SB

533

Senate Health, Education and Social Services Committee

Legislation Checklist

Bill number: SB 33

Sponsor: V. Fischer

Date referred to committee:

Synopsis completed: 1/10/85

Fiscal note:

Further referrals:

CONTACTS:

sandra

MEDICAID (Dennis DeWitt 1/85)

Federal/State 50/50 matching funds. Federal government prescribes maximum rate it will pay; state can get waiver to pay more than limit, but state pays 100% of costs over the limit. AK nursing care costs are higher than fed. limit (higher cost of living, generally provide more acute care) so state has waiver & ends up paying 60% of cost

Qualifying criteria are federally established. Need based (income and assets. Assets of $1500 excluding house.)

Total coverage. Patient pays no share. Covers specific activities and services only. Covers any age group as long as income status appropriate. (By contrast, Medicare is for those over 65 or under 21, not needs based, and totally federal funds.)

90% of nursing home beds in Alaska are Medicaid patients. State's annual share is $70-80 million. ($40,000/yr./bed)

Medicaid Rate Commission appointed by Governor to set prospective rates Medicaid will pay at nursing homes and hospitals throughout the state (can charge other patients whatever they want). Rates to be based on budget submitted by each institution (can include a "capital factor" for maintenance, expansion, etc.). Prospective rate-setting will provide forecasting ability so state knows what funding needs will be.

State used to use "cost settlement" approach - Medicaid would pay general monthly amount to each nursing home, then at end of year home would submit actual costs and settle any differences. Cumbersome; always 18-24 months behind in settlement.

Dept. set FY 84 rates (1st time); Commission is involved in hearing appeals on those .

SB 33 (V. Fischer) would impose Medicaid Rate Commission rates on all patients (not just Medicaid recipients). Fischer wants industry regulated; DeWitt opposes. Fact of matter is, once Medicaid rate is set, will be hard for a hospital to justify a different rate for general patients. Plus timing wrong -- Medicaid rate setting is still in infancy (sensitive issue with Hospital Association).

Certificate of Need protects state and federal government from entitlement program (Medicaid) the government created but that now we can't afford.

GENERAL RELIEF MEDICAL cares for those who fall through Medicaid cracks - "working poor". Needs based -- someone who doesn't qualify for Medicaid but can't afford health care payments . Is an exception program - Commissioner approves each applicant. In past years, program has received inadequate funding. Are reviewing all outstanding cases every 3-months in a phase-out effort. (Abortions...)

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Senate Bill No. 33

"An Act renaming and expanding the functions of the Medicaid Rate Commission and providing for the regulation of rates charged for services provided by health facilities."

The intent of SB 33 is to expand the responsibilities of the existing Medicaid Rate Commission (MRC) to include rate-setting for all buyers of medical care and to add administration of the Certificate of Need program to their duties. The Department of Health and Social Services feels that passage of SB 33 would be premature at this time. The MRC members have been consulted on this matter and they agree with this assessment.

The Department and the Medicaid Rate Commission feel the intended expansion under SB 33 is premature for the following reasons:

1. The MRC is still in its first year of operation and has just completed a nine month effort to define rate setting policies to be applied in Alaska. The Commission has not set any rates to date therefore no data exists from which to determine whether the program has been successful.

2. The MRC needs more time to develop a mature rate setting system within the more limited constraints of Medicaid/GR Medical reimbursement before expanding its application to all medical buyers. A great deal must be learned by both the MRC and the medical community before the MRC will be in a position to assume greater responsibility in this area.

The Department recommends against passage of SB 33 ~~at this time~~

Recommended By: Rod Betit

Rod Betit, Director
Division of Medical Assistance

Date: 1/23/85

Approved By: John R. Pugh

John R. Pugh, Commissioner
Department of Health & Social Services

Date: 1/25/85

STATE OF ALASKA 1984 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date:

REQUEST
Bill/Resolution No.: SB33
Title: An act renaming and expanding functions of the Medicaid Rate Commission
Sponsor: V. Fischer
Requestor:
Date of Request: 1/23/85

FISCAL DETAIL
Agency Affected: Division of Medical Assistance
Program Category Affected:
BRU, Program or Subprogram(s) Affected:
Medical Assistance

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
OPERATING						
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 SUPPLIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS						
800 MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

SOURCE OF FUNDS TO OFFSET FISCAL IMPACT OF BILL:

ANALYSIS: Attach a separate page for analysis

Prepared By: Rod Betit (RBETIT) Phone: 465-3355
Division: Medical Assistance Date:

Approved by Commissioner: Date: 1/25/85 fcc
Agency: Health & Social Services

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

12/1/83

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

Senate Bill No. 33

"An Act renaming and expanding the functions of the Medicaid Rate Commission and providing for the regulation of rates charged for services provided by health facilities."

The intent of SB 33 is to expand the responsibilities of the existing Medicaid Rate Commission (MRC) to include rate-setting for all buyers of medical care and to add administration of the Certificate of Need program to their duties. The Department of Health and Social Services feels that passage of SB 33 would be premature at this time. The MRC members have been consulted on this matter and they agree with this assessment.

The Department and the Medicaid Rate Commission feel the intended expansion under SB 33 is premature for the following reasons:

1. The MRC is still in its first year of operation and has just completed a nine month effort to define rate setting policies to be applied in Alaska. The Commission has not set any rates to date. Therefore, no data exists from which to determine whether the program has been successful.

2. The MRC needs more time to develop a mature rate setting system within the more limited constraints of Medicaid/GR Medical reimbursement before expanding its application to all medical buyers. A great deal must be learned by both the MRC and the medical community before the MRC will be in a position to assume greater responsibility in this area.

Senate Bill 33 also assigns the administration of the certificate of need program to the Medicaid Rate Commission. The certificate of need program and the health planning activities for the state are jointly funded in part under a federal health planning grant. One of the federal grant requirements is that the state health planning program be organizationally placed with the certificate of need program under the "State Health Planning and Development Agency." The Division of Planning, designated as the State Health Planning and Development Agency, currently administers both programs. If the certificate of need program were transferred to the Medicaid Rate Commission, the Division of Planning, as the designated SHPDA, could negotiate a reimbursable services agreement with the Medicaid Rate Commission for the administration of the certificate of need program. It is impossible to say at this time whether the federal government would approve the reimbursable service agreement as a reasonable means of accomplishing grant activities.

The Certificate of Need program and the other health planning activities complement each other and have common factors including, but not limited to, a need for the expertise of the Department of Health and Social Services' Architect and coordination with health systems agencies, regional health corporations, local governments, citizens' groups and state agencies.

POSITION PAPER/Department of Health & Social Services

Because of similarities between the administration of the Certificate of Need program and the other health planning activities, the Department finds that the certificate of need program belongs within the Division of Planning.

The Department recommends against passage of Senate Bill No. 33 because expansion of the Medicaid Rate Commission to include rate-setting for all buyers is premature at this time and because passage would obstruct continued close association between the Certificate of Need program and other health planning activities.

RECOMMENDED BY: Rod Betit

ROD BETIT, DIRECTOR
DIVISION OF MEDICAL ASSISTANCE

DATE: 3/4/85

RECOMMENDED BY: Patricia R. Alexander

PATRICIA R. ALEXANDER, DIRECTOR
DIVISION OF PLANNING

DATE: 3/4/85

APPROVED BY: John R. Pugh

JOHN R. PUGH
COMMISSIONER
DEPARTMENT OF HEALTH & SOCIAL SERVICES

DATE: 3/20/85

STATE OF ALASKA 1985 LEGISLATIVE SESSION

FISCAL NOTE

Revision Date:

REQUEST

Bill/Resolution No.: SB 33

Title: Renaming and expanding the functions of the Medicaid Rate Comm.

Sponsor: V. Fischer

Requestor:

Date of Request: 2/19/85

FISCAL DETAIL

Agency Affected: Health & Social Services

Program Category Affected: Soc. & Econ. Asst. Prog. for the Gen. Pop.

BRU, Program or Subprogram(s) Affected: Medicaid Rate Commission

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90
OPERATING						
100 PERSONAL SERVICES	0	161.7	168.2	174.9	181.9	189.2
200 TRAVEL	0	8.4	8.7	9.1	9.4	9.8
300 CONTRACTUAL	0	62.6	65.1	67.7	70.4	73.2
400 SUPPLIES	0	8.0	8.3	8.7	9.0	9.2
500 EQUIPMENT	0	20.0	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS	0	0	0	0	0	0
800 MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING		260.7	250.3	260.4	270.7	281.4
CAPITAL	0					
REVENUE	0					

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	203.1	190.4	198.1	205.9	214.1
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	57.6	59.9	62.3	64.8	67.3
TOTAL	0	260.7	250.3	260.4	270.7	281.4

POSITIONS:

FULL-TIME	0	3	3	3	3	3
PART-TIME	0	1	1	1	1	1
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attachment.

Prepared By: Joanne C. Clark Joanne C. Clark Phone: 465-3082

Division: Budget and Finance Date: 3/19/85

Approved by Commissioner: John A. Cox Date: 3/21/85

Agency: Department of Health and Social Services

Distribution (by Agency preparing fiscal note):

Legislative Finance

Legislative Sponsor

Requestor

Office of Management and Budget

The fiscal note includes an assumption of 4% as the rate of inflation with the exception of one-time equipment expense.

Increases in personal services include salaries and benefits for two Program Budget Analyst IIIs (range 19, step A) to perform tasks required to meet the additional rate setting responsibilities set out in the bill. Salary and benefits for a Health and Social Services Planner I position (range 17, step A) to perform certificate of need functions is included. One half-time Clerk Typist III position (range 8, step A) is also included to perform word processing and other clerical tasks.

Travel costs reflect an estimated ten additional site visits by Program Budget Analysts at $700 per trip. Travel by the Health and Social Services Planner I for one preapplication conference and one public meeting for certificate of need at an estimated $700 per trip is also included.

The contractual expenses include $35,000 for contractual audits and consultant assistance in developing viable rate-setting methodology to accomplish the Commission's goals. $4,600 is included for publishing public notices for six certificate of need applications. Communication expenses are estimated at $5,000. Lease costs are based on an assumed rate of $2.50 per gross square foot and 150 gross square feet per position.

Supplies expense is based on an average of $2,000 for each of the four positions.

Funding revenues reflect interagency receipts for performance of certificate of need tasks. This fiscal note assumes a transfer of a Health and Social Services Planner I and a reallocation of line item amounts for the Planning and development component as follows to fund an RSA with the Medical Rate Commission:

	Governors	SB 33 Change	Revised
100	816.1	<45.1>	771.0
200	35.1	<1.4>	33.7
300	43.3	48.5	91.8
400	5.7	<2.0>	3.7
700	300.0	<0.0>	300.0
TOTAL	1200.2	0.0	1200.2

1. POSITION TITLE				RANGE/STEP	BARG. UNIT	PAGE/LINE	GOV.	APPROV.	DISAPP.
	Program Budget Analyst III			19/A	GGU				
2. TYPE OF POSITION	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION	ELECTION DISTRICT	LEG.		
Permanent/full					Anchorage				

3. CONTINUATION LEVEL | | ADDITION | |

4. TYPE OF EXPENDITURE		AMOUNT
1	2	3
PERSONAL SERVICES		
5. Salary	40,030.20	
6. Benefits	12,044.77	
7. Supplemental Benefits		
8. Fixed Benefits		
9. TOTAL PERSONAL SERVICES	01	52,075
10. Travel	02	3,500
11. Contractual	03	24,500
12. Commodities	04	2,000
13. Equipment	05	2,500
14. Other		
15. TOTAL COST		84,575

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		C.F. Match	1003	
18.		General Funds	1004	84,575
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR B&M USE ONLY
KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

Two additional program budget analyst III's are needed to complete the tasks associated with SB 33's proposed expansion of the Medicaid Rate Commission's responsibilities to include regulation of rates charged by all non-federally owned or operated health facilities. The present budget analysts are fully occupied with analyzing and evaluating budgets and other financial records of facilities and preparing and submitting findings and recommendations to the Medicaid Rate Commission which, based on information from the analysts, determines the payment rates to the facilities for services rendered under medicaid and general relief medical.

REQUEST FOR NEW POSITION

AGENCY DHSS

PROGRAM Soc. and Econ. Asst. Prog. for the Gen. Pop.

BRU Medicaid Rate Commission

COMPONENT Medicaid Rate Commission

Revised Date

FY 86

1.	POSITION TITLE Program Budget Analyst III			RANGE/STEP 19/A	BARG. UNIT GGU	PAGE/LINE	COV.	APPROV.	DISAPP.
2.	TYPE OF POSITION Permanent/full	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION Anchorage	ELECTION DISTRICT	LEG.		
3.	CONTINUATION LEVEL		ADDITION						

	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES		
5.	Salary	40,030.20	
6.	Benefits	12,044.77	
7.	Supplemental Benefits		
8.	Fixed Benefits		
9.	TOTAL PERSONAL SERVICES 01		52,075
10.	Travel 02		3,500
11.	Contractual 03		24,500
12.	Commodities 04		2,000
13.	Equipment 05		2,500
14.	Other		
15.	TOTAL COST		84,575

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		C.F. Match	1003	
18.		General Funds	1004	84,575
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR B&M USE ONLY
KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

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REQUEST FOR NEW POSITION

AGENCY DHSS

PROGRAM Soc. and Econ. Asst. Prog. for the Gen. Pop.

BRU Medicaid Rate Commission

COMPONENT Medicaid Rate Commission

Revised Date

FY 86

01-113617/831-18

	POSITION TITLE				RANGE/STEP	BARG. UNIT	PAGE/LINE	COV.	APPROV.	DISAPP.
1.	Clerk Typist III				8/A	GGU				
2.	TYPE OF POSITION: Permanent/part time	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Anchorage	ELECTION DISTRICT	LEG.		
3.	CONTINUATION LEVEL		ADDITION							

4.	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES		
5.	Salary	9,690.00	
6.	Benefits	2,713.00	
7.	Supplemental Benefits		
8.	Fixed Benefits		
9.	TOTAL PERSONAL SERVICES 01		12,403
10.	Travel 02		0
11.	Contractual 03		4,500
12.	Commodities 04		2,000
13.	Equipment 05		12,500
14.	Other		
15.	TOTAL COST		31,403

	RECEIPT CODE	FUNDING SOURCE		
16.		Federal Receipts	1002	
17.		C.F. Match	1003	
18.		General Funds	1004	31,403
19.		I-A Receipts	1005	
20.		Program Receipts	1028	
21.		Other		

FOR B&M USE ONLY
KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

This half-time position provides clerical support to two program budget analysts and a health and social services planner needed to carry out the additional responsibilities assigned to the Medicaid Rate Commission under SB 33.

REQUEST FOR NEW POSITION

AGENCY DHSS

PROGRAM Soc. and Econ. Asst. Prog. for the Gen. Pop.

BRU Medicaid Rate Commission

COMPONENT Medicaid Rate Commission

Revised Date

FY 86

01-1136 (7/82)-13

	POSITION TITLE				RANGE/STEP	BARG. UNIT	PAGE/LINE	COV.	APPROV.	DISAPP.
1.	Health and Social Services Planner I				17/A	GGU				
2.	TYPE OF POSITION: Permanent/ful	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION: Anchorage	ELECTION DISTRICT	LEG.		
3.	CONTINUATION LEVEL		ADDITION							

4.	TYPE OF EXPENDITURE		AMOUNT
	1	2	3
	PERSONAL SERVICES		
5.	Salary	34,740.00	
6.	Benefits	10,374.00	
7.	Supplemental Benefits		
8.	Fixed Benefits		
9.	TOTAL PERSONAL SERVICES 01		45,114
10.	Travel 02		1,400
11.	Contractual 03		9,100
12.	Commodities 04		2,000
13.	Equipment 05		2,500
14.	Other		
15.	TOTAL COST		60,114

	RECEIPT CODE	FUNDING SOURCE	
16.		Federal Receipts 1002	
17.		C.F. Match 1003	
18.		General Funds 1004	2,500
19.		I-A Receipts 1005	57,614
20.		Program Receipts 1028	
21.		Other	

FOR B&M USE ONLY
KEY NUMBER __ __ - __ __ - __ __ - __ __ - __ __

JUSTIFICATION

SB 33 assigns responsibility for administration of the certificate of need program to the Medicaid Rate Commission. The job duties require the skills of a health and social services planner. A health and social services planner I is requested because the position reflects a transfer of the health planner I that presently performs certificate of need functions within the Department of Health and Social Services.

REQUEST FOR NEW POSITION

AGENCY DHSS

PROGRAM Soc. and Econ. Asst. Proq. for the Gen. Pop.

BRU Medicaid Rate Commission

COMPONENT Medicaid Rate Commission

Page 4 of 4

Revised Date

FY 86

01-113617/831-13

Senator Vic Fischer
Alaska State Legislature
Pouch V • Juneau, Alaska 99811 • (907) 465-4954

March 6, 1985

To: Senator Bettye Fahrenkamp

From: Senator Vic Fischer

Re: Hearing Request for SB 33 - Medicaid Rate Commission

I am requesting that you schedule SB 33 at your earliest convenience. This bill is a broad measure that provides for the regulation of costs charged by health care facilities.

Hospital and other health care costs have been increasing dramatically, so that now they exceed 10% of the GNP. With annual inflation for these expenses well above other costs, the elderly and those on fixed incomes are particularly hard pressed to find adequate care. But as you know, we are all affected.

Increasingly, states are becoming the principal forum for regulating health care costs. Several other states have adopted similiar legislation that have demonstrated significant savings to consumers and slowed the rate of inflation.

I am aware that Alaska has taken the first step and established a Medicaid Rate Commission to review Medicaid costs in hospitals. However, this program does not address the majority of the public who are not Medicare recipients, and as such does not help most Alaskans.

