from outpatient hospital departments back to inpatient settings. The shift of surgery from inpatient started prior to PPS but has been encouraged by PPS. Combining the two sites in a single payment system may reduce the incentive for outpatient surgery, but PRO monitoring should be sufficient to prevent unnecessary inpatient surgery.

Conclusion

Although prospective payment to the medical staff would be a major change in how physicians are paid, it is a natural extension of several existing institutions. First, hospital PPS provides a model that would be relatively easy to adapt. Second, many IPAs create risk pools of physicians in the same medical group or in the same hospital; this proposal would create a risk pool of each medical staff. Third, in most medical schools, professional fees are collected by faculty practice plans, which disburse them to clinical departments and physicians. This proposal would encourage, but not force, similar arrangements for other medical staffs.

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NOTES

4. PPRC, Medicare Physician Payment: An Agenda for Reform.


12. Paying the attending physician has several more minor problems. Determining who is attending, and hence who would be paid, could be a problem. Sometimes several physicians provide routine care to a patient during a hospital stay. To overcome this problem, Mitchell and colleagues defined the attending physician to be the physician with the largest Part B charges. Mitchell et al., “Creating DRG-Based Physician Reimbursement Schemes,” 3–8. This is fine for research but unusable for administration, if only because the data may come in long after the payment decision must be made. Another problem is that other physicians would object to the contractor-subcontractor relationship. Consultants would perceive themselves to be at the mercy of the attending physician and would fear losing income.

13. In addition, the attending physician does not have to be identified for the purposes of payment, and the issue of the relationship between the attending and other physicians is sidestepped.


18. Pedagogically, suppose each area received two budgets, one for physician services in the hospital and the other for services out of the hospital. The former budget would be allocated by DRGs to medical staffs, and the following proposal would apply. If admissions in the area increased total payment beyond the budget, payment from the area budget to each medical staff budget would be decreased proportionately. This would give the peer review organizations in each area an incentive to control admissions. (Other arrangements would be made for the out-of-hospital expenditures.) If an area approach was desired, incorporating the medical staff as a risk pool would move the risk for inhospital expenditures to a lower level, where it would be more easily managed.

19. For the purposes of this discussion, assume that beneficiaries make all copayments to
Medicare. Then budget and expense categories are comparable, because both include dollars paid by beneficiaries.

20. This withholding system is an incentive structure that could be established under the present system of customary, prevailing, and reasonable charges or under a fee schedule.


24. In general, physicians (or any supplier) can respond to different market conditions by varying the price or by varying the quantity supplied. Once the price for treating Medicare patients is fixed, physicians can only respond by varying the quantity, one form of which is to give preference to non-Medicare patients.

25. Ginsburg et al., “Planning a Demonstration.”

26. As with physician PPS for inpatient cases, an episode must be defined to exclude periods immediately preceding hospitalization when fee-for-service charges would not be reimbursed.


29. In teaching hospitals, residents play a major role in utilization. Under this scheme, medical staffs might select them with more of an eye to their practicing cost-effective medicine. Given their junior status, they may be particularly responsive to changes in incentives.

30. For a good summary of the literature on approaches to changing physician practices, albeit in a fee-for-service environment, see J.M. Eisenberg, *Doctors’ Decisions and the Cost of Medical Care* (Ann Arbor, Mich.: Health Administration Press, 1986).


33. Morrisey and Brooks, “The Myth of the Closed Medical Staff.” When weighted by number of beds, these become 72, 42, and 75 percent, respectively.


35. HCFA will implement a fee schedule for radiologists in 1989 and is studying one for anesthesiologists. Because the fees will be based on charges in an environment without competition, competition should drive fees down from these levels.

36. MacLeod and Swartz, “Faculty Practice Plans.”


40. Physicians spent 20 percent of their time at secondary hospitals, but had only 11 percent of their cases there. Musacchio et al., “Hospital Ownership.” This probably reflects the spreading of “fixed costs” over fewer patients; that is, the time spent for travel, administrative functions, and talking to nurses is probably greater per admission. The distribution of admissions is conceptually more appropriate here because it relates to payment.

41. Prior to prospective payment, hospitals competed through quality. See, for example, J.C. Robinson et al., “Hospital Competition and Surgical Length of Stay,” Journal of the American Medical Association (5 February 1988): 696–700. Whether quality attracted patients directly or attracted physicians who brought along their patients is unclear. In any case, the nature of competition is changed when hospitals and their medical staffs are paid prospectively.

42. For instance, prior to the energy crisis, it was widely believed that consumers and firms were insensitive to energy prices. However, when the real price of energy increased in 1974, demand fell sharply.

43. HCFA, Paying Physicians, 3–57.

44. The proposal would cover half of physician expenditures. (This estimate is based on extrapolation of 1985–1987 trends to 1989 and recognizes that a small proportion of outpatient department expenditures are not for surgery.) Physician expenditures are 78 percent of Part B. Hence, about 40 percent of Part B expenditures would be covered. In addition, 16 percent of Part B expenditures are facility fees to outpatient hospital departments, most of which would be covered by prospective payment. SMI Trust Fund, 1988 Annual Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund (Washington, D.C.: U.S. GPO, 1988).


46. H.S. Luft, Health Maintenance Organizations: Dimensions of Performance (New York: John Wiley, 1981). A group-model HMO contracts with its physician group. If the group meets cost targets, bonuses are paid to all full-fledged members. Thus, a medical staff risk pool can be seen as a groupmodel HMO in which the incentives are limited to inhospital physician services.

47. HCFA, Paying Physicians, 3–47.

48. Ginsburg et al., “Planning a Demonstration.”