Because this is one of the most important consumer issues before us today, I ask that you take action on this bill, despite the opposition of the Department of Health and Social Services at this time.

Attached you should find the position paper of the Department of Health and Social Services. The fiscal note is zero. Other back-up materials are also enclosed for your review.

During Interim • 1024 W. 6th Avenue, Suite 204C • Anchorage, Alaska 99501 • (907) 278-3654

OVERVIEW
OF
STATE COST CONTAINMENT STRATEGIES

By

Elliot K. Wicks, Ph.D.

Office of Health and Medical Affairs
Department of Management and Budget
STATE OF MICHIGAN

Delivered at Region VIII, IX, and X Health
Planning Meeting

Sponsored by

Western Center for Health Planning
San Francisco, California

June 12, 1984

OVERVIEW OF STATE COST CONTAINMENT STRATEGIES

The purpose of this paper is to give an overview of the cost containment activity that is taking place at the state level. Increasingly, states have become the focal point for health care cost containment efforts. In an attempt to document that activity, the National Governors' Association recently prepared a series of publications summarizing state cost containment efforts. This paper draws heavily on those materials.

Reasons for State Activity

Why have states become a focus of cost containment activity? One reason is their involvement in the Medicaid program. To some extent, state governments have always been involved in trying to reduce costs because they pay for Medicaid. The need to limit Medicaid costs is strongest when states are under fiscal pressure, which has obviously been intense in the last few years during periods of recession. But that is not new; Medicaid cost containment activity has been going on for years.

A second reason for increased state activity is that state governments are major employers and therefore purchase health care services not just for Medicaid recipients but for a very large workforce. In the past, states as employers have taken the view of most employers: negotiate the level of benefits with employees but then leave the system alone. The basic issue in such negotiation was who would pay -- the patient out-of-pocket or the employer through insurance coverage. Employers would perhaps consider various techniques such as self-insurance, coordination of benefits, or other steps to reduce administrative costs, but typically they didn't get involved in direct attempts to change utilization or unit costs.

Like other employers, state governments are beginning to try direct limiting of their payout by affecting utilization and provider and consumer behavior -- by limiting the total amount spent, given a particular level of coverage, not just by negotiating who pays the bill. The reason for states' change of attitude is the rapidly rising cost of employee health coverage. Among states responding to a National Governors' Association survey, between 1981 and 1983

- total state general fund expenditures rose by 6.7 percent;
- Medicaid costs rose by 20.9 percent;
- state expenditures on employee health benefits rose by 47 percent.

Thus employee benefits rose 7 times as fast as all general fund spending and more than twice as fast as Medicaid spending.

A third reason for increased cost containment activity at the state level is increased pressure from private sector purchasers. The burden of health care costs is now evident to everybody, and many employers recognize it as a major cost of doing business -- a cost which is important in influencing their "bottom line" and a factor in their ability to compete in international as well as national markets. These employers are becoming involved as direct purchasers, but they need the cooperation of state government for several reasons:

> in order to change the legal environment so that they can take the steps they think are necessary to bring change to the delivery and financing system;
>
> to use the regulatory authority of government to mandate changes in providers' behavior where such regulation is thought to be effective.

The purchasers recognize that conditions differ from area to area and that they can often be most influential by using their economic clout as purchasers and as agents to influence legislation at the local and state level rather than the national level. Hence the attention to state action.

A fourth reason for state attention to cost containment is that the federal government isn't doing (or perhaps can't to) the job. The administration opposes the regulatory approach, and thus little action in this direction can be expected. If regulation is the answer, it will have to be done at the state level. Medicare's change to DRG-based reimbursement for hospitals shows that the federal government is interested in cutting its own cost but not necessarily system-wide costs. If DRGs are effective in holding down Medicare costs, the hospitals will try to make up the shortfall by shifting costs to other payers. If such "cost shifting" is to be prevented, it will have to be done through initiatives at the state level. Finally, states have to deal with the problem regardless of the federal attitude simply because there is no single simple solution that can be imposed at any one level of government; we must confront the problem at all levels.

Causes of Cost Escalation

Although there is often fundamental disagreement from state to state about how to solve the problem, there is very little disagreement about the cause.

Some of the factors which raise costs are largely beyond the power of states or decision-makers within states to influence:

> The aging of the population: Since aged people use more services, as the population includes more and more older people, use will rise and so will costs.

General price inflation: There is no reason to expect prices of health resources to be immune to pressures that create general price inflation. To the extent that wages rise throughout the economy, wages of health workers will have to rise too if they are not to fall behind. The same applies to raw materials that are common to many industries -- food, construction, energy, etc.

The cost-producing influences which are unique to the medical economy are possible to change although they can be changed only with difficulty. The litany of faults is familiar.

The major problem is that the decision-making system does not require any of the decision-makers to bear directly the financial costs of their decisions to use resources. No one is held accountable for decisions that determine costs, and there are few financial incentives to make decisions by balancing costs against benefits.

In fact, the present system creases perverse incentives: the incentive structure tends to reward cost-inducing behavior and to penalize cost-reducing behavior, especially for providers.

Consumers have few incentives to economize because insurance pays much of the cost of care. There is no apparent connection between what they use and what they pay -- a "free lunch" system.

Given the highly technical nature of medicine, cost-effective decisions are difficult for consumers to make (even if they had incentives to do so) because they must rely on the advice of physicians about what services are appropriate.

Under the fee-for-service system, the more services physicians provide, the higher their income.

The highest payments go to the physicians who use resources most intensively -- those who provide hospital-based acute-care services and the specialists who employ expensive technologies.

Hospital reimbursement systems which pay charges or reimburse retrospectively for costs provide no incentives for efficiency and encourage high utilization and expensive technologies.

The competition among hospitals takes the form of competition for patients and thus doctors, which gives them incentives to offer the widest range of services and the newest technologies. The result is often duplication and high costs.

We have built too many hospitals and trained too many physicians, particularly specialists. Both the facilities and the professionals have to generate income to stay in business. They can generate income and costs because there is so much room for discretion in determining how much and what kind of care is appropriate; the consequence is a higher level of demand than is cost-effective.

Solutions

Although there is agreement that the cause of the problem is lack of appropriate incentives so that normal market forces don't work, there is less agreement about the proper solution. People generally agree that the kind of competition that provides economic discipline in most markets doesn't serve that function in the medical market. The disagreement comes over how to react to lack of appropriate competitive forces. In some states the dominant response is to try to create conditions under which market forces can operate properly. This is the dominant philosophy in Utah, for example. Where that view prevails, the strategy is to change the incentive structure so that people bear the economic consequences of their actions. This is done in the expectation that individual decision-makers will act in the public interest (although inadvertently) as they seek their own self-interest.

In other states, the response is to acknowledge market failure, explicitly abandon primary reliance on market forces to allocate resources, and substitute greater allocation by government or quasi-government agencies. Implementation of this strategy involves policies such as those which give government approval or veto power over expenditure and investment decisions (certificate of need), which set prices (rate regulation), or which establish limits that define the boundaries within which individual decision-makers can exercise discretion (expenditure or investment "caps").

These two contrasting reactions to market failure can be labeled the "competitive strategy" and the "regulatory strategy." It is useful to look at the rationale for each in more detail.

The Competitive Strategy

The key element in the competitive strategy is change in the incentive system -- structuring financial rewards so that consumers and providers voluntarily make decisions that economize on use of resources.

Because of the technical nature of medical decisions, physicians make most of the important decisions that determine how much medical treatment will cost. Therefore the reimbursement system should reward physicians for cost-reducing behavior. Several possibilities exist:

Pay on a basis like capitation. Such a basis increases the providers' net revenue if they hold down costs. HMOs are an example.

Reward cost-effective providers by directing patients to them and away from those that are not cost effective. HMOs and PPOs are examples. When physicians were in short supply, this approach would not have worked. But since the physician supply is increasing more rapidly than the patient supply and there is an excess of hospital capacity, the medical market is changing from a sellers' market to a buyers' market. The power to direct patients to particular providers is an important bargaining chip.

Give consumers incentives to choose cost-effective providers. Although consumers have insufficient knowledge about medical science to make the actual resource allocation decisions on a cost-benefit basis, it is possible to create incentives for consumers to choose providers who do have the expertise to make cost-effective choices.

Alternative delivery system -- HMOs and PPOs -- clearly play a key role in this strategy since they are collections of providers to whom the purchasers can send patients to get conservative, cost-effective care. One reason for the intense interest in PPOs is the advantage the PPO has over the HMO of representing a less radical departure for both consumer and physician. The consumer can choose non-preferred providers but has financial incentives to seek care from preferred providers. The physician is held accountable for the cost of resources (in that the provider has to be economical to stay on the provider panel) but is not "at risk" as he or she would be in an HMO.

In many states employers are promoting HMOs and PPOs themselves -- an indication of employers' recognition of a new role for themselves. They see themselves as purchasers of health care in the same way they are purchasers of raw materials: the perspective is to establish a payer/vender relationship and to give the business to the vendor (the PPO or HMO) that provides product they want at the best price. They no longer take a hands-off position in negotiating with the suppliers, the providers. Nestle Enterprise in Ohio, for example, has been very active in helping to start and develop PPOs for employees. If one PPO doesn't perform, Nestle informs them that they will terminate the relationship if they don't "shape up."

To induce development of the kind of system that directs patients to efficient providers requires several things, some of which require state legislation:

A legal environment which allows (and even encourages) purchasers to use their market power to negotiate the best deal -- for example, to contract directly (or through intermediaries) with providers and to establish a benefit

package that limits "freedom of choice." Some states have insurance requirements that subscribers or insured persons have complete freedom of choice of provider regardless of cost. It was the legislative change in this legal requirement in California that stimulated selective contracting and PPOs in that state and brought the concept of PPOs to the forefront of attention.*

Incentives for insured persons to choose the most cost effective, conservative providers, and the information to identify these efficient providers. Incentives are absent when the employer pays the entire premium of very comprehensive coverage. Under this "free lunch" arrangement, the employee gains no advantage by choosing an efficient provider. To avoid this situation, employers will have to structure premium-sharing so that the employee has to pay part of the premium cost of the more expensive plans. Wisconsin, for example, this last year changed premium sharing provisions for state employees. Now the state pays a maximum of only 105 percent of the least expensive plan. Memberships in HMOs after this change jumped from 18 to 67 percent of state employees in one year. Another possibility is co-pays for the standard plan. These co-pays can be reduced or eliminated for choosing cost-effective providers (the PPO approach).

A way of identifying the cost-effective providers and of identifying increases in utilization as they crop up. PPOs depend upon being able to discriminate between costly and efficient providers and to detect unjustified differences in use among regions. To do such analysis requires population-based utilization data -- something which many planning agencies can provide. To get such data from all providers and in a uniform format may require state legal mandates. In Iowa, where there is support for the competitive approach, the Iowa Health Data Corporation has been established for just these purposes.

A number of people who support the "competitive" strategy suggest a different approach. They want consumers to themselves have direct financial incentives to reduce consumption. They propose increasing co-pays and deductibles on the theory that when people have to pay more they will use less.

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* We've found in Michigan that providers, especially physicians, say they are all in favor of competition and PPOs. The "only" provision they want is one which requires that all providers be eligible for participation in the PPOs. They insist on this provision -- which, of course, jeopardizes the basic concept -- because they know that there are too many physicians and they can be cut out of the business.

A similar idea is to structure the benefit package so that people have to pay a deductible or co-pay if they use a more expensive form of care when a less expensive substitute is available -- for example, co-pays for inpatient hospital use but no co-pays if procedure can (safely) be done on an outpatient basis.

The Regulatory Strategy

The proponents of the regulatory approach say that the way to correct the failures of the market is to substitute for market forces explicit decisions by public policy-makers. Examples include hospital rate regulation, strengthened certificate of need, "caps" on capital expenditures, etc. Those who favor the regulatory strategy offer the following arguments:

> Competition will take too long. We've had HMOs for years, and nowhere has the existence of HMOs clearly changed the whole system to make it truly competitive. The problem is too severe to wait for such competition to develop; we have to have results now, not 10 to 15 years from now.
>
> Regulation works -- at least hospital price controls work. In the seven states with on-going rate-setting programs (Maryland, Rhode Island, Massachusetts, New York, New Jersey, Washington, and Connecticut), hospital costs rose 11.9 percent in 1982 whereas, in the nation as a whole, they rose by 14.9 percent. Three states adopted all-payer rate-setting systems in 1983: Maine, West Virginia, and Wisconsin. The proponents of hospital rate-setting would argue that the key to success is the political will to make it work. (The critics might agree, saying that the long-run lack of political will is precisely the problem.)
>
> Competition may never work. To one extent or another, it depends upon consumers being able to make medical judgments, to "second guess" the physician. They really can't do a good job of that even if they have incentives.
>
> Regulation is necessary to protect the weak and the vulnerable. The big buyers, the employers with large work forces, are going to negotiate the best deal for themselves; they are not going to be worrying about everybody else. If they succeed, the revenues of providers who serve them will tend to go down. They will look to make up the revenue loss from other payers -- the older population, the under-insured, the workers who are not represented by unions or big employers. Costs may be shifted to them.
>
> In a competitive environment, producers (providers) go where the money is. The providers may simply not find it profitable to serve certain populations. They may cater to the employers who can send them many patients and simply decide it isn't worthwhile to serve some other population groups -- those in rural areas, city centers, older parts of

cities, etc. So access could be jeopardized. This "skimming" problem could be especially troublesome in areas of the market in which for-profit firms play a prominent role.

Regulation can assure that everybody pays a fair share.

Regulation advocates also point out that it is misleading to say that competition is the only method to provide proper incentives. Prospective hospital reimbursement systems, imposed by regulation, attempt to create incentives which allow managers to decide themselves how they can manage their hospitals in the way that minimizes costs so that they can share in the savings. Government is setting the boundaries within which resource allocation decisions are made but is not actually allocating those resources through regulation.

While hospital price control is the most obvious regulatory approach to which states are giving consideration, some states are still proposing to strengthen certificate of need. Maine adopted a "capital cap" which limits the total amount of capital expenditures in the state, and the Michigan legislature is considering such a bill. Other states have imposed moratoriums: Arkansas, Kansas, Kentucky, Minnesota, Mississippi, Missouri, New York, and North Carolina. Still other states have committed themselves to the competitive approach to the extent that they are abandoning certificate of need authority altogether: Utah, New Mexico, and Idaho.

Another regulatory approach is to reduce hospital capacity. The Michigan legislature endorsed this approach several years ago by mandating reduction in beds.

A further policy which some would consider regulatory in nature is to use state power as provider of funds for medical training to bring pressure to bear on medical schools to lower enrollments in order to bring production of physicians into line with needs.

Criticisms of Regulation

The critics of regulation point out that no matter how attractive regulation appears, the history of other industries shows that the short-run benefits are outweighed by the long-run costs:

Regulation stifles innovation and new arrangements. For example, rate-setting regulations frequently prohibit major purchasers from negotiating their own deals with hospitals because rate setting often requires that all payers pay the same rates.

Regulation lets the private sector, both purchasers and providers, "off the hook." They are likely to say, "It's government's job, and if the policies fail, government is to blame. It's not our responsibility."

Regulators are often "captured" by the regulated industry. The regulators begin to see their job as assuring the economic health and viability of the industry, not protecting the public.

It is very hard to sustain the political will to be tough. If competition puts somebody out of business, we accept the outcome as natural, just the way markets work. If government action threatens to put somebody out of business, even if for very good and rational reasons, politicians come under extreme pressure to "cave in" and assure the business survives. Market forces are seen as neutral. Government intervention is seen as being arbitrary and unfair.

Combined Strategy

The most common approach in most states seems to be a combination of regulation and an attempt to strengthen market forces -- a melding of the two strategies. This combined approach is not seen as inconsistent but rather as a way of meeting the problem in the short-run while the long-run solution is taking hold.

A large number of states are restructuring state employee health benefits to encourage greater cost consciousness. Some are providing incentives for shortened stays and ambulatory surgery by adding co-pays for choice of more expensive care -- Kentucky, for example. Others are increasing the employees' premium share to encourage employees to choose the least expensive plans as has been done in Wisconsin.

Florida is a good example of the combined strategy. The legislature just passed legislation to strengthen the state hospital authority by establishing standby rate controls. The authority sets budget targets, but hospitals which fail to meet targets come under increasing scrutiny; and, if they continue to fail to meet targets, eventually fines are imposed, and the hospital's license can even be revoked. A revenue cap is established which is 3 percent above a price index that measures the cost of hospital inputs. If a hospital exceeds the cap in the first year, it can be ordered to roll back its budget in the next year. If a hospital exceeds the cap for 2 years out of 5, it can be required to contribute the excess to a state pool that is used to pay for indigent care. If the overrun occurs in 3 years out of 5, the hospital can lose its license and administrators can be fined. At the same time the legislature passed this stand-by rate-setting bill, it established a mechanism to collect data and publish a consumers' guide on premium charges on health insurance and physician charges -- to help consumers make cost-effective decisions.

Wisconsin is another state that has established a comprehensive reform program that combines regulatory and competitive elements. Last year the legislature did all of the following:

Established all-payer rate-setting authority.

Greatly strengthened certificate of need.

Allowed for closed-panel HMOs and for PPOs.

Changed health benefits for state employees so that the state pays only 105 percent of the premium of the least costly plan.

Cut Medical school size by 10 percent.

Required employers with more than 250 employees to offer a choice of at least two health plans, including HMO and PPO.

Conclusion

One of the exciting things about the last several years is the great variety of activities that are being tried to address the health care cost problem. As the focus has shifted away from Washington to the states, we see many innovative policies and much experimentation. These activities provide natural experiments to test what works and what doesn't work. It will be interesting and useful to observe the outcomes.

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The Maryland Health Services Cost Review Commission

Health Care Cost Containment Project
National Conference of
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Background

A number of states have established public commissions in an effort to control the rate of increase in hospital costs. One of the most successful such bodies has been the Maryland Health Services Cost Review Commission. In 1977, for example, the Commission estimates that it saved $48 million by holding the rate of hospital inflation to less than two-thirds of the national average. In 1978, the rate of increase per admission was only 7.8 percent. In that same year, despite the addition of a significant number of new hospital beds in the state, total hospital costs increased by only 10.5 percent—compared to a national average of 12.8 percent.

The Maryland General Assembly established the Health Services Cost Review Commission in 1971 and gave it four broad tasks: (1) To ensure annual public disclosure of the financial position of all Maryland hospitals and related institutions; (2) To keep itself informed as to whether the financial resources of each institution are sufficient to meet its financial requirements, and to concern itself when resources are inadequate; (3) To require the annual disclosure by any employee, partner, director or officer of any non-profit hospital of business totalling $10,000 or more annually that is transacted between that institution and any other business entity in which the person has an interest; and (4) To assure the public (a) that hospitals' total costs are reasonably related to the total services offered by the hospital; (b) that hospitals' aggregate rates are set in reasonable relationship to its aggregate costs; and (c) that rates are set equitably among all purchasers of services without undue discrimination. While the first three tasks are an important part of the Commission's operation, it is primarily from the fourth function that its cost containment activities derive.

Hospitals, particularly those in Baltimore's inner city, were the prime movers behind the establishment of the Commission. Their motivations included a fear that the federal government was on the verge of imposing stringent cost controls on hospitals and an inability to recover the costs of charity care and bad debts because Blue Cross, Medicare and Medicaid paid on the basis of costs. To increase chances for an exemption from federal controls, and in return for guaranteed solvency for an efficient hospital and for equity in rate setting, hospitals lobbied for and were willing to accept increased state regulation. While the Commission's rates have applied to private payers and Blue Cross since 1974, it was only in 1977 that Medicaid and Medicare agreed, on an experimental basis, to pay the rates set by the Commission. Because of these agreements, particularly with Medicare, the Maryland Commission is the only state agency in the country that sets rates for all payers.

Structure and Jurisdiction

The seven member part-time Commission is an independent body in the Department of Health and Mental Hygiene. Commissioners are appointed by the Governor for four-year terms and may be reappointed once. The exact composition of the Commission is not detailed in statute, although the law does specify that no more than three commissioners may be associated with the health care industry. The present commissioners are a physician, an economist, a housewife, a realtor, two business executives, and a hospital trustee. The second term of the Commission's first chairman, a hospital administrator, expired on June 30, 1979. The new chairman is a business executive.

The Commission's budget and staff have remained fairly constant since the Commission commenced full operation. Approximately one-third of the annual budget of $750,000 is provided through a contract with the Health Care Financing Administration, U.S. Department of Health, Education and Welfare, with the balance funded from general state revenues. Legislation has been introduced to change the method of financing to an assessment on individual hospitals, but that legislation has not been successful. Accountants are most numerous among the 29 person Commission staff. Additional staff include an economist, mathematicians, attorneys, computer engineers, an industrial engineer, a registered nurse, a physician and clerical help. The Commission staff is divided into three main sections: Administration, Institutional Analysis and Methodology Development.

In addition to general administrative responsibilities, the Administration section handles the advisory relationship of the Commission with external parties such as health planning agencies. The Institutional Analysis section determines and recommends individual hospital service rates to the Commission and conducts hospital audit and compliance activities. The Methodology Development division is responsible for ongoing research and the development of improvements and innovations in rate setting methodology. That division also monitors national, state and local inflation indices to be used in determining hospital inflation adjustments.

The Commission has jurisdiction over 50 acute care and 5 psychiatric hospitals, with annual revenues of approximately $1 billion and an average size in excess of 200 beds. The majority of the hospitals are located in one of two metropolitan areas — the Washington, D.C. suburbs, and Baltimore City and its suburbs. Two major teaching hospitals are located in Maryland. The vast majority of the hospitals are public or non-profit institutions.

Rate Approval Process

The Commissioners have little direct involvement in the actual calculation of rates. Their role is that of an impartial judge, balancing staff recommendations with arguments and recommendations presented by hospitals, third party payers, and other interested parties.

The rate review process for a particular institution may be initiated either by the Commission itself or by a hospital which requests an increase in its approved rates. Staff analyze the institution's data on such factors as costs, volume, and case mix, comparing departmental costs with those of other hospitals after adjusting for regional wage differences. Costs in excess of a pre-determined screen are challenged and, if not adequately justified by the hospital, are disallowed.

At a public meeting, the Commission reviews staff recommendations which it may approve, revise or reject. If the interested parties have no objection to the Commission's decision, these rates go into effect. If one of the interested parties challenges the recommendations, however, a second public hearing is held at which evi-

dence and testimony are presented, subject to cross examination. In practice, very few reviews go to a second public hearing, since Commission staff work closely with hospital representatives to resolve differences prior to submitting their recommendations.

Inflation Adjustment System

The Maryland system is unique in that it does not perform an annual review of each hospital's budget. Instead, rates are based on an in-depth analysis of each hospital's budget which was undertaken during the Commission's first three years of operation. Since the time the base budget review was completed, however, most rates have been changed only by an inflation adjustment factor. Thus, the only hospitals subjected to annual review are those requesting rates in excess of the adjustment factor, or those hospitals which merit further examination (for example, because of financial difficulties or markedly changed capacity or utilization).

The major tool used to control hospital cost increases is an inflation adjustment factor. This factor is based on two broad measures. One measure reflects items beyond the control of the hospital such as ERISA costs, FICA tax increases, and malpractice costs. The other factor is designed to account for the impact of inflation in the general economy. For example, the local consumer price index is used to determine the allowance for increases in wages and fringe benefit costs. The allowance for supply and contracted service cost increases is based on a weighted average of the wholesale and consumer price indices of those elements of hospital costs which can be reasonably determined, such as food and insurance. In areas with no appropriate external indices —such as medical-surgical supplies. and radiological supplies — allowable increases are based on a weighted average of cost increases in those fields as reflected through a hospital survey.

This inflation adjustment system has a number of advantages. First, it enables the Commission staff size to be kept small; rather than reviewing each hospital's entire budget in detail every year, the only requirement is that inflation be monitored. Second, those hospitals which are performing well — keeping their costs in line with inflation — are not subject to excessive government intrusion, yet will still be granted an increase sufficient to keep up with inflation.

Third, the inflation adjustment approach gives hospitals a very strong incentive to control their own costs. Under many prospective reimbursement and annual budget review systems, hospitals are discouraged from saving because any savings experienced in one year are disallowed in the following year's budget review. Under the Maryland inflation adjustment system, the hospital can keep any savings it makes — the increase for the next year is independent of the prior year's performance. Although efficiencies may result in disallowed costs after a future detailed budget review, that review might not be performed for several years, and the hospital keeps any savings it accrues over that time.

For example, if the approved base year charge per admission is $2,000 and inflation in the next year measured 10 percent, the hospital would be permitted to charge an average of $2,200 per admission ($2,000 + 10%). If the hospital's costs increased by only 8 percent (to $2,160) the hospital would be able to keep the extra $40. In addition, the inflation adjustment factor for the following year would be applied to the $2,200 figure (not to $2,160) so the hospital will continue to reap the benefit of its efficiencies and accrue savings over time.

Basis of Payment

Hospitals are paid through one of two mechanisms. Under the first method, which the Commission has used since it began regulating hospital rates in 1974, payments are set on the basis of an average rate per unit of service for each department within the hospital. Within that constraint, the hospital is free to set charges for each individual unit of service. For example, an average rate for all procedures performed in the radiology department of a particular hospital is set by the Commission, but the hospital itself sets the individual charges for different x-ray procedures. While this system establishes control over the average cost of each unit of service, a hospital's revenue can be increased if more procedures are performed. According to Commission staff, although increases in individual charges per unit of service were held to approximately seven per cent per year, total hospital cost increases have averaged between eleven and twelve percent per year, due to the increased amount of services provided.

To deal with this problem of fiscal incentives for increased utilization of services, especially ancillary services, the Commission initiated a second payment method in 1977 on an experimental basis in six hospitals. Under this "Guaranteed Inpatient Revenue" program, a hospital is guaranteed in advance an average revenue for each admission, based on projected volume and patient case mix. The basic charges for each patient are still computed as a charge per unit of service, but the *average* charge for each admission must equal the amount set in advance. Adjustments are made at the end of the year to reflect the actual number of admissions and any changes in case mix. The major problem with a "per admission" payment system is that it may encourage hospitals to increase admissions. That is, because the average charge is designed to recover fixed costs based on an estimated total patient volume, each admission in excess of that volume will generate revenue exceeding the marginal cost of providing the service. Thus, there will be a fiscal incentive to increase admissions. To counter this incentive to increase admissions, hospitals on the Guaranteed Inpatient Revenue program are paid only for the variable costs associated with each additional admission. Thus for the first two percent increase in admissions, the hospital receives only 50 percent of the per admission revenue, and it receives 70 percent of the per admissions revenue for increases between two and ten percent. The Commission has also decided that a hospital which reduces admissions should be able to recover its fixed costs. It does this by guaranteeing that for the difference, i.e., for the number of admissions by which actual is less than the estimated total admissions (volume), the hospital will still receive 80 percent of the revenue it would have ordinarily received as an average charge. Since hospital costs are made up of fixed and variable costs, this system allows the hospital to recover its full fixed costs as well as the profit for the variable costs it did not experience, due to lower than expected volume. This technique serves the dual purpose of rewarding hospitals for reducing utilization while saving money for the public. Through these adjustments, the Commission hopes the system will control volume as well as price.

Since the costs of caring for a patient varies according to the severity of the illness, the Guaranteed Inpatient Revenue system must also consider the case mix which each hospital treats. Reimbursement on the basis of case mix is a new art, however, and the Commission has begun a major effort to refine currently available case mix measures so that they can be used as part of a hospital reimbursement system. Five methods are now used to adjust for case mix, considering diagnosis and, in some cases, payer and patient age.

Eighteen hospitals voluntarily

participate in the Guaranteed Inpatient Revenue program at the present time. All of the large hospitals — those over 400 beds — as well as some small hospitals are reimbursed under this system. Because the program requires sophisticated data processing and reporting capabilities, a capacity primarily available in larger institutions, the Commission is particularly interested in assessing the impact of this system on small hospitals.

The Guaranteed Inpatient Revenue system does appear to be having the desired effect of controlling increases in total hospital costs. In Fiscal Year 1978, the average cost per admission in all Maryland hospitals was 7.8 per cent higher than in 1977; in hospitals on the Guaranteed Inpatient Revenue program, however, the cost per admission rose by only 6.8 percent. In those hospitals, the average length of stay dropped 3.5 percent, compared to an average decrease in length of stay for all Maryland hospitals of 0.5 percent. Thus, from preliminary indications, hospitals are responding to the fiscal incentives in this system.

Reimbursement For Capital Costs

The Maryland Commission is unique in that it does not reimburse hospitals for capital equipment on the basis of historical cost depreciation. For capital intensive equipment, such as a radiology machine, the Commission utilizes a price level depreciation factor. This factor is the cost of replacing the equipment at current market prices, divided by the useful life of the equipment. The result of price level depreciation is to offset the effects of inflation on the price of such equipment.

For depreciation allowances on buildings and building equipment, the hospital receives the maximum of either of two calculations. The first calculation is the amount of money necessary to meet cash requirements for an existing mortgage. The second calculation allows a 20 percent down payment at current market prices on the needed portion of the facility. The "needed portion" of the facility reflects average occupancy, plus a reasonable standby capacity for the hospital. In general, the "cash requirements" provision is more often utilized.

Charity Care and Bad Debts

In most Maryland hospitals, a prospective fixed allowance is provided for charity care and bad debts, based on historical costs. To encourage hospitals to undertake adequate debt collection procedures, the Commission can reduce the allowance below the level of historical costs if bad debts and charity costs in one hospital exceed those in comparable hospitals.

The Commission is reimbursing three hospitals for charity care and bad debts under an experimental program. For charity care these hospitals must validate charity cases treated, and the actual costs of such care are allocated among paying patients. For bad debts these three hospitals are reimbursed on the basis of a fixed allowance. This provides an incentive to the hospital to improve its debt collection practices, since the hospital is able to keep the money it collects in excess of the allowance.

A recent statewide study found that charity care and bad debts average approximately 4 percent of hospital revenues. In Maryland over 86 percent of the costs of charity care and bad debts occurs in metropolitan areas.

Payer Discounts

The Commission does permit payer discounts, (e.g. for Blue Cross). This practice, however, has been brought to litigation by one hospital. A lower court ruling has required the Commission to set rates in that hospital without a payer discount. The Commission has recently let a contract to determine the need for and appropriate size of a payer discount.

With regard to all the hospitals in Maryland, a two percent discount is

granted as an incentive allowance to help improve the hospital's flow of working capital. The discount is available both for patients who pay at discharge, and for payers which give the hospital an advance equal to the average amount of accounts receivable.

In addition, as a matter of public policy, payers providing substantial affordable and available insurance coverage — such as open enrollment and group conversion privileges — receive an additional four percent discount. At present, however, only Blue Cross plans and some Health Maintenance Organizations meet these requirements. Under the Commission's contract with the Health Care Financing Administration, Medicaid and Medicare also receive a four percent discount.

Relationships with Other Parties

Obviously, the Commission must work closely with other groups involved in the regulation and delivery of health care services. Relations with the hospital industry appear to be good. While some individual hospitals have occasional problems with the Commission, on the whole Maryland's hospitals continue to support the state agency as a preferable alternative to direct federal regulation. Although there are some concerns over the speed with which innovations in reimbursement—such as the Guaranteed Inpatient Revenue program—are implemented, the Commission and its staff are aware of the need to work with the hospitals and to keep them informed of pending actions.

In its efforts to control hospital costs, however, the Commission has run into conflict with some individual practitioners. At some hospitals, radiologists and anesthesiologists have begun to bill independently as a means of evading its jurisdiction. While the issue of whether or not the Commission's jurisdiction extends to such practitioners has been brought to court by a group of physicians at one hospital, a judicial resolution has not yet been forthcoming.

The Commission also has been embroiled in conflicts with health planning agencies. The Commission renders advisory opinions on the financial feasibility of proposed hospital expansion and additions but the opinions are not binding. On a number of occasions, new hospital beds have been added in already overbedded areas despite the Commission's objections. The new State Commissioner of Health and Mental Hygiene is making efforts to resolve the conflict between the Commission and planners by clarifying the jurisdiction of the two bodies. In addition, a statewide revenue cap has been proposed, to be allocated to each Health Systems Agency, and to individual hospitals by the HSA. Among other functions, this revenue cap would permit health planning bodies to approve expansions and additions only within the constraints of the revenue cap. The revenue cap, however, remains only a proposal, and it has not yet been approved.

For further information on Maryland Health Services Cost Review Commission, interested parties may contact Russ Hereford at NCSL or the Commission itself at 201 West Preston Street, 1st Floor, Baltimore, MD 21201.

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"State Hospital Cost Containment Programs"

Statement of Russell W. Hereford
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National Conference of State Legislatures

Health Care Cost Seminar
held by the
Hawaii Legislature
and
Department of Social Services and Housing

October 2, 1980

On behalf of the National Conference of State Legislatures, I would like to welcome you to this meeting. I am pleased to be with you to discuss programs which some states have undertaken to control the rising costs of hospital care.

As you know, the National Conference of State Legislatures is the only national non-partisan organization which represents the nation's 7500 state legislators. The NCSL has three basic objectives: to improve the quality and effectiveness of state legislatures; to assure state legislatures a strong, cohesive voice in the federal decision making process; and to foster inter-state communication and cooperation. The NCSL is headquartered in Denver, Colorado, and maintains an office of State-Federal Relations in Washington, D.C.

Much of our activity in the health care field is funded through a grant from the Health Care Financing Administration, U.S. Department of Health and Human Services. Through this grant we are able to provide a number of services to state legislatures as they work to control the rising costs of health care. These services include assisting with seminars such as this; providing information at public hearings; publishing periodic reports on significant state and federal health care cost containment activities; and providing a central information clearinghouse on state and federal health care initiatives.

I would like to offer the continued assistance of the National Conference of State Legislatures, now and in the future, as you examine issues in the health care field.

In my presentation today, I would like to provide you with an overview of actions taken by other states to control rising hospital costs.

Seventeen states now operate hospital cost containment programs. These range from comprehensive programs, such as those underway in New York, Maryland, and other states; to programs in California and West Virginia which merely require hospitals to file financial and statistical data with a state commission; to programs in Maine and Virginia which depend primarily on the hospital industry itself to review hospital budgets.

I. General Considerations - Several considerations bear examination for each of these programs:

A. Location: Is the program operated by the executive branch, an independent commission, or a private sector group? Or, is it a combined public/private sector venture?

B. Payors Covered: Does the program apply to all third-party payors; only to state controlled rates (Medicaid); to cost based payors (Medicaid and Blue Cross); or to charge paying patients?

C. Compliance: Are hospitals required to participate? Must they adhere to the findings of the program, or is compliance with program findings voluntary?

D. Method of Review: Is the methodology employed a formula approach or a budget review? Under a formula approach, costs for a base year -- typically, two years prior to the current year -- are examined. Approved costs are then projected forward to the current year to reflect inflation. While New York and Massachusetts use a formula approach, most states with cost containment programs have adopted a budget review system. There are two broad types of budget review:

1. A hospital's budget for the current year is examined for inefficiencies -- normally, by comparing it with the budgets of similar hospitals. The budget is then projected forward to the next year to account for inflation, changes in volume, etc. A hospital is then given an overall limit for the next year, within which it sets charges and rates.

2. A hospital submits a prospective and a current budget. An inflation factor is applied by the reviewing agency to the current budget -- either overall, or on a department-by-department basis. If the projected budget is below the inflated current budget, it is approved. If it is above the inflated budget, a detailed examination of the budget is undertaken to find inefficiencies (which will be disallowed) or to see if the higher budget is justified (i.e., a change in case mix or a new capital expenditure). The approved budget forms the basis for the hospital's schedule of rates and charges.

E. Effectiveness: A variety of methods are used to measure the effectiveness of cost containment programs. Perhaps the most common method is comparing the rate of increase in hospital expenditures in states with cost containment programs with the rate of increase in states without such programs. On the whole, rates of increase in hospital costs in states with cost containment programs -- particularly in those states with mandatory programs -- are lower than in states without such programs. I will address the issues of effectiveness in more detail after giving a description of each of the state programs.

II. Overview of State Cost Containment Programs - While it is possible to describe some common features of state hospital cost containment programs, it is important to note that each program is unique. In general, state legislated cost containment programs may be divided into two categories: Those under which hospital compliance with program findings is not required (Voluntary Programs), and those under which hospitals must adhere to the findings of the program (Mandatory Programs).

A. Voluntary Programs

1. ARIZONA:

Hospitals are required to file on prescribed forms a notice of any proposed change in charges with both the local Health Systems Agency and the Department of Health Services 60 days prior to the implementation date.

The HSA holds a public hearing after which it decides whether or not to recommend approval. The Department of Health Services simultaneously conducts its own review, during which it considers, but is not bound by, the recommendation of the HSA. After its review the Department issues a statement as to whether the proposed rates are justified, and if not, what, if any, level of increase would be justified.

The changes from historical costs to the proposed budget year are analyzed, with primary consideration given to inflation, volume changes, and the total financial needs of the institution. Although all hospitals must participate, there is no fiscal risk or incentive since compliance is voluntary, and depends primarily on public disclosure of unfavorable findings. (It is worth noting that Arizona does not have a Medicaid program.)

2. CALIFORNIA:

The California Health Facilities Commission consists of 15 members appointed by the Governor; seven represent the health care industry and eight represent the public. All California health care facilities must submit financial and statistical information to the Commission in accordance with uniform accounting and reporting systems. Although legislation has been introduced for several years to expand the Commission's authority, it presently has no rate review or approval function.

This year legislation was enacted requiring hospitals to submit additional financial and utilization data. The Commission would utilize this data to monitor California hospitals' performance under the Voluntary Effort being undertaken nationally by the hospital industry.

3. FLORIDA:
Florida enacted legislation in 1979 establishing a nine member Hospital Cost Containment Board within the State Insurance Department. All hospitals must submit financial and accounting data (other than information relating to the costs of physician services which are billed independently) to the Board. While the legislation requires the Board to specify a uniform system of financial reporting, it specifically prohibits the Board from adopting a uniform accounting system.

The Board reviews hospital budgets, rates and charges. If a hospital's rates and charges or other statistical indicators (such as percentage increase in rates over the preceding year), are in the upper 20 percent of such indicators for comparable hospitals, the Board is authorized to review the budget at a public hearing. The findings of any such hearing must be published in the newspaper of largest general circulation in the county in which the hospital is located.

4. MAINE:
An independent ten member state Health Facilities Cost Review Board, part of the state government, may review hospital budgets, or the review may be done by a private sector Voluntary Budget Review Organization (VBRO). Most of Maine's hospitals have contracted with the private sector VBRO, which is now in the process of performing its first set of reviews. There are no compliance requirements in the law, which sunsets in 1982. If the private sector approach is successful in holding down rates of increase, that system will probably be permitted to continue. If that approach is not successful, however, it appears likely that the legislature may reevaluate the need for stronger controls.

5. MINNESOTA:
A similar program is underway in Minnesota where the Minnesota Hospital Association reviews hospital rates for charge-based payors, and the Commissioner of Health must review and comment on the reasonableness of these rates.

Hospital budgets are analyzed through a grouping system based on geographic location, service index, ratio of surgery to total admissions, ratio of Medicaid and Medicare to total admissions, and level of teaching activity. Within each group hospital costs are analyzed for variance from the average cost per adjusted admission.

Actual review and comment on rate requests is performed by one of six rate review panels, composed of three hospital representatives, two third-party payor representatives, and two consumer representatives. At a meeting with the rate review panel, hospitals must justify variances from the group average. The hospital is notified of the panel's decision, and then must give written notice of whether or not it intends to comply with the findings.

6. OREGON:
The Oregon State Health Planning and Development Agency is responsible for review of and comment on existing and proposed hospital rates. The agency has no enforcement powers, but it is required to make public rates which it finds to be unreasonable. The SHPDA Director, appointed by the Governor, has the authority to review and determine the reasonableness of the rates. While all facilities must participate, compliance is voluntary. Charge-based payors, including Blue Cross, are covered.

7. VIRGINIA:
In 1978, Virginia passed legislation forming an independent rate review commission. The Commission, however, is empowered only to examine costs retrospectively and to publish its findings of reasonableness. Virginia had been operating a voluntary program in which about 70 percent of the hospitals must report their data to the Commission but are under no obligation to heed its findings.

8. WEST VIRGINIA:
The 1979 West Virginia legislature enacted a law requiring financial disclosure by all hospitals with more than 15 beds. Hospitals must file with the Director of Health and publish as a legal advertisement in a local newspaper, an annual report prepared by the facility's auditor or by an independent public accountant. The report must contain a complete statement of the facility's assets and liabilities; income and expenses; and profit or loss; and a statement of ownership for persons owning more than five percent of the capital stock. The complete report is made available at the Department of Health as public information.

Each hospital must also file:

a. A statement of services available and services rendered;
b. A statement of its total financial needs and resources available;
c. A schedule of current rates, with costs allocated to each category;
d. A copy of any reports filed with the Health Care Financing Administration; and
e. A statement of all charges, fees or salaries in excess of $55,000.

The Director of Health is empowered to carry out analyses and studies related to health care costs, the financial status of any hospital, and to make determinations as to whether, in his opinion, the rates charged by a hospital are economically justified.

3. Mandatory Programs

a. CONNECTICUT:

The Connecticut Commission on Hospitals and Health Care was established in 1973. Its seventeen members include three ex-officio members from State government (Commissioners of Health, Mental Health, and Insurance), and fourteen appointees (12 executive and 2 legislative) from the public and the health care industry.

All nongovernmental hospitals are required to participate and comply with the program. All charge payors are covered by the program. Since Connecticut Blue Cross pays the lower of billed charges or actual costs, the Commission, in effect, also sets Blue Cross rates.

The program utilizes a mandatory reporting system, gathering data on a hospital's past, current, and proposed budgets. The data is used to place hospitals in groups, according to the size of the hospital, and the number of services offered. For the base (current) year, both the hospital's operating budget, which is broken into ancillary, routine, and general service clusters, and its capital budget are compared to the median for a hospital's group. Adjustment for inflation, volume, and service changes are considered in establishing the prospective budget, resulting in both a projected budget and a revenue limit.

Once the new rates are established, they cannot be altered unless the hospital can show unforeseen and material changes in expenses. Should the hospital receive revenues in excess of approved levels, after adjusting for changes in volume, it must apply excess revenues to the following year's financial requirements.

10. ILLINOIS:

In 1978, the Illinois Legislature established the Illinois Health Finance Authority, with five voting and five non-voting members. The five voting members, no more than three of whom may be from the same political party, are four public members and one hospital trustee. The Director of Public Aid serves as an ex-officio, non-voting member. The other four non-voting members must be two hospital administrators and two representatives of third-party payors.

The Authority must approve hospital rates on a prospective basis. All hospitals, purchasers and third-party payors must recognize and accept the rate approved by the Authority, and the rates must be accepted as payment in full. The Authority must assure purchasers and payors that a hospital's rates are reasonably related to its financial requirements, and that the rates apply equitably to all purchasers of care without unfair discrimination.

Hospitals seeking a rate change must submit the proposed changes to the Authority at least 90 days prior to the proposed effective date. If the Authority does not act within 60 days, the rates are deemed approved. The legislation specifies that a hospital may keep any surplus which it is able to achieve within the approved rate. It must also bear any deficits which it incurs in excess of the approved rate.

The Illinois law is unique, in that all major public payors — i.e., Medicaid and Medicare -- must agree to pay the rates set by the Authority before the rate setting function may begin. The Authority has held a number of educational seminars on hospital economics. Draft regulations have been circulated, but the Authority has not yet officially set rates.

The legislation has a sunset date of October 1, 1982.

11. MARYLAND:

The seven member, part time, Maryland Health Services Cost Review Commission is an independent body in the Department of Health and Mental Hygiene. Commissioners are appointed by the Governor for four year terms and may be reappointed once. The exact composition of the Commission is not detailed in statute, although the law does specify that no more than three commissioners may be associated with the health care industry.

The rate review process for a particular institution may be initiated either by the Commission itself or by a hospital which requests an increase in its approved rates. Staff analyze the institution's data on such factors as cost, volume, and case mix, comparing departmental costs with those of other hospitals after adjusting for regional wage differences. Costs in excess of a predetermined screen are challenged and, if not adequately justified by the hospital, are disallowed.

At a public meeting, the Commission reviews staff recommendations which it may approve, revise or reject. If the interested parties have no objection to the Commission's decision, these rates go into effect. If one of the interested parties challenges the recommendations, however, a second public hearing is held at which evidence and testimony are presented, subject to cross examination by the other parties to the appeal. In practice, very few reviews go to a second public hearing, since Commission staff work closely with hospital representatives to resolve differences prior to submitting their recommendations.

The Maryland system is unique, in that it does not perform an annual review of each hospital's budget. Over a three year period the Commission reviewed each hospital in the state. Since that base budget review was completed, however, only hospitals requesting a rate increase and hospitals which the Commission feels bear further examination are subjected to individual review.

The major tool used to control hospital cost increases is an inflation adjustment factor. This factor is based on two broad measures. One measure reflects items beyond the control of the hospital, such as ERISA costs, FICA tax increases, and malpractice costs. The other factor is designed to account for the impact of inflation in the general economy. This inflation adjustment system has a number of advantages. First, it enables the Commission staff size to be kept small; rather than reviewing each hospital's entire budget in detail every year, the only requirement is that inflation be monitored. Secondly, those hospitals which are performing well -- keeping their costs in line with inflation -- are not subjected to excessive government intrusion, yet will still be granted an increase sufficient to keep up with inflation. Third, the inflation adjustment approach gives hospitals a very strong incentive to control their own costs. The hospital can keep any savings it effects --

the increase for next year is independent of this year's performance. While efficiencies may result in disallowed costs after a future detailed budget review, that review might not be performed for several years, and the hospital keeps any savings it accrues over that time.

Hospitals are paid through one of two mechanisms. Under the first method, payments are set on the basis of an average rate per unit of service for each department within the hospital. Within that constraint, the hospital is free to set charges for each individual unit of service. The second payment method is an experimental approach which now applies to 13 hospitals. Under this "Guaranteed Inpatient Revenue" program, a hospital is guaranteed, in advance, an average revenue for each admission, based on projected volume and case mix. The average charge for each admission must equal the amount set in advance. Adjustments are made at the end of the year to reflect the actual number of admissions and any changes in case mix. To counter any incentive to increase admissions, hospitals on the Guaranteed Inpatient Revenue program are paid only for the variable costs associated with each additional admission.

12. MASSACHUSETTS:

The Massachusetts State Rate Setting Commission was established in 1974. The program is administered by three full-time commissioners, appointed by the Governor. All non-federal hospitals are required to participate and comply with the program. In effect, three different programs operate in Massachusetts.

For Blue Cross there is a two-stage review process. First, the Commission has review and approval authority over the contract made between a hospital and Blue Cross. At the second stage, a hospital's cost reports are audited by the staff, and compared to data for prior years, in order to assess changes in case-mix and uncontrollable costs. Any amount in excess of reasonable costs may be denied to the hospital in the next year's rates.

For Medicaid rates, the process is predicated on the inflation of base year costs. Costs reports for the base year are inflated forward to obtain an overall budget for the rate setting year. The overall budget, rather than its components, is examined. Any costs in a hospital's proposed budget in excess of the projected budget are disallowed, unless the hospital can show that the excessive cost is due to uncontrollable factors, or new capital expenditures (obtained with certificate-

of-need approval). The projected cost is then converted into an overall per diem, subject only to minimum occupancy levels. During the new year, adjustments may be made in the per diem for uncontrollable costs. However, all other excess expenditures occur at the risk of the hospital.

For charge payors, a budget/rate review and approval process is used. The uniform data is used to establish base year (previous year) costs. This base is adjusted for inflation for uncontrollable increases in costs and for changes in volume. The resulting allowable costs are used to establish allowable charges, subject to a maximum cost-to-charge ratio of 95%. The facility is at risk for all over-expenditures, but is the beneficiary of all profits. Earlier this year, the Commission proposed new regulations which would have required hospitals to submit more detailed information for determination of charges. Due to an uproar from the hospital industry, the Commission withdrew the regulations. At the same time, the Legislature approved a one year increase of 11.5% in charges, and established a special commission to study the state's reimbursement policies and to make recommendations for future actions.

13. NEW JERSEY:

New Jersey has had the authority to regulate hospital rates since 1971. In 1978, the legislature enacted a law which made three significant changes in New Jersey's hospital reimbursement program. First, the law extended the state's authority to control hospital reimbursement from all payors. Second, the legislation required that the costs of uncompensated care be spread among all payors. Third, a five member Hospital Rate Setting Commission was created to approve or adjust hospital rates.

New Jersey has developed a payment system under which hospitals are paid a fixed amount based on the average costs incurred in treating patients with a particular diagnosis, rather than for the number of services provided or the number of days which a patient resides in the hospital. This Diagnostic Related Group (DRG) system has now been implemented in 26 of the state's 117 hospitals. The Department of Health anticipates that the system will be gradually expanded each year, and that it will be applied statewide in 1983.

The theory behind diagnostic related groups is simple: Patients with like medical conditions tend to use similar amounts of hospital resources. A DRG is mutually exclusive; every patient is assigned to one, and only one, DRG. To be of use in a reimbursement system, DRGs need to meet the following conditions: the number must be manageable; each must be medically meaningful; and they must be statistically valid.

This general classification scheme, developed by researchers at Yale University, was applied to over 500,000 discharge abstracts from New Jersey hospitals to develop a DRG system specific to that state. The first step was to divide the universe of medical diagnoses into 83 "major diagnostic categories." Five predictor variables were applied to each of these major diagnostic categories: primary diagnosis, secondary diagnosis, primary surgical procedure, secondary surgical procedure, and age. The variables were chosen because they explained, with an acceptable degree of accuracy, variations in resource consumption, as measured by length of stay, for different illnesses. This procedure yielded 383 diagnostic related groups for patients discharged from hospitals in New Jersey.

To develop this payment system, three basic sets of information -- two patient specific and one hospital specific -- are required. For each patient, a medical discharge abstract is obtained from the hospital. This abstract provides information on the illness treated, surgery performed, and length of stay. Patient confidentiality is strictly maintained; each abstract is identified only by a number. Hospitals must also submit a bill for each patient -- identified by the same number as the abstract. This bill lists the charges for each patient, by routine and ancillary cost center.

The third type of information required is financial and statistical reports from the hospital. These reports are used to develop an institutional profile which permits apportioning of inpatient costs, ratios of costs to charges, and other pertinent hospital information.

Rates of payment are calculated for each DRG for each hospital. The basic DRG rate is composed of two components: direct costs and indirect costs. The costs of general overhead services, such as medical record keeping, are allocated to direct and indirect cost centers in a cost allocation process similar to that used by Medicare.

Direct costs for each DRG are determined in the following manner: Routine care costs (such as nursing services, room and board) are allocated to each patient in proportion to that patient's length of stay. Ancillary costs (such as laboratory and radiology) are apportioned by dividing the total cost of each cost center by the revenue produced by that cost center. This ratio is then applied to each inpatient's charges for c st center, which yields the approximate cost for that patient. For each patient, costs incurred in each cost center are added to arrive at a total direct cost. After adjusting for area wage differentials, the costs of all patients in the state in each DRG are aggregated, and an average statewide DRG cost (referred to as the "incentive standard") is calculated. Separate standards are calculated for teaching hospitals and non-teaching hospitals. The actual payment rate for direct patient care which a hospital receives for a particular DRG is composed of a portion of the hospital's own average DRG cost and a portion of the incentive standard. The portion of each that is actually used to set the payment rate depends on the inter-hospital statistical reliability of that DRG. For example, the average cost per case for DRG 313 (Normal Full Term Newborn) varies much less than for DRG 121 (Acute Myocardial Infarction).

To determine indirect costs (such items as utilities, administration and maintenance), hospitals are separated into teaching and nonteaching categories. Each hospital's indirect costs are divided by direct costs, resulting in a percentage ratio. These ratios are ranked from highest to lowest for each category, and a median is determined. Indirect costs in excess of 110 percent of the median percentage are disallowed.

Physician fees and salaries are excluded from this calculation, except in teaching hospitals, where resident physician salaries and fees are included. These excluded costs for physicians are added to indirect costs that pass the screen.

Under the 1978 legislation several additional costs of doing business are included in a hospital's rates. These additional financial elements are added to the approved indirect cost rate. A capital facilities allowance (CFA), calculated for each hospital, covers current and future year capital funding requirements. The CFA includes an amount to meet cash needs for buildings and fixed equipment for the current year, as well as funding for renovation and replacement. A personnel health allowance is available for hospitals which self-insure. In order to provide for a hospital's working capital needs, all

costs are increased by five percent; this working capital allowance is reduced by payors who may take discounts of up to five percent for prompt payment. Hospitals in a poor financial position are also paid a one-time working cash infusion.

To arrive at the hospital's basic rate for each DRG, costs are projected forward to adjust for inflation that has occurred between the base year (two years prior) and the rate year. The basic rate is composed of the approved direct cost and a percentage markup for indirect costs.

Various payors are permitted discounts from the rates for practices which benefit the health care system as a whole, such as lower bad debt ratios and subsidization of open enrollment. The actual percentage of this differential is set by the Hospital Rate Setting Commission. Blue Cross, for example, has been granted a differential of 4.05 percent.

In actually paying for a hospital patient, an additional calculation is necessary to allocate the costs of uncompensated care. Uncompensated care is reimbursed under the New Jersey system in a unique manner. Rather than placing the burden of funding uncompensated care on charge paying patients alone, the 1978 legislation required that the costs be spread among all payors. Each payor's share of uncompensated care in a particular hospital is determined not by its patient load in that hospital, but by its statewide share of hospital patient days. Thus, for example, assume that Blue Cross's share of the patient load across the state is approximately 26%. Even if its share in a particular hospital were only 20%, Blue Cross would still be responsible for 26% of that hospital's uncompensated care. To allocate its total share to individual patients, a payor's uncompensated care factor is calculated by dividing that payor's statewide patient load by its load in that particular hospital; this ratio is then applied to the uncompensated care burden in the hospital.

In order to provide for working capital and to encourage prompt payment, an additional discount is given for timely remittance. This discount, which ranges up to five percent for payment upon discharge, is applied to the amount due from the payor.

To show how this system works, the following example conceptually demonstrates a payment calculation. The actual method which the Department uses is somewhat different and more complex than this example. Assume a direct rate for the DRG in Hospital A of $1200, an indirect

rate of 40 percent, and an uncompensated care load of five percent. Also assume that Blue Cross has a payor differential of 4.05 percent, a statewide patient load of 26 percent, and a hospital patient load of 20 percent, and that payment is made on a timely basis, allowing a five percent discount. Payment would be made on the following basis:

Step 1. Basic DRG Rate = direct cost + indirect costs
= $1200 + ($1200 x 40%) = $1680

Step 2. Uncompensated Care Factor =
Hospital uncompensated care load x [statewide payor load / hospital payor load]
= .05 x [.26/.20] = .065

Step 3. Payor Factor = Uncompensated care factor - Payor Differential
= 6.5% - 4.05%
= 2.45%

Step 4. Basic Payment = (1 + Payor factor) x basic DRG rate
= [1 + 2.45%] x $1680
= 1.0245 x $1680 = $1721.16

Step 5. Final Payment = Basic Payment - Prompt Payment Discount
= $1721.16 - 5%
= $1635.10

With one exception, payment for all hospital inpatients is made on the DRG system. Patients with abnormally short or long lengths of stay, (referred to as "outliers") are isolated from their groups; reimbursement for these patients, as well as for hospital outpatients, is made on the basis of actual controlled charges for services rendered.

The Department of Health issues to each hospital a schedule of rates, which shows the rate for each DRG. The hospital may accept the rates outright, in which case it may appeal only its capital facility allowance formula, or it may appeal the rates to the Hospital Rate Setting Commission, under one of two procedures. A hospital which accepts the rates conditionally may appeal such items as the capital facility allowance, costs of approved expansion, changes in teaching responsibility, and revenue adjustments; a hospital which rejects the rates may appeal all items. Under the first set of rates issued, seventeen hospitals gave conditional acceptance, while nine hospitals rejected the rates.

The Commission also informs each hospital of its approved revenue budget for the coming year. This amount is determined by multiplying the anticipated patient load for each DRG by the approved rate; the totals for each DRG are then added to arrive at the DRG total. Expected revenue from outpatient services and outliers is added to this figure.

Since the revenue budget is based on projections and estimations, at the end of the rate year a process entitled "reconciliation" takes place. This process adjusts direct revenues in light of the hospital's actual experience. (Indirect costs are fixed at the beginning of the year and are not subject to adjustment.) Any over or undercharges are reflected in the following year's rates. If a hospital has received revenue in excess of the approved amount, an interest penalty is levied; should the revenue collected be less than the approved amount, the hospital receives interest on the undercollected amount.

14. NEW YORK:

In 1969, New York enacted the nation's first hospital cost containment law. Under this legislation, the state was given the power to regulate Blue Cross and Medicaid rates. In 1978, the Legislature enacted a law limiting the amount a hospital may charge to self-pay patients and to patients who carry commercial health insurance policies. In addition, hospitals are prohibited from charging Blue Cross patients in excess of the state approved rates. Under the 1978 legislation, a panel of independent health economists is charged with developing a methodology to be used in establishing a semi-annual inflation factor, which is applied to all the payment sources.

The New York system is based in the executive branch -- the Office of Health Systems Management, one of two components of the Department of Health (the other is the Public Health Office, which concentrates on traditional public health activities). The state has had a uniform reporting system in place for several years.

Rates are set on a per diem basis. Blue Cross rates are actually calculated by the Blue Cross plans, and approved by the Commissioner of Insurance. Medicaid rates are calculated by the Office of Health Systems Management and are approved by the Director of the Budget.

Hospitals are grouped on the basis of size, location (rural or urban), sponsorship and teaching status. Hospitals are then compared with those in the peer group. If a hospital's base year costs exceed the group average, the excess costs are disallowed. Separate calculations are performed for both routine and ancillary costs. The approved base year costs are then projected forward to account for inflation.

The New York system contains a system to penalize hospitals for inefficient utilization. To avoid a penalty, hospitals must have an occupancy rate of at least 60% for obstetrical services, 70% for pediatrics, and 80% for Medical-Surgical services.

New York is also working with case-mix in an effort to further refine its grouping system.

15. RHODE ISLAND:

Representatives from Blue Cross, the Rhode Island State Budget Office, and the Hospital Association of Rhode Island annually negotiate hospital budgets. The staff of the Blue Cross and State Budget Office are responsible for the budget review process. (Rhode Island is unusual in that an exceptionally large proportion -- over 80% -- of its population has Blue Cross coverage.)

All non-federal hospitals receiving reimbursement from Blue Cross and Medicaid are required to participate and comply with the program. Blue Cross and Medicaid rates are set according to the outcome of the negotiations.

Statewide negotiations among Blue Cross, the State Budget Office, and the Hospital Association are conducted annually to set a ceiling for the percentage increase for hospital expenditure in the state for the upcoming fiscal year.

Individual budget negotiations are conducted between Blue Cross, the State Budget Office and each hospital. Total hospital cost increases must fall within the statewide cap. Hospitals submit cost data annually on their current and prospective fiscal years. Budget review is used to examine the proposed increases. These increases are reviewed on a global, as well as a cost center level. Inflation, changes in volume, and changes in types of services are considered in reviewing the prospective budget. In the case of new or expanded services, a statewide medical program review and priority process is used to determine appropriateness. A hospital, after having

its total operating expenses negotiated, will establish a fee schedule. This schedule is subject to final review and approval by the third parties. Blue Cross and Medicaid use this schedule to set their respective rates.

If an agreement cannot be reached by the third parties and a hospital, both sides will be brought together for a formal mediation. This process will include representatives from the hospital and third parties. If the mediation does not result in agreement, the unresolved issues go before an independent arbitrator for binding arbitration.

16. WASHINGTON:

Washington in 1973 established a five member, independent Hospital Commission. The Commission has developed a classification system to enable it to measure services and costs associated with these services. The Commission groups hospitals for comparison purposes on the basis of two sets of variables: a) Endogenous variables focus on factors within the control of the hospital. These are:

1. Number of available beds;
2. Proprietary or nonprofit;
3. Government or nongovernment;
4. Accredited or not accredited;
5. Service Index (based on 43 services);
6. Physician Mix Index (number of specialties);
7. Number of interns;
8. Number of intern specialties;
9. Number of residents;
10. Number of resident specialties;
11. Medicare days/total inpatient days; and
12. Medicaid days/total inpatient days.

b) Exogenous variables focus on economic, market related variables, which affect hospital performance, but over which they have no control. These are primarily socio-economic and demographic variables. The measurement unit is applied in the county in which the hospital is located. These exogenous variables are:

1. Number of physicians per 1000 population;
2. Number of hospital beds per 1000 population;
3. Percent of population female between 15 and 44;
4. Percent of population 65 and older;
5. Percent urban; and
6. Median income.

The budget review process focuses on relating costs to services and follows through to determine the reasonableness of the relationship between costs and rates. Requested rates are reviewed in seven areas:

1. Changes in services, number of beds and medical staff composition, as well as any significant economic or demographic changes in the hospital's service area;
2. A review of trends in admission, patient days and units of measure by department;
3. A screening system which compares each hospital's projected operating expenses to the operating expenses of its hospital peer group. Expenses such as salaries and wages, professional fees, and supplies are evaluated. In all, more than 370 variables are evaluated in this process. Any expense that is in the top 30 percent of a hospital's group requires justification. Comparisons are also made between the current year, the prior year, and the year for which the budget request is made;
4. A review of a hospital's projected financial position compared to its current position, the need for additional working capital, and changes in other assets and liabilities;
5. An analysis of other financial requirements including existing debt, costs for new equipment and replacement costs;
6. A comparison of the financial needs of each department with the revenues expected to be generated from the proposed rates. A cross-departmental subsidy in excess of five percent is routinely disallowed by the Commission unless the hospital is able to justify a higher percentage; and
7. A review of the hospital's performance against previously approved rates.

Through June of this year, the Commission undertook an experiment to assess the impact of different payment methods. Hospitals were divided into three groups.

Type I reimbursement incorporated incentives to control both cost and volume. Under this reimbursement method, hospitals were guaranteed, in advance, a lump sum reimbursement representing 55 percent of the revenues approved by the Commission. If a hospital's projected costs or volumes were maintained at lower than projected levels, it realized additional reserves for meeting future needs for additional services or equipment. However, a hospital was at risk if its costs or volumes exceeded those forecasted.

Type II reimbursement tested incentives for cost control, with no incentive or disincentive for volume. The major payors reimbursed each hospital on the basis of adjusted billed charges, which reflect the same principles of payor costs differentials incorporated in Type I reimbursement. An adjustment was permitted, however, for changes in volume.

Type III reimbursement -- in effect, a control group -- was a continuation of the existing reimbursement system, including the customary retrospective cost reimbursement employed by Medicare and Medicaid.

This experiment, however, terminated when the state Department of Health and Social Services (the state Medicaid agency) refused to approve an extension, primarily because of cash flow problems. The Commission will continue to operate the controlled charges program which is described in the first few paragraphs of this section.

17. WISCONSIN:

The Wisconsin program is a cooperative venture between the State Department of Health and Social Services, Blue Cross of Wisconsin and the Wisconsin Hospital Association established in 1975. The program, however, has only been operational since 1977 when it received an anti-trust exemption from the Department of Justice.

By a mutually binding contract, the State, Blue Cross and State Hospital Association formed the Wisconsin Hospital Rate Review Committee. The Committee is composed of twenty members; six appointed by the Governor, six appointed by the hospital association, six appointed by the Blue Cross and two appointed jointly by the State and hospital association.

Authority to approve rates is vested in the Committee. However, actual analysis is performed by the Blue Cross staff. The methodology applied by Blue Cross was developed by the State Department of Health and Social Services.

All nonfederal hospitals are required to participate and comply with the program, which covers all payors except Medicare.

Unlike most other programs, the review process is invoked only when a hospital makes a request for a rate change. Upon making the request, a hospital must submit its current and prospective operating budgets, interim income statement, balance sheet, capital budget, debt schedule, and additional revenue request. All of these reports are transferred by Blue Cross into a uniform format for analysis.

The reasonableness of a hospital's budget is determined by grouping hospitals according to location, size and teaching status, and comparing various per diem and per admission costs. Costs in excess of the group average which are not justified by a hospital, may be removed from the budget.

The staff subsequently make a recommendation to the Committee to approve, modify or reject the rate request. If a hospital is dissatisfied with the staff recommendation, it may present its position to the Committee. Should a hospital remain dissatisfied after final Committee action, review may be taken before an appeals board, whose findings are final.

Except for unforeseen or extraordinary circumstances, neither retroactive adjustments nor additional rate requests are permitted during the prospective year.

A recent legislative audit of the program recommended that the program establish cost control standards and impose sanctions against hospitals which violate the standards.

III. Effectiveness of State Cost Containment Programs - Obviously, a major interest regarding state hospital cost containment programs is the extent to which these programs have been successful in controlling the rate of increase in hospital costs. Attached at the end of this testimony is a summary of hospital expenditure data on a state-by-state basis for the years 1976 through 1978.

Several caveats, however, are in order when one attempts to compare rates of increase in these programs:

1) Each program was established at a different time, so there is no common date at which one can begin to measure cost containment programs as a group.

2) Each program has evolved differently, reflecting the unique characteristics of that state.

3) Hospital cost containment is an art, not a science. It is important to remember that the first state legislated program was enacted only ten years ago. The programs, techniques, and methodologies have changed over time as experience has brought increased sophistication to the operation of these systems.

4) The definition of "mandatory program" differs, depending on the one who defines it. In this discussion, we consider the following eight states as having mandatory programs: Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Wisconsin and Washington. These are used because hospitals in those states would have been exempted from federal controls under the Administration's Hospital Cost Containment Act, if the state program remains in effect.

Of the variety of methods in which the effectiveness of these programs in containing costs can be measured, the following three appear to be particularly useful, and reveal some enlightening information.

A. Total Expenses: While comparing total hospital expenses on a state-by-state basis does not provide a reflection of changes in population for each state, it does demonstrate the total resources which citizens of that state must devote to hospital care.

In the eight states with mandatory programs, total hospital expenses in 1978 increased by 8.6 percent over 1977, as compared with an increase of 14.3 percent in states without mandatory programs. The average increase in total expenditures for the entire country was 12.6 percent. (Total hospital expenses in Hawaii increased 11.6 percent over this period.)

B. Expense Per Day: While comparing the increase in expenses per day reflects neither changes in the number of days which a patient spends in the hospital, nor changes in the number of hospital admissions, it provides a useful measure of the resources devoted to a single day of hospital care. In the eight mandatory states, expenses per day in 1978 increased by 9.0 percent over 1977, versus an increase in the other 42 states and District of Columbia of 12.7 percent. The national increase was 11.7 percent. (Expense per day in Hawaii increased by 10.9 percent.)

C. Expense Per Admission: While expense per admission does not reflect increases in the number of hospital admissions, it shows changes in the costs of a hospital stay. This reflects both changes in the intensity of care (number of services provided), as well as in the length of stay. In the eight mandatory states, 1978 expenses per admission increased 9.1 percent over 1977, versus increases of 12.4 percent in the rest of the country. The national average increase in expense per admission was 11.5 percent. (Expense per admission increased 13.2 percent in Hawaii.)

IV. Conclusion - The operation of hospital cost containment programs in seventeen states is evidence of the increasing concern at the state level over the high rate of inflation in the hospital sector. States appear to be the appropriate level at which to regulate hospital costs for a number of reasons. First, the protection of the citizenry's health has traditionally been within the recognized police powers of the state. In addition, states have a major financial stake in the success of cost containment programs

through their contributions to the Medicaid program and as purchasers of health care for state employees. States are also in the best position to view individual hospitals' needs, priorities, budgets, and operations within the context of statewide needs, priorities, and resources. States are in the most appropriate position to assure the coordination of hospital cost control programs with other forms of regulation, such as certificate of need review, and facility licensure.

As Hawaii continues its deliberations in this field, the National Conference of State Legislatures will be pleased to provide assistance in this crucial public policy area.

HEALTH CARE
VIEWPOINT
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Fair Payment Systems

A Necessary Approach to Containing Hospital Costs

Fair payment systems, considered by many in the health care arena to be a most promising approach to hospital cost containment, are rapidly gaining support across the country. The systems, which determine hospital reimbursement rates in advance for *all* payers — private as well as government — seek to provide strong financial incentives for hospitals to reduce unnecessary utilization of services and slow down the rate of cost increases. A number of states have adopted fair payment systems, and the movement is picking up momentum.

The Health Insurance Association of America (HIAA) is seeking to increase public awareness of "fair payment" programs, which provide equitable payment for all payers. The message: fundamental reform of the nation's hospital reimbursement system is essential in the quest to contain health care cost inflation.

The Problem

Health care costs in the United States were $322 billion in 1982, exceeding 10 percent of the Gross National Product for the first time in history.

The average cost of a day in a semi-private hospital room has risen dramatically, from $91 in January, 1977 to $165 in January, 1982. And while the general rate of inflation in 1982 was nearly 4 percent, daily hospital charges rose by 13 percent.

Although the rate of increase in health care expenditures dropped in 1983, it is estimated that these costs still rose twice as fast as the Consumer Price Index.

As a result of these increases, annual health insurance premiums have been rising to keep pace with prices and use of services.

Hospital Payment Reform

In a major attempt to moderate hospital cost inflation for the federal sector, Congress enacted the Social Security Amendments of 1983, changing the way that hospitals are reimbursed for Medicare patients.

Under a new prospective payment system, hospitals are reimbursed on the basis of "diagnosis-related groups" or DRGs. Hospital rates — but not physician fees — are pre-determined for specific diagnoses, regardless of the length of stay or extent of services provided. For example, the standard Medicare price in Boulder, Colorado is approximately $2,048 for a medically treated back problem and $17,989 for a kidney transplant.

The intent of the Medicare prospective payment system is to reduce the amount of money paid by the federal government for hospitalization. At the same time, the system is designed to give hospitals an incentive they have not had before — receipt of a financial reward when they are cost-effective. Hospitals which operate below the pre-set DRG level will profit, while those with cost overruns will have to absorb the losses.

But in applying only to Medicare patients, the prospective payment system does little, if anything, to solve a serious deterrent to health care cost containment — "cost shifting" by hospitals to private patients to offset their losses in treating government patients. An average hospital bill for a private, non-government patient is nearly 13 percent higher as a result of such a cost shift.

Under this new system, the government has redefined "reasonable cost" in such a way as to permit government payments to fall further and further below an adequate rate. Thus, hospitals have been forced to raise charges to private patients disproportionately in order to meet their expenses. In addition, there is every indication that Medicare and Medicaid reimbursement rates are likely to tighten even more in the future.

The HIAA has estimated the cost shift for 1983 at $7.2 billion, up $1.4 billion from 1982. Current estimates put the cost shift for 1984 at $8.8 billion. This cost shift, which many view as a "hidden tax" on health care, places an unfair burden on private sector patients.

Need for State Action

Under the new Medicare system, states are encouraged to adopt their own hospital cost containment programs, or "fair payment" systems. This does not mean that all charges for the same services would be identical, but that rates would be set fairly, with any Medicare differential cost-justified.

In order for a state to implement a fair payment system, the federal government must "waive" its usual reimbursement regulations, and allow Medicare and Medicaid payments to be governed by the state's cost containment program, applicable to all payers. Under federal law, the government may agree to forego its normal payment practices and participate in the program if the system:

- Applies to substantially all non-federal, acute-care hospitals;
- Applies to at least 75 percent of hospital revenues in the state;
- Treats payers, employees, and patients equitably;
- Will not result in greater Medicare expenditures over a three-year period than would otherwise have been made;
- Will not preclude HMOs from negotiating directly with hospitals with respect to payment for inpatient hospital services; and
- Prohibits hospitals from billing under Part B for services rendered to Medicare patients.

If the state meets six additional minor criteria, the government must grant a waiver.

In such waiver states, the Medicare program is guaranteed against undue cost increases. Congress has written such a provision into the law. If the government finds that, over a three-year period, Medicare has paid more under the state system than it would have paid without such a system, it may reduce subsequent Medicare payments to hospitals under the system by that amount.

Properly designed fair payment systems can:

- Slow the rate of increase in hospital costs;
- Achieve equity of payment for all payers of hospital services;
- Provide incentives for hospitals to reduce unnecessary utilization of services;
- Allow hospitals and third-party payers to budget their expenditures in advance; and
- Inform the public about hospital costs, thereby further promoting competition.

Maryland and New Jersey have had fair payment systems for all payers in place for several years; Massachusetts and New York established cost containment programs in 1983. Maine and West Virginia recently passed legislation and will soon apply for a Medicare waiver. Washington State is continuing to operate under a state hospital cost commission, until an application for a waiver is drafted. In Connecticut, a fair payment bill has just been enacted in the state legislature.

Profile of Two States

The cost effectiveness of fair payment systems can be illustrated by comparing the state of Maryland, which has such a system, and the neighboring state of Pennsylvania, which does not.

Between 1976 (the year preceding the implementation of the Maryland all-payer system) and 1982, payments for hospital care in that state rose far less than in Pennsylvania or the nation as a whole. On a patient-day basis, the net patient revenue* in Maryland increased by 96.5 percent, far lower than the national increase of 121.2 percent. In contrast, Pennsylvania's rate of increase was 127.4 percent. (See Table I.)

The rate of increase in Maryland's gross patient revenue per admission** also was well below the national rate and that of Pennsylvania. While the national rate was 133.5 percent and Pennsylvania's 155.8 percent, Maryland's was only 85.5 percent. This is an indication of how private payers have been affected by the cost shift phenomenon in Pennsylvania hospitals. Conversely, it speaks well for the effectiveness of Maryland's rate-setting commission. (See Table II.)

Savings to Medicare

To determine actual savings to Medicare under a fair payment system, it is necessary to calculate whether Medicare spent more in a particular state than it would have spent in the absence of a state program. Among the four states that have Medicare waivers, Maryland has accumulated the most meaningful data.

During the first three years the Medicare waiver was in effect in Maryland, the Medicare program saved more than $52 million, and Medicaid saved almost $34 million. Notably, the Maryland waiver has been continually renewed since 1977 on an experimental basis, and the state is now eligible to apply for a permanent waiver from the Health Care Financing Administration.

A 1981 survey of hospital executives conducted by the Maryland Health Services Cost Review Commission showed satisfaction with the state program: 82 percent said they believed that the Maryland prospective payment system had been very or somewhat effective in limiting the growth of patient cost per admission.

The New Jersey Program

In New Jersey, where the state prospective payment system served as the model for the new Medicare DRG reimbursement program, participating hospitals have reported cost increases almost five percent lower than the national average.

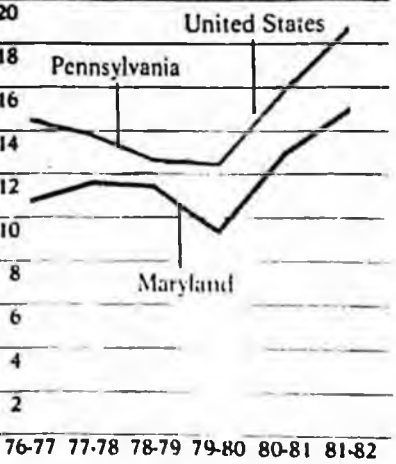
Sister Jane Frances Brady, president and chief executive officer at St. Joseph's Hospital and Medical Center in Paterson, New Jersey, told the HIAA that without the DRG system, the hospital would have been forced to close.

"DRG has made us whole, and has enabled us to keep high quality care where it is most needed and to continue to provide the greatest clinical field experience a physician in training could possibly have.

Table I
Percent Change in Community Hospital Indicators—Maryland, Pennsylvania and the United States, 1976-1982

Net Patient Revenue/Adjusted[1] Patient Day

	% Change	% Change	% Change
1976-77	10.9	14.6	15.5
1977-78	11.8	13.9	11.8
1978-79	11.6	12.7	12.2
1979-80	9.3	12.6	13.1
1980-81	13.0	16.0	16.2
1981-82	15.0	18.4	16.1
1976-82	96.5	127.4	121.2

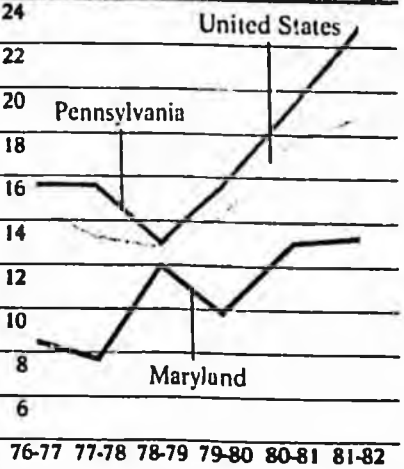


[1]*Adjusted Patient Days include a factor for outpatient utilization.*
Source: *American Hospital Association*

Table II

Gross Inpatient Revenue/Admission

	% Change	% Change	% Change
1976-77	8.6	15.7	14.7
1977-78	8.0	15.7	13.1
1978-79	12.0	13.0	13.0
1979-80	9.9	15.8	14.0
1980-81	13.1	19.2	17.9
1981-82	13.5	22.5	18.4
1976-82	85.5	155.8	133.5



Source: *American Hospital Association*

"We feel that DRG holds the greatest potential of any system yet on the scene to contain costs. There still are refinements to be made in the system. But basically it's working—dollars are following intensity of illness, costs are being held down, and we are all managing as we never had to manage before—seeking innovative ways to cut costs and to provide services in a less expensive manner without impairing quality of care," she said.

The New York and Massachusetts Programs

Ray Sweeney, director of the Office of Health Systems Management in New York, explained that while it is too early to have concrete financial information on the state's fair payment system, "the general consensus is that the . . . system has had a positive impact on facilities.

"Even some of the largest detractors of the . . . system prior to its implementation now seem to be pointing to its virtues—stability and predictability over a three-year period.

"While facilities with significant financial troubles remain, the number has been reduced, and all facilities have benefitted from the existence of funding pools to offset the cost of bad debts and charity care," he said.

Preliminary figures in Massachusetts show that the all-payer system has slowed the inflation of costs from 15 percent in fiscal 1982 to 8.8 percent in fiscal 1983, according to the Massachusetts Hospital Association.

Other Study Findings

The Administration's *Private Sector Survey on Cost Control*, conducted by business leaders to review government operations and recommend cost saving measures, shows that states with some form of prospective reimbursement for all payers between 1976 and 1980 experienced a significantly lower rate of increase in hospital costs than states without such systems. Its task force report further recommends that states implement prospective payment systems for all payers, private as well as government.

A study undertaken by Abt Associates also furnishes data showing that all-payer prospective payment systems can be effective in controlling the rate of increase of hospital costs for all patients.

In states where such programs have been implemented, the report points out, rates of increase in hospital expenses per admission have been reduced by 2 to 6 percent each year. In response to fears that prospective reimbursement will lead to large operating deficits for hospitals, the report notes that evidence "indicates that such fears are unfounded."

Finally, it should be noted that while states with fair payment systems have slowed the rate of hospital cost escalation, there is no evidence that either quality of care or patients' access to appropriate services has declined.

Individual State Systems

No single fair payment model best suits every community's needs. While DRG-based programs may be suitable for some states, different systems may work better for others. Therefore, each state should adopt a fair payment system tailored to its own requirements. A single federally controlled all-payer system simply is not in the best interest of the health care system and its patients.

Based on the experience of states that already have fair payment systems, and on research and consultation with experts in the field, the following elements should be incorporated into any state program:

1. A state system of review of hospital prices and revenues that is prospective in nature;
2. Equitable (fair) payment for *all* payers, regardless of the third party payer (private or government) involved;
3. Incentives for efficient management and penalties for inefficient management;
4. Reasonable standards of review that are based on uniform information and include prices and patient volume;
5. Management by a body that is objective and accountable to the public, and implementation and enforcement of the system by an expert professional staff;
6. Assurance that hospitals are financed to the extent that the public has ready access to quality health care; and
7. A coordinated cost containment program ensured by an approval process that has a formal connection with the planning and certificate-of-need process.

A Federal System?

Certainly, state systems are preferable, because they can be uniquely suited to the needs of each state. However, the HIAA would support federal legislation that encourages the development of state fair payment systems. To this end, the association advocates legislation that provides a residual federal system of prospective pricing for all payers in states that do not adopt their own systems within four years of the effective date of the measure.

Groundwork in Place

Enactment of the Medicare prospective payment legislation has paved the way for fair payment systems at the state level. The hospital management incentives created by this legislation are effective only if applied to all patients.

Fair payment is *not* a panacea — there is no single solution to the health care inflation problem. But it constitutes a major step in the right direction. Through fair payment systems, positive results can be achieved in bringing the nation's health care costs under control.

**Payments actually received by hospitals after deductions for contractual allowances, bad debts, charity care and other free care rendered by hospitals.*

***Billed charges before any deductions.*

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CURRENT DEVELOPMENTS IN PROSPECTIVE REIMBURSEMENT SYSTEMS FOR FINANCING HOSPITAL CARE

AN INFORMATION PAPER

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CURRENT DEVELOPMENTS IN PROSPECTIVE REIMBURSEMENT SYSTEMS FOR FINANCING HOSPITAL CARE [1]

EXECUTIVE SUMMARY

State ratesetting programs have, at least in some cases, been effective in reducing the rate of growth in hospital expenditures. For example, the national growth in average annual per capita hospital costs between 1976 and 1980 was 13.8 percent per year. In contrast, seven States with mandatory ratesetting programs had an average annual per capita increase of 10.5 percent—a 25-percent reduction in the rate of increase.

These States and their annual average rates of increase in per capita hospital costs between 1976 and 1980 include: Connecticut, 11.2 percent; Maryland, 13.2 percent; Massachusetts, 11.4 percent; New Jersey, 11.8 percent; New York, 9.1 percent; Washington, 10.9 percent; Wisconsin, 12.5 percent.[2]

A majority of States now have prospective payment systems for at least one payer in operation. Using such devices as revenue caps, rate and budget review, DRG's, price competition, and primary care networks, State governments are actively seeking reasonable and affordable prices for hospital care.

The trend toward prospective payment systems includes a variety of new and creative State and local programs developed, and in some cases implemented over the last year. Leading examples of these innovative approaches to hospital cost containment include:

—*Arizona.* Under the Arizona health care cost-containment system—AHCCCS (pronounced "ACCESS")—the State and participating private employers use a broker to contract with case managers to provide care on a prepaid, per capita basis.

—*California.* The State negotiates with each hospital willing to treat medicaid patients and then signs contracts with those hospitals that meet Medi-Cal requirements for care at the lowest price. Also, private third-party payers are authorized to contract with "preferred providers"—hospitals and physicians—at a discounted rate and to offer policyholders significant reductions in premiums if the insured choose to receive all care through contracted providers.

—*Massachusetts.* In legislation enacted in 1983, a revenue "cap" is placed on each hospital that limits the amount of revenue to be paid to the hospital over a fiscal year. In addition, the al-

[1] Prepared by Donald L. Zimmerman, Ph. D., for the Intergovernmental Health Policy Project, George Washington University, Richard E. Merritt, director. This paper significantly revises, updates, and enlarges a June 22, 1982 report prepared by the staff of the Subcommittee on Health, Senate Finance Committee (with assistance of Janet Pennie Lundy and Glenn Markus of the Congressional Research Service), entitled, "Prospective Reimbursement of Hospitals."

[2] These estimates of program effectiveness are calculations made by ICF, Inc., from census data made available in June 1982.

lowable projected increase in hospital revenues will be reduced by 7.5 percent over the next 6 years.

—*New York.* In 1983, the State enacted a total revenue cap on each hospital and created common "pools" of third-party funds to reimburse hospitals that are financially strained by patient bad debt and charity care.

In light of the increasing commitment of State governments to new cost-containment strategies, several questions are raised:

—Do these programs maintain an appropriate balance between reduced costs and quality of care?

—Are successful State programs transferable to other States?

—Are these programs appropriate models for a national "all-payer" system?

—What is the impact of hospital ratesetting programs on physicians and other providers?

—What is the fiscal impact of hospital ratesetting or other segments of the health economy?

These questions are not easily answered. But because of immediate fiscal pressures, an increasing number of States are operating and developing payment systems that seek to establish a fixed purchase price for hospital services. This paper presents a framework for understanding the many different State prospective systems now in operation. In addition, a number of key State systems are described and recent innovations are reviewed.

A. INTRODUCTION

Since the mid-1960's, hospital cost increases have consistently outpaced the Consumer Price Index (CPI), rising at an average annual rate of 13 percent. From 1965 to 1981, expenditures for hospital care grew by roughly 750 percent (from $14 to $118 billion). In 1965, the average cost of a day of hospital care was $41; by 1981, that cost had reached $229. During 1982, when the rate of inflation was only 5 percent, hospital costs grew more than twice that fast.

In response to dramatic cost increases, many policymakers have proposed a variety of cost-containment strategies. Such initiatives have traditionally targeted reductions in eligibility, restriction of services, increased copayments and deductibles, and peer utilization review. Although these efforts to control costs have had some short-term success, their cumulative impact has created only minor deviations in the overall rate of increase for hospital costs.

While there are a number of factors that contribute to the upward spiral of hospital costs, the primary mechanism driving hospital expenditures is the *cost-based retrospective reimbursement methodology* used historically by the public and private sectors to pay for hospital services. Recognizing the inherently inflationary nature of retrospective reimbursement, many programs have been adopted to alter the basic method for paying for hospital care by replacing it with alternative *prospective reimbursement systems.*

Generically, prospective reimbursement systems move the focus of pricing power from individual hospitals to an external authority that establishes fixed-dollar limits for payments to hospitals. These dollar limits are established prior to the time period in which the care is actually provided, forcing hospitals to contain costs within the fiscal constraints of the set price.

The introduction of fixed prospective payment rates severs the direct link which exists in retrospective reimbursement between the cost of services provided to patients by a hospital and the amount paid to the hospital by third-party payers. Under a fixed-rate program, if a hospital's costs exceed the established payment rates, the hospital will face a real dollar loss. The possibility of noncompensated care thus creates an incentive for hospitals to be more cost conscious and efficient.

A primary example of a prospective payment strategy is the recent Federal decision to introduce fixed dollar rates for different types of diagnostic related groups (DRG's) in the medicare program. But the price constraint imposed on medicare costs will not, alone, resolve the overall problem of hospital cost increases.

With only medicare reimbursement under a fixed-price prospective system, hospitals may shift the medicare revenue costs that exceed their other payers. This possibility is significantly reduced in many States by new and important approaches to the full containment of hospital costs.

B. OVERVIEW OF PROSPECTIVE REIMBURSEMENT SYSTEMS

1. Background

The factors impelling the creation of prospective payment programs have varied almost as much as the systems themselves. Some programs were the result of unbridled increases in medicaid budgets and dwindling State revenues; others were influenced by alarming increases in health insurance premiums and hikes in employer contributions for employee benefits; in still others, the growing tide of cost shifting among third-party payers was important; and, in a few, the threat of Blue Cross insolvency was paramount. Cutting across these forces, however, were some significant modifications in Federal policy which fostered experiments and demonstrations with prospective reimbursement.

As early as 1967, Congress authorized payment experiments to search for strategies to contain hospital costs; however, very few alternative experiments evolved. In 1972, Congress expanded HEW's authority to experiment with prospective and other alternative reimbursement systems for medicare and medicaid. Under this authority, HEW provided development and demonstration funds to test the efficiency and effectiveness of a number of alternatives. In 1974 and 1978, HEW supported evaluations of several such systems. Moreover, in 1974, as part of the National Health Planning Act, Congress reaffirmed its interest in prospective reimbursement and funded six State hospital ratesetting demonstration programs.

Hence, by the end of 1976, about 20 prospective reimbursement systems were underway, most of which were initiated and administered by Blue Cross plans or hospital associations. Eleven programs, however, were the result of State legislation. In 3 of the 11 State-legislated programs, commissions were created to perform the ratesetting function; in the remaining States, the authority rested with a public agency, usually the health department.

The Omnibus Budget Reconciliation Act of 1981 (section 2173) encouraged State development of prospective payment systems. This key section allows States to replace medicaid reimbursement systems based on retrospective cost-based medicare principles with systems that set rates adequate to meet the cost of "efficiently and economically operated facilities."

By the summer of 1983, prospective ratesetting programs were in operation in 26 States—all aimed at establishing a reasonable price for quality hospital care.

Current State efforts to control hospital costs through prospectively determined rates and payments comprise a mosaic of strategies and program designs.

2. The Basic Framework of State Programs

(A) TYPE OF ADMINISTRATIVE BODY RESPONSIBLE FOR THE PROGRAM

There is considerable variation in the definition of the "external authority" responsible for operating the prospective ratesetting program. Key variations include: (1) How the authority is established—it might be created by specific legislative action, independent activities of private insurers, local decisionmaking bodies, or coalitions of business, labor, and consumer groups; (2) how the authority is organized—it may take the form of a temporary or permanent commission, government agency, community board, or in one particular case, a legislatively mandated office of health care negotiations led by a "czar"; and (3) how the authority is staffed—it may include volunteer representatives of all involved parties, a full-time professional staff recruited from the private sector, or a reorganized component of a standing State administrative unit.

(B) TYPES OF RISKS AND INCENTIVES INTRODUCED

A fundamental goal of a prospective reimbursement system is to compel hospitals to bear a greater degree of financial risk than that encountered when paid on a retrospective cost or charge basis. The basic "risk" created by prospective payment systems forces hospitals to provide care at a previously agreed-upon price. The hospital is "at-risk" for all costs exceeding the established price. This type of risk creates the incentive for hospital managers concerned with the fiscal solvency of their hospitals to implement new "cost conscious" medical and administrative practices that insure adequate payment for the services rendered to the patient.

In addition to such negative incentives, many prospective payment programs use positive incentives to encourage cost containment. One of the most basic incentives permits institutions to retain, as profit, some or all of any dollar difference between incurred costs that are less than the prospective payment amounts. Such an incentive may not always contribute successfully to cost containment in systems that base future payment determinations on the present cost experience. It is quite possible that hospitals may be encouraged to keep their expenses as close to the prospective rate as possible in order to preserve a high base from which any calculations are made.

(C) MANDATORY VERSUS VOLUNTARY HOSPITAL PARTICIPATION

Some studies of prospective payment systems suggest that mandatory participation by hospitals is an essential ingredient of an effective system. Mandatory programs are those with legal authority to require hospitals' participation and to force hospitals to comply with program rulings. Prospective systems may be made mandatory by statute for all third-party purchasers of care to create an all-payers system. Alternatively, the mandatory nature of the program may extend only to services reimbursed by specific governmental programs of private third-party purchasers. Voluntary programs are those in which either hospital participation or compliance, or both, is left to the discretion of the institutions. Both man

datory and voluntary programs may apply to one, multiple, or all payers.

(D) STRINGENCY OF THE PAYMENT RATES

A stringent rate is one that requires hospital management to exercise considerable skill and operating efficiency to provide services at the established price. Since hospitals that fail to keep costs under their price are likely to face financial difficulties, rates set too low can raise special problems.

Cost shifting to other third-party payers is a potential consequence when fewer than all third-party payers are involved. In situations where only one third-party payer has established a fixed-rate payment program, hospitals may find it advantageous to shift costs in excess of the fixed amount to other payers. Because of different financial requirements of different types of hospitals (i.e., profit, teaching, community, public), the potential for shifting of costs is greatest in hospitals with significant revenues from a variety of third-party payers. In contrast, financially marginal hospitals and hospitals that serve a high proportion of publicly financed beneficiaries and uninsured patients may require special allowances if they are to continue providing care.

(E) EQUITY OF THE SYSTEM

A key characteristic of different prospective payment systems is the method used to equitably balance the total aggregate dollar amount to be paid to hospitals over the next fiscal term with the particular financial strains a given hospital may experience as a result of the impact of cost-related factors out of the hospital's direct control. For example, specific hospitals may be faced with an unexpected and dramatic increase in the rate and incidence of a specific type of illness through an epidemic. Or a financially distressed urban hospital serving a disproportionate number of publicly supported patients may require special assistance to insure adequate beneficiary access. A regional teaching facility may require additional supplementary funds to continue providing medical education.

Methods for determining the legitimate criteria for differentiating the amount to be paid to different hospitals in a fair and equitable fashion are quite varied. Examples include: (a) Setting different rates for different groups of hospitals sharing similar characteristics; (b) authorizing additional payments to a hospital providing care to patients requiring extraordinary and unusually expensive care; and (c) creating a dollar pool above the prospective rate that can be used to pay for special costs incurred by a given hospital because of "special circumstances."

3. Prospective Payment Mechanisms

At the heart of each alternative prospective payment system is the mechanism for determining the actual dollars to be spent for hospital services. At a minimum, attention must be given to the following components: (a) Determination of the unit of payment; (b) scope of revenue subject to the perspective system; (c) establishing the rate; and (d) reviewing and modifying established rule.

(A) DETERMINATION OF THE UNIT OF PAYMENT

Prospective payments are made on the basis of hospital cost performance as measured by specific units of payment, which may include the total hospital budget, separate department budgets, direct medical and indirect administrative costs, actuarially defined costs per subpopulation, type of diagnosis, length of stay, average per diem costs, and units of service produced. Different units of payment can produce different kinds of hospital responses in order to keep costs below the prospective payment rates. For example, prospective systems that control a hospital's total revenues, rather than establish per diem or per case payment rates, create less incentive for the hospital to try to circumvent the cost-control system by increasing admissions or lengths of stay. Payment units based on per case, per diem, or specific services are all open to circumvention by increases in volume. In addition, if such units are used, extensive utilization controls may be necessary in order to insure that only the needed quantity of care is provided. The use of total revenue caps or capitated reimbursement strategies may motivate hospitals to reduce the quantity (admissions and patient days) and the unit costs of services (through changes in case mix or reductions in scope of service).

(B) SCOPE OF REVENUE SUBJECT TO THE PROSPECTIVE SYSTEM

Much of the discussion about prospective payment systems focuses on the scope of the revenues subject to the incentives contained in such systems. As a general rule, all-payer systems that prospectively determine all hospital revenue will have a more significant impact on hospital expenditures than single or partial payer programs, because the greater proportion of hospital revenues controlled, the more the cost-containment potential of the prospective system is increased. A common fear expressed about such unilateral payment systems is that a centralized regulatory environment may be created that may not recognize the legitimate fiscal needs of hospitals for meeting future contingencies such as the purchase price of new technology, increased demands by physicians, and requests to create new community "outreach" programs.

(C) ESTABLISHING THE RATE

One of the basic components of a prospective reimbursement program is the method used for establishing the actual rate to be paid for hospital care.

Although there are a variety of practical methods currently used, four general methods can be identified. *Direct negotiation* typically involves direct contact between the ratesetting organization and either individual hospitals or their collective representatives. In general, hospitals present their financial requirements and ratesetters challenge these needs on the basis of designated target rates. Bargaining over payment amounts often provides the opportunity

for the ratesetters to consider the circumstances and requirements of individual facilities.

The negotiation approach can require extensive administrative effort when applied to large numbers of institutions or to widely diverse hospital facilities. The relative skills of the respective ratesetters, rather than clear objective factors, can also play a major role in determining the actual prices paid.

The *bidding approach* involves the solicitation of bids from hospitals prior to the payment period. The purchasers of services select the lowest bid or establish criteria for evaluating the submitted bids. Although the bidding approach reflects market-based assumptions, since price competition among hospitals may be weak in a given market, securing meaningful cost-containing bids in this manner may be impractical. This is particularly true if hospitals are unwilling to participate or compete with each other by offering different price and service packages.

Under the *budget review and approval* approach, the rate-determining authority or agency periodically examines the budgets and schedules of individual hospitals and establishes rates according to guidelines prescribed by the authority. The frequency and extent of the review determines the influence this approach may have on hospital costs. The success of the budget review approach typically depends on the extent of good data, technical resources, and the expertise of the budget reviewers in evaluating hospital costs, operations, and accounting procedures.

Setting rates through the *application of a formula* is an approach that varies widely from simple techniques to quite sophisticated methods. One common application of this approach is the calculation of appropriate payment levels for a given hospital based on a projection of the historically averaged costs of care for patients likely to be served by that institution. For example, by determining the "average cost per patient" for the prior year and trending it forward to the coming year with adjustments for such variables as case mix, potential demand, changes in actuarially defined population characteristics, and inflation, estimates of expected costs can be developed. The DRG methodology in the medicare program uses a formula that fixes future prices for different types of medical diagnoses based on an adjusted estimate of the expected costs for each separate diagnostic group.

Another way of using a formula for determining prices is to place each individual hospital into a "peer group" of similar facilities based on a set of key differentiating variables. In this approach, each hospital in a given group is assumed to share common fiscal requirements with all other hospitals in the same group. After calculating an aggregate measure of costs for each group for the prior year and adjusting it to reflect probable changes, the same prospective rate is applied to each hospital in each separate group.

These four approaches to setting prospective rates are not mutually exclusive. Many of the programs currently in place combine elements from each of the methods. For example, formulae are often found with budget review and approval approaches that set overall financial ceilings, and direct negotiation is often a part of the bidding approach.

(D) REVIEWING AND MODIFYING THE ESTABLISHED RATE

Several different techniques are used to review and modify prospective hospital payment rates. Some involve an examination of the internal cost history and past trends within a single hospital. Others involve comparative examinations of groups of similarly situated hospitals. Such reviews may be based on an examination of the use of cost screens or statistical analyses, the examination of specific operating procedures, financial data, or the simultaneous review of budget and cost reports.

Other guidelines are used to evaluate proposed increases or to modify previously established rates, such as imposition of legislatively determined ceilings or variable rates of increase based on external economic factors (e.g., consumer or market-basket indices) and internal factors (e.g., case mix, bed size, etc.).

Although not exhaustive, this brief framework for describing prospective payment systems highlights a number of variables that should be considered in the evaluation of current State initiatives to contain hospital costs.

C. DESCRIPTION OF SELECTED STATE PROSPECTIVE REIMBURSEMENT SYSTEMS

The following brief descriptions of State initiatives to control hospital costs through prospective payment systems provide a basic orientation to the variety of cost-containment options currently being explored by State governments as well as private insurers. Recently enacted programs are described in detail. The existing programs selected for description demonstrate the diversity of program alternatives and State activities.

1. Arizona

Arizona has recently established a unique and potentially dramatic approach to publicly financed health care. Starting in 1981, the Arizona health care cost containment system (AHCCCS) has combined several innovative concepts with a prospective payment system including:

Price competition. Competition is encouraged through the requirement that providers compete for contracts to serve AHCCCS patients in a statewide bidding process. Each provider winning a contract must then compete for patients in each local area with more than one contractor.

Case management. As a means to control utilization, each contracting provider is placed at financial risk for providing and/or authorizing access to all other services required or desired by an enrolled member.

Expanded purchasing power of Government. AHCCCS, in distinction to other State medicaid programs, covers State and county government employees, employees without subsidy, in addition to the low-income population. Thus, the Arizona program has attempted to enlarge the purchasing power of government beyond the scope defined by Federal health programs to include significant subpopulations traditionally served by private sector third-party payers.

Driving the entire program is a prospective payment system that pays contractors a fixed monthly capitated dollar amount for each AHCCCS member served by a given case manager. These dollars must pay for all services, including hospitalization, lab work, and drugs. If funds are left over, the contracting provider can realize a profit; however, if costs exceed this amount, the contractor suffers a loss. To prevent providers from minimizing care in the hope of generating inappropriate levels of profit, there is a quality control system that includes medical interviews, site visits, audits, and a grievance procedure.

In addition to the risk incurred by individual providers, the State also assumes risk by entering into a prospective payment arrangement with the Federal Government. Under this arrangement, the

amount of Federal matching funds for Arizona's medicaid program is set at 95 percent of the funds that would be paid to the State *if* it had a more traditional medicaid program.

2. California

One of the more unique methods for containing hospital costs was enacted into law in California through AB 799, SB 2012, and AB 3480, as the Medi-Cal reform legislation of 1982. In this legislation, California lawmakers took the following steps to introduce market-based reforms into the purchase and delivery systems of health care services:

First. Authorized the creation, effective July 1, 1982, of a 1-year position in the office of the Governor of a special hospital negotiator to act as a prudent purchaser of all inpatient hospital services for the Medi-Cal population by contracting with the most price-competitive facilities. On July 1, 1983, the functions, powers, and duties of the special hospital negotiator (the office of special health care negotiations) were transferred to a newly created California Medical Assistance Commission with the executive director serving as chief negotiator.

Second. Authorized the Department of Health Services (beginning July 1, 1983) to enter into selective contracts with noninstitutional providers for services to the Medi-Cal population. (Potentially, contracts with noninstitutional providers could be negotiated through the Medical Assistance Commission or with the Department of Health Services.)

Third. Authorized private insurance companies and nonprofit hospital plans (i.e., Blue Cross) to contract with preferred providers and to create a set of economic incentives for consumers to restrict their choice of providers to those under contract. This authority became effective January 1, 1983, for hospitals, and July 1, 1983, for physicians.

These three reforms are intended to create two major changes in the marketplace for medical services in coming years. The first and most basic reform is the authorization of contracting for Medi-Cal hospital services. This mechanism is intended to create a new administrative role of the *prudent purchaser* that combines complete and full knowledge of both the sellers' and consumers' needs into a single decisionmaking process (i.e., the special hospital negotiator and the Medical Assistance Commission). The informed purchasing of hospital services for the Medi-Cal population is restrained by available dollars allocated by the State legislature and by State and Federal law specifying the minimum set of services to be purchased. Thus, the prudent purchaser is responsible for buying the most price-competitive services available in the medical marketplace for meeting the legislatively defined needs of the Medi-Cal consumer. As a result, it is assumed that provider knowledge of the State's fiscal constraints and buying needs will induce price competition among providers wishing to sell their services to the State. Each hospital under contract will be prospectively limited to a fixed per diem rate.

The second important reform is the authorization of private health insurance companies to contract with preferred providers

and to direct their policyholders to these providers for medical care. This reform is intended to have two direct consequences. First, it is intended to inhibit cost shifting to private payers that could result from the selective contracting of Medi-Cal services. (For example, it was estimated that the negotiated purchasing of Medi-Cal services could, without suitable offsetting *legislation*, create a shift of more than $800 million to other third-party payers.) Second, because private insurance companies can deliver a captive population of policyholders, it is assumed that providers will compete for access to medical business by offering a discount in current market prices to major third-party purchasers. It is expected that private insurance companies will pass the reductions in provider costs along to consumers by way of reduced premiums. In so doing, the costs of private insurance should decrease as companies compete for new customers by offering more cost-attractive plans.

Taken together, the California system is intended to change the medical marketplace from one where providers determine both the cost of services and the population served, to one where the State and private insurers define both the available dollars for health care and also the providers who may receive these dollars.

3. Connecticut

Long in the ratesetting business, the Connecticut Commission on Hospitals and Health Care annually reviews and approves hospital capital expenditures budgets. Participation and compliance by all nongovernment hospitals in budget and rate review is mandatory. The program covers charge-based payers directly, and other payers indirectly, through total budget controls.

Previously, the commission would review each hospital's proposed budget for inpatient revenues based on an overall test of reasonableness. Hospitals failing this test were subjected to detailed regulatory review and modification. However, recent legislation has modified this approach by replacing the test for reasonableness by a less stringent "superscreen." The superscreen is based on the Health Care Financing Administration's estimated inflation rate for Connecticut hospitals, plus 2 percent to account for increases in volume and service intensity. If a hospital's proposed budget is less than the superscreen allowance, it is excluded from further review. If the budget exceeds the screen, the review continues as in previous years.

By moving to a system where detailed budget review is used only for hospitals exceeding higher fiscal screens, the recent modifications in Connecticut are likely to decrease the effectiveness of its cost-containment program.

4. Maryland

One of the first States to establish a prospective hospital payment system, the Maryland Health Services Cost Review Commission sets and reviews rates for all non-Federal acute short-term general hospitals and all nongovernment long-term and specialty

from the implementation of the Federal DRG methodology for the medicare program.

In this program, detailed budget reviews of each hospital are initially used to establish a set of rates. In subsequent years, automatic adjustments for inflation, volume, case mix, and certain pass-through costs are applied. A hospital may, however, request a detailed budget review instead, which uses comparisons of costs across similar hospitals. In addition, the guaranteed inpatient revenue system (GIR) is used for all hospitals in excess of 400 beds and any other hospital wishing to participate. The GIR system applies DRG-determined payment rates to each case serviced by a given hospital. The hospital is at risk for any saving or loss realized under the system.

5. Massachusetts

The recently enacted "chapter 372" system places prospectively determined *caps* on hospital revenue from all payers. These caps place a strict limitation on the total amount of dollars to be paid to hospitals. Hospitals that keep costs below their revenue limit can keep the balance as discretionary profit; if the limit is exceeded, the amount in excess of the cap must be absorbed by the hospital as loss.

In determining the actual dollar limit to be used as the cap, all hospital revenues are to be reduced by a cumulative 7.5 percent over the next 6 years. The cap is calculated for each hospital on the basis of the previous year's State-approved revenue limitation. If volume exceeds the previous year's by more than 4 percent, hospitals will be reimbursed for ancillary services at rates below the marginal costs. Such disincentives to increasing volume are complemented by incentives to reduce volume: Hospitals are allowed a 7-percent decrease of inpatient days without losing any revenues. The formula for calculating revenue limits also recognizes legitimate cost increases due to inflation, changes in service volume, and certain exceptional circumstances. The calculation, however, specifically excludes the fiscal impact of changes in the severity or intensity of services required by patients. The exclusion of the severity and intensity variable is intended to minimize any incentive for a hospital to engage in "preferred selection" of patients requiring cost-effective care over cases requiring more complex and costly services.

6. New Jersey

Under the New Jersey system, a hospital ratesetting commission was established to approve and adjust hospital rates based on diagnosis related groups (DRG's). Participation and compliance by all short-term acute hospitals is mandatory. The program covers all third-party payers, including medicare through a specific waiver.

The case mix system in effect in New Jersey was used as the model for the national DRG medicare methodology. Briefly, it establishes a per case rate of payment specific to approximately 450 diagnostic groups. The dollar rate for each DRG is developed from base year costs derived from medical discharge abstracts, patient

ports. Adjustments to the base DRG payment rate for direct costs are made for local and regional variations in wages, an "economic factor" for inflation, and patient volume. Indirect administrative costs are considered fixed and not subject to variation because of changes in case mix or volume. At the end of the rate year, if the revenues collected are over or under the approved revenue budget, they are included in the next year's rates. In this system, prospective rates are established that reflect the differential costs expected to be treated by each hospital in the coming term.

7. New York

The New York prospective hospital reimbursement methodology (NYPHRM) was implemented in January 1983. In this system, prospective cost-based rates are established for all hospitals as a guaranteed revenue cap. Like Massachusetts, this cap places a limit on total revenues available to a hospital from all payers. The revenue cap is determined on the basis of each hospital's 1981 allowable costs, trended forward for inflation and adjusted for changes in volume, case mix, services added or deleted, and reasonable increases in labor costs.

In addition, each hospital's allowable costs are limited to the average cost experienced by its peer group, plus 5 percent. A 7.5-percent "risk corridor" is available to pay hospitals with costs above the group average. In addition, a 1-percent discretionary fund allowance has added to each hospital's 1983 per diem rate.

One of the most innovative aspects of New York's program is its mechanism for providing an allowance for bad debt and charity care. In this system, each hospital payer is required to add a specified dollar amount to its rate that is added to a regional pool and distributed back to hospitals in need of additional funds. Separate pools are established for public hospitals, voluntary nonprofit, and proprietary facilities. Any shortfall created by the medicare share of bad debt will be made up by other third-party payers.

8. Rhode Island

Under Rhode Island's system, the staffs of Blue Cross, the State budget office, and the Rhode Island Hospital Association negotiate an annual "maxicap" that places a limit in the statewide budget for all hospital care for the upcoming year. Participation and compliance by all non-Federal hospitals is mandatory. The program covers Blue Cross and medicaid (medicare participated from 1975 to 1978).

Once the maxicap is established, hospital budgets are reviewed in detail and negotiated with Blue Cross staff. Adjustments are made to the base for inflation, volume changes, and new and expanded services. After total operating expenses are negotiated, the hospital establishes a schedule of charges which is reviewed by Blue Cross and the State budget office. The schedule of charges is then used to establish separate rates for Blue Cross and medicaid by adjusting for cost and benefit differences.

9. Rochester and Finger Lakes, N.Y.

The Health Care Financing Administration has contracted with the Rochester Area Hospitals' Corporation (RAHC) Project and the Finger Lakes Area Hospitals' Corporation (FLAHC) Project to test whether an areawide budget cap is effective in controlling hospital costs. Participation in the project was initially voluntary for the nine RAHC and the eight FLAHC hospitals. All hospitals must now remain in the system for the duration of the demonstration. The programs in both areas directly control payments from medicare, medicaid, Blue Cross, and all other hospital income.

The RAHC and the FLAHC systems are virtually the same, except that RAHC is a test of an areawide budget in a metropolitan area and FLAHC is in a rural area. Both systems operate by determining an overall limit on the yearly pool of revenues for all of the area hospitals. From this pool of revenues, individual hospitals are guaranteed payments equal to their base year costs, adjusted for inflation, increases in volume, and for approved new projects. In addition, a contingency fund equal to about 2 percent of the hospitals' allowable cost basis is established to make payments to hospitals for volume changes, certificate-of-need projects, case-mix adjustments, and other purposes.

The total payments available to each hospital from the common pool of revenues are used to pay *all* operating costs for the year, including outpatient care. Because each hospital is free to allocate its given revenues in its own fashion, this system offers a variety of options to hospital administrators for targeting dollars in cost-efficient ways.

10. Washington

The Washington State Hospital Commission annually reviews and approves hospital budgets. Participation and compliance by all non-Federal hospitals is mandatory. The program covers all charge-based payers.

The commission reviews in detail various cost centers in each hospital's budget annually. Costs which exceed previously defined dollar limits are either disallowed or justified by the hospital. Budgets are analyzed for significant changes in the area, such as new beds, services, and the reasonableness of volume projections. Further reviews are based on a comparison of individual hospital budgets to the budgets of similar hospitals. After capital costs and financial ratios (revenues to expenses) are reviewed in detail, the commission then negotiates the amount of total revenue to be allowed for a given hospital. The hospital establishes its list of charges from the resulting total dollar figure.

In addition to the State systems described above, three additional States have adopted comprehensive hospital cost-containment legislation during the last year that deserves mention.

11. West Virginia

The enacting legislation for the health care cost review authority empowers the review board to initiate reviews and investigations of hospital rates for specific services and the component factors which

determine such rates, as well as total operating budgets. The specific rate-determination criteria require that: (1) The costs of hospital services are reasonably related to services provided, and the rates are reasonably related to the costs; (2) the rates are equitably established among all purchasers with a hospital; (3) medicaid rates are reasonable and adequate to meet the costs incurred by efficiently and economically operated hospitals; and (4) the rates are equitable in comparison to prevailing rates for similar services in similar hospitals.

As an incentive to efficient hospital management, hospitals will be allowed to retain any saving realized under the prospective rate and be partially liable for any resulting deficits.

Until rates are established, all payment limits have been established by freezing hospital revenues at their February 1, 1983, levels plus a 12-percent annual increase.

12. Wisconsin

Wisconsin's new program, which sets *maximum* rates, will go into effect on January 1, 1985. Meanwhile, the commission is directed by law to review and evaluate each hospital's rate request in light of a variety of standards for decisionmaking, including: (1) Comparisons with prudently administered hospitals of similar size or providing similar services that offer quality health care with sufficient staff; (2) the special circumstances of rural hospitals and teaching hospitals; and (3) findings of utilization review program relating to the applicant hospital. In classifying hospitals for purposes of comparison, the commission is directed to consider volume, intensity, educational programs, and special services provided.

Price competition among both physicians and hospitals has been encouraged in this new legislation by allowing major third-party payers to establish preferred provider organizations PPO's. In addition, the legislation introduces the unique requirement that all major employers (over 250 employees) must offer at least two competing health plans to their employees, one of which to be either a PPO or HMO plan.

13. Maine

Maine's commission will be funded by an assessment of up to .15 percent of each hospital's gross patient service revenues. A uniform system for reporting financial and health care information will be required of all hospitals.

The law provides that the commission shall establish a gross patient service revenue limit for each hospital for each payment year beginning October 1, 1984. The statute also directs the commission to exercise its best efforts to design a program which will qualify for a waiver for medicare participation in the State program.

The commission also has the authority to implement experimental or demonstration projects designed to assess methods of establishing revenue limits or payment methodologies other than those established by the statute. The experimental or demonstration projects may include such alternatives as diagnostic related groups, capitation, preferred provider relationships, and regional hospital corporations.

D. RELATED STRATEGIES

In response to the flexibility granted to States through the Omnibus Budget Reconciliation Act (OBRA), a number of important program initiatives are taking place in the medicaid program that link alternative payment systems with new forms of utilization controls through section 2175 waivers. One of the most significant opportunities granted by this section of OBRA allows States to establish systems of utilization control by limiting beneficiary "freedom of choice" through case management and primary care networks. In this approach, primary care physicians generally take medical and financial control and responsibility for the care of a given number of medicaid beneficiaries served.

Beneficiaries cannot receive any medical services without the direct authorization of the primary care physician responsible for their care. Physicians in the primary care network are expected to limit unnecessary beneficiary utilization by serving a gatekeeping function to such high-cost services as inpatient care and nonemergency use of emergency rooms. Contracting physicians are typically paid a prospective rate, capitated for different subpopulations as defined by such actuarial variables as age, sex, and category of welfare eligibility.

Between October 1, 1981 and May 1, 1983, 53 requests for the "freedom of choice" waiver necessary for the implementation of a case management system were filed with the Department of Health and Human Services. Of these, 29 have been approved, and 8 are pending.

Examples of States developing prospectively paid case management systems include California, Colorado, Michigan, and Tennessee.

1. California

Monterey County has developed a countywide primary care network that includes all Medi-Cal eligibles living in the county. To encourage cost containment, a special budget account is created for each primary care physician. For each beneficiary who has chosen that particular physician, an amount is paid into that budget account each month. The specific amount represents the average per capita expense for a beneficiary, standardized by actuarial variables. The plan further adjusts expectations of expense or allocations to budget accounts in which a severity bias is discernable.

All claims (hospital, specialist, ancillary service expense, prescriptions) are charged against the budget account of the primary physician.

The financial risk associated with the variability of incidence and severity of illness is pooled among all participating physicians' budget accounts.

Physicians with surplus budget accounts can receive, as a bonus, an amount equal to the net surplus remaining in their budget account (after a risk-pool assessment) multiplied by an adjustment for their level of risk. Although this bonus is limited to an amount sufficient to cover the difference in reimbursement between medicaid (Medi-Cal) payments and customary fees in the community for those services, it is intended to encourage physicians' participation.

Any remaining surplus balances within each budget account are carried forward to be used to offset deficits in that budget account in the subsequent year or to be merged with any subsequent surplus in calculating the bonus payment entitlement for that physician's budget account.

Santa Barbara has developed the Santa Barbara County Special Health Care Authority as an independent public agency to assume all responsibility for the Medi-Cal program in the county. With the exception of emergency services, any health care provider wishing to receive payments for services rendered to Medi-Cal beneficiaries can do so only by contracting with the authority. Primary care and specialty physicians may contract with the authority either individually or as formal groups known as service contracting entities (SCE).

A rather complex method has been developed for determining reimbursement for contracting providers. First, the State's payment to the authority will be based on a monthly per capita calculation. Projected expenditures in the Medi-Cal program in Santa Barbara County are converted into rates per beneficiary (which vary by aid category) per month. The State then prepays to the authority a sum each month based on the number of eligible beneficiaries in each Medi-Cal aid category for that month, multiplied by the rate for that particular aid catetory.

Based on this capitation rate, the authority will actuarially allocate amounts to necessary reserves and to specific types of services.

The authority will retain a reserve pool in order to protect against unanticipated losses. In addition, the State limits the risk of providers and the authority to a maximum of $15,000 of expenses per beneficiary per contract year.

Payments to providers can be made in two ways: (1) The authority can retain the aggregate capitation payments for non-case-managed beneficiaries (these are high risk beneficiaries). All contracted providers may render services to this class of beneficiary after receiving authorization from SBHA, and are reimbursed at prevailing Medi-Cal fee-for-service rates; (2) the majority of beneficiaries are case managed by a primary care physician or an SCE. Payments are made to providers by allocating service capitation rates to individual primary care physicians and SCE accounts according to the number of case-managed beneficiaries in each practice.

The authority has also created an account for each primary care physician contracting with the authority to encourage full participation. Each month the authority credits the account with the full capitation amount and pays a portion of it as guaranteed payment. This "up front" compensation is made regardless of whether the beneficiaries in the primary care physician's practice use any services in any particular month

Hospitals in the county will participate in the program by signing contracts with the authority. Based on previous Medi-Cal costs and utilization experience, prospective rates are set as all-inclusive per diem amounts. Each hospital receives monthly advanced payments in the form of a block payment. Block payment amounts are recalculated each month, depending on the previous month's experience. Payments are made to hospitals only for services authorized by the primary care physician and rendered to case-managed beneficiaries and are charged against the appropriate physician and SCE accounts.

2. Colorado

Colorado is currently in the early stages of implementing a primary care physician program PCPP. In addition to creating a primary care network, this program adds an additional incentive to encourage physician participation through the creation of an "incentive pool" to be added to the physician line item in the 1983-84 medicaid budget. These dollars are to be used to increase physician reimbursement under medicaid *prior* to payment of the prospective rate.

3. Michigan

A physician primary sponsor plan has recently been implemented in Wayne County. In this approach, physicians and HMO's are placed under contract to serve both as case manager and primary medical provider for medicaid recipients. Each contracting case manager is placed at risk for the cost of all services directly provided or authorized for each enrolled recipient. Although initial beneficiary response has not been as positive as wished, methods for allowing enrollees more flexibility in selecting a case manager are currently being explored.

4. Tennessee

Tennessee has developed a statewide primary care network through a contract with the Tennessee Association of Primary Health Care Centers (TAPHCC). The TAPHCC has the responsibility for developing a series of subcontracts for the provision of medicaid services to qualified individuals with the 22-member health care centers and private providers.

All community primary health care centers and primary health care physicians are eligible to participate in the PCN. The primary care providers will deliver primary services and authorize all other medical services covered by the plan except for emergency cases.

Participating providers will be at financial risk through the payment of capitated service rates.

E. CONCLUSION

Hospital care is expensive and not easily subjected to cost containment. Decisions to confront the hospital industry with clear strategies to alter its basic financing mechanism is a bold and significant event.

Through the many methods described in this paper, State governments are working toward structural reforms that hold real promise for controlling the grants in hospital expenditures. Such reforms may both reduce the rate of increase of hospital expenditures and also realize real dollar savings. In design and methodology, these programs reflect the wide diversity of options for constraining the ever-increasing costs of health care.

APPENDIX

MEDICAID HOSPITAL REIMBURSEMENT

(As of July, 1983)

STATE	Medicare Principles	Alternative Payment Systems				Expected Changes in 1984
		Medicaid Only			Multiple Payer	
		Prosp. Rate Setting	Rate of increase control	Other		
Alabama		X[1]				
Alaska	X					
Arizona				X[4]		
Arkansas	X			X[5]		
California						
Colorado			X[1]			
Connecticut	X					
Delevare	X					
Florida			X[1]			
Georgia		X[2]				
Hawaii	X					
Idaho			X[3]			
Illinois		X[1]				
Indiana	X					
Iowa		X[1]				
Kansas	X					
Kentucky			X[1]			
Louisiana	X					
Maine	X					X[12]
Maryland					X[6]	
Massachutts					X[4]	
Michigan			X[1]			
Minnesota	X					
Mississippi		X[1]				
Missouri		X[1]				
Montana	X					

STATE	Medicare Principles	Alternative Payment System: Medicaid Only: Prosp. Rate Setting	Medicaid Only: Rate of Increase control	Medicaid Only: Other	Multiple Payer	Expected Changes in 1984
Nebraska		X[1]				
Nevada	X					
New Hampshire	X					
New Jersey					X[8]	
New Mexico	X					
New York					X[9]	
North Carolina		X[1]				
North Dakota	X					
Ohio	X					
Oklahoma		X[1]				
Oregon	X					
Pennsylvania	X					X[11]
Rhode Island					X[10]	
South Carolina	X					
South Dakota	X					
Tennessee	X					
Texas	X					
Utah			X[2]			X[14]
Vermont	X					
Virginia		X[1]				
Washington					X	
West Virginia	X					X[15]
Wisconsin			X[2]			X[16]
Wyoming	X					
District of Columbia	X					
TOTAL	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

FOOTNOTES

1. Per diem
2. Per discharge
3. Per admission
4. Negotiation/Per discharge
5. Negotiation/Per diem
6. Budget/Rate review and approval (all payer system)
7. Budget/Revenue limits (all payer system)
8. Budget/Rate review and Approval/Rate per case (all payer)
9. Prospective cap on revenues (all payer system)
10. Negotiated "Maxi-Cap" -- statewide percentage revenue limit increase
11. Budget/Rate review and approval
12. In 1983 Maine established a Health Care Finance Commission empowered to implement a mandatory, all payer prospective rate setting program. The law authorizes the Commission to seek a waiver for Medicare participation in the system.
13. Pennsylvania is considering implementing a prospective reimbursement system for Medicaid only, based upon diagnosis related groups.
14. Utah is considering adopting a DRG methodology to its alternative payment system for Medicaid.
15. In 1983 West Virginia created a Health Care Cost Review Authority to implement a mandatory, all payer rate setting program by mid-1984. A waiver for Medicare participation has not been granted as yet.
16. In 1983 Wisconsin modified its program by creating a mandatory all payer rate-setting program to be administered by a three member commission. The program is to be fully implemented by January 1, 1985. The law specifically prohibits the commission from using a case-mix methodology, such as DRGs, until January 1, 1987.

Source: Intergovernmental Health Policy Project and Office of Reimbursement Policy, Health Care Financing Administration, DHHS.

